Signia Podcast Series: The Business of Blended Hearing Care with Lisa Klop and Brian Taylor (Podcast #2 - Developing Your Treatment Philosophy in a Blended Hearing Care Model)

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- Welcome everyone to our new Signia Podcast Series: The Business of Blended Hearing Care with Lisa Klop and Brian Taylor. I am Lisa Klop. I'm one of the managers of the clinical education team. In part two of our Blended Hearing Care series, we're going to discuss the importance of developing and implementing a treatment philosophy in your clinic. And with me today, as usual is Brian Taylor, my coworker and colleague. He is the director of Clinical Content Development for Signia, welcome, Brian.

- Thanks, Lisa. It's always good to be with you. And as you said today, we're going to be tackling a very abstract, I call it a naughty topic that is developing and implementing your treatment philosophy. What it is, why developing a treatment philosophy in your clinic is important. And the process of actually, bringing that to life in a blended hearing care model.

- I think it would be helpful to remind our listeners what is blended care. We did talk about it in our first installment and then why do they even need to know about it?

- Yeah, good point. Like you said, we talked about it in the first, part one of the series, but blended, just to remind everybody in case you hadn't heard the first one, blended hearing care combines in-person and remote tele-audiology, so that people with hearing loss can access some of the services from home using standard computer, smartphone, WiFi technology. In a blended hearing care model, the patient and the provider decide when to conduct in-person and remote visits. And we tried to make the point that a blended hearing care approach has the potential to enhance relationship centered communication and patient outcomes, because it allows for additional touch points without the patients having to find the time to get into the clinic.

And of course, COVID-19 force many of us to start utilizing tele-audiology and remote care. But after the pandemic is over, I believe that many patients and many hearing care professionals are going to continue to want to enhance or supplement their in-person experience in the clinic with remote care.

- Good point, and I couldn't agree more. I think that the pandemic has forced us to kind of embrace a new model. And I can think that we've learned some things in the past few months and yes, that this could contribute to, the typical patient care scenarios going forward. I know that in our first podcast in the Splendid Care Series, you talked about why it's critical for hearing care professionals to embrace this model of blended hearing care. Maybe you could just reinforce or reiterate why this is so important.

- Sure, well, I tried to make the point in the first podcast of the series that it boils down to the retailization of healthcare and like it or not the patient who traditionally has been uninformed and a passive recipient of their care that today they want to be more involved in the entire decision making process. And I tried to make the point that in other words, traditional patients are much more, I would say, consumers who shop around, do their homework, talk to others before they make a buying decision. As to why it's critical for hearing care professionals, to think of patients as consumers and to embrace a blended hearing care model. I mentioned in the first podcast five reasons, and I'll just very quickly reiterate those reasons. People wanna Google in comparison shop that's number one. Number two, they expect price transparency. Number three, they want quality metrics. Number four, they expect a memorable engaging and convenient experience and they want efficacy of care. So those are the five reasons. And considering many patients with hearing loss who are also older and more vulnerable to the effects of COVID. I think the big challenge now is how do we embrace these five principles or five hallmarks of the new consumer? How do we embrace those using a blended approach to hearing care?

- Yeah, I think that's a fair question. So, okay, I understand why a blended model it's kind of been thrust upon us due to the pandemic, right. And that is likely is the wave of the future, but I'm a little curious as to how a provider's treatment philosophy is related to this blended hearing care approach you've been talking about.

- Yeah, that's that nebulous term treatment philosophy that I'm gonna try to define and put a little more meat on the bone, so to speak when it comes to it. So that's a great question, Lisa. I think that developing and implementing a treatment philosophy in your clinic is always a good idea, but in times of tremendous change and uncertainty, like most of us are experiencing today, developing your own treatment philosophy. Your own approach to care is probably more critical than ever. For one reason, it gives your practice a clear identity, for then that reason alone, I think it's important to think about it. But let me just say that. I think I use this term treatment philosophy and it is sort of like talking about religion. There are many different kinds of religions, but they're really no wrong answers. They all have sort of the same kernel of truth in them. So that's kind of how treatment philosophies a little bit like religion in that sense. But unlike religion, a treatment philosophy is not based on faith, but it really should be grounded in science, and whatever your treatment philosophy might be, and my job here today is not to tell somebody, this is your treatment philosophy, but to think about this approach, but whatever your treatment philosophy might be at the end of the day, it comes down to being true to your own values and convictions as a hearing care professional.

- I'm really finding this very interesting, but how does a treatment philosophy relate to what happens on a day to day basis in your clinic? You know, helping people hear and communicate more effectively?

- Well, I think in, at least in my own simple way of thinking about things, having a well thought out and executable or implementable treatment philosophy gives your clinic

structure and direction. Like I said before, it kind of gives your practice an identity that's grounded in science. And that structure and direction is critical when any new hearing aid feature comes to market or some new clinical tool like, virtual tele-audiology is introduced. There's lots of examples of what I mean here. Whenever a manufacturer introduces a new feature or whenever a new vendor brings a new piece of equipment to market or a new test protocol comes to market, the hearing care professional in a clinic needs to ask themselves, does this new hearing aid feature, does this new piece of equipment, does this new test or protocol, does it fit into my or our treatment philosophy? And you can take tele-audiology as an example. And it's kind of a hot topic right now. And before any of us in the clinics jump into using virtual care, it's critical to do some investigating to review some of the peer reviewed literature and survey data around tele-audiology to see if its benefits and its limitations, to better understand if older adults can use it or if they like to use it, or if it benefits them. Luckily, we have some people that are kind of ahead of the curve in this area that have done some really, I think nice review articles out there in the trade journals that provide us with some good preliminary insights.

Just the last week or so, I think most of the listeners are familiar with Harvey Abrams. He used to be with the VA. Now he's with a company called Lively or Listen Lively. They do a lot of remote care. He did a really nice review of some peer reviewed studies to show the effectiveness of telehealth in general. And he published that at the hearing health and technologies blog a week or so ago, you can probably find that. And then Gabby Saunders, J. Hall and others at the hearing journal have done some really, I think important features on different types of tele-audiology, and the evidence to support its effectiveness and even at WS Audiology, we conducted a survey that indicates that many current hearing aid users are open-minded about using virtual and remote care that survey is not yet been published, but that's something to look forward to, but it shows that. People once they're exposed to tele-audiology are more likely to embrace it, but anyway, it really comes down to this, having a clear and thoughtful

treatment philosophy helps you articulate your practices, core value, values and missions to all patients. And remember one of the five hallmarks of the new consumer is efficacy of care. Well, having a treatment philosophy, I think leads to optimal outcomes and practicing with a high level or large amount of efficacy of care.

- Brian, that sounds pretty abstract. And I'm kind of a black and white kind of person. And I think about, you know, how I would feel hearing this if I was still in practice and running a busy clinic. So how does a typical busy clinician go about developing this treatment philosophy even if they haven't even thought about it?

- Yeah, that's a pretty fair point. I don't want it to sound like this is something that you read in a textbook when you're in school and then you forget about it because that doesn't do anybody any good. So first let's agree that it's helpful to have some structure in how we make any clinical decision in our practice, but especially clinical decisions about treatment options that people have to pay, a fairly, a large amount of money or percentage of at least out of pocket for those devices and services. Next, I think when you're developing a treatment plan, I'll try to bring it down to a practical level. When you're developing a treatment philosophy, you need to ask yourself or your team, I think four critical questions in the context of how care is going to be delivered in your practice. So what I'd like to do is have our listeners sort of imagine they're a part of a staff of, I don't know, maybe two or three audiologist, a couple of front office people, maybe an audiology assistant, whatever it might be. When you're having maybe monthly or biweekly staff meetings during those staff meetings, that would be an ideal time to ask the following four questions. So let me just state what the questions are that you would kind of debate mull over with your staff. I'll state the four questions and then I'll go back and I'll try to, provide a little bit of insight in how you might address each one of the questions. So question number one, I think you have to ask your staff is what is the mission and purpose of our practice? Why do we exist? What do we want to be known for? Those are all kind of derivatives of that question.

What is our mission and purpose? Question number two, what is a favorable patient outcome? What does success from our treatments look like to the patient? Number three, how do we as a group achieve these outcomes? I think that's a really important question. And then the fourth one, in the context of blended hearing care, what is the best way for us to deliver these services that lead to the most favorable outcomes? So those are the four questions that I think any staff, it would be time well spent over the course of three to six months at these biweekly, monthly staff meetings, debating and hashing out what your answers to those questions are. So I'll just, let me just, 'cause I've done this exercise with practices myself, let me kind of maybe provide some insight or some direction on how you might approach each one of those questions. So the first question is what is our mission and purpose? What's the mission and purpose of our practice? And I think the common answers that I hear out there is to provide high-quality a hearing care to everyone in the community, or to provide high quality hearing care to those that value time with the professional.

So you can either go very narrow and say, we want to address and provide a very high level of care for a specific segment of the market, or you could go more broad and to provide quality care to a more, a wider range of people with hearing loss that maybe value other things than just hearing aids that want some other type of service in addition. So that's some guidance on that first question. The second question, what is a favorable patient outcome? I think a good answer to this question are things like improve participation in daily activities, improve day-to-day communication in noisy situations. And it's important to remember that those types of outcomes they need to be measured. And those outcomes also stem from full time hearing aid use. And so measuring benefit and measuring satisfaction, those things are important. And then question number three, how do we as a group achieve these outcomes? I think a good response to that question is revolves around three factors. The first factor are patient based factors, factors like motivation and attitude, self-confidence, budgeted, cognitive ability. A lot of these factors, we as providers, we don't control, but we can

certainly shape them. And we can very certainly measure those factors. The second factor around achieving outcomes is a provider based factors. Your ability to be attentive, to be compassionate, to ask good questions, to take the time to meet the needs of the patient above all else that's going on in your clinic. Those are all factors that we can control. We can hire, we can train to make sure that all of the people on our staff are doing the things like that, that we want them to do. And then the third factor around achieving optimal out around, how the group is gonna achieve outcomes would be what I would call them vice or performance based, factors that are more related to the technology you might be fitting. Can optimal outcomes be achieved by wearing a certain device? What, besides a properly fitted device is needed to achieve optimal outcomes? What level of hearing aid technology is needed to achieve the best outcome? Those are really important considerations that we have to hash out. And then the fourth question, what is the best way to deliver these services that lead to favorable patient outcomes? There are surveys out there that show the majority of patients favor in-person visits, but they're open-minded and receptive to some of the appointments being offloaded or complimented with remote or virtual care. And there's also data out there that shows most satisfied wears, tend to visit the clinic less often. But for those that need adjustments to their hearing aids, we can supplement with remote care or the use of a tool like Signia Assist.

- Brian, so I think our listeners will be very appreciative that you actually provided examples or your own responses to these questions, but in the end, they're really going to have to do this on their own, come up with their own answers. So how would our listeners go about doing that? How could they arrive at their own answers to these questions that you posed?

- Yeah, that, I'll give you a framework that I use to help answer those questions and really a framework that can be used with, I think, any clinical decision that you have to make, this framework that I'll introduce to everybody, it works particularly well when it

comes to treatment decisions. You know, what type of hearing aid? What type of service do you provide that say a first time hearing aid user? So this is a little bit difficult to talk about without a visual aid. So if you're not driving or doing something that requires you to be looking out, I want you to imagine on a continuum, I call this the evidence orthodoxy continuum. So you could draw a straight line on a piece of paper. You can imagine a straight line when you close your eyes, assuming it's okay to do that. And on the left side, you have evidence, on the left side of the continuum you have evidence. And on the right side of the continuum you have orthodoxy. And every clinical decision can be placed on this continuum. On one end of the continuum, you have decisions that are based primarily on evidence. These involve the hearing care professionals ability to weigh and study facts from well-designed studies that reflect the values and the needs of the person sitting in front of you, that you might be working with at the time.

The other end of the continuum is orthodoxy, which means making decisions based on what others maybe have told you to do, or what others have told you works well, or maybe some cool buzz marketing buzzword. But essentially orthodoxy means sticking with conventional wisdom, even when better data might be available, but because it's simply easier, out of inertia or just force of habit, just kind of keep doing things the way you do. In other words, when you're on the orthodoxy end of the continuum, when you're making a clinical decision, there's a certain rigidity of your thinking, things have always been done this way. I'm not gonna change. I'm just gonna continue to do it this way. But when you go to the evidence side of the continuum, your decisions are grounded on facts, that really, I think when you stick to, grounded in science that leads to doing what's truly best for the patient, weighing out facts from well-designed studies, using data from studies that are reflective of the person that you happen to be working with, tempering those facts with your own clinical experience and intuition. That's maybe not on the far left of the continuum, more towards the middle, but when you're on the evidence side of the continuum, there's sort of a fluidity of thinking you're

willing to change your approach when new evidence emerges and essentially, there's no right or wrong answer here, but it's important that you're mindful of your professional ethics that you're doing it's always trying to make your decision in what reflects the best interest of each patient. And I think it's important for providers to be on the evidence side of that continuum. That that's how you establish trust. That's how you establish yourself as the person I call the compassionate expert.

- That's wonderful, that's, what I am curious about though, maybe you could give us some examples of how you might use this continuum to develop the treatment plan involving hearing aids. That's why we're all here.

- You know, I'd love to. I think this evidence orthodoxy continuum, this, what I'm trying to explain is really works particularly well when you're trying to develop a treatment philosophy or make clinical decisions around treatment packages or levels of technology. So we can use that as an example. So I think most of us are familiar with the orthodoxy of selecting hearing aids based on good, better, best technology tiers, three, four, five choices, strided based on level of technology. So this is where you can look at evidence from well-designed studies to help you develop your own treatment philosophy. And when it comes to, good, better, best levels of technology, there are a couple of studies, actually, I would say two families of studies that help us address this when we're trying to develop a treatment philosophy. The first family of studies that looked at this, came from the University of Memphis and they were published in 2013, 2014 in Ear and Hearing. And then about two years ago, the University of Iowa published a very similar study. And that's the one that's probably worth a little bit of time talking about today. So in this Iowa study, it involved 54 older adults with medically uncomplicated, mild to moderate hearing loss. And they compared advanced directional microphone, noise reduction technology to basic directional microphone, noise reduction technology. And they compared the two levels of technology in both lab and real world settings. And the primary difference between the

two tiers was the sophistication of the directional microphone and the noise reduction setting. So they have two different looking at, basically an advanced set of hearing aids and a basic set of hearing aids. And let me share you some of the details of the study design. So the lab testing was comprised of speech, understanding, sound, quality, judgments, listening, effort, and localization ability. And the real world benefit of the study was measured with a ecological momentary assessment, which I think more and more providers are getting familiar with this. It's basically the patients using an app to make ratings on sound quality and benefit. It's taking your, AFAB, the pencil and paper version of the AFAB essentially, or the cozy and putting it into the smartphone or into an app. And then, the benefit of course of that is you get instantaneous results. The patient doesn't have to wait two weeks to see, the clinician doesn't have to wait two weeks to see the patient it's done instantaneously with EMA.

Anyway, back to the study design, there were four conditions in the study, basic technology versus advanced technology with directional mics and noise reduction, both on and off in each condition, so that makes four conditions. And in each of those four conditions, they use the devices five weeks in each condition and all participants. The interesting here are the results that all participants had better results with directional microphone and noise reduction technology turned on for both the advanced and the basic tiers of technology. In the lab setting, the advanced level outperform the basic level and measures of speech understanding and localization, but the performance differences between the advanced and the basic, they actually disappeared in the real world. They didn't see any difference. That is the technology. And what that really means is the technology itself didn't matter in real world listening situations. It's important to note that in the discussion section of the study, the authors noted that the results could have been different, could be different for patients who were exposed to more persistent background noise. But I can tell you from a couple of other studies that people in general are not in very challenging backgrounds noisy situations day to day. Anyway, so that's the Iowa study that really shows no difference

between advanced and basic in real world listening situations. But there's one really important blind spot in this study. And maybe it's not so much of a blind spot, maybe it's because the technology wasn't as readily available a few years ago and they actually conducted the study and that is they didn't use any Bluetooth wireless streaming technology in any of the devices. So if you look, so here's an example of taking another piece of evidence to help you maybe update your treatment philosophy. So if you look at the recent MarkeTrak 10, series of papers that were published earlier this year, it shows that many patients or many hearing aid wears report that they have Bluetooth streaming capability. But very few of those patients actually use it, Bluetooth enabled hearing aids with remote mics and TV streamers. But those very few that use those, that Bluetooth enabled technology a lot are very satisfied with it. And so even though we can't really, or necessarily equate use rates with benefit. The point I wanna make is that the MarkeTrak finding suggests that Bluetooth enabled hearing aids and accessories are quite helpful and likely worth the money.

So what that really, so here's how this, I think, impacts your treatment philosophy rather than creating good, better, best technology tiers, it actually, based on my reading of these studies, it makes more sense to create what I would call treatment packages. So treatment package could be a pair of hearing aids alone, and that could be one treatment package and other treatment package could be what I call a hearing system, a pair of hearing aids with these Bluetooth enabled accessories. That could be two different packages, hearing aids alone and hearing systems with accessories. But I know I'm getting a little long winded here, Lisa, but there's one more point that I'd like to make on this notion of treatment packages. And that is there's another study, we've actually talked about a few times in these podcasts and that's from the acronym is ACHIEVE. The ACHIEVE Group is looking at the relationship between hearing aid use and the effects on cognition in older adults. And we've mentioned this study a few times and in their preliminary work, they published a protocol that was this year earlier published in Ear and Hearing. And one of the findings from that study was that in order

to maximize outcome, a patient really needed five appointments spread over about four collective hours within the first 60 or so days of initial hearing aid use that if you did that, it was more likely, that would lead to more favorable patient outcomes. So long story short from these three studies that I mentioned, we have ample evidence that says that a standard treatment package, one offered to just about all of your patients that you're paying out of pocket as kind of a default would have a service component with about four hours of professional time spread over the first two or three months of initial use. And based on my reading of the evidence that would lead to optimal outcomes.

- Wow, Brian, that's really a lot to consider. I can see why treatment packages might be a more scientific approach, but I have one simple question. Why would it matter to take the time to develop a treatment philosophy based on scientific principles?

- Well, I think it's sort of a professional obligation, and it gets back to one of the five factors we've talked about in the first podcast in the series, which, one of the five factors that have turned patients into consumers, and that is they want efficacy of care, what that is, what they're buying, they wanna make sure that it's beneficial and that it's proven to work. And many people know that they have a choice on how they spend their money, and they are more educated than ever before with respect to those choices. And that means in a lot of ways that we have to up our game, we have to incorporate new research findings, as long as they're from well-designed studies. We want to incorporate those findings into our clinical approach. And that requires, back to the evidence orthodoxy continuum that requires, that we stay up on current literature that requires a certain fluidity of thinking, what worked 10 years ago, may not be the optimal approach today based on changes in technology, changes in the marketplace and what these studies bear. So what it boils down to is it means we have to make sure that we're making decisions based more on evidence than on orthodoxy.

- Brian, that reminds me of a previous discussion you and I had. And I wanna ask you, I think our listeners might find this pretty interesting. You talked about something called the Mike Wallace effect. Could you tell our listeners what that is?

- Well, if they're under the age of 35, they probably don't know who Mike Wallace is. They might know his son, Chris Wallace, but Mike Wallace was probably the most famous investigative journalist of the 1970s and 80s. And he was one of the cornerstones of "60 Minutes". He passed away, not that long ago, actually and he worked till he was about, I think, 85 or 90 years old. But anyway, yes, Lisa, I think the point is you want to avoid the Mike Wallace effect. So those of you that don't know Mike Wallace, and those of you that may, maybe this is conjuring some memories, but Sunday nights at six o'clock here in Minnesota, you could watch "60 Minutes" and you would hope, if you're lucky enough to see Mike Wallace, you would see, he might walk into some unscrupulous business owner, take any business of your choice and start interrogating that business owner about some unethical practices or business dealings. Maybe they got caught in the act of lying, or maybe they got caught in the act of some dishonest business practice. And Mike Wallace would sort of rake them over the coals. So the point is you want to avoid the Mike Wallace effect. You don't want somebody like that showing up at your door, kind of spilling the beans on some unethical business practice. And the way to avoid the Mike Wallace effect is to always be on the evidence side of the evidence orthodoxy continuum. You always wanna have the perception that your number one priority is the interest of the patient that you're not being influenced by any other sort of extraneous factor, because at the end of the day, it's really important. And it's really, I think, valued by consumers that you stick to your ethics, that you take the high road. And ultimately, that's why it's important, I think to spend some time ferreting out your own treatment philosophy and one that is based and grounded in science or on evidence, because that will keep Mike Wallace and other investigative journalists away from your practice.

- Brian, I think we could all agree. We want to avoid a visit from someone like Mike Wallace.

- Right.

- I hope our listeners are able to appreciate the value of taking the high road. I see that our time is actually, I was about to say is about up, but I think we've gone over a little bit, but you've given us some great information and we look forward to the next installment of The Blended Care Series from Signia. Thanks everybody.

- Yeah, thanks everybody. Pardon the longer monologue this time. Next time, hopefully we'll avoid that on my part. Thanks.