Task Force 6:

Community Aural Rehabilitation Programs

Jerome Alpiner, Ethel Mussen, Jerry Northern, Deno Reed, Marilyn Soderberg

The issues related to community programs in aural rehabilitation are rather complex since we must be concerned with far more than implementing one single type of program. We must establish guidelines as to who should be served, by whom the hearing impaired should be served, and where they should be served. A practical problem, in terms of the above, has to do with the financing of aural rehabilitation programs within a community. This leads into a question regarding responsibility of selling our services to someone or some agency.

Let us first outline more specifically these areas of concern:

1. The location of community programs.
2. The populations to be served.
3. The actual types of programs to be established.
4. The personnel who will engage in community programs.
5. The financing of community programs.
6. The selling of community programs to physicians, hearing aid dealers, etc.
7. The identification or mechanisms for locating the hearing impaired.
8. The short term and long term goals of community aural rehabilitation programs.

1. Community programs need to be located in strategic locations so that all persons with hearing impairment may be served. The implication is tnat not all persons are found in larger communities where services generally are available. A large percentage of our hearing impaired citizens are in smaller and rural type communities where the population does not justify full time audiologists. A related and increasing area is that of the senior citizen residing in nursing or residential homes; there are thousands of homes located throughout the country and we generally will find that services are not available to those senior citizens, even if they happen to reside in metropolitan areas. A complicating factor is that there is no Federal stipulation that services for senior citizens be provided as far as hearing services are concerned. In addition, most communities have no provisions for services for screening adults compared to other services which frequent communities for the purpose of checking for TB. Most geographical locations also have no provision for the identification of pre-school children; the problem is even more serious in rural area locations where the population of hearing impaired children would be minimal even though they need service.

PROBLEM AREA: The need for some kind of outreach program which would allow us to provide services, including identification, for all children and adults, specifically in areas where professionals are not found. Here the focus is on the smaller and rural community areas, all areas in which senior citizen's homes are found, and in all areas where there are pre-school children.

2. All populations must be served. Even though there is some redundancy with item one, the point of emphasis is provision of services for all hearing impaired, oral, manual only (usually older adults), and total communication (now very much a part of some children's needs although not exclusively). Federal estimates indicate that there are at least eight million persons with significant degree of hearing impairment and another 300,000 classified as deaf.

PROBLEM AREA: The need to provide services for the total population. Audiologists still need to resolve their emotional issue regarding provision of services to manual deaf adults— should we or should we not be involved with this aspect of the population under which many of the 300,000 classified as deaf fall.

3. The actual types of program will definitely vary from community to community in this country. Most metropolitan areas have a variety of facilities in which they can offer services: university centers, community centers, hospital clinics, otologist's offices, private practice, some school districts, some church groups, etc. Rural areas have nothing available (usually). Even though services are available in metropolitan area, there is no real mechanism by which we are able to get adults to partake of the services offered. There are some exceptions of course with referrals from otologists, other physicians, and certain community agencies. But, as most of us are aware, the majority of adults who need rehabilitation services do not generally come for services. They either are not interested or do not know where to come. It is uncommon for adults to say they found out about us in the yellow pages or in a public service announcement in the newspaper or on the radio. A majority do not come from direct otologic or hearing aid dealer referral sources. Rural area persons may come to the city for an evaluation on a "one-shot" basis, return to the home community and find no rehabilitation or follow-up services.

PROBLEM AREA: The need to somehow inform persons about our services in metropolitan areas so that all may be served. The need to determine how services can be provided for rural area children and adults in their *home* communities. It usually is not feasible for rural area persons to come to the large community for continuing rehabilitation services on a regular basis.

4. The personnel serving the hearing impaired should be qualified to perform the task for which they have been trained. For audiologic assessment and hearing aid evaluation, and for formal rehabilitation services, professional personnel should be ASHA certified (at the present time, this is the index for the provision of quality service). We

cannot ignore the audiometric technician who may be able to engage in some type of identification audiometry. Although there is no general agreement on the utilization of these people, they are being trained, usually in NAHSA type community centers. A real problem exists because no formal guidelines exist regarding what technicians can or cannot do; there are no legal restrictions on technicians in most states. This problem will not go away; it will become more critical unless we involve ourselves in guidelines for technicians. Some of the centers that train technicians are not concerned whether or not they work under the direction of certified ASHA audiologists.

PROBLEM AREA: Qualified personnel are not located in all geographic regions for the provision of services. How do we provide quality services under these circumstances? How do we utilize the audiometric technician in a meaningful and ethical way? Should we utilize the audiometric technician in rural areas after they are trained? How are they directed or supervised?

5. The financing of community programs may be difficult. University programs are usually self-supporting but with decreased Federal support, we may encounter manpower difficulties. The Federal government appears not to be concerned. Community Centers are usually self-supporting and are tending to shy away from indigent persons because of the simple matter of financial survival. Hospital clinics find themselves with some financing problems now with Federal cutbacks. School districts are reluctant to add programs for children under the ages of either three or five-taxes are already too high. Senior citizen's homes usually have no services because they can't afford them. It would seem logical for responsibility to be assumed by state departments of health and education for finding ways to provide services to all children and adults.

PROBLEM AREA: Financial resources are limited for establishment of services for all persons; a dollars and cents problem. How do we secure funds for community programs? How do we finance programs in rural areas"

6. Throughout the years, many hearing aid dealers and physicians have not referred their clients for rehabilitation services. In those cases where they do not, it appears that they have not been sold on the value of rehabilitation services. We have short-changed ourselves on selling rehabilitative audiology—our research has been shoddy compared to other areas of communication disorders. The research base is weak, primarily on adults. We must have something to sell, we need to be able to present some kind of accountability data. There appears to be a great need for inservice training or workshops designed for the allied health professions, for hearing aid dealers, and for the public media which disseminates information to the public.

PROBLEM AREA: We have yet to say our profession, specifically rehabilitative audiology, has been accepted in this country. What techniques can we utilize to sell ourselves to those persons and disciplines mentioned? Can we do it without resorting to emotionalism such has been utilized by some

national groups which unfortunately have lead the public to believe that, unless you use manual language, you really do not have a hearing problem. Are we professionalists or emotionalists? Is there a happy compromise?

7. The need to identify those with hearing impairment is a necessary requisite to even implementing hearing rehabilitation programs. The hearing impaired must be found. This item relates to all of the items in this presentation. There is a need to be able to locate the hearing impaired senior citizen, the pre-school child, etc. There is no universally accepted mechanism for accomplishing this goal today.

PROBLEM AREA: The need to establish mechanisms to locate and identify persons with hearing impairment. How do we do it? How do we reach these persons? Is there a realistic way to reach rural area children and adults utilizing certified audiologists? In an era where there is a general downward trend in the numbers of jobs available for audiologists, the problem does not seem to be a shortage of jobs that could be available. Rather, the problem seems to be the need to sell our profession and the need to find ways of financially supporting programs.

8. Both short term and long range goals for community programs logically would be the preservation of human resources so that all citizens with hearing impairment may be productive. Communication is the link by which people survive in this society and all of us probably would agree that we must work toward improving communication as much as possible for each hearing impaired person.

PROBLEM AREA: With the above ideas in mind, what should be our short term and long range goals for community programs? How can these goals best be implemented? In spite of limitations cited in this report, we can begin to develop community programs with existing resources working toward continued improvement. Innovation seems to be the key. The responsibility is that of the audiologist who believes in aural rehabilitation.