04.14—Vol.33 No.04

bulletin

American Academy of Otolaryngology—Head and Neck Surgery

April 2014—Vol.33 No.04

Out of Committee: Hearing and Equilibrium Standards for Diagnosis and Evaluation of Therapy in Meniere's Disease and More 9 & 10

Value-Based Modifier Program: How Will It Affect You? 34

Working for Better Hearing and Speech Month: Age-Related Hearing Loss 18

Building Strategy for CHEER with the World Café Model 24

www.entnet.org

Certification in Otolaryngology Practice Management

ASSOCIATION OF OTOLARYNGOLOGY ADMINISTRATORS

The AOA provides members with the opportunity to earn the Certification in Otolaryngology Practice Management (COPM) - the ONLY ENT-specific practice management certification through a formal pathway to certification. It represents the standard of excellence in today's otolaryngology practice manager.

Why did you decide to become a Certified Otolaryngology Practice Manager (COPM)?

"To prove not only to my physician employers but to myself, that I am of value in this position - that I have made certain I am the best equipped with the knowledge I need to make their business and career(s) thrive. The educational knowledge involved with successful completion of the COPM program is something that physicians respect - they know and appreciate education."

- Tricia Long, COPM
Allergy & ENT Associates
of Middle Tennessee I Hermitage, TN

"After only three years of working in the medical field, I wanted to measure where I was and what areas of managing an ENT practice I needed to continue working on. Not having a clinical background, I thought it was a good opportunity to continue learning while showing my doctors and my staff that I was fully committed to the practice."

- Mitchell Azar, COPM
ENT Associates of Johnstown
Johnstown, PA

How has becoming a COPM helped you in your role?

"Having my COPM helps me make the best decisions for our practice (big or small) using the tools that apply directly to our specialty."

- Amy Gonzales, COPM
Wooster ENT I Wooster, OH

"Becoming a COPM has helped me to feel more confident in my role as a practice manager. It has also given me valuable resources to use when I need to ask for help."

- Dana Goetz, COPM
Head and Neck Surgery of Central Virginia I Lynchburg, VA

Scan the QR Code or Visit www.AOAnow.org/COPM to Learn More and to Begin the Pathway to Success

bulletin

American Academy of Otolaryngology—Head and Neck Surgery

April 2014—Vol.33 No.04

Working for Better Hearing and Speech Month: Age-Related Hearing Loss

18

9 & 10 Out of Committee: Hearing and Equilibrium Standards for Diagnosis and Evaluation of Therapy in Meniere's Disease and More

34 Value-Based Modifier Program: How Will It Affect You?

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

David R. Nielsen, MD
Executive Vice President, CEO, and Editor, the *Bulletin*

Letters to the Editor Questions, concerns, or comments about *Bulletin* articles and other content may be addressed to the Editor via email at bulletin@entnet.org.

Article Submissions Author guidelines are online at www.entnet.org/press/bulletin/ and AAO-HNS members are encouraged to submit articles via email to bulletin@entnet.org. *Bulletin* staff will contact the author at the completion of the editorial review process for any article submitted.

Ad Index

Association of Otolaryngology Administrators ..... IFC
Olympus 3
AAO-HNSF IRT 4
Doc's Proplugs 6
Invotec International, Inc 13
Dr. Nielsen Endowment Fund 20
AAO-HNS Membership Renewal 25
2014 Annual Meeting 26
AAO-HNSF ICD-10 28
AAO-HNSF Education Coordinator ... 29
AAO-HNS Leaflets Licensing 30
AAO-HNSF Development Coord. 32
AAO-HNS/F EVP/CEO Search 37
AAO-HNSF Position Statements 43
Doc's Proplugs ..... IBC
Officite ..... BC

This advertiser index is provided for the reader's convenience and is not part of the advertising contract. While every attempt is made to provide accurate information, the publisher cannot be held responsible for errors or omissions.

05 aao-hns/f news

5 Another Species in Peril: The Otolaryngosaurus
7 The Road to Relevance
8 Your Hospital Is Planning to Close: What Can You Do?
9 Out of Committee: Hearing and Equilibrium Standards for the Diagnosis and Evaluation of Therapy in Meniere's Disease
10 Out of Committee: Medical Devices and Drugs Update on Oral Appliances for Obstructive Sleep Apnea
12 HPV: How Did It Sneak Its Way Up to Head and Neck Cancer?
13 View Candidate Videos
14 Newly Redesigned Academy Website Coming Soon!
15 ENTConnect: A Powerful New Resource for Members
17 First Live AAO-HNSF International Webcast

18 feature: age-related hearing loss

18 Working for Better Hearing and Speech Month: Age-Related Hearing Loss
21 OHANCAW: A Week to Make a Difference
24 Building Strategy for CHEER with the World Café Construct

27 legislative & political advocacy

27 A Note of Thanks to Our AAO-HNS State Trackers
28 Follow Government Affairs on Twitter

29 regulatory advocacy & business of medicine

29 It is Our Choice...
31 CPT for ENT: Changes to the Esophagoscopy Family of Codes
33 CMS Issues Changes to Defining 'Inpatients' in the Hospital Setting
34 Value-Based Modifier Program: How Will It Affect You?

38 education

38 The Ideal Learning Platform: Addressing the Learning Styles of All Otolaryngologists

40 community

40 Global ENT Outreach Trip to Cambodia
42 Orlando Annual Meeting Welcomes the World
44 Academy Represented at WHO Eastern Mediterranean Workshop

bulletin

April 2014 | Vol.33 No.04

The *Bulletin* (ISSN 0731-8359) is published monthly by the American Academy of Otolaryngology—Head and Neck Surgery 1650 Diagonal Road, Alexandria, VA 22314-2857.

Richard W. Waguespack, MD, President; David R. Nielsen, MD, Executive Vice President, CEO, Editor, the *Bulletin*; Jeanne McIntyre, CAE, Managing Editor (bulletin@entnet.org); Periodical postage paid at Alexandria, VA, and additional mailing offices. Yearly subscription included in dues of Academy Members: $27 U.S., and $52 International. Nonmembers: U.S. $55 per year; International $65 per year. Allied Health Personnel: $25 per year. Copy deadline: first of preceding month.

Changes of address must reach the Academy four weeks in advance of the next issue date.

POSTMASTER Send address changes to the American Academy of Otolaryngology—Head and Neck Surgery
1650 Diagonal Road, Alexandria, VA 22314-2857
Telephone: 1-703-836-4444.
Member Toll-Free Telephone: 1-877-722-6467.

Publications Mail Agreement NO. 40721518
Return Undeliverable Canadian Addresses to
PO Box 503, RPO West Beaver Creek,
Richmond Hill, Ontario, Canada L4B 4R6

The DIEGO ELITE MULTIDEBRIDER delivers multiple options for ENT Surgery

- Standard, Bipolar and Monopolar Blades
- Unique “Toggle Stop” and “Declog” features
- Distal suction increases visualization with fewer clogs and instrument changes
- Optimized tissue dissection for sinus, turbinate and tonsil & adenoids

For more information, please contact your Olympus sales representative at 800.773.4301 or visit medical.olympusamerica.com/diegoelite

OLYMPUS®
Your Vision, Our Future

AAO-HNS
irt industry round table

Special Thanks to Our IRT PARTNERS

We extend a special thank you to the partners of the AAO-HNSF Industry Round Table (IRT) program. Corporate support is critical to realizing the mission of the Academy, to help our members achieve excellence and provide the best ear, nose, and throat care through professional and public education and research. Our partnerships with these organizations that share this mission allow the Academy to continue to provide the programs and initiatives that are integral to our members providing the best patient care.

IRT Members

Alcon

TEVA Respiratory

IRT Associates

entellus MEDICAL

For more information on **support opportunities,** please contact:

David Buckner
Phone: 1-703-535-3718
Email: dbuckner@entnet.org

As of February 2014

AAO-HNS
irt industry round table

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

EMPOWERING PHYSICIANS TO DELIVER THE BEST PATIENT CARE

1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A. | www.entnet.org

Another Species in Peril: The Otolaryngosaurus

In the role of president of this prestigious organization, I am honored to take my turn at the tiller.

This organization conveys both a degree of power and significant responsibility to its leaders. And this has been by my participation with other members in our Leadership Forum this past month.

For those who were unable to attend, you will want to read more on the following pages by our EVP/CEO **David R. Nielsen, MD**. He addresses the intricacies and knotty issues that face our specialty this year, and outlines our strategic framework for addressing them. Developing our strategic plan is both stimulating in terms of possible initiatives and frustrating, knowing our limitations in available human and monetary resources.

One thing, however, I feel compelled to say, **the state of the American Academy of Otolaryngology—Head and Neck Surgery is strong.**

This past January, prior to the State of the Union address, I learned that the presidential speechwriter's favorite word is "strong." "Strong is a tempting word," according to speechwriter, David Kusnet. "It's simple, declarative." It has the added benefit of being accurate and it applies to AAO-HNS/F.

I can offer you a sampling of the AAO-HNS/F strengths and some examples of how you might have benefited.

Strength in Our Knowledge

Last month, one of the calls that staff took came from a Texas member who asked about licensing our patient information library. Our staff explained the depth of the library and how it is developed by clinical committees and updated to reflect guidelines and consensus statements. He was relieved and happy with the product as he sampled the content online. He felt it would address his hospital's requirement to document patient consultation as part of his participation in the Meaningful Use initiatives.

He was grateful that the Academy's product could meet his needs in such a straightforward fashion.

Strength in Our Vision

As Dr. Nielsen conveys, the matrix of AAO-HNS products and services is impressive. Many are available as a benefit of membership, including analyses of CMS regulations and Medicare physician fee schedules each year. One upcoming struggle facing all practices is just six months away.

The October 1st transition to ICD-10 will be a tremendous challenge. On that day, unlike the much-feared arrival of Y2K (the arrival of which proved anticlimactic), the way in which we do business with patients and payers really will change. Many organizations have worked, to put off this upcoming deadline which, was postponed once already. This is one of a number of practice mandates that seem to threaten us with a sense of "mass extinction," at least financially. So, will you become a member of another species in peril, the Otolaryngosaurus?

No. This Academy has been working continually to inform and prepare you, its members, for its inevitable arrival. During the 2009 Annual Meeting, I moderated a miniseminar offered by AAPC's **Rhonda Buckholtz, "ICD-9 Transition Hurdles to ICD-10 Diagnostic Coding." And such courses have continued since**. Last May, the *Bulletin* offered, "The Transition to ICD-10: Will You Be Ready?" by members, **Robert R. Lorenz, MD,** and **Lee D. Eisenberg, MD.** Dr Lorenz updated attendees at the recent BOG component of the Leadership Forum.

Richard W. Waguespack, MD
AAO-HNS/F President

Strength in the Quality of Patient Care

Last year's strategic focus was to provide members with the quality and cost measures and tools to meet the demands of stakeholders. To this end, AAO-HNSF has updated its web-based application (PQRS Wizard) for uploading measures to the CMS PQRS program with 2014 reporting changes as noted in the July *Bulletin*. CMS shows about 23 percent of otolaryngologists participating, which is similar to the overall reporting rate.

Clinical Practice Guideline and Consensus Statement development continues with the *Clinical Practice Guidelines: Acute Otitis Externa* (update), which came out this February, and *Tinnitus* which is close to publication. *Allergic Rhinitis* and *Adult Sinusitis* (an update) are in development while a Clinical Consensus Statement on Chronic and Recurrent Pediatric Sinusitis is getting underway.

AAOHNS/F strategic planning was just completed and we are integrating this into our next year's planning and budget. The goal is to balance the needs of our members and specialty with available resources to keep neither you, the member, nor the Academy from becoming an endangered species.

clear, vented

pink, non-vented

red, vented

blue, non-vented

DOC'S PROPLUGS

THE ULTIMATE IN EAR PROTECTION SINCE 1977

800.521.2982 proplugs.com

"Less cold, less Surfer's Ear."

"DPP help prevent repetitive Otitis Media after Tubes."

" DOC'S PROPLUGS are the ultimate after Ventilation Tubes."

"I'm sure glad my instructor turned me on to vented DOC'S PROPLUGS."

"Proplugs or bust, cold water and wind gives me Surfer's Ear."

"I can whack at my drums and still hear the singer."

"Less high-frequency wind & engine,can hear girlfriend's voice."

International Aquatic Trades, Inc. ~ 719 Swift Street, #56
Santa Cruz, CA 95060 831.425.5920 ext.104

The Road to Relevance

David R. Nielsen MD

David R. Nielsen, MD
AAO-HNS/F EVP/CEO

Last month, the Academy and Foundation conducted their board meetings, immediately following our annual strategic planning. These events were part of our Leadership Forum, which included our Board of Governors meetings and their associated committees, and advocacy and health policy training. Additionally, clinical practice guidelines, The Sunshine Act, practice management, and a Model Society Forum sharing best practices from our BOG societies, among others, were topics of interest. The breadth of offerings and knowledge needed for otolaryngologists to learn what's necessary to comfortably navigate the healthcare industry can be daunting.

As you can imagine, when your boards of directors meet, one of their greatest challenges is how to cover that broad range of needed information, and still maintain the focus necessary to target the highest priority issues for you, our members, and your patients.

> "Work less stressfully, more productively, and more profitably."
>
> **Harrison Coerver and Mory Byers**
> ***Road to Relevance*, p. v-vii**

For the last two years, the Academy has benefited from the personal facilitation and the published knowledge of Harrison Coerver, who along with Mary Byers, has co-authored two books for association management professionals: *Race for Relevance* and *Road to Relevance*. Following a model, which they have proposed, Academy leaders have done a lot of pre-strategic planning homework reviewing Academy and Foundation projects and processes, and creating a "forced ranking" of all our work. Just the simple tabled outline of this prioritized matrix takes almost 70 rows and 14 columns to summarize on a spreadsheet. A more detailed work plan is many times that size. Everything from products (educational, journal, quality improvement guidelines and measures, Annual Meeting programming) to advocacy services (health policy, legislative, and regulatory) to support services (humanitarian support, grants and financial services, communications, IT) and much more is part of this review.

The purpose of this critical evaluation, and the points of Coerver's books and consultative services, is to strategically maximize benefit to members. Coerver defines strategy as "the skillful, creative, and disciplined use of an organization's resources to achieve its objectives."

Like most primary national medical associations, our membership is robust and diverse in its needs, desires, and expectations. Without a systematic and disciplined process, "mission creep" expands our initiatives to the point that excellence and efficiency in critical areas are compromised to accommodate wide-ranging desires. The process of prioritizing is painful and fraught with strongly held competitive positions, passionately expressed.

Concentrating our efforts is essential to increasing our relevance to you. A famed management consultant, author, and educator, Peter Drucker, is quoted as writing, "Wherever we find a business that is outstandingly successful, we will find that it has thought through the concentration alternatives, and has made a concentration decision." He continues: "The worst thing to do is a little bit of everything. This makes sure that nothing is being accomplished. It is better to pick the wrong priority than none at all."

While we have no desire to pick the wrong priority, we agree with Drucker that it's dangerous to pick none at all. Any list of services suggested by our members, even if it contains elements that the majority of our members do not value or would not use, contains items that somebody felt was a priority. *But, when you prioritize everything, you've prioritized nothing*. Coerver writes, "[It's] better to have an honest conversation about [the] future—however difficult this may be—than not to talk at all."

Based on this facilitation, membership surveys and engagement, and board and staff preparation, including extensive review of our past strategies, products, and services, and our future challenges, we are working to advance our effectiveness and value to otolaryngologist-head and neck surgeons by:

- Building on strengths
- Concentrating resources
- Integrating programs and services
- Aligning people and processes for efficiency, and when indicated,
- Abandoning services and activities when necessary

This year you will see the Academy offering you increasingly relevant products and services, as well as opportunities for community, engagement, service, and a more satisfying professional experience. With *Road to Relevance*, we intend to focus on helping you "work less stressfully, more productively, and more profitably."

Your Hospital Is Planning to Close: What Can You Do?

Winston Churchill once said, "Nothing in life is so exhilarating as to be shot at without results." I thought of this quote one Sunday morning in 1998 when I suddenly read in *The New York Times* that my hospital was about to be closed. This news came as a shock since I had just attended a recent board meeting at which nothing of the sort was discussed. As a physician, I had been trained to take care of sick patients, teach residents, prepare research grants, and manage audiology staff, but nothing had prepared me to respond to this assault on my institution, our residents, and my livelihood.

My experience is not uncommon. Nineteen hospitals have been slated to close in New York state during the last year. The impending closures of Interfaith Medical Center and Long Island College Hospital in Brooklyn have been on the front page of every New York newspaper for the last six months. The current mayor of New York City even decided to get himself arrested last August to prove the point that hospital closures should not be taken lightly.

The social contract is that doctors train, often sleep little, and work weekends to treat patients in return for a reasonable living and job security. How else could society induce young adults to give up their youth to attend college, medical school, residency, and fellowships while taking on sizable financial debt? Closing a hospital disrupts the flow of patients, disturbs the continuity of care, displaces healthcare workers, changes residency-training programs, and removes emergency rooms, often in underserved areas. It also affects doctors and their families.

Hospital closures occur for many reasons including the economy, lack of donors, reimbursement cuts, demographic shifts, local politics, and poor judgment on the part of hospital boards. Hospital downsizing, conversions, and consolidations have been occurring increasingly alongside closures. The $9.9 billion in government sequester cuts to Medicare, increasing hospital debt, and the changes in Medicaid have also served to remove the financial net, which protected even the greatest hospitals. Additionally, confusion caused by the Affordable Care Act does not add to hospital confidence. The Office of the Actuary for the Centers for Medicare and Medicaid Services has predicted that by 2019, 15 percent of all healthcare institutions will close. The greatest challenges may occur in rural areas that are without access to major donors and have limited geographic access to patients, producing "medical deserts."

Doctors are not entirely without recourse in the face of proposed closures. Action steps that the medical leadership of the threatened institutions can take include: good planning, hard work, political action, coordination with workers and unions, and community activism. Each step can help save the day. My institution, Manhattan Eye, Ear, and Throat Hospital (MEETH), was saved by a combination of the following steps:

1. Organize the medical staff.
2. Identify donors who can raise funds for legal and public relations advice.
3. Find political allies such as local politicians or your state's attorney general.
4. Establish common ground with the employees of the hospital, who stand to lose their livelihoods.
5. Conduct outreach to the community that would lose the hospital's services. In the case of my hospital, we prepared a document about "what makes MEETH unique" so the people we spoke with would understand the impact of a closing on the blind, deaf, and disfigured.
6. Consider using the court system to challenge the closure. The permission of the state is often required for closure since hospitals use public funds for their bonds and serve the public good.
7. Develop backup plans for the residents and fellows, whose education would be disrupted.

Most importantly, physicians should get organized earlier before closure plans are even discussed to help the hospital leadership consider other business options or mergers. Physicians should think strategically of the economic risks of their institution and remember that hospital boards do not have the same "skin in the game" as we do. Unfortunately, with more doctors becoming employees of hospitals, the business acumen needed for activism and reduced independence may limit our resources to help our hospitals when they cannot help themselves. We cannot ignore signs of economic failure and must plan for downsizing and restructuring. It would be wise to remember that Churchill also said, "Courage is what it takes to stand up and speak; courage is also what it takes to sit down and [truly] listen." Call if you need help.

David R. Edelstein, MD
Chair, BOG Socioeconomic & Grassroots Committee

****Stay alert and connect: bog@ent.org***

Out of Committee: Hearing and Equilibrium Standards for the Diagnosis and Evaluation of Therapy in Meniere's Disease

Communication from the Committee on Equilibrium

The 1995 Committee on Hearing and Equilibrium Guidelines for the Diagnosis and Evaluation of Therapy in Meniere's Disease established a practical and useful framework for the reporting of results in Meniere's treatment and outcomes research, by comparing the frequency of definite attacks for the period six months before treatment compared with the interval occurring between 18 and 24 months after treatment (ref1). Class A-F results were defined, based on a comparison of the frequency of spells (see Table 1). Class F outcome was reported if secondary treatment was initiated due to disability from vertigo. As Meniere's disease has evolved from a "disease" to Meniere's syndrome, and as treatment options have changed since the initial publication in 1995, the Committee on Equilibrium has prepared this document to serve as an assessment and publication standard for current and future reporting on Meniere's syndrome.

With the advent of intratympanic therapy for Meniere's syndrome, the accurate application of the prior guidelines to reports including intratympanic therapy as a treatment was impossible, since intratympanic therapy is often performed repeatedly, dependent on symptom severity. As such, the committee suggests considering intratympanic therapies as "intent to treat" events. The patient would enter the "intratympanic steroid treatment" or "intratympanic gentamicin treatment" arm, and irrespective of the number of treatments, outcome at 18 months to 24 months could be compared to other treatments, such as medical management or surgery. Progression to a secondary treatment other than the original "intent to treat" arm would still be considered a class F event. Patients in the "intratympanic steroid intent to treat" arm would be classified as class F if they entered the "intratympanic gentamicin intent to treat" arm.

> "More information regarding the severity of attacks would be useful in evaluating therapies."

The frequency of intratympanic treatment could also be reported in any publication, and would add additional relevant detail to the evaluation of this treatment.

The committee considered whether outcome reporting based totally on frequency of attacks was an optimal strategy. The current A-F reporting guidelines are based solely on frequency of attacks, are in wide use, and have been a standard of comparability in the literature. However, more information regarding the severity of attacks would be useful in evaluating therapies.

The committee recommended the following five-point scale of daily vertigo severity, with acknowledgement that other daily vertigo severity scales are also in use:

- 0—No vertigo.
- 1—Mild attack—brief episode of vertigo lasting less than 20 minutes and/or vague sense of disequilibrium lasting less than two hours.
- 2—Moderate attack—vertigo lasting between 20 to 60 minutes and/or disequilibrium lasting greater than two hours with reduction in daily activities from 0 percent to 50 percent.
- 3—Severe attack—vertigo lasting more than one hour with or without accompanying nausea and vomiting, with or without lingering disequilibrium lasting greater than two hours with reduction in daily activities. between 50 percent to 100 percent.
- 4—Extreme attack—vertigo lasting more than one hour with nausea and vomiting and persistent lingering severe disequilibrium requiring bed rest the entire day.

Table 1. 1995 AAO-HNS Classification Description

Numerical Value	
0	Class A
1-40	Class B
41-80	Class C
81-120	Class D
>120	Class E
Secondary treatment initiated because of disability from vertigo	Class F

The numerical value is the ratio of the average number of vertigo spells during the pretreatment period divided by the average number of vertigo spells for the same number of months at the end of the reporting period.

Class A indicates complete control of definite spells.

References

1. Committee on Hearing and Equilibrium guidelines for the diagnosis and evaluation of therapy in Meniere's disease *Otolaryngol Head Neck Surg* 1995:113:181-5.
2. Monsell, E. New and revised reporting guidelines from the Committee on Hearing and Equilibrium *Otolaryngol Head Neck Surg* 1995;113:176-8.

Out of Committee: Medical Devices and Drugs Update on Oral Appliances for Obstructive Sleep Apnea

Ofer Jacobowitz, MD, PhD
ENT and Allergy Associates
Assistant Professor, Mount Sinai School of Medicine
and
Anand K. Devaiah, MD
Associate Professor, Departments of Otolaryngology, Neurological Surgery, and Ophthalmology
Boston University School of Medicine and Boston Medical Center

Obstructive Sleep Apnea (OSA) is a highly prevalent disease, associated with cardiovascular morbidity, mortality, and reduced quality of life. While Positive Airway Pressure (PAP) is efficacious for resolving the airway obstructions that define OSA, many patients are unable to adhere to PAP therapy. Surgical reconstruction can reduce the Apnea Hypopnea Index (AHI), improve quality of life and survival, but many patients defer surgery. Oral appliance therapy has emerged as an efficacious, non-invasive treatment modality for OSA, often preferred to PAP.

Oral appliances that advance the mandible have been shown to be effective for OSA treatment. The mechanism of action includes upper-air dilation and stabilization that occurs via tongue advancement and pharyngeal wall lateralization. In recent studies, oral appliances effectiveness was demonstrated for reduction of the AHI and sleepiness, improvement of quality of life and driving performance, and cardiovascular event reduction, even for those with severe OSA (Anandam, *Respirology* 2013; Doff, *Sleep* 2013; Holley, *Chest* 2011; Phillips, *AJRCCM* 2013). Clinical outcomes were comparable to those achieved with CPAP but AHI reduction was greater with CPAP therapy.

New Technologies

Two recent technologies may improve outcome for oral appliance therapy. A limitation of appliances for OSA is that the optimal mandibular advancement distance for a patient is not known. Thus, to test treatment efficacy, the patient usually undergoes a polysomnogram or home sleep study once symptoms improve at a given advancement setting. If the result is inadequate, the test may need to be repeated after further adjustment. For some appliances and in certain sleep centers, during the sleep study the technician enters the room and advances the appliance once or twice to determine the better position. Thus, efficacy is determined only *after* appliance delivery and somewhat imprecisely. A device called MATRx (Zephyr Sleep Technologies) was developed for use at the sleep center, advancing the mandible using an oral tray that stays in the patient's mouth during sleep. The device is remote-controlled to advance the mandible in fine increments in order to determine the precise protrusion distance for efficacy and whether jaw advancement would be effective at all, prior to production of a costly custom-fitted appliance.

The assessment of oral appliance therapy has also been limited by the absence of *objective compliance monitoring*. Objective monitoring is now available. A tiny data-recording device that attaches to an oral appliance, called DentiTrac (Braebon Medical), allows for assessment of compliance using temperature and position sensors. The manufacturer states that extensive anti-deception algorithms are utilized in data processing so that, for example, placing the device in a bath would be detected. Additional companies are seeking approval at present for other compliance monitoring devices. Compliance monitoring for oral appliances may increase their acceptance as an OSA treatment modality by the transportation industry that requires adherence monitoring for its drivers.

Coding

Commercial insurance carriers usually cover treatment of OSA with oral appliances. Most policies allow for oral appliances to be used as primary therapy, based on patient preference over CPAP, for patients with mild to moderate OSA, as defined by an AHI between five and 30 events per hour. For patients with severe OSA, as noted by AHI >30/hour, CPAP must be tried first, but oral appliances are usually covered for CPAP intolerant patients.

Oral appliances may be billed under two HCPCS codes: E0485 and E0486.

E0485 is used for prefabricated, commonly thermoplastic appliances, which are heated and molded to the patient's dentition in the office. The CMS definition is below:

"A prefabricated oral appliance (e0485) is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated oral appliance may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom-fitted). Any appliance that does not meet the definition of a custom-fabricated oral appliance is considered prefabricated. E0485 is used for all prefabricated oral appliances used for the treatment of OSA including, but not limited to, mandibular advancement devices, tongue positioning appliances, etc."

E0486 is used for a custom-made appliance, laboratory manufactured for a specific patient. This appliance requires taking dental impressions for production and after production is custom-fitted in the office. The CMS definition is below:

A custom fabricated oral appliance (E0486) is one that is individually and uniquely made for an individual beneficiary. It involves taking an impression of the beneficiary's teeth and

making a positive model of plaster or equivalent material. Basic materials are cut, bent, and molded using the positive model. It requires more than trimming, bending, or making other modifications to a substantially prefabricated item. A custom fabricated oral appliance may include a prefabricated component (e.g., the joint mechanism).

The Otolaryngologist's Role

A qualified otolaryngologist can take impressions, fit, and bill for an oral appliance with most commercial insurance carriers. For CMS, however, when oral appliance therapy became a covered service in 2012, language was introduced specifying that the appliance needs to be provided and billed for by a licensed *dentist (DDS or DMD).* CMS covers oral appliances for treatment of OSA in patients with mild OSA (AHI five to15) who have symptoms or cardiovascular comorbidities, for patients with moderate OSA (AHI between 15 and 30), and for those with severe OSA (AHI>30) if CPAP is not tolerated or contraindicated.

The device needs to be "ordered by the treating *physician* following review of the report of the sleep test." There is a 90-day global period for fitting any adjustments. Oral appliances fall under the DME category.

When a qualified otolaryngologist provides the oral appliance for an OSA patient with a commercial insurance policy that covers oral appliance therapy, patients will usually be able to afford oral appliance therapy. Most dentists do not take commercial insurance as payment or do not participate with CMS, thus patient access to this therapy is often limited due to prohibitive cost.

Otherwise, the otolaryngologist can collaborate with a treating dentist. Patients who use oral appliances need to have a patent nasal airway, as the appliance obstructs their oral airway. The otolaryngologist can assist by optimizing the nasal airway for therapy.

FDA Approval

There are more than 70 FDA-approved oral appliances. Unfortunately, the device code LRK, "Device, anti-snoring,"

includes devices for both treatment of primary snoring and OSA. It is therefore important to check a given oral appliance's approved indications prior to use. Oral appliances are not FDA-approved for use in severe OSA, and thus their use for severe OSA patients would represent an off-label use.

One can check a given device for FDA approval status at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm, or obtain a list of devices where their indications may be checked by searching the web page under product code "LRK" and "LQZ."

Disclosures: Dr. Jacobowitz is an otolaryngologist who is board certified in sleep medicine. He does not have any commercial or competing interests in the devices mentioned above. Dr. Devaiah does not have any relevant disclosures to the topic above.

This is another in a series of articles being produced by the Medical Devices and Drugs Committee, written by committee members, consultants, and invited guests for the AAO-HNS membership. Do you have a question or topic we can address, which may fall under the committee's charge? Do you have a comment about an article? Email our coordinator, Harrison Peery, at hpeery@entnet.org and the chair, **Anand Devaiah, MD,** at anand.devaiah@bmc.org, with the subject line "MDDC question/article," so we can identify and answer your query. We may ask your permission to publish your note, in anonymous or edited form, if it becomes the inspiration for a *Bulletin* article.

HPV: How Did It Sneak Its Way Up to Head and Neck Cancer?

Mathieu Bergeron, MD

For information: Laval University, Department of Otolaryngology–Head and Neck Surgery, 1050, avenue de la Médecine, Pavillon Ferdinand-Vandry, bureau 4889, Quebec, QC, G1V 0A6 Canada. mathieu.bergeron.10@ulaval.ca

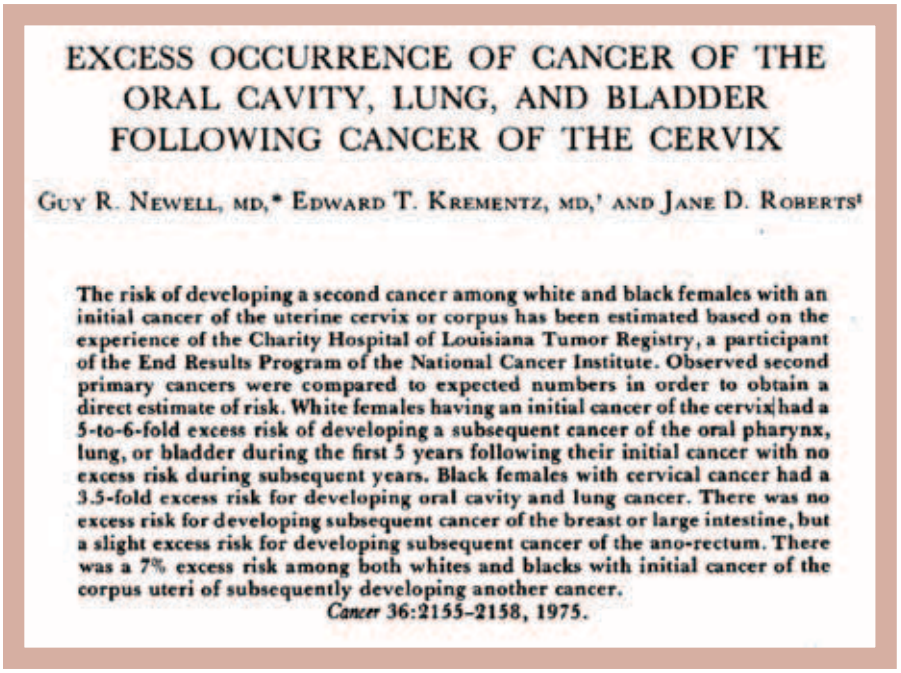
Human papillomavirus, commonly known as HPV, is a topic of great interest in head and neck oncology. Who could have guessed that this virus would have such an impact, from simple human warts to oral squamous-cell carcinoma?

At the end of the 19th century, an infectious pattern of transmission for human warts was discerned. The same transmission pattern was then suspected in the head and neck with laryngeal papillomatosis.[1] In 1983, after many teams of scientists partially defined the double-stranded virus responsible for this spectrum of disease, Harald zur Hausen, MD, a German scientist and virologist, refined the research and described the now famous HPV 16.[1] This scientist would later win the Nobel Prize in 2008 for his discovery of the role of HPV in cervical cancer.[2]

In otolaryngology, Newell and colleagues are considered one of the first teams to mention a link between a virus and head and neck cancer.[3] In 1975, their paper in *Cancer* claimed an increased risk for women with cervical cancer to later develop oral cancer.[3] However, in the early 1980s, it was Syrjänen's team that first presented evidence on the involvement of HPV infections in both laryngeal and oral carcinogenesis.[4] This was prompted by the discovery of morphological similarities between oral and cervical squamous cell lesions.[4]

Interestingly, HPV infection was first held responsible for the development of head and neck cancer in certain individuals who lacked the classical risk factors for this disease.[1] Today, HPV could be considered by many clinicians as a distinct subgroup of head and neck cancers. With the introduction of HPV vaccine for prevention of cervical carcinoma and anal cancer, head and neck cancer is now the next target of choice. What does the future hold for HPV treatment?

Harald zur Hausen, MD



EXCESS OCCURRENCE OF CANCER OF THE ORAL CAVITY, LUNG, AND BLADDER FOLLOWING CANCER OF THE CERVIX

GUY R. NEWELL, MD,* EDWARD T. KREMENTZ, MD,† AND JANE D. ROBERTS‡

The risk of developing a second cancer among white and black females with an initial cancer of the uterine cervix or corpus has been estimated based on the experience of the Charity Hospital of Louisiana Tumor Registry, a participant of the End Results Program of the National Cancer Institute. Observed second primary cancers were compared to expected numbers in order to obtain a direct estimate of risk. White females having an initial cancer of the cervix had a 5-to-6-fold excess risk of developing a subsequent cancer of the oral pharynx, lung, or bladder during the first 5 years following their initial cancer with no excess risk during subsequent years. Black females with cervical cancer had a 3.5-fold excess risk for developing oral cavity and lung cancer. There was no excess risk for developing subsequent cancer of the breast or large intestine, but a slight excess risk for developing subsequent cancer of the ano-rectum. There was a 7% excess risk among both whites and blacks with initial cancer of the corpus uteri of subsequently developing another cancer.

Cancer 36:2155–2158, 1975.

References

1. zur Hausen H. Papillomaviruses in the causation of human cancers—a brief historical account. *Virology.* 2009;384(2):260-265.
2. Nobel Media AB. Harald zur Hausen—Facts. Nobel Prize website. 2013. http://www.nobelprize.org/nobel_prizes/medicine/laureates/2008/hausen-facts.html. Accessed December 19, 2013.
3. Newell GRet al. Excess occurrence of cancer of the oral cavity, lung, and bladder, following cancer of the cervix. *Cancer.* 1975. Dec; 36(6):2155-2158.
4. Syrjänen KJ, Pyrhonen S, Syrjänen SM, Lamberg MA. Immunohistochemical demonstration of human papilloma virus (HPV) antigens in oral squamous cell lesions. *Br J Oral Surg.* 1983;21(2):147-153.

View Candidate Videos

The Academy is proud to announce the release of its presidential candidate videos. Our 2014 presidential candidates, Susana Chandrasekhar, MD, and J. Pablo Stolovitzky, MD, sat down with us to answer two tough questions about adapting to the changing healthcare reform landscape and their vision for the Academy. Each interview is 90 seconds long and can be found at http://www.entnet.org/candidates.

Take a quick break and watch both videos today.

Newly Redesigned Academy Website Coming Soon!

AND FIVE REASONS YOU'LL WANT TO USE IT EVERY DAY

Your Academy provides a wide array of resources to help you achieve excellence and provide the best ear, nose, and throat care. As a busy ENT professional, you want to take advantage of these resources how, when, and wherever you want.

With that in mind, we are proud to announce that a newly redesigned Academy website is coming soon. Enhanced functionality will offer quick, easy, and customized access to the tools necessary for advancing professional development, managing your practice, and finding opportunities to become more engaged.

The proliferation of mobile devices has forever changed the digital landscape and allows new opportunities for access to the many Academy resources you need in today's healthcare environment. Whether you're in an office, home, on the road, using a desktop, using a touchscreen tablet, or on a smartphone, you need access to the resources that support your being an exceptional ENT professional. And now you'll be able to access the tools you need faster and easier through a top-down redesign of entnet.org.

Using member interviews and survey results, best-practice and technology research, and a thorough examination of content, navigation, analytics, and design, the Academy has partnered with Social Driver, an award-winning digital innovation agency, to deliver an intuitive and engaging new website. Here are five reasons you'll be coming to entnet.org every day:

1. Responsive Design

We have built the site using responsive design, a technology that allows entnet.org to display consistently across all screen sizes—smartphone, tablet, laptop, or desktop; Apple, Android, Windows, or Blackberry. Gone are the days of pinch and zoom. Responsive design offers a seamless interface on all devices.

2. Intuitive Navigation

Based on your feedback, we've completely restructured the way content is organized on the site, using an occasion-based navigation system. Instead of wondering where to find the content you're looking for, you'll be guided to the resources you need based on the most common actions of entnet.org visitors. So whether reading a Clinical Practice Guideline or accessing ICD-10 coding materials on your smartphone, taking Academy U professional development courses on your laptop, or sharing health information with patients on your tablet, you get the same optimized user experience.

3. Single sign-on

One password and done. The new site requires a single login for the website, the *Journal*, *Bulletin,* and ENTConnect member portal without having to re-enter your credentials.

4. Search

Our new and improved search function will help you find the resources you need faster than ever before. You'll be able to drill down into exactly what you need by filtering results based on Resource Type, Clinical Condition, Anatomy, and Subspecialty. More of our resources will be indexed so that you won't need to go to different areas of the site to find what you are looking for.

5. Sharing

Social sharing is built in to our resources so that you can easily pass along a helpful link to patients or other office administrators.

We look forward to sharing the new site with you and continuing to provide more value to you as Academy members.

ENTConnect: A Powerful Resource for New Members

We are living in the Digital Age. Content and relationships have never been more accessible yet complex. Valuable content and meaningful relationships have been buried under a bevy of baby pictures, nonsensical memes, and "silly-cat" videos. In order to better serve the growing needs of our members and to make relevant use of digital communications in a trusted environment, the American Academy of Otolaryngology—Head and Neck Surgery is proud to introduce ENTConnect!

Q: What Is ENTConnect?

A: ENTConnect is a brand new private online social network exclusively for members of the American Academy of Otolaryngology—Head and Neck Surgery. This private environment will bring Academy members together to; converse with colleagues, collaborate on committees, share news, spread information, establish new contacts, and strengthen current connections.

Q: Why Does the Academy Need a Social Network?

A: While the main website for AAO-HNS is filled with useful content and information, members of the Academy have expressed the need to engage with fellow members and connect with staff. To respond to and fulfill this need, we have created ENTConnect. This new platform contains tools that will help you better manage your Academy membership, network with colleagues, and keep on top of the latest news and information. ENTConnect will continue to grow organically to fill the needs of our members and of the Academy.

Q: How Is ENTConnect Different from Facebook, LinkedIn, or Other Social Media?

A: Digital interactions are spreading over an increasing number of websites.

ENTCONNECT
ENGAGE • NETWORK • TRANSFORM

7 Helpful Hints for a Successful Social Media Presence

1. Add a Profile Picture—This will make your profile look professional and allow other users to know whom they are talking to and encourages better response.
2. Contribute—An online community is about people, not the platform or tools. Adding to the conversation increases your reputation and strengthens the community. A robust discussion makes the online community more enticing for new people to participate and enhances the overall experience.
3. Keep It Brief—Posting concise questions or answers increases the likelihood that someone will take the time to read and respond. Over-posting or consistently posting unnecessarily lengthy questions and comments will wear down your audience. People may even start skipping over your posts.
4. Don't Forget to Respond—Reciprocity matters! If someone messages you or posts a response, make sure to reply. They are expecting it just as you would.
5. Think before You Post—It is important to consider the negative impact a post could have. Always remember that whenever you post something on the internet that you not only represent yourself, but also your practice or institution and the specialty as a whole.
6. Offer Value—Offer succinct and timely information that may help others, as well as your personal experiences and knowledge, but refrain from promoting yourself or your own business.
7. Be Consistent—Visit ENTConnect on a regular basis. Just as you need to consistently check in with your professional and personal offline communities, you're more likely to benefit from the discussions and make connections in your online communities when you visit regularly.

Logins and privacy have become complicated with this proliferation of social networking sites. Furthermore, popular sites e.g., Facebook and Twitter) are open to everyone—family, friends, patients…everyone.

ENTConnect eliminates the need for multiple social media accounts, it allows Academy members and staff to communicate and collaborate on issues that affect the specialty on one, private platform. This also helps to simplify your privacy concerns by putting your digital interactions behind a member-exclusive password protected platform.

Q: How Will ENTConnect Benefit Me?

A: If you had to find someone that knows what you need to know, where would you go? ENTConnect helps you find colleagues who might be able to provide answers to your questions. The discussion boards allow you to draw upon the knowledge of a global organization to support your practice and expand your knowledge. It will also be easy to enhance your reputation within the ENT community by participating and answering others' questions and sharing your experience.

ENTConnect will also allow you to better manage your Academy experience. All of your contact information is now stored in one place where you can view and update, control the privacy settings, and search for fellow colleagues. Committees will now have one place to go for all of their documents and conversations. This will cut down on searching through months of old emails and will help bring new committee members up to speed faster.

Q: How Do I Join ENTConnect?

A: As a member of the Academy, you will have access to the site as a part of your membership, there is no need to sign up separately. When the site officially opens, you will simply need to log in with your existing Academy ID number and password.

Q: When Can I Start Using ENTConnect?

A: Working on feedback from its members, the Academy staff has been hard at work enhancing the Academy's online experience, including a complete overhaul of the AAO-HNS homepage, www.entnet.org. We look forward to introducing both in May.

This past December, several AAO-HNS/F Committees and Task Forces assisted the Academy by participating in a beta test of ENTConnect. Their feedback and insights have been invaluable in helping to prepare ENTConnect for the upcoming release.

A special thank you to:

- The Board of Directors
- BOG Executive Committee
- BOG Rules and Regulations Committee
- BOG Socioeconomic & Grassroots Committee
- Education Steering Committee
- Ethics Committee
- Executive Committee
- Humanitarian Committee
- Nominating Committee
- Plastic and Reconstructive Surgery Committee
- SRF Governing Council
- Surgical Simulation Task Force
- Young Physicians Transition Task Force

First Live AAO-HNSF International Webcast

J. Pablo Stolovitzky, MD
Regional Advisor for Latin America, International Steering Committee

The Academy is the world leader in otolaryngology and it has become so through education and through the AAO-HNSF Annual Meeting & OTO EXPO℠, which is the largest gathering of otolaryngologists in the world.

As a result, the meeting is held in high regard in the international otolaryngologic community due to the excellence of the activities—particularly educational and research—that it has presented during the last several decades.

With a goal of broadening the Academy's outreach on global education, we successfully launched the first International webcast to more than 350 participants in 20 countries at the 2013 Annual Meeting & OTO EXPO℠ in Vancouver, Canada.

The growing demand for knowledge that exists in many emerging countries—coupled with their often limited capacity to adequately fill that gap—offers the Academy an opportunity to serve as a global forum and to foster worldwide education.

> "We broadcasted live one miniseminar and four instructional courses, allowing otolaryngologists abroad to actively participate and ask questions."

The first live AAO-HNSF International Webcast in progress.

The first live International webcast of the Foundation's Annual Meeting supports the strategic goal of collaboration and participation to advance our knowledge base to a world forum.

In addition to supporting the first live webcast and other innovations with the Annual Meeting, Scientific Program Coordinator **Eben L Rosenthal, MD** and Instruction Course Coordinator **Sukgi Choi, MD** are overseeing a comprehensive review of the meeting to ensure its continued relevancy far into the future. Plan now to join us in Orlando, September 21-24, 2014. Watch for the preliminary program insert in the May *Bulletin*.

Interested in Our History?

- Join or renew your membership in the Otolaryngology Historical Society (OHS). Check the box on your Academy dues renewal or email museum@entnet.org.
- Save the date for the OHS annual meeting and reception: 6:30 pm-8:30 pm, September 22, in Orlando, FL.
- Present a paper at the OHS meeting. Email museum@entnet.org. The deadline is May 15.

Working for Better Hearing and Speech Month: Age-Related Hearing Loss

Michael S. Harris, MD and
Douglas D. Backous, MD
AAO-HNS Hearing Committee

The American Academy of Otolaryngology-Head and Neck Surgery Foundation works collaboratively with members and with other organizations to improve awareness, to promote public policy, and to advocate for people with hearing loss in the United States. The AAO-HNSF helped support an evidenced-based workshop on "Hearing Loss and Healthy Aging" hosted by the Institute of Medicine (IOM) and the National Research Council (NRC) held in Washington, DC on January 13-14, 2014.

Frank Lin MD, PhD of Johns Hopkins University School of Medicine and Alan Jette, PhD of Boston University School of Public Health and acted as co-chairs of the workshop. Otolaryngologists, neurotologists, audiologists, and industry and consumer representatives held open forums to: (1) characterize the public health impact of hearing loss and the relationship between hearing loss and healthy aging, (2) discuss the range of hearing needs and the current array of hearing rehabilitation strategies, (3) identify areas of needed research and opportunities to explore innovative technologies and barriers to their use, and (4) consider collaborative strategies that can be adopted to identify hearing loss and intervention strategies.

A Growing Public Health Issue

The prevalence of hearing impairment doubles with each decade and is reported to affect two-thirds of adults over 65 years and 80% of adults over 80 years.[1] The significance of Age-related hearing loss (ARHL) has historically been minimized, viewed as a normal "part of aging," and the subject of considerable social stigma.[2] Current insight into the intimate relationship between hearing health and healthy aging, together with rapid progress in technology and wireless connectivity, and an aging global patient population have catalyzed a major change in this view.

Despite the high prevalence of ARHL, hearing aids are only used by approximately 14% of those suffering from ARHL. Lack of awareness among health professionals of the role of hearing as a determinant of healthy aging and of the treatment options beyond traditional hearing aids, the insidious nature of ARHL progression, and the lack of third party coverage for hearing healthcare services contribute to this low rate of access to comprehensive hearing loss treatment.

The Connection between Hearing Health and Healthy Aging

Evidence amassed from longitudinal and cross-sectional studies demonstrates that ARHL has implications extending far beyond traditional domains of speech and environmental awareness. Kathy Pichora-Fuller, PhD, Professor of Psychology and Audiology at the University of Toronto explained that many individuals with ARHL avoid the cascade of frustration associated with conversational speech in challenging auditory environments such as family gatherings and public meeting places by social withdrawal and isolation correlating strongly with depression.[3]

Neurotologist and AAO-HNS member Dr. Lin presented his compelling data showing that older adults with ARHL expend a greater amount of cognitive resources to decode a very impoverished

auditory signal. Coupling this higher cognitive load with social isolation and direct changes in brain structure imparting functional changes, older adults with ARHL, may have a lower threshold for decline in cognitive function and development of dementia.[4,5,6] Functional disabilities and their associated societal costs are higher in those with ARHL. Data presented from the Baltimore Longitudinal Study on Aging and other longitudinal correlation studies showed increased risk of falls, walking difficulty, poor mobility, and incident disability among those with ARHL.[7,8,9] Those with ARHL are less likely to be employed and more likely to develop reliance on community support services.[10, 11] Most profoundly, ARHL is associated with increased all-cause mortality via three mediating variables: disability in walking, cognitive impairment, and self-rated health.[12]

Identifying and Eliminating Barriers to Access of Hearing Healthcare Delivery

Significant barriers to access of hearing healthcare delivery must be understood and overcome. Social stigma associated with hearing loss and use of hearing aids continues. Payment systems such as Medicare do not support hearing health due to exclusionary clauses (Section 1862 (a)(7) of the Social Security Act),[13] which classify hearing aids and auditory assistive devices as "comfort items" resulting in categorical denials. Limitations in access to patient information about hearing health and ARHL interventions, an uncoordinated and highly variable auditory assistive device market for people who do make it to a hearing health specialist, and the high costs associated with these devices further challenges to people with ARHL.

In the second half of the workshop, various stakeholders in hearing healthcare including consumer advocates, healthcare providers, industry representatives, policy makers, and public health professionals discussed innovative strategies toward eliminating these barriers to hearing healthcare delivery. Charlotte Yeh, MD, Chief Medical Officer for AARP Services, Inc., outlined the need to shift the emphasis to "what can be gained from what has been lost." For patients and consumers this may take the form of raising awareness about the impact of hearing impairment and the tremendous potential quality-of-life gains associated with improved hearing health. In medical professional and public health domains this means promoting recognition among primary care providers of the link between hearing health and healthy aging and the opportunities for improving outcomes through preventative and protective measures.

Establishing partnerships between hearing health professionals, technology and business innovators, and policy-makers holds promise for making hearing health more affordable and more accessible to consumers. David Green, a MacArthur Fellow and founder of Sound World Solutions™, related his experience meeting the hearing health market needs and maintain profitability while using a social enterprise business model. Based on the tenets of price affordability and accessibility, this model aims to bring hearing aids and assistive listening devices to underserved consumers and to change the competitive landscape through pricing. Other novel strategies discussed included

tele-audiology (i.e., remote hearing aid programming, remote screening), taking advantage of smart phone technologies, and expanding online patient and provider education forums and support groups.

A James Firman, EdD, President and CEO of the National Council on Aging, remarked, hearing loss in older adults in the U.S. is "prevalent and insidious, but treatable, and it should be recognized as a solvable public health challenge." By making hearing health a priority for policy makers we can influence allocation of funds for critical research on ARHL, improve auditory assistive device standards, bring pricing within reach of more consumers, and affect major changes toward improving healthy aging.

The Hearing Committee continues to track these critical debates in order to provide the AAO-HNS with needed expert input as our academy maintains a critical role in consumer advocacy and public policy making by governmental agencies. Please join us this May, during Better Hearing and Speech Month, to enhance opportunity for people with ARHL.

For more information and to view talks from "Hearing Loss and Healthy Aging: An IOM-NRC Workshop," visit http://www.iom.edu/Activities/PublicHealth/HearingLossAging.aspx.

Works Cited

1. Chien W, Lin FR. Prevalence of hearing aid use among older adults in the United States. Arch Intern Med, 2012 Feb 13; 172(3):292-3.
2. Bainbridge K, Walhagen MI. The Extent and Effects of Hearing Problems, and Treatment, in an Aging American Population. Annual Review of Public Health. Vol. 35 (Volume publication date April 2014).
3. Li CM, Zhang X, Hoffman HJ, Cotch MF, Themann CL, Wilson MR. Hearing Impairment Associated With Depression in US Adults, National Health and Nutrition Examination Survey 2005-2010. JAMA Otolaryngol Head Neck Surg. 2014 Mar 6. doi: 10.1001/jamaoto.2014.42. [Epub ahead of print]
4. Uhlmann RF, Larson EB, Rees TS, Koepsell TD, Duckert LG. Relationship of hearing impairment to dementia and cognitive dysfunction in older adults. JAMA. 1989 Apr 7;261(13):1916-9.
5. Gallacher J, Ilubaera V, Ben-Shlomo Y, Bayer A, Fish M, Babisch W, Elwood P. Auditory threshold, phonologic demand, and incident dementia. Neurology. 2012 Oct 9;79(15):1583-90.
6. Peelle JE, Troiani V, Grossman M, Wingfield A. Hearing loss in older adults affects neural systems supporting speech comprehension. J Neurosci. 2011 Aug 31;31(35):12638-43.
7. http://www.nia.nih.gov/health/publication/healthy-aging-lessons-baltimore-longitudinal-study-aging; site accessed March 12rd, 2014.
8. Lin FR, Ferrucci L. Hearing loss and falls among older adults in the United States. Arch Intern Med. 2012. 172(4): 366-7.
9. Viljanen A, Kaprio J, Pyykko I, et al. Hearing as a predictor of falls and postural balance in older female twins. J Gerontol A Biol Sci Med Sci. 2009 Feb;64(2):312–317.
10. Dalton DS, Cruickshanks KJ, Klein BE, Klein R, Wiley TL, Nondahl DM. The impact of hearing loss on quality of life in older adults. Gerontologist. 2003 Oct;43(5):661-8.
11. Schneider J, Gopinath B, Karpa MJ, McMahon CM, Rochtchina E, Leeder SR, Mitchell P. Hearing loss impacts on the use of community and informal supports. Age Ageing. 2010 Jul;39(4):458-64.
12. Karpa MJ, Gopinath B, Beath K, Rochtchina E, Cumming RG, Wang JJ, Mitchell P. Associations between hearing impairment and mortality risk in older persons: the Blue Mountains Hearing Study. Ann Epidemiol. 2010 Jun;20(6):452-9.
13. http://www.ssa.gov/OP_Home/ssact/title18/1862.htm; site accessed March 12th, 2014.

OHANCAW: A Week to Make a Difference

The 2014 Oral, Head and Neck Cancer Awareness Week® (OHANCAW), led annually by the Head and Neck Cancer Alliance (HNCA), is scheduled for April 20-26. OHANCAW is a weeklong series of events promoting awareness of oral, head, and neck cancer. The capstone is a day of free cancer screenings. Two Academy members who have long been involved with the awareness week are private practitioner **Wendy B. Stern, MD**, and professor **Cherie-Ann O. Nathan, MD**. Wanting to share the physician experience of OHANCAW, Dr. Stern, chair of the Academy's Media and Public Relations Committee, interviewed Dr. Nathan about her 18 years celebrating Oral, Head and Neck Cancer Awareness Week.

Wendy B. Stern, MD: Why Is Oral, Head and Neck Cancer Awareness Week (OHANCAW) important?

Cherie-Ann O. Nathan, MD: Head and neck cancer is an orphan disease that has not received much publicity, unlike breast or prostate cancer. Unfortunately, the majority of our patients present with advanced stage disease. Recurrence and survival is significantly worse for advanced stage disease. Hence why educating the public about early signs, symptoms, and lifestyle risk factors—especially the benefits of voluntary screening—will decrease the poor outcomes in our patient population. For example, previous surveys conducted by Harris Interactive on behalf of the HNCA have shown that a small percentage of the public is aware of the symptoms and risk factors associated with the human papillomavirus (HPV). There is an epidemic of HPV-associated oropharyngeal cancers and educating the public about this disease, its prevention, and early detection is important.

Planning for OHANCAW helps us as surgeons to step back and see how we can reach out and contribute to the education of our community, recognize our cancer survivors, and celebrate with their families. Many institutions use this week to have educational sessions for school kids about the health hazards of tobacco, host survivor banquets, and offer free screenings. The community at large comes together for OHANCAW.

Stern: So what do you think is the biggest gap in public education when it comes to oral, head, and neck cancers? Any misconceptions?

Nathan: Although the public is well aware of smoking risks and cancer, it has become obvious to us through OHANCAW that they are not as educated about the association between chewing tobacco and head and neck cancer. One of our Louisiana HNCA state chapter board members has been educating kids on local baseball teams about avoiding chewing tobacco as her tobacco-chewing husband succumbed to tongue cancer in his 30s. Persistent sore throat and a neck mass for example are important symptoms people should note and yet are often ignored, as many are unaware that they require attention.

Stern: How do you celebrate Oral, Head and Neck Cancer Awareness Week (OHANCAW)?

Nathan: Each year the Otolaryngology-Head and Neck Surgery Department at LSU-Health Shreveport conducts free screenings at the Feist-Weiller Cancer Center (FWCC). Our unique program, "Partners in Wellness," has a mobile van that is used to provide free cancer screenings. Some of the events have included:

- Free screenings with United Way and Shreveport Bossier Rescue Mission, a homeless shelter in Shreveport.
- Free screenings at Barksdale Air Force Base during the air show. We also talked about sun protection and prevention of skin cancers and handed out samples of free sunscreen.
- Free screenings at two local college campuses, Centenary College and LSU-Shreveport, to educate college kids about the risk factors associated

Cherie-Ann O. Nathan, MD is the fourth person from the left.

with HPV-associated oropharygeal tumors, in addition to risks of tobacco use. In Louisiana, among youth aged 12-17 years, 11 percent smoke. The new wave of Hookah smoking has the same deleterious effects and it is important that we educate our youth.

- Free screenings at a patient's church in Monroe, LA. That patient's wife, who is also a patient advocate with her legislators, arranged for us to screen. As a patient advocate she has volunteered to help educate legislators about the importance of reimbursement for prosthesis as our patients suffer severe functional loss affecting speech and swallowing. This affects the ability to go back to work and in turn affects productivity.

Stern: When did you get involved in OHANCAW and why?

Nathan: The Otolaryngology-Head and Neck Surgery Dept. at LSU-Health Shreveport has been involved with free screenings since 1996 when the HNCA was known as the Yul Brynner Head and Neck Foundation. Terry Day, President of the HNCA, had reached out to us and we started our screenings. Our head and neck coordinator Teresa Harris is passionate about the screening week and puts in a lot of time and effort into planning this event every year. As a result of our funding from the National Cancer Institute, we publicized this event through the *Shreveport Times*, news and radio stations. Our turnout has always been good and we enroll some of the highest numbers during the screening week. Just knowing that we are educating the public about the risk factors, early signs, and symptoms for head and neck cancer has been very gratifying for our entire staff.

Stern: What do you remember most from the first screening you hosted?

Nathan: The fun that our entire team had putting the event together and the influence we had on the community are what I remember most. It was very rewarding and indelibly etched in our memory. We have made a point to commit to this event every year since.

We were expecting people at risk for head and neck cancer to attend the free screenings (i.e., smokers), but attendees included those who did not necessarily have any of the risk factors and were routinely seeing their primary care physicians. Since then, we have started using the mobile screening van provided by the Cancer Center to go out to sites where high-risk groups could be screened. Other institutions around the country have had unique events such as screenings at NASCAR races to promote awareness of head and neck cancer.

Stern: So you've participated in this observance for 18 years. What keeps you coming back?

Nathan: As a head and neck surgeon who treats this special patient population, it is frustrating that most patients present with advanced stage disease and therefore

have high recurrence rates. Educating the public about early signs, symptoms, and risk factors is important to mitigating this issue. I believe free screenings provide that opportunity for the community.

Also, OHANCAW brings people together in a way that has really surprised me. The institution and physicians have to make sacrifices in terms of cancelled clinics and ORs to make this happen. It is also popular amongst medical students who like to volunteer their time. We have made it fun for our residents and students by having crawfish broils and jambalaya after the screening, too.

Stern: Any interesting anecdotes?

Nathan: A few years ago when the epidemic of HPV-associated oropharyngeal cancers was first noted, we decided to screen on college campuses. We typically hold free screening events on Fridays. A college professor told me that we would get a lower turnout as kids leave campus early on Friday. This professor is also a board member of our HNCA Louisiana Chapter, and so intent on raising awareness among his students he announced he would give them credit and bonus points if they showed up for the event. It worked! It was one of the best-attended screenings.

We once had a screening at a fire station, as the fire marshal's wife was a head and neck cancer patient. He had challenged his fire department to raise money by selling T-shirts for breast cancer awareness week. Expecting only a few hundred dollars in sales, he pledged to personally match the funds raised by the department to give to cancer research. The fire department raised $8,000 and he happily matched the funds.

Stern: What are the pearls and the pitfalls for setting up a successful screening program?

Nathan:

- Identify a coordinator who enjoys putting the event together and is passionate about head and neck patients.
- Get the community involved—school board members, church groups, and homeless shelters—and reach out to remote areas where healthcare is not easily accessible.
- Have your institution's public relations team help with publicity so the community knows about the event.
- Identify a celebrity who has been diagnosed with head and neck cancer, as that always seems to get people's attention. When Michael Douglas was kind enough to be our spokesperson a few years ago, we had one of the best turnouts of all the sites in the U.S.
- Get other nearby members involved as they come up with wonderful ideas thanks to their local knowledge.
- Be aware that this does require a commitment from the department and institution as you do run fewer clinics and ORs on screening day in order to have personnel available for the event.

Stern: Do you have any advice for the physician in a non-academic setting who would like to participate?

Nathan: I believe the private practice group setting would also have to make the same time commitment. I would suggest getting nurse practitioners or physician assistants involved to set up free screenings, or talk to the hospital where you practice to help run the event.

This year, we have all but seven states signed up for free screenings. I encourage other Academy members to celebrate OHANCAW and give back to the community. Be sure to let HNCA know of your Oral, Head and Neck Cancer Awareness Week event, too.

Want to Participate?

AAO-HNS members who wish to host a free screening event during OHANCAW® (April 20-26) should go to www.ohancaw.headandneck.org/setup where you can:

- Register as a free screening site
- Get tips on how to organize a screening as well as other events to promote oral cancer awareness, such as middle school talks and walkathons
- Download a variety of materials for use with your screening event including:
  - Patient screening forms (English and Spanish)
  - Press materials for use with your local media to publicize your screening
  - Posters to promote the event

Building Strategy for CHEER with the World Café Construct

David L. Witsell, MD, MHS
Kristine Schulz, MPH

"Strategy making is uncomfortable; it's about taking risks and facing the unknown. Unsurprisingly, managers try to turn it into a comfortable set of activities. But reassurance won't deliver performance…reconcile yourself to feeling uncomfortable." (Harvard Business Review, January-February 2014, The Big Lie of Strategic Planning*)*

In mid-January 2014, CHEER (Creating Healthcare Excellence through Education and Research) conducted a strategic planning meeting at our Academy headquarters in Alexandria, VA. CHEER is a practice-based research network of 30 academic and community sites across the country—the training, education, and regulatory program for CHEER is supported by an NIH grant. In its second five-year funding cycle, CHEER has begun to make our mark as the only practice-based research network in otolaryngology with multiple publications; a successful >1,500 patient pilot study in dizziness and tinnitus; a 750,000 visits administrative database; a voice therapy study near completion; and a sudden hearing loss study under way. However, we know that to grow our success and be sustainable in today's environment, we need to be innovative and dynamic.

We all recognize that strategic planning can be one of those "groan" activities that is necessary, can be tedious, and does not always arrive at actionable steps within an identified strategic goal. CHEER wanted to create an environment for a different experience that could facilitate rapid exchange of information and ideas, as well as build key relationships and allow personal investments to be realized. We embraced "feeling uncomfortable" to ensure an open and honest exchange of information from which true strategies could emerge. To do this, we used a "World Café" format to facilitate the gathering of collective wisdom that can emerge from *conversational leadership*.

To set the context for the World Café, all the right stakeholders need to be in the room. For CHEER, that included the newly established AAO-HNSF Practice-based Task Force, The CHEER executive team, and AAO-HNS leadership. There were 17 participants in all. The physical space for the meeting was set up with four "café" tables complete with working paper tablecloths and marking pens. Before the actual meeting, each participant provided a fair analysis of CHEER and where the strengths, opportunities, weaknesses, and threats lie. Responses were summarized prior to the meeting with the goal to use these four key challenge groupings to catalyze discussion.

Our group divided itself among the four tables and each table was given the same challenge grouping to discuss for 10 minutes. They were encouraged to write their thoughts down on the "tablecloth." After 10 minutes, one person stayed at that table to host and summarize the group's ideas and the other three participants separated and went to each of the other café tables. The conversations then began again for 10 minutes. Each key challenge grouping had three rounds of conversations with a

Principles of the World Café Format

1. Set the context
2. Create the space
3. Define the questions of importance
4. Encourage courage to speak
5. Connect perspectives and conversation
6. Listen together
7. Harvest and integrate discoveries

Attendee	Institution
Jean Brereton, MBA	AAO-HNSF
Kevin D. Brown, MD, PhD	Weill Cornell Medical College
David R. Nielsen, MD	AAO-HNSF
Brenda Hargett, CPA, CAE	AAO-HNSF
Alan W. Langman, MD	Puget Sound Hearing & Balance
Walter T. Lee, MD	Duke University Medical Center
Anh T. Nguyen-Huynh, MD, PhD	Oregon Health & Science University
Kourosh Parham, MD, PhD	University of Connecticut
Melissa A. Pynnonen, MD	University of Michigan
Peter S. Roland, MD	University of Texas – Southwestern
Sheila Ryan, MD	Duke (Community Site)
Jerry M. Schreibstein, MD	Western New England ENT
Kris Schulz, MPH	Duke University Medical Center
Jennifer J. Shin, MD, SM	Brigham & Women's
Debara L. Tucci, MD, MBA	Duke University Medical Center
Andrea Vambutas, MD	North Shore – LIJ Health System
David L. Witsell, MD, MHS	Duke University Medical Center
* Unable to Attend: David J. Eisenman, MD, University of Maryland (Task Force), Lisa E. Ishii, MD, MHS, Johns Hopkins (Task Force), Steven D. Rauch, MD, Massachusetts Eye & Ear Infirmary (CHEER Executive Team)	

different mix of participants. Significant and robust cross talk, exchange of perspective, and dispersion of ideas resulted. At the end of the speed rounds, one person was asked to summarize to the entire group the salient points that were discussed and written down at his or her table.

Actionable strategies were identified for each key challenge. Places to invest and places to not expend resources were clear; novel consensus-based ideas were brought forward and began maturation.

One of the specific aims of the CHEER network is to build new contemporary leadership and an organizational structure that can address the research and healthcare challenges that face us every day. We are practice-based, an evolving and *involving* network of colleagues that collaborate and seek to address the needs for effective care. Conversation is of the upmost importance and is the only way to build and create a dialogue for healthcare excellence. The World Café process is a consensus- and relationship-building activity that enables each participant to lead from a personal perspective in a respectful and fun way. We emerged with eight strategies that leverage internal strengths and external opportunities to mitigate internal weaknesses and external threats.

One exciting strategy is to explore the development of a nonprofit organizational model that would potentially reduce overhead costs and provide a structure for ownership of the network. Another innovative strategy is to develop a "priority project portfolio"—a compendium of vetted project plans (and budgets) of importance to the AAO-HNSF (and feasible in the practice setting) that can be marketed for outside support or used as the basis for a grant.

Two programs of note provide a foundation for CHEER leadership development: Leading Organizations to Health (www.lohweb.com) led by Tony Suchman, MD; Penny Williamson, ScD; and Diane Rawlins, and Courage to Lead (http://www.couragerenewal.org/events/couragetolead-series-ma-2014-16-1) led by Penny Williamson, ScD, and Hanna Sherman, MD. These are dynamic advanced leadership programs for healthcare leaders, primarily physicians, stretching more than 12 and 15 months respectively through a series of intensive retreats. Only 10 to 12 participants are enrolled in each program each year providing for an intimate and accountable experience. You cannot escape the learning. The programs are resources that our medicine colleagues have tapped into and now several otolaryngologists have participated.

Leadership is important, and better when not driven by dogma, but conversation. This is so important that NIDCD recognized and funded leadership development as a specific aim for the CHEER grant. Both Tony Suchman and Penny Williamson are CHEER consultants and helped to design the program to launch the Practice-based Task Force for the AAO-HNSF. We began this meeting with personal stories of leadership…but that is another article all together!

For more information on CHEER, visit www.cheerresearch.org or email Kristine Schulz at kristine.schulz@duke.edu.

SAVE THE DATE!

TO COME EXPERIENCE THE
PREMIER OTOLARYNGOLOGY EVENT
IN ORLANDO, FLORIDA

AAO-HNSF ANNUAL MEETING & OTO EXPO℠ 2014 SEPTEMBER 21–24 ORLANDO, FL

DON'T MISS OUT! Join us in Orlando for our **2014 ANNUAL MEETING & OTO EXPO℠**
For 118 years we have been the premiere event for Otolaryngologists, showcasing the latest advancements in our specialty, dynamic scientific oral presentations, instruction courses, miniseminars, and posters. This year promises to be the best yet.

ORANGE COUNTY CONVENTION CENTER
• LEED Certified, Best in Service

TOP 10 REASONS TO ATTEND

1. **Receive hands-on knowledge.** 300+ continuing education courses offer plenty of skills and ideas for you to take home and use right away.
2. **Customize your experience.** Tracks for otolaryngology specialties ensure that your education needs are met and your time is maximized.
3. **Optimize your time.** 250+ exhibitors in the OTO EXPO℠ offer an almost endless array of new products and services along with cutting-edge technology for you to touch, feel, and compare.
4. **Meet industry visionaries.** The best and brightest leaders in the otolaryngology community share the latest research, techniques, and clinical applications. It's ideal for perfecting your clinical skills and enhancing the success of your practice.
5. **Forge connections.** Participate in insightful discussions with colleagues from around the world and make new friends.
6. **Leverage essential resources.** Whether it is ENTConnect, AcademyU® Learning Center, or the Member Resource Center, you'll find essential resources around every corner.
7. **Explore Orlando.** Orlando was recently ranked by the Healthcare Convention & Exhibitors Association as the No. 3 destination for medical meetings in 2011.
8. **Revel in inspiration.** Feel rejuvenated and inspired from spending time with your colleagues, and return home with practical techniques to improve care for your patients.
9. **Make your voice heard.** Only at the AAO-HNSF Annual Meeting can you meet with our Advocacy staff to learn the latest legislative and political updates that impact the future of otolaryngology.
10. **Capture best value.** Save up to 40% off your registration, when you register before July 11th.

WWW.ENTNET.ORG/ANNUAL_MEETING

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

EMPOWERING PHYSICIANS TO DELIVER THE BEST PATIENT CARE

1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.
1-703-836-4444 1-703-683-5100 fax www.entnet.org

A Note of Thanks to Our AAO-HNS State Trackers

"Leadership is an action, not a position." In just seven words, this Donald McGannon quote encompasses the spirit of our AAO-HNS state trackers. Each day, these Academy members, with their full workloads and family obligations, take action and volunteer their time to closely monitor and report on legislative activity in their statehouses. They often serve in this critical role with few people knowing they are the key reason the AAO-HNS is able to successfully advance its legislative priorities and protect our patients and our practices from ill-advised proposals being debated in state legislatures across the nation.

Whether it is looking through bills every morning or alerting AAO-HNS staff to a bill of interest, our state trackers have repeatedly proved themselves as leaders of the specialty. I want to take this opportunity to recognize their efforts and thank them for their work on behalf of all otolaryngologist-head and neck surgeons. Your dedication and commitment are greatly appreciated and benefit us all.

For those members interested in joining this "boots on the ground" effort, I encourage you to email the AAO-HNS Government Affairs team at govtaffairs@entnet.org for more information.

Sincerely,
David R. Nielsen, MD
AAO-HNS Executive Vice President/ CEO

State	Name
Alabama	J. Noble Anderson, Jr., MD
Arizona	Mariel Stroschein, MD
Arkansas	Lance A. Manning, MD
Arkansas	Paul R. Neis, MD
California	Art A. Ambrosio, MD
California	Geoffrey A. Smith, MD
California	Marcella R. Bothwell, MD
California	Steven T. Kmucha, MD, JD
Colorado	Jeremy D. Prager, MD
Connecticut	David S. Boisoneau, MD
Connecticut	Ken Yanagisawa, MD
Connecticut	Raymond Winicki, MD
Delaware	Paul M. Imber, DO
District of Columbia	William R. Bond, MD
Florida	K. Paul Boyev, MD
Georgia	Julie L. Zweig, MD
Georgia	Lisa Perry-Gilkes, MD
Georgia	Peter J. Abramson, MD
Georgia	Zara M. Patel, MD
Illinois	Soha N. Ghossaini, MD
Illinois	Ira D. Uretzky, MD
Indiana	Edward J. Krowiak, MD
Indiana	Susan R. Cordes, MD
Indiana	Michael Agostino, MD
Iowa	Joseph E. Hart, MD MS
Kansas	Mark G. Bell, MD
Kentucky	K. John Yun, MD
Louisiana	Keith F. DeSonier, MD
Louisiana	Lawrence M. Simon, MD
Maine	Benjamin D. Liess, MD
Maryland	Michael H. Weiss, MD
Massachusetts	Robert W. Dolan, MD
Massachusetts	Kenneth Whittemore, MD
Michigan	Hamad Chaudhary, MD
Michigan	Charles F. Koopmann, MD, MHSA
Michigan	Michael D. Seidman, MD
Michigan	Seilesh Babu, MD
Minnesota	Joshua G. Yorgason, MD
Montana	Neal L. Rogers, MD
Montana	Paul Byorth, MD
Nebraska	Ryan K. Sewell, MD
New Hampshire	Christopher J. Knox, DO
New Hampshire	Mark F. Kelly, MD
New Jersey	Jeffrey D. Roffman, MD
New Jersey	Lee D. Eisenberg, MD, MPH
New Jersey	Nathan A. Deckard, MD
New Mexico	Jeremy D. Prager, MD
New York	Gavin Setzen, MD
New York	Hayes H. Wanamaker, MD
New York	Jay S. Youngerman, MD
New York	Paul E. Hammerschlag, MD
New York	Steven M. Parnes, MD
New York	Phillip L. Massengill, MD
North Carolina	Merritt J. Seshul, MD
Ohio	Stacey L. Ishman, MD, MPH
Oklahoma	Christopher F. Baranano, MD
Oklahoma	Mark W. Wood, MD
Pennsylvania	Jeffrey P. Simons, MD
Pennsylvania	Stephen M. Froman, MD
Pennsylvania	Nathan A. Deckard, MD
South Carolina	Gregory Tarasidis, MD
South Carolina	Robert Puchalski, MD
Tennessee	Ronald H. Kirkland, MD MBA
Texas	Enrique T. Garcia, MD
Utah	Joshua G. Yorgason, MD
Vermont	Kristofer E. Anderson, MD
Vermont	Richard N. Hubbell, MD
Virginia	Andrew J. Heller, MD
Virginia	Edilberto O. Pelausa, MD
Virginia	Michelle M. Roeser, MD
Washington	Sanjay R. Parikh, MD
West Virginia	F. Thomas Sporck, MD
Wisconsin	Scott R. Chaiet, MD

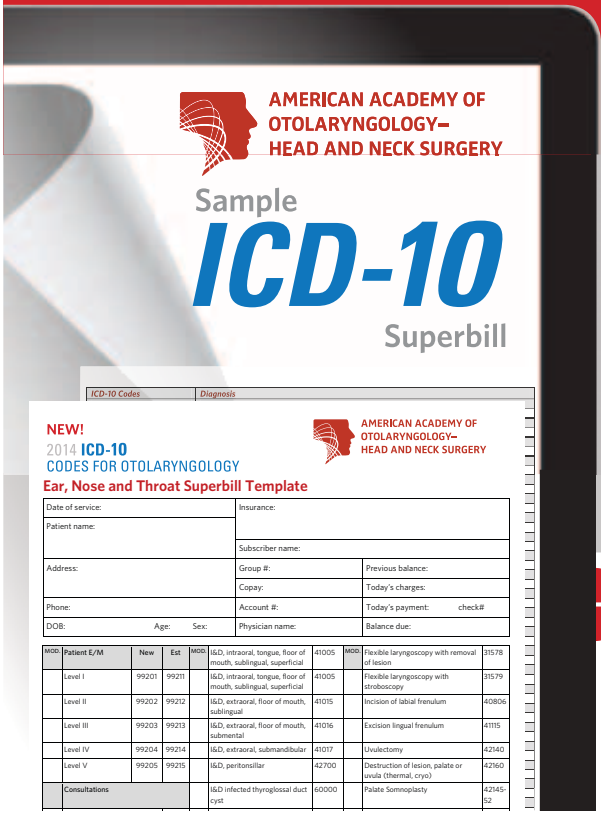
*State Tracker vacancies still remain in: AK, GU, HI, ID, MS, MO, NV, ND, OR, PR, RI, SD, VI, WY.

Follow Government Affairs on Twitter

Do you want to be one of the first to know the status of healthcare bills moving through Congress? Follow the Government Affairs Twitter account @AAOHNSGovtAffrs. By following us, you can learn more about the issues affecting the specialty, including repeal of the flawed Sustainable Growth Rate (SGR) formula, medical liability reform, scope-of-practice battles, Graduate Medical Education (GME) funding, truth-in-advertising (TIA) initiatives, and efforts to repeal the Independent Payment Advisory Board (IPAB). Not a fan of Twitter? You also can check the Government Affairs webpage for updates at http://www.entnet.org/Advocacy.

ENT PAC

2014 is an election year for Congress. ENT PAC, the political action committee of the AAO-HNS, financially supports federal congressional candidates and incumbents who help and/or advance the issues important to otolaryngology–head and neck surgery. ENT PAC is a NON-PARTISAN, ISSUE-DRIVEN entity that serves as your collective voice on Capitol Hill to increase the visibility of the specialty with key policymakers. To learn more about ENT PAC, visit our PAC website at www.entpac.org (log-in with your AAO-HNS ID and password).



Code in Confidence with the NEW AAO-HNS Sample ICD-10 Superbill

The Academy is pleased to announce the completion of a **sample ICD-10 superbill** which is available to members now on the Academy website at: **http://bit.ly/entICD10**. The superbill is designed to assist otolaryngology practices in quickly completing and submitting procedure(s) and diagnosis(s) codes from a patient visit for reimbursement. A word version of the superbill has been made available so that practices can customize it to include the most frequently provided services, and associated diagnostic codes.

* Members should note that this superbill is intended solely as an exercise in demonstrating the process of transitioning to the new ICD-10-CM coding system and it does not represent an endorsement by the Academy of the use of superbills or this particular superbill format.

With 8 pages of comprehensive codes, you can customize the superbill template to fit your practice.

Scan this code with your Smartphone or tablet

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care
1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.

It is Our Choice...

Rahul K. Shah, MD
George Washington University School of Medicine
Children's National Medical Center, Washington, DC

I am rarely dogmatic, but I implore our Academy membership to visit http://www.nejm.org/doi/full/10.1056/NEJMp1314965 and take 15 minutes to read an article from the *New England Journal of Medicine* about the *Choosing Wisely* campaign.[1] The authors begin with a noble goal of elevating the status of the *Choosing Wisely* campaign in the Perspective column of the journal. In the introductory paragraphs, they accurately note how the campaign is different from other initiatives in that, "The message, the messenger, and the method are key features of this stewardship initiative."[1] The *Choosing Wisely* campaign has been embraced and applauded by medical societies as it asks providers to define those services that are low-value services, "emphasizing individual patients' needs as the top priority, preserving the preeminence of physician judgment, patient choice, and the therapeutic dyad. Doctors and their societies, not payers, develop the lists."[1]

Unfortunately, the article continues with the theme that by empowering physicians and our respective societies to create a list of low-value services, that we as practitioners are inherently self-serving and have political motives driven by a desire to optimize our own reimbursement. Aided by Academy member **Richard M. Rosenfeld, MD, MPH**, and our EVP and CEO, **David R. Nielsen, MD**, we immediately wrote a letter to the editor at the *New England Journal of Medicine*. Whether this is published or not is beyond the point; what is imperative is that Academy

members understand that we interpreted and responded to the *Choosing Wisely* campaign as we were instructed. The goal of *Choosing Wisely* is to aid patients in interpreting medical advice and to curb overutilization of those services that physicians and societies consider as low-value. As such, many societies provided examples

of low-value services that broadly influence a significant number of patients. The authors inaccurately assert that these societies listed their low-value services to preserve our own economic interests while directing attention to other specialties. This is quite a perverse argument that is not justified by data, rather by simply showing the lists of the societies and claiming that they were created by self-interested societies.

It is unfortunate and obvious that the authors did not seek out an opportunity to speak with or read our explanation from the societies to understand our methodology, which has been documented.[2] The article calls out the American Academy of Orthopaedic Surgeons and other societies, including ours: "The American Academy of Otolaryngology—Head and Neck Surgery, for example, lists three imaging tests and two uses of antibiotics but no procedures, despite decades of literature on wide variation and overuse of tonsillectomy and tympanostomy tube placement."[1] The inherent conflict with this assertion juxtaposed to the rest of their article is frustrating—our Academy approached the *Choosing Wisely* list in a democratic manner, asking the various subspecialties to identify low-value services that they see and experience with their patients.

Indeed, if we had focused solely on procedures that are low-value services, then we would not have the largest influence that we believe we can by looking at antibiotic and radiologic overuse—items that influence various disciplines of providers—family practitioners, internists, emergency physicians, pediatricians, etc. We anticipate in further versions of the *Choosing Wisely* campaign we will use our guidelines and other evidence-based medicine to identify such low-value services.

I am going to make an unfounded assertion that is simply a personal observance—we all think that some other society besides our own—generalists' or specialists'—are part of the problem of overuse. Hence, we are quick to assert that such "calling the other out" was motivated by economic self-interest rather than what it is—an attempt to genuinely help patients on a broad level.

I applaud our executive leadership and Boards of the Academy for leading the surgical specialties in the *Choosing Wisely* campaign; we are fortunate to continue to be national leaders in improving the care of our patients and we eagerly look forward to participating in this unique endeavor to identify more opportunities for healthcare as a whole to influence the broadest proportion of patients—one low-value service at a time.

We encourage members to write us with any topic of interest and we will try to research and discuss the issue. Members' names are published only after they have been contacted directly by Academy staff and have given consent to the use of their names. Please email the Academy at qualityimprovement@entnet.org to engage us in a patient safety and quality discussion that is pertinent to your practice.

References

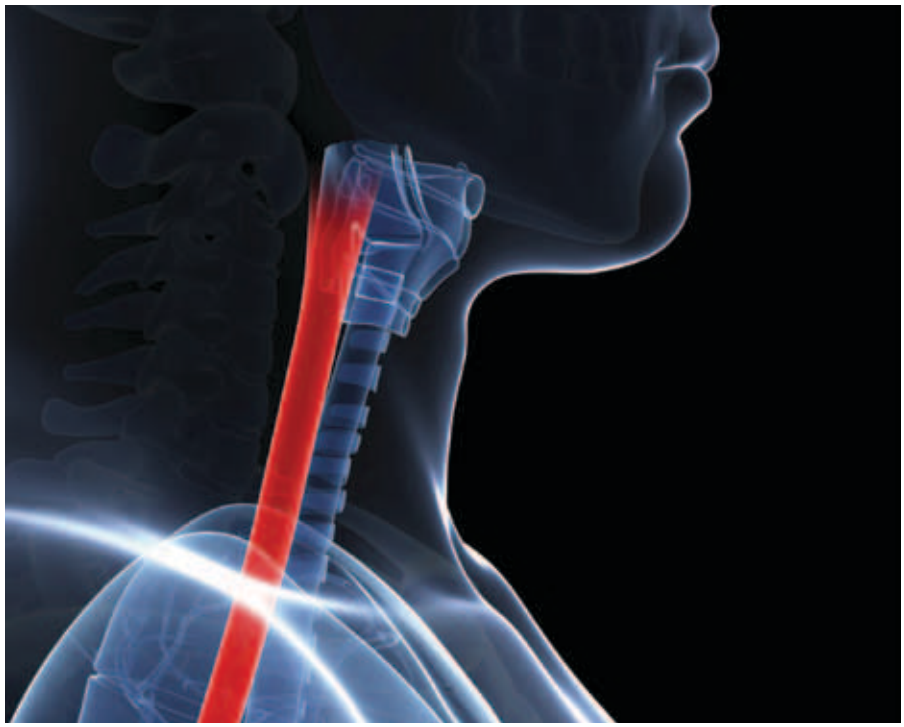
1. Morden NE, Colla CH, Sequist TD, Rosenthal MB. Choosing Wisely—The Politics and Economics of Labeling Low-Value Services. *N Engl J Med.* 2014 Feb13;370(7):589-592.
2. Robertson PJ, Brereton JM, Roberson DW, Shah RK, Nielsen DR. Choosing Wisely: our list.
3. *Otolaryngol Head Neck Surg.* 2013 Apr;148(4):534-6.

CPT for ENT: Changes to the Esophagoscopy Family of Codes

As members are likely aware, 2014 brings significant changes to the esophagoscopy family of CPT codes. Specifically, the code set was revised to more clearly identify the types of endoscope and approaches used when performing the procedure, as it was agreed that the physician work involved varied depending on these factors. The codes are also grouped by type of anesthesia or sedation used (e.g., general, moderate sedation, or local). Therefore, the new codes are organized based on whether a rigid or flexible endoscope is used, and whether the approach is transoral or transnasal. Given that these procedures are performed by multiple specialties (otolaryngology and gastroenterology), the Academy's RUC and CPT teams collaborated with several GI societies to revise and present this code set to the AMA RUC, and ultimately, to CMS for valuation in 2014. Of note, the six new rigid transoral codes were valued solely by otolaryngology, whereas several of the flexible transoral and both of the new flexible transnasal codes were valued by both specialties.

Esophagoscopy, Rigid, Transoral

- **43191–Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)**(To report transnasal esophagoscopy, see 43197, 43198)
  (For diagnostic flexible transoral esophagoscopy, use 43200)
- **43192–with directed submucosal injection(s), any substance**
  (For flexible transoral esophagoscopy with directed submucosal injection(s), use 43201)
  (For flexible transoral esophagoscopy with injection sclerosis of esophageal varices, use 43204)
  (For rigid transoral esophagoscopy with injection sclerosis of esophageal varices, use 43499)
- **43193–with biopsy, single or multiple**
  (For flexible transoral esophagoscopy with collection of specimen or biopsy, see 43200, 43202)
- **43194–with removal of foreign body**
  (For radiological supervision and interpretation, use 74235)
  (For flexible transoral esophagoscopy with removal of foreign body, use 43215)
- **43195–with balloon dilation (less than 30 mm diameter)**
  (If imaging guidance is performed, use 74360)
  (For esophageal dilation with balloon 30 mm diameter or larger, see 43214, 43233)
  (For dilation without endoscopic visualization, see 43450, 43453)
  (For flexible transoral esophagoscopy with balloon dilation [less than 30 mm diameter], use 43220)
- **43196–with insertion of guide wire followed by dilation over guide wire**
  (For flexible transoral esophagoscopy with insertion of guide wire followed by dilation over guide wire, use 43226)
  (For radiological supervision and interpretation, use 74360)



Esophagoscopy, Flexible, Transnasal (TNE)

- **43197–Esophagoscopy, flexible, transnasal; diagnostic, includes collection of specimen(s) by brushing or washing when performed (separate procedure)**(Do not report 43197 in conjunction with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43200-43232, 43235-43259, 92511)
  (For transoral esophagoscopy with biopsy or collection of specimen, see 43191, 43193, 43200, 43202)
  (Do not report 43197 in conjunction with 31231 unless separate type of endoscope [e.g., rigid endoscope] is used)
- **43198–with biopsy, single or multiple**
  (For transoral esophagoscopy with biopsy or collection of specimen, see 43191, 43193, 43200, 43202)
  (Do not report 43198 in conjunction

with 31575, 43191, 43192, 43193, 43194, 43195, 43196, 43200-43232, 43235-43259, 92511)
(Do not report 43198 in conjunction with 31231 unless separate type of endoscope [e.g., rigid endoscope] is used)

Esophagoscopy, Flexible, Transoral

- **43200–Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**
(For diagnostic rigid transoral esophagoscopy, use 43191)
(For diagnostic flexible transnasal esophagoscopy, use 43197)
(For diagnostic upper gastrointestinal endoscopy, use 43235)
- **43201–with directed submucosal injection(s), any substance**
(For rigid transoral esophagoscopy with directed submucosal injection[s], use 43192)
(For flexible transoral esophagoscopy with injection sclerosis of esophageal varices, use 43204)
(For rigid transoral esophagoscopy with injection sclerosis of esophageal varices, use 43499)
(Do not report 43201 in conjunction with 43211, 43204, 43227)
- **43202–with biopsy, single or multiple**
(For rigid transoral esophagoscopy with biopsy, use 43193)
(For flexible transnasal esophagoscopy with biopsy, use 43198)
(For upper gastrointestinal endoscopy with biopsy or collection of specimen, see 43235, 43239)
- **43215–with removal of foreign body**
(For radiological supervision and interpretation, use 74235)
(For rigid transoral esophagoscopy with removal of foreign body, use 43194)
(For upper gastrointestinal endoscopy with removal of foreign body, use 43247)
- **43220–with transendoscopic balloon dilation (less than 30 mm diameter)**
(For rigid transoral esophagoscopy with balloon dilation [less than 30 mm diameter], use 43195
(If imaging guidance is performed, use 74360)
(For esophageal dilation with balloon 30 mm diameter or larger, use 43214)
(For dilation without endoscopic visualization, see 43450, 43453)
(Do not report 43220 in conjunction with 43212, 43226, 43229)
- **43226–with insertion of guide wire followed by passage of dilator(s) over guide wire**
(For radiological supervision and interpretation, use 74360)
(For rigid transoral esophagoscopy with insertion of guide wire followed by dilation over guide wire, use 43196)
(Do not report 43226 in conjunction with 43212, 43229)
(For additional Flexible, transoral codes see 43200-43233 in the 2014 CPT® Book).

Call for Applications for the Position of Coordinator-Elect for Development

The AAO-HNS/F Coordinator-elect for Development serves for one year, starting October 1, 2014 and works closely with the Coordinator through a transition/learning period before assuming the position of Coordinator for a four-year term beginning October 1, 2015.

Term of Office and Voting

The Coordinator-elect serves for one year followed by four years as Coordinator. The Coordinator is a non-voting member of the Foundation Board of Directors. The Coordinator-elect is required to attend and participate in Foundation Board meetings, strategic planning, and other related activities.

Qualifications and Stipend

Qualifications include a strong interest in, and prior involvement with, fundraising. This includes all levels of identification and solicitation of individuals and corporations. S/he must be committed to the goals of the Foundation and be versed in communicating those goals to donor prospects. The Foundation currently provides a stipend for the Coordinator.

Application Process

Academy members interested in this position must submit a one (1) page candidate statement, in a PDF format, highlighting relevant qualifications and experience, as well as a personal vision for the future of development within the AAO-HNSF.

Curriculum vitae and three (3) letters of recommendation are also required.

Applications must be submitted **by May 16** to **rsallerson@entnet.org**

For a more detailed description of the roles and responsibilities of the Coordinator position and a listing of qualifications and expectations visit **http://www.entnet.org/DevelopmentCoordinator.cfm**

Final applicants will be invited to participate in telephone and in-person interviews. A final decision will be made during August 2014.

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY

Empowering otolaryngologist—head and neck surgeons to deliver the best patient care
1650 Diagonal Road, Alexandria, Virginia 22314-2857 U.S.A.

CMS Issues Changes to Defining 'Inpatients' in the Hospital Setting

CMS recently released the 2014 Inpatient Prospective Payment System final rule, which included a new requirement, commonly referred to as the "2 Midnight Rule." As members are aware, Medicare has two distinct "Programs" known as Part A (which relates to payment for inpatient services) and Part B (which relates to professional and hospital outpatient services). According to CMS, Medicare beneficiaries having long stays in hospitals as outpatients raised concerns regarding improper payments. Because of such, CMS revised its rule relating to when a patient is deemed "inpatient" versus "outpatient" for payment purposes. Essentially, the rule clarifies that ***a beneficiary is an inpatient of a hospital if formally admitted via an order by a physician or other qualified practitioner.*** There are two key principles physicians and qualified practitioners should be aware of regarding the new rule.

First, admission must be "certified" by a physician with an order being a required component of that certification. The order must be written, cited in the medical chart, signed by a physician or other qualified practitioner, and must be completed either prior to admission or at the time of admission. Inpatient status only applies prospectively from the time of formal admission, and the order must specifically state admission as an inpatient. A specific format for the certification and order is not required.

Additionally, certification must include the reason for the inpatient admission, estimated duration of the patient's stay, and a tentative post-discharge plan. CMS has highlighted some inpatient admission guidelines, which can be viewed at http://www.cms.gov/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/IP-Certification-and-Order-09-05-13.pdf. ***If a procedure involves one designated by the Hospital Outpatient Prospective Payment System (OPPS) as an inpatient-only procedure then admission and payment under Part A are deemed appropriate. Further, if a physician expects a patient's stay to transcend two midnights due to a surgical procedure, diagnostic test, or other treatment, and admits the patient based on that expectation, the admission will generally be deemed appropriate for Part A payment purposes***. It is important to note, however, CMS has emphasized that ***there must be "no reasonable possibility that the care could have been adequately provided in an outpatient setting."*** It should also be noted that payment will not be deemed inappropriate in circumstances where the expected 2 Midnight stay is cut short, such as by death, transfer, or unexpected rapid improvement.

Second, the new rule distinguishes between the 2 Midnight benchmark and the 2 Midnight presumption. The benchmark serves as guidance for admitting physicians and practitioners and allows Medicare reviewers to identify when an inpatient admission is generally appropriate for coverage and payment. The starting point for determining whether the 2 Midnight benchmark has been met is when the patient begins receiving hospital care on an inpatient basis. In other words, the 2 Midnight clock starts when the beneficiary begins receiving hospital care as an inpatient, assuming admission was reasonable and expected. Conversely, a patient who is receiving care as an outpatient in a hospital operating room and is later formally admitted is not deemed an inpatient during the time spent in the operating room.

CMS cites high improper payment rates for inpatient admissions as the reason for the heightened scrutiny. If a physician cannot make a reasonable prediction, it has been suggested that the patient should not be admitted, but rather, should continue receiving care on an outpatient basis. The actual length of care, patients who are in intensive care, and level of care required are not exceptions to the premise that inpatient regulation is based upon a reasonable and supportable expectation of a 2 Midnight stay.

The 2 Midnight Presumption is guidance for Medicare review contractors when reviewing claims and determining which to review. The presumption is that claims with lengths of stay greater than 2 midnights *after* formal admission are presumed appropriate for Part A payment. Such stays will not be the focus of review, unless an unwarranted delay or other evidence exists of an abuse of discretion. In other words, the 2 Midnight presumption serves to flag claims that may need additional scrutiny or review, especially in light of CMS' argument that 36 percent of improper payments are made for inpatient admissions lasting one-day or less. CMS has stated it will continue to monitor all hospitals for intentional or unwarranted delays, abuses of discretion, or any other unnecessary patterns with inpatient services.

The new rules are aimed at reducing long beneficiary stays as outpatients, and clarify if the ordering practitioner expects a beneficiary to stay at least two midnights, they should be admitted as an inpatient. The Health Policy Team will continue to monitor any changes, updates, or alterations to the new rule. To view the complete final rule, visit http://www.entnet.org/Practice/CMS-News.cfm. Members also can email CMS IPPSAdmissions@cms.hhs.gov with any questions regarding admission and/or medical review under the new rule.

Value-Based Modifier Program: How Will It Affect You?

The Value-Based Modifier (VBM) Program assesses both quality of care furnished and the cost of care under the Medicare Physician Fee Schedule (MPFS). The Centers for Medicare & Medicaid Services (CMS) are beginning with a phase-in of the VBM in 2015, which **will apply to all physicians by January 1, 2017**. Implementation of the VBM is based on participation in Physician Quality Reporting System (PQRS). For CY 2013, the VBM applied to groups of physicians with 100 or more eligible professionals (EPs). ***In 2014, CMS is expanding this to groups with 10 or more.***

Groups are defined, for purposes of the VBM, as "a physician (includes doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors); OR a practitioner described as (a physical or occupational therapist or qualified SLP; or a qualified audiologist)." To determine what groups have more than 10 providers for purposes of the 2014 VBM reporting period, CMS will query their PECOS system to identify groups and will perform the query 10 days after the close of the PQRS group self-nomination/registration process which occurs in the fall of the year prior to the upcoming reporting period (i.e. occurred in October 2013 for CY 2014 PQRS reporting period). **Of note, CMS *will not* apply the VBM to groups of physicians that are participating in the MSSP program, the Pioneer ACO models, or the Comprehensive Primary Care initiative.**

Physician Quality Resource Use Reports

Eligible professionals (EPs) are able to assess their performance, and how they would have performed had the VBM been applied to them in 2013, by downloading their Quality Resource Use Reports (QRURs) from the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html. These reports will inform physicians how they compare in cost and quality of care to their peers. Visit the Academy website for specifics on obtaining your report at http://bit.ly/entVBPM.

Each group then receives two composite scores (quality and cost), based on the group's standardized performance (e.g., how far away from the national mean). Group cost measures are adjusted for specialty composition of the group. This approach identifies statistically significant outliers and assigns them to their respective quality and cost tiers.

Quality/ Cost	Low Cost	Average Cost	High Cost
High Quality	+2.0x*	+1.0x*	+0.0%
Medium Quality	+1.0x*	+0.0%	-1.0%
Low Quality	+0.0%	-1.0%	-2.0%

Attribution of Beneficiaries for Purposes of Assigning Costs

CMS will use the same methodology used for the MSSP ACO program to assign beneficiaries to groups for purposes of the VBM. That is, they will assign beneficiaries based on the delivery of primary care services. For groups that do not provide primary care services, or who have fewer than 20 beneficiaries attributed to them, CMS will assign their cost composite as "average" cost.

For the new 2014 cost measure on Medicare Spending Per Beneficiary (see chart), CMS will attribute the Medicare spending per beneficiary (MSPB) episode solely to the physician group, identified by the TIN, that provided the plurality of Part B services billed during the index hospitalization. CMS will also require physicians to have a minimum of MSPB episodes attributed to them before this measure would be included in their cost composite for calculation of the VBM.

Value Modifier Components	2015 Finalized Policies	2016 Finalized Policies (take effect in 2014)
Performance Year	2013	2014
Group Size	100+	10+
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, OR 50% of EPs reporting individually **note: CMS expects to raise this % threshold in future years**
Quality/Outcome Measures	Measures reported through the GPRO PQRS reporting mechanism selected by the group OR individual measures reported by at least 70% of the EPs within the group All Cause Readmission Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease [COPD], heart failure, diabetes)	These requirements are the same for CY 2014 reporting, however, CMS also: Finalizes that groups of physicians with 25 or more eligible professionals will be able to elect to have the patient experience of care measures collected through the PQRS CAHPS for CY 2014 included in their payment modifier for CY 2016. If all the EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in CY 2014 and CMS cannot receive quality performance data from such registry, CMS will classify the group's quality composite score as "average" because they would not have data to reliably indicate whether the group should be classified as high or low quality.
Patient Experience of Care Measures	N/A	PQRS CAHPS: Option for groups of 25+ EPs
Cost Measures	Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	Same as 2015 and Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
Benchmarks	Group Comparison	Specialty Adjusted Group Cost: CMS also finalizes a specialty adjustment that allows for peer group comparisons related to the new cost measure for CY 2015.
Quality Tiering	Optional	Mandatory Groups of 10-99 EPs receive only the upward or neutral adjustment, no downward adjustment. Groups of 100+ are subject to an upward, neutral or downward adjustment. **CMS notes that groups of 100+ that furnish high quality care at high cost, for CY 2014 reporting, will not be subject to a payment penalty**
Payment at Risk	-1.0%	-2.0% if you don't participate in PQRS -2% if you're 100+ and provide low quality/high cost care -1% if you're 100+ and provide either low quality/average cost or average quality/high cost care.
Physician Feedback Reports (QRURs)	Reports sent to 24,000 providers in Iowa, Kansas, Missouri and Nebraska.	On September 16, 2013 groups with 25+ EPs received Quality Resource Use Reports (QRURs) that reflect their performance on quality and cost reporting measures based on their 2012 PQRS reporting. All physicians can expect QRURs in late summer of 2014.

Cost Composites and Benchmarking

CMS will account for specialty mix using a "specialty adjustment" method as it relates to calculating a group's standardized score for each cost measure and benchmarking against other groups for that performance year. The new specialty adjustment will entail the following:

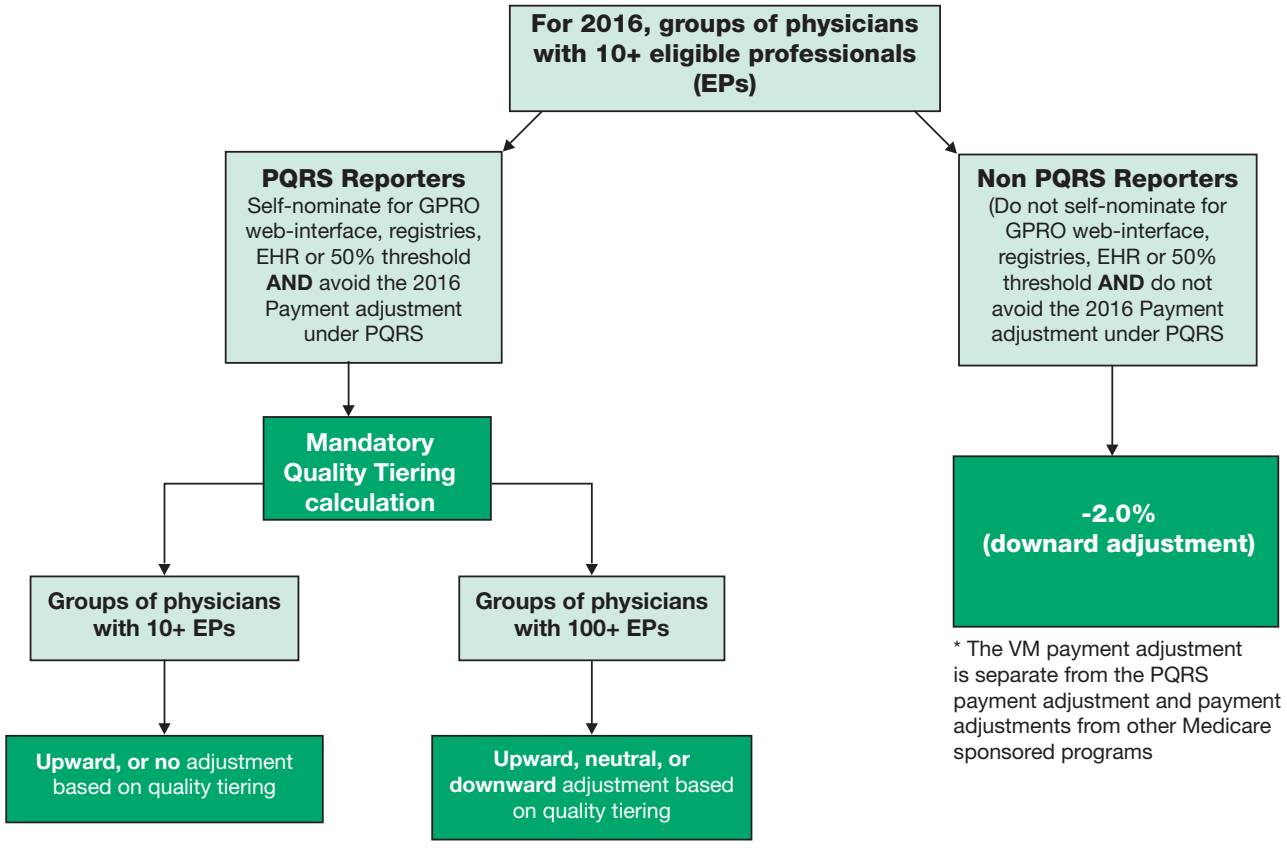
1. Creating a national specialty-specific expected costs;
2. Calculating a specialty-adjusted expected cost for each group of physicians by weighing the national specialty-specific expected costs by the group's specialty composition of Part B payments; and
3. Calculating a specialty-adjusted total per capita cost.

CMS will identify the specialty for each EP based on the specialty they have listed on the largest share of their Part B claims. CMS states that the "specialty adjustment" method accounts for the specialty composition of the group of physicians when making peer group comparisons and creates standardized scores for each cost measure. They also believe this methodology allows the payment modifier to apply to smaller size groups and solo practitioners. CMS states that although the calculations are very detailed, they are transparent and they can provide each group of physicians information on how their costs were benchmarked. CMS believes that the "comparability peer group" method would be less transparent. CMS does not believe it is necessary to delay implementation and will monitor the influence of the specialty adjustment method on physician groups.

Specifics on 2014 VBM requirements are outlined and additional information is available on the Academy website, including a new VBM Fact Sheet, at http://bit.ly/entVBPM.

How Does the Value Modifier Work with PQRS?

Value Modifier and the Physician Quality Reporting System (PQRS)

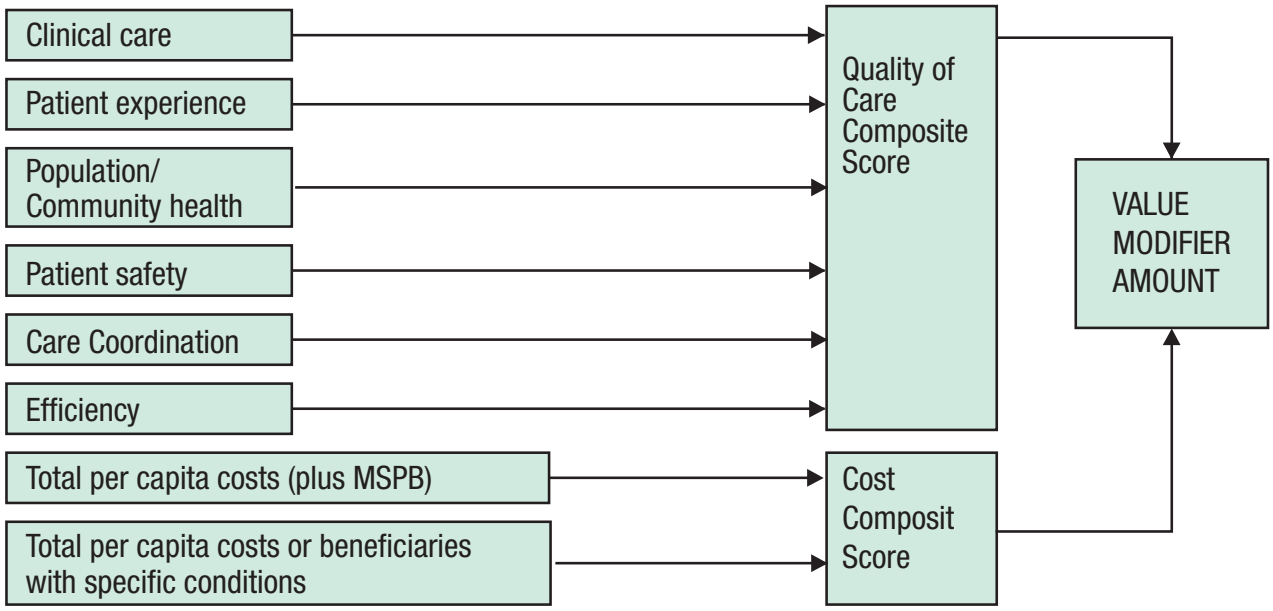


* The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs

How are My Quality and Cost Scores Calculated?

Quality-Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



The Ideal Learning Platform: Addressing the Learning Styles of All Otolaryngologists

In continuing medical education (CME) it is important that we use evidence-based adult and organizational learning principles to improve the performance and outcomes of our physician learners. In 1970, Educator Malcolm Knowles described "andragogy" as the art and science of helping adults learn. He came up with five assumptions about adult learners that formed the basis for his model. These assumptions are:

- Self-concept—being self-directed learners
- Experience—accumulated experiences become resources for learning
- Readiness to Learn—learning becomes oriented to what is occurring in real life
- Orientation to Learning—shifting from subject-centered to problem-centered learning
- Motivation—motivation to learn becomes internal in contrast to external rewards

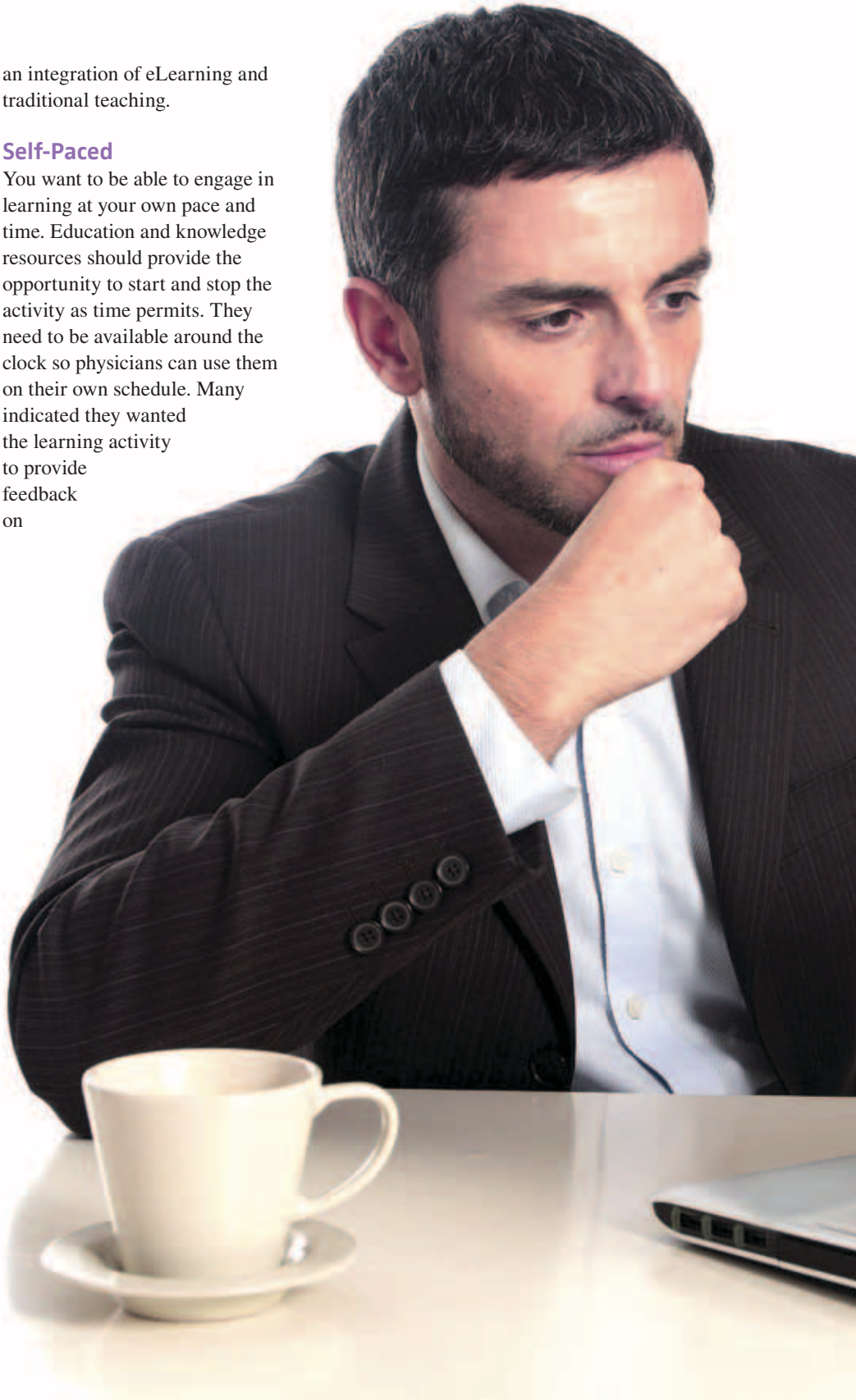
The Foundation considers each of these assumptions as it designs, implements, and evaluates the education opportunities it provides to its members. With this in mind, the 2013 Member Education Needs Assessment Survey asked, as adult learners, what your ideal learning resource would look like. The purpose is to identify the critical features and functionality of an ideal learning platform. Your responses can be summarized into the concept of "On Demand Learning," with five specific characteristics.

Accessible

You want to have easy access to education and knowledge resources. This includes making sure they are portable and can be found on mobile apps and tablets, as web-based, and in print. Many survey respondents suggested an integration of eLearning and traditional teaching.

Self-Paced

You want to be able to engage in learning at your own pace and time. Education and knowledge resources should provide the opportunity to start and stop the activity as time permits. They need to be available around the clock so physicians can use them on their own schedule. Many indicated they wanted the learning activity to provide feedback on



their progress and to assess their learning.

Interactive

Overwhelmingly, you want education and knowledge resources to be engaging and interactive. Many examples were case-based courses, combined lectures and interactive components, hands-on techniques, simulation, practice assessments, and clinical problem solving. Many felt this was the best way not only to gain knowledge but also to master competencies and improve performance.

Easily Digested

This characteristic included easy access, time efficiency, and continuous availability. It also encompassed how the material should be presented such as videos, diagrams and images, algorithms and flow charts, indexing and search functions, and demonstrations.

Customized

Members want the ability to customize their learning experience so that it meets their specific performance gaps and education needs. This includes availability of a variety of offerings, in a variety of formats, addressing all otolaryngology-head and neck specialties. The concept of "personalized learning" would provide a customized education platform specific to each learner.

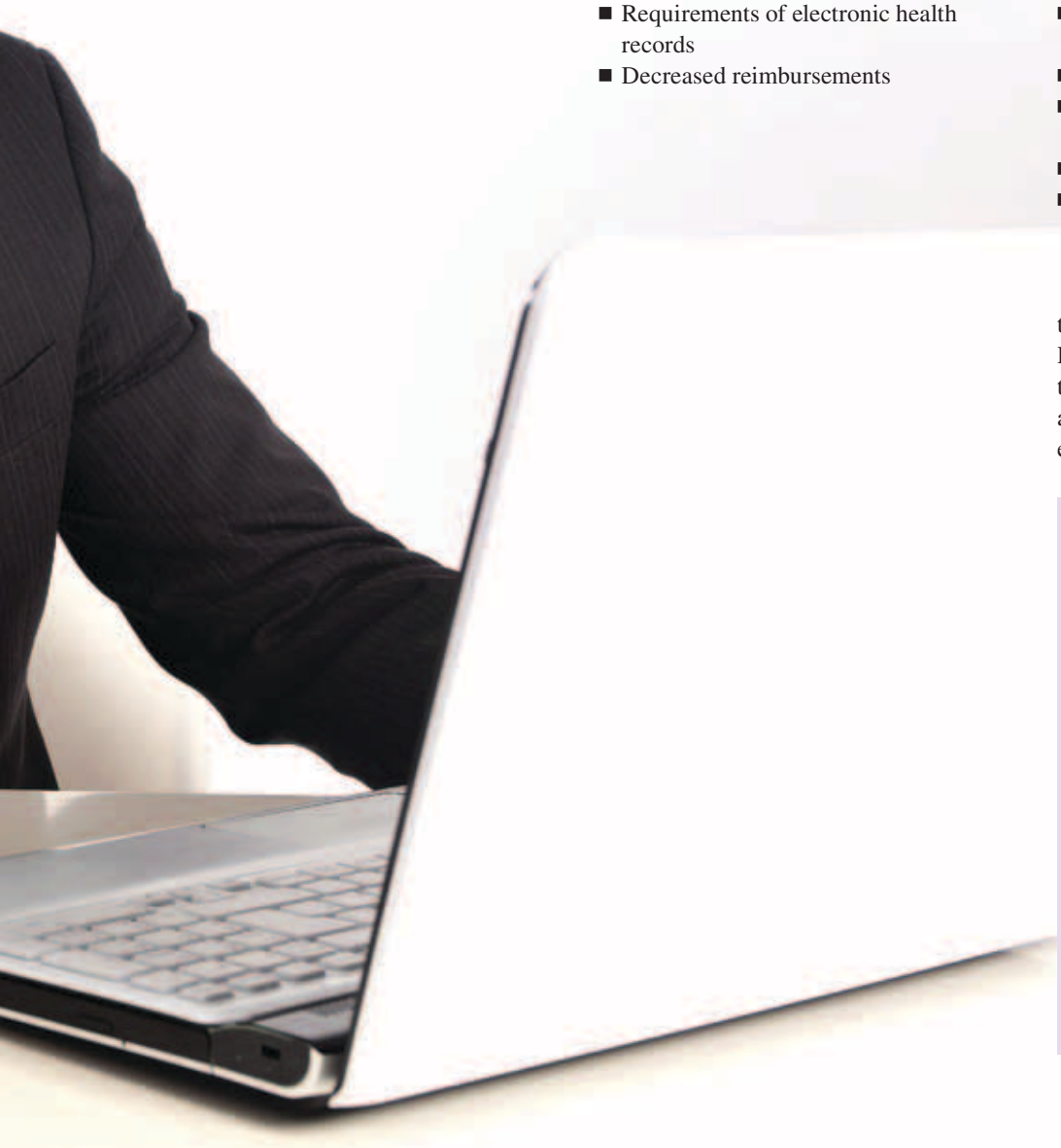
Another component of the education needs survey addressed the changes in healthcare that would have a significant impact on members' education needs. The changes include:

- Healthcare reform
- Government regulation
- Requirements of electronic health records
- Decreased reimbursements
- Focus on electronic education formats with less printed material
- Education delivery methods and content
- Decreased time to spend on education
- Cost of education and knowledge resources

Lastly, we asked your opinions on the need to collaborate with other healthcare groups. The vast majority of respondents agreed that it is very important to partner with other organizations. Suggestions of ways AAO-HNS/F can collaborate include:

- Board certification/recertification preparation
- Coordination and organization of education resources
- Development of guidelines and best practices
- Informing members of cutting edge research
- Improved patient care and outcomes
- More in-depth/specialized information
- Joint conferences
- Consistency in education messaging and goals

The evolution of healthcare will drive the need for collaboration for AAO-HNS/F. Each of the responses from the member survey will be considered as we develop the next generation of education and knowledge resources.



The Member Education Needs Assessment Survey yielded very valuable feedback and useful information. We have spent the past four months presenting the results to you through a series of *Bulletin* articles. Much work is underway to implement changes to the Foundation education platform based on the results from the survey. This will be a multi-year effort to build the ideal education platform. Look for future *Bulletin* articles and other messages describing both incremental and big changes that will impact member engagement and the value placed on the Education Program of the Foundation.

Global ENT Outreach Trip to Cambodia

Ameet K. Grewal, MD
Humanitarian Travel Grant Awardee

With the generosity of the AAO-HNSF Humanitarian Efforts Committee, I was given the opportunity to travel to Southeast Asia to participate in a mission trip focused on otologic surgery. As a current PGY-4 at Georgetown University Hospital, I was honored and excited by the experience. Cambodia is a country severely traumatized by its recent history; it is a nation struggling to find its path after enduring a tumultuous civil war and the perpetration of a vicious genocide on its people. In an effort to eradicate intellectuals, the majority of doctors were executed or exiled from the country. Among the many long-term effects of the Khmer Rouge regime is the lack of physicians and medical access. Considering this history of poverty and violence, coupled with the prevalence of treatable ear disease, patients here benefit greatly from foreign medical missions.

Upon arrival in Phnom Penh in September 2013, I was greeted warmly by the IMPACT Cambodia team. Richard Wagner, MD, founder of Global ENT Outreach (GEO), travels throughout the world teaching and performing otologic surgery. Our team also included Davide Panciera, MD, of Italy, Ineke Wever, MD, of Australia, and Denise Carmer, RN, of Arizona.

We began the week by conducting a clinic in the Preah Ang Duong Hospital and selecting surgical candidates. With the help of Cambodian physicians, we were able to obtain histories from our patients and send them for preoperative audiograms and imaging if needed. After selecting patients, we began operating that afternoon. The strong camaraderie between operating room staff and surgeons overcame whatever language barriers existed, and we operated together into the evening hours. The days that followed only built on that sentiment, proving the bond of operating together surpasses cultural differences.

Team members at Preah Ang Duong Hospital (l to r) Ineke Wever, MD, Davide Panciera, MD, Richard Wagner, MD, Denise Carmer, RN, and Ameet Grewal, MD.

The Preah Ang Duong Hospital in Phnom Penh is unique in that it caters only to otolaryngological and ophthalmologic surgery. Patients who would have undergone same day surgery in the United States are kept here for a one-week observation on the inpatient unit. Many patients traveled from remote villages to obtain care and remaining in Phnom Penh was the best post-operative option. Routine tympanoplasties and mastoidectomies for chronic middle ear disease were performed under local anesthesia with minimal intravenous sedation. Basic supplies such as ear speculums, gloves, syringes, local anesthetics, operating room drapes, and ear dressings would be helpful to gather prior to a trip. Compared with the United States, operative time was greatly reduced. Without general anesthesia or facial nerve monitoring, we were able to complete 47 cases in five days. The pace and the motivation of every person on our team helped achieve our goal.

I believe a real difference was made in many ways; the patients underwent procedures that allowed them to eradicate middle ear disease and hopefully restore hearing. Our fellow Cambodian physicians were engaged and learned how to work up these patients and perform surgeries as well. We made a connection with the ENT residents at the hospital and were able to learn from them about the difficulties of training where resources are so limited. The clinic days that generated our cases were busy and crowded, but satisfying. We worked together in a highly effective and efficient manner, with a common goal of helping as many people as we could in that short time.

I highly recommend humanitarian travel to fellow doctors. Seeing how patients are treated in other places in the world allows you to learn and reflect on common practices. I plan on future travel, both as a resident and an attending, to continue to help address the need for service throughout the world.

Dr. Wagner examines a clinic patient.

Dr. Grewal stands with patients waiting for surgery.

Orlando Annual Meeting Welcomes the World

When the AAO-HNSF 2014 Annual Meeting & OTO EXPO℠ opens September 21 in Orlando, we will welcome ENTs from around the globe. Led by International Coordinator **James E. Saunders, MD**, the International Steering Committee is hard at work developing events tailored especially to international visitors.

New Regional Advisors

New assignments on the committee are **Susan R. Cordes, MD**, as co-regional advisor for Africa with **James L. Netterville, MD**; **Prof. Marc Remacle, MD, PhD**, president, European Federation of Otolaryngology Societies (EUFOS), replacing **Prof. Karl Hoermann**; and **Soha N. Ghossaini, MD**, and **Ahmed A. H. Soliman, MD**, who will step in as co-regional advisors for the Middle East, replacing **G. Richard Holt, MD, D-BE, MSE, MPH**; and **Elizabeth H. Toh, MD**, who becomes a regional advisor for Asia-Pacific Rim, with **K.J. Lee, MD**.

Caucuses and Satellite Meetings

Regional advisors will host caucuses for delegates from Africa, Europe, Latin America, the Middle East, and, for the first time, Asia-Pacific Rim. Other international meetings include an International Women's Caucus for women leaders from the U.S. and around the world. **J. Pablo Stolovitzky, MD**, will facilitate the Cumbre de Lideres (Latin American Leaders' Summit) in Spanish, and **Juan Manuel Garcia Gomez, MD,** chairs the Panamerican Committee, so there are ample opportunities for Latin American visitors, who constitute the largest international group.

The AAO-HNS-Egyptian satellite meeting, which was a great success at the 2013 meeting in Vancouver, will be expanded to a Middle East Satellite meeting with attendees from Egypt, the Gulf, Lebanon, Saudi Arabia, and many other countries.

Spearheaded by **Gregory W. Randolph, MD**, and **Prof. Bernard G. Fraysse, MD**, an AAO-HNS-Francophone satellite meeting is planned for visitors from French-speaking countries.

International Assembly

Last year's International Assembly was well received, and Orlando will see a robust program for leaders of our International Corresponding Societies (ICS) network. The network now numbers 54 with the newest addition of the Taiwan Society of Otolaryngology. The Assembly will also present the 2014 International Visiting Scholars (IVS), including the Antonio Dela Cruz, MD, Memorial IVS from Latin America; the Nancy L. Snyderman, MD, IVS, awarded to an international woman otolaryngologist; and the Baxiram S. and Kankuben B. Gelot IVS, made possible by the generous support of Raghuvir B. Gelot, MD, and Carolyn Gelot.

Guest Countries and Global Health Symposium

This year, our president, **Richard W. Waguespack, MD**, will honor four guest countries: Ecuador, the Dominican Republic, Saudi Arabia, and the United Kingdom. The Global Health Symposium will highlight these countries, where regional advisors will introduce experts from these countries to speak on the state of the specialty in their country or region.

Mark Your Calendar

AAO-HNSF Annual Meeting & OTO Expo 2014

9/21 – 9/24/2014

Orange County Convention Center

International Steering Committee (including regional advisors)

- **James E. Saunders, MD**, coordinator for International Affairs, ex officio committee chair
- **Nikhil J. Bhatt, MD**, development coordinator and chair, International Otolaryngology Committee
- **Susan R. Cordes, MD**, regional advisor for Africa
- **Terry A. Day, MD**, regional advisor for the Caribbean
- **Ramon A. Franco Jr., MD**, regional advisor for Central America
- **Bernard Gil Fraysse, MD**, regional advisor for Francophone Africa
- **Juan Manuel Garcia Gomez, MD**, chair, Panamerican Committee
- **Soha N. Ghossaini, MD***, regional advisor for the Middle East
- **G. Richard Holt, MD, D-BE, MSE, MPH**, regional advisor for the Middle East
- **David W. Kennedy, MD**, regional advisor for Europe
- **Chong-Sun Kim, MD, PhD**, president of IFOS
- **K. J. Lee, MD**, regional advisor for Asia-Pacific Rim
- **Eugene N. Myers, MD, FRCS Edin (Hon)**, regional advisor for the Balkans, Greece, and Turkey
- **James L. Netterville, MD**, regional advisor for Africa
- **Milan Profant, MD, PhD**, secretary-general IFOS
- **Gregory W. Randolph, MD**, consultant
- **Marc J. Remacle, MD, PhD***, regional advisor for Europe
- **Anatoly F. Romanchishen, MD, PhD, DSc**, regional advisor for Russia
- **Hector E. Ruiz, MD**, secretary-general, Panamerican Association
- **Merry E. Sebelik, MD**, chair, Humanitarian Efforts Committee
- **Nancy L. Snyderman, MD**, advisor for International Women
- **Ahmed M. S. Soliman, MD***, regional advisor for the Middle East
- **J. Pablo Stolovitzky, MD**, regional advisor for Latin America
- **Elizabeth H. Toh, MD***, regional advisor for Asia-Pacific Rim
- **Mark E. Zafereo, Jr., MD**, advisor for International Young Professionals

**Newly appointed*

Panamerican Committee

- **Juan Manuel Garcia Gomez, MD** (Colombia), chair
- **Jacqueline Alvarado Medina, MD** (Venezuela)
- **Hemendra N. Bhatnagar, MD** (U.S.)
- **Emiro E. Caicedo Granados, MD** (El Salvador)
- **Gabriel Calzada, MD** (U.S.)
- **Jose Roberto Castro Montoya, MD** (El Salvador)
- **Alejandra Daza, MD** (Venezuela)
- **Luis A. Macias Fernandez, MD** (Mexico)
- **Hernan Goldsztein, MD** (U.S.)
- **Adam M Klein, MD** (U.S.)
- **Graciela Pepe, MD, PhD** (Argentina)
- **Kevin D. Pereira, MD, MS** (ORL) (U.S.)
- **Steven Daniel Pletcher, MD** (U.S.)
- **Edmund A. Pribitkin, MD** (U.S.)
- **Jonathon O. Russell, MD** (U.S.)
- **Hector M. Santini, MD** (U.S.)
- **Giovana R. Thomas, MD** (U.S.)
- **Tulio A. Valdez, MD** (U.S.)
- **Richard L. Voegels, MD, PhD** (Brazil)

International Otolaryngology Committee

- **Nikhil J. Bhatt, MD,** committee chair
- **Dunia Abdul-Aziz, MD**
- **Sanjay Athavale, MD**
- **Nicolas BuSaba, MD**
- **Juan A. Chiossone Kerdel, MA, MD, FRCS**
- **David W. Clark, MD**
- **W. J. Cornay, III, MD**
- **Arun K. Gadre, MD**
- **Soha N. Ghossaini, MD**
- **Mohammed A. Gomaa, MD**
- **Anthony F. Jahn, MD**
- **Herman A. Jenkins, MD**
- **Ashutosh Kacker, MD**
- **Rajesh S. Kakani, MD**
- **Lily Love, MD**
- **Kevin Christopher McMains, MD**
- **Dinesh C. Mehta, MD**
- **Shri K. Nadig, MD, FRCS, DLO**
- **Mohsen Naraghi, MD**
- **Vaclav Pavelec, MD, PhD**
- **Hassan H. Ramadan, MD, MSc**
- **Anais Rameau, MD**
- **Nikhila M. Raol, MD**
- **Michael J. Rutter, MD, FRACS**
- **Samuel H. Selesnick, MD**
- **Aristides Sismanis, MD**
- **Carl H. Snyderman, MD, MBA**
- **Jesse G. Wardlow, Jr., MD**
- **K. John Yun, MD**
- **Catherine R. Lincoln, CAE, MA** (Oxon)

Academy Represented at WHO Eastern Mediterranean Workshop

Soha N. Ghossaini, MD

The World Health Organization (WHO) estimates that at least 360 million people—nearly five percent of the world's population—have disabling hearing loss of greater than 40 dB. The vast majority of these individuals live in resource-poor countries where hearing services are limited or non-existent.

In November 2013, WHO's Regional Office for the Eastern Mediterranean (WHO-EMRO) invited AAO-HNS to participate in its regional workshop on "Strengthening and Integrating the Ear and Hearing Care Programme within Primary Health Care and Health Systems."

The workshop took place November 18-20 in Doha, Qatar, in collaboration with the Qatar Supreme Council for Health (SCH), and was moderated by Haroon Awan, MBChB, MMedOphth, consultant. Fifty-three participants representing many of the 23 EMR member states, plus professional societies and nongovernmental organizations, discussed ways to improve the ear and hearing healthcare in the region.

After the opening session by Salih Ali Al-Marri, MD, General Secretary Assistant for Medical Affairs, SCH, Qatar, Shelly Chadha, MD, technical officer, WHO Prevention of Blindness and Deafness (PBD), presented a global overview of the WHO PBD program.

Abdul Hanan Choudhry, MD, WHO-EMRO medical officer, PBD, reviewed the current state of the ear and hearing care program in the region's healthcare. In addition, representatives from countries that are successfully integrating ear and hearing healthcare presented their programs.

Representing the Academy, **Soha N. Ghossaini, MD**, associate professor, University of Illinois, Chicago, shared the goals and scope of the Academy's international outreach, including worldwide collaboration, exchange of knowledge and education, and the way the Academy can help promote ear and hearing health globally.

Most of the workshop was dedicated to group work sessions aimed at helping the WHO/EMRO countries develop their own strategy on integrating hearing health within primary care. Sessions focused on research and evidence, service delivery, ear and hearing health workforce, and development of one-year country plans.

Dr. Ghossaini actively participated in group work with attendees from Egypt, India, Iran, Jordan, Tunisia, and the U.K. She proposed that the recommendations 1. include partners, professional societies, NGOs, and collaborating centers to provide academic support to ear and hearing health conferences in the region, and 2. promote sharing of information with governments and NGOs.

For details, visit http://www.emro.who.int/control-and-preventions-of-blindness-and-deafness/events-and-meetings/workshop-ear-hearing-care-within-primary-health-care-doha-qatar.html.

WHO-EMR Meeting on Deafness, Qatar (front row, R to L). Dr. Khalid Ali Altalhi Abu Alwah (Saudi Arabia); Dr. Jaouad Hammou (Morocco); Dr. Haroon Awan (Pakistan); Dr. Saad Abdillahi Awaleh (Djibouti); Dr. Mohamed Hosny Abdel Alim (Egypt); Dr. Abdul Hanan Choudhury (WHO-EMRO, Egypt); Dr. Salih Ali Al-Marri (Qatar); Dr. Khalid Abdul Hadi (Qatar); Dr. Ghulam Kazi (WHO Pakistan); Dr. Soha Ghossaini (U.S.); Dr. Monzer Hamzeh Al Labadi (Jordan); Dr. Abdul Karim Al Saei (Bahrain); Dr. Hassan Falih Al Sultany (Iraq); and Prof. Manzoor Ahmad (Pakistan).

Pittsburgh Ear Research Foundation
Division of Otology Research and Neurotology
Allegheny General Hospital, Pittsburgh, Pennsylvania

Presents

Temporal Bone and Microanatomy Hands-on Dissection Workshop

June 20 & 21, 2014
October 24 & 25, 2014

This workshop is intended for otolaryngologists interested in the most recent development in temporal bone surgical techniques.

Registration fee: $425
Location: Allegheny General Hospital, Pittsburgh, Pennsylvania
Course Co-Directors: Douglas A. Chen, MD, FACS
Todd A. Hillman, MD

For additional information, please contact Allegheny General Hospital, Continuing Medical Education by e-mail to **cjackel@wpahs.org**, by phone at 412-359-4952, or by fax at 412-359-8218. To download a brochure or to register online, please visit our Web site at **www.aghcme.org**. Select Conference Schedule on the left, then scroll until you find the appropriate Temporal Bone Course.

Allegheny Health Network
Allegheny General Hospital

14TH ANNUAL

Charleston Magnolia Conference

May 30 - 31, 2014

– Guest Speakers –

Howard W. Francis, M.D., M.B.A.
Professor and Vice Director
Department of Otolaryngology - Head and Neck Surgery
Director of Johns Hopkins' Listening Center
Johns Hopkins University School of Medicine, Baltimore, MD

Peter A. Hilger, M.D.
Professor and Director
Division of Facial Plastic and Reconstructive Surgery
Department of Otolaryngology - Head and Neck Surgery
University of Minnesota, Minneapolis, MN

William M. Lydiatt, M.D.
Professor and Vice Chair
Department of Otolaryngology - Head and Neck Surgery
Director of Head & Neck Surgery
University of Nebraska Medical Center, Omaha, NE

– Topics –

• Endoscopic Sinus Surgery • Endocrine Surgery
• Endoscopic and Robotic Head and Neck Cancer Surgery
• Management of Cholesteatoma • Cochlear Implants
• Facial Plastic Surgery • Bell's Palsy • Salivary Gland Surgery

– Recreation –

Beaches | Golf | Historic Charleston | Spoleto Arts Festival USA

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Otolaryngology – Head & Neck Surgery
Contact: 843-876-0493 • Email: mansfiee@musc.edu
http://ENT.musc.edu

Twelfth Annual

Porubsky Symposium and Chief Resident Graduation/Alumni Weekend

May 30–31, 2014

An update and overview of current concepts in general otolaryngology, laryngology, rhinology, otology, and head and neck surgery.

Distinguished Guest Speaker
Dennis H. Kraus, MD, FACS
Director, Center for Head & Neck Oncology
New York Head & Neck Institute
North Shore - LIJ Cancer Institute

Course Co-Directors
Michael W. Groves, MD, FACS
David J. Terris, MD, FACS
Department of Otolaryngology - Head and Neck Surgery
Georgia Regents University, Augusta, GA

For Questions:
Georgia Regents University
Medical College of Georgia
Division of Professional and
Community Education
1120 15th Street, FI1066
Augusta, GA 30912
Phone: 800-221-6437 or 706-721-3967
Fax: 706-721-4642
E-mail: MQUARLES@gru.edu
Internet: gru.edu/ce

GRU
GEORGIA REGENTS UNIVERSITY
AUGUSTA

THERE'S STILL TIME...
REGISTER ONLINE NOW!

WWW.COSM.MD

COMBINED OTOLARYNGOLOGY
COSM
SPRING MEETINGS

MAY 14-18, 2014

CAESAR'S PALACE, LAS VEGAS, NEVADA

ATTEND COSM AND...

- ☑ Network with over 1,500 Otolaryngologists
- ☑ Attend multiple scientific sessions
- ☑ View over 500 posters
- ☑ Listen to research and studies conducted by your colleagues
- ☑ Visit with over 85 exhibiting companies with products geared towards your specialty
- ☑ Enjoy the ultimate Las Vegas experience at an iconic luxury hotel in the center of "the Strip"

MEETING DETAILS AVAILABLE AT WWW.COSM.MD

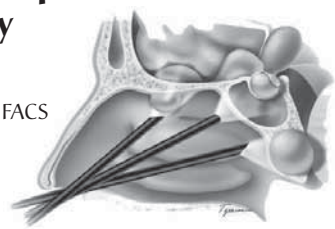
2014 PARTICIPATING SOCIETIES:

ABEA – American Broncho-Esophagological Association
ALA – American Laryngological Association
ANS – American Neurotology Society
AOS – American Otological Society
ARS – American Rhinologic Society
ASPO – American Society of Pediatric Otolaryngology
TRIO – The Triological Society

Questions? Email **cosmsupport@facs.org**
or visit **www.cosm.md**

May 30–31, 2014 • New York City

Advanced Endoscopic Skull Base and Pituitary Surgery



COURSE DIRECTORS:
Vijay K. Anand, MD, FACS
Theodore H. Schwartz, MD, FACS

GUEST FACULTY:
John Jane Jr., MD
Nelson Oyesiku, MD

2-DAY COURSE DESCRIPTION: This course is a comprehensive overview of the newly emerging field of endoscopic skull base surgery combining didactic sessions with hands-on cadaver dissection. At the completion of this course, participants should be well equipped to start utilizing these approaches in their own practices. Endoscopic instruments and surgical navigation equipment will be available to participants for use on fresh cadavers during laboratory sessions. Participants will have an opportunity to discuss difficult cases with the faculty during panel discussions. Early registration is highly recommended.

LOCATION: Weill Cornell Medical College
1300 York Avenue, New York, NY 10065

INFORMATION: Course Coordinator
Tel: 212-585-6800
email: nypcme@nyp.org
www.weillcornellbrainandspine.org

Weill Cornell Medical College
NewYork-Presbyterian
Weill Cornell Medical Center

20th Utah Otolaryngology Update

June 20-21st, 2014 Salt Lake City

Guest Speakers:

David J. Brown, MD
Steven Gray Memorial Lecturer
University of Michigan

Eric Kezirian, MD, MPH
David Dolowitz Memorial Lecturer
University of Southern California

Samuel H. Selesnick, MD, FACS
James Parkin Lecturer
Weill Cornell Medical College

For more information contact:
Halley Langford | (801) 581-7515 | Halley.Langford@hsc.utah.edu

Sponsored by the University of Utah Otolaryngology - Head and Neck Surgery, and by the University of Utah School of Medicine.

BEST EVIDENCE ENT 2014

AUGUST 2-5

At The American Club in Kohler, Wisconsin, USA
Home to Whistling Straits - site of the 2015 PGA Championship and the 2020 Ryder Cup, and ranked #2 by Golf Digest Magazine among US Public Courses

FEATURING:

HONORARY GUEST LECTURERS,
TIMOTHY L. SMITH, MD, MPH
DEAN TORIUMI, MD

MINI SLEEP SURGERY COURSE
PRESENTED BY
B. TUCKER WOODSON, MD

Conference Directors:
John S. Rhee, MD, MPH
David R. Friedland, MD, PhD
Charles H. Harkins, MD

For more information & to register visit: WWW.MCW.EDU/ENT

EXPLORE NEW HORIZONS

At the Beach

Imagine working where award-winning healthcare goes hand-in-hand with an exceptional quality of life! **Beebe Healthcare** is a progressive, not-for-profit community healthcare system with a 210-bed medical center located just blocks from the Atlantic Coast.

- General/Surgical Otolaryngologist; BC/BE
- Join a well-established practice with a strong otolaryngology patient base
- Employed within the hospital network; comprehensive salary and benefits
- Cardiac surgery, interventional cardiology, board-certified radiation oncologists, regular tumor board meetings, 256-slice CT, 3.0T MRI, PET scan, endoscopic navigation

Exceptional location, with close proximity to Baltimore, DC, Philly, NYC. Family-oriented Southern Delaware Beaches rank among Top 10 Beaches/Boardwalks *(Parents Magazine, National Geographic, Travel and Leisure, American Profiles Magazine)*. Come discover Beebe, where you will make a difference!

424 Savannah Road I Lewes, DE 19958 I www.beebehealthcare.org
Email cover letter and CV to: mhill@beebehealthcare.org
Visit www.beebehealthcare.org to view additional physician opportunities.

Beebe Healthcare

ARS American Rhinologic Society

3RD ANNUAL SUMMER SINUS SYMPOSIUM

SAVE THE DATE:
JULY 18-19, 2014
WESTIN, MICHIGAN AVENUE, CHICAGO, IL

50% DISCOUNT
Half-price registration for first time attendees of the meeting

The ARS Summer Sinus Symposium is a meeting for all Otolaryngologists who treat and manage nasal and sinus issues, from the office to the operating room. Don't miss your chance to attend in 2014!

REGISTRATION IS NOW OPEN!

Visit **www.american-rhinologic.org/ars_courses** for more information on complete program details, including hotel and registration information.

COURSE HIGHLIGHTS:

- Demonstration dissections using the latest technology
- Panel discussions with renown faculty on a variety of hot topics
- Sinus Surgery
- Allergy & Immunology
- Rhinoplasty
- Office Procedures
- Practice Management

COURSE DIRECTORS:

Rakesh Chandra, MD,
James Palmer, MD, Kevin Welch, MD

QUESTIONS?

Email us at ARS@facs.org

RUTGERS
New Jersey Medical School

Faculty Position, Pediatric Otolaryngology
Department of Otolaryngology-Head and Neck Surgery

Rutgers New Jersey Medical School, Department of Otolaryngology-Head and Neck Surgery is recruiting a fellowship-trained Pediatric Otolaryngologist faculty member for July 2014. The successful applicant will join a rapidly growing academic department, and will be expected to contribute to its clinical, educational and research activities. The faculty member will split his/her time between our practices at Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center and Rutgers New Jersey Medical School campus. The Department houses the only allopathic residency training program in New Jersey and collaborates with an extensive array or health care providers across the Rutgers Biomedical and Health Sciences units.

Applicants for this position must be able to perform at a high level both clinically and academically. Salary will be commensurate with ability, training, experience and demonstrated prior performance, and is designed to attract an outstanding physician and surgeon.

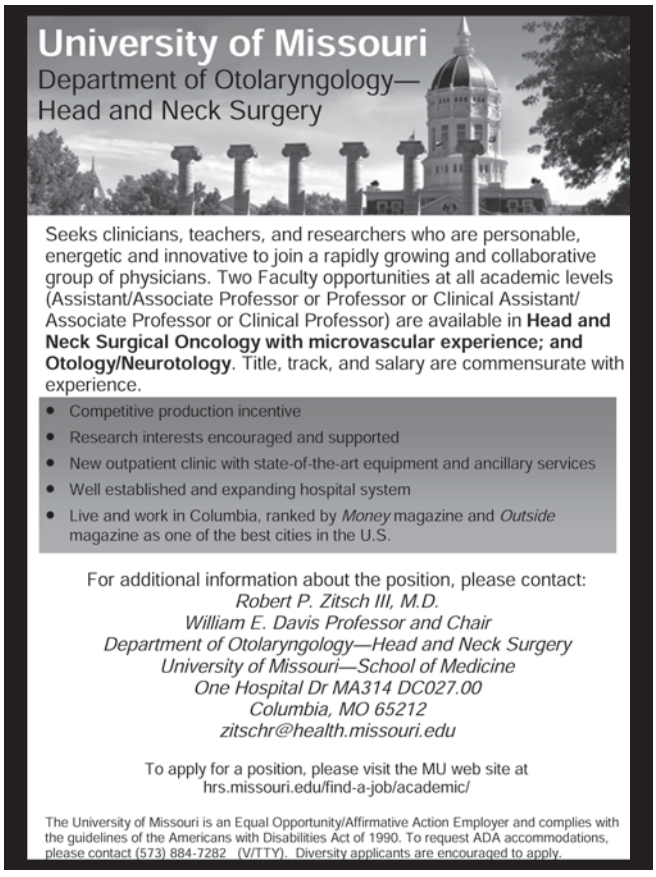
Submit inquiries and current Curriculum Vitae to:

Soly Baredes, M.D.
Professor and Chairman

Huma Quraishi, M.D.
Director of Pediatric Otolaryngology

Aaron Hajart, MS, ATC
Sr. Director of Administration

Rutgers New Jersey Medical School
Department of Otolaryngology-Head and Neck Surgery
90 Bergen Street, Suite 8100, Newark, NJ 07103
(973) 972-2341 • hajartaf@njms.rutgers.edu



Seeks clinicians, teachers, and researchers who are personable, energetic and innovative to join a rapidly growing and collaborative group of physicians. Two Faculty opportunities at all academic levels (Assistant/Associate Professor or Professor or Clinical Assistant/ Associate Professor or Clinical Professor) are available in **Head and Neck Surgical Oncology with microvascular experience; and Otology/Neurotology**. Title, track, and salary are commensurate with experience.

- Competitive production incentive
- Research interests encouraged and supported
- New outpatient clinic with state-of-the-art equipment and ancillary services
- Well established and expanding hospital system
- Live and work in Columbia, ranked by *Money* magazine and *Outside* magazine as one of the best cities in the U.S.

For additional information about the position, please contact:
Robert P. Zitsch III, M.D.
William E. Davis Professor and Chair
Department of Otolaryngology—Head and Neck Surgery
University of Missouri—School of Medicine
One Hospital Dr MA314 DC027.00
Columbia, MO 65212
zitschr@health.missouri.edu

To apply for a position, please visit the MU web site at
hrs.missouri.edu/find-a-job/academic/

The University of Missouri is an Equal Opportunity/Affirmative Action Employer and complies with the guidelines of the Americans with Disabilities Act of 1990. To request ADA accommodations, please contact (573) 884-7282 (V/TTY). Diversity applicants are encouraged to apply.

Six-physician single specialty group seeking a partner with BC/BE physician interested in general ENT with Laryngology emphasis. Fellowship training preferred but not required. Successful practice provides broad spectrum of ENT care with subspecialties in rhinology, head and neck surgery, facial plastic and reconstructive surgery. Our 16,000 square foot facility includes an AAAHC approved Surgery Center, an in-house CT scanner, full service Audiology and Allergy departments. Office is adjacent to a regional medical center.

Compensation package includes a first year salary with productivity incentives and the opportunity for partnership after the 1st year.

Boise is often cited as one of the top 10 best cities in which to live. It is a safe, family-oriented community with an excellent education system and a wonderful climate. Boise's Rocky Mountain location offers plenty of recreational activities including skiing, white water rafting, mountain biking, fishing, hunting, etc.

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

BRIGHAM AND WOMEN'S HOSPITAL

Massachusetts Eye and Ear Infirmary

Head and Neck Surgical Oncologist Faculty Position, Director

The Department of Otology and Laryngology at Harvard Medical School and the Division of Otolaryngology and Head and Neck Oncology at the Dana-Farber and Brigham and Women's Hospitals are recruiting a full-time academic head and neck surgical oncologist clinician-scientist to support the clinical and research goals of the Dana-Farber/Brigham and Women's Cancer Center and the academic mission of the Harvard Department of Otology and Laryngology. This position will serve as the Surgical Director of the Head and Neck Oncology Program at the Dana-Farber and Brigham and Women's Cancer Center.

The ideal applicant will have medical leadership experience and training and expertise in head and neck surgical oncology and otolaryngology.

The candidate should be board certified in otolaryngology and qualified to be appointed as a faculty member at Harvard Medical School. Salary and academic appointment will be commensurate with training and level of experience.

Brigham and Women's Hospital is a Top 10 ranked US News and World Report Academic Medical Center and is a major teaching hospital of Harvard Medical School.

Interested applicants should submit curriculum vitae to:

Jo Shapiro, MD at **aschwarzer@partners.org**.

Harvard Medical School and Brigham and Women's Hospital are equal opportunity/affirmative action employers with strong institutional commitments to diversity in their faculty. Women and minority candidates are particularly encouraged to apply.

General Otolaryngologist Needed

Atlanta, Georgia
Private Practice
(4 Physician Group Practice)
Immediate Opening

Full Benefit Package
E.R. Call 1:7 Weeks
Metropolitan City
Great Schools

Email Resume to:
Ear, Nose & Throat Plastic Surgery Center
Attn: Neil Persaud
<napent@bellsouth.net>

UCONN | HEALTH CENTER

NEUROTOLOGY OPPORTUNITY
Farmington, Connecticut

The Department of Otolaryngology at UConn Health Center seeks an additional fellowship trained Neurotologist. Interested candidates should be board certified/board eligible and eligible for licensure in the state of Connecticut. In this position, you will join a well-established group of six physicians.

This position will allow you to be a vital component of a thriving ENT Division. You would be expected to practice in their new 300,000 sq ft faculty practice facility in Farmington CT. You will have the opportunity to direct a fully equipped balance center and would work collaboratively with Neurosurgery, Neurology, and the Center on Aging. In addition, you would expand on the existing skull base surgery and chronic ear practice.

Position will include education responsibilities with students and residents of the University Connecticut integrated residency program in Otolaryngology along with the opportunity for clinical research in collaboration with a world renowned group of Hearing Scientists.

The Farmington Valley is a wonderful place to raise a family and has many outstanding schools and neighborhoods. The area was recently named one of the 10 best places in the United States to live for the next decade by Kiplinger's magazine. It has a four season climate and is within two hours of Boston and New York.

The University of Connecticut Health Center is an affirmative action employer, in addition to an EEO and M/F/V/PWD employer. http://uconnent.uchc.edu/patientcare/index.html

For more information please contact:
Beth Briggs
800-678-7858 ext 64454 | ebriggs@cejkasearch.com

ID#152296AD cejkasearch.com

KU UNIVERSITY of KANSAS
DEPARTMENT OF
OTOLARYNGOLOGY-
HEAD & NECK SURGERY

Head and Neck Fellowship

Clinical Focus: Head and neck surgical oncology, skull base surgery, endoscopic laser surgery, minimally invasive endocrine surgery, microvascular reconstructive surgery and robotic surgery

Applications are accepted through the American Head and Neck Society: **www.ahns.info**

To view position online, go to **http://jobs.kumc.edu** and search by position number.

Letters of inquiry and CV may be mailed or emailed to:

Dan Bruegger, MD, Associate Professor and Interim Chairman
The University of Kansas School of Medicine
Department of Otolaryngology-Head & Neck Surgery
3901 Rainbow Blvd, MS 3010, Kansas City, KS 66160
Email: **dbruegge@kumc.edu**

Otolaryngology

Call This Top 10 Community Home

McFarland Clinic PC

- daVinci Robot and the Olympus Video System
- In-office laryngeal biopsies
- New state-of-the-art minor procedure room
- Epic EMR System
- Weekly cancer case conference
- Established, collegial team and support staff
- Physician owned and governed
- Large, established referral network
- One of the least litigious states in the country

Featured 9th in Money Magazine's "Best Places to Live", Ames, Iowa is recognized as an active, friendly community with plenty to do. Ames is a vibrant university town with one of the highest-rated public school systems in the nation. Having close access to several major metropolitan cities means that this versatile community provides small-town serenity and charm plus big-city amenities and culture.

EOE/AA Employer

Contact Doug Kenner
866.670.0334 or dkenner@mountainmed.net

Job Opportunity in South Florida

Chief of Adult Otolaryngology Services

About the Opportunity:

Memorial Healthcare System is seeking a Chief of Adult Otolaryngology Services. This is a full-time hospital employed leadership position with competitive benefits and compensation package. Memorial Healthcare System currently employs three otolaryngologists supporting an established ENT service covering outpatient clinic, inpatient hospital consults, including the ER. The Memorial Cancer Institute and the Memorial Neuroscience Institute collaborate needed services within the otolaryngology sub specialized areas.

Memorial Healthcare System

Successful candidates will meet the following criteria:

- Fellowship training in skull based head and neck surgery required;
- Advanced training in reconstructive skull based surgery preferred;
- Board certified in general otolaryngology;
- Minimum of five (5) years leadership experience in a hospital-based ENT service line;
- Understands and practices evidence-based medicine;
- Proficient with electronic medical records;
- Excellent communication, interpersonal and team leadership skills;
- Establish policies and guidelines to monitor effectiveness of medical care, evidence-based clinical outcomes, and patient progress;
- New program development experience;
- Will perform adult general ENT procedures and surgeries, share call and cover the Emergency Department.

About Memorial Healthcare System:

Memorial Healthcare System is a 1,900-bed healthcare system located in South Florida and is highly regarded for its exceptional patient- and family-centered care. Memorial's patient, physician and employee satisfaction rates are some of the most admired in the country, and the system is recognized as a national leader in quality healthcare.

About South Florida:

South Florida offers quality of life, is rich in cultural and recreational amenities, and offers pristine beaches, top-rated golf courses, museums and world-class dining. The greater Ft. Lauderdale area offers numerous communities in which to raise a family. In addition, Florida has no state income tax.

To apply for this opportunity or learn more, visit memorialphysician.com.

PremierMedical®

Join a well-established practice in Alabama.

ENT practice is seeking a BC/BE Otolaryngologist to join our current 12 physicians July 2015.

Premier Medical is one of the largest multi-specialty eye, ear, nose & throat groups in the southeast. The diverse practice includes an Audiology & Allergy Department, an in-house CT scanner and is associated with a surgery center.

On-call schedule would include – Once every 6 week days and once every 12 weekends. This position offers a comprehensive benefit package and a competitive salary.

Mobile is the second largest metropolitan area in Alabama and is located only 30 miles from the Gulf of Mexico. The region offers an abundance of cultural & recreational opportunities for everyone - affordable living, arts, hunting, fishing, sailing, good schools and is a family friendly environment. A great place to live & work!

Interested individuals should send CV to or may contact:
Jimmy Hartman
2880 Dauphin Street
Mobile, AL 36606
251-341-3406 • jhartman@pmg.md
www.premiermedicalgrp.com

South Florida ENT Associates, P.A.

South Florida ENT Associates, a forty-seven physician group practice in Miami-Dade, Broward and Palm Beach has immediate openings for full-time ENT Physicians. South Florida ENT Associates is the second largest ENT group in the country and the largest in the state of Florida. We provide full service ENT including Audiology, Hearing Aid Sales, Allergy, Facial Plastics, Robotics and CT services.

We offer an excellent salary/bonus with partnership track, health insurance, paid vacation time, malpractice insurance and CME reimbursement, plus other benefits.

Candidate must have strong clinical knowledge, excellent communication skills, be highly motivated and hardworking.

This position will include both office and hospital settings.

Requirements:
Board Certified or Eligible preferred
MD/DO from approved medical/osteopathy school and graduation from accredited residency program in ENT
Current Florida license
Bilingual (English/Spanish) preferred
Excellent communication and interpersonal skills
F/T - M-F plus call
For more information about us, please visit www.sfenta.com.

Contact Information:
Contact name: Stacey Citrin, CEO
Phone: (305) 558-3724 • Cellular: (954) 803-9511
E-mail: scitrin@southfloridaent.com

Otolaryngologist Opportunity

Geisinger Health System (GHS) is seeking a BC/BE Otolaryngologist for Geisinger-Scenery Park, located in State College, Pa.

Bring your expertise to a growing practice with an established referral base. Enjoy a balanced schedule and the opportunity to participate in program development.

Geisinger Health System serves nearly 3 million people in Northeastern and Central Pennsylvania and has been nationally recognized for innovative practices and quality care. A mature electronic health record connects a comprehensive network of 4 hospitals, 38 community practice sites and more than 900 Geisinger primary and specialty care physicians.

The State College region offers an outstanding quality of life in a university town environment, including excellent restaurants and cultural activities, and some of the top nationally-ranked public and private schools. State College offers easy access to Interstate-80 and a local airport for weekend getaways to Philadelphia, Washington D.C. and New York City.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

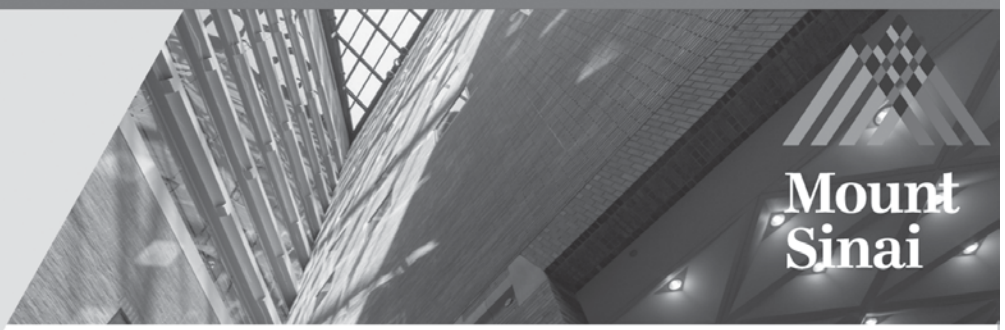
For more information, please visit Join-Geisinger.org or contact: Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu.

Follow us: | LinkedIn

GEISINGER HEALTH SYSTEM

Icahn School of Medicine at Mount Sinai • Department of Otolaryngology – Head and Neck Surgery

Director of Otology/ Neurotology



THE MOUNT SINAI HEALTH SYSTEM

Mount Sinai Hospital • Beth Israel Hospital • New York Eye and Ear Infirmary • St. Luke's Hospital • Roosevelt Hospital

The **Mount Sinai Health System Department of Otolaryngology – Head and Neck Surgery** is seeking applications for the Director of Otology/Neurotology of theEar Institute. The Institute represents one of the largest academic otologic-neurotologic practices in the country.

Located in the heart of Manhattan, the Ear Institute is staffed by 6 full-time and 7 voluntary otologic surgeons and 16 audiologists. The Director will lead the otology division of the **Mount Sinai Health System** working with the multidisciplinary team of physicians to expand skull base surgery, the cochlear implant program, clinical audiology, balance disorders, research and clinical trials. The candidate will work closely and collaborate with the Department of Neurosurgery as an integral part of the skull base surgery program. The candidate will also serve as the medical director for audiology services and oversee otologic research of the health system and developing philanthropy.

The **Mount Sinai Health System** is the largest health system in New York and is composed of the Mount Sinai Hospital, New York Eye and Ear Infirmary, Beth Israel Hospital, and St. Luke's and Roosevelt Hospitals. The Ear Institute is based at New York Eye and Ear Infirmary. The Health System is composed of 50 full-time otolaryngologists and 291 community otolaryngologists. The department of otolaryngology has 12 satellite offices with audiology programs in 8 offices.

The candidate should be fellowship-trained in otology/neurotology and qualified for faculty appointment at the Associate Professor or Professor level commensurate with his/her level of experience. The candidate is required to have a medical degree, board certification and able to obtain a New York State medical license.

Recruitment for Faculty

• General Otolaryngologist • Head and Neck Surgeon • Neurotologist
• Pediatric Otolaryngologist • Rhinologist

The Department of Otolaryngology-Head and Neck Surgery is seeking full-time otolaryngologists to join the academic staff of the Icahn School of Medicine at Mount Sinai Health System.

The Department offers candidates an outstanding opportunity to join our team of highly specialized otolaryngologists who practice in modern state-of-the-art facilities including Mount Sinai Medical Center, New York Eye and Ear Infirmary, Beth Israel Medical Center, St. Luke's and Roosevelt Hospital Center and in our satellite practices.

The physician will provide the highest level of quality patient-centered healthcare and will embrace the teaching of medical students and residents, as well as participate in clinical research.

The candidate is required to have a medical degree, board certified or board eligible, and able to obtain a New York State medical license.

Please send inquires and curriculum vitae to:

Eric M. Genden, MD
Icahn School of Medicine at Mount Sinai
The Mount Sinai Health System
Department of Otolaryngology-
Head and Neck Surgery
One Gustave L. Levy Place - Box 1189
New York, NY 10029
Email: kerry.feeney@mssm.edu

Washington University in St. Louis
SCHOOL OF MEDICINE

Department of Otolaryngology-Head and Neck Surgery

Adult Comprehensive Otolaryngologist

The Department of Otolaryngology-Head and Neck Surgery invites applications for a full time faculty position at the Assistant Professor level on the Clinician/Educator track. This position carries a full academic appointment at Washington University School of Medicine. This faculty member will devote 100% time to clinical practice in the Otolaryngology clinics at the Center for Advanced Medicine and our West County Office. Clinical responsibilities will include inpatient and outpatient responsibilities within the Department of Otolaryngology at Barnes-Jewish Hospital and Barnes-Jewish West County Hospital, supervision of residents and medical students, as well as teaching and interdisciplinary collaborations in a very supportive and stimulating academic department. The position includes opportunities for innovation and discovery in education and clinical care. Candidates must be board certified or eligible for certification. Applicants may send their curriculum vitae to: Richard A. Chole, M.D., Ph.D., Lindburg Professor and Head, Department of Otolaryngology, Washington University School of Medicine, 660 South Euclid Avenue, Box 8115, St. Louis, MO 63110 or rchole@wustl.edu.

BARNES-JEWISH Hospital
BJC HealthCare
Washington University in St. Louis Physicians
Children's HOSPITAL • ST. LOUIS

Otolaryngologist Opportunity

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is seeking a BC/BE Otolaryngologist.

Geisinger's otolaryngology specialists treat a wide range of conditions of the head and neck by providing the latest technologies in diagnostic, medical, surgical and rehabilitative techniques. We have board-certified and fellowship-trained specialists who collaborate to ensure the most comprehensive care.

About the Position

- Take part in the growth of this dynamic department
- Benefit from support from advanced practitioners as well as two on-staff audiologists
- Pursue research in your area of interest

Medical school loan repayment and residency and fellowship stipends are available.

Geisinger Wyoming Valley (GWV) Medical Center, Wilkes-Barre, Pa., is an acute care hospital that is licensed for 243 beds and houses the only Level II Trauma center in Luzerne County. The campus includes the Frank M. and Dorothea Henry Cancer Center, The Richard and Marion Pearsall Heart Hospital, the Janet Weis Children's Hospital Pediatric Unit, a transplant program and the Brain & Spine Tumor Institute. GWV is affiliated with an accredited otolaryngology residency program.

Discover for yourself why Geisinger has been nationally recognized as a visionary model of integrated healthcare.

For more information, please visit geisinger.org/careers or contact: Autum Ellis, Department of Professional Staffing, at 1-800-845-7112 or amellis1@geisinger.edu.

GEISINGER HEALTH SYSTEM

Follow us: | LinkedIn Geisinger is a drug-screening employer; EOE/M/F/D/V

FELLOWSHIP
TRANSORAL SURGERY
MICROVASCULAR HEAD & NECK RECONSTRUCTION
HEAD AND NECK ONCOLOGY

Washington University School of Medicine in the Department of Otolaryngology is seeking applicants for a one-year fellowship starting July 1, 2015. This excellent high volume fellowship provides in-depth exposure to a broad variety of advanced microvascular reconstructive head & neck techniques, transoral resections (TLM and TORS), and skull base surgery. Applicant must be able to obtain a Missouri State license and must be board eligible. Salary and benefits according to PGY year. License expenses also covered.

Send inquiries and curriculum vitae to:

Bruce H. Haughey, MBChB & Brian Nussenbaum, M.D.

Division of Head and Neck Surgical Oncology
Washington University School of Medicine
Department of Otolaryngology Head and Neck Surgery
660 S. Euclid Ave.
Campus Box 8115
St. Louis, MO. 63110
Phone 314/362-0365
Fax 314/362-7522
http://oto.wustl.edu

UNMC UNIVERSITY OF NEBRASKA MEDICAL CENTER

General Otolaryngologist
Excellent opportunity is available for a general Otolaryngologist. A combination of general ENT and subspecialty interest in the surgical treatment of sleep disorders would be of special consideration.

Otologist
Fellowship trained or equivalent experience Otologist is sought to maintain and grow a developed Otology practice.

Applicants should be BC/BE, licensed to practice in Nebraska and have a strong interest in clinical care, teaching and scholarship. Salary is negotiable and commensurate with experience and training.

Send Inquiries To:
Dwight Jones, MD, Chair
Department of Otolaryngology – Head & Neck Surgery
981225 Nebraska Medical Center
Omaha, NE 68198-1225
ent@unmc.edu

An equal opportunity/affirmative action employer. Minorities and women are encouraged to apply.

Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

CHIEF OF PEDIATRIC OTOLARYNGOLOGY AT WEILL CORNELL/NEW YORK-PRESBYTERIAN

Excellent growth opportunity for a motivated leader

Opportunities include:

- Dynamic Top-10 academic hospital and Ivy League medical college with new research building opening, and new outpatient center in progress.
- Large department with multiple growth opportunities including new outpatient practice locations on the Upper West Side and Lower Manhattan.
- Primary practice location in desirable Upper East Side of Manhattan with state-of-the-art pediatrics-only specialty space.
- Inpatient and OR at New York-Presbyterian Hospital/Weill Cornell Medical Center on the Upper East Side.
- New hospital site: New York-Presbyterian/Lower Manhattan Hospital, in prime growth location.
- Large Department of Pediatrics with all surgical and medical subspecialties represented.
- Busy NICU and PICU receiving tertiary referrals from multiple network hospitals.
- Peds Oto is within a large collaborative department with multiple areas of subspecialty expertise for collaboration.
- Opportunity to build a pediatric fellowship program.
- Outstanding junior faculty in place.
- Faculty housing available.

If interested, please contact Kim Ocasio at <kio2004@med.cornell.edu>.
EOE M/F/D/V

Joe Dimaggio Children's Hospital Seeks Pediatric Otolaryngologist

About the Opportunity:

The Division of Pediatric Otolaryngology–Head & Neck Surgery at Joe DiMaggio Children's Hospital seeks a motivated board-certified/board-eligible fellowship-trained pediatric otolaryngologist interested in growing our rapidly expanding tertiary care division. The Division of Pediatric Otolaryngology is a robust outpatient and hospital-based program, with dedicated pediatric audiology, mid-level practitioners and a diverse patient population. We have an established aerodigestive team and cochlear implant center as well as pediatric videostroboscopy in addition to the busiest Craniofacial Center in Florida. Qualified candidates should have an interest in head and neck, airway, vascular malformations or otology. Excellent opportunities exist for interdisciplinary collaboration, program development, research and teaching. We have a new affiliation with a four (4) year Allopathic Medical school. Emergency room call is 1:7.

About Joe DiMaggio Children's Hospital:

Joe DiMaggio Children's Hospital, a 204-bed facility, opened in 1992 and is located in Hollywood, Florida. As South Florida's newest freestanding children's hospital, Joe DiMaggio Children's Hospital is redefining the pediatric healthcare experience. We combine cutting-edge excellence with a commitment to patient- and family-centered care, and have the largest and most diverse group of board-certified pediatric specialists in the region. Thanks to exemplary medical expertise, advanced technology and exclusive pediatric programs, JDCH has earned the distinction of being the leading children's hospital in Broward and Palm Beach counties. JDCH is the only Pediatric Trauma Center in South Broward County and is dedicated to the physical and emotional care of children. We're continuing to pioneer revolutionary programs that define the standard in pediatric care. To learn more, please visit JDCH.com.

About South Florida:

South Florida offers an outstanding quality of life rich in cultural and recreational amenities. Residents enjoy pristine beaches, top-rated golf courses, museums, world-class dining and myriad family-friendly communities. Further, Florida also has no state income tax.

Please submit CV and letter of interest to:
jdchdoctor@mhs.net

Are you more interested in building a legacy than just finding a job?

The Department of Otolaryngology at West Virginia University is seeking a pediatric otolaryngologist to join a thriving academic practice. Applicants must be board certified/eligible by the American Board of Otolaryngology. Responsibilities include teaching of residents and medical students, patient care and clinical/basic research.

You'll join a highly skilled team making an extraordinary difference in the lives of patients across our entire state. Ours is a collaborative atmosphere that encourages you to grow and evolve as you practice advanced medicine in a highly satisfying academic setting.

The department currently has thirteen physician faculty members and fifteen residents and has an active NIH-funded research division with three PhD members.

U.S. News & World Report ranked West Virginia University Hospitals in Morgantown #1 in the state for the last two years. Forbes recently ranked Morgantown as one of the Best Small Metros in America. Our area offers the cultural diversity and amenities of a large city in a safe, family-friendly environment. There is also an excellent school system and an abundance of beautiful homes and recreational activities.

Build your legacy as you serve, teach, learn and make a difference from day one. To learn more, visit http://medicine.hsc.wvu.edu/otolaryngology/Home or submit your CV directly to Laura Blake, Director of Physician Recruitment, at blakel@wvuhealthcare.com.

WestVirginiaUniversity.

WVU is an AA/EO employer and is the recipient of an NSF ADVANCE award for gender equity. Position will remain open until filled.

THE UNIVERSITY of TENNESSEE HEALTH SCIENCE CENTER

Pediatric Otolaryngologist - We are seeking a fellowship-trained, board eligible/certified individual to join a high-volume practice. This position will be recruited at the Assistant/Associate Professor level. It is an excellent opportunity for a Pediatric Otolaryngologist interested in academic growth and excellent clinical experience.

Candidates must be able to obtain a Tennessee medical license.

Letters of inquiry and curriculum vitae should be sent to:

Jerome W. Thompson, M.D., MBA, Chairman
Department of Otolaryngology-Head and Neck Surgery
The University of Tennessee Health Science Center
910 Madison Avenue, Suite 408
Memphis, TN 38163

Or email to: jkeys@uthsc.edu

The University of Tennessee is an EEO/AA/Title VI/Title IX/Section 504/ADA/ADEA institution in the provision of its education and employment program and services.

Louis Stokes Cleveland VA Medical Center
in partnership with Case Western Reserve University:

Otolaryngologist/ Head & Neck Surgical Oncologist

The Louis Stokes Cleveland VA Medical Center (LSCVAMC) is seeking a full time academic Otolaryngologist-Head & Neck Surgeon in the OTO-HNS section of the department of Surgery at the level of assistant, associate, or full professor.

The successful candidate will have either fellowship training in head and neck surgical oncology or at least 2 years' post-residency experience practicing as a head & neck surgeon.

The position involves running the clinical head & neck cancer program at the LSCVAMC and also includes directing the Head & Neck multidisciplinary tumor board. The successful candidate must possess excellent patient care and operative skills and have a strong interest in educating residents and medical students.

The VA and CWRU both place a strong emphasis on research. Accordingly, the preferred candidate will have the skills and interest to develop a research program in head & neck surgical oncology in either the clinical or basic sciences. He or she will be given protected time to ensure success in this objective. The individual who takes this position will have an academic appointment at Case Western Reserve University School of Medicine.

Interested candidates should submit their curriculum vitae at
www.USAJobs.gov
and reference vacancy identification number:
1024055.

UNIVERSITY OF COLORADO CHILDREN'S HOSPITAL COLORADO

The University of Colorado Department of Otolaryngology, is seeking two pediatric otolaryngologists interested in full-time academic positions.

Pediatric Clinician/Scientist Otolaryngologist
Responsibilities include: teaching, research and clinical service in pediatric practice at Children's Hospital Colorado.
Required Education/Qualifications: MD and PhD, BC/BE, Fellowship training in Pediatric Otolaryngology

Pediatric Otolaryngologist
Responsibilities include: clinical service, with teaching and research opportunities in pediatric practice at Children's Hospital Colorado - Colorado Springs.
Required Education/Qualifications: MD and BC/BE, Fellowship training in Pediatric Otolaryngology

Letter of interest, CV and three references may be emailed to:
Kenny Chan, MD, Professor
The University of Colorado School of Medicine
Department of Otolaryngology
Email: **Kenny.Chan@childrenscolorado.org**

School of Medicine
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

UMassMemorial

Our Academic Partner
University of Massachusetts Medical School
UMASS

Otolaryngologist Faculty Position

UMass Memorial Medical Center, the clinical partner of the University of Massachusetts Medical School in Worcester, MA, is seeking a BC/BE general otolaryngologist. An interest in head and neck, otology, or pediatric otolaryngology is welcome. Join an established group of 6 physicians in a busy tertiary care referral center. Responsibilities include clinical care as well as student and resident education. Opportunities exist for clinical and basic science investigation and research. An academic appointment commensurate with education and training is offered. We are looking for a dynamic new or recent graduate with energy, desire and drive to expand our presence.

Worcester is the second largest city in Massachusetts and in New England, and has a very large patient referral base. Worcester and the surrounding area have a strong and diverse economic base with family oriented communities and excellent school systems. Boston is only forty miles away, and lakes, beaches and mountains are all easily accessible.

Interested applicants should submit a CV and letter of interest to:

Daniel Kim, MD
Chair of Otolaryngology- Head and Neck Surgery
UMass Memorial Medical Center
c/o Carolyn Jacobs, Physician Recruiter
Carolyn.Jacobs @umassmemorial.org
Telephone: 508-334-0806

As the leading employer in the Worcester area, we seek talent and ideas from individuals of varied backgrounds and viewpoints.

UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

The University of Miami Miller School of Medicine's nationally ranked Department of Otolaryngology has immediate openings for fellowship trained.

Consult Attending/Hospitalist
We are seeking a board-certified or board-eligible otolaryngologist and will be hired on the clinical faculty track. They will staff inpatient consultation requests at UHealth and Jackson Memorial Hospitals. The consult patients may require operating room procedures which would be performed by this surgeon if appropriate, or they may be referred to sub-specialists in the department. They will also staff Emergency Room requests when available. Strong experience with airway management is preferred. Must have a record of successfully teaching residents and fellows. They may have a general ENT outpatient clinic. Must possess or eligible for Florida medical license. Please send Curriculum Vitae to: Mr. Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm#571, Miami, Florida 33136.

Neurotologist
We are seeking a full-time fellowship-trained otologist/neurotologist. The applicant must be board-certified or board-eligible in Otolaryngology and in Neurotology. This is a position involving a mix of clinical practice, research and education of residents and fellows. The candidate will be expected to develop a clinical practice in all aspects of otology-neurotology and lateral skull base surgery, and lead research efforts in clinical and translational research. The candidate will participate in the University of Miami community as a faculty member where in our state-of-the art facility he/she will interact with institutional Otolaryngology residents, Neurotology fellows, audiologist, basic science researchers, neurologist, and neurosurgeons. Must possess or eligible for Florida medical license. Please send Curriculum Vitae to: Mr. Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm# 571, Miami, Florida 33136.

Research Faculty
The Department of Otolaryngology Head & Neck Surgery is seeking applications for an open ranking professor (basic science) tenure-track faculty position. We are interested in applicants whose research relates to inner ear function, therapies and/or disease. A successful candidate will be a member of the vibrant and well-NIH funded Hearing Research Program within the department. The successful candidate should have a track record of NIH funded projects, a strong publication record, and the potential to secure/maintain extramural funding. Please send Curriculum Vitae to: Tony Etzel Vice-Chair, Administration and Finance Department of Otolaryngology 1120 NW 14th Street, CRB Rm#571, Miami, Florida 33136.

DOC'S PROPLUGS
THE ULTIMATE IN EAR PROTECTION SINCE 1977

800.521.2982

and not a summer lost... even with ventilation tubes

Please consider **DOC'S PROPLUGS** for all your child's swimming and bathing needs

proplugs.com

pink, non-vented

blue, non-vented

International Aquatic Trades, Inc. ~ 719 Swift Street, Suite 56 ~ Santa Cruz, CA 95060 ~ phone: 831.425.5920

Think Beyond YOUR WEBSITE

WATCH OUR 90 SEC. VIDEO

www.ThinkNewPatients.com

Starting at $995 setup

- Premium Websites
- Mobile Websites
- Social Media
- Search Engine Optimization
- Reputation Monitoring
- Patient Education

IT'S EASY. A complete Web Presence packs all your online marketing into one simple platform. It's time to make the upgrade. Officite can help.

1. CALL YOUR WEB PRESENCE ADVISOR
   Meet your full-time, dedicated expert.
2. CHOOSE YOUR WEB PRESENCE PACKAGE
   Select a package customized for your practice.
3. LAUNCH YOUR WEB PRESENCE
   And watch the new patients come in.

Officite

AAO-HNS academy advantage PARTNER

(877) 437-3010
WWW.THINKNEWPATIENTS.COM