Promoting Healthy Aging in Your Clinic with the Geriatric 5M's

Recorded March 6, 2023

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- Hello, and welcome to the Signia Podcast at AudiologyOnline, I'm Brian Taylor. Today's topic is "Interdisciplinary Care in the Geriatric 5Ms". A few years ago, the American Academy of Geriatrics updated their minimum competencies for graduating medical students. They created 27 competencies that reflect some of the changes in how care should be delivered to older adults. Changes such as being more patient-centric in your communication, the use of fall-risk screening, and also, a focus on cognitive well-being. These 27 competencies were framed around five areas, and they are called the Geriatric 5Ms, Mind, Mobility, Medications, Multi-complexity, and Matters Most.

Considering how important hearing is to all five of those Ms, this new framework seems to be a great opportunity for audiologists to collaborate with other medical professionals in an interdisciplinary fashion and to practice in a more... and to practice more holistically with older adults as they age. Here today to help us better understand the Geriatric 5Ms, and how they can be applied in clinical practice is Dr. Steve Huart. Steve is an Audiologist at the Rocky Mountain Regional VA Medical Center in Aurora, Colorado, and we're really happy to have him on our podcast today. And we really wanna thank him for taking time out of his busy schedules to spend some time with us. Welcome to the podcast, Steve.

- Hi, Brian, thank you for having me, great to be here.

- Yeah, so before we jump into this topic of the Geriatric 5MS and interdisciplinary care, I thought it'd be helpful for you to kind of explain to our listeners a little bit about yourself, your career path, and how you ended up where you are today at the VA Regional Medical Center.

- Okay, to keep it short, I've been an Audiologist for almost 40 years now. I was a Navy veteran. After I got out of the Navy, I actually moved to Wisconsin and became a

lumberjack but decided there was not much of a future in destroying the landscape. So, I went to college in Wisconsin and I came across Audiology, and studied Audiology, got interested and became an audiologist in the early '80s. And my careers pretty much been divided into three relatively equal parts, most of them clinical. I was an audiologist in Wisconsin for 10 years. I was at Mayo Clinic in Arizona for the last 10, 13 years. I've been with the VA with a little break in between to work in the industry with cochlear implants for a little while. And so, basically been an audiologist for almost 40 years, and 35 of those have been in the Clinic.

- So, it's safe to say that you're a grizzled veteran who probably wears a plaid shirt to honor your lumberjack days.

- Absolutely, at least the grizzled and veteran part is correct, yeah.

- All right, well, we have you here because of this Geriatric 5Ms concept. So, maybe, I introduced it a little bit, but maybe you could elaborate on where this comes from, the Geriatric 5Ms, and really what they signify.

- I'm glad to, yeah, I think you have me here because I am a Geriatric Audiologist. Not so much because I've studied the topic, but you did a very nice job describing it, Brian. Really, it's kind of new in the healthcare arena. It was 2017; it was introduced by a group of geriatric experts at a conference in Canada, and these geriatricians must like audiologists, they came to the conclusion that people really didn't know too much about what they did. So, they created this 5M framework to help people kind of wrap their heads around what geriatricians do. What they bring to the table. What patients might be the ones that you wanna consider for referring on to geriatrics when they have these geriatric syndromes that include a lot of different conditions and comorbidities.

So, the 5Ms is created by these guys just to help people like us, you know, non-geriatricians primary care providers, more specifically than audiologists. Of course, they wanted other healthcare providers to know when to start thinking about making that referral to geriatrics, and that's what the 5Ms kind of encapsulates. And as you indicated, it includes those 27 competencies that graduating medical students are required to have. And they all five... All 27 of those competencies can be grouped under one of the 5Ms.

- Yeah, I guess it's easier to try to wrap your head around 5Ms than it is 27 competencies.

- Especially the older you get, absolutely.

- Yeah, that's the irony of this, I guess. I guess for the audiologists that are interested in this, or the reason they should be interested in it, I would guess is that the average age of a patient in a typical audiology practice has gotta be someone over the age of 60, somewhere over the age of 65, wouldn't you guess?

- Oh, I would say, I actually think I have just a little bit of evidence to support that. The Colorado Academy of Audiology Meeting was held in the fall, and I was talking to a room full of audiologists, about 50 audiologists, and I asked them, "How many of you see kids?" And three raised their hands. And I said, "How many of you see older adults?" Everybody's hand went up, even the three, well, I don't remember the three who raised their hands, because I think they worked at the pediatric at the Children's Hospital. But clearly, you know, 47 out of 50 audiologists, that was one room but I'm sure if you increase the sample size, yeah, most audiologists are treating adults well, and a lot of those are by default older adults.

- Right, and I just off the top of my head, I'm kind of curious, in your practice at the VA there, what would you say the average age is?

- In the average age, well, it's over 65.

- Yeah, it's for the people you see in the VA, right?

- Yeah, yeah, as a matter of fact, 37% of the veterans treated in the United States or living in the United States, 37% of them are over 65. Whereas the US population, it's only about 17% roughly, so.

- Mm-hmm, yeah, that's interesting. So, veterans, we are an older subset of the population.

- Right, well that's good to know. And I think that's kind of a reason why people should pay attention to this topic. So, let's get into the nuts and bolts of the 5Ms. I thought we could maybe go through each one, one-by-one, and you could tell us a little bit about what the M is, and then, maybe talk about and relate it to audiology and hearing healthcare, so let's start with the first one, which is mind. What do you have to say about that?

- Mind is, all of these to me, Brian-

- Mm-hmm.

- are really no-brainers. I think the correlation between each one of these Ms, and what we all do as audiologists is so apparent. And I hope that if anybody listening to this disagrees with me, that they'll let you know and you can get that feedback to me because the connection is just so obvious, and so strong that I hope people feel half

way as enthusiastic about this as I do. And mind is a great place to start because look at all the proliferation of literature now on how hearing loss and cognition are combined and everybody in healthcare knows about it. Because a lot of people will talk to me and ask questions about, "Well, if I get hearing aids, will it prevent cognitive decline?"

And you know, you think about those of us who've been practicing for two or three decades, we used to talk about how if you don't use it, you're gonna lose it. Well, now we have evidence to support that. I mean, through the geroimaging Studies that we can do now, we can show that the brain remaps itself if you have a hearing loss, and then, by putting hearing aids on those people, the brain is reorganized. So, there's such a strong, strong correlation between hearing and cognition that this is, it's just an easy sell. And it, what's interesting about this is as you talk to healthcare providers, they're interested in this too. You know, they're older patients don't want to become cognitively impaired.

They don't wanna develop dementia. And you look at the work of people like Lynn or you mentioned an article in "The Lancet" that was published by Gill Livingston at all. And it's a meta-analysis that talks about modifiable risk factors for dementia, and hearing loss is the greatest one in there. So, there's a lot of evidence, a lot of research, and it's real easy for us as audiologists to be talking about the data that's out there that supports the fact that if you hear better, your brain will be healthier. So, mind is a great area for us to focus on and let other healthcare providers know what we bring to the table that contributes to that.

- Right, so it sounds like that's something that you talk about with your patients when they come in this relationship.

- We do. Well, you know, of course, every practitioner's a little bit different. But I, again, I think of myself 20 years ago. If I saw a 60-year-old patient and they had a mild

hearing loss and said, "Well, I'm gonna wait until I have a real problem," I would say, "Yeah, okay, that makes sense to me." Well, when I see people now, I don't say that anymore. I say, "Well, you could do that, but here's the problem, how hearing loss contributes to brain reorganization and maybe ultimately cognitive decline." And it's just, I mean, I've switched my position 180 degrees. I'm much more aggressive about what I... When I recommend the amplification now than I used to be.

- Yeah, that's good to know, and I, so in addition to changing the way you counsel patients, are there any kinds of clinical tests or procedures that you might do a little different maybe to differentiate between cognitive decline or a screen for depression? Or is there anything like that, you know, because sometimes, depression can masquerade as cognitive decline and vice versa. Anything that you do in that area that you would suggest or wanna talk about?

- Here, I'm very lucky it'd be at a large VA like this where we have a lot of other disciplines to rely on. And we actually looked at that question, you know, and we considered doing things like the MoCA doing formal cognitive screening during evaluation. And like everybody in the world, we don't have enough time. We don't have the resources to do that. And quite frankly, we're really not the best trained professionals to be doing that. I'm lucky enough to work with a geropsychology team, and I asked them, "Should audiologists be doing a MoCA, for example?" And, you know, they said, "Well, no, but you could screen for a cognition and cognitive decline." And we tried to come up with a very efficient, practical way to do that.

And, again, because we have resources available to us, we came up with a simple question with what, that we included in our history is, "Do you have any concerns about your memory?" And if the patient responds affirmatively, then we have a chat with them. Well, you know, is it a big deal? I mean, you're talking about you forgot your car keys or you can't remember your birthday. And then, we dig a little bit deeper

depending on how they answer the question. But then, we refer out, and I think the beauty of the 5Ms and what it was created for in the first place is to let a practitioner realize that there are other resources available. And like I said, I'm lucky.

I've worked in large multidisciplinary medical centers. I'm at a Class 1A, which means a high-complexity medical center. Now, I've worked at Mayo Clinic for many years, so I had a lot of resources there, but I think if I was in private practice, I'd be even more, I can't... I've never been in private practice, so if those of you who are listening are private practitioners and you think this is just me blowing smoke, you're probably right. But if I was in private practice, these are the things that I would be using to build relationships with outside providers. I would ask those questions about cognition and I would find out who the mental health providers were in my community, and then I'd let them know about the connection between hearing loss and cognitive decline.

And when I had patients that could benefit from their services, I would refer to them and they would obviously identify people with hearing loss, they refer to me. So, long answer to a short question, Brian.

- No, that's good.

- We just ask a simple question here as part of our intake history is "Do you have any concerns about your memory?" And that was something that we got input from a geropsychologist, Dawn Nate, she said that was a, yeah, that's a reasonable question to ask. Doesn't take too much time, alerts you if there is a concern, and then, you can refer them on for further evaluation.

- Yeah, I like that, that's a really sensible approach that anyone can apply, and I think it encourages more of a interdisciplinary approach to how you handle these situations. And I think that's kind of the whole theme here as we move through the 5Ms is that it

really encourages you to collaborate with other medical specialties to help the patient in any dimension that they might need. So, we got one of the 5Ms down. Let's go to the second M and that one is Mobility. Tell us what that involves and maybe how you talk about it, or assess that in your clinic.

- Yeah, well, by definition, mobility's maintaining the ability to walk and maintain balance, and-

- And does that make sense?

- Yeah, and obviously audiologists, you know, that's part, that's in our wheelhouse, right, vestibular system, so there's all the obvious connections there. If a person's got a hearing loss and there's some kind of a common pathology that might be contributing to a vestibular disorder as well, where the professionals who would be able to diagnose that, make an appropriate referral for medical treatment, if it's indicated vestibular rehabilitation, if it, you know, if that's indicated, that's part of our domain. And, you know, one of the things that I find is people outside of audiology don't know that there's a strong correlation between people with hearing loss and falls. There's data out there that suggests if you have a hearing loss, you're three times more likely to fall than your age peers who have normal hearing.

And so, it's easy for me to talk about the vestibular system and people can wrap their head around that. But when you talk about hearing and balance, I try to make it a little bit more grassroots. And then, I talk about things like, well, actually, another tip I got from my geropsychologist colleague, we were having an interdisciplinary conference and I brought this up, and we were talking about environmental cues, and if you have a hearing loss, you miss environmental cues. And she said, "Well, yeah, what if you got a dog and the dog walks up behind you and you don't hear the dog, and you stand up and you trip?" That's a fall risk. So, not only can we talk about the anatomy and

physiology, and how audiology contribute to the mobility question, but then, we can also talk about how hearing loss contributes to mobility.

And another big item on that falls under that umbrella, is people who are hard of hearing often don't do the things that they used to do. So, you can talk about lowered-level of activity, and people who are inactive tend to fall more. They lose their muscle mass, they just don't get out, and they just simply don't move as much as they used to. So, if I have a hearing loss and it contributes to me becoming less active, that can contribute to me falling. So, there's, again, a whole myriad of things that we can talk about as audiologists that contribute to a patient's mobility.

- Yeah, that's good, I think that... And now, we have hearing aids that actually can help detect falls too, which probably is beneficial in some ways.

- Right, right.

- Let's move to the third M, and there's no special order here. So, the next M is Medications. Tell us about how you approach that M.

- This is an interesting one for audiologists, and I think a lot of audiologists don't feel real confidence in talking about medications except the ones that we know, cisplatin, aminoglycoside, things that we know are ototoxic. But what we found from our research here, we've looked at over 600 patients that were seen in a Geriatrics Clinic. The average number of medications that these patients are on is 16.

- But the range is horrendous, Brian. It's anywhere from one to 45, so-

- Wow.

- As an audiologist, a bunch of things come to my mind. First of all, maybe no one of those medications is ototoxic, but put 40 of them together in a soup, something's probably gonna happen to your hearing. If it doesn't happen to your hearing, what's it contributing to your level of awareness, and how well you're hearing and understanding things. So, there's, I wish I was just beginning my career because I think there's a Ph.D. dissertation in this just waiting to be uncovered. That's the big cloud but if you look for the lightning strike for how audiology contributes to that, again, there's data that shows that people who have hearing loss, don't communicate as effectively with their providers. It doesn't have to be data to support that. It just makes common sense, right?

- Mm-hmm.

- So, if you think about an older adult who's taking 15 or 20 different medications and has to sit in an exam room with his physician or his nurse practitioner, and talk about all the different medications that they have to take if they've got a hearing loss, we know about cognitive bandwidth and all of those things. If I'm focusing so hard on my hearing, I'm not understanding what you're telling me about my medications. So, the likelihood of making a medication error goes up exponentially when you have a hearing loss. So, when I talk to pharmacists about that, that gets their attention to go, "Wow, that, yeah, that just makes sense," and pharmacists today, you know, it's not like just... You don't just go to Walgreens and get your prescription filled.

Pharmacists today, are, you know, they're advanced-level practitioners. They're on the phone to patients doing a lot of medication reconciliations, especially in these polypharmacy geriatric patients. People were taking 15, 20, 25 medications. They do a lot of telephone work, so anytime I have an opportunity to talk to a group of pharmacists, the first question I say is, "How do you know they can hear you when you're on the phone?" And you can just see their light bulbs go on over their head? So,

yeah, hearing loss and medication, or hearing and medication, we fit right in with that M just like we do the other ones.

- Yeah, that's really interesting about, you bring up a great point about not being able to hear what the doctor, the nurse practitioner may have to say about your medications and the likelihood of messing something up if you don't hear, and I know there are a few practices around the country that partner with pharmacists and primary care to make sure that they at least have some high quality PSAPs available. So, if somebody really has trouble hearing, they can use one of those while they're in the office. And that seems like a kind of a logical thing to do.

- Very logical.

- And an opportunity. Let's go to the next M and this is the one that intuitively, I can't really wrap my head around it, so I'm hoping that you can help explain what this word means and that M is Multi-complexity.

- Oh, good, I hope, I can't help you wrap your head around it because we've, this fits like a glove for an audiologist too. You think about geriatric syndromes include a lot of different things where I go to, when I think of monthly complexity is the list of comorbidities for adult hearing loss that was published by the American Academy of Audiology. If there's a great infographic that they've got out that shows the seven comorbidities, and so many of them are also age-related, cardiovascular disease, cognitive decline, diabetes, kidney disease, by definition, those are multi-complex medical conditions. They also contribute to hearing loss. And I bang the same drum frequently because it's so important that when I'm talking to providers about their communication with their patients, I say, "What good is it to have a patient come into your office if they can't hear you, they can't understand you, and your education is falling on, I don't wanna say deaf ears because that's too cliche, but you know, if

they're so struggling so much to hear you that they're not understanding and comprehending what you're trying to say."

So, when you're counseling a patient about their insulin medication and all of education that you have to do when a patient's got kidney disease or diabetes or any of these chronic comorbid conditions, hearing loss just fits into it. And, you know, I also don't wanna cry wolf to a bunch of these. These are smart people. They know that if all you do is say, "Well, everything revolves around a hearing loss," it's not like that at all. But I tell them "Hearing loss doesn't necessarily cause these problems, but it certainly exacerbates them." If you're trying to educate somebody about a problem and they misunderstand you, the problem gets worse. If they get frustrated and just quit listening to you because they're struggling and they're exhausted because they can't hear, then they just don't know what they're supposed to do. So, good hearing, call it healthy hearing if you will, contributes to minimizing the adverse effects of all of these complex multi-complex comorbidities. Does that help, does that make sense?

- Yes, it does, and I think that, again, I think, speak to the fact that hearing, just the general sense of hearing is so often taken for granted that we don't realize how important it is until we start to lose it, and even then, we don't realize it.

- Right, yeah, Because so many people don't know what they're not hearing, right?

- Exactly, it happens so slowly and you can get by for such a long time with-

- If I may, Brian, before you move on. Under, if you look at the chart of the 5Ms if you will, under multi-complexity, they list sensory impairment. That's one of those 27 competencies that a graduating medical provider should be able to address sensory impairments, and, of course, hearing vision, those fall under there, so.

- Right.

- By definition, hearing loss falls under the multi-complexity M.

- It's good to know, and by the way, just to remind everybody who's listening to this, there should be some notes so that correspond to this podcast, you can click on the notes and you can look at some of the, Steve mentioned an infographic, we'll include that so people can see exactly what you talked about. I think it's a really handy infographic that AAA developed a few years ago. You could probably share that with patients, right? That's what it's designed to do.

- The comorbidity one, yeah, you can certainly, again, share it with patients. I personally think it'd be overwhelming a little bit for a patient-

- Yeah, for most patients. Right.

- But I love it when I'm talking to providers, I don't go, if I have an opportunity to talk to a group of nurses, pharmacists, psychologists, physical therapists, anything, I take that infographic with me and they get it when I leave, because that's where those people live, right? They don't live in the world of hearing loss. They live in the world of falls. They live in a world of cardiovascular disease. They live in a world of cancer. They live in a world of cognitive decline. If I can give 'em a piece of paper that shows that audiologists understand that we can help them manage those patients, we're friends for life.

- Very well said, that was good, yeah. That's a reason right there to download that infographic and use it when you interact with other medical professionals. Let's move to the fifth and final M. This is the one that has the most vivid name and that is Matters

Most. Tell us how you think of matters most; what's that mean, and how do you use that in clinical practice.

- Matters most, I know you're gonna find this hard to believe because each one of these has gotten more and more directly related to what we do. But this is the frosting on the cake. What matters most is really what audiology's all about. Particularly, you think about an older patient who may or may not be at the end of their life, but certainly, their activities are restricted. They're not necessarily doing, and I'm talking about the older adults who, you know, they're not out biking 60 miles and climbing 14ers like we do here in Colorado, you know? They have a sedentary lifestyle, and the thing that matters most to a lot of those people is spending time with family, spending time with friends, talking to relatives, grandkids, great grandkids in different states, maybe watching TV, watching a ballgame, listening to music, they're just not as active as they used to be.

So, when you're not as active as you used to be, where you get a lot of your enjoyment out of life is from doing things like listening to music, watching TV, having conversation with your friends. So, when we have interdisciplinary case conferences once a month, and so we have all these different disciplines come together, and each discipline that we talk about the case and why it's important and what each provider brings to the table for that particular patient. And at the end of it, each specialty has an opportunity to say, all right, wrap it up in a nutshell, then, almost without fail, when it comes to audiology, I say this guy's 80 years old, his wife is gone, the only thing he likes to do for fun and recreation is go down to the VFW, have a cup of coffee with his friends and just visit.

Well, what's more obvious than the ability to be able to hear those people and those friends when you're there? So, and you know, nowadays, everything, not everything, but there's a big movement towards, at the VA we call it Whole Health. And it just

takes, it's not, what's the matter with you, it what matters to you. It's a whole paradigm shift in medical care at the VA recently, so if I'm talking to you and you're old and you live alone, and the only thing you like to do is visit with your friends, what matters to you? "Well, I wanna be able to hear my friends," so-

- Wow.

- How, I mean, how can you be more audiology centric than that? So, if you really drill down to what matters the most to a patient, certainly, and here's where our job is tough, because, you know, what matters most is relieving my pain, right?

- Mm-hmm.

- Controlling my blood pressure, controlling my blood sugar. I've gotta be able to chew my food and swallow. I've gotta be able to take care of myself, my activities of daily living, they're called the ADLs. You know, I gotta be able to do those things, right? And that's what takes all the funder away from medical care is, well, if he can do this, and, you know, if he can feed himself, if he can dress himself, if he can bathe himself and he can get himself up and ambulate and move, then he's doing okay. Well, he's doing, he's not necessarily doing okay. Quality of life and what matters most to me, of course, I'm looking at this through an audiology lens, but to me, the ability to hear, the ability to communicate, the ability to enjoy the things that life has to offer because I can actively participate, hearing is a big contributor to that. And you'd be hard-pressed to argue otherwise. So, yeah, what matters most to me is really the feathering, the audiology cap on what we bring to the 5Ms.

- Yeah, no, I think there, if there's one question you wanna ask somebody when you're setting goals, "Where are the places that matter the most when you wanna hear our communicator or interact or socialize?"

- Sure, right.

- So that's a... So, that's a, I love that last one matters most and all the things that you said around it. A couple more things I wanted to get your take on, Steve. And one is you hear a lot of talk these days about healthy aging, so I guess I'm kind of curious, what does that term mean to you and how do you think the 5Ms relate to the concept of healthy aging?

- Oh, God, healthy aging is huge, obviously, you know, there are whole conferences that revolve around that. And I'm actually talking about this at the Audiology Conference that the VA and the Department of Defense have next month, and wanted to come up with a simple, because it is so big and so all-encompassing, a simple definition that I came up with for healthy aging is just having the ability to do the things that you need to do and more importantly, the things that you want to do. It doesn't matter how old you are, you know, we've all seen patients in our office that are 90-plus-years-old and you think, "Wow, I mean, this guy's in better shape than I am." So, age, really has nothing to do with it. It's how we age, and if you're able to do what you need to do those activities of daily living and the things that you wanna do, socialize with your friends, listen to music, watch a movie when you want to, and you'd be able to hear it, to me, that's healthy aging.

- Yes, that's, I like your definition. It's short and to the point. That's great. We've been talking a little bit about the 5Ms and how that lends itself well to interdisciplinary care. And I know when we've had conversations about this before, Steve, you've mentioned something called the GRECC, which is an acronym. And I think I'd like you to talk a little bit about the GRECC because I think all hearing care professionals kind of need to know about what that is and kind of the value that it brings to the profession and to patients.

- Well, I love the GRECC. I'm glad you asked. GRECC stands for Geriatric Research Education and Clinical Centers. They were established, GRECC were established in the VA in 1975 because it was obvious, as I had mentioned earlier, the percentage of veterans who are over 65 is almost double the percentage of the general population that is over 65. So, because of the aging veteran population, Congress came up, this was decreed by Congress that there will be GRECCs across the country and there are currently 20 of them. And what the beauty of is, it is not just VA. In order to be a GRECC, you are required by Congress to have an affiliation with a Research University. So, the University of Colorado, I can walk across the street across the Campus to the Children's Hospital and I'm at the University of Colorado.

So, their providers come here, our providers go there, and it's just a beautiful collaboration, so they're are... It's not just VA but they're all large multi, or high-complexity medical centers, you know, you can't be a GRECC if you're in resume-speed Arizona. You have to have a certain population and demographic to be able to do that. You just gotta be a big multidisciplinary medical center, to make a long story short. So, there are 20 of them around the country and they have three missions to build knowledge to improve healthcare for veterans, which was really kind of the emphasis when GRECCs were originated and to provide training and education. And so, we audiology only the Colorado GRECC is one of the newer of the 21, 20 GRECCs.

We've only been a GRECC for like 10 years or so, and audiology only got involved a few years, maybe five years ago. Yeah, it was 2018 when audiology got involved, and we were invited to participate because, by definition, GRECCs have to include multiple specialties. And I didn't know what the GRECC was. Somebody called me and said, "Hey, we've got... The Office of Academic Affiliations has funding for a trainee, and we need different specialties to participate in the GRECC. Would you be interested?" Well, of course, we were thrilled to have the opportunity to offer an audiology external paid

stipend for a year. And that's what got us to the GRECC, so we just kind of fell into it, and it's-

- That's great.

- Yeah, it's been the greatest experience, multi-disciplinary experience that I've had as an audiologist in over 30 years. It's just amazing.

- And I know that you can go out there, you go on the websites and you can see different things that they're doing and research that they published. And it just seems like a valuable tool for clinicians to know about, even if you're not affiliated with the University or a VA, so-

- Oh, yeah, yeah, there's a ton of research. There's actually a, if you go to the GRECC website, there's another thing called Geri Scholars for people who are interested in learning about older adults, it's just a wealth of information there.

- That's awesome, one final question, and I know I might be poking the bear a little bit when I mention this to you, Steve, but I wanted to get your take on AAA. I know they have certification for pediatrics, for balance, for tinnitus, but there is no geriatric certification.

- Mm-hmm.

- How do we make that happen and why? It seems like, to me, it seems kind of obvious that they'd want that because so many audiologists spend so much time with the geriatric population. What gives, what's the deal?

- Boy, I wish I had an answer to that and nothing would make me happier than to see that change. Because, again, by being involved in the GRECC and working intimately with other disciplines, you start to learn about what their training programs are like. As a matter of fact, one of the exercises that we do when we're, in our GRECC, we have seven disciplines. First of all, they're geriatric fellows, geropsychologists, physical therapists, speech pathologists, social workers, audiologists, and I'm forgetting what the seventh one is. Oh, pharmacists.

- Mm.

- So, all these trainees, young people who are just beginning their careers and, look, you know, they're just starting their careers and they're meeting all these other people in different specialties and we say, "What do you have to do to be an audiologist?" So, you tell 'em, "Okay, it's a Doctoral Program," and then you talk to the geriatric fellows while I went through Medical School and then I did a residency. Now, I'm doing my Geriatric Fellowship Pharmacy People. And then they start to find out, well, pharmacists have credential for geriatrics. Social workers have a credential for geriatrics. It's a subspecialty in psychology. You could be a Board-Certified Geriatric Psychologist, Physical Therapist, I don't know if I mentioned that.

So, so many of these different disciplines have specialty certifications in geriatrics, and I don't know why we don't, I can't believe that we don't. It's almost an embarrassment for me to sit with other people and I, you know, not only am I an older guy myself, but I have nothing to offer that makes me, you know, like a Board-Certified Geriatric Audiologists.

- Yeah, it's interesting.

- I would love to see that-

- Yeah. I'd love to see that happen.

- Maybe it's one of those things that it's so routine that people see geriatrics that they don't think it needs a specialization, but the topics like we're talking about today, would fly in the face of that logic. So, yeah, anyways, Steve, I wanna thank you for your time. Steve Huart, Audiologist at the Rocky Mountain Regional VA Medical Center in Aurora, Colorado. Any final words of wisdom that you have for our audience?

- Well, if I may, since you did poke the bear, I would really like to see the next generation of audiologists change that, so that we do have some specialty certifications. Because if you think about it, 20 or 30 years ago, we didn't even have a licensure in audiology. And, of course, there were no Board Certifications for pediatrics or cochlear implants. So, we know that the knowledge base is increasing and that there is room for specialty certifications and very specific knowledge about certain populations. And I would love to see the people who come up behind you and me, Brian, lead the charge on getting some kind of a specialty certification in geriatrics.

- Well, that sounds like a good place to end. Steve, thanks for your time. A lot of great information, a lot of great insights. Really appreciate it.

- Thank you, Brian.