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

JUNE 2022

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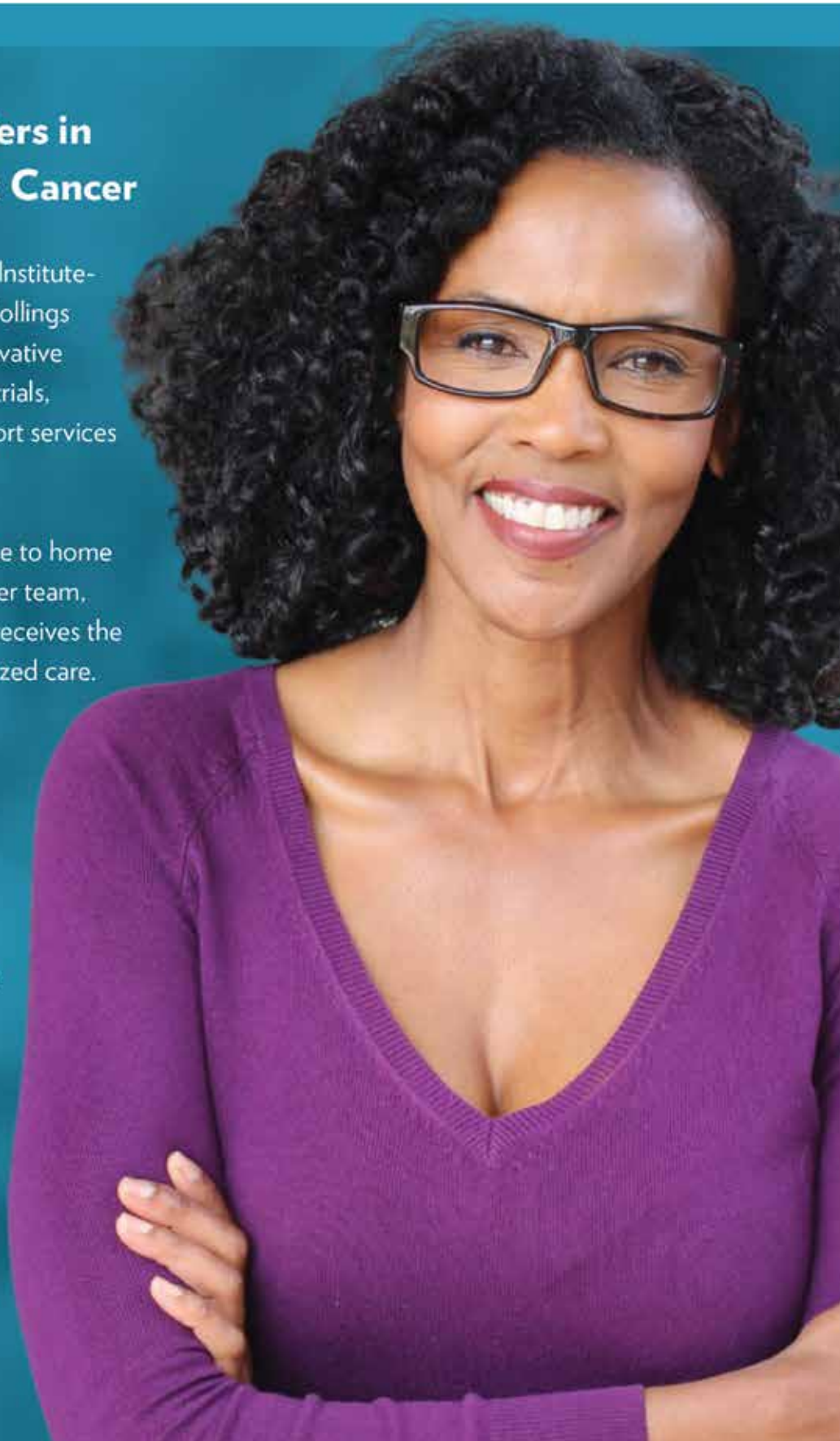

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JUNE 2022
Volume 41, No. 05

The Bulletin (ISSN 0731-8359) is published 11 times per year (with a combined December/January issue) by the **American Academy of Otolaryngology–Head and Neck Surgery**
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Alexandria, VA 22314-2857
Telephone: 1-703-836-4444
Member toll-free telephone: 1-877-722-6467

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Postmaster: Send address changes to the American Academy of Otolaryngology–Head and Neck Surgery, 1650 Diagonal Road, Alexandria, VA 22314-2857
Return undeliverable Canadian addresses to PO Box 503, RPO West Beaver Creek, Richmond Hill, Ontario, Canada L4B 4R6
Publications Mail Agreement NO. 40721518

BULLETIN ADVERTISING
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features

AAO-HNSF 2022 Annual Meeting & OTO Experience

departments

The leading edge

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Graduation Joys and Wishes

"Wherever you go, go with all your heart."
~Confucius

Graduation celebrations abound in this spring of 2022! There is certainly much to be grateful for as we see our graduates complete their studies, enduring and overcoming incredible challenges and restrictions due to the pandemic with so many difficult modifications to their educations and experiences.

Our family recently celebrated our youngest son's college graduation where hope and excitement filled the air. The magnitude of this achievement was matched by the relief that they had successfully navigated through these turbulent COVID-19 times. Most importantly, they rejoiced in celebrating in person filled with congratulatory hugs, with loved ones in attendance, and with physically receiving their well-earned diplomas from their dean and educators.

Similar sentiments are occurring with the graduation of our otolaryngology residents. As we congratulate them and wish for their success, we should reflect and appreciate their incredible work over the past two years. Our residents tackled the initially unknown perils and behavior of COVID-19, front-line workers who bravely and courageously cared for our patients armed often only with personal protective equipment and caution. They had to manage their own personal emotions and health as they were exposed, and at times infected, as well as to grapple with how to keep their own loved ones and families safe as they proceeded to fight the battle to help others in need. Thank you to all our residents and healthcare providers who have given so much during a time of such dire need.

Individually, we have each had to reflect on our own expectations and values in this profession that had previously brought so much fulfillment and satisfaction in light of health concerns and exposures. This balancing act has created turmoil and has certainly challenged each one of our states of wellness and work/life balance. Fortunately, for most, we have reaffirmed the reasons we entered our noble profession to provide care and solace for our patients, doing so with utmost maintenance of safety and precautions to protect our patients, staffs, and providers.

We must consider what impact this has on the vital next generation of physicians. I was stunned by a recent conversation with a medical student who informed me that more than a few of his classmates, as they neared graduation, had opted to not continue on to residency. After all the time, cost, and commitment that had been sacrificed to get to this point, they made the difficult decision to pursue other careers.

Our mission is to help educate students in college and medical school alike the values and benefits of a career in medicine, and to set realistic and honest expectations. It is incumbent on us to explore, nurture, and develop opportunities for outreach, exposure, and education about otolaryngology.

Dr. Albert Merati channeled interest and resources during his AAO-HNS presidency toward educating and exposing medical students to our world of otolaryngology-head and neck surgery. Opportunities for students to understand life as an otolaryngologist have included well attended webinars, support at meeting attendance, and shadowing and mentorship opportunities. Our specialty has so much to offer, and we must continue to ensure that undergraduate and medical students alike recognize these offerings and opportunities.

A critical piece of recruiting students to our specialty is to gain an accurate and up-to-date understanding of our own workforce in 2022, specifically demographic and socioeconomic information. To that end, please participate and complete the Workforce and Socioeconomic survey which will be distributed this summer. Armed with such information, we can understand the current climate, and develop plans for identified areas of improvement which may include provider, diversity and inclusivity, and regional needs. With numerous studies citing upcoming physician shortages, it is important for us to seek and mentor students who have interest in our field.

There is no question that medicine faces hurdles on many fronts, including regulatory oversight, payment models and quality expectations, and finding acceptable work/life balances, yet the underlying tenets of our profession in caring for and treating our patients remain so rewarding. We must identify and support students in understanding the values, rewards, and benefits of a career in otolaryngology-head and neck surgery and help them navigate a successful course.

Congratulations to all our graduates and their families and for the wonderful challenges and successes that lie ahead. Your achievements and perseverance are admirable and truly appreciated. And we eagerly look forward to promoting our next generation of providers and leaders. ■

Ken Yanagisawa, MD
AAO-HNS/F President

> "Thank you to all our residents and healthcare providers who have given so much during a time of such dire need."

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 your years of dedication, perseverance, and sacrifice required to reach your goal and begin the independent practice of medicine in the setting of your choice.

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 faculty, mentors, and families on your great accomplishments. We extend our best wishes for your future. As an organization, we remain committed to meeting your needs as you commit to the delivery of quality patient care.

We're proud of all you have accomplished and want to continue supporting you as you transition into the next stage of your career. Please update your contact information with your nonacademic email and mailing address to receive a special AAO-HNS surgical cap.

Scan to Access the Residents Form

Scan to Access the Fellows-in-Training Form

Help Strengthen Our Specialty's Voice: An Urgent Call to Action

Healthcare advocacy has been around for decades as a highly valued and essential component service of medical associations. Since the advent of Medicare in 1965 when healthcare costs represented 5.5% of the United States GDP, there has been unprecedented growth of the healthcare industry that now represents 19.7% of the United States GDP. Needless to say, as this rapid growth has occurred with the introduction of many industries that did not exist in 1965, advocacy has become much more complex in all the major areas that affect the practice of medicine and patient care. One could certainly argue as to what is the most important area to be active in, but the reality is that physicians and their associations have to be knowledgeable and simultaneously involved in federal and state legislative arenas, federal and state regulatory processes, and private payer policies. Detrimental changes in any of these areas can drastically affect the ability to practice inclusive, high-quality medicine focused on the best results for patients. This month's *Bulletin* highlights the Academy's efforts in all these areas.

Current political conditions have resulted in an increased reliance on regulatory language and policies as the divisiveness of the federal legislative bodies make it very difficult to pass meaningful healthcare reform. This has been significantly worsened by the highest inflation rate in the last 40 years that makes "big ticket" items needed for healthcare much more difficult to pass. The house of medicine was blindsided by the Biden Administration's regulatory interpretation of the "No Surprises Act" (NSA) that has opened the door for the insurance industry to lower provider fees, increase administrative burdens, and deny care as well as try to force providers to join their networks to avoid the out-of-network hassles contained in the NSA regulations. There were multiple lawsuits filed against these regulations, and the Academy joined in through an amicus brief to the AMA and AHA lawsuit. The first lawsuit filed by the Texas Medical Association (TMA) resulted in an initial ruling in favor of the TMA that would strike down provisions of the Independent Dispute Resolution (IDR) process. The Administration has announced it will appeal that ruling and the other lawsuits that are pending the outcome of the initial action.

Unfortunately, none of the lawsuits filed addressed the excessive and unnecessary administrative burden placed on medical providers as they deal with out-of-network, uninsured, and those patients who choose to be private pay even though insured. The Academy has individually and through coalitions opposed many facets of the Administration's regulations and awaits the final set of rules. The "Good Faith Estimates" provisions alone will add hours a day to providers' burdens as they attempt to deliver the most up-to-date care for patients across the spectrum of clinical disease. Many of these policies will disproportionately affect those patients with the least financial resources who are already struggling to get care in the current system.

At a time when advocacy has never been more important, active participation by our members is critical to planning and implementing successful strategies that will allow us to provide safe and effective care to patients regardless of their health plan or financial status. The expanding list of "experimental" or "investigational" descriptors added to the majority of new technology CPT codes, the increased number of procedures requiring pre-authorization, the denial of appropriate use of modifiers, and the overall administrative burden that has been transferred to individual practices is not sustainable over time and is inappropriately resulting in denial of medically necessary care. The recent revelation by *The New York Times* article, "Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds," describes the frequent denial of necessary care by Medicare Advantage plans as determined by federal investigation. The same situation is happening on the private insurance side as well and has increased since the release of the regulatory language by the Biden Administration for the implementation of the NSA. The final results of the lawsuits filed against the Administration over the regulations are still pending.

We need our members to send us information of any changes to your private insurance contracts related to these regulations including care denial, reimbursement decreases, narrowing of networks, and lists of procedures that will not be covered under any circumstance. We also need you to advocate with your state and federal legislative representatives when called upon and help support our specialty's political advocacy. Without your help in strengthening our collective voice on these issues, our chances of reversing these detrimental policies are "slim to none." ■

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

> "At a time when advocacy has never been more important, active participation by our members is critical to planning and implementing successful strategies that will allow us to provide safe and effective care to patients regardless of their health plan or financial status."

HALL OF DISTINCTION

AAO-HNS CELEBRATES EXCELLENCE

ESTABLISHED 2021

Announcing the 2022

The American Academy of Otolaryngology–Head and Neck Surgery and its Foundation (AAO-HNS/F) are pleased to announce the selection of the second class of inductees into the AAO-HNS Hall of Distinction. A special thank you to the Awards Committee, chaired by Past President **Al Merati, MD**, who selected six individuals for the "Pioneer" category and six individuals for the "Living Legends" category. Those recommendations were approved by the Board of Directors in April.

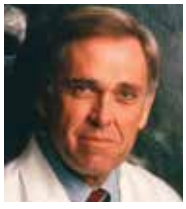
President **Ken Yanagisawa, MD**, will honor this outstanding class of inductees during a special presentation, followed by a reception at the AAO-HNSF 2022 Annual Meeting & OTO Experience, in Philadelphia, Pennsylvania, on September 11, from 4:00 – 6:00 pm (ET).

Hall of Distinction (Pioneers)

Jack R. Anderson, MD

Jack R. Anderson, MD, was a visionary and dedicated leader with a passion for increasing the public visibility and understanding of otolaryngology and facial plastic and reconstructive surgery, qualities that were assets to the many organizations he served, including the American Council of Otolaryngology as President (1975-1976); American Academy of Otolaryngology–Head and Neck Surgery as President (1980); and American Academy of Facial Plastic and Reconstructive Surgery as the first Secretary (1964-1969) and President (1971-1972). Dr. Anderson championed the addition of "head and neck surgery" to "otolaryngology," noting that otolaryngology did not encompass the entire practice of the field. He was a proponent of public relations and public education and was an outspoken advocate and pioneer of the right of otolaryngologists to perform facial plastic surgery. His efforts in the 1970s and 1980s in this arena have had a long-lasting impact that is present today in defining the scope of practice for the specialty.

Bobby R. Alford, MD



Bobby R. Alford, MD, was a renowned, national leader whose dedication to excellence permeated all facets of his career, leading to an amazing legacy that expanded the specialty's scope of practice to include head and neck surgery. In 1981, he simultaneously served as the President of both the American Academy of Otolaryngology–Head and Neck Surgery and the American Council of Otolaryngology–Head and Neck Surgery (ACO-HNS) and was instrumentational in the unification of the two organizations into the Academy we know today. During Dr. Alford 40+ year tenure as chair of the Department of Otolaryngology-Head and Neck Surgery at Baylor College of Medicine, he imbued generations of physicians with a deep commitment to leadership and public service. He believed strongly in the link between research and patient care. Among his many achievements, he played a significant role in the creation of the Neurosensory Center of Houston for The Methodist Hospital and Baylor College of Medicine and was a founder of the National Space Biomedical Research Institute.

Reginald F. Baugh, MD

Reginald F. Baugh, MD, dedicated his life's work to advancing the field of otolaryngology. His reach was far and wide as a physician, mentor, published author, colleague, collaborator, and more. His undoubtable passion and tireless pursuit for quality, patient care, and education was contagious and had a long-lasting impact on the countless lives who crossed his path throughout his remarkable career. The AAO-HNS/F was the honored recipient of his volunteerism. Dr. Baugh dedicated his time, expertise, and diplomacy to advancing the AAO-HNSF's clinical practice guidelines (CPGs). Specifically, his leadership led to the development of the Tonsillectomy CPG in 2011 and the Bell's Palsy CPG in 2013, both of which he served as Chair, as well as the Benign Paroxysmal Positional Vertigo CPG in 2008 when he served as Assistant Chair. He also served on the AAO-HNS/F Voice and Patient Safety and Quality Improvement Committees and on the Editorial Board of *Otolaryngology–Head and Neck Surgery*.

Linda S. Brodsky, MD

Linda S. Brodsky, MD, is lauded for her dedication to and advocacy for the equitable treatment of all who practice in the specialty and was a driving force behind the creation of the Women in Otolaryngology (WIO) Section. She was also one of the major supporters of the AAO-HNSF WIO Endowment and one of the first to pledge a Millennium Society Life Member commitment to help seed the endowment. This action set an example of her philanthropic leadership, which inspired others to contribute to

Hall of Distinction Inductees

provide funding for research activities that supported the advancement of women in the specialty. Dr. Brodsky also founded Women MD Resources, an organization dedicated to helping women physicians navigate the medical work environment and offering mentorship to early-career women in medicine. Throughout her life, Dr. Brodsky strived for excellence in her commitment to quality patient care. She established the "Brodsky Classification" of tonsillar disease, a diagnostic tool utilized by medical professionals throughout the globe.

William Wayne Montgomery, MD

William Wayne Montgomery, MD, a world-renowned professor at Harvard Medical School and a surgeon at the Massachusetts Eye and Ear Infirmary, had a major influence on the development and transformation of the specialty through his ingenuity and innovation, writing, mentorship, and teaching. The breadth of his scientific contributions and illustration is demonstrated in his two-volume book and atlas, *Surgery of the Upper Respiratory System*. These works helped shape contemporary otolaryngology-head and neck surgery and displayed his broad portfolio of seminal contributions to otology and neurotology; cranial base surgery; head and neck surgery and reconstruction; laryngology; rhinology, especially frontal sinus surgery; and pediatric otolaryngology. Dr. Montgomery was the inventor of the tracheal T-tube, the laryngeal keel, a facial nerve stimulator, and one of the first stapes prostheses. He introduced the frontal sinus obliteration procedure in the United States and was an early advocate of the use of closed suction drains in head and neck surgery.

Joseph H. Ogura, MD

Joseph H. Ogura, MD, whose surgical innovations forever changed the treatment of laryngeal cancer, was chair of the Department of Otolaryngology at the Washington University School of Medicine in St. Louis, Missouri, and a legend in the field. Dr. Ogura helped change the direction of the specialty by serving as a national pioneer progressing otolaryngology into more advanced head and neck surgery. Dr. Ogura developed many surgical techniques in head and neck cancer surgery, especially conservation surgery of the larynx. During a distinguished career spanning nearly 40 years, he did more than improve surgical technique and patient care. He was a prolific researcher, writer, and lecturer. The extent of his legacy also reaches the lives he touched during his professional career—the patients who benefited from his surgical brilliance, his residents who were inspired to pursue excellence through his mentorship, and his colleagues who achieved more supported by his strength and encouragement.

Hall of Distinction (Living Legends)

Charles D. Bluestone, MD

Charles D. Bluestone, MD, is a pioneering leader in the formalization and recognition of pediatric otolaryngology as a subspecialty, particularly for his contributions as founding chair of the American Academy of Pediatrics (AAP) Pediatric Otolaryngology Section, which provided an educational venue between otolaryngologists and their pediatric colleagues that continues today; as a charter member and past president (1990-1991) of the American Society of Pediatric Otolaryngology; and as a founder of both the Society for Middle Ear Disease and the NIH-funded Pittsburgh Otitis Media Research Center. Dr. Bluestone in collaboration with Sylvan Stool, MD, also created the first formal pediatric otolaryngology fellowship at the Children's Hospital of Pittsburgh from 1975-1976. Additionally, he, David J. Lim, MD, and Ben H. Senturia, MD, organized the first of 10 quadrennial international symposia in 1975 on advances in otitis media. Dr. Bluestone's distinguished career and leadership earned him the first University of Pittsburgh Eberly Professor of Pediatric Otolaryngology.

Sujana S. Chandrasekhar, MD

Sujana S. Chandrasekhar, MD, is a dynamic influencer in leadership and an extremely effective ambassador for the specialty. She was instrumental in transforming the Women in Otolaryngology (WIO) Committee into the WIO Section. And through her collaboration and determination, helped to establish the WIO Endowment, raising over $400,000 in pledges and gifts in four days. Dr. Chandrasekhar served as the Chair of the AAO-HNS Board of Governors (2012) and then was elected to serve as the AAO-HNS/F President (2015-2016). She brought an energy level and excitement to her presidency and leadership in general and instilled a vision that put diversity and inclusion at the forefront of the Academy's Strategic Plan. Her contributions to the Academy and specialty continue to flourish and expand. In her commitment to patient care, Dr. Chandrasekhar served as Chair to the Guideline Development Group for the Clinical Practice Guideline: Sudden Hearing

HALL OF DISTINCTION

AAO-HNS CELEBRATES EXCELLENCE

ESTABLISHED 2021

Loss, and she has worked as a content expert for ENThealth.org, among many other contributions.

James C. Denneny III, MD

James C. Denneny III, MD, is an innovative visionary who has contributed decades of service to the specialty and patient care. He served as both AAO-HNS/F President (2007-2008) and AAO-HNS Board of Governors Chair (1998-1999). Immediately prior to his appointment as Executive Vice President/CEO (2014)—a position he currently holds—he was simultaneously the Coordinator of Socioeconomic Affairs, Co-chair of the Physician Payment Policy Workgroup, and Chair of the Ad Hoc Payment Model Workgroup. He has been instrumental in prioritizing specialty unity to maximize the Academy's effectiveness in education, research and quality, advocacy, and member services. His leadership has positioned the Academy at the forefront of the global otolaryngology community, especially during the COVID-19 pandemic, with an increased international presence and collaboration; has focused on enhanced value for members, their practices, and their patients through varied mechanisms, such as Reg-ent[SM]; and has strengthened the voice of the specialty within the house of medicine and with decision-makers in the ongoing climate of healthcare reform.

Richard M. Rosenfeld, MD, MPH, MBA

Richard M. Rosenfeld, MD, MPH, MBA, is a trailblazer in research and quality patient care, having substantial impact on the implementation of evidence-informed research and measures in the specialty. His notable contributions are significant, demonstrated by being only one of two individuals to have received five AAO-HNS Distinguished Honor Awards in the Academy's history. His leadership is demonstrated by his service as Editor in Chief of *Otolaryngology–Head and Neck Surgery* (2006-2014); Senior Advisor for Quality and Guidelines; and Chair of the Research Committee (now CORE), Guidelines Task Force (GTF), Science and Education Council (SEC), Cochrane Scholars Program, and the Subspecialty Advisory Council (SSAC). Dr. Rosenfeld has been a driving force behind the AAO-HNSF clinical practice guideline (CPG) program. He is the lead author of the "AAO-HNSF Guideline Development Manual," and he has authored or co-authored a considerable number of CPGs. Among other leadership roles, Dr. Rosenfeld founded the Guidelines International Network North American Community.

Pablo Stolovitzky, MD

Pablo Stolovitzky, MD, is a dedicated champion of the international otolaryngology community who has contributed decades of service to the Academy and the specialty. Among many leadership roles, he served as Chair of the AAO-HNS Board of Governors (2007-2008), Coordinator for International Affairs (2017-2021), and President of the XXXVII Pan American Congress of Otolaryngology-Head and Neck Surgery (2022). During his term as Coordinator, he had a profound influence in enlarging the Academy's international footprint leading to increased membership and expanded global partnerships. His vision and work toward a more collaborative global otolaryngology community has resulted in expanded education opportunities with the International Corresponding Societies through joint meetings and the creation of the Global Grand Rounds—both in person and virtual—as well as for individuals with the International Visiting Scholars program and the AAO-HNSF journals. His contributions toward weaving the international otolaryngology community into the threads of the AAO-HNSF International Affairs Program is significant with everlasting impact.

M. Eugene Tardy, Jr., MD

M. Eugene Tardy, Jr., MD, is a proactive, pioneering leader who identified and addressed several significant issues facing the specialty and helped guide the Academy onward after the merger with the American Council of Otolaryngology. During his term as AAO-HNS President (1985-1986), the Academy drafted and formally approved its first code of ethics. He also initiated a fundraising campaign to support the building fund for an Academy-owned headquarters, providing financial stability to support enhanced programs and services. Dr. Tardy has demonstrated a commitment to encouraging specialty unity to preserve the highest level of quality in otolaryngology-head and neck surgery and was able to integrate that vision as President of the American Academy of Facial Plastic and Reconstructive Surgery (1982) and President of the American Board of Otolaryngology. Dr. Tardy's dedication to education and the advancement in quality patient care has defined his professional life and influence on the specialty and those who had the opportunity to learn from him and work with him. ■

AAO-HNS CELEBRATING 125 YEARS 1896 - 2021

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AAO-HNSF Coordinator for Education

CALL FOR APPLICANTS

The AAO-HNS/F Board of Directors is seeking applicants for Coordinator for Education for the 2023-2027 term.

Interested applicants should submit a letter of intent by June 13. The complete application is due July 11.

Please scan the QR code for a detailed description of the role and responsibilities of the Coordinator and a listing of qualifications and expectations.

QUESTIONS AND SUBMISSIONS SHOULD BE DIRECTED TO:

Tirza Lofgreen, CHCP
Senior Director, Professional Education & Digital Learning

tlofgreen@entnet.org

1-703-535-3771

OTO Journal

OTO Journal Publishes Special Focus Issue in June: Health Equity and Diversity

Under the direction of **John H. Krouse, MD, PhD, MBA**, Editor in Chief of *Otolaryngology–Head and Neck Surgery* and *OTO Open*, the June 2022 issue of *Otolaryngology–Head and Neck Surgery* published as a special-focus issue on the topics of health equity and diversity.

"Health equity and diversity are critical topics for the specialty of otolaryngology-head and neck surgery," said Dr. Krouse. "In its Strategic Plan, the AAO-HNS/F has emphasized the advancement of health equity and diversity and has spearheaded programs in important areas such as education, workforce development, and access to healthcare for its members and patients. The journal is proud to have sponsored this focused issue and to join with the Academy in these vital initiatives."

The issue includes an invited editorial, "Challenges in Achieving Health Equity and Diversity in Otolaryngology," from the issue's guest editor, **Helene J. Krouse, PhD, RN, FAAN**. There are also two invited commentaries: "Not in my Backyard: Centering Health Equity in the Quadruple Aim," from **J. Nwando Olayiwola, MD, MPH**, and "Moving Beyond Detection: Charting a Path to Eliminate Healthcare Disparities in Otolaryngology," by **Sarah N. Bowe, MD**, and colleagues.

This issue includes original research on the topics of social determinants, health economics, and research. There are state-of-the-art reviews on ethics and research as well as systematic reviews/meta-analyses on workforce issues and research. The issue also includes two short scientific communication articles addressing education, and more.

The call for papers for the special-focus issue ran through much of 2021 and closed in December. To access this and all OTO Journal articles, go to **www.entnet.org** and log in using your member ID and password. Once you are logged in, click on "OTO Journal" in the top left of the navigation bar, which will automatically log you in to access and download OTO Journal articles. ■

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June Is National Dysphagia Awareness Month

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

For more patient information on ENThealth, search "Conditions and Treatments" and "Be ENT Smart" for articles using keyword "swallowing." ■

ENThealth.org is dedicated to educating patients. The content is developed by a team of AAO-HNS members, and information is delivered via peer-reviewed articles and video content featuring physicians.

Proposed Fiscal Year 2023 (FY23) Combined Budget

AAO-HNS/F Combined Budgets

	Proposed Budget FY23	Approved Budget FY22
Revenue		
Membership Dues	$6,925,000	$6,950,000
Annual Meeting Revenues	5,965,000	5,345,000
Education and Other Product Sales	1,198,000	1,484,000
Publication Revenues	1,087,000	1,194,000
Other Revenues	803,000	1,370,000
Use of Donor Restricted Net Assets	215,000	250,000
Operating Revenue	**16,193,000**	**16,593,000**
Use of Board Designated Net Assets	3,480,000	3,037,000
Total Revenue	**$19,673,000**	**$19,630,000**
Expenses		
Salaries & Benefits	$9,525,000	$9,329,000
Consultants & Professional Fees	2,026,000	2,083,000
Annual Meeting Costs	4,275,000	3,616,000
Other Expenses	2,438,000	3,201,000
Occupancy	959,000	951,000
Contingencies	450,000	450,000
Total Expenses	**$19,673,000**	**$19,630,000**

The Executive Committees (ECs) of the AAO-HNS/F Boards of Directors (BODs) were presented with the Finance and Investment Subcommittee (FISC) proposed budget for the next fiscal year, July 1, 2022 – June 30, 2023 (FY23), and endorsed it for approval by the BODs. During their April meeting, the BODs reviewed and conditionally approved the FY23 budget that is presented here to the membership.

Budgeting for FY23 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 FY23 budget is structured to meet the AAO-HNS/F Strategic Plan goals and 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 FY22 budget year. Based on this information, it is projected that the FY22 actual results will be within budget.

Highlights of the FY23 Budget

The FY23 balanced budget is proposed at $19.7M. Operating revenues are budgeted to fund $16.2M of expenses and Board Designated Net Assets to fund the remaining $3.5M. The BODs approved using accumulated net assets to retain all current programming, as an alternative to increasing member dues, Annual Meeting registration fees, or other fee-based offerings. Annual Meeting costs for the FY23 meeting in Philadelphia, Pennsylvania, will be higher than average, mostly due to convention center related costs. Also, as the return to in-person meetings is expected to be gradual, Annual Meeting registration is budgeted at approximately 75% of pre-pandemic levels. With higher costs and lower than average revenues, the FY23 Annual Meeting is the main driver of the need to use accumulated net assets to balance the FY23 budget. The Board also approved the use of accumulated net assets to fund Reg-ent[SM] technology costs, as has been done in past years.

Member Dues are budgeted slightly below the prior year reflecting an increase in retiring members. Calendar year 2023 will be the sixth year without a membership dues increase. Education and Other Product Sales, largely revenue from FLEX subscriptions, are budgeted equal to actual sales in FY22. Publication Revenues are based on contractual agreements with publishers of the journals, *Otolaryngology–Head and Neck Surgery* and *OTO Open*, and the *Bulletin*, both of which will be up for contract renewal in FY23. The guarantees under the renewal contracts are expected to be at slightly lower levels in both cases. Other revenues include royalties from Academy Advantage partners, corporate support not related to the Annual Meeting, and donor contributions to the Foundation's Annual Fund. In FY22, revenues and expenses related to the Pan American Congress, a non-recurring meeting, are included in Other Revenues and Other Expenses. No revenue or expenses for this meeting are budgeted in FY23.

Donor Restricted Net Assets are budgeted to support $215K of programming, including CORE grants, Annual Meeting lectures, travel grants for residents, humanitarian efforts, and International Visiting Scholars.

The complete budget is available to any Academy member who requests it in writing. Email requests to Carrie Hanlon, CPA, Senior Director, Finance and Administration, at bulletin@entnet.org. ■

Diverse Journeys to Otolaryngology

Nneoma S. Wamkpah, MD, MSCI
Resident Physician, Department of Otolaryngology-Head and Neck Surgery, Washington University in St. Louis, Missouri

The AAO-HNS Diversity and Inclusion Committee (DIC) hosted a webinar in May 2021 for prospective students,[1] "Diverse Journeys to Otolaryngology," in which I had the honorable opportunity to provide a resident's perspective to applying for residency. In this article, I briefly recount my path to otolaryngology as well as provide three pearls of advice for students pursuing an otolaryngology residency.

My journey to otolaryngology predates medical school, from key lessons I learned from my parents. Growing up as a child of immigrants, I experienced secondhand as my parents strived to raise my siblings and me, work nights, and put themselves through nursing school. My parents engendered my internal motivation and helped me appreciate the importance of drive and dedication in pursuit of my goals. In medical school, after I chose to apply for otolaryngology residency, I ardently focused on ways to learn more and express my interest through multiple subinternships and a T32 Summer Research Training Program at Washington University. I credit the relationships formed with mentors along the way, combined with the efforts I put forth, as reasons for my match. To this day, I still draw on my mentors for advice and deeply appreciate them for supporting me through residency and my future career plans.

There are three keys to success that I hope to pass on to prospective applicants.

1) Know yourself. As you are putting together your application and preparing for residency interviews, take note of "deliverables," i.e., what attributes you can bring to a residency program, and in turn, what important qualities you would like to gain from a program.

2) Get involved. Participate in events held by your local residency program and the AAO-HNS. For example, try to attend residency didactic sessions or apply for travel grants to attend the AAO-HNSF Annual Meeting & OTO Experience.

3) Identify mentors. Mentorship can occur in structured and unstructured formats[2] and may require some initial effort to develop; however, a transparent relationship with an advocate in your corner is extremely helpful during the residency application process. Equally important is maintaining those relationships after matching. The Society of University Otolaryngologists-Head and Neck Surgeons has a list of faculty contacts,[3] particularly for students who constitute underrepresented groups in medicine or who lack local otolaryngology residency programs.

I would like to thank **Erynne A. Faucett, MD**, current Chair of AAO-HNS DIC, for inviting me to participate on the "Diverse Journeys to Otolaryngology" panel. I encourage students to watch this webinar and to anticipate more content from the AAO-HNS DIC.

References

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3. Diversity Liaisons - Society of University .. - suo-aado.org. https://suo-aado.org/page/DiversityLiaisons. Accessed February 28, 2022.

Erynne A. Faucett, MD
Chair, AAO-HNS Diversity and Inclusion Committee
Assistant Professor of Otolaryngology, Phoenix Children's Hospital, Arizona

On reflection of my personal journey into otolaryngology-head and neck surgery, I immediately think of the monumental encounters of the many people with whom I have run into on my path as a physician, educator, and surgeon. My parents supported my drive to do whatever I wanted, and therefore I am a product of both—a physician and an educator. After playing basketball through college and coaching on the intercollegiate level, I decided to hang up my shoes and follow in my father's footsteps to become a physician.

After completing a post-baccalaureate program to fulfill prerequisites, I matriculated into medical school. While there, I was directed into primary care so I could give back to my community; however, I realized late that I really enjoyed using my hands. At

the end of my third year, I knew I wanted to become a surgeon. My only exposure to surgery at that time had been general surgery, and therefore that was the specialty I chose. I ultimately started my general surgery residency at the University of Arizona-Tucson (UA).

My first rotation as an intern was otolaryngology-head and neck surgery under the new leadership of **Alexander G. Chiu, MD**. It was during this month that I learned all about the many intricacies of the specialty and complexities of the patients. I started to spend more time in the operating room with the faculty. I created opportunities during my night float rotations to offer an extra hand on cases running late.

During my second year as a general surgery resident, I continued my relationship with the otolaryngology-head and neck surgery faculty, and I was approached with a life-changing opportunity by Dr. Chiu—they were creating a residency program, and ultimately, I became the program's first resident. As a resident, I started to venture into my other calling—an educator (following in my mother's footsteps). From teaching medical students and helping pave the path for the future residents of the program, I reached out to leaders to help me become a physician-educator.

As I continue my journey, I have had mentors turned sponsors who have propelled me into opportunities that would not have been available to me otherwise. I continue to be thankful for these individuals as I continue through my academic career. I hope that I can be as monumental in the journeys of those who come behind me.

Rodney J. Taylor, MD, MSPH
Professor, Chair of Otorhinolaryngology-Head and Neck Surgery, University of Maryland Medical Center, Baltimore, Maryland

When contemplating my personal journey into otolaryngology, I immediately focus on my parents' contributions. As the youngest of two boys just a year apart, my parents struggled for my brother and me to attend private schools, which in our inner-city Philadelphia neighborhood was a doorway into opportunities not otherwise available. In that environment, there were many individuals committed to advancing my education and fostering in me a confidence in learning. Great high school mentors facilitated my enrollment into Harvard College and subsequent mentors into Harvard Medical School (HMS).

Early in medical school, I met an upper-class peer-mentor from the underrepresented community, **Charles M. Boyd, MD**, who not only was the key to my discovering otolaryngology, as importantly he demonstrated what a strong otolaryngology applicant looked like. Once exposed to the specialty, I was drawn in by the wonderful breadth and complexities.

Subsequently, I learned the value of a champion and sponsor when I met **Marshall Strome, MD**. One HMS faculty advised me to take a year off for more otolaryngology-specific research; the financial realities of that advice was distressing. Instead, Dr. Strome assured me that I was match-ready, and that I should focus on six-year research-integrated programs that would prepare me for an academic career.

During my training, there was a trove of peer and senior mentors who shaped me. The unifying importance of their support resulted in my developing a deep sense of assurance and encouragement that I was more than able to have my dreams realized. The outcome has been a career that is deeply fulfilling. If I can advise a prospective student, especially someone from an underrepresented community like me, it would be to protect your confidence and seek answers to processes and unanswered questions to inform your understanding of the rich possibilities. My experience convinces me that there are many who are energized to lend their time and influence to propel young careers. ■

#OTOMTG22

Learning together

AMPC Members Share Personal Stories of How Mentors from the Annual Meetings Enriched Their Lives

Daniel C. Chelius, Jr., MD
Annual Meeting Program Coordinator

"Tell me and I forget. Teach me and I remember. Involve me and I learn."
—Benjamin Franklin

"Tell me about your favorite teacher." It's one of my favorite interview topics; it never fails to make the individual smile, relax, and paint an incredible portrait of an influential mentor and role model. As I think of my cherished teachers, I often revisit specific conversations that were emblematic of both their wisdom and effectiveness.

One of the core aspects of attending the Annual Meeting is the opportunity to have these conversations and to learn from the very best in otolaryngology—our esteemed faculty on the program.

Whether clinical, personal, or professional in nature, the conversations I've had at the Annual Meeting over the years have informed and sharpened my decisions back at home. Mentors have inspired me to find solutions for difficult clinical scenarios, to navigate key career decisions, and to move initial ideas to operational success. As I've worked closely with the members of the Annual Meeting Program Committee (AMPC), we often speak of the individuals who have inspired us that we've met by attending the meeting. This is where the seeds of mentorship and friendship were planted for many of us, and those experiences inform our decisions as we craft each year's program.

Much as Benjamin Franklin mused, the faculty come not only to present, but to invite each of us to learn together and define who we are and where we're going as a profession.

I look forward to seeing you in Philadelphia and learning together.

Following are a few of the incredible teachers that our AMPC members cherish and who you can meet at the Annual Meeting.

Registration is open now
Register today at **www.entannualmeeting.org**

"**Richard M. Rosenfeld, MD, MPH, MBA**, has been doing update talks on otitis media and ventilation tubes at the AAO-HNSF Annual Meetings for as long as I can remember; I know that the hour spent listening to him will keep us all up to date. He can connect with the audience, and the room is always full. Through much of my career, I brought my daughter to the Annual Meeting, either with a nanny or with hotel babysitting. This took some juggling. The year she was four, we were standing in the hall outside the meeting rooms, trying to figure out logistics, when **K.J. Lee, MD**, came up to her and started talking to her. He was high profile at that time, being the editor of the book most of us used to get through our board exams. He was very warm and friendly, and it was reassuring to be acknowledged and supported even in that small way. These small gestures mean so much."

—Michele M. Carr, DDS, MD, PhD

Michael J. Brenner, MD

"My unforgettable moment at the Academy Meeting was running into **Mark K. Wax, MD**, who was then Coordinator of the Annual Meeting Program. He pulled back the curtain for me, as only a great mentor can, and shared invaluable insights into how the Academy works and unveiled untapped opportunities. This conversation changed my career, leading to an invitation to serve on a committee, to grow my network, and to elevate the profile of safety and quality at our Annual Meetings! Another high point was meeting **Valerie A. Flanary, MD**, in person for the first time during the Presidents' Reception in Los Angeles. She was so warm and welcoming, sharing her insights into leadership in the Academy, and that encounter started a friendship that opened doors for later collaboration."

—Michael J. Brenner, MD

Arrive in Philadelphia early to attend the Presidents' Reception, **Saturday, September 10, 6:30 pm (ET)**

Eileen M. Raynor, MD

"I would like to specifically call out **Sujana S. Chandrasekhar, MD**. She is a dynamic leader with a huge personality. She has a deep understanding of how the Academy functions and is a true advocate for its members. She is encouraging of women in the Academy and has helped forge a strong pathway to leadership through the Board of Governors. She is extremely approachable and has great insight into ways to be more engaged and involved with the Academy. I have really benefited from her knowledge and leadership and know the future is bright because of her vision."

—Eileen M. Raynor, MD

Mark K. Wax, MD

"I was introduced to the working side of the meeting by **Frank E. Lucente, MD**, who opened the door to the old instruction course. He was looking for volunteers and offered me a seat at the table. He said if you have ideas and you're willing to come to the meeting and you're willing to put in the work, we've got a place for you. **Jonas T. Johnson, MD**, taught me the same lessons. If the door is open and you go through, then commit to doing the work. There are those who find their way to being involved as a natural course of events. And there are those who need to put the work in. Either way there is always an avenue that if you work hard, people will notice. It's hard and long, but you need to show up to the meetings and contribute. I learned early on by the leaders in the field to fulfill my commitments. They led by example and taught by example."

—Mark K. Wax, MD

Photo Credit: A Golod for PHLCVB

Photo Credit: Edward Savaria, Jr. for PHLCVB

Photo Credit: K Huff for PHLCVB

Photo Credit: Edward Savaria, Jr. for PHLCVB

Photo Credit: Greg Benson for PHLCVB

The Liberty Bell Center, Independence Hall, Congress Hall, the National Constitution Center, the Benjamin Franklin Museum, and the Independence Visitor Center are just some of the highlights that make up Independence National Historical Park—most of which are free for visitors to explore. For more "must-see" attractions in Philly, go to https://bulletin.entnet.org/home/article/22093249/set-your-sights-on-philly-for-otomtg22 and https://bulletin.entnet.org/home/article/22093247/medical-history-in-philadelphia-five-medical-history-spots-to-explore.

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AAO-HNSF 2022 Annual Meeting Guest Lecturers (Listed in order of appearance)

John Conley, MD Lecture on Medical Ethics

Sunday, September 11

Presented during the Opening Ceremony, which starts at 8:00 am (ET).

Reflections on Our Profession in the Face of an Ongoing Pandemic

Andrew G. Shuman, MD, HEC-C

Andrew G. Shuman, MD, HEC-C, is an associate professor in the Department of Otolaryngology - Head and Neck Surgery at the University of Michigan Medical School. He serves as a chief of the Clinical Ethics Service in the Center for Bioethics and Social Sciences in Medicine (CBSSM). Dr. Shuman is the associate chief of staff at the VA Ann Arbor Health System, where he directs the educational experience for a diverse cadre of pre- and post-doctoral trainees and learners. He is also the current Chair-elect of the Ethics Committee and will assume the role as Chair at the close of the Annual Meeting in September 2022.

Dr. Shuman is recognized as a thought leader in ethical issues arising within the field of otolaryngology and surgical oncology. His work is defining the conceptual dimensions of "surgical ethics," an emerging focus in the broader field of bioethics, by applying his perspective as a practicing surgeon and clinical ethicist to normative and empirical bioethics research. He has recently focused on cancer treatment decision-making and precision oncology, scarce resource allocation, and institutional and national responses to the COVID-19 pandemic.

Dr. Shuman completed fellowships in head and neck surgical oncology at Memorial Sloan-Kettering Cancer Center, and in medical ethics at Weill Medical College of Cornell University. He completed his residency and medical school at the University of Michigan.

Eugene N. Myers, MD International Lecture on Head and Neck Cancer

Monday, September 12
10:30 – 11:30 am (ET)

Unraveling Locally Recurrent Head and Neck Cancer: From Clinical Problem to Molecular Explanation

C. René Leemans, MD, PhD, FRCSEd (Hon)

C. René Leemans, MD, PhD, FRCSEd (Hon), is professor of otolaryngology-head and neck surgery at the VU University, Amsterdam, the Netherlands, and chair of the department of otolaryngology-head and neck surgery at Amsterdam University Medical Centers. Dr. Leemans is also the director of the Advanced Fellowship Program in Head and Neck Surgery and Oncology.

Dr. Leemans' research interests include the various aspects of head and neck cancer, reconstructive and microvascular surgery, and basic translational research. He is the lead investigator in a number of clinical trials, including those sponsored by the European Union, Dutch Cancer Society, and industry. He has made a sustained and internationally recognized contribution to cancer care and research in the field of head and neck oncology over the past decades, has authored multiple research papers and textbook chapters, lectures internationally, and serves on the editorial boards of scientific journals.

Dr. Leemans was co-director of the Cancer Center Amsterdam until 2020. He has served as president of the Dutch and European Head and Neck Society. He leads the successful Make Sense Awareness Campaign on head and neck cancers in Europe.

Dr. Leemans graduated from the Erasmus University Rotterdam and completed his specialist qualifications in Amsterdam. He then completed a fellowship in head and neck/microvascular surgery in Amsterdam and Glasgow, United Kingdom.

H. Bryan Neel III, MD, PhD Distinguished Research Lecture

Tuesday, September 13
10:30 – 11:30 am (ET)

Konstantina "Tina" Stankovic, MD, PhD

Konstantina "Tina" Stankovic, MD, PhD, is the Bertarelli Foundation Professor and chair of the Department of Otolaryngology – Head & Neck Surgery at Stanford University School of Medicine. She is a Harvard-trained ear and skull-base surgeon and a Massachusetts Institute of Technology-trained auditory neuroscientist. Her clinical focus is in otology and neurotology, and she previously served as chief of the Division of Otology and Neurotology at Massachusetts Eye and Ear, a teaching hospital of Harvard Medical School.

In addition to her clinical and administrative duties, she directs a basic science laboratory focused on improving diagnostics and therapeutics for sensorineural hearing loss. She has initiated and led successful cross-departmental, national, and international collaborations to develop and deploy novel molecular diagnostics and therapeutics for hearing loss and otologic diseases in general while educating the next generation of leaders in surgery and science. ■

Our Town: Philadelphia, Part II

D. Gregory Farwell, MD
Chair of the Department of Otorhinolaryngology–Head and Neck Surgery at Penn Medicine

How does Philadelphia encompass this year's Forward Together theme?

The recent renaissance of the Philadelphia area has great synergy with the AAO-HNSF's Forward Together theme. Philadelphia has an incredible history, but it is the future of Philadelphia that is so exciting. Whether it is the emergence of the Philadelphia restaurant scene, art culture, or dynamic economy, Philadelphia is on a roll.

What do you love most about Philadelphia?

As a newcomer to the City of Brotherly Love, I have been blown away by the culinary and entertainment opportunities in the city. There are incredible restaurants, museums, and historical venues at every turn.

What advice do you have for first-time attendees?

For first-time attendees, I would recommend a true immersion into the Annual Meeting. There are so many educational, networking, and service opportunities for new members who want to be engaged in the Academy. Learn a ton, reacquaint with peers and colleagues, make new connections, and find ways to participate and give back to our organization.

How would you complete this sentence: Don't leave Philly before you have a chance to [fill in the blank]

See the history—the Liberty Bell, the National Constitution Center, but be sure to also take in the places that make Philly one of a kind—The Reading Terminal Market, The Franklin Institute, The Barnes, and of course the Philadelphia Museum of Art and Rocky Steps, to name a few.

How will Philadelphia's rich medical history contribute to making this year's Annual Meeting destination a unique experience?

Philadelphia's contributions to medicine in the United States are truly unique. Whether it is the nation's first hospital (University of Pennsylvania, Pennsylvania Hospital), first medical school (University of Pennsylvania), first Children's Hospital (CHOP), or the historic College of Physicians of Philadelphia and its world-famous Mütter Medical Museum, the spirit of innovation and medical education runs deep through this city.

Is there anything else you would like to share?

After a couple of years of pandemic challenges, it is so exciting to be able to reconvene a more normal Academy meeting. The connections and education are truly unique and important. You will have a great time in Philly … see you here! ■

Philadelphia Hotel Map

1. **Aloft Philadelphia Downtown**
   101 N. Broad Street
   Attached to the Convention Center
2. **Canopy by Hilton Philadelphia Center City**
   1180 Ludlow Street
   2 blocks from the Convention Center
3. **Element Philadelphia**
   1441 Chestnut Street
   5 blocks from the Convention Center
4. **Four Points by Sheraton Philadelphia Center City**
   1201 Race Street
   1 blocks from the Convention Center
5. **Hampton Inn**
   1301 Race Street
   2 blocks from the Convention Center
6. **Hilton Garden Inn Philadelphia Center City**
   1100 Arch Street
   Adjacent to the Convention Center
7. **Holiday Inn Express Philadelphia - Midtown**
   1305 Walnut Street
   4 blocks from the Convention Center
8. **Home2 Suites by Hilton Philadelphia Center City**
   1200 Arch Street
   1 block from the Convention Center
9. **Le Meridien**
   1421 Arch Street
   2 blocks from the Convention Center
10. **Loews Hotel Philadelphia**
    1200 Market Street
    1 block from the Convention Center
11. **Philadelphia Marriott Downtown - HQ**
    1201 Market Street
    Attached to the Convention Center
12. **Residence Inn Philadelphia Center City**
    1 E. Penn Square
    2 blocks from the Convention Center
13. **Sheraton Philadelphia**
    201 N 17th Street
    4 blocks from the Convention Center
14. **The Notary Hotel, Autograph Collection**
    21 N. Juniper St
    2 blocks from the Convention Center
15. **The Ritz Carlton Hotel, Philadelphia**
    10 Broad Street
    4 blocks from the Convention Center
16. **Westin Philadelphia**
    99 S 17th Street
    5 blocks from the Convention Center
17. **W Hotel Philadelphia**
    1439 Chestnut Street
    5 blocks from the Convention Center

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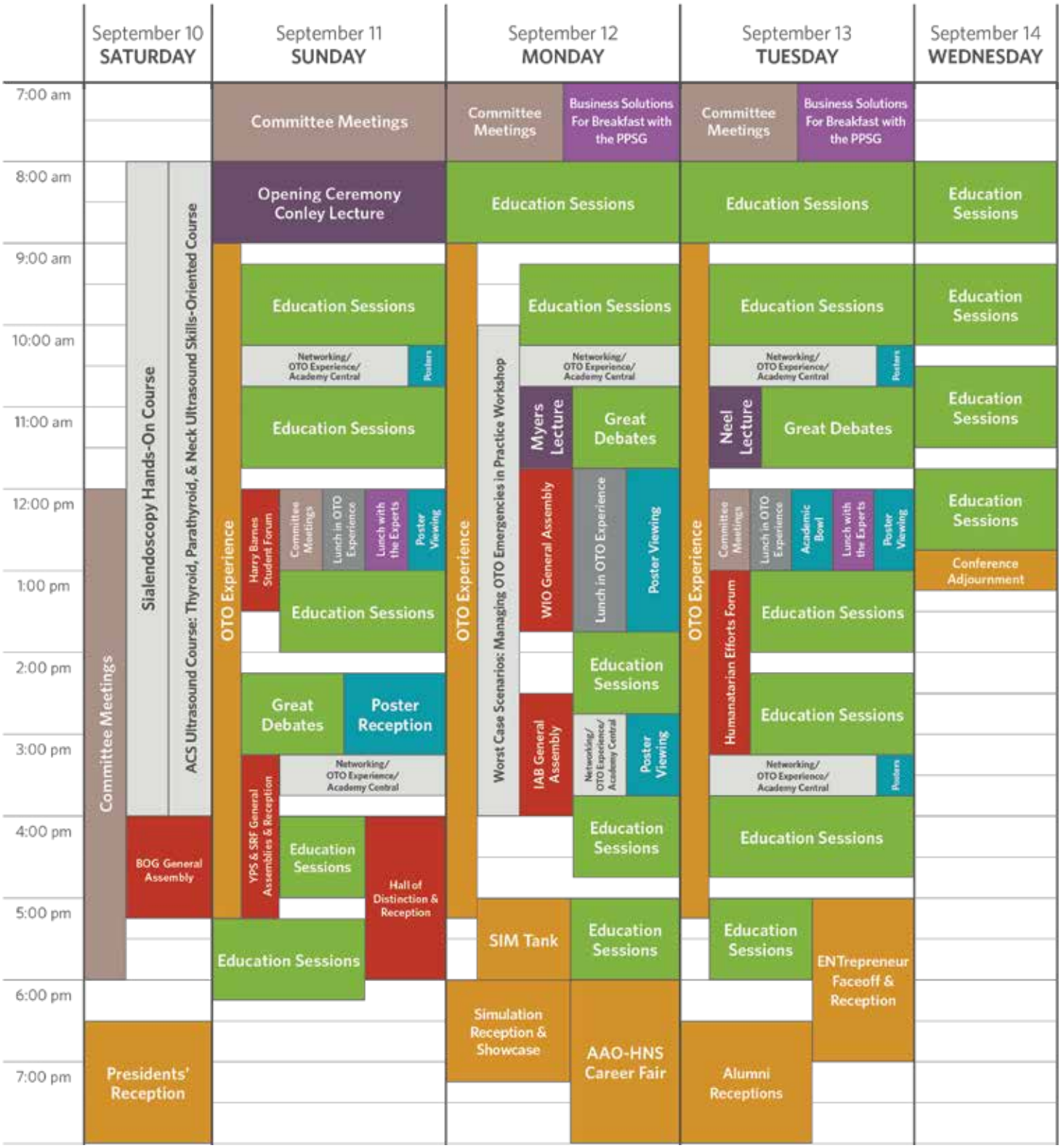
September 10 SATURDAY
September 11 SUNDAY
September 12 MONDAY
September 13 TUESDAY
September 14 WEDNESDAY
7:00 am
8:00 am
9:00 am
10:00 am
11:00 am
12:00 pm
1:00 pm
2:00 pm
3:00 pm
4:00 pm
5:00 pm
6:00 pm
7:00 pm
Committee Meetings
Business Solutions For Breakfast with the PPSG
Opening Ceremony Conley Lecture
Education Sessions
Networking/ OTO Experience/ Academy Central
Posters
Committee Meetings
Lunch in OTO Experience
Lunch with the Experts
Poster Viewing
Harry Barnes Student Forum
Great Debates
Poster Reception
YPS & SRF General Assemblies & Reception
Hall of Distinction & Reception
Sialendoscopy Hands-On Course
ACS Ultrasound Course: Thyroid, Parathyroid, & Neck Ultrasound Skills-Oriented Course
OTO Experience
Committee Meetings
BOG General Assembly
Presidents' Reception
Worst Case Scenarios: Managing OTO Emergencies in Practice Workshop
Myers Lecture
WIO General Assembly
IAB General Assembly
SIM Tank
Simulation Reception & Showcase
AAO-HNS Career Fair
Neel Lecture
Academic Bowl
Humanatarian Efforts Forum
ENTrepreneur Faceoff & Reception
Alumni Receptions
Conference Adjournment

Advocacy: RepresENTing You

The Academy is committed to advocating for the enactment of policies that strengthen the delivery of, and access to, quality healthcare services in the United States. The Academy also works to identify and combat harmful regulatory and coverage policies that threaten access to quality otolaryngology-head and neck services. The Academy staff actively engages with legislative and regulatory officials, at the national and state levels, and private payers to achieve these goals and protect the specialty, your practice, and your patients.

The 2022 Medicare Fee Schedule contains two new codes for otolaryngologists approved by CPT and valued by RUC after considerable work by the CPT/RUC teams and staff. Codes for implanting, removing, and revising hypoglossal nerve stimulators (64582, 64583, 62584) and drug induced sleep endoscopy (42975) became available for use in this calendar year. Please visit the Academy's Coding Corner at **https://www.entnet.org/content/coding-corner** for additional updates, as well as the newest coding and reimbursement tools for members.

This year the Academy hosted a (virtual) Congressional Advocacy Day for the first time since 2019, where otolaryngologist-head and neck surgeons had the opportunity to engage with Members of Congress and their staff on the issues of importance to the specialty. Working in concert with other physician organizations and surgical societies, the Academy helped to avert a 9.75% cut to Medicare reimbursement for 2022. This year, we are focused on a permanent solution for this problem as well as advocating for Congress to pass a prior authorization bill for Medicare Advantage plans and weighing in on possible Medicare expansion to include hearing services and hearing aids. We are also heavily involved in the fallout from the regulations promulgated by the Biden Administration relating to the "No Surprises Act".

At the state level, there continues to be increased activity surrounding the Audiology & Speech Language Pathology Interstate Compact. The Academy has interacted with many states to prevent inappropriate scope-of-practice expansion.

The articles on the following pages will put a spotlight on select advocacy initiatives from the past year, along with some recent developments in health policy that impact the specialty, your practice, and your patients. Sign up to receive *The ENT Advocate*, a monthly newsletter that provides updates about the Academy's advocacy efforts and the federal and state issues impacting your practice. Email **govtaffairs@entnet.org** to learn more. ■

Advocacy: RepresENTing You!

Throughout the Academy's history, it has been the groundswell of support and participation of the members that has strengthened the organization's ability to affect change for the practicing otolaryngologist-head and neck surgeons and your patients. The following members sat down with Academy staff to share their thoughts and experiences in the advocacy arena: **Douglas D. Backous, MD; R. Peter Manes, MD**, Coordinator for Advocacy; **Karen A. Rizzo, MD**, Board of Governors Chair-elect; and **Yolanda L. Troublefield, MD, JD**, Board of Governors Legislative Affairs Committee Chair. Hear from your colleagues who have incorporated advocacy into their commitment to the specialty and their patients.

Douglas D. Backous, MD

R. Peter Manes, MD, Coordinator for Advocacy

Karen A. Rizzo, MD, Board of Governors Chair-elect

Yolanda L. Troublefield, MD, JD, Board of Governors Legislative Affairs Committee Chair

Tell us a little about you, your practice, and your experience with advocating for the specialty.

Dr. Backous: I am a neurotologist practicing in the Seattle, Washington area. I have practices in the south end of the Puget Sound region and up north in Edmunds, Washington. I have been in Seattle for my entire career after training at Baylor for my residency and Johns Hopkins for my fellowship. My practice is limited to otology and neurotology, and I have been boarded at both levels with the American Board of Otolaryngology — Head and Neck Surgery.

Dr. Manes: I am a rhinologist at Yale School of Medicine, I have been there almost 12 years now. I first got involved with the Academy on our RUC team, which works to value new codes and revalue current codes. Through that work I was exposed to a variety of different aspects of health policy, including advocacy efforts both with private payers as well as government institutions.

Dr. Rizzo: I am a general otolaryngologist in private practice in Lancaster, Pennsylvania, for 31 years. I have been very much involved in advocacy both at the state level and nationally since I finished my training at [Thomas] Jefferson [University Hospital] in 1990. I have been the president of the Pennsylvania Academy of Otolaryngology as well as president of the Pennsylvania Medical Society. In both of those capacities, I did a lot of advocating on behalf of our specialty as well as the house of medicine for issues that impact patient care, socioeconomic concerns, as well as legislative issues.

Dr. Troublefield: I am a general otolaryngologist. I practice with four other physicians as well as a few other part-time physicians. We are associated with three hospitals, one of which is the second busiest emergency room in the state of Massachusetts outside of Boston. Working with local groups, our legislatures in the state, and on the federal level allows us to bring the kind of care that we believe all the Massachusetts patients deserve.

What was the impetus of your involvement in the Academy's advocacy efforts? How did you get started and what are some things that you have done?

Dr. Backous: My experience with advocacy goes back to newborn hearing screening in 1999 in the state of Washington. We really had to work together with the representatives from the Deaf community and representatives from the various hearing organizations in the state to convene people and to come together as a united front to find some common ground—to promote newborn hearing screening. We ultimately agreed that we wanted all children to be identified and then they would have a choice as to what pathway they would take.

I think the big issue when advocating is to really understand what change we're looking for and what we're targeting from our side of the story. We then need to listen to others as they lay out their needs and try to find that common thread. I've been advocating quite a lot for the specialty—since prior to 2010—whenever asked on a state level and more recently at the federal level.

> I think the big issue when advocating is to really understand what change we're looking for and what we're targeting from our side of the story. We then need to listen to others as they lay out their needs and try to find that common thread.
>
> *—Douglas D. Backous, MD*

Dr. Troublefield: My former partner was incredibly involved in advocacy, deeply involved in bringing the specialty to a higher level in terms of its awareness of how legislation and regulation impact us. She got

me involved in the Massachusetts Society of Otolaryngology (MSO). Through my involvement in the MSO, I became aware of what kind of impact I could have in helping my patients by working within the legislative process. From the MSO, I had the opportunity to work on a lot of local legislation, and then I became more involved in the Academy. Surgeons are results-oriented people, so being able to work on initiatives that impact medical care delivery allows you to actually see the impact that you have on our specialty.

What has your favorite experience with advocating for the specialty and patient care been? Do you have any advocacy "wins" that you are particularly proud of?

Dr. Manes: One thing that I am most fond of doing is our Advocacy Day that takes place on Capitol Hill often in the spring. This year it was virtual, but I just think it is a terrific experience. Advocacy Day is where you have an opportunity to speak with people who are making the rules; you get to tell them your stories and your patients' stories. And whether things work out the way you want them to or don't, at least you feel at the end of the day, you were able to share your prospective, your patients' prospectives, and your voice was heard. You're not always going to win, but you are always going to have that opportunity to present your story.

Dr. Rizzo: Probably my most impactful win, if you will, was when I sat on the Speech Language Pathology and Audiology Board in Pennsylvania representing otolaryngology. Many times that body tried to present bills modifying their prospective on independent practice, trying to remove physician oversight and trying to have direct access to Medicare patients, which is what they still continue to ask for at the federal level. On two separate occasions I was able to modify the language on these bills. In essence, they did not progress because of the concerns we had as a specialty. I thought that was significant, at least for Pennsylvania, and I hope we will get to the same endpoint at the national level.

> "Advocacy allows us to be a source of information for the legislators to help them make decisions on bills and on regulations that impact the way we practice. It allows us to be a champion for our patients' needs, and at the end of the day, it allows us to do our jobs in a better way, which has a significant impact on the quality of care we give to our patients and helping them achieve happier and healthier lives."
>
> *—Karen A. Rizzo, MD*

> "Advocacy for our specialty is not a new career—this is something that you can do to assist yourself, your colleagues, and your patients in smaller doses."
>
> *—R. Peter Manes, MD*

Why do you think it is important that you and others in the specialty continue to be involved in advocacy? How does it benefit and impact current and future practice and patient care?

Dr. Rizzo: I think advocacy is an opportunity to communicate, educate, and collaborate with elected leaders on issues that are important to us as a specialty. Advocacy allows us to be a source of information for the legislators to help them make decisions on bills and on regulations that impact the way we practice. It allows us to be a champion for our patients' needs, and at the end of the day, it allows us to do our jobs in a better way, which has a significant impact on the quality of care we give to our patients and helping them achieve happier and healthier lives.

Dr. Troublefield: Medicine isn't practiced in isolation. There are many different stressors on the system. One of the problems with the system is that many patients feel that they are not the focus of our intricate healthcare system and when it comes to meaningful change they are on the outside looking in. So, who else to be their advocate but their physicians? We are their safeguard. We are the person they can come to with lots of other issues. And being an advocate for patients allows us to continue to advance the practice, to make new discoveries by partnering with agencies such as the CDC or the NIH. We are the ones who are practicing medicine so we have the intricate knowledge to help our representatives understand the things that we need to help take care of the American population. It's got to be done.

How would you finish this phrase: Without advocacy...

Dr. Backous: Without advocacy, patient care would flounder. When you look at elected

and agency officials and regulators, they're tasked with an enormous job. At the end of the day, the government is about how they allocate funds. And what we're doing is important enough to get a piece of that spending that's going to improve the overall health and well-being of their constituents.

Dr. Manes: Without advocacy, the specialty would fall more out of our hands. We are the best advocates for ourselves and for our patients, and we want to maintain that. If we ignore those responsibilities someone else is going to make decisions for us. We want that seat at the table. We want the input. We won't like the outcome if we don't have it.

Dr. Troublefield: Without advocacy, the specialty would suffer tremendously. Because of the complexity of the healthcare system, it is difficult for our patents to have a deep understanding of what occurs in the background in terms of payments, insurance, and oversight. They implicitly look to physician leaders to fight for their healthcare needs. On the other hand, from a legislative standpoint, we can't expect our representatives to know what we do on a day-to-day basis. So, without providing them with the critically relevant information, they would make decisions in a vacuum. Without advocacy, we would have a really broken healthcare system.

What tips can you share for someone who wants to get involved but isn't sure where to start.

Dr. Backous: I would borrow from Nike; I would say just do it. I view the advocacy division at the Academy as fly fishing guides. You do not need to know how to fly fish to catch a fish on a fly-fishing guided trip. They will put you in a raft, they'll put the life vest on you, they'll put the pole in your hand to tell you where to cast. That's how the Academy has provided a framework for people to advocate effectively, which takes a lot of the stress away when learning how to do it. I think the Academy does a very good job setting people up with specific content, the points that we're trying to get across, and also provides opportunities in follow-up calls after those advocacy efforts to talk about what we learned.

> We can't expect our representatives to know what we do on a day-to-day basis. Without advocacy, we would have a really broken healthcare system.
>
> —*Yolanda M. Troublefield, MD, JD*

Dr. Manes: I think there are a couple ways you can get involved. One is to respond when large calls to action come out, which I think is important because a lot of people say to themselves, "I'm not very knowledgeable about this," but that's not the case. You're a content expert and that is vital in this process. So, try to step up when asked. And then there is also presenting yourself as someone who is interested in this, and how do you do that? Well, I think a great way is getting involved with the Academy. Making connections to those who are involved will allow you to become more involved. It is daunting and none of us have hours of unstructured time, but that is not what it takes. Advocacy for our specialty is not a new career—this is something that you can do to assist yourself, your colleagues, and your patients in smaller doses.

How have prior authorization requirements impacted your practice? Specifics on other issues we advocate on (Medicare reimbursement, scope, state issues, etc.)

Dr. Manes: We don't talk about it often, but it affects one's bottom line. If we know anything, it's that we know physician reimbursements have not kept pace with inflation. If you ask someone if they would be okay making less per unit work time now than they did in the 1990s, chances are they would not feel very good about that. And how does that then affect us? It can affect patient access and the ability to take care of patients in a variety of different ways, such as the ability to see Medicare patients. It can also affect the ability to hire enough staff, to have enough supplies in one's office in order to provide a volume of care that you want to provide to people. So, it ends up affecting you in so many different ways. It's actually about the ability to provide care for your patients.

Dr. Rizzo: In my practice alone, I have a full-time employee dedicated to getting prior authorizations done for medications, CT scans, MRIs, surgery, and it's such a time-consuming process. If you look at the process and the time that is involved to get it done, it can last from minutes, to hours, to even days, especially if you have to do a peer-to-peer review. At the end, 98% of the time, whatever we are asking for gets approved, so the waste of time, energy, and cost on the office side to get that done is a big frustration and burden for most practices and patients. They can't get the tests done to answer the question or they can't get the medication that they are waiting for to help them feel better, so they leave the office also frustrated and anxious. The whole process just leads to a delay in diagnosis, a delay in treatment, and at the end of the day it's the patient who suffers.

Dr. Troublefield: I had a patient who was a long-time smoker who came into the office with a pronounced hoarseness. I suspected that she had cancer and as a part of her work-up needed a CT scan before going to the OR to perform a direct laryngoscopy and biopsies. Her surgery was delayed by a week and a half because of prior authorization. This lengthy process led to delay in care, and added stress and anxiety experienced by my patient. To a cancer patient, a week and a half seems like years. In my mind, to place this burden on a patient is entirely unacceptable. ■

Physicians Notch Victory in Surprise Billing Lawsuit

In a major initial victory for providers, a federal district court judge in February sided with the Texas Medical Association (TMA) and struck down certain regulations related to the IDR issued by the Biden Administration that implemented provisions of the No Surprises Act—the landmark surprise billing law.

Background

After two years of contentious debate, Congress passed the No Surprises Act in December 2020 to protect patients from surprise medical bills. The largely bipartisan No Surprises Act was the result of extended negotiations in Congress. As part of the law's patient protection provisions, it requires health insurance companies to cover surprise out-of-network medical bills at in-network rates, prohibits out-of-network providers from billing patients for excess charges, mandates "good faith estimates" for private pay patients, and bans the practice of balance billing in most scenarios.

The law also establishes an independent dispute resolution (IDR) process—known as arbitration—for addressing payment disputes between out-of-network providers and insurers and private pay patients and providers and facilities. Under the law, providers and health plans submit a proposed payment amount to an IDR entity, which in turn chooses one of the competing offers. To make this decision, the arbiter weighs several factors, including the health plan's median in-network rate—known as the qualifying payment amount (QPA)—and information about the provider's training and experience. Importantly, the law bars IDR entities from considering the provider's "usual and customary" charge as well as rates paid by government programs like Medicare and Medicaid.

Texas Medical Association Lawsuit

At the heart of the lawsuit brought by the TMA were concerns about how the new IDR process would function. In October 2021, the Biden Administration issued an interim final rule (IFR) with guidance on the IDR process among other areas. TMA subsequently filed a lawsuit against the Administration in October, arguing that the IFR "undermines Congress' design" of the IDR process under the No Surprises Act. According to the lawsuit, TMA argued that the IFR wrongly instructs IDR entities to favor the QPA over other factors—conflicting with the statutory language in the No Surprises Act.

TMA also took issue with the timeliness of the federal rulemaking process, arguing that the IFR should be vacated because it did not provide an opportunity for stakeholders to comment on the proposal, pursuant to the Administrative Procedure Act (APA).

Following the release of the IFR, the AAO-HNS joined 20 other surgical specialties in December and submitted comments to the Administration expressing concern with the IFR as written. The Academy argued that, by establishing the QPA as the default factor considered in the arbitration process, the rule could incentivize payers to set artificially low payment rates, creating more narrow provider networks and reducing access to care.

Then, on January 4, 2022, the AAO-HNS joined in filing an amicus brief supporting a similar lawsuit brought by the American Medical Association (AMA) and American Hospital Association (AHA) challenging certain provisions of the IFR. The Academy strongly believes that the IFR does not represent congressional intent in drafting and passing the No Surprises Act and would cause irreparable harm to otolaryngologists and other physicians throughout the United States. The AAO-HNS joined seven other national medical associations and 14 state medical societies in this effort.

The Decision

In a 35-page decision, Judge Jeremy D. Kernodle of the Eastern District of Texas ruled that the regulations described in the lawsuit are inconsistent with the text of the No Surprises Act and must be set aside. Judge Kernodle also agreed with TMA and ruled that the Biden Administration improperly bypassed the APA's notice and comment requirements. Notably, Judge Kernodle did not strike down the patient protections included in the No Surprises Act, which the plaintiffs and AAO-HNS have long supported.

Looking Ahead

In April, the Biden Administration decided it would appeal Judge Kernodle's decision to the Fifth Circuit Court of Appeals. A decision on the appeal has not yet been reached. However, there are five other lawsuits brought by provider and other healthcare groups similarly challenging portions of the Administration's interim final rule. The AMA and AHA lawsuit is set to be considered before the District Court for the District of Columbia over the coming months. The Administration is also expected to release a final rule on the No Surprises Act regulations early this summer.

The Academy continues to advocate on behalf of physicians and patients, both in Congress and with the Executive Branch, on the issue of surprise billing and the implementation of the No Surprises Act and will keep the membership up to date on this and all issues impacting your practice and patient care via OTO News and the Academy website.

Resources

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AAO-HNS Joins Amicus Brief Challenging Provisions of No Surprises Act https://www.entnet.org/wp-content/uploads/2022/01/PAI-Neurosurgery-Specialty-State-Amicus-Brief-in-AMA-AHA-NSA-Lawsuit-010722.pdf Retrieved May 5, 2022.

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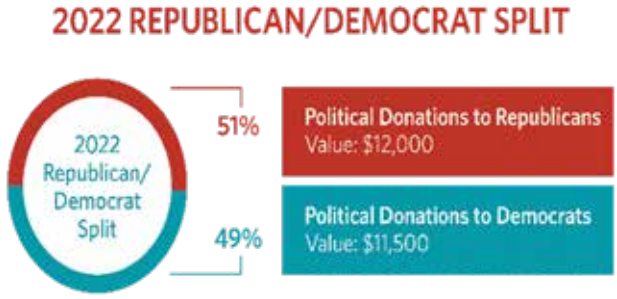
ENT PAC Update



ENT PAC, the political action committee of the AAO-HNS, is a nonpartisan, issue-driven entity that supplements the Academy's legislative advocacy efforts and helps to increase the visibility of the specialty on Capitol Hill and with key policymakers. ENT PAC has already supported the campaigns of 14 incumbent Members of Congress during the first quarter of 2022, for a total of $23,500 worth of contributions.

The ENT PAC Board of Advisors and staff are grateful to all ENT PAC supporters, especially to the 50 contributors who committed at least $1,000 to ENT PAC through the "First 50" campaign.

If you have questions or would like additional information, please contact ENT PAC* staff at entpac@entnet.org. ■

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virtual CONGRESSIONAL ADVOCACY DAY

APRIL 10-11, 2022

After a two-year hiatus due to the pandemic, the Academy hosted its annual Congressional Advocacy Day on April 11. This event was held in tandem with the AAO-HNS/F 2022 Virtual Leadership Forum & BOG Spring Meeting. This year's Advocacy Day was held virtually and was open to all Academy members, making it easy for participants with busy schedules to meet with priority congressional offices. Although many of the participants this year were seasoned advocates, it was exciting to see new names and faces advocating for the specialty.

AAO-HNS members used the Virtual Congressional Advocacy Day (VCAD) platform to advocate on the following top federal legislative priorities for the Academy in 2022:

- Support for legislation reforming prior authorization in the Medicare Advantage program (H.R. 3173 / S. 3018, the Improving Seniors' Timely Access to Care Act)
- The importance of providing more long-term stability to the Medicare reimbursement system for physicians
- Alerting congressional offices to patient safety concerns with scope-of-practice legislation (H.R. 1587 / S. 1731, the Medicare Audiologist Access and Services Act)
- Advocating for Congress to reauthorize the vastly successful, bipartisan Early Hearing Detection and Intervention (EHDI) program

AAO-HNS member advocates met with 27 congressional offices as part of the Congressional Advocacy Day event, mainly focusing on key lawmakers who serve on the committees with jurisdiction over health legislation. Some participants were also able to meet directly with physician members of Congress, including U.S. Representatives Andy Harris, MD (R-MD), Larry Bucshon, MD (R-IN), and Kim Schrier, MD (D-WA). These meetings were particularly impactful for our members, as these lawmakers understand the unique challenges physicians and patients face every day.

Advocacy Days are vital for educating congressional offices, particularly the staff who work on health policy in those offices, on the many issues affecting physicians, their practices, and their patients. These events also allow Academy members an opportunity to share their personal experiences with members of Congress and staff, which helps to drive home the message how federal legislation can impact physicians, patients, and the constituents that these offices serve.

The Academy looks forward to building on the momentum from VCAD by scheduling additional congressional outreach for members in the near-term to engage new advocates to represent the specialty on Capitol Hill. Thank you to everyone who participated, and we hope to see you next year in person in Washington, DC. ■

Stay Connected

If you are interested in getting involved in our advocacy efforts or want to stay up to date on featured news and trending topics in the advocacy and health policy arena, please visit **www.entnet.org/advocacy/** or email **govtaffairs@entnet.org**.

OUT OF COMMITTEE: Veterans Affairs

Veterans Affairs and Otolaryngology: Current Perspectives and the MISSION Act

Ameya A. Asarkar, MD, and **Reena Dhanda Patil, MD**, for the Veterans Affairs Committee

Chances are that you are one of the many otolaryngologists in the United States who has trained at a Veterans Affairs (VA) medical center, whether during medical school, residency, or both. Did you know that the Veterans Health Administration is the largest integrated healthcare system in the country, serving nine million veterans and employing about 370,000 full-time health professionals at 1,300 healthcare facilities?[1]

Dedicated care for veterans began as early as 1789 when the U.S. government ensured pensions for disabled Revolutionary War veterans and increased after the Civil War left the Union with 1.9 million veterans, many of whom were disabled and indigent. Growth of medical centers for veterans has especially accelerated over the past 100 years, particularly after World Wars I and II. At the end of World War II, there were approximately 15 million veterans in the U.S., and all 97 VA hospitals were filled to capacity. In response, the VA opened 54 new hospitals over the next five years, many of which followed standardized building plans—these are the hospitals many of us remember from various phases of our careers.[2] Some of these facilities have been modernized, but many bear the original footprint of those built more than 50 years ago!

Academic affiliations with VA medical centers became integral to providing the necessary specialized care to millions of soldiers who became veterans after World War II. Today, the VA Office of Affiliate Education emphasizes a tripartite mission with its affiliates: patient care, education, and research. Currently, three-quarters of U.S. physicians receive at least part of their training at VA facilities working with academic medical centers, and 90% of U.S. medical schools collaborate with VA centers to provide medical education.[3] As a result, the majority of otolaryngologists practicing in the U.S. today have spent time working with patients at a VA facility and many consider it a valuable portion of their education and training.

Over time, various demographic, economic, and political pressures have shifted delivery of patient care at VA facilities with models of fee-basis care outside VA becoming increasingly common over the past two decades. The latest legislation that affected veterans' ability to seek care outside the VA is the Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which grew out of its predecessor, the Veterans Choice Program (2014-2018). As former VA Secretary Robert Wilkie stated, "[The MISSION Act] will put veterans at the center of their care and offer options… so they can find the balance in the system that is right for them."[4]

The MISSION Act has affected care for many veterans and also has allowed community otolaryngologists to become caregivers for these patients within their non-VA offices. An important determinant of patient outcomes is the timeliness in receiving care and this has been one of the main drivers behind the MISSION Act. For specialty clinics, veterans are eligible for community healthcare if the VA is unable to provide care within a specified wait time of 28 days or if the veteran lives beyond the maximum drive time of 60 minutes from the VA facility. The MISSION Act not only stresses access to care but also emphasizes the need for high-quality healthcare. An important addition to community care eligibility has been the "in the veterans best medical interest" criterion as determined by the veteran and the VA primary care provider.[5] Table 1 enumerates eligibility criteria under the MISSION Act 2019.

Despite the MISSION Act's intentions to provide excellent care, both patients and providers have reported significant challenges in navigating the process of accessing community care. Difficulties range from finding a provider who has the time and interest in offering the specialty care needed to duplicating investigations due to inability of the community provider to access patient records from the VA electronic health record. To circumvent these issues, the MISSION Act has implemented provisions wherein community care networks facilitated by third-party administrators have been created to provide the medical services to the eligible veterans.[5] Furthermore, the VA uses a software platform, HealthShare Referral Manager, to improve the referral and preauthorization along with improved information sharing between VA and non-VA providers.[6] This unified platform is available to all community providers both within and outside the network.

Although these efforts have mitigated certain difficulties in coordinating community care, some providers and patients express frustration in accessing community care in a timely and efficient manner. Research suggests that coordination among different healthcare systems to ensure continuity of care can be

arduous in some situations for both VA and non-VA providers. Furthermore, monitoring the quality of care offered by every community healthcare provider may be impractical. In the past, providers have also expressed concerns with timely reimbursements for services provided, especially under the Veterans Choice Program. The MISSION Act recognizes these pitfalls and formally addresses them through its provisions; however, providers in certain areas have been reluctant to participate in the new community care program due to their past experiences.[7]

What is the future of the VA in medical education and residency training? How will the MISSION Act evolve as the financial and political pressures of various administrations affect its implementation and funding? These are questions that remain highly relevant to our specialty, as the majority of otolaryngology training programs in the U.S. remain affiliated with VA medical centers. Residents often spend a significant portion of their five years of training committed to otolaryngology services at VA facilities. Although the Congressional Budget Office estimates that VA's costs for community care grew from $7.9 billion in 2014 to $17.6 billion in 2021,[8] the pendulum may swing in the other direction with regard to funding, and we may find consolidation of care firmly centering once again in the physical auspices of dedicated VA facilities. Despite uncertainties in the long-term structures surrounding care of U.S. veterans, our VA otolaryngology providers continue to enjoy a close relationship with the wonderful population of veteran patients and gain tremendously from the educational experiences within VA as students and trainees. ■

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Table 1. Veterans Community Care Criteria

1. VA does not offer care at all or is unable to provide care within a specified wait time (proposed standard: 28 days for specialty clinics); or
2. Veteran resides in a state lacking a full-service VA; or
3. Veteran lives beyond a maximum drive time from a VA facility offering the care needed (proposed standard: 60-minute average drive time for specialty care); or
4. VA cannot provide veteran with care meeting specified VA quality standards; or
5. Veteran and primary care provider determine it is in veteran's "best medical interest" to receive care in the community

Adapted from Adams et al.[5]

FROM THE EDUCATION COMMITTEES

The Trouble with Temporomandibular Dysfunction

Cristina Cabrera-Muffly, MD, Chair-elect, General Otolaryngology and Sleep Education Committee

More than 5% of the population is thought to be affected by temporomandibular disorders (TMD). TMD disproportionately affects women of childbearing age, which is also the group with some of the highest levels of pandemic-associated stressors, including balancing work demands, child and elder care, and economic challenges. Many comprehensive otolaryngologists saw a significant increase in patients presenting with TMD type symptoms, especially early in the pandemic but also recently as we begin to approach the virus' endemic period.

One of the first descriptions of the relationship of ear, jaw, and sinus pain attributed to the temporomandibular joint was published by Costen in his 1934 paper in *Annals of Otology, Rhinology, and Laryngology*. While Costen incorrectly attributed all the symptoms to malocclusion of the temporomandibular joint, he did understand the concept of referred pain's role in TMD.[1] Although aspects of the diagnosis and treatment of TMD remain controversial, researchers have developed useful algorithms for patients with TMD who present to the otolaryngologist.

Most patients with TMD present with some combination of otalgia or facial pain, ear fullness, and tinnitus.[2] While the prevalence of these symptoms vary between studies, more than 50% of patients in all studies present with the above. Less commonly, patients report vertigo, hearing loss, trismus, or displacement of the joint. The most common exam finding is masticatory muscle tenderness.[3] Turning to our dental and oro-maxillofacial colleagues, the International Research Diagnostic Criteria TMD Consortium Network developed a commonly used classification tool differentiating TMD into four categories, including TMJ anatomical dysfunction, masticatory muscle disorders, headache disorders, and problems with associated structures. Patients can have diagnoses from more than one category.[4]

> "Many patients seek care from otolaryngologists for TMD-related symptoms, and our specialty is frequently the first line for assessment of these disorders."

Symptoms of temporomandibular joint (TMJ) anatomical dysfunction—pain over the joint, popping, locking, and limited range of motion—should be treated differently than masticatory muscle disorders, which typically present with facial pain, muscle point tenderness, and otolaryngological symptoms in the absence of any anatomical pathology.[5] The Consortium Network also implements assessment of TMD to include two axes. The axes divide TMD into physical dysfunction (Axis I) and the psychological impact of the disorder (Axis II), both of which are significant in determining appropriate therapeutic options.[4]

Common sensory innervation via the auriculotemporal nerve can make it difficult to differentiate between primary and secondary (referred) otalgia. Therefore, eliciting associated symptoms and a comprehensive physical exam of the head and neck are critical to rule out other disorders, such as primary ear disorders, neoplasia, sinus disorders, temporal arteritis, trigeminal neuralgia, cervical spine disease, or even cardiac disease. Patients with hearing loss or tinnitus should be worked up with an audiogram. Consider vestibular testing in patients with otherwise unexplained vertigo. In cases of otalgia in

the absence of classic TMJ pathology or muscle tenderness, nasopharyngoscopy and laryngoscopy should be used to rule out infectious or malignant causes of referred pain.[6] Consider imaging in patients with concurrent nasal symptoms if red flag symptoms such as cranial neuropathy are present, when conservative treatment strategies are not effective, or if symptoms worsen despite treatment.[1] If cardiac, rheumatologic, or spinal disease is suspected, referral to the appropriate specialist is warranted. Remember to screen for sleep apnea since bruxism and apnea are correlated.

Once the diagnosis of TMD has been confirmed, the patient should be counseled on conservative treatment strategies. These include warm or cool compresses, massage, soft diet, and gentle stretching exercises. Pharmacotherapy can be used as a short- or long-term adjunct, including non-steroidal anti-inflammatory drugs, muscle relaxants, neuromodulators, or tricyclic antidepressants.[3] Referral to a dentist or oral surgeon who can make a custom splint can be helpful, although a Cochran review found insufficient evidence for splinting.[7] Patients with TMJ anatomical dysfunction will also benefit from referral to an oral surgeon to discuss treatment options specific to the joint. If first-line conservative treatment is not sufficient, other treatment options include physical therapy, electrical stimulation, acupuncture, dry needling, or trigger point injections with steroids or botulinum.[7] Many of these treatments can be performed by a physical therapist, although it may be necessary to involve an orofacial pain management specialist.

Many patients seek care from otolaryngologists for TMD-related symptoms, and our specialty is frequently the first line for assessment of these disorders. The skilled otolaryngologist must rule out more concerning diagnoses, verify that the TMD diagnosis is correct, and educate the patient on both the cause and treatment options for their symptoms. ■

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Otolaryngology Patients with Dementia: A Growing Care Need and Opportunity

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The population is aging, both nationally and globally, and with an aging population, the burden of age-related conditions is also growing. Within otolaryngology-head and neck surgery, when we consider aging, we often focus on conditions such as age-related hearing loss or presbylaryngus or the effect of frailty on head and neck cancer outcomes, among others. However, Alzheimer's disease and related dementias represent a significant clinical and public health concern where age is also the primary risk factor. Given the associated personal and societal burden, dementia is one of the greatest global challenges for health and social care in the coming century.

Approximately 55 million individuals are living with dementia globally with an associated cost of $1.3 trillion, which is expected to increase to almost 80 million individuals by 2030 and $2.8 trillion associated costs. While age-related otolaryngic conditions, like age-related hearing loss, are highly prevalent in the United States, dementia is also prevalent—one in three older Americans will die with a diagnosis of dementia. The cost of caring for persons living with dementia in the U.S. is $321 billion, which does not include the estimated $272 billion of unpaid care provided by over 11 million care partners, primarily family and friends.

Although many of us experience dementia through the care of a loved one, professionally we have a role to play in caring for the growing population of persons aging with dementia. There are considerable contributions that we can provide as otolaryngologists to the person-centered care of individuals living with dementia and their quality of life, including the identification and management of hearing loss, falls, and dysphagia—some of the most common comorbidities that can occur alongside dementia. The prevalence of audiometric hearing loss ranges from 60% to 90% among persons living with dementia, while vestibular impairment is twice as common among persons living with dementia as age-matched controls. Regarding dysphagia, over 85% of individuals in late-stage dementia have swallowing dysfunction.

The relationship between hearing loss and dementia and the potential for hearing care to serve as primary prevention of dementia has garnered significant attention in the past decade. However, relatively little is known regarding hearing care as tertiary prevention to mitigate some of the consequences of dementia by addressing hearing loss among individuals already aging with dementia and hearing loss. Increasingly recognized for its role in healthy aging, hearing loss has been independently associated with aspects of dementia that can lead to significant burden for individuals, care partners, and society, namely neuropsychiatric symptoms.

Neuropsychiatric symptoms include the noncognitive aspects of dementia, such as anxiety, depression, and agitation, and are almost universally experienced by patients with cognitive impairment, from those with mild cognitive impairment to dementia. Neuropsychiatric symptoms are associated with worse outcomes for patients, from increased morbidity and mortality to institutionalization. Hearing loss has been independently associated with a greater number of neuropsychiatric symptoms and increased severity, and hearing care, in the form of hearing aids, may be protective.

In counseling patients with cognitive impairment and their care partners, providers should assume the patient has some degree of hearing loss and incorporate communication strategies. Strategies include speaking clearly, using written and visual cues as much as possible along with clear transitions between topics, incorporating nonverbal communication, and including care partners whenever possible. When discussing hearing loss management, providers should discuss communication strategies that care partners can also employ. Regarding sensory management through amplification, providers should consider options that may benefit an individual's hearing goals but also fit within their broader communication and cognitive needs.

When considering device recommendations, providers need to consider the patient's manual dexterity, prior technology experience and openness to using technology, and availability of ongoing support at home. Providers must also consider the severity of the individual's cognitive impairment and may consider counseling individuals with mild cognitive impairment to begin wearing hearing aids or an amplification device sooner in order to routinize device use as much as possible prior to continued cognitive declines. However, an individual's cognitive status, particularly if more severe, should not be used as the sole determination of whether they may benefit from amplification in some form.

Hearing aids can be helpful, but over-the-counter options can offer a greater degree of affordability and accessibility for patients and their care partners who are often managing

a number of competing priorities. Larger, hand-held devices, such as the Pocketalker or SuperEar, can be easier to manipulate for the patient and care partner and can also be easier for the care partner to place the device on the patient and manage settings, like volume, off of the patient's ear. Larger devices are also less likely to be misplaced or forgotten in the laundry. Affordable over-the-counter devices can be replaced more readily, or multiple devices can be purchased and stationed around the individual's living space for easy access. By prioritizing hearing and communication, otolaryngologists can provide practical and affordable hearing care options that can ease frustrations and foster meaningful engagement.

Similar to hearing loss, the prevalence of vestibular impairment increases with age, where >80% of older adults 80 years and older have clinically significant vestibular impairment. Vestibular impairment is also increasingly recognized as a contributor to falls among persons living with dementia. Falls occur more commonly among individuals with dementia and, similar to neuropsychiatric symptoms, falls are associated with institutionalization, mortality, and greater costs. The contribution of the vestibular system to the risk of falls among persons living with dementia highlights the potential role of vestibular physical therapy for fall prevention, which may be an underutilized intervention that otolaryngologists can offer to their patients.

Beyond hearing and balance, otolaryngologists can also contribute to the identification and management of dysphagia. Feeding difficulties along with swallowing dysfunction are common among persons living with dementia, and the leading cause of mortality. They can lead to weight loss, aspiration, dehydration, and, ultimately, functional deterioration, morbidity from aspiration pneumonia and death.

Discussions with individuals and their care partners should begin as early as concerns are detected because proactive and interdisciplinary approaches can benefit patients in reducing the rate of swallowing function decline. Although there are limitations, bedside swallow evaluations or instrumental evaluations can play a role in screening for dysphagia. Evidence-based interventions that target dysphagia in persons living with dementia exist. Education around dysphagia and, specifically engaging the care partner, can improve weight and oral intake. Modification of food consistencies, such as honey-thick textures, may be helpful, but data are limited on the effectiveness of thickening food to prevent aspiration. Finally, postural maneuvers, like the chin tuck, can be beneficial but compliance can be challenging. Regardless, swallowing concerns should be elicited from patients and their care partners as an important component of maintaining quality of life for persons living with dementia.

As our field begins to care for a growing number of older adults, otolaryngologists will increasingly encounter patients who are aging with dementia. We have tangible and meaningful care contributions that can benefit individuals and their care partners. Partnering with local primary care providers or geriatricians as well as patient-facing organizations, such as the Alzheimer's Association, can open avenues for collaboration and access to needed care for persons living with dementia. ■

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Gender-Affirming Voice Care Defined and in Practice

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With recent increasing numbers of transgender, nonbinary, and gender nonconforming (TGNC) people of myriad gender expressions seeking voice care, many otolaryngologists and speech-language pathologists find themselves serving a community they may know little about. Gender-affirming care extends well beyond the advanced technical skills required to help someone change the sound of their voice. It requires a humble understanding of the diversity of gender expression, advanced counseling skills, and a readiness to uniquely tailor the support to the individual's needs.

The authors acknowledge that although this article was written with the leadership of our one transgender team member, this topic requires the leadership of many TGNC people of diverse lived experiences. Thus, this article is a starting point for conceptualizing gender-affirming voice care for the otolaryngologist, to be expanded upon in the future.

Responsibilities of the Gender-Affirming Healthcare Provider: Beyond Clinical Skills

Healthcare providers play a gatekeeping role. Our decisions and recommendations inform the type, duration, and quality of care an individual receives. The transgender community has experienced a long history of negative gatekeeping from healthcare providers that continues today. Individuals often face barriers to accessing gender aligning healthcare. When treating transgender people, it is, therefore, not enough to be an expert in one's chosen specialty. Healthcare providers must be gender-affirming practitioners. (See Table 1.)

Gender-affirming practitioners recognize that 1) gender variation is not a disorder; 2) gender is diverse and varied across culture and thus requires cultural sensitivity and responsiveness); 3) gender may be binary or not binary and may be fluid over time.[1] Furthermore, 4) gender-affirming care requires interdisciplinary collaboration in which 5) providers deconstruct and are transparent about their biases about gender and the binary.[2] Finally, gender-affirming practitioners eliminate negative gatekeeping by working under the assumption that 6) a fully informed individual (in this case, the person seeking care) knows what is best for them.[3, 4]

Gender Expression

Gender can be binary (man versus woman) or nonbinary (neither male or female, genderfluid, genderqueer, agender, and more), and its expression is diverse and unique to each individual. There is no one way to be feminine, masculine, or nonbinary, and transgender individuals may wish to change their voice a lot, a little, or not at all. Although some normative data exist on what is perceived as feminine or masculine through characteristics of pitch, resonance, and intonation, there is no "correct way" to communicate to express one's gender. Therefore, it is critical that the gender-affirming clinician listens to the communication goals of the patient so that their care recommendations align with their patient's.

Clinically relevant tools are available to assist the gender-affirming healthcare provider in assessing the communication goals of the TGNC patient. Along with a thorough history and patient interview, using validated patient-reported outcome measures, such as the Trans Woman Voice Questionnaire, the Voice Handicap Index-10 or Voice-Related Quality of Life Index, and the Vocal Fatigue Index, are helpful in identifying specific current voice complaints and future voice and communication goals.

Medical and Surgical Intervention for the Gender-Affirming Patient

Medical and surgical intervention for transgender voice is limited to changing pitch. Lowering the pitch is often achieved with the use of testosterone. There can be a role for cricothyroid muscle paralysis or division as well as laryngeal framework surgery (Isshiki type III thyroplasty). Surgical procedures for pitch elevation aim to decrease the length and size of the vocal folds. The most common procedure is the endoscopic glottoplasty or Wendler glottoplasty, which creates an anterior glottic web to shorten the length of the vocal folds. Cricothyroid approximation is framework surgery that increases vocal fold tension, elevating pitch. Laser reduction glottoplasty decreases true vocal fold size or bulk. As with all laryngeal surgical interventions, there is the risk of worsening voice, dysphagia, and need for revision procedures. Specific risks of these procedures include reduction or loss of singing voice range and reduced loudness, which should be discussed during surgical consultation.

It has been well established that altering pitch alone is not sufficient for most people to achieve a gender congruent voice. In most cases, gender-affirming voice therapy to address other targets such as resonance, timbre, and more, is necessary for individual satisfaction. Furthermore, voice therapy is necessary to optimize wound healing and help the patient balance their breathing, phonatory, and resonance systems for efficient use of the altered anatomy. Without this therapy, the patient may develop

Table 1. Gender-affirming voice care can thus be conceptualized.

Gender variation is not a disorder.	Gender may be binary, nonbinary, and may change with time.	Healthcare providers should critically examine and deconstruct their gender biases and be transparent about their limitations.
An incongruent voice with gender is not itself a disorder, but the distress this incongruence causes must be treated. This distress and attempted amelioration of this distress can lead to voice disorders, such as muscle tension dysphonia. Preventing and treating such disorders by skilled voice specialists is a part of this care.	Although it is important to be familiar with gender binary voice norms to support those who may have binary voice goals, these binary voice goals should never be considered the only markers of success. Some may wish to change their voice a little bit, while others may seek drastic change. Some TGNC people may have more static voice goals, while others may wish for fluid voice and gender expression.	Remember, there are options for vocal gender expression that you may have never previously imagined. Everyone's gender expression is unique. To avoid harm to the TGNC individuals, it is necessary to engage in ongoing cultural responsiveness/humility training and practice especially as it relates to gender so as not to perpetuate harmful stereotypes or norms that don't align with the individual's goals.
Gender expression is diverse and varies across cultures.	**TGNC care requires interdisciplinary collaboration.**	**A fully informed individual knows what is best for them.**
No two TGNC individuals will have the same voice goals, and care for this population requires an intersectional (race, class, gender, neurotype, and other experiences) lens.	Voice care involves the collaboration of a laryngologist and speech-language pathologist to optimize outcomes. Collaboration with endocrinologists, mental health therapists, other surgeons, and other healthcare professionals is important. Development of these alliances across gender-affirming disciplines would further benefit the vocal health of this population.	We must eliminate negative gatekeeping. This means we do not require such things as "living full time" as a stated gender or a certain amount of time in psychotherapy to get a "letter of validation" before providing care. We DO fully inform the individual on the pathways to optimal vocal health and remember that while most surgical candidates will benefit from voice therapy, we do not require a certain number of sessions but instead tailor the treatment plan according to the individual's needs. Ultimately, the individual must be fully informed of all risks, benefits, and costs of a treatment plan, surgical or not, so that they can make an informed decision. This is informed consent.

Important Reminders and Take-Aways

- Research has demonstrated that alteration of pitch alone is insufficient in achieving a gender-aligned voice.
- Surgical limitations and risks, such as loss of upper singing voice range, reduced loudness, and need for revision, are important to discuss with the patient so that they can make a fully informed decision about what is best for them.
- Individuals may wish to change their voice a lot, a little, or not at all. They may wish to change their voice permanently, or in some situations only.
- Many people achieve their vocal goals with voice therapy only. If surgical options are pursued, voice therapy plays an important role in rehabilitation of the voice as well as with addressing other gender-affirming targets.
- Interdisciplinary collaboration with speech-language pathology is necessary for optimal voice outcomes.

maladaptive compensatory strain leading to suboptimal surgical results and overall dissatisfaction.

Behavioral Intervention for the Gender-Affirming Patient

As with medical and surgical care, gender-affirming voice therapy must be provided by a voice-specialized speech-language pathologist who has sought additional training in intersectional TGNC cultural responsiveness, as well as advanced gender-affirming voice skills. The literature on voice treatment for the transgender patient cites anywhere from 4.8 to 12 therapy sessions but is highly patient-specific and may be shorter or longer based on the patient's communication needs and speed of progress toward meeting those needs.[5,6] As with all behavioral voice interventions, the ultimate goal is functional use of the target voice across various communicative activities of daily living. For the transgender patient, individual treatment goals may include identifying and maintaining gender-congruent pitch and resonance and may or may not extend to intonation, articulation, and/or nonverbal communication strategies. Frequent check-ins with the patient on how treatment sessions are or are not in line with their stated communication goals is critical for patient-provider calibration on the long-term goal and efficient use of patient healthcare resources.

Summary

Voice can be a critical aspect of gender affirmation. It can affect both self-identification and gender perception by others. The multidisciplinary team of skilled laryngologists and voice-specialized speech language pathologists can help transgender patients reach their communication goals. Healthcare providers must maintain an awareness of their patient's individual needs, as well as their own personal biases that may impede care. Creating a welcoming and gender-affirming environment requires training, nondiscrimination policies, and cooperation among the entire healthcare team. ■

See the online version of this article for a complete list of references.

Dysphagia and Anterior Cervical Osteophytes

Ozlem E. Tulunay-Ugur, MD, and **Hayley Born, MD**, for the Airway and Swallowing Committee

June Is National Dysphagia Awareness Month

Dysphagia is a frequent complaint in the aging population and can have many different and coexisting etiologies. Did you know that cervical spinal disease can be a primary cause of dysphagia?

Cervical osteophytes are common in an older population with 75% of people aged 65 years or older showing age-related changes of the cervical vertebral anatomy.[1] While cervical osteophytes are mostly asymptomatic, nonspecific cervicalgia can be seen in symptomatic patients. Additionally, some patients who have prominent cervical osteophytes have presented with dysphonia, dyspnea, and dysphagia.[2]

Osteophytes are generally idiopathic and can be single level or diffuse. Eponymously known as Forestier disease, osteophytes can also be seen as a part of diffuse idiopathic skeletal hyperostosis (DISH). The development of anterior cervical osteophytes mainly involves the cartilage-periosteum attachment and capsule ligament traction areas. This is a non-inflammatory enthesopathy of the anterolateral regions of the spinal cord.[1] A number of factors are responsible for the local osteogenesis, notably mechanical factors.[3] Trauma or surgery induced injury can also induce the formation of osteophytes.

Dysphagia has been reported as the most common presentation of symptomatic anterior cervical osteophytes (ACO).[4] Granville et al. report that 10.6% of people presenting with dysphagia have cervical osteophytes, and Utsinger et al. suggest 17% of patients with cervical osteophytes develop dysphagia.[5,6]

Dysphagia due to osteophytes is generally progressive, starting with solid food dysphagia and progressing to problems with liquids and aspiration. This eventually can lead to weight loss and aspiration.

The otolaryngologic symptoms reported in the literature include dysphagia, dysphonia, and stridor.[1] Coughing and bronchopulmonary aspiration have also been reported.[7] Dysphagia is an isolated symptom in nearly 75% of the cases but has been found to be associated with dyspnea in 14% of patients. Stridor is only reported in 3% of cases. Swallowing impairment resulting in aspiration is found in 9% of cases. Dysphonia is a rare symptom, only 2.5% of patients; sleep apnea syndrome, referred otalgia, rhinolalia, and cervical emphysema are reported anecdotally.[8-10]

A meta-analysis of 204 cases by Verlaan et al. has reported that the male-to-female ratio of osteophyte incidence is 6.1:1, and the average age is 68.9 years. Kim et al. report similar numbers, which was corroborated by the series from Choi et al.[4,11,12] The prevalence is known to increase with age.[12] Seidler et al. have also reported that the severity of dysphagia increases with age.[13]

As stated, patients will present with varying degrees of dysphagia, but generally solid food dysphagia precedes other symptoms. After a thorough history taking, including current diet, consistency of the diet tolerated, presence of unintentional weight loss, history of aspiration pneumonia, voice changes, and coughing, indirect flexible laryngoscopy is key in diagnosis. This can lead to posterior pharyngeal wall bulging at various levels in the pharynx. In patients who have lower cervical osteophytes, posterior pharyngeal wall changes may be beyond the visualization during laryngoscopy; in these cases, indirect signs of obstruction, such as pooling in the hypopharynx, could be noted. Seidler et al. report no correlation between the size of the osteophyte and patient symptoms, but rather a correlation between patient age and symptoms. This points to the importance of underlying presbyphagia as a contributing factor that can make ACOs symptomatic.[13]

The gold standard of diagnosis of osteophyte-related dysphagia is a videofluoroscopic swallow study (VFSS), which not only shows the degree of swallowing impairment, but also the level of osteophytes. Choi et al, in their series that included 23 patients with ACO, reported the most common findings to be pharyngeal phase dysphagia, including penetration, decreased laryngeal elevation, and reduced epiglottic inversion. They then compared their patients by treatment choice, surgical intervention, swallowing therapy, and observation with diet modification. The surgical group had a significantly higher pharyngeal phase

> Cervical osteophyte related dysphagia is going to be an increasingly common diagnosis in our practices due to an aging population.

score than the other groups. Moreover, in the surgical group the thickest and most affected level of ACO were at a higher level of the cervical spine and their ACOs were significantly thicker than the other groups.[4]

The epiglottic inversion is significantly affected when the osteophytes are at C3-5. Di Vito suggests the bolus deflects off directly into the open larynx because of the shelf formed by an anterior osteophyte at C3-5 levels leading to aspiration.[14] It has been suggested that aspiration is rare in patients with osteophytes less than 10 mm in the anteroposterior length and clinically relevant obstruction of the pharynx occurs from about 12 to 15 mm osteophyte thickness.[13,15] Necessary cervical computed tomography and magnetic resonance imaging should be obtained following VFSS.

There is no consensus on the management of dysphagia related to ACO. Patient symptoms and comorbidities will drive the decision making. The degree of dysphagia and the risk of aspiration aids in patient selection for surgery. In patients with mild symptoms, swallowing therapy and diet modification may be adequate for successful management. If the patient symptoms are severe, they are generally referred for management by a spine surgeon. It should be noted that progressive changes of the spine and surrounding tissue changes may hinder complete resolution of dysphagia symptoms. This should be discussed with patients, along with risk of worsening symptoms due to the risks of osteophyte surgery, such as laryngeal nerve damage. Additionally, it has been suggested that because symptoms are likely to worsen with age, one might suggest earlier procedural intervention when the patient is medically more optimized for surgery and surgical recovery.[16]

In order to improve epiglottic inversion and reduce risk of aspiration as well as vallecular pooling, Chhetri and his group have reported on a novel technique. They performed partial epiglottoplasty on nine patients, either with ACOs or cervical spine fusion related hardware. The surgery, which is performed endoscopically, resulted in improved swallowing in eight patients, including one patient who was able to progress to an oral diet from feeding tube dependence. Vallecular residue improved as well as subjective feeling of globus sensation. They reported one case of aspiration pneumonia following surgery.[17]

In conclusion, cervical osteophyte related dysphagia is going to be an increasingly common diagnosis in our practices due to an aging population. While most of these patients can be managed conservatively, it is important to know when to refer these patients for surgical management, as they will rely on our expertise for appropriate guidance on need for osteophyte reduction. ■

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Geriatric Surgery Verification Quality Improvement Program

For older adults, surgery is often a process not just a procedure.

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The American College of Surgeons (ACS) was founded in 1913 on the principle of "doing what's right for the patient." The ACS has spearheaded successful initiatives on surgical care related to cancer, trauma, and pediatrics.[1] Now the ACS aims to improve surgical care related to older adults. In America, adults 65 years and older are the fastest-growing segment of the population. From 2019 to 2040, adults over the age of 85 are projected to more than double from 6.6 million to 14.4 million.[2] The unique features of this patient population, such as multidisciplinary care, polypharmacy, and complex social support systems, all place strain on healthcare infrastructure and communication. Furthermore, older adults disproportionately undergo surgery. The growth of this vulnerable patient population is poised to create significant healthcare challenges in the years to come. The ACS seeks to define what aspects of perioperative care are most pertinent to older adults and provide recommendations for delivering geriatric-friendly surgical care.

Geriatric Surgery Verification Program

The Geriatric Surgery Verification (GSV) Quality Improvement Program defines a set of standards related to the surgical care of older adults, specifically those 75 years or older undergoing inpatient surgery. These standards are intended solely as qualification criteria for healthcare systems or individual departments seeking GSV accreditation through the ACS. They do not constitute a standard of care or replace the medical judgment of individual providers.

In 2019, 30 GSV standards were developed by a diverse group of over 50 stakeholders that included the American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS). These standards aim to concisely address the most important aspects of geriatric surgical care within the four-part framework of ACS quality improvement: 1) program-specific standards; 2) infrastructure needed for delivering high-quality, high-value care; 3) data collection and use; and (4) verification site visits to ensure proper implementation. Recently, the AAO-HNS and the American Society of Geriatric Otolaryngology (ASGO) sent representatives to a stakeholder meeting to reflect on implementation of the standards and analysis of the program to date. In the three years since its inception, the GSV Program has been initiated by 54 hospitals and secured funding through The John A. Hartford Foundation.

GSV Standards

Full details of the 30 GSV Program standards can be found at www.facs.org/geriatrics. Administrative requirements include institutional support from the hospital's CEO and creation of a geriatric surgery director, geriatric surgery coordinator, geriatric nurse champion, and geriatric surgery quality committee. Patient-centric standards include recommendations on geriatric-friendly patient rooms, defining code status and advanced directives, framing surgical outcomes in context of overall health goals, vulnerability screens, improved surgeon-PCP communication, interdisciplinary conferences for complex patients, opioid-sparing multimodality pain management, and optimization of personal sensory equipment (e.g., glasses, hearing aids, dentures, and other devices essential for routine function). Additional standards pertain to data collection, quality infrastructure, nurse education, and community outreach.

The ACS recognizes two levels of commitment by hospitals and may involve one or more surgical specialties for GSV Program accreditation. For either level, hospitals must demonstrate all 30 GSV standards are in place to provide optimal resources for the surgical care of older adult patients. Level 1 (Comprehensive Excellence) specifies 50% or more of eligible surgical patients receive the required processes set forth by the standards, while Level 2 (Focused Excellence) ensure 25% to 50% of eligible patients receive this care.

Relevance for Otolaryngology

Care of the aging patient is commonplace in many otolaryngology practices. Presbycusis, presbystasis, presbyosmia, and presbyphonia are just a few commonly encountered hallmarks of the aging process. We see firsthand how challenges in hearing, speaking, and swallowing can lead to isolation and potentially cognitive decline. Otolaryngologists are leading efforts to better understand and treat these common issues in the geriatric context. For those who undergo more complex inpatient surgical care, the frailty of aging combined with challenges inherent to operating on the head and neck make our patient population particularly vulnerable to perioperative issues that can increase length of stay, readmission rates, need for a skilled-nursing facility on discharge, functional and cognitive decline, as well as all-cause mortality. The economic implications of these issues are profound, particularly when constraints on resources available for geriatric healthcare are considered. The AAO-HNS and ASGO remain stakeholders in support of the ACS' GSV Quality Improvement Program. The standards set forth by the program provide a framework for hospitals and departments interested in optimizing the quality of surgical care in older adults. Participation in a hospital-based geriatric surgery quality improvement program is likely to further advance specialty-specific initiatives to improve outcomes for a growing proportion of patients seeking otolaryngologic care. ■

A position is available at the Assistant or Associate Professor level in the Department of Otolaryngology - Head & Neck Surgery

GENERAL OTOLARYNGOLOGIST

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- Part-time appointment at the Medical College of Georgia at Augusta University
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To apply and receive additional information, please contact:
Stil Kountakis, MD, PhD, Professor and Chairman - **skountakis@augusta.edu**

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AUGUSTA UNIVERSITY
MEDICAL COLLEGE OF GEORGIA

Department of Surgery, Division of Otolaryngology
Yale University, School of Medicine

The Division of Otolaryngology at the Yale School of Medicine is seeking a Board Certified or **Board Eligible *Comprehensive/General Otolaryngologist – Head and Neck Surgeon*** to join our growing team of full-time faculty. Clinical responsibilities include providing ambulatory and surgical patient care at Yale-New Haven Hospital in New Haven, Bridgeport Hospital, and nearby outpatient clinics. In addition to clinical duties, this faculty member will provide educational training to medical students and residents, and based on their level of interest will have opportunities to contribute to our research mission. Applicants can expect to work in a supportive and friendly environment with collegial administrative and clinical partners.

We are seeking candidates with a strong academic record in clinical care, education, and research. Candidates should have exceptional clinical and interpersonal skills, and a commitment to education and patient centered care. Those with a strong research interest will be considered and are also encouraged to apply. Applicants will be considered for appointment as an Assistant or Associate Professor of Surgery at the Yale School of Medicine.

New Haven is conveniently located along the Connecticut coast in between Boston and New York. It is a great place to live, work, and enjoy life. There are great places to live in New Haven and surrounding towns with short travel times to work. The greater New Haven area offers some of the top public and private schools in the country.

Yale University is an Affirmative Action/Equal Opportunity Employer and welcomes applications from women, persons with disabilities, protected veterans, and members of minority groups.

Please submit a cover letter, a current curriculum vita, and three letters of reference.
All application materials should be submitted electronically to: apply.interfolio.com/105177
Review of applications will begin immediately and will continue until the position is filled.

Should you have any questions, please reach out to:
Deb Kieslich, MBA
Division Administrator, Yale Otolaryngology
Phone: 203-737-1578
debra.kieslich@yale.edu

Yale University is an Affirmative Action/Equal Opportunity employer. Yale values diversity among its students, staff, and faculty and strongly welcomes applications from women, persons with disabilities, protected veterans, and underrepresented minorities.

We're ready for you!

Busy ENT practice seeking a well-rounded BC/BE Otolaryngologist in Atlanta GA. The practice is well established and fully equipped with state of the art equipment including Video Stroboscopy, Medtronics CT scan, EMR, networked fiberoptic scopes in the exam rooms. Fully equipped allergy and audiology department, AuD audiologist, VNG, ABR, hearing aids. Competitive salary.

Qualifications:
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- Current and unrestricted Georgia License
- Active and unrestricted DEA license
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- Ability to work well alone and within a team
- Bilingual (English/Spanish) a plus

Benefits:
- Competitive Salary
- Health, Dental, and Vision insurance
- Covered Malpractice insurance
- Paid company holidays and paid time off
- CME allowance
- Company sponsored 401(K)

Interested candidates please send CV to:
Controller@buckheadent.net

Buckhead ENT
Ear, Nose & Throat

UTHealth Houston
McGovern Medical School

Faculty Position

The Department of Otorhinolaryngology-Head & Neck Surgery at McGovern Medical School (part of The University of Texas Health Science Center at Houston) is recruiting Pediatric ENT faculty. This is a unique opportunity to build a comprehensive Pediatric ENT practice in a large, diverse, and growing metropolitan area. The ideal candidate should be comfortable in providing full-spectrum Pediatric ENT services primarily at our academic medical center location, which includes a clinic and Children's Memorial Herman Hospital.

This position is primarily focused on clinical care and resident education, although opportunities for scholarship are encouraged. Fellowship training in Pediatric ENT is required, and the successful candidate must have certification in complex pediatric otolaryngology or be planning to obtain certification. All applicants should be board-certified or board-eligible in otolaryngology.

Academic appointment commensurate with experience. Excellent salary and benefits. Outstanding opportunities for teaching and research.

Please submit your CV and application here: **www.ent4.med/recruit**

Interest and questions may be directed to:
Zi Yang Jiang, MD (Pediatric ENT Chief)
Department of Otorhinolaryngology-Head & Neck Surgery
McGovern Medical School
The University of Texas Health Science Center at Houston
Phone: 713-500-5414 Fax: 713-383-1410
Email: zi.yang.jiang@uth.tmc.edu

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Mass General Brigham
Mass Eye and Ear

Department of Otolaryngology
Head and Neck Surgery

Open position in hospital-based
Emergency Department

The Massachusetts Eye and Ear Department of Otolaryngology–Head and Neck Surgery is actively recruiting a qualified candidate for the position of Otolaryngologist, Emergency Department, at its 243 Charles Street location in Boston, Massachusetts.

About Mass Eye and Ear

Massachusetts Eye and Ear is a subspecialty acute care hospital and a regional referral center for all of New England and is a member of the Mass General Brigham healthcare organization. Our goal is to deliver the very best health care in a safe, compassionate environment and we continually strive to create a diverse, inclusive faculty and staff.

We are an equal opportunity employer, and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status, protected veteran status or any other characteristic protected by law.

About the role

This full-time position is to support clinical otolaryngology efforts in our Otolaryngology and Ophthalmology specific Emergency Room. There will be regular interactions with otolaryngology trainees and medical students. The ideal candidate will have had strong training in general otolaryngology, is interested in teaching and mentoring otolaryngology residents and medical students and is seeking a career in Otolaryngology in an academic setting.

This position includes a full-time appointment at Harvard Medical School at a rank appropriate to the candidate's level of scholarship with the possibility for academic advancement. Research opportunities are available, including collaboration across a wide variety of disciplines, although the primary institutional goal for this position is the delivery of clinical care and resident teaching.

Application instructions

Interested applicants should send their cover letter and CV to theresa_morohan@meei.harvard.edu, and all materials should be addressed to the following:

Mark A. Varvares, MD, FACS
Chief, Department of Otolaryngology,
Head and Neck Surgery
Massachusetts Eye and Ear
243 Charles Street
8th Floor, Suite 815
Boston, MA 02114

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Contact Information
Florida Medical Practice Brokers
813-212-3122

EMORY UNIVERSITY

Emory University's Department of Otolaryngology - Head & Neck Surgery seeks to hire an Assistant/ Associate Professor Otolaryngologist – Atlanta VA. Head & neck or laryngology preferred

Interested applicants should apply online at Emory University Careers (Requisition 31425) and/or contact:
Kaltun Mire: Kaltun.mire@emory.edu and
Dr. Douglas Mattox: dmattox@emory.edu

The highly motivated team has long been actively involved in academic, research, and professional endeavors at the national and international levels. Opportunities to teach medical students, residents and fellows, and participate in scholarly activities. Duties will include patient care, resident and fellow teaching, and academic and research productivity.

Applicants must be Board Certified or Board Eligible in Otolaryngology.

Penn State Health is seeking Otolaryngologists to join our growing team in either academic or community-based settings. Penn State is a multi-hospital health system serving patients and communities across 29 counties in central Pennsylvania. It employs more than 16,500 people system-wide.

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- Otologist/Neurotologist
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- Otolaryngology subspecialists

Penn State Health is fundamentally committed to the diversity of our faculty and staff. We believe diversity is unapologetically expressing itself through every person's perspectives and lived experiences. We are an equal opportunity and affirmative action employer. All qualified applicants will receive consideration for employment without regard to age, color, disability, gender identity or expression, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information.

FOR MORE INFORMATION, PLEASE CONTACT:

Ashley Nippert, Physician Recruiter
anippert@pennstatehealth.psu.edu

PennState Health

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Department of Otolaryngology-Head and Neck Surgery
Come Grow with Us!

The Department of Otolaryngology at The Ohio State University Wexner Medical Center is experiencing tremendous growth and offering multiple opportunities to join one of the top ranked departments in the country. Applicants must demonstrate excellence in patient care, research, teaching and leadership. Current openings are:

- **General ENT:** The medical center is currently opening multiple state of the art ambulatory clinic locations throughout the greater Columbus area. This is a great opportunity to kick-start your practice. The division currently consists of two general otolaryngologists and two nurse practitioners.

- **Otologist/Neurotologist**: Seeking an academically productive Otologist/Neurotologist for a clinician or clinician/scientist position. Applicants must be board certified/board eligible in otology/neurotology and fellowship trained. The division has nine full-time clinical and research faculty, several research scientists, a robust audiology division, and a vestibular program.

- **Rhinology Division Director:** Seeking an academically productive Rhinologist for the position of division director. Applicants must be board certified/board eligible in rhinology and fellowship trained. A history of research funding is desirable, but not required. Collaboration with department leadership to create a vision for the future of the program is a high priority. The ideal applicants will be highly motivated to set up a successful clinical or basic research effort, work well independently, and be funded or on track to submit for NIH or equivalent funding. There are currently two full-time clinical faculty and a dedicated full-time research faculty member.

Located in the heart of Ohio, Columbus is the fastest growing city in the Midwest and offers a population of over 1.5 million people. Voted as one of the most-livable cities in the USA, Columbus has excellent cultural, sporting, and family activities.

To build a diverse and inclusive workforce, all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability status or protected veteran status. The Ohio State University Wexner Medical Center is an Equal Opportunity/Affirmative Action employer.

Send letter of interest and CV to:
James Rocco, MD, PhD, Professor and Chair
The Ohio State University Department of Otolaryngology
915 Olentangy River Rd. Suite 4000
Columbus, Ohio 43212

Contact the Department Administrator via
Email: mark.inman@osumc.edu
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