Teleaudiology

April 2020

Teleaudiology, also referred to as telepractice or telehealth, is defined as the use of telecommunications and digital technology to provide access to audiological services for clients who are not in the same location as the clinician (AudA 2013). The American Speech-Language-Hearing Association (2018) identifies teleaudiology as an alternative method of service delivery for Audiologists that encompasses diagnostics and intervention services. Counselling and education for clients and their family/carers are also appropriate for teleaudiology.

Audiology Australia’s position is that teleaudiology is an appropriate model of service delivery for the audiology profession. To advance the practice of teleaudiology in Australia, Audiology Australia makes the following recommendations:

**Recommendation 1:** That the Australian Government add hearing health services provided directly by Audiologists and delivered via telehealth to the Medicare Benefits Schedule and the Hearing Services Program on an ongoing basis.

**Recommendation 2:** That Audiologists review their service delivery model and incorporate teleaudiology when appropriate to deliver person-centred services.

**Background**

Hearing loss is a common condition that affects approximately one in seven people in Australia. The prevalence of hearing loss, in the better ear, was estimated to be 3.95 million people in 2019-20 or 15.3% of the population. The prevalence of hearing loss is expected to rise to 7.78 million people by 2066 – 18.2% of the total population (HCIA, 2020).

An ageing population also places significant burden on hearing health services as the number of people with age-related hearing loss increases.

The majority of health services provided in Australia are delivered as face-to-face services in clinical environments. For Australians living in rural and remote areas, specialist medical practitioners visit infrequently resulting in long waiting times if people are to be seen in their local environment. Alternatively, patients travel long distances to be seen in a large metropolitan centre. Health outcomes of Australians who experience these barriers to accessing health care are reduced relative to their peers in metropolitan Australia (AudA 2014).

Technology provides a tool to obtain better care, better access, and ultimately a lower cost for care. The hearing health profession is adding teleaudiology and self-management as alternatives to traditional face-to-face hearing healthcare delivery. Health services that offer
value for money has been identified as a desirable outcome of integrated health care (Productivity Commission 2017).

Teleaudiology also features strongly in the future planning of all state and territory health departments. For example, Australia’s National Digital Health Strategy (2017) includes a priority outcome of digitally enabled models of care including widening access to telehealth services, especially in rural and remote Australia.

**Person-centred care**

Audiology Australia advocates that all audiological services should be delivered in a person-centred fashion (AudA 2014). Person-centred care respects the client’s preferences and values, involves family and friends, reinforces shared decision-making and goal setting, and prioritises the free-flow of information (Ida Institute 2019).

A person-centred health system puts patients first – giving more choice, control and transparency. Digital health technology will reflect the transition from provider-centred healthcare towards preventive health and personalised pathways centred on the individual; it is responsive to their needs and location, and is practically and clinically effective (DHHS 2016). Fabry and Groth (2017) explain that this empowerment of the client is resulting in clients behaving more like consumers rather than passive participants in their healthcare.

**Self-managed care**

The Productivity Commission (2017) identified an element of a successful person-centred model of care as not only giving people information that allows them to be participants in their care, but also includes the capacity for people to self-manage. Australians are already choosing to use digital apps, tools and services as the preferred way to manage their personal and professional lives (ADHA 2017). The consultation process used by ADHA in preparing Australia’s National Health Digital Strategy has reinforced the increasing expectation that Australians want to use digital apps and services to support their health and care needs.

Taylor (2018) describes self-management as “teaching individuals to actively identify challenges and solve problems associated with hearing loss”. In Taylor’s view, a primary role of audiology is to help patients become more effective self-managers of their condition. For Audiologists, providing self-management skills training could be an opportunity to offer a tangible service that stands apart from the delivery of a device.

Given many of the factors related to the affordability and accessibility of hearing care, especially in view of a savvy, ageing baby-boomer population, self-directed care is likely to gain traction within the profession of audiology (Taylor 2018).
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Audiology services in the digital age

Teleaudiology has the potential to change existing service delivery methods and the opportunity to provide audiology services to those who would otherwise not have benefited from them (Ruskbrooke & Todd Houston 2016). From a clinical perspective in developed countries, tele-audiology is a potential means to enable each service to structure a scalable and less costly service to attract more clients and achieve greater impact on the hearing health of the population (Saunders 2019). In their research into the sustainability of teleaudiology, Wade Elliot and Hiller (2012) also reported that teleaudiology is beneficial in reducing adverse events, improving health outcomes, offering increased patient choice of service delivery and improving access to services in rural areas and home care.

Psarros (2014) identified the following barriers that emerged after three years of clinical use of teleaudiology as a model of service delivery: organisational attitudes, consumer choice, reimbursement issues, equipment costs and access to remote site to deliver services.

However, Psarros reported that organisational attitudes and consumer choice have been strongly impacted by positive experiences through teleaudiology along with increased access to a range of sites. In addition, the Ida Institute publishes a range of tools that will assist audiologists in successfully implementing teleaudiology, including the selection of the teleaudiology service.

The DHHS Audiology Workforce Report (2018) reported that only fifteen per cent of audiology respondents use teleaudiology or other forms of technology for remote or virtual service delivery. However, in their survey of the attitudes of practitioners toward teleaudiology, Singh et.al (2014) concluded that practitioners were most receptive to teleaudiology for tasks related to the exchange of information (i.e., answering questions or providing counselling and aural rehabilitation), programming of hearing aids for counselling and aural rehabilitation, programming adjustments to a hearing aid, and screening activities, and for patients who are technologically-savvy, living in remote locations, or who experience mobility or transportation limitations.

The lack of recognition of and reimbursement for teleaudiology in government schemes has presented a major barrier for the widespread use of teleaudiology in recent years. For instance, while the Hearing Services Program (HSP) service items do not specifically refer to teleaudiology the Australian Government’s response to Still Waiting to be Heard stated that the HSP does not prohibit the use of teleaudiology as long as the services are delivered in accordance with its technical and clinical standards. However, it was not clear how technical and clinical standards were assessed for teleaudiology services and the HSP did not offer extra reimbursement for services delivered via teleaudiology.
In addition, while Medicare funded teleaudiology services provided by ear, nose and throat specialists to patients who live in non-urban Australia, allied health practitioners have not been eligible for Medicare services provided via telehealth. The Allied Health Reference Group Report of the MBS Review Taskforce (2018) noted that the MBS does not create the right incentives for teleaudiology and recommended the creation of a new MBS item. However, the proposed descriptor for the new MBS item was limited to services for patients consulting with an allied health professional via teleconference providing the patient had had two previous face-to-face consultations.

However, there has been major changes recently introduced to both the HSP and MBS as a result of the COVID-19 pandemic. The traditional hearing health care service delivery model has been severely disrupted due to the need to limit face-to-face service delivery wherever possible but it has also created important opportunities for audiologists who wish to provide services via teleaudiology under the HSP and the MBS.

From 16 March 2020 until further notice, the HSP has amended its service items to enable providers to continue to see vulnerable clients but encouraging them to use teleaudiology services wherever clinically appropriate and to strictly enforce social distancing and disinfecting procedures within their clinics when services must be completed face to face to minimise clinical risk (HSP, 2020).

From 30 March until 30 September 2020, all audiologists who provided services to patients under MBS Item 10952 (Patients with chronic or complex health conditions), MBS Item 81310 (Aboriginal and Torres Strait Islander patients), MBS Item 82030 (Early intervention services for children with Autism, Autism, Pervasive Developmental Disorder And Disability Services to children aged under 13 years) and MBS Item 82035 (Audiology services to a children aged under 15 years for treatment of a pervasive developmental disorder (PDD) or eligible disability) can now do so via telehealth services – video or phone (MBS, 2020). It is expected that further MBS items relevant to audiologists will be expanded to enable service delivery via telehealth in the near future.

The sudden and rapid expansion of teleaudiology services as a result of the COVID-19 pandemic has the potential to transform audiology in the longer term. While the capability for teleaudiology has existed for a long time, there has been no previous example of it being available on such a widespread scale for the audiology profession through government schemes. These changes create an important precedent for the ability of audiologists to provide clinically appropriate services remotely via video and/or phone without compromising clinical outcomes. At the same time, it also creates a new experience for clients who may have never considered telehealth as a way to receive ongoing hearing health care. While teleaudiology is currently being used as a replacement for face to face services under the HSP and MBS, the example of audiologists across Australia successfully providing these services strongly supports the idea of teleaudiology being utilised in tandem...
with face to face hearing health care on an ongoing basis to provide the best outcomes for clients and for the changes introduced as a result of COVID-19 to be made permanent.

**Recommendation 1: That the Australian Government add hearing health services provided directly by Audiologists and delivered via teleaudiology to the Medicare Benefits Schedule and the Hearing Services Program on an ongoing basis.**

**Person-centred audiological services in the future**

Technology is enabling person-centred and self-managed hearing health care. Seventy-three per cent of Australians have already used the Internet to research a health issue (ADHA 2017) and in 2018 Australians spent $21.3 billion buying goods online (an increase of 18.7% from 2017). Given these trends, clients may look to online sources for hearing solutions. This may include purchasing personal sound amplification products or consumer hearing aid devices over the Internet. There is some evidence that people will investigate buying a hearing device directly over the Internet as they do not believe that their level of hearing loss merited a visit to a professional (Fabry & Groth 2017).

In addition, technology provides a tool for clients to self-customise devices without the need for multiple office visits to successfully fit hearing devices. According to Fabry & Groth (2017), users need to try out fine-tuned adjustments in their everyday environments that are difficult to replicate in clinical settings.

The *Roadmap for Hearing Health* (2019) identified user choice as critical to individuals and their families effectively exercising choice and control. Clients will need comprehensive, balanced information and price transparency to help them make informed choices.

Given this environment and the increasing evidence that outcomes of teleaudiology are comparable to in-person care (DHHS 2018), there is an opportunity for Audiologists to consider flexibility in hearing health service delivery.

Audiologists should consider unbundling services to identify aspects of care that are appropriate for teleaudiology, such as the remote fitting of a hearing device. In particular, “the continued bundling of the costs of products (devices) with the costs of services does not ...encourage consumers to appreciate the role the Audiologist plays in assuring optimal outcomes when treatment is indicated” (AAA 2017).

The Ida Institute’s decision aid can assist in choosing between face-to-face, remote or blended (hybrid) audiological services. Considerations include:

- Outcomes that are comparable to in-person hearing services; and
- Standards for documentation, safety, equipment, settings that are consistent with all methods of service delivery in audiology.

Ida Institute’s *Investigation Guide* assists Audiologists in the consideration of the factors to successfully implement teleaudiology. These factors include patients’ wants and
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needs, hearing service provider considerations, stakeholder/partnership considerations, government requirements, and IT considerations.

Some examples of services that might be suitable for teleaudiology include an online appointment system, links to trusted websites with general information about hearing loss, an online tool or app to check hearing, phone or a video conferencing call to talk about what might be involved in consulting an Audiologist and remote programming of a hearing device.

 Recommendation 2: That Audiologists review their service delivery model and incorporate teleaudiology when appropriate to deliver person-centred services.