

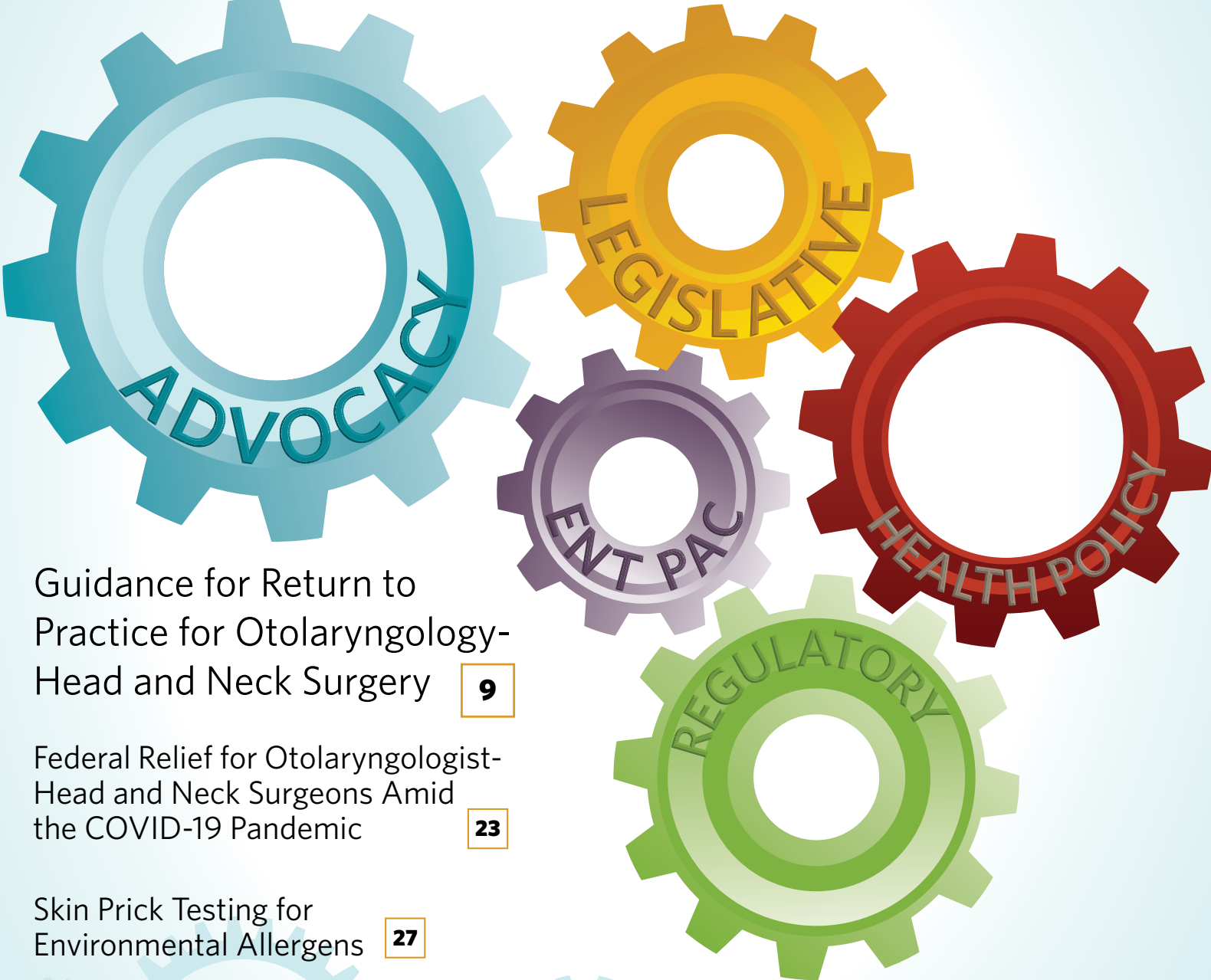
# bulletin



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The official member magazine of the **American Academy of Otolaryngology-Head and Neck Surgery**

**JUNE 2020**



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# Finding Our Way - Choosing Your Path and Understanding the Journey

Clinging to clichés that include "silver linings" or "lemons to lemonade" seems challenging at best these days; however, daily we are becoming more equipped to find our way sustained by optimism, positivity, and hope that we will get through this. Here we are less than four months into a pandemic—at a point where it seems like it has been much longer and where our concerns have been complex and multifaceted—as we all attempt to navigate next steps toward the "new normal" in how we will practice in our field.

The process of returning to normal in our practices and our lives as we have known them in the past may never occur. We have acquired new knowledge and insights in areas most of us never had to focus on in our training or prior years of practice. Certainly this is a time of greater caution and anxiety, but also a time for change and innovation, as well as an opportunity to reset, recreate, research, and rethink how we approach things in our practice, in our family lives, and in our community. Through digital technology (like Zoom, webinars, etc.) we have become closer to our colleagues who practice in different settings throughout our specialty. We have finally taken the time to work in the garden, pursue a home project, or have "family time" in a way we didn't quite have time for before. Perhaps the dramatic halt to our "normal routine" has given us an opportunity for growth and made us more prepared to understand and relate to the lives and challenges of our patients as we care for them. Many of us have become more adept at retrieving and processing information from our patients through telemedicine prior to them even getting to our office; thus, making their face-to-face interaction even more effective and efficient.

Ask yourself if this new environment has brought us closer together in a way we had not seen before and given us a foundation for a transition and change?

I want to highlight the many resources available to you on our Academy website as we prepare for the next phase of moving back toward practice. There are more than 16 podcasts, with some that also include video versions, covering the topics of safety, ethics, physician wellness, international perspectives, business practices, financial resources, and more. The Guidance for Return to Practice for

Otolaryngology-Head and Neck Surgery information will help you with the transitions, and our AAO-HNS Future of Otolaryngology Task Force [whose members include **Gavin Setzen, MD** (Chair), **Samantha Anne, MD**, **Eugene G. Brown III, MD**, **James C. Denny III, MD**, **Marc G. Dubin, MD**, **Stacey L. Ishman, MD, MPH**, **Ronald B. Kuppersmith, MD, MBA**, and **Richard V. Smith, MD**] has been instrumental in pulling together and presenting information. The various committee and subspecialty society contributions to these resources have been invaluable and demonstrate the collaborative and collective knowledge and power that can assist in strengthening our specialty during this difficult time. Please take the time to review the information (read more in a special guest column from Dr. Setzen on page 4 with more details on page 9) as it represents countless hours of hard work and commitment by your colleagues and our staff to help us all move forward. The COVID-19 resource page also includes countless research, resources, and articles, as well as living documents that will be updated as needed.

Finally, a standing ovation to our new graduating residents who complete their training this month and will chart a course to begin their careers (or continue with further training) and have a perspective that includes COVID-19 or pandemic awareness as a part of how they will practice in the future. We are confident you will approach practice in a way that blends the knowledge, surgical skills, and compassion for your patients obtained from your training with the attention you must also have for yourself, your family, and your communities as you go out into the world. Remember you are the future of our specialty, and you can count on your Academy to support you as you find your way, choose your paths, understand the journey, and give back to our specialty. ■



**Duane J. Taylor, MD**  
AAO-HNS/F President

“Perhaps the dramatic halt to our 'normal routine' has given us an opportunity for growth and made us more prepared to understand and relate to the lives and challenges of our patients as we care for them.”

“Never doubt that a small group of thoughtful, committed people can change the world.”

— Margaret Mead

# The Future of Otolaryngology - Emerging from the Fog of War



**Gavin Setzen, MD**

AAO-HNS/F Past President (2017-2018) and Chair of the AAO-HNS Future of Otolaryngology Task Force

Over the course of just three months, the COVID-19 pandemic has fractured several assumptions commonly held by the medical establishment—including hospitals, health systems, health plan executives, physicians, and patients alike—about traditional provision of medical care and also patient attitudes and behaviors toward healthcare.

None of us could have anticipated a crisis of such global proportion, devastating the healthcare system as we know it, and quickly stripping away the notion that “medicine is recession-proof.” While the U.S. healthcare system has been moving toward a more consumer-focused experience, progress has been slow and cost-containment efforts have been largely ineffective. For decades, regulatory barriers have made it difficult to create a transparent, consumer-friendly, efficient, cost-effective, and physician-friendly healthcare delivery system.

The pandemic, however, has caused regulators to remove some barriers, and some healthcare executives are beginning to rethink long-held beliefs. I would venture to say that those who do not question these beliefs and care provision paradigms now could face a consumer trust problem and will find practice and healthcare recovery to be even more challenging.

I am optimistic that our patients, however, do intend to return to our medical health facilities (private practice and academic), and I expect to see pent-up demand for otolaryngology-head and neck surgery specialty care, including elective surgeries

and other postponed diagnostic and therapeutic procedures. In fact, we are already seeing healthy recovery in various parts of the country.

To maintain or even re-earn the trust of patients, we will need to demonstrate competence, reliability, transparency, and most importantly, a sense of empathy in how we conduct practice operations moving forward. Like any consumer, patients will more carefully consider their options for where they will get their care during this time of uncertainty. We must *inspire hope* to suppress anxiety and *create a sense of control* that helps reduce uncertainty to facilitate the optimal patient experience and clinical outcomes.

Now more than ever, it is important to consider physician *wellness* and ensure that we can support each other; we need to look to our mentors and colleagues in our practices, communities, and our American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) family for support.

Despite the challenging emotions we are experiencing right now, both as clinicians and patients, we are also seeing tremendous human resilience, restoring confidence in the human condition. We will be required to act fast, moving with more agility than we have ever seen in the healthcare industry. Patients are experiencing the start of a new normal, and many will likely not revert to their pre-COVID-19 preferences, making it critical for otolaryngologists to prepare for the future. The AAO-HNS and Future of Otolaryngology Task Force will continue to provide guidance and support in addressing member and specialty-wide concerns.

With disruption of this magnitude, comes tremendous potential opportunity. Continuously reassess your environment and remain flexible and ready to pivot with the following considerations:

## Workforce readiness

- Recruit advanced practice providers (APPs)—physician assistants and nurse practitioners—for patient care and access expansion
- Older physicians experiencing the current disruptions caused by the pandemic could decide to retire
- Successful recruitment will increasingly depend on lifestyle factors
- Align clinicians and staff to support quality,

patient experience, and cost effectiveness

- While there has been a historic trend toward increased physician employment levels, at the same time there is growing dissatisfaction with employment models due to rigid “top-down protocolization” and lack of autonomy

## Clinical pathways and protocols

- Moving patient care from inpatient settings to free-standing facilities
- Accelerated shift toward in-office and ASC surgical care

## Technology, infrastructure, and integration

- Enhanced provision of virtual health tools for transmission of data and telehealth capabilities
- Increasing role of artificial intelligence, virtual care, and non-clinical care

## Supply chain

- Ensure adequate personal protective equipment (PPE), medical equipment and supplies – procurement pipeline

## The future of healthcare financing

- Proliferation of value-based payment models supporting lower total cost of care and population health management
- Employers likely to continue to take greater role in managing costs, including virtual care incentives
- Venture capital firms will continue to invest funds they have already raised, but with greater scrutiny

So, as we embark on the future of otolaryngology care post COVID-19—a time where exponential change can accelerate the pace of disruption in the marketplace—continued collaboration between the AAO-HNS and our specialty societies will allow us to successfully manage and lead this transformation.

As physician leaders we must continue to inspire our teams, patients, and each other through challenging times. We must stand shoulder to shoulder and remain hopeful that by demonstrating understanding and compassion, listening carefully, and communicating regularly with candor and consistency, we will prevail and continue to provide the best ENT care for our patients.

Onwards and forwards... ■

# Emerging from the Pandemic with Lessons Learned to Impact Change

I have spent considerably more time during the last three months reading about, researching, and commenting on viral disease than in the previous 40+ years of my medical career. The current COVID-19 pandemic lately has focused my interest on several aspects related to the consequences of this widespread, easily transmissible virus that happens to be highly concentrated in areas of our primary expertise, the nose, nasopharynx, and pharynx. The extreme worldwide disruption of entire countries' healthcare, economic, and social systems has been unprecedented during my lifetime. As we emerge from the worst of this pandemic, just as with previous disasters, epidemics, and wars, opportunities to embrace change in many areas will present themselves.

We are already seeing acceleration of pre-existing trends such as the expansion of telemedicine and society-wide teleworking, contemporaneous adoption of novel educational strategies from primary education to residency and fellowship training, and the explosion of virtual meetings as adjuncts to face-to-face meetings and travel. Most of these advances are being structured to handle immediate needs as well as plan for short- and long-term strategic evolution.

I was curious about some of the lessons learned by otolaryngologists from the last worldwide pandemic roughly a century ago. I must confess that prior to the recent COVID-19 pandemic, I really knew nothing about the Spanish flu of 1918-19 other than it was the worst respiratory epidemic of its time that was transmitted through coughing or sneezing millions of viral particles to surrounding people in a similar manner to that of the coronavirus. I thought it would be interesting to review some of the old otolaryngology literature as to what was being said contemporaneously about the Spanish flu. I was surprised to find that there were no articles related to the Spanish flu in the *Transactions of the American Academy of Ophthalmology and Otolaryngology* (1918-20), the *Annals of Otolaryngology, Rhinology and Laryngology* (1918-20), and the *Laryngoscope* (1918-20). This is in stark contrast to the rapid dissemination of emerging clinical and scientific information by the otolaryngology family of journals. Clearly, we are in a different era of communications than a century ago, but it was still surprising not to find anything related in our literature over that three-year period.

One of my goals in the search was to evaluate changes made based on experiences and lessons learned during that epidemic in order to incorporate the successful interventions into our process. I did run across a very interesting article by Allen Greenwood,

MD, in *Transactions* titled, "The Role of the American Academy of Ophthalmology in Otolaryngology in the Recent World War." There is widespread agreement that there was a direct relationship between the spread of the Spanish flu and military personnel movements, particularly in Europe toward the end of the war. Both otolaryngologists and ophthalmologists were integrally involved stateside in working with the Surgeon General's office and overseas with the various military branches to help with policies improving care through preparedness and strategic deployment of resources. As I review what has happened to date globally, similar adjustments and strategies have been made across the world during the current pandemic.

Two major areas that have been problematic for some time come to mind as potential beneficiaries of the drastic consequences of the COVID-19 experience. The first comes from many who are closely involved in medical student and resident education and who have been concerned about the increasing time and expense that graduating medical students face as they interview for residency positions in otolaryngology. This not only takes away from educational opportunities, but also carries a significant price tag for the many interviews that most candidates schedule. Virtual conferencing and virtual interviews will be relied upon due to travel restrictions for this year's candidate group. Experience in other industries and professions have shown significant value and benefits that tend to bring more consistency in the process and allow greater participation by both the candidate and interviewers. Additionally, this process can significantly improve the recruitment of underrepresented minorities into the specialty.

The second area is that the current health crisis, not surprisingly, has demonstrated without question the skills and dedication of otolaryngologists and trainees of all demographics across all sites of service. The ongoing leadership and contributions to the care of our citizens have not been based on ethnicity, gender identity, or religious beliefs, but rather performance. In our time of need, the inspirational performances of women across otolaryngology has been critical. This "real world evidence" should act as a springboard for equality in both pay and advancement opportunities that has been too slow in coming.

My hope is that future generations will look back at COVID-19 for lessons learned and find it resulted in a more fair and equitable approach so that all demographics are afforded equal access to care, opportunities, recognition, and advancement. ■



**James C. Denny III, MD**  
AAO-HNS/F EVP/CEO

“My hope is that future generations will look back ... and find it resulted in a more fair and equitable approach so that all demographics are afforded equal access to care, opportunities, recognition, and advancement.”

”

# Individual and System Well-being: How Do We Resume Caring for Others during and Post Pandemic?

Julie L. Wei, MD

The insightful article “Peer Support: Taking Care of Ourselves and Each Other,” by **Jo A. Shapiro, MD**, in the May issue inspired us to focus on four core principles during and after the COVID pandemic:

1. Value what we do.
2. Acknowledge our pain.
3. Rely on our professional collegial community.
4. Individual peer support is key.

All of us have been grappling with our own anxiety, fear, and concerns not only for our own safety, but for that of our trainees, colleagues, office staff, patients, and loved ones for what feels like a lifetime. As you read this, we have likely returned from shutdown mode to a phase of restrictive or nonrestrictive surgical and office practice. Regrettably, some of our colleagues have had to close their practices permanently due to this pandemic.

No matter your geographic location or practice setting, each of us likely has developed a recovery plan. In addition to the logistics

of resuming surgeries and seeing patients safely, hopefully you have also reflected upon and developed increased self-awareness in preparation to live our new “normal” as we resume our roles as physicians, surgeons, teachers, and colleagues.

Since governors’ stay-at-home orders and mandates to stop all nonemergent elective cases and appointments, many of us have mounting anxiety over the immense backlog of cases, cancelled appointments, and revenue. Many of our staff were furloughed. Despite rapid adoption of telehealth—with perhaps surprising, even successful experiences and the likelihood of continuing telehealth in some form—we MISSED physical interactions with patients and families. Those of us who care for children ACHED to hold a child, see their smiles, hear their giggles, and steal some hugs. This pandemic robbed me of the joy of caring for and holding children of all ages, especially infants.

We surgeons are a highly driven, overachieving stereotype. Our years of training shaped our identities with immense internally and externally imposed pressures to produce in EVERY aspect of our careers. For the first time ever, some of us had “time” and “space” because we didn’t live and practice in the pandemic’s epicenters such as New York, Washington, or Louisiana. Those caring for adults, including pediatric ENT colleagues in New York, worked exhausting hours or were redeployed to care for COVID-19 positive adults. They experienced unimaginable stress, bearing witness to unanticipated mortality of the young and the old, sharing in the heartbreaking devastation of so many affected families. Some of us lost family members, friends, and colleagues to COVID-19, contracting it as they cared for others.

No matter our individual experiences

through this pandemic, we must reflect on who we are and represent in humanity as healers and surgeons. We must admit that doctors ARE human and not immune to what threatens those we treat. We have been forced to confront our natural tendency to be in denial about our own needs. The truth is, many of us have had trauma in our lives; suffered pain and loss; have anxiety, depression, and unhealthy coping mechanisms including addiction; and have endured divorce, separation from loved ones, and broken relationships.

How many of us, if forced to be honest and vulnerable, will admit that we have neglected to invest in the loving and healing of ourselves and the most important relationships in our lives? How many have used our profession and career as a noble and convenient excuse to maintain the status quo, leaving the needs of our loved ones unmet? I mean undivided attention, time, and mindful presence for those who love us most. Who among us cares for our bodies with mindful eating? We tell our patients to avoid certain food and beverages because they cause poor health, obesity, high blood pressure, and cardiac and pulmonary diseases, yet do we consume ourselves? How many of us smoke despite performing cancer procedures or having trained in resecting parts of vital head and neck anatomy? How many of us know we must MOVE and exercise but have not made the commitment?

Resuming clinics and surgeries will never be the same because we can never “unknown” what we have seen and heard. The SARS-CoV-2 virus, as will future viruses and pathogens, taught us that we are NOT immune and will never be. Yet despite the best algorithms and protocols with appropriate PPEs, AGPs, or not, each of us will have to banish that tiny voice of fear and uncertainty every morning as we show up to see patients, perform office procedures, and be the healers as we have always been.



## LISTEN NOW!

The AAO-HNS COVID-19 Podcast Series includes a number of episodes related to managing wellness, reducing stress, and boosting resilience.

<https://www.entnet.org/content/covid-19-podcast-series>

Many hospitals and health systems have lost employees to COVID-19 or furloughed them. Some have or will declare bankruptcy. Many colleagues lost loved ones during the pandemic to non-COVID-19 causes. This is a *wake-up call*. We must heed it and not waste what silver lining there may be to this pandemic. We already had a glaring epidemic of physician and provider burnout pre-pandemic, so what will happen to us now?

We can and must CHOOSE individual and collective optimism and positivity, because that is the only way forward. We can become as contagious as the virus, but with positivity, for ourselves, others, and our hospitals. But first, for our physical and emotional well-being, we must embrace where we came from—acknowledge and forgive ourselves for the lack of personal accountability. Without self-love and forgiveness, we won't be able to fully embrace and love others professionally and personally.

*BE WELL*, so we can leverage our collective talents and intellect to care for patients and others who desperately need us now more than ever, especially those who—as the pandemic highlighted—suffer disparities in access and care. If your well-being requires mental health support for ANY reason, please find it NOW. We need you.

During this pandemic, I went to the hospital daily and checked in with my team, stayed in my office to perform telehealth, did administrative tasks as chief, joined Webex meetings, made ED/inpatient consults, and saw urgent patients. To ensure my own physical and mental well-being, I walked during the week and continued my weekend four-mile walks and tennis. I continued witnessing the sun rise and set each day and feeling gratitude for my coronavirus-free zone. I sent positivity emails to my team and others daily. Journaling is my love; it lets me hear

"Did it really take a pandemic for us to realize the love that we shared but were always 'too busy' to experience?"

my inner voice and increases self-awareness. I initiated family Zoom calls every Sunday, including my amazing cousin Justin Wei who just finished otolaryngology training from Tripler Army Medical Center. We shared laughter and tears from New York, Oahu, Los Angeles, Orange County, and Orlando. Did it really take a pandemic for us to realize the love that we shared but were always "too busy" to experience?

Our Health and Wellness Committee staff continued monthly meetings and sponsored virtual peer support sessions with the psychologists who were accessible 24/7 to all residents and faculty. We even hosted a virtual happy hour! We acknowledged and showed gratitude to our hospital environmental service and security teams whose daily work kept us safe. I am indebted to volunteers in Los Angeles who, through my sister's connection, sent our hospital 2,000 hand-sewn masks and to several women in my neighborhood who dropped off masks for our hospital. The human spirit and capacity to love others is *infinite*, but our capacity to love ourselves has not been realized.

Dr. Shapiro is wise: "We can't fix each other's pain, but we can go a long way to helping each other through the pain." Start with self, then ask others what they need. Listen generously. Let them know they are not alone, because none of us are and we don't need to be. Inspire your hospital or practice to create a culture of well-being—volume and productivity will never be enough again. ■

# Hindsight is 2020: Lessons on Racial Health Disparity during the COVID-19 Pandemic

**Basit A. Jawad, MD,** (PGY-4) Tulane University School of Medicine, Otolaryngology-Head and Neck Surgery, For the AAO-HNS Diversity and Inclusion Committee

As cities across the globe were gearing up in the fight against SARS-CoV-2, New Orleans, LA, was deep in the festivities of Mardi Gras. In the weeks that followed the traditional March event, something disastrous was unfolding. Hospitals around the world were becoming overrun by the novel virus, and New Orleans noticed the number of cases quickly rising. It wasn't long before many floors had transformed into respiratory isolation units. Like many otolaryngology departments across the United States, we too were diverted to help cover the COVID-19 respiratory ICUs. Although the circumstances were unfortunate, the sense of camaraderie was commendable. Working side-by-side under the guidance of critical care intensivists, the invisible barriers that once separated residents from attendings quickly faded. **The shared goal was simple: help by any means possible.** Although not always victorious, small milestones such as weaning patients off vasopressors or the occasional extubation were cherished.

Looking back now as we return to our regular duties, one trend is glaringly obvious. Racial and ethnic minorities disproportionately suffered from COVID-19. At one point in Louisiana, roughly 70% of

coronavirus-related deaths were African Americans.<sup>1</sup> This is not an isolated trend. Various studies describe similar findings. The U.S. Centers for Disease Control and Prevention (CDC) reports that African American and Hispanic communities have disturbingly poorer outcomes compared with other racial groups.<sup>2,3,4</sup> Studies find that African American individuals have twice the death rate per capita as their white counterparts (92.3 vs 45.2, per 100,000).<sup>3</sup>

Although the data are evolving, the consensus remains that patients with preexisting medical conditions are at a higher risk. With a greater prevalence of disorders such as hypertension, diabetes, obesity, cardiac and renal disease, certain racial minorities are increasingly affected.<sup>3</sup> One preexisting condition, however, is rarely mentioned in medical records—racial inequality. Decades-long policies have resulted in residential housing segregation.<sup>5</sup> This creates an environment where minority groups are more likely to live in densely populated areas. As a result health policies such as social distancing are challenging to adhere to and rapid access to hospitals may be difficult. Additionally, there is increased employment of minority communities within high-contact essential industries: ancillary healthcare workers (housekeeping, food services), agriculture, gas station/grocery store clerks, automobile mechanics, etc.<sup>6</sup> As with medical providers on the front lines, these individuals are at high risk of contact

with infected persons. The availability of paid sick leave may also not exist, increasing the likelihood of individuals continuing to work through minor illness.<sup>6</sup>

As otolaryngologists we are fortunate to treat patients from all demographics. It is well known in the world of head and neck cancer that social factors intimately interact with health outcomes. Moving into an unknown post-COVID-19 world, who knows how the medical landscape will transform? As with any issue, acknowledging the existence of a problem remains the first step in the path to finding a solution. Alas, hindsight is 2020. ■

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# We Are One

AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY

## Guidance for Return to Practice for Otolaryngology-Head and Neck Surgery

*Note: This article reflects the current COVID-19 situation as of May 22, 2020. The fast-changing pace of information related to this pandemic may not all be reflected in this column due to the Bulletin's publication schedule.*

**James C. Denny III, MD**, AAO-HNS/F Executive Vice President and CEO

As the United States transitions back toward more widespread delivery of healthcare and otolaryngologists expand their practice to include non-emergent and time-sensitive patients, they are seeking consistent guidance and principles to reinstitute diagnostic and therapeutic interventions. The American Academy of Otolaryngology-Head and Neck Surgery, with the collaboration of the otolaryngology specialty societies, has developed recommendations for a safe return to practice that are being presented in two parts. **These are living documents updated on a regular basis as new information becomes available.**

These documents were prepared by the AAO-HNS Future of Otolaryngology Task Force with input from the Infectious Disease and Patient Safety and Quality Improvement Committees. The AAO-HNS approached the specialty societies within otolaryngology to set up a collaborative process to produce guidance for otolaryngologists that would be consistent, practical, and implementable at the appropriate time, based on local conditions and regulatory guidance. The American Academy of

Otolaryngic Allergy (AAOA), American Broncho-Esophagological Association (ABEA), American Laryngological Association (ALA), American Neurotology Society (ANS), American Otolologic Society (AOS), American Rhinologic Society (ARS), American Head and Neck Society (AHNS), American Society of Pediatric Otolaryngology (ASPO), and the International Surgical Sleep Society (ISSS) worked with the corresponding AAO-HNS Committee to submit recommendations from their respective areas of expertise. We are extremely grateful for the quick response and true collaborative spirit exhibited during this process. This is a perfect example of how a “We Are One” mentality can succeed and benefit the entire specialty. We will continue to provide you the resources you need for you, your practice, and your patients.

### Guidance for Return to Practice for Otolaryngology-Head and Neck Surgery

**Part One [Released May 7]:** Contains comprehensive general considerations that are applicable to all practice settings and specialty areas of otolaryngologists' practice.

**Part Two [Released May 15]:** Contains specific recommendations encompassing prioritization and special circumstances related to surgical procedures for all specialty areas.

All “Guidance for Return to Practice in Otolaryngology-Head and Neck Surgery” materials and resources, including

### AAO-HNS Future of Otolaryngology Task Force Members:

Gavin Setzen, MD (Chair)  
Samantha Anne, MD  
Eugene G. Brown III, MD  
James C. Denny III, MD  
Marc G. Dubin, MD  
Stacey L. Ishman, MD, MPH  
Ronald B. Koppersmith, MD, MBA  
Richard V. Smith, MD

podcasts with video versions, can be found at <https://www.entnet.org/content/guidance-return-practice-otolaryngology-head-and-neck-surgery>.

### More COVID-19 resources

Please bookmark the AAO-HNS Coronavirus Disease 2019 Resources webpage for access to the latest information and tools, including:

- AAO-HNS Position Statements
- AAO-HNS COVID-19 Podcast Series: Episodes 1-16
- OTO Journal COVID-19 Articles: Newly Accepted and Published Online First
- Information for you, your practice, and your patients
- Shared clinical research and news from around the specialty

Content is being added frequently to address the varying and timely needs of our global otolaryngology community. Learn more at <https://www.entnet.org/content/coronavirus-disease-2019-resources>. ■

# ■ at the forefront

## Information, resources, and updates in this section

Announcing the International  
Advisory Board (IAB) Chair-elect

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AAO-HNSF Board of Directors  
Select Mark E. Zafereo, Jr., MD,  
as Board Coordinator-elect for  
International Affairs

AAO-HNSF Quality Resources on  
Allergic Rhinitis

Humanitarian Travel Grant:  
Otolaryngology and Plastic Surgery  
in Rural Belize

June Is National Dysphagia Month

OTOSource Education  
Opportunities

## ➔ READ MORE ONLINE

Humanitarian Travel Grant:  
Otolaryngology and Plastic Surgery  
in Rural Belize

## Announcing the International Advisory Board (IAB) Chair-elect

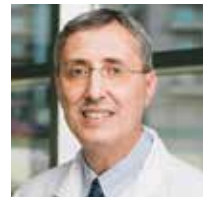
The AAO-HNSF call for nominees for Chair-elect of the International Advisory Board (IAB) was highly successful and resulted in the selection of **Muaaz Tarabichi, MD**.

Dr. Tarabichi is a native of Syria where he grew up and started his medical education. He left Syria in 1980 and arrived in the United States as a political refugee. He then went to Montreal, Quebec, and did his residency at McGill University, during which he received the 1988 AAO-HNS Award for Excellence in Original Investigation for his study on application of finite element methods. He then returned to the Middle East and has been practicing in Dubai, United Arab Emirates, for 24 years.

Much of Dr. Tarabichi's professional life has been centered on innovating, advocating, and teaching endoscopy ear surgery (EES), being widely referred to as the "Father of EES." He struck a long-lasting friendship with the late Heinz Stammberger, MD,

FRCS Ed(Hon), during years of travel teaching endoscopic techniques in ear and sinus surgery. This relationship was the seed for their mutual project—TSESI: Tarabichi - Stammberger Ear & Sinus Institute in Dubai ([www.TSESI.org](http://www.TSESI.org)). The facility includes a wet lab and state-of-art broadcasting and video production facilities and offers scholarships, including travel and boarding, for younger otolaryngologists from around the world.

Dr. Tarabichi's term as Chair-elect will start at the conclusion of the AAO-HNSF 2020 Annual Meeting & OTO Experience, September 13-16, in Boston, Massachusetts, when current Chair-elect Karl Hoermann, MD, PhD, assumes the IAB Chair position. For more information about the IAB and the AAO-HNSF International Program visit <https://www.entnet.org/content/international-outreach>. ■



Muaaz Tarabichi, MD

## "Supporting the Specialty: Meet Our Academy Member Donors" Online Brochure

<https://www.entnet.org/foundation>

The AAO-HNS *foundation* offers its sincerest appreciation to our donors for creating a tradition of giving back to their specialty and providing opportunities for the next generation of otolaryngologists around the globe.



[www.entnet.org/donate](http://www.entnet.org/donate)

## AAO-HNSF Board of Directors Selects Mark E. Zafereo, Jr., MD, as Board Coordinator-elect for International Affairs

**Mark E. Zafereo, Jr., MD**, is an associate professor of head and neck surgery at MD Anderson Cancer Center in Houston, Texas, where he also serves as section chief of head and neck endocrine surgery and associate medical director of the Endocrine Center. He has held many roles within the American Academy of Otolaryngology–Head and Neck

Surgery and its Foundation over the last 15 years, particularly within the international realm, and looks forward to serving the AAO-HNSF Board in collaborative leadership of the International Program.

As Coordinator-elect, Dr. Zafereo will shadow the current Coordinator for International Affairs, J. Pablo Stolovitzky, MD.

The Coordinator for International Affairs, which is a four-year term appointment, oversees implementation of the high-profile, important portfolio of AAO-HNSF's global outreach and programs and ensures alignment with the strategic plan. ■



Mark E. Zafereo, Jr., MD



## AAO-HNSF Quality Resources on Allergic Rhinitis

Read the Clinical Practice Guideline on Allergic Rhinitis by visiting [www.entnet.org/allergicrhinitiscpg](http://www.entnet.org/allergicrhinitiscpg).

In addition, review the Qualified Clinical Data Registry (QCDR) measures on allergic rhinitis. These measures were developed by the AAO-HNSF measure development workgroup in partnership with the ECRI

Institute and available exclusively through the Reg-ent<sup>SM</sup> registry:

- AAO23 - Allergic Rhinitis: Intranasal Corticosteroids or Oral Antihistamines
- AAO24 - Allergic Rhinitis: Avoidance of Leukotriene Inhibitors

To view the measure specifications and learn more, visit [www.entnet.org/2020-measures](http://www.entnet.org/2020-measures). ■



## June is National Dysphagia Month

**ENThealth.org** offers information for your patients on these topics and more:

- Dysphagia
- Aging and Swallowing
- Do I Have a Swallowing Problem?

For more patient information on ENThealth, search under Conditions and Treatments and Be ENT Smart for articles using the keyword “swallowing.”

**ENThealth.org** is dedicated to helping patients. The content is developed from a team of AAO-HNS members, and information is delivered via peer-reviewed articles, interactive features, and video content featuring physicians. Learn more about the site and our contributors at <https://www.enthealth.org/about-us/>. ■



## Education Opportunities

With more than 200 education modules as study guides and numerous surgical videos, OTOSource provides a wealth of free information on multiple topics. From basic immunology with regard to allergies through specific topics such as dysphagia, consider reviewing treatment options, case studies, and possible complications at [www.otosource.org](http://www.otosource.org). ■

### HUMANITARIAN TRAVEL GRANT

## Otolaryngology and Plastic Surgery in Rural Belize

**Brittany A. Leader, MD**, traveled to Corozal, Belize, to provide medical and surgical care to a predominantly rural population alongside a team led by facial plastic surgeon Devinder S. Mangat, MD, his fellow Sidney J. Starkman, MD, and otolaryngologist **Mark Gutowski, MD**. The group spent a day conducting preoperative screening followed by four busy operative days, treating pediatric and adult patients and performing a wide range of surgeries.

One such surgery was for a five-year-old girl named Jacklyn, who had previously been seen and treated for a cleft lip. This time, the group repaired her cleft palate.

“This was my first mission trip,” said Dr. Leader, “But it will not be my last. I was truly humbled and honored to be able to work with the people of Corozal. This experience provided an incredible

opportunity to advance my knowledge of complex pathology, as well as serve those with extremely limited access to healthcare.” ■



➔ **READ MORE ONLINE**  
Longer article available



# Society Spotlight:

## AAOA

### Providing Clinical Pearls in Allergy and Immunology

Alpen A. Patel, MD, AAOA President

Building off of Simon Sinek's *Start with Why: How Great Leaders Inspire Everyone to Take Action* (2011) at our recent strategic retreat, the American Academy of Otolaryngic Allergy (AAOA) leadership focused on how to engage members, what drives members, and what the AAOA can do to meet member needs. The AAOA has had a strong education curriculum at its forefront for years. In addition to our free annual meeting (October 23–25, Scottsdale, Arizona), our education resources support the basic (July 9–11, Orlando, Florida) and advanced (December 9–12, Vail, Colorado) courses in allergy and immunology. We aim to offer members some clinical pearls or takeaways that can be implemented in their practices. The AAOA has rebuilt the annual meeting

to integrate clinical medicine with the business of medicine.

A better understanding of coding, service lines, optimal workflows, staffing, and contracting is valuable as the healthcare landscape continues to evolve and physicians need to work more efficiently.

As the AAOA looks forward in 2020, we have had some advances in our field, which we are incorporating in our programming. We are also developing resources for these topics. ■



Alpen A. Patel, MD

### Biologics in Otolaryngology

Biologics and their role in nasal polyposis, AERD, asthma, and atopic dermatitis have been a focus for the AAOA. The AAOA has a workgroup crafting a review of biologics, clinical trials, and how this research translates to everyday patient care and management. The 2020 AAOA Annual Meeting this fall will feature many sessions on the practical application of biologics in an otolaryngology practice. ■

### Peanut Allergy

The U.S. Food and Drug Administration recently approved a new treatment option for patients with peanut allergy. The new drug, Palforzia, is not a cure but may reduce risk for children and their families who live with the fear of accidental exposure to peanuts. Approved for children ages 4–17, it is dosed in increasing amounts of peanut protein to reach the maximum dose (usually around six months). Palforzia is designed to provide a “safety net” in the event of an accidental exposure.

Like many of my colleagues, I am excited to see how these new therapeutic options will improve outcomes in our patients. I recognize that this is a challenging time to practice otolaryngology and allergy, especially with the recent pandemic. Nonetheless, I am optimistic and confident that the house of medicine will prevail, and the practice of medicine will be just as rewarding as ever. ■

### USP General Chapter <797> Pharmaceutical Compounding—Sterile Preparations

The U.S. Pharmacopeia (USP) has issued new guidance for in-office physician compounding. Guidelines specific to allergy immunotherapy preparation are under Section 21 (<https://www.usp.org/compounding/general-chapter-797>). Currently, implementation is on hold due to the appeal process. The new guidelines have some key stipulations

related to personnel, hygiene and garbing, labeling, documentation, etc. The AAOA has developed an online compliance tool, along with several other resources in its Practice Resource Tool Kit, to help practices understand and comply with these guidelines. Information is available on the AAOA website at <http://www.aaallergy.org/>. ■



CONNECT AND SHARE: #BOGENT

# Together We Are Stronger

Sitting sequestered in my home after a shortened day of work due to the COVID-19 pandemic, mixed feelings persist. Sadness looms given the amount of sickness and mortality that has stricken the world, but the amount of self-reflection, quality time with my wife and kids, and even exercise (yes, it does exist) that has occurred over the past three weeks has been a refreshing change. Much of my self-reflection has revolved around how our interactions in the medical community have changed and evolved as a result of current world events.

Spring is the time when religions around the world have important observances. As I write this, it is Holy Week for Christians. One of the major complaints about Christianity, especially in the United States, is that some only choose to go to church on Christmas and Easter, because those are the days that “matter” most. A parallel exists in our current medical community. When this pandemic hit, everyone ran to their local, state, and national medical societies in search of answers, solutions, and political representation. Many of these providers have been absent for years, or even decades, from their representative organizations. Where did all these people come from? Why did they wait until a catastrophic event to become involved and engaged? Is it simply the fear of the unknown that has driven them to this end?

While there are many questions still to ponder, I must congratulate the AAO-HNS for being a constant source of reason, information, and collegiality. Every time I have seen a new question posted on ENTConnect or social media, the Academy has had an answer or resource posted within a day. It even had the foresight to expand its bandwidth and spread information to nonmembers through podcasts on FrequENTcy and invite commentary and early research through its journals *Otolaryngology–Head Neck Surgery* and *OTO Open*.

While our Academy has been instrumental in looking at the bigger picture, right now there is a real opportunity to address the finer details, specifically

the individual needs of our heterogenous practices. For example, imagine a private practice with two providers, three staff, and an office manager, three of whom are COVID-19 positive. How do two staff members run a practice? What resources are available to them? Academic systems generally have processes in place, but what if you work as a hospital-employed otolaryngologist where you are asked to come up with policy? What resources do you have, what resources do you need? How should these very different practices enter a recovery phase as they ramp up, moving forward once the curve flattens and declines?

While I am quite hopeful that the peak of COVID-19 is behind us and that we are on the road to recovery when you read this in June, I also recognize that we need input from otolaryngologists across borders. Survival, not success, is achieved during a crisis. Success is earned during the interim with careful planning and development of strong chains of command. Not every detail can be exacted, but we must be motivated in times of ease so that we prevail in times of trial. As Chair of the Socioeconomic and Grassroots Committee (SEGR) for the AAO-HNS Board of Governors, I am in constant need of new people and new ideas. This pandemic has hit all of us directly in our backyards and clearly should be the impetus to get us involved now! I am calling all of you to do one of three things:

1. Call or email the [SEGR Committee](#) if you want to be involved with our committee’s work.
2. Call or email your [Regional Representative](#) and tell them what is plaguing your practice.
3. Identify an otolaryngologist who is not a member of the AAO-HNS but has benefited from the Academy’s strong work during this pandemic. Encourage them to join and get involved.

Together We Are Stronger.

The Board of Governors and its committees can be reached by emailing [bog@entnet.org](mailto:bog@entnet.org).

The BOG Regional Representatives can be reached at [BOGRegionalRepresentatives@entnet.org](mailto:BOGRegionalRepresentatives@entnet.org). ■



**Andrew M. Coughlin, MD**

Chair of the BOG  
Socioeconomic and  
Grassroots Committee

“Survival, not success, is achieved during a crisis. Success is earned during the interim with careful planning and development of strong chains of command. Not every detail can be exacted, but we must be motivated in times of ease so that we prevail in times of trial.”



# New Flagship Education Product: Focused Lifelong Education Xperience



**Jeffrey P. Simons, MD**  
AAO-HNSF Coordinator  
for Education

This past year, the AAO-HNSF Education Committees and Foundation staff have been working to develop an ambitious new program set forth by the Future of Education Task Force to propel our Foundation education agenda forward for the next five to 10 years. This program, the Academy's new flagship education product, is FLEX—Focused Lifelong Education Xperience. It will replace the Home Study Course, which is sunsetting this year after more than three decades.

Launching this fall, FLEX will span all eight specialty areas throughout the year, delivered in a variety of contemporary learning modalities to help you meet the challenges of your otolaryngology practice and build mastery throughout your career.

Built on the fundamental learning philosophy that the needs and preferences for otolaryngology education will continue to evolve over time, the tools provided in

the FLEX subscription will stay current to ensure that they remain timely and relevant for all learners.

There are numerous upgrades that FLEX offers when compared with the Home Study Course, including access to more than 200 courses residing in AcademyU®. FLEX will also be priced lower than the Home Study Course for both residents and practicing physicians. We believe learners will find their FLEX subscription to be educational, interactive, engaging, challenging, and—most important of all—directly applicable to practice.

## 2020-2021 FLEX Specialty Topic Release Schedule

1. Rhinology & Allergy (September 2020)
2. Laryngology & Bronchoesophagology (October 2020)
3. Head & Neck Surgery (November 2020)
4. Otolaryngology (January 2021)
5. Pediatric Otolaryngology (February 2021)
6. Practice Management (March 2021)
7. General Otolaryngology & Sleep Medicine (April 2021)
8. Facial Plastic & Reconstructive Surgery (May 2021)

## Subscription Details

Residency training programs are encouraged to enroll their residents this summer before the academic year begins.

All physicians can secure early-bird pricing between now and September 30.

To learn more and register, visit [www.entnet.org/FLEX](http://www.entnet.org/FLEX). ■

**Highlighted education tools in this inaugural year's subscription package include:**



# Proposed Fiscal Year 2021 (FY21) Combined Budget

**Kenneth W. Altman, MD, PhD**  
AAO-HNS/F Secretary-Treasurer

The Executive Committees (ECs) of the Boards of Directors (BODs) were presented with the Finance and Investment Subcommittee (FISC) proposed budget for the next fiscal year, July 1, 2020–June 30, 2021 (FY21), and endorsed it for approval by the BODs. During their May meeting, the BODs reviewed and conditionally approved the FY21 budget that is presented here to the membership.

Budgeting for FY21 represents the collaborative work of both the staff leadership and the members of the FISC to match stable funding to the mission we aspire to accomplish. The proposed FY21 budget is structured to meet the strategic plan goals of the AAO-HNS/F and to continue to provide member services in the most effective and efficient way possible.

In early spring, the FISC reviewed financial results for the first six months of the FY20 budget year. Based on this information, it is projected that the FY20 actual results will be within budget.

## Highlights of the FY21 Budget

The FY21 balanced budget is proposed at \$18.8 million, with \$17.2 million funded from operating revenues and \$1.6 million funded from Board-designated net asset reserve funds. Member dues remain at the same rate as the past three years. Annual Meeting revenues are budgeted conservatively in recognition of the impact the coronavirus may have on meeting attendance. Education

and other product sales are budgeted to include the new FLEX product and phase out of the Home Study Course. Royalties and advertising revenues continue from publishers of the *Otolaryngology–Head and Neck Surgery* and the *Bulletin*. Other revenues include royalties from our Academy Advantage partners, the new Corporate Champions program, and donor contributions to the Foundation's Annual Fund.

The Board has designated net asset reserves for use in the FY21 budget to fund \$750,000 of operating expenses, \$695,000 of Reg-ent<sup>SM</sup> technology costs, and \$120,000 for redesign and upgrade of the Academy's main website.

Operating expenses are budgeted 1.3% more than the prior year attributed to higher Annual Meeting costs for the Boston venue. Delivering the world's best otolaryngology education program continues to be a priority in the allocation of budget resources.

Subsequent to the preparation of the FY21 budget, the new Academy Cares program was introduced in response to the hardships created by the coronavirus for our members. This program, which is estimated to cost approximately \$800,000, will be funded from net asset reserves that were accumulated as a result of positive operating variances in prior years. This use of reserves will be spread over fiscal years FY20 and FY21 and is not included in the presented budgets.

The complete budget is available to any Academy member who requests it in writing. Email requests should be made to Carrie Hanlon, CPA, Senior Director, Finance and Administration, at [bulletin@entnet.org](mailto:bulletin@entnet.org). ■

## AAO-HNS/F combined budgets

	Approved Budget FY20	Proposed Budget FY21
<b>Revenue</b>		
Membership Dues	\$6,925,000	\$6,950,000
Annual Meeting Revenues	6,741,000	6,438,000
Education and Other Product Sales	1,858,000	1,349,000
Publication Revenues	1,208,000	1,210,000
Other Revenues	743,000	1,009,000
Use of Donor Restricted Net Assets	258,000	262,000
<b>Operating Revenue</b>	<b>17,733,000</b>	<b>17,218,000</b>
Use of Board-Designated Net Assets	1,700,000	1,565,000
<b>Total Revenue</b>	<b>\$19,433,000</b>	<b>\$18,783,000</b>
<b>Expenses</b>		
Salaries & Benefits	\$9,125,000	\$9,180,000
Consultants & Professional Fees	1,750,000	1,421,000
Annual Meeting Costs	2,671,000	3,314,000
Other Expenses	2,734,000	2,618,000
Occupancy	1,003,000	985,000
Contingencies	450,000	450,000
<b>Subtotal</b>	<b>17,733,000</b>	<b>17,968,000</b>
Board-Designated Reserve Expenses	1,700,000	815,000
<b>Total Expenses</b>	<b>\$19,433,000</b>	<b>\$18,783,000</b>



# AAO-HNSF 2020 SEPTEMBER ANNUAL MEETING & OTO EXPERIENCE 13-16 BOSTON, MA



JOHN CONLEY, MD LECTURE ON  
MEDICAL ETHICS  
**Sunday, September 13, 2:30 pm–3:30 pm**  
Anand K. Devaiah, MD

**Anand K. Devaiah, MD**, is director of the Biomedical & Health Technology Development & Transfer Domain at the Institute for Health System Innovation & Policy (IHSIP). He is an associate professor in the Department of Otolaryngology – Head and Neck Surgery, with joint appointments in Neurological Surgery and Ophthalmology at the Boston University School of Medicine and Boston Medical Center. His clinical interests center around skull base surgery, including endoscopic approaches to the cranial base.



At IHSIP, Dr. Devaiah leads the Institute's activities integrating the tools for health improvement that are being rapidly developed by science and technology. In his role, Dr. Devaiah bridges the worlds of development and implementation, leading collaborations focused on improving value in the health system through technological innovations.

Dr. Devaiah's experience in healthcare technology and innovation spans technology development, evaluation, implementation, research, administration, regulatory science, and intersections with social determinants of health. Working closely with individuals and companies, from startups to established enterprises, he has worked with teams to develop new technologies as well as implementation strategies for emerging health technologies.

Dr. Devaiah also served as a medical officer and fellow with the FDA in the Center for Devices and Radiologic Health, Ear, Nose, and Throat Branch. He has served on several medical society committees and is the immediate past president of the Society of University Otolaryngologists Head and Neck Surgeons. ■

H. BRYAN NEEL III, MD, PHD  
DISTINGUISHED RESEARCH LECTURE  
**Monday, September 14, 10:00 am–11:00 am**  
**Shifting Paradigms in Otolaryngology with 3D Printing**  
Glenn E. Green, MD

**Glenn E. Green, MD**, is a professor of otolaryngology-head and neck surgery at the University of Michigan, which has been leading the transformation of medicine through the use of 3D printing.

During the COVID-19 pandemic, Dr. Green's team, which included **Kyle K. VanKoeveering, MD**, and **David A. Zopf, MD**, rapidly developed life-saving technologies that received Emergency Use Authorization from the U.S. Food and Drug Administration. He has also developed surgical techniques and devices for complex airway reconstruction. Dr. Green is coinventor, along with Scott Hollister, PhD, of a 3D-printed airway splint and was part of the first surgical team to place the device. Other novel devices include 3D-printed scaffolds for facial reconstruction of auricular and nasal defects, 3D-printed customized devices to treat airway obstruction for craniofacial defects and/or neurologic diseases, and skull base reconstruction plates.



After graduating with a degree in chemical engineering, Dr. Green entered medical school at the University of Michigan. He completed an otolaryngology residency at Wayne State University, an NIH-supported research fellowship, and a subspecialty fellowship in pediatric otolaryngology at the University of Iowa, where he worked with **Richard J.H. Smith, MD**.

Dr. Green has won several awards, including the 2015 Honored Maker Award from former President Barack Obama. He has over 70 publications related to both his clinical and research work, and he has been widely featured with his constructs on featured display at the British Science Museum in London. ■

EUGENE N. MYERS, MD  
INTERNATIONAL LECTURE ON HEAD  
AND NECK CANCER  
**Tuesday, September 15, 10:00 am–11:00 am**  
**Surgeon Is a Major Prognostic Factor of Head and Neck Cancer Patients Undergoing Primary and Salvage Surgery**  
Luiz P. Kowalski, MD, PhD

**Luiz P. Kowalski, MD, PhD**, is chair of the Department of Head and Neck Surgery and Otorhinolaryngology at A.C. Camargo Cancer Center and professor and chair of the Head and Neck Surgery Department at the University of São Paulo Medical School. He is committed to surgical practice, research, and medical education, with special interest in head and neck surgical oncology, multidisciplinary management of cancer, clinical and translational research, and prognostic factors. He is also active in training graduate students, residents, fellows, and postgraduate students.



Dr. Kowalski is a prolific author and has published more than 680 peer-reviewed articles, written three theses and 141 book chapters, and edited 13 books. He has been an honored guest lecturer internationally and is a member of several professional organizations and is currently serving as vice-chair of the Head and Neck Cancer Group of the Latin American Cooperative Oncology Group.

Dr. Kowalski received a medical degree from the Medical School of the Federal University of Parana, Brazil, completed a three-year residency in surgical oncology at A.C. Camargo Cancer Center, São Paulo, and then a one-year fellowship in head and neck surgery at Hospital Heliopolis, São Paulo. He obtained an MS degree and PhD degree in otorhinolaryngology from Escola Paulista de Medicina, São Paulo. During postgraduate training he also completed a six-month observership in head and neck surgery at Memorial Sloan-Kettering Cancer Center, New York. Afterward, he joined the faculty of A.C. Camargo Cancer Center. ■



Joel Selanikio, MD

## #OTOMTG20 to Feature Keynote from Physician and Renowned Thought Leader, Joel Selanikio, MD

The AAO-HNSF 2020 Annual Meeting & OTO Experience theme, "Bringing Together the World of Otolaryngology," takes on a new meaning as the world strives to overcome the unprecedented COVID-19 pandemic.



On episode 11 of the AAO-HNS COVID-19 Podcast Series, Dr. Selanikio, **James C. Denny III, MD**, **Eugene G. Brown III, MD**, and **Cecilia E. Schmalbach, MD**, discuss What Is the "New Normal" Otolaryngology Practice? And How Has COVID-19 Affected It? Listen to the full podcast at [www.entnet.org/content/covid-19-podcast-series](http://www.entnet.org/content/covid-19-podcast-series).

The 2020 Opening Ceremony will unite leaders in the specialty, a groundbreaking keynote speaker, and enthusiastic attendees, setting the tone and pace for the Annual Meeting & OTO Experience. Don't miss this special event at 8:30 am on Sunday, September 13. The AAO-HNSF is honored to welcome Joel Selanikio, MD, as this year's keynote speaker. As the specialty rebuilds for the future after COVID-19, Dr. Selanikio will provide a futurist outlook for the healthcare industry.

In addition to being a physician, Dr. Selanikio is a TED speaker, inventor, emergency responder, and consultant working in the fields of technology, healthcare, artificial intelligence, entrepreneurship, social innovation, big data, child health, and disaster response.

As an emergency responder and former U.S. Center for Disease Control and Prevention (CDC) epidemiologist and outbreak investigator, from December 2014 to January 2015, he was the lead physician at the IMC Ebola Treatment Center at Lunsar, Sierra Leone. When in the Public Health Service, Dr. Selanikio served as

chief of operations for the U.S. Health and Human Services Secretary's Emergency Command Center after the 9/11 attacks.

A founding member of the World Health Organization's Digital Health Roster of Experts, he is the winner of both *The Wall Street Journal* Technology Innovation Award for Healthcare and the Lemelson-MIT Award for Sustainable Innovation for the development of the Magpi mobile data collection system, the first cloud-based application created for global health and international development.

Dr. Selanikio has consulted for or spoken at Davos, Foo Camp, WHO, UNICEF, IFRC, Harvard, MIT, Stanford, Google, DARPA, CNN, Fox News, the Clinton Global Initiative, the Royal Society of Medicine, and the pharmaceutical and healthcare industries. He has also been profiled by *The Guardian*, *Wired*, *Forbes*, *TED*, *The Economist*, *The Wall Street Journal*, *Fox News*, *BBC*, *NPR*, *Information Week*, and *The Washington Post*, among many others.

Visit [www.entannualmeeting.org](http://www.entannualmeeting.org) to learn more and register for the AAO-HNSF 2020 Annual Meeting & OTO Experience. ■



## Trauma Symposium: Wartime and Peacetime Advances in Head and Neck Reconstruction

The AAO-HNS Trauma Committee and the Society of Military Otolaryngologists (SMO) Annual Symposium will present continuing medical education (CME) sessions starting at 5:00 pm, Saturday, September 12, at the AAO-HNSF 2020 Annual Meeting & OTO Experience in Boston. The education sessions include a panel discussion on rehabilitation of facial paralysis and a lecture on facial transplantation.

This event, open to civilian and military attendees, includes a reception, dinner, awards, and displays.

Speakers include **Donald J. Annino, Jr., MD, DMD**, assistant professor of otolaryngology-head and neck surgery, Harvard Medical School; **Nate Jowett, MD, FRCS**, assistant professor of otolaryngology-head and neck surgery, Harvard Medical School; **Prabhat K. Bhama, MD**, clinical assistant professor of otolaryngology-head and neck surgery, University of Hawaii; and **Scott Bevans, MD**, assistant professor of otolaryngology-head and neck surgery, Uniformed Services University.

Lecture topics include reconstruction of subtotal facial defects with composite tissue allograft transplantation and rehabilitation of the paralyzed face through reinnervation and reanimation techniques.

Additional topics of discussion will focus on surgical research and the use of technology in medicine.

Please note this event is not included in the AAO-HNS registration fees. On-site registration is \$100 for nonmembers of SMO.

To register for the dinner meeting, please go to <https://www.miloto.org/> ■

## 2020 Annual Meeting & OTO Experience “Hot Topic” Education Programming

Experts and science converge at the AAO-HNSF Annual Meeting & OTO Experience, September 13-16, in Boston, Massachusetts. This year’s education program features a world-renowned faculty discussing state-of-the-art treatment modalities, new therapies, and ongoing research in the field. The education program is divided into 11 distinct tracks, allowing you to focus within your subspecialty or expand your knowledge in other areas. We would like to highlight the following sessions that have earned the recognition as “Hot Topic” sessions by receiving the highest reviewer scores across all specialty areas from the Annual Meeting Program Committee.

### Business of Medicine/Practice Management

- Developing Professional Expertise: Plan, Publish, and Present
- From Vapor to Venture: How to Start and Sustain Something Big
- Continuing Certification in Otolaryngology-Head and Neck Surgery: Need-to-Know Updates for 2020

### Comprehensive Otolaryngology

- Telemedicine: Practical Tips for Implementation into Your Daily Practice
- Medical Marijuana in Otolaryngology: What is its Role?

### Endocrine Surgery

- Beyond the Guidelines: Advanced Pediatric Thyroid Cancer Evaluation and Management
- Intraoperative Parathyroid Localization: A Panel Review of New Technologies and Presentation of Cases
- Neck Dissection for Thyroid Cancer and the ATA Guidelines

### Facial Plastic and Reconstructive Surgery

- Comprehensive Management of Facial Palsy
- Modern Concepts in Nasal Reconstruction
- Transgender Care in Otolaryngology: Facial and Vocal Gender Affirming Surgery

### Head and Neck Surgery

- Cutaneous Melanoma: Contemporary 2020 Management Pearls
- Controversies in Parotid Surgery: Is There Evidence?
- Immunotherapy for Cancer Treatment: What the Otolaryngologist Needs to Know

### Laryngology/Broncho-Esophagology

- Airway Manifestations of Autoimmune Disease: Diagnosis, Evaluation, and Treatment Challenges

- Diagnostic Test Selection in Chronic Cough and Dysphagia
- How Data-Driven Multidisciplinary Trach Teams Transform Care, Prevent Harm, and Save Lives

### Otology/Neurotology

- Chronic Ear Surgery: Surgical Techniques and Avoidance of Complications Pt. I & II
- Endoscopic Ear Surgery: Tips and Pearls
- Vestibular Migraines: 2020 Management Update

### Patient Safety and Quality Improvement

- Do you Juul? Vaping and Related Emerging Public Health Threats in Otolaryngology
- What Matters in the End: Care at the End of Life in Otolaryngology?

### Pediatric

- Kids Today: Rapid Review of Guidelines and Consensus Statements
- Pediatric Hearing Loss: CMV, Genetics, Imaging, and More
- Pediatric Open Airway Surgery: State-of-the-Art

### Rhinology/Allergy

- FESS, Biologics, and Biomarkers, Oh My!: A Case-Based Approach to Decision-Making for Nasal Polyposis
- Harnessing the Opportunities of Novel Office Based Treatment for Management of Rhinitis and Sinusitis
- New and Improved Therapeutic Options for Patients with Olfactory Loss

### Sleep Medicine

- Alternatives to Upper Airway Surgery for Obstructive Sleep Apnea
- Drug-Induced Sleep Endoscopy in Obstructive Sleep Apnea
- Update on Scientific Trials and Systematic Reviews in Sleep Surgery 2020

Learn more and register today at [www.entannualmeeting.org](http://www.entannualmeeting.org). ■



# Private Payer Advocacy Spotlight: Wins and Challenges

**T**he AAO-HNS is actively engaged in private payer advocacy efforts to ensure coverage and reimbursement of procedures provided by our members to improve health outcomes. The Academy relies on multiple avenues to identify coverage topics for advocacy prioritization. In addition to reaching out directly to the Health Policy Advocacy Team and sharing copies of policies via email or phone, members are also encouraged to notify staff via the online inquiry tool at <https://www.entnet.org/content/practice-management-tool>. The AAO-HNS Advocacy Team reviews payers' monthly newsletters announcing changes in coverage

and monitors numerous online resources. In addition, staff collaborates with the Academy's physician leaders, as well as other medical societies to recognize detrimental policies.

Throughout the past year, the Academy has been active on a wide range of private payer coverage and reimbursement issues, including payment issues surrounding Modifier 25, coverage of functional endoscopic sinus surgery (FESS), and the use of balloon ostial dilation for treatment of chronic rhinosinusitis (BSOD). Following an extensive review process by multiple AAO-HNS Committees and the Physician Payment Policy (3P) Workgroup, the AAO-HNS submitted responses to seven BlueCross BlueShield

Association (BCBSA) Evidence Street reviews:

- Implantable Bone-Conduction and Bone-Anchored Hearing Aids
- Cochlear Implant
- Eustachian Tube Balloon Dilation
- Functional Endoscopic Sinus Surgery for Chronic Rhinosinusitis
- Middle Ear Implantable Hearing Aids
- Steroid-Eluting Sinus Stents
- Treatment of Tinnitus

By providing clinical input on these evidence reviews, the AAO-HNS had an opportunity to directly impact the clinical evidence that will be assessed in future medical coverage policies by BCBSA member plans.

## Functional Endoscopic Sinus Surgery

In November 2019, in response to comments submitted by the AAO-HNS, United Healthcare revised its FESS medical policies. The revisions include the addition of the CT finding of opacified sinus to the chronic sinusitis criteria and the removal of the use of an independent radiologist for interpretation of CT scan findings from documentation requirements. Additionally, in March 2020, Academy staff conducted a telephone meeting with Aetna to discuss our concerns surrounding FESS reimbursement denials.

## Balloon Ostial Dilation for Treatment of Chronic Rhinosinusitis

In response to outreach by numerous Academy members regarding payer denials of BSOD procedures, the AAO-HNS has been active in fighting policies that deem BSOD to be a noncovered service. On February 5 the AAO-HNS sent comments to BlueCross BlueShield's Federal Employee Program opposing its medical policy designating BSOD as experimental/investigational. The comment letter highlighted the AAO-HNS Position Statement and Clinical Consensus Statement on BSOD, as well as provided extensive literature support demonstrating the procedure as consistent with the standard of care.

## Modifier 25 Policies

Last summer the Academy sent a letter to Anthem expressing our strong opposition to its revised modifier 25 reimbursement policy. According to the policy, Anthem may deny an E/M service with modifier 25 billed on the same day of a related procedure when there is a recent service or procedure for the same or similar diagnosis. The Academy also sent a letter to Anthem BCBS of Virginia expressing our strong opposition to a modifier 25 reimbursement policy that mirrored Anthem's national policy.

The AAO-HNS comment letters cited flaws with the rationale used by the companies in developing these policies. We called on Anthem and Anthem BCBS of Virginia to immediately reverse their policies by providing full reimbursement for all clinically appropriate E/M services.

The letter also requested clarification on two issues: the definition of recent or related procedures and what is considered the same or similar diagnosis.

Members experiencing coverage and reimbursement denials are encouraged to reach out to the Academy's Health Policy Advocacy Team, so the AAO-HNS can continue to fight for appropriate coverage of otolaryngology-head and neck surgery procedures.

To stay up to date on the latest information from the Academy's Health Policy Advocacy Team, bookmark <https://www.entnet.org/trending-topics>. ■

## AAO-HNS Position Statements:

<https://www.entnet.org/content/position-statements>

## Clinical Consensus Statements:

<https://www.entnet.org/content/clinical-consensus-statements>



## Thank You to the 2020 ENT PAC First 50 Investors!

The First 50 campaign is a fundraising effort to garner at least 50 \$1,000+ (Chairman's Club or Leadership Club) contributions during the month of January every year. The First 50 campaign helps ensure the Academy can actively engage on issues critical to the specialty. First 50 contributors receive exclusive access to a 2020 conference call series with high-ranking individuals from Congress or the Administration. If you have questions or would like additional information about contribution to ENT PAC\*, contact ENT PAC staff at [entpac@entnet.org](mailto:entpac@entnet.org). The Academy would like to thank the following First 50 Investors for their dedication and financial support of the advocacy efforts on behalf of the specialty:

### Leadership Club

Eugene G. Brown III, MD  
Paul M. Imber, DO  
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\*Contributions to ENT PAC are not deductible as charitable contributions for federal income tax purposes. Contributions are voluntary, and all members of the American Academy of Otolaryngology-Head and Neck Surgery have the right to refuse to contribute without reprisal. Federal law prohibits ENT PAC from accepting contributions from foreign nationals. By law, if your contributions are made using a personal check or credit card, ENT PAC may use your contribution only to support candidates in federal elections. All corporate contributions to ENT PAC will be used for educational and administrative fees of ENT PAC, and other activities permissible under federal law. Federal law requires ENT PAC use its best efforts to collect and report the name, mailing address, occupation, and the name of the employer of individuals whose contributions exceed \$200 in a calendar year.

# Changes Are Coming to E/Ms Starting in 2021

**B**eginning January 1, 2021, changes to the Current Procedural Terminology (CPT®) code structure for office or outpatient evaluation and management (E/M) services will take effect. The Centers for Medicare & Medicaid Services (CMS) finalized these changes in the 2020 Medicare Physician Fee Schedule final rule. The new updates include revisions to the CPT descriptors for codes 99201-99215 and documentation standards. While private payers are not bound by CMS policy, they will likely adopt a similar coding structure.

The new documentation requirements will be based on the traditional subjective, objective, assessment, and plan format—in which physicians document what the patient was there for (subjective), what was learned from their history and exam (objective), what the physician assessed to be the problem, and the plan for resolving it.

## Major changes include:

- Eliminating history and physical exam as elements for code selection
- Allowing physicians to choose whether their documentation is based on medical decision making (MDM) or total time
- Modifying MDM criteria to move away from simply adding up tasks to focusing on tasks that affect the management of a patient's condition

Physicians will now be able to choose whether their documentation is based on MDM or total time. The definition of “time” is minimum time, not typical time, and represents total physician/qualified healthcare professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to recognize the work involved in non-face-to-face services like care coordination. These definitions only apply

when code selection is primarily based on time and not MDM.

If MDM is used to determine the E/M code for the outpatient visit, there are a variety of factors one must weigh that differ based on the site of service. If one evaluates a patient in the office setting, the factors in MDM include number and complexity of problems addressed, amount and/or complexity of the data reviewed and analyzed, and risk of complications and/or morbidity of patient management. Factors considered for an inpatient setting include number of diagnoses or management options, amount and/or complexity of data to be reviewed, and risk of complications and/or morbidity.

If time spent on the encounter is used as the determinant for the CPT code billed, the time values will change next year from typical time used to total time used. CPT code 99201 will be deleted, effective January 1, 2021. For new patient codes, times begin at 15–29 minutes for CPT code 99202 and then advance in 15-minute increments with 99205 assigned 60–74 minutes. For existing patients, the time element was removed from CPT code 99211. For CPT code 99212, time for the encounter will be 10–19 minutes. Ten-minute increments are used for codes 99213 and 99214. CPT code 99215 has a 15-minute time frame and is utilized for exams 40–54 minutes in duration.

If these time frames do not reflect enough time to describe the encounter, there will be a new code (the current 99xxx is a placeholder) for CPT codes 99205 and 99215 for those reporting based on time. 99xxx will be used in 15-minute increments when the visit takes longer than the times allowed in the new codes. Prolonged services of less than 15 minutes should not be reported. 99xxx can be reported multiple times for the same visit. For example, if an encounter takes 90–104 minutes, 99205 should be reported in addition

to 99xxx being reported twice.

CPT code 99358 should only be utilized for non-face-to-face, usually telehealth, encounters and therefore should not be reported on days when other E/M codes are reported. The CPT code 99358 can be reported for visits on days other than when the E/M encounter is reported.

Please visit the Academy's Coding Corner, <https://www.entnet.org/content/coding-corner>, for additional updates on the revised E/M codes, as well as the newest coding and reimbursement tools for members. ■

## AAO-HNS State Trackers

Calling all Academy members for participation in the AAO-HNS State Trackers program. The Advocacy Team provides the following resources to help guide you during your state's legislative session.

- AAO-HNS State Trackers List
- State Legislative Tracker - Introductory Slideshow
- State Tracker State-mENT newsletter
- Academy State Advocacy Bill Tracking
  - Legislative Tracking by State
- State Legislative Tracking Resources
  - 2020 State Legislative Session Dates
  - State Legislative Priorities
  - State "Mark-up" Styles
  - Glossary of legislative terms
  - Example of the state legislative process
  - Explanation of the crossover period

If you have any questions or problems, please contact the Academy State Advocacy Team at [legstate@entnet.org](mailto:legstate@entnet.org). ■

## Advocacy in Action: A Win for Children in Virginia

Working over a holiday weekend in January, the AAO-HNS, the Virginia Society of Otolaryngology, and the Virginia Chapter of the American Academy of Pediatrics coalesced to inform Commonwealth of Virginia legislators of their significant concerns surrounding SB 423, a bill to require health insurance coverage of hearing aids for minors. Noting that hearing loss is the number one birth defect in the United States and that early diagnosis and treatment are crucial to a child's development over a lifetime, it was stressed that a physician who specializes in the medical diagnosis and treatment of pediatric hearing problems was an essential but missing component of the bill. The three organizations cosigned a letter to the Virginia Senate sponsor and the Committee on Commerce and Labor urgently requesting an amendment to the bill that added otolaryngologists for medical clearance and, if appropriate, for the dispensing of hearing aids. The bill was successfully amended and passed the Senate. Next came the real battle. The House of Delegates developed and passed its own amendments reducing the proposal to a study bill, with which the Senate did not agree. The bill then went to conference and the Senate amendments that included otolaryngologists prevailed. The governor signed the bill into law on April 10, 2020.

Beginning January 1, 2021, most health insurers in the Commonwealth of Virginia will cover hearing aids for children 18 years of age or younger, one per impaired ear, every 24 months up to \$1,500 per aid **when recommended by an otolaryngologist**. In addition to audiologists and hearing aid specialists, otolaryngologists can also dispense the appropriate services and equipment—a win for the children, their families, and their advocates. ■

# PROJECT 535

## The Power of Project 535

There are few tools more powerful than direct advocacy between a constituent and a member of Congress. Project 535 was established in 2015 by the Board of Governors in order to create an avenue for AAO-HNS members to get involved in direct advocacy on issues which significantly impact our specialty. By volunteering for Project 535, Academy members ensure their voices are heard and assist the AAO-HNS advocacy efforts in two distinct ways: emailing members of Congress, urging them to support or oppose specific legislation, and meeting with members of Congress in person, either in Washington, DC, or in their district offices.

In the past, through Project 535, AAO-HNS members have served a vital role in assisting with the efforts related to the repeal of the Independent Payment Advisory Board, passage in the House of H.R. 2339 "Reversing the Youth Tobacco Epidemic Act," reauthorization of the Early Hearing Detection and Intervention program, truth in advertising legislation, and medical liability reform. Our grassroots advocates' most recent victory was evidenced by securing integral physician protections within the "Coronavirus Aid, Relief, and Economic Security (CARES) Act." This success, our continued work with Congress on ongoing COVID-19 federal relief efforts, and our ongoing fight against the "Medicare Audiologist Access and Services Act" (H.R. 4056/S. 2446), highlight that grassroots advocacy from our members is now more critical than ever. The Academy's Advocacy Team needs your help to raise your voice!

### Become A Member of Project 535

Successful legislative advocacy starts with a solid grassroots foundation. Our goal is to recruit a key contact for each U.S. Senate and House congressional seat to strengthen outreach to federal legislators when major healthcare issues are debated by Congress. There are still a number of states and districts where we need coverage. The commitment is minimal, but the impact is immense. Sign up today to join this exciting program! Please contact us at [govtaffairs@entnet.org](mailto:govtaffairs@entnet.org) to sign up for Project 535 or ask any questions. The Academy appreciates the efforts of our current Project 535 volunteers and looks forward to future members joining the ranks and strengthening our collective voice! ■

## Federal Relief for Otolaryngologist-Head and Neck Surgeons Amid the COVID-19 Pandemic

**A**s the novel coronavirus has spread in communities across the United States, the AAO-HNS has fiercely advocated for relief for otolaryngologist-head and neck surgeons on the federal level. With the steadfast support of AAO-HNS members through grassroots advocacy, the Academy has worked to negotiate on behalf of the specialty to ensure that our members and the patients they serve are protected during this unprecedented time. Congress has passed, and President Trump has signed into law, four separate pieces of legislation to address the COVID-19 pandemic. Of these four bills, H.R. 748, “The Coronavirus Aid, Relief, and Economic Security (CARES) Act,” was the largest package from Congress, totaling \$2.2 trillion in federal aid, aimed to provide emergency relief to individuals and businesses during the COVID-19 crisis. While other legislation has been enacted, the CARES Act is the most comprehensive in its relief provided to our specialty. The CARES Act (the “Act”), which President Trump signed into law on March 27, includes the following relief provisions for otolaryngologist-head and neck surgeons practicing across a range of settings.

### Paycheck Protection Program

The Act included roughly \$350 billion in funding to support small businesses experiencing economic strains caused by COVID-19. The Paycheck Protection Program (PPP) created Small Business Administration loans of up to \$10 million to help cover salaries, leave and health benefits, rent, and/or retirement obligations, among other uses. Physician practices with no more than 500 employees may qualify. While initial funding for the PPP was expended on April 16, President Trump signed into law the “Paycheck Protection Program and Health Care Enhancement Act” on April 24 that appropriated an additional \$321 billion for PPP loans. At the time of publication, the second round of PPP funding is nearly expended.

### Personal Protective Equipment

The Act takes steps to address the medical supply shortages and provides \$16 billion for the Strategic National Stockpile in order to procure personal protective equipment, ventilators, and other medical supplies for federal and state response efforts.

### Medicare Telehealth Flexibilities

The Act grants the U.S. Secretary of Health and Human Services the authority to waive telehealth coverage requirements for new Medicare patients for the duration of the current COVID-19 emergency. Previous legislation provided flexibility only for established patients seen within the past three years. Another provision allows for enhanced use of telehealth under Medicare for federally qualified health centers (FQHCs) and rural health clinics (RHCs). FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. Services at these sites would be reimbursed at the national average under the Medicare Physician Fee Schedule.

### Temporary Medicare Payment Update

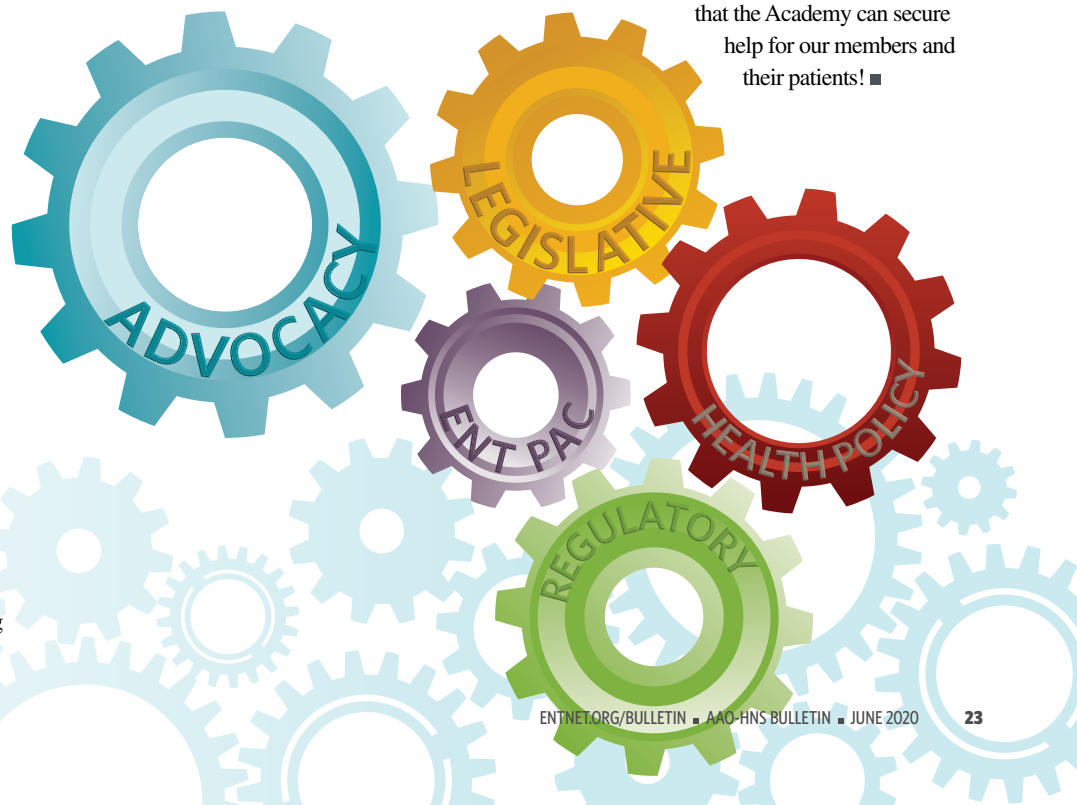
The Act temporarily lifts the 2% sequestration on Medicare payments from May 1, 2020, until December 31, 2020. This provision provides an immediate 2% increase in Medicare physician payment.

### Liability Protections

The Act includes critical liability protections for physicians and healthcare professionals who volunteer to provide healthcare services in response to the coronavirus pandemic for the extent of the public health crisis.

While these CARES Act provisions illustrate that Congress is listening and responding to the clinical and economic challenges that otolaryngologist-head and neck surgeons are currently faced with, the effects of COVID-19 on physicians and their practices will remain in the face of the pandemic. As such, the Academy’s Advocacy Team will continue to advocate for further meaningful relief. The AAO-HNS thanks the physician volunteers who have helped ensure the success of the Academy’s advocacy efforts.

It is with your hard work and support that the Academy can secure help for our members and their patients! ■



# Otolaryngology–Head and Neck Surgery at the Forefront of the COVID-19 Pandemic



**John H. Krouse, MD, PhD, MBA**

Editor in Chief, *Otolaryngology–Head and Neck Surgery* and *OTO Open*

**T**he arrival of the novel coronavirus, COVID-19, in winter 2020 marked a watershed moment in international healthcare. As information began to circulate about the rapidly expanding pandemic, it became clear early in its expansion that this respiratory virus would have a significant impact on otolaryngologists and their patients. Not only did the transmission of COVID-19 depend on a reservoir of virus in the upper respiratory tract, many of its earliest patient presentations involved symptoms such as anosmia, ageusia, cough, and throat clearing.

In such an era of uncertainty, with problematic science and questionable public reports, the need for valid, reliable, and evidence-based communications becomes even more critical. It is with this

thirst for accurate, actionable data and expert opinion from trusted colleagues that *Otolaryngology–Head and Neck Surgery* adopted a strategy of engaging the international otolaryngology community and providing rapid review and acceptance of important and relevant content from around the world. Not only was there the demand for this information from our readership, but also a strong desire of our colleagues who have been on the front lines of dealing with COVID-19 to share their experiences and interventions with our community.

In early April the journal received a communication that described the experience of otolaryngologists in China from the earliest days of the pandemic.<sup>1</sup> This paper was among the first to highlight that otolaryngologists were at increased risk of infection due to occupational exposure. In addition, it warned that patients could transmit COVID-19 with minimal or no symptoms. The paper further advised that otolaryngologists had been infected at higher rates than other health providers in China due to intimate contact with aerosolized secretions and admonished strict environmental controls and use of protective equipment in dealing with all patients.

Within a period of several days, *Otolaryngology–Head and Neck Surgery* received over a dozen commentaries and short research communications from countries around the world, including China, Italy, Singapore, and the United

States. An especially instructive Italian paper related the experiences of otolaryngologists in Lombardy, providing detail of how to best operate a head and neck service in the midst of the COVID-19 crisis.<sup>2</sup> The authors discussed their approaches to improving safety measures for otolaryngologists, including residents in graded responsibilities with patients, and increasing specialty care through a variety of methods.

It was clear that the experiences being offered by colleagues in areas such as tracheotomy management, flexible laryngology, otologic surgery, and the ethics of care were important to rapidly disseminate to the otolaryngology community. Along with our Deputy Editor **Jennifer J. Shin, MD**, I determined that we would expedite the peer review process to allow publication decisions within 48 hours. For many article types, such as commentaries, Jennifer and I would make these decisions editorially, without sending them for additional levels of review. For original research papers, systematic and state-of-the-art reviews, and short scientific communications, we instructed our associate editors to rapidly turn around their assessments of the submissions so that quick decisions could be returned to authors.

We also implemented several policies to increase rapid dissemination of COVID-19 articles. With the help of AAO-HNS Executive Vice President and CEO James C. Denny III, MD, and our editorial



staff, and with permission of each article's authors, we started to post all accepted COVID-19 papers on the [www.otojournal.com](http://www.otojournal.com) website at the time of their acceptance in their original typed form as submitted. This decision allowed the papers to be available to our readership prior to being typeset by the publisher and resulted in papers being available several weeks earlier. In addition, these accepted papers were referenced on ENTConnect so that members would be aware of newly published articles as they were posted. Finally, we decided to make all of these COVID-19 papers open access in *Otolaryngology–Head and Neck Surgery* so that readers around the world would be able to read and utilize these manuscripts, even if they did not have a subscription or license for access. We made the important editorial decision that otolaryngologists and other healthcare providers around the world would be able to use these vital papers as they became available and without cost or restriction. Dozens of papers have therefore been added to the otolaryngology literature through these important decisions at our journal.

It was clear in the early phases of the COVID-19 pandemic that many patients were experiencing a loss of taste or smell. For some patients taste and smell aberrations were their earliest symptoms and return of function would often provide an early signal of recovery from the virus. To contribute to the understanding of these important otolaryngologic symptoms, one

accepted paper reported the development and initial validation of a COVID-19 anosmia reporting tool.<sup>3</sup> Early use of this tool demonstrated that 73% of patients reported anosmia prior to the diagnosis of COVID-19 and that anosmia was the initial symptom in 27%. A recently accepted state-of-the-art review examined 12 papers that reported on anosmia and confirmed these rates; it also concluded that sudden anosmia should be considered a symptom of COVID-19.<sup>4</sup> Manuscripts such as these provide significant value to the otolaryngology community.

It is clear that COVID-19 is a serious disease and that it creates a serious burden for otolaryngologists in the care of their patients. A recent publication demonstrated that American otolaryngologists have seen a 75% decline in outpatient visit volumes since the onset of the pandemic, second only as a specialty to ophthalmology.<sup>5</sup> Given the uncertainties surrounding COVID-19, it has been important for *Otolaryngology–Head and Neck Surgery* to take the lead in bringing evidence-based science and expert opinion to our readers around the world. By taking a proactive and aggressive approach to manuscript review and by offering rapid and freely accessible articles on the topic, *Otolaryngology–Head and Neck Surgery* sustains its role at the forefront of scientific publication for our specialty. We will continue to publish these important papers for the duration of this unprecedented crisis. ■

### **OTO Journal** COVID-19 ACCEPTED PAPERS

*Otolaryngology–Head and Neck Surgery* has accepted several COVID-19-related papers for publication. In an effort to expeditiously distribute this research, the authors have agreed to share their accepted manuscripts. A list of these manuscripts as well as those that are now published online can be found at <https://www.entnet.org/content/oto-journal-covid-19-accepted-papers>.

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# How to Identify and Protect Yourself Against Predatory Journals

Members are always encouraged to collaborate and share your research, findings, and thought leadership with the otolaryngology specialty at large. You may even receive unsolicited invitations to submit your research to a new, open access journal or to join a new editorial board. Unfortunately, not all of these “opportunities” are legitimate and do not ultimately promote the science and practice of medicine.

The American Academy of Otolaryngology–Head and Neck Surgery Foundation has our own open access journal, *OTO Open*, and according to our publisher, SAGE Publishing, there are a number of benefits to working with open access journals, including:

**Increased visibility**—With content free to all—not just paying subscribers—anyone with internet access can view and download your research. This allows for broader and faster impact as well as enhanced collaboration. Studies have shown increased citations to open access content and science as a whole moves forward faster when access to research is not limited to those who can pay.

**Increased access**—Open access content is available to everyone, regardless of their financial situation.

**Authors retain copyright**—Most open access content is published under a Creative Commons or similar type of license, which allows the author to retain more control over their intellectual property including rights to distribute and reuse.

**Meeting funder requirements**—Increasingly, funders are making open access publishing a prerequisite for funding. Publishing in an open access journal easily fulfills funders’ requirements.<sup>1</sup>

## Sounds Good. What’s the Problem?

SAGE goes on to explain that “predatory companies take advantage of the crowded open access environment to launch journals with highly questionable practices. Some predatory

titles list entirely fabricated editorial boards on their websites. Others go further by listing real academics without their knowledge or consent. ‘Pay to Publish’ journals conduct little to no peer review and will accept any manuscript so long as the author is willing to pay a fee. Some predatory publishers even mimic existing, high quality peer-reviewed journals, down to the journal logo.”<sup>2</sup>

## How Can I Identify Reputable, Worthwhile Journals?

A 2018 *Otolaryngology–Head and Neck Surgery* editorial written by a consortium of editors in chief of otolaryngology-related journals and titled “Open Access: Is There a Predator at the Door?” explains how you can recognize legitimate open access journals by looking for these features:

- A well-known editorial board of recognized experts in the field
- An International Standard Serial Number (ISSN)
- Listing in the Directory of Open Access Journals (DOAJ) at <https://doaj.org>
- Publisher membership in the Open Access Scholarly Publishers Association
- Affiliation with recognized societies
- Official website that provides complete contact information
- Publication fees that are clearly listed and are not submission fees<sup>3</sup>

On the other hand, the editors in chief say you should be cautious if:

- Invitations to submit research or to join editorial boards are overly flattering
- There is a guarantee of rapid publication
- The journals’ titles are very similar to those of legitimate journals, but are not established journals
- The journal website has no address or contact information
- The mission of the publisher and/or the journal is described in vague terms
- There is no mention of peer review or basic submission requirements



**OTO Open is the official open access journal of the American Academy of Otolaryngology–Head and Neck Surgery Foundation.** We invite submission of

articles on topics pertaining to the science and art of medicine that help fulfill the journal’s mission of publishing contemporary, ethical, clinically relevant information in otolaryngology, head and neck surgery (ear, nose, throat, head, and neck disorders) that can be used by otolaryngologists, scientists, and clinicians to improve patient care and public health. Articles are published because of scientific merit and are not to be considered general practice standards. Learn more at <https://journals.sagepub.com/home/opn>.

- Manuscripts are submitted by email rather than through the publisher’s online manuscript peer review system
- There is a requirement to submit a minimum number of articles per year, and there is no clear statement that your open access publication fee will be waived<sup>4</sup>

Another resource you can use to identify trusted journals and publishers for your research is called Think. Check. Submit. This international, cross-sector initiative employs a range of tools and practical resources to educate researchers, promote integrity, and build trust in credible research and publications.<sup>5</sup> ■

## References:

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5. <https://thinkchecksubmit.org/>

# Skin Prick Testing for Environmental Allergens

**Christopher Brook, MD**, for the Rhinology and Allergy Education Committee

**A**llergic rhinitis is a common problem and is estimated to impact approximately 35% of the general population.<sup>1</sup> With such a high prevalence and multiple manifestations of the disease in the head and neck, it is not a surprise that allergic rhinitis is encountered frequently by otolaryngologists. One survey found that about 54% of otolaryngology practices provide immunotherapy either in subcutaneous or sublingual form for their patients.<sup>2</sup> The diagnosis of allergy is made by taking a focused history with association of allergic triggers and symptoms. In the absence of a historical diagnosis, that value of specific allergy testing is limited given that allergen sensitization often occurs in patients without allergy symptoms.<sup>3</sup>

Allergy testing techniques are widely debated, with practitioners diagnosing, treating, and prescribing immunotherapy based on skin prick testing, in vitro testing, and intradermal testing.<sup>4</sup> All three techniques provide different advantages and disadvantages and can be used to safely test and treat aero-allergen sensitivities effectively. Skin prick testing uses an application device that pierces the epidermis and applies a small amount of allergen. A whealing response is then read 15–20 minutes later to determine the results (Figure 1). Intradermal testing involves application of antigen directly into the dermis, which increases the sensitivity of testing but can also lead to more discomfort and higher rates of false positive testing. Intradermal testing can be performed in a dilutional technique and can also be performed in a blended technique (known as modified

quantitative testing or MQT) with skin prick testing to quantitate the degree of sensitivity and identify a safe starting dose for immunotherapy. Finally, in vitro testing can be used to measure the amount of circulating IgE antibodies to a specific antigen.<sup>5</sup>

Skin prick testing is the most commonly used technique in most allergy and otolaryngology practices according to surveys,<sup>6</sup> likely stemming from ease of use and immediate results gained after testing. There is ample evidence that skin prick testing is accurate for specific allergy testing, faster than intradermal testing, more comfortable than intradermal testing, less likely to cause systemic reactions, and cheaper than in vitro testing.<sup>3</sup> Disadvantages are that there is less sensitivity than intradermal dilutional testing and that skin prick testing does not necessarily provide information on the relative degree of sensitivity.<sup>3</sup> By basing immunotherapy on skin prick testing alone, assigning an “endpoint” to determine the starting dose of immunotherapy can be challenging due to the nonquantitative nature. Therefore, many practitioners utilize a very conservative starting dose or “endpoint” that is considered safer but leads to longer periods of escalation during immunotherapy treatment (due to a more conservative starting dose).

Practitioners must make their own decisions regarding the tradeoffs between rapid and safe skin prick testing but longer periods of escalation to get to maintenance immunotherapy dosing. This is in contrast to intradermal testing or MQT, which provides more quantitative starting points (and therefore faster escalation) but is more time-consuming to perform. This can also be contrasted with in vitro testing, which is more expensive and requires a delay between testing and obtaining results



Figure 1. Wheal responses seen after skin prick testing.

Ultimately, the decision of testing technique lies with the individual practitioner, and all forms discussed in this article are acceptable with their own advantages and disadvantages.<sup>5</sup> ■

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# June Is National

**Ozlem Tulunay-Ugur, MD, and Derrick R. Randall, MD, MSc, FRCS,** for the AAO-HNS Airway and Swallowing Committee

Patients with throat discomfort are frequently seen in otolaryngology clinics, with population-based studies from the United States reporting 12.5% of otherwise healthy people reporting globus, reaching as high as 46% in some series.<sup>1-3</sup> Distinguishing globus—first described by Hippocrates 2,500 years ago—from bona fide swallowing impairment can be challenging. This is so not only due to myriad potential etiologies, but also because the degree of symptoms and impact on quality of life associated with different clinical conditions range widely.<sup>5-7</sup> Notably, even those affected with a limited degree of dysphagia can still report appreciable impact on quality of life, and these effects of dysphagia extend to caregivers.<sup>8,9</sup> Between otolaryngology and gastroenterology, consensus exists that globus has organic and functional causes. Nonetheless, it is considered a diagnosis of exclusion after evaluation of organic etiologies. Gastroesophageal reflux disease, laryngopharyngeal reflux, chronic irritation due to postnasal drainage, xerostomia, environmental dryness, esophageal motility disorders, and upper esophageal dysfunction have been implicated as causes of globus.<sup>10,11</sup>

The role of a thorough history-making is central to medicine, and separation of most patients with benign, functional complaints from problematic dysphagia by historical features is well established.<sup>12,13</sup> Managing patients with severe swallowing impairment is relatively straightforward for most otolaryngologists, but the spectrum of diseases presenting with mild dysphagia or globus is extensive and presents potential difficulties. Balancing the need for further testing in a patient with globus sensation should be based on the potential for identification of an underlying process versus exposing patients to unnecessary risks; healthcare systems meanwhile must mitigate unnecessary demand and cost.

Patients who show no red flags such as odynophagia, weight loss, chest pain, lateralization of symptoms, or cough usually require no further testing once a laryngoscopy has been performed. In a large series of 451 patients with exclusive globus-type symptoms and no red flags, only six patients were noted to have an abnormality not detectable during standard office examination; if in-office esophagoscopy were incorporated into practice, then all causes could have been identified.<sup>14</sup> A recent Finnish series recognized that no patients with typical globus symptoms, as well as an unremarkable history and examination, developed a malignancy over six years. Half the patients in this series had resolution of their symptoms with time

and no specific intervention.<sup>15</sup> Therefore, patients with mild symptoms largely benefit from reassurance alone.

Transnasal esophagoscopy (TNE) can be beneficial in this patient population in order to rule out pathologies such as gastric inlet patch or eosinophilic esophagitis, as recommended by the Rome IV diagnostic criteria. The literature is clear that TNE is well tolerated by patients, has a very low risk of complications, and is highly efficient for the surgeon.<sup>16</sup> Luk et al. in their review of videofluoroscopic swallow studies (VFSS) of 908 globus patients reported 86% had normal results.<sup>17</sup> Authors concluded that the examination has limited diagnostic value and therefore is not recommended for globus patients. Järvenpää et al. corroborated these findings and showed that VFSS had no benefit in globus diagnostics.<sup>15</sup>

For most patients with globus sensation, the management is a comprehensive explanation of findings and reassurance that there is no worrisome pathology nor need for further testing. On the other hand, practitioners frequently pursue trial of antireflux therapy in the management of globus pharyngeus.<sup>14</sup> The treatment of acid reflux, an ever-evolving entity, is beyond the scope of this paper. Nonetheless, the management of reflux should include not only medication trial but also emphasis on necessary lifestyle measures. In patients who fail this trial or have partial response,

# Dysphagia Month

further testing can be pursued. High-resolution manometry and pH-probe testing with impedance can be offered. It has been noted that patients with other accompanying symptoms of GERD or LPR, such as throat clearing or heartburn, respond better to antacid treatment and have higher rates of resolution of globus.<sup>14</sup>

In patients with findings of muscle tension on laryngoscopy, voice therapy should be offered. Wareing et al. reported improvement in 23 of 25 patients with complete resolution in 72% of cases.<sup>18</sup> Similarly, in a randomized controlled trial comparing speech therapy with reassurance, Khalil et al. found significant improvement in globus symptom scores in the therapy group compared with reassurance only at three months.<sup>19</sup>

It has been noted that patients with globus sensation can have high prevalence of anxiety. Deary et al. reported that globus patients are significantly more depressed than controls.<sup>20</sup> Cognitive behavioral therapy has been suggested by Burns et al. for patients with refractory symptoms, while Kiebles et al. reported successful use of hypnotically assisted relaxation therapy. There is also scant evidence to suggest antidepressants may be of benefit in select patients.<sup>21,22</sup>

In summary, globus is a benign condition that can cause patients significant distress. Our role is to differentiate these patients from patients with frank dysphagia

and possible underlying pathologies. This is mainly established through good history taking and office laryngoscopy. Patients without findings on either can be reassured and spared from costly testing and potential risks of procedures. ■

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# Tech Talk

## Demystifying the Cloud

**Mike Robey, MS**, AAO-HNS/F Senior Director,  
Information Technology

Since the outbreak of the coronavirus pandemic, business continuity has been on a lot of people's minds. To comply with social distancing many organizations were forced to move to teleworking almost overnight. Staff having remote access to their programs and data is essential for continuing operations. Business continuity demands that IT resources be cloud-based. But what is the cloud? The purpose of this article is to explain and demystify this modern service paradigm.

Two underlying technology advancements have made cloud computing possible: (1) high-speed internet access and (2) server virtualization. Long gone are the days of dial-up modems. Speeds up to 1 gigabit per second are common even in residential settings. Without adequate access speed, cloud computing simply would not work.

The second technological innovation making cloud computing possible is server virtualization. Traditional servers have the operating system (OS) installed directly on top of the hardware. Virtualization inserts

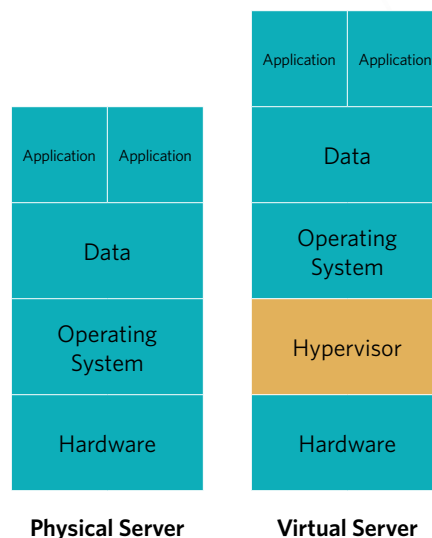


Figure 1. Technology layers.

a software layer between the hardware and OS. The OS still thinks it is "talking" to the hardware, but in fact the OS is dialoging with a hypervisor software layer. This abstraction of the OS from the hardware opens many possibilities. Servers are no longer tied to specific hardware. Additional resources can be added in real time to boost performance. Figure 1 shows the technology layers associated with physical and virtual servers.

The combination of high-speed

internet access and virtualization has made it possible to host equipment in vast warehouse-like facilities and provide scalable computing services. These facilities are the cloud. Enterprises no longer need their own on-premise servers. Instead, businesses can take advantage of economies of scale while still providing their users access to the operational tools needed.

Some may equate cloud computing with time-sharing. It is true that time-sharing has been around since the 1970s when one organization owned a computer, and another dialed into it to consume resources. However, there are major differences with cloud computing. The National Institute of Standards and Technology (NIST) defines two of the most significant differences:

- *On-demand self-service.* The consumer can request and provision resources as needed.
- *Rapid elasticity.* Modern virtualization technologies enable the rapid deployment of additional computing and storage resources.

Most cloud-based offerings can be classified into one of the following NIST-defined cloud service models:

- Software-as-a-service (SaaS)
- Platform-as-a-service (PaaS)
- Infrastructure-as-a-service (IaaS)

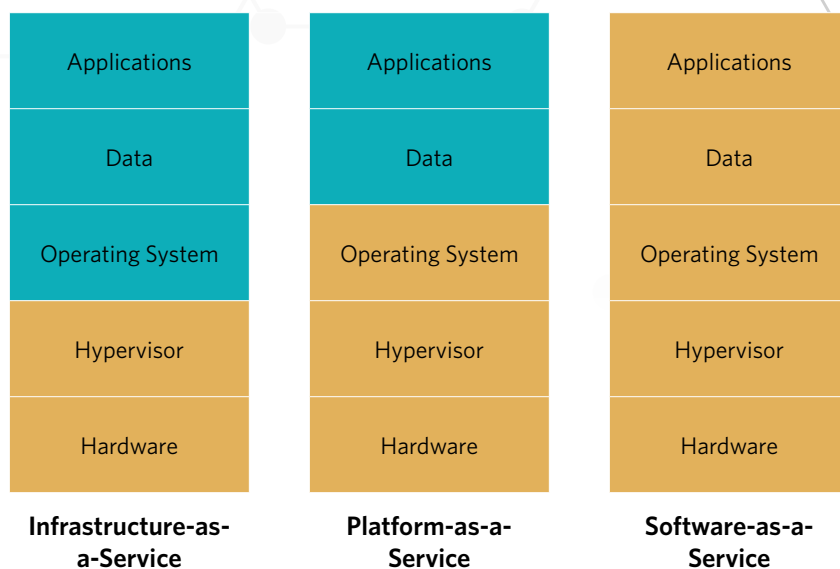


Figure 2. Cloud service models.

Figure 2 shows the differences in these models by highlighting the layers the cloud provider is responsible for (orange) and the ones the customer is responsible for (blue). With the infrastructure-as-a-service model, the consumer is responsible for managing the OS, data, and applications. Amazon Web Services (AWS) is an example of IaaS. With platform-as-a-service, the cloud provider is responsible for the OS. An example of PaaS is Microsoft

Azure. With software-as-a-service, the cloud provider is responsible for all the layers. The consumer is an end user of the service. Probably the biggest example of SaaS is Salesforce. Some offerings may be a blending of these models. As an example, a SaaS service may use AWS as its infrastructure layer—the Lego effect of the cloud.

There are drawbacks to cloud computing. Setting aside the obvious vendor lock-in,

where is your data? Regardless of the cloud model, your data is in the provider's enclave. If you have multiple SaaS services, then your data is in multiple places. How are you going to join the different data sources together? Are the cloud providers offering adequate backups for your data? How are you going to get your data back if you need to switch providers?

Another issue to be addressed are changes to your operational procedures (business processes). You need to align how you do things to the functionality of the chosen cloud solution. This can be very advantageous since most cloud-based software applications are basically collections of automated business processes. Standardizing these off-the-shelf solutions can help streamline your operations. However, this means changes to the way things are handled now.

Moving to the cloud is a must for business continuity. It also frees staff to concentrate on the use of technology, not maintaining the underlying layers. Because of the implications the cloud has to business operations plus data protection and governance concerns, finding a seasoned consultant who understands your business and the cloud is the first step in optimizing how your organization uses technology. ■



# AAO-HNSF Partners with OM1 to Empower More Measured and Precise Care and Treatments for Otolaryngology-Head and Neck Surgery

*Collaboration enables otolaryngologists and researchers to leverage data for real-world evidence, outcomes, and personalized medicine programs.*

The American Academy of Otolaryngology–Head and Neck Surgery Foundation (AAO-HNSF) and OM1, a real-world outcomes and technology company, announced in May a strategic partnership connecting the Reg-ent<sup>SM</sup> clinical data registry to OM1's real-world data and evidence platforms.

Reg-ent, which collects data on ENT conditions and their treatments, has thousands of members and includes nearly 25 million patient visits. The data is used to guide the best otolaryngology-head and neck surgery care with a focus on improving quality and patient outcomes. Leveraging billions of data points, artificial intelligence technology, and advanced analytics, OM1's real-world data cloud and technology platforms connect and process condition-driven health information to help healthcare stakeholders use real-world data for advancing medical research and personalizing care.

The Reg-ent and OM1 partnership will enable otolaryngologists, researchers, and life sciences companies to more rapidly and effectively leverage and collaborate around clinical data for real-world evidence, outcomes, regulatory, and personalized medicine programs.

Learn more about the value of Reg-ent and how you can support the specialty by visiting [www.reg-ent.org](http://www.reg-ent.org). ■



# Transition to In-office Treatments: Allergy

## Penicillin Allergy Testing – Something We All Can Do for Our Community

Erik R. Swanson, MD, and Jamie F. Kimbrough, MD

**D**uring this unprecedented season of social distancing and significant restrictions in patient care as a result of the coronavirus pandemic, it is easy to feel helpless in finding ways to help our patients and our communities. Without question, our systems for delivery of otolaryngic and allergy care to our patients will change as a result of this pandemic. And although we still have much to learn regarding keeping our patients safe from novel viral infections, there is a step we can all take to decrease the rise of resistant bacterial infections in our community—engage more in skin testing for penicillin allergy.

Approximately 10% of patients report an allergy to penicillin. However, when skin tested to penicillin, over 90% of these patients test negative and tolerate a subsequent oral challenge.<sup>1</sup> Treating patients who report a penicillin allergy without a complete evaluation of this potential drug allergy impacts patients and our communities in several ways. These patients are often treated with broad spectrum antibiotics for infections that could have been appropriately managed with a beta-lactam antibiotic. In our specialty, this includes avoiding preferred first-line antibiotics for our most common infectious presentations such as sinusitis, tonsillitis, and otitis media. It also includes

our use of perioperative antibiotics for soft tissue surgical cases. Use of alternative antibiotics in these cases leads to increased healthcare costs, the progression of multiple drug-resistant organisms, and higher risks of toxicity for patients receiving these antibiotics. Patients who report a penicillin allergy have increased risk for contracting *Clostridium difficile* colitis (23%), methicillin-resistant *Staphylococcus aureus* (14%), and vancomycin-resistant *Enterococcus* (30%) compared with the general population.<sup>2</sup>

Skin testing for penicillin allergy has been performed since the 1950s and now is commercially available in an FDA-approved, standardized test kit. This allows for the testing of a major antigenic determinant in all our clinics in a safe manner. In fact, penicillin allergy testing is safe in most all populations, including pregnant patients<sup>3</sup> and those requiring organ transplantation.<sup>4</sup> Patients who have had a negative skin test have minimal risk of developing an IgE-mediated reaction to an oral challenge of penicillin. We perform this oral challenge in our clinic in a controlled setting following the receipt of a negative penicillin skin test. We use a graded oral challenge starting with a 50 mg dose of amoxicillin followed by a dose of 250 mg. We have the fortune of having exceptional medical allergists in our practice who can support us in cases of equivocal skin test results or complicated histories with severe reactions. Resensitization is rare after treatment

with oral penicillin, but it can occur more commonly after parenteral administration. Following a negative skin test and successful oral challenge, the patient should still be counseled of the very low risk of a false negative test and the risk for resensitization.

Unfortunately, at this time, skin testing for antibiotic allergies other than beta-lactams is not standardized. But we all have an opportunity to use the highly effective tool of penicillin allergy testing to improve the lives of our patients and the trajectory of infectious disease in our community. For most disease entities we treat, very few can be permanently removed from a patient's medical record as a result of our care for them. Penicillin drug allergy is a wonderful exception to this rule. By simply setting up our clinics with the ability to skin test patients and asking screening questions on a routine basis, we can remove this harmful “diagnosis” from our patient's medical record in over 90% of cases. What a great example of “First, do no harm.” ■

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# Incorporating Advanced Practice Providers into Your Practice

## Part IV: Onboarding and Financials



Wendy B. Stern, MD



Ken Yanagisawa, MD

### Wendy B. Stern, MD

**C**ongratulations! Now that you have recruited an advanced practice provider (APP), we will review the final crucial steps for successful integration into your practice—onboarding tips and optimizing financial relationships. In the prior three *APP Bulletin* articles in this series, we reviewed APP training and scope of practice, the benefits of working with APPs, and recruitment and contracting.

I have invited **Ken Yanagisawa, MD**, immediate past Chair of the AAO-HNS Board of Governors and managing partner of Southern New England Ear, Nose, Throat and Facial Plastic Surgery Group, LLP, to discuss onboarding and financial aspects of APP integration.

### What education materials and resources do you offer for your APP?

The designated supervising physician should spearhead the education of your new APP employee. An overview based on selected otolaryngology textbooks, Academy U® offerings, and the AAO-HNSF Clinical Practice Guidelines should be studied and jointly reviewed to teach best practices, standards of care, and recognition of expected and variant outcomes. Coding sessions must be included to ensure proper levels of coding and appropriate supporting documentation. ALL questions and concerns should be encouraged and welcomed to create a trusting, supportive, and collaborative relationship. Highly recommended is attending the Academy's annual ENT for the PA-C

conference, which offers excellent lectures and workshops. On a regular basis, charts need to be reviewed for content and completeness and discussed with the APP.

### In Part III, Dr. Stringer mentioned a six-month ramp-up to onboard an APP. Is there a method to the madness?

Many APPs will have little to no otolaryngological experience, and the ramp-up will take approximately six months. In our practice, new APPs shadow each of our 10 physicians and our PAs to understand their practice styles, areas of expertise, and interoffice referral patterns. Patient history and physical exam encounters, under direct supervision with teaching and sharing of pearls and pitfalls, focus on each patient's condition and presentation and leads to independent encounters based on APP progress and ability. Be sure to include strategies for handling challenging patients (angry, defiant, or simply scared) and learning how to properly channel patient expectations and concerns. Like any new provider, initiate the insurance participation, hospital privileging, and state licensure paperwork early/immediately, as these will take time to process and can ultimately be the bottleneck that restricts your new APP from seeing patients.

### What is the best approach for teaching procedures?

In-office procedures such as nasal and laryngeal endoscopy, microscopic ear manipulations, and epistaxis control are thoroughly taught and discussed with each APP. The APP is closely supervised and evaluated as they perform each procedure. Immediate feedback and suggestions for improvement are offered until the APP has honed and perfected their skills.

### APPs need their own National Provider Identifier (NPI) number. Can you explain incident to billing?

When APPs bill directly for their services,

they are reimbursed at 85% of the Medicare Physician Fee Schedule. "Incident to" is at times a misunderstood term that permits billing at 100% of the Medicare Physician Fee Schedule as if services were performed by the physician using the supervising physician's NPI. Only established problems in established patients with an established plan overseen by the physician can be billed as "incident to;" new patients or even new issues in an established patient are not permitted. Strict rules apply including office (not hospital or skilled nursing facility) visitation, physician presence in the office at the time of the visit, and proper documentation. If "incident to" is used, exercise caution as penalties will ensue if all conditions are not met. Since "incident to" credits and reimburses the billing physician, make sure you have a system to distinguish and track the APP's charges and payments, as well as their MIPS-related activities such as Quality measures.

### How do you incentivize your APP?

Financially, we guarantee a base salary, which is annually increased based on a consumer price index. Bonuses are offered annually for any APP attributable income that exceeds a mutually agreed-upon threshold, as well as around contract signings. From a quality of life standpoint, our APPs are offered generous vacation time in addition to the ample PTO and benefits that all our employees are offered. We include payment of dues, malpractice, and a continuing medical education allowance. Appreciation incentive is key—let your APP know when they are doing a good job and thank them for their contributions to the practice. Precious positive reinforcement fortifies lasting relationships.

Parts I-III in this series were published in the March, April, and May issues of the *Bulletin*. You can find them all online at <https://bulletin.entnet.org/>. ■

# CONGRATULATIONS

## Residents and Fellows

One of the most highly anticipated dates on the academic calendar is June 30. It is a day for great celebration honoring graduating otolaryngology residents and fellows for their years of dedication, perseverance, and sacrifice required to reach their goal and begin the independent practice of medicine in the setting of their choice.

This year “surviving” the residency took on an entirely new, literal meaning. In addition to the expected hundreds of hours of study, numerous nights on call, expanding administrative responsibilities, completing required case logs, and the inherent stress and fatigue of being a physician and planning for the future; residents, fellows, and faculty at academic centers were thrust into situations not seen or planned for in their lifetimes. During the height of the pandemic, when proper PPE was being debated and often not available, residents,

fellows, and their faculty were providing frontline care. Their flexibility and determination during a time of great uncertainty—as their education platform suddenly shifted and the sense of community was disrupted—came at a time it was needed the most and was remarkable.

The American Academy of Otolaryngology–Head and Neck Surgery, its officers, Boards of Directors, and staff take great pride in playing a role in the evolution of your careers and offer our heartfelt congratulations to you and your highly committed teachers and families on your great accomplishments. We extend our sincere thanks for taking care of the sickest patients during suboptimal conditions and offer our best wishes for your future. As an organization, we remain committed to meeting your needs as you deliver the best patient care. Now, as always, We Are One.



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# Voice Disorders in the

William Z. Gao, MD

**W**e enter this world with a mere cry but before long, incomprehensible sounds become first words. Our voice becomes the primary means by which we communicate and interact with family, friends, and the rest of society. As an instrument of expression, it forms a primary pillar of our identity. Thus, it is of vital importance to our relationships and sense of self throughout life. However, as we age, our voices can change. Sometimes that change is directly related to normal physiologic effects of advancing age, but other times it may reflect underlying pathology. Vocal handicap in elderly individuals can then lead to adverse psychosocial consequences, especially in the setting of other domains of functional decline. Hence, it is imperative for us as otolaryngologists to recognize and investigate dysphonia in our geriatric patients when it arises.

## Epidemiology

### Why is geriatric voice care important?

With advances in medicine helping people live longer, there is an increasing proportion

of the general population comprising the elderly. Based on the U.S. Census Bureau, the number of Americans aged 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060.<sup>1</sup> And the prevalence of dysphonia in this growing geriatric population has been estimated to be 12-35%,<sup>2</sup> which is substantial. Occupational voice demands remain at the forefront, with an increasing number of those over age 65 staying in the workforce. Even outside of occupational needs, a robust voice is critical to maintaining social relationships and conveying needs to caregivers. With this broad reach into patient lives, it therefore behooves us to be acquainted with the more common voice disorders that uniquely affect this aging population.

### Voice Disorders Unique to the Golden Years

While older patients can suffer from a multitude of vocal pathology that similarly affects younger patients, they are also distinctly predisposed to a few specific conditions. One of the more common conditions is presbyphonia, or age-related dysphonia. This is related to thinning of the vocal folds from a loss of muscle/tissue bulk (atrophy) that contributes to difficulty achieving full closure during phonation

(glottal insufficiency), as well as changes in tissue composition with consequent effects on vibratory characteristics. Patients who suffer from presbyphonia may complain of a breathy or rough voice, decreased volume, difficulty projecting their voices or being heard, altered pitch, and increased vocal effort/strain leading to fatigue.

Another common affliction of the elderly is essential tremor, which can affect the larynx in addition to or independently of extremity tremor. Different anatomic subsites may be affected, including the palate, pharyngeal constrictors, and intrinsic laryngeal musculature, which will then determine the manner in which it presents. Vocal tremor can be relatively well masked during conversational speech but present with more distinct pitch fluctuation during vowel phonation. With greater severity, more prominent voice breaks may be present, especially in the setting of concurrent presbyphonia.

Parkinson's disease (PD) is a neuromuscular disorder also with greater incidence among the elderly, estimated to affect 2% of the U.S. population over age 60. Of those diagnosed, up to 90% suffer from communication issues that arise from PD.<sup>3</sup> In fact, changes in voice are usually the first physical manifestations of PD that are

# Geriatric Population

noticed. Speech can be impaired with loss of prosody and reduced fluency. The voice may be softer and breathier, but sometimes this is only perceived by those around the patient such as family, leading to increased communication challenges.

Frequently, dysphonia in the elderly is multifactorial in nature and may result from compounding effects of coexisting problems.<sup>4</sup> For example, essential voice tremor may be exacerbated in the setting of significant vocal fold atrophy and glottal insufficiency. Recognizing comorbid conditions and the interplay between them is key to constructing an optimal treatment plan. In efforts to compensate for underlying difficulties, patients may also develop secondary muscle tension dysphonia. Multidisciplinary evaluation as well as collaboration between experienced otolaryngologists and speech language pathologists is fundamental to pinpointing an accurate diagnosis, which then guides treatment.

## Treatment

So what treatments are effective for specific voice disorders encountered in the elderly? Voice therapy with a speech language pathologist can be quite efficacious in many scenarios including mild presbyphonia, Parkinson's disease–related hypophonia,

and muscle tension dysphonia. More severe presbyphonia responds better to interventions that correct glottal insufficiency such as vocal fold injection augmentation or medialization thyroplasty as a durable option. Medical management of essential voice tremor can be helpful for many, with procedures such as laryngeal chemodenervation or injection medialization reserved for refractory cases. Treatment decisions can be complex, depending on individual desires and risk tolerance. Finally, it is important to remember that geriatric patients can derive tremendous benefit from appropriately targeted treatments. Voice disorders in this population present an opportunity for us to dramatically improve quality of living well into the golden years. ■

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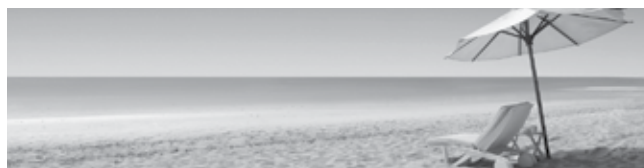
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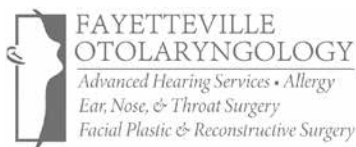
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