Audiology Services in Nursing Homes and Communal Living, in partnership with the American Academy of Audiology

Presenter: Kathy Dowd, AuD

It is my honor to introduce our webinar today titled Audiology Services in Nursing Homes and Communal Living. Today's course is presented in partnership with the American Academy of Audiology. Our presenter today is Dr. Kathy Dowd. Dr. Dowd is the Executive Director of the Audiology Project. Her work involves raising awareness of the impact of chronic diseases, medications, trauma and noise induced noise and hearing, balance and auditory processing.

Please read more about our presenter in the handout and at this time I'm going to turn it over to Dr. Dowd. Thank you so much, Anna. And I'm going to play a video from Dr. Gaffney from AAA. Welcome. I'm Tish Gaffney, the President of the American Academy of Audiology, and I'm here to share important information about the organization.

The Academy is dedicated to achieving recognition of audiologists as the experts in hearing and balance care and the field of audiology as an independent clinical specialty that is integral to the healthcare team. Through our partnership with Audiology Online, we're excited to offer courses like this one to help you broaden your knowledge and skills. We also offer the latest resources in practice management and evidence based clinical practice so you can grow professionally and improve patient care. We advocate for our members in Washington and across the country to ensure that the voices of audiologists are heard and we help connect audiologists to one another through our valuable networking opportunities like our annual convention. To learn more about the Academy, make sure to visit audiology.org thank you.

Thank you so much. Dr. Gaffney, welcome. I'm Tish. I actually am not the Executive Director. I'm the founding director of the audiology project.

Dr. Jen Sherwood has taken my Executive Director position, fortunately in the beginning of this year. I've had a broad wealth of work in audiology since 1978 and I worked in nursing homes from 1993 until 2014. So I learned a lot of what I'm going to tell you by the direct care that I was giving in our

surrounding area. As you know, we did get guidelines from the Centers for Disease Control on diabetes for both hearing and balance assessments. These are my presenter disclosures, any limitations and risk for the content in the course, The learning outcomes for this course and today's agenda will go over the current hearing crisis in the US for nursing homes, the legal man today, and medical necessity for work in nursing homes and three strategies that could close the gap where there's unidentified and undertreated hearing loss.

So I'm first going to go into the legal mandates for hearing services. When I started working in 1993, I knew nothing about OBRA or the Olmstead Act. Well, that wasn't even in place. Or the Americans with Disabilities Act. So at one of my facilities, a social worker handed me the Omnibus Budget and Reconciliation act of 1987, specific for hearing.

In that federal law, it says there must be assessments within four days of admission. Now has developed a hearing assessment, which is only a subjective observation, asking the resident if they have a problem. Well, that doesn't work. Or observing that there's a hearing loss, that doesn't work. So the law says it has to be comprehensive, accurate and reproducible.

There's already huge knowledge about hearing services, similar to my calls with CDC initially, where they knew nothing about diabetes effects on hearing imbalance. So the medical directors who provide medical services in the facilities are very surprised. And again, it's an invisible handicap you can't see. Looks like something else. But right now, I have not been able to get CMS to change their current protocols, which are in violation of the law.

So these are actual statements from the law. A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. So that includes hearing, that includes vision, that includes lots of things. It's not being done at this point. And if you look, it has to be no later than four days after the date of admission.

Now they have modified that to 14, 14 days after the date of admission, but that's still not happening. And if you see also if there is a significant change in the resident's physical or mental condition, it needs to be assessed again and in no case less often than once every 12 months.

And that really falls into what we learn as audiologists in that if there's a change in someone's mental or physical condition, it could be a significant hearing loss or in once every 12 months. Obviously, you want to track if there's even a mild shift in hearing. So it's very important that this information is understood by audiologists, but also by the skilled nursing facility. If your state is not complying with these laws, and states have their own laws also which fall which say the same thing, you have to have a comprehensive, accurate, standardized assessment within 14 days of admission. So if the state is.

If the state facilities are not doing it, you can request to be an independent assessor for that state.

Again, I'm not sure your success in doing that, but it is in the federal law, the current lack of compliance with OBRA in skilled nursing facilities. Now, I was a nursing home ombudsman from 2019 to 2023. So these are examples of things that I encountered. An administrator says they don't do any hearing services in part A. They wait till the person gets to part B.

But they do have someone who comes in to test quarterly, which is every three months. That's not in compliance. A speech therapist. When questioned about a resident who couldn't hear during this ombudsman visit, she said, I can tell he hears better out of his left ear. That same speech therapist says she has never screened hearing in any of her jobs, but she evaluation the resident who in my opinion had a hearing problem just from trying to talk to him.

A rehab director, when given the list of chronic diseases and ototoxic meds that contribute to hearing loss, said, I've never heard that diabetes causes hearing loss. So we have a lot we have to do in

education for audiology in hearing and balance. One administrator said she has 90% of her residents with a cognitive problem but almost no hearing impaired residents. The research shows that the incidence of hearing loss in skilled nursing is 80%. My sense is those people she thinks have cognitive actually are hearing impaired.

A medical director says he has 19 facilities and he has never signed an order for a hearing assessment and he was in California, so. But I don't think that's going to be unusual for any state because they're left out of the issue of needing hearing assessments. In addition, there is the Olmstead act of 1999, which was a Supreme Court decision affecting all states. So its origin was the Americans with Disabilities act or ada, and their mandate for community integration. The integration mandate requires all individuals receive services in their most integrated setting appropriate to their needs.

The preamble states, an integrated setting is one that enables individuals with disabilities to interact with people to the fullest extent possible. Any communal living situation must supply hearing assessments. It's very important. I quit working with assisted living around 1999 because I couldn't find any program of support. The state agency said, we don't have any support, etc.

I only learned of the Olmstead act in 2022 when a state agency did a presentation on this. I was floored. How does it help people that live in with people with disabilities who live in facilities, for example, intermediate care facilities which are younger handicapped persons who cannot live on their own. Also developmental centers, psychiatric hospitals, including skilled nursing facilities and adult care homes. So any communal living situation, the Olmstead plan mandates that these people receive help for hearing and in other segregated settings such as prisons, juvenile detention centers, Juvenile detention centers.

The incidence of hearing loss in that setting is 40 to 50% of those kids have a hearing problem. And I'm in North Carolina. I called the head of clinical services for juvenile detention and she said, We don't

have any services for that each if it's needed, but we don't cover hearing. And she basically closed down any potential for coming in to do assessments. People are at a serious risk of institutionalization or segregation in these facilities if they cannot hear.

The target population is cross disability and across lifespan. Even if they're in a psychiatric hospital, don't discount that their mental illness could be linked to their inability or their confusion to not understanding what people are telling them.

Your work in nursing homes or any communal living situation will dramatically improve quality of life and quality of care. Every single facility has to report quality indicators. And there's 30 or 40 quality indicators that they have to report on a monthly basis. Some of those include medication rates, are they going up, are they going down? Unintended weight loss falls, episodes of disruptive behavior, or their participation in activities.

They don't go to bingo anymore, they don't come out of their rooms. You have to contract with the facility to improve all of these quality indicators. So I will go to. One of the questions on our exam is when are hearing assessments to be conducted per the laws discussed in this course? Is it only in short term care, which is part A?

Only in long term care, which is part B? Only when a hearing change is noted for any residential. Or if you see a difference in behavior and answer D is in short term care, in long term care and when hearing is noted. So obviously the correct answer is D. In addition, what laws mandate hearing services in prisons and juvenile detention centers? That is the Olmstead act and Americans with Disabilities Act.

It's not the Stark Law or hipaa. It's not the Omnibus Budget and Reconciliation act or obra, it's not the Sarbanes Oxley Act. So you're looking at the Olmstead act for all those communal living situations.

The first step in delivering services in a facility, and this is question number four, is whether you offer training to the staff. You contract with them, you provide on site services, you. You conduct hearing screenings for all residents. The answer is the first step is to contract with the facility. Nothing happens until you have a contract.

One of the reasons I know so much about medical necessity for hearing services is through my work in nursing homes. I had to note the medical reason, which for Medicare is illness, injury, trauma or complaint. Those are the Four things they want to see in order to pay for audiology or hearing services. So you're looking at chronic diseases, you're looking at ototoxic medications, you're looking at falls, trauma.

Somebody just had a terrible accident and they were comatose for five days. Well, very possibly they have a hearing loss from that genetics. All of these things must be vetted.

And there's been a lot of Talk. Back in 2016, there was a huge national program about improving access to hearing health care due to aging. I really had a problem with that, because advancing age, is that really associated with hearing loss? Only in that you have weakened immunity, and so you may have an increased prevalence of chronic disease. You may have more incidences where they need to use ototoxic medications.

It's more common, as well as the genetics and cumulative noise and trauma events that you've had over your lifetime. And now you are a resident in an assisted living or in a skilled nursing. So all of those issues have to be considered as medical necessity, not age in and of itself. When you're trying to find medical necessity, you want to know what diseases, medications, trauma. And I put down FL2 and phase sheet.

The FL2 for North Carolina is the discharge paper that comes with a resident from the hospital to the facility. And it's called different things in different states is what I've learned. So you want to look at the hospital discharge paper in the chart for that resident, what does it say? Why were they in the hospital? Did they have a stroke, diabetes, out of control, traumatic accident?

And then what's on their face sheet, which the facility puts together? What kind of work did they do? Did they work in a manufacturing plant where there was a lot of noise? So you have to establish medical necessities. Room and management is often needed in skilled nursing facilities, so just be prepared.

And hearing testing and treatment must occur before cognitive evaluations and treatment. Obviously, we know that we need to educate speech therapists on not doing cognitive evaluation and treatment and billing for it when hearing has not been vetted. The CMS Division of Nursing Home Triage team has said there is no timeline for getting cognitive evals and treatment. Other issues must be vetted first. Medical management will include the family and the healthcare power of attorney.

Make sure you're talking to them. They may not be there at the facility, but talk to them before you come out. If they can come while you're there, that's great. Are hearing aids going to improve their quality of life sometimes? No.

I mean, if their hearing is so bad that hearing aids are not going to bring back anything. In my 21 years, I found two people with that situation. It really was not going to improve their quality of life or quality of care. But it's a very low percentage. Hearing aids and all services in our scope of practice can be billed.

So don't hesitate billing anything in your scope of practice. Again, I've been in conversations with the CMS Division of Nursing Home Triage Team and these are some of the comments that they've made. You also must provide staff training. They need to understand medical necessity. What causes a hearing problem.

Monitoring and noticing if there's a change in someone's affect, someone's behavior, reporting issues and troubleshooting devices. This all comes from training.

One of the confounding factors is anosognosia, the inability to know that you're sick or you have a sensory impairment. So I would have patients come in my office many times and I'd say, why are you here? Well, I don't know. Do you have a hearing problem? Maybe.

But they don't really think, because they've never had it checked, that they have a problem. So they deny that they have a problem. Usually the family and spouse notice it first. It's not denial, but a true neurological deficit. It also happens when somebody has a stroke and doesn't realize they can't move the whole right side of their body.

It's anosognosia. And hearing loss is invisible. You cannot see it. So this is why the CMS MDS hearing assessment is not an accurate hearing assessment by any means. And that has to be changed.

Some of the diseases affecting hearing and balance is diabetes. You can go to the audiology project. We do have the CDC guidelines there. Chronic kidney disease can cause hearing loss. Cardiovascular disease, hypothyroidism, Alzheimer's, Paget's disease, Crohn's disease.

Balance comes forward. And there was a big review in 2025 of all the nursing in the United States. And they found that there had been a lot of nothing of traumatic falls, no reporting of death because of a fall. So make sure that those people in the nursing home understand that you can also provide balance screening and perhaps balance assessments. North Carolina Medicare comorbidities.

Now this is across all persons who are on Medicare. The incidence of hearing loss for each one of these, if you see diabetes, it's 29.1% of the people with diabetes have a hearing problem. Now, that's

all Medicare participants. Traditional Medicare for North Carolina. That's exactly what Dr. Katherine Bainbridge found in her study of the NHANES study from 1999 to 2004, she found an incidence of 29 point something percent.

So this is tracking up till 2017. But look at hypertension. 65% of people with hypertension have hearing loss, 55% of hyperlipidemia, chronic kidney disease, all of these things. It would be nice if we had these, if we had this incident just for persons in communal, in nursing homes and communal living. But this is for all Medicare.

So again, it's very important that we check and that we find out what is their medical issues that's causing this.

For diabetes, for hearing loss, we have cochlear microangiopathy and neurodegeneration microangiopath. Microangiopathy is the disruption of the microvascular system where blood leaks out of the microvascular system into the surrounding areas. Also neural degeneration, the eighth nerve loses its myelin sheath. So that's going to affect both balance and hearing, getting the signal up to the brain. In addition, you've got microangiopathy in the brain.

When you look at balance and fall risk, the person cannot feel their feet. They have foot neuropathy, often with diabetes, and they may have diabetic retinopathy where they cannot see what's in front of them. And so they trip, they run into a wall, they run into a door jam, as well as the vestibular effects of diabetes. So this is important. And my question on that is what is the triple threat of falls with diabetes?

Answer. A is retinopathy, peripheral neuropathy, vestibular dysfunction. B is fracture, migraine or hyperglycemia. C is neuropathy, kidney disease and cardiac event, diabetes. D is mobility impairment, poor nutrition and fibromyalgia.

The answer is A retinopathy, peripheral neuropathy and vestibular dysfunction. So this is a slide from Dr. Michael Duanes. I spoke with him in 2016. He said, oh sure, use this, because this was a slide he used for a congressional hearing and he did note that hearing was affected. But look at all the things that are affected.

The brain, the ear, the eye, teeth, blood pressure, vision impairment. Of course, they're very keen on vision impairment as an optometrist. But it's important that you be aware of all of these things and you may have to make referrals to an optometrist, to a podiatrist, to a dentist, or even to a pharmacist regarding any concerns that you have.

This is a slide from Frank Lin. He gave a presentation at ASHA in 2016 which I attended. And this slide shows you hearing impairment linked to to microvascular disease. Bingo. Diabetes as well as Alzheimer's and neuropathology.

So people are seeing it and we need to elevate this to medical directors of these facilities. They need to understand this, they don't know about this. We have a lot of education to do as audiology. Cardiovascular. If you have a stroke, it usually kills the hearing in one ear.

Cardiovascular assault, deep vein thrombosis, pulmonary.

Those things can affect hearing as far as extremities. It might cause a loss of feeling which is the neuropathy, hypertension related. And then the medication you take for cardiovascular causes is ototoxic loop inhibiting diuretics like Lasix, furosemide as well as pain medication that is given more frequently with cardiovascular can be impacting hearing. Chronic kidney disease. You're going to have an increased creatine count, electrolytic urea levels.

DPOAE testing usually will show early disorders. And DPOAE testing is also valuable for some residents who may not be very responsive. So just so you have that on your radar. Balance and fall risk may be hypotension related and then again loop inhibiting diuretics or aminoglycosides for infections which are all ototoxic.

So medications that affect hearing imbalance could be hormone replacement treatment, cancer, chemotherapeutics, pain medications, loop inhibiting diuretics, infection control medications. You can go to rxlist.com any medication in addition quinine and malaria drugs. I had a patient once called my office to come in for a test and I told my receptionist, find out why. And the receptionist said she can't hear me. The night before her doctor had told her just drink a half a cup of tonic water to help you sleep instead of me giving you something for your restless legs.

She lost all hearing, which is very unusual. She had no hearing left. I immediately referred her to an ent. But even in three months when I did a follow up after their treatment, she still had not recovered her hearing. Unfortunately.

Now that's unusual because quinine usually just causes a mild hearing problem. But you have to be aware of all of these, look up all of the medications and see if hearing is on the radar or balance.

You're going to risk, you're going to increase the risk of ototoxicity. If they already have an impaired renal function, if they already have a kidney problem, it increases the risk if they're on a prolonged treatment course over 10 days. If, if they use Loop diuretics along with ototoxic drugs like vancomycin.

If their age is over 65 years old, if they've had previous aminoglycoside treatment, if they already have sensorineural hearing loss, it puts them at greater risk. Or if they're out there working in noise while they're taking these medications and they do landscaping, so they've got lawnmowers, leaf blowers, and they're not wearing noise prevention. So make sure that you consider all this when you take a case

history or when you're putting the case history together.

I think I went over this one thing about starting. What's the first step in the process of delivering services in a facility? You can offer to train the staff, you can contract with the facilities, you can provide on site services, or you can conduct hearing screening for all residents. Contracting with the facility is the first step. You have to get a contract with signatures on your side and the facility side.

So that's going to be important.

The role of audiology obviously is going to be implementation of these services as well as staff training.

So there's a high incidence of hearing loss in nursing homes. 80%. I mean, it's going to be unusual for you to find somebody who doesn't have a hearing problem. Hearing has to be monitored because of illnesses and medications. If they're diabetes, if their A1C peaks, that could have an impact on their hearing.

So talk with the nurses. If their A1C or their blood sugar count goes high, you need to be alerted. You might need to start monitoring more frequently, maybe every few weeks.

You have to train the staff in the referral process and how to take care of hearing aids.

The obra, federal and state laws require hearing to be assessed within 14 days of admission. It will definitely improve the resident's quality of life and the quality of care that they receive. So if a CNA certified nursing assistant comes into a room and says, do you ladies want breakfast? And only one lady says, yes, yes I do. And the other lady never responds.

She doesn't get breakfast. And I saw this myself as an ombudsman for that woman. I had to go over, lean down into her ear and holler for her to even hear anything. She had never been tested before. She was not getting breakfast.

It is sad. So you have to be part of the assessment team again, especially before cognitive evaluations are administered. That's very important.

So if you're looking at what the similarities are between a cognitive problem and hearing loss, this is a study that was done at The University of south Florida in 1998. It's wonderful because it compares for Alzheimer's. You see depression, anxiety, disorientation. That's exactly what you're going to see with hearing loss. People are depressed, nobody talks to them anymore.

They get anxious because there's nothing to do with. They feel overwhelmed. On Alzheimer's, there's reduced language comprehension. Well, bingo. Reduced communication ability.

If they can't hear you, they're not going to comprehend what you said. It may look that they have impaired memory. They didn't remember that you just asked them something. But again, if the input is reduced, it will affect their cognition. If they don't hear, they're not going to understand inappropriate psychosocial responses.

That's exactly the same for both, whether it's a cognitive issue or hearing loss. Vet hearing first they have a loss of ability to recognize, but then on the hearing loss side they have reduced mental scores.

Someone with a cognitive problem might be defensive and in denial. You're going to find the same thing with somebody with a hearing loss. Distrust suspicion regarding others motives. It's exactly the same for hearing loss and cognitive or Alzheimer's disease. One gentleman that I found that had a severe loss, I told the staff I need to get him hearing aids.

And they said, oh, we don't think that's going to work. I said why not? They said, oh, well, when we come in to give him a shower and get him dressed, he's physically fighting with us. And I said, well, I don't know anything about that, but I do know he needs hearing aids. So let's see how it works.

I fit him with hearing aids. I came back in two weeks and asked the staff, how is he doing? They said night and day we come into his room, he starts telling us jokes, we talk to him, we ask questions. He's engaged again, he has a life again. How important is that?

How important is that?

These are the speech therapist ASHA professional guidelines for adults. When they are supposed to screen or ethically. If they cannot screen, they must refer advancing age, anybody over 65, any chronic health conditions, diabetes, cardiovascular, kidney disease, any disorders of the ear, any history of ototoxic, vestibulotoxic medications, exposure to recreational noise or occupational noise, lawnmowers, leaf blowers, chainsaws, genetic factors. Is it in their family? Other people in their family have this problem?

Have they had head trauma, history of ear infections, history of falls that prompts a hearing screening, speech, language or cognitive impairments. They must screen the person first for a hearing problem. If they've had a stroke, again, that's cardiovascular. Or if they report tinnitus, a ringing in their ear. So I think we have a lot of education to do with speech therapists.

It is so unfortunate that they are ignoring, I don't think they're ignorant of this issue. They are ignoring the need for hearing for these residents. So when you're looking at coverage for hearing services in part A and part B for nursing homes in part A in a nursing home, that means the first 14 to 21 days, if they're on managed Medicare or for traditional Medicare, it's up to 90 to 100 days. They're going to be

in part A. That's short term care.

You are billing everything to the nursing facility. You do not bill Medicare. So I would advise as far as needing hearing aids, that you do a loaner program, give them a hearing assessment, a comprehensive hearing assessment. But as far as hearing aids, I would do a loaner set of hearing aids until they make that transition to part B, which is long term care or perhaps they go home. Either way, then you have a contract for their own hearing aids.

There's also coverage of hearing services in part B under Medicaid and Medicare. There's also a thing called a spend down position. If they are now in long term care of a nursing home, but they have assets like a house that they have to sell or a car, that money has to be spent down before Medicaid will come into action. During the spend down position is a good time for them to get hearing aids and get it covered.

There's also an unmet medical need in some states. Every state is a little bit different. So unmet medical need means that they. This state does not cover hearing services in Medicaid for adults. So they work on an unmet medical need, which means you will access their Social Security check over a period of a couple months to pay for the hearing aids.

That's the way you do it. Oral rehab can be billed directly to the facility or to Medicare. Auditory processing, testing again the same way, annual monitoring or immediately if there's a change in communication. So all of those things are covered.

Now let's see.

Oh, so you also have to know the place of service codes for billing. Now the facility in the law should pay for bringing the resident to your office. However, you will be much more productive if you provide

services at these facilities. So then you have to know what the code is, the place of service code, if you're going to an assisted living or some similar residential care. If you go to a group home, if you go to a psychiatric hospital, if you go to a skilled nursing, it's 31 which is post acute care, or 32 which is long term care.

And then unspecified is 99. So those are some of the codes for billing in addition to I believe 11 if they come into your office. But again, some of these people are bedridden or they're in jury chairs. It's very difficult to get them around. So again, you're much better off just going to the facility.

Reimbursement. As we discussed for part A, you build a nursing home usual and customary for your service, and you have loaner hearing aids. Part B is looking at whether they're in a spend down position to go on Medicaid. They might be private pay, they may not qualify for Medicaid. And so it's an out of pocket or it's an unmet medical need process.

If that state does not cover hearing aids for adults.

Under Medicaid living, intermediate care, group homes, family homes, juvenile detention centers, prison, you will bill Medicare or Medicaid or the state for these services. They are mandated to cover them.

I'll give you a little bit of an overview of Florida hearing needs. Now, every state is different. There's 682 certified nursing homes in Florida. That compares to Kentucky having 270. South Carolina has 180.

North Carolina has 415. I think Texas has them the most. And Pennsylvania and New York have high numbers of nursing homes. So every state is going to be a little bit different. If you looked at a conservative number of assessments for new admissions in Florida for those 682 homes, you would have 81,840 assessments.

Hearing assessments, annual assessments that you have to conduct would be 68,200, which is a total of 150,000 hearing assessments every year. Do we have the boots on the ground to do this? I don't think so, but I think it's a wonderful opportunity to interest undergrad communication students into the work that we do with audiology and actually help support them to get into an audiology program. When you look at communal living centers in Florida, low income housing, I don't have a number for that. Assisted living centers, there's 129 intermediate care facilities, 104 residential treatment centers, which is behaviorally and emotionally disturbed people, is 191 juvenile detention centers, is 21 prisons, is 134 facilities.

And just in prisons alone, let's see, we have 89,000 prisoners. I used to work at Central Prison in Raleigh, North Carolina only part time. I was amazed that some of these guys were put in prison and they had a severe loss they could not hear during their trial and so my recommendation was they needed to be retried. Now whether that happened or not I don't know. But it is egregious if someone doesn't know that this person cannot hear.

Florida Resources There is a CMP training grant for nursing homes. You if you develop a grant, you have to have every single nursing home or corporate list of nursing homes sign on. Then you would get $6,000 annually for each skilled nursing times up to three years. You may only want to do it for one year, but you can go up to three years. You can do on site or virtual training them on the causes of hearing loss, training them on the care and use of hearing aids.

When to refer interpreting the audiogram and communication needs. Fall Prevention your state has a CMP grant agency. CMP means civil monetary penalties. So when the nursing homes get dinged for not doing what they're supposed to be doing, money goes into the CMP account and it's to be used for a training grant. Again, your other resources is to go with other audiologists in the state and request appointment by the state as independent assessors if the facilities are not providing hearing services as

they are needed.

So in Florida there are 1807 registered audiologists in Florida. How many of them are active? How many of them even do direct service? How many are Florida hearing aid dispensers? So again you can train undergrad students and interested who may be interested in audiology as dispensers.

You can hire SLPs under your practice for oral rehab services. Oral rehab used to only be under our professional guidelines, But Asha around 2016 has now put oral rehab under their professional guidelines. So under your practice I think you can hire SLPs both for your in clinic and also your outside work that you're doing with skilled nursing or other facilities.

What services can be billed by audiology? Any service in the scope of practice for audiology and that was told to me by a CMS executive. The orders must be written and signed by the medical director and that includes auditory processing disorders. Oral rehab. Any special test, get a signature from the medical director at the facility the audiologist will complete and they sign the orders but then the medical director has to sign them.

So it's put in the chart for the next visit when the medical director comes in. Sometimes the nurse practitioner is assigned to a facility and they sign assessments the order should say hearing assessments for medical management purposes. Again, that is the reason why we're testing them. Treatments, you'll need orders to use drops in advance of the next visit to clean ears as well as cleaning. So you need to write an order for that.

You sign it and then the doctor signs it. You'll need orders for amplification, you'll need it for the part A loaner order. You'll need it for part B. Long term care order for hearing aids. They have to sign the order for hearing aids.

The medical director and in the chart notes you have to show the delivery of hearing aids and the services that are going to be needed by the staff as well as the serial numbers, etc. We have a lot of forms that we're getting ready to put on the Audiology project website so you can download these and use these if you are interested in starting work in these facilities.

Again, the civil monetary penalty grants are monetary funds imposed by CMS when they violate their requirements. CMP grants are funding opportunities for training.

They have to improve resident care and quality of life. And each facility participates in a one to three year training project.

So every, every budget is contingent on what's in their bank account for CMPs. But I'll tell you, it's 20 million, $30 million. They're not setting up enough of these grants to pare down the fines that they're getting from CMP for these violations. So. But again you have to have every single facility sign up or the corporate sign up for all of their facilities as part of your application.

The necessity of hearing services doing on site services is very valuable if you train the staff to let you know or to mark down, you need to test these new admissions and they mark that down on your schedule. Or these people are due for their annual, or these people had a change, they're no longer talking to us, or they're getting really upset with us. Training for care of hearing aids and other devices, how to troubleshoot devices. It's not rocket science as long as they're trained. What are communication strategies that some people may need?

They may need to see captions on an iPad as you're talking if they really don't have the ability to hear. But then again they have to have good vision. So you may have to refer for a vision assessment. They have to report to Audiology as soon as possible for the assessments. Remember that CNAs provide direct resident care and they in particular need to know this information.

So I'm going to go back and just go through One question, which is, who will sign the orders for hearing and balance assessments with medical necessity noted in the orders? Is it the director of nursing, the medical director, the assistant director of nursing, or the speech therapy director? Obviously it's a medical director which is B for that particular question. What are examples of quality indicators? Food and drinks, bathing and clothing, mental illness and disruptive behavior or ability to walk.

Quality indicators are mental illness and disruptive behavior. Mental illness is usually the prescription of medications.

What is the state grant for training in nursing homes? Is it the civil monetary penalty? Is it the NIDCD National Institute of Deafness and Communication Disorders? Is it the Small Business Innovation Research? It is the her.

Is it the HRSA workforce grant? We've just gone over that. That is a civil monetary penalty grant.

What staff provide essential services for food, bathing and personal care to residents? Is it the nurses, medical directors, certified nursing assistants, audiologist? It's C, which is certified nursing assistants. CNAs, they are the direct people for most service directly to the residents. And there is someone who was an executive at ASHA who is now on the National CNA Association.

I think she would like to be included in some of the work that we're doing because she does understand how difficult it is for cnas.

So when you get into starting up, who are you going to call? The first is the administrator. You'll need to explain the law. You'll need to explain how it's going to positively affect their residence. Legally, they're mandated.

But then you're also, you know, once you talk with the administrator and get the process of signing a contract. Remember, with your contract you're going to have to put an appendix of what your part A billing cost will be. Short term care. When they first come in, you're billing the facility.

You need to write down what is the cost of your comprehensive hearing examination assessment. 92557, what is that cost? But list all the potential services that you can provide in part A and provide that with the contract. You also want to talk with the director of nursing because they have their pulse on all the medical issues with residents. For the most part, the business office is critical.

After I would go in and test somebody and find out what was needed. Did they need a medical Referral, which is 20% of the time, or did they need amplification? The business office will tell you how that person stands in part A or part B. Part A, you're going to have to do a loaner. Part B, how is it going to be paid?

And they are the people that will help you with that. They were wonderful when I had contracts with facilities the medical director make sure you touch base with them, offer to do a presentation to their state medical director association and also visit the rehab center which is pt, OT and speech. Obviously the PT you want to talk to about balance and you want to talk to them about we will provide on site hearing services for your residents. Can we schedule a time to discuss our programs? So it's it all starts with that first contact and if you I'm going to go to the next two questions here which are which statement below correctly answers this question?

Are independent low income housing residents included for hearing services under the Supreme Court Olmstead Act? Yes is answer A because all low income residents qualify for federal hearing services regardless of setting B is yes because of the Olmstead act mandates that individuals with disabilities receive services in the most integrated setting appropriate for their needs. No, because the Olmstead

act only applies to residents in skilled nursing or D is no because independent housing residents are not considered institutionalized under federal law. Well, it's B. The Olmstead act mandates that individuals with disabilities receive services for the most integrated settings appropriate for their needs.

Who is billed for resident services in part A? Are you going to build the health care power of attorney which is answer A Medicare or Medicaid Advantage, the skilled nursing facility or the resident's next of kin? Part A as you remember, is the skilled nursing facility. You bill them directly, they pay you directly.

So thank you very much. I think that we may have hit all of the targets that we were trying to get to at the end and if there are questions and I'll leave it up to you.

Thank you so much. Dr. Dowd, that was a fantastic presentation and I think so much of it was is so important for audiologists to really learn more about. We do have a couple questions. I'll quickly go over them. I think some of these you have answered in your presentation, they came earlier but we'll just cover them just in case.

So when you talk about initiating getting a contract with a nursing home, who should you go to first? First I know you had a list of people to contact, but who would you start with? I would start with the administrator. That's the person who's going to sign the contract.

So now if they're telling you that they don't have anybody with a hearing loss, I would just make a note of the date and time who you talk to and that's your backup for when you and other audiologists go to the state and Request independent assessor. But it's, they're the gatekeeper. Is the, is the administrator. The medical director is also important because they don't understand again, hearing loss is invisible. So then they don't see it.

Oh, we thought he had schizophrenia. Oh, I'm so sorry. He had a mild to moderate loss. That happened to me.

But I would start with the administrator and then maybe work my way down. But again, you may not get success, but it is success because you've got hard facts now about who's not getting these services. Thank you. Yeah, perfect. And when you talk about training for staff, do those staff members need CEUs or special certifications?

Is there a way to group in training with about hearing loss with that type of extra education that they might need? Actually, when I, I knew nothing about a CMP grant until the last couple years, but I would do services and they got it so that they got CEUs. So I would do two segments, one from two to three and get first, the first shift and then I would do three to four and I'd get second shift. Or they just have them come like from 2:30 to 3:30. But then they would get CEUs.

Sometimes there were no CEUs. But I think that's an excellent idea because they do need to have CEUs for their licensure. Perfect. That's really great. The idea of crossing over into the different shifts.

I think that's something else to think about. And this last one, I'm pretty sure you did just cover. But who is responsible for paying for the audiological services provided by the skilled nursing facility? Again, it's split. If it's part A, you build a facility, they get a big chunk of change from Medicare in part A and that's to cover all services, all their pharmaceuticals, all their rehab, etc.

Audiology falls into that. So you bill the facility in part A, short term care. You bill Medicare or Medicaid for long term care, part B. Perfect. All right.

Well, thank you so much, Dr. Dowd, for coming today. This was a wonderful presentation. And at this time we're going to go ahead and end the session for today. Thank you so much, Anna. I appreciate

your help.

Thank you.