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Guess who’s talking?

An investigation of person- and family-centered communication in adult audiology consultations

Caitlin Grenness, PhD 1, 2
Louise Hickson, PhD 1, 3
Carly Meyer, PhD 1, 3
Katie Ekberg, PhD 3

1 HEARing Cooperative Research Centre,
2 The University of Melbourne,
3 The University of Queensland &
4 Eriksholm Research Centre

Learning objectives

As a result of this Continuing Education Activity, participants will be able to:

1. Describe why it is pertinent to study the nature of person- and family-centered care in hearing rehabilitation
2. Critically appraise the evidence for the presence of person- and family-centered in adult audiological rehabilitation consultations
3. Implement one strategy for providing person- and family-centered communication back in own workplace
Greater adherence
Greater satisfaction & experience
Fewer malpractice claims
Positive influence on quality of care from the profession
Greater efficiency
Less burnout
Greater work satisfaction

Patient-practitioner communication

Practitioner or technology-centered
Gathering information
Explanation and planning
Relationship building
Person-/family-centered
Consumerist

Ong et al, 1995
Patient-centered care in audiological rehabilitation

“Technical audiological skills are assumed, interaction skills are valued…”


Research question

Does person-/family centered communication occur in adult audiological rehabilitation consultations?

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Results

- Few audiologist utterances related to explaining the specific lifestyle implications
- Lack of psychosocial exchange
- Patients' concerns unaddressed or responded to with technical information

- Hearing aids dominated
- Very few options provided
- Information was complex and technical

- Audiologist talked the most
- Rarely sought patients' options or preferences
- No partnership building
- Little engagement in decision making
- Little companion involvement

Structure of a consultation

- Getting Started
- Gathering Information
- Clinical Tasks
- Explanation and Planning
- Closing the Session
Methods

Consultations filmed
- Initial consultations
- iPod touch/iPhone
- 63 adults patients
- 17 companions
- 26 audiologists

Verbal communication explored
- Observation of processes and timing
- Consultation phases documented

Methods

63 Initial Assessment Consultations

Roter Interaction Analysis System (RIAS)

Conversation Analysis (CA)

Microsoft Word™ readability statistics & jargon identification
Participants

- Audiologists (N=26)
  - 11.4 years experience (1-40)
  - 62% female

- Adult patients (N=63)
  - Mean age = 71.6 (55-93)
  - 57% male

- Companions (N=17)
  - Mean age = 69.4 (50-82)
  - 65% female
  - 88% spouse

Consultations

- Mean length
  - Total = 57.8 (27.3-111.0)
  - History-taking = 8.8 (1.7-22.6)
  - Counselling = 29.0 (2.2-78.5)

- Funding source
  - Public = 52%
  - Private = 48%

- Recommendations/decision
  - 97% patients diagnosed with hearing loss
  - 83% with loss recommended hearing aids
  - 56% decided to obtain hearing aids

GATHERING INFORMATION
Structure of a consultation

Providing Structure

- Getting Started
- Gathering Information
- Clinical Tasks
- Explanation and Planning
- Closing the Session

Building the Relationship

An example

Case history video
Invest in the Beginning

<table>
<thead>
<tr>
<th>Skills</th>
<th>Technique and Examples</th>
</tr>
</thead>
</table>
| Elicit the patient’s concerns | ✷ Start with open-ended questions: “What would you like help with today?”  
                              | ✷ “I understand that you’re here for ... Could you tell me more about that?  
                              | ✷ Speak directly with patient when using an interpreter|
| Plan the visit with the patient | ✷ Repeat concerns back to check understanding  
                              | ✷ Let patient know what to expect: “How about if we start with talking more about ... then I’ll do an exam, and then we’ll go over possible test/ways to treat this? Sound OK?”  
                              | ✷ Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s...” |

Invest in the Beginning

**Payoffs**

- Establishes a welcoming atmosphere
- Allows faster access to real reason for visit
- Increases diagnostic accuracy
- Requires less work
- Minimizes “Oh by the way ... “ at the end of visit
- Facilitates negotiating an agenda
- Decreases potential for conflict
**Elicit the Patient’s Perspective**

<table>
<thead>
<tr>
<th>Skills</th>
<th>Technique and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask for the patient’s ideas</td>
<td>◆ Assess patient’s point of view:</td>
</tr>
<tr>
<td></td>
<td>“What do you think might be causing your problem?”</td>
</tr>
<tr>
<td></td>
<td>“What worries or concerns you most about this problem?”</td>
</tr>
<tr>
<td></td>
<td>“What have you done to manage things so far?”</td>
</tr>
<tr>
<td></td>
<td>◆ Ask about ideas from loved ones</td>
</tr>
<tr>
<td>Elicit specific request</td>
<td>◆ Determine patient’s goal in seeking care:</td>
</tr>
<tr>
<td></td>
<td>“How were you hoping I could help?”</td>
</tr>
<tr>
<td>Explore the impact on the patient’s life</td>
<td>◆ Check context: “How has this affected your daily activities/work/family?”</td>
</tr>
</tbody>
</table>

**Payoffs**

- Respects diversity
- Uncovers hidden concerns and diagnostic clues
- Reveals use of alternative treatments or requests for tests
- Improves diagnosis of depression and anxiety
Evidence for audiology consultations - consultation opening

- Audiologist interrupted pts in 76% of consultations, after 21 secs
- When not interrupted, pts spoke for 43 secs

- 77.8% of initial questions were closed ended or confirmatory

- Verbal dominance (aud:pt) 1.1:1
- Content was more biomedical in the presence of a significant other

Evidence for audiology consultations - case history

- 86% of audiologist’s questions were closed ended
- 56% of questions were biomedical in nature

- When aud asked concern, patient had greater control

- Audiologist asked 97% of questions
- Patients asked fewer questions in the presence of a significant other

Summary of opportunities

- Listen more, talk less
- Change the talk from biomedical to more biopsychosocial
- Solicit patients (and SOs) reason for attending

EXPLANATION AND PLANNING
Structure of a consultation

Providing Structure
- Getting Started
- Gathering Information
- Clinical Tasks
- Explanation and Planning
- Closing the Session

Building the Relationship

An example

Shared decision making video
# Explanations and planning

## Skills  |  Technique and Examples
---|---
Deliver diagnostic information | Frame diagnosis in terms of patient’s original concerns
Provide education | Explain rationale for tests and treatments
| Review realistic function of management
| Discuss options that are consistent with patient’s lifestyle, cultural values and beliefs
| Provide resources (e.g., written materials) in patient’s preferred language when possible

## Share decision making with all parties

- Discuss treatment goals: express respect towards alternative options and practices
- Assess patient’s motivation and readiness to carry out plan
- Explore barriers: “What do you think we could do to help overcome any problems you might have with the treatment plan?”
- Check understanding
- Check preferences and perceptions: “what are you thoughts on what we have discussed?”
### Skills and Technique and Examples

<table>
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<th>Technique and Examples</th>
</tr>
</thead>
</table>
| Complete the visit | - Summarize visit and review next steps  
|                  | - Ask for additional questions: “What questions do you have?”  
|                  | - Assess satisfaction: ” Did you get what you needed?”  
|                  | - Close visit in a positive way: “It’s been nice meeting you. Thanks for coming in.” |

### Payoffs

- Increases potential for collaboration
- Influences health outcomes
- Improves adherence
- Reduces return calls and visits
- Encourages self care
Evidence for audiology consultations - results and management planning

- >75% information related to Hearing aids
- Use of unclarified jargon common
- When auds used more simple language = more likely to purchase HAs
- Patients who demonstrated pre-contemplation resisted hearing aids (80%)
- 56% of patients decided against hearing aids overall
- >75% information related to Hearing aids
- Use of unclarified jargon common
- When auds used more simple language = more likely to purchase HAs
- Hearing aids were recommended in 83% of consultations
- Alternative options were offered in 8%
- Recommendations rarely specific to goals


Evidence for audiology consultations - results and management planning

- Verbal dominance = 1.6:1
- 1% audiologist utterances sought patients opinion or preferences
- 0% audiologist utterances related to partnership building
- When less time, greater aud control of topic
- Audiologist asked 97% of questions
- Patients asked fewer questions in the presence of a significant other
- Auds gave less information and counselling in the presentence of a significant other
- SO contributed 17% of talk


continued
Summary of opportunities

Consider complexity and focus of information

Offer array of options

Shared decision making

RELATIONSHIP BUILDING
Structure of a consultation

An example

Psychosocial engagement video
Evidence for audiology consultations - building relationships

Make sure you tune in to Dr. Katie Ekberg’s webinar ‘Are you listening...?’

Ask psychosocial questions

Respond to psychosocial concerns

Empathy


Implications
But... (barriers)

- It takes too long...
- It will open a ‘can of worms’
- What if I can’t solve their problem?
- I’m not a counsellor/psychologist/doctor
- My boss/I just want/s me to sell hearing aids
- I don’t have the resources...
- It’s not my priority...

So you’re saying...? (facilitators)

- Implementing small changes can make you more person/family-centered (P/FCC), more of the time!
- P/FCC can improve your patients and SOs outcomes AND your/your employer’s outcomes
- P/FCC can improve your work satisfaction
- You have control over how person/-family-centered you are in your interaction style
Future research and ongoing questions...

- Influence on outcomes
- Patient and family engagement
- Audiology education and training
- Clinician behaviour change
Key references


With thanks to...

Participating clinicians, patients and SOs

Please contact me for more information...

Caitlin Grenness
caitlin.grenness@unimelb.edu.au

This research was financially supported by the HEARing CRC established and supported under the Australian Government’s Cooperative Research Centres Programme. The CRC Programme supports industry-led end-user driven research collaborations to address the major challenges facing Australia.
Are you listening?
Addressing patients’ psychosocial concerns in audiology appointments

Katie Ekberg¹, Caitlin Grenness²,³, & Louise Hickson¹,³

¹The University of Queensland, ²The University of Melbourne, ³The HEARing CRC

Learning Outcomes

As a result of this Continuing Education Activity, participants will be able to:

• Identify some ways that clients raise psychosocial concerns within audiology appointments, and how audiologists may address them.
• List one new strategy to implement in clinical practice to address psychosocial concerns.
Patients often express **emotional reactions** to a diagnosis of HL or to a recommendation of hearing aids.

- Fear
- Worry
- Sadness
- Disappointment

Patients will also sometimes **raise concerns** regarding hearing rehabilitation during audiology appointments.

- "I see you're not happy and not happy hearing aids these damn wires coming down here aren't all this"
Psychosocial concerns around HL

- An important aspect of patient-centred care is that the patient feels his/her concerns are heard and validated.
- Interaction in the clinical encounter building blocks of therapeutic relationships.

Patient-centered care (PCC)

“Technical audiological skills are assumed, interaction skills are valued…”
**Structure of a consultation**

- Providing Structure
  - Getting Started
  - Gathering Information
  - Clinical Tasks
  - Explanation and Planning
  - Closing the Session
- Building the Relationship

**Addressing psychosocial concerns**

- **Research from other areas of healthcare:**
  - Clinicians often miss opportunities to respond to psychosocial concerns
    (Easter & Beach, 2004; Hall et al., 1999; Pollak et al., 2007; Ruusuvuori, 2005)
  - Attending to patients’ concerns leads to clinician-patient alignment and increased agreement about treatment plans
    (Adams et al., 2012)
The current study aimed to examine 63 real-life, video-recorded initial audiology appointments for:

- how patients present concerns about hearing aids during initial audiology appointments
- how they are responded to by audiologists
Consultations filmed
- Initial audiology appointments with older adults (55+)
- 26 audiologists
- 63 adult patients
- 17 companions

Analysis
- Conversation analysis (CA)
- Provides an in-grained, sequential analysis of the interaction

Participants
- Audiologists (N=26)
  - 11.4 years experience (1-40)
  - 62% female
- Adult patients (N=63)
  - Mean age = 71.6 (55-93)
  - 57% male
  - Mean age = 69.4 (50-82)
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Consultations
- Mean length
  - Total = 57.8 (27.3-111.0)
  - History-taking = 8.8 (1.7-22.6)
  - Counselling = 29.0 (2.2-78.5)
- Funding source
  - Public = 52%
  - Private = 48%
- Recommendations/decision
  - 97% patients diagnosed with hearing loss
  - 94% with loss recommended hearing aids
  - 61% decided to obtain hearing aids
Results

- Patients raised concerns in 51% of appointments
- Patients’ concerns about hearing aids were psychosocial in nature
- Expressed with a negative emotional stance
- Invited an empathic receipt or display of affiliation

Real-life consultations

Let’s look at some real-life examples of patients raising concerns...
Example 1

(1a) [C11-1 at 31:04]

1 A: U:::m (0.5) .tch have you thought about
2 a hearing aid: um [before now? ]
3 P: [I don’t know]
4 whether I can s::tand it actually.
5 A: Ye:s hah hah .hhh sure .hh u:::m well
6 look lets go to my office:, and I’ll
7 just (. ) we’ll have a bit more of a
8 chat and I’ll show you a couple what
9 they look like::,

Example 1

(1b) [C11-1 at 43:37]

1 A: So you know you [d;on’t really] see it anyway
2 P: [ Hah hah ]
3 A: because your hair’s there.
4 P: I don’t think I’ll be bothered with that (0.8)
5 because I’ve been used t(h)o huh not getting
6 everything now huh huh huh £you know what I
7 mean£ [.HHHH] so um (3.0)
8 A: [ "Mm" ]
9 P: actually I wouldn’t have come if I wasn’t
10 invited heh [heh hah hah ]
11 A: [Oh::: I see]
12 C: hah hah hah hah
13 A: £Yeah£
Example 2

(2a) [C5-1 at 25:25]

1. A: So what these results say to us is that you do have a hearing loss in both ears, it is effecting the higher pitches of sound, (0.6) hh you may benefit from something like a hearing aid, (0.7) um (1.0) have you ever thought about hearing aids before is it something that you’d be interested 
2. P: [No.]
3. A: in or r (0.2) 
4. P: Well not unless I really have to: 
5. A: [Okay] 
6. P: [Yeah].
7. (.)
8. A: Well I’ll show you what the styles of the hearing aids have <changed recently> um so they’re (1.5) a bit more cosmetically appealing than what they used to be,

Example 2

(2b) [C5-1 at 26:15]

1. A: Um (1.6) so is that would that be something that you’d like to do: r, 
2. P: U:mm (0.4) 
3. A: Or you’re not too keen at this [time?] 
4. P: [Yeah] I really m I- huh no [yeah I- not really ] 
5. A: [Not really keen huh] 
6. P: kee:n .hh u:mm (1.5) I: don’t know if- whether I really need one just yet, 
7. ... 
8. A: Well (0.2) what I’ll do I’ll give you this, (0.3) this is a handout, (0.8) on having a mild hearing loss...
Example 3

(3a) [C20-1 at 31:53]

1 P: I’ve got a horror.
2 (0.2)
3 P: A horror-er I don’t know how bad this is going
to get an’ probably you can’t envisage what’s
going to happen in the next year or two.
4 A: No.
5 P: I mean say I could be gone hh but um (0.6) I
want to try and not have hearing aids
[ because these] damn wires coming
6 A: [Fair enough. ]
7 P: down here an’ all this.
8 A: THEY’RE not so BAD these days, let me go grab
something for you. Stay right here

(3b) [C20-1 at 39:23]

1 A: Here we go. ((door closes)) So have a look yourself,
you can see it’s [ba:relly]
2 P: [It’s te:rible in your ear isn’t
3 it, it’s- (1.6) [ no::: ]
4 F: [Don’t think] that. You can’t see
5 it.
6 P: Yuck.
7 (0.3)
8 F: Now what’s wrong- [Can you] see that?
9 P: [ Yu:ck.]
10 A: [You ] can’t tih hih heh

continued
Summary of findings

- Patients often raised concerns in appointments, however they were not typically addressed
- Audiologists progressed a discussion about hearing aids
- Mismatch in communication between audiologist and patient
- Led to expanded sequences of interaction where patients persistently re-raised their concerns
- Appointment often ended without patient agreeing to hearing aids

What can you do?

**Personal adjustment counselling skills:**

- Empathy - identify & calibrate the emotion in patient’s talk
- Talk less
- Allow the patient to expand (e.g., continuers – “mmhm”)
- Empathic receipts (e.g., “That sounds…”, “I’m sorry to hear that”)
- Sign post if necessary
Empathy

• Video by Dr Brené Brown on Empathy Can be viewed on YouTube: https://youtu.be/1Evwgu369Jw

Guidelines for empathic listening

• ‘Active listening’:
  – Showing you are attentive – facing the patient
  – Nonverbal acknowledgements (e.g., head nodding, facial expressions, open and relaxed body expression, eye contact).
  – Providing brief acknowledgements (e.g., "Uh-huh," "I see.")
  – Invitations for the patient to say more (e.g., "Tell me about it," "I'd like to hear about that.")
  – Don't change the subject or move in a new direction.
  – Reflect back to the patient what you understand and how you think the patient feels.

You don’t have to have all the solutions!
What can you do?

- Addressing patients’ psychosocial concerns can aid discussion about rehabilitation recommendations
- Offering other **options** may also be beneficial

What are the benefits?

- Direct engagement with patients’ emotions associated with:
  - greater patient satisfaction and self-efficacy
    (Ong, Visser, Lammes, & de Haes, 2000; Stewart, 1995; Zachariae et al., 2003)
  - better understanding of patients’ readiness for change
    (Britt et al., 2004)
  - improved patient outcomes
    (Stewart, 1995)
But I don’t have time!

- Patients persist in re-raising their concerns
- Interaction becomes significantly extended

Taking time to address patients’ concerns can (perhaps counter-intuitively) make the audiological process more efficient!

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Key reference

Acknowledgements

Please contact me for more information …

Katie Ekberg
k.ekberg@uq.edu.au

This research was financially supported by the HEARing CRC established and supported under the Australian Government’s Cooperative Research Centres Programme. The CRC Programme supports industry led end-user driven research collaborations to address the major challenges facing Australia.