MESSAGE FROM THE CHAIR
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Good news folks, we are finally in the latter half of 2020 (will it ever end?). Unfortunately, we are still in the midst of COVID-19, and now Florida is “winning” for the highest number of cases per day. Another piece of bad news is I didn’t buy stock in Zoom last year, but I digress. What a year!

Literally every educational meeting/training/conference was cancelled since late March, and most organizers found a way to implement a virtual alternative for attendees, many who likely would not have accessed the content otherwise. (CI2020 was the highlight for sure!) I can honestly say that I miss the in-person interaction with colleagues from around the globe, but I have enjoyed giving a few virtual international lectures while wearing my pajama pants. Fortunately, elective surgeries around the nation have picked up since May, and cochlear implantation is back on the menu at most centers. While this is terrific for our patients with hearing loss, all of us clinicians have been faced with the reality that our usual way of providing hearing healthcare is a thing of the past. Whether we like it or not, we now have a new CI service delivery model as virtual post-op CI care has substantially increased over the last several months due to the need to serve patients remotely during this global pandemic.

I don’t know about you, but here at the University of Miami we have jumped full force into virtual visits and plan to incorporate them into our CI protocols even after COVID-19 subsides (whenever that happens). Many clinics are now using virtual audiology visits with live captioning for counseling new patients prior to in-person CI candidacy testing and the patients love it. A sweet 91-year-old patient in assistive living successfully completed a telehealth visit for CI counseling with a little help from one...
of his friends and he raved about the process. A family of a 10-month-old said the virtual visits have allowed them to learn more about their child’s hearing loss and cochlear implantation while staying safe in their home with their other children. Several clinics are even programming cochlear implants remotely with great success. ACI Alliance vigorously advocated to CMS for telehealth coverage under Medicare in April and also urged that such coverage be continued once the COVID crisis is over. [https://www.acialliance.org/page/covid-19updates] Our governmental affairs counsel at the Powers firm discusses the likelihood that such coverage will be retained once the COVID crisis is over on page 6 of this issue.

When a disaster strikes, we must adapt quickly for the sake of personal and professional survival. It has been amazing to watch our field change throughout this year in response to COVID-19, and it is exciting to see what the future holds for hearing healthcare.

We were gratified when remote programming as well as other aspects of CI care were approved for appropriate Medicare beneficiaries. Virtual speech therapy sessions are routinely completed with the help of Zoom, WebX, Microsoft Teams or some other virtual platform. And, virtual IEP meetings are also working out well for schools, families, and the child’s entire CI team. The CI companies quickly introduced virtual customer service and consumer engagement outreach programs for consumers, virtual trainings and meetings with CI centers, and electronic methods of communicating with clinics to ensure consumers are back “on-air” quickly if equipment breaks. Of course, we are all still working through various obstacles with virtual healthcare (paused screens, the other party on mute, screen sharing, and the occasional visitor from the other room), but overall things seem to be moving along well.

Sometimes we get stuck in our old way of doing things and find excuses to not try new systems as it is difficult to get out of our comfort zones. When a disaster strikes, we must adapt quickly for the sake of personal and professional survival. It has been amazing to watch our field change throughout this year in response to COVID-19, and it is exciting to see what the future holds for hearing healthcare. I’m proud of this organization and each of you for your willingness to evolve as CI professionals during a time that continues to challenge us as humans.

Stay safe, everyone!
Meredith
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Plans are moving forward for our annual cochlear implant conference, which is slated to occur in Dallas (TX) April 28–May 1, 2021. You are probably wondering whether we will be able to have a physical meeting during the early second quarter of this coming year. The answer depends upon issues that are beyond our control such as whether the pandemic is active, whether Texas remains a hot spot, and whether our members will be able to travel. We simply don’t know enough right now to determine whether we are able to move forward with a physical meeting—though we certainly hope it is possible. We will make a decision in early 2021.

To address the need for safety during meetings in the current environment, we are planning for changes that would be made in the configuration of the meeting including the need for attendees to be spread out with a different sort of exhibit and poster area, modified service, and wearing of masks with social distancing and cleaning. Regardless of whether or not there is a physical meeting in 2021, there will be a virtual option (with CEUs and CME). If there is a physical meeting, we expect that podium talks would be given in person. If we need to pivot to an entirely virtual meeting, we will be prepared to do so.

With this conference, we are moving to a new process for developing the scientific program utilizing a national CI Conferences Program Committee. This new format allows opportunities for members to contribute to our conferences. Our Conferences Program Committee is geographically broad and includes representatives of wide-ranging institutions. It incorporates the diversity of training and knowledge that represents cochlear implantation including clinical care, education, and research. A listing of the committee membership is here: https://www.acialliance.org/page/ConferencesProgramCommittee

The Program Committee is especially encouraging of proposals that address how CI can continue to be provided during the COVID pandemic timeframe without sacrificing care as well as scientific papers on telehealth.
Build your knowledge + earn up to 13 hours of CE!

CI2020 Online, presented in partnership with American Cochlear Implant Alliance, explores current and emerging topics that significantly impact outcomes for adults and children with cochlear implants and other auditory devices.

“The best people in the field presenting organized and interesting information in the comfort of my living room is a recipe for an excellent conference.”

Ilana C., AudiologyOnline member

VIEW COURSES: AudiologyOnline.com/CI2020NOW

CI2020 Online includes courses from Advanced Bionics, Cochlear, and MED-EL. Courses are offered for AAA, ASHA, and AG Bell-LSLS CEUs.
CI2021 Opportunities for Students and Residents in Hearing Science

Jessica Houk MBA, Manager of Information Technology and Membership Services, ACI Alliance, jhouk@acialliance.org

American Cochlear Implant (ACI) Alliance invites students and residents with an interest in hearing loss and auditory implants to attend the CI2021 Conference on Cochlear Implants in Children and Adults. Students will receive a reduced registration rate and ACI Alliance is offering scholarship opportunities as part of a competitive process for a limited number of students/fellows. Scholarship awards will include registration, a $120 travel stipend to help offset travel expenses, and a one-year student membership in ACI Alliance. Scholarship recipients are required to attend the conference in full. If there is not an in-person conference, the scholarship will allow for a waived virtual conference registration fee. We are especially encouraging of students from diverse ethnic and socio-economic backgrounds and those with disabilities. Application forms will be available mid-August and will be due October 15, 2020.

A Student Poster Competition will be held for those enrolled in an undergraduate, graduate, residency, or fellowship program. An academic adviser or another university official must verify student/resident status. Click www.CI2021.org or visit https://www.acialliance.org/page/CI2021 to review additional details. Submission for abstracts opens August 15 and the deadline for submission is October 15, 2020. Posters will be judged on:

- Content/Poster Organization and Preparation
- Display Appearance
- Originality and Merit
- Oral Discussion/Knowledge and Presentation

Please share this information with students in hearing science at the undergraduate, graduate, resident or fellow level. https://www.acialliance.org/page/CI2021

Federal Outlook for Telehealth After COVID-19

Peter Thomas J.D., Governmental Affairs Counsel to ACI Alliance

Joe Nahra, Director of Governmental Relations

Powers Pyles Sutter & Verville PC

As the COVID-19 (“coronavirus”) pandemic has upended the provision of health care nationwide, a key pillar of the federal government response has been the proliferation of telehealth. The Medicare and Medicaid programs, along with many private payers, have greatly expanded telehealth services across many areas of care, with new authorities being granted for providers to offer a wider range of services virtually and with increased reimbursement. While many of these new policies are tied to the declared public health emergency (PHE) period, the embrace of telehealth services by the public over the past few months has made it clear that in some form, telehealth is here to stay.

Even when the threat of the virus has subsided, the shifts in the health care system are likely to remain crucial to the new treatment paradigm, and consumers who have become accustomed to the convenience of telehealth, especially for routine care and consultations, will expect to be able to receive these services going forward. However, it is also clear that both the Administration and the U.S. Congress will have to act to make telehealth a more permanent and more robust feature of American health care.

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COVID-19 and Telehealth Waivers Thus Far
Legislation enacted by Congress to date to respond to the pandemic has included significant expansions of authority for the Centers for Medicare and Medicaid Services (CMS), and the agency has broadly utilized its new powers to promote telehealth as beneficiaries are encouraged to socially distance. Telehealth is now able to be provided to beneficiaries nationwide in their homes and in any health care facility.

Additionally, all providers (including audiologists and speech-language pathologists) who traditionally bill the Medicare program are now able to provide telehealth. CMS has significantly expanded the service codes which can be provided via telehealth, including several codes relating to CI programming, speech therapy, and hearing therapy. Finally, for many of these services, CMS has temporarily standardized reimbursement rates so that telehealth is paid at the same level as in-person care. These policies and CMS’ authority to establish them will currently expire when the PHE is lifted, unless Congress acts.

Regulatory Telehealth Expansion
The declared PHE is set to expire on July 25, though Health and Human Services (HHS) Secretary Alex Azar and White House staff have signaled President Trump intends to extend the emergency period for some amount of time past that initial deadline. However, CMS and other Administration leaders have signaled that they are considering how to make some of these changes permanent. CMS Administrator Seema Verma has said that she “can’t imagine going back” and forcing beneficiaries to receive care solely via in-person visits. Similarly, Secretary Azar recently stated that telehealth is now “an embedded part of our healthcare system.”

CMS has already proposed making certain telehealth provisions in the home health payment system permanent through its Fiscal Year 2021 proposed rule, and representatives of the agency have told stakeholders that additional, permanent flexibilities should be expected in the Physician Fee Schedule and other proposed rules expected to be published later this summer, including permanent additions to the telehealth service list. However, officials have cautioned that many of the expanded telehealth policies will require congressional action in order to be extended permanently, after the PHE period has lapsed.

Expected Congressional Action
While most of the focus on Capitol Hill is on the next COVID response package (which is not expected to significantly address permanent telehealth expansion), there are already several congressional efforts underway to move towards permanent telehealth expansion. Representatives Mikie Sherrill (D-NJ) and Liz Cheney (R-WY) have each introduced bills to remove (or allow CMS to permanently waive) existing laws that restrict Medicare-reimbursed telehealth only to beneficiaries in rural or underserved areas. Additionally, several members, including Rep. Cynthia Axne (D-IA), Rep. Troy Balderson (R-OH), Rep. Robin Kelly (D-IL), and others have proposed legislation which would mandate various studies on the utilization and impact of telehealth during the pandemic, which are intended to bolster the evidence and support for further legislative expansions.

While these bills have not yet progressed very far in the legislative process, there is significant bipartisan agreement in both chambers that Congress should act to protect telehealth expansions after the PHE has passed. In fact, 38 senators in both parties sent a letter to Secretary Azar and Administrator Verma in early July commending the agency’s work thus far on telehealth and requesting a formal list of telehealth changes that will require congressional action.

Congressional action is, of course, always tentative until bills have passed, and the changing environment as the November election draws closer has the potential to impede bipartisan work on Capitol Hill; however, it seems that there is significant political will in Congress to address telehealth quickly to ensure that there are no harmful gaps in health care once the PHE is lifted. We expect that many, if not all, of the policies making up the new telehealth paradigm are here to stay in one form or another. ACI Alliance will continue its advocacy to help ensure that speech language pathologists and audiologists are included in this debate.
Veterans and Access to Cochlear Implants

Donna L. Sorkin MA Executive Director, ACI Alliance, dsorkin@acialliance.org

Veterans’ Stories
As part of our mission of expanding availability of cochlear implantation for individuals who may benefit, American Cochlear Implant Alliance is investigating issues related to Veterans’ awareness about, and access to, cochlear implant care within the VA system. We are interviewing Veterans from around the country who have been through the CI process. Nichole Westin of our staff is reaching out to wide-ranging individuals about their experiences in obtaining a cochlear implant as a Veteran. Her wonderful interviews and insights about the process can be found on our website here: https://www.acialliance.org/page/Veterans

The majority of Veterans were delighted with their care and improved hearing and readily offer to share their experiences with other Veterans. US Air Force Veteran Rick Berger could not have been more pleased: “Seriously consider getting a CI. We’re incredibly lucky to be living in an age of technology where this miracle process is available. I’m so glad I have my hearing back thanks to my implant!”

Though the experience of those we interviewed was generally very positive, some Veterans noted obstacles. In general these related to the complexity of traveling to a distant site to be able to access VA CI care, needing to self-advocate to access closer to home CI care options, referrals not occurring from VA audiologists, delays related to the availability of CI surgeons providing VA services, and in one instance VA audiology care that was not what it should have been.

If you know of a Veteran who is willing to tell their story, please let Nichole Westin nwestin@acialliance.org know. The interview process is done entirely via email and the Veteran being interviewed has the opportunity to review the final copy. These stories help us improve Veterans’ understanding of the value of pursuing a CI for themselves.

Hearing Healthcare through the VA Community Care Program
The Veterans Community Care Program (previously known as the VA MISSION Act of 2018) provides authority for covered Veterans to receive necessary hospital care, medical services or extended care from non-VA entities or providers in the community. Jerrica Maxon, an audiologist in Minot (ND), recently wrote for us explaining the program and her own experience with it as a provider at Trinity Health. Through this VA program, her hospital is able to provide hearing diagnostic evaluations, counseling, fitting and following for hearing aids, osseo-integrated devices, and cochlear implants. Jerrica provides details on the process and also how a clinic may become a provider.

When a Veteran is seen by a VA primary care physician and indicates concern about hearing or tinnitus, a referral for a hearing evaluation is initiated. A VA nurse then reviews the case and determines if a Veteran is eligible to receive services through Community Care. Eligibility is a function of nearest drive time to a VA facility that could provide care and wait time for a VA appointment. Given what we learned from Veterans as part of the Stories project, access to a VA CI clinic is sometimes an issue. To read Maxon’s full article, go to the Veterans section of the website: https://www.acialliance.org/page/Veterans
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Most issues of ACI Alliance Calling mention the activities of our State Champions and the critical work they do in the advocacy arena. More than 120 members from 41 states support ACI Alliance in establishing and implementing policy goals at the state and national levels. They address a variety of issues including early intervention, access for veterans, and insurance coverage. In this issue, instead of us talking about them, we thought our Champions could speak for themselves about why they are energetic advocates for cochlear implantation.

There is an adage that one should never know how sausages or laws are made. For Virginia’s Lori Bobsin, the reality of the process drove her to become a Champion. “Throughout the past four years, I had the opportunity to witness how bills are passed into law. Significant decisions were made regarding the lives of constituents without the stakeholders ever being made aware that life- and profession-altering decisions were being made on their behalf. Often, these decisions were made by individuals who had no idea of how they would affect lives and professions.” Bobsin joined a robust group of champions in Virginia who actively work to support the CI community by working for a Cytomegalovirus (CMV) testing bill and against passage of LEAD-K bills with problematic language that could cause problems for families who wish to make their own choices for their children.

Michigan’s Casey Stach signed on in 2013 and was one of our very first State Champions. She notes that she has also learned a great deal on how to impact the process. Casey says, “This experience has allowed me to acquire a better understanding of insurance coverage, legislative issues, and how to advocate for our cochlear implant patients at the state and national levels.” Stach is an audiologist who has found that being a Champ is an opportunity to interact with others from across the country. “Additionally, I have met some amazing professionals from all over the country who have shared their experiences with issues in their states and provided valuable information on how to overcome obstacles related to these issues.”

In Tennessee, Christine Brown was pleased to find out that changes can be made to state Medicaid programs. “Being a Champ allows us to see how other states and stakeholders are advocating to improve coverage and adopt similar strategies in their states. For example, we learned that it might be possible to advocate for Medicaid CI coverage for adults.” Nate Page in Arizona concurs; “The value of the State Champion program lies in communication: from our state to the society at large, as well as from ACI Alliance to the providers in our state. The phone calls and in-person meetings address issues that we are dealing with here and also allows us to gain insights from all over the country.”

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For our consumer and parent Champions, living their life is often the greatest testimony to the benefits of a CI. Richard Reed of Rhode Island is a recipient and musician who often talks with potential candidates and families. He says, “In general, parents and candidates won’t ask us many medical questions. They more often want to know, ‘Did the surgery hurt?’ and especially, ‘What does it sound like?’ Your firsthand knowledge offers an invaluable perspective.”

Reed also participated in a community event hosted by the RI Commission on the Deaf and Hard of Hearing to bring awareness to CI usage. “I didn’t know what to expect upon being invited to a coffee hour at the State House. I just showed up, set-up a table and took part. Organizers and attendees could not have been nicer. Thankfully, ACIA Alliance had sent along written materials to distribute, as well as lending me an ACI Alliance tablecloth for the exhibit table. If you can take the time to attend local hearing loss organization meetings and symposia, do sign up.”

When the ACI Alliance meets with Congressional staff and other policy makers, your stories personalize our discussions about the reality of working or living with a CI. But as much as Donna and I love to brag about you, it is more impactful if your elected officials hear your story directly from you. Stach makes the point better than I could: “Become a State Champion. Let your local legislators know what you do and why your services are important. If you have been wondering how to get involved, contact ACI Alliance and express your interest in becoming a State Champion. Taking an active role can leave a lasting impression for your profession.”

This year has been one that we never could have anticipated in February. The reverberations will be felt for years to come and our community will see it echo in the worlds of telehealth, early education, insurance coverage and more. Join us in raising our voices to support policies that better support not only recipients and families, but clinical practices as well. A list of our current State Champions is on our website. If interested in joining them, please contact me at nwestin@acialliance.org.

I’ll let Brown have the last word. “There are many at the state or local levels that may have the desire to advocate for change but are unsure where to start. Being a part of this group allows us to reach out to others with more experience and work collaboratively to come up with an effective plan to address such situations.”
A CONSUMER’S PERSPECTIVE

Paying It Forward to Help All Children with Hearing Loss Have a Chance to Succeed  Paige Stringer, MA, MPH

The course of our lives is greatly affected by where we are born and the opportunities afforded to us. I was born with a severe to profound hearing loss that was identified when I was 11 months old in an era before newborn hearing screening programs. I was immediately fit with hearing aids and provided with professional expertise as a baby and toddler that I needed to learn to listen and speak.

After attending an early intervention program for children who were deaf or hard of hearing, I joined my hearing peers in mainstream schools starting at kindergarten. I earned a full tennis scholarship to the University of Washington and, after graduation, embarked on a career in marketing and business development that included positions at The Clorox Company and Amazon. I later obtained a Master’s degree from the University of San Francisco and a Master’s of Public Health, Global Health degree from the University of Washington. I know that my academic and career successes and the personal fulfillment I enjoyed along the way would not have been possible without the resources and support that I received in my earliest years.

While I was a candidate for a cochlear implant, I did not make the leap to a CI until just seven years ago as an adult. I felt I was doing well enough with hearing aids and, after a lifetime of wearing them, certainly had figured out how to adapt to the world with less than optimal hearing. To trade the hearing that I was familiar with for something different, even if it was projected to be much better than my current reality, was not an easy decision. I faced the inevitable when it came time for me to upgrade my hearing aids and I was having a difficult time finding a new pair that worked for me. It was clear that another solution was warranted. I am very grateful to friends, family and colleagues who were patient and supported me in this process.

When my CI was turned on, my initial reaction was relief that the sound I was hearing did not seem to be any worse than what I had experienced with hearing aids. In the months and years since activation of my CI, my appreciation for this amazing technology has grown tremendously. All the sounds of life have become more accessible, louder, and clearer. My hearing with the CI continues to progress bit by bit over time and I am hearing better now than I ever have. I joke to family and friends with normal hearing that while their hearing may disintegrate as they get older, mine may actually get better as I age.

My personal experience with hearing loss is in stark contrast with my work experience in developing countries as the Founder and Executive Director of the Global Foundation for Children with Hearing Loss (GFCHL).

In 2008, I had the opportunity to volunteer at a school for the deaf in Vietnam. My task was to support the Vietnamese teachers as they taught English to the children. However, it quickly became clear that my mandate for being there would be much larger. Many of the professionals I met in Vietnam in 2008 had never encountered an adult with my degree of hearing loss who could communicate through spoken language, and they marveled at my ability to do so. At one point, they asked me politely to undergo a hearing test to verify my hearing loss. It was the first time in my life that I was happy to have such a horrible audiogram.

My ability to listen and speak in spite of a significant hearing loss is not unique in the more developed countries of the world. However, it was unusual in Vietnam at that time. Hope seemed to be sparked among these professionals that perhaps their commitment to figuring out how to help their youngest children with hearing loss develop listening and spoken language skills could eventually result in positive outcomes.

During my time there and in subsequent visits, the Vietnamese provided me with a broad perspective of the challenges that their professionals and families faced in helping their children with hearing loss. There was no hearing screening taking place and few early intervention programs were available. The cost of hearing technology was prohibitive for families. Audiology services were limited and expertise in speech pathology and auditory-verbal therapy was just starting to develop. The universities did not offer degree programs in these topics. Medical and educational professionals who worked specifically with children with hearing loss were hungry for more knowledge to better prepare themselves for their work.

An Asian proverb states, “one generation plants the trees, another gets continued on page 13
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the shade.” As I increased my understanding about the detrimental impact that limited expertise and support services were having on the lives of hundreds of deaf and hard of hearing children in Vietnam—as in many developing countries—I felt the impact of those gaps very personally. I understood deeply how different my life would have been had I not received the services I did when I was young. I felt empathy for these children and was compelled to help by paying forward the benefits that were provided to me. I founded the Global Foundation for Children with Hearing Loss (GFCHL) to help children in developing countries access the early identification, hearing technology, and professional expertise they need to learn to listen and speak and be able to achieve whatever goals they have for their lives.

The GFCHL is an international nonprofit organization that provides training programs in pediatric audiology and auditory-verbal practice to local medical and educational professionals in developing countries who work with children with CIs and hearing aids and their families. Our training team is comprised of professionals in audiology and auditory-verbal practice from several countries who help to develop the GFCHL training curriculum and customize the material to accommodate the culture and language of the country in which we are working.

They also travel to the countries where we have programs to contribute their time and expertise to the training effort. Participants in our training programs are prepared to train others in their own countries to make the benefits exponential and sustainable. The GFCHL also works to raise awareness with government officials, local practitioners, and families about the continuum of care from early identification to habilitation support that is required for young children with hearing loss to learn to listen and speak. We help our local partners address gaps in services across hearing health care and early intervention.

Our efforts in Vietnam over the past decade have contributed to a solid foundation of knowledge and professional expertise to support young children who are deaf or hard of hearing in that country. This strong foundation has helped the government become aware that children with hearing loss can learn to listen and speak. Today, there are many early intervention programs and audiology services for children with hearing loss in Vietnam. Children with cochlear implants and hearing aids attending mainstream schools are no longer the novelty that they were a decade ago. Perhaps in the future a governmental program will be established in Vietnam to provide families with financial support to help offset the cost of hearing technology and habilitation.

Before the GFCHL began its work in Mongolia in 2016, the government started providing subsidized CIs to families of children with hearing loss who would benefit from the technology. The Mongolian government also passed a mandate to implement a national newborn hearing screening program. However, at the time there was just one hospital in Mongolia that had the equipment to do the testing. There was also an opportunity to strengthen their audiology and auditory-verbal therapy services. The GFCHL helped the Mongolian government meet its mandate in the capital of Ulaanbaatar by providing hearing screening devices, a tracking system, and technical support which has resulted in about 33,000 babies to be screened for hearing loss each year. Additionally, the GFCHL initiated its training programs in audiology and auditory-verbal therapy for Mongolian medical and educational professionals in Ulaanbaatar. With the support of the government and other partners, both aspects of this program will be expanded to the rural areas of the country.

Increasingly, low resource countries are becoming aware of CIs and the potential life-changing benefits of the technology for young children with significant hearing loss. However, the focus is usually squared on the hearing technology and associated surgery alone. There is not enough emphasis on developing the continuum of care that is required for children to have successful outcomes with the technology.

We are fortunate to live in a time when cochlear implants are available. Programs such as those provided by the GFCHL help to lay the foundation of support services and expertise required to ensure that young children with hearing loss can take advantage of hearing technology to learn to listen and speak, attend mainstream schools, and reach their potential—no matter where in the world they live.
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