Supplemental Material S3. Summary of included studies.

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Authors' conclusions
Ferrari	2006	Brazil	Randomized study	Synchronous Internet-based	Fitting	HA programming, verification (REM)	"To evaluate the efficacy of an internet-based HA programming and verification as a tool to improve quality of HA fitting in distant areas."	New HA users. Mild to severe sensorineural HL (around 60% moderate). Symmetrical HL (n = 27). 30 participants: control group (n = 15), M = 60.8 y.o.; range = 47–78 y.o.; experimental group (n = 25), M = 61.6 y.o., range = 44–75 y.o.	Control group received standard HA consultation. Intervention group received the HA programming and verification (REM) remotely. Facilitator was an untrained audiologist. At the end of the session, a designed questionnaire was applied to all participants to access confidence, interaction, counseling, communication quality, and satisfaction. Ten participants of the intervention group remotely repeated REM in the better ear in 3 distinct intervals (6 weeks), and REIG analysis were reported.	"The findings, yet preliminary, suggest that R HA programming and verification can be used to improve the quality of HA fitting and professional training."
Ferrari & Bernardez-Braga	2009	Brazil	Not reported	Synchronous Internet-based	Fitting	Verification (REM)	"To assess the feasibility of HA probe microphone measurement via R computing technology."	Experienced HA users. Unilateral and bilateral HL. 60 participants (105 ears tested), M = 67 y.o., range = 18–84 y.o.	Evaluations took place in the same room and same set up for both, FF and R consultations. Participants were in a sound-treated room with a loudspeaker positioned in front of them (0.5 m away). A facilitator (audiologist not familiar with probe measures) performed the R measurements after otoscopy by following instructions. Speech noise was used at 65 dB SPL. The REUR, REAR, and REIG were measured at frequencies from 250 Hz to 6 kHz.	"R probe microphone measurements are feasible and might improve the quality of public HAs services and professional training in Brazil." "Therefore R computing measures were also affected by the facilitator's ability to follow the instructions provided by the audiologist, via videoconference."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Campos & Ferrari	2012	Brazil	Prospective, randomized, blind study	Synchronous Internet-based. (R consultations were from another building 300 m away)	Fitting	Fitting, verification (REM), programming, instructions, and counseling	"To obtain more information regarding the outcomes of teleconsultation for: HA programming, verification, fitting; and the provision of informational counseling to patients, when compared to FF consultations."	New users. Mild to severe HL. Symmetrical HL. Not perceived associated disabilities. 50 participants (39–88 y.o.): control group (n = 25); experimental group (n = 25)	Facilitator (SLP–Aud. student without experience in HA fitting) performed: otologic inspection, HA connection to the programming cables and the Hi-Pro interface, HA/ear mold insertion and removal, participant positioning in the test environment and probe tube calibration, insertion, and removal. In FF and R consultations, audiologist performed: HA programming (Hi-Pro use), verification (REMs; used unmodulated speech in noise stimuli; only REIG analysis were reported), fine-tuning, informational counseling, instructions, demonstration, and training on HA use and management. Gain sometimes had to be reduced to a comfortable level or modified if complaints persisted. A second evaluator blinded for the service model assessed the outcomes by applying Hearing in Noise Test (HINT) in quiet and in noise (using HINT PRO software) straight after the fitting consultations. Measured the time spent for specific procedures (fitting, programming, verification, instructions, and counseling) and for the overall consultations (FF and R). One month later, patient returned for a FF consultation, the data logging was accessed and the IOI-HA questionnaire was applied. In cases that data logging showed "zero," patients received the service (HA adjustments, instructions, and counseling), were booked for a new appointment, and then completed the IOI-HA questionnaire.	"Teleconsultation is an effective service model to perform HA programming, verification and to provide informational counseling."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Reginato & Ferrari	2014	Brazil	Prospective, randomized and controlled study	Synchronous Internet-based	Fitting	Fitting, verification (REM), programming, instructions and counseling	"To evaluate professional–patient communication during the process of HA programming and fitting via teleconsultation and patient satisfaction with this kind of service compared to traditional FF consultation."	New users. Mild to severe HL. Symmetrical HL. Not perceived associated disabilities, except for visual impairment correctable with lenses. 40 participants: control group (n = 20), M = 69.15 y.o. ±14.97; experimental group (n = 20), M = 69.95 y.o. ±13.46	Same procedures for control and experimental group. Facilitator (SLP–Aud. without any experience in the HA selection and fitting process) to connect the HAs to the programming cables, to calibrate probe tube, insert and remove HA and/or probe tube. After Audiologist perform the HA programming and verification, instructions and counseling on: HA and/or ear molds handling and care; battery insertion and removal; HA and/or ear mold insertion and removal, program and volume buttons when available, and phone use. Prosthesis Evaluation Questionnaire (PEQ) was applied in both groups after HA programming and verification procedure to capture patient's experience of interaction, emotion, and consultation immediate outcome and to evaluate the quality of the service after consultation. Clinician–patient behaviors were observed in both type of consultations (FF and R) and evaluated using the Davis Observation Code (DOC).	"In the programming and verification process of the individual device of sound amplification, there was a prevalence of technical, information supply and professional in the professional–patient communication behaviors, which may have reflected the generally procedural nature of this consultation as well as the influence of the biomedical model. The performance of the HA programming and fitting via teleconsultation impacted some aspects of professional–patient communication; however, patient satisfaction regarding the care provided was not affected."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Pearce, Ching, & Dillon	2009	Australia	Pilot study	Synchronous (wireless broadband mobile card, up to 7.2 megabits per second)	Fitting (case 3) and follow up (cases 4 and 5)	Programming and verification (case 3)/fine-adjustments and counseling (case 4)/instructions (case 5)	"To explore the feasibility of an alternative means of delivering services."	5 participants (2 in assessments and 3 in HA rehabilitation)	"Hearing assistants were trained to assist with fitting headsets or REM probes" in the R site. Audiologist was in the city clinic and the assistant were in the R clinic. Assessment (video-otoscopy, audiometry, and tympanometry; case 1 and 2); fitting consultation (programming and verification; case 3); follow-up consultation (adjustments and counseling; case 4; and also instructions on HA demonstrations; case 5) were described. No outcome measure was applied.	"HA fitting and fine-tuning can be carried out remotely. Maintenance of the devices, however, relies on the effectiveness of the local health worker in performing minor troubleshooting and knowing about the battery requirements of the range of HAs fitted to individual clients on site."
Penteado, De Lima Ramos, Battistella, Marone, & Bento	2012	Brazil	Case study	Synchronous Internet-based. R consultation were 200 km away	Fitting	Programming	"To evaluate the benefits and limitations of telemedicine applied to digital HA fittings and to analyze its effective application to hearing rehabilitation under current public policies in Brazil using case presentations from a test telemedicine event."	Bilateral HA experienced users of three different brands (in-the-ear [ITC], open-fit, and behind-the-ear [BTE] with ear mold). 3 participants (61, 64, 81 y.o.)	A 30-min R training on the research protocol was provided prior R consultation to 3 audiologists at the R site. Despite participants being bilateral HA users, they were fitted in only one ear (justified by not having a secondary objective in assessing the satisfaction with the HA). Their previous HA was maintained in the other ear. HAs were fitted with domes and ear molds (previously made) and programed. After that, the participants could return to their previous HA without any change. No outcome measure was applied.	"This pioneering work features a R HA fitting with cooperation between specialists in 2 cities that are 200 km apart."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Penteado, Bento, Battistella, Silva, & Sooful	2014	Brazil	Randomized experimental research design. Pilot study	Synchronous Internet-based	Follow-up	Fine-adjustments/ counseling	"To examine the feasibility and outcomes of R HA adjustments by assessing patient satisfaction via the Portuguese version of the SADL questionnaire."	New users (no prior experience with HAs). Mild to severe sensorineural HL. No neurological or psychological impairment, post-lingual HL. 8 participants (*M* = 71.5, range = 18–90 y.o.)	Facilitator was a nontrained SLP–Aud. Two FF sessions with 15 days apart from each other (one for assessments, ear impressions and another for fitting and initial programming). One follow-up R consultation after 15 days from the second FF consultation, when HA adjustments and counseling were done and SADL questionnaire was applied straight after the consultation to measure satisfaction with amplification. The results from SADL (means and *SD*) were compared to the original normative data and to others papers' results that also used SADL.	"R HA adjustments (telefitting) have proved effective for these 8 patients, as indicated by their dynamic responses in SADL. Results were comparable to those of patients fitted in the conventional manner (i.e., FF fittings). Thus, the use of telefitting can be seen as an effective method to improve service delivery of hearing health in Brazil."
Laplante-Lévesque, Pichora-Fuller, & Gagné	2006	Canada	Multiple-case study	Asynchronous (e-mails)	Follow-up	Counseling	"To explore how an e-health approach could be used to facilitate communication between a new HA user and the audiologist."	New users. Mild to severe sensorineural HL. Sufficient cognitive, visual, and manual dexterity to potentially make them manage their HA autonomously and use the computer to check e-mails. 3 participants (62, 69, 73 y.o.)	Daily internet-based communications with the audiologist (researcher) during the first month after HA fitting. The e-mails provided elements of informational and emotional counseling to encourage the participants. These were not in replacement of regular appointments with their audiologists. Content of the daily discussions: hearing fact of the day, questions, and comments/experience. Two FF interviews to document their experiences with HA and with the counseling program: one before HA fitting and other after the follow-up appointment (1 month later). A qualitative analysis was done through all the e-mails and interviews transcripts, which were open coded and accorded to grounded theory.	"An internet-based audiological counseling program in the form of daily e-mails with an audiologist can be a powerful communication medium to explore the day-to-day experiences of new HA users. It also allows the observation of changes in the behaviors and perceptions of new HA users during the period after the HA fitting." Also "can be an interesting communication medium to provide audiological counseling to new HA users."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Cherry & Rubinstein	1994	USA	Randomized study	Synchronous (telephone initiated contact)	Follow-up	Instructions/ counseling	"To determine whether periodic clinician-initiated telephone contact during 3 months period following purchase would reduce the number of unresolved complaints and increase satisfaction, use, and perceived benefit."	New (*n* = 33) and experience HA users (*n* = 27). Majority fitted unilaterally in both groups. Mild to moderate HL (based on 3 PTA: control-38dB HL ±13.3; experimental 43 dB HL ±14.8). 58 participants: control and experimental group (*n* = 29 interviews and *n* = 26 HHIE).	Telephone and no telephone intervention (TI) group. "Subjects in the TI group were contacted by telephone at 6, 9, and 12 wk post-HA fitting, in which times they were asked whether they were experiencing any problems (e.g., feedback, discomfort, handling of aid, etc.). Problems were addressed through troubleshooting (e.g., dead batteries) and counseling over the phone, or if indicated, subjects were scheduled for a clinic appointment. Subjects' questions were answered at that time as well. Four months after the dispensing of the aid, subjects in both groups were interviewed on the telephone regarding their use, satisfaction, and problems" (audiologist had a prompt list to follow). "A significant other, when available, was also asked several questions regarding use and benefit of the aid in order to verify responses and gain further insight." Complaints transcripts were analyzed. HHIE was filled out prior HA fitting in unaided condition. Immediately following the telephone interview (aided condition), the "HHIE questionnaire was mailed along with a self-addressed envelope to evaluate satisfaction, use, and perceived benefit. Subjects were asked to respond according to their aided communication function."	N/A

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Cherry & Rubinstein	1995	USA	Not reported	Synchronous (telephone calls)	Follow-up	Instructions/ Counseling	"To determine whether early intervention would result in fewer complaints, greater satisfaction and more frequent use at 1 year post-dispensing."	New (n = 30) and experience HA users (n = 25). Majority fitted unilaterally in both groups. Mild to moderate HL (based on 3 PTA: control-38dB HL/23–75 dB HL; experimental 40 dB HL/15–75 dB HL). 55 participants: control group (n = 27), M = 74, range = 68–92 y.o.; experimental group (n = 28), M = 79, range = 57–88 y.o.	Same study as in 1994, but participants were interviewed again at 1 year postfitting. Between the interviews (4-mo to 1-y), no clinician-initiated telephone contacts were made. For analysis, the registration of complaints was done during the first 3 months and at the 4-mo interview (study in 1994), during the 4-mo to 1-y period without additional clinician-initiated telephone contacts, and at 1-y interview. No questionnaire was applied. Not reported how satisfaction and use were measured.	N/A

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Lundberg, Andersson, & Lunner	2011	Sweden	Randomized controlled design	Synchronous (telephone calls)	Follow-up	Counseling	"To examine the effects of a telephone-supported educational program on hearing and HAs for HA users."	Experienced users (fitted 1 year before the study)—binaural fitting: 17 of 33 (experimental group) and 12 of 36 (control group). Mild to moderate conductive or sensorineural HL (3 PTA: control, 38 dBHL ±7.5–R; 39.4 dBHL ±9.0–L; experimental, 39.2 dBHL ±10.9–R, 39.2 dBHL ±10.6–L. HHIE score of at least 20 points (indicative of some residual self-reported hearing handicap). 69 participants (range = 60–75 y.o.): control (n = 36), M = 69, SD = 4.6 y.o.; experimental (n = 33), M = 68, range = 4.0 y.o.	HHIE, HADS, IOI-HA and Client Oriented Scale of Improvement (COSI) were filled out in the recruitment process. Control and intervention group received the same book chapters: (1 & 2) basic information about hearing, (3 & 4) explain the audiogram, (5) challenges when inner ear damage, (6 & 7) information about HAs, including benefits and limitations, and (8) communication strategies. The control participants had 2 weeks to read the book, but they did not discuss the contents of the book with a professional. The intervention group received weekly topic-based reading instructions related to the different chapters. Five telephone calls were made (5-week program), in which an audiologist discussed new information with the participant as needed. Weekly tasks were given based on COSI goals. HHIE, HADS and IOI-HA were mailed to all participants at the end of the program. The intervention was evaluated at the last visit to the clinic by applying a self-designed form that included questions about the study process. Evaluation of the book was also assessed.	"Reading about hearing and HAs can reduce the hearing handicap and reported anxiety in HA users. In this study, discussing the content of the book that was provided with a professional during weekly telephone consultations and having weekly home assignments further improved emotional well-being, as demonstrated by the HHIE (emotional scale) and HADS (depression scale), but these activities had no effect on HA outcomes as measured by the IOI-HA."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Thorén et al.	2011	Sweden	Randomized controlled study. Proof of concept	Asynchronous (e-mails/ postings)	Follow-up	Counseling	" To evaluate an online education program for adult experienced HA users including professional guidance by an audiologist."	Experienced HA users for at least 1 year (42% using for >10 years). With significant communication difficulties. 90% of the participants were fitted bilaterally. 67% completed education at university level.Moderate sloping HL (4PTA 52 dB HL ± 25). 59 included participants but 48 analyzed - 63.5/ 24-84 y.o.: control (n=29 included /24 analyzed); experimental (n=30 included/24 analyzed)	Participants were recruited through advertisements in daily newspapers. Control attended a discussion forum with weekly topics to discuss with each other but no interaction with an Audiologist (for 5 weeks) and received a hard copy of the course book by mail at the end of the program. Intervention group attended a 5-wk online education program including weekly interaction with an Aud. Five chapters of a book were used as online weekly modules: introduction and hearing anatomy; measuring HL; five dimensions of hearing; HAs; and coping strategies and future goals. Tasks and assignments related to the book were given to the intervention group and each module ended with a short quiz of five questions on the content of the week's module (access to next module, only if all the questions was correctly answered) while the intervention group discussed with peers in an online open source platform that was monitored. Participants in the intervention group sent their written work to the audiologist who gave e-mail feedback and advice to the participants within five working days. HHIE, SADL, IOI-HA and HADS questionnaires were completed before the program started (T0), immediately after the study was finished (T1), and at the 6-mo follow-up (T2). These questionnaires were administered online and were to measure the perceived HA benefit, satisfaction with HAs, perceived activity limitation, and participation restriction.	"The two forms of intervention applied here, (1) rehabilitative online education and interaction with professional audiologists, and (2) peer group online discussions, both provide positive rehabilitation effects, though not in entirely similar domains of outcome. It is suggested that combining elements of both approaches may provide a more comprehensive rehabilitation, without losing the benefits of either approach."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Thorén et al.	2014	Sweden	Randomized controlled studyProof of concept	Asynchronous (e-mails/ postings)	Follow-up	Counseling	"To evaluate an online intervention program for adult experienced HA uses."	Experienced HA users for at least 1 year (41% using for > 10 years). With significant communication difficulties. 90% of the participants were fitted bilaterally. 75% completed education at university level. Moderate sensorineural sloping HL (4 PTA 42 dB HL ±21). 76 participants, *M* = 69.3, range = 26–81 y.o.: control (*n* = 38); experimental group (*n* = 38)	The intervention group underwent a 5-wk online intervention while the control group was referred to a waiting list. HHIE, IOI-HA, and HADS questionnaires were applied online to measure the perceived activity limitation, participation, restriction, perceived HA benefit, satisfaction with the HA, and symptoms of anxiety and depression. The questionnaires administration was before the intervention program started, immediately after the online intervention was finished, and at the 3-month follow-up (participants were contacted by e-mail). The online intervention program included self-studies, training and professional coaching in hearing physiology, HAs, and communication strategies, as well as online contact with peers. The program was developed based on four elements; (a) reading (weekly modules: [1 & 2] introduction, hearing anatomy, HAs; [3 & 4] communication strategies; and [5] assistive listening devices, applied relaxation, and guidelines for significant others), (b) home training (related to the book. each week, the participants had to complete 4 to 6 different tasks and training), (c) interaction with an audiologist (to express how they had addressed the weekly training, discuss their experiences, ask questions related to their hearing situation, etc. Audiologist in turn gave e-mail feedback and advice to the participants on the reflections within 5 working days), and (d) interaction with peers in an online discussion forum (built on the open-source platform, weekly new topic of discussion).	"This study provides further evidence that the internet can be used to deliver intervention of rehabilitation to HA users."

Supplemental Material S3. Summary of included studies. *(continued)*

Author	Year	Country	Study design (reported by the authors)	Telehealth model	Intervention category (type of consultation)	Intervention subcategory (intervention procedures)	Aim	Study population	Procedures	Author's conclusions
Pross, Bourne & Cheung	2016	USA	Retrospective case-control	Synchronous (real-time video conferencing)	Fitting	Programming and verification	"To assess effectiveness of TeleAudiology (TA) for HA services." The primary goal of this project is a non-inferiority analysis of TA relative to in-person (IP) on patient perception of HA effectiveness.	Not specified if new or experienced HA users: "veterans nationwide who received HAs." National VHA: experimental group (n = 1,009): control (n = 41,688). Regional VHA: subgroup analysis: control (n =169), 100% male and mean age 74 y.o.; experimental group (n = 338), 96% male and M = 76 y.o.	Participants were patients from two different care delivery venues: Centralized Ambulatory Veterans Health Administration and Community-Based Outpatient Clinics (CBOCs). The intervention group received teleaudiology program that was offered to veterans who mainly have difficulty traveling a long distance for a FF consultation. It made use of an audiology technician (facilitator) on the R side that assisted the audiologist that conducted a hearing evaluation, HA fitting, adjustment and REMs. IOI-HA was distributed by mail after HA fitting and was applied to measure HA effectiveness. "Age, sex, IOI-HA scores and elapsed time between return of IOI-HA survey and receipt of HA(s)" were extracted for subgroup analysis.	"IP and TA encounters to provide HA services to veterans are comparable, as both are highly effective based on IOI-HA results. The noninferiority of TA suggests its adoption to non-veterans may improve access while preserving high satisfaction."

Note. HA = hearing aid; REM = real ear measurement; HL = hearing loss; y.o. = years old; REIG = real-ear insertion gain; REUR = real-ear unaided response; REAG = real-ear aided gain; FF = face-to-face; R = R; SLP = speech-language pathology; Aud. = audiology; IOI-HA = International Outcome Inventory for Hearing Aids; SADL = Satisfaction With Amplification in Daily Life; HHIE = Hearing Handicap Inventory for the Elderly; HADS = Hospital Anxiety and Depression Scale; PTA = pure-tone average.

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