Hearing Loss Association of America

The Nation's Voice for People with Hearing Loss

POLICY STATEMENT

Screening for Hearing Loss in Primary Health Care Settings

According to the National Institute on Deafness and Other Communication Disorders (NIDCD), National Institutes of Health, more than 36 million Americans report that they have hearing loss, 10 percent of the U.S. population.[1] A study by researchers at Johns Hopkins University School of Medicine, which based its statistics on audiometric testings, found that one in five Americans age 12 and over, approximately 48 million people in the U.S. has a hearing loss.[2] It is also well documented that hearing loss adversely affects quality of life and is linked to other serious health conditions, including falls, depression, and cognitive decline. At the same time, access to hearing health care and the technology that could help people with hearing loss is hindered because consumers face multiple barriers which include a complex and confusing system. One such barrier is lack of screening in primary care. Reports indicate that hearing screening in primary care is uncommon, occurring approximately 17-30 percent of the time even in elderly individuals who are at risk for hearing loss.

The Hearing Loss Association of America (HLAA) supports the inclusion of a standardized approach to screening for hearing loss in primary health care settings that includes both a subjective and objective component in all adults during routine physicals; the "Welcome to Medicare" assessment; and Medicare annual risk assessments, that are accomplished in primary care settings.

Background

Hearing loss can occur at any point in an individual's life, from birth through old age. The majority of people with hearing loss are in the workforce. Hearing loss impacts communication and functional ability, and is strongly associated with decreased quality of life, cognitive decline, and depression.[3] Despite its prevalence and morbidity, hearing loss is under recognized and undertreated. It may be under recognized because it is a slowly developing problem or because of the belief that hearing loss is a normal part of aging. Under treatment might result from poor appreciation of options for hearing enhancement, or patient resistance or inability to use hearing aids and assistive

[1] National Institute on Deafness and Other Communication Disorders (NIDCD). National Strategic Research Plan: Hearing and Hearing Impairment. Bethesda, MD: HHS, NIH, 2010.
[2] Lin, Frank.; Niparko, John.; Ferruci, Luigi. Hearing Loss Prevalence in the United States. Archives of Internal Medicine 171(20): 1851-2, 2011.
[3] Yueh B, Shapiro N, MacLean CH, Shekelle PG. Screening and management of adult hearing loss in primary care: scientific review. *JAMA*. 2003;289(15):1976–1985

listening technology. Cost and social stigma are also major factors in the diagnosis and management of hearing loss[4].

According to the Ear Professionals International Corporation's (EPIC) "Listen Hear!" survey, more than 10 percent of full-time employees have a diagnosed hearing problem. Another 30 percent suspect they have a problem but have not sought treatment.[5]

According to the NIDCD, 18 percent of adults aged 45-64, 30 percent of adults aged 65-74, and 47 percent of adults 75 years or older, report hearing loss.[6] In fact, according to AARP, hearing loss is the third most prevalent chronic health condition facing seniors. Over the next 15 years, 78 million people will move into the 60+ age bracket and the incidence of hearing loss will escalate well beyond the current one in 10 affected persons.

The result of this demographic shift will place greater demands on all age-related health care issues, particularly on hearing health care. However, among adults age 70 and older with hearing loss who could benefit from hearing aids, fewer than one in three (30 percent) has ever used them. Even fewer adults age 20-69 (approximately 16 percent) who could benefit from wearing aids have ever used them.[7] In addition, data suggest there is a significant delay, ranging between 5 to 10 years, between when hearing loss is first recognized and when treatment is sought.[8]

Access to hearing health care and personal hearing technology is critical for those who need it. Numerous studies document that the economic and societal cost of ignoring hearing loss occur across the trajectory of a person's life, from a newborn's ability to acquire language, through school, to a working adult's ability to compete in the marketplace, to a senior's ability to stay engaged with their family and community.

The cost of untreated hearing loss was documented in a study by the National Council on Aging. This study, which surveyed 2,069 individuals with hearing loss and 1,710 of their family members, revealed that hearing aid users were more likely to report better physical, emotional, mental and social well-being than those who do not use hearing aids.[9] Conversely, those who do not take advantage of treatment and amplification are

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[4] Walling, Anne, Dickson, Gretchen, *Am Fam Physician.* 2012 June 15;85(12):1150-1156.
[5] Address Hearing Loss in the Workplace and Reap the Rewards, BHI Urges Employers and Employees for National Employee Wellness Month, Washington, DC, June 2, 2014. http://www.betterhearing.org/news/address-hearing-loss-workplace-and-reap-rewards, downloaded March 31, 2015.
[6] NIDCD Working Group on Accessible and Affordable Hearing Health Care for Adults with Mild to Moderate Hearing Loss. August 25-27, 2009, Bethesda, Maryland. http://www.nidcd.nih.gov/funding/programs/09HHC/Pages/summary.aspx, downloaded March 31, 2015
[7] "Quick Statistics." NIDCD Health Information. National Institutes of Health, 3 Oct. 2014. http://www.nidcd.nih.gov/health/statistics/pages/quick.asp
[8] ASHA, http://www.asha.org/Aud/Articles/Untreated-Hearing-Loss-in-Adults/ http://www.hearingcarecentre.co.uk/Info_page_two_pic_2_det.asp?art_id=6899&sec_id=3018
[9] Kochkin PhD, Sergei & Rogin MA, Carole, Quantifying the Obvious: The Impact of Hearing Instruments on Quality of Life, *The Hearing Review,* p. 13.

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likely to place unnecessary additional cost on both private insurance and Medicare. Hearing loss also impacts an older adult's ability to remain in the workforce or engage in voluntary activities which is a personal and societal loss.

Numerous studies have also linked untreated hearing loss to other serious conditions which are significant issues for people, especially older Americans who are more likely to have hearing loss. It has been demonstrated that the symptoms of depression are reduced, and quality of life improved for people with hearing loss who use hearing aids.[10] In addition, research has indicated that dementia risk might be up to five times greater for people who do not address their hearing loss.[11] Also, untreated hearing loss is connected to a tripling of the risk for falling, which is of special concern to older Americans.[12]

Value of Screening in Primary Care

A hearing screening is an initial, quick and cost-effective standard tool to determine if an individual has a hearing loss. The screening tool should include both subjective and objective components, but should not be a full hearing evaluation. When the screening reveals the presence of hearing loss, the patient should be referred for a full hearing evaluation. The purpose of the hearing evaluation is to determine the nature and degree of the hearing loss and the best treatment options.

Hearing loss is rarely screened during primary care visits. In one study, 86 percent of those who expressed clear recall about their experience in primary care said their primary care provider never asked about or assessed their hearing, nor referred them for a hearing evaluation unless it was specifically requested. Other studies support these findings. In 2005, one report estimated a screening rate among older adults to be as low as 12.9 percent. Data obtained for the Healthy People 2010 Hearing Health Progress Review indicated that only 29 percent of adults 20 -69 years of age and 37 percent of adults age 70 years or older had their hearing tested in the past five years.[13]

The important role the primary care physician can have in the identification and treatment of hearing loss was highlighted by the findings in a 2000 study that showed 63 percent of people listed their primary care physician as the most important source of information about where to go for hearing health care services.[14] Based on the results of another study, Kochkin found "that individuals with hearing loss, reluctant as they are, will listen to their doctors." He concluded that if the physician reports a positive

[10] Boi, Raffaella.; Raca, Luca; et. al. Hearing loss and depressive symptoms in elderly patients. Geriatrics and Gerontology International 12(3):440-445, 2012.
[11] Lin, Frank. Hearing Loss in Older Adults: Who's Listening? The Journal of the American Medical Association 307(11): 1147-1148, 2012.
[12] Lin, Frank; Ferrucci, Luigi. Hearing Loss and Falls Among Older Adults in the United States. *Archives of Internal Medicine*. 172(4): 369-371, 2012.
[13] National Center for Health Statistics. Preliminary data for Healthy People 2010, Vision and Hearing Objectives
[14] Hase M: Is marketing to physicians worthwhile? Results of a survey. *Hear Rev* 2000;7(4):43

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experience with hearing instruments, an individual with hearing loss will be more motivated to seek treatment for hearing loss. Kochkin further illustrated the importance of the physician's role in hearing loss identification and treatment when he reported that persons with hearing loss are eight times more likely to be positively inclined to purchase a hearing instrument if their physician has recommended one.[15]

Even in the veterans population screening rates have been found to be low. In a retrospective chart review of 250 veterans with mild traumatic brain injury, 87 percent reported some level of disturbance in daily living due to hearing difficulty, yet only 31.3 percent received a referral to an audiologist. Further, when individuals raise the issue of hearing problems with their primary care providers, their concerns and the benefits of hearing aids are often either not addressed or are discounted.

Although hearing screening is included in the components of the “Welcome to Medicare” visit, it only covers fee-for-service Medicare beneficiaries and is a one-time screening. No standardized assessment or objective assessment is recommended and a hearing evaluation is not included in the physical exam component of the evaluation.[16] Similarly, although a hearing screening is included in the Medicare Annual Wellness Assessment, it is found in the section that suggests it is adequate to use “observation” or a tool that is recommended by a professional organization. Neither screening provides a recommendation for referral. In addition, it is emphasized that these screenings are meant to focus on wellness and prevention and are not the same as any annual physical exam that the individual might have.

Referrals made by primary care practitioners have the potential to positively impact patient behavior. One survey found that persons with hearing loss were eight times more likely to consider obtaining a hearing instrument if their physician recommended one.[17] A survey of consumers’ use of hearing aids in six European countries and Japan revealed that obstacles to obtaining a hearing aid included the opinion of the physician and whether or not the physician made a referral.[18]

Basic Considerations for Screening

Standardization: Hearing loss is often an invisible condition and insidious. Because it comes on slowly, individuals are unaware of the extent of their hearing loss or, if appreciated, is denied and not reported. Because age-related hearing loss usually involves greater loss of high-frequency tones than the low-frequency sounds, older adults often complain of being able to “hear” but not “understand” speech or attribute their hearing problems to others, believing they are mumbling. Thus, merely asking a patient about hearing loss is not effective in identifying early or moderate hearing loss

[15] Kochkin S: MarkeTrac IV: Correlates of hearing aid purchase intent. *Hear J* 1998;51(1):30-41
[16] Medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html
[17] Kochkin S: MarkeTrac IV: Correlates of hearing aid purchase intent. Hear J 1998; 51(1):30-41.
[18] *The Hearing Review*, March, 2013.

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and needs to be combined with an objective and standardized screening assessment of hearing loss.

Collaboration Between and Education of Health Care Providers
Greater collaboration between primary care providers and hearing health care professionals is needed to assure coordination of care and appropriate follow-up. Currently, health care providers have little training in hearing and hearing loss. Additional educational opportunities would emphasize the importance of hearing, support the integration of hearing screening into routine care, and potentially minimize misunderstandings between health care providers and their patients which might enhance better adherence to health care regimens.

HLAA believes the goal for hearing health care must be to eliminate barriers to effective, accessible, and affordable hearing health care. The Hearing Loss Association of America supports the inclusion of a standardized approach to screening for hearing loss that includes both a subjective and objective component in all adults during routine physicals, the "Welcome to Medicare" assessment, and annual risk assessments, that are accomplished in primary care settings.

Approved by the Board of Trustees of Hearing Loss Association of America April, 2015.

Other position statements that relate to this topic include:

Wider Access to the Full Spectrum of Hearing Technology Benefiting People with Hearing Loss

Medicare Coverage of Hearing Aids and Aural Rehabilitation

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