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Improving Care, Outcomes and Efficiency Through the Use of Oto-techs

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- [Rose] Hello and thank you very much, Anna, for that lovely hand-off. Welcome to Improving Care, Outcomes, and Efficiency Through the Use of Audiology Assistants or Oto-Techs. The outcomes for our course today are as follows. The participants will be able to explain how to utilize the Oto-Tech position within a practice, illustrate the positive financial aspects and enhanced patient care of Oto-Tech integration into a practice, and define the scope of practice and plan for implementation, recruitment, and integration into the practice.

First, let me introduce myself. I am Rose DuLude. I am a clinical audiologist with over a decade of experience in ENT settings, another decade of experience in private practice settings, and I'm speaking to you now as an employee and team member of Fuel Medical Group. I am part of the Professional Development team at Fuel, and what I do every day is help practices all over the country elevate what they do and how they do it. Today, I'm going to use a mix of terms. Often, we hear this position called Audiology Assistant or Oto-Technician, or Oto-Assistant, or Audiology Tech. They are used interchangeably by people in the industry like me, but large organizations such as AAO, AOA, now Ascent, Triple A, ASHA, and ADA, make a very specific delineation and definition of each of these terms. These professional organizations may suggest specific roles and strategies and scopes of practice depending on the title used. We'll discuss all of these differences later, but I'm going to be using these terms interchangeably, because truthfully, their scopes of practice intersect and, do intersect on many levels.

What you choose to use as a term may be a choice that's going to be based solely on the state that you work in. But more on that later. So we have reached the point of the workshop when I'm going to talk to you about my historical attitude on support personnel in the audiology field. But first, I had to throw this stock photo in just to horrify all of you at the lack of proper bracing for this otoscopy, and it runs rampant through all the stock photos. We talk about it so much in our social media groups it made me laugh just to think about the expressions on your faces when you saw it, because I'm sure the expression that you have mirrored the same look of horror that's on mine whenever I see a photo like this. But now, with all sincerity and with full transparency, as an audiology, when I began my investigation and education several years ago on support personnel within our industry, I will absolutely be honest with you all and tell you that I felt that advocating for these positions was like eating my young. I am an extremely strong supporter of this field. Audiology has been really good to me. This field has been my entire adult life, and I have devoted myself to always endeavoring to improve my practice of audiology and also support any other colleagues of mine who has ever asked for my help.

So introducing support personnel into the mix seemed, at first glance, both threatening and abhorrent. The further I dug into the subject, though, I will tell you that my mindset and my viewpoint has changed drastically. A large portion of this talk today will provide the facts and the data that assisted my own journey in understanding what a positive aspect including support personnel in your daily practice actually is. So let's dive in. The demand for audiological services is surpassing the supply of trained audiologists. There exists a very real challenge confronting audiology. There's a high dropout rate, a high attrition rate, and the fact that too few audiologists are graduating to meet the demographic demands. Windmill and Freeman report the attrition in audiology is surprisingly high. So those are the number of people who voluntarily leave this profession after graduating. It's approximately 40%. They report that there are likely 16,000 licensed audiologists in the United States, some 20% of all audiologists do not impact or participate in patient care.

So these are the people who work for manufacturers, they teach, or maybe they're managers or directors of departments, and so they don't have hands-on patient care. So that leaves about 12,800 audiologists actively providing patient care, and of that number, there's a whole bunch of part-timers. I think there's an argument that many of us chose this profession hoping to find some work-life balance. Let me know if any of you have and then for heaven sakes, tell me what I'm doing wrong, but it really leaves only about 1100 full-time equivalent audiologists. 20 years ago, there was 1,000 new audiology graduates per year and now there are approximately 600.

So Windmill and Freemen report approximately 400 audiologists retire annually. Doesn't that seem like a lot? That's 3.5% of the full-time equivalence, amazing. Just to give some perspective, optometry, with only a quarter of the number of graduate programs that audiology has, optometry has more than twice as many students enrolled in the United States. Dentistry has 10 times as many students as audiology, while only offering 56 programs. But what's the other side of the problem here? Well, the aging of the Baby Boomers is creating a dramatic shift in the composition of ages in our population in the United States. Projections of the entire older population, so that includes the Pre-Baby Boomers, born before 1946, and the Baby Boomers, born 1946 and after, they're suggesting that there's 31.4 million people that are going to be over the age of 65 in 2029. It means that the elderly age is 65 and older, which actually doesn't sound very elderly to me, but that population will make up about 22.9% of the United States population, and that's up from 14% in 2012. But we all know this.

Even without the statistics I gave you, because the first thing that I get asked to help with when I walk into a practice as a consultant is, "Uh, can you help me with scheduling?" It's a problem, it's pervasive, it crosses the boundary of every practice type. There are too many people to see and not enough staff to see them. There just isn't enough time in a day to see everyone who needs help. Since we can't increase the number of hours in the day, can we hire more audiologists to help cover the deluge of people who need their help? Well, no, because there isn't enough of us. Even if there were an unlimited number of audiologists, economic pressures really have forced all of us to consider cost-effectiveness, the cost-effectiveness in each and every professional that we employ. Listen, we're expensive, and most of us ask for a nice living in exchange for our employment. So what's our answer? We need to have a tier of technicians, of assistants, that can maximum the value of our expensive and rare audiologist. This isn't a new concept.

People with zero training have been provided, providing services in one way or another in offices for years. You know, you've got your office manager who has been there so long that they know how to pull out a stuck battery out of a hearing aid. There's a scheduler who can change a wax guard in a matter of seconds. You have medical assistants who do screening tymps on kids who have historically Type Bs, and then that's how we know whether or not we need to do an add-on audiogram. You even have pediatric nurses doing hearing screenings without ever having cracked open the manual for the audiometer. We have all used assistants and technicians. We just haven't formally trained them, provided supervision, or implemented process standards. In fact, the first formal training program was the Audiometric Technician Program developed about 20 years ago by the American Neurotology Society. That curriculum evolved into what is now known as the CPOP Oto Tech Program, and that's offered today. The bottom line is that technicians and assistants improve access to patient care because they increase the availability of audiological services. They totally increase productivity by reducing wait times, enhancing patient satisfaction, and they reduce costs by doing tasks that don't require the professional skills of a certified, licensed audiologist.

Now, there are a number of caveats that are right off the bat. First, these positions are closely regulated by some states. Then there are some states that have no regulation or even talk about assistants and techs in their scope of practice. It's like the wild, wild west. You could do anything you want. Therefore, you've got to check your state specifically, the state where the practice is, for all of the minutia, all of the detail, to find out if you can have an assistant or tech, and if you can, what the heck can they even do? Second, the quality of care, the cost benefit, and the successful use of assistants is totally dependent upon the quality and the training and the supervision that they're allowed to do, and the degree of decision-making autonomy that they're allowed to have. Then like any good idea, adding a support staff member into your practice requires pre-planning, it does.

We need to make sure it's the right person with proper training, under appropriate supervision, and at the right time. Technicians and assistants are not audiologists, and they're not intended to replace audiologists, although lots of audiologists view them as a threat, as I certainly did from the very beginning. No, they are designed to fill an important role. They are there to collaborate with otolaryngologists and audiologists, and help provide excellent and cost-effective hearing health care, and improve patients' access to the expert. What these support staff members can do, and what you choose to have them do in your practice, may be delineated specifically by the way you choose to bill. All right, so this is the part of the workshop that requires a big flashing sign and strobe lights as I make this disclaimer. I am not here to speak to you as a billing specialists, and I am not going to pretend that I should be. I am here to provide some general thoughts on billing, but if you have ever sat in a room with two billing specialists who have a difference of opinion, and I speak here from personal experience, the differences in interpretations of billing guidelines and the heated discussion that ensues is like sitting next to a fireworks display. It makes the Democrats and the Republicans look like nothing.

So this is what I'm going to say. While I'm going to cover some generally agreed upon interpretations, I need you to speak to your billing specialist. Speak to the person who guides you through the confusing and often contradictory, the world of billing, and figure out what interpretation you can agree on. Then own that interpretation. You need to know and understand and stand by what you do and how you do it when it comes to billing in general, but certainly as it pertains to support staff. So here we go, into the quagmire of billing codes we go. Per the centers of Medicare and Medicaid service requirements, Incident to services are, quote, procedures that are furnished as an integral, although incidental, part of the physician's personal, professional services, end quote. It's called Incident to. Incident to services are billed using the physician's NPI, but are performed by ancillary or non-physician personnel like technicians or nurses.

Now, if a physician orders a comprehensive audiometric threshold evaluation and speech recognition test, CPT code 92557, can their audiology technician perform endo for this? In most states, the answer is no, they can't. According to Medicare, technicians can't bill Medicare for a 92557, because there's no separate professional component which is a modifier, the modifier 26, from the technical component, which is the TC Incident to breakout where the technician would be able to bill for the technical component. However, qualified professionals that have their own Medicare NPIs such as an audiologist, may bill for this. So what can a tech bill under Medicare guidelines under the direct supervision of an MD? Well, you can't bill for services performed by a technician under the provider number of an audiologist. It can only be billed under the Provider Number of the supervising physician, and that physician is someone who is in the office suite at the time of testing. Now, there is some interpretation that the supervising physician must be, the patient who was being tested, that patient must belong to that physician.

But that's one of those questions that you need to speak to your billing specialist about because there are about 100 different thoughts on it. But technicians can perform procedures that have technical professional components so they can perform otoacoustic emissions, the vestibular family of codes, auditory brain response testing. They can perform technical component of those procedures and also tympanometry. Those are the only ones that a tech can perform in the Medicare system. So again, it is OAEs, ABR and the vestibular codes. Everything else requires the skill of an audiologist or a physician in order to have Medicare cover the procedure. But guess what, there are private insurance companies that allow techs to bill for testing. Read your guidelines, read each individual contract you have with each individual carrier that you participate with. Look, I know, I know we're not gonna be friends anyone now that I have urged you to do this. I know, it's a terrible thing to have to do, but do it over a glass of wine and know that investing that time can pay off big when it's time to figure out how you are going to legally implement your new staff member into your practice. Or better yet, get your brother-in-law or your stepsister who's an attorney, bake them some cookies and ask them to help you get through all of it.

But let's say you take my advice. You sit down with your billing specialist who you totally trust and totally adore and they say, "Nope, you can't have a tech "do anything related to diagnostic work, end of story." So you don't want your new assistant testing, or, let's say you don't have a physician who can supervise, which is required under Medicare billing. Well, what else can they do? Technicians and assistants can staff designated walk-in hours devoted to providing on-the-spot service to patients. They can conduct annual hearing screenings, they can perform hearing aid warranty checks, troubleshoot dead hearing aids, and goodness knows, they can complete all of that paperwork that's required to have hearing aids repaired and even log in through portals to order hearing aids. Their role is to handle anything of the routine, less technical activities of your clinic. So that enables the audiologist to devote more time to perform diagnostic, educational, and rehabilitative services with their patients. There is, therefore, a need for an Oto-Technician or an assistant to have protocols with forced-choice decision tracks based on objective data, and all of this needs to be step-by-step with an audiologist-approved guidance. They can include forced-choice decisions points that if they are followed correctly, it's going to ensure that technicians and assistants are always going to refer to the audiologist when there's a possibility of hearing loss that's getting worse, or the need for advanced hearing aid programing or decision-making, when making in-office repairs just aren't good enough, that the aids need to be sent out for repair.

So we're gonna take some time to look at some of these more common forced-decision tracks, because they're worth noting that planning this out in advance before you ever hire someone will also help you make concrete decision as to when you want your support staff to turn around and say, "Whoops, over my head, I need to give it to somebody else." So if we look at our first Decision Track, this is going to be one of the most obvious. This is when that patient walks in and says, "Oh my gosh, my hearing aid just isn't loud enough." Well, first thing that that assistant needs to do is do that visual inspection. We want them to look to see if there is anything that is obviously wrong, obviously broken. Did the cat attack the hearing aid or does it look perfectly fine? Do we have wax sitting in the microphone, in the receiver? Is there anything that's obvious? If there is, then obviously, we want them to repair those physical repairs, clean, do anything they feel that is necessary in order to to get it up to specification, and then we want them to test to see if it's up to specification.

That's why having one of those test boxes is a good thing. We want a test box run when the hearing aids are first fixed, to have something for that assistant to be able to compare the potentially broken hearing aid to to see if it's out of spec. We can also have them use Noah to see if there's anything that Noah can diagnose, if there is a way to run any of the tests. Some of the manufacturers have that. If it's up to specification, well, we want the patient to try it on. But if it's not up to specification, we want them to know that they're going to send it out and tell the patient to come back. If that patient tries the hearing aids on and there isn't an improvement, that's when we want them to be able to know that they can refer up to the audiologist, to the ENT, to make sure that, you know what, maybe the hearing aid is working just fine, and maybe we have a significant change in someone's hearing loss. Maybe it's just wax. But that patient needs to be triaged by a higher medical carer than the assistant. They need someone with more experience. Hopefully all it was was a broken receiver, and then that patient can certainly go ahead and leave.

We have an alternative as far as using an assistant with orientations for hearing aids. So in many states, assistants and technicians cannot counsel with regard to the hearing aids, but they can help us do a tremendous amount of the legwork that comes along with it. So if you look at each one of these things that they, assistant is able to do, you're gonna see, there is a tremendous amount that they are capable of. First, those hearing aids have to be unboxed, they have to be logged in, they have to be run through the test box. The patient needs to be called in order to arrange the appointment, and think of all the paperwork that's required before anyone sits down to get hearing aids for the first time. When the patient comes in, well, that's gonna be on the audiologist.

So the audiologist programs and fits the aid, aids, and then they're gonna go through their orientation, they are gonna counsel the patient. But the tech gets to be able to come back in, and this warm hand-off from the audiologist to the assistant truly makes a huge impact on the patient. Because if we are smart enough to warmly introduce our assistant to a patient during the orientation as our right hand person, "I wouldn't be able to do my job without this person, "she's wonderful and you will love her. "She's going to sit down "and go through all of the paperwork "that comes along with your new hearing aids," that's going to open the door for those patients to feel comfortable going to the assistant so that they don't automatically ask for the audiologist when they need help. They can be triaged by that assistant. So the faith that we have in our assistants need to be communicated to our patients with a warm hand-off. The tech can also review accessories, and then guess what, they can schedule those followup visits for you after the orientation is over, and they can even arrange for payment so the audiologist isn't in charge of that.

The patient can go and, guess what, the audiologist doesn't have to do the followup call over the next day or two, the assistant can. If the patient is doing well, cool, all they're gonna do, they're just come back in with their scheduled followup the way it was planned, and if the patient is having some issues that are, again, above the head or the understanding of the assistant, they're going to make sure that they let that audiologist know so that they can get back in touch with that patient. Well, we also have the ability, if we choose to have them test, we can have our front desk determine who, in fact, is going to be seeing a patient for a test. So should we have an incoming call, and that patient requires a hearing test, and that patient is not Medicare, then perhaps they might belong to one of the insurances that a tech would be able to test them. Perhaps we're in an environment where we don't feel comfortable having a tech do any kind of Medicare testing. Well guess what, that's when we're gonna automatically schedule them with the audiologists. The tech is going to do some otoscopy, and if that is completely normal, then they can go ahead and do whatever testing is within their scope of practice as set up by your protocols in your practice, and then it's going to be reviewed by the audiologist.

However, if it's not, that otoscopy isn't within normal limits, we can send them directly over to the audiologist or ENT so that we know they're going to receive the level of care that is required. Another option for new patients is when that incoming call comes in, we need to know, what is that person calling for. Is there a severe ear complaint? All right, maybe the audiologist should take this one. Is it going to be an annual audiogram, but they don't feel that there are any changes? Is it just a followup to see if there are any changes? That Oto-Tech would be able to make those testing choices and have the Au.D. review, eventually, all of the information that they were able to gather. With testing in particular, and this is certainly the way that I would suggest you all move forward very cautiously with your assistant, this is where the majority of the training should take place.

First of all, we want them to be able to take all of those FDA questions in the case history for us. We may even ask them to ask some basic questions about any difficulty the patient might be having. If there's anything abnormal about those FDA questions, we're going to refer them all, that patient, up to the audiologist. Should nothing be abnormal, then we're going to send them on the way of the tech testing. We'll start we otoscopy. If that's abnormal, we'll send it to the Au.D. If it's normal, we can do tymps and OOAS. Are those normal? If those are abnormal, we we send it to the audiologist, if they're normal, then we're gonna do air and bone. Is that normal? If it isn't, send it to the Au.D. If it is normal, then we can do the speech. Then all of this information that the tech has gathered, saving the audiologist all the time for those more within normal limits patients, is going to be reviewed by the audiologist to ensure that they feel that there is accuracy and that the tech has done a thorough enough job.

So as you can see, this can take time, but it's worth the time in order to make sure that our assistants, our techs, are making good decisions, so that they are never stepping above or beyond their scope of practice. They're going to allow the higher educated professional to come in when it's necessary. Let's face it. There's going to be a lot of time invested on your part to bringing an assistant up to the level that they can function as a productive member of the team, and training counts, and continued training counts. For those of you who have had audiology externs or fourth years in your practice, you know that a significant amount of resources will be put towards an individual before they are ready to be on their own. Now this, there will be a scale of how much resource you're going to have to put into someone, because some people learn very quickly and will obtain autonomy more quickly than others, but everybody is going to need support and coaching and resources.

While there are online solutions for some of the technical aspects to these roles, your new staff member is going to need a mentor within the practice that really knows his or her stuff, and is incredible patient, and can assist the new person in learning a role that requires a lot of problem-solving. But I'm gonna give you a secret, because this was one of the easiest things that I have done to help a new assistant out. We take the stress off of the mentor by creating visual cheat sheets that delineate specific aspects of each hearing aid, because there are so many manufacturers with so many options, it's hard for even the most seasoned of us to keep things straight. So a simple binder with large pictures like this one, with each model of the hearing aids will help. In addition to showing this picture and describing the anatomy, I would put a picture of what the possible domes look like for that hearing aid, and a picture of the external packaging of whatever wax guard fits with that hearing aid, and if there is a tricky way to remove the receiver, like a pin that needs to be pushed or a mic cover that needs to be removed first, something like that, make a note of it on that piece of paper. Now, will this binder take you some time to put together, absolutely.

Will this binder save you hours upon hours of repetitive mentoring, oh yes, it absolutely will. Continued training on products is vital as well. Invite your support staff members to join in when manufacture represents come to the office or host meetings. Let them get a chance to play with new technology as it comes out. We're not talking about software, we're talking about where's the battery door, how does it fit into the charge? Anything that is going to be something that they are routinely going to troubleshoot, let them know in advance. Ultimately, a well-informed assistant will save you time. So there isn't one thing that defines a practice's readiness for the addition of an assistant, in fact, there are several factors that can indicate that it's the right time. But I wanna look at some of the numbers that illustrate quite eloquently how support staff is cost-effective for us.

So if we take an average salary of an audiologist on a nation level of about 85,000, it breaks down into about 40, $41 an hour. Then we take the highest salary we have found for an assistant, which is 45,000, and that's a little over $21 an hour. If we have an average reimbursement for a 92557 of $32 on a good day, right, then it means our audiologist needs to perform one and a quarter test to cover their hourly salary. Not to cover their cost per hour, not to cover the overhead of the clinic, just their salary. An assistant or tech only needs to perform two thirds to cover theirs. It's a nice way to look at the cost-effectiveness of a lower-level professional. So if we take a typical day for an audiologist patient load, and I say that laughingly, because is there such a thing as a typical day in our profession? I don't think so. But let's pretend there is.

We're gonna see one hearing eval or communication needs assessment, eight audios, three hearing aid followups that would be during an acclimation period to the hearing aid, so we're talking new users, four clean and checks, and some time, hopefully, for lunch. But we know that's the first to go. If we take the no-charge visits, the visits that require little training and expertise and give them to an assistant, that frees up an entire hour in the audiologist's schedule. Now, convert that hour a day to an opportunity for a hearing aid sale, treat one of those a week, and you've covered your tech's salary of $865 a week. So here are some more examples of the possibilities. If we're able to convert that extra time into either two, three, four or five communication needs assessment on a weekly basis, and we're going to take what we find to be a national average of treatment rate of about 52%, although that is a little high, with an average sale price of $2,224, you see that that revenue becomes substantial when we're able to stack up all of the possibilities because we have given away the routine and the mundane to the assistants.

Now the bottom line is the line that I like the best, because I always hope that all of us in our profession are aiming to be absolute rock stars. So if we're able to have five extra communication needs assessment a week, we have a closure rate of 73%, which we know there are people that do even better than that, and we have the high ASP, look at what the weekly revenue we are capable of. $19,000 a week, which translate into a really large number with two big commas for our yearly revenue. That's a substantial difference for a small change to your practice, and I am all about making small changes that have big impact. An assistant who is utilized appropriately can be that small change with that big impact. But we're all about evidence-based practice, right. So let me give you some case studies. We have, at our disposal, the largest case study we could possibly ask for. We have the U.S. Department of Veterans Affairs, in 1996, which is actually just after I left the VA as an audiologist, which means I guess I was, I was a direct contributor to this regulation, which of course makes me famous, Congress passed the Veterans Health Care Reform Act. It required special rules to be established for eligibility for the health care service, and eligibility for hearing aids. A year later, the VA determined guidelines for that eligibility, and when they did that, they totally increased the number of vets that could come in and get treatment for their hearing loss.

So unfortunately, this made the supply for services from audiologists increase so drastically so quickly that the wait times became untenable. So now, the VA had to take a very hard look at the efficiencies of those service, that they had just made a huge population eligible for. So they figured out that they needed support personnel, and they needed to expand how they used that support personnel. So in the active military, they're called either Audiology or ENT Technicians, but in the VA, they're called Help Techs. So VA audiology clinics totally reevaluated the range of duties that a licensed audiologist conducted throughout a normal business day and what they figured out was that there's a huge number of these activities that could be accomplished by a well-trained technician. Audiologists were doing tons of non-patient care tasks, and I bet this is going to sound familiar. They're doing tasks like scheduling or answering phones or filing charts.

Remember, this is back when we had paper charts. Or searching for charts and again, remember, this is when a misfiled patient chart could result in a drawn-out hunt that was similar to finding Waldo in a Where's Waldo book. So not only were they wasting time doing admin work, they were also doing very repetitive and very mundane tasks that are associated with patient care like boxing up hearing aids and ear molds for shipment to be sent out to manufacturers, or inspecting and logging hearing aids and accessories in, they were doing hearing aid troubleshooting, they were taking walk-ins, they were stocking batteries in exam rooms, and they were maintaining equipment like flushing out the water of a caloric irrigator, and they were also doing hearing aid repair services for scheduled patients.

So yes, the VA did respond to the demand by adding staff audiologists, but the most significant improvement in efficiency were really made with the addition of the health care techs. The number of clinical audiologists in the VA grew 83% from 1996 to 2005. It went from 317 audiologists to 580. However, the number of health technicians increased two, I'm sorry, not two, 720% during the same period from 15 to 123. So now there are some VAs that don't have any techs, and there are some VAs that have a one-to-one ratio of techs. But the average ratio is five audiologists to one tech. This efficiency strategy along with a couple other tweaks and a couple other additions allowed the VA to respond to an unprecedented increase in the demand. To give you some perspective, in a year, audiology visits at the VA approached 900,000. 900,000 in a year? You thought you were busy.

They have been increasing about 6% every year. So it's no wonder that the VA really shows the rest of us how to streamline and improve practice, and we see that even now with the addition of Telehealth. The health technicians and the clinic care team allow audiologists to hand over a large portion of clerical work, and it lets the audiologist focus on the professional task that they're trained for: diagnostic hearing services, fitting hearing aids, patient education, oral rehabilitation, counseling, all of the stuff that the techs are not trained for. In addition to general support functions, the health tech, they provide about 20% of direct patient care services, and they focus primarily on minor hearing aid repairs, troubling, trouble shooting, and, not troublemaking, which is what I said, which is actually funnier if they were, in fact, focusing on troublemaking, and the process of hearing aid and assisted listening device orders, that sort of thing. Audiologists can therefore provide high quality, timely, and patient-centered care when our veteran's need it.

Our second case history hopefully has no trouble making in it. It comes from the northwest. This clinic is big, it's three locations, and it's lots and lots of hearing aid patients. They've been around for about 40 years, so they've had patients that have had children who are now in their patient purview. So they've got five MDs, four audiologists, and four years ago, they incorporated two techs. It was their decision to use them for non-Medicare testing. They wanna use them for hearing aid walk-ins, and have the techs support audiologists in any clerical process that the audiologist deemed necessary. So the staff members were sending out repairs, filling out order forms online, checking in new hearing aids, testing new hearing aids, and most importantly, handling anyone who walk in and says, "Ugh, my hearing aid isn't work." Look at these results. Not only were the assistants actually producing 12% of the diagnostic revenue for the practice, but they have saved the higher cost employee, the audiologist, from seeing any no-charge visits.

The audiologists have been freed to see higher revenue-producing and more complicated and more sophisticated appointments. That's totally appropriate. The audiologist's expertise and education is being used for appointments that are commensurate with their level of training versus the tech's level of training. Our third case study is from an ENT clinic in the southeast. It's a pretty robust and busy practice. It's got three physicians, two audiologists, and it's located in this adorable small town where they really are the only ENT practice for miles around. They tried for, maybe three years, to hire another audiologist, couldn't do it. Then they tried to hire a dispenser, couldn't do it. The problem was this small town isn't where most people wanna live. It's fun to visit, but it's really hard to recruit for this off-the-beaten-path, small southern town. So after they finally gave up, but they desperately needed help, they hired two locals to become assistants. They hired the right people, they trained them well. They devoted five hours a week to mentoring these two new hires and found that within eight months, both were able to operate with autonomy. In the first 12 months, when they would be able to work without audiologists hovering over them, these new hires saw every single walk-in troubleshooting hearing aid patient.

There were over a thousand visits, and now let's pretend that each walk-in took around five minutes to take care of, although we all know in this workshop that there are walk-ins that take much longer, than equates to 86 hours of time that is totally given back to the audiologist to do something far more productive, hopefully not go on Facebook, and perform activities that produce greater revenue for the practice. In fact, let's look at what can be done with 86 extra hours. What happens if we take those 86 extra hours and we turn them into communication needs assessment appointments. Well, if we have 86 of those with maybe a 52% treatment rate at a 2,224 ASP with 100% binaural rate, wow, that's a whole lot of revenue. Certainly enough revenue to cover the cost of the assistants. Let's talk about some training. The first part of the program for an Oto-Tech is self study.

Students are provided with all sorts of educational materials including a standard audiology textbook that we all probably have on our shelves, and then they have to pass an examination having actually read that book in order to be able to get to that next level. The next level is a two and a half day hands-on training workshop with lectures and hands-on with audiometers, and those are provided by an otolaryngologist. So these candidates learn to perform otoscopic, that's funny, I can't say this word, otoscopic examination, they do pure-tone, they do speech, they actually learn how to mask, and they do tympanometry. They're also given some basic informational lectures on some more of the advanced audiological testing so they know what it's all about. They're given some information on hearing aids, they talk about balance problems with them and other relevant subjects. Not because they assume that the tech is going to be involved in all of them, but it gives them a nice overview of the entire profession. So in this whole workshop, scope of practice training is stressed at all times so that they know that they are not going to step over boundaries.

The third part of the program is the supervisory period of approximately six months. During that time, there's a certain number of procedures that have to be performed and reviewed for accuracy. At the conclusion of the six month period, all the log books are sent to AAO, and the certificate is awarded for satisfactory completion of the program. So that's for an Oto-Tech. How does one become an Audiology Assistant? Okay, truth be told, depending on state regulation, assistants can be mentored totally privately within the process of your own practice. There are some online courses that prospective assistants can take to improve some of their skills, but ultimately, the task of making them ready to work autonomously is going to land on your shoulders if you choose not to have them follow a text certification and merely call them an assistant.

Either path, either path, assistant or technician, I urge you to choose your candidate wisely. While it may be easy just to grab someone already under your employ, I beg you to think about that before you promote anyone, because I have some cautionary tales. I've interviewed a plethora of people who have employed assistants, fired assistants, worked with assistants, and have been assistants, and I have cautionary tales. In a few practices, audiologists have quit when confronted with having an assistant in the office. The decision-makers did not do a good job of garnering buy-in on the part of the professional staff, and there was an uprising. One of them quit. The others who stuck around found that having an assistant increased their quality of life while at work, but it took them a year to change their opinion. Another cautionary tale, a tech that has an ego issue is a liability. There was a tech, several times I have heard this story, techs performing tests that weren't admitting when someone was presenting with problems that were beyond their scope of practice. This, of course, let to flawed decision-making on a part of the physician, and that is a scary thought. MDs were making health care choices based on inaccurate testing.

Now, I will say that this was one of the offices in particular that did not have the forced-decision tracks in place, and they have since removed that tech from a testing position, and are now using them solely for hearing aid triage and administrative health, and it's working out far better. We have members who have hired, trained, implemented assistants, and used them successfully for years, and then the tech figures out that he or she is doing virtually the same thing as the audiologist at half the pay, and they get unhappy. However, there is a career path that can be created for very enterprising people. Take them down the path to dispenser, get 'em licensed, and then they get a chance to generate revenue for the practice, substantial revenue, which would allow you to pay them more.

But truthfully, when we look at turnover rates between audiologists and assistants, you will see that, in fact, assistants stick around longer than audiologists do on average. But who should be a tech? Listen, it's gotta be a mix of a person who is a people person, and a problem-solver. We want a real extrovert mixed in with a fearlessness of technology and no desire to get angry at repetition. We need someone who's willing to learn a lot of information, and most importantly, we need someone who is going to admit what they don't know. We need someone who's willing to turn around to us and say, "I don't know what's going with this, "I don't get it. "I need it to be kicked up to an audiologist." They need to say it freely and without shame. The biggest complaint that I have had, heard, interviewing audiologists and physicians is that when their assistants were too uncomfortable to alert medical professionals when they were in over their head, they were concerned that there was going to be retribution if they couldn't handle every single patient.

We wanna make sure we have realistic expectations for that assistant. So should you hire from within or, I'm sorry, hire from outside is what I meant to say, or promote from within? Well, that's a really good question, and it has everything to do with the staff members that you currently have. Just because that they're there, doesn't mean that they're gonna be good. I would urge you to hire a person who has natural people skills, that they excel in customer services. They have an easy affinity with new people, and then teach them the hearing aid or testing skills. We can't teach good nature, but we can teach someone how to clean wax out of a receiver. So is there a litmus test for when it's time to incorporate an Oto-Tech? No, there really isn't. But there are some good indicators.

If audiologists are seeing more than an hour's worth of no-charge visits in a day, or spending time, more than an hour, filling out forms or boxing up hearing aids, unpacking, checking new hearing aids in, time to think about a tech. If you're booking more than seven days out for hearing aid evaluations, it's time to think about an assistant. If your audiologist has less than 20 minutes to do an audiogram, it's time. If the audiologists are pulled from doing the highest revenue-producing activity they can do, a hearing aid evaluation, just to do an add-on hearing test, which happens, it's time. If you've got room or space in your office that's not being used, like a treatment room or a testing room, well then, you have room for expansion, and it may be time to thinking about an assistant. But obviously, there are considerations and the first is, does your state allow it? Do you have the room? But does your culture allow it? On first blush, most audiologists do not take kindly to the addition of what they consider to be a threat. I am all about making sure audiologists stay happy.

We all have to be explained the value that the Oto-Techs and Assistants bring to our practice. We have to be shown that it elevates our practice as a whole. Menial tasks and those that are repetitive can be given to a subordinate without fear of encroachment on our purview. But it's a discussion that is important, and data should be provided to all of the audiologists explaining the benefit to them. When we look at our recent historical past, the entire profession shows to raise the level to a doctoral profession. While we have increased our professional education and our student loans, we also have to look to see how we can act like a doctoral profession and guess what, doctors have help, doctors have support. Let this addition to your practice be yet one more elevation to our profession. So this line looks at how to get started. Don't skip steps, don't assume that everything is just gonna shake out. You have to think, you have to plan, you have to have something that's step-by-step in order to get good results.

So that is the whole of the information I will be sharing with you today. I would be happy to answer any questions that you may have, and I will do the best of my ability to give you the expertise that I have. Okay, first question. How do I find out about my state's regulation about assistants? Ah, okay, usually one is able to go to their state licensing department, and it's going to be a horrific amount of legalese within a document, but you are going to be able to print that out as a PDF and go through it bit by bit to see if assistants are mentioned, if techs are mentioned, and then we have to see if they delineate scope of practice. It isn't a fun activity to do. I love how lawyers can take words that I know in the English language and put them together in a way that makes me have to read them three or four times in order to understand the message that they're trying to get across. But obviously, an incredibly important aspect.

Oh, next trick question. How much money does it cost to train an assistant? Well, it's not just money, is it? It is some investment of resources like time and patience and probably a few gray hairs. But having the hours of knowing that you can put a certain number of hours every week towards mentoring your candidate for assistant is going to be the most important aspect of that training, that there needs to be enough time that you are comfortable knowing that he or she has the information that they require and that you're watching their autonomy grow so you know when it's time to say, okay, we're good, you can go off and be on your own. I'm not sure, the question is, I'm not sure if my office is going to hire a tech or an assistant, but which training program would you recommend? I actually wouldn't recommend any of them necessarily, because I do feel that education, whether it's a bachelor's or a master's or a Ph.D. or an Au.D. or air conditioning repair, or for a tech, education is only as good as what the candidate will put into it. It is less about what is provided informationally to the candidate, and far more about the enthusiasm and the effort that the candidate is willing to put into their education, and that's the kind of spark and joy than you want to be able to find in someone who is going to be the best candidate for your office.

Well, it looks like there are no more questions, so I will say thank you very much. I certainly appreciate you taking this time on a Friday. It's been my pleasure to give you this information, and I hope you all have an excellent weekend.