Bridging Lived Experience and Clinical Practice: A Panel of DHH Professionals, in partnership with ACI Alliance

Presenters: Elaine Smolen, PhD, CED, LSLS Cert. AVEd, James R. Dornhoffer, MD, Mike Hoffman, PhD, Viral Tejani, AuD, PhD, Jessica Hoffman, AuD, Caroline Ruocco, MS, CCC-SLP, Jacquelyn Briggs, MA

At this time, it's my pleasure to welcome today's moderator, Dr. Elaine Smolen. Dr. Smolen is an assistant professor of teaching in the special education Deaf and Hard of Hearing program at Teachers College, Columbia University. Dr. Smolen will be today's moderator. She'll introduce our presenters. Before I turn it over to her, I would just like to give a shout out and thank you to the American Cochlear Implant Alliance, who partnered with us on today's course.

We'll hear a little bit more about the organization at the end, but in the meantime, I invite you to Visit their website, ACIA Alliance.org ACIA Alliance.org so, Dr. Smolen, I'll turn it over to you. All right, wonderful. Thank you so much, Carolyn. And we are thrilled to be here. As you said, we are thrilled to be in partnership with ACIA Alliance and to represent our special interest group, the Professionals with Hearing Loss Sigma.

Here are disclosures, and here are the limitations and risks for today's course.

And here are our learning outcomes.

All right. As Carolyn said, we have a wonderful panel here today. All of us are deaf or hard of hearing, and all of us work in the hearing loss or hearing health space. I am Dr. Elaine Smolen. I am an assistant professor of teaching at Teachers College.

I'm a teacher of the deaf and listening and spoken language specialist by training. I worked for many years with little kids and their families, and now I work with big kids, college students learning to be teachers of the deaf. And I do research in early language and literacy development as well as parent support. I'm hard of hearing and I use hearing aids. My typical way that I communicate is using spoken language, but I do use ASL with my colleagues and students who sign.

I'm going to turn it over to our panel to introduce themselves in the order they're on the slide.

Hey, everyone. My name is Mike Hoffman. I am a clinical psychologist by training. I work at Children's Hospital of Philadelphia within the center for Childhood Communication. Specifically, within there, I do behavioral health services, including therapy, consultation, diagnostics.

I'm also the clinical director of our integrated psychosocial program. So I oversee all of our behavioral health supports happening for kids who are deaf and hard of hearing. I myself have bimodal setup. So one hearing aid and one implant got implanted about 10 years ago at this point, but I've had hearing loss since birth. I generally identify as a lowercase D. Deaf, communicate primarily via spoken language.

I know a little bit of ASL. Working to learn some more.

Jim. Oh, I can go Next. Sure. Sorry to cut you off girl. My name is Jim Dornhoffer.

I'm a neurotologist or so an ear surgeon at the Mayo Clinic in Rochester, Minnesota. I have a progressive hearing loss. I currently wear hearing aids. Many of my family members ultimately have progressed to a cochlear implant. So I'm very happy and proud to be able to kind of serve on both sides of that.

In addition to my clinical practice, I do also do a lot of research on trying to improve how we can care for and help support cochlear implant users after their implant process as they're learning to hear their new device.

Classic father I was muted. I'm Viral Tejani. I am based out of University Hospital Cleveland Medical center over in Cleveland, Ohio. I'm an AuD PhD audiologist and I'm the subdivision lead of our cochlear implant program here. I have a clinical practice seeing patients 50% of the time and then I also do

research as well the other 50% of the time.

As far as my hearing loss history, I was born with hearing loss. There is a genetic component. I have a very rare genetic component that infects like less than 1% of South Asians. So I have a recessive gene that caused me to lose my hearing and then I want hearing aids all of my life in both years.

Hello everyone, My name is Jessica Hoffman. I am an audiologist at Westchester Medical center and Phelps Hospital in Westchester County, New York. I currently work with cochlear implants, hearing aids and diagnostics with all ages. I was born profoundly deaf. I have bilateral cochlear implants.

I got my first one at 14 and my second one at 23 right before I started grad school and audiology. I am also fluent in American Sign Language and I actually classify myself as lowercase D, deaf and uppercase D depending on the situation I'm in. I also classify myself as an in betweener. So I use my implant and I use ASL and spoken language pretty much every day, both personally and in the clinic.

Hi everyone, my name is Caroline Ruocco. I am a speech language pathologist at Weill Cornell Medicine in New York where I work on the cochlear implant team with both children and adults with hearing loss. My clinical work is primarily focused on listening and spoken language and oral hab and oral rehab. I'm also currently pursuing my clinical doctorate at the Mass General Brigham University of Health Professions where my capstone research is focusing on language counseling provided to parents post diagnosis of hearing loss in their child. I was diagnosed with hearing loss when I was 11.

The age of onset is unknown, and I've worn hearing aids since my teens. So hearing healthcare is something that I am very passionate about. I primarily have identified as hard of hearing so far.

Hi, everyone. It's really wonderful to be here with you all this afternoon. My name is Jacquelyn Briggs. I'm a teacher of the deaf and also a certified music teacher. And I work in early intervention, so from

ages birth to three with children that have hearing loss and their families.

And I've done a lot of research and work in how music helps our little ones with hearing loss also learn language and grow.

We are thrilled to have Jackie with us. Before we move on to our conversation of the day, I want to really acknowledge the work of ACIA Alliance. All of us are part of it. The ACIA Alliance is a nonprofit organization dedicated to eliminating barriers to cochlear implantation through advocacy, research, support, and education for professionals, patients, and families. And all of that relates to the work that we're going to be talking about today.

Again, you can go to acialliance.org to learn more about their work. And all of us here on the panel today are a part of the Professionals with Hearing Loss Special Interest Group, or SIG, or the DHH SIG as we like to call it. We are really focused on fostering community and promoting awareness and representation related to the inclusion of deaf and hard of hearing professionals in the field of cochlear implantation.

All right, so let's start ourselves off today. The first thing that I wanted to talk about is shared experience. So all of us work in the field of hearing healthcare. And as you heard, all of us have had experience being patients or being people in the field of hearing healthcare. And so there is a shared experience there.

And I want to hear about how that has worked for each of us in the room. I want to just mention, and I'll call this out several times, that we really tried to build a panel of people across the professions who work in hearing healthcare. And so I'm really interested to hear people's shared experiences and then also the unique experiences and situations they found themselves in as an SLP or an educator or an audiologist or a physician or a psychologist. Okay, so our first question I'm going to throw to Jackie and

Mike and Jess. How has your own experience with hearing loss or hearing technology shaped how you build rapport with patients and families?

And how did it make you a stronger clinician, educator, or therapist? I really loved this question. When we were talking about it. And so I just want to share again. I lost my hearing when I was a teenager.

I lost it as a result of a cochlear implant. Sorry, as a car accident. And I have now received a single sided cochlear implant. I've had it for about seven years. My cochlear implant journey actually started as a result of other difficulties that I was trying to figure out.

And then I learned that I was a candidate, and I was. When I was actually finally approved for a single sided cochlear implant, the process moved really, really quickly because it had already almost been about 10 years since I had received any sort of stimulation on that side of the auditory nerve. And so when I received approval, everything was moving really, really quickly. But one of the things that I think is unique about me is that I was an adult making these decisions. And so in my field of work, I meet families all the time that are super interested in my hearing loss and my story.

And I always have an easy time laying the foundation by saying, I lost my hearing or I have a hearing loss. And they usually ask me, were you born that way? And so I already have an immediate foundation to be like, no, I wasn't. Here's what my story looks like. And I'm very careful to make sure that they understand.

Just because this has been my experience doesn't mean that it's going to be theirs as they're navigating some of these things with their kids. And. But I really find those conversations to be a time when real vulnerability comes through. And so it reminds me, I was thinking as we were talking about this class, one of the youngest little ones I've ever worked with received a single sided cochlear implant. And when I make a huge deal out of wearing my cochlear implant really loudly, and I wear stickers and

I put really fun coils on it.

And I know that if I am proud of who I am and I'm proud of my hearing loss, that my students that see me will too. And so I was working with probably the youngest little one that I had ever, ever worked with with a cochlear implant. And I always model when they notice my processor, they say, you know, they'll point, they'll look at it and I'll say, that's my processor. It helps me hear. And so as we were working on all of this, this little one was, was celebrating her birthday and somebody, her family members were asking, like, what is that?

They were pointing and she pointed at it. And she said, it's my processor, it helps me. I found a lot of success in just owning exactly who I am. And it really opens the door for me to be able to communicate with the families that I work with.

I think that's really beautifully said and certainly echoes some of the experiences I've had. I picture I worked in a preschool for kids who were deaf and hard of hearing. And even the 23 year olds would see me walking around with my implant and my hearing aids and they're like, oh, that right. Some of them didn't even have any spoken words yet. They're already calling that out.

And that was always a really cool, powerful moment. I think what you said beautifully, Jackie, is essentially that that representation really, really matters. Which we'll talk a little bit more about. I'm sure that will come up again. But also encapsulating that diversity that all of us have in different backgrounds, different experiences, our degrees of hearing loss, our configurations or devices.

You know, for me, I always joke that having my hearing loss gets me a lot of street cred, right? It get me a lot of buy in with families and with patients because you see me and I think the wall sometimes drops a little bit where they're a little bit more willing to be open, to be vulnerable, as Jackie said. And I even tell the audiologists and the SLPs that I work with, when they're referring patients my way, you can tell

them that I've got hearing loss and that's okay. That is totally a valid card to play. And for me, the experience is I've had hearing aids my whole life prior to getting implant.

And so I can remember going to camp, going to school, having the old FM systems, having it break, listening in class, not hearing in class, falling asleep in class because I'm not hearing in class, being exhausted from listening fatigue at the end of the day. I also think a lot about the teenagers that I work with specifically having that anxiety that's developmentally appropriate and expected for the teen years, but what it's like to be a teenage boy wanting to be cool, wanting to fit in and walking around, having hearing loss and trying to think about navigating academics or social relationships, romantic relationships. So those things really play a role for me. I also have the opportunity to serve on our cochlear implant team. And so similar to what you mentioned, Jackie, I went through the experience of deciding to get a cochlear implant as an adult.

But it took me about a year to decide whether or not to move forward with it. And I can still pretty vividly remember that anxiety and that stress in that. And for me, when I get the chance to talk to our implant candidates and our families, whether it's a kid or a teenager, I think they're often curious to hear and see a little bit about what it was like for someone to make that decision. And that experience really helps me have conversations with families and meet them where they are and not feel pressure or judgment in that decision making while I'm choosing to pursue an implant. So all that lived experience certainly comes into play in how we approach families, the way that families are willing to talk to us, the questions we might ask, the way that we frame things.

I think, quite honestly, I'd be an entirely different provider if I didn't have hearing loss.

I. So I love how Dr. Hoffman and Jackie explained their explanations. And I know coming from an audiologist perspective and someone who's profoundly deaf since birth, and I got my implant also a little bit later in life, especially as a teenager and an early adult, that all my life experiences has really

encapsulated of how I work with my patients. And I know, and I always have a. That there is not one single deaf or hard of hearing experience, not one cochlear implant experience or one communication outcome that is right for everybody.

So my role as an audiologist isn't just to help patients become me. I try to help patients discover what success could look like for them. That's really the foundation of how I build my report. A lot of my patients tell me they feel often relieved. They feel excited when they find out that the audiologist also has hearing loss.

Too often I find that there's an interesting sense of connection with them because a lot of times they will meet other people with hearing loss or know anybody else other than, you know, maybe one other person or nobody. So I'm trying. I try to be careful not to assume that connection is going to be uniform for everybody. But I can try to relate many of my personal experiences with my patients by. I try not to assume that our experience is going to be completely identical.

So my perspective as someone born deaf is going to be very different from someone like an adult who suddenly lost their hearing or as someone like a parent who's making decisions for their young child. So my job isn't just to relate through the sameness, but I also try to relate through, like, empathy, shared strategy, or even some lived experiences that are always identical.

Thank you, Jess. I love what you said about relating through empathy and, like, recognizing that not all experiences are going to be identical. So I'm sure we all have stories and that's what I want to zoom in. Now. I want to invite Jim and Mike to think about this question.

Can you share a moment, a specific moment, when disclosing your hearing loss changed your dynamic with a patient or a family?

I can go ahead and take the lead. So I do ear surgery. It's my primary job. So I would find that I'm very upfront with my own hearing loss, both my family and personally. And I find there's kind of two key flavors where I see some pretty distinct benefits.

One's from a standpoint of encouraging patients to move forward with something which could improve their quality of life. And one is kind of offering some sense of hope. To dig into the specific details briefly, I see a lot of children who are born congenitally deaf for consultation for a cochlear implant. For someone who comes from a normal hearing environment, is not really aware of a lot of these technologies. It's a world shattering discovery.

And I think a lot of patients wonder, oh gosh, is my child going to develop normally? Are they going to have a normal life? Is what are we going to do? And I think it's very encouraging to see someone who's in the same shoes. Obviously I don't have a cochlear implant myself, but that's a yet moment.

I'll probably get there one of these days. But it's encouraging to see someone in a traditionally high achieving career and audiologist, speech pathologist, physician, having the same issue their child has. And I think that offers a lot of hope for them. And then the other part is offering an encouragement to move forward with the procedure.

Again, we are in a privileged situation where we know a lot about these technologies, procedures and the benefits that they can have. To a lot of people, the idea of putting a machine in your head sounds like science fiction, sounds very theoretical. And I think that scares a lot of patients. And without effective counseling or encouragement, they may never pursue that intervention. And we see this published all the time about how poor our acquisition of cochlear implants is.

Like, I think that's only about 5 to 10% of candidates ever end up getting an implant. And I routinely see a patient who will be very anxious about getting a cochlear implant. I can very easily share like my

dad's got one, my aunt's got one, my coworker's got one, and I'm probably going to need one in 10 to 20 years. These are not experimental. These are effective interventions.

And I've, you know, very specific, anecdotally seen patients kind of take that switch and like, okay, that I'm, I'm picking up a bit more now. What you're putting down, this is an experimental thing. This is just a fact of life. And so I think from a standpoint of hope and just comfort, that I'm willing to have this done to myself and I've had it done to my family members. Really encourages people to move forward with what I find to be, and I think we all find to be very effective here in healthcare.

Yeah, well said, Jim. The idea of putting a machine in your head. I joked with patients before that I'm like the Terminator. But unfortunately, that reference has become quite dated at this time, so I need a new one. But, yeah, telling people about that and certainly to what you said, families actually having the chance to see someone who has an implant who is in front of them, I think brings a certain level of comfort.

It's interesting, the question of choosing to disclose. I wear short hair. I get a skin fade when I go to my barber. I have a bright blue cochlear implanted hearing aids. That disclosure happens automatically with every patient that I see.

When I walk out into the waiting room and I go grab a patient and bring them back, they're immediately seeing that some of them might know already that I'm a person who has hearing loss, and some might not and often have those moments where kids are catching it for the first time. But for me, I really tried to make a choice of something similar to what Jackie said before about owning it, embracing it, and saying, this is a part of who I am. And, well, why not swag out my implant and swag out my hearing aid to be something that I like. Blue's my favorite color. Why not do that?

And to walk into modeling that for a lot of families and patients, I think having the chance to see me as a person who wears a device, who has short hair, who picks a fun color, kind of owning and living in that experience. What you said, Jim, is entirely true too. Where they look at me sometimes and then they go, hey, you were able to be successful. You've earned a PhD, you got married, you have kids. That inspires a certain level of hope.

Jumping back to again, some of the teenagers I've worked with. There are definitely many times where me being a person who has an implant or a hearing aid has really helped to establish more rapport. I'm thinking of a patient who I did Therapy with who was a young black male from Philadelphia who had experienced a lot of trauma, gun related violence and really had some depression and anxiety and needed mental health support and previously wasn't willing to talk to anybody. He came in by way of our cochlear implant team and I met him as part of that eval and like, why do you want to talk to me? I'm a little white Jewish guy from the suburbs.

But it was just the fact that I had hearing loss that allowed us to build that initial connection and then start a therapeutic relationship to support this young man who I think otherwise probably wouldn't have been willing to engage in the mental health system. So those moments of patients feeling like they can see themselves in you is really, really powerful. And it's really interesting because historically in behavioral health at least, the therapist is supposed to be a blank slate. But for me, that's a really large strength of what I do and how I work with families. And so I don't come in as a blank slate and I'm okay with that.

Excellent. I just want to mention that I also love very cool colored hearing devices, but it's very hard to find for adults. So those industry folks who are listening on the call today, there is interest. I want the purple. All right, we are going to move on, switch gears a little bit, because so far, you know, we talked, we started on a really positive note and we want to keep it on a positive note.

But we also want to be, you know, upfront about the obstacles or barriers that we have encountered. And I think in our professions, we're getting much better at recognizing the challenges that patients might have and helping our patients prepare for those challenges. But we as professionals who are deaf or hard of hearing also might encounter some barriers and challenges. So, Caroline and Jessica, I want to invite you to come and talk a little bit about what the hardest obstacle that you've experienced related to your hearing loss has been and tell us how you addressed it.

I really love this question. As you mentioned, Elaine, I think as people with hearing loss in the hearing healthcare realm, not only are we truly confident in our hearing loss, and we've grown so much in terms of acceptance and embracing our hearing loss as a part of our identity. It doesn't take away the fact that there are still moments where it's challenging and sometimes that's day to day, sometimes it's really in your face, and sometimes it's more in the background. I think for me, one of the hardest obstacles has actually been the pressure that I put on myself to not let my hearing loss affect me professionally As a clinician and especially as a clinician who works in hearing health care, though not exclusively hearing health care anymore. I think there can be this feeling that I should be able to manage everyday listening experiences because it's my area of expertise.

But expertise doesn't eliminate hearing loss. It's an and situation, not a or I still miss things in meetings. I struggle if there's more than one person talking or if there's background noise. And I do need to ask for help. I think earlier in my career I was much more reluctant to acknowledge these things because I never wanted someone to question whether I could do my job.

And that went so far even to not mark that I have a disability when applying for a role. And I think that that is something that deserves looking at. So I think there's an interesting dynamic when you're a hearing. When you're a healthcare professional treating the same condition that you have. It's.

I think we've already talked about in this discussion. I think Mike mentioned straight cred. I think that that is absolutely true. Your patient with hearing loss can see you with hearing aids and you automatically, not all the time, but frequently you have an in. You get your foot in the door in terms of establishing rapport and trust.

But I think I can't value hearing loss as an important part of my clinical identity while also expecting myself to function as if I don't have it. So I've been better about getting more specific about what I need. And I think, you know, in my current role, I also see patients who don't have hearing loss. They're coming in to see me or members of my team for other reasons and I am treating them. And so it's been a really.

It's been definitely come with its challenges and I've had to re navigate even in terms of using more specific language to talk about my hearing loss because these are people who don't have a pre existing knowledge base of it. Right. And that was something I took for granted before when I was exclusively working with people who had hearing losses. So I think constantly recognizing that I need to advocate for myself and that it's possible to do so. Just creating the framework for that.

Hi everyone. I think that Carolyn hit the key pretty well as someone who's been born deaf and I. I've always had to overcome many different obstacles throughout my entire life, especially in the academic world, even when I was considering audiology. I've had several audiologists before I even applied to grad school tell me that I should not be even considering audiology. And even my journey as a student. I've had mentors and other.

Not mentors, but other individuals tell me that, you know, a person with my degree of hearing loss or hearing status, shouldn't I even consider audiology? So I've had to work really hard to navigate through this adversity towards the people who did not believe in my abilities. So the hardest part was not just figuring out the logistics of how to do my job in the clinic. Those were quite easily solvable. But I found

that the hardest part was constantly having to prove my competence, my competence and my values to my peers and my colleagues.

I always feel like there's an assumption that deaf and hard of hearing professional can't fully perform all of the responsibilities, especially as an audiologist. I see this in other professions as well. But I find it a bit ironic in the field that we're all in. And sometimes I find that, you know, the dynamic of, like, a lot of people think that they treat me as I'm inspirational rather than just simply qualified for what I do. So I.

It's like, as if I'm here for the story rather than just saying, like, oh, she's really good at what she does. So a lot of it is like, my biggest obstacle as professional is not just only the access to the job itself, but also having to continue to demonstrate that my hearing loss doesn't always define my ability to do the job well. You know, I'm also constantly advocating for my hospital to improve access, more access for meetings in terms of an interpreter or captioning or even an affirmative, a remote microphone system. A lot of times my colleagues underestimate how much I really hear. And a lot of times I don't always hear everything.

And it can be quite frustrating at times. But, you know, I always have to tell myself, like, you know, it is what it is, but then you have to, like, show them this is what it takes for me to do well in these different situations, and this is my capabilities.

Excellent. Thank you, Jess. And you've really nicely teed up what we. What we're going to talk about next. I really like that both you and Caroline, you know, mentioned some of the actual practical challenges that you've encountered, as well as these, like, wider kind of societal challenges of pressure and expectations and, you know, not being seen as competent, which are really, really important and I think really powerful for us to consider.

Moving on now, I want to talk about some of those practical and clinical challenges. We all work in different parts of the field and all encounter different small, everyday kind of barriers. And we've all actually come up with a lot of interesting workarounds. So I'm going to invite Viral, Jim, Jessica and Jackie to talk to us a little bit about the logistical challenges that you've encountered in your role and then what workarounds or accommodations you've come up with, either on your own or with your employer.

So, okay, once again, thank you for the chance to speak on this panel. I think this is a really exciting opportunity to talk about all of our experiences here. So I'll talk about from the perspective of the research side, I do practice clinically speaking, but I know Jessica will talk about some of the accommodations that, that she's used. And to be honest, a lot of us use similar accommodations. So I don't want to be redundant.

But from the research perspective, a big part of my job is actually attending a lot of conferences and meetings, which obviously is very tiring from an auditorist perspective because you're talking to so many people and you're networking, you're listening to podium presentations, you're in posted sessions, and some of those posted sessions have horrible acoustics.

So, you know, two of the biggest solutions, actually, three of the biggest solutions have evolved using. One of them has evolved using a smartphone speech to text application. So, you know, so then I. So, you know, especially when speakers have assets that I can't understand or. So this feature text has been very useful and there are some apps that are really more iPhone friendly versus Android friendly and vice versa.

So I've had some colleagues actually giving me specific recommendations. A remote microphone has been incredibly useful as well. Sometimes you'll see me end up putting a microphone on the podium itself so that I can hear the speaker with less effort. Or sometimes, you know, if I'm sitting next to a

colleague who's kind of whispering me about how, you know, he or she doesn't like the research findings or the methodology. I give her the him or her the microphone so she can whisper and not be loud and rude to everybody else.

So, and then a huge thing is cart. And you know, I'm part of a group called HR aro, pairing impaired members of the association for Research and Otolaryngology. And through a lot of advocacy efforts, you know, we've been able to get a cart at a lot of these big meetings, including ARL, as well as another conference called ciap, which is a conference on auditory implantable Prosthesis. And of course, you know, Some of our big meetings like acia, you'll see cart pretty prominent. And these are, you know, and partly due to efforts of many hearing scientists who have hearing loss as well as audiologists who have hearing loss.

So those are the big three things that I rely on in order to be able to function the way I want to.

I'm happy to go next. Thanks for speaking about that. I'm going to share a lot of the same kind of workarounds in my thinking about this question. I kind of have three brief things that I find in my career I have to deal with. One is just, you know, clinical communication, especially with the rise of telemedicine.

One of the things which Covid kind of may have been beneficial for us and I think a lot of that is very frequent use of text to speech applications both with captioning for things like this or zoom calls which I do with patients or just something in clinic. There's so many free Texas speech applications on most smartphones which I just, I use very frequently. I and patients like that, it takes no time. My staff use it very frequently and that's a very easy tool to use at minimal to no cost. The second thing I find is just organization.

In the clinic or in kind of an outpatient setting, we at my institution, we use a lot of rather than calling for patients or kind of handing off information verbally, we use a lot of lights. We have codes for each provider, we have codes for kind of what the setting is for, who's in with the patient right now. And in the waiting room, patients have, you know, lights or I don't know if we have it anymore, but even little buzzers just to help know when it's their time. Because let's be honest, we work with a lot of patients who are hearing impaired and fortunately our clinic has adopted a lot of that. The other thing is in meeting to kind of wayland to kind of meetings and research kind of like Viral talked about already.

In addition to using captioning, you can also take make use of a lot of our current technologies like Coke, like a lot of the Microsoft AI note generating technologies. Nowadays all our division meetings, it's kind of automatically done. So and we get a minute of the meetings done after every session. So we can kind of review that for those of who may have not caught it live or if the captioning wasn't keeping up perfectly. And then finally I work in the OR a lot.

And one of the easiest simple ways I've worked around having trouble hearing because that's a noisy environment. It's just trying to work with a consistent team if you can and just be very honest with your preferences. They know me, so if I'm not answering them, I'm not being rude, I'm not ignoring them. I just didn't hear them and they know that. So they know, just give me a tap on the back or flick the lights or something like that.

So just communicating up front and if you can, try to work with a consistent team, I understand, I understand that's not always possible. But just talking and being very frank and say, hey, I'm going to have trouble with this. I swear I'm not being rude. This is how you can get in touch with me or get my attention if you need.

I use pretty much like all these different types of techniques that both Viral and Jim has mentioned. So as an audiologist in the clinic, I found very different ways and unique ways that a lot of myself and also

other deaf and hard of hearing audiology colleagues have used. So for example, for listening shocks, I have an external. I use my remote microphone system or another type of system that I can use like telcoil directly to my implants to help me check the hearing aids. Sometimes I even ask my hearing colleagues to do a quick listening check for me if they're available.

Also, I just make sure that I use the electroacoustic analyzer machine to check the function of the hearing aid. Sometimes if I'm not exactly sure if the hearing aid sounds great and if there's no other colleague around to help me listen to it, I depend a lot on the remote microphone technology. That's like one of the biggest things that made a difference for my day to day work. I use it for meetings, I use it for testing my patients, especially for speech perception testing. It really helps reduce the background noise and the distance.

And also in the booth, I find that the headset through the roof doesn't always help me hear my patients well. I also use it in group settings and meetings because a lot of times the sound can get really muddy with all the reverberation. And then for speech testing in the booth, I always, always, always use recorded unless I really have to do live voice. And then for the kids, for my little ones, obviously they don't do well with recorded. I do live voice and sometimes I have my speech pathologist colleague come in and assist me at times if needed.

Also have sometimes like, if it's a child who has like articulation issues or a patient who has a different thick accent Sometimes I have like either a colleague or a family member to help me with some of the translations. There's a lot of like things you can work around these different opticals. Also for calling patients and whatnot, I rely on captioning even for some time. For meetings, I use an ASL interpreter. I've also found that doing certain phone calls, I actually just recently discovered Innocaption's voice program, which has been even more reliable, is able to plug this device into my work landline phone.

And I'm able to use my app on my phone to read what the patient's saying with using my work number. So it's been really helpful and pretty seamless. So I feel like all these solutions are solvable. And I just find that there's so many different ways that depending on your hearing status and your clinical abilities, you find ways. And plus, I work in a very quiet environment, so a lot of times when I'm with patients one on one, it's never really been an issue.

So I, over the years as a practice, been working for 15 years, so I've been able to find ways around each of these different challenges.

Jess, I love what you said. I love what you said about all of this. And I actually was really, I was really resonating when you were talking earlier about wanting to prove competence. And so I want to talk just like briefly about being a teacher of the deaf and a music educator with hearing loss. Because being on the music ed side of things, I really didn't disclose my hearing loss all that often.

And it's only been in the last couple years that I've been like, actually I have a hearing loss. And here's all of these really cool things I do to navigate that when I'm teaching music. So I work in early intervention. I think I said that before. So I work with babies birth to three.

And in the morning I have a nursery class of our babies with hearing loss and neighborhood kids. And that nursery class is from 18 to 20, 18 months to 36 months. And so one of the biggest challenges that I have, and it's especially going on right now at the beginning of the year, is that I can't hear much, especially with all of their crying. And so this gets really challenging, right? If I've got crying babies in both arms and I'm trying to communicate with the people across the room, I can't hear them.

And the crying limits my ability to read lips, which is one of my also go tos. Like, if I can't hear them, can I Figure out what they're saying by staring at their lips. And so I've had a couple. We have a couple workarounds. We do have a classroom sound field.

And so sometimes I'll give my paraprofessional the transmitter so that I can hear her voice. I'll also give people around me my own mini mic, because if I can't hear but they're streaming to me, that gives me more access. I also do this, like in gym workout classes, I do this when I'm in loud restaurants. I'll hand over my mini microphone. The other thing that we find challenging or that I find challenging is that because they're so little, I sometimes miss what they're saying.

I don't always hear them, and it's not like they're going to repeat it. So throughout the day, I'm always on the floor, I'm watching them. I am in everything that they're doing so that I can make sure I'm present for the learning and the language that's going on. And that's exhausting. So there are times I get to the end of the day, day, and I'm like, nobody talk to me.

Don't look at me. I need a little bit of a break. And so those are just some, some challenges that I've experienced. One of the other things I want to chat about, but I also for sure don't want to take from any anybody else, is that I do telehealth as well. And so usually when I'm meeting or reaching out to speak to a family for the first time, one of my first conversations with them is I have a hearing loss and I we're going to meet on telehealth.

These are the things that I need you to do so that I can make sure that I hear one of them is making sure that the camera is on. Sometimes this is challenging. Sometimes that's like, hey, we're going to have this session. Please don't sit in front of a window so that I can make sure there's no glare and I can see your face. I've done really well about navigating some of those challenges.

There's just a couple of them that I navigate on a daily basis and have found some really wonderful solutions and also have a really wonderful team, people who make sure that not only am I hearing, but I am aware of what's going on.

Oh, thank you all. I think that there are so many practical solutions that you just mentioned in that really brief time. And I think something that really stood out to me was not just all the technology but the ways that we can collaborate with colleagues. It sounds like many of you rely on a consistent team that you really take, you've taken the work of training, right, or you've worked with parents who are now your partners. And so I think I want to widen in our view a little bit and move away just from those like little logistical challenges that you've solved yourself to think about accessibility as a systems issue.

So all of us are experts. As Caroline said, being an expert doesn't necessarily mean that's going to solve the problems that you, you're encountering. But you know, if anyone has a good chance of solving them, it's, it's we, right? Like we, we are the people who know all about this and have experienced it, but that can also come with a burden. Right?

Is it, is it always on us to be advocating for ourselves or is this a larger systems kind of issue? So I want to talk a little bit about that and invite Caroline and Jess to talk about bigger changes that have made their workplaces more accessible to DHH professionals like you. And then also like, what would you tell an institution trying to become more inclusive of DHH staff?

One thing I would tell institutions is that accessibility needs to be built in to the system rather than depending on us individuals to repeatedly identify a problem and ask someone to solve it. And I think what happens is you can't have the what we desire without that first part, which is us really working through the nitty gritty advocating which leads to bigger change. To get specific from my own experience, you know, and a lot of us have these types of jobs where we work in different offices. Maybe it's every single day. And I've had more than one of these kinds of jobs.

I'm not just working from one physical location every day of the week. And so, you know, something that really helps me as being able to readily talk to people on the phone, which is challenging for those of us with hearing loss. And I had a situation where I was essentially told, we can make this

accommodation for you, but only in one of the offices that you're working in. So it would be my responsibility to take either the technology that was going to give me accessibility from office, office to office, or find another solution altogether. And I think for the employer in that instance it was a funding problem and for me it was an accessibility problem.

And those two, I mean that's those two butt heads all the time. We see it all the time. And that's, you know, Unfortunately, a barrier to us receiving what we need to receive in the workplace. But the advocacy can become exhausting, particularly because many of the things we're asking for are relatively small. And so I think institutions need to be careful, especially if their employer employee is doing well, not to confuse high performance with not needing for things to change.

I agree with Caroline with, and I echo everything she has said. And to add on to this, like, I just want to point out like two things. Accessibility needs to be treated as an infrastructure for sure. And it's definitely not something that, you know, you know, I think it's something that it depends on how comfortable someone is with their own self efficacy, but it should be provided by the false no matter what. And you know, captioning should be available by default.

Visual alert systems should be built into the workplace. Meetings should be planned with accessibility from the mind from the beginning, rather than having to retrofit all these accommodations afterwards. You know, every one of us have different communication needs, so the communication needs to be flexible because there shouldn't be like one side that fits all approach. And secondly, I feel like there's often a gap between the patient advocacy and the colleague advocacy, you know, someone with a hearing. As a hearing health care professional, we're used to advocating for our communication needs and for our patients, that's like pretty second nature for a lot of us.

But as Kellen said, you know, a lot of the institution can be much slower at providing that same access to their own deaf and hard of hearing colleagues and the clinicians, the staff, the students. So I think as

a whole it's been challenging and I see this on my jobs. And you know, I think true accessibility means that looking beyond the patient, making sure that people are providing the care, can also have the access to. It should be both ways if they can provide the access for the patient, but they should also provide it for the staff. And they said, as Kellen said, that just because we have a hearing loss does not mean that it reflects our competence as well.

Wow, Jess. I love that. If they can do that for the patients, they should be able to do that for us. Yes. So powerful.

Thank you. And I think a big reason that, you know, we wanted to do this panel was to offer, you know, all of these amazing solutions and these, you know, issues to our colleagues who are also deaf and hard of hearing health care providers, but also to those of you who are, who have typically hearing and I who have typical hearing. And one of the reasons we wanted to do that is because we know that there Are many more of us coming in the pipeline? Many of you may be working with students or trainees who are deaf or hard of hearing and maybe wondering how, how to help them, right. How to guide them.

And so I really wanted to make sure we touched on this topic here. But I'm going to invite Jim and Jessica to kind of comment on. I wanted to think specifically about what happens before you become a professional. So what barriers do you see that exist in training or licensing or credentialing in our fields? And what do you think preceptors or mentors could have done better during training to actually support you?

I can speak briefly from the medical standpoint. I think there's kind of two issues where having, you know, different modality for hearing can be challenging. The easy one to talk about is exams and tests. Medicine still loves the oral board format, meaning you have to go in front of a panel and talk and explain your thoughts over something that can be hard, especially because this is oftentimes done in

telemedicine. And I think things that can be done to help people you're training or mentoring and things which fortunately, I think have been done for me, I'm happy to say is first off, make sure your trainees know kind of what they're allowed, what their rights are.

You know, there's laws, the Americans with Disabilities act, you are, they cannot bar someone from using a hearing aid or a cochlear implant during an oral exam. Obviously, they're always got. There's always that concern. Or are you listening in on something? But the fact is, this is something I was told, you know, make sure that when you're doing oral boards, you let them know if you're hearing impairment.

And they are, they should and are required to allow you to do what they need to make sure you can go through that comfortably. So, and I was fortunate to have some mentors who are really good about that. And I think, you know, I'm also fortunate to be in the field, which is very supportive of that. So just making sure they know what rights you have to support to make sure that you are allowed the same access to examinations and the exam material that your peers do. The other side of things is from the actual just clinical practice.

A lot of medicine is learned on the job. And this is a fact with a lot of careers medicine, they like to formalize it a little bit. And the problem with learning on the job is it's easy to miss stuff if people aren't aware you have trouble hearing. And again, I've Been very fortunate to work in a field which is super supportive of hearing impairments of all types. But just again, my.

What I tell people who I mentor who have hearing impairment, what was told to me is again, be very upfront with, you know, your hearing impairment. It's gonna, it's gonna make sure that people are aware of it. And so they on one hand are very, are hopefully direct with you and you know, do what they can to just make sure they're speaking directly to you. They're, they are not taking for granted that you may have heard something. And on the other hand, it prevents any kind of, kind of passive concern

they may develop like, oh, is this person being rude or are they being standoffish?

It's like, no, I just didn't hear what you said. So just being very upfront with that is what I was advised to me. And fortunately that is proven successful for me. You know, I'm happy for that. I understand that's not always going to be the situation in some places, but going to bat for your, your mentees, reminding them of their rights and reminding them of, you know, the, the support they can seek out and just like I said, going to bath for them with their, with your colleagues because if your colleagues don't know and, and they are going to treat them like in a normal hearing individual, you might run into some friction.

So those are kind of my two little points which I've been fortunate to have very good mentorship for and very good support for, but it is something you're going to run into. It's just the nature of the beast with any sort of, you know, any sort of career really.

Jim has pointed out some really great points and definitely being open about your own needs and being completely transparent from the start with your mentors and your communication needs right from the bat is so important and so critical. The most important, especially where it helped for me because I find that like, you know, I always ask like perceptors and mentors to be proactive but, but not reactive to our needs and to be almost more collaborative. So I feel like the communication needs and the accommodation should always be discussed, discussed up front rather than waiting for the student to bring them up themselves if there's been a problem. Because sometimes, for example, like, I was not always upfront about it, especially at one point during my, one of my rotations as a student and it became a problem. So I realized I have to be extremely transparent from the get go and have a communication plan in the very beginning explaining how you do Things in the clinic, what works with it doesn't work.

What you do when there's a communication breakdown, I feel like also perceptors and mentors, which I've been lucky for most of my mentors and perceptors, but there has been one or two replacement that

did not have that kind of ability for them to be willing to adapt and be flexible. So if something was not working, we would work and collaborate and find a better accommodation. But then I had one placement that was not willing to do that, so that became an issue. But sometimes when things aren't working, it should be seen as a failure. So we should always be able to find ways to adjust and figure it out.

But there is a solution for everything, especially for that particular student or a situation. I think having these conversations happen, especially in the very beginning, beginning and also throughout the entire placement is really important, you know, and also having the empathy and the sensitivity, you know, is really critical as well, because it's hard as a student not knowing if I'm doing something right, am I doing something wrong, and it can really harm your self esteem at times. So it's really important for, you know, having to work through all these things because there's a lot of barriers that we have to fight and overcome. So having a collaborative mentor is really great because a lot of times the obstacle is not a reflection of their student ability or competence, but it can be something else. So I also find that deaf and hard of hearing students should not always have to be reinventing the wheel at every single rotation.

So I feel like with every new supervisor, I feel like figuring things out over and over works for them. So they should have like an idea and a plan in place and a program that who can really like, work with them and work with the placements as well, because it helps relieve some of that enormous invisible burden on top of the clinical work. So I always find that good mentorships is creating that structure from the beginning rather than expecting the student to be constantly advocating for themselves and troubleshoot along the way. Yeah, excellent. Thanks, Jess.

You brought up so many good points about how to like remove some of those barriers. And I think ultimately what we hope happens in removing some of those barriers or increasing, you know, the field

sensitivity is that we increase the number of deaf and hard of hearing professionals in our field. And so for our final set of planned questions, I really want to zoom out and think about why this matters. Why is all the stuff we've been talking about for the last hour important? You know, the priority for our field is to have excellence for our patients.

And I want to think about the ways that representation of deaf and hard of hearing people in our space as colleagues and professionals really leads to that goal. So I'm going to invite Caroline and Viral to come on and talk to us a little bit about your thoughts here. So how do you think deaf and hard of hearing and other representation changes or can change patients perspectives of outcomes or clinical excellence?

I can go first and I'll keep this pretty brief. I think we've spoken a little bit about patient provider concordance so far and that's when patients are able to see some aspect of themselves in their provider and that's shown and proven to be really meaningful. But I also think representation contributes to clinical excellence in another way, which is that for many of us who have hearing loss and we choose to work in this field of hearing healthcare, there is an inherent level of interest and dedication to the work because it is personal. I didn't just happen to become an SLP who works with people with hearing loss. I didn't fall into this role.

This is the population that I actively sought out and it's the area that I continue to pursue additional training and education in. And I care about it very deeply. And so I do think that that personal investment is something that we all share and it doesn't replace clinical knowledge or automatically make every DHH professional a better clinician than their hearing counterpart just because they have hearing loss. But I do think that kind of genuine interest can drive you to keep learning to ask different questions. And you know, in a field or an area of employment where there can be burnout, it can lead to us really having staying power.

And I think that benefits our patients long term.

I'm always muted. So going along those lines, you know, in terms of, you know, it is personal. Like we, we want to make sure our patients are doing well in whatever modality they're in.

The other thing is that, you know, there is a certain credibility you get as a hard of hearing provider. I do. For example, when I do a cochlear implant evaluation, every once in a while I'll have a patient ask me, would you do it? And that's a question that's hard to avoid when you have hearing aids. And I told them, and I'm very honest about it, I said, I told them I do it in a heartbeat.

And I think that does put them at ease. And I told them the reasons why I do it in a heartbeat. I told them that I know the Data that's out there. I know the surgeons, I know how the procedures are. Like, I know how the post operative rehab period is.

Like, I've seen it from the clinical end and if I had to do it, I would not be scared. There's a certain level of faith you have to have, of course, if you're going to get a cochlear implant. But to have a deaf hard hearing provider say that they will do it if they were a candidate, I think puts some of my patients at ease.

And the other thing is that even within our industry, within all of our cochlear implant companies, there are inevitably personnel there who have implants themselves in all those companies.

For example, this one company that we work with here, and we have a local person who works for one of the companies and who has bilateral cochlear implants. And you know, I've often used that person as a resource as well. And I told them, hey, you know, this person has two cochlear implants. Granted, she works for the company, but, you know, she can tell you her firsthand experiences being a provider, but also working on the industry side as well. So I think there is a certain level of ease that some of

these patients get that even though I don't have implants myself, I have a comfort in doing it and I would do it great.

The next aspect of clinical excellence I want to think about here is how we all work in such a multidisciplinary or interdisciplinary way. Like I said, I'm so thrilled about the way this panel came together because we're all from different parts of the field. We're all passionate obviously about hearing health care, but we all work in different areas. And that really mirrors the way that patients experience hearing healthcare. It should be interdisciplinary or multidisciplinary, and we all should bring our expertise together on a team.

So I want to ask Jackie and Mike to think about the strengths that you think having deaf and hard of hearing professionals on multidisciplinary teams has. Like, what do you think we bring to these teams that might not always be recognized? I really loved answering this question. I thought it was. It was.

It made me think a lot. And I want to just go to something Caroline said a little earlier where she said, I chose this. She said, I chose this field because for a reason, it was Percival. And so for me, I chose my two fields, music and deaf education, because I knew I had the ability to make a difference both as a professional in music and deaf education. And one of my biggest reasons for this is because I lost my hearing at a super critical time in my life.

I was getting ready to audition for four year universities as a vocal performance major and I still managed to do that, but I really didn't have a lot of support when I was navigating that. It was just me, I was a teenager trying to figure out what I was going to do next. And I had, I had the genuine benefit in grad school of having some of the best professors and that I now call friends who helped me navigate that experience. I also love what, I think what Jessica says about relating through empathy is really, really crucial in this particular moment. And so I want to share.

I love being part of a team. That's one of my favorite things. And I've had a really genuine privilege to be part of two very different teams. And right now the team that I work with, it has teachers of the deaf, it has SLPs, motor therapists. But on our team there's only two of us that have a hearing loss.

And it really does change and affect how we, what we bring to a conversation. So I want to share a little bit. I have a colleague who had a hearing loss from the time that she was a young girl and she loves working with parents because for her, she feels like she's helping parents like, like hers that didn't really know what to do and didn't really know how to help them make the right choices. And we're looking at the hearing loss in their children going, I had no idea, like, what do I do now? And her heart for parents is one is so big.

And I love watching her work with them. And for me, thinking about when I lost my hearing at such a critical moment, I love working directly with parents and their babies, working on that interaction to be like, I, I know you're afraid. I have been here, let me show you what the next steps look like. And so, I mean, I can personally sit on the floor and sing and play all day with infants, even if I'm just singing to myself. But one of my greatest joys is coming alongside a parent being like, I understand exactly what you are experiencing.

I know. And I know that the next thing that we're going to focus on is the relationship between the, the two of you. Because if you can, if we can be proud, if we can learn to share these things and be and learn advocacy and learn all of the right ways, we're modeling that for them as they grow, even just down to like equipment, knowledge, connection for lived experiences. All of those things are Just really wonderful, especially on a multidisciplinary team.

Really, really well said. And I agree, this is an interesting question that, excuse me, made me think a little bit deeper, like, you know, what, what exactly might not be as obvious. And where I settled was to quote the quarterback and philosopher Jalen Hurts, who loves to say, you got to keep the main thing.

The main thing and the way that I apply that in this context is I was talking to an audiologist yesterday and she said, a lot of the data and the things that we do in clinic is very contrived. When we stick someone in a booth, we make it soundproof.

We take away lip reading, we take away context clues. It's good, reliable data, but it's contract data. And it is really ultimately the main thing is what that person's lived experience is like outside in the world once they leave these halls. And so I think for us, by keeping the main thing, the main thing. As deaf and hard of hearing hearing individuals, we probably are often thinking about what it's like to move through life with a hearing loss loss.

And that's the ultimate goal, is to support our patients, the children, the families, the adults living day to day with deafness. And so I think in that way, focusing on that also just the questions we ask, the things that might come to mind that might not be so obvious all the time. I'm thinking of an example. Not too long ago, I went to do a presentation at another institution and they got ready to do the talk. We had an interpreter on the other side of the screen and they dim the lights for the PowerPoint.

And I'm turning, looking at the interpreter like, whoever is here for the interpreter, that is way too dark, they're not going to be able to see them. And I was the only one in that moment who's like, hey, can we turn up the house lights a little bit so that the interpreter can be seen? And the folks who were there for the ASL kind of turned to me and were like, yes, thank you, thank you. Right. So I think sometimes it's the questions we ask, the perspective that we bring and being able to focus on that lived experience.

The other piece I'd add to that is a lot of our patients come in with stress. We don't often think about them being stressed, coming to clinical visits, but they know they're going to get questions about, why aren't you wearing your devices all the time? Why is your data logging not so great? How come you haven't been following through on the medical recommendations? I Think that's where having people with lived experience sometimes humanizes what some of those families might be going through.

Because for us as professionals who are doing it every day, it can be easy to lose sight of that.

Absolutely. Thank you, Mike. And then so finally I want to end on like a really big, broad note, you know, thinking about all of the challenges and solutions we've talked about. You know, I think we've been really candid about our feelings. And by we I mean you all have been really candid about, you know, what, what's been hard and what's been successful.

And so I want to think like really broadly, you know, if we have strong DHH representation in our hearing healthcare space, what is gained? What's the ultimate gain for everybody? And I'm going to invite Jim and Viral and Mike to respond to this one.

I can go ahead and get started. I think the shortest answer is simply it provides a better patient experience. Obviously healthcare I think is, you know, a necessity, but at the heart we are still a service industry. We're there to make the best experience for a patient. And I think having, as we've discussed earlier in this topic, we can, you know, we have a lived experience for them to bounce ideas off of.

We know what they're going through. We can offer hope, we can offer encouragement. And I think that's very valuable because that's ultimately our, one of our major goals. Give make patients a hap. The end all be all, as I always tell my residents is we may be watching a number go up on a chart, but the end all be all is a happy patient.

And I think that can we or it's easier to have a happy patient, especially in here in healthcare. And I think Vero may plan to talk about this. So I don't want to talk very long, but many of the things we've talked about about reducing barriers for ourself is yields either purposefully or secondarily reduced barriers for patients. Because if we need those same accesses, they're going to get them too. And I think all those, you know, all those are positives.

So.

Yeah, so to expand on what Chima is saying, you know, there's, you know, there's actually a lot of evidence out there in the literature to support that having a diverse pool of providers actually reduces barrier to care. It's not just limited to deaf and hard of hearing hearing providers, providers of all different types of cultural and ethnic backgrounds. And a lot of this is because simply going along the lines in which I said providing that experience to the patient and giving them the best experience possible. And, you know, sometimes the best experience is when they have a provider that they can, that they don't have to explain. You know, because we're, we're both in that same, you know, cultural or racial or ethnic demographic.

It's understood. And when it's understood, it just makes things a lot smoother. You can move along, you can move to the heart of the matter, but if you have to explain it to someone who's not part of that demographic, then it's hard to explain because there's so many little nuances to your background. And it's hard to explain all the nuance in the extremely short appointment time that we have. And then it takes away from the root of the matter is why are you here and what is the issue that we need to address?

So, you know, having a diverse pool of providers is arguably a very clinically huge matter and an ethical matter in many ways because, you know, we see it all across our system, all the systemic barriers and one of the biggest barriers is not enough diversity in many, many ways. Shape and form. Yeah, very well said, Viral. I think that research is pretty well established that having providers who look like and reflect the patient populations they serve leads to better outcomes. And that's not exclusive to those who are deaf and hard of hearing.

I'd push that even further to say we know there's a ton of health disparities and health inequities that exist in the United States and part not going to solve all the problems, but part of solving that problem is having a more diverse workforce of healthcare providers who are reflect those families and those patients. Similar to what Jim said, there's a legacy in healthcare of a paternalistic model of medicine where we know and we understand everything and we are the experts. We've got the white coat, we've got the fancy letters after our name and your job is to shut up and listen to what I say. And if you don't do that, well, that's on you. Obviously, there's been more of a shift to move towards a collaborative care model where we are partnering in and co piloting with our families and our patients to really figure out their values and what matters to them.

And like Jim said, to have happy, healthy patients out there. And I'd argue that having folks who are deaf and hard of hearing in this space is like collaborative care on steroids. Not only are we partnering with them, we are able to add an extra layer to that by having that lived experience that Allows that partnership to be even stronger. So I hope that continues.

Absolutely. Collaborative care on steroids. That's a great tagline for our movement here. Thank you all. We have a few minutes here at the end for questions which participants or attendees can submit using the Q and A feature.

In the meantime, you guys have teed us up really nicely by talking about research for a brief shameless plug for one of the other projects that our SIG is working on. All of us here on the call are working on learning more about the experience of patients who have deaf and hard of hearing providers or who might want to have deaf and hard of hearing providers. What we were able to offer here on the panel was our own perspectives, what we've seen happen with patients. But although we do, as you guys mentioned, have a lot of reasons, research about patient provider concordance on various different demographic levels, we don't have a ton of research actually asking patients who are deaf or hard of

hearing about having a deaf or hard of hearing provider. And so what we're hoping to do is fill that gap with a survey that we are conducting.

We have a lot of great responses so far, but we want to widen it even more. So what you see here on the screen is a flyer and a QR code that will bring you right to our survey. We're looking to hear from deaf and hard of hearing adults and also parents of deaf and hard of hearing children. So if you fit into one of those groups, please, please help us and take our survey. If you work with or know folks who fit into those groups, we would really appreciate your sharing this work.

I think having even more responses is going to be even more helpful for us to figure out, you know, whether perspectives change based on age or based on the kind of hearing technology that a patient has or based on the kind of provider they're thinking about. So there's a lot more that we need to know. We want to know to make the field better for everybody. So we would love your help in sharing that. All right, so let's invite everybody up on here and address some questions.

All right, here's a good one to start with. How has caring for patients influenced your own perception perspective on hearing loss? And you can just raise your hand and I'll call on you like I'm the professor that I am.

What do you think? How has caring for patients influenced your own perspective on hearing loss?

I will jump in. You know, I think one thing that's been really interesting for me is obviously I'm self centered in the beginning My own perspective as what my own journey and experience has been. But what I think is really beautiful and cool about caring for the deaf and hard of hearing community is it's giving me such a wider lens and aperture to see and understand the diversity within the world of deafness. And for someone like me who grew up primarily spoken language, who had no exposure to ASL, trying to learn and understand the experiences of maybe someone who communicates primarily

via ASL, or someone who's deaf plus or someone who has acquired hearing loss. So it's really broadened my understanding of the community beyond just my lived experience to having really beautiful exposure to lots of other experiences that folks has had.

And I think that then informs the work that I do.

Yeah, Jim, took me a while to figure out how to do the hand raise. I think the shortest just statement about this is it's made me a lot more flexible with kind of my approach to what is like success and what I do and how I can help a patient I feel, and rightfully so. In healthcare training, we're all taught, you know, there's kind of an objective we want to get to. You know, I want to see the numbers go up, I want to see the chart looking better. But I have a lot of patients who talk to me and like, you know, I, you know, that doesn't matter to me as much as X or Y.

Like, for example, I just had a patient the other day who is congenitally deaf and wanted a cold plan. We had to have that conversation about, you know, you may not get great outcomes from this. And she said she is I and she still want to go forward with it. And she saw her back as a post op. She's exceptionally happy.

Is the, is. Did the, did the bar go up like I wanted? Yeah, not as much. But she's got something that allows some sound awareness. She gets it helps augment her other ways of communicating and she loves it.

She is a textbook terrible patient, but she's a very happy patient. So just trying to be open to what is success now that I, you know, you know, being hearing impaired myself is, you know, that's kind of the biggest change I've had since, you know, you know, school when I was, you know, training the right way to do things or what is an appropriate outcome.

Excellent. Yeah. I think what's so cool about our field and what's so challenging is that, you know, we all have such different experiences and I think that just speaks to the need for more of us to be in the field. Like, you know, As I said, we really wanted our panel to have a broad range of disciplines, and. And we do, and we have a broad range of.

Of hearing loss. But there are other ways that we need to have more representation, more. More people who use visual language or cued speech are all different ways of communicating. And I see. Jess, you want to add?

Go ahead. Sorry, I can't figure out how to do the virtual hand raise, so took me a couple minutes to figure that out. But so, like, from someone who comes from, like, being raised within the deaf community and just going back and forth between the two different worlds, and I just find that, you know, having. There's such a big gap and a lack of understanding, especially the people in the deaf community, towards hearing healthcare professionals. There's a lot of distrust.

There's a lot of uncertainty. And I find that my unique position as a deaf audiologist who is fluent in ASL but also use spoken language and have implants to bridge those gaps, and I see there's a lot of lack of understanding on both sides of, you know, from a cultural standpoint and also from a medical standpoint. And I'm trying to, as part of my goal and my career and my, like, personal experiences, to bridge those gaps together and create a better understanding of both sides. And, you know, I find that a lot of my culturally deaf patients feel relieved when their own provider is fluent in ASL and that believes in them and understand. Like, I'm not trying to push this technology on them.

They're trying to respect their language needs, but also, at the same time, respect, like, why they want to go for the technology and trying to give them that resourcing tool and give them the benefit of the doubt and give them the hope that they can use the technology if they want to, for whatever reason. You'll be surprised how many culturally deaf people really actually like having technology. But then a lot

of them prefer hearing aids over an implant. Some want to go for the implant for whatever reason. So, you know, I have one patient, she's closely deaf, and she got an implant child.

She stopped using it for 20 years and then decided she wanted to wear again. And she only knows she uses it for sound awareness, and she's happy as a clam. So, like, really trying to understand the root of why patients want to go for certain things is so critical. And so I'm able to use my personal background to help bridge those gaps. Amazing.

We have another question here, taking a little bit of a different turn. Thinking about technology, this person asks, how do you feel newer Hearing aid technology benefits you with your loss and what do you feel can be improved? So I guess this is an opportunity for us to provide some feedback to technology manufacturers. Who wants to start?

So, you know, the holy grail of hearing aid technology is speech and noise processing, right? We all know that. But I have to tell you that, you know, having tried out several pairs over my lifetime and I still have some of my older pairs from when I was a kid and all of us here guarantee have our own hearing aid museum and implant museum in our houses. That's a guarantee. I can, I can tell you that, you know, we're a little spoiled.

We have some direct access, but being able to. But we, you know, some of us have been able to try some of the later technology offered by different companies and it is pretty impressive at how far the signal processing has advanced, you know, and in certain cases it's advanced to a point where you're normally hearing colleagues comment that I can hear better than them, which is huge victory for me. So I always. So it's noise reduction for the wind. But I think, you know, always continuing to work towards that is a huge thing.

And I'm always impressed by connectivity as well because connectivity solutions allow us to, you know, be a little bit more integrated into the world. So you know, when I first, you know, start able to stream things to my hearing aids, I thought that was the most amazing thing ever. And it still is and I use it all the time. But I love being able to participate in like zoom calls and strange my hearing aids because I can hear a lot better. I can hear music a lot better.

So, you know, it's been fun to see some of the changes in technology and I could tell you that, you know, if I, if my current hearing is broken, it has to be repaired. I have to go to my previous set. Even though they're really good at the time I wear them and I'm like, oh, that sounds so awful. I can't believe I wore this for five years before I upgraded. And it's not that they're awful, it's just because the technology changed.

So and you know, and you know, definitely with the cochlear implant space, you know, we were expect the same thing as well.

Jackie, did you want to add. Yeah, actually all the things that you were saying Viral were just. They reminded me of when I first got my implant because with the single sided loss I, I want to say I hear pretty well out of my left ear. I have a little bit of a fluctuating Loss because of some eustachian tube difficulties that I struggle with. But when I had an N7 first and a couple years later, I got an N8.

And I've been really good at. At having both inputs have meaning in my brain, but I'm always aware of what's going on, what I'm hearing through my cochlear implant processor. And when I upgraded to an N8, I think because I accidentally, like, dropped my N7 in a sink or something, I don't know, while I was at work, who knows, I got an N8. It was easier for me to upgrade than it was to get my N7 repaired by that point. And so I upgraded to the N8.

And when I tell you that the technology change from the N7 to the N8 gave me so much more clarity, I never realized how much background noise my N7 picked up, like fans and air vents, things like that. And then all of a sudden I got this N8 and I was like, holy cow. Like, this sounds really clear. And so it's still. There's still a.

There's still a discrepancy, obviously, between what I hear in my typically hearing ear and what I hear in the implant. But as technology develops, just the ability for the processor itself to take in sound and have it make meaning, that technology, too just continues to. To grow all the time. And it makes me excited for what could happen in the future.

Elaine, I just want to really quickly shout out the audiologists of the world who are so patient with some of us who may have more difficult case histories. Personally speaking, I have cookie bite hearing loss, which, for those who don't know, it dips pretty deeply in the middle, like it's a significant cookie bite. And I recently got a new pair of hearing aids. And I just know that I was a nightmare for my audiologist and I apologized in advance, and she was super patient with me and just did everything she could to accommodate my very specific. I'm actually the opposite, Jackie.

Like, I need to hear all the background noise, which is crazy. I don't. She. And I don't consider myself a maximalist. I just kind of.

I feel safest when I'm getting almost too much. And she really worked with me. And so just shout out to all the wonderful audiologists, Jess, you're included in there.

I have a quick comment, obviously, as a hearing aid user who's actually up for a new set soon. So I. From a technical standpoint, I think a lot of the new noise reduction technology, which is coming out is very impressive and I'm excited to see that make its way into hearing aids more broadly and also cochlear implants. Eventually they do need to work on power consumption. It's still pretty power heavy

but it's still very impressive and I think a very great lateral step.

In a lot of ways we can improve our communication, especially in noisy environments, which is life. The one, the one thing I think we can improve beyond, you know, the technical specifics, getting it in the cochlear implants, reducing power consumption is more just kind of a systems based thing. And that is we need to improve if we can affordability or insurance coViralge for hearing aids. One of my worst situations I run into is when I'm seeing a patient for a cochlear implant. And medically they have really good options.

They're kind of borderline. So they could do an implant or they could do a hearing aid but the implant will be covered by insurance, the hearing aid won't. Which always feels very bad to have to bring that into the conversation. And some states do offer do have laws requiring insurance to cover hearing aids. So it is certainly possible.

I understand that's well beyond the scope of hear but I just wanted to hop on that soapbox for a second.

Absolutely, Jim. Thank you. Seconded. Agreed. Systemic issues need a systemic solution and we can just offer for so much here.

But this has been a fabulous conversation. There's obviously so much more that we can talk about and we are going to be talking about some of this at my next shameless plug here at the end at the ACIA Alliance conference. So CI 2027 is coming up in May in San Diego. It's going to be fantastic. Our SIG has a lunch and networking.

We hope to share some the preliminary results from our survey and there will be lots of other research and clinical information shared. So we invite you to join us there. Thank you again to the ACIA Alliance to Audiology Online. I want to give a big shout out to Carrie Spangler and Donna Sorkin from the ACIA

Alliance for helping us host this webinar today. And if you would like to connect with our sig if you are a deaf or hard of hearing professional in the cochlear implantation space, feel free to reach out to Viral and me and we can get you on our list.

And I'm going to turn it back over to Carolyn with a big thank you to you. Yeah, I'm just going to extend another thank you on behalf of our team. They always say to me but you say every webinar you moderate is your favorite. I'm like, no, but this one really works. Was they're like, yeah, we get it.

It was great. I just want to thank all of you very busy professionals for being so authentic and vulnerable, sharing so much great information. I think these types of CE opportunities are really not available out there for audiologists. So thank you. Thanks to Carrie and the AC alliance for bringing this to us and hope we can do it again sometime.

Thank you all.