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Article & Quiz

Baby Boomers—Taking a Different Approach

By Christina Young

This new consumer has not only strained our patience, they have blown our closing ratios. Although we were confident in dealing with WWII era patients, their adult children are forcing us in new directions. There are now 38 million people in the U.S. between the ages of 60 and 70, and the "trailing edge" boomers (born between 1954 and 1964) number 37 million. So how do we welcome them into our practice?

The plain truth is that we are no longer in the business of the one-call close. This is perhaps the most difficult change to make. For years, we have been accustomed to pulling out all the stops to help the first-time visitor become a patient with an order in hand. We knew this was best for them if they had an "aidable" loss. And, we knew we weren't doing our jobs if we didn't demonstrate a clear case for getting the help they needed, and now was the time.

Baby boomers will have none of that. They know hearing aids are expensive and not completely effective in solving communications difficulties. They have watched their parents struggle with their aids, and so they won't get help until they are confident they'll do better. The good news is that baby boomers fully understand the consequences of delayed treatment. They have personally experienced what happens when you wait too long before being fitted. I've heard many stories from 55 year olds about their grandparents who didn't get hearing aids when they should have. Grandma still said "what" with her hearing aids in, only wore them to church, and couldn't hear in restaurants.

It's no wonder that no one wants hearing aids. According to Dr. Frank Lin of Johns Hopkins University, there are an estimated 22.9 million people over age 50 with hearing loss, but they do not wear aids. Now, because of their experience with grandma and her limited success with hearing aids, baby boomers know the consequences of delayed treatment. This generation actually approaches hearing instruments as a therapeutic tool.

"Grandma should have started sooner when she could still make sense of things. Her brain was too foggy to make the best use of her aids." I have heard this from many, many people in their fifties and sixties, and it really upsets me. Sometimes they say Grandma's aids faded over time, and she sat on the couch hoping someone would have enough patience to come and talk with her at family gatherings.

These examples remind us of all the bad experiences that we need to overcome in our profession. It's no surprise that baby boomers approach us with caution, and sometimes outright hostility. Everyone who knows a "grandma" has personal proof that "hearing aids don't work". It's only logical that they would resist hearing aids for themselves.

Instead of feeling threatened by these complaints, this is a teachable moment. This means the baby boomer has some understanding of hearing aids, as well as limits of their functioning. If we congratulate them for having practical experience, we show the baby boomer customer that we believe them, and that we are listening. This may seem a strange thing for a licensed specialist to believe, but this is the essential shift that we must demonstrate in our initial consultations with our baby boomer clients. Their own success as a hearing aid user doesn't rely entirely upon the instrument chosen for them, and this is the time to point that out. All of the experience they bring, even a story of failure rather than success, is actually good for us as clinicians. And, I propose that it's also good for your practice. This is exactly what we have been working toward in our field for years: getting wearers to understand the relationship between speech processing, acoustic properties of each situation, and the ability of the wearer to focus on the signal source, preferably from the beginning of the sentence.

In initial fitting appointments, it is a good idea to explain that we will spend as much time discussing expectations as we do on care and mechanics of the instruments. For example, we should tell our client's loved ones that they'll still have to say "Honey," or "George," before the rest of the sentence, so that the wearer can be with them from the beginning of their conversation. Hearing aids are not magical solutions for comprehension, so it is wise to share the brain research from UCLA: We have more than 70,000 thoughts in a day! After I share that piece of information, I then typically ask the spouse if they were thinking about the grocery list or their evening plans while I was talking to "George." To which they often respond, "No, I was thinking "George" would be lucky to have seventy thoughts in a day!" Either way she answers, it's good for a chuckle and points out how our minds skip from subject to subject.

"…there are an estimated 22.9 million people over age 50 with hearing loss, but they do not wear aids."

It is important to discuss the habits we develop to cope with hearing loss, and how our "what?" response to a question can become automatic. Be sure to point the blame for disagreements back to hearing loss, which takes the responsibility away from the patient. Assigning blame to an actual physical disability, rather than willful resistance, allows the patient to be liberated from the shame and guilt that has become a part of their self-image. They see that many of their family arguments are the direct result of hearing loss.

While it's obvious to us that our clients should choose a booth at a restaurant rather than a table, it is helpful to share these lifestyle tips every time. Tell them to choose a place against the wall if there are no booths available. Try this experiment with new clients: have them cup their hands behind their ears to experience the improvement when the sound is stopped and directed into the ear. Or, use a sound pressure meter, turn sideways and talk, and then have the spouse read the drop in volume to show how important it is to face each other when speaking.

Establishing how voices carry allows the patient to understand that the hearing aid is not the entire solution to hearing loss. This is essential to their future success in noisy places. The patient has to learn to assess their listening environment by understanding factors such as carpeting and draperies, ceiling

height, and the number of people in a room. They have to know who to focus on in a group setting. Explain to them that even people with good hearing will also have trouble at a table of six people. The person with normal hearing can hear the people next to them very well, but if someone across the table pulls them into the middle of their conversation, it can be confusing. That person won't know what they've been talking about, so they can't respond without asking questions. Our brains can only understand one conversation at a time, normal hearing or not.

Sometimes, people will remark that they don't want to hear everything that's being said around them. Depending on the situation, this may be an adaptive attitude that helps us cope with a physical disability, which (in this case) is hearing loss. We can lighten the mood, and describe this as the "selective listening license" that you get on your wedding day. Be sure to explain that the difference between hearing and listening is another important factor in speech comprehension. This helps to reinforce the need to get each other's attention from the beginning of the sentence. Another personal example I often share is my love of reading. Sometimes I'll be so focused on my book that I don't notice that the phone is ringing. When I use this as an example of concentration and how we tune things out, calling each other's name makes more sense. It is vital to use such practical scenarios with our clients in the fitting appointment. Skipping these examples, will set our customers up for frustration.

In order to get to an actual fitting, however, we have to establish trust. There will be no opportunity to make recommendations and ask for their business if we fail at this point. It's a new way to look at patient care, as if we are providing five-star service from a luxury hotel. We have to listen to what the patient says, and confirm that we heard them. We have to empathize with their frustrations, and share our own professional successes. They have to see that we are really equipped to help them, and that we have the patience and expertise needed.

Shifting our perspective to consulting, rather than selling, can make all the difference.

This new prospect is not just looking for the results of a hearing evaluation. They are shopping for someone whom they'll be able to work with as a consultant. They want to be able to ask questions and understand our recommendations. If we invoke a "doctor-patient" power dynamic, you will not get to welcome them in to our practice. Baby boomers are different from their parents, and they expect full disclosure when it comes to their health.

This can be a difficult shift to make in our professional approach, because we are not staffing the front desk of an exclusive resort! It is natural to think, "This is my "turf," and I'm the expert here." But, we have to let go of our ego, and remember why we chose this field. Shifting our perspective to consulting, rather than selling, can make all the difference. It is imperative to make a personal connection, let them see how we work, and plant the seeds for a future professional relationship. Baby boomers will not be pushed into getting help for themselves. After watching their loved ones struggle with aids, they won't make a move until they're confident they'll do better than that family member.

Baby boomers are voracious researchers, and use the Internet to gather specs and pricing. Unfortunately, it can become impossible to make a decision with the overwhelming amount of technical information available. This is where our clinical experience becomes invaluable to the consumer. They need our years of experience to pursue the best course of action for their specific needs.

One of the first questions we can ask in our initial meeting is, "Who do you know with hearing aids?" We should even welcome complaints about their own family members. If there is a bad story there, is good to ask, "How long ago was this?" This provides a good segue for providing an accurate description of microphone improvements, proprietary algorithms, and noise filtering. We may even take the time to discuss the evolution of mold manufacturing, and our clinical understanding of style selection based on slope and severity. We can also explain the importance of individual ear anatomy, and ask whether grandma's aid was behind the ear or in the ear. This can lead to a discussion on occlusion and venting, using an anatomical sketch for reference. To illustrate occlusion and venting, curve your left hand into the letter "C", then touch your fingers to your thumb on the right hand, and reach inside the "C". Then describe the open ear canal, and how the instrument must direct sound to the tympanic membrane without leakage (or, that there must be venting to allow sounds to escape that aren't speech cues). All of this is purely educational, and while it is possible to share too much technical information, such discussions are essential for the doubting family member to understand the necessary prerequisites for hearing aid success.

Another topic we need to be ready to discuss is explaining the shortfalls of older hearing aids. This may make us feel like we are risking the credibility of the entire industry. However, it shows clients that we are well-informed about technology, and it helps build trust in our abilities when we promise improvement with their hearing trouble.

All of the above discussions may occur in the initial consultation. It is vital to be prepared to convey to the baby boomer how we have helped other people in their same situation. While the baby boomer may come in armed with technical research and manufacturer comparison charts, we cannot be annoyed. This is how the field of health care has evolved. If we want our practices to meet demand as the baby boomers age into our client base, we have to adapt as well. Allow yourself to be that trusted advisor, and share your experience and recommendations.

Sometimes the informed consumer even believes they can fit themselves through an Internet purchase. While it may seem that we're losing ownership of our exclusive knowledge, this is not the end of our specialty. There is no substitute for our years of patient stories, or our ability to point the cause of family arguments back to hearing loss. We are there to take the responsibility off their shoulders, and place it onto a definable hearing loss.

Perhaps this is the best part of fitting hearing aids: releasing the personal blame that had slowly crept into their family relationships (accusations of selective hearing and withdrawal from social situations). This can restore the dignity of the accused, and show them how deeply their relationships may have affected by hearing loss. If we believe we can help people, be encouraged by the sheer number of potential new patients entering your practice. With a shift in our perspective, we will find the baby boomer is exactly what we had been waiting for.

Christina Young is a certified Commercial Copywriter specializing in the hearing instrument market. For over half a decade, she welcomed nearly 1,400 new patients to the world of hearing instruments and auditory therapy as a Licensed Hearing Aid Specialist. Watching the patient base shift from WWII era patients to their children now in their early sixties, Christina is committed to capturing this emerging segment through direct mail, email marketing and online content. She combines her sales background, patient care philosophy and on-trend technological savvy to create powerful digital and print packages to engage, convert, and retain. Her website is www.convoscribe.com

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1. **In initial fitting appointments, it is necessary to spend equal time discussing**
   a) cost and care of hearing aids
   b) care of hearing aids and expectations
   c) mechanics and cost of hearing aids
   d) none of the above
2. **Discussing habits/disagreements that families develop/experience in coping with hearing loss**
   a) allows them to point the blame to the hearing loss
   b) enables them to blame a disability rather than willful resistance
   c) liberates them from shame & guilt
   d) all of the above
3. **Reviewing how to assess restaurant seating for optimal conversation flow for baby boomers can be**
   a) too overwhelming to share in an initial visit
   b) insulting to their intelligence
   c) essential to their future success in noisy places
   d) viewed as a condescending topic in an initial consultation
4. **Baby boomers can be overwhelmed by their voracious research so your clinical experience becomes invaluable to them.**
   a) true
   b) false
5. **There are now 50 million people in the U.S. between the ages of 60 and 70.**
   a) true
   b) false
6. **The human brain can understand only this many conversations a one time**
   a) one
   b) two
   c) three
   d) between three and five
7. **Focusing in a group setting involves assessing these factors**
   a) carpeting
   b) number of people in a room
   c) ceiling height
   d) all of the above
8. **UCLA research shows that humans have this many thoughts a day:**
   a) 70 per hour
   b) 700 on average
   c) about 7,000
   d) more than 70,000
9. **The youngest U.S. baby boomers (born between 1954-1964) number:**
   a) 48 million
   b) 40 million
   c) 38 million
   d) 37 million
10. **There are an estimated 22.9 million people over age 50 with hearing loss who do not wear hearing aids.**
    a) true
    b) false

For continuing education credit, complete this test and send the answer section at the bottom of the page to:

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