Minnesota Academy of Audiology
Newsletter
May 2020

Feature Story

Better Hearing Month is here...

and it's asking you to think differently about your practice

Kevin D. Seitz-Paquette, Au.D.

The American Speech-language and Hearing Association (ASHA) first designated May as 'Better Hearing Month' in 1927, a designation each May since has carried.[1] Better Hearing Month has been with us through the Great Depression, World War II, the polio epidemic of the 1940s and 50s, the Korean and Vietnam Wars, the September 11 attacks and ensuing warfare, and the Great Recession of 2007-2009. Even so, this Better Hearing Month will certainly meet a challenged hearing healthcare community, struggling to balance the needs of our patients with their overall best interests, all while maintaining a viable business.

COVID-19 (also known as the coronavirus) is one of the most significant global crises in the past century, but life will eventually return to normal—or at least something much closer to normal than what many of us are experiencing today. By the end of March, roughly half of US states had imposed some form of a 'stay-at-home' order, thereby limiting the frequency of and reasons for trips outside the home for over 100 million Americans.[2] Guidelines as to which business may remain open during these orders differ by state, but the American Academy of Audiology (AAA) weighed in to state that "audiology practices are 'non-essential' in terms of the life-sustaining definition. We need to close our physical doors, so individuals do not come in person.[3]" Thanks to these conditions, this Better Hearing Month has many hearing healthcare providers questioning their role in the overall healthcare landscape, or even how essential they are to their patients well-being.

The ability for the hearing impaired to remain up-to-date with the latest information from local and federal authorities is crucial. The fact that those most severely impacted by COVID-19 are those most likely to need hearing healthcare amplifies this need. How then, can hearing healthcare providers continue to serve their patients in a way that protects everyone from infection? Do hearing healthcare providers have any options to continue to serve their patients in a responsible way? Of course they do (and, for their part, AAA argued as much in the statement cited above).

Remote programming functionality is now offered by all of the major hearing aid manufacturers. This technology allows any patient with a smartphone to access fine-tuning services without making a trip to his provider's office. Despite the convenience that this technology offers to patients, it has not yet achieved mainstream adoption within the profession. In fact, in a survey conducted in March 2020 for The Hearing Review, only about 38% of respondents reported using telehealth as a means of continuing to serve patients, and only 43% said they would do so.[4] This reticence

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Better Hearing Month, *cont.*

may be due in part to the novelty of such technology—the first remote programming capabilities only appeared about three years ago. However, there remain commonly cited objections, summarized below according to this author's anecdotal experience:

1. Most patients who need hearing care do not own a smartphone.
2. Patients who do own smartphones are not confident when using new apps.
3. Remote programming requests would inundate a clinic and/or distract from other patients and activities.

While the first point may feel true on an intuitive level, the reality is that Americans' smartphone adoption has increased steadily over the past ten years. Today, over half of Americans 65 years or older own a smartphone, and 12% of all Americans in that age bracket rely solely on a smartphone for internet access.[5]

Both the second and third objection detailed above stem from a common concern: telehealth, and the time it takes to teach a patient how to use it, consumes valuable time without generating any revenue. Indeed, each minute spent not bringing in new dollars is a net drain on revenue, as the opportunity cost of each of those minutes is a lost sale or revenue-generating service.

Hearing aid pricing has followed the same model for generations; buy a device, get all the services needed to maintain that device for x years. This model works well for hearing care providers, assuming that the practice has adequate access to new patients and more 'easy' patients than 'hard' patients. Put another way, this model requires that every patient who comes in frequently for help has his time subsidized by a greater number of patients who do not need frequent contact. Although separating charges for services from the cost of the device (i.e., 'unbundling') has been a topic of almost unceasing discussion in the profession, as of May 2018, about 60% of hearing care providers reported using 'bundled' pricing exclusively.[6]

Empirical evidence suggests that patients do perceive value in the services provided by hearing healthcare professionals, and further, that patients are willing to pay for those services in exchange for a lower device cost.

Moving from a bundled to an unbundled model gives the professional the freedom to spend additional time training patients how to use telehealth and respond to remote fine-tuning requests. Training a patient how to use a remote programming service or other mobile app and providing remote programming assistance are services that have value. If patients who require such services pay for them at an appropriate rate, that time is not 'lost' to a potential sale, it is the sale.

Some professionals may either object outright to unbundling or be intimidated by the change, because the practice and its cash flow have been designed around bundled hearing aid sales for years. Such concerns are understandable, but ultimately surmountable. Clinics, whether private or embedded in a larger institution, should know their operating expenses and their average number of sales and services (by service type) for a typical month. Armed with the knowledge of how many hearing aids the clinic sells, how much time is spent on each type of service, how much revenue is required to break even, and a target profit, setting unbundled prices on devices and services becomes an algebra problem.

Others may object to charging for services based on real or anticipated negative patient reaction. They may fear that patients would reject such a paradigm out of hand, or they may have heard from patients who felt nickeled and dimed by charges for services. These, too, are understandable concerns, and there is certainly no reason that an unbundled practice could not offer service packages covering either a particular number of appointments or a particular span of time. It is even conceivable to offer a 'standard' package and a 'remote service' package for patients who either do or do not want access to telehealth services, respectively.

Empirical evidence suggests that patients do perceive value in the services provided by hearing healthcare professionals, and further, that patients are willing to pay for those services in exchange for a lower device cost. In a study presented at the annual meeting of the American Auditory Society in March, 2020, Dr. Anna Jilla found that 69% of participants were willing to pay between $100-500 for hearing aid services, and only 15% reported an unwillingness to pay anything.[7] By finding the pricing 'sweet spot' where the cost of a service is enough to allow sustainable business operation and is below the average patient's willingness to pay, a clinic can ensure responsible financial footing and patients who perceive benefit in each dollar they spend.

It remains to be seen what toll COVID-19 takes on the hearing healthcare community, but early data is grim. The Hearing Review found in late March, 2020 that 67% of hearing care professionals expect hearing aid sales to at least cut in half compared to this time last year, and 73% expect revenue

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Better Hearing Month, *cont.*

to halve compared to a similar period in the previous month.[8] Time will tell whether hearing care practices change their pricing structure or telehealth offerings in response to this crisis. Those practices that do currently offer telehealth (and charge for that service at an appropriate rate) will at least maintain a revenue stream while the office may be closed, and patients using those services will continue to hear their best in a time when connection matters more than ever. Although that revenue stream will almost certainly be reduced compared to a typical month, it will at least soften the blow in a time when fixed expenses—like rent and payroll—aren't at home sick.

This Better Hearing Month, the hearing care profession and the nation will be lucky to begin returning to normal. As normal life does return, every member of the profession should be asking how they can better serve their patients and their business. A hearing care practice does a patient no good when its doors are closed for good. Although the crises caused by COVID-19 will likely be a once-in-a-lifetime event, the profession will do well to use the experience to strategize and prepare for the next disruption (recalling that the arrival of over-the-counter devices is just around the corner).

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Message From Your President

Audiology in the Time of COVID

Kristi Gravel, Au.D.
2020 MAA President

Hey all you cool cats and kittens!

I am going a bit nutty during Governor Walz's Stay at Home order, and like many of you, I am balancing being concerned with the future (personally and professionally) while trying to be optimistic and supportive of the needs of those around me. The lives of everyone in our community has been dramatically disrupted and affected by the COVID-19 pandemic. Our national academies have asked that we close the physical doors of our practices and continue to support our clients while practicing social distancing, through telepractice, curbside instrument drop-offs, or other means to reduce the spread of the virus and "flatten the curve." Never before have we had a challenge like this present itself to our professional community. There is no denying the intense pressure that is currently on employers, supervisors, and staff audiologists. Please take care of yourselves, and please reach out to MAA if you have thoughts on how we can be supporting our audiology community—we are listening.

Virtual MAA Happy Hours, organized by President-Elect Dr. Hughes, have been a great venue for members to connect remotely, sharing their challenges and day-to-day successes. It has been refreshing to see everyone's faces and learn how each one of us is coping with the current circumstances. While we do not have all the answers, merely knowing that we are not alone can be reassuring. We are truly a community.

If you find yourself with more time on your hands, reach out—we would love to discuss your interests and find a place for you on one of MAA's committees or on the board of directors (nominations will be accepted in the coming months). We are continually seeking audiologists who are able to share their time and talents with MAA.

Please follow communications from the national audiology organizations for up-to-date recommendations on service delivery adjustments. Even once restrictions are lifted at the state level, every service provider will have to consider how their practice will enact more diligent infection control practices as we strive to mitigate the impact of the COVID-19 virus on our communities.

We are the Minnesota Academy of Audiology. We will continue to protect and advance the profession of audiology in Minnesota. We will continue to set our bar high for professional integrity. When we come together, we are strongest. Thank you for membership and your contributions to your state association. Hang in there, everyone.

Free Resource
The app HeadSpace is offering free subscription through 2020 for healthcare providers with an NPI (https://www.headspace.com/health-covid-19). This is an outstanding resource for practicing mindfulness and also provides support for specific situations, such as those times when you may struggle with winding down at the end of the day.

MAA Webinar

Managing Stress in a Time of Uncertainty

Information about the coronavirus seems to be changing by the hour—creating unprecedented uncertainty and stress. There is an excellent reason to feel unsettled, anxious, or jangled.

Eliz Greene, author of *Stress-Proof Your Heart*, will present a **free, one-hour program especially for MAA members on Tuesday, May 5th at 5:30 p.m.** to offer four implementable strategies to:

- Understand why uncertainty causes stress
- Insulate yourself from external triggers of stress
- Shut down the stress reaction and recover
- Be kind to yourself

Register at no charge at www.minnesotaaudiology.org/event-3820378.

A Vocal Team Member—The Interpreter

Tips for Audiologists on How to Successfully Work with Spoken Language Interpreters

Kristen Olivero, CMI-Spanish

Working with an interpreter can be intimidating especially if you've never done it before or haven't had the opportunity to do so very often. It may feel unnatural to trust someone else to deliver your words to your patient or client. As language access laws continue to evolve along with the focus on quality of care, interpreting services are becoming more robust and commonplace. The good news is that working successfully with interpreters is an attainable skill, just like so many other things in life. With a little bit of preparation and a lot of teamwork, you'll be able to successfully work with interpreters and serve individuals of any language!

To give a little background on how interpreting services came to be, I'll briefly mention something you may already be familiar with, Title VI of the Civil Rights Act of 1964. This is the groundwork legislation for language access in our country which states that any agency receiving federal funds must provide equal access to services for Limited English Proficient (LEP) individuals at no cost to the individuals themselves. The goal of this legislation was to create "meaningful access" and prevent discrimination. Further legislation and guidelines have also addressed topics such as never using minor children as interpreters and the requirement to post signs in the top 15 languages of the area announcing that free language services are available. There are many more detailed requirements within the language access laws, and even more when it comes to the ASL population, but these are the basics to be aware of.

I'd like to share with you some pointers on how to effectively work with interpreters and LEP individuals. The following is based on my experiences over the past few years as a full-time Spanish interpreter at a large, urban hospital in the Twin Cities with a significant LEP patient population. I've been fortunate to regularly interpret for an excellent team of audiologists who are very skilled at working with interpreters and including them as part of the care team. In fact, they are so dedicated that they graciously gave me their input for this article!

Here are my top tips for audiologists on how to successfully work with spoken language interpreters:

1. Speak in first-person to your patient and make sure to look in their direction.

This means addressing the patient directly, just as you would when conversing with someone in English, rather than referring to the patient in the third person. For example, say, "Mr. Rivera, we're going to be doing some hearing tests today," rather than saying to the interpreter, "Tell Mr. Rivera we're going to be doing some hearing tests on him today." This allows the interpreter to interpret exactly what is said and keep the communication as clear as possible. As far as eye contact goes, it's okay to look at the interpreter at times, but make sure your primary focus is the patient, so you can gauge their reactions, especially while the interpreter is talking. It can be tempting to look at the interpreter the entire time or focus on computer work when you're not speaking, but you risk missing nonverbal communication and could struggle building rapport with the patient if they sense your attention isn't on the immediate conversation.

2. Speak in Segments

Most interpreting done in clinics is consecutive interpreting. This means the provider says a chunk of information and then pauses to allow the interpreter to render that information into the target language. The other mode of delivery is simultaneous interpretation, which is when the interpreter renders the message into the target language at the same time the speaker is saying it. Since most healthcare situations work best with consecutive interpretation, I recommend getting comfortable with saying two to three sentences at a time and finishing your idea as you do this. As much as possible, try not to abruptly stop a thought in the middle of a sentence. This is important because each language has unique sentence structures and grammar. An interpreter may have

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Address all questions and comments to the editors:
Rachel E. Allgor, Au.D., FAAA
Eric Robert Barrett, Au.D., ABAC

The Interpreter, *cont.*

A good interpreter will clarify as necessary to try to avoid misunderstandings while also maintaining transparency throughout the whole process.

to say things in a slightly different order than the English way for it to make sense. This is a skill that you will develop over time, so be patient with yourself as you learn it.

3. Engage in teamwork throughout the appointment.

Treat the interpreter as part of the care team. If you get a chance to give a quick briefing to him or her before the start of the appointment, make sure you do so. It can be something as simple as, "We'll be working with Ms. Rodriguez, a 72-year-old female. She's back today for a hearing aid fitting." This helps the interpreter to be mentally prepared for the vocabulary that will be used during the encounter and also establishes rapport with the interpreter. I, personally, am more likely to share a cultural nuance or doubt about patient comprehension with a provider if I feel like we've established an open flow of communication ourselves. I also feel more comfortable asking for clarification on something I'm unsure of before I interpret if I feel like the provider treats me as a fellow member of the care team.

4. Know that an interpretation may take longer than the original English words.

Some languages are longer than the English language to begin with, and some languages don't have direct equivalents for terms in English. For example, "hearing aid" may need to be interpreted as "a device that helps you hear better." That's potentially seven words versus two words. There are also situations where the interpreter may recognize the need to clarify some information related to the US medical culture in order to allow for understanding. An example that comes to mind may be the need to define what a medication "refill" is for a patient. The concept of refills is unfamiliar for many LEPs as it doesn't exist in some of their countries of origin. A good interpreter will clarify as necessary to try to avoid misunderstandings while also maintaining transparency throughout the whole process.

5. Avoid Using Abbreviations

Beware of using abbreviations when working with speakers of other languages. Referring to the "ENT Clinic" may be something basic and routine for most of us, but a patient who is new to the country and unfamiliar with the US medical system will likely not know what that means even if the abbreviation is accurately translated into their language. It's best to just say, "The Ear, Nose & Throat Clinic" in its entirety.

6. Utilize the Teach-Back Method

It is common for LEP patients to nod their heads and say "Yes" even when they are not actually understanding what is being said. Whenever possible, it's good practice to use the teach-back method and ask them to tell you what they understood from your conversation to see if they are truly grasping the information. And if a patient responds to something by saying, "What?", try and rephrase what you've said in a slightly different way instead of repeating the exact same thing again.

7. Be Intentional About Positioning

An interpreter who is experienced at working with audiologists and hard of hearing patients will likely recognize the need to be physically near the patient while speaking in a position where their face is easily visible. However, some interpreters may need your guidance. When in doubt, feel free to tell the interpreter where you'd like them to be during the conversation. You may also need to instruct the interpreter to speak loudly or towards a specific side of the patient depending on what you know about their hearing loss.

8. Modality: In-Person May Work Better Than Remote

It's okay to insist on an in-person or on-site interpreter instead of a remote interpreter on the phone or video. There are many challenges already in place with LEP patients including language barriers, cultural barriers, literacy barriers, and auditory challenges. Per the audiologists I work with, there are some patients where remote interpretation is just not an option due to the added challenges it presents. You may discover your communication with LEP patients is more effective with an in-person interpreter as he or she can use tactics like speaking louder or closer to the patient, enunciating more clearly or using nonverbal communication to enhance comprehension. Of note, in our hospital, the audiology clinic is considered "high priority" for in-person interpreters. As remote interpreting becomes more widely used across the healthcare system, this means that the audiology clinic is one of the designated areas that in-person interpreters are assigned to before other places. This decision was reached over time, after recognizing the challenges of achieving meaningful communication with the patient population accessing the audiology clinic. To attain an in-person interpreter, you may need to speak to whoever is in charge of interpreter scheduling at your place of employment and explain to them why

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Student Spotlight

Jessica Krause

First Year Au.D. Student, University of Minnesota

You will be completing your first year in the Au.D. program this spring, what has been the biggest adjustment for you going from undergrad to graduate school?

For me, the biggest adjustment from undergrad has been in expectations. There's a lot less doing assignments to tick off boxes on a syllabus but rather information that you are accountable for knowing to be a good audiologist. There's a lot less structured work but a lot more individual work to make sure you really understand what you need to know.

If you could take a vacation anywhere in the world, where would you go and why?

Someday when I have time and money, I really want to go somewhere I can see mountains! I grew up in Wisconsin and have lived in Minnesota the past four years and there aren't any mountains here.

You had the chance to volunteer and attend some of the sessions at the recent MAA Upper Midwest Audiology Conference. What were some of the things you found most educational or interesting about the conference?

I loved going to the UMAC conference! My favorite part about the conference was going through the expo hall and getting to try and learn about new and upcoming products, and get a chance to learn about opportunities for getting more involved in the field.

What are some of the future audiology classes or clinical placements you are most looking forward to and why?

There are two classes I am most excited for: Auditory Processing Disorders, and Balance Assessment. I am deeply fascinated with APD because it is such a unique problem and there is still so much unknown about it. I am also really excited for balance assessment because I have struggled with vestibular problems since my early teens and the testing is so different from anything else that we do. I can't wait to learn more about it!

Rumor has it you are an amazing baker, what is your favorite thing to bake? Did you teach yourself or learn from someone?

I have been baking with my grandma since I was a child so I learned a lot of techniques from her. There's always a lot of trial and error with baking new things too. As for my favorite thing to bake, that's a tough question! I mostly do "everyday baking" like bread and cookies so it's always fun to bake something special, or something fancier with a ~wow factor~.

The Interpreter *cont.*

this is important. Don't be afraid to make your voice heard and advocate for your patients. Additionally, in the event that an in-person interpreter cannot be accessed, I recommend knowing how to access remote interpreters whether that be via phone, iPad, or some other means.

And finally, don't forget, if a patient ever declines interpreter services but you have doubts about successfully communicating in English alone, you as a provider can ask for an interpreter to be present. We are there for you just as much as we are there for the patient.

Above all, remember that whether we are interpreters or audiologists we all have the same goal as members of the patient's care team. We want to have a successful interaction that leads to an optimal outcome for the patient. With a learning spirit, teamwork, and open communication, that is very achievable!

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Kristen Olivero has worked as a Spanish medical interpreter since 2013. She is currently a lead staff interpreter at Hennepin Healthcare in downtown Minneapolis. At Hennepin, she works in over 50 primary care and specialty clinics, a wide variety of inpatient units and the largest emergency department in Minnesota. She completed the Century College Translation and Interpretation certificate in 2014 and is also a nationally certified medical interpreter. She is an active member in the Upper Midwest Translators and Interpreters Association (UMTIA).

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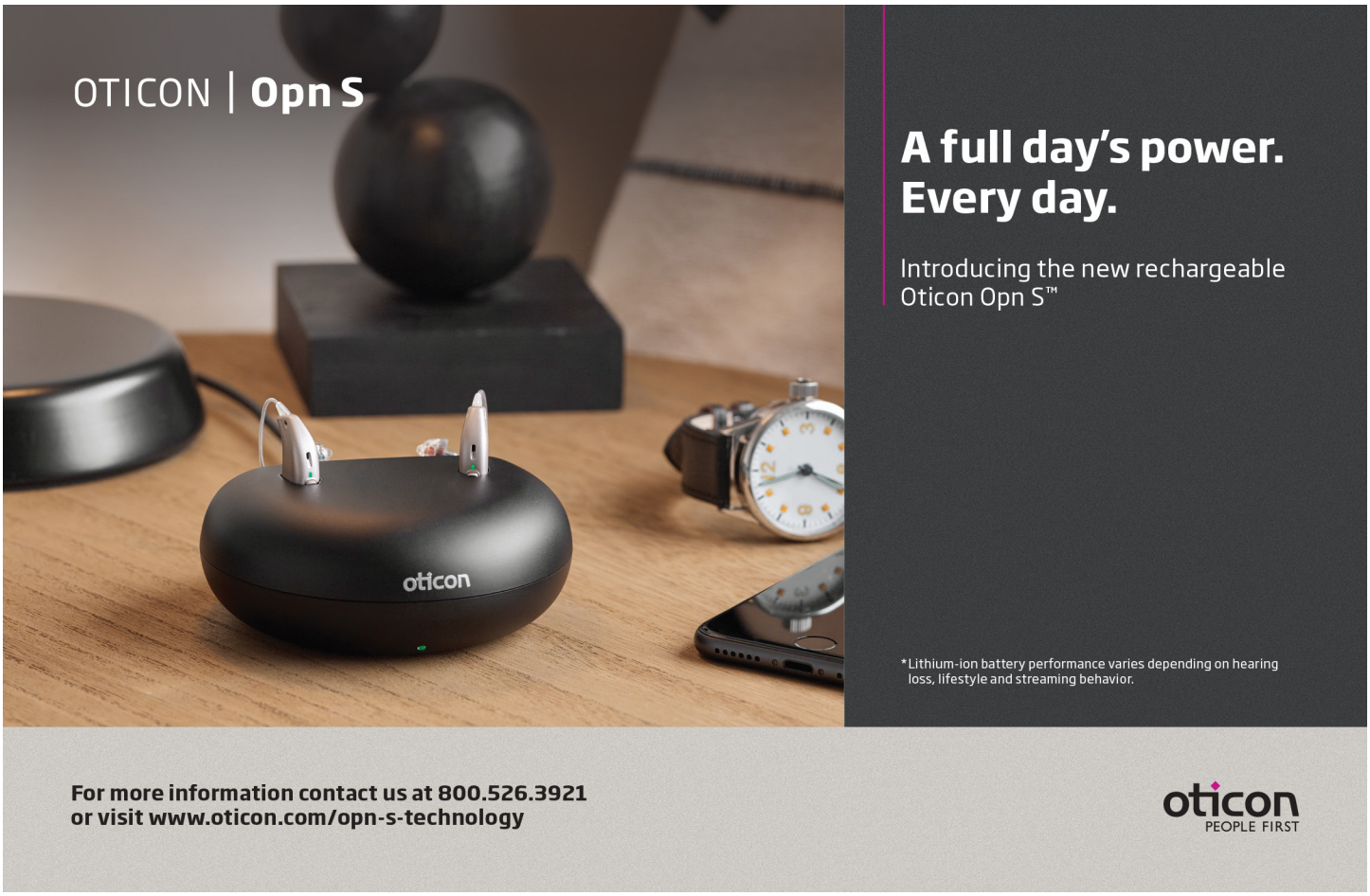

Member Spotlight

Barbara Friedman, Au.D., CCC-A

How did you become interested in the field of audiology?

I have always liked being and working with children, with my academic interest in science and math. Speech/language pathology initially seemed like a good fit for those interests. However, after taking my introduction to audiology, I realized it was the perfect balance of personal interaction and science.

What has been the most memorable/rewarding part of your career so far?

It has been a long career, with so many memorable and rewarding experiences. So, I have to name a few. One is watching the children who were implanted as babies grow and develop into amazing adults. Another is the opportunity to engage with interesting people/patients and feel I really helped make a difference in their lives. Finally, but not lastly, to come to work each day, and love what I do, love the people I serve, and love the many people/colleagues I have been gifted to work with over the years.

What advice do you have for new audiologists entering the field?

Embrace being a lifelong learner as our field continues to grow and change. Think of audiology as a calling, and appreciate each day what you do for the people you serve and what they do for you.

You are always doing exciting things outside of work, how do you make sure to find work/life balance?

Being outside jogging, biking, skiing, walking, kayaking... alone and with friends, provides the balance of my health, my community, and my happiness. I have wonderful friends and family, and my retired husband has taken up cooking. So, work is fun, and home is fun.

You celebrated 40 years with Fairview this last year, what keeps you passionate about your job?

If not daily, weekly I continue to learn new things about hearing aids, technology, and computer systems which is great at the end of the day. My patients are so interesting, that it is a joy to be in their presence, and feel just a little I have helped them. It is also amazing to continue to work with such bright and interesting colleagues.

What has been the most surprising change in the field of audiology over the course of your career?

There have been a few significant "aha moments" of new knowledge over the years. When I was an educational audiologist in Manitoba, I used to be in my car a bit, traveling between schools. I would purchase educational "cassette tapes" to listen to. Once in 1978 I was listening to some new research on what was to become cochlear implants, and thought "wow that is so cool". Twelve years later I was fortunate enough to be part of the team doing the first pediatric cochlear implant in the state. A more recent one was hearing the research on the relationship with hearing loss and dementia. It seemed profound, and it really changed how I thought about the hearing aid process.

Why are you an MAA member?

Well, that is a no brainer. I am a member because I am an audiologist in this state. MAA provides a community to support legislation, to support education, to support patients, and to support all Minnesota Audiologists. It is a fair price to pay for all this support.

Anything else you'd like to share?!

Okay you mentioned 40 years, and yes, I will retire at some point, but audiology has provided a soul to my work, and I will always remember a soul searching day, thinking about what my career should be, and I am so pleased I selected audiology.

UMAC 2020 Recap

Kristi Gravel, Au.D., CCC-A, PASC
MAA President

UMAC 2020 was themed "Advocating for Audiology" and brought together nearly 100 Audiologists and key members of the Audiology community. We were fortunate to have the generous support of sponsors and exhibitors which made UMAC 2020 possible.

We thanked **Dr. Angie Mucci,** who has served as continuing education committee chair for the past seven years, for her dedication to MAA and UMAC. In this role, she has balanced sponsors, speakers, attendees, and logistics with ease and I truly appreciate her contribution to our organization.

A total of 11 hours of CEUs were offered, including a remarkable seven Tier 1 hours. The conference began on Thursday afternoon with a 3-hour, Tier 1 presentation by **Dr. Deb Abel** on Itemizing, Billing, and Coding. Dr. Abel applauded Minnesota for our conference attendance.

She noted that a standardized benefit for hearing devices and hearing/balance services would be utopia, yet given our current reimbursement structure, every audiologist should be aware of their responsibilities with coding including taking a thorough case history which should guide one's differential diagnosis. She stressed that one's state licensure defines professional scope of practice, highlighting the importance of understanding state licensure and advocating at the local level when needed.

Friday morning kicked off with more Tier 1 hours with **Dr. A.U. Bankaitis** providing an in-depth tutorial on Cerumen Management and Infection Control. Dr. Bankaitis set the stage with the estimate that 12 million individuals seek medical care for cerumen management each year. An anatomy and physiology refresher was completed before best practices for removing cerumen were reviewed. With the current pandemic in which we are living, multiple attendees have commented on the relevance of the infection control lecture which took place at UMAC 2020.

Our Tier 1 offerings were capped off with a one-hour Ethics lecture presented by **Dr. Melissa Ferrello**, current chair of the AAA Ethics Committee and former MAA board member. As with the Trolley Problem, ethical dilemmas can exist in Audiology, yet we have guidance in our Code of Ethics to help navigate those difficult situations and the AAA Ethics committee can also assist when an audiologist has a question about professional ethics.

UMAC 2020 featured two grand rounds sessions. On Thursday evening, **Hearing Aid Grand Rounds** emphasized the necessity of completing real ear measurement and the importance of evaluating individual needs to determine rehabilitative options for asymmetric hearing loss (e.g, CROS vs. BAHA vs. conventional hearing aid). On Friday afternoon, **Cochlear Implant Grand Rounds** featured challenging cases related to candidacy and management, as well as changing candidacy requirements. Thank you to **Dr. Kristi Oeding** and **Dr. Jesi Spratt** for facilitating and our many case presenters.

The following individuals were recognized on Thursday evening **Awards and Honors** presentation:

- Outstanding Achievement in Audiology: **Carissa Kucala, AuD**
- Outstanding Service to Minnesotans Who are Deaf and Hard of Hearing: **Mary Hartnett**
- Honors of the Academy: **John Tunnell, AuD**

The Membership Development committee worked diligently to seek nominations, determine recipients, then create presentations to share the recipients's accomplishments with UMAC attendees. I absolutely love celebrating our colleagues through the annual Awards and Honors ceremony!

The **Exhibitor Hall** was held on Friday, featuring 24 valued sponsors and exhibitors, which is a record number for UMAC! Our attendees visited the booths and completed a BINGO card by having the exhibitors answer a question about their newest technology or services. Congratulations to **Dr. Gretchen Burke**, our winner of the Nescafe machine in the BINGO card drawing!

Our **annual silent auction**, facilitated by the Audiology Awareness committee,

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UMAC Recap, *cont.*

was a sight to be seen! Proceeds totaled nearly $4700 for the **Gloria Gross Scholarship**. The Audiology Awareness committee will be accepting scholarship nominations for high school seniors with hearing loss pursuing post-secondary education, the deadline of which has been extended to June 30, 2020.

We held our annual business meeting on Friday over the lunch break and received updates from each of our committees, including a summary of **Au.D. student Taylor Nelson**'s capstone project which featured State Fair hearing screening results and participant questionnaires related to hearing healthcare. Thank you to the committee chairs who presented committee updates—your work is so appreciated and allows MAA to fulfill its mission.

This year we introduced an interactive session on **Legislative Advocacy**, facilitated by **Dr. Josie Helmbrecht**. Recently, our Government Relations Committee (GRC) distributed a survey to as many audiologists as possible in Minnesota to identify the top three issues for the committee to focus on in the coming year. Dr. Helmbrecht presented that the top three issues were: 1) Licensure Portability, 2) Hearing Aid Coverage for Individuals 18 and over, and 3) Third Party Administrators (TPAs). All attendees then divided into groups to further discuss each of the issues, identifying opportunities/pros and possible obstacles/cons to each issue before bringing them back to the entire group. Thank you to our **lobbyist, Rob Vanasek**, and **David Dively** with the Minnesota Commission of the Deaf, DeafBlind, and Hard of Hearing for participating in the session.

Many of us have been disappointed by the cancellation of conferences since the COVID-19 pandemic, including the American Academy of Audiology annual conference. I am grateful that we were able to connect at the Upper Midwest Audiology Conference in February and thankful for everyone who was able to attend and participate. Plans are underway for UMAC 2021 and I hope that we will meet in person once again.

Recognizing Listening Effort in People with Hearing Loss

Matthew B. Winn, Au.D., Ph.D.
University of Minnesota

For people with hearing loss, listening is exhausting. It's not just a matter of hearing a word correctly or not – it's the uncertainty about whether a word makes sense in the context of conversation, and whether you need to "fix" the word in your head. By the time a person ponders one word, the meaning of the sentence might be gone, or the conversation might be two sentences ahead. A big part of the effort is the time it takes to understand what is heard, using context and intuition about what a person was likely to say.

The medical and economic effects of hearing loss have major impact on people's lives. People with hearing loss show increased anxiety and fatigue relating to listening, less feeling of control at work, increased need for "recovery time" after work, and increased leaves of absence from work relating to mental exhaustion. But only recently has this problem been given careful attention in the field of audiology and hearing science. The goal of this article is to raise awareness of this issue and how we can address it as audiologists.

The Long Timeline of Noticing Effort

People who experience the mental fatigue, anxiety and effort relating to hearing loss might not even notice it. For most people, hearing loss is acquired very gradually, so there isn't any single day that is much different than the last. A slow steady process of subtle lifestyle changes are made to accommodate hearing difficulty and avoid fatigue. Instead of going to a restaurant and getting frustrated with background noise, it's easier to just stay home. Instead of tidying up the house after work, it stays cluttered up because it's too tiring to walk around and clean up. Paper plates get used because they can be tossed out without spending energy washing them. Instead of speaking up about a new bold idea at work, a person remains shy because they aren't confident that they will clearly hear others' opinions of the idea. People are economical with their effort because it is a valuable resource that can't be spent feeling frustrated or anxious. They behave as any of us would. If one road has lots of traffic backups, we want to take an alternate route, so there is no traffic to complain about. The story shifts from the traffic to the planning necessary to accommodate it and find a new path.

Avoidance behaviors present a conundrum for audiologists. If the patient has adapted their life to avoid listening effort, they are less likely to notice it and thus less likely to report it to us. It's not difficult to hear at a restaurant if you chose to not go to the restaurant! So when we inquire about how hearing loss has affected peoples' lives, we could consider questions like "What situations did you once enjoy that you don't do as often?" "Are there any social situations that your friends and family enjoy, but which you avoid?" 'How much energy do you need to socialize?" And then there's my favorite question: "What do other people not understand about hearing loss?"

Why This Is Important for Audiologists

There are two main reasons why questions about frustration and listening effort are important for audiologists. The first is establishing rapport: when you understand someone's real-life challenges, they give you more trust and will allow you to help them find the right path. The second reason is that it raises the patient's own awareness of the things to track as they consider whether they could benefit from amplification. It shifts the focus from percent-correct on a word test to "did you leave the party earlier than everybody else because you were so drained?" or "after wearing these hearing aids, did you have more energy than usual after getting home from work?" This kind of feedback can help the audiologist, but also help the patient appreciate the quality-of-life factors that might otherwise go unnoticed.

Research on Listening Effort

In the Listen Lab at the University of Minnesota, we are doing research that helps explain the nature of listening effort, with the goal of developing clinically-appropriate tests. Listening effort is evaluated in the lab by measuring pupil dilation as a person listens to speech. When the speech gets harder and requires more mental energy, the pupils get larger, and remain large until the person is done thinking. By using this technique – called pupillometry – we have been able to identify some interesting patterns that might not have been noticed before.

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Listening, *cont.*

One of the most interesting findings about effort in the lab is about using context in speech. We all know that context is important – especially for people with hearing loss. But the research shows that people with hearing loss use context later in time, as if they're waiting for more information before taking action on it. The signature of this behavior is that predictable sentences with context elicit lower pupil dilation during the sentence for people with normal hearing (a sign of prediction), but generally after the sentence for people with hearing loss (a sign of mental repair). This measurement is not just about accuracy; it's about the timing of understanding. Did you use context to predict the next word? Or to go backwards and correct a mistake that was made a moment ago? Using extra effort to correct mistakes is what can build up and cause problems in a conversation. Ask someone with hearing loss how often they need to mentally correct something that they misheard – you'll get a ton of stories!

Using an "Extra Moment" When Listening

Think about how you test speech recognition with masking noise. Do you turn the noise off between trials? Do you let the listener use a moment to form their thoughts first before responding? There is no standardization. Recent research in the lab shows that some listeners with hearing loss rely very heavily on the extra moment after a sentence to re-process the speech and figure out what was said. That behavior is good if the goal is to increase a test score, but it's not going to be a successful strategy in real conversation, which would flow on to the next two or three sentences before the first one was understood.

Research shows that people with hearing loss use context later in time, as if they're waiting for more information before taking action on it.

Listen Lab director Matthew Winn and audiologist/PhD student Steven Gianakas are developing a quick clinical protocol to detect patients at risk for this inefficient type of listening. We track sentence perception scores when the sentence is followed by quiet, and also when the sentences are followed by 2 seconds of noise. If the sentence-before-noise scores are lower, then the person was relying on that extra moment to fill in the gaps and boost their score. Of course there are careful controls, language factors, randomization, and counterbalancing involved in conducting a proper test. Using those controls, we have measured the extra-moment-reliance of a few dozen people who use cochlear implants. Some of them show that upwards of 50% of their score is attributable to using the extra moment to correct mistakes! We think these are the people who score well in the clinic but struggle in everyday life.

Watch out for...

Increasing awareness of listening effort also means increasing attempts by companies to monetize effort in their advertisements, by using buzz words to stretch the truth or simply make unfounded claims. Be on the lookout for companies that scare patients into taking action on their hearing specifically to avoid cognitive decline and dementia – there is still not clear evidence that specific interventions are preventative. Companies are claiming that certain devices reduce effort, sometimes without doing actual measurements of effort. Are we sure that one product is better than any other product at reducing effort? Do we know the right way to measure it? Do we need to rely on technology to lower effort? Can we make a bigger impact by counseling better communication strategies and awareness of one's own listening tendencies? An educated and critical clinical team is necessary to protect our patients from sensational claims and to protect the clinic from being duped.

Conclusion

The goal of audiology care isn't just to improve scores on clinical tests – it is to expand the range of situations in which a person is confident and comfortable communicating. When common situations like restaurants and social gatherings are avoided because they are too effortful, it means that part of the world is shut off because it's too much of a hassle. We want to open that world back up.

Welcome New Members

Fellows
Sara Downs, Au.D.
Rondi Eggenberger, Au.D.
Jonathan Gervais, Au.D.
Jumana Harianawala, Au.D.
Carly Kempton, Au.D.
Laura Pett, Au.D.
Emily Pfisterer, Au.D.

Students
Allie Russell
Mackenzie Springman

Surviving Tough Times

Gyl Kasewurm, Au.D.

These past few weeks have proven to be extremely challenging. The world has basically shut down, millions of workers have been furloughed and many have lost their lives to the coronavirus. I have experienced my share of meltdowns wondering how and if my business would survive this pandemic, but after some research and some heartfelt discussions with colleagues, and a lot of prayer, I am absolutely convinced, "**We will Survive!"** But the real question for most business owners is "*How* will I survive this?"

It's easy to panic when you are running on emotions and don't have any facts and every action is based on uncertainty. When I am faced with doubt in business, I always return to the thing that clearly tells the story and that is the financial statistics of the business. I have become a numbers fanatic because looking at data is critical for making quick decisions and in this unprecedented time it is critical to make quick decisions that will ensure the long-term health of the business.

The only way to monitor and guide a business is by analyzing and monitoring the numbers. You will *know* what you need to do and the decisions you will need to make to keep your business afloat when you dig into the numbers. The first step is to determine both how much YOU need to survive *personally* and also how much you need to cover *business* costs.

After you know your financial needs, you will need to explore how much cash you have on hand *right now*. I'm not talking accounts receivable because you don't know when you will get that money. Payments may slow down and some insurance companies may delay payments because of a shortage of staff or whatever during this unusual time. I am a person that is filled with hope but businesses don't run on hope. You can't count on money you *may* get from loans or possible grants. Initially, just deal with the facts and that is the *cash you have on hand right now.*

The second thing to look at are the bills that need to be paid. Keep in mind some lenders, credit card companies, landlords, etc., are willing to delay payment and give you terms. Try negotiating terms if you can. I would advise not to build up debt on high interest credit cards as those fees can bury you and the business in additional debt.

If you have employees, at some point you will need to determine how long you can afford to continue paying them if little or no revenue is generated. I would suggest that you keep employees as long as you can as long as it doesn't threaten the long-term health of the business. Business is sure to pick up, but if you don't have the cash, you may need to furlough employees so you can pay expenses and/or yourself.

When assessing the financial health of the business, leverage any and all resources. Do you have any untapped funds available for marketing, etc.? Do you have a cash value in an insurance plan? Perhaps you can put the bills on a credit card and then have 30 days to pay it off without interest, but be careful. You cannot afford to rack up debt on a card that has a high interest rate. Ask your landlord for one month's free rent or at least a 10% reduction. Get rid of ANY unnecessary expenses. Do you have a line of credit with a bank? If not, perhaps it is time to get one. Banks are loaning money at low interest rates right now. Are your accounts receivable up to date? Call the insurance companies that haven't paid or rebill outstanding invoices and send statements as needed. Keep that cash flowing as long as you can.

During this shutdown, we have a captive audience. Now is the time to reconnect and communicate with patients. Call your patients and make sure you have a text or email address and ask them what method of communication they prefer. And, when you contact patients, make notes and set a recall date with specific info on their needs or concerns so when you call them back you remember details from the original call. Let them know you care about more than their hearing. Send out emails to current, previous, and TNT [Tested Not Treated] patients and let them know what's happening and what you are doing to ensure their safety when your office reopens. Send funny videos. This doesn't take skill and they don't have to be perfect. Send recipes or great apps that can help keep people occupied and busy while they are at home. Schedule Zoom meetings and virtual game nights.

Develop a marketing plan that you can apply aggressively when this nightmare is over. While we all want to attract new patients, we are never quite sure of the most cost effective way to do so and after being home, we will have to really conserve what we spend on marketing

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Tough Times, *cont.*

and make certain that the money we invest is paying off. The best place to start is embracing the way people have stayed connected during this pandemic and that is with digital marketing. While this concept may be intimidating to anyone over the age of 40, remember what you don't know, you can learn. You can view YouTube videos on the subject and read some blogs to get started.

Producing the right kind of content is an important part of effective digital marketing as content can make or break a digital marketing campaign. Probably the easiest place to start is Facebook Advertising. Dawn Heiman, Au.D., has some great resources in her Entre Audiology program.

Online reviews are extremely important to the success of a business! Think about where you gain your opinions of places to shop or where to go on vacation and online reviews usually play a part in those decisions. According to Kevin St. Clergy, owner of EducatedPatients.com, one of the most important efforts in gaining a following on social media is to accumulate positive online reviews. St. Clergy contends that online reviews are an extraordinarily powerful marketing tool for local businesses and the reviews are automatically posted on all of our social media sites. You can contact St. Clergy at kevin@medpb.com.

I recently read that good businesses will become great businesses if they use this time to transform. Life as we know it will never be the same. What new and improved services are you going to offer patients? Our patients love the curbside clean and checks we are offering and there is no reason that we will discontinue those once the office reopens. My friend and fellow Minnesotan, Dave Fabry, has been promoting the benefits of telehealth for the past 20+ years. NOW is the time to embrace the many advantages that telehealth and remote programming offer for patients and professionals. Most manufacturers and office management software have these options.

Get ready for things to reopen and for patients to be interested in ways to improve their hearing. Plan an upgrade program for all patients that have aids over three years old and promote new technology that would have helped them during the pandemic...

One of the most important things to consider is how you will make up revenue lost as a result of the shutdown. Get ready for things to reopen and for patients to be interested in ways to improve their hearing. Plan an upgrade program for all patients that have aids over three years old and promote new technology that would have helped them during the pandemic, i.e., hearing aid self checks, hearing care at home, improved connectivity, fall prevention, activity trackers, and more sophisticated noise reduction.

If you offer a service plan, call patients that don't have one and advise them that it would be a good idea to protect their investment in these uncertain times and allow patients to purchase it over the phone. If you don't have a service plan, now is a perfect time to start one. Caution, for these programs to be as profitable as possible, it's beneficial to do in-office repairs and cleanings and avoid purchasing extended coverage from an outside vendor.

This is certainly an unprecedented time that has caused major stress and uncertainty for all of us, but the bad times will end and good times will come again. People will still need to hear when this crisis ends so don't give up hope. In fact, I heard someone say that after being together so closely for so long, people will be *flocking* to our offices because their spouse is so sick of them always asking them to repeat.

So, be ready. Develop a marketing plan that you can run with when things reopen, stay connected to patients, and consider how you will transform your business to be even better and stay positive.

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Gyl Kasewurm, Au.D. started and has operated Professional Hearing Services (PHS) in Saint Joseph, Michigan, for many years. The practice is known for its innovation and is a benchmark for the patient experience. Dr. Kasewurm has served many leadership roles in the hearing healthcare arena and has thousands of followers on her DrGyl.com website where she posts blogs that focus on taking practices from Fine to Fabulous. Dr. Kasewurm has earned many awards and honors including a Distinguished Achievement Award from the American Academy of Audiology and was recently honored as a Distinguished Alumnus by the Health and Human Services Department at Western Michigan University, an honor bestowed on less than 100 of it's 18,000+ graduates. Dr. Kasewurm is a well-known author and sought after speaker and is an author of Dr. Gyl's Guide to Successful Hearing Healthcare Practices.

Follow her at DrGyl.com. Women audiologists are invited to join her Woman of Wonder Facebook community https://www.facebook.com/groups/womenofwondernetwork.

I've Referred a Child for Educational Services, Now What? (Age 3-5)

Authored by the Early Hearing Detection and Intervention Community of Practice Educational Audiologists. **Sarah Kahley, Au.D.**, is one of the authors and a long-time member of MAA.

In the last newsletter (*Minnesota Academy of Audiology Newsletter, January 2020*), we provided some information about what happens when you refer a child to the state of Minnesota Early Childhood Intervention program Help Me Grow. Help Me Grow services cover infants and toddlers up to their third birthday. To summarize the last article, Help Me Grow is the same as Part C Early Intervention serving children up to age three-years-old and being on an Individual Family Service Plan (IFSP). At the youngest ages, children are served in their homes or "natural environment" such as a child care setting. A plan is centered around the family rather than just the individual. The guidelines surrounding services for children in preschool can be interpreted in many ways, and every school district will be different in how children with hearing impairment are served at this age. This article will help with understanding what happens when the child with hearing impairment turns three-years-old, and what the referral process and services look like for children in preschool.

When a child is getting ready to turn three, the educational team must evaluate him or her for the next level of services, which are called Preschool Early Intervention, Early Childhood Special Education (ECSE) or Part B services. Part B services are provided under an Individualized Education Plan (IEP) and cover children ages three to 21-years-old; the services are now centered around the individual instead of the family. While Part C/IFSP services are usually provided year-round, Part B/IEP services are provided during the school year. For Part C services, the child can have any type or level of permanent hearing loss or a condition known to cause permanent hearing loss (such as ear canal atresia) in one or both ears to qualify for services for hearing impairment. Part B services specifically for the Deaf/Hard of Hearing (DHH) category requires specific levels of hearing loss and no longer recognizes conditions known to cause hearing loss. We must have air and bone conduction thresholds for hearing for each ear, which can be provided with Auditory Brainstem Response (ABR) testing or behavioral audiometry. Conductive hearing impairment has separate criteria from sensorineural impairment. High frequency hearing loss also has its own rule for qualifying for services. Because of the complexity of the criteria, as much medical information about the hearing impairment can be helpful in determining a child's eligibility. There are two parts to qualifying for Part B services: the first part is the audiometric data; the second part is having an academic, visual language, behavioral or technology need as related to the hearing loss. However, please refer children identified with any type, level or configuration of permanent or persistent hearing impairment. School districts have more flexibility in the preschool age group to get specialized educational services to the kids who need it.

Children who were receiving services under Part C are automatically offered an evaluation for Part B. The evaluation is typically completed by the IFSP team, but not always, depending on the district. Newly identified children ages three until about five or prior to entering kindergarten can still be referred for an evaluation for Part B services through the Help Me Grow website (http://helpmegrowmn.org/HMG/index.htm). They can also be referred directly to the school district personnel or audiologist. Many referrals come from preschool screenings. The evaluation for new referrals is similar to those who were served on an IFSP, but the team completing the evaluation is typically the preschool service team rather than the IFSP team. The team will follow up on referrals and once parents agree to an evaluation, the district has 30 school days to obtain and present results. Children aged three and older who are referred for an evaluation during the summer months will likely not be evaluated until September.

Many times, the audiologist and Teacher of the Deaf/Hard of Hearing (ToDHH) on the IFSP move with the child to the IEP for preschool-aged children. For those of you wondering, the ToDHH is a teacher who specializes in how children with hearing loss learn differently from children with typical hearing in each ear, and teaches them how to compensate and accommodate for those differences. In preschool, the ToDHH might be center-based, meaning they are the primary teacher for the preschool children with hearing impairment, and would have an early education license in order to provide traditional preschool

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Now What, *cont.*

activities and combine these with advocacy, language/communication and social skills that typically are missed by kids with hearing impairment. More commonly, the ToDHH is itinerant, meaning they travel to see each of the students on their caseload and provides education in just the skills for hearing impairment needs. For the child's regular day-to-day schooling, the ToDHH consults with the child's classroom teachers so they understand how to help the child compensate as well.

The audiologist, on the other hand, is primarily involved with access to auditory information at school. This includes all personal and school technology, and can include fitting personal hearing aids if the child does not otherwise have access to getting aids through other sources. The types of technology and services provided at school are all determined by the Part B/ IEP evaluation. Additional technology provided by the district is only for use while the child attends in-district school or services. This means that children might be benefitting from services and technology for as little as two to six hours per week. If a child has significant needs, it is not unreasonable to expect the family to also provide private services. This is also true in the birth to three age group. Other service providers might include a special education teacher for those with additional developmental delays, a speech-language pathologist, or a language facilitator (a visual language interpreter who works with young children who are not developmentally ready to benefit from a traditional sign interpreter).

IEP services are provided at no charge to families; however, preschool is not free in Minnesota. This is where differences in districts can be seen. If a child attends private preschool, the district may send the school personnel to that location to provide the necessary services. Or, the district may require the services be provided at the district's preschool education center. This could mean that a child takes a bus to school for services, parents transport their child to the special education program, or the district places the child in their preschool program for the number of days or hours per week that the child needs in order to make IEP progress. Although some districts reserve spaces for children on an IEP who can join the preschool class at any time during the school year, most districts have limited placements and those spots are filled months in advance. Furthermore, private locations are not obligated to allow district personnel into their buildings (although most, if not all, do). Parents might also be apprehensive about the district transportation. The family might send their children to a private preschool that is not in the same school district where they live. There are a variety of reasons that preschool IEP services tend to be the most variable from district to district.

There are a lot of "right" ways to serve kids with hearing impairment in preschool. The goal of all types and provisions of ECSE is Kindergarten readiness. This includes appropriate social skills, healthy emotional and behavioral interactions with adults and peers, well-developed language, and reaching developmental milestones in all areas including academics. This makes preschool a time of big transition and growth. Kindergarten can be very similar to preschool, but is a full day, every day of the week. Most children who were in ECSE are evaluated again at some point in Kindergarten, around the time they turn six-years-old. At this age, school personnel are better able to assess a child's specific academic and developmental needs. Ready to know more? The referral and service process for school-aged students will be reviewed in the next newsletter.

Scholarship Applications

The Gloria Gross scholarship application deadline has been extended to June 30, 2020. Scholarship applicants must be high school seniors with hearing loss and nominated by an MAA member. For more information and to access the application, please go to www.minnesotaaudiology.org/Scholarship.

MAA Booth at the State Fair

MAA's Audiology Awareness committee has been in communication with Kare11 and Minnesota State Fair. Final decision has not yet been made regarding the status of MAA hearing screenings at the fair this year. MAA's top priority is the health and safety of our members. Decision regarding the fair is expected in early May, please watch your emails and MAA social media pages for updates.

Coding Corner

Unbundling, Billing, and Coding

***Deb Abel, Au.D.**, Manager of Coding and Contract Services for Audigy Group, presented a two-hour session on Unbundling, Billing, and Coding at UMAC 2020. Here are some highlights from the Coding & Reimbursement Committee:*

A CPT code for VEMP testing will be coming in 2021.

- The value of a code will be determined by the pre service, the service itself, and post service. CMS can combine codes typically billed together and cut out the pre and post work to reduce the relative value unit (RVU), which reduces reimbursement. This happened with vestibular codes a few years ago.

Audiology, like radiology, needs physician orders for testing due to our status of "other diagnostic testing."

Audiologists cannot opt out Medicare if they provide and bill diagnostic services to any patient.

92700-Unlisted otorhinolaryngological service or procedure.

- Consider using this for procedures that do not have dedicated code; QuickSin, VEMPs, ASSRs, saccades, head shake, removal of non impacting cerumen, eustachian tube dysfunction testing, Frenzel goggles.
- High likelihood of denial so include specific documentation; what you did, why you did it, what you learned, how long it took, materials used, etc.

Modifiers to consider using:

- 53-Discontinued procedure: ex. ototoxic hearing test; patient gets sick and cannot continue.
- 22-Unusual procedure: ex. 92557-22 for extensive re-instruction; work greater than 25% compared to typical.
- 33-Preventative service: ex. OAE/ABR newborn screening.

cont.

Coding, *cont.*

- 52-Reduced service: ex. 92557; completed air/bone but speech testing only possible in one ear.
- 59-Distinct procedural service: ex. vestibular codes; when performing only one to three procedures of this four code bundle (92541, 92542, 92544, 92545). Include why.
- 76-Procedure performed more than once on same day of service: ex. ototoxicity monitoring.

Ototoxicity billing; need H and T code, and you need to go out to the 7th digit extension.

Go to the App Store and download ICD10 Consult. It's accurate and free.

Deb recommends billing V5011 Fit/ Orientation/checking of HA as part of your itemized hearing aid billing.

- MN Medical Assistance will not cover V5011 when billed by audiologists. You can still bill it with your dispensing fee and hearing aid V Code as part of your standard itemized billing, only that code will be denied.
- Other insurances may reimburse V5011 with RT/LT modifier for each ear.

Q&A with Deb: What is the difference between "Dispensing Fee" and V5011?

- Deb stated that she believes "Dispensing Fee" includes everything from when you are starting with a "blank slate" hearing aid and what you need to do to get the frequency response ready for patient use. And that V5011 includes the work with the patient present that follows for fitting, orientation and optimization on the day of the fitting appointment.

Consider using V5298-Hearing aid not otherwise specified for Lyric devices.

Consider using V5299-Miscellaneous services for tinnitus sound generator and BAHA fittings.

MAA Members Make Masks

MAA members Evan Maraghy, Au.D. (right) and Joscelyn Martin, Au.D. (below) show off the masks they have been sewing and donating. Evan reports having made close to 100 so far. Also shown are just a few of the 225 masks that MAA Administrator Dana Robb has sewn and given away. Are you making masks or other PPE? Post a picture on the MAA Facebook page!