Editorial

Functional Outcomes in Audiology: There is Room for Improvement

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There have been a large number of articles in JAAA over the years have been centered on or around the measuring and documenting of "patient related outcomes or PROs" in audiology. There is no argument that audiologists spend a significant amount of time in training programs learning about techniques and methods to maximize their patient outcomes. We as a field understand that measuring and documenting objective and subjective patient outcomes in the clinic are one of the most important components of our practice. However, as clinicians we have the ability to "hedge our bets" that our patients will reach a higher level of function after our intervention. We can use verification measures such as real ear measures (REM) or sound-field testing to confirm that the patients are leaving with our best attempt to restore their function in a clinical environment. Of course our patients all have different challenges and comorbities that must be accounted for when counseling and determining the best intervention. The challenge we face is the ability to confirm or capture what the effect of our interventions are on a patient's function after they leave the clinic and go out into their own environment and live their lives. When one thinks about it, this is really what counts yet it is extremely difficult to measure. That is, how can we improve a patient's function to as close to their premorbid level as possible? Function after the intervention is the key. It is the key component in many of the standard health-related QOL measures (e.g., Shortform-26 and EuroQOL). In the case of audiology, we need to be asking the question; are we able to get patients to do the things that they previously did before they incurred their impairment.

We have learned over the years that there are innumerable variables that can affect the success or failure of a patient's intervention. These include items such as age, cognitive impairments, emotional/mental state, and motivation. The fact that we are able to hit a target using real ear measures while the patient is in the office or give patients a hearing handicap inventory and their score decreases may not be capturing the essence of their functional improvement or lack thereof. This issue brings up that we must look beyond just treating the hearing loss but also include a pathway to increasing their function in their natural environment. We approach this by using what we call evidence-based practice. As a profession we need to begin to make efforts that show that in fact our services increase our patients function after they leave the office. There is no question that our disease-centric focus on restoring the hearing loss or the treating the symptoms of dizziness has led to the development of numerous innovative technologies to assess and restore hearing and have undeniably improved patients' function. However, I believe that we can do better in connecting clinical functional outcomes with continued maintenance and focus on continued improvement after they have left our clinic. One way we can start is to ensure that we connect with different disciplines to coordinate communication about the patients overall function and involve the patient in providing feedback. Another is to evaluate the current way we measure functional outcomes and refine or develop new methods.

In this month's issue of JAAA, Johnstone and colleagues report their findings regarding the functional benefits of open-fit hearing aid domes in children with sensorineural hearing loss. Specifically the authors evaluated each child's sound localization accuracy, in children with hearing loss in order to determine the extent to which hearing loss, age, duration of CE use, and affect their performance to localize sound. I encourage you to read this study as it is an illustration of how our profession is continually searching through research to assess and improve patients function.

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