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The Connection Between Hearing Loss and Falls: Risk Factors, Prevention, and Clinical Strategies

Presenters: Dave Fabry, PhD, Patricia Gaffney, AuD

Welcome to Starkey Sound Bites. I'm your host, Dave Fabry, Starkey's chief hearing health officer. This week, September 23rd through September 27th, is Falls Prevention Awareness Week. And it's observed every September. You get the little double entendre.

It's right around the beginning of fall because really the beginning of fall is already too late for many individuals, especially if they break a limb like my mother did. And although falls don't necessarily kill people, there are non fatal falls. But if it's accompanied by a broken limb, it often begins a downward spiral. And so my guest on this episode of Starkey Sound Bites is someone I've known for longer than either of us probably care to admit. But I looked and it's probably well over 20 years now.

Dr. Patricia Gaffney Tish, if I may, thank you for joining us here and I'm really excited to do this episode of Sound Bites with you. Thank you so much for having me, Dave. And yes, it has been quite a long time that we've known each other. Well, it's really been a pleasure. And as I said, I was really looking forward to this episode because I have known you for more than 20 years when you were a student at Pitt at the time.

And I had the opportunity to come out numerous times during your training program because Dr. Kathryn Palmer is a longtime friend and colleague of mine. And so I began to get to know you there and then certainly watching you blossom in your career. I mean, the, the list of awards that you've received from various organizations and your participation in organizations dates back to really when you were a student. I'm a lifetime member of an organization that no longer exists. Thanks to you, I was given a lifetime membership of the national association for Future Doctors of Audiology.

Thank you for that. That's how much we like you as we gave you an award that an organization that disappeared. Yes. And I, I've begun to outlive organizations now, which is sad testimony to this point in my career. But in all seriousness, with, you know, Fall Prevention Week, and we'll come to that in a minute, but this year it begins on my birthday and this is my 65th birthday.

So we know and we'll come to this, but we know that falls in the aging population are a significant issue. We know, however, that falls can occur at any age with a variety of different comorbid conditions to hearing loss. But as Dr. Frank Lynn published about a decade ago, an article really just looking at the prevalence and insolvency and comorbidity between falls and hearing loss, and even a mild hearing loss places an individual at three times the risk of falling. And that risk increases with increased hearing loss. And so we'll come to that.

But I want to begin with your journey. How did you find audiology and talk about the path that really brought you first to GW George Washington University for your undergraduate, continued at Pitt, and then a couple shorter stops along the way. But you've been with NOVA Southeastern, where you're now a professor for quite a while. But. But talk a little bit about that journey, if you would.

Sure. So I've always just loved science and anything science related. I thought I was going to be an astronaut or a marine biologist. You know, all these things when you're little. And it really was my uncle, who was an ENT in Delaware, and I had the opportunities to kind of work in some summer, you know, weeks, you know, help filing and things like that.

But I was able to observe him and more importantly, is actually able to observe his audiologist. And, you know, as I was in an undergrad at gw, you know, thinking about where I wanted to go with my professional career, you know, I really liked medicine, but, you know, I would look at my uncle's appointments, and they would be 15 minutes and they'd be crammed, and it would be, you know, got to do this, this, this, this in a very short period of time. But then when I watched his audiologist, you know, there was that science, medical component to it, but also the ability to just sit there and talk to your patients and have a little bit more time to help counsel them and, and give them that information they were looking for. And you'd see them be in the, in the, in the physician office, have all these questions, but then they could ask the audiologist because there was a little bit more time. And that kind of

balance between those two was really what drew me to audiology was you have this health care component, but you have this ability to take a little bit more of a breath and talk to your patients.

And so in my undergrad, I was a speech and hearing students, the, you know, the only audiology student that was planning to go to an audiology program. And then when I was applying to graduate school, it was just as the AUD was coming out, and I ended up applying half aud, half master's. My advisor to my undergrad was, well, we're not sure if the AUD is going to work out. And so just think about that as you're applying. And so I ended up getting into Pitt which was a master's program.

When I started in our first semester, they said to us, we're going to change to an aud so you can decide whether you want to stay or if you want to leave with the masters. And I ended up staying. And, you know, Pitt's such a great school. I felt so prepared for my career ahead of me. I ended up doing my externship at the VA in Miami, which is what brought me to South Florida.

And I was there for about two years after graduation before I took the job at nova. But as you pointed out, you know, I was on the NAFTA board. I was, you know, a national representative and then the national secretary. And I feel like that had such a big impact on my career as a whole. It gave me opportunities.

I got my externship because one of the other NAFTA board members was going there for a job, and he was like, hey, they're looking for externs. And, you know, I knew about the NOVA position being open from another NAFTA person. And so that experience of being on that board as a student gave me a real commitment to the profession as a whole. It let me, you know, see how beneficial it was to volunteer and to give back to my profession. Even as a student.

I had you as one of the great advisors to. To our organization and then, you know, developing that mentorship kind of going forward. Yeah. And then in 2007, I took the job at Nova, and I have been here

since, and it has been a great opportunity. I love working with students.

I. I really enjoy teaching. I love talking to them. And as you mentioned, my area is, you know, dizziness and balance. And I've had the opportunity to really grow great dizziness and balance vestibular program here. And so it has been wonderful.

And I've continued to volunteer for various national organizations, including the American Academy of Audiology, where I'm definitely the most involved, but also the American Balance Society, Audiology Practice Standards Organization, where we were on the board together.

Various organizations that had different inputs into the profession. Well, lots to unpack there. And thank you for providing that background. I mean, first off, I think the majority of our listeners are either audiologists or hearing instrument specialists. And one thing I would have ask you first is what lit that fire under you to become and recognize at an early stage the need for professional involvement?

You know, it's funny because I didn't volunteer a lot in high school and Undergrad. Undergrad. I had a job in undergrad where I worked a lot. And so I Didn't really have the flexibility of volunteering as much. And I went to my first aaa, which was in Philadelphia, which is my hometown.

I was a first year student, and Pitt was still in that transition period. And so we went to Philadelphia for the conference and we saw students walking around with the little NAFTA ribbons, and we're like, what is that? And so they describe it to us. I went back and I immediately was like, we need a chapter. We need to start it.

And I think part of it being that, you know, I saw audiology not just like, as a major, but as my career and as my professional home. Like, this is. This is who I'm going to be. And if this is where I'm going to be for the rest of my life as a working individual, I need to participate in that and I need to provide, you

know, work and time to it. And, you know, I think there's always benefits to that too.

Right. You know, so when I was a NAFTA student, I got to meet students from all these other programs and I got to see, okay, well, how are they doing it at this school and how are they doing it at that school? Like, you know, how can I take that information and bring it back and how can we change things to make it better? And it was just this, you know, opportunity to give back. I mean, and I think that's, you know, it's so cliché to say that, but, you know, it's tough for professional organizations because you rely a lot on volunteers.

And it takes time and it takes commitment. And the more I did, the more I was rewarded internally for doing that. I got to meet other people. I have, you know, friends across the spectrum of audiology, and that was rewarding and getting to see things accomplished. Like, one of the early committees I was on was the public relations committee for aaa, and they wanted to start Audiology Awareness Month or something like it.

And they're like, we need somebody to work on this. And I'm like, I'll do it. And so I sat down and I compared, like, different types of organizations and their months. And from that created Audiology Awareness Month in October. And so that was something.

I'm like, okay, well, this gives back and this is something that we can use going forward. So those things were just very internally motivating. And, you know, it was beneficial to me as something that I accomplished, but it was also beneficial to the profession, patients, colleagues, future students. And that's kind of what has propelled me to keep doing that. Yeah.

And timing is everything. The Other area that I'm interested in is, you know, you chose to focus on vestibular as an area of research and clinic. You know, both when, when you were at the va, I remember. And do you still see patients occasionally? Now I see patients.

I saw patients today. I had clinic today. Yeah, I do still see patients. Yeah, I think that's particularly important. I do as well.

And I think it's a way to keep your saw sharp and patients will always challenge you, to really challenge the assumptions of what it is that, that you're doing and why it is that you're doing that. But so many audiologists I think really kind of take for granted that it's hearing and balance within our scope of profession. And I say it's, it's a big capital H and a little B in many cases, but you've really embraced that. And I think looking at the way that falls impact and the opportunity for many audiologists to establish themselves in their area if they go into a clinical practice or in an academic center, vestibular is an area of great opportunity because I like to say it's one of the areas that audiologists get to do where we really get to treat patients if they have benign positional vertigo in a way that can, can resolve the issue. But when you got to nova, how important was it to you that you really grow that, that vestibular area?

Yeah, so vestibular has interested me since my first year at Pitt. And you know, Pitt's actually really well known in the vestibular world, but not in audiology and, you know, in medicine and pt, but not in audiology. But the thing I liked about it the most was puzzle format. You have all these pieces and you're trying to put it all together to create this, you know, this answer to why they're dizzy. And it takes a lot more parts to it, you know.

And I just liked that puzzle component. And so my entire time when I was a student, any project that I could possibly make about dizziness or vestibular or balance, I did it. And you know, when I went to the VA for my externship and I was like, oh, I really like vestibulum. And you know, when I was a student, there wasn't as many people who were truly specialized in vestibular. I can think of a handful of people out there, but that was a very small number.

And so, you know, a lot of the people who are my generation or older were really self taught or had limited information and we had to really grow the rest of it. And, you know, vestibular testing has changed dramatically since I was a student. Like, vemps were C bump was just coming out. You know, OVM didn't exist. I mean, it wasn't a test.

Vhit wasn't a test. There was all these things that didn't really. We didn't know. And so when I got to Nova and, you know, I told them that, you know, this is my area of interest. And, you know, as I developed, you know, I was given, you know, half of an advanced course right up front.

And, you know, as I progressed in my, my tenure here, you know, I really was showing them the benefit of, you know, teaching this to our students and growing a whole new generation of audiologists who know that vestibular is a specialty. It's not just tacked on somewhere. It's not half of an electrophys course. It's not, you know, by the wayside that this really is something that's really important and it's a place where you can specialize and, and do things a little differently, you know, and I, you know, I'm looking at eyeballs all day instead of, you know, ears, you know, so it really was important for me to really, you know, focus on that. And I will say that the people who are my generation who are also vestibular audiologists, you know, who are kind of placed throughout the country, you know, over time, we've really seen this influx of students being interested in vestibular because there's people for them to look up to who do it and do it well.

Yeah, I love that. And I think you've. You've really led by example in that regard. Now, I would say that it's not just audiology where we sort of, you know, push balance away a little bit, just because many people like myself grew up in the era where we simply did caloric testing. And that usually ended with someone getting sick or maybe multiple people getting sick and.

But. But I would say ents as well. It's hard in many cases to find otorhinolaryngologists that are keenly interested in working with dizzy patients or patients who have their ears ringing. In your dad's practice,

did he see dizzy patients? Did he embrace it?

Did he sort of tolerate it? Or was that a model for you as well that kindled that interest early on. Yeah.

So with my uncle's practice, he was. Uncle.

Sorry. Yeah, it's okay. With my uncle's practice, he, you know, it's a rural part of Delaware, so he did see pretty Much everything. But dizziness was certainly not his expertise. And so if he did have, you know, more significant disease issues where he couldn't figure them out, you know, he would refer them either up to Wilmington or to Baltimore, to Johns Hopkins.

And so that's a significant drive to either one. And you know, so that, that is a hardship. So he tried to do as much as he could as a more, you know, small town, rural area, but he, it certainly was not his, his favorite type of patient. And that's, as you mentioned, that's true amongst Ents. I mean, they're just as specialized, you know, between you know, the nose people and the throat people and you know, and even just the ear people don't always want to see the dizzy people.

Well, and not the least of which is the equipment necessary to do state of the art testing is expensive.

And now if you establish yourself as the expert in that area, it's, it can be very profitable as well. But, but it is an investment in equipment that goes beyond an audiometer and a test booth in many cases.

Yeah, I mean, he had vng and, and when Bems came along, he had electrosis, so he could do vemps.

But yeah, I mean the equipment is expensive, you know, and, and you know, when you're looking at physician time where they may have multiple patients scheduled for a short incremental, a vestibular history is a long period of time.

And so, you know, taking up this much time to get at a dizzy history is also problematic, you know, for a lot of their, you know, revenue streams to try and keep up with how many patients they need to see to, to make a profit. And well, and even in the audiology training programs. I've seen your program and

your facility at Nova and it's beautiful. But, but it is, and probably took some, some arm twisting to sort of commit to the investment necessary. And I think this is really in many ways a large part of, in a lot of programs, given that we have many smaller programs that then, you know, making that investment for the vestibular equipment to educate the next generation and provide the clinical expertise in house is really challenging.

Yeah. And you know, and if you're, if that's your expertise, it's, you can talk about the benefits to that equipment. But a lot of programs don't have somebody where that's their expertise. So not only do you have expensive equipment, but you don't have somebody who, you know, wants to maybe deal with that equipment on a regular basis. You know, they're teaching that class because it's necessary, but that may not be their area of expertise.

So that makes it even a harder sell when you're looking at, you know, a bunch of different pieces of equipment that are all expensive and take up space. It does. Yeah. And well. And now turning to Fall Prevention Week, I think beginning September 23rd, I know this year's theme is awareness to Action.

We've seen awareness for the importance of preventing falls increase in recent years and this fall I think is no different. But now what are some of the goals for moving as somebody that, as you mentioned, was on the the Balance Society board and now you are president elect of AAA and will begin your term as president on October 1, what would you say are some of the high level awareness into action goals for this year's Fall Prevention Week? Yeah, you know, I think it's just really simple in one regard. You know, I think one thing that every person can do is just ask about falls and fall history. And that's, you know, in the past several presentations I've done to various groups, you know, not everybody's going to be interested in doing vestibular testing and not everybody's going to have the time or the resources to do that.

But everybody, you know, takes some amount of case history and just asking have you had a fall or a near fall in the past several months of the past year can really make a big difference because if somebody has had a fall or a near fall, they are so much more likely to have a fall in the future. And, you know, there are, you know, injuries related to falls. Right. We've talked about, you know, hip fractures and you know, I think a big one that I don't think it's talked about enough is really traumatic brain injuries related to falls. And so just very simply, just asking and then having a place to refer them to, you know, whether it's to a vestibular audiologist to do vestibular assessments or if you don't have that in your area, because not, you know, I live in a pretty metropolitan area, but if you're in a more rural area, you may not have access to that type of person.

So referring them to physical therapy for, you know, a gait and balance assessment, just doing those two things can literally help save somebody's life in the future because there are deaths that are related to falls. And you know, in that statistic, I think the CDC quotes it like Every 20 minutes somebody dies from a fall. And, you know, if you can just, you know, add that to your history, it can make a difference. I'M glad you brought up the cdc, because they did as you said, they, they studied and said. Three questions that every clinician can ask is do you feel unsteady while walking?

Do you worry about falling or have you fallen in the past year? As you said, falling in the past year is a strong indicator. But those three questions, unsteady while walking, worry, worry about falling and having fallen in the past year. If, if people address one of those three questions or more with a yes, that predicts 95% of the patients who are at elevated risk of falls. And then, as we mentioned, the mere presence of untreated hearing loss.

And it's thought to be for a variety of reasons, but cognitive load, if you will, the amount you have to concentrate on hearing and then navigating your visual environment to make sure that there isn't a trip hazard or some other hazard, if the lighting is low, etc. But those three, you don't have to immediately

invest in a bunch of equipment. But if you're seeing patients with hearing loss, it's very likely that you're seeing patients who are at a risk. And those three questions will address 95% of those at elevated risk. We, I think, as you know, since 2019, have wanted to take that one step further as we became the industry's first and still only manufacturer to incorporate motion sensors, gyroscope that, that can detect a signature of a fall and then alert up to three contacts in the hopefully unlikely event that someone's wearing their devices and suffers a fall.

And then even taking advantage of the smartphone world these days, that if they're wearing their devices, they're connected to their smartphone and they fall. If they lose consciousness, as you said, or have suffer a temporary or traumatic brain injury, the person that received the alert can actually see where that person was when they suffered the fall. And you know, we think, and we've heard a lot from the field, from patients, from their family members, from caregivers about the peace of mind that that provides. And I don't know whether you've ever had the opportunity to see it or see it in action. I think it's not designed as a 24, 7, 365 for someone who's at extreme risk, like if they get up in the night and they're not wearing their hearing aids.

But for, for patients who are at an elevated fall risk and they simply want to wear their hearing aids and have the confidence to know that if they suffer a fall, someone's going to know about it. And speaking as A baby boomer. They're not going to be the woman laying on the floor that said, I've fallen and I can't get up. Yeah. And, and those situations of people falling and not getting up are absolutely true.

You know, I remember those commercials and everybody kind of laughed because they were a little over the top. But I mean, I've had patients who have fallen and said they've laid on the floor for hours until somebody came to check on them and that person just happened to come check on them. Yeah. So, you know, Starkey's fall detection has, has. Has been on my mind since I first saw it come out.

And I have brought it up in presentations, you know, for those patients who we do think are fall risk, that this is another tool that can be used. Absolutely. And I was so glad because I remember Starkey in the beginning first had it in their kind of premium level technology. And I was so glad to see it come down into all of the levels because, you know, we know that, you know, people who have a lower socioeconomic status have generally poor health and therefore higher risk of a potential fall. So I was so glad that that technology was available across the spectrum of products.

And yeah, it is something that I have brought up in presentations because it is such a great tool for this population that I see and patients who are being seen by other providers, the non vestibular people may not necessarily think about it. And so if you're asking that question and they have, you know, some sort of concern about their balance, that that may be one of those kind of, you know, features, hearing aid features that may drive you to that type of product. Well, we've had more than a few providers who also haven't have hearing loss, who thought, well, you know, fall, fall detection features just for old people, and then they suffered a fall. And now they are some of our biggest advocates in this space. And so thank you for bringing that up.

I also agree completely that falls should know no budget or socioeconomic status. And that's why we did want to extend that, because we believe that hearing care is healthcare and those highly comorbid conditions and falls in the aging population are right at the top is something that we really feel is important. Obviously hearing the job one for any hearing aid is to help people hear better. But if we can tie along other features that all they have to do is just wear the devices and then know that they'll have some peace of mind for themselves, for their family, even professional caregivers, that's a win. But you know, one of the things we also know.

And it's a fall detection feature as good as it is. If it accompanies a broken limb, broken hip, broke broken leg in the aging population it can almost be too late. And so we've been working aggressively

towards moving from a fall detection or a fall alert feature into one that can also take advantage of those inertial measurement units. And the elements of the steady protocol, the stopping elderly accidents, deaths and injuries also developed by the cdc, the Steadi protocol. And we we picked and isolated three categories of the subset of the steady exercises that were focused on gait strength and balance.

And we completed a study with Stanford and are in the midst of rolling out a feature in a new product that will have the capability of providing compare comparison results to what would typically be done in a clinical environment where an observer, typically a physician audiologist as PT would look and see how well a person can balance for 10 seconds with their feet next to each other, astride one in front or with one foot up and how they compare to the normative data. And we found high correlation and I think you came to my presentation with Matt Fitzgerald that we did at AAA this last year and you know, high correlation between the observer on the, on the balance part of the thing. The strength test, how many times they can stand up and sit down in 30 seconds. And then the final one assessing gait is starting in a seated position in a chair, getting up, walking 10ft, turning around and sitting back down again. It's a timed test, but it can also pick up sway.

And then really the longer term goal will be to pair that with identifying which area specifically balance, gait or strength where there is a weakness and then allow the individual to partner that with using balanced training tools that could ideally then reduce their risk and hopefully in the long, long goal, prevent a fall before it occurs. We're a ways from that yet but that's our really plan and we really share that with those who are interested in balance. And so you know, for me it's, it's vestibular has always been second or third on my list of priorities within the hearing space. Hearing aids has always been number one, cochlear implants and vestibular two and three, sometimes changing that order. But but it's exciting to see to bring that to market again for those individuals who are at risk of falling and want to do something about it, want to do it in the convenience of their home to supplement what would be

done with physical or occupational training and therapy rather and then visits to a vestibular audiologist for assessment.

So we're excited about that and that's exciting. You know, it's, you know, any of those tools are really helpful. And you know, the next step is really bringing PT in so that they understand what hearing aids are capable of, you know, and what they can use. I mean, I could see a whole line of research looking at, you know, how that impacts assessment on the PT side as well, and monitoring, you know, improvements in gait and balance training. So you have a long line of research ahead.

As usual. We're running out of time. I knew we would because you've got a lot to say. But I do want to transition a little bit. You'll begin your term as AAA American Academy of Audiology President in October.

And you know, you've been a part of that organization, as you said, since you were a student and you participated and received awards so many I can't even list, you know, outstanding Educator award. You were in the future leaders of audiology group, the, I believe, if not the inaugural one, one of the very early ones around 2010. And you have been on the ABS board of directors, but now with the AAA board and then coming back to serve as president, talk a little bit about what are the issues that are most concerning you. You have one year term and that's always the challenge with AAA is that it's a very short term and about the time you're just getting going, you're passing the baton to the next leader. Yeah, I mean that one year is a, is a short period of time, but, you know, it's all about, you know, collaborating with, you know, the president before you and the president after you.

And so Bopada Bachandra has been the current president and his big focus was on increasing membership. And so that is still something that, you know, we'll continue to focus on. You know, members are so important to help drive, you know, what are the goals, what are, what do we need as far as advocacy, you know, and those components of a healthy, successful organization. But you know,

I think one of the things that is kind of a crux of the, of the perfection is really our compensation. And you know, throughout the years, you know, I was on the board 10 years ago as a, as a board of directors member at large.

And now coming back, some of the same issues are still here and I'm sure they've been here for a very long period of time. But you know, compensation and how we get paid is always such an issue. And, and really how do we go about Improving that. And you know, part of it may be, you know, legislative and coding related, but also part of it is just standing up for, you know, the services that we provide and, you know, having the ability to say, well, this is what it, this is what it costs and this is what we're charging to do the things that we need to do to help successfully see patients and provide the care that we need to. So, you know, compensation is kind of a background focus and thinking about, you know, where the organization is going and where can we help our membership.

That's definitely one of them. Another is, you know, looking at what really sets us apart and how, how does Audiology really fit in the healthcare space going forward and where are the areas where we have opportunity for growth, where do we have opportunities for showing our excellence, showing our ability to provide high level care, practicing at the top of our license. So, you know, we're really looking at what is the organization doing and how does it support our membership in these, these types of ways. So part of, part of what we're going to be doing is kind of looking in house to see, okay, what are we doing? How do we, how can we fine tune this a little bit better for what our membership needs and wants that will help project us into a, into a more, you know, into a better space for the future to come in Audiology.

I think, you know, and as you said, some of these problems have been around and challenges have been around for a while. Back near the turn of the millennium, when I was president of the academy, we were really focused on direct access and really wrapped up in that is just really the ability for someone to come to an audiologist without needing to be referred. And then also I would say

embedded in that is the value of service untethered from a device or a product. And I think that's a miss from my generation. You know, I think we really need to harness that for the discipline moving forward to really have the perception of the benefit of service and also the value provided by the professional of that service.

So I know you're on top of that. I think also you mentioned compensation and really embedded with that is the cost of tuition. When I was an undergrad and graduate student, it was a very different environment to when you graduated. And I know you did an excellent paper several years ago now that you published in Audiology today looking at generational debt load, if you will, cost of expense. And when you graduated back in 2005, 23% of the students surveyed from who graduated that year had debt of less than \$10,000.

And then you fast forwarded in your examples to a decade later and it was 15% had debt over 160,000. And in 2022, the last year that you had in your paper, it was nearly 17% had debt of more than \$200,000. That's just mind blowing for the baby boomers. And you know, and, and thinking about all of the opportunities that we had to offset tuition is a burden that I think I worry about the students coming out now. I'm still as optimistic for the future as I was when I was a student.

But how do you address that? Because I'm sure that's gotta be top of mind for a lot of young professionals recently graduated or those still paying off tuition debt. Yeah, and it is. I mean, and I will full disclosure, I graduated between undergrad and graduate work. I graduated with about 160,000 in debt in 2005.

So you look at that graph and there's that small percentage. Yeah, that was me because my particularly my undergrad cost quite a bit. You know, it's tough because, you know, I think that programs have, they don't have as much say in how much they can charge within this gigantic institution of a university. And I think that's where, you know, I think a lot of program like I, you know, we would love to make our

program so much less expensive to attract students, but the university is not going to allow us. And so I know some programs, including ours, have gone to a three year model to try and get students out quicker.

But I think that, you know, part of the issue is that you're coming out with this debt, but then what's your salary on the back end? You know, if you're looking at medicine and you say, okay, well you're going to take out 300 grand in student loans, but your salary is going to be, you know, several hundred thousand dollars. It's a lot easier to swallow that versus you're going to come out and the average audiologist is making like \$80,000. It makes it really hard to justify that. And I think it's that debt to income ratio that's really off.

And so what can we do? Well, we can't say to X university, well, you need to charge less per credit. But we can say, okay, well from the professional side, how can we increase that income side so that we can make it more attractive? I feel like audiology has not been able to keep up with, you know, changes in salary over time. And I think that's really where that Crux of that situation is, yeah, the student loan debt is, is definitely a problem.

And, and trying to address that across, you know, different institutions, you know, scholarship availability, you know, money availability, that, you know, that's really hard and the income side is hard too. That's, that's, it's always going to be hard, but I think that's where we have a lot more push or a lot more opportunity to change things. But, yeah, I mean, there was a point. So I do that survey every other year. So this fall I will be collecting 2024 data.

And, you know, at one point I had to add. I was only going up to like 150 to like 200,000. And it got to a point where I had to add another category of student loan debt amounts. And, you know, it's a, it's a tough, it's a tough pill to swallow considering that I'm still paid. You know, I know if anyone's up to the task to really assess where the students are and considering with the board that you'll be working with,

you've got this.

But the, the, the last thing. And we really are out of time. But I know as well, equity has been an issue for you as well. You mentioned, you know, equity. We're, we're a profession that is nearly 80% female, yet in many cases, it's still the case that males disproportionately are in positions, leadership positions, more than females are.

I know that's part of your platform, and I know at AAA in Seattle, I think it was, we had an outstanding speaker on diversity, equity, inclusion and belongingness. And so my last question to you, Israel Green was his name. He's outstanding. But to a young professional, or to an existing professional, as now the, the, the figurehead for the Academy of American Academy of Audiology, what, what, what do people need to feel or how, how is it that you make them feel like they belong in the academy as part of your platform? What would, what will you do to increase the feeling of belongingness to the professional organization?

Because there's a lot of organizations out there. Yeah, you know, I think that, I think we have a lot of work to do to, you know, make our profession a profession of belonging where we're, you know, very heavily, you know, women in numbers, but we're also a very white profession. And so I think that first of all, you know, beyond, you know, the academy, but I think programs need to, you know, reach out to people from various backgrounds to just even enter the profession. You know, we, you know, we reach out to historically Hispanic universities and historically black colleges and universities to try and bring, you know, diversity into our profession. We need that.

And so, you know, I really, you know, the academy has, you know, a DEIB committee and we have representation to the different councils for that. But I think it's also, you know, trying to invite various people into presenter positions, into committee positions and really bring people in because, you know, we need that diversity and hearing from people from diverse backgrounds. You know, I have one life

and I have one perspective and I, you know, I don't necessarily understand some of the issues that other people have. And so we need to bring them to the table so that we can hear the various lived experiences that people have had so that we can make our academic program stronger, that we can make our patient care stronger, we can make our profession stronger. So I, I really feel like that's a, that's a big part of, you know, what we need to strengthen in audiology.

Overall, 100%. And, you know, I've heard it said, you can't be what you can't see. And so we need to have representation from individuals because I would say college is too late. High school maybe is already borderline too late. We got to capture people's interests and unless they can see audiologists that look like them, if you're a minority, that you don't even consider it as a profession.

So. Well, thank you so much, Tish, for having this conversation about your professional journey and your professional involvement through every stage of your career, through the important Fall Prevention Awareness Week. And then also, I wish you much success during your tenure as president of the Academy, American Academy of Audiology. And I know that you're up to the task, but thank you for being with us today on Sound Bites. Thank you so much for having me.

And for our listeners, thank you for listening, as always. If you like this episode, please share it with your friends, your colleagues, your network. Subscribe so you don't miss any future episodes. And if you have ideas for future content, send us an email@soundbytestarkey.com that's soundbitestarkey. Thank you for listening, and we look forward to seeing and hearing you again very soon.