Keeping Recipients Connected: Clinical Considerations for Replacement Sound Processors

Presenter: Sara Neumann, AuD

Okay, so thank you all for attending today. Today's session, our learning objectives are to be able to implement techniques for more effective clinical documentation when it comes to replacement sound processors. After this course, we will also hope that you're able to identify and effectively delegate those non billable tasks to your your clinical support staff and then as well be able to know strategies for keeping recipients from being without sound. Next slide please. Our risks and limitations for this course are described here and they will be provided to you following this webinar as well.

And with that, today's course is called Keeping Recipients Clinical Considerations for Replacement Sound Processors. This will be presented by Sara Neumann from Hearts for Hearing. Thank you Sara for hosting this with regards to her clinical practice management and how they work with our recipients to keep them appearing at their best. So with that I'll pass it to you Sara. Thank you.

Great. Thank you everyone for taking the time to join me today and hopefully you will get some good takeaways that will help make your practice more efficient here. So these are my disclosures. In our agenda today we're going to review Hearts for Hearings program. Just give you a little background about how we do things here and set things up and then we'll talk about how we keep recipients in sound and how we implement techniques for effective clinical documentation.

And then we'll move on to delegation of non billable tasks and review any discussion and questions that we might have.

So quickly here, a review of our program and our focus on our recipient population. We have quite a large population of cochlear users. Our mission is to advocate for, educate about and innovatively provide comprehensive life changing hearing health care for all ages and that we started and continue to be a nonprofit. We're probably one of the largest, if not the largest listening and spoken language and audiology program in the country. We provide the first set of hearing technology at no cost to families for children 0 to 18 years of age.

That includes soft band bone conduction hearing devices, hearing aids, remote microphones for children that need them for like ssc, single sided deafness, things like that. We also have no out of pocket costs up to age 3, so we cover ear molds services and then we have financial aid for families beyond age three for those who qualify. And and we have about 13 listening and spoken language specialists here. We have three locations in Oklahoma City, Tulsa and Norman and provide all the same services at all those locations. To give you an overview of how our team works in terms of the cochlear implant side of things, we have 33 total audiologists, 21 of whom are pediatric cochlear implant audiologists.

So if you're a CI audiologist, you also see pediatrics and do pretty much all diagnostics and pediatric care. And then we have a separate hearing aid program for adults who need hearing AIDS. We have 16 audiologists in Oklahoma City that do CI and five in Tulsa. And we also have five full time pediatric audiologists, audiology assistants, and one part time. Before I forget, I want to talk about, we use audiology assistants and also we have a state licensure for that that may differ by your state.

So when I refer to audiology assistant, that could transfer to a hearing aid dispenser, a hearing aid tech, even an office manager, a patient care coordinator, another professional, or even a student. And in terms of how you want to do that, it just has to align with how your state licensure might work and how you can, how you can make that work as to whether they're going to be patient facing or whether it's going to be more in the background. Because we're going to talk about that more in a few slides. In looking at what our audiology audiologist to audiology assistant ratio. In Tulsa we have two audiology assistants to seven audiologists.

In Oklahoma City, we have three and a half audiology assistants to 16 audiologists. The difference between those two is in Tulsa we have our adult hearing aid. Hearing aid needs are also covered by the audiology assistant. Whereas here we have an additional three audiology assistants in our adult

hearing aid clinic that manage just adult hearing aid users. So that's kind of how we split it out.

We also have two to three AUD students annually, a CI coordinator and an audiology administrative assistant. So we have a lot of staff behind us that helps make us more efficient and also reduces our billable time. And that's part of what we're hoping to share with you today. Another thing that I want to just kind of share is how we do replacement sound processors in our clinic. We have traditionally taken that on ourselves with the assistance of our audiology assistants.

We have had in 2025, 190 orders placed in 2025, 166 orders placed so far in 2026. So you can see that we are trending with much higher number of orders placed. But we all know that's because of the obsolescence of the N7 in recent months. And then when we can look at our data further, we have currently 918 legacy sound processor users, 544N7 and older and 74Kanso2 and older. Of those that upgrade orders that we have placed, we have had 217 orders shipped in 2025 and 137 shipped so far in 2026.

And you may say, well, that that number doesn't add up. That is orders shipped for our program total compared to what we actually placed as a clinic. So when we look at the percentages, 85% of the orders that we have placed by us through our clinic, 80% of those replacement orders have shipped. And so that's a pretty high outcome. And we're going to talk more how we got to that point.

This is just kind of showing you our appointment overview and how we kind of have run our program. We used to see our patients annually. We've moved to seeing them every other year after their first year of implant use. And we have been able to do that pretty easily by the way we are managing it and setting up our appointments. So once we hit that one year point, we say congratulations, we're going to move you to every other year.

Unless you have concerns you, here's how to respond if you're having trouble, we don't want you to wait. Of course, here's what we're gonna do. So we have it set up so we have them call in if they have difficulty, need assistance with their equipment, something's broken, they just don't know how to do something. And they know to call and ask for an audiology assistant. So does our front office staff.

They know when to direct it to the audiology assistant versus us. And then for those patients that we know are gonna need more help between the first year and the third year, we have them also scheduled to see our audiology assistants every three to six months, depending on what they may need. So that includes our patients who maybe just have, maybe they're elderly and they can't clean their own equipment or they're bimodal users and they, you know, their acoustic component goes down all the time and it's so subtle they don't realize it. So we want someone to clean and check that regularly. That's things that we can't technically bill for in many, many ways.

So again, an audiology assistant can do that, take that off our plate and get that managed. If there something that requires a replacement or a new order, the audiology assistant can facilitate that note and get it to us for signatures. And then we also tend to try and set up patients, if it works schedule wise, to get them in for an appointment, whether it's with an audiology assistant or an audiologist one month prior to their sound processor warranty ending. So we can look at it, talk about what needs to be replaced and what doesn't. So going along with that, that same same line, we're keeping recipients in sound, and we're being very proactive about how we talk about it with our patients and counseling them.

So we have set our expectations in between appointments. A lot of this is just verbal instruction, but we do have rack cards in our clinic that are also set up to remind them of these things so we can send them on their way with this information. So the things that we do during our appointments and even in between is remind them of their warranty expiration dates. I keep a note in the chart similar to hearing

aid warranties. I make the patients, I don't make them, but I ask them to put a reminder in their phone.

And I say, hey, your warranty ends on this date. I want you to put a reminder in your phone for this date. And then I also want you to put a reminder in your phone for a month ahead of time to look over all your equipment and determine if you need to replace something or if you're not sure, you can call a clinic and we can help walk you through what might need to be swapped out. We always discuss also what might happen after the warranty expires. We want people to understand that if you don't have backup equipment, here's what I need you to do.

Because we do have quite a loaner stock. So we do really try to keep patients in sound as much as we can. And then if patients are interested, we can refer them to the company to discuss an extended warranty, if that's of interest to them. Another thing that we do that I think is really, really helpful is we keep assignment of benefits up to date. So the assignment of benefits, AOB documentation, we have them fill that out annually when they come in.

I do that when I go to check. You know, I might take and clean their devices or when I'm getting their devices set up, connected to the, to the computer, maybe there's a software update. They can be filling out that form while we're doing our work, so we're not wasting any of our time during our appointment. But then having that on file for when they actually do need something, we can just send it off with the order and we don't have to track that down from the patient. And then I talk to them about the expectations about.

You're going to get an email from Cochlear and it may be a DocuSign email. You have to keep an eye on these, check your spam folder so that we can keep this process going to get their replacement equipment.

Another strategy that we have and things that we do is that I want to share with you is some ways that we complete effective clinical documentation. I think this is the biggest area of hang up and frustration because insurances are picky and they, they ask a lot of us. But I think our numbers speak for themselves in that we have set this up really well so that we don't get a lot of kickback from insurance. So we don't have this document. We don't have this document.

This hasn't been stated in the phone notes or the clinic notes. So I'm sharing that with you. There's actually I want to point out a handout that is available to you that takes a lot of what we're going to talk about here so that you can potentially implement that in your own way with your clinic.

So documentation can come in several different forms. It can be in the visit notes, so the actual note on the day the patient comes in for their regular appointment, or it can be, you know, if they come in for an additional visit, information can go there. But if a patient calls in or emails in with current concerns or problems, we can do something like a chart note or in our EMR system, it's a phone note. Again, all of this depends on how your EMR system works. You may be able to add an addendum to your note or create a new chart note within that note.

But for our, our purposes, we have a phone note that we do if they see the audiology assistant, the audiology assistant can document what they observe, what they saw, and then we can actually incorporate that into our note as part of our documentation and then they can bring it to us to get signature on the phone note. Because the phone note we don't typically sign off on or a chart note we don't sign off on because it's not actually like a visit note. So we also probably maybe over document, but again, over documentation can save a lot of replacement or catch up documentation on the back side of things. So we like to document in three different places in our history, we share what a patient reports. In our procedures, we document anything we personally observe, such as loose connections, cable coil issues, diminished battery life, poor sound quality, if we're doing a listening check, things like

that.

And then within our recommendations, we restate any issues that we see or the patient identified. And also document medical necessity. And we'll get into the nitty gritty of that here.

So for examples of our history, we actually, and let me take a step back and say with our EMR system, we don't necessarily have a template per se, but we have click boxes that we can check through. And so we have a place in our history where we can line out these in different topics related to equipment issues and just click on it real easily. So you know, patient reports that they're having trouble listening in background noise. And we know that, you know, the N8, for example, may be better than the N7 in background noise. We can use that to corroborate and recommend a replacement.

In our recommendation section, we can quickly click if a patient's cable coil is intermittent or fraying, we have a checkbox and we can. We have a sentence that basically says that so we don't have to type it out so that we can save time in our report documentation. And we can also report on reduction in performance. If they're saying, hey, I can hear, but my battery lasts two hours and I have to bring three batteries with me to make it through the day, we can document that all there and pretty quickly. Then of course, you know, it's pretty self explanatory in procedures you can document what you see.

And then when we get to the recommendations part of our note, we have a full basically statement that again, for our clinic, we have it set up as a click box. And we also have it specifically, we have one that says N7 to N8. We have one specifically written for an N7 to a Kanso 3, we have one written for a Kanso 2 to an N8. We have them written for all the different potential scenarios. And again, it's just a quick click box.

And then if we have some additional details that we want to add, we just double click into that and just start adding our additional details if we need to. But in general, it takes us less than two minutes to

make this documentation. So this is just kind of a blanket example. And I do want to make sure I give mad credit to Dr. Mila Duke and Patty Burns, who is our audiology assistant, who helped generate these statements that have worked for us in getting insurance approval. And I want to kind of point out here, this is an example of a patient who called in and I just wrote a narrative.

Parent reported this. These things are happening, noted the obsolescence specifically for the N7 and then discussed the medical necessity. So very similar to what's in my regular Reports added into a phone note. They brought it to me, I was able to sign off on it, that worked as documentation. And then this is just here for you just to have another example of.

You know we haven't really talked about this yet but in this, in the instance of a loss device and this one is specific to a single ear loss out of a bilateral set because we have to, you know, they may say oh well they can still hear with one, why would we replace the other one? But here we have an option to go ahead and share this information. I also have created in your handout one for a bilateral loss devices as well.

So my pearls for documentation. I'm an over documenter but I think it's really important to emphasize that you must state medical necessity. I used to shy away from it thinking oh well it's the doctor's role to do that, the surgeon's role. But guys, we are the experts, we are the professionals. We know what our patients need.

We can tell the insurance company this is medically necessary and be feel really confident about it. I mean say it over and over again so it can just like hit him in the face I guess and, and explain why that's important that they need to be able to function like in everyday life. You know, if it has to be hey like they, they use listening as spoken language. They don't have another way to communicate. It has to be obvious.

I hate to say that, but we have to be cap obvious about our documentation. I think insurance providers tend to have less experience with hearing loss compared to other specialties. So we have to be really just almost beat a dead horse. And that's why we have it in three different places in our report. And that has worked for us because we don't get a lot of insurances coming back saying you didn't document medical necessity, you didn't give us the information we need.

It is there so it works. And then with the patients we work through the order process of what to expect because there are some realistic expectations around the replacement process. It's not always cut and dry. You know, they want to know what their out of pocket is, all the things. And we have to set up what's realistic about what we can tell them, what, what cochlear can tell them, things like that.

But I always communicate with them, you know, some things may need be needed based on your insurance. You may need to see your surgeon again for them to sign off on, on the note as well. And so if they haven't seen that surgeon within Two or three years. It depends on the surgeon. Some surgeons have to see them within the year, some will do it within two years.

Again, know your surgeon's expectations and guide the patients based on that. Typically. And then I also tell them, you know, typically orders take six to 10 weeks, sometimes longer. You know, I know that, that right now it seems like it's taking a lot longer. But, you know, insurance kind of did this to us because they wouldn't replace sound processors unless they were obsolete if they could be repaired.

And so it's kind of become this tsunami of upgrades or replacements because of just the way insurance has made things go. So it's going to take some time. But one of the things that I do ask patients to do is to reach out if they haven't heard anything about their replacement in about four weeks. Because, you know, I would say it was like sometimes we send orders off, we don't know what happens to them. It's like socks in a dryer.

Nobody knows what happened to them. So if someone reaches out and reminds us and that puts the onus back on the patient, like, like, we will help, we will do whatever we can. But like, you ultimately have to make sure the upgrade goes through. So if you let us know you haven't heard anything, we can, we can follow up. You can call cochlear directly and find out what's going on.

Just to keep the ball rolling. Sometimes it's sitting in the PCPS or the MD's inbox for signature and they didn't realize it was there. So we can kind of help facilitate some of that. And then of course we sure to tell patients if your device stops working, like, say it's on the fritz and it's really close to cut to not working at all. We'll say, you know, if, if you, you're without sound or whatever, we'll reach out to cochlear, ask them to mark it as urgent and we also try to get them back in sound as well.

And then we give them a few options to check on order status. So again, this is a lot of talking, but you could put this on a little handout for the patient if you wanted to just give them something and go and you can develop that with your team.

So in terms of order forms, ordering programs, things like that, we really like to utilize the ready to wear option. I think the ready to wear option is probably one of the greatest inventions in my opinion. I remember just being stressed out trying to find a place to bring a patient in to upgrade them Put their new. Get their new device set up and going. This allows it to show up at their house ready to go.

Some caveats to that, there are ideal candidates. There are less than ideal candidates. The ready to wear is not a great option for patients who have been without sound for more than a day or two, because you know if they haven't worn, it's going to be way too loud. So that's going to create a barrier. So that's especially important when you think about kids that have been without sound.

Hopefully we don't have that situation, but that's a consideration. You wouldn't want to send it to their house and then tell them to put it on and it'd be way too loud, and you'd have to figure out how to work

them back up to wearing it again. If we've loaned them equipment, we will have the ready to wear set up, but we'll have it shipped to our clinic so that we can get that loaner equipment back. Now, if a patient lives three or four hours from our clinic, and we trust that they will mail the device back, we won't ask them to do that. But it's a great way to make sure you get your loan equipment back.

We have patients, of course, that are transient that tend to move a lot. If I'm concerned that it's not going to get shipped to the right address, I will have a ready to wear initiated, but I'll have it sent to the clinic. And then the ones that I truly often don't have a ready to wear is those who are legacy users that are upgrading. So if, say, they're going from an N5 to an N8, that's a big switch or something similar to that. I will tend to want to bring those patients in to set them up.

And then some patients just really want to come and see you no matter what you do. So you do what you got to do in that situation. And then I always counsel, hey, it's going to come to your house. You can put it on right away. It might sound different.

You know, I remind them, hey, your old devices from 2017, the microphones have probably deteriorated over time, so they may not sound the same. Please give it at least two full weeks before you call and make an appointment with me. And then if I'm going to try a new program, like if I'm going to add a scan with forward focus, I also remind them this may not sound right to you. You have other programs. Please try all of your programs before you call me again.

Also trying to save you on trying to find an appointment for a patient that you don't have space for. Then also counseling on battery expectations. If a patient's like, well, my battery is only lasting five hours with my new processor, it might just need a save to the head. And so we'll have them make an appointment with an audiology assistant to come in and get it saved to head to maximize or optimize their battery life. Okay, so moving into the last section here is how do we do all this?

You know, I think this is where we can make up a lot of our time in delegating non billable tasks. This is how to work at the top of your license and decrease your paperwork burden. So we try to think of all the things that are non billable that we are asked to do by our patients, by insurances, other providers, and doing orders, tracking orders, taking emails, troubleshooting with patients, submitting documentation. All these things are time sucks and they're unfortunately unbillable. Here are the ways we use audiology assistants to do non billable tasks.

They are set up to do troubleshooting by both phone and email, and in person if needed. They can support updated chart notes with signatures. They can get it to us for us, printed out for us to sign, and then it can get sent off with the whole order. They interface with patients to keep them in sound. They can set up backup processors, troubleshoot all the things related to that.

We have created a culture here about donating equipment when it's no longer being used. So obviously we want patients to have backups. So if they have an N7 and an N8, we'll have them donate their N6s. And I recognize that you can't do a ton with N6s, but we still have a few patients out there in N6s and we also can send them over to third world countries where they will still use them. And so creating that culture of bringing it back and loading it, you know, when patients pass away, they bring it back.

And so we can manage that and keep patients in sound really well that way and then really help triage. I get emails all the time from patients that forget or just want to email me. And I can forward it to our audiology assistants and they're on it quickly. And there's no expectation that I have to do that after work hours because they have time carved out in their schedule to do that. And this is just a look at our patient support flow in our clinic, our audit.

Our front office staff knows we also talk to our patients. They know to ask for an audiology assistant. The audiology assistant takes that phone call and they can triage. Is this a hearing problem? Are they having problems with, with things being too loud, sound quality?

They can kind of triage a little bit and maybe, you know, see if turning the volume down helps, talking them through those things. But if it's truly something they don't think they can help with, they escalate it to an audiologist or say, hey, I'm going to ask your audiologist and I'll get back with you, whatever it may be. Or they put it on the schedule for us, or they realize it's an equipment problem and they can go through troubleshooting, they can work on the connectivity. I think most of us here probably roll our eyes when we hear questions or get asked to help with the Bluetooth connectivity side of things. They can take this off our plate.

And, you know, I know we have the RSMs that can help with that, but some patients just really want someone sitting right next to them, doing it with them. And this is where we can take care of some of that. That's more for our elderly patients who are less tech savvy and can't even figure out how to get, do a video call, things like that. And then they can help facilitate the repair or replacement. And in the situation where we need to do an upgrade, replacement documentation, they can start the note and the order, fill out the order form and get that going, and then keep them in sound if we need it.

So that's kind of how our clinic is set up to guide and coach patient flow. So hopefully that gave you kind of a good look into how we are making replacement sound processors a doable task in the clinic. How to make it reasonable without burning anyone out, without creating stacks and stacks of paperwork, either in real life or electronically. And so I thought, what are three things that might make your life easier? It's a Monday.

Again, I thank you for coming on a Monday and joining us when, when it's the start of a busy week. But here's three things we can do. Take some of the templates, some of the ideas of quick phrases that I gave you. Create, you know, a template that maybe you can delete things you don't need, or use check checkboxes like we do and create something that can make documentation quicker and faster and efficient. Another thing you can do is start identifying who might be able to help you with unbillable

tasks.

Maybe it's not an audiology assistant, maybe it's your new student that just joined you or a patient care coordinator or even a really savvy front office staff member if it's just filing paperwork and making sure things are moving forward. And then create and find ways to communicate with your patients around equipment expectations. Whether it's a handout that says here's what to expect after the first year, here's what to do before your warranty ends. You know, here's how to get equipment replaced when something breaks, things like that. I hope that that will be helpful and I am ready to open up for any questions that we might have.

I really hope you know that you guys will take and adapt the documentation that we provided. Again, it's what works for us. And you may not like my wording, our wording. Please feel free to change it to whatever works for you. But it has been shown to effective to be effective.

Sara, One of the questions or two of the questions now are what EMR system do you use? We use intelligent medical systems IMS for short. We've been using that for probably 10 plus years now and it works pretty well. You have to build your own templates from the ground up and for those who are still with us on the webinar, the Resources tab and it should be followed up as well. Sara did create, which I think is really wonderful, the replacement statements that they use.

So please refer to that when she says the quick parts or the wording that she's using. Yep, I know a lot of you guys use epic and I don't know really anything about epic, but it's pretty, I think you could probably build the smartphrases pretty quick with, with that.

And the next question is what is the age range of your patient population? Sara? Oh, it's 0 to 102 probably. It's all over the place in terms of cochlear implant users. We have have babies all the way up through Centurions.

We have a few hundred year old patients. Not, not very many obviously. But yeah, it's a, it's a full age range. What do you feel the mix is, Sara, there? Do you feel your pediatric population takes up most of your time?

It's probably about 60, 40.

So I would, I would say most 60% kids, 40% adults. But it's, it's quickly approaching about 50, 50.

I will give it one more minute. We are at the half hour, just past the half hour. Thank you again Sara for sharing. I think this was really wonderful and I hope all that participated today found it valuable as well.