# Physician Referral Marketing Guide for Hearing Healthcare Providers


## Physician Referral Marketing with emphasis on Disease State Marketing Strategies and Relationship Marketing Strategies

*"Reach More Patients by Reaching More Physicians, More Frequently"®*

Presented by: Bob Tysoe, Founder
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# Physician Marketing

## A Patient Referral Development Program

## Cornerstone Marketing Strategies:

***"Educate to obligate."®***

***"Reach more patients by reaching more physicians, more frequently."®***

*John Bakke, MD MBA*
*Healthcare Consultant*

*"Today, the evaluation and treatment of hearing loss – even mild to moderate hearing loss – is an essential component of primary care and population health management. Better treatment of hearing loss leads to better health outcomes, more efficient care, and higher patient satisfaction. The hearing healthcare specialist has become an essential partner for the primary care provider."*

– John Bakke, MD MBA

# Testimonials from Hearing Healthcare Providers

*"We are a three-clinic audiology company in rural Pennsylvania. We enrolled in Bob Tysoe's 90 Day Physician Marketing Training Program in September 2016, after we hired an FTE "Physician Liaison" that Bob recruited for us, to promote our practice locations. Our initial results were modest, and Bob prepared us for that. See the following results for our progress with new physician referrals to date:*

*Sept. 2016: 16 physician referrals*
*Oct. 2016: 13 physician referrals*
*Nov. 2016: 13 physician referrals*
*Dec. 2016: 15 physician referrals*
*Jan. 2017: 37 physician referrals*

*Jan. 2016: 83 units dispensed*
*Jan. 2017: 140 units dispensed*

*The number of hearing aids dispensed in 2016 grew by 8.5% approximately, so some of the increase can be attributed to that, however we believe that the "internal marketing" and the "external marketing" training that Bob provided, got everyone empowered, supporting our new business objectives, and morale really picked up as the whole team responded and made this work."*

– J.S. Physician Liaison, PA.

*"We had 72 physician referrals in the last 30 days. As far as I know that is the highest we have ever seen. And I am sure it will continue to grow. And one of the physicians to whom we market heavily, his father just came in and bought hearing aids today. This is definitely a program that works! "*

– Elizabeth "R" Au.D., C, KY., 2019

*"Since we started the physician marketing program eleven months ago, I have increased the average number of patients per month from 350 to 500, which includes both the ENT and Audiology side of the practice. I think the main thing is just being positive, and persistent without being pushy. Even if I never get past the receptionist, at least that is one more person in the community who knows who I am."*

– Diane J. "E" Au.D, NC.

*"Thank you Bob. It's actually a lot of fun to watch a physician marketing program actually work – between January 21st and March 13th 2015, I have a total of 25 physician referrals by blocking myself out of the clinic 1 – 2 hours per week. I believe it is absolutely the way audiology should be marketed and it helps to put audiology on the medical team, rather than an outlier that is viewed as a non-essential service."*

– Kim "K" Au.D., MI.

# Table of Contents

## The Benefit of Physician Referrals means Referred Patients are 49% more likely to agree to be treated for their hearing loss.

On the following pages you will discover simple, proven methods for reaching out to physicians and their staff in order to grow your practice.

### Questions About the Program?

If you have questions or concerns while developing your referral program, please contact your Regional Sales Manager, your Physician Marketing Trainer, or Bob Tysoe, Consultant, Hearing Healthcare Marketing Company, Portland, Oregon. robert.tysoe@netzero.net

### Why Physician Referrals Matter

Keeping your Hearing Health Care practice growing and prospering depends on attracting a steady stream of new patients. Since approximately 15 percent of all hearing aid sales in the United States are the result of a physician referral to a hearing healthcare provider, it makes sense that hearing healthcare specialists reach out to the physicians in the medical community.

Successful Audiologists and Hearing Health Care Professionals agree that a proven way to reach more patients is through physician referrals. Here's why:

- Over 73% of patients with hearing loss say they rely on their physician for advice on where to go for hearing health care services.
- 22% of first time hearing aid buyers are referred through a medical channel.
- Patients, especially those over age 40 trust their physicians and are 49% more likely to get audiologic care when referred by a physician or a nurse.
- Medical Assistants and Registered Nurses frequently triage care for the elderly patient, the sudden hearing loss patient, and they must receive the latest research and educational literature so that they can effectively guide their patients to appropriate hearing healthcare.

### Marketing Calls on 50 Physicians per Month

The goal of the Hearing Healthcare Marketing Company Physician Referral Program is to help you have physician's practices referring patients to your clinic each month.

- Actively referring physicians practices can result in up to six referrals per month. If half of these patients test with loss, it is reasonable to assume that one sale for binaural hearing aids will be made each month, resulting in an increase in revenue of $40,000 - $60,000 per year. The average annual revenue generated by an audiology clinic in the U.S. is $400,000. $60,000 per year is equal to 15% of your gross revenue, which is the national average. Many clinics with committed, consistent implementation of a physician marketing program easily exceed $60,000 annually. As your network of referring physicians grows, so will your patient base, because the opportunity is there!
- Your communication with the primary care physicians, nurses and ,medical assistants, diabetes educators, specialist physicians, and the medical community will change substantially, and this will have an early and enjoyable impact on your professional satisfaction, because of your partnership with the physicians in the comprehensive care of their patients that seeks to minimize impairment and maximize function of the hearing impaired person.

# Best Practices in Creating a Marketing Budget

## Primary Care Physicians are the Target Market

With the fast pace of changes in the hearing care marketplace today, and the ever changing consumer, it is imperative that you stay current with your marketing message and choose your media that will provide you with the best opportunity to reach your target audience. Gone are the days of simply placing a direct mail piece or a newspaper ad and being able to predict a result. It is more critical than ever to build and design a budget that encompasses various marketing channels to reach potential patients. The "HHMC Physician Referral Marketing Guide" gives valuable insight into marketing your practice to primary care physicians. This proven practice development strategy provides the most financially rewarding, productive form of marketing that we see year over year in various hearing care benchmark studies. Physician marketing isn't just an option anymore, it is imperative to a practice that seeks a return on investment of resources, that are the result of maintaining an effective marketing plan.

With the ideas and concepts shared in the "HHMC Physician Referral Marketing Guide", the question comes up, well how much should I allocate to this marketing initiative? What are others doing? With the most recent benchmark study results conducted by major hearing aid manufacturers now available, we see that those hearing care providers who are committed to practice growth, and who are consistent in the implementation of their marketing plans, who are diverse in their marketing spend , are the ones seeing sustainable increases in revenue over the long term.

***The following are marketing budgets that have been implemented in the US, within the last 24 months , broken out as follows:***

| Practice Type | % spend of annual gross sales |
|---|---|
| **New Practice** (no repeat patient business) | 18-20% |
| **Young Practice** (Some market awareness) | 15-18% |
| **Mature Practice** (Repeat patients along with new) | 12-15% |
| **Maintain Practice** (Keep stable growth with no decline) | 10-12% |

Now with this outline above, it's time to think about the allocation of your marketing spend. This is where your market conditions, competitive breakout, and history can shape what is best suited for your growth and success. What we have learned from benchmark study results is that it is critical to have a presence in multiple forms of marketing media to stay current with new trends in consumer behavior. Below are the forms of media you need to ensure you are evaluating:

***Modern Marketing Budget Allocations:***

| Media Type | % spend of marketing budget |
|---|---|
| **Traditional** (Direct Mail, Newspaper, TV, Radio) | 35% |
| **Database** (Mailers, Upgrades, Specials, Clean & Checks) | 10% |
| **Digital** (Website, Emails, Adwords, Social Media, Referrals) | 35% |
| **Physician** (Mailers, Luncheons, KAM, Reporting, Telemarketing) | 20% |

Ensuring that you have a plan and strategy in each media type above will help you to meet the evolving changes in consumer behavior and marketing concepts. One trend that is evident in recent benchmark surveys are the allocation of "spends" in both the digital space, as well as in physician marketing. Both will continue to increase earnings for your practices, while traditional marketing becomes less and less effective.

Update your marketing plan and be willing to change to meet the demands of the current market place. Stay committed, and remain consistent in your practice development efforts, because these are the common denominators among high revenue, successful audiology clinics and hearing healthcare practices.

*Ref: Zachary Call, MBA., Sivantos.*

# Developing Your Marketing Plan with the Five "P's"

### Marketing Plans, and "Product, Price, Promotion, Place and Process"

**Find your most promotable competitive edge, and turn it into a powerful marketing message, and deliver it to the right prospects.**
First things first...

Define the problem you want to solve for your customers - physicians and patients need a hearing health care provider who they can respect and trust.

Define the market segment of your customers – primary care physicians, and specialists who have patients in common with hearing health care providers.

Define the message you want to deliver – first define the disease state of hearing loss, then define the patient type, eg diabetic with sensorineural hearing loss, depression, and lack of patient engagement, define the negative consequences of untreated hearing loss, define the benefits of care, finally define **the reasons why** the physician and his/her staff may refer their patients to your practice.

### Each Marketing Plan Needs the Five "P's" Every Time.

What is your "product"? This is you and your services – they are synonymous and inseparable.

What is your "price"? Choose a high quality, mid-level technology, mid-level price that can be used for a majority of the hearing impaired patients.

What is your "promotion"? This means multi-channel marketing that includes direct mail, newspapers, telemarketing, email marketing, in-person relationship marketing, off-site testing, accessibility, flexible payment plans, assistance with processing insurance paperwork, and more.

What is your "place"? Where patients can access your care and your services, at your practice location, nursing homes, physician's offices, retirement villages, the patients residence, health fares, mobile testing units etc.

What is your "process"? This is everything that happens inside your practice. From the first phone call to the last. Warm, friendly, approachable, greetings, coffee and cookies, help with intake forms, comprehensive testing, efficient treatment plans, physician reports, education brochures, billing, caring attitude by every staff member, emotional connections, follow up care, parking spaces, after hours care.

***Each Plan Must Include Implementable Actions that Require the Following:***

- Be "Specific" – know what the problem is, and what must be done to improve.
- Be "Measurable" – this means accountability. We manage what we measure.
- Be "Achievable" – is what you are doing possible to achieve.
- Be "Realistic" – is it realistic? When can this be done, and how often, etc.
- Be "Timebound" – we need to know when we need to complete steps in the marketing program.

# Define Your Market

## Primary Care Physicians are the Target Market

Primary Care Physicians (PCPs) are the primary gatekeepers for the majority of health care that is delivered in the United States.

- There are over 250,000 Primary Care Physicians in the U.S. who generate 17 percent plus of the gross domestic product revenue
- Each primary care physician has approximately 2000 patients in his/her practice
- For every 25 primary care physicians who care for 50,000 patients, approximately 20.1% cannot pass a 25 decibel hearing screening. Of the 10,000 patients who test with loss, approximately 20% have already been treated. This leaves us with approximately 8000 patients who will test with loss, and who have not sought care for their hearing loss disability that interferes with daily communication.
- There are approximately 48 million people over the age of 12 years in the U.S. who will fail a 25 db hearing screening in one or both ears. Ref:NIH and Johns Hopkins research data on file.
- The Primary Care Provider is the person who the patients trust for initial guidance when they experience hearing problems.

## The U.S. Hearing Healthcare marketing dilemma

In countries where socialized medicine is the norm, the primary care physician is obligated to make the diagnosis of hearing loss. The patient is then referred to an ENT physician, and then referred to an audiologist. The patient is tested, and if there is a treatable loss, he/she is referred back to the primary care physician. A prescription for hearing aids is provided to the patient who returns to the audiologist who fits and provides follow up care.

In the United States patients hearing aids are typically not covered by health plans. Employers may be reluctant to provide a hearing aid benefit because of increased premium costs for the employees, and an increased cost to provide those benefits to the employer.

The treatment of hearing loss is considered elective medicine, and patients are frequently left to their own resources to decide if they need care, and who should provide it.

Here lies the opportunity for the U.S. audiology industry to "educate and obligate" the primary care physicians to make the diagnosis and refer the patient to a hearing healthcare specialist who they trust to provide quality care to the patient.

## What Primary Care Physicians Think About Hearing Loss

While Primary Care Providers are the gatekeepers standing between their patients and the hearing healthcare they need; there is much education about hearing loss that needs to be done.

- Many physicians are not aware that hearing loss is at epidemic proportions in the United States, that it is the third most prevalent chronic disease state after hypertension (the most prevalent) and arthritis. Approximately 48 million plus people have hearing loss in one or both ears, and hearing impairment has become an important public health problem that can be addressed.
- Physicians may need to be updated on how the latest hearing aids work. They show great interest in their clinical capabilities when they are presented with the information about how they work, how they benefit the patient, and potentially how they may improve patient's quality of life.
- Primary Care Providers rely on professional relationships where they like, respect, and trust their "top of the mind" specialist of choice. Your goal is to become a trusted partner on the same team as the physician in the care of his/her patients.

### Earning Trust With Physician Customers

Primary Care Physicians may need to be educated about hearing loss and that Audiologists and Hearing Healthcare Providers are members of the medical community who may assist them in a partnership to provide comprehensive care. Patient care is the common ground between the physician and the hearing healthcare provider.

When physicians are emotionally invested in an attitude, a product, or other referral source, respect their decision; attempting to dissuade them may cause resistance, so confidently bring new information to their attention with new benefits so that they can make a new decision about you and your services that may be of value to them and their patients.

### "Test With Loss" Patients are Quality Referrals

A successful physician referral program that will increase your patient base depends on getting high quality referrals from physicians:

- High quality referrals are patients with comorbidities who are most likely to "test with loss".
- These are hearing impaired patients with reduced quality of life issues.
- "Test no loss" patients do not need our help and can be screened out by physicians with HHIE (Hearing Handicap Inventory for the Elderly) or like hearing screening tests.

### Educate Physicians on What to Look For – Describe the Patient Types

The best way to ensure quality referrals is to clearly define for the doctor who will most likely "test for loss". These hearing impaired patients have:

- Difficulty picking out words in the presence of background noise
- Reduced quality of life issues as a result of impaired hearing
- Depression, worry or anxiety, regarding the inability to hear clearly
- Social withdrawal
- Tinnitus, buzzing or ringing sounds in one or both ears
- Reduced income, and loss of employment
- Paranoia and other psychosocial issues
- The existence of concomitant comorbidities such as diabetes, pre-diabetes, obesity, cardiovascular disease, hypertension, cigarette smoke/nicotine addiction, second-hand smoke, ototoxic medications, tinnitus, age over 65 years, noisy home and work environment, cerebrovascular disease related dementia, macrovascular disease and microvascular disease.

When distributing **Physician Referral Folders**, provide pads of pre-printed "Questionnaires/Hearing Screens/Tests" which referring physicians and nurses can use to identify "test with loss" patients who can then be referred on to you. Another option is to provide an inexpensive pure tone screener, usually pre-programmed to test across 500 hz, 1000 hz, 2000 hz, and 4000 hz at 40 db.

### Satisfied Patients, Contented Doctors

By helping physicians identify their patients who will most benefit from coming to a Hearing Healthcare Specialists clinic, you will add to your long list of satisfied patients. And when patients are content, referring physicians are, too.

Patients with poor healthcare literacy and hearing impairment are less able to comply with the physician's verbal instructions. As patient compliance declines so does efficacy, making improvement in the patient's quality of life less certain, thus potentially increasing the cost of care. For example, 80 percent of diabetics do not reach their annual health care goals for blood sugar, hypertension, and cholesterol. All are implicated in the cause of hearing impairment.

Partnering with physicians seeking to practice preventive care requires that hearing healthcare specialists effectively communicate how they can assist them with interventional audiologic strategies that both manage the patients hearing impairment, and prevent unnecessary complications. e.g. providing a hearing evaluation on patients who may be at risk for falls, since research by leading Universities in the United States and Europe has verified that high frequency hearing loss has a robust association with an Increased incidence of falls. Patients with a 25 db hearing loss were nearly three times more likely to have a history of falling. Every additional 10 db of hearing loss increased the chances of falling by 1.4 fold. Ref: F.Lin MD., Johns Hopkins University ENT. 2.27. 2012.

## *Patient Types in Common by Physician Specialty*

Expanding your physician marketing activities can be as simple as expanding your geographic "reach" to primary care doctors without altering the "frequency" of your monthly calls.

It also involves adding other "specialists" to your physician data base, who have "patients in common" with hearing healthcare specialists. The following list is a starting point for you:

1. ***Endocrinologists*** – patient types have Type 1, and Type 2 diabetes, pre-diabetes. This specialist either has a Diabetes Educator on site, or who is employed by a local hospital.
2. ***Geriatricians*** – patient type has age-related hearing loss, hypertension, diabetes, cardiovascular disease, peripheral vascular and micro-vascular diseases and presbycusis.
3. ***Pediatricians*** – patient types may be obese, pre-diabetic, diabetes, hypertension; noise related hearing loss due to ear buds, and may suffer from second-hand smoke exposure. Hearing loss may be genetic; patients may suffer speech impediment.

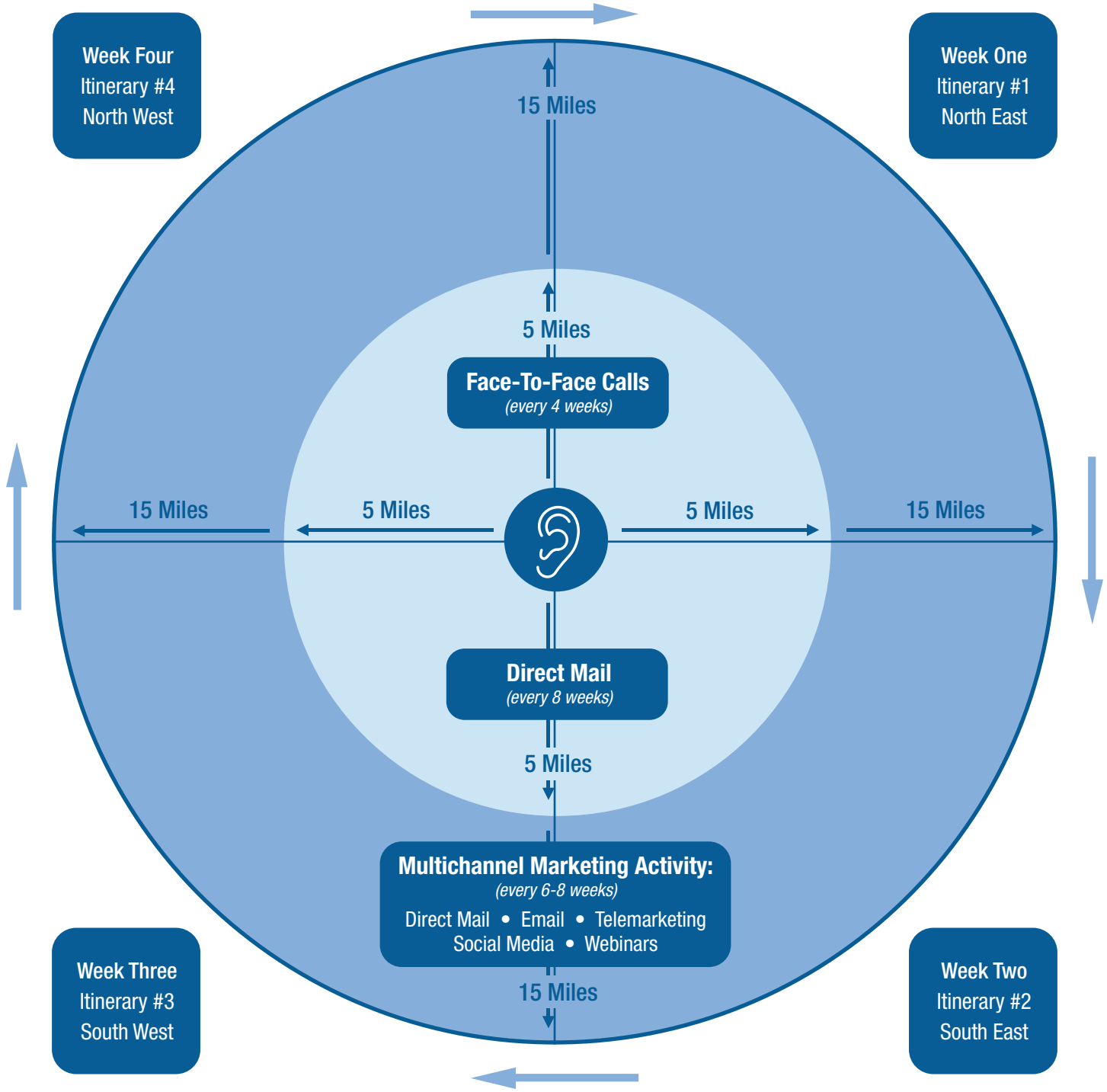
4. ***Cardiologists*** – patient types may be diabetic, pre-diabetic, obese, hyperlipidemia, hypertensive, smokers, previous smokers, passive smokers, ie secondhand smokers, complications of macrovascular and micro-vascular disease including hearing loss and balance disorders. Hearing loss, as well as retinopathy always precedes cardiovascular disease in this patient type. Patients may have atherosclerosis and arterioschelosis. May have multiple medications, including statins.
5. ***Podiatrists*** – patient types are elderly, cardiovascular disease, diabetic, pre-diabetic, with diabetic neuropathy, possible ulcers in the extremities/feet. This usually means microvascular disease caused by hyperglycemia, when blood sugar is too high for too long. They have patients in common with audiology, but audiology needs to be aware that they can refer to hearing healthcare specialists, without waiting for the primary care physician to initiate a referral unless it is a medicare patient.
6. ***Pulmonologist*** – patient types are smokers, ex-smokers, passive smokers, ex-passive smokers, COPD, emphasema, all may have hearing loss caused by smoking that causes tissue ischemia, tissue necrosis, end-organ diseases and ultimately, hearing loss.
7. ***Allergists*** – patient types suffer from allergies related to cigarettes, which causes hearing loss.
8. ***OB/Gyn*** – patient types are smokers, passive smokers, patients who develop gestational diabetes that progresses chronic diabetes, body-mass index patient with high numbers, diabetic and pre-diabetic patients, obese patients.
9. ***Weight loss clinics*** – patient types are diabetic, pre-diabetic, overweight/obese, hyperlipidemia, high cholesterol, hypertensive, cardiovascular disease.
10. ***Dialysis clinics*** – usually staffed by an R.N. and the Medical Director is a Nephrologist who treats kidney diseases, and diabetes causes both kidney disease and hearing loss. Patients are also hypertensive which causes hearing loss, and frequently suffer from hearing loss and retinopathy.
11. ***ENT's*** – have many patient types in common with audiology – do not presume they are aware of all of the major comorbid conditions that are independent risk factors for hearing loss. Establish collaborative relationships with this important specialist, whether he/she has an audiologist/HIS on site or not.
12. ***Optometrists*** – patient types are diabetics who need annual exams to detect retinopathy.
13. ***Oncologists*** – patient types diagnosed with cancer and chemotherapy-induced hearing loss both during therapy, and post cessation of chemotherapy. Protocols for testing and preventing or minimizing hearing loss are established and need to be implemented.

Content Marketing with published clinical research articles is an essential part of your objective to bring educational value to all of the "Specialists" listed here.

## *Time and Territory Management Plan*

**Daily Call Goal is 8-10 Physician Clinics Per Day**

*(i.e. 10 Referral Folders Distributed)*



## *List of Primary Care Physicians*

Itinerary #4

Itinerary #1

Itinerary #3

Itinerary #2

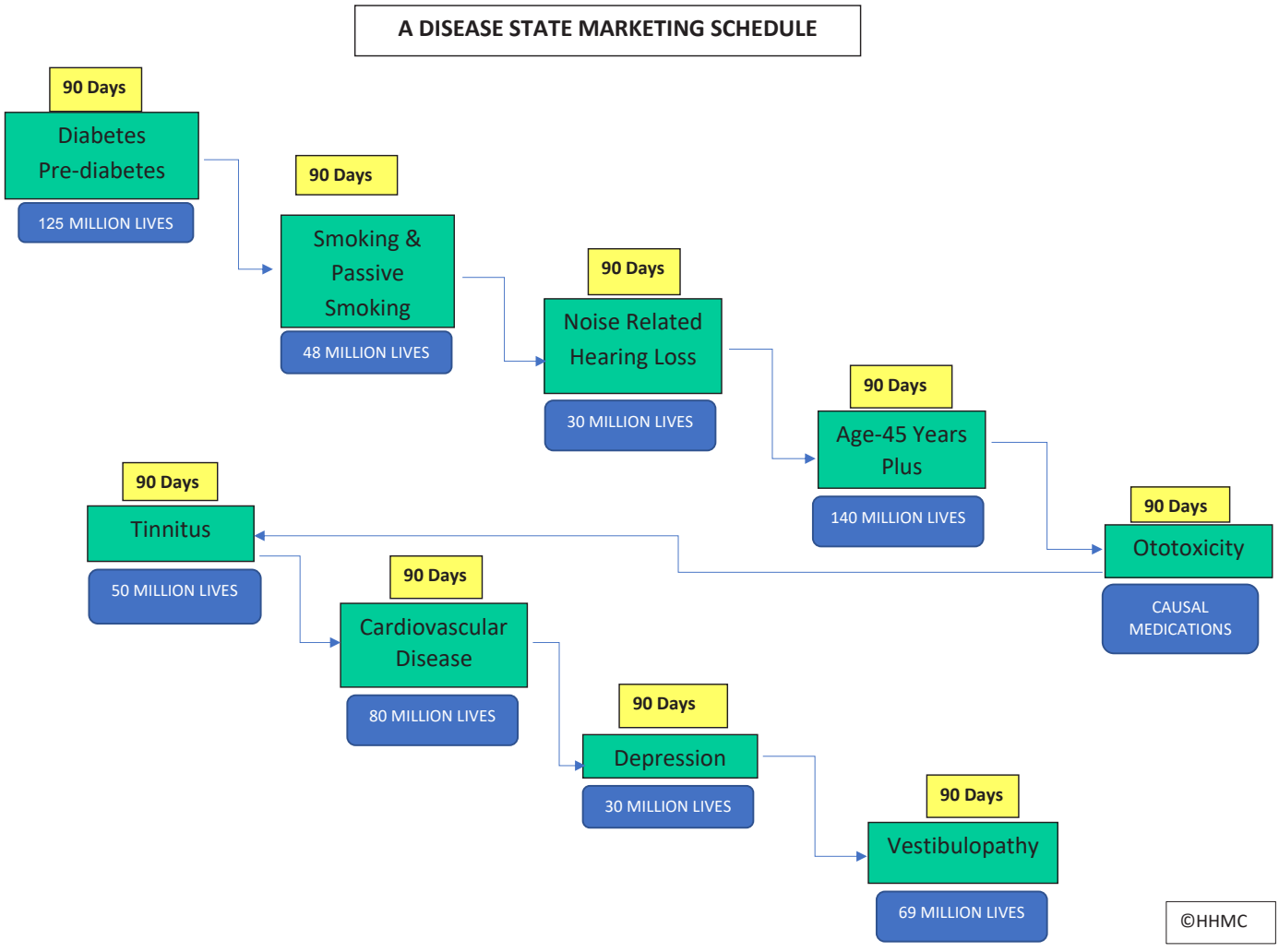
Those clinics that implement physician outreach marketing well, with commitment and consistency, are achieving twenty to thirty percent of their gross revenue from physician referrals.

The treatment of hearing loss is moving higher up the preventive care priority list for physicians, because of recent new research about comorbidities that contribute to the cause of hearing loss; especially new publications about hearing loss which is now recognized as a modifiable risk factor for the development of cognitive decline and dementia, and because of high profile positive publicity from the Congress of the U.S.

Now is the time to expand the market, to expand audiology's services, to take ownership of more patient types, to "seize the high ground", and prepare ourselves for worthwhile roles in audiology and medicine for the next fifty years.

Physicians develop computerized lists of "Specialists" to whom they refer, whenever a patient's care needs dictate. Hearing Healthcare Specialists can develop partnerships in patient care, (ie. Interdisciplinary care) with primary care physicians by utilizing the following examples of "©Educate to Obligate" messaging strategies so that they too are placed on that priority list of "Specialists" whom they trust.

- Appoint or recruit a "Physician Outreach Liaison" who is capable of building relationships for the long term, who is respectful and trustworthy, who keeps promises, who is solution oriented, and achievement focused with patient care as his/her priority.
- Create a target list of physicians. Google the following specialties in the zip codes within a five and ten mile radius of your practice location: family practitioners, nurse practitioners, physicians assistants, doctors of osteopathy, internal medicine



specialists, endocrinologists, concierge physicians, nephrologists, cardiologists, geriatricians, ophthalmologists, and other specialties). Start with 50 plus physicians. Choose your target market by using the following criteria:

- Include those physicians who currently refer to you – they may also need to know which patients have the highest risk because of modifiable lifestyle behaviors that cause, or are associated with coexisting comorbidities.
  - » Choose those physician clinics that are closest to you – proximity counts when it comes to better patient engagement.
  - » Choose those clinics that have multiple physicians on staff – time is a scarce resource for them and for you.
  - » Select those physicians who are in busy clinics that do not refer to you, but who have a high potential to do so if you invest in developing peer-to-peer relationships, with the physician and the staff. All physician's clinic office staff may contribute directly or indirectly to the patient care outcome.
- Create your practice brochure with an updated list of your services, so that you can use it to validate the reasons why the physicians and their staff should refer their patients to you; this allows you to differentiate your practice from the competition. No put downs of the competition, please.
- Compose a hand-addressed, "lumpy letter of introduction", and mail it to your target market of physicians – examples can be obtained from "The Physician Referral Marketing Guide" – Author: Bob Tysoe at HHMC. Include your practice brochure, ear plugs, and extra business cards. You may begin making optional "cold calls" two weeks after the initial mailing, depending on whether you have a designated physician liaison.
- Every four weeks, distribute "Physician Referral Folders" that include clinical research articles about the comorbidities that are major contributors to the pandemic-like numbers of the disease state of hearing loss, to primary care physicians clinics, and specialty physicians so that you promote interdisciplinary care that includes you, that may improve the QOL for the patient with hearing loss.
- Distribute copies of the Nurses/Medical Assistants "Exam Room Guide for Patients Who May Need to See a Hearing Healthcare Specialist". Send four copies, one for the physician, one for the medical assistant, one for the referral coordinator, and extras for the patient exam room walls. (See example on page 33, available from Sycle Marketing Group, Portland OR).
- Mail out the patient education handouts every eight weeks; available from the National Institute of Health – go online to nidcdinfo@nidcd.nih.gov to obtain the "NIDCD Publications Order Form" – you may order these at no-fee, in generous quantities, in both English and Spanish. These help improve patient health literacy about hearing loss, and enhance patient engagement.
- Mail out clinically oriented newsletters every six to eight weeks; your target audience is the physician and his/her staff since everyone contributes to the patient's care outcome. These are customized and available from HHMC at East Side Printing in Portland, OR.
- Contact your local ENT clinic and suggest that you "collaborate not compete" with them. Offer to provide call coverage for them at nights and on weekends; provide care for their patients if their own hearing healthcare provider is sick, has an over-booked schedule, has patients with "hassle factors", goes on vacation, resigns or retires, does not take certain insurances that you may. Respect their patients, while they respect yours – ask to become their "Plan B" provider of choice. It works!
- Since forty percent of physicians are now employed by hospitals, you may access new hearing impaired patients by placing patient education videos about the disease state of hearing loss and the comorbidities that drive the pandemic-like numbers of the hearing impaired, in the "closed practice" waiting rooms. These proven effective videos will provide your contact information, and are readily available from Clear Digital Media in Chicago.
- Send out a patient report to each patient's primary care physician, with their permission. You will now have "patients in common", plus stronger reasons to collaborate in inter-disciplinary patient care on "patient types in common". "Counsel Ear Co"., in Chicago has a convenient software system to accomplish this for you.
- Hand-deliver any patient report when upon assessment you detect "unusual findings" to the primary care physician's offices, and be sure to have the hearing healthcare specialist follow up with a phone call of explanation. This demonstrates your commitment to quality care for your mutual patients.
- Follow the pharmaceutical industry marketing model, and conduct monthly telemarketing campaigns to your database of physicians; meet the referral coordinators, medical assistants, and clinic managers by both phone and email.

- Provide patient-care solutions for them, and earn their referrals. "Clear Digital Media Co." in Chicago can help provide you with newsletters, and a list of email addresses (order the list of email addresses from the American Medical Association) for your target market of physicians.
- Schedule quarterly "lunch and learns" in high priority practices with the receptionist or medical assistant, by phone, and provide an "in-service" on the new hearing aid technology that simultaneously treats tinnitus, (provide a copy of the new treatment guidelines recently published in JAMA) and hearing loss.
- What is in it for the doctor, you may ask? The following article may answer that question for you.

## *Understanding the Physician's Exam Room Priorities Has Benefits for the Patient and for Audiology ©*

*By: Bob Tysoe*

Donna M. Zulman, M.D. wrote in a recently published JAMA article about Francis Peabody's presentation to Harvard Medical School, 90 years ago, about the complex and deeply human experience of illness, that "the secret of the care of the patient is in caring for the patient". This is such a powerful observation, wrote Doctor Zulman, that we must know more.

Those who create marketing programs for the world of audiology, as they seek to enter the world of medicine to access new patients, would do well to internalize those words, and contemplate how they may bring additional solutions that help the physician meet their daily challenges in the comprehensive care of their patients.

Let's address the following physician priorities. "Efficacy, Side Effects, and Cost", with an emphasis on "Efficacy". Whether the physician is deliberating about a new medication, an innovative treatment process, or a proven surgical procedure, "Efficacy", (it works!) always comes first.

How can audiology help? The very definition of "Patient Engagement" provides us with some answers: "Providers and patients working together to improve health. A patient's engagement in healthcare contributes to improved health outcomes, and information technologies can support engagement. Patients want to be engaged in their healthcare decision-making process, and those who are engaged as decision-makers in their care tend to be healthier and have better outcomes". (Ref: Patient Engagement, Health IT Topics, HIMSS 6/13/2016).

Audiology hearing care professionals can ensure that the patient can hear the physician's verbal instructions. We can make sure that we provide testing and treatment for at risk patient populations, (diabetics, smokers, cardiovascular disease patients, those exposed to toxic noise, and the aged patient to name a few) to reduce the unacceptably high incidence of depression in these patients with untreated hearing loss. (Approximately 12 percent, versus 6 percent for those whose hearing loss has been treated). Depression is a significant risk-factor for non-compliance with medical treatment. Compared with non-depressed patients, the odds are 3 times greater that depressed patients will be non-compliant, or not engaged, with medical treatment recommendations.

Audiology can altruistically distribute authoritative research about the various modifiable life-style related behaviors that lead to comorbid conditions that are proven to be independent risk factors for hearing loss, so that physicians may be more effective with their "risk versus benefit" counseling. More patients will get care!

Further, Audiology may provide further benefit for the physician as they seek efficacy, improvement in patient quality of life, and an overall lower cost of care by providing patient education material about the disease state of hearing loss, in both English and Spanish. Poor health literacy causes limitations for patients that are clearly hazardous to health.

By hearing healthcare providers seeking partnerships in patient care with primary care physicians, audiology can help improve communication between physician and patient in the exam room, may alleviate a significant cause of depression which is a barrier to care, and may improve the patients understanding of their diagnosis so that they are "engaged enough to be decision-makers in their care, become healthier, and achieve better outcomes".

When providers, patients, and hearing care specialists work together to improve health we have a compelling mission we can all believe in!

Everyone in the audiology practice has marketing responsibilities. Yes, you may incur additional marketing expenses, however your ROI will more than cover them. The access road to the twenty percent of Americans age 12 years and above, who cannot pass a 25 dB hearing screening in their worse ear, goes through the primary care physician's offices. You need to take that road!

# Know Your Core Message and Deliver it with Commitment and Consistency

### The Importance of Clinical Research Papers

Persuading physicians to refer patients to your office is more effective when you have outcomes based, statistically significant, peer reviewed clinical research to support your recommendations for improving patient care. e.g.: NHANES July 2008 Diabetes and Hearing Impairment in the United States. Bainbridge et al. Annals of Internal Medicine.

### The Importance of Core Messages:

Fortunately, Hearing Healthcare Providers have compelling hearing health care benefits for their patients. Here is an example of a Core Message and the facts you need to back it up. Commit it to memory and share it with Primary Care Physicians every chance you get.

- "Hearing Health Care Providers may rapidly improve patients' quality of life by improving their ability to hear."
- Early intervention, earlier hearing.
- Well worth the drive when it is your hearing we revive.
- We helped another patient hear today, and we are not going to stop now.
- The sooner we treat, the better the outcome.

***Hearing Loss is a Problem for Your Patients***

- Over 30 % of primary care patients age 65 and over suffer from hearing loss.
- One in four workers exposed to high noise levels develops hearing loss.
- Untreated hearing loss affects patients physically and emotionally, negatively impacting mental health, family relationships and social interaction.

***Today's Advanced Hearing Aids Work***

- Advances in technology make today's hearing aids comfortable, secure and effective.
- Nine out of ten hearing aid users report improved quality of life.
- People who wear hearing aids say they are in better health as a result.

***Our Success Rate is Over 90%***

- Hearing Health Care providers successfully improve the symptoms of hearing loss in over 90% of confirmed cases where patients may be treated with hearing aids.
- A comprehensive patient history, family history, diagnostic evaluation, treatment plan that may or may not include hearing aids, plus a long term follow up plan of care contributes to a high quality of care, and improved outcomes.

***More Physicians Refer Their Patients to Audiology***

- More Primary Care Physicians refer their patients to hearing health care providers because of their confidence in partnering with hearing health care professionals and the use of improved hearing aid technology.
- More Primary Care Physicians trust Hearing Health Care providers to make a reliable diagnosis, and provide quality patient treatment.

***Hearing Health Care Professionals are Licensed and Certified and Accountable***

- Hearing Healthcare Clinics are staffed by a trained, licensed hearing health care professional. They carry malpractice insurance just as physicians are obligated to do.
- They provide long-term comprehensive care.
- They are dedicated professionals here to provide the highest quality hearing health care for your patients.

***We Partner With Physicians to Improve Care***

- Our goal is to make referring patients to hearing healthcare clinics both simple and rewarding for the patient and the physician's staff.
- We rapidly provide the patient reports and other clinical information that physicians need within 48 hours or less.
- We are here to make handling the administrative details hassle-free for the doctor's staff and the patient. (e.g., approvals for coverage by insurance plans, payment plans, etc.).
- All patients, especially the elderly, or the computer illiterate patient will receive the utmost assistance with processing insurance paperwork, and ensuring coverage if appropriate.

## *Examples of Core Messages*

### The Next Stage, Access Strategies

Now that you have developed some "core messages" and created a list of the benefits of your patient care services, you must begin to focus on the access strategies that you will use with your target market.

This process is **relationship development** with all physician's clinic staff, establishing brand name recognition, and brand name loyalty. You will utilize effective marketing strategies from the pharmaceutical industry, including "ethical marketing", "relationship marketing", "trust-based marketing", and "loyalty-based marketing" to build bridges to primary care clinics.

### 1. Create a List of Primary Care Physician Prospects

Start by creating a list of Primary Care Physicians who are good prospects for referrals by following these common sense guidelines:

- Current referring physicians
- Physicians who are geographically closest to your clinic
- Busy physician's clinics with a high potential to refer to you
- Multi-staffed primary care physician's offices
- Ask all of your new and current patients for the name of their Primary Care Physician.
- Use medical society directories (national, state, county, local).
- Subscribe to "The Little Blue Book" for a list of physicians in your zip codes
- Review insurance company/managed care provider lists.
- Include as many group practices as possible—offering the potential to get many times the number of referrals than a sole practitioner.
- Check with local hospitals for physicians who are on staff.

Assuming that several of the names you have on your list are group practices, you should have a minimum of 25 primary care physicians to begin your marketing efforts to grow new patient referrals. Continue to update and add to your list as time goes on.

### 2. Put Together Your Promotional Physician Referral Folders

Next, put together a folder of promotional information for each of the primary care physician prospects on your target market list.

The referral folder functions as both a calling card introducing you and your practice's services, and as a source of valuable physician and patient education material concerning hearing loss.

Each referral folder should consist of:

- Complete Clinic Information Brochure with Map
- Providers Bio
- A comprehensive List of Your Clinic Services
- Patient Education Brochures
- **Outcomes based clinical research reprints of your choosing. e.g. NHANES Article on the Link Between Diabetes and Hearing Loss. Journal of the American Medical Association (JAMA) Articles eg F. Lin M.D. Dementia and Hearing Loss. National Council of Aging (NCOA) Article.**
- Written Patient Hearing/Self Evaluation Test
- Patient Referral Forms (Optional)
- Your Business Card
- Free Hearing Screening Coupons
- Newsletters
- Manufacturers Hearing Aid Brochures

You have been supplied with a Physician Referral Folder example, and Educational Brochures as part of this program.

- Additional folders and brochures are available from the sponsoring company
- You will find the JAMA article, NCOA article, NHANES articles online, and from sample Physician Referral Folder packets available from Hearing Healthcare Marketing Company.
- Make as many photocopies as necessary and save the originals for future use.

### 3. Introduce Yourself to Your Prospects

With a good list of prospects and a folder of information in your hand, you are ready to introduce yourself to the primary care providers in your area. There are several ways to make that first contact—and make that first good impression:

***Introductory Letter***

- Send out letters to all of the physicians on your list introducing yourself and your Hearing Health Care practice (See intro sample letter).
- This letter outlines who you are, what makes your clinic unique, and why they should refer patients to you.
- Also lets your prospects know you will be contacting them soon to share more information
- Friendly Phone Call
- Follow up the introductory letter with a friendly phone call (See sample script). Ask to speak to the doctor or the doctor's nurse.
- Introduce yourself and your practice. Say that you would like to drop off some information and speak to them in person if possible.

***Drop-in/Drop-off Visits***

- Drop in on the doctor's office to drop off a Referral Folder and chocolate cream pies/treats.
- Ask to see physician or the staff person you spoke to on the phone.
- Introduce yourself and quickly explain why many physicians refer patients to your clinic (See sample "The Two Minute Presentation, and the 60-second sales pitch").

***Lunch & Learns***

- Call on the physician's office and ask to speak to the person who schedules Lunch & Learns or in-services for the doctor.
- Say you want to schedule an educational Lunch & Learn for the doctors and staff, and state your purpose for same.
- Bring a healthy lunch. It must not be extravagant—but certainly a quality food and beverage.

***Physician Reference List***

- Physicians practice "standards of care" so another provider who refers to you can help you obtain more referrals if you have approval to use he/she as a reference.
- Prepare a list of physicians who have referred patients to you and share it with Primary Care Providers where appropriate.
- Obtain approval from each referring physician before including his/her name on your reference list.

***Your Customers Include the Nurses and Supporting Staff***

- The doctor's nurse and staff can be your most influential allies in reaching the physician.
- They also are uniquely positioned to identify hearing loss and to discuss these issues with patients.
- Develop strong staff-to-staff relationships. Consider educating the medical assistant/nurse/staff by calling to request a meeting or lunch specifically for the nurses or medical assistants, and referral coordinators in the group.

## *Lunch & Learns*

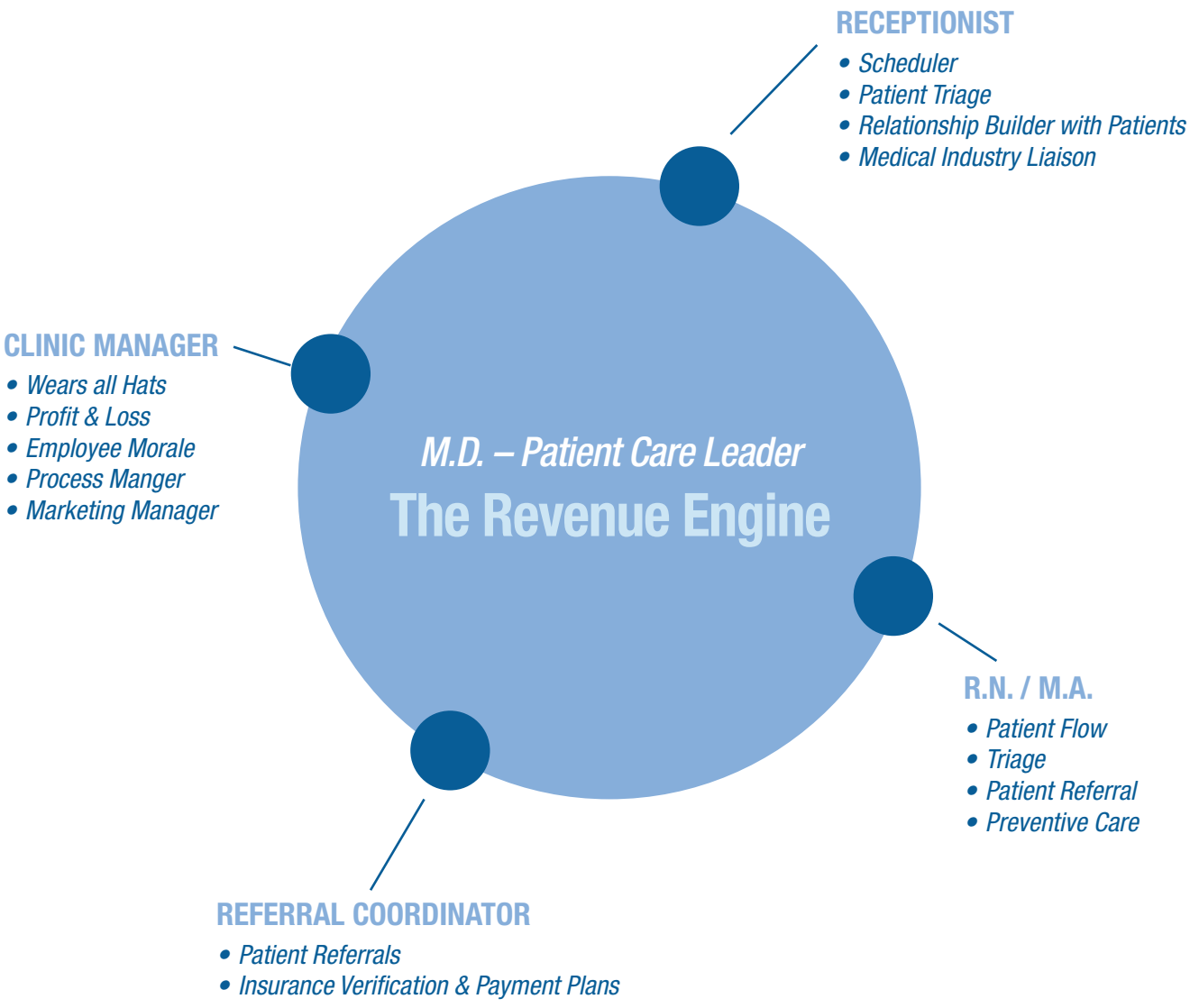
### Strategies for a Medical Office "Lunch & Learn" – An Important Physician Access Strategy

- Conducting an effective lunch and learn can grow your sales/referrals. They can provide a face to face interaction with the physician/provider, the nursing/medical assistant staff, and support people such as the referral coordinator, the clinic manager, social workers, receptionist's and others who may be able to assist us in getting our message heard.
- Each physician's clinic has its own policy or procedure here. Not all will allow them to be held. We must inquire if they do allow them and how a lunch and learn can be scheduled. The receptionist usually knows where the appointment schedule is – be sure to ask when, the starting time, and how much time is allotted, how many people will be there, confirm that this number includes the providers; ask about any special dietary considerations.
- Confirm each luncheon, and number of attendees a couple of days before the event – ask about recent menus and don't repeat those. Try to be original, but not lavish.
- Develop a list of restaurants that can cater/deliver – Your time can get pinched because of traffic jams, etc. Order lunches that you have to personally pick up from restaurants that are close to the physician's office – this cuts down on lost selling time.
- Bring diet and low calorie sodas/drinks, plus a dessert. Allow for extra servings for yourself, your special guest, and big eaters at the clinic.
- It is better to dress up for these, as opposed to dressing down. Look professional, act professional, and be the best you can be – this may be your only opportunity this year.
- Your sales call goals are to discuss the clinical importance of hearing loss and the impact on the patient's quality of life. Then describe your services, and the benefits that will accrue to the physician and the patient if we receive a patient referral. Finally, help the physician and nurse understand the process of a successful referral of a patient to your clinic. Ask to be included in their data base of specialists to whom they refer their patients when necessary. Provide copies of your clinic map, referral folders, fax number, website, business cards etc.
- This is your time to make friends, build trust, and make your sales presentations. They expect you to talk about your product or service, so come prepared with enough educational folders, CD presentations, literature and "giveaways". You may get extra time with the doctors, but don't be surprised if that doesn't happen – go with the flow here.
- The Physician Liaison conducts these, and the audiologist/hearing instrument specialist. Do not overwhelm them with more than two representatives.
- Try to eat before the providers get there. Make your presentation after you have eaten. Occasionally you wont have a chance to eat until everyone has gone, or not at all.
- Respect every one because you want all of them to be your allies/champions. Be gracious if the providers don't have time to speak with you if they have to rush off to the hospital, do charts, make lunch time phone calls to patients etc. You always have to come back again, so don't burn those bridges by getting peeved about poor attendance.
- Don't be grumpy to grumpy doctors! They may have been up all night with a sick patient, or lost the battle for someone who is dear to them. Come back another day, and they are usually fine when things are going better.
- Leave promptly after you have made your presentations, fulfilled all requests for samples, educational material etc. They need their private time with each other too.
- Reschedule your next lunch and learn immediately because medical industry reps compete hard for open dates – usually one a quarter is fine for your good customers; and ask for special consideration to reschedule if you have a new product, new service, or a new clinician you want to introduce to them.
- This is just one call, so don't expect big results right away. Follow up each month to grow the relationships you have begun to foster.
- Sharing is caring. Lunch and learns break down barriers, both socially and professionally. Enjoy being there with them, for them, and your physician referral sales will grow because of it.

## *List Your Access Strategies*

# The Total Office Call

The physician is the revenue engine, and their priority is providing quality patient care within the time limits dictated by their schedule. Every staff member in a physician's office either directly, or indirectly contributes to the patient care outcome. Each person needs to receive a package of information from audiology that educates them on the most frequently encountered patient types, comorbid conditions that cause/are related to hearing loss, the negative consequences of untreated hearing loss, the benefits of care, and the reasons why they should refer a hearing impaired person to you, and your practice. It is an easier decision for the receptionist to allow you to meet with the medical assistant. This valuable professional is the "patient care coordinator" and can be your information conduit to the physician. In the absence of the physician, or the unavailability of the physician, he/she needs to be your "learning champion" by default. Every staff member needs to be aware of the need to diagnose, treat, and prevent hearing loss, and how to make the patient referral to your clinic. We need to develop a working relationship with each member of the physicians staff, as well as the physician, by making the "Total Office Call".



## *Presentation Notes*

# Sample Introductory Letter to Physicians
## (Print on Office Letterhead)

(Date)

(Doctor's name & credentials)
(Address)
(City, State, Zip)

Dear Doctor (doctor's name):

Do you have patients come to you exhibiting signs of hearing loss? If so, you are not alone. Hearing loss is one of the most common chronic conditions physicians encounter. It affects more than 30% of patients over the age of 65 years, and more than 20% of Americans older than 12 years of age as well.

As a licensed hearing health care professional, I am here to help you provide your patients with the professional hearing health care they need to effectively improve their hearing loss symptoms and potentially improve their quality of life.

More physicians now refer their patients to audiologists and hearing healthcare providers than ever before. You can count on me and my dedicated staff to provide your patients with the best hearing health care available, including:

State-of-the-art audiometric testing and treatment programs
Specialized care for tinnitus and disorders of the inner ear
The newest hearing aid technology that is carefully matched to meet the patient's audiometric needs, cosmetic requirements, budget, and lifestyle

As your hearing health care specialist, I will work diligently to provide you with the information you need including a comprehensive written report containing our findings for each patient who you refer to me, within twenty-four hours.

I look forward to working with you to meet the needs of your patients suffering from the negative consequences of hearing loss. I will call your office to see if we can arrange a time to discuss how our clinic can partner with you in the comprehensive care of your patients so that we minimize impairment and maximize function in patients with this disability.

Sincerely,

(Provider's name, credentials)

# Sample Introductory Letter to Physicians
## (Print on Office Letterhead)

(Date)

(Doctor's name & credentials)
(Address)
(City, State, Zip)

Dear Doctor (Doctor's name):

Do your patients come to you exhibiting signs of hearing loss? If so, you are not alone. Hearing loss is one of the most common chronic conditions physicians encounter. It affects more than 30% of Americans older than 65 years of age and many more younger patients as well.

As an audiologist (or hearing health care professional), I am here to help you provide your patients with the professional care they need to effectively overcome hearing loss and potentially improve their quality of life.

More physicians now confidently refer their patients to hearing industry professionals. You can count on me and my dedicated staff to provide your patients with the best hearing health care available, including:

- State-of-the-art audiometric testing and treatment
- Specialized care for tinnitus and other disorders of the inner ear
- Free hearing loss screening with no co-pay for your patients
- State of the art hearing aids carefully matched to meet the patient's audiometric needs, lifestyle, cosmetic requirements, and budget
- Risk-free hearing aid trial period
- No fee consultations for patient transfers from other providers

As your hearing health care partner, I will work effectively to provide you with the information need, including a comprehensive written report containing our findings for each patient you refer to me here at our clinic.

I look forward to working with you to meet the needs of your patients suffering from hearing loss. I will call your office to see if we can arrange a time to discuss how our clinic may help.

Sincerely,

(Provider name, credentials)

# Sample Letter to ENT Physicians Plan B
## (Print on Office Letterhead)

(Date)

(Doctor's name & credentials)
(Address)
(City, State, Zip)

Dear Doctor (Doctor's name):

You have many patients who come to you exhibiting signs of hearing loss. Hearing loss is the third most common chronic condition physicians encounter. It affects more than 30% of patients over the age of 65 years, as well as more than 20% of all Americans age 12 years and above.

Our staff at Audiology Associates is here to provide you and your patients with collaborative interdisciplinary hearing health care that may be needed to effectively improve the patients hearing loss symptoms and potentially improve their quality of life.

We respectfully propose that Audiology Associates provide you with a "Plan B" option for you and for your patients. By that, we mean that we can provide the following tenets of collaborative care that may be in the healthy best interests of your practice, and your patients so that we help minimize impairment and maximize function in those who suffer from hearing loss:

- Consider cross referrals for patients whose insurances do not fit with your practice, yet may with those of Audiology Associates.
- Allow Audiology Associates to be your "patient care pressure relief valve" when your schedule is overwhelmed.
- Audiology Associates will accept those patients in your practice who have "hassle factors".
- Consider Audiology Associates when your audiologist/hearing healthcare provider is on vacation; is ill; has recently left your practice or is otherwise unavailable.
- On those occasions when the patient resides too far away for the most desirable patient engagement, and Audiology Associates location may be a more practical option.
- Audiology Associates will see most, if not all patients outside of normal clinic hours – we have a 7/24 hour on-call answering service, and our providers are available for those patients who need to be attended to in emergency situations.
- Whenever possible, Audiology Associates will provide on-site hearing aid repairs by our highly experienced staff.
- Ear wax, cerumen removal is provided with the latest technology that can provide both efficacy and patient comfort.
- Audiology Associates have four providers including board certified Audiologists, and Hearing Aid Specialists.
- And yes, when necessary we will provide mobile testing services, at a physician's practice, nursing home, and for those patients who may lack quality transportation.

Our compassionate hearing healthcare providers are Thomas _____, Au D. and Elizabeth _____, HAS, a father-daughter team who work together to provide quality care to our patients. We also have caring supportive staff, and hearing healthcare technicians: Viola _____, HAS and Alyson _____, HAS who are both certified dispensers.

You can count on our dedicated staff to provide your patients with the highest quality hearing healthcare available, including:

- State-of-the-art audiometric testing and treatment plans
- Specialized care for tinnitus and other disorders of the ear
- No-fee initial hearing screenings
- State-of-the-art hearing aid technology which is carefully matched to meet the patients audiometric needs, lifestyle, cosmetic requirements, and budget needs
- No-fee consultations
- Professional cerumen removal that is effective and comfortable while utilizing the latest technology

As your hearing health partner, we will work effectively with you to provide you with the information you need in a timely manner, including a comprehensive patient report, and supportive clinical research when necessary.

At Audiology Associates we look forward to working with you, collaboratively, so that our mutual patients are afforded the highest quality audiological care available.

Respectfully,

_____,
Office Manager

# Sample Letter of Request to Provide an Inservice
## (Print on Office Letterhead)

(Date)

(Doctor's name & credentials)
(Address)
(City, State, Zip)

Dear Sir/Ms.,

The increasing number of patients who are suffering from hearing loss has given rise to hearing impaired patients of pandemic proportions in the United States and globally. There is a growing need for audiology specialists to participate in interdisciplinary care efforts on behalf of our partners in patient care, ie. physicians, nurses, and educators.

"ABC Audiology" has authorized me to contact you about their wish to provide not just patient care expertise, but educational resources about hearing loss, tinnitus, dizziness and balance disorders that may benefit your physicians, residents, staff, and patients.

We seek to provide an inservice, or lecture on the increasingly important role that comorbidities such as diabetes, pre-diabetes, obesity, microvascular disease, cardiovascular disease, and others play in causing our mutual patients to become deaf and hard of hearing.

It is proposed that we provide a presentation, (without a fee) focused on the role of the comorbidities and hearing loss, that may lead to improved communication between the physician and patient in the exam room, a potentially improved ability to achieve efficacy, an improved quality of life for the patient, a lower cost of care for both the patient and your practice, the now proven fewer hospitalizations of the treated hearing impaired patient, and thus improved profitability for each of your practice locations.

Dr._____, AuD. would be one of the primary presenters, and I would be the other, (see the attached curriculum vitae) lunch would be provided for attendees, and handouts of published articles that educate the physicians, residents, and staff that can also support their "risk versus benefit" counseling on behalf of the comprehensive care of the patient; so that together we can minimize impairment and maximize the function of the deaf and hard of hearing patient.

Would it be possible for our Office Manager, Nancy _____, Ph: _____ at "ABC Audiology" to contact you to confirm how and when we may begin to work together to provide preventive hearing health care, to educate the physicians and staff, as well as educate the hearing impaired patients so that they and their loved ones may live more enjoyable, productive lives?

Respectfully,

_____,
(Physician Liaison)

# Sample "Thanks for the Referral" Letter to Physicians (For use with physician and/or staff)

(Date)

(Doctor's name & credentials)
(Address)
(City, State, Zip)

Dear Doctor (Doctor's name):

Thank you for the recent patient referral for a hearing evaluation. I appreciate the confidence you have shown in my staff and I here at our hearing health care practice. We will continue to strive to provide the best hearing health care possible for each and every patient you refer to our office.

Do not hesitate to contact me if you have questions or wish to discuss the care of a specific patient.

Sincerely,

(Provider name, credential)

Enc./Referral form

# Sample Phone Call Scripts
## (Print on Office Letterhead)

**Friendly Introductory Phone Call Scripts**
(For use with nurse/staff)

Hi, I'm _____, a licensed Hearing Health Care professional. I was wondering if it would be possible to set up a time to meet with Dr. _____ to introduce myself. I'd like to take a few minutes to show him/her how we can work together to help his/her hearing impaired patients. Is there a convenient time for Dr. _____ or his/her staff to meet?

**Friendly Introductory Phone Call Scripts**
(For use with physician)

Hello, Dr. _____. I'm _____, a licensed Hearing Health Care professional. Several Primary Care Physicians in the area refer patients to us for audiometric testing and treatment. I was wondering if I could set up a time to meet with you and discuss how I can help you meet the needs of your hearing impaired patients.

**"60 Second Sales Presentation"**
(For use at Drop-in/Drop-off visits)

Hi, I'm _____, a licensed Hearing Health Care professional. I called a few days ago and spoke to _____ about dropping off some new patient care information. I've included a brochure about why more physicians confidently refer their patients to hearing care providers. ***I've also included clinical research papers that help illustrate how common hearing loss is among your patient population.*** You may not know it, but more than 30% of your patients 65 years and older have some level of hearing loss. And untreated, hearing loss can lead to anxiety, depression and a wide range of functional and psychosocial issues. Several physicians in the area refer their patients to my clinic for audiometric testing and treatment. I'd like to work together with you to meet the hearing health care needs of your patients as well.

# Audiology News
## for Primary Care Providers

### Study: Diabetes Linked to Hearing Loss in Nationally Representative Study

More than 17 percent of the U.S. adult population (36 million people) has hearing loss, including an estimated 30 percent of the U.S. population over 65 years of age. Risk for hearing impairment is most strongly associated with males of lower education with an industrial or military background and leisure-time noise exposure. Given the known associations with hearing loss — cognitive decline, brain atrophy, increased risk of falls — high prevalence rates imply that many individuals are susceptible to possible functional and social limitations.

Nearly 10 percent of the U.S. adult population has diabetes, which has been associated with complications of the retinas, kidneys, and the arteries and nerves in the arms and legs. Other changes that have been known to occur in the bodies of those with diabetes include a hardening of the internal auditory artery and damage or atrophy to nerves associated with auditory centers in the brain.

These detrimental effects on the auditory system led to this national survey study, which was meant to examine data regarding the relationship between hearing loss and diabetes. Data for this study, "Diabetes and Hearing Impairment in the United States: Audiometric Evidence from the National Health and Nutrition Examination Survey," was collected by the National Center for Health Statistics from 1999 to 2004. The 5,140 participants were adults aged 20 to 69.

The resulting data showed that changes caused by diabetes could injure the tiny arteries and nerves in the inner ear, causing permanent hearing damage (defined as an impairment of 25 dB or more). On average, individuals with a hearing loss were older than those with normal hearing by an average of 13 years, were more likely to be white, and were more likely to have less than a high school education. Those with a hearing loss were also more likely to have served in the military, worked a job with heavy noise exposure, and more likely to have used ototoxic medications.

All people with a hearing loss were more likely to have diabetes with the exception of those aged 60 to 69 in the testing group, indicating that the effect of diabetes on hearing loss lessened as age became a greater factor. All diabetics had higher hearing thresholds at all frequencies than those without diabetes — and the gap widened at frequencies greater than 2,000 Hz.

Overall, the results indicated that those with diabetes were 28 percent more likely to have a hearing loss of mild or greater severity. Associations between diabetes and high-frequency hearing loss were stronger than associations between diabetes and low- or mid-frequency hearing loss.

Knowing the risks associated with hearing loss and diabetes will help our local community healthcare providers create a happier, healthier local community — and we look forward to doing our part.

[YOUR LOGO HERE]

123 Your Street Ave
Yourtown, OR 55555
**555.123.4567**
www.YourWebsite.com

*Bainbridge KE, Cowie CC, Hoffman HJ. Diabetes and Hearing Impairment in the United States: Audiometric Evidence from the National Health and Nutrition Examination Survey, 1999 to 2004. Annals of Internal Medicine. 2008;149(1):1–10.*

(sample newsletter)

## *Presentation Notes*

The diagnosis, treatment, and prevention of hearing loss can be complex. The patient frequently needs to be cared for by a hearing healthcare specialist. The following guide identifies which patient types are most at risk for hearing loss.

***– Bob Tysoe***

**[YOUR LOGO HERE]**

## Patients Who May Need to See a Hearing Healthcare Specialist

- Difficulty picking out words in the presence of background noise
- Speaks loudly and has trouble understanding or responding
- Have history of falls; or have problems with balance or dizziness
- Depression, worry or anxiety, related to the inability to hear
- Complaints of Tinnitus - buzzing or ringing sounds in one or both ears
- Patients exposed to high noise levels on their jobs above 85 decibels
- Everybody mumbles - difficulty hearing women and children's voices

## Risk Factors and Symptoms for Hearing Loss

- Age (45-65 years old~ 20%) or anyone 65 or older (29%)
- Age above 50 years
- Age above 18 years when a high-risk co-morbidity is present – eg. diabetes
- Cardiovascular Disease, Hypertension – 3x greater incidence
- Diabetes – 2x greater incidence
- Obesity – 2x greater incidence
- Smoker, past smoker or exposed to second hand smoke - 2x greater incidence
- Dizziness – lightheadedness, imbalance/ or vertigo
- Balance issues may co-exist with hearing loss
- Irritability or socially withdrawn, symptoms of depression
- Usage of ototoxic medications – Salicylates (aspirin and NSAIDS), Aminoglycosides (Antibiotics), Loop Diuretics, and Antineoplastic Agents (Anti-Cancer Drugs)

**[CLINIC NAME]**
[Address]
PH: 555-555-5555 • CELL: 555-555-5555 • EMAIL: youremail@gmail.com

# Comorbidities and Hearing Loss

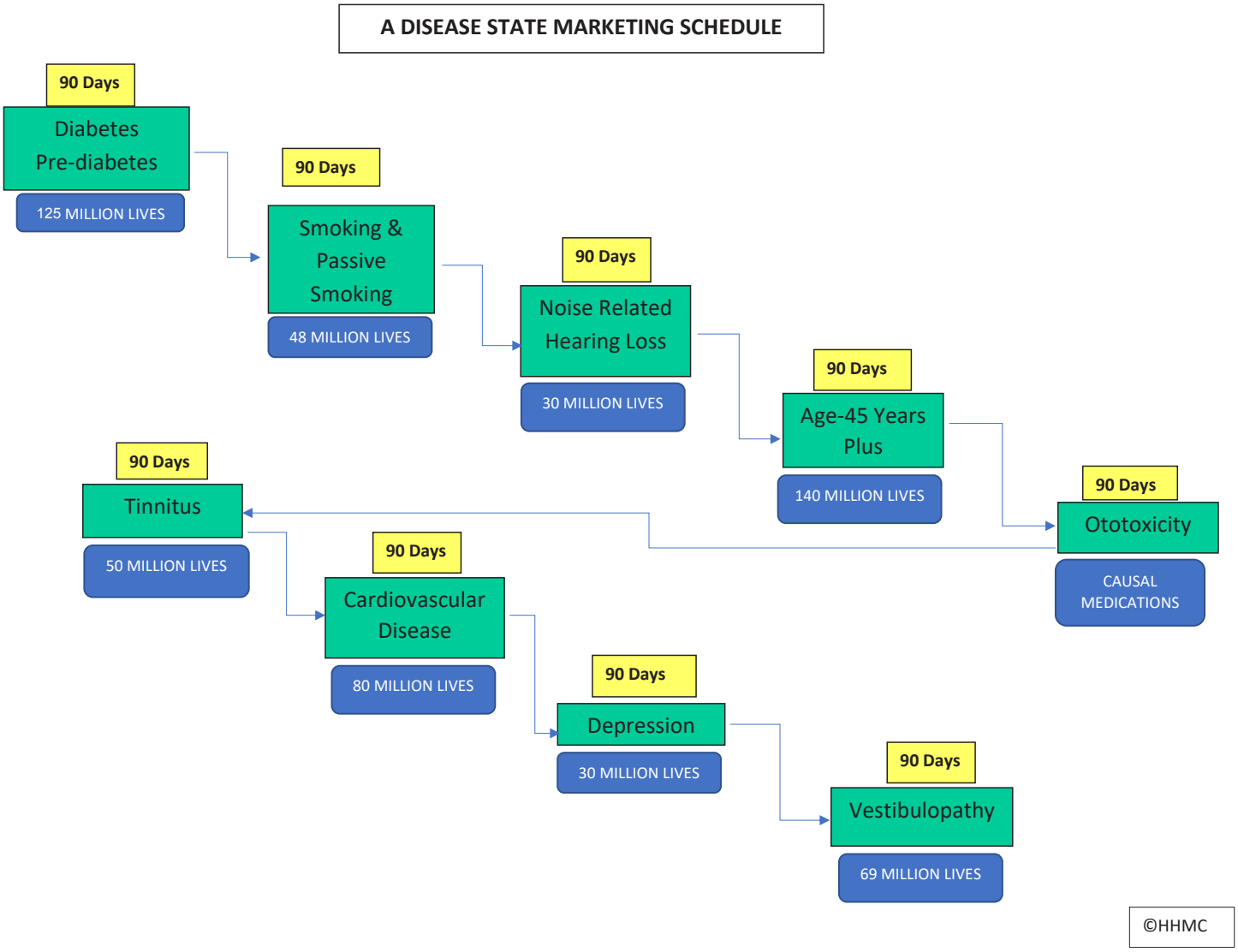
## Prevalence of Hearing Loss and Differences by Demographic Characteristics Among US Adults

*Data from the National Health and Nutrition and Examination Survey, 1999 - 2004*

***Conclusions:*** Hearing loss is more prevalent among US adults than previously reported. The prevalence of US hearing loss differs across racial/ethnic groups, and our data demonstrates associations with risk factors identified in prior smaller-cohort studies. Our findings suggest that hearing loss prevention (through modifiable risk factor reduction) and screening should begin in young adulthood. Arch Inten Med 2008:168(14):1522-1530.

"Comorbidities, and known risk factors for hearing loss such as diabetes and pre-diabetes, smoking and second hand smoke, toxic noise exposure, cardiovascular disease, hypertension, ototoxic medications and chemicals, and advanced age must be included in the required "educate to obligate" marketing strategies implemented by hearing health care providers who seek to partner with primary care in the treatment of the patient with hearing loss". Ref: Bob Tysoe, HHMC Data on File, 2015.

*Ref: Yuri Agrawal, MD; Elizabeth A. Platz, ScD, MPH; John K. Niparko, M.D.*



## *Presentation Notes*

# Important Customer Profile Questions to Ask

### Questions?

Building relationships in physician's offices with the physician and his/her staff will involve your commitment to providing solutions for their patient's needs as your primary goal. This means there are questions that need to be asked, over time, which will provide you with information that will help you to implement the "Key Account Management" process, which will lead to a more rewarding partnership in patient care.

### Here are some examples:

- Ask the receptionist what are the rules of engagement for medical industry representatives in the practice – knowing these rules will allow you to demonstrate your respect for them.
- Ask which days and times are best to make your calls, without an appointment.
- Ask when to stay away.
- Ask if any staff or physician does not wish to have contact with medical industry representatives.
- Ask if you may have their email address to communicate in case of a patient emergency.
- Ask if it is ok to email clinical research articles to physicians via that email address.
- Ask for their after-hours number.
- Ask for each of their business cards.
- Ask for their hours of operation.
- Ask who is the point person (learning champion) responsible for meeting with you, and/or to deliver your printed promotional articles/value proposition to the intended recipients in- box.
- Ask who is the Clinic Manager, Medical Assistant, Referral Coordinator, Nurse Case Manager, Social Worker, because all contribute to the patient care outcome and they each may need the same information from you about your practice, and services.
- Ask which physician, or nurse specializes in the care of the patient type for whom you are providing clinical research information/published articles.
- Ask whether they allow "In-services, or Lunch and Learns", time to arrive/leave, special diets, food allergies, number of attendees, how soon you can schedule your event.
- Ask if they do breakfast meetings, coffee and chat meetings, off site lunches, etc. Always ask if you may make a presentation on a new product or service.

- Ask who is responsible for adding you to the computerized database of the "List of Specialists" to whom they refer – it is vital that you make it to this list if you wish to be considered for a patient referral for a chronic or urgent hearing healthcare problem.
- Ask if you can go back to see the medical assistant to provide samples of ear wax removal kits, ear plugs, pocket talkers, etc.
- Ask if it is possible to meet with the clinic manager so that you can explain how patients with hearing loss may drive up the cost of care, negatively affect clinic profitability, and how your patient care partnership with them can help alleviate that.
- Ask where you should park.
- Ask if you need to check in with the purchasing department to get permission to be in the facility, especially hospitals with physician's office buildings attached, wear a badge, fill out forms, sign HIPAA regulation forms etc.

# Important Customer Profile Questions to Ask

- Ask is it ok to leave promotional literature in the waiting room, and who has the authority to approve the content of same.
- Ask how you would obtain an introduction to the physicians.
- Ask who is in charge of the patient education material in the physician's back office.
- Ask if you can cosponsor public education, and patient education events with them as they occur.
- Ask which ENT do they refer to – you may have patients in common.
- Ask which Endocrinologist do they refer to – you may have patients in common.
- Ask which Cardiologist do they refer their patients to – you may have patients in common.
- Ask which Nephrologist, Ophthalmologist do they refer to – you may have patients in common.
- Ask if there are dominant insurance plans in their practice that their patients utilize.
- Ask if they accept Medicare or Medicaid patients.
- Ask if you may leave a chocolate cream pie.
- Ask, spontaneously, if you can deliver some pizza for lunch if they are totally crushed with patients.
- Ask if you can be on their patient care team, so that you may help to minimize impairment, and maximize function in the hearing impaired patient, while improving quality of life, and potentially lowering the overall cost of care.
- Ask who repairs their patients broken or malfunctioning hearing aids.
- Ask who treats their tinnitus patients.

As you can deduct, gathering this information must be done gently, over time, with the intention of providing solution oriented representation of your practice, which may be of benefit to the physician and his/her staff.

This is by no means a complete list of questions, however if you demonstrate commitment and consistency with your in-person monthly calls, you will earn the right to provide preventive hearing health care, as they seek to provide preventive medical care and above all, do no harm, while achieving efficacy and improved quality of life for their patients.

## *Face to Falls Calls*

### With Access Comes Opportunity

You will have limited opportunities to make a presentation to physicians and/or their staff. Once you gain access, this is your chance to convince the doctor that referring patients to you is in his/her best interest and those of his/her patients.

### Do's and Don'ts to Persuasive Presentations

***DO...***

- Thank the physician for his/her time. The doctor is usually a very busy person. Let him/her know how much you appreciate his/her willingness to see you.
- Be brief and to the point. The best you can hope for is 2-5 minutes of the doctor's time.
- Give him/her a Referral Folder. Take a few minutes to review the materials inside.
- Explain how common hearing loss is. One in four of the physician's own retired patients could have a hearing impairment. 40 % of his diabetic patients suffer from hearing loss.
- Alert him/her to the negative consequences. Hearing loss can take a heavy mental and emotional toll when left untreated.
- Deliver the good news. Proper diagnosis and treatment is effective in 90% of all treatable cases. Discuss the benefits of the care that you provide
- Tell him/her how your clinic can help. As a certified provider, you test, diagnose and successfully treat patients with a wide range of hearing loss conditions.
- Remember the core message. 'An early intervention may mean an earlier improvement in patient function and thus quality of life.'
- Talk about the patients that have been referred to you. Review an audiogram of one of his/her patients. Case presentations are influential teaching tools.
- Use social proof; Mention that other doctors refer patients to you. Share your physician references list, if appropriate (with permission of referring physicians).
- Provide the name of the ENT clinic that you refer to when a patient's condition is outside your scope of practice - this is reassuring to the primary care physician.
- Alleviate any fears. Many doctors still fear that hearing aids do not really work. Put those fears to rest with a hearing aid demonstration and explanation of their capabilities.
- Benefits usually trump costs so provide evidence-based research literature and quality proof sources that validate the benefits that you provide.
- Ask for a referral. Let the doctor know that you would appreciate the opportunity to help him/her meet his/her patient's hearing health care needs.
- ***Sharing is caring***. Bring cream pies! Bring chocolates, fruit baskets for the doctor and his/her staff to help get your presentation off to a good start and help your audience remember you when you leave.

***DON'T...***

- Be negative. Most people respond better to an upbeat representative. Smile and keep a positive attitude.
- Get too technical. Show the physician you know your science, and provide important patient care diagnosis, prevention and treatment strategies where necessary.
- Be pushy. Confident and self-assured, soft sell, consultative, yes. Aggressive, most definitely, no!
- Give up. Just because the physician does not refer patients on the first visit does not mean you did not make a good impression. Do not give up. If a presentation does not go well, learn from it. Keep coming back for as long as it takes to earn their like, respect, and trust.
- Rely on one call, or one lunch and learn to generate referrals. Patient referrals will start slowly in the first six months. Early adopters will refer quickly, and then most others will continue to improve referring over time; by the end of the second year you will be generating a strong revenue stream that is a reliable income annuity for your clinic.

***Talking points (For preparing your own presentation)***

- Over 30% of people over the age of 65 have hearing loss.
- 20.1% of "baby-boomers" (age 45-65) have hearing loss.
- 1.4 million children have hearing loss.
- Approximately 82% of people with hearing loss do not seek treatment.
- Patients with untreated hearing loss are more likely to report depression, worry, anxiety, social isolation and other quality of life issues.

- The signs of hearing loss can be subtle and emerge slowly, or be significant and come on suddenly. Be the ready resource for sudden hearing loss diagnosis.
- The majority of patients with hearing loss listed their primary care doctor as their most important source of information about where to go for hearing health care services.
- Only 13 - 15% of primary physicians screen for hearing loss. Only 8 % of internal medicine specialists screen for hearing loss.
- Physicians and allied health professionals should encourage patients suspected of having hearing loss to seek appropriate testing, diagnosis and treatment. e.g. the diabetic patient. This is especially true for patients over the age of 12 years, in high-risk categories. eg those exposed to both second-hand smoke and who have previously smoked or are an active smoker, those with hypertension, cardiovascular disease, peripheral vascular disease.
- A simple written questionnaire administered to patients will help identify those in need of referral.
- More physicians confidently refer their patients to hearing healthcare providers.
- We use hearing aids to treat hearing loss, and will readily refer to an ENT or neuro-otologist when medically necessary.
- We are hearing health care professionals committed to providing your patients with the highest quality care.
- We offer state-of-the-art audiometric testing and treatment.
- We also provide specialized care for tinnitus and inner-ear related balance disorders.
- At our clinic we offer a wide range of the latest hearing aid technology which is carefully matched to meet the patient's audiometric needs, cosmetics, lifestyle and budget.
- Efficacy - 90% of patients with hearing loss who can be treated with hearing aids show improved symptoms, improved mental well-being and quality of life when treated with this advanced, highly efficient technology.
- Physicians receive a full written report for each patient referred to our office by mail, fax or email depending on your preference.
- Our goal is to be more than a provider; our goal is to be your hearing health care specialist and participate with you in the comprehensive care of your patients.

# A Proven Sales Track Strategy – "R.D.R.C."

The original author of the "RDRC" sales presentation strategy is unknown. It first came to my attention in 1969 at the A.M.P. Society, the country's largest insurance provider, in Sydney, NSW, Australia.

This basic format is used in face-to-face sales presentations, approach letters to customers, newspaper advertisements and in television adds worldwide.

### The "R" means RELAX.

In the beginning of the sales presentation is where we establish rapport, communication with trust, and discover needs, wants, and problems.

### The "D" means DISTURB.

Here we acknowledge the customers need, want, or identified problem and confirm it with them. If we have not yet discovered a problem for us to solve, we create a problem. Using credible proof sources from the literature, citing customers in similar situations or industries, quoting historical references, etc; we can gain agreement from the customer that they, or their own customers have a need, want, or problem waiting for a solution. This must be always be demonstrated with our utmost integrity.

### The "R" means RELIEVE.

This is why we make the sales presentation. I.E. by providing a service that offers a solution to the customers needs, wants, or problems. We must provide the benefits of our solution – they must be directly related to the discovered or created problem. Benefits usually trump cost, and this is where we create value in the customers mind.

### The "C" means CLOSE.

Now we convey our sincere belief in our ability to serve our customers by asking them to do business with us. We must demonstrate our conviction that the resources we will bring, that provide solutions and value to our customers, are unwavering. We must demonstrate our confidence in the benefits of our services and products by humbly yet assertively, asking them for their business or custom.

When we ask for a commitment from the customer, and it is not forthcoming, go back to the discovery process, identify the correct problem, accurately relate the benefits of your service or product, and respectfully ask for their business again.





**The sequence of "disease state" marketing calls with physicians and nurses may follow the sequence listed:**

1. ***Identify the disease state*** – the patient with hearing loss.
2. ***Identify the patient type*** – a 50 year old male diabetic; BMI index category of obese; abnormal blood sugar level; high blood pressure; high cholesterol level; mild chronic depression; peripheral arterial disease associated diabetic neuropathy in hands and feet; sedentary professional occupation; low exercise tolerance; poor dietary control; non-compliant with physicians instructions; diagnosed with mild to moderate hearing loss.
3. ***Identify the negative consequences of uncorrected hearing loss*** – patient acknowledges stress in marital, social, and work relationships. He is concerned about losing his job because of his declining health and financial status. Non-compliant with doctors care instructions; is becoming less engaged with others due to inability to hear effectively.
4. ***Identify the solution that you provide for patients hearing impairment*** – patient may need to be referred to a hearing healthcare specialist for diagnostic evaluation; possible balance test to rule out diabetic vestibulopathy; provide list of your clinic services, what tests you recommend, the possible treatment plan for this complex patient – emphasize early intervention and rapid restoration of patients ability to hear; explain the reasons why this patient should be referred to you, and how to refer this patient type to your hearing healthcare clinic/business location.
5. ***Identify possible improvements in patients condition resulting from audiologic care***. ie improved ability to communicate; improved sense of confidence; improved balance and reduced risk of falls; improved psychosocial function; reduced level of anxiety and depression; patient may improve compliance with physicians orders due to change in hearing status, and ability to understand physicians verbal instructions. This patient requires a long term patient care/management plan by the hearing healthcare specialist in partnership with the physician in the comprehensive care of the patient, so that they minimize impairment and maximize function in this diabetic patient.

# The Two Minute Diabetes and Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing health care clinic. The reason for my call today is because we want to begin the process of providing your clinic with improved customer service, in the form of the **latest clinical research articles** on diabetes and hearing loss for your physicians, new patient education brochures for your nurses to give to the hearing impaired patients, and updated insurance and payment plan information for your referral coordinator. Would it be possible for me to explain the contents of this "Patient Referral Folder" to either your nurse or your referral coordinator?

**Disturb:**
The National Institute of Health sponsored research on over 5000 patients that proved diabetics have twice the incidence of hearing loss versus non-diabetics, and pre-diabetics have a 30 percent increase in hearing loss versus non pre-diabetics. Poor blood sugar control increases the incidence and severity of hearing loss in this population. Some negative consequences of untreated hearing loss are increased incidence of depression, increased risk of falls, decreased earnings and job retention, decreased social activity, and increased loss of confidence and sense of well being. It is worth noting that the loss we may find now is permanent, and cannot be improved with dietary control, and increased exercise. Yet the severity of the loss may be restricted by improved life style behavior.

**Relieve:**
The now recommended annual hearing evaluation by both leading physicians and audiologists for this patient population means we can improve the symptoms and the adverse effects of hearing loss. We need to provide a baseline hearing evaluation with a routine annual follow-up. Patients who fail this examination will be advised of their loss, and given the option for further testing and treatment. Should they choose to decline we will respect that, and forward their test results to their primary care physician.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, based upon the research findings by the National Institute of Health and published in the Annals of Internal Medicine,( that caused recommendations for changes in best practices by leading institutions for the management of diabetics and pre-diabetics with suspected hearing loss), does it make sense for you to refer the diabetic and pre-diabetic patient type to us for their baseline hearing evaluation and routine annual follow up?

# The Two Minute Smoking and Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing health clinic. The reason for my call today is because we want to begin the process of providing your clinic with improved customer service, in the form of the latest clinical research articles on smoking, and second hand smoke related hearing loss for your physicians, plus new patient education brochures for your nurses to give to the hearing impaired patients, and updated referral, insurance and payment plan information for your referral coordinator. Would it be possible for me to briefly explain the contents of this "Patient Referral Folder" to either your nurse or the referral coordinator?

**Disturb:**
Published research from multiple study sites, and published in JAMA (Cruickshanks, June, 1998) and other peer reviewed journals have proved that after adjusting for other factors, current smokers were 2.1 times as likely to have a hearing loss as non-smokers. The odds of having a hearing loss due to exposure to second-hand smoke were an "almost 2-fold increase in the risk for hearing loss in teenagers". (New York University Langone Medical Center, NY. 2005 – 2006 NHANES Survey). Some negative consequences of uncorrected hearing loss are increased risk of depression, increased risk of falls, decreased earnings and job retention, decreased social activity, and increased loss of confidence and sense of well- being. It is worth noting that the loss we may find now is permanent, and cannot be improved with smoking cessation or exposure. Yet the severity of the hearing loss may be restricted by improved life style behavior.

**Relieve:**
The now recommended annual hearing evaluation by both leading physicians and audiologists for this at-risk patient population means we can improve the symptoms and the adverse effects of hearing loss. We need to provide a baseline hearing evaluation with a routine annual follow-up. Patients who fail this examination will be advised of their loss, and given the option for further testing and treatment. Should they choose to decline, we will respect that, and forward their screening/test results to their primary care physician – with their written permission.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, based upon the research findings by respected physicians and audiologists, plus the National Institute of Health , that caused recommendations for changes in best practices by leading institutions in audiology and medicine for the management of smoking related hearing loss, does it makes sense for you to refer this at-risk patient type to us for their annual hearing evaluation?

# The Two Minute Noise Related Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing health care clinic. The reason why I wanted to call today is because we want to begin the process of providing your clinic with improved customer service. In the form of the **latest clinical research** papers on noise related hearing loss and tinnitus for your physicians, as well as new patient education brochures on these conditions for your nurses to give to the hearing impaired patients, and updated insurance and payment plan information for your referral coordinator. Would it be possible for me to explain the contents of this "Patient Referral Folder" to either your nurse or the referral coordinator?

**Disturb:**
Noises are dangerous. The prevalence of acoustic trauma, or noise induced hearing loss is such that noise induced hearing loss is the second leading cause of hearing impairment in the United States. Over 30 million workers are exposed to toxic noise levels in excess of the OSHA safety standard of 85 decibels for an eight hour period every single day.
Whenever an employee has a standard threshold shift of 10 db from baseline for frequencies of 2000 hz, 3000 hz, and 4000 hz, this finding should stimulate the physician to explore with the employer various interventions which might benefit the worker, and coworkers.

***Some basic red flag rules:***
1. If it is necessary to shout to hear yourself over a noise, the level of sound can be damaging.
2. Should ringing in the ears occur after exposure to a loud sound, damage has been done, and that sound should be avoided or ear protection used in future.
3. If diminished hearing or a sense of fullness in the ears is experienced after noise exposure, the level of noise is damaging.

The prevalence and characteristics of tinnitus in noise exposed workers in a study completed by The Ministry of Labor, Republic of Singapore, February 1995, was shown to be 151 workers out of a total of 647, or 23.3 percent of total participants. Bilateral hearing loss was 42.4 %, and high frequency hearing loss was reported as 44.4%. Workers often are told that noise exposure causes deafness. Awareness of the possible occurrence of tinnitus may encourage employees to cooperate more actively in a company sponsored hearing conservation program.

***Some examples of high risk industries are:***
Construction, mining, agriculture, manufacturing, utilities, transportation, and the military. Also included are fab metal products, stone, clay and glass production, primary metals industries, rubber and plastic production & manufacture of paper, chemicals, and electrical equipment.

**Relieve:**
Prevention and treatment – prevention by avoidance of loud noises using compressible foam ear plugs, when properly fitted, can decrease noise exposure by 20 – 29 decibels. They increase the signal to noise ratio of speech and make it more easily heard. Workers exposed to potentially harmful noise must be identified. The primary care physician and the hearing healthcare specialist can partner to provide baseline testing, and regular follow up testing that may help to minimize impairment and maximize function.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, based upon the research findings by OSHA and other leading institutions on diagnosis, treatment, and prevention strategies for workers exposed to the risk of noise induced hearing loss, would it be possible for you to consider referring patients to our hearing healthcare clinic so that we can provide the initial baseline hearing loss evaluations and follow up testing in this at-risk patient population?

# The Two Minute Age Related Hearing Loss Presentation

**Relax:**
"Hi, my name is _____, from your neighborhood hearing healthcare clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research papers on age related hearing loss for your physicians, as well as new patient education brochures on this conditions for your nurses/medical assistants to hand out to hearing impaired patients; and also updated insurance information for your referral coordinator. Would it be possible for me to take a couple of minutes to explain the contents of this "Patient Referral Folder" to either your nurse/medical assistant or the referral coordinator?"

**Disturb:**
"Preserving older adults sense of hearing and helping them to maintain communication in the face of changes that occur with age are areas of concern for physicians, nurses, and family members."

"Older people with hearing impairments that go untreated suffer many negative effects. Compared to older hearing impaired people who use hearing aids, those who do not use hearing aids are more likely to report:

- Sadness and depression
- Worry and anxiety
- Paranoia
- Less social activity
- Emotional turmoil and insecurity
- Loss of community
- Loss of self esteem

These differences remain when controlling for other factors such as patients age, gender, and income." Ref: NCOA, May 1999. The Consequences of Untreated Hearing Loss in Older Persons.

"There is no clear proof that hearing loss is the cause of reduced cognitive function but indirect evidence supports this hypothesis. If the hearing loss is indeed the cause of cognitive decline, this is a very strong argument for early detection of hearing loss, and fitting of hearing aids." Ref: Stig Arlinger AuD., Negative consequences of uncorrected hearing loss – a review. 2003. University Hospital, Lincoping, Sweden.

**Relieve:**
Fortunately, over 90 Percent of patients who are treatment eligible with hearing aids show improvement in the symptoms of their hearing loss. At our clinic we are able to provide the latest amplification/tinnitus masking technology, that is cosmetically acceptable, affordable, and that matches the patient's lifestyle.

***Validate all claims with clinical research papers.***

**Close:**
"Doctor_____, based upon the research findings by the National Council of Aging and other leading institutions in audiology, on hearing loss in the elderly patient, would it be possible for you to consider referring the aged patient to our hearing healthcare clinic so that we may provide the initial baseline hearing loss evaluations and routine follow up testing in this at-risk patient population?"

# The Two Minute Ototoxicity Related Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing health care clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research on ototoxicity related hearing loss, as well as new patient education brochures on this condition for your nurses to give out to the hearing impaired patient; and also updated insurance and payment plan information for your referral coordinator. Would it be possible for me to explain the contents of this "Patient Referral Folder" to either your nurse/m.a.'s or the referral coordinator.

**Disturb:**
Ototoxicity may occur as a result of taking both prescription and over the counter medications, direct or indirect exposure to toxic chemicals in an industrial setting, from the nicotine in cigarettes, and other sources.

Usually a hearing problem will only be caused by exceeding the recommended dosage of medications. Often the hearing loss is transient, and reversible on discontinuation of the drugs/exposure. Unfortunately there are times when the hearing loss is sudden, and permanent.

Referral to an audiologist is usually necessary in this context for at least two reasons. First it is important to document the hearing loss, as some patients may, in fact, not have a measurable loss. Second the severity of hearing loss may have prognostic value, as patients with worse hearing loss tend to recover less hearing. Patients who complain of significant hearing loss and the examination does not reveal an obvious and treatable cause require a referral to an otolaryngologist.

**Relieve:**
Doctor, here is a list of ototoxic medications published by The League For The Hard of Hearing, Orin S. Kaufman, D.O. that indicates which most commonly used medications could potentially cause damage to your hearing, cause tinnitus, or may aggravate an already existing problem.

Sudden hearing loss is an otological emergency and requires an immediate referral to an audiologist, and possibly to an ENT for further evaluation and appropriate care for this patient type. You will be notified asap of our findings.

***Validate all claims with clinical research papers.***

**Close:**
Doctor_____, based upon the research findings by Orin S. Kaufman, D.O. and other leading institutions on the diagnosis, treatment, and prevention strategies for both sudden and chronic hearing loss due to exposure to ototoxic medications and chemicals, would it be possible for you to consider referring patients to our hearing healthcare clinic so that we can provide the essential hearing evaluations and follow up testing in this at-risk patient population?

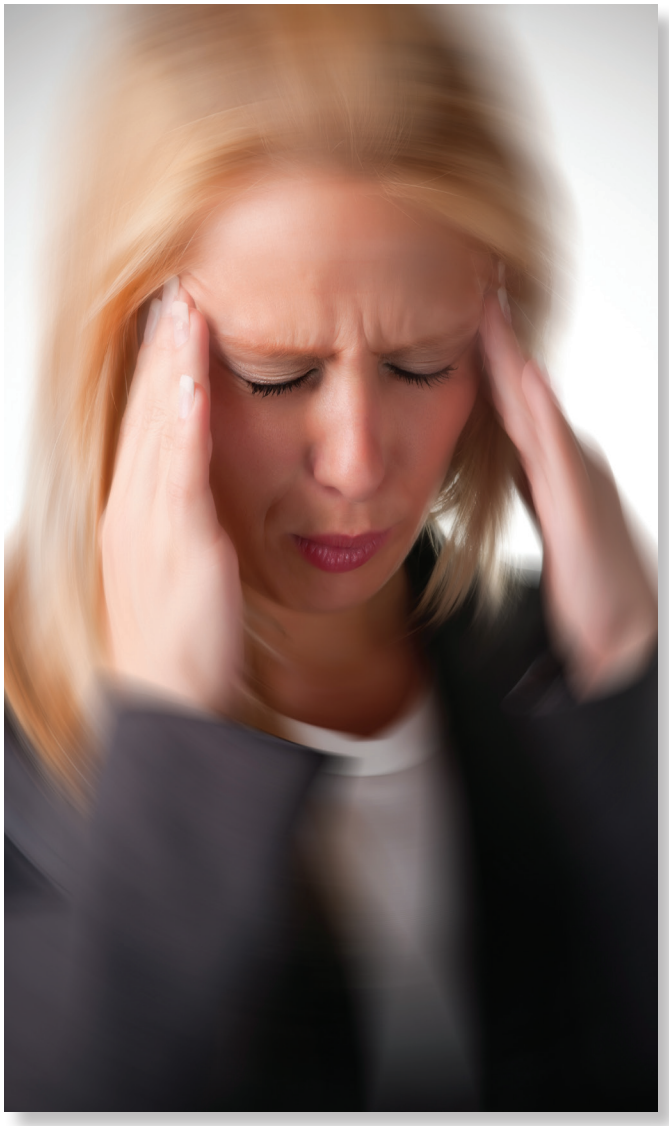
**Relax:**
Hi, my name is _____, from your neighborhood hearing healthcare clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research on the tinnitus related hearing loss sufferer, as well as new patient education brochures on this condition for your nurses to give to the tinnitus patient; and also I want to provide updated insurance and payment plan information for your referral coordinator. Would it be possible for me to explain the contents of the "Patient Care Folder" to either your nurse/medical assistant, or the referral coordinator?

**Disturb:**
When tinnitus first begins, most of us would be concerned and seek information. Not knowing the cause, wondering whether it is a sign of something worse, and not having control over it, could lead to distress for anyone. Discovering there is no cure can make that initial reaction even worse. Adverse effects include increased difficulty with hearing, sleep, concentration, and a wide variety of secondary problems/effects on the patient's daily lives. While some people do not appear to be bothered by their tinnitus, most would wish it would go away.

**Relieve:**
But there is help. Approximately 90 percent of those with tinnitus have clinically relevant hearing loss. While there are a number of things you can do to improve listening strategies, such as counseling and sound therapy, hearing aids often improve hearing loss and tinnitus symptoms. Newly developed masking devices are available, and recently introduced combination technology that treats both the hearing loss and tinnitus have proven effective. Approximately 60 percent of patients who receive tinnitus treatment from a hearing healthcare specialist have shown an improvement in symptoms. For your review, here are the latest clinical research articles on tinnitus treatment.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, based upon the research findings by Richard Tyler, PhD at The University of Iowa, Iowa City, IA and other leading institutions on the diagnosis, treatment, and prevention strategies for tinnitus, would it be possible for you to consider referring tinnitus sufferers to our hearing healthcare clinic so that we may provide the essential evaluations, treatment plans, and follow up care for this at-risk patient population.



# The Two Minute Cardiovascular Disease and Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing healthcare clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research on the correlation between cardiovascular disease and the hearing loss, as well as new patient education brochures on this condition for your nurses to give to the hearing impaired patient; also, I would like to provide updated insurance and payment plan information for your referral coordinator. Would it be possible for me to take a couple of minutes to explain the contents of the "Patient Care Folder" to either your nurse/medical assistant, or the referral coordinator?

**Disturb:**
A significant association was found between low-frequency hearing loss and cardiovascular disease. When controlling for age, hypertension, diabetes, smoking, and hyperlipidemia, low frequency presbycusis was significantly associated with intracranial vascular pathology such as stroke and transient ischemic attacks. Significant associations were also seen with peripheral vascular disease, coronary artery disease, and a history of myocardial infarction.

Patients with low-frequency hearing loss should be regarded as at risk for cardiovascular events, and appropriate referrals should be considered.

**Relieve:**
The Audiogram pattern correlates strongly with cerebrovascular disease and peripheral vascular disease and may represent a screening test for those at risk. Doctor _____, like you, at our practice we take a comprehensive family history/patient history because establishing cause and effect is simply sound patient care.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, based upon the research findings by Drs. Friedland, Cederburg, and Tarima published in "Laryngoscope" 2009 Mar; 119 (3) and in the interests of preventive patient care, would it be possible for you to consider referring patients with a proven history of either hearing loss or cardiovascular disease to our hearing healthcare practice so that we may provide the essential evaluations, treatment plans, and follow- up care, for this at-risk patient population?

# The Two Minute Depression and Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing healthcare clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research on the strong association between depression and hearing loss; as well as new patient education brochures on this condition for your nurses to give to the hearing impaired patient; also, I would like to provide updated insurance and payment plan information for your referral coordinator. Would it be possible for me to take a couple of minutes to explain the contents of the "Patient Care Folder" to either your nurse/medical assistant, or the referral coordinator?

**Disturb:**
The prevalence of moderate-to-severe depression was significantly higher among adults age 18-69 years who had self-reported hearing loss (11.4%) compared with those who reported good-to-excellent hearing (5.9%). The prevalence of depression rose as the degree of reported hearing loss increased from "a little trouble" to "moderate trouble" to "a lot of trouble" hearing, but not for adults self-identified as deaf.

**Relieve:**
What can people with hearing loss do to avoid depression? We suggest they seek hearing healthcare and consider joining national organizations for people with hearing loss. When recommended, rehabilitation via hearing aids, alternate listening devices, etc. may assuage the difficult personal and social adjustments of hearing loss.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, Although the mechanism connecting hearing loss with depression is unclear, the association suggests that treating people with hearing loss at early stages may reduce their risk of depression. Based upon the research findings by Drs. Li M.D. PhD & Howard J. Hoffman, MA from the National Institute on Deafness and Other Communication Disorders, National Institutes of Health (NIH), would it be possible for you to consider referring patients with a proven history of either hearing loss and/or depression to our hearing healthcare practice so that we may provide the essential evaluations, treatment plans, and follow up care for this at-risk patient population?

# The Two Minute Dizziness, Balance and Hearing Loss Presentation

**Relax:**
Hi, my name is _____, from your neighborhood hearing healthcare clinic. The reason why I am here today is because we want to begin the process of providing your clinic with improved customer service. In the form of the latest clinical research on the correlation between hearing impairment, dizziness, balance issues, and the increased incidence of falls, especially in the elderly patient; as well as new patient education brochures on this condition for your nurses to give to the hearing impaired patient; also I would like to provide updated insurance and payment plan information for your referral coordinator. Would it be possible for me to take a couple of minutes to explain the contents of the "Patient Care Folder" to either your nurse/medical assistant, or the referral coordinator?

**Disturb:**
Symptoms of dizziness, light-headedness, or unsteadiness are terms used to broadly describe how a patient feels when their sense of balance is impaired. The sensations are not the same for all people, and there are many medical problems that cause the symptoms that patients report as vertigo, unsteadiness, wooziness, dizziness, and light-headedness that are not related to the inner ears of balance. These include circulatory problems, low blood sugar, high blood sugar, thyroid disorders, and now the latest research indicates that high frequency hearing loss may play a significant role as well. A recent report of a cohort of older Finnish female twins demonstrated a strong association between audiometric hearing loss and incident falls.

**Relieve:**
Possible pathways that could explain this observed association include concomitant cochlear and vestibular dysfunction, poor awareness of the auditory and spatial environment, or mediation through the effects of hearing loss on cognitive load and shared attention. In patients 40 – 69 years greater hearing loss was independently associated with self-reported falls over the preceding 12 months. The magnitude of the association of hearing loss with falls is clinically significant, with a 25 dB hearing loss being associated with a nearly 3-fold increased odds of reporting a fall over the preceding year.

***Validate all claims with clinical research papers.***

**Close:**
Doctor _____, both self-reported and audiometric measures of hearing have demonstrated that hearing loss is robustly associated with balance function and incident falls after adjustment for multiple confounders. Would it be possible for you and your team to systematically refer the patient aged 40 – 69 years to our hearing healthcare practice so that we may provide the essential evaluations, treatment plans, and follow -up care for this at-risk patient population?

# Growing Your Business with "Like", "Respect", and "Trust"

## Liking

In Dale Carnegie's book, *"How to Win Friends and Influence People"*, Mr. Carnegie states these six principles in Chapter 6 – How to Make People Like You Instantly:

- ***Principle 1*** – Become genuinely interested in other people.
- ***Principle 2*** – Smile.
- ***Principle 3*** – Remember that a person's name is to that person the sweetest and most important sound in any language.
- ***Principle 4*** – Be a good listener. Encourage others to talk about themselves.
- ***Principle 5*** – Talk in terms of the other person's interests.
- ***Principle 6*** – Make the other person feel important, and do it sincerely.

Over 75 percent of all buying decisions are based on Like, Respect, and Trust, and when all else is equal, the customer chooses a business relationship with the person they like the most.

*"To obtain an assured favorable response from people, it is better to offer them something for their stomachs instead of their brains".* *Ref. Albert Einstein. March 3rd, 1954.*

## Likenomics

In Rohit Bhargava's book, *"Likenomics – The Unexpected Truth Behind Earning Trust, Influencing Behavior, and Inspiring Action"* it states that "success in business has everything to do with your ability to build trust. Transporting this to the patient/physician encounter, means that a patient is more likely to:

- Understand the course of treatment – earned trust
- Diligently comply with recommendations and medications – influence behavior
- Gain maximum benefit from treatment and/or health recommendations
- Experience greater satisfaction and return to the practice in the future
- Go out of their way to make patient-to-patient referrals – inspired action."

*"In a broader sense, it's simply good business. Professional colleagues will, in all probability, refer patients to another practice when they know, like, and trust their fellow provider. In short, people do business and build relationships with people (audiologists) they like".*

*"Differentiation is hard to accomplish, and even harder to maintain. In a world where almost any product or idea can be copied relatively quickly, the only competitive edge that lasts is what you can build based on relationships".* *Ref. R. Bhargava.*

## Writing Personal Notes

In 2007, as a Physician Liaison responsible for increasing physician referrals for hearing impaired patients to seven audiology clinics (from 300 per year to over 1000 per year within 30 months), I wrote 2600 personal hand written notes to physicians – these were attached to a clinical research paper, a business card, a list of clinic services, a provider bio, and a clinic location map.

Here is one for brevity: "Dr._____, sorry I missed you today. Attached is the latest research on the link between hypertension and hearing loss. Thank you for considering our hearing health care practice for the diagnosis, treatment, and prevention of hearing loss in this important patient type."

## Comment

- We open the hand written letter in the mailbox first.
- We believe that the handwritten note has greater authenticity, and authority.©
- We hand write our thank you cards, and our birthday cards – on important occasions we hand write our messages of love and caring.
- The hand written note attached to your promotional literature provides a greater chance of it ending up on your target customer's desk – which is the most influential location for all advertising material.

***Bob Tysoe and Robert Logan, M.D., ENT***

# Sample Presentation Script
## (For use with physician and/or staff)

Hello, my name is _____. I am a certified Hearing Health Care professional, and I would like to talk to you about how I can help your patients suffering from hearing loss.

Hearing loss is much more common than you may think. In fact, over 30% of the patients in your waiting room 65 years or older have some degree of hearing loss. For patients 75 years or older it is more like 40%.

While it may not seem like a big problem to younger patients, hearing loss can and does take a heavy physical, mental and emotional toll. Studies show that hearing impaired patients are much more likely to suffer from depression, anxiety, social withdrawal, loss of income and a wide variety of quality of life issues.

The good news is that more than 90% of treatable patients can be successfully diagnosed and their symptoms improved with hearing aids. At our clinic my staff and I test, diagnose and treat a variety of hearing loss conditions ranging from nerve deafness and tinnitus to inner-ear related balance problems.

Choosing who to refer patients to for hearing loss testing or treatment is an important decision. You want your patients to see competent, qualified professionals.

I am confident in saying that at our clinic we are certified, experienced hearing health care professionals dedicated to providing the best care available. As a result, more patients have improved hearing and improved quality of life.

You can count on me and my staff to provide your patients with:

- Comprehensive audiometric testing, diagnosis and treatment
- Advanced hearing aid technology, and other amplification products carefully matched to meet your patients' audiometric needs, lifestyle, cosmetic needs and budget
- Specialized care for tinnitus and disorders of the inner-ear

As your hearing health care specialist, I will provide the test information you need including a full written report or phone call containing our findings for each patient you refer to my office within twenty-four hours of the patient's appointment.

I look forward to working with you to meet the needs of your patients. Are there any questions I can answer for you at this time?

## *Presentation Notes*

# Frequency, Follow-Up, Measuring Means Success

### Why is Frequency so Important to the Physician Referral Program?

The Physician Referral Program is not a program of sending out one letter or making a single physician presentation, and then sitting back waiting for patient referrals to roll in. It takes consistent monthly contacts and follow-up to ensure success. Just as a pharmaceutical company must use all of a drug's patent life to recoup their investment and make a profit from a drug, the Hearing Healthcare provider must market his/her clinic for the duration of time he/she owns/operates the clinic. This is a long-term marketing commitment.

### Frequency: How Often is Enough?

It typically takes four to six contacts with a physician's office before actually earning a referral. These contacts include an introductory letter and a phone call, providing a Referral Folder as well as several office visits. That may sound like a lot, but once you earn the physician's trust you may very well have earned a valuable source of referrals for years to come.

In order to make your Referral Program as productive as possible, we recommend that you:

- Mail an Audiology Newsletter once a month, but not the same week as you make a face-to-face call
- Schedule two - three physician office visits per week - six to ten physicians per week. Call on each physician once a month. This equates to 300 to 600 calls per year. Divided by an average of six calls to generate a referral, this marketing program can potentially net you 100 physician referrals per year, and more in the second year and beyond.
- If you successfully describe the disease state, ie hearing loss, the patient type, ie the 50 year old diabetic, sedentary employment, poor diet and exercise regimen, and blood sugars out of control, who is depressed, having communication problems at home, and with friends and coworkers; describe the diagnosis and care you and your clinic can provide, and the potential early benefits of that care, and then confidently ask the physician if you can partner with he/she in the comprehensive care of the patient; then out of those 100 patient referrals, perhaps 60 will test with loss. If your closing rate is 50 percent, you may fit an additional 25 binaural patients per year; multiply that by your average selling price, say $5000.00, and you potentially can earn $125,000.00 in additional revenue with an effective, committed, and consistently implemented physician marketing program in your medical community.
- Each clinics formula for gaining additional revenue will vary based upon number of physicians, total number of calls, call effectiveness, relationship building skills, and commitment and consistency by the hearing healthcare provider, or physician liaison, who is implementing this marketing process.

### Follow-up #1: Remember ALWAYS to say "Thank you"

Remember that building a successful referral program is really about building a strong relationship with referring physicians and their staff. That is why it is vitally important to show them you appreciate their interest by sending a follow-up letter (see sample thank you letters).

It is a good idea to send a thank you letter after:

- Your initial office visit
- Lunch and Learn presentations
- Most important…Receiving a referral from the physician!

### Follow-up #2: Timely Clinical Communication

"One of the top reasons more physicians refer their patients to our Clinic than many other hearing health care providers is our commitment to providing physicians with the clinical information they need when they need it. (Within 24 – 48 hours!)"

To keep your referring physicians fully informed about their patient's case, be sure to:

- Mail, fax or email a patient report to the physician within 24--48 hours of seeing the patient.
- Call the physician on every test necessitating amplification or ENT referral and explain what you are recommending and why.
- Gain approval from each of your patients for you to send the audiogram to their primary care physician, so you may develop a strong communication with his/her clinic.
- Provide audiogram and patient report for every patient who you test and send to their primary care physician. This enhances the patient care partnership between audiology and medicine.

### Measuring Success: Track Your Results

In order to measure the success of your referral program and what effect it is having on building your practice, you need to track results by documenting:

- Number of physician contacts
- Location of physician clinics
- Medical Assistant presentations
- Referral Coordinator presentations
- Receptionist presentations
- Actual number of referrals
- Types of patients referred
- Resulting hearing device sales
- Most profitable referring physicians/groups
- Presentation topic

By closely tracking your results, you may find that the majority of your referrals are coming from certain types of physician/groups or from a particular part of your city/region.

This information will enable you to refine and tailor your referral development efforts to enhance your marketing effectiveness.

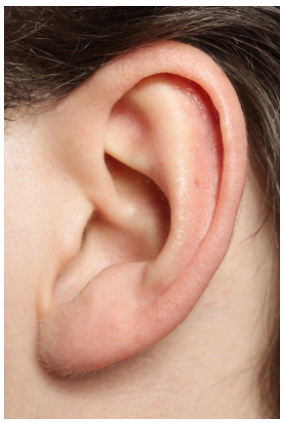
Contact Bob Tysoe at Hearing Healthcare Marketing Company for a copy of "Physician Call Activity Equals Results" Excel spreadsheet.

### Reach Out in as Many Ways as You Can

- Regular mailings and newsletters are another way to build a bond with referring physicians. Consider sending mailings to Primary Care Physicians announcing new technologies, new staff/hearing healthcare providers, and new services that you now provide, upcoming special events, new managed care contacts.
- Consider telemarketing to primary care physicians. Offer to send samples of earwax removal kits offer to remove ear wax, repair hearing aids, provide pure tone screeners, ear plugs, business cards, referral forms, patient education brochures, free hearing screening certificates, invitations to your open house, and to simply continue to establish brand name recognition and enhance brand name loyalty.
- **Add new clinical research results to your website** that is specific to both patients and physicians so that you are branding yourself as a clinically oriented hearing healthcare provider and educating them about the disease state of hearing loss, the negative consequences of untreated hearing loss, and the early benefits of the care that you provide.

## *Presentation Notes*

# The Medicine & Audiology Alliance



# Partners in Patient Care and Interdisciplinary Care

## *Presentation Notes*

# DISEASE STATE MARKETING

## a perspective from outside the profession

BY ROBERT TYSOE
MARKETING CONSULTANT

Do you own the disease state called "hearing loss" in your market place? Do you classify "hearing loss" as a disease state? Change your thinking and get ready to change your behavior. . . in the future. This is the main takeaway for most disease-state advertising. Convincing physicians to think differently while waiting for a means to act differently is not easy. And reminding them of an unmet urgent need without offending them is even more difficult. These are the challenges for the disease-state awareness campaigns that are a must-have for those who seek to influence the treatment strategies of physicians who are responsible for deciding which product or service to choose, and which is in the best interests of the patient's care.

Have you hung out your shingle, placed an advertisement in your local paper, conducted direct mail campaigns to your existing customers, or joined a buying group waiting for all those new patient referrals to just roll in? These conventional forms of marketing are simply not pulling patients into most offices like they once did, especially in this tepid, uncertain economy. Disease state marketing presents an exciting alternative to them. Learning how to utilize disease state marketing tactics is a unique opportunity for your practice.

Diabetes is a medical condition associated with hearing loss. Because of the 79 million pre-diabetes population, which has a thirty percent increase in the incidence of hearing loss versus the non pre-diabetic population, the number of individuals in need of hearing care services is quite high. (Note: pre-diabetes is not age dependent, so our own patient population is probably getting younger because of life-style related behavior.) Now add the already diagnosed diabetics with twice the rate of hearing loss as non-diabetics. That number is 26 million adults in the United States and continuing to expand to the point of epidemic proportions, resulting in an astounding increase in our hearing loss market size. Not to mention the 140 million people over the age of 45 years, many of whom are baby-boomers who are also expanding our market place. (The American Diabetes Association, 2011; & Frank Lin, M.D. Johns Hopkins University, 2011)

The Federal Reserve just announced it would keep interest rates below 1% until late 2014 because of the economy's continued weakness. What does this mean for an audiology practice? We now have an expanding marketplace, with inelastic demand, and with inelastic pricing. Given these circumstances, this is actually an amazing era of abundant opportunities for growth. That is not the case, however, if you exclusively rely on conventional forms of marketing.

The audiology profession must embrace new marketing behavior in this uncertain economy. We must cease relying on old belief systems about our marketplace. How many years did we hear that there were 30 million people in the United States with hearing loss, that only twenty percent ever sought care, and that we were impotent when it came to expanding our market, our patient population and our incomes?

It is time to look at a new potentially rewarding strategy that is right before our eyes. It is called "disease state marketing" and it must be implemented in combination with "relationship marketing" so that we maximize our ability to change the status quo in the physician's office, and increase the size of our patient load in our audiology practice. This means the audiologist must be willing to accept the responsibility of changing the way our 250,000 primary care providers in the United States think about hearing loss. Audiologists must combine their scientific knowledge with their relationship building skills, so that they bring value and trust to the interaction with the physicians and nurses. Ultimately, this dynamic relationship between audiologists and the greater medical community will result in improvement in the patient's quality of life.

## Hearing Loss is a Benign Condition

Physicians mostly ignore hearing loss as a disease state. Research shows that only eight percent of Internal Medicine Specialists in the United States test for hearing loss. Why is that? They can't make enough money from hearing loss to justify taking time away from their fifteen-minutes-per-patient schedule to evaluate, diagnose, make out a treatment plan, reassure the patient, and fill out the patient chart/medical records, and stay profitable. The result is that hearing loss falls into the category of elective care, and not obligatory care. Furthermore, hearing loss is thought of by physicians as a benign condition, which does not, in most cases, warrant immediate medical attention. Herein lies our major challenge, as well as our major opportunity. We must "educate to obligate" the physicians and the nurses. Audiologists must accept the challenge of making the disease state of hearing loss important enough to the physician so that they willingly make the diagnosis, and refer the patient to an audiologist.

When a patient suddenly loses their sense of taste, smell, touch, or sight, immediate care is sought, sometimes in the emergency room at the hospital, and the physician responds in kind. They also respond rapidly with sudden hearing loss. So why not chronic hearing loss? Because the patient is in denial, and many audiologists are unaware that they have the responsibility and ability to change the way physicians prioritize hearing loss as a disease state. It is up to audiologists to lead the discussion on the negative effects of untreated hearing loss, and the benefits of care that often lead to an improvement in the quality of life of the patient.

Audiologists must bravely accept the challenge of developing disease state marketing programs for hearing loss, and the major contributing concomitant conditions: diabetes, and pre-diabetes, smoking and second-hand smoking, age related hearing loss, and noise induced hearing loss. One could also include cardiovascular disease; however diabetes, obesity, and smoking are the major contributors of heart disease so we are able to combine our educational efforts here.

It's important to spend some time thinking about the role of marketing in an audiology practice. Marketing is defined as

"an organizational function and a set of processes for creating, communicating, and delivering value to customers and for managing customer relationships in ways that benefit the organization and its stakeholders. It generates the strategy that underlies sales techniques, business communication, and business developments. It is an integrated process through which companies build strong customer relationships and create value for their customers and themselves."

Marketing is used to identify the customer, satisfy the customer, and keep the customer. With the customer as the focus of its activities, marketing management is one of the major components of business management. The term "marketing concept" holds that achieving organizational goals depends on knowing the needs and wants of target markets and delivering the desired satisfactions. It proposes that in order to satisfy its organizational objectives, an organization should anticipate the needs and wants of consumers and satisfy them more effectively than competitors.

Marketing practice tended to be seen as a creative industry in the past, which included advertising, distribution and selling. However, because the academic study of marketing makes extensive use of psychology, sociology, mathematics, economics, anthropology and neuroscience, the profession is now widely recognized as a science. The overall process starts with marketing research and goes through market segmentation, business planning and execution, ending with pre- and post-sales promotional activities.

Relationship marketing is defined as the practice of marketing that differs from other forms of marketing in that it recognizes the long term value of customer relationships and extends communication beyond intrusive advertising and sales promotional messages. Relationship marketing extends to include inbound marketing efforts, public relations, social media, and application development. Relationship marketing is a broadly recognized, widely-implemented strategy for managing and nurturing a company's interactions with clients and sales prospects. When implementation is effective, people, processes, and technology work in synergy to increase profitability, and reduce operational costs. Relationship marketing involves the application of the marketing philosophy to all parts of the organization. Every employee is a "part-time marketer".

Just as important is the definition of "Disease Management". Disease management is defined as a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. For people who can access health care practitioners

## Guidelines for Identifying Individuals At-Risk for Hearing Loss in Adults

- Patients over the age of 60
- Diabetes – Diabetics are more than twice as likely to have hearing loss
- Smoking – Smokers are almost twice as likely to have hearing loss
- Heart Disease – Cardiovascular disease is strongly linked to hearing loss, especially in women
- Noise Exposure (Recreational or Occupational)

or peer support, it is the process whereby patients (and often family/friends/care-givers) share knowledge, responsibility and care plans with healthcare practitioners and/or peers. To be effective it requires "whole system" implementation with community social support networks, a range of satisfying occupations and activities relevant to the context, clinical professionals willing to act as partners or coaches and online resources which are verified and relevant to the country and context. Knowledge sharing, knowledge building and a learning community are integral to the concept of disease management. It is a population health strategy as well as an approach to personal health. It may reduce healthcare costs and/or improve quality of life for individuals by preventing or minimizing the effects of disease, usually a chronic condition, through knowledge, skills, enabling a sense of control over life (despite symptoms of disease) and integrative care.

## Marketing or Mongering?

How is "disease state marketing" different from disease mongering? Disease mongering is a pejorative term for the practice of widening the diagnostic boundaries of illnesses, and promoting public awareness of such, in order to expand the markets for those who sell and deliver treatments, which may include pharmaceutical companies, physicians, and other professional or consumer organizations. Examples include male pattern baldness, erectile dysfunction and certain social phobias.

What is the definition of disease state marketing? We need to think carefully about how to strategically expand the disease state of "hearing loss" to include new conditions without diluting our message to the medical community and the

patient. Because of the myriad of causes of hearing loss, it is best to refrain from casting too wide a net for new patients. However, audiology marketers would be wise to begin promoting to younger, healthier patients, educating them about behaviors that put their ability to hear at risk, and informing them of available interventional strategies. We are best served by focusing our efforts on the major causes of hearing loss as previously mentioned: diabetes and pre-diabetes, smoking and second hand smoke, age related hearing loss, and noise induced hearing loss.

Practitioners can ill afford to be labeled as disease mongers with the general public. Newspaper advertisements for hearing aids now read like the garish jargon in auto industry advertisements in Saturday's paper. We are distorting our image of caring providers of hearing healthcare into that of the slick, quick hook, pushy, discount driven, innuendo laden, and half-truth teller, interested only in the sales transaction of the moment. While there are segments of our peers who persist with this type of promotion, this kind of marketing activity serves to bring about the destruction of our image, our reputation, our livelihood, and push the consumer towards the big box retailers with hearing aid counters; to the internet to price shop hoping to find someone to ship them a pair of hearing aids with minimal diagnostic testing; low to no fees, rock bottom prices, non – existent human caring, and sketchy follow up service.

The hearing healthcare community arrived at this cross-road because of an outdated vision, and a lack of care about what role of responsibility we need to assume in the very large arena of healthcare. Our services have been devalued because the treatment of hearing loss is considered elective care in America – we have allowed the apathetic attitude of "let the patient find a treatment solution, it is not my role" to prevail because of our inaction, and self-isolation. The care of the hearing impaired in the United States is not "obligatory care", as it is in countries with more inclusive healthcare benefits.

The hearing impaired customer sees all hearing healthcare professionals as equal service providers, and now shops among us without bothering to educate themselves about their affliction, the disease state called "hearing loss". Physicians compound the problem because 85 to 90 percent or more don't test for hearing loss and lack knowledge about the negative consequences of untreated hearing loss. As previously stated, they make little or no money trying to care for this patient type, and insurance companies avoid the problem of coverage at all costs, unless the employer insists on paying the extra premiums to protect their employees.

## A Call to Action

The answer is a long term strategy by audiology leaders who are committed to the concept of "disease state marketing." We can create the resources to educate the primary care providers to the point where they follow their Hippocratic Oath teachings and obligate themselves to diagnose and care about the patient and refer them to the audiologist. When we altruistically commit our educational resources for the benefit of improved patient care, physicians will eventually respond in kind without manipulation on our part.

Because hearing loss is the third highest chronic disease state in the United States, we are at an epidemic level of incidence. There is a crucial need for more disease state (hearing loss) awareness. Most will not argue that the health of Americans is out of control when it comes to preventable or treatable diseases like Type 2 diabetes, hypertension and high cholesterol. We are a people who "treat" ourselves with bad food, and since so many other parts of our lives are stressed, we just don't seem to have the time or energy to make changes to lifestyles that can benefit our own health and lower our healthcare costs.

It is estimated that up to 79 million people in the U.S. are pre-diabetic.(NIH NHANES, 2008). That is a staggering number of people, and worse still, most of them probably don't really understand what it means to their health. It is time for us to explain the realities of having such a terrible disease on both their lifestyles and to their longevity. Audiologist marketers need to do more disease state awareness advertising, because the best patient is one that takes charge of her health and says "I'm not going to let this happen to me."

Recently published research by Frank Lin, M.D. of Johns Hopkins University in the Archives of Internal Medicine, shows that about one in five Americans age 12 years and over suffers from hearing loss in at least one ear that is severe enough to interfere with daily communication. The researchers took data from the National Health and Nutritional Examination Surveys (NHANES), which has tracked Americans' health since 1971, and analyzed data from just over 7000 hearing tests between 2001 and 2008.

Forty-eight million plus people, or 20.3 percent of people 12 years and over in the United States have hearing loss in at least one ear; while 30 million, or 12.7 percent of the population, have it in both ears (Frank Lin M.D. Johns Hopkins University, 2011).

## Hearing Loss is Not Exclusive to the Elderly

According to the World Health Organization (WHO), about 278 million

people worldwide suffer from moderate to profound hearing impairment, or about four percent of the world population. Figure 1 lists life-style related conditions that significantly contribute to hearing loss. Obesity is recognized as a major healthcare problem in the United States. The NHANES research verified that there is a thirty percent increase in the incidence of hearing loss in people who are pre-diabetic with evidence of metabolic disorders. This is difficult to contemplate when one considers that pre-diabetes is not an age dependent diagnosis. We can confidently state that this predominantly lifestyle related disease has changed the age demographics for those who suffer from hearing loss.

Diagnosed diabetes in the United States accounts for 26 million people who are currently under care, and many millions more who have yet to be diagnosed. This patient population, according to the NIH sponsored NHANES research, has twice the rate of hearing loss as the non-diabetic. Disturbingly, few audiologists and hearing aid manufacturers were aware of these statistics. The American Diabetes Association is yet to heed the recommendations by leaders in medical health care, and within the audiology profession, who state that annual hearing evaluations for all diabetic and pre-diabetic patients must now be a routine standard of care.

Another disease state linked to hearing loss is smoking. Smoking is now related to one in every three deaths worldwide according to the WHO. There are almost 50 million smokers in the United States. This is important because smokers have over twice the rate of hearing loss as the "never-smokers". This evidence based research is unfamiliar territory with most of the 250,000 primary care physicians in the United States. Audiologists must alert the pulmonologists, the internal medicine specialists, and the primary care physicians that their smoker patients at age sixty-five have a seventy percent higher incidence of hearing loss than the non-smoking population. Women now smoke at a higher rate than men in the United States. Who will educate the women's health care specialists about the potential risk of hearing loss from smoking to their female patients? Additionally, with over sixty million children in the United States exposed to second-hand smoke every day, who will carry this message to the pediatricians, and educate them about the risk to this patient population for eventual hearing loss, which is at almost twice the rate of those who have never been exposed? According to Yuri Agarawal, MD of Johns Hopkins University, hearing screening should be conducted in this at-risk population in early adulthood.

Recently published research now shows that impaired cardiovascular health has a negative influence on auditory function, and another research article published by BHI states that high frequency hearing loss may be a marker for cardiovascular disease and heart attack. There is an obvious need for the audiology profession to provide educational resources to our medical schools so that can we expand the body of knowledge of the residents, interns, and professors of medicine about the most dominant causes of hearing loss, and the negative impacts on patients left without care.

Now you have an insight into why I said we have this tremendous challenge, and this tremendous opportunity for the audiology profession. Shall we stand tall, shoulder to shoulder and accept the long term task of changing the way the disease state of hearing loss is diagnosed and treated, by the healthcare industry providers in the United States? Just how shall we bring about this change?

We shall do it if we "reach more patients, by reaching more physicians, with the right message, more frequently." (©HHMC) By personally marketing outside the four walls of our clinics using sound Relationship Marketing principles. We shall do it with science-based physician education programs that offer CEU's; by ethically expanding the parameters of the disease of hearing loss, without lurching irresponsibly

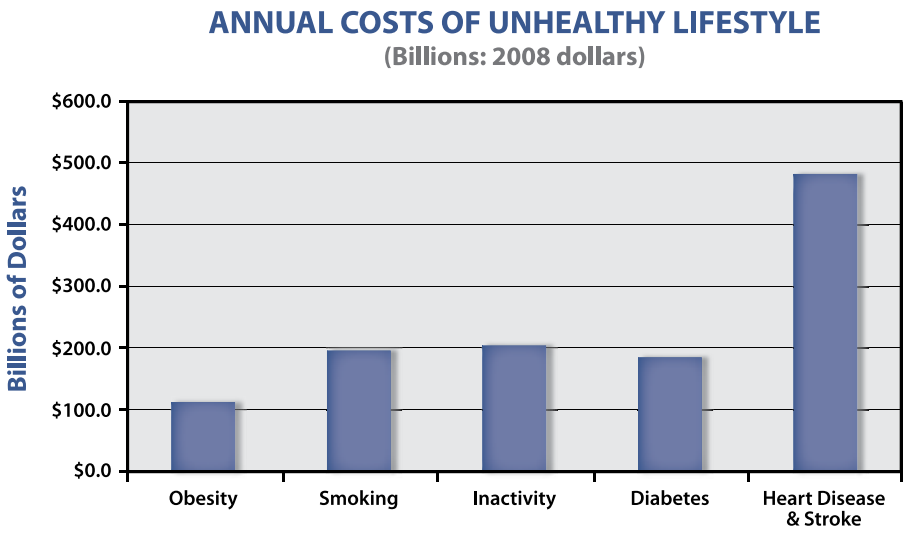



**Figure 1. The estimated annual costs of unhealthy lifestyles.** ***Ref: World of DTC Marketing, 2011.***

*The original author of the "RDRC" sales presentation strategy is unknown. It first came to my attention in 1969, in Sydney, NSW, Australia while I was an Insurance Agent for A.M.P. Society, the country's largest insurance provider. This basic format is used in face-to-face sales presentations, approach letters to customers, newspaper advertisements and in television ads worldwide. Once you become familiar with the literature surrounding various disease states and their link to hearing loss, you can apply it to your interaction with physicians.*

## R The "R" means RELAX.

In the beginning of the sales presentation is where we establish rapport, communication with trust, and discover needs, wants, and problems.

## D The "D" means DISTURB.

Here we acknowledge the customers need, want, or identified problem and confirm it with them. If we have not yet discovered a problem for us to solve, we create a problem. Using credible proof sources from the literature, citing customers in similar situations or industries, quoting historical references, etc; we can gain agreement from the customer that they, or their own customers have a need, want, or problem waiting for a solution. This must be always be demonstrated with our utmost integrity.

## R The "R" means RELIEVE.

This is why we make the sales presentation. That is, by providing a service that offers a solution to the customers needs, wants, or problems. We must provide the benefits of our solution – they must be directly related to the discovered or created problem. Benefits usually trump cost, and this is where we create value in the customers mind.

## C The "C" means CLOSE.

Now we convey our sincere belief in our ability to serve our customers by asking them to do business with us. We must demonstrate our conviction that the resources we will bring, that provide solutions and value to our customers, are unwavering. We must demonstrate our confidence in the benefits of our services and products by humbly yet assertively, asking them for their business or custom.

When we ask for a commitment from the customer, and it is not forthcoming, go back to the discovery process, identify the correct problem, accurately relate the benefits of your service or product, and respectfully ask for their business again.

into disease mongering; by being resolute in our efforts to engage the health care professionals who share our mutual patients; by sincerely expressing our desire to become part of their patient care team; by becoming their hearing healthcare provider of choice; and by changing the standard of care for hearing loss patients from today on..

Audiologists will need to become better educated about diabetes and its potential effects on blood viscosity, the impaired microcirculation, end stage organ disease, and why the cochlear and the eighth cranial nerve can fail to function in the presence of high blood sugar, and atherosclerosis.

They will need to understand the research on the devastating effects of highly ototoxic nicotine, it's ability to constrict blood vessels, break down tissues, displace oxygen from red cells, cause ischemia, cause platelet aggregation, enhance atherosclerosis, exacerbate otosclerosis, and cause clot formation. With this knowledge, audiologic specialists are able to educate the physician about why smokers need a hearing assessment and recommendations for appropriate follow up care.

Thirty million Americans are exposed to toxic noise levels, those above 85 decibels, on the job every single day. (John J. May M.D., 2000) Frequently workers ignore safety devices, and safety regulations; and industry leaders may turn a blind eye to employee violations of the OSHA standards. As health care providers, we need to explain the difference between an audiogram for presbycusis, and that of a noise induced hearing loss patient's audiogram, and make the subsequent recommendations for prevention and or care to physicians and nurses.

When the perceived benefits of care are greater than the negative consequences

of persevering with hearing loss we will increase our opportunities to provide care. When the physician is able to do the same because we have educated him or her about the deleterious effects of hearing loss in the aging population, such as depression, irritability, functional decline, cognitive decline, social withdrawal, paranoia, declining confidence, disappearing curiosity about life, then we will be increasingly likely to receive a patient referral from the physician (NCOA May 1999). The improved quality of life is a tangible benefit which will strengthen the relationship between physician and patient and will benefit both. Who can place a value on the restoration of the patients ability to hear a loved one sing, answer the phone, have dinner with friends at a popular restaurant, play a DVD, look for a job, and whistle a tune because they can hear themselves again.

## Putting Ideas into Practice

Time is a genuine barrier to implementation of a disease state marketing program. Your time is worth money, so how much time can you spend in order to grow the market that sits there like low hanging fruit? Let's use an audiology practice that generates $400,000 annually as example of where we will find the time to get outside our four walls. If you took two hours out of each week, and went fishing instead of working in the clinic, your opportunity cost is $20,000 per year. Using that same two hours calling on/connecting with ten physicians and or the clinic nurse per week , you will generate approximately 80 physician referrals per year. Proven marketing research shows that you will dispense a minimum of one binaural fitting per month, and generate between $30,000 and $60,000 per year in hearing aid sales depending on your average selling price. The choice seems simple, go fishing for fish, or go fishing for physician referrals. The greater your commitment to "educate to obligate" the greater will be your reward.

What proof can I offer you that "disease state marketing" works in audiology? Over a five year period, from 2004 through 2009 I conducted a physician marketing trial in the Pacific Northwest for a major audiology company, combining components of the pharmaceutical industry's "ethical marketing" criteria, (which includes relationship marketing, and science based/evidence based marketing) as well as the recommendations from the findings of the research on physician marketing by The Better Hearing Institute, and the audiology profession's own marketing criteria. For the seven clinics that were in the trial, we were able to grow the annual number of physician referrals from 300 to 1000 in a two year period. Annual revenue from physician referrals alone grew from $180,000 to $750,000 in a three year period. As part of a similar initiative, in the Chicago area, we doubled revenue from physician referrals in one year. In Los Angeles, revenue tripled from physician referrals in two years.

In 2011, I represented a large audiology practice consisting of three clinics in Oregon. Working twenty hours per week, and by implementing disease state marketing strategies, I was able to generate $260,000 in annual revenue as a result of physician referrals.

Audiologists around the country need to allocate some of their precious marketing resources to educating the care-givers and influencers of people at risk for hearing loss. We need to commit our resources to educating ourselves about the co-morbidities that contribute to impaired hearing. We need to devote the time to do this, because there is more than enough proof of the rewards for the patients, the physicians, and the audiology profession when we access the greatest source of opportunity for our market growth, which is the 250,000 primary care physicians in the United States. ■

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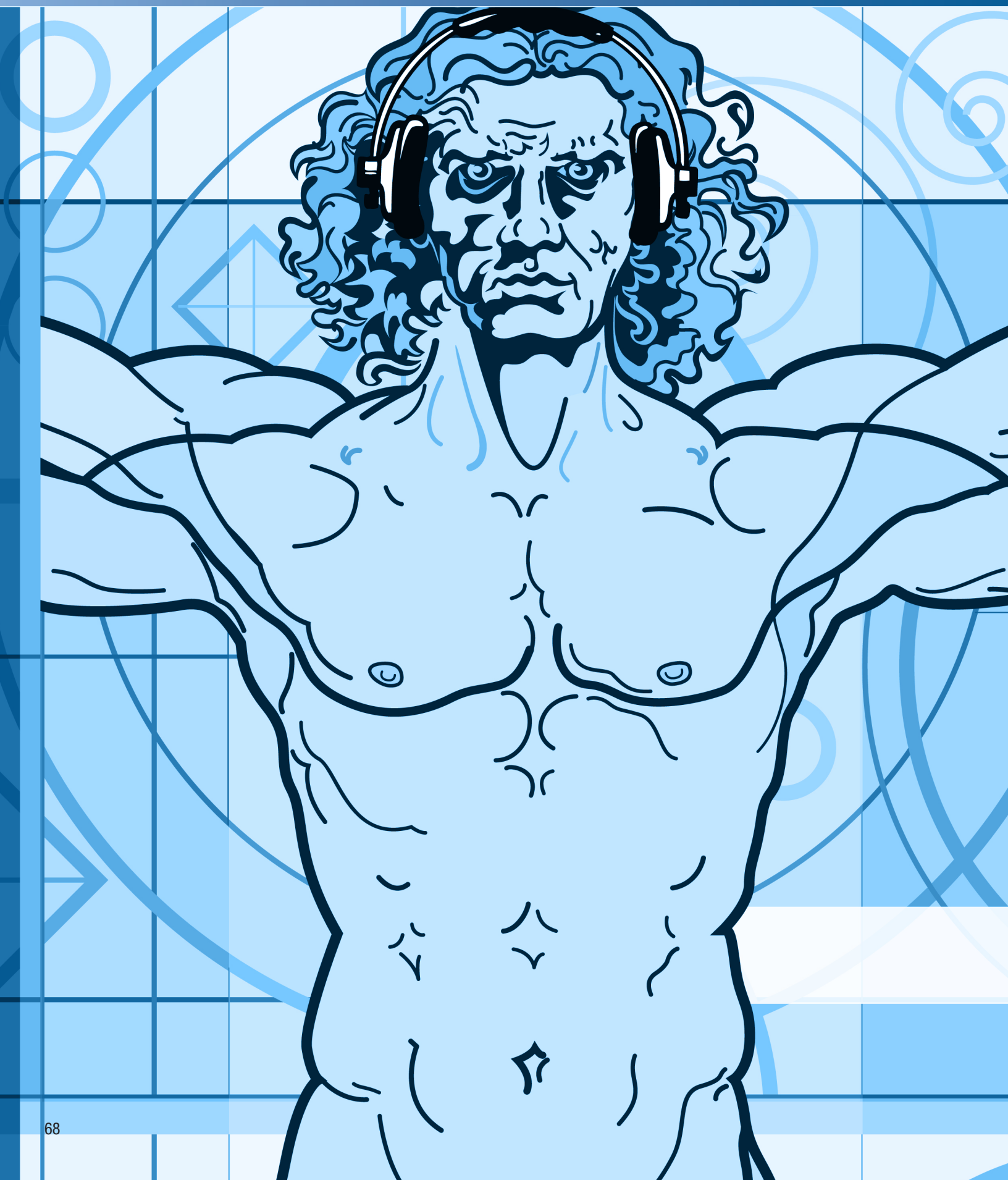
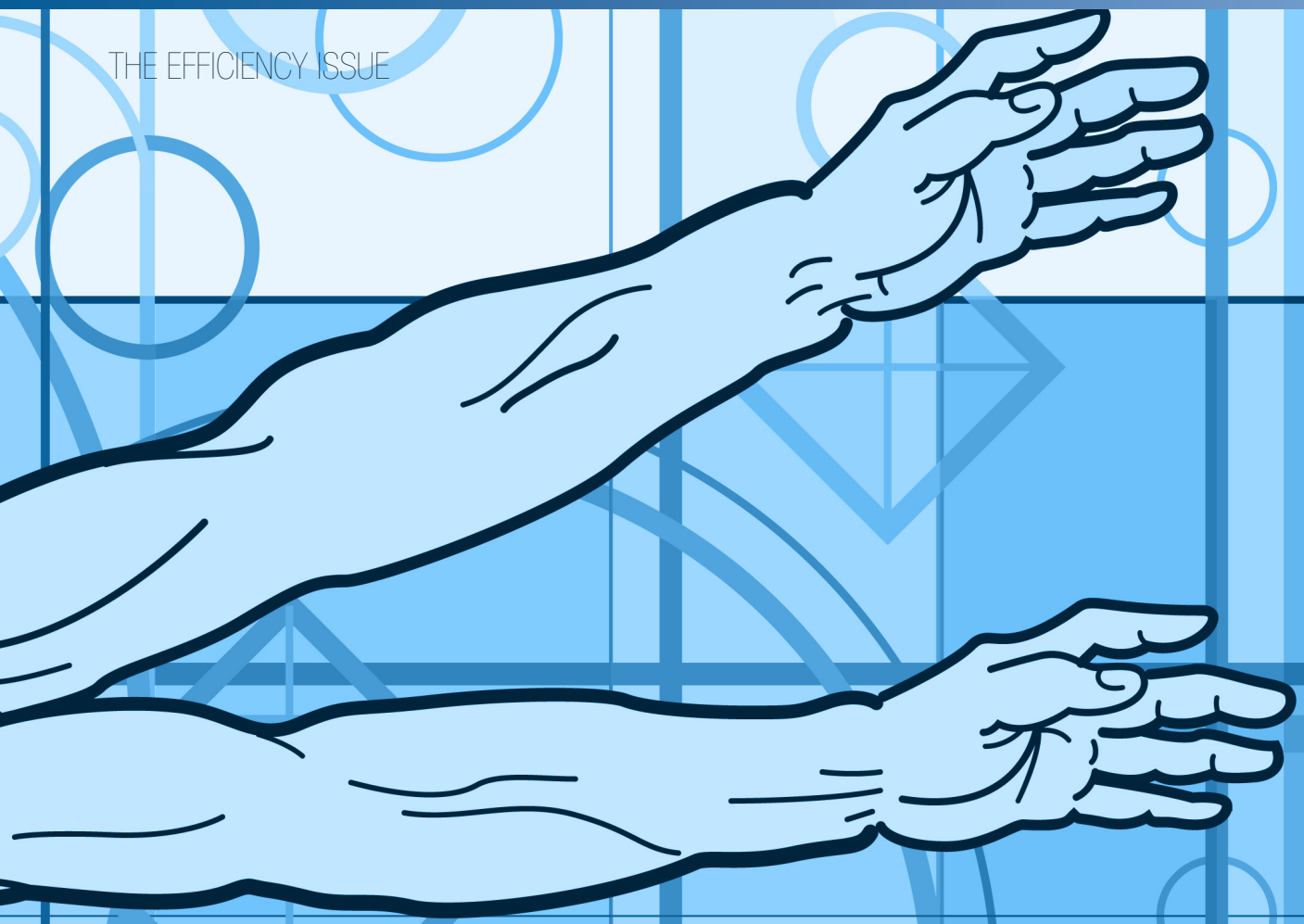
*Robert Tysoe is the owner of Hearing Healthcare Marketing Company, Portland, Oregon. He can be reached at Robert.Tysoe@netzero.net*

**Disclosure: Mr. Tysoe has consulted with Unitron Unite members. The editor of AP is an employee of Unitron.**

## *Presentation Notes*



THE EFFICIENCY ISSUE



# MEDICINE & AUDIOLOGY

## Moving Toward a Stronger Alliance in the New Health Care Landscape

BY ROBERT TYSOE

According to the 2010 Census Bureau the U.S. population at 306,000,000, and the Health Care industry consumes almost 19 percent of the total GDP, which equates to almost $2.7 trillion. There are approximately 260,000 primary care physicians in the United States, who to a remarkable extent help to direct and control this enormous expenditure. The U.S. Audiology industry with approximately 15,000 providers fits approximately 2,000,000 units annually, which produces about $6 billion. Clearly audiology is the "little brother" of medicine.

To date, physicians only generate about 15 percent of the total audiology market revenue. (See Figure 1 for details). In a recently published article, Lin et al (2011) estimated that 30 million, or 12.7% of Americans 12 years and older had bilateral hearing loss from 2001 through 2008, and this estimate increases to 48.1 million or 20.35% when also including individuals with unilateral hearing loss.

## A Mandate from Medicine

Assessing health information collected from 5,700 Americans aged 20 – 69 years between 1999 – 2004 in the federal National Health and Nutrition Examination Survey, Agrawal et al (2008) found men twice as likely as women (21 percent versus 11 percent) to have speech-frequency hearing loss in one or both ears. Agrawal et al (2008) have called for annual hearing screenings for all individuals from young - adulthood onward, particularly for vulnerable groups.

Marketing research results show that 73 % of the U.S. population prefers to ask their primary care physician first about their hearing loss, and get recommendations for care. Audiology industry research estimates that only 20% of those with a treatable loss get care. It should be obvious that physicians are not readily diagnosing hearing loss or initiating significant patient referrals for hearing healthcare, yet.

What is wrong with this picture? If most of the potential growth for audiology referrals lies in the country's primary care providers, what are the approximately 15,000 audiologists and hearing instrument specialists in those 11,000 store fronts doing to reach out to the 260,000 primary care physicians, (pediatricians, family practice, internal medicine, geriatricians) to change the way they practice medicine and encourage them to include hearing health care recommendations in their routine standard of care?

## Kissing the Cheek

It is said that in most relationships there is the one who offers the cheek, and there is the one who kisses the cheek. The Audiology industry must accept the reality that it needs to kiss the cheek of the Medical industry by engaging in productive, mutually rewarding patient care and patient education and co-marketing strategies. Audiology may include Disease State Marketing, Physician Marketing, and Services Marketing in order to substantially grow physician referrals and increase their own hearing impaired patient case load.

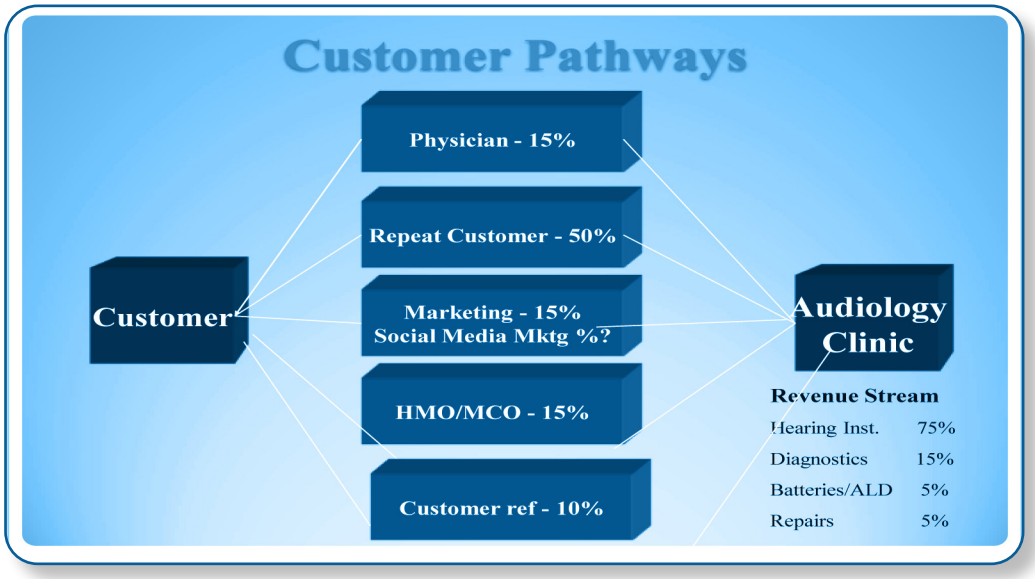



*Figure 1. The various pathways hearing impaired "customers" find their way to an audiology clinic. Along with the pathway, the expected amount of revenue, expressed as a percentage is listed.*

### Disease State Marketing

The disease state of hearing loss includes conductive, sensorineural, mixed, and centrally mediated hearing loss, each with an array of causes, and vast patient populations with comorbidities that substantially contribute to loss of hearing, and decreased quality of life. Diabetes, pre-diabetes, smoking/nicotine addiction, passive smoking, age related hearing loss with corresponding comorbidities such as dementia and Alzheimer's, noise-induced hearing loss, cardiovascular disease, ototoxicity and tinnitus are major contributing disease states that affect the patient's ability to enjoy a hearing life.

Disease State Marketing by hearing health care specialists requires that they schedule time out of their clinics, and bring evidence based clinical research about the disease state of hearing loss, and it's comorbidities to the physician to explain cause and effect, with peer reviewed state-of-the art treatment modalities that lead to efficacy of care; provide patient educational materials to the nurse or medical assistant; deliver referral and billing process information to the referral coordinator, as well as detailed explanations of the services that they provide that may benefit the patient.

### "Above all do not harm."

Audiology can use substantial resources to create an effective dialogue with physicians so that they are educated about the complexities of making the diagnosis of hearing loss, encouraged to develop a treatment action plan that includes a referral to an audiology specialist. As Parker (2010) stated, "the audiologist should be a part of the comprehensive team of care givers striving to assist the patient to minimize impairment and achieve maximal function". The onus is on both the physician and the audiologist to ensure they develop a committed, consistent, partnership of patient care. This can be achieved if audiology will altruistically reach out to medicine for the "patent life of their clinic ownership".

### Audiology and Preventive Medicine

Preventive medicine or preventive care consists of measures taken to prevent diseases, or injuries rather than curing them or treating their symptoms. Historically, preventive medicine has been the concern of public health activities while physicians focused on the treatment of established disease. However the concerns of public and private health and private practice are developing an increasing overlap, especially for primary care physicians. Today, the emphasis is on preventing or slowing the progression of chronic illness by optimizing other aspects of the patient's health. Consequently, the treatment of hearing impairment becomes part and parcel medical preventive care. This is leading to a fundamental change in the relationship between audiology and traditional medical practice.

*Kathleen F., 92 years old, upon being fitted with a new cochlear implant successfully returned to living independently with an active social life after suffering loss of self esteem, social withdrawal and isolation caused by profound hearing loss. Photo reprinted with permission of the patient.*

Some examples of preventive audiologic care that have positive outcomes are early treatment of hearing loss in the elderly so that the progression to depression and subsequent need for treatment is reduced. Treatment costs for the patient suffering with social withdrawal and isolation, hearing loss associated dementia, decreased functional status, poor communication skills that compromise patient safety. The impact of all these conditions can be significantly modified with early audiologic intervention. These patients may well lead lives of longer independence in their own homes with effective treatment of their hearing loss.

Lin et al (2012) recently published findings which show that patients with high frequency hearing loss have a higher incidence of falls. A recent report of a cohort of older Finnish female twins demonstrated a strong association between audiometric hearing loss and incident falls (Lin et al, 2012). Early treatment of hearing loss may prevent falls that cause injury, hospitalization and even death, not to mention the health care costs that could be avoided. Audiology is obligated to educate primary care physicians in how to effectively intervene, prevent or reduce hearing loss associated with known morbidities and mortalities.

## Changes in Health Care Policy Has Positive Effects for Both Audiology and Medicine

The traditional medical care paradigm was based on treatment of overt illness. Physicians were basically passive in terms of initiating patient contact. They used their knowledge, experience and judgment to diagnose, treat, and or refer. If problems developed, it was up to the patient to determine when those problems necessitated a call to the doctor, or a return to the hospital.

A new paradigm of medical care is rapidly taking hold in the American healthcare system. In this new approach:

- Providers, especially primary care providers and their patients have an interactive relationship that is continuous. Providers are expected to periodically initiate contact with patients who have complex and/or chronic illnesses in order to detect clinically relevant signs and symptoms at the earliest possible time.
- Diagnostic processes, referral protocols, and treatment regimens are evidence based; providers are actively tracked for adherence to evidence based guidelines with reimbursement based to a significant extent on evidence supported performance standards.
- Provider reimbursement is based on care quality, (the real value of the service in terms of helping the patient) rather than service volume (the number of visits, tests, procedures and treatments).

In the traditional paradigm, audiologists addressed the patient's desire for improved hearing. Physicians generally did not test or refer the patient with mild, moderate, or even severe hearing loss unless the patient or his or her family members defined it as a problem and wanted it taken care of. The treatment of hearing loss is considered to be elective medicine rather than necessary patient care.

In the new model of medical care, the patient's active understanding and participation in their medical treatment is far more important. If the patient does not understand their discharge instructions when they leave the hospital or the physician's office, and potentially fails to take a medication correctly or does not attend a follow-up visit, and as a result has an adverse health event due to that failure to understand, it is now the provider who will suffer a financial penalty. The provider (hospital or physician) will be paid less, or not at all, for the care necessary to address the avoidable event. If such events happen to a given provider more often than average, they may soon find that they are no longer a "preferred provider" by insurers and that they are receiving fewer referrals from other providers.

Thus, it is the physician/provider's responsibility to make sure that the patient's ability to communicate, and interpret their physicians instructions effectively so that the most desirable possible outcome is achieved. Verbal contact between the patient and physician is the most effective way to communicate the critically important aspects of care for the frail and elderly and chronically ill. If hearing loss impairs this communication, that hearing loss becomes a threat to the patient's health and a threat to the provider's income.

The audiologist's value in their partnership with primary care physicians with this objective is going to become a very important issue. According to J. Bakke M.D. MBA Senior Consultant, Zolo Healthcare Solutions, audiologists who provide high quality patient centered care should expect to be become an integral part of the medical care team.

## The Newer, Younger Patient Market

Pre-diabetes mostly occurs independently of age, so there needs to be an increased education and marketing focus on the younger patient population with metabolic diseases. Tobacco use is growing around the world. Among 15 year old Germans, 25 percent of all German males and 27 percent of females, now smoke on a regular basis. With evidenced based research proving that tobacco smoke causes hearing loss at twice the rate of non-smokers, audiology marketers can be agents of positive social change, as well as helping to decrease overall health care consequences.

Noise related hearing loss in the younger patient population is growing unabated, while those who are devoted to marketing the "attributes of sound" devise ever more recklessly clever ways for youth to have the ultimate in listening entertainment.

## Audiology's Mandate

As previously noted, Frank Lin M.D. and Yuri Agrawal M.D. from Johns Hopkins University state that hearing screening must begin in young adulthood. The Audiology industry now has a mandate from Medicine to confidently ask primary care physicians to refer their all their patients from early adulthood to the aged, for routine annual audiologic evaluations. This is not just good medicine, but preventive medicine as well.

## Audiology Marketing Efficiencies

A basic plan of action for audiologists that "reaches more patients, by reaching more physicians more frequently" involves organizing a four week call cycle to consistently educate the physicians and nurses about the negative consequences of untreated hearing loss, to promote the benefits of care, and explain why they should refer the patient to their clinic for compassionate, quality care, the latest diagnostic and treatment technologies, and friendly, efficient customer service.

This example of a "Disease State Marketing Schedule," shown in Figure 2, demonstrates how to alternate the educational priorities for your target market of physicians, by comorbidities. These are the largest patient populations who are likely to test with loss, and who will require the most educational emphasis by audiology providers. When this is done effectively over time, patient referrals will increase, marketing costs will decrease, a reliable revenue stream will be created, and the audiology clinic profitability will be enhanced.

Many audiologists require understandable, quality training programs, and a proven process before they commit to a long term practice development program that involves physician marketing, disease state marketing, and services marketing. Those who see the opportunities that await them by entering into a stronger working relationship with the medical community now will prevail in the current healthcare environment, as well as in the new health care landscape in the years ahead.

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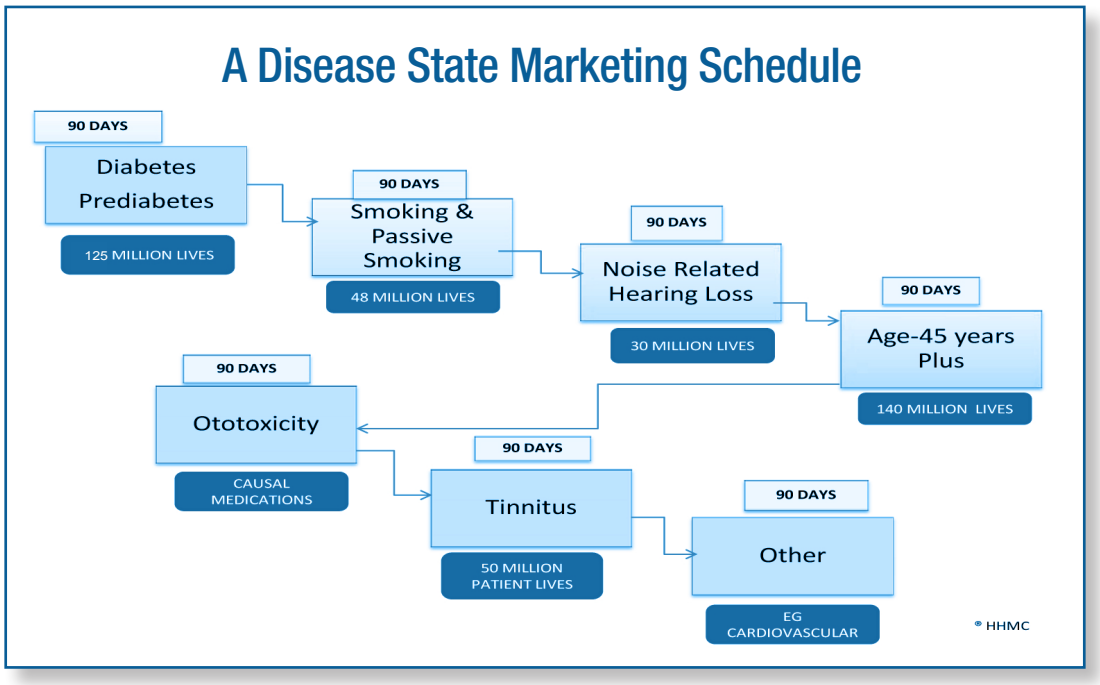


*Figure 2. An example of a Disease State Marketing schedule implemented by one audiology practice.*

## *Presentation Notes*

# *Partnering with Physicians to Deliver Integrative and Preventative Hearing Care*

*By: Brian Taylor, Au.D., and Bob Tysoe*

*November, 2013*

## Why physicians need audiologists and dispensing professionals, and why we need them.

*Interventional audiology requires that audiologists and other hearing care professionals change their orientation toward patient care. Rather than centering on the dispensing of a hearing aid or medical device, interventional audiology revolves around the disease state of hearing loss and its relationship to the chronic medical conditions listed in this article.*

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As we grow older, most of us are inclined to ask, what is the secret to a happy life? Fortunately, we live in an era in which the near-infinite processing power of computer algorithms can help us more definitely answer this question.

A team of researchers led by George Vaillant at Harvard University have been collecting data for a longitudinal study that is attempting to better understand the secrets of a happy life. Through a painstaking, 4-decade process, 268 men participated in a series of interviews, which researchers used to establish a Decathlon of Flourishing – a set of 10 accomplishments that define success. Two of the 10 items were related to economic success, four with mental and physical health, and four with social supports and relationships. Researchers found that a loving childhood, filled with warm relationships through young adulthood, was highly correlated with all items on the Decathlon of Flourishing.

On the other hand, there were weak correlations among the other socioeconomic and biologic variables. Their work, *Triumphs of Experience,*[1] demonstrates that an entire lifetime filled with warm and loving relationships (not high IQ, good grades, or wealth) are predictive of a happy life as you grow older.

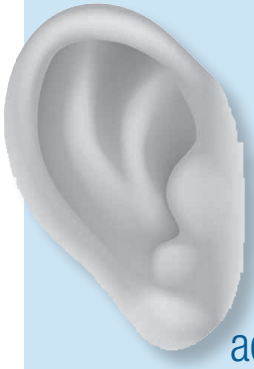
This fascinating longitudinal study serves as a reminder that audiologists and hearing instrument specialists play a crucial role in maintaining the overall health and vitality of all individuals regardless of age. After all, if you have difficulty hearing, those warm and loving relationships that are the secret to a long and happy life are bound to suffer.

The primary objective of this article is to shed light on the emerging role audiology plays in the long-term delivery of care to patients of all ages, especially those with multiple chronic medical conditions. It is only through better communication – of which good hearing acuity is imperative – that adults suffering from multiple chronic medical conditions will be better able to more actively participate in their care, including the ability to follow a physician's verbal instructions during a routine appointment.

The secret to a healthy practice may be similar to the secrets of a happy life: warm, lasting relationships with patients, colleagues, and other professionals. These interconnected networks may be more critical to your success than effective business management principals or the latest hearing aid technology that you offer in the clinic.

After reading this article, we hope you take action by fostering deeper relationships with the primary care physicians (PCPs) in your area. Before taking action, however, there are certain standards that must be put into place. Audiologists and their hearing instrument specialists cannot simply show up at PCPs' offices and expect them to embrace your request to create a long-term partnership. Thus, we believe the profession needs a new subcategory, called Interventional Audiology. *Authors' Note: We use the term PCP to broadly define physicians, such as family medicine doctors, gerontologists, general practitioners, and others who are often the first to examine individuals who are likely to suffer from hearing loss and other conditions associated with hearing impairment. Likewise, although we use the term Interventional Audiology, we do not mean to exclude any qualified hearing care professional, including hearing instrument specialists, from this discussion.*

## By the Numbers



**48 million**
hearing impaired Americans

**22 million**
adults under age 70 with self-reported hearing loss

**250,000**
approximate Primary care physicians

**12,000**
Dispensing Audiologists

**9,050**
Hearing Instrument Specialists

**12:1**
ratio of PCPs to hearing care professionals dispensing hearing aids

### Interventional Medicine

Over the past few decades, interventional medicine has become an important part of healthcare. As modern science has devised effective treatments for many disease states, healthcare delivery models have increasingly emphasized the treatment of chronic disease and the promotion of healthy lifestyles. By early detection and non-invasive treatment of various medical conditions, interventional medicine fits squarely within this preventive healthcare delivery model.

It should come as no surprise that the fundamental issue driving this change is the growing cost of healthcare. As costs have increased, so has the urgency to prevent illness whenever possible. The mantra of primary care today is "right care, right time, right provider." This means prevention or the earliest possible intervention with the best possible treatment for chronic illnesses, such as diabetes, dementia, cardiovascular disease, and related disorders.

In fact, the most common chronic condition experienced by adults is some combination of many of these conditions, which is called *multi-morbidity*. Recent research suggests that almost 3 in 4 individuals over the age of 65 have multiple chronic conditions.[2] Additionally, 1 in 4 adults 65 years of age and younger also have multiple chronic conditions.[3] According to Anderson,[3] patients with multi-morbidities are the major users of healthcare services and *account for more than two-thirds* of the healthcare spending in this country. To align with the clinical reality of multi-morbidity, experts have called for care to evolve from a disease orientation to a patient-goal orientation, focused on optimizing the long term health of individuals.[4] Hearing care professionals are well-equipped to step into this situation and provide valuable interventional services.

The rising costs of healthcare and the growing aging population are on a collision course that requires intervention from audiology. Audiologists have a significant opportunity to become an integral part of a physician's team of trusted advisors and play an essential role in this effort to provide the right care at the right time. With interventional hearing healthcare strategies that seek to minimize impairment and maximize function, the audiologist will play an increasingly prominent role in the future in controlling healthcare costs, while delivering timely, cost-efficient, and highly effective care.

### Interventional Audiology

Before going into the details of the role of audiology and hearing healthcare in an interventional delivery model, it is helpful to review the history of interventional medicine. Interventional medicine's origins can be traced back to ancient Egypt and the Babylonian Period. With long-term accumulation of experiences, interventional

medicine evolved as a system with the rise of interventional radiology treatment in the 20th century. New technological advances and innovative procedures have accelerated the improvement of interventional medicine in specialties that notably include interventional oncology, chemotherapeutic drug-eluting systems and bland beads for the targeted treatment of liver cancer, interventional cardiology, pulmonology, nephrology, pain management, as well as interventional otology and neuro-otology. Interventional audiology may soon be added to this list, as it offers tremendous promise in helping audiologists and hearing instrument specialists expand their reach to greater numbers of patients.

According to MarkeTrak data, the average age of a patient in the United States who is fitted with their first pair of hearing aids is 69 years, many of whom are seen for the first time by an audiologist for a hearing test shortly before their initial purchase. This suggests that society categorizes hearing loss as "a disease of the aged." Recent research, however, demonstrates that hearing loss is now "a disease for all ages"

Evolving to an interventional audiology model means, using one example, that a 21-year-old with a hearing disability caused by the comorbid condition of type 2 diabetes may spend over 60 years of their life with communication disorders, an increased risk of depression, enhanced social isolation, and reduced employment opportunities because of a lack of systematic interventional strategies by both primary care specialists and hearing healthcare professionals. Earlier intervention from a hearing care professional has the potential to turn a lifelong handicap into a long-term improvement in quality of life that benefits the public good.

## Hearing Loss as a Multi-morbidity

Hearing loss is the second leading cause of years living with disability (YLD) – second only to depression.[5] John Bakke, MD, of Zolo Healthcare Solutions, refers to acquired hearing loss of adult onset as a triple threat to patients [personal communication, July 27, 2013]:

1. Clinically significant hearing impairment is itself a disability, and is an indication for effective remediation in its own right;

2. Hearing loss interferes with a patient's ability to be treated for other medical conditions because it hinders an individual's ability to engage with physicians and understand treatment advice and directives; and

3. Emerging research suggests that hearing loss may actually accelerate some disabilities such as cognitive dysfunction and vestibular impairment.

The prevalence, comorbidity, and disabling effects of hearing loss underscore the need for aggressive preventive programs that identify conditions such as hearing loss that threaten health outcomes.[6] Hearing healthcare may be an emerging interventional discipline within medicine that has an important role in breaking the cycle of morbidity and mortality associated with a patient's inability to hear. The treatment of hearing loss by audiologists and qualified professionals can provide interventional assistance by providing routine hearing evaluations for patients of "patient centered medical care homes" (PCMH) that seek to focus on prevention, early detection, and evidence-based treatment. This is likely to result in improved quality of care, patient compliance, improved outcomes, and reduced overall cost of care.

Audiologists and hearing instrument specialists are now being increasingly viewed within the wider medical community as an essential component of patient care for a broad range of disease processes, which, previously, were not considered relevant to hearing impairment. Examples of the value of interventional audiology being included in the comprehensive team of primary care-givers who seek to minimize impairment and maximize function include:

***Dizzy Patients.*** Lin and Ferrucci[7] recently published research documenting the robust association between high frequency hearing loss and an increased risk of falls. The researchers found for every 10 dB increase in hearing loss, there was a 1.4-fold (95% CI, 1.3-1.5) increased odds of an individual reporting a fall over the preceding 12 months.[7]

Early interventional audiological assessment, as well as balance testing, may allow primary care physicians to prevent unnecessary fulls, hospitalizations, and even death associated with complications of hip fracture and other fall-related trauma.

***Diabetic patients.*** The diabetic patient is at greater risk due to neuropathies in the feet that may cause ataxic gait, and with a twofold increase in the risk of high frequency hearing loss.[8] Physicians and hearing healthcare specialists may jointly counsel this patient type on preventive care strategies that intervene in possible trauma-related health concerns related to falls.

***Why intervention?*** Hearing impairment is a hidden disability that is not visible to patients and their support systems, including physicians. Audiologists and other healthcare professionals would be wise to intervene in the care of individuals with medical conditions, and high-risk comorbidities associated with a higher incidence of hearing loss.

Although there is a paucity of evidence from randomized controlled trials, early identification, remediation, and treatment of hearing loss are thought to lead to higher overall quality of life outcomes. Common sense requires hearing care professionals to educate physicians and other medical practitioners about the linkage between hearing impairment and numerous medical conditions. Let's examine some of these comorbid conditions in great detail.

### Hearing Loss and Cognitive Decline

By 2050, 1 in 30 Americans will suffer from dementia. It is thought that delaying the onset of dementia by 1 year could potentially reduce the incidence of dementia by 15%, thus saving billions of dollars in healthcare costs. Lin et al[9] at John Hopkins University followed 1,984 individuals between the ages of 36 and 90 years of age. None of the participants had cognitive impairment as measured on standardized tests at the beginning of the study, while some of them did have hearing loss. The participants were followed over an 18-year period. The effects of age, medical risk factors, diabetes, and hypertension were controlled in the study design. Results of the study indicated that individuals with hearing loss have a greater risk of subsequently developing dementia than do individuals without hearing loss.

Specifically, Lin and colleagues[9] found that study participants with hearing loss at the beginning of this longitudinal study have a 40% chance of a greater rate of cognitive decline compared to those with normal hearing at the beginning of the study. Additionally, the researchers surmise that *a mild (25 dB) hearing loss equates to a 7-year cognitive decline.* A by-product of Lin et al findings would be to encourage patients to have their hearing screened at an earlier age, and to actively participate in the appropriate auditory treatment program, if indicated, which may result in a lower incidence of clinically significant dementia.

### Hearing Loss and Diabetes

Hearing loss is more than twice as common in adults with diabetes compared to those who do not have the disease, according to a new study funded by the National Institutes of Health (listen to the *HR* podcast, "Diabetes and Hearing Loss," an interview with Kathleen E. Bainbridge, PhD, which aired in January 2009).[8] About one-fifth (21%) of the diabetics surveyed had hearing loss, compared to only 9% of non-diabetics in this outcomes-based study, which controlled for other variables. Of the diabetics tested, 68% of them were found to have hearing loss in the higher frequencies. Lin et al[10] also evaluated NIH data with a higher age cutoff and also showed that diabetics have about twice the prevalence of hearing loss (20%) in the US population compared to those who do not suffer from type 2 diabetes.

### *Understanding the PCP Perspective*

Hearing care professionals need to recognize the challenge and obstacles associated with building referral networks with PCPs. Specifically, we must recognize the busy nature of a PCP's practice. Most PCP practices see patients of all ages with a range of conditions, many of which can be life threatening. For the typical PCP, issues related to hearing loss will remain a relatively low priority; therefore, hearing care professionals need to be sensitive to the practice's needs. This usually means that we must work directly with the office manager or lead nurse to ensure our message is being received.

Due to the extremely busy nature of their schedule, hearing care providers must package educational material so that it is specific and free of jargon and slant. The educational material needs to be in alignment with how PCPs absorb information, thus materials need to be evidenced-based and translate research into quality patient care. Finally, the educational material needs to be delivered to the PCP in a familiar format, such as grand rounds or one-page summary sheets.

A certain degree of hearing loss is a normal part of the aging process for all of us, but it is often accelerated in patients with diabetes – especially if blood-glucose levels are not being controlled with medication, diet, and exercise. Some 85% of diabetics do not achieve their annual healthcare goals for hypertension, cholesterol, and blood sugar; poor patient compliance is problematic in this population, and may be enhanced by diabetics who cannot hear, thus reducing their engagement with their caregivers, and increasing the risk of further complications.

Henry Ford Hospital in Detroit conducted a study showing that women between the ages of 60 and 75 with poorly controlled diabetes had significantly worse hearing then those whose diabetes was controlled. Given these findings, diabetic patients and those at-risk for developing diabetes should have their hearing screened on an annual basis. Recently, the American Diabetes Association recommended that diabetics who suspect they may have a hearing loss contact their primary care provider, who may refer them to either an audiologist or a licensed hearing aid dispenser for a hearing screening.[11]

### Hearing Loss and Smoking

Approximately 45 to 48 million Americans currently smoke, with female smokers slightly outnumbering male smokers. Current estimates suggest that approximately 60% of children in the United States are exposed to secondhand smoke each day.

Research indicates that smokers were 1.7 to 2.1 times as likely to have a hearing loss as non-smokers.[12] Secondhand smoking also appears to have a deleterious effect on hearing, as individuals exposed to smokers have a 1.83 increased risk of sensorineural hearing loss compared to those not exposed to secondhand smoking.[13]

Research findings show that different mechanisms play a role in hearing loss due to exposure to smoking. The first may be related to tissue hypoxia (lack of oxygen); nicotine and carbon monoxide may actually deplete oxygen levels to the highly vascularized cochlea, which is bathed in electrolytic fluids. If oxygen is depleted, tissue damage can occur.[14]

The effect smoking has on hearing also appears to be correlated with the amount of cigarettes smoked. In a study conducted on Japanese office workers who smoke,[15] the research showed that, as the number of cigarettes smoked per day and pack years of smoking increased, the risk of high frequency hearing loss increased in a dose dependent manner. In other words, the more people smoked each day and the longer they smoked, the worse the hearing damage – especially in the high frequency range. Smoking and secondhand smoke are associated with elevated pure-tone thresholds and an increased prevalence of both low and high frequency sensorineural hearing loss that is directly related to level of exposure.

### Hearing Loss and Depression

Depression is also associated with the elderly patient suffering from acquired hearing loss. Jones and White[16] conducted a meta-analysis on studies that examined the relationship between hearing loss and mental health. They concluded that individuals with hearing loss were more vulnerable to depression than people from the general population.

More recently, Garnefski and Kraaij[17] examined the relationship between cognitive coping strategies, anxiety, depression, and acquired hearing loss. Their results suggested that maladaptive coping skills and symptoms of anxiety and depression are related issues among individuals with acquired hearing loss. Simply stated, patients with hearing loss tend to suffer more from the ill effects of depression and anxiety when compared to individuals with normal hearing. It seems that hearing loss adds to the complexity of the situation for patients suffering from these conditions. Given the paucity of studies in this area, however, further research is necessary to better understand the relationship between hearing loss, anxiety, and depression.

### Hearing Loss and Aging-in-Place

The importance of interventional audiology goes beyond its relationship to chronic medical conditions. There are also lifestyle necessities requiring the practice of interventional hearing care.

The Centers for Disease Control and Prevention (CDC) defines "aging-in-place" as the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level.[18] Of course, most adults would prefer to age in place; in fact, 78% of adults between the ages of 50 and 64 report that they would prefer to stay in their current residence as they age. One-third of American households are home to one or more residents 60 years of age or older.

People unable to age-in-place are more likely to be socially isolated and may become institutionalized – thus becoming more of a drain on the current healthcare system, including Medicare and Medicaid. In fact, the CDC estimates that, in the year 2020, for Medicare beneficiaries who are admitted to the hospital due to injuries resulting from an accidental fall, the hospitalization charges paid by Medicare average in the range of $9,113 to $13,507.

As Genther aet al[19] recently demonstrated, adults with hearing loss have a higher rate of hospitalization and poorer overall health. This data represents an enormous opportunity for hearing care professionals to intervene in the efficient delivery of services that maintain a higher quality of life for a large and growing population of people.

Considering the growing aging-in-place population and the fact that nearly 2 out of every 3 adults over age 70 have hearing loss, hearing healthcare providers certainly have a significant role to play in the aging-in-place movement, and it is reasonable to hypothesize that proper treatment of hearing loss in the elderly population may result in a higher percentage of that population being able to remain in their own homes until a more advanced age than would otherwise be the case.

### Hearing Loss and Healthy Aging

Another sub-category of patients who could potentially benefit from interventional audiology services are healthy-agers. Unline Baby Boomers – who are defined as those born between 1946 and 1964 – healthy-agers are best described as individuals who want to live to be 100 in the mind and body of a 45-year-old, and they often are willing to spare no expense to accomplish this goal.

Since healthy-agers are defined by lifestyle needs and not year of birth, this segment of the population is comprised of people of various ages. The role of interventional audiology within the healthy-aging movement is to raise the awareness of the impact diet, nutrition, and physical fitness play on hearing acuity. Additionally, interventional audiologists could demonstrate to healthy-agers the use of downloadable apps, which can be used to improve hearing and overall cognitive function.

### Implementation of Interventional Audiology in Your Clinic

Let's examine some specific areas in which audiologists can work in partnership with physicians and other medical professionals to deliver preventive, interventional patient care. Because 80% of older adults make at least one annual physician visit and sections of the Affordable Care Act incentivize younger adults to see their healthcare provider for routine check-ups, it is imperative for audiologists to educate primary care physicians and physician assistants. By adapting an "educate to obligate" communication strategy between audiology and primary care medicine, audiologists can partner with physicians to provide more rapid and effective diagnosis and treatment of hearing loss. There are three broad categories of audiologist-primary care physician engagement: 1) education about the impact of hearing loss; 2) identification and screening; and 3) professional services and aural rehabilitation.

### Education on Impact of Hearing Loss

Physicians must be educated about the impact hearing loss has on their ability to deliver effective care. Systematic, evidence-based targeted education of PCPs is the most fundamentally important component of implementation of interventional audiology. Given that most PCPs have had very little formal training on the consequences of untreated hearing loss, the education process must begin by raising awareness with the PCPs in your area. In short, PCPs need to know that untreated hearing loss impacts their own clinical effectiveness with patients suffering from hearing impairments. Some of the aspects of patient-physician communication affected by hearing loss include:

- Review of medication use, dosage, etc;
- Cognitive assessment when dementia or other cognitive deficits are suspected;
- Communicate key components of a treatment plan or follow-up care;
- Discussion of palliative care and end of life issues;
- Cognitive or depression screenings as part of routine practice or in advance of a surgical procedure.

### *Getting Started: Ensure Successful Outcomes*

Ensure that the culture of your practice is devoted to providing comprehensive hearing care services, including aural rehabilitation. Physicians must be given the proper signal that your practice exudes quality, and this starts with your ability to delivery complete care in a trusting and nurturing environment. Failure to deliver on this first step is likely to stymie any success with development of a physician referral network. To see if your office is signaling a culture of quality and excellence, contact the authors to find your Total Quality Score.

| | Yes | No |
|---|---|---|
| **Health Condition** | | |
| 1. Do you smoke cigarettes? | | |
| 2. Do you or a family member believe that you have difficulty hearing or understanding? | | |
| 3. Have you been told that you now have diabetes? | | |
| 4. Have you been told that you have cardiovascular disease at this time? | | |
| 5. Have you been told that you now have arthritis? | | |
| 6. Are you taking aminoglycoside cisplatin, an anti-inflammatory agent, or a loop diuretic? | | |
| 7. Have you had a fall within the past year? | | |
| 8. Have you been told that you have low vision or blindness? | | |
| 9. Have you been told that you are suffering from depression? | | |
| ***Total*** | | |

*Figure 1. The multifactorial risk assessment created by Weinstein.[20] Reprinted with her permission.*

A miscommunication because of hearing loss during any of these routine patient interactions may result in the inefficient delivery of care, which undoubtedly increases costs, but may result in catastrophic consequences – even death.

In regard to education of physicians, audiologists and others within the hearing care industry have a twofold responsibility:

1. Educate the medical community about the potential catastrophic consequences of untreated hearing loss.
2. The comorbid relationship hearing loss has to chronic conditions mentioned previously.

Educating the community is another important component to interventional audiology. In addition to the use of traditional newsletters, social media and websites are useful educational tools that raise awareness within the community of the consequences of untreated hearing loss, especially among the chronically ill. A practice's website can be designed to meet the lay public's educational needs, as well as primary care medicine's, with the goal of informing physicians about their interventional capabilities.

Audiologists and hearing instrument specialists may seek to present the latest preventive and interventional treatment strategies to the medical community through presentations at hospital grand rounds, and at primary care physician teaching institutions. Educational opportunities that seek to provide hearing health educational programs can be offered in partnership with the American Diabetes Association, the American Cancer Society, and the American Lung Association.

Professionals also can attend, display, and educate at cardiology, pulmonology, endocrinology, neurology, trauma, geriatric, and other physician specialty conferences, so that we begin to engage in a more effective partnership with medicine, and intervene where it is medically appropriate.

## Identification/Screening

The second component to implementing an interventional audiology program in your practice is the ability to conduct routine hearing screening. Currently, the Preventive Services Task Force (PSTF) does not support hearing healthcare screening. This statement, along with other factors mentioned below, makes it challenging for hearing care professionals to move PCPs toward conducting hearing screening in their practices. Despite the position of the PSTF, audiologists may find themselves advising PCP practices in the implementation of an adult hearing screening program.

Due to the evolution of digital technology, accurate hearing screenings now can be conducted in an automated fashion using tablet computers or apps on a smartphone. Before using any of these computer-based hearing screening technologies, practitioners are urged to evaluate their reliability and accuracy. When establishing a screening program within a medical practice, there are 6 W's that need to be thoughtfully considered:

***Who does the screening?*** If it is not feasible for the hearing care professional to conduct the screening in the primary care physician's office, a nurse or medical office assistant needs to be trained to conduct the screening or oversee it. Even automated tools (eg, Ultimate Kiosk system) require the presence of someone to monitor them.

***Who gets screened?*** It is probably not feasible to conduct the hearing screen on every patient examined by the PCP, even all patients over age 65. We recommend the use of a comorbidity risk assessment, like the example designed by Weinstein,[20] shown in Figure 1. This assessment can be added to a routine patient intake form, and medical assistants can be instructed to refer anyone with a score of 2 or higher, as this score indicates that hearing loss is more likely to be identified in these patients.

***What screen is used?*** After consideration of who conducts the screening, as well as the target population, the next detail is to determine what screening tool you will use. There are many choices from smartphone apps (eg, uHear) to handheld devices to automated hearing screening programs placed on a tablet computer. In addition, practitioners may decide to forego a pure-tone screening and use any number of pencil and paper questionnaires. The 10-item Screening for Otologic Functional Impairments (SOFI)[6] can be used to identify patients likely to be suffering from hearing loss (Figure 2). The SOFI is high in reliability, valid, and highly correlated with similar hearing handicap self-reports.[20] Another pen and paper screening tool that has been validated is the Quick hearing Check,[21,22] which can be found at the Better Hearing Institute website: http://www.betterhearing.org/press/pdfs/QuickHearingCheck.pdf

***Where does the screening occur?*** A separate consideration is where the hearing screening will take place. Some of the choices include in an examination room, in a reception area, or even from the comfort of home if an app or questionnaire is used. Locations need to be chosen that minimally impact the normal workflow of a busy practice.

***When does the screening occur?*** Another consideration is when the hearing screening should be conducted. Options include before or after the patient's visit with the PCP.

***What is the referral process?*** Perhaps the most critical question: you must determine the process in which patients who fail

Instructions: The purpose of this questionnaire is to identify any problems you are having which may relate to your ears – including hearing difficulties, dizziness, or tinnitus (ringing/buzzing noises in your ears or head). Please circle either *Yes, Sometimes, or No* for each question. If you use hearing aids, please answer the way you hear while using your hearing aids. If you are not experiencing any difficulties, please indicate by marking *No*.

| | | | | |
|---|---|---|---|---|
| D-1 | Because of feelings of dizziness, is it difficult for you to walk around the house in the dark? | Yes | Sometimes | No |
| D-2 | Does dizziness interfere with your job or household responsibilities? | Yes | Sometimes | No |
| D-3 | Does bending over increase your feeling of dizziness? | Yes | Sometimes | No |
| H-1 | Does a hearing problem cause you difficulty when listening to the television or radio? | Yes | Sometimes | No |
| H-2 | Does your hearing problem cause you to feel frustrated when talking to members of your family? | Yes | Sometimes | No |
| H-3 | Does a hearing problem cause you difficulty when visiting with friends, relatives, or neighbors? | Yes | Sometimes | No |
| T-1 | Do you feel that you can no longer cope with tinnitus? | Yes | Sometimes | No |
| T-2 | Because of tinnitus, do you have trouble falling or staying asleep at night? | Yes | Sometimes | No |
| T-3 | Do you feel you cannot escape your tinnitus? | Yes | Sometimes | No |
| G-1 | Do you feel that any difficulty with your hearing, dizziness, or tinnitus significantly restricts your participation in social activities such as going to restaurants, dancing, movies, or other events? | Yes | Sometimes | No |
| | | **Global Score:** | | |
| | | **Total Score:** | | |

In the box below, please circle the number that corresponds with the severity of the problem.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Dizziness | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Hearing Loss | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Tinnitus | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

*Figure 2. Screening Otologic Function of Older Adults (SOFI).[6,20] Reprinted with permission.*

the screening are referred to the hearing care practice. Some of the considerations include the establishment of pass/fail criteria, scheduling an appointment to see the audiologist for a comprehensive assessment, and the manner in which follow-up reports are sent back to the patient's primary care physician.

## Professional Services and Aural Rehabilitation

As Lin[25] stated, "Contrary to popular perceptions, proper hearing rehabilitative treatment is complex, does not simply consist of hearing aid use, can vary substantially depending on the treating audiologist." This strongly suggests that audiologists and hearing instrument specialists must offer comprehensive and personalized aural rehabilitation services, if they want to develop viable partnerships with physicians.

Additionally, the entire profession needs to put into practice evidence-based clinical standards to ensure high-quality outcomes, as this will further enhance our professional credibility with PCPs. This process starts with educating PCPs on the comprehensive nature of the services a modern practice offers, including:

- Computer-based auditory training:
- Apps that allow patients to conduct auditory training exercises on their own;
- Aural rehabilitation classes, both group and individual;
- Comprehensive hearing aid orientation services;
- A choice of service packages that are bundled with product offerings;
- Consistent use of an evidence-based clinical protocol; and
- Use of self-report measures that document patient outcomes.

## Change Is Inevitable, Transformation Is Optional

Interventional audiology requires that audiologists and others associated with the care of hearing-impaired individuals *change their orientation toward patient care.* Rather than centering on the dispensing of a hearing aid/medical device, interventional audiology revolves around the disease state of hearing loss and its relationship to the chronic medical conditions listed here.

## An "All Hands on Board" Approach Needed

You don't necessarily need to be a licensed audiologist to deliver interventional audiology care to the growing number of individuals requiring integrative and preventive care. Licensed hearing instrument specialists who possess the following are a good fit for an interventional care model:

- Maintain a strong referral network with audiologists and physicians
- Provide comprehensive services, including aural rehabilitation and auditory training
- Follow IHS best practice standards and code of ethics

In order for the interventional hearing healthcare professional to become a valuable and respected member of the physician's preventive care team, several items and procedures are needed. These are listed in Table 1. Notice there are three distinct phases of interventional audiology: 1) awareness; 2) identification; and 3) treatment/follow-up. Table 1 lists the tasks and procedures that many audiologists currently don't process, but are necessary to successfully implement an interventional audiology strategy.

Chronic diseases are the most costly health problem in the United States.[23] The conditions mentioned in this article have evidence indicating a higher rate of hearing loss associated with them. Thus, hearing care professionals need to be directly involved in all phases of identification and remediation. The process must begin with a dedicated effort on the part of every audiologist and hearing instrument specialist to educate PCPs, as many of them lack the appropriate knowledge base to effectively identify patients with hearing loss and its ramifications for quality of life and successful outcomes.[24]

The broader negative consequences of hearing loss, particularly in older adults, are now beginning to surface. It is the responsibility of audiologists to draw attention to this using the best available evidence. This paper is intended to offer some preliminary guidance, foster the beginning of dialogue, and offer some first steps on a journey toward interventional hearing care for patients of all ages. It is in the best interest of primary care physician, of the hearing healthcare professions, and certainly in the best interest of the patient's quality of life.

***References*** can be found at www.hearingreview.com.

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## Components of an Interventional Audiology Tool Kit

### Education/Awareness

- Website and social media that provide data on the relationship of hearing loss to various chronic diseases, including links to patient organizations
- Informational newsletters with latest evidence on the disease state of hearing loss, delivered to physicians on a monthly basis
- Public lectures for the community that discuss disease state of hearing loss and what to do about it
- Clinical processes and patient materials that facilitate the practice of healthy hearing behaviors
- Evidence-based educational materials on the disease state of hearing loss that can be personally delivered to physicians
- Use of a referral form like the one in the addendum

### Identification/Screening

- Multifactorial risk assessment form[6]
- SOFI questionnaire[20]
- Use of a comprehensive case history form that asks patients about chronic diseases associated with hearing loss
- Referral network of physicians that specialize in various chronic diseases
- Detailed reports back to referring physicians, outlining auditory assessment outcome and comprehensive treatment options

### Treatment and Follow-up

- Comprehensive habilitation services, aural rehabilitation programs – beyond simply dispensing hearing aids
- Active participation in the health and wellness of patients, including providing support on healthy diets and exercise, consistent with regimens recommended by their physician

## *Presentation Notes*

# *Forming Strategic Alliances with Primary Care Medicine: Interventional Audiology in Practice*

*By: Brian Taylor, Au.D., and Bob Tysoe*

*July, 2014*

## How to leverage peer-reviewed health science to build a physician referral base

*"The people who think they are crazy enough to change the world are the ones who do so."*

*– Steve Jobs*

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In previous publications and blog posts, we have touted the importance of obtaining "pillar of community" status and how it can be used to build a sustainable independent practice over the long term. This article will delve into a specific realm of pillar of community—your ability to form meaningful connections with primary care medicine. This approach is one component of interventional audiology, which we introduced in the November 2012 edition of *Hearing Review.*[1]

There are approximately 260,000 primary care physicians (PCPs) in the United States who influence 19% of the gross domestic product (GDP). This amounts to *$2.7 trillion* spent per year on healthcare in the United States.[2]

Each one of these primary care physicians has approximately 2,000 patients in his/her practice. Based on a review of National Institutes of Health (NIH) data, Lin et al[3] estimated that 20.1% of Americans (48 million people) cannot pass a 25 dB hearing screening in either one or both ears using the World Health Organization's standard hearing screening regimen.

Most hearing care professionals (HCPs) would agree that this degree of hearing loss is severe enough to interfere with daily communication. Although it may have taken awhile, other healthcare professionals—particularly physicians—are beginning to recognize the growing epidemic of age-related hearing loss and its impact on public health. The pertinent question is: Will the relatively small and obscure profession of audiology and hearing healthcare influence the practice of primary care medicine and nearly a fifth of a nation of more than 315 million people's GDP?

The marvels of modern medicine are so ubiquitous that we often take them for granted. For example, average life expectancy of an American now approaches 79 years—an increase of more than 30 years since 1900![4] Individuals ages 70 to 75, those who are just now beginning to seek the services of audiologists on a massive scale, have scarcely experienced the premature death of siblings, friends, or neighbors, making this group unlike any other generation in history. Thanks to antibiotics, science-based clinical practices, and vaccinations, infectious diseases such as scarlet fever and influenza are no longer a possible death sentence for those afflicted with them. A consequence of this much longer lifespan is our ability as a society to manage the expenses of a rapidly aging population. The combination of a rapidly aging population, along with significant increases in the cost of medical care, has necessitated the changes we are beginning to see in how medical care is delivered in the United States.

These changes in the US healthcare system are huge opportunities for audiologists and dispensing professionals, especially in the context of the increasing awareness of age-related hearing loss as a public health concern. (See coverage of the Institute of Medicine's January 2014 2-day workshop on "Age-related Hearing Loss and Healthy Aging" at: http://www.hearingreview.com/2014/02/iom-nrc-hosts-hearing-lossand-healthy-aging-workshop.)

The growing awareness of age-related hearing loss as a public health concern represents a monumental opportunity for hearing care professionals to touch the lives of more patients in need of their services. This can only occur if we are willing to form partnerships with primary care physicians around the triple threat of untreated age-related hearing loss and the comorbid conditions associated with it. From a business perspective, a strategic alliance between audiologists and primary care physicians in communities

across the country represents a sustainable revenue stream for clinicians willing to unbundle and charge for professional services. More importantly, from a patient's perspective, early intervention of age-related hearing loss and its consequences has the potential to allow individuals the ability to maintain an active and participatory life as they age.

Let's deconstruct this incredible opportunity to build bridges with the primary care physician community. Should a hearing healthcare provider establish a defined market of primary care doctors within a 5- to 10-mile radius from his/her practice (eg, 50 physicians), all of whom have 2,000 patients per practice, the target market is actually 100,000 patients—20.1% of whom have a potentially treatable loss. That amounts to 20,000 patients. Approximately 25% have already been treated for hearing loss,[3,5] so 15,000 patients remain for hearing care professionals to find mutually beneficial ways to partner with primary care physicians in the comprehensive care of their patients.

### The 4 Ps of Modern Healthcare: Preventive, Participatory, Preemptive, and Personalized

Due to changes in the American healthcare system, the practice of medicine is expected to see a marked increase in demand for services, especially for primary and preventive care. Because it is not possible to increase the supply of physicians in the short term (and in the long term, increasing the number of physicians is likely to increase the costs of delivering these types of services), the American healthcare system needs strategies for maintaining access in the face of increasing demand. In view of these proposed changes to the American healthcare system, physicians are now being encouraged to implement the following[6]:

1. Create primary care teams in which each member of the team functions at the highest level of her license.
2. Encourage self-care through better education of patients about their condition.
3. Organize seniors who can no longer live independently into patient-centered primary care homes in which the same physician or team of physicians orchestrates delivery of healthcare, so that the appropriate type of preventive services can be delivered in a consistent manner and duplication of services is minimized.
4. Use alternatives to a single patient-physician visit when possible, such as group visits for diabetic patients and the use of telemedicine.[5,6]
5. Eliminate unnecessary testing and overuse of medications.


*Figure 1. The three keys to attaining Pillar of Community status.*

These recommended changes in medical practice are a golden opportunity to demonstrate how audiology and hearing healthcare contribute to improving the overall quality of care of patients at risk for hearing loss, while reducing the overall costs to the entire healthcare system. This process starts with how audiologists and dispensing professionals fit into the larger picture of healthcare from the perspective of an entry point for hearing care, the primary care physician.

The transformation of healthcare to personalized, preventive, preemptive, and participatory is demanding audiologists, in particular, to rethink how they create value in the marketplace. In short, the future of audiology may be less dependent on dispensing a device and more dependent on our ability to offer personalized, preventive, preemptive, and participatory services to younger patients with milder hearing losses.

At the heart of this transformation from the device being the center of our universe to a myriad of diverse rehabilitative services taking center stage is our ability to effectively communicate with the medical community using the three traits shown in Figure 1.

### Building Effective Relationships

In an era of smartphones and Skype, where global communication is instantaneous and almost free, there is something downright old fashioned and quaint about how to build an effective relationship with the primary care physician community. After more than a decade of helping hearing care professionals build relationships with physicians, we believe the key drivers of an effective HCP-PCP relationship in which all parties, including patients, benefit are

depicted in Figure 1. Let's examine each of the three key drivers more carefully.

***Authenticity.*** Ensuring to the PCP that you have the best interests of the patient as your highest priority begins with the ability to be authentic. Authenticity is best described as the ability to engender trust and respect in another person by putting your true self forward.

Due to our increasingly transparent world where information travels at lightning speed to anyone with an Internet connection who happens to be paying attention, the rhetoric of your marketing efforts must be congruent with the reality of how you interact with patients, the community, and other professionals, including PCPs. Other people quickly recognize when a marketing campaign centered around the promise of delivering a transcendent patient experience is overshadowed by the reality of an ordinary, high-pressure sales pitch revolving around hearing aids.

In simple terms, authenticity means that you deliver on the promise of your marketing and advertising campaigns. Any disconnect between the two is likely to damage your reputation or brand. Being perceived as authentic—saying what you mean and meaning what you say—can only occur if you are visible within your community and credible in your communications.

***Visibility.*** In a world in which your brand centers on the professional and not the devices you dispense, it is imperative you are visible to the entire community, especially PCPs. Despite all the efforts of hearing aid manufacturers, industry consultants, and buying groups to create glossy physician outreach materials, *these materials still need to be delivered by the person who is going to be seeing the patient.*[7]

Taking no more than 2 hours per week to personally visit a PCP practice is a proven approach to becoming more visible and building your brand image.

***Credibility.*** The final section of the PCP relationship triangle is credibility. In short, a credible professional is one who knows the latest science as it relates to hearing loss and amplification and can apply it to clinical practice. From the perspective of building relationships with the PCP community, credibility relates to the fact that you can read, evaluate, apply, and articulate the peer-reviewed research pertaining to age-related hearing loss and its myriad comorbidities.

Physicians are trained in the scientific method and are taught in medical school to evaluate new information with healthy skepticism. Therefore, any communication or attempt to educate medical professions must be grounded in well-reasoned evidence.

## Arm Yourself with Data: Five Studies You Need to Understand

Hearing care professionals would be wise to read these five studies, which use well designed methods and have been published in peer-reviewed journals within the past 2 years, and cite their relevant findings in any professional communication with PCPs.

### *1) Lin F, et al. Hearing loss and cognitive decline in older adults. JAMA Internal Medicine. 2013;173(4):293-299.*

A total of 1,984 adults between the ages of 70 and 79 were followed up to 12 years in order to evaluate whether hearing loss is independently associated with accelerated cognitive decline. Cognitive testing consisted of the Digit Symbol Substitution (DSS) test and the 3MS, which are two standardized tests of cognitive function in adults.

Results indicated that 1,162 individuals with baseline hearing loss had a 32% poorer score on the DSS and a 41% poorer score on the 3MS compared to those with normal hearing. Compared to those with normal hearing, individuals with hearing loss at baseline had a 24% increased risk for incident cognitive impairment.

The authors concluded that hearing loss is independently associated with accelerated cognitive decline and incident cognitive impairment in older adults. On average, individuals with hearing loss would require 7.7 years to decline by 5 points of the 3MS, while individuals with normal hearing experienced a 5 point decline over a 10.9 year period. Furthermore, the authors indicated that a 25 dB hearing loss equates to 7 years of cognitive decline when compared to a similar age group with normal hearing.

### *2) Fisher D, et al. Impairments in hearing and vision impact on mortality in older people. Age and Aging. 2014;43(1):69-76.*

The main objective of this study was to examine the relationship between hearing and vision impairments and mortality from all cause (all-cause mortality by age group is the annual number of deaths in a given age group per the population in that age group, usually expressed per 100,000) and cardiovascular disease among older people. All 4,926 study participants were from Iceland and 67 years of age or older.

Participants were placed into one of three categories: vision-only impairment (VI), hearing-only impairment (HI), and dual sensory impaired (DSI), and they were followed up to 7 years. After adjusting for age, significantly increased mortality from all-cause and cardiovascular disease was observed for the HI and DSI, especially among men. After further adjustment for mortality risk factors, individuals with HI remained at higher risk for death from cardiovascular disease.

Whether hearing loss is an indicator of aging or frailty, physical manifestations resulting in reduced social competence, or a reflection of other adverse health status is unclear. However, results indicated that older men with DSI or HI were at a significantly greater risk for all-cause and cardiovascular death. Regular hearing assessments and rehabilitation services at an earlier age in order to promote long-term health and longevity are warranted based on these findings.

***3) Mick P, et al. The association between hearing loss and social isolation in older adults.*** *Otolaryngology-Head & Neck Surgery. 2014;150:378-384.*
The objective of this study was to determine if age-related hearing loss is associated with social isolation, and whether factors such as age, gender, and hearing aid use moderate this association. There were 1,453 male and female participants in this study, all between the ages of 60 and 84 years. Social isolation was defined using the social isolation score (SIS).

Results indicated that greater amounts of hearing loss were associated with increased odds of social isolation in women aged 60 to 69. Other groups did not show a significant relationship between hearing loss and social isolation. These results suggest that women within this age range are more likely to alter their lifestyle due to their hearing loss; thus, they are more likely to become socially isolated.

***4) Chuan-Ming L, et al. Hearing impairment associated with depression in US adults, NHANES 2005-2010.*** *Otolaryngology-Head & Neck Surgery. 2014;140(4):293-302.*
This study estimated the prevalence of depression among adults with hearing loss. Using the 9-item Patient Health Questionnaire (PHQ-9), the prevalence of depression among 18,318 participants of the National Health and Nutrition Examination Survey (NHANES) was examined.

The prevalence of depression increased as hearing loss became worse, except among those self-reported as deaf. Among individuals over the age of 70, no significant association between self-reported hearing loss and depression was found. Adults under the age of 70, particularly women, had a significant association between moderate hearing loss and depression.

***5) Lin F, et al. Association of hearing impairment with brain volume changes in older adults.*** *Neuroimage. 2014;90:84-92.*
Brain volume changes were monitored for a mean span of 6.4 years in 126 adults between the ages of 56 and 86. Using sophisticated brain volume measurement techniques, and after adjusting for cardiovascular and demographic factors, the researchers found that individuals with hearing loss had accelerated brain volume declines. These declines in brain volume were primarily confined to the right temporal lobe.

The findings of this study indicate that peripheral hearing loss is independently associated with accelerated brain atrophy in whole brain and regional volumes concentrated in the right temporal lobe.

Taken as a whole, these five studies suggest that age-related hearing loss has implications well beyond affecting basic communication skills. Although remediating these basic communication skills through early identification using hearing screening has merit in its own right, these five studies provide a high level of evidence demonstrating broader functional implications of age-related hearing impairment on cognitive function, depression, social isolation, cortical changes in the brain, and even early death.

Hearing care professionals have a professional obligation—perhaps bordering on a moral imperative—to communicate these findings without hyperbole, inaccuracy, or embellishment. Each study cited here stands on its own as an outstanding contribution to our evolving understanding of the relationship between age-related hearing loss and other common chronic conditions associated with the aging process. By understanding the design of each study, appreciating each study's limitations, and not exaggerating the authors' conclusions, we can begin to develop an evidence-based core message, likely to resonant with the primary care medical community.

Audiologists and hearing care professionals would be wise to develop this core message independent of marketers, who may be tempted to embellish the message, thus jeopardizing our credibility.

## The Core Message

After reading these five recently published papers and evaluating their findings using your ability to deconstruct each study's design and conclusions, it is likely that you will be able to craft a succinct message similar to the one below. After tailoring it to your liking, the next step is to infuse this message in all your personal communication with the PCP community.

*"Age-related hearing loss (AHL) is a public health concern of very high priority. It's a high priority because several recent studies using randomized-controls show AHL contributes to the acceleration of cognitive and physical decline in adults. Hearing loss imposes a heavy social and economic burden on individuals, families, and communities, as a hearing loss isolates people. Given these find-*

*ings, all individuals over the age of 50 should have a baseline hearing screening, and patients with a history of depression, cardiovascular disease, diabetes, and dementia should have their hearing screened annually."*

### Implementation: Systematically Communicating with PCPs

The next questions for hearing care professionals who want to form a strong strategic relationship with primary care medicine are:
1) How can I help these patients get the care they so obviously need? and 2) Is my unique market under-served, and will I be rewarded for investing my time and resources in trying to add new patients to my practice with "physician marketing" strategies? The answer to these questions largely resides in your ability to implement a pillar of community communication strategy in place for your practice.

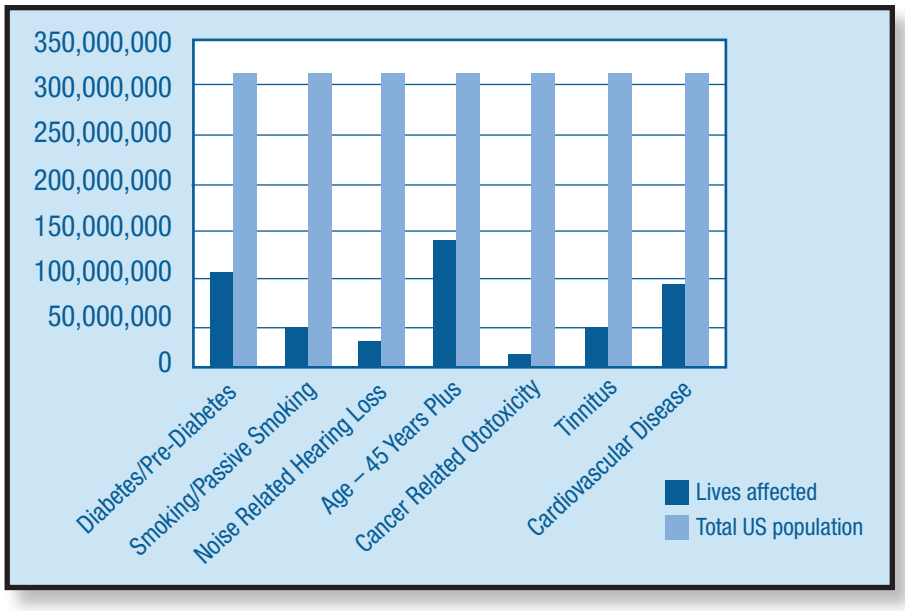


*Figure 2. Prevalence of various conditions compared to American population.*

Historically, marketing research[8] and testimonials from audiologists who have implemented a physician outreach program support the conclusion that the risk is worth taking, and that you will be adequately rewarded.

Pharmaceutical industry marketing research shows it takes five to six calls on a physician to generate a prescription for a new drug. It takes the same number of calls to a primary care physician to generate a new patient referral for an audiologic evaluation. Based on our experience, the number of calls required decreases over time as the relationship between the HCP and PCP evolves.

Currently, the average US audiology clinic generates $400,000 per year in annual revenue, of which 15% ($60,000) is derived from patients who have been referred by a physician. If one could double the percentage of physician referrals—a very attainable goal based on our experience—then total revenue from physicians becomes $120,000, of which $60,000 is new income.

To equal this return on investment (ROI), you would need to have $1,000,000 invested in the stock market with an annual return of 12%. For those of you who are not high-risk investors, this may not even be attainable, assuming of course that you have a discretionary $1 million to give to your stockbroker.

Let's revisit the 12,750 patients who will test with hearing loss (TWHL), and assume that all are referred to a hearing healthcare specialist. We will project that the average number of TWHL referrals to obtain a binaural hearing aid fitting is three, then there are 4,250 patients who will purchase a pair of instruments. At an average of $5,000 per set, the total dollar value of the attainable target market is $2,125,000.

Again, we must ask the question, "Which are those patient types that are in a high-risk patient category over the age of 12 years who should be tested?" The answer lies with those patients with the presence of coexisting conditions or comorbidities that contribute to the cause of, and increased incidence of, hearing loss. By the numbers they are:

- **106,000,000** people in the United States who are either diabetic (twice the incidence) or prediabetic (30% increase in the incidence) who have up to 2 times the incidence of hearing loss versus those who do not have diabetes or prediabetes.[5] (Although we did not cite any recent studies showing the relationship between Type II diabetes and hearing loss, there are several, including Bainbridge[5] and Parker.[8])
- **48,000,000** Americans smoke cigarettes. Smokers have 2 times the incidence of hearing loss versus nonsmokers, and secondhand smokers have a 1.7 time incidence of hearing loss versus non-secondhand smokers.[9]
- **30,000,000** of the US working population are exposed to on-the-job toxic noise levels above the OSHA standard of 85 dB every day.[10]

- **140,000,000** Americans are older than age 45, with 10,000 turning 65 every day.[11] Over 30% of the age 65+ group have a treatable loss, and this number increases with advancing age.
- **12,000,000** people in the United States currently have cancer, and over 50% will be treated with chemotherapy, which may include cisplatin-based derivative drugs. Almost 100% will suffer high frequency hearing loss post cessation of chemotherapy.[12]
- **50,000,000 to 60,000,000** Americans suffer from tinnitus, and approximately 90% have concomitant hearing loss.[13]
- **80,000,000** suffer from cardiovascular disease and the disease's many complications that include 3 times the incidence of hearing loss (versus the patient who does not have cardiovascular disease). Hypertension, a subcategory of cardiovascular disease that is now the most prevalent treatable chronic disease in the United States and the world, is a proven cause of hearing loss.[14]

Figure 2 shows the prevalence of these various medical conditions in relation to the total population of the United States.

### Pillar of Community Marketing

A pillar of community marketing strategy comprised of a physician outreach component is a long-term marketing strategy requiring commitment for the entire life of the practice (Figure 4). Given the second author's previous experience working for a leading pharmaceutical company, let's take a look at how those lessons may or may not apply to physician outreach for the HCP.

In the United States, the pharmaceutical industry's experience when marketing new medications to physicians so that they will write prescriptions for the new drugs closely follows the bell curve in Figure 3.2 Physician outreach programs initiated by the hearing care industry in the United States, and validated by BHI MarkeTrak data and Hearing Healthcare Marketing Company, verify the identical experience in generating new patient referrals.[7]

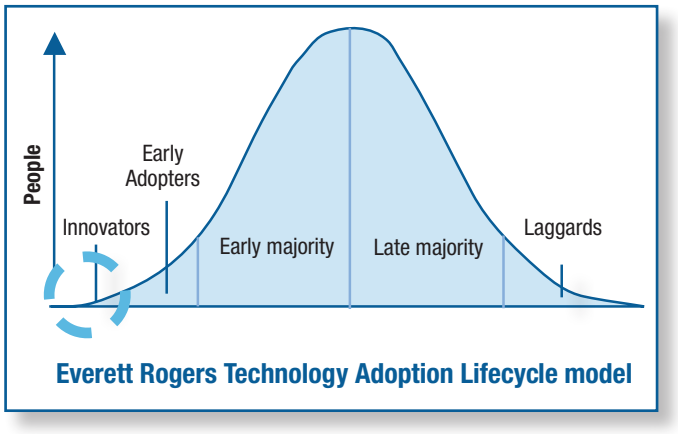


*Figure 3. The Everett Rogers Technology Lifecycle Model.*

Approximately 5% of physicians are "Innovators" and "Early Adopters." In the first 6 months, this group will listen and readily initiate new patient care strategies because of your messaging regarding which patient types need audiologic care. However, there are not enough of these physician types in your target market to make a ROI feasible for the long term.

The *real rewards* are in the "Early Majority" and "Late Majority" category of customers. It will take approximately 3 years to get to the top of the bell curve with a consistently implemented physician marketing program. You will have another 3 to 5 years of peak sustainable revenue, and increasingly profitable returns on your time and resources invested.

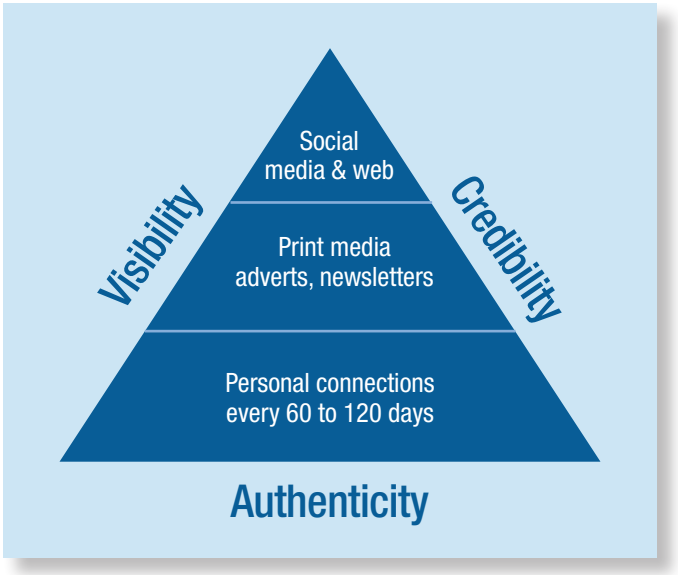


*Figure 4. The marketing tactics needed to create a sustainable physician outreach program.*

If there is a single message gleaned from Figure 3, it is that you must make a commitment to educate the early and late majority of adopters. This can take 2 to 3 years based on our experience, but by using the findings from well-designed clinical studies showing the comorbid relationship between hearing loss and other common chronic conditions, you have quality material to sustain those efforts.

New hearing care technological innovations, enlightened joint clinical research by physicians and audiologists, and expanded services that differentiate you and your practice's patient care capabilities will allow you to maintain a "top of the mind" presence in physicians' clinics, generating another revenue stream and potentially bringing in younger patients for preemptive care.

*Now* is the time to boldly instill these ideas into your practice by initiating calls and developing relationships with the receptionists, referral coordinators, medical assistants and nurses, primary care physicians, and their office managers. Tailor the core message mentioned above in an authentic manner in order to build credibility and trust. Ask PCPs to heed our patient care calls to action, and accept us as part of the patient care team that seeks to minimize impairment and maximize function in adults with age-related hearing loss.

The peer-reviewed articles cited here provide a rational argument. Are you bold enough to bring it to life within your practice and crazy enough to change the world?

***References*** can be found at www.hearingreview.com or by clicking in the digital edition of this article at: http://hr.alliedmedia360.com

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## *Presentation Notes*

# *Changes in Primary Care and Health Belief Systems Are Opportunities for Hearing Healthcare*

*By: Brian Taylor, Au.D., J.N. Bakke, MD, and Bob Tysoe*

*2013*

## Value-based reimbursement in medicine has huge implications for hearing healthcare

*Hearing healthcare has a new opportunity to become a partner with primary care providers because, in the new reimbursement environment that places value of care over volume of patients seen, the hearing healthcare specialist can help primary care providers succeed—especially with the elderly or those with chronic illnesses. As it becomes increasingly evident that better hearing leads to better patient compliance and better overall outcomes, hearing healthcare professionals stand to reap huge benefits and an increasingly important role in the overall healthcare system.*

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This is the third part in a series of articles on the topic of interventional audiology. In Part 1 (November 2013 *Hearing Review*),1 we pointed out that, rather than centering on the dispensing of a hearing aid or medical device, we should be practicing interventional audiology: a focus on the disease state of hearing loss and its relationship to the chronic medical consequences of hearing loss. In Part 2 (July 2014 *HR*),2 we explored some of the specific research that directly encourages the medical-audiological relationship and how to leverage peer reviewed health science to build a physician referral base. In Part 3, we link the changes in healthcare and our emerging knowledge of behavioral models of hearing loss with in-clinic success.

### Patient Communication as a Basic Healthcare Problem

Let's begin with an all too common situation, which until rather recently has been unreported in the literature: An individual in his early 70s with Type II diabetes and mild, sensorineural hearing loss delays medical care because he hesitates to call for an appointment with his primary care provider due to difficulty understanding the appointment clerk on the phone. Once he finally calls, the patient misunderstands the instructions he is given. Thinking he has been told to alter his medication regimen, his diabetes is soon out of control and he ends up in the emergency room. Such patients are perhaps more common than we realize, and as recent research suggests, mild-to-moderate age-related hearing loss (ARHL) can contribute to poor health in many ways—including delaying appropriate care as well as being a cause of poor patient compliance due to unintended miscommunication.

### Changing medical priorities and reimbursement.

There is a constellation of forces at work within the American healthcare system that may enable hearing care professionals to emerge as integral members of a patient's health and wellness team. The graying of the American population, the notion that baby boomers want more active participation in their healthcare, the emergence of direct-to-consumer amplification products, the unsustainably rising costs of healthcare—all of these factors have the potential to profoundly change the way audiology and hearing care are perceived by primary care physicians.

Primary care in the United States is changing. Both private and public insurance programs, as well as large employers, are changing the way primary care providers are being reimbursed for their services. The reason for these changes is the rising cost of healthcare and the realization that primary care is the key to reducing those costs.

The focus of the change is that "value" payments are being added to the traditional "volume" based fee-for-service reimbursement system in primary care. Reimbursement in traditional primary care is a function of volume: the more patient visits a primary care practice sees in a year, the higher the annual revenue will be. The system is complex in that some patient visits receive higher reimbursement than do others, but the system has nevertheless been purely volume-based.

As a result, the efficiency of the primary care office is key. The focus is on seeing the maximum number of patients a day that can reasonably be accommodated with the minimum of overhead expenses. The most successful practices in this traditional volume-based model were usually the busiest. Acutely ill patients were seen promptly, but other patients waited patiently, sometimes for many days and even weeks for routine appointments.

Over the last decade or two, it has been recognized that this traditional system has a very significant unintended consequence. Primarily because of delays in care, patients became sicker. When they finally had their appointment, they needed more care than would have been the case if they had been seen sooner. As a result, the *value* of the care was less than what it could have been. Volume was consistently trumping value.

There were other problems as well. If patients were not sufficiently motivated to take care of their health, they would often miss recommended screening tests or take medicines irregularly. As a result, they suffered from illnesses that could have been avoided, and caring for those illnesses was yet another *cost* to the healthcare system. That cost is large, and it turns out that paying primary care to focus more attention on prevention and earlier treatment is far less expensive that paying the entire healthcare system for the cost of caring for patients who had missed opportunities to detect, prevent, or treat illnesses at an earlier stage.

***Modifying payment systems for a value emphasis.*** There are many ways being used today to pay primary care practices to improve the value of their services. One common method is to pay the primary care practice a periodic bonus if certain performance standards—usually called "Quality Metrics"—are met. A common quality metric in primary care today focuses on the care of diabetic patients: if lab and other tests done to measure the effectiveness of diabetic treatment meet certain standards, the primary care practice receives periodic cash payment from the insurer based on the number of diabetics in their practice and the quality measure performance. This payment is in *addition* to the usual volume based reimbursement which the practice receives for each visit.

There are numerous quality metrics being applied to primary care practices today, though the specific value-based payment varies by insurer and location. These payments tend to focus on the quality of care for chronic diseases and also on the percent of patients who receive preventive treatments (eg, vaccinations) or screenings (cancer, cholesterol, etc). The number and sophistication of these quality metrics is rapidly increasing, and as this occurs, the potential dollar value of the payments to the practice is also increasing.

Only a few years ago, most primary care practices had little or no opportunity to receive revenue on the basis of quality metric performance. Today, *almost all* traditional primary care practices are eligible for such payments. It is not uncommon for practices to receive an additional 10% of their annual revenue from quality metric performance; and 20% and even 30% of traditional volume-based revenue are being seen from high performing practices. Recent announcements by Medicare suggest this trend will continue.

The "new money" for primary care actually represents a transfer of money from hospitals and specialists. The key concept is *right care, right provider, right place, right time*. If primary care provides patients with "right care/provider/place/time," then the patient will need fewer hospitalizations, fewer ER visits, and fewer specialty referrals.

The language being used to capture this idea is that primary care is doing *population health*. Hospitals and specialists, naturally, are having trouble accepting the fact that this idea has gained traction with insurers, Medicare, and Medicaid. But it *has* gained traction because it works. The increase in income to primary care is only a small fraction of the decrease in income to hospitals and specialists, and the savings in healthcare costs for large employers, insurers, and government programs is why this is going to grow.

## What Does This Mean for Hearing Healthcare?

Referrals to audiology and hearing care professionals from primary care in the past were generated for the most part by requests from the patient and their family. Treatment of hearing loss was considered elective, an issue that was almost entirely related to patient preference.

Today, if hearing loss is recognized as a factor leading to poor patient compliance with medical care, then the poor compliance will cost the physicians' practice *real money*. This makes a difference in how hearing loss is viewed by the primary care physician.

In the traditional reimbursement environment, primary care providers are not at financial risk if their patients do not take their medicine, do not have recommended vaccinations or screening tests, or do not follow up after they are seen by another doctor. With value-based reimbursement systems growing rapidly, these same primary care practices are now at a clear financial risk. And that financial risk is large enough that they are paying attention.

The evidence is growing that hearing loss—even mild to moderate hearing loss (see Barbara Timmer's article[3] in the April 2014 *Hearing Review*)—interferes with communication and speech un-

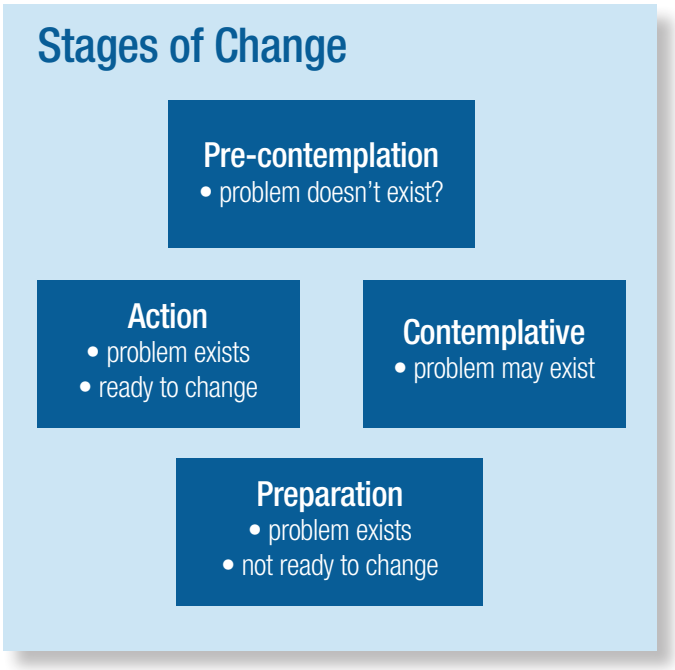


*Figure 1. The Transtheoretical Model of Behavior Change.*[6]

derstanding at a very basic level. This communication and understanding is critically important for patient compliance with medical care, especially for patients with chronic illnesses and the elderly. And, of course, these are the very patients who have the highest incidence of hearing loss.

Hearing healthcare has a new opportunity to become a partner with primary care providers because the hearing healthcare specialist can help the primary care provider succeed. Audiologists, in particular, should understand these new issues in primary care and be clear that the services which audiology offers are not simply services to the patient, but they represent *a service that will help the primary care practice as well.*

In short, interventional audiology can help primary care practices add value in a way that boosts their bottom line as well as improve the quality of life for many of their Baby-boomer patients.

### It Starts With Education to PCPs

Clearly, hearing care professionals must leverage the changing healthcare system by working closely with primary care physicians and administrators so that a greater number of patients suffering from conditions associated with hearing loss come forward at an earlier age for hearing screening. Part of this strategy includes educating primary care medicine about the increased costs associated with caring for individuals with hearing loss.

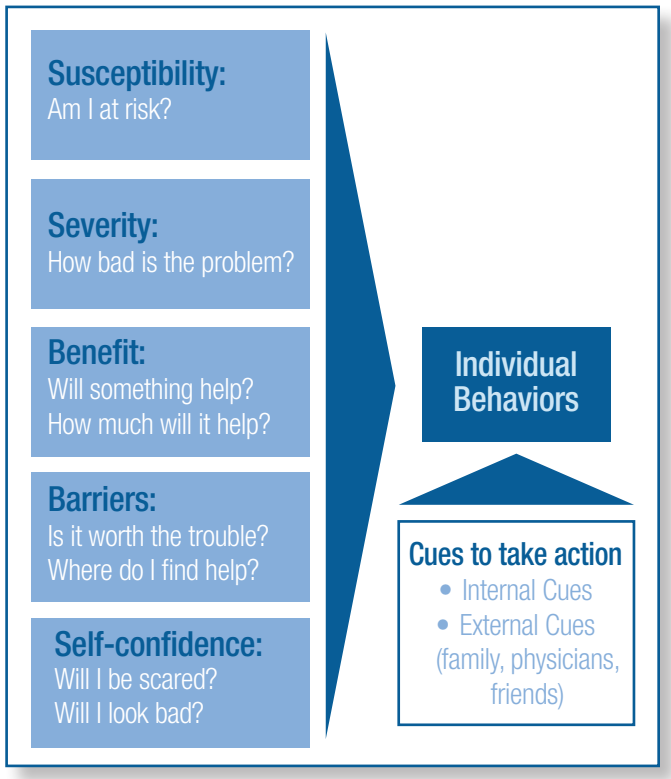


*Figure 2. The Health Belief Model for Age-related Hearing Loss.*[7]

Foley et al[4] recently demonstrated that self-reported hearing loss is independently associated with higher total medical expenditures. In the population of individuals with self-reported *hearing loss in the US population aged 65 and older in 2010 (7.91 million lives) indicates that hearing loss is associated with approximately $3.10 billion in excess total medical expenditures.* Hearing loss was associated with greater odds of office-based, outpatient, and emergency department visits and not only costs that would be directly attributable to hearing loss treatment (eg, medical equipment expense). Future work should investigate the mechanistic basis of the observed association and whether public health strategies focused on hearing rehabilitative treatment could mitigate excess medical expenditures associated with hearing loss.

Future hearing healthcare marketing strategies need to focus on how to integrate the "knowledge economy" to generate tangible and intangible values in the primary care market place. The key component of a "knowledge economy" is a greater reliance on intellectual capabilities.

Unfortunately, hearing care's marketing focus has been primarily based on technology. A transition to marketing our knowledge of modifiable risk factors that contribute to the presence of comorbidities, resulting in an increased risk and incidence of hearing loss

is vital to the future of hearing healthcare. We should implement an "Educate to Obligate" marketing strategy aimed squarely at primary care physicians, utilizing clinical research, changing healthcare economics, patient education, and services-focused marketing that persuades them to think differently about how to enter into a patient care partnership with us.

This partnership can be entered into if audiologists and hearing care professionals change their roles to that of "interventionist" and "knowledge marketers" who inform primary care about how our expertise and services can assist in primary care's ability to practice "preventive care." Ultimately this partnership improves the quality of care, the quality of lives, and the quality of the financial performance of the primary care, as well as the hearing care practice.

### In-Clinic Success and Help-Seeking Behavior Models

Even a partnership based on mutual respect between primary care medicine and the hearing care professions may not be enough to overcome the forces associated with the ambivalent patient who is often resistant to our interventions. *Interventional audiology strategies* are not confined only to marketing efforts. Recent reports have indicated that a recommendation for a hearing screening often does not prompt individuals to take action to resolve a suspected hearing problem.[5]

This inability to take swift action can be explained through the lens of help-seeking behavior. Over the past few years, several studies have enriched our knowledge of how adults with chronic medical conditions, such as ARHL, manage their condition and what cues to action may influence their behavior change. Various models have been proposed to explain the process of coping with chronic conditions, some of which have been applied to ARHL.

***Transtheoretical Stages of Change model.*** The *Transtheoretical Stages of Change* model (Figure 1) has been used to describe how adults with hearing loss cope with their condition.[6] The "stages of change" model suggests that an individual's ability to change passes through four distinct levels. These levels are best summarized as:

1) *Pre-contemplation*, at which time the individual cannot even consider acknowledging a problem exists and that behavior change is needed;

2) *Contemplation*, at which time individuals are ambivalent about the existence of a problem and the need to change behaviors;

3) *Preparation*, at which time an individual is preparing to make changes by seeking information and talking about this possible change with others;

4) *Action*, during which time individuals make actual changes to their behaviors.

5) Maintenance, when the individual makes a deliberate attempt to maintain their changed behaviors.

Two self-report questionnaires have been used in "stages of change" research to ascertain the underlying decision making process of individuals with hearing loss. The Health Belief Questionnaire (HBQ)[7] is a 33-item assessment, developed by Saunders and colleagues that measures five constructs: severity, benefits, barriers, self-efficacy, and cues to action on a 10-point scale. A summary of the five constructs comprising the Health Belief Model is shown in Figure 2. Additionally, the University of Rhode Island Change Assessment (URICA)[8] is a 24-item self-report assessing the first four stages of change outlined in Figure 1, using a 5-point scale. Although both tools have been validated, given their length, neither questionnaire is considered viable clinical tools in their current form.

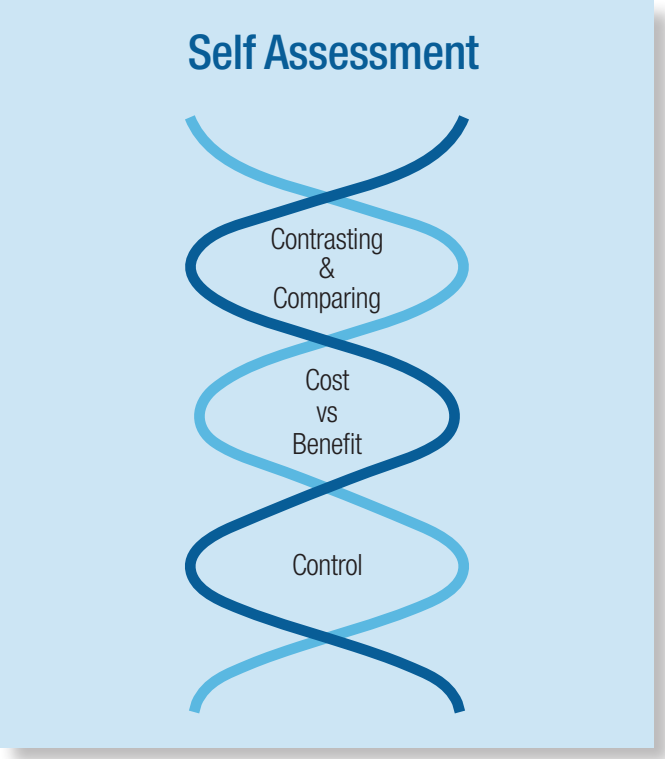


*Figure 3. The Spiral of Decision Making Model proposed by Carson.*[12]

Research using the Health Belief Model and Stages of Change model have attempted to better understand behaviors of individu-

als with hearing impairment who have failed hearing screening. Milstein and Weinstein[9] evaluated the "stage of change" in 147 older adults participating in hearing screening. Before the screening, 76% of the participants were in the pre-contemplative or contemplative stages. Stages-of-change scores did not significantly change as a result of the screening.

More recently, Laplante-Levesque et al[10] evaluated the stage of change of 224 adults who failed an online hearing screening. In this study, 50% of the participants were in the preparation stage of change, while 38% were represented by the contemplation stage and another 9% by the pre-contemplation stage. Only 3% of the participants were in the action stage.

Taken as a whole these studies suggest that hearing screening alone is not enough to improve help-seeking rates. Clearly, there are opportunities beyond the offering of an easy-to-use automated or online hearing screening tool that must be considered if our profession is to improve our acceptance rates.

***The Spiral of Decision Making model.*** Another line of research attempting to explain the underlying decision-making process of hearing-impaired individuals was proposed by Carson.[11] The Spiral of Decision Making model (Figure 3) explains the "push-pull" between seeking and not seeking help that many patients with hearing loss of gradual onset experience.

Carson based her Spiral of Decision Making model on the longitudinal study of a group of woman between the ages of 72 and 82 years of age. Her model suggests that individuals with gradual hearing loss evaluate, analyze, and make decisions around three themes that define self-assessment: "comparing/ contrasting," "cost vs benefit," and "control." Carson's model proposes that this spiral of decision-making is ongoing, even after remediation for hearing loss has begun.

Changes in the primary care delivery model and implementation of knowledge-based marketing tactics intended to foster a deeper relationship between audiologists and physicians do not alter the fact that onset of hearing loss in adults is a stigmatizing condition. In order to embrace the health belief models shown in Figures 1-3, hearing care professionals are encouraged to view the condition of ARHL through the lens of the social model of disability. Given the ambivalence of all stakeholders—patients, families, physicians, etc—toward onset of hearing loss in adults, the social model of disability (Figure 4) is the common thread tying together the concepts discussed in this article.

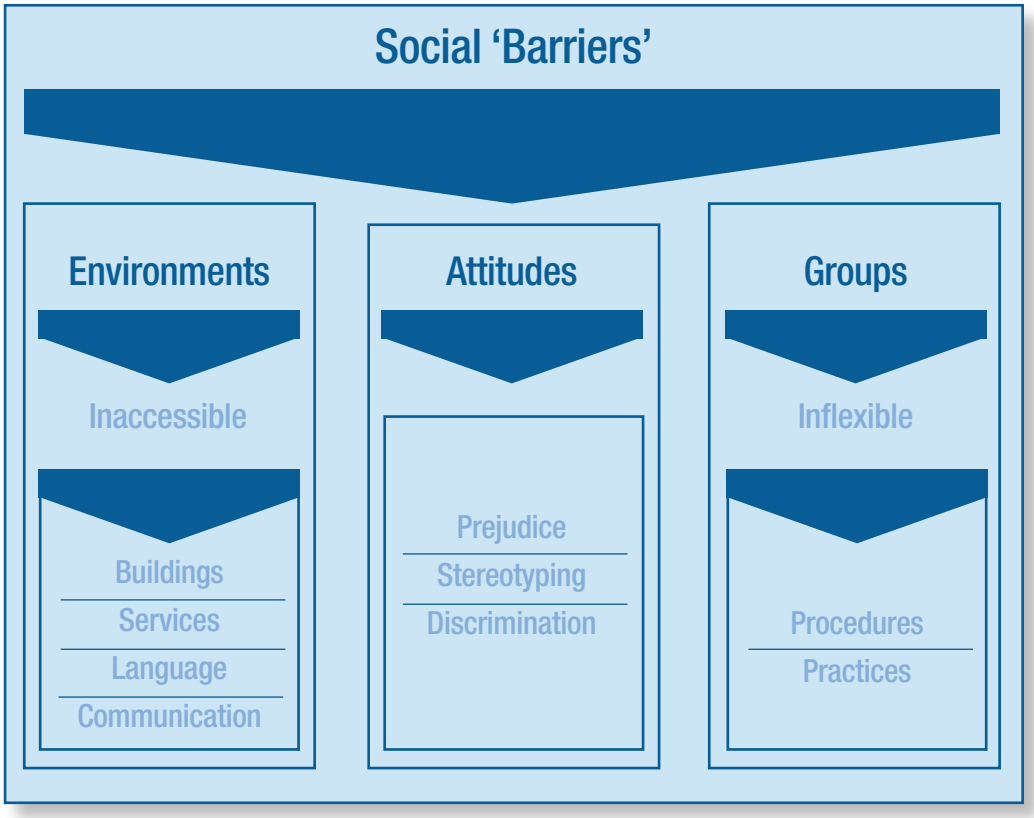


*Figure 4. The Social Model of Hearing Loss.*[12]

The social model of disability identifies systemic barriers, negative attitudes, and exclusion by society for individuals suffering from a chronic condition, such as ARHL. While physical, sensory, intellectual, or psychological variations may cause individual functional limitation or impairments, these do not have to lead to disability unless society fails to take account of and include people regardless of their individual differences.

In an evolving healthcare system, the role of physicians, audiologists, hearing instrument specialists, and others is to ease, reduce, or eliminate environmental, attitudinal, and societal barriers of patients.

## Executive Summary

1) The way primary care medicine is practiced is changing and this change affords hearing care professionals an opportunity to get more directly involved in the care of patients at younger ages with milder hearing loss.

2) If hearing care professionals are to leverage these opportunities they must use evidence from peer reviewed studies, which shows a relationship between various medical conditions and ARHL as a key part of their marketing message. This change requires a significant shift away from price-driven, product-centric advertising to knowledge-based marketing strategies, which place the skills of the practitioner at the center.

3) Given the psychological nature of ARHL, long-term professional success is largely predicated on what happens once a patient decides to seek the services of a practitioner. The essence of the practitioners skills rests with their ability to unravel the so-called spiral of decision making. Ultimately, it is the personal relationship between hearing care professional and primary care physician; hearing care professional and patient that drives the sustainability of the our profession. Viewing our value proposition through the lens of the social model of disability, rather than through the lens of the medical model of disability in which the dispensing of hearing aids is at the center, has the potential to transcend the marketplace. The next installment of our interventional audiology series will examine the role of solution-based interviewing techniques and how they can be used to improve in-clinic success.

***References*** can be found at www.hearingreview.com or by clicking in the digital edition of this article at: http://hr.alliedmedia360.com

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## *Presentation Notes*

## Interventional Audiology in Primary Care

Audiologists know there are many causes of tinnitus, and often the cause is unknown. According to Richard Tyler, professor at the University of Iowa, the most common causes of tinnitus are noise exposure, (from shooting or machines at work), a natural part of the aging process, a head injury (e.g. from a car accident or fall), or as a side effect of medications (e.g. aspirin).

The onset of tinnitus is often accompanied by the onset of hearing loss, as research estimates that 90 percent of tinnitus sufferers have an associated hearing loss. Of course, if patients have tinnitus, they should have their hearing tested by an audiologist. Estimates of the incidence of tinnitus in the U.S. range from 30 – 50 million adults, many suffer from persistent tinnitus.

While hearing aid manufacturers have developed exciting new technology that can treat hearing loss, and simultaneously mask and improve the symptoms of tinnitus, most physicians are unaware of the role audiology plays in the identification, treatment and management of tinnitus. They need to be informed about how an audiologist can help. Audiologists provide the latest research on tinnitus and information about the benefits of the new therapeutic modalities. Thus, the physician can avoid recommending often useless tinnitus medications and prevent associated side effects associated with unregulated over-the-counter tinnitus relief products.

In addition to tinnitus, another common, yet under-appreciated comorbidity is depression. The incidence of depression in the US is approximately 10 percent of the adult population. Untreated hearing loss is strongly linked to depression, among other psychosocial disorders. The prevalence of moderate-to-severe depression was significantly higher among adults aged 18 – 69 who had self-reported hearing loss (11.4%) compared to those who reported good-to-excellent hearing (5.9%) (Chuan-Ming, 2015). Depression is among the leading causes of disability in persons 15 years and older. It affects individuals, families, businesses, and society, and is common in patients seeking care in the primary care setting. Depression is also common in postpartum and pregnant women and affects not only the woman but her child as well.

Audiologists need to know that recently the US Preventive Services Task Force (USPSTF) recommended screening for depression in the general adult population, including pregnant and postpartum women. Screening for depression should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The Patient Health Questionnaire is a recommended screening tool that could be used by audiologists to screen their patients for depression, but only after they have developed a solid treatment and follow-up network involving the appropriate professionals.

According to Siu (2016), the USPSTF found adequate evidence that programs combining depression screening with adequate support systems in place improve clinical outcomes (i.e., reduction or remission of depression symptoms) in adults, including pregnant and postpartum women. The USPSTF found convincing evidence that treatment of adults and older adults with depression, identified through screening in primary care settings, with antidepressants, psychotherapy, or both, decreases clinical morbidity. The USPSTF also found adequate evidence that treatment with cognitive behavioral therapy (CBT) improves clinical outcomes in pregnant and postpartum women with depression.

No discussion about hearing loss, depression and tinnitus is complete without addressing patients' emotional reactions to their suffering from both comorbidities. Feelings of annoyance, depression, anxiety and anger are common, and professional help may be required. (See the interview with Jennifer Gans on page 34)

## Poor Health Literacy is an Added Factor

The World Health Organization (WHO) reports that unipolar depression occupies first place for years lost to disability. Hearing loss is the third leading cause of years lost due to disability. Now, add in the communication challenges caused by the patient's poor health literacy. According to Koh, et al (2015), "In the midst of rapid expansion of medical knowledge intended to benefit many, too few actually understand medical information well enough to improve their health. A landmark 2006 report notes that only about 12 % of US adults had a proficient state of health literacy whereby individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. As a result, despite abundant messaging from health professionals, the media, the internet, and other sources, too many patients still have difficulty with seemingly routine tasks such as taking the right medicine at the right time, properly self-managing diabetes, or correctly following hospital discharge instructions. In this increasingly complicated health environment, even the most sophisticated adult can be overwhelmed by unfamiliar medical terms, unexplained acronyms, and technical jargon. The paradox is that people are awash in knowledge they may be unable to use.

These limitations are clearly hazardous to health." Undoubtedly, untreated hearing loss, an all too common occurrence in patients suffering from tinnitus, depression and other common chronic medical conditions, has an impact on a patient's ability to communicate effectively with their physician.

Audiologists can do something about a patient's health literacy, the physician's ability to engage the patient as well as the patient's potential improvement in quality of life. The partnership between the primary care physician and the audiologist may afford the opportunity to lower the cost of care, by reducing total patient visits to the physician's practice, a potential reduction in the risk of an emergency room visit, or a hospitalization requiring surgery.

The audiologist is able to impact the patient's health literacy by providing the latest patient education brochures, (see the NIH website www.nidcd.nih.gov for free, quality handouts in both English and Spanish) about the disease state of hearing loss, tinnitus, and balance disorders. An informed patient will be more inclined to seek appropriate hearing care.

As a result of the audiologist providing the latest authoritative clinical research about the deaf and hard of hearing patient, the physician becomes more effective in counseling the hearing impaired patient to agree to have a hearing evaluation and a routine annual follow up.

When the treatment of hearing loss occurs earlier because of a physician's preventive care management strategies, the patient care partnership with the audiologist may reduce the prevalence of, and the need to treat depression, which is independently associated with hearing loss, and is in and of itself a barrier to improved outcomes; The earlier the patient receives recommended hearing health care, the sooner the physician may also prevent increased isolation, reduced social connectivity, decreased sense of well-being, loss of community, early mortality, and reduced economic productivity; thus there is also the additional possibility of an improved outcome.

*By Bob Tysoe*

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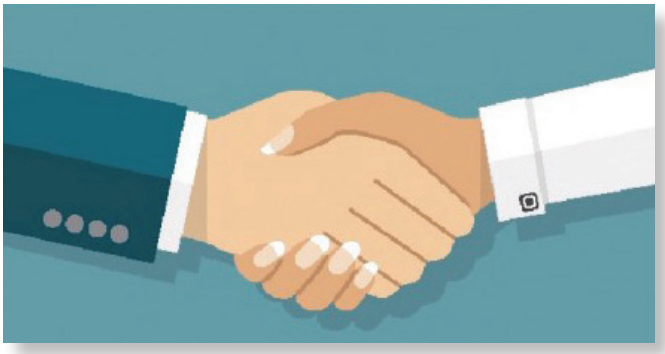
## *Presentation Notes*



## A unique window of opportunity for outreach to physicians and their patients

Hearing loss is one of the most common untreated chronic health conditions, and without doubt this has important implications for patient quality of life. Age-related hearing loss, however, is substantially under-detected and under-treated.[1] Just as the unrelenting growth of the comorbidity of diabetes and pre-diabetes (which is an independent risk factor for hearing loss) has caused the World Health Organization (WHO) to recently categorize both diseases as pandemics—health problems so large that they could overwhelm the healthcare systems of all the developed countries—untreated age-related hearing loss can now be added to the list of chronic conditions contributing to skyrocketing healthcare costs.

> People are awash in information, but oftentimes are unable to use it. These limitations are clearly hazardous to health. Hearing healthcare now has a unique window of opportunity to provide the latest clinical research about individuals with hearing loss to primary care physicians, including the latest patient education and literature about patients with age-related hearing loss to the medical assistant, so that patients (and their friends and family) become more actively engaged in seeking care for their hearing loss.

The WHO has declared that hearing loss ranks third among all of the chronic diseases on earth in terms of years lost to living with a disability. Given the age of the first-time wearer of hearing aids ranges somewhere between 63 years and 70 years of age,[2,3] this should not come as a surprise. Due to the hidden nature of hearing loss as a disabling condition, at-risk adults are often dismissed by physicians, other allied healthcare professionals, and even the lay public's stereotypical attitude about hearing loss of gradual onset being confined to "old people." Although the industry's marketing efforts have been largely confined to getting senior adults to make an appointment to see a hearing care professional, statistics reveal other populations for outreach: 20% of the US population 12 years of age and above cannot pass a 25 dB hearing test in their worse ear. This means that 48 million plus US citizens may suffer from a communicative disorder that could be detrimental to their overall health.[4]

# *Interventional Audiology Services: Physician Outreach*

*By: Bob Tysoe*

*October 2016 Hearing Review*

While 75% of the US population state that the first person they ask about treatment for hearing loss is a primary care provider, calculations from available consumer data[2,3] suggest only one binaural hearing aid fitting per month, per US hearing healthcare provider, is fitted with new devices as a result of a physician referral. Elective care, as opposed to obligatory care, is hardly the right strategy to manage a condition of epidemic proportions that can profoundly affect the health and quality of life of the general population.

### Relationship-building Marketing to Physicians for Improved Patient Access

There are too few adequately trained professional physician liaisons—people who actively market a practice's services to medical clinics and hospitals—employed by hearing healthcare practices. The need to assess an individual's hearing difficulties, diagnose and refer medical conditions, evaluate a patient's hearing loss and treatment needs, and provide counseling and services are all central to supporting hearing health. Additionally, there are few professional training programs for representatives of audiology clinics that embrace the pharmaceutical marketing model and that teach patient-centered relationship marketing strategies. Yet, this "educate to obligate" marketing strategy is necessary if significant improvement in physician referral behavior for the hearing-impaired patient is to occur.

The bell-curve of adoption with this marketing strategy shows that the return on investment (ROI) is not immediate; it often takes 1 to 2 years (and as many as 3 years, depending on the area) to maximize market share, but the use of physician liaisons results in many more patients receiving the hearing care they need to main-

tain an active and healthy lifestyle. New patients, referred by their primary health care provider, enable a long-term, sustainable, more profitable revenue stream to hearing care practices that engage in relationship-building marketing strategies with physicians.

### Patient Engagement Strategies

Patient engagement simply means providers and patients working together to improve health in a more efficient manner. Typical patient engagement strategies attempt to get the patients more actively involved at the earliest stages of onset of a medical condition in order to prevent the condition from worsening and becoming more complicated (and expensive) to treat. A patient's greater engagement in their own healthcare is thought to contribute to improved health outcomes, and new Information Technologies (IT) can support this process. Patients want to be engaged in their healthcare decision-making process, and those who are engaged as decision-makers in their care tend to be healthier and have better outcomes.

Stated differently, patient engagement is defined as combining the patients' knowledge, skills, ability, and willingness to manage their own health and care with interventions designed to increase activation and promote positive patient behavior. Hearing healthcare providers can leverage patient engagement strategies—a hot topic with third-party payers and healthcare organizations—to build stronger bonds with physicians and other medical gatekeepers.

### "Risk vs Benefit" Counseling

One approach to leveraging patient engagement in the relationship-building process with medical gatekeepers is to utilize risk vs benefit counseling. An increasingly common part of the information exchange between a patient and their healthcare provider, it is important to understand how risk vs benefit counseling works.

Physicians and hearing care professionals are trained to provide detailed information about potential risks and benefits associated with a treatment plan, a product, or a medication. In addition, they provide information about the probability, potential harm and magnitude, and other risks associated with treatment and, importantly, non-treatment. This can lead to an increase in hearing healthcare interventions that improve overall patient outcomes.

For example, it is common to review with the patient in a face-to-face consultation the potential risks of not using hearing aids, and during that same conversation discussing the potential benefits of amplification within the context of the individual's audiological evaluation results and daily communication demands and expectations. Most would agree this is a standard part of the consult appointment with most adult patients. Taken one step further, interventional counseling can be employed by the loved one of the patient who is not ready to have the discussion with the professional about the risks and benefits of getting help.

### Interventional Counseling

One type of risk vs benefit counseling is interventional in nature. Consider, for example, the parallels between the alcoholic and the adult with hearing loss. Although it may seem like an unlikely parallel, it is common for individuals suffering from both to lack awareness of the condition and the impact it has on relationships. Further, it is common in both chronic conditions for the patient to adamantly resist or even refuse care.

To succeed with an intervention, we need to rely on the hard work, dedication, and perseverance of every concerned family member or close friend. These are strong words, and for people who live in families that have been touched by the negative consequences of untreated hearing loss, they are easy to take to heart. Each time a family bands together and holds an intervention, that family is taking a step toward a better future for a hearing-impaired person in need.

Holding an intervention might not be easy, as these types of actions often take a significant amount of planning. Discussing a sensitive subject with someone who is upset, angry, depressed, anxious, paranoid, withdrawn, or in cognitive decline, can be difficult to accomplish.

**Preparing a script can be a good first step.** When the conversation is mapped out in advance, the stress level for all participants can drop, and conversation can flow more easily. The hearing care professional may facilitate the interventional counseling process by offering the following guidance with patients and their loved ones. In this sense, the clinician is acting as an interventionist by facilitating the process:

**Step 1: Open with affection.** Interventions can be confrontations in which emotions run high. Lead off with expressions of love, support, and concern from people who truly love and respect the hearing-impaired person.

**Step 2: Describe specific behaviors.** Denial is a common part of coping with gradual onset hearing loss. Denial or lack of awareness can even keep people from getting the help they need in order to improve relationships. The dialogue between patient and loved ones should concern behaviors that family members, friends, and coworkers have witnessed on a first-hand basis. When hearing-impaired people are shown that their behavior is both obvious and distressing, they might begin to think more critically about seeking treatment.

**Step 3: Detail the physical problems hearing loss can cause.** The emotional and financial damage caused by hearing loss might compel some people to change, and there are people who might be more likely to address their hearing loss if they are forced to think about the health issues that can develop as a result of inaction. In some cases, families might be wise to hire a family mediator who can work with the hearing care professional to develop a list of specific health problems that are associated with certain types of hearing loss. It should be factual and precise, providing the person in denial with information that is hard to ignore.

**Step 4: Outline treatment options.** At the end of a successful audiological intervention, the person who needs care may go directly to a hearing clinic for evaluation, testing, and treatment. Family members need to find the right hearing healthcare professional to help smooth the first appointment process for the person they love. At this point in the intervention, the family, friends, or coworkers can begin to outline how treatment works and why it is beneficial.

When instructing a family or loved ones on conducting interventional counseling it is important to inform them about both device and non-device treatment options. Although the minority of hearing care professionals offer stand-alone aural rehabilitation options, these options do exist and individuals in need of help should know about all possible treatment options. Furthermore, treatment options involving a device include more than hearing aids. Patients need to know about assistive listening devices, PSAPs, as well as other assistive technologies that might be beneficial—in addition to the value of seeing a dedicated hearing professional who can help sort through the myriad options.

**Step 5: Express love and support.** Providing facts and figures may be persuasive, but simply expressing how much the hearing-impaired person is loved is persuasive on its own. It is appropriate for family members to talk about how much they love, admire, support, and respect the person who needs care, and how much they want their loved one to overcome their denial of care so that they can move forward with a healthier and happier life. Family members can outline how they plan to help them cope with their new devices or listening skills. Family members who promise support can help newly treated patients feel more comfortable with amplification and accepting care.

**Optional Step 6: Set consequences.** If the individual does not agree to seek hearing care, families may choose to outline specific consequences that will take place if treatment for the hearing loss does not go forward. It might seem harsh to threaten someone who is dealing with the negative consequences of untreated hearing loss, but it is important to remember that this can cause people to make decisions that can be difficult for the family members to endure. People with untreated hearing loss might:

- Place other family members or others at risk due to poor hearing (eg, when caring for children, driving, etc);
- Place themselves at greater risk for falls, which could result in hospitalization, surgery, and endanger their life;
- Deprive other family members of enjoyable social outings due to the self-isolation of the hearing-impaired person, thus risking further alienation, loneliness, and depression;
- Suffer from a life-long learning handicap or disability associated with untreated hearing loss that deprives them of opportunities in life;
- Place the family in significant financial hardship should the person deny amplification, which may lead to a greater or more rapid decline in cognitive function, and thus require care in an expensive memory care facility.

These aren't minor problems, and they could cause the family to experience a significant amount of distress. When put in this context, it's easy to see why families might choose to place harsh and negative consequences on the person they love. Without audiological intervention, the person refusing treatment could threaten or even destroy their family life. An audiological interventionist can outline the risks and benefits of this step and help families make the right decision.

**Putting it all together.** Create a script or key talking points that contain all the proper elements of persuasion, and share this script with family and loved ones who desire to intervene. Practice sessions can also allow family members to advise one another on their scripts, and how to tweak individual messages until they seem perfectly crafted to reach the person who is in obstinate denial about their hearing impairment, and who clearly needs help.

Interventions for people who have hearing loss can be complicated, and if family members are feeling overwhelmed, there is help available from experienced hearing healthcare providers and family mediators who can handle the conversation with polish and skill so that there is more opportunity for a positive outcome.

### Interventional Counseling by Primary Care Providers

Alarmingly, a random cross-sectional survey of general practitioner activity in Australia between 2003 and 2008 identified that ap-

proximately 3/1000 (0.3%) consultations for older adults included hearing loss management.[5] Why is this rate, when the Australian government provides no-fee hearing aids for those who are 26 years and younger and 65 years and older, so abysmally low?

Several studies, many of which were outlined in the recent National Academy of Sciences report,6 indicate high levels of unmet need for hearing health services, and poor use of prescribed hearing aids. Denial or non-acceptance of hearing loss, and the stigma associated with hearing loss in adults are factors associated with this reluctance to seek help. Other reasons include an underestimation of the negative impacts of hearing impairment on overall health by general practitioners (GPs), leading to poor referral to hearing healthcare providers.

There are three potential critical roles for the GP in hearing health:

1) Early identification of patients with hearing loss, and recognition of resulting negative consequences/disabilities;

2) Assistance in reducing the stigma of hearing loss and counseling/motivating patients to seek help; and

3) Appropriate referral of these patients to hearing care providers.

This could be achieved by sensitizing GPs to recognize at-risk individuals, and use targeted questions to identify hearing loss disability. The challenge that remains for hearing care professionals is to effectively increase GP knowledge and practice behavior in this area.

Physicians need to consider whether the risk of not treating hearing loss in a given patient is reasonable in relation to anticipated benefits. A risk to the patient is considered minimal where the probability and magnitude of harm or discomfort anticipated are not greater, in and of themselves, than those encountered in the daily lives of the general population.

Clearly, research shows that adults with gradual onset hearing loss may benefit from collaborative interdisciplinary care between audiologic and primary care providers. Consider the following findings:

- **Depression.** The prevalence of unipolar depression in untreated hearing loss is 11.4% compared to those who reported good to excellent hearing (5.9%).[7]
- **Psychological disorders.** Psycho-social disorders, such as anxiety, paranoia, social isolation, loss of community, anger, and irritability, are reported to be present in the elderly with untreated hearing loss.[8]
- **Falls.** Identifying modifiable risk factors for falls in older adults are of significant public health importance. The magnitude of the association of hearing loss with falls is clinically significant, with a 25 dB hearing loss (equivalent of going from normal to mild hearing loss) being associated with a nearly 3-fold increase in odds of reporting a fall over the previous year.[9] The average length of time an elderly person survives following a fall that results in a broken hip is 11 months. This is typical of the patient who falls into the "5% category" and who contributes to the generation of 50% of the $3 trillion dollars spent annually on US healthcare (see the October 2016 article by John Bakke, MD).
- **Cognitive decline.** Age-related hearing loss has been found to be independently associated with poorer cognitive functioning and incident dementia. Compared with individuals with normal hearing, those with mild, moderate, and severe hearing loss have a 2-, 3-, and 5-fold increased risk of developing dementia, respectively.[10]
- **Social isolation.** Declining social engagement in older adults with a hearing impairment is a key determinant of overall morbidity and mortality in later life with direct causal and neurobiological pathways linking loneliness and physiologic pathology.[11]

Frequently, the physician's clinic staff is less than adequately trained to effectively guide or advocate for hearing healthcare on behalf of the patient. Further, the training program curricula of medical assistants does not include education about the care of the adult with hearing loss.

Patient education literature about the treatment of hearing loss is sorely needed in physician's offices, and a routine hearing screening, while rarely performed in the age of production-based medicine should be part of primary care medicine's best practices because of new Medicare guidelines.[12] Additionally, improving population-based information on hearing loss and hearing healthcare, while promoting hearing in wellness and medical visits for those with concerns with their hearing are among the 12 National Academy of Sciences recent recommendations.[6]

### The Risk of "Poor Health Literacy"

This leads to the troubling paradox of poor health literacy in the United States, and its impact on both quality and cost of hearing healthcare. A 2006 report notes that only about 12% of US adults had a proficient state of health literacy, defined as individuals who can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.[13]

The paradox is that people are awash in information, but oftentimes unable to use it. These limitations are clearly hazardous to health.

Research has linked limited health literacy to a cascade of suboptimal health outcomes, including worse overall health status and increased mortality rates in elderly persons.[13]

However, this same disconcerting research by Berkman also provides the answer: "Over the past 2 decades the lens of health literacy has widened greatly. In addition to focusing on the needs of individual patients, the field now brings the promise of greater commitment and shared responsibility from clinicians, institutions, and care systems."[13] This is an opportunity for hearing care professionals to provide the latest clinical research about individuals with hearing loss to primary care physicians, including the latest patient education and literature about patients with age-related hearing loss to the medical assistant, so that patients become more engaged in seeking care for their hearing loss.

## New Preparation; New Training

What kind of new training is necessary for a new era of shared responsibility in patient care between audiologists and hearing care professionals, primary care, and institutions such as Medicare, Medicaid, and health insurance companies? Hearing care professionals need to invest in certified "Physician Liaisons" training programs that work directly with universities, community colleges, and private sales and marketing coaching companies.

Physicians will benefit by completing a training rotation through audiology during medical school that enhances their diagnostic capabilities, and their "risk vs benefit" patient counseling skills. Audiologists in the US are already volunteering their time in respected university medical residency programs to help ensure the quality of future interventional interdisciplinary care for deaf and hard-of-hearing patients.

Audiologists may be trained in collaborative patient care partnerships with primary care physicians at universities, with guest lecturers provided by physician specialists from local medical schools. Whenever the adult patient with hearing loss seeks help, the hearing healthcare specialists will altruistically find a way to be part of their PCP's patient care team, to minimize impairment and maximize function, provide timely interventions, the right counseling, the right care, and be there for them—at the right time (sooner rather than later)—so that the hearing-impaired patient has the best opportunity for improved outcomes.

We have arrived at a unique time in hearing healthcare, with ample opportunities for enhanced relationship-building marketing to physicians and patient engagement strategies. We are all in this together, so let's collaborate!

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## *Presentation Notes*

# THE ESSENTIAL STEPS TO EFFECTIVE PHYSICIAN ENGAGEMENT

By Robert Tysoe
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Hearing Healthcare Marketing Company

## FIRST, DEFINE THE PROBLEM

In 2008 the World Health Organization, based upon the "Global Burden of Disease: 2004 Update" stated that hearing loss is the third leading cause of years lost to disability worldwide. An estimated 299 million men and 239 million women globally have moderate or worse hearing loss.

Hearing loss in the United States (U.S.) represents a major public health concern. It is the third most common chronic condition in older Americans after hypertension and arthritis, and it is strongly associated with functional cognitive decline and depression. However, age-related hearing loss is substantially under-detected and under-treated.[1]

The U.S. Census Bureau estimates there are in excess of 320 million U.S. citizens, with an estimated prevalence of bilateral hearing loss at 30 million, for those 12 years of age and older, (2001 – 2008) and this estimate increases to 48.1 million or 20.3% of the population when individuals with unilateral hearing loss are included in the cohort.

Overall, the prevalence of hearing loss increases with every age decade. The prevalence of hearing loss is lower in women than in men and black vs white individuals across nearly all age decades. To date an estimated 20% to 25% of hearing-impaired Americans have been treated for hearing loss.[2]

**ATTRIBUTES OF IMPORTANCE TO THE PATIENT PURCHASING A HEARING AID – NON USERS**

| | |
|---|---|
| 81% | Nearly Invisible |
| 79% | Fitting and Follow-up |
| 78% | Affordable |
| 74% | Good Reputation |
| 73% | Physician Recommended |
| 71% | Professional on Staff |
| 70% | Extended Warranty |
| 69% | Take care of Insurance/Paperwork |

Despite the fact that nearly three-quarters of MarkeTrak IXsurvey respondents asked their primary care physician or ENT first about their hearing loss, audiology practices self-reporting a US average gross revenue of $450,000.00 per annum estimate only 15 percent of their income is derived from physician referrals.[3] Additional information about how non-users of hearing aids view their condition is summarized in Box 1.

## DEFINE THE SOLUTION

This begs the question, why the discrepancy between the patient requesting a physician's opinion, consult, and guidance about hearing impairment and the low incidence of subsequent professional audiological care?

Hypothetically, the already large course loads at medical teaching institutions have caused pared curriculums, which may result in limited time and training devoted to the condition of hearing impairment. The educational focus is frequently limited to basic anatomy and physiology of the hearing and balance organs. Few medical programs offer a rotation through an audiology clinic, thus reducing the physician's ability to gain additional knowledge that would help provide effective risk versus benefit patient counseling. Audiology's educational marketing role may facilitate increased patient access to hearing health care, more effective treatment, improved quality of life, and a potential lower cost of overall care may result.[4,5]

Marketing research in the form of benchmark studies, conducted by Siemens-Sivantos, Phonak, and Unitron have verified that physician outreach marketing, which prioritizes the strategic use of relationship marketing, science-based, evidence-based research marketing and services marketing increases physician referrals, and shows a proven share of the audiology practice's gross revenue ranging between 20 – 30%, when implemented with commitment and consistency.[6,7]

## A GLIMPSE AT THE PAST

One way to predict the future of audiology is to look to the past in medicine. In 1910, Professor Paul Ehrlich M.D., Ph.D. (Germany) and Sahachiro Hata M.D. (Japan) jointly researched and developed the first antibiotic shown to be effective for the treatment of syphilis (Salvarsan). This landmark discovery was called a "silver bullet", a chemo-therapeutic breakthrough that provided relief for millions of afflicted men, women and children worldwide.

This could not have happened without the role of the German pharmaceutical company Hoechst AG Pharmaceuticals, that sponsored Dr. Ehrlich and Hata's research project. Hoechst AG Pharma subsequently patented and mass-produced the antibiotic and then launched the foundations of large-scale disease state marketing, evidence-based marketing, and relationship-marketing strategies. Salvarsan (arsphenamine) was effective in treating syphilis, yet it was extremely toxic, and an inappropriate dose could cause dangerous side effects, up to and including death.

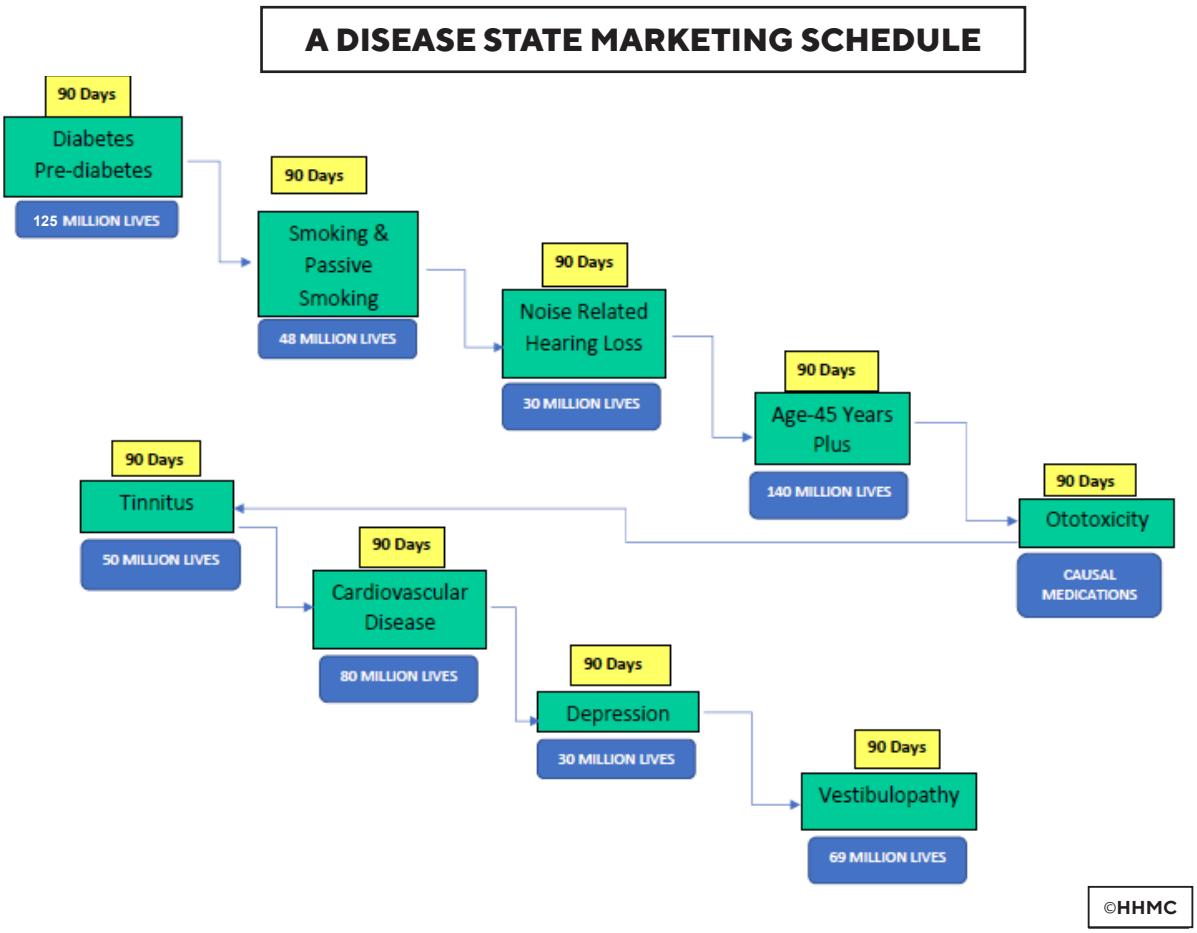
Hoeschst AG Pharmaceuticals set about building relationships of respect, trust, and integrity with physicians and nurses with teams of trained pharmaceutical representatives spanning the globe. The need for a comprehensive, sophisticated physician education program that provided doctors with the reasons why it made sense to make the diagnosis of syphilis and treat the patient effectively and safely with Salvarsan (arsphenamine) was vital for public health. Medicine had just taken "a giant leap for mankind"[8]

## LOOKING AHEAD: "EDUCATE TO OBLIGATE"™

U.S. Audiology professionals have begun to replicate similar steps to implement best practices in physician engagement that result in a collaborative, team approach to patient care that minimizes the disability and handicap of hearing loss while maximizes daily function and quality of life for the patient.

Audiology may invest in the future of the industry by adding business development, marketing, and evidence-based research education programs to university audiology training curriculums, with an added emphasis on understanding co-morbidities, lifestyle-related behaviors, and their associated links to hearing loss. Sharing audiology's resources, such as published research on the disease state of hearing impairment, tinnitus, dizziness and balance disorders, the audiology specialist's qualifications, range of services and treatment plans with physicians is an imperative in 2019.

Box 2 outlines a disease state marketing timeline that can be used by audiology practices to build stronger relationships with primary care physicians and other front-line healthcare professionals such as diabetes educators, physician assistants, and nurses.



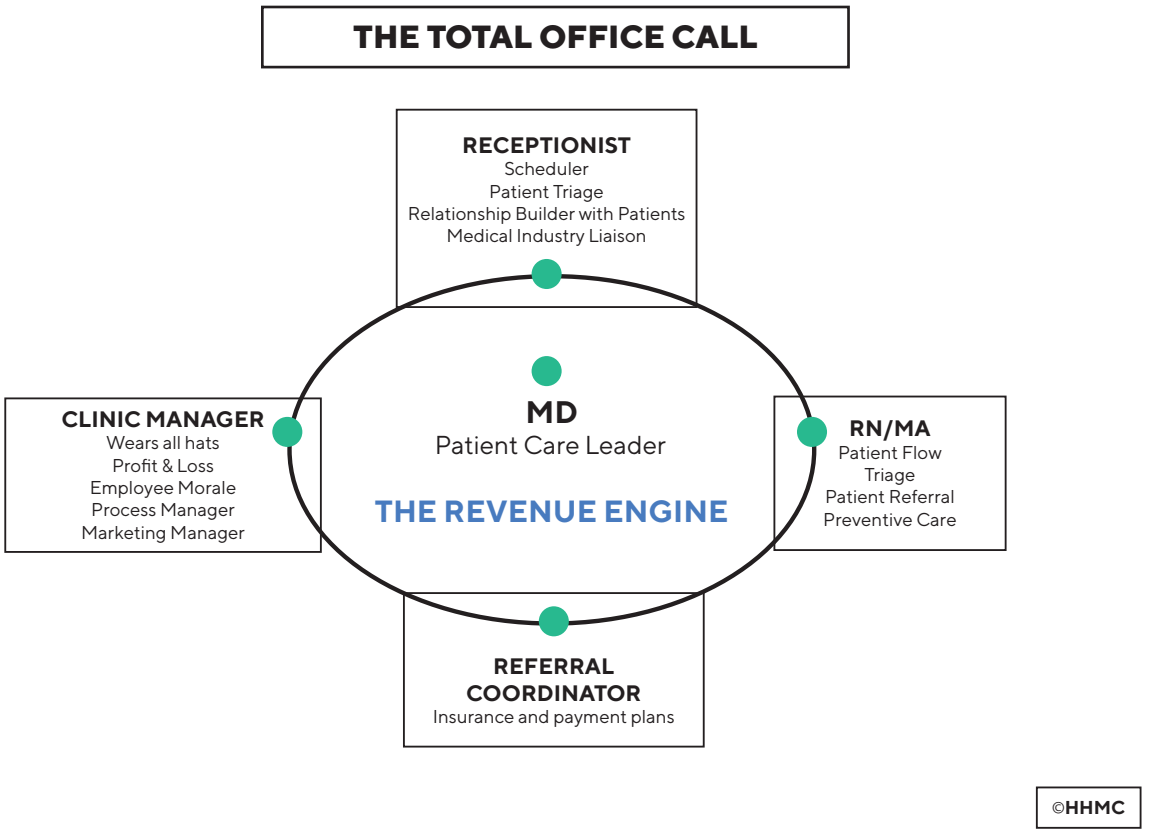

**Box 2. An example of a disease state marketing schedule and time line[16]**

Acquiring no-fee patient education materials from the National Institutes of Health (NIH) that can be distributed by nurses to patients, and providing insurance and payment plan details for newly diagnosed patients all may result in a successful referral of a suffering patient to an audiology practice.

## HOW DOES THE PHYSICIAN BENEFIT FROM AN INTER-DISCIPLINARY CARE RELATIONSHIP WITH AUDIOLOGY?

Both hearing loss and depression are proven barriers to efficacy, and improved quality of life. Recently published evidence from Johns Hopkins University by Reed, Lin et al. in an article titled, *Trends in Health Care Costs with Untreated Hearing Loss*, published in the November 2018 issue of JAMA Otolaryngology-Head & Neck Surgery shows "untreated hearing loss increases the cost of care in older adults, compared to adults without hearing loss. The present study suggests that hearing loss is associated with increased healthcare care expenditures and resource utilization. Notably, hearing loss was associated with an average 46.5 % increase in health costs and a 44% increase in risk of 30-day hospital readmission over a 10 year period. Awareness of the burden that hearing loss places on individuals, insurers, and hospitals contributes to the growing evidence of hearing loss as a public health concern."

Untreated hearing loss also can result in a 12% incidence of associated depression.[10] Further, the World Health Organization (WHO) reports that unipolar depression occupies first place for years lost to disability world-wide by chronic disease states. Patients suffering from depression are three times more likely to not be engaged in their care, further compromising the physician's best efforts in caring for the patient. Audiology can certainly make a difference here, which may result in an elevated and appreciated role for hearing care specialists in the public health arena, and in medicine while serving the greater good.




**Box 3. Key roles in The Total Office Call. Each of these players in the medical practice needs to be targeted and educated by the audiology practice physician liaison.**

## BEST PRACTICES IN PHYSICIAN ENGAGEMENT: WHAT SHOULD I DO FIRST?

Once the decision is made to commit to the implementation of a physician outreach program, the first priority is to recruit, hire, and train a mature, personable, results-oriented, problem-solving person. This person must be able to develop long-term relationships of respect and trust with receptionists, nurses and medical assistants, referral coordinators, office managers, physicians, and effectively make "The Total Office Call" with altruism and integrity to all staff members within the physician's office. Box 3 outlines the roles of all key players in a disease state marketing program.

"Reach and Frequency" is the next step is to create a database of primary care physicians and staff within a five- to ten-mile radius of the audiology practice. This is the audience for your monthly outreach efforts. It is necessary to provide them with previously published, classic, and new peer-reviewed research articles related to hearing impairment, tinnitus, and balance disorders (for physicians), as well as patient education literature from the NIH for nurses and insurance and payment plan information for referral coordinators and office managers.

The third step is to mail out a "hand-addressed, lumpy letter of introduction" to the primary care physician database, two to three weeks prior to making a first face-to-face visit with promised literature. Include a clinic brochure with your list of services, a map of your practice location, a published research article about hearing loss, ten business cards, a patient education brochure, some ear plugs, and Reese's Peanut Butter Cups to surprise and delight the recipient.

The next step is to follow up in-person every 30 – 60 days and provide a continuing stream of published research articles related to hearing loss, co-morbidities, tinnitus, balance disorders, cochlear implants, ear wax removal, hearing aid technology, and a current comprehensive list of your services.

It is now apparent that physician referrals to audiology are the largest untapped source of new audiology patients in the United States and world-wide.[11]

Persuading physicians to think differently while waiting for a means to act differently is not easy. Reminding them of an unmet urgent need, on behalf of the patient, without offending them, requires patience and skill. Hearing aid manufacturer-sponsored benchmark studies have received extensive feedback from thousands of audiology practices that have had substantial success in developing new patient referrals from physicians who have begun requesting hearing evaluations for their patients. These are the challenges and rewards for the hearing-impaired patient awareness campaigns that are a must-have for those who seek to influence the treatment strategies used by physicians who are responsible for deciding which product or service to choose, and which one is in the best interest of the patient's hearing care".[12]

Standard practice by medical industry sales representatives is to make a routine call to a physician's practice every 30 – 60 days. Consistent and routine office visits builds awareness, loyalty, and demonstrates your consistent commitment to bringing value to the physician's practice and his/her patients.

An additional step is the use of multi-channel marketing. This step may include direct mail every 90 days, an email marketing program, telemarketing, webinars with CEU's, promotional videos in the physicians' waiting rooms that drive self-referrals to the audiology practice, co-sponsored displays at health fairs, and other activities. As long as the content comes from scientific journals and other trustworthy sources, and aims to educate, rather than convince or directly influence physicians, the material will perceived to be credible.

When you wish to implement an interdisciplinary care approach to your physician marketing plan, it helps to choose physicians who have both "patients in common" and "patient types" in common with your own practice. Examples of these specialists are: endocrinologists, cardiologists, internal medicine specialists, nephrologists, podiatrists, ophthalmologists, neurologists, geriatricians, and otolaryngologists.[14] These medical specialties share a common bond with audiologists, as a plurality of their patient workload are often adults over the age of 50 years.

## LOOKING AHEAD: SERVICES MARKETING

Build a pipeline of knowledge-based products, and new services-based products that increases your practice's value to potential customers and allows you to effectively differentiate your specialty from online and category-specialty retailers of audiology products. Comprehensive services that can differentiate audiologists from other providers include offering pediatric-to-geriatric evaluations, tinnitus treatment, balance and dizziness treatment, cochlear implant mapping, and quick and comfortable ear wax removal services.

Audiologists in private practice may consider instituting a 24/7 answering service so they are the go-to emergency care audiology specialist in their community. Collaborate with four other audiologists in a "audiologist on call" service in your community so that patients always have a professional specialist to guide them in their hearing care issues, whether it is a chronic or an urgent care situation. This sets you and your profession apart from others and allows you to be more aligned with the medical community, while earning the professional respect of physicians in your area.

Finally, independent stand-alone audiologists need to collaborate with ENT/Audiology medical centers rather than avoiding them or treating them as competitors. The benefits can be startlingly beneficial for the ENT, the independent audiologists, and the patients. Suggest to the ENT medical practices that you become their "Plan B Option," should they require additional staffing coverage due to an absence, or in the event of an off-hours or urgent situation (sudden hearing loss, broken hearing aid etc.). Offer to accept difficult patients that may not be a good fit for the ENT practice.

Do all of this while respecting each other's existing patients, and watch both of your practices grow all because you promoted what is in the best interests of improved patient care and collaboration, not competition.

## AUDIOLOGY'S CALLS TO ACTION

**As a profession that should be viewed as an essential part of the medical community, it is imperative for audiologists to become more visible to their colleagues that practice other specialties under the broad tent of healthcare services.** Increased efforts to strengthen cross-disciplinary training of professionals in the hearing sciences and public health are needed to advance research, and to support broad-based public information campaigns that educate consumers. According to Dr. Frank Lin, "…developing strategies to promote core competencies among primary care physicians in how to address hearing loss is critical; so that patient concerns about hearing deficits that are expressed at primary care visits can be acted upon. As a society with a rapidly aging population, implementing innovative strategies to promote successful again in older adults is a public health, economic, and moral imperative. Concerted and

interdisciplinary public health and research initiatives joining physicians, audiologists, gerontologists, public health researchers, and community advocates to study and treat hearing loss in older adults could potentially have substantial implications for society and the health of older adults – a message to which everyone needs to listen."[15]

Using a systematic approach, like the one outlined here, is a proven strategy for ethically and responsibly educating front-line healthcare professionals, including primary care physicians so that they are obliged to refer patients at-risk for hearing loss to an audiologist for assessment and treatment. In turn, it is the responsibility of the audiologist to provide evidence-based, comprehensive care in a manner that doesn't pressure the patient to buy hearing aids, but instead focuses on providing care that puts the wants and needs of the patient first.

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## *Presentation Notes*

# Frequently Asked Questions

**Q. How much time should I devote to my referral program each week?**
**A.** Plan on committing 2 – 4 hours per week at first. Once they understand how to do it, many Hearing Care Professionals are successful spending just 60 – 90 minutes per week on developing new patient referrals.

**Q. How long should a presentation last?**
**A.** As little as 3 minutes for a quick chat with a doctor on a stand-up sales call to as long as 10 – 15 minutes at a pre scheduled Lunch & Learn. A good rule to follow is that "less is more". Once the physician has agreed with your call to action, thank them for their time, and leave. You need to return in a month to continue to tell the "never ending story" about hearing loss, and the care you provide, so respect their time.

**Q. What are the main messages we want referring physicians to remember?**
**A.** We want physicians to remember the following:

1. You are a licensed, certified Hearing Health Care professional.
2. Your list of services, and that you provide the most advanced testing and treatment technologies.
3. The comorbidities that most significantly contribute to the disease state of hearing loss. e.g. diabetes and pre-diabetes, cardiovascular disease, hypertension, smoking, noise, age, etc.
4. You accept most insurance plans.
5. You have convenient locations, with maps for patients to find your clinic.
6. You offer competitively priced treatment plans, with time to pay.
7. The hearing healthcare specialist takes care of the patient care paperwork.

**Q. What should I do if the physician says he/she does not believe hearing loss is a problem or that hearing aids do not work?**
**A. Show him/her the clinical research data**. Eg: NCOA-1999, JAMA-2003, and NHANES-2008. These studies show definitively that hearing loss profoundly impacts physical/mental health and that amplification is highly effective in treating sensorineural hearing loss, and improving patient's quality of life.

**Q. How many new patients can I expect by implementing this program?**
**A.** The goal of the Physician Referral Program is to help you have at least 5 to 10 new patient referrals to your clinic each month. Three "test with loss" referrals can result in one binaural sale.

**Q. "Test no loss" referrals can be unproductive. How do I make sure physicians refer "test with loss" patients?**
**A.** Encourage the physicians and nurses who you work with to screen their patients with a written self-evaluation/test, which can be placed in the patient's chart. Yes, it is subjective, but if they fail this, they must be referred to a hearing healthcare provider. Also consider providing compelling clinical case studies of patient types with diabetes, smoking, cardiovascular diseases, age, and noise related hearing loss who you have treated, and can be used as a physicians learning guide so that they refer these patients to you. Use a single page format, with your logo, name and address on the case studies.

**Q. Do I have to do all this work myself?**
**A.** Your referral program is a team effort. Place your office manager or other staff member in charge of creating your physician database, mailing out introductory letters, collating and delivering your referral folders. Every staff member is a part-time marketer.

**Q. Who can I contact if I have questions or need help?**
**A.** For answers or advice concerning your referral development efforts, call or email your Regional Sales Manager or Physician Marketing Manager. For additional folders, brochures and other marketing materials, contact Bob Tysoe, who is the physician marketing consultant at Hearing Healthcare Marketing Company. robert.tysoe@netzero.net.

## *Presentation Notes*


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*Bob Tysoe and the audiology students of University of Kansas in Kansas City, KS*

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