NAS Hearing Report and Recommendations: The Good, the Bad, and the Unknown

government affairs

Take the Continuing Education Quiz on page 61.

On June 2nd the National Academies of Sciences, Engineering and Medicine (NAS, previously Institute of Medicine) Committee on Accessible and Affordable Hearing Care for Adults Committee released its long-awaited report to a crowd that was both in person at the Keck Center in Washington, DC, and attending virtually from around the country via a webcast. You can watch the release at http://bit.ly/NASPublicRelease. (The NAS' Health and Medicine Division was previously called the Institute of Medicine or IOM, a reference that is still being used within the hearing health industry.)

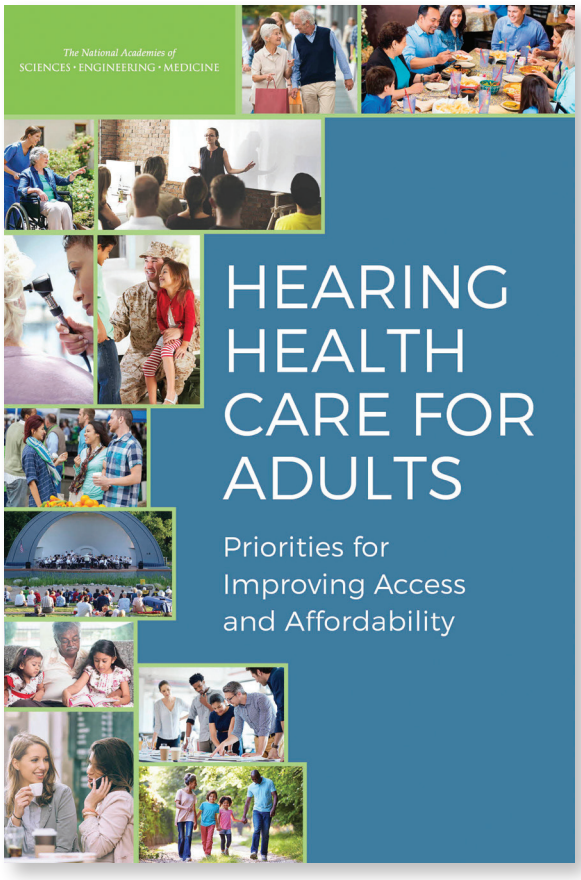
Over the course of a year, the NAS Committee met to discuss and evaluate the health and societal implications of hearing loss, the existing regulatory framework, hearing healthcare access and affordability for devices and services, and innovative approaches for advancing accessibility. Its full charge and a listing of the committee members can be viewed on the committee's website at http://bit.ly/NASCommittee. The committee's work was funded by several federal agencies: the U.S. Food and Drug Administration, the National Institute on Aging, the National Institute on Deafness and Other Communication Disorders, the Department of Defense, the Department of Veterans Affairs, and the Centers for Disease Control; as well as the Hearing Loss Association of America.

During the public release, Committee Chairman Dan Blazer shared with attendees the committee's abbreviated statement of task as addressing:

how to improve accessibility to and affordability of hearing health care for adults, excluding surgical devices and related services and pharmacological therapies. Specifically, the committee will:

- Provide a contextual background addressing the importance of hearing to individual and societal health, productivity and engagement
- Address federal regulations for hearing aid dispensing
- Address hearing health care access and affordability
- Provide recommendations aimed both at solutions that are implementable and sustainable in the short term as well as those that may require a longer timeframe for implementation

He also reviewed the committee's guiding principles, "Prioritize the needs of individuals with hearing loss; emphasize hearing as a public health concern with societal responsibilities and effects; move toward equity and transparency; recognize that hearing



To download the Hearing Health Care for Adults: Priorities for Improving Access and Affordability report, go to this link: http://nationalacademies.org/hmd/reports/2016/hearing-health-care-for-adults.aspx

loss may require a range of solutions; improve outcomes with a focus on value, quality, and safety; and work toward an integrated approach that provides options."

On the surface, IHS agrees with each of these laudable goals that comprise the committee's guiding principles. However, there are several recommendations for which IHS has significant concern, which will be reviewed later in this article. By and large, though, the majority of the report generally provides a well-rounded summary of hearing loss, hearing devices, the current body of research, and challenges and opportunities to increase utilization.

The report also, as Chairman Blazer pointed out, does not discriminate between hearing aid specialists and audiologists – whereby the recommendations are generally meant to apply to all hearing healthcare providers. IHS believes our involvement with the committee – by having a hearing aid specialist appointed to the committee, having two hearing aid specialist speakers on panels, and our written comments – contributed to the report's unbiased nature as it relates to provider type.

The following is a listing of the twelve recommendations made within the report as well as IHS observations. Note at the time of writing, the IHS Board of Governors was still actively deliberating the report and determining its strategy for responding to the many recommendations, which not only will involve federal advocacy but engagement with state chapters and other key stakeholders. Of note, the committee was directed to make recommendations based on "sound scientific reasoning in the context of the current healthcare environment" when "robust evidence is lacking or absent." IHS found several examples of this approach in the report/recommendations, which are indicated in the following pages.

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GOAL 1: Improve Population-Based Information on Hearing Loss and Hearing Health Care

The National Institutes of Health, the Centers for Disease Control and Prevention, the Patient-Centered Outcomes Research Institute, the Department of Defense, the Department of Veterans Affairs, state public health agencies, and other relevant government agencies, as well as nonprofit organizations, hearing health care professional associations, academic institutions, and researchers, should strengthen efforts to collect, analyze, and disseminate prospective population-based data on hearing loss in adults and the effects of hearing loss and its treatment on patient outcomes.

Specifically,

- *Support and conduct studies to develop, evaluate, strengthen, and align metrics for hearing loss and communication abilities;*
- *Support and conduct studies, including longitudinal studies, in diverse populations to better understand:*
  - *the risk and natural history of hearing loss;*
  - *risk factors and co-morbidities of hearing loss;*
  - *hearing health care needs; and*
  - *the impact of hearing loss and its treatment on health, function, economic productivity, and quality of life; and*
- *Develop and strengthen research training programs to address hearing loss as a public health concern with attention to cross-disciplinary training on sensory disorders, epidemiological methods, advanced biostatistics, and health services and health economics research methods.*

IHS Comments: IHS agrees that more research is needed. The report cites a traditionally low demand for research compared with other healthcare conditions due to few insurance companies covering hearing care services – insurance companies being a substantial driver for research investments when a healthcare service or treatment is covered. Research cited in the report also contains useful data about the prevalence of hearing loss by age and by severity; the risk of hearing loss vs. other major medical conditions; and hearing loss incidence by socioeconomics and race. Studies show the prevalence of hearing loss is on a slow decline, and while the report includes a few possible contributing factors, it does not point to a specific cause or causes for this trend.

GOAL 2: Develop and Promote Measures to Assess and Improve Quality of Hearing Health Care Services

The Centers for Medicare & Medicaid Services, the National Institutes of Health, the Department of Defense, the Department of Veterans Affairs, other relevant federal agencies hearing health care professional associations and providers, advocacy organizations, health care quality improvement organizations, health insurance companies, and health systems should collaborate to:

- *Align and promote best practices and core competencies across the continuum of hearing health care, and implement mechanisms to ensure widespread adherence; and*
- *Research, develop, and implement a set of quality metrics and measures to evaluate hearing health care services with the end goal of improving hearing- and communication-focused patient outcomes.*

IHS Comments: IHS agrees with the use of best practices in the identification and treatment of hearing loss, including through the use of hearing aids and provision of aural rehabilitation and counseling. While our standards are evident throughout our distance learning course, trainer manual, and practice guidelines, collaboration with other hearing health providers is critical, particularly because quality metrics and measures could be a tool used by insurance companies in the future just as they are by Medicare today. Not only could the application of standards and outcomes data lead to better patient care, but they would provide hearing aid providers a fantastic measure of how the business is doing in serving patients.

In turn, practices can share performance data with primary care physicians or insurance companies, for example, to encourage referrals or network inclusion.

GOAL 3: Remove FDA Regulation for Medical Evaluation or Waiver

The Food and Drug Administration should remove the regulation that an adult seeking hearing aids be required to first have a medical evaluation or sign a waiver of that evaluation and should ensure consumers receive information about the medical conditions that could cause hearing loss through continued inclusion of that information in hearing aid user instructional brochures.

IHS Comments: IHS has serious concerns with this recommendation, which would essentially eliminate the association of hearing loss as a medical condition. Not only is the limited research presented inappropriate and misleading in IHS' opinion, but it is contradictory. IHS' evidence through member surveys strongly supports the role of the medical clearance and waiver option, which insures that patients are, at the very least, screened for the FDA red flags and other indications warranting a physician evaluation; and that a hearing aid is an appropriate option. For a full discussion of IHS' concerns on this topic, go to http://bit.ly/IHStoFDAJune30.

GOAL 4: Empower Consumers and Patients in Their Use of Hearing Health Care

Hearing health care professionals, professional associations, advocacy organizations, and relevant govern-mental agencies such as the Office for Civil Rights at the Department of Health and Human Services should ensure patients are aware of, and understand how to exercise, their rights of access to information about themselves under the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Section 164.524), including their audiograms and hearing aid programming history.

IHS Comments: IHS encourages hearing aid providers to comply in full with their obligations under HIPAA, if applicable. Non-compliance can result in serious penalties. IHS hosted two webinars on this topic that can be accessed at http://bit.ly/IHSWebinars. According to 45 CFR 164.524, "an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set." Protected health information includes individually identifiable health information that is transmitted or maintained in electronic or any other form of media. "Health information includes any information that 'Relates to the past, present, or future physical or mental health or condition of an individual; or the provision of health care to an individual.'" (45 CFR 160.103) While the NAS report lacks any evidence to support the value of providing audiograms and hearing aid programming history to patients, the committee's intent is stated as two-fold: 1) it "could facilitate consumers' ability to change their hearing health care providers for subsequent care if their providers are not meeting their needs, or it could allow changes in providers if an individual moves to another location or is away from home for an extended period of time," and 2) it could reduce the number of complaints filed against providers who are unwilling to share patient records for which HIPAA applies.

GOAL 5: Improve Access to Hearing Health Care for Underserved and Vulnerable Populations

The Health Resources & Services Administration, state health departments, advocacy organizations, and hearing health care professional schools and associations should

- *Collaborate and partner with health care providers to*

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ensure hearing health care accessibility throughout rural and underserved areas using mechanisms such as telehealth, outreach clinics (including federally qualified community health centers), and community health workers;

- *Support and promote programs, including incentives such as tuition assistance, to increase diversity in all sectors of the hearing health care workforce; and*
- *Promote the training of cultural competency in the hearing health care workforce and incentivize practice in underserved communities.*

IHS Comments: IHS supports expanding hearing health access to underserved populations, and in this case, those for whom cultural attitudes or distance may be a barrier. In this case, the NAS focuses its attention on what it considers "innovative" delivery methods for care, to include telehealth, outreach clinics and community health workers, as well as retail clinics like drug stores and Costco. While retail clinics in their current forms (Walgreens and Costco cited in the report) utilize licensed hearing aid providers, concepts for increasing services through telehealth, outreach clinics and community health workers has been largely untested in the United States so their application still falls in the "unknown" category. IHS incorporated language in its Model Licensure Act in 2013 that states, "The [licensing] board shall promulgate rules governing the appropriate use of tele-practice, including which services may not be provided using tele-practice, such as the initial hearing assessment and initial hearing aid fitting." The report suggests community health workers could be used to provide basic hearing/aid services – a concept that would be of concern to IHS if they are providing hearing aid services for which a state license is required.

IHS has been supportive of increased diversity in the field, particularly through its promotion to hire veterans and veteran medics, and sees a more diverse workforce as a tool for tapping into underserved populations. The report states, "Among respondents to the 2014 Survey of Household Economics and Decisionmaking who had a household income of less than $40,000, 45 percent reported going without some form of medical treatment in the preceding 12 months." Several studies suggest that more than 60% of the US population falls into the lower middle class, working class, or working poor – the people who still have hearing needs but would likely not have access to public assistance. IHS sees vast potential for hearing aid practices to develop new models to bring access to the individuals.

GOAL 6: Promote Hearing Health Care in Wellness and Medical Visits

Public health agencies (including the Centers for Disease Control and Prevention and state health departments), health care systems (including those of the Department of Defense and the Department of Veterans Affairs), health care professional schools and associations, advocacy organizations, health care providers, and individuals and their families should promote hearing health in regular medical and wellness visits (including the Medicare Annual Wellness Visit).

Specifically,

- *Use patient visits to assess and discuss potential hearing difficulties that could affect doctor–patient communication and overall patient well-being, to encourage individuals and their family members and caregivers to discuss hearing concerns, to raise awareness among older adults about age-related hearing loss, and to encourage referral when appropriate; and*
- *Develop and disseminate core competencies, curricula, and continuing education opportunities focused on hearing health care, particularly for primary care providers.*

IHS Comments: IHS strongly supports this recommendation.

GOAL 7: Implement a New FDA Device Category for Over-the-Counter Wearable Hearing Devices

The Food and Drug Administration should establish a new category of over-the-counter (OTC) wearable hearing devices. This device classification would be separate from "hearing aids." OTC wearable hearing devices would be defined as wearable, OTC devices that can assist adults with mild to moderate hearing loss.

These devices would:

- *Explicitly be defined by FDA as intended for OTC sale;*
- *Be able to be marketed as devices that may assist with hearing loss and be sold as OTC, by mail, or online; and would include mobile apps and associated wearable technologies intended to function as an OTC wearable hearing device for mild to moderate hearing loss;*
- *Be subject to regulatory requirements that would explicitly preempt current state laws and regulations for hearing aids and dispensing and preempt potential future state laws and regulations seeking to limit OTC access;*
- *Be exempt from 510(k) premarket review to the extent that the technology is not fundamentally different from air conduction hearing aids;*
- *Include thorough consumer labeling, including information on:*
  - *frequency gain characteristics*
  - *adequate directions for use*
  - *communication challenges for which it may be helpful to seek professional consultation*
  - *medical situations, symptoms, or signs for which to consult with a physician*
- *Meet minimum safety requirements and standards, including but not limited to:*
  - *safe maximal sound output (e.g., upper limit for dB SPL [decibel of sound pressure level] peak output) at levels to be determined in conjunction with national experts in hearing conservation*
  - *criteria for ear tips (e.g., maximum depth for insertion into the ear canal)*
  - *amplification via air conduction only. Wireless technology for programming and connectivity should be permitted*
  - *American National Standards Institute or other voluntary standards for audio characteristics and performance as determined by FDA, as appropriate for this category*
- *Be subject to quality system regulation (QSR) requirements, but be considered for exemption from certain QSR requirements as determined by FDA to be appropriate for this category; and*
- *Have the option to include accessory tests for self assessment of mild to moderate hearing loss for purposes of selecting and fitting an OTC hearing device.*

To further clarify the types of hearing technologies and their oversight and regulation:

- *FDA should retain a guidance document on personal sound amplification products (PSAPs) that describes PSAPs as products that are not to be offered or promoted to address hearing loss and are subject to the electronic product provisions of the Federal Food, Drug, and Cosmetic Act through its 2009 PSAP guidance document or a revision of its 2013 PSAP draft guidance document. The PSAP guidance document would establish the distinction between PSAPs for normal hearing and the OTC wearable hearing device category for hearing loss.*
- *The Consumer Product Safety Commission and the Federal Trade Commission should exercise their respective authorities in the regulation of consumer products marketed as PSAPs.*

IHS Comments: As with goal three, IHS is very concerned with and strongly opposed to this recommendation. Again, the NAS report lacks well-formed evidence to support this recommendation. There is no data presented that demonstrates the consumer's ability to self-diagnose and self-treat his/her own hearing loss. IHS presented in its case to the FDA via the FDA's April 21 workshop (**http://bit.ly/FDAOTCWorkshop**) and IHS' June comments (**http://bit.ly/IHStoFDAJune30**) the many reasons why an accurate self-diagnosis and proper self-treatment is an impossibility. One of the NAS committee's arguments for a new classification stems from their desire to make

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hearing healthcare accessible to all and specific findings of a MarkeTrak study released in 2010 in which almost half of PSAP users indicated that if PSAPs were not available, they would not purchase custom hearing aids. The committee also referenced the existence of over-the-counter devices like noninvasive blood pressure monitoring systems, stethoscopes, and burn dressings, which "enable consumers and patients to take more control of their own health and medical conditions." IHS disagrees with these correlations because many such devices are only useful if a consumer has a baseline understanding of their condition and/or diagnosis from a healthcare professional, therefore they are inconsistent with a fully OTC model, as the committee recommends.

GOAL 8: Improve the Compatibility and Interoperability of Hearing Technologies with Communications Systems and the Transparency of Hearing Aid Programming

The Federal Communications Commission, Federal Trade Commission, Food and Drug Administration, National Institutes of Health, and other relevant federal agencies; the American National Standards Institute and other standards setting organizations; manufacturers; and industry, professional, and consumer advocacy organizations should:

- *develop standards that ensure that hearing aids and over-the-counter (OTC) wearable hearing devices are compatible and interoperable with other technologies and communications systems;*
- *increase public awareness and consumer-friendly information on the availability, connectivity, and use of hearing aids and hearing assistive technologies; and*
- *develop and implement standards for an open platform approach for hearing aid programming that allows any hearing health care professional (or, as evolving technology allows, the device owner) to program the device settings, and require point-of-sale information about the programming features and programming portability of hearing aids in order to enable more informed purchasing decisions.*

IHS Comments: This goal includes provisions consistent with IHS' recommendations to the NAS to encourage the use of assistive technologies to promote greater acceptance and awareness of hearing aids, and drive hearing aid adoption and use. Of concern is the recommendation to develop standards for over the counter hearing aids (devices), which IHS opposes. Separately, given recent attempts at the state level to legislate the integration or promotion of telecoils in hearing aids as part of the patient encounter, the NAS's endorsement of this approach could drive increased activity at the state level. Therefore, state associations should be prepared to activate as needed. Finally, the open platform approach standards, per the report, are recommended in order to provide consumers the option of having their hearing aids programmed by a different professional than they purchased the aids from and as a result enhance "provider choice" options.

GOAL 9: Improve Affordability of Hearing Health Care

The Centers for Medicare & Medicaid Services (CMS), other relevant federal agencies, state Medicaid agencies, health insurance companies, employers, hearing health care providers, and vocational rehabilitation service agencies should improve hearing health care affordability for consumers by taking the following actions:

- *Hearing health care professionals should improve transparency in their fee structure by clearly itemizing the prices of technologies and related professional services to enable consumers to make more informed decisions;*
- *CMS should evaluate options, including possible statutory or regulatory changes, in order to provide*

coverage so that treating hearing loss (e.g., assessment, services, and technologies, including hearing aids) is affordable for Medicare beneficiaries;

- *CMS should examine pathways for enhancing access to assessment for and delivery of auditory rehabilitation services for Medicare beneficiaries, including reimbursement to audiologists for these services;*
- *State Medicaid agencies should evaluate options for providing coverage for treating hearing loss (e.g., assessment, services, and hearing aids and hearing assistive technologies as needed) for adult beneficiaries;*
- *Vocational rehabilitation agencies should raise public awareness about their services that enable adults to participate in the workforce, and they should collaborate with other programs in their respective state to raise this awareness;*
- *Hearing health care professionals and professional associations should increase their awareness and understanding of vocational rehabilitation programs and refer as appropriate; and*
- *Employers, private health insurance plans, and Medicare Advantage plans should evaluate options for providing their beneficiaries with affordable hearing health care insurance coverage.*

IHS Comments: IHS is generally supportive of expanded coverage for hearing aids and related services through programs like Medicaid, Vocational Rehabilitation and private insurance plans. However, we are concerned that these recommendations could translate into more rampant use of third-party discount plans, which essentially eliminates the independent decision making of the provider and may impact existing contracts. And while we agree with the concept of greater pricing transparency, the NAS Committee's recommendation for using an unbundled model specifically is inconsistent with our belief that providers are the best positioned to determine the pricing structure that works best for their business patients and business.

GOAL 10: Evaluate and Implement Innovative Models of Hearing Health Care to Improve Access, Quality, and Affordability

The Centers for Medicare & Medicaid Services, the Patient-Centered Outcomes Research Institute, the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources & Services Administration, the Department of Defense, the Department of Veterans Affairs, researchers, and health care systems should prioritize and fund demonstration projects and studies, including randomized controlled trials, to improve the evidence base for current and innovative payment and delivery models for treating hearing loss.

Specifically,

- *Innovative models to be evaluated should include, but not be limited to, community health workers, telehealth, mobile health, retail clinics, and self-administered hearing health care. These projects and studies should include outcomes that are patient-centered and assess value, comparative effectiveness, and cost effectiveness.*
- *Demonstration projects should evaluate the health impact of beneficiary direct access to audiologist-based hearing-related diagnostic services, specifically to clarify impact on hearing health care accessibility, safety, and the effectiveness of the medical home. This excludes direct access to audiologic testing for assessment of vestibular and balance disorders and dizziness, which require physician referral. Successful outcomes would provide evidence of effective communication and coordination of care with primary care providers within a model of integrated health care, and evidence of appropriate identification and referral for evaluation of medical conditions related to hearing loss and otologic disease.*

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- *Models that are found to be most effective should be widely implemented.*

IHS Comments: This goal supports the development of research to test or support assertions that new and emerging models including those suggested in the report, could have on accessibility and affordability issues. Generally, in IHS' opinion, this indicates a bit of a "cart before the horse approach" as it relates to several of the NAS recommendations, though the NAS was directed to make recommendations based on assumptions when the evidence was lacking. Of note, one area of study is whether direct access to an audiologist would be beneficial, and based on the contents of the report, this recommendation is likely driven by the lack of committee consensus on whether a physician order or direct-access is the preferred method of patient management under Medicare.

GOAL 11: Improve Publicly Available Information on Hearing Health

The National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, the Department of Defense, the Department of Veterans Affairs, the Administration for Community Living, state public health agencies, other relevant government agencies, advocacy organizations, hearing health care professional associations, hearing technology manufacturers, hearing health care professionals, and media organizations should improve public information on hearing health and hearing-related technologies and services and promote public awareness about hearing and hearing health care.

Specifically,

- *Strengthen publicly available, evidence-based information on hearing through multiple avenues (e.g., centralized websites, community-based services, local councils on aging) that explain hearing and related health concerns for adults of all health literacy levels, and address the breadth of services and technologies, including their comparative effectiveness and costs;*
- *Work through media, social marketing, and public education campaigns to disseminate and evaluate key evidence-based messages about hearing and hearing health and to promote accuracy in media portrayals;*
- *Implement and support a consumer-based metric to enable individuals to understand and track their communication abilities and hearing needs and a consumer-oriented format for audiogram and other hearing test results;*
- *Adopt standardized terminology across manufacturers about the features and capabilities of hearing aids and hearing assistive technologies so that consumers and hearing health care professionals can make easy, clear, unambiguous comparisons; and*
- *Develop and disseminate criteria that individuals and families can use to evaluate and compare hearing-related products and services.*

IHS Comments: IHS is supportive of efforts to increase public awareness about hearing loss, and the role the licensed provider and hearing aids play in improving outcomes and quality of life. Of particular interest in this section is a focus on patients' health literacy levels, which can vary widely, and methods for helping patients to be more successful with hearing aids. This recommendation and related portions of the report also provide a glimpse into the possible future models for: hearing testing, which support a test more representative of a real-world listening environment; and characterizing the findings of the audiometric evaluation into a simpler format such as those used for vision (20/20) or blood pressure (110/80).

GOAL 12: Promote Individual, Employer, Private-Sector, and Community-Based Actions to Support and Manage Hearing Health and Effective Communication

Individuals, families, community-based organizations, advocacy organizations, employers, private-sector businesses, and government agencies (local, state, federal) should take actions to support and manage hearing health and foster environments that maximize hearing and communication for all individuals.

- *Individuals and their family members can*
  - *Reduce exposure to noise that is at high volume levels for extended periods of time and use hearing protection as appropriate,*
  - *Be aware of and recognize difficulties in hearing and communication and seek information and care through the range of available services and technologies when appropriate, and*
  - *Seek out peer-support groups and other opportunities for those living with hearing loss, when appropriate.*
- *Community-based organizations, advocacy organizations, employers, private-sector businesses, and government agencies (local, state, federal) should promote work and community environments that are conducive to effective communication and that support individuals with hearing loss. Specifically, they should:*
  - *Ensure compliance with the Americans with Disabilities Act and other related laws supporting people with disabilities and strive to exceed their minimum requirements;*
  - *Research and incorporate features into buildings and public spaces that improve hearing and communication (e.g., universal design, hearing assistive technologies).*

IHS Comments: IHS supports this goal which promotes the education and self-empowerment of the patient and their support system – a process in which hearing aid dispensing professionals can play a powerful role.

IHS encourages members to review the NAS report in its entirety because – despite its length – it may offer empowerment and inspiration as hearing aid businesses: evaluate ways in which to grow their patient bases to include underserved populations, reposition themselves as one-stop shops for all hearing-oriented resources, and anticipate and better respond to future changes in the way hearing is considered and treated more broadly. You can view the full report at **http://bit.ly/FinalNASReport**. And be sure to check out our June 2016 webinar on over the counter hearing aids at **http://bit.ly/IHSOTCWebinar**, which includes additional commentary on the NAS report and our "Top Ten List of Opportunities for Hearing Aid Practices."

WHAT'S NEXT?

The NAS report has been made publically available and no doubt will be the subject of ongoing discussions among the many key stakeholders who inhabit the hearing health population and industry about how to move forward. IHS will be closely monitoring the FDA and other governmental entities, and has already included in its June 2016 comments to the FDA a discussion of our concerns with NAS proposals regarding an over the counter hearing aid classification and elimination of the medical clearance/waiver. FDA action on this topic would require federal rule-making, the process for which can be slow and arduous, but most importantly involves the public. IHS will keep members apprised of future actions and opportunities stemming from the report and recommendations and their potential application. There is no expectation that these recommendations will be acted on overnight, and some may not be acted on at all if interest is lacking or an approach does not have a perceived value. In the meantime, IHS will focus on arming our members with tools to take advantage of opportunities while minimizing any potential negative impacts, just as we have done in the past. ■

IHS Continuing Education Test

NAS Hearing Report and Recommendations: The Good, the Bad, and the Unknown—article on page 38

1. When the committee deliberated a goal or recommendation that lacked robust evidence to support it, the committee was directed to:
   a. qualify the recommendation as having conditional support pending validated evidence.
   b. use sound scientific reasoning in the context of the current healthcare environment.
   c. recommend further study.
   d. All of the above
2. Studies show that the prevalence of hearing loss over time is:
   a. increasing.
   b. has not changed.
   c. declining.
3. Why should hearing aid practices embrace best practices and quality metrics in the delivery of hearing care?
   a. To Improve patient outcomes
   b. Outcomes data can be translated into marketing tools
   c. To gauge the practice's overall performance
   d. To anticipate the possible future demands of insurance companies
   e. All of the above
4. The NAS Committee recommended the elimination of the medical clearance requirement for both children and adults seeking hearing aids.
   a. True b. False
5. What percentage of households with an income of less than $40,000 reported going without some form of medical treatment in the prior year?
   a. 45% b. 50%
   c. 53% d. 65%
6. The NAS Committee report lacks meaningful data to support an individual's ability to self-diagnose and self-treat hearing loss.
   a. True b. False
7. NAS supports permitting audiologists to be reimbursed to provide which service(s) under Medicare?
   a. Hearing-related diagnostic services
   b. Audiologic testing for assessment of vestibular and balance disorders and dizziness
   c. Auditory rehabilitation services
   d. All of the above
8. According to the NAS, how can providers and other community-based organizations enhance information available to the public about hearing healthcare?
   a. By promoting the use of more actors in television and movies who have hearing loss
   b. By making information available at all health literacy levels
   c. By requiring them to provide information to all patients on potential coverage through Medicaid
9. One way employers can promote a work environment that is supportive of individuals with hearing loss is to ensure compliance with:
   a. Americans with Disabilities Act (ADA).
   b. Health Insurance Portability and Accountability Act (HIPAA).
   c. U.S. Food and Drug Administration (FDA) Hearing Aid Rules.
10. Which answer is NOT true? The decision on whether the federal government will adopt regulations to create-an-over the counter hearing device:
    a. Would involve public input
    b. Will be considered by Congress
    c. Would require federal rule-making

For continuing education credit, complete this test and send the answer section to:

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NAS HEARING REPORT AND RECOMMENDATIONS: THE GOOD, THE BAD, AND THE UNKNOWN

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2.	a	b	c			7.	a	b	c	d
3.	a	b	c	d	e	8.	a	b	c	
4.	a	b				9.	a	b	c	
5.	a	b	c	d		10.	a	b	c	