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Setting the Standard: The Standardization of Audiology, presented in partnership with the Audiology Practice Standards Organization (APSO)

**Presenters: John A. Coverstone, AuD, Amit Gosalia, AuD, Emily McMahan, AuD,
Nicole Anzalone, AuD**

Hello, my name is Carolyn Smaka with Audiology Online, and I'll be the moderator for your course.

Today I'm very excited to introduce Setting the Standard, the standardization of audiology, and today's course is presented in partnership with the Audiology Practice Standards Organization.

These are our disclosures.

These are some risks and limitations, and these are the learning outcomes. After this course, you'll be able to explain the difference between practice standards, guidelines, and best practices. You'll be able to explain the practice standards and how they are used in the didactic and practical education of audiology students, and list three ways standardizing practices are important to patient care. We're very pleased to work with APSO on this course. You'll see this format is a little bit different than our other courses.

There are no slides for today. This is actually a dynamic video recording of panelists from the organization discussing how practice standards work, their role in clinical practice and in audiology education. Please download the handout that goes along with today's course. Like I mentioned, there won't be slides, but that handout will serve as a great resource for you. And without further ado, we'll start our video.

I'm John A. Coverstone, executive Director of Audiology Practice Standards Organization, and I would like to welcome you to our very first episode of Setting the Standard. Joining me today is, to our far right, Dr. Amit Gosalia, who is a founding board member of APSO, a prior president of APSO and an audiologist at West Valley Hearing center in the Los Angeles area. Next to Here is Dr. Emily McMahan, former president of Audiology Practice Standards Organization and owner of Alaska Hearing and Tinnitus Center. And to my right, Your left, is Dr. Nicole Anzalone, who is current vice president of APSO and the owner of Syracuse Hearing Solutions. Welcome, everyone.

Thanks for joining me today. Thank you for having us. So I'm going to start with a question for Dr. Anzalone, and our topic today that we're discussing is standards in audiology and standardization in audiology, why that's important and what that means to us as audiologists to become standardized in our practices. And so, Dr. Anzalone, when we talk about standards, what would you say we're describing when we say a standard, and how are these different from guidelines or best practices or scope of practice and all these other things we talk about? Sure.

So a standard is basically the foundation of the minimal requirement that's sufficient enough to be able to take care of patients efficiently and safely, whereas if you think about guidelines, they're more like the structure to build from there. So they're more of recommended guidelines of what we should do for practice that have a little bit more flexibility. Okay. I know sometimes at apso, we talk about laying the foundation with our scope of practice, because that's our legal definition. Standards kind of being right on top of that.

Dr. McMahon, how do you use standards in your practice? So I think it's important that when you have multiple providers in a clinic, especially when we get patients from all over, is that they are receiving the same experience from one clinic to the next. At a minimal level, you never want someone to have gone to a different clinic, whether they've moved or had a transfer of care and feel like they weren't receiving certain parts of the testing or protocols. And so from a standards level, I know that all of my providers in my clinic are at least performing X, Y, and Z, so that we have consistency, and that also should be consistent. If I were to get a patient from Dr. Anzalone's clinic or from your clinic, those patients should have a very shared experience.

Now, our goal is never to only provide that experience, but at minimum, we want to make sure everyone's receiving the same standard of care, and in very timely fashion. We have an emergency going on outside our recording room, but such is life that happens. Dr. Ghazalia, I know that you did a

lot of that foundational work for APSO in researching other professions. There are standards. One of the things I've noticed is standards are talked about a lot in other professions.

How did we miss that boat in audiology? Yeah, that's a great question. There's probably not one single answer about that. I think the reality is that audiology is a fairly young profession. I don't like saying that often, but we are.

And I believe that when we first got into creating audiology, we looked so hard at creating not only the foundation of just scope of practice, but then we jumped to best practices. And I think sometimes we. Or back when we started, we missed that first foundational thing that Nicole was talking about earlier, which was the standards of practice. There are so many other professions that we looked at. Physical therapy, optometry, not only in the US but even international.

What are their standards, and what did they do or what are they continuing to do to keep their standards up to date? So, unfortunately, we didn't miss that boat. But luckily, APSO is here to fill that gap. We're certainly trying. And when you talk about the standards like that, it kind of occurs to me that we talk about best practices in a lot of the same way when we talk about these different things.

So for the audiologist who isn't familiar with this, how would we differentiate those? How would we use these differently? Yeah, great question as well. So if we think about standards of practice are the minimum that we should be doing. Right.

So as Emily mentioned, you get a patient from another practice, there should be just a minimum amount of stuff that we should be doing. Best practices should be what we're striving to achieve. Right. In our practice, we strive to provide best practices for every single patient. And unfortunately, some practices just don't do that.

But at least we have to create that foundation first that at least do this. And if you do this, then you can try to achieve this, but you can't achieve best practices without at least having the foundation of standards of practice. Sure. So it becomes a little bit of a measurement. Absolutely.

Something you can measure yourself against. 100%. Yeah. Okay. I want to ask Dr. Anselm another question.

Dr. McMahon talked about this a little bit earlier, but how do you use standards in your practice? What does that mean to you and its importance in your clinical practice? It's the basic, most basic level of things that I should be minimally doing to make sure that I am effectively taking care of the patient based on evidence, so that I know that in my office we have some consistency amongst our providers and to make sure that we are offering them the best care possible and so we don't miss anything. Okay. And I want to just to get all around because I want to hear everyone's different perspective.

How do you use standards in your practice? Yeah. So when we especially we see a lot of students and we train a lot of students, and, you know, the beauty of standards of practice is that we can actually provide this educational model for our students to say, hey, when you're seeing a patient, this is the minimum amount that you have to do. Right. So every single patient that comes in, you know, we document everything that we do, make sure from top to bottom that we're following not only the practice standards, but also, as I mentioned earlier, best practices as well.

Sure. Well, and then you mentioned students, and that's something I wanted to ask about. It seems as if standards would be applicable to education. I think all four of us teach in some capacity and work with students. And so just to stay with you, Dr. Ghazalia, how important do you think that is to educating our Future colleagues?

Oh, 100%. And I think some of this needs to be all of it should be taught at the educational level. Right. It shouldn't be left up to us and our practices to do it. But there is some hands on that needs to be taught in the universities and the AED programs.

They need to be teaching these students that, hey, these are the practice standards that this is what you minimally have to do and every student has to follow that. I think at some point every state in this country, hopefully if things go right, will adopt the standards of practice that we've developed at APSO so that no matter what you get licensed in a state in this country, you have to follow these basic minimum standards. 100%. Teaching students from day one that this is the minimum that you have to do is hyper important. Well, and I'm going to ask the hard question.

Do we think there are students that are being educated not to minimum standards? Yes. Oh absolutely. Unfortunately. Unfortunately there's a wide gap in terms of just where do they come in from a knowledge level, can they recognize that something wasn't performed?

Do they know why they didn't? Or why would we even ask to do certain tests? I do think that there's a lot of inconsistencies. Certain programs definitely seem to have a really positive track record covering more bases than others. But there's definitely a gap in consistent education across our AUD programs right now.

And I think there's also maybe a lack of education on the provider side on what are practice standards? What should I be teaching my students? Because unfortunately right now, as long as we have a license, we can actually mentor students. There's no prerequisite that hey, you have to do all these things before we'll ever send you a student from the university. So educating the providers on what are the standards of practice is also equally as important as teaching the students.

I'd like to see the programs hold preceptors and locations to those standards as well. So if the schools are teaching it and inherently teaching our young providers that this is what you minimally need to be performing. That way when they go into different externships and rotations, if something's not happening, they have a voice to be able to speak up, to be able to safely be able to make a change, rather than just continuing bad habits and not creating that standard for themselves as a future provider, but then also their patients that they're helping to take care of during those times. Sure. Well, and let's talk about those consequences because that's part of this and we get that question a lot at apso.

What if I don't follow them or for the people that want the profession to be at this standards level universally, some people talk about the person down the street from them, you know what's going to make them follow them. So however you want to frame that, what's your thought on that? What are the consequences? What happens if you don't follow standards and you just go by the seat of your pants? Well, sometimes it could become a legal issue if a patient, if something happens to a patient and they're in a court and you have to be a witness, an expert witness, you have to prove why you are an expert, why do you know what you know in your profession and why you do or why you didn't do what you didn't do.

So you have to prove that in those cases and that could cause some trouble for you or the patient. Yeah. What else? How do we think that standards maybe affect, for instance, ethics? You know, I think when we're looking at there, there's a lot of we've thrown a few words around, we've got our standards of care, but then we also have to pull scope of practice in because different states have different scope of practice rules.

Not only are you beholden to the licensure of which we all hold based on our different states, but we need to be aware of that as well. For example, I practice in more than one state and I have to, in certain

states have a slight different scope of practice that I have to be aware of. When you're looking at that, you always want to be practicing to the highest level. That way, in the event, like what she was speaking of, is if someone were to end up in court or there were to be something that gets brought into question, can you appropriately defend the choices of which you had made? Was it within the patient's best interest from both a safety perspective as well as what their health care was dictating?

We do. But then also being able to uphold on the back end the licensure laws of which we have agreed to adhere to when we're practicing healthcare in that state. It also allows to make these laws more universal between states. And again, looking at the consistency state by state, they should be universal measures. There should be universal means and standards by which we follow no matter where we are.

Hopefully one day. Yeah, that's the goal, right? It is, yeah. That's the goal.

Okay. I didn't want to dwell on that too much, but I think that's a question we get a lot, and I think that was an important one to answer.

We have this really popular idea in patient care for the last, I don't know how long, 10, 15, 20 years, where we talk about patient centered care. Right. We're all supposed to be providing patient centered care, and that might even mean slightly different things to people, but it's supposed to be about the patient. So how do standards fit within that model of patient centered care? Yeah, I think the fundamental idea of patient centered care, which you just mentioned, is we focus on the patient.

We're doing everything that we do to help that patient. Well, it's all tied together. If we look at practice standards, that's what practice standards afford. We provide consistency between every single provider that's out there, every audiologist that's out there. If we're providing that consistency, then hopefully everyone's following patient centered care.

Well, and that sounds like that goes back to Dr. McMahon's point earlier that if we have consistency amongst clinics. So I mean, should a patient reasonably expect to get the same care when they go to an audiologist in California versus an audiologist in New York or an audiologist in Minnesota? Yeah. I think the word care can be very subjective. Right.

I think some people are personality wise, the way that they provide care might be different than the way I provide care. However, what we are providing has to be consistent. I think that's the important part is maybe not necessarily the delivery method, but were the correct basis checked, was there anything missed in their hearing health care picture and were all the right tests completed based on what case history was provided and what their concerns were given to us? And that should be consistent regardless of where you go and receive your audiology services. It's funny because how many times have we all had a patient come in and you're doing a hearing test or a hearing evaluation and you start doing in word rec and they're like, oh, my previous provider never did this.

They probably did, right? We hope they did, but how often does that happen? Or. I've never had this on my head before. What is this like?

Well, I did it last year on you, but, you know, I'm feeling pretty confident. You have, but yeah, so, I mean, it does make a difference because without those. There are some situations though that we've all had audiograms before that we've seen that have something missing. The patient doesn't know that they were missing something. And so then it makes for sometimes a difficult conversation to say, I'd like to do a retest or I'd like to have more testing completed.

We have some gaps in the picture that you came to me with. And this would help us be able to solve what concerns you were bringing forward today. If we had a little bit more adopted standards across the board, the goal would be those patients wouldn't have those gaps every time we got a transfer or an

audiogram from somewhere else or we got their records. In theory, it would be much more complete and we wouldn't have to have some of those difficult conversations. Yeah, it's nice to have that as a checklist.

It is. And it's good for historical purposes. You know, you can look back at old tests, you can see what's changed, what's not changed. But it's hard when you're trying to help build what that future of their hearing healthcare looks like if there's big gaps in their old history. Well, and how many times have we seen someone in our profession talk about I don't trust other people's results?

And so it seems like that kind of is what we're talking about here in some respect. Sometimes. Yeah. And I don't want to be negative, but it's out there. I mean, I hear people say that all the time.

And so would standardization help with that? It should. If everyone subscribes to following the standards, which would be what the intent and at that point would be the legal ramification. If it was able to get into true standards like what we've been working on in publishing and then getting it across all the states, then it would be needed to be adhered to. So that would provide some back end protection.

Now, things that we can't say is that suddenly would competitor A accept competitor B's evaluation? I can't change somebody's opinion on someone, but if it is a full, valid evaluation with no gaps in care, then you, the provider need to be making a decision. Is this an ethical concern or is this that I prefer to do my own testing? Well, is it in the patient's best interest to have a retest or is it just that you have a preference for it, but when there's lapse in the care, then you have a little bit more justification for asking for additional testing. And sometimes you really need that baseline to monitor the patient throughout their healthcare journey.

Sure. Yeah. You can't compare, for example, monitor live voice versus a recorded list. Right. It's not apples to apples.

Yeah.

And that brings up something that we haven't talked about and that is the basis for the standards. I mean, we're supposed to be following evidence based practices. And I'm just going to Go ahead and say we know that monitor, light, voice is not evidence based. Not to say that there's not ever a time for it. And I think we would all agree on that.

But these standards do need to be based in evidence to the greatest extent they can. Agreed.

There might be some times where we can't. I mean, would we say there are gaps in our knowledge at this point still? Oh, yeah, absolutely, in our profession. And so how would throw this back at you? How would you address that?

So if we do have a standard, or if you're trying to follow a standard and you recognize there maybe isn't good literature on something, how would you go about addressing that? Well, I, you know, it always follow things to the patient's best interest and in their care and their safety. So you do what you can. The way the standards are built is to make sure that you do have some adaptability and flexibility. Because there are exceptions to the rule in some cases because of personal unique differences between patients.

Every patient is different. But the standards are developed in such a way that we're following efficacy, we're following evidence based practices and research, but at the same time, we leave it open to those exceptions to the rule as long as we could justify why we have exceptions to those rules. Well, and that brings up a good point too. When we're talking about the standards, we're not trying to lock people into doing things a certain way. And that even would be why we have guidelines on some things.

They may describe different ways of doing things that are acceptable with different populations, for example. That's a real easy example. But I think that delineation for a lot of people is a confusing one. So I'm glad you brought that up. We've talked a lot about us as audiologists using standards.

We talked about using that for our patients, using it for students. There are a whole host of other providers out there in the world and I read an article a few years back that was written by a physician and it talked a bit about why standardization is important. When you're communicating and referring with other providers. Thoughts on that? How important do you think that is for audiologists when we're part of the healthcare community?

Well, you know, there's interprofessional collaboration is so important. And if a physician is going to refer a patient to me versus Emily or Nicole, for example, of course we're in three different corners of the country. However, let's say that was going to happen. Well, we have to ensure that we're all providing this consistent level of not only patient care, but also providing the right procedures for the right outcomes. So it has to be there.

I mean, we have to provide that, hey, audiology does have practice standards so that even physician groups or other allied health organizations or professionals can send their patients. Us knowing that the outcome is going to be a positive outcome, and you're looking at the whole person and we should know. And that's actually in their standards too, know when to refer to different types of professionals that may be involved in their care and share in the patient's concerns and help. Yeah, so I was gonna say that we have the trust between us as the provider and our patient. But when we're looking at that outside referral source, the physicians need to be able to trust that if they send a patient into our clinic, that we are then upholding that trust on the back end, that we will accomplish what was needed, but then also address it and then take care of it.

So I think it kind of closes that full circle that's so important. Yeah. And so how does that reflect on us if we're not standardizing our practices, if we're not following standards and we're referring patients to a physician and a physician one time from audiologist A gets this report and the next time from audiologist B gets a very different looking report. I mean, how does that reflect on us as a profession? I mean, I think as a whole, it hurts us as a profession.

If the physicians are receiving such inconsistent information back from our colleagues, how do they know who to refer to? How can we ask them to make a referral to us if they don't receive consistent information back when they do receive consistent information back from other areas? So, I mean, for our own self advocacy, being able to get that as a rule would be wonderful. But I know in my clinic we had a new provider come up. They just moved into the state, and in the state that they're coming from, they only referred to Costco because they knew what Costco was sending back to them.

Without question, the audiologist in their hometown was very. Sometimes would send things back, sometimes wouldn't send things back. Never knew if the patient showed up, never knew if they didn't come back. By completing that kind of circle, since that provider has moved into town, we've all been working on this and we had a good conversation a few weeks ago saying, I've enjoyed having options to refer and know that when I send them to your clinic, you guys respond back to me. It's such a tiny little moment of they took the time to refer a patient, we take the time to communicate back with them, send back the results and thank them for that referral.

But that's grown outside of him just making a blanket. Go to Costco, don't look outside of other referrals, all just based on basic communication. Well, and that was something I wasn't even thinking of. But that is a consequence as well. If we're not following standards, people might go find someone else who looks like they do, whether it's what we would consider a standard or not.

And so that's a little disturbing for our profession in a way that that would be an alternative is to not using an audiologist. Yeah. It does affect our reputation as a profession if we have so many inconsistencies in what we do. I mean, other referring physicians see that and say, okay, whose wheelhouse is this? Is this your position?

Is this within your scope of practice or is this someone else? So it really stabilizes us as the experts in this field, and this is what we should be doing for the patient. It is our job and our responsibility.

Is using standards and adhering to a standard something that we can promote?

Oh, absolutely. Yeah, for sure. Yeah. I don't see why we couldn't. Yeah.

I think within the profession and also outside the profession. Right. I think when we research different organizations or professionals. Excuse me, when we research different professions, most healthcare, if not all healthcare professions, have practice standards. And if they ever look up audiology practice standards, until recently, they would not have seen anything.

And some things that say their standards, they're actually guidelines, or they were best practices or they were scope practice, they weren't standards of practice. Whether it's interprofessional or outside the profession as well. I think it's very important that we advertise that, if you will, and solidify our position. Sure.

I would like each of you actually to address this one by one, if you could. But what would you still like to see in standards and audiology? What do you think we still need to accomplish? Yeah. I think the good news is that we've accomplished a lot already.

Right. We've gotten a lot of general standards. I know that there's tinnitus and other subjects that we're working on in terms of providing that standard of care. I just see a bright future I'm looking forward to seeing. I always joke that talking about real ear with hearing aid fittings shouldn't be best practices, that should be standard of care, those type of things.

I'm excited to see more and more audiologists doing that as just a standard of practice versus saying oh, best practices doing really or doing verification or validation. That should all be standards of practice. But in terms of the future, I think what APSO has in the pipeline is very exciting. I think it's been exciting.

I joined right after the first term, so I've been around from pre any standards being and looking at how many standards we've produced over the last several years and just knowing what is upcoming. I think from my perspective, one of the most refreshing things that I have found and I would like to see continue in the trend is when universities come up and say, hey, we've adopted these standards in our school's clinic. I think that's a refreshing information that they're open to new information, they're teaching the next generation of providers this information. And then to take it one step farther, I think the next step, big goal that I would love to be able to see get a little more traction is getting it into each state's scope of practice. I think if we could get some traction from that, this would just grow quickly because not only would it grow from an accountability standpoint, but we would have untapped potential.

Maybe there's another audiologist out there that we just don't know who's really passionate about a certain area that could help us create the next level of standards, depending on what content matter we have left to continue writing. And so I think every time we grow and get new people in, we just learn that many more people to, to help build a more quality standard by having different opinions from within the profession. So I think just the more kind of grassroots that we see grow, it will just be really exciting to

see it catch on. And not only just creating new standards, but also this is ever evolving. Right.

Every few years we have to readdress. Every five years. Every five years, right. So there could be some new blood edge that can come in there and say, well, you know what, this isn't the way it's supposed to be. And then have the consensus with the group.

Yeah, well, we'll have some of our first standards upcoming here for review soon. And you know, every time new people come in, it just gets that many more fresh opinions and ideas. And I think that's just, it's a cool way that such a small organization has grown in such a short period of time and following the new research that comes out and what's effective as treatment or evaluations and tests and things. So it's really, it's great that we evolve with the times and with the research and what it shows, I would really love to see all the state boards adopt the standards so that everyone is on the same level, even the certifying bodies, seeing aaa, seeing ASHA adopt them, just so it's out there, even internationally, being able to see everyone on the same page and even outside providers, non audiologists, to show them the strength in our profession and the credibility of our profession as well. Well, and that goes back to consequences.

Right. We talked about that a little bit earlier. And one of the things that might be good to touch on is you probably all remember, I actually researched this years ago and brought this to the group. But one of the landmark legal cases in standards is actually in optometry, and it goes back to the 1970s, 1972, I believe, where at that time the profession did not routinely do tonometry, which is a pressure test of the eye for those of you who may not be familiar with people under 50, because glaucoma is very rare with people under 50 or was found to be fairly rare. And so it was not routinely done.

Well, there was a lady who developed glaucoma and did not have tonometry done because she was under 50 and she sued. And this is, of course, one of the risks. We talked about this earlier, you know, having some basis for defending yourself, if that should ever happen. We've been pretty fortunate in

audiology. We don't see a lot of lawsuits in audiology.

We're fairly safe as professions go. We're not surgical, we're not prescribing, and that does give us some shelter. But in this case, there was a common practice, but no standard in the profession. And the court said, sorry, you should have done it. It's minimally invasive, it's low cost, it's quick and easy to do.

There is no reason that you shouldn't be doing that more widely. And so found that practitioner to be at fault, even though it was the common practice. And that case said common practice is not the same as a minimum practice. Sure. And I think that's a lesson that we have to take to heart as we talk about things like is a standard, ethical practice is a standard, you know, protecting ourselves somewhat legally and talking about state boards adopting standards and, and things such as that.

When we talk about standards development, just to shift a little bit, we're all on the same. You guys have all been in, in subject matter expert groups, so you've all, all helped develop standards. And we're always all on the same page with those. Right. Everybody agrees with Everything we talk about in the standards.

Yes, right. That's how it goes. Correct. Exactly.

Probably of the people here, the, the, the, the two on either side of me, the two doctors on your side of me are the ones that have been part of more contentious standards development processes. Talk about that a little bit. Let's, let's get into the, not the gossip but let's, let's talk about that process. I think before we get into some of that, let's back up and just explain it because I even sure self was quite unfamiliar with what this, this undertaking was going to be when we got started. And so what starts with is we put out kind of a call to action of is this something that you're passionate about?

Do you have, you know, do you have any published publications of articles or have you written the textbooks? Because if you look at often our subject matter experts, you're going to see very familiar names of who have credibility within the field for their contributions far before APSO came involved. And so you put together a subject matter expert group. John corrals us like a bunch of wet herding cats regularly and you just start putting together our ideas for what do we think and you know, kind of building this outline so to say. And then we argue for weeks upon end over this word versus that word.

And I think it's cool to see the passions come out to see why are some of the ones that Nicole and I have been on so contentious. And it's never been contentious as in you're wrong or I'm wrong or that's wrong. But just we feel so strongly about why we want these patients to have this level of protection and why we want to see these things there so that our future colleagues who maybe this isn't their level of passion, they can learn how to adopt to that or like what you brought up earlier, when do you know how to refer out? And so I think that's important. So after the first group of subject matter experts gets finished beating it for quite some time, it then goes to a second set of review where they then come in another group of subject matter experts and essentially rip apart everything that the first group did that comes back to us as feedback.

We then come and either make an adjustment, sometimes we do, we say, you know what, actually we accept their revision and we will adopt it or maybe we edited it. You know, it's this constant back and forth process. There's also a legal review that gets involved is also a public review that allows for comments from our colleagues from other providers, from Anyone that would like to comment. And then once it comes back from public review once again, that original subject matter expert team group sits down sometimes has to very carefully read their comments and think, okay, how did we fail at explaining what we were trying to deliver or did we miss a message and do we need to go back and re edit? And it kind of goes through that process again.

And so I just, I had no, no idea when we first started this that it was that intricate and how many times it went back and forth. And so I think having a little bit of an understanding of that and it's not just something that we sit down in one day and write and put out there. There is a lot. What would you say the average hour per standard, if you can potentially maybe not intake the rest of them? I mean there's a significant number of manpower in just the creation and then how much editing and back and forth goes into these.

Yeah, I've never thought of it in terms of hours, but a standard typically takes a year to year and a half to develop. Yeah. So I think, you know, when you're looking at it there, it's cool to think that something that comes down to 2 ish pages took a group of highly educated professionals that long to come up with because it really did come with the utmost intent. Thought education research. If you've ever wondered how to pick apart a works cited page, submit something for review and allow your colleagues to tell you they don't like any of your works cited to be put in.

You know, we laugh about that, but it's important because we want to make sure that if we're putting something in there that we are backing it up with the valid data that we can support it with, making sure that it's current and that it's something that we can be proud of for at least the next five years. And then like what you were saying earlier is we have to relook at it. Maybe some of it still holds true, maybe some of it completely has to change. And I think that's the beauty of this intricate process that John, especially you are so the organization wouldn't be where it is without your continued spearheading of it. But I think when you're looking at it from a manpower perspective, I think it's a, it's pretty incredible to see how much time, energy and fully volunteer goes into creating a standard, which is also then why we're so passionate about having our colleagues want to use them.

Yeah, you really put your heart and soul into it to make sure Everything's done right and done well. And I was intrigued at first because I had no idea what to expect as well. And it was kind of like a mental

data dump of all these really smart people that got together and we had to kind of strip it apart and simplify it to the most basic means to make it so that we are effectively saying what we need to say, not overdoing it and still pertaining to all the research that's out there and keep it basic and keep it not so time sensitive so that it does last for five years and not sensitive to any specific changes that may occur so frequently or recently. So it was an interesting process for sure. And it was great to work with some great colleagues, really, really intelligent people who are really passionate about what they do.

And we want to see it out there. We want to see people using them. Well, I'm glad you brought that up because when we write a standard, of course, what we've seen, especially for a subject matter expert, but even just for people reading them, they often want to go into more detail. And there are reasons for staying away from that detail. And you just mentioned a big one, which is timeliness.

And we have a lot of discussions about that. That. And I know that the two of you with, with a recently finished standard can talk about having to be reigned in a little bit from. Basically want what, let's be honest, you want to write a guideline as a subject matter expert because you know this in and out and you want to, you want to dive in, you want to get into that detail. But we can't do that because we want to make sure that these have a shelf life.

Yep. And we also want to make sure. This is what I want to talk about next. That we preserve the autonomy of the provider. Yep.

So let's talk about that for a minute. Because a standard is not trying to pigeonhole audiologists. Correct? Correct.

You want to take that one? Sure. Yes. Well, you know, the reality is that just. I think it was Emily that mentioned that it's a short document.

Right. The standard is not supposed to be this very detailed 10 page document on a specific topic. It's supposed to be a little bit broader. Right. And so that way there's a little bit of leeway.

But again, as we mentioned earlier, the consistency has to be key between providers. Providers. So when you're developing a standard, it has to be a little bit broad, broadly based. So. Well, I'm open for interpretation.

Open for interpretation. So that you, you still allow the audiologist to do what they think is right for the patient and. And have that leeway so they can decide what testing should I do or what treatment should I prescribe, for example. So that's why it's. It's.

It gets hard because we as audiologists want to write everything in there. Okay. Right. You know, I open the door, I need to face the patient and call their name. You know, there was one of our colleagues who's long retired, had a video out with one of the manufacturers where he's walking in front of the patient while the patient's behind him, saying, what?

I can't hear you. Those kind of things. You have to leave that, you know, up to interpretation of the right of the provider. Well, and the expertise of the audiologist. Correct.

We're not trying to take the expertise of the audiologist way. Nope. And that's part of the. Especially in some of the more like specific standards or like tinnitus or specialty areas or specialty areas is you have to address that there are specialty areas that require a different level of knowledge base coming into it. And so often what we would run into is how do you write it and allow them to know, but then also say, this is no longer my area, and then be able to come up with a stopgap for like what you were mentioning earlier.

We need to have a spot of knowing. This is a referral moment. It doesn't take away from providing care. It doesn't take away from the care that we are actively and continuing to provide. But how do you write into a standard also that it's time to make a referral to a different professional depending upon what was written in.

And that's where it gets a little hard, is you've got to have flexibility and there has to be room for motion and movement, but you also have to have a stop line that says it's now time to cross into a different field and then know how to do something with that. And so I think that was something we always tried, struggled with, was we wanted to have all of those details. And it's not out of fear, but it's out of protection of the patient. We want to make sure that someone maybe doesn't know these. Knew how to do it.

But then we would often get told to quit and back off and just say go elsewhere. And so, yeah, I think, you know, we would look at it from both protecting the patient, but protecting ourselves and then also protecting that value referral source because it really just keeps that such a nice, fluid picture. Yeah. And all these patients have such unique Needs that we have to stay adaptable and flexible and make sure those standards allow for that so that we could best take care of them and make sure of their safety as well with these referrals. Well, and we just had a discussion yesterday about something kind of related to this, and that is we get comments from people saying you should write in there that you shouldn't be doing this unless you have appropriate training and an expertise in this area.

And that we tend not to do that, but address that. Yeah. So the question comes up is, you know, what allows you to do this within your scope of practice? Is this in your comfort zone and knowing when to refer? So we have to kind of build that into the standard saying, are, you know, do you have specific training in this?

And if it is out of your comfort zone, you know, you should refer to the next professional who can take care of this patient because again, it's in the patient's best interest and the patient's safety. And that line could be different for different audiologists in different practices. So if you are looking at a specialty standard and you have a clinic that, that specializes in that, they're probably going to have a longer ability to care for a patient than someone that doesn't practice in that specialty. But within the standard, both are addressed and covered. And so, you know, being able to have that flexibility and the wherewithal of knowing, well, do I have the ability to take care of this patient or should I probably find someone else that is more capable in this situation?

And so even just in that one standard, you know, it covers both. Both someone that is an expert in an area and then someone who's maybe just getting started or wants nothing to do with it so that they both can be protected and know when to take the next steps. And we do address. It's a collaborative process. Yes.

Yeah, that goes back to ethics as well. I mean, for God's sakes, we're masters and or doctoral level professionals. We should know what our limitations are strengths are at. You know, I hear, we all hear this where, you know, certain physician groups that have audiologists, they don't want to call them doctors. Well, no, because it confuses the patient.

I don't believe that at all. I think the reality is that if I'm taking care of a patient and they need a surgical question, I'm going to say that's not in my realm. Let's get you out to the right professional. Right. So it kind of goes back to that as well, that knowing our limits, knowing when we're supposed to refer out.

You know, I know that we don't do auditory processing disorders in our office. If somebody comes in for that, you know, we're probably going to just refer them back to an APD specialist. Yep. I always say every specialist has their specialty. Yes.

Yeah, there you go. Well, and one thing we hear a lot from our colleagues is I'm a hundred miles away from anyone who does this. And so I feel like I need to do something for my patient that comes in with this condition. I mean, how does that relate to this? Because you're still basically admitting that you're practicing outside of your area of expertise.

And so what would you say to someone who said something like that to get the training? Yeah, I mean, we have continuing education available. We have different coursework. We can go. You don't only have to attend audiology coursework.

So go learn at some of the interdisciplinary. Learn how to make those good connections to better support that patient. If you're in a more rural area where there's larger gaps in care, I think that's part of our due diligence, is maybe we can't treat it, but we can know how or when or who to refer to to help close some of those gaps. But at the end of the day, if. If you're already making a concession for.

But it's because I'm so far away, you probably shouldn't be seeing that patient, because are you providing that patient your best version of your clinical self in that moment? Probably not. And they deserve to have the best version of yourself as a provider. And you can argue that if you're out in that environment where you're 100 miles away from the next, it's actually more important that you have that extra. Because you have more responsibilities than somebody who's in a very urban environment.

Sure. And what's great about us is that we're in a network. And I think collaboration is always important. We could always reach out, you know. Yeah.

Telehealth processes and things like that. We could always reach out to someone who does specialize in the field and, you know, can give you a call and say, hey, Emily. Yeah. I mean, being a small field, we all know each other from all across the country, and it is a. It is a skill set.

I mean, I. I've talked to. We've talked during the day before with patients around. I've talked to you. We've all done it. And if that's how we're able to provide the best level of care, then pass it off or find the gap, figure it out, make the referral, or go take the classes and go learn more.

If that's something you choose that you want to go get more passionate about providing that level of care to your patient. So maybe an opportunity. Yep. Always learning. Maybe those things present an opportunity.

One way to think about it, students learning. So I actually had wanted. Thank you again. I. I had wanted to circle back around to talking about students a little bit. I mean, I'm passionate about working with students.

I know you all are as well. And we talked about the importance of teaching students to the standard. I mean, if you're not starting with the standard right in a practice area, then what are you teaching?

But what are you all finding? Because I know you all work with students. So what are you all finding? I'm going to throw this to each of you in turn in terms of the students coming into your practice, how well prepared they are to standards that exist and how you're using standards, maybe in your education of students. Years ago, there was.

You and I were both on a board together and created a preceptor certificate. And I believe it was your voice on the actual classes that we could have been. It may have been, yes. And it actually was. The reality is that that was kind of a really nice foundational way of teaching providers.

Hey, this is what you should be learning when you're teaching students. Right? So from that, taking that and expanding on it, that, hey, these are the minimal things that we need to do as an audiologist, when you see this patient who's complaining about A, B and C, here's what we should be focusing on.

We keep focusing on best practices all the time. But again, I'm repeating now, but we've seemed to have forgotten about the foundation, which is what should we be doing versus what are we trying to achieve? I think that transition from going from a student to an audiologist as a professional is difficult because they're coming into the field knowing so much, they learn so much, but what do you do with all that information? So having that baseline, that groundwork, and using the standard for that, that base for them, that gives them some foundation of what they need to do. So they know they're taking this information and using it in a very organized, effective manner.

So it makes it easier for them to do their job and transition into an audiologist. I think it also builds confidence for the students if you know that, hey, here's the. Here, the. Here are the standards that you should be doing. Okay, well, that's what I need to be doing right versus do I have to think very hard about what I'm supposed to be doing versus you already have it, right.

I think they all come in at different levels. You have some that come in heavy with skill sets and diagnostics, and then you have others that come in heavy with counseling skills. And they don't always line up at the same time. So when they don't have to rely on just what am I supposed to do at every moment, that rubric being present for them is just a helpful guide. And think of how many different rotations they've been through before they get to their fourth year.

It's at least six, if not more. Well, that's at least six different clinics versions of ways of doing things that often are not standardized. So they then have to navigate that as well. And what habits do I bring here versus here and here? And so I think, you know, having that as a standard is just going to strengthen our students abilities to navigate from clinic environment to clinic environment, which will just strengthen their skill set while they still have the room to make errors and grow.

And that is the beauty of being a student is being allowed to still make those mistakes and ask and learn and do further. And so I think, you know, it just, it just allows a better teaching moment. That's consistency, that's not, well, this is my clinic's role or your, your clinic's rule. This is just what we all should be doing. And then they can start building in those little intricacies that's kind of who shapes them as an audiologist.

It is amazing. I do see a lot of students are like, yeah, we didn't do that at the other office. Yeah, yeah, I haven't done this before. So it is better for them and education wise for them to be consistent. Well, does that even provide a roadmap for students?

It just kind of popped into my head just now. But if you this, you know, putting myself back in those shoes from so many years ago of being a student, okay, I have a patient in front of me. I have to remember like everything we need to do right and much more how to do it. But even just making sure I don't forget to do something with this person when I take that first step into autonomy, into autonomous practice, where, where my, you know, preceptor has maybe gone from that, that personal supervision being in the room with me to that more general supervision where they're in the office and they're checking in with me after every patient but allowing me that autonomy. Is this something that, you know, could we have a diagnostic hearing standard at their fingertips, you know, for them to say, okay, I'll make sure you know that you.

I think it was you that mentioned checklist. Yep. It's almost kind of a checklist. Yeah. Or for your tinnitus patients, which is certainly a big area of practice.

And for hearing aid fittings, you. You may have something like that. I don't know if you use checklists. We do. I think it's.

I think it's important, especially when they're learning that they can kind of figure out their own repertoire of how they complete it to what feels natural for them, but then also knowing, yep, I did do all of those things. And we might say similar answers, but we all somehow hit those different marks, which I think is important for learning your own verbiage, rather than just trying to sound like Nicole or you trying to sound like me will never do it as well. So they have to find their own way. Hurting. But having checklists, I think is a very easy way to just let them know, like, I've covered all of my marks.

Yeah. You know, kudos for you, too, remembering your days as a student. I have no collection there. It's a dim memory. However, I tell my students, never script what you're going to say to every patient because that discussion might go a different direction and now you're stuck on your script that.

Wait, I have to answer this when they just answered it. So that roadmap idea or the checklist idea helps them. Oh, well, we just talked about that. Let me just check that off. I don't have to ask them, you know, why are you here today?

Well, I've got this ring in my ears. Oh, do you have any ringing in your ears? Didn't I just answer that? Right? Yeah.

So having that checklist idea is super important. Yeah. I think, Dr. Gazali, you've worked a little bit in. In medical education as well, or had some exposure to medical education. That has always struck me as being very standardized.

That, that experience of a student, of a. Of a. Like a fourth year, they changed about 20 years ago trying to get the fourth year medical students out more, into rotations earlier and not waiting until residency. But we'll say the fourth year in the residency being a highly standardized process from what I've seen. Would you agree with that?

It means that. Oh, yeah. You know, and of course, we're. We're in a different position in terms of health care. You know, I think you hit it on the head earlier.

We're sheltered that we don't. 99.99% time. Aren't dealing with life or death situations. But the reality is that their standards have to be so dialed in and you have to follow that to a tee because if you don't, you have a patient's life. Right.

So. Sure. So that's why it's so important for them. And we, we have to get to that point in audiology. Even though it's not life or death death, it's still something that has to be.

Usually that's why I said 99 point. But it can be. Yes. Yeah, it can. You know, you don't hear the truck backing up about to hit you.

That's the problem as a patient. Right. So, you know, we want to help those patients. Yeah, yeah. I like to compare it to air traffic control.

If every airport's doing something different, they're going to crash. Yeah, that's true. That's a good analogy. That is a good analogy. Yeah, that is.

Any, Any closing thoughts? No, I think that, you know, creating the standards has been eye opening because of course, before we started this process in 2017, 2018, I had no idea. Right. And so now understanding it over those first couple of years, you know, joining the board initially and then learning from you and some of the other leaders that were involved, it really was an eye opener because I didn't realize that this is something that everybody had except audiologists. And knowing that if we did something and, and we had to take it to court, that the courts would determine our standards versus us taking control of creating our own standards was like, we gotta jump on this right away.

So, you know, I appreciate everything that APSL continues to do and it's been very, very rewarding and I think the profession is gonna be so much better for it. I would just say I'm just excited to see it continue. I'm excited for the next few that are about to hit the press, so to say. And I can't wait to see where we're heading in the next few years. Where do you hope we're heading in the next few years?

Years I would love to see. I think now that we have a decent foundation of standards out covering most broad spectrum and now getting into the specialty areas. I would like to see different state leaders start taking it to state boards. That's where I think the next logical step is. I think that's where we have to start moving.

And like with most things, if we can get just a couple of states going, other states don't want to be left behind. And hopefully that will be the, the pendulum that just gets it moving. And it's not going to be a recommendation, it's going to be a requirement. Yes. Absolute requirement.

Yeah. Well, could standards feasibly be used by a state board if they are questioning the practice. I'm saying this lightly, I'm being nice. But questioning the practice of someone, if there is a report and they want to question that, I mean, where, where do they go? Right now?

Nowhere. That's the problem. It's up for their interpretation. And they may have never heard of audiology before. Your case is in their hands.

And that's not the person I want evaluating intricacies of why we made choices A, B versus C. So, yeah, they can use them. Yeah. Protects you as a professional as well as the, the patient. And this is, this is our wheelhouse. This is what we should be doing to get it out there so that other professionals understand what we do as well.

Yeah. And we have good relationships with our otolaryngology colleagues, but I don't want them defining what we should or should not be doing, just as they don't want me defining what they should or should not be doing. So it's, it's very, very important. Yeah. Okay.

Well, I want to thank all of you so much for joining me for this hour. Dr. Ghazalia, Dr. McMahon, Dr. Anzalone, it was wonderful to have you on. I hope I'll have some of you on again as we continue to do these sessions. I want to just invite anyone watching to visit audiologystandards.org where you can find out more about standards development, the role of standards in your practice and in the profession as a general in general, and also access any of the published standards or, or find a way to become involved yourself. We're always looking for people.

We, we kind of come from the. The idea, the concept that we all have something to contribute. Right. That's how a profession works. We all have expertise and we didn't really talk about that, but that's kind of part of this too, isn't it?

Yeah. So thank you for joining us. We look forward to having you join us for the next episode. I'm John A. Coverstone and we'll sign off until next time.