Being Part of the Solution: An Epilogue Commentary

Arlene J. Carson, MSc

and

Lisa M. Dillon, MSc

University of British Columbia
Vancouver, British Columbia

"If you're not part of the solution, you're part of the problem." Remember this expression? It came to mind as we considered the daunting statistics on aging. In the next decade or two, those of us who are now at the height of our careers delivering audiologic services to seniors may be on the receiving end of such services. We will be part of the tidal wave of 'baby-boomers' that will present challenges to service delivery like nothing experienced to date in audiology. What will await us? Young clinicians being trained now and in the next few years will be the service providers. Have we had the foresight in planning their training to carefully consider the impact our society's changing demographics will have on this new generation of audiologists? How conscientious have we been in our own continuing education to be sure that we are up-to-date on recent advances in research on aging?

This Special Issue of *JSLPA* on hearing and aging is timely for all of us. It is encouraging and inspiring to see the creative and dedicated approaches adopted by clinicians and researchers as they attempt to meet the needs of specific aging communities that have not been satisfied by the traditional clinic-based model of audiology service delivery. As well as developing new services, new ways to evaluate program effectiveness are also presented. The four different programs described in this issue provide unique perspectives on collaboration in all aspects of the geriatric audiologic rehabilitation enterprise: program planning, implementation, and evaluation. The To Hear Again program, coordinated by Dahl (1997) and evaluated by Carson (1997), is unique in several respects. First, the program concept was developed by individuals from the hard-of-hearing community, in particular, members of the Canadian Hard of Hearing Association (CHHA). Second, program planners recognized the large pool of talent and energy available in utilizing volunteers for service delivery. We are reminded through this example not to overlook a tremendous resource pool that has been largely untapped in the community, namely senior volunteers. Seniors who help seniors have proven themselves to be an invaluable resource in today's health care economy (see Fischer & Schaffer, 1993, for a good overview of volunteerism and aging). Third, the hearing helpers trained to help institutionalized seniors were themselves hard of hearing and they were able to use their own experiences of living with a hearing loss, thereby contributing unique skills and role modeling for residents and professionals. Fourth, a novel partnership in program delivery was forged between a consumer group (CHHA) and a public health unit (York Municipality). This program serves as a model of collaboration among several parties at both the grass roots and professional levels.

In a paper on outreach services to Vancouver seniors, the development of another unique community partnership model is described (Hoek, Paccioretti, Pichora-Fuller, McDonald, & Shyng, 1997). The idea for this program came from the Seniors' Advisory Committee to Vancouver City Hall and it was the seniors themselves who initiated novel partnerships among the Health Subcommittee of the Seniors' Advisory Committee to the Mayor of the City of Vancouver, Vancouver Continuing Care, the Vancouver Health Department Audiology Centre, the Western Institute for the Deaf and Hard of Hearing, the University of British Columbia School of Audiology and Speech Sciences, and a large number of care facilities across the city. This innovative program reaches out to seniors for whom traditional clinic-based facilities were virtually inaccessible. These seniors now receive needed services through visits by project staff to community centres, designated seniors' housing, adult day-centres, or continuing care facilities. The Outreach to Hard of Hearing Seniors project effectively uses a combination of volunteers, audiometric technicians, students, and rehabilitative audiologists to maximize the use of funds, limited time, knowledge, and expertise. This program is an important example of how large numbers in this once neglected subpopulation of seniors can be served within budget restraints.

In all of these partnerships, it is important not to lose sight of the fact that seniors, including the residents of care facilities, are the most important stakeholders and team members. While this may seem obvious, such a client-centred approach has not always been the service delivery method of choice by audiologists. Traditional approaches to service delivery treated the client as a passive recipient of our interventions. This uneven power distribution between audiologist and client is now changing; a more commensurate and mutually beneficial relationship is moving to the forefront of our vocation as a result of distinct

changes in the demands from those we are trying to help. A growing consumer movement (such as CHHA), increasing demands for accountability in our services, and a realization that our traditional services simply may not be achieving our ultimate goal (to make the world more "hearing accessible") have led to new ways of looking at the relationship between clients and clinicians and encouraged us to re-evaluate our role in this helping profession (McKellin, 1994; Pichora-Fuller, 1994).

The changing role of clients, the establishment of new partnerships, and the new environments that these papers describe show how audiologists' roles are indeed changing. More than ever before, there is demand for our service and the need for audiological expertise in new forms of service delivery. For example, the study at St. Joseph's Villa demonstrated that with on-site audiologic support, residents sustained effective use of hearing aids and residents and staff learned to use assistive technology (Pichora-Fuller & Robertson, 1997). Similarly, Lewsen and Cashman (1997) convince us that a high rate of hearing aid use can be achieved if there is adequate on-site audiological support. Good clinicians have been able to adapt the traditional skills in rehabilitative audiology that they developed in hospital-based clinics and use them successfully in new and challenging settings. In addition, we now need to redefine our concept of expertise so that it meets the needs of hard-of-hearing persons in the ways that they hold to be important. More than ever, our services must provide the help demanded by stakeholders and consumers. Most importantly, we must come to an understanding of their aspirations and goals in seeking our help.

Audiologists' roles in community service positions have been forced to expand to include more varied applications of expertise in hearing health care. Innovative roles, such as program promoter, volunteer recruiter, fund raiser, and room acoustic consultant (Hoek et al., 1997) certainly may become a necessary part of the typical audiological job description. Jennings and Head (1997) point out the importance of educating the person with the hearing impairment, caregivers, and significant others as well as addressing the physical environment. Involving all participants from the onset of program implementation is advantageous in the challenge to ensure the highest quality of life for our clients.

Orange, MacNeill, and Stouffer (1997) discuss the need and opportunity to integrate necessary training in geriatrics by looking creatively at new sources of training that have not previously been considered, such as continuing education programs in geriatric audiology. As more audiologists adopt an ecological model of practice, our definition of and criteria for clinical practica need to be reshaped. Why limit our definition of 'experience' with hard-of-hearing persons to clinic-based interactions? Recasting audiologic rehabilitation objectives to focus on hearing accessibility and handicapping situations (Carson & Pichora-Fuller, 1997; Gagné, Hétu, Getty & McDuff, 1995; Noble & Hétu, 1994; Pichora-Fuller, 1994) gets us out of the clinic and into the community, an essential move if we are to grow to incorporate the new demands placed on our profession and the health care system in general. If we are willing to look for them, there is no shortage of opportunities to acquire and practise our skills within an ecological model of practice, a model that is client-centered and recognizes the importance of environment and the value and strengths inherent in collaborative efforts.

Toward this goal, we have discovered a model developed within the field of health promotion that we feel may be helpful to organise concepts central to ecological practice in both audiology and speech-language pathology. The PRECEDE-PROCEED health promotion model (Green & Kreuter, 1991) gives us a comprehensive framework through which we can envision these much needed professional changes discussed above. The essence of this framework supports the changes that we find evidence of in this special issue. This model consists of two components: the diagnostic phase and the implementation/evaluation phase (for an application to audiologic rehabilitation see Carson & Pichora-Fuller, 1997; Pichora-Fuller, in press). The PRECEDE (diagnostic) phase shows us we must begin at the beginning. We must discover, through communication with our clients, the issues which are affecting their quality of life. Once we understand what issues are priorities for the clients, we can determine which behavioral and environmental factors may enhance the identified quality of life issues. As we continue this effort to target our objectives, we identify the predisposing, reinforcing, and enabling factors which influence these behaviors and conditions of living. These are then framed in explicit statements of our project goals. This process allows us to target a focused set of factors which represent our objectives and also serve as criteria for evaluation (PROCEED). Criteria for program evaluation are imperative if we are to continue to grow as health professionals engaged in program planning. Finally, it is important to recognize that this framework gives us not only a model to help us make the changes necessary to keep our profession vital, but also the framework to serve our clients, evaluate our existing programs, and design and evaluate new programs, both in our professional training and in our rehabilitation practices. Using this framework enables us, as the papers in this issue demonstrate, to be part of the solution, by asking *why* before we ask *how*.

Please address all correspondence to: Arlene Carson, 5804 Fairview Ave., Vancouver, BC V6T 1Z3. E-mail: lmd@audiospeech.ubc.ca or arlene@audiospeech.ubc.ca.

References

Carson, A. J. (1997). Evaluation of the To Hear Again project. *Journal of Speech-Language Pathology and Audiology, 21,* 160-166.

Carson, A. J., & Pichora-Fuller, M. K. (1997). Health promotion and audiology: The community-clinic link. *Journal of the Academy of Rehabilitative Audiology, 30,* 1-23.

Dahl, M. (1997). To Hear Again: A volunteer program in hearing health care for hard-of-hearing seniors. *Journal of Speech-Language Pathology and Audiology, 21,* 153-159.

Fischer, L. R., & Schaffer, K. B. (1993). *Older volunteers: A guide to research and practice*. Newbury Park, CA: Sage.

Gagné, J. P., Hétu, R., Getty, L. & McDuff, S. (1995). Towards the development of paradigms to conduct functional evaluative research in audiological rehabilitation. *Journal of the Academy of Rehabilitative Audiology, 28,* 7-25.

Green, L.W., & Kreuter, M.W. (1991). *Health promotion planning: An educational and environmental approach (2nd ed.)*. Mountain View, CA: Mayfield.

Hoek, D., Paccioretti, D., Pichora-Fuller, M. K., McDonald, M., & Shyng, G. (1997). Outreach to hard-of-hearing seniors. *Journal of Speech-Language Pathology and Audiology, 21,* 199-208.

Jennings, M. B., & Head, B. G. (1997). Resident and staff education within an ecological audiologic rehabilitation program in a home for the aged. *Journal of Speech-Language Pathology and Audiology, 21,* 167-173.

Lewsen, B. J., & Cashman, M. (1997). Hearing aids and assistive listening devices in long-term care. *Journal of Speech-Language Pathology and Audiology, 21,* 149-152.

McKellin, W. (1994). Hearing and listening: Audiology, hearing, and hearing impairment in everyday life. *Journal of Speech-Language Pathology and Audiology, 18,* 212-219.

Noble, W., & Hétu, R. (1994). An ecological approach to disability and handicap in relation to impaired hearing. *Audiology, 33,* 117-126.

Orange, J. B., MacNeill, C. L., & Stouffer, J. L. (1997). Geriatric audiology curricula and clinical practice: A Canadian perspective. *Journal of Speech-Language Pathology and Audiology, 21,* 84-103.

Pichora-Fuller, M.K. (1994). Introduction to the special issue on the psycho-social impact of hearing loss in everyday life. *Journal of Speech-Language Pathology and Audiology, 18,* 209-211.

Pichora-Fuller, M.K. (in press). Assistive listening devices in accessibility programs for the elderly: A health promotion approach. In R. Lubinski and J. Higginbotham (Eds.), *Communication Technologies for the Elderly*. Singular: San Diego.

Pichora-Fuller, M. K., & Robertson, L. (1997). Planning and Evaluation of a rehabilitation program in a home for the aged: Use of hearing aids and assistive listening devices. *Journal of Speech-Language Pathology and Audiology, 21,* 174-186.