The Value of Professional Person-Centered Hearing Care

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Welcome to today's session on the value of professional person centered hearing care. My name is Virginia Ramachandran. I am the Vice President of Audiology for oticon. I do have a couple disclosures. I am employed by OTICON and receive a salary.

I also am an author and editor for Plural Publishing and an adjunct assistant professor for Wayne State University.

The learning outcomes for this session are shown on the screen. I have no doubt that the care that you are providing to your patients is excellent. And I'm not suggesting an overhaul of what your current practices are. But I am hoping that you walk away with some useful ideas and tools that might assist you or others in your clinic in supporting your person centered care approach via these learning outcomes. There are risks and limitations inherent in today's course and these are listed here and will be available in your course handout.

So one of the questions that I think it's important that we as providers continuously ask ourselves is about the importance of the care that we're providing to our patients. And so a question, rhetorical question that I'd like to pose to you at this moment is really how important is the care that you're providing to your patients? So not the devices or technologies themselves, but the care that's associated with it. So I'm going to just reflect, reflect on that. I'll have you reflect on that for a moment while I get into some data that can help shed some light on this.

There was a very recent study published in early 2025 from the University of Iowa and from Vanderbilt. It's an open source article so you can access this if you'd like to follow up. The primary goal of this article was to understand the impact of hearing aid service model on patient outcomes. So fundamentally this is really a question of whether patients truly need audiologic care or can they go without care if the technology were good enough and structured in a way that would allow them to do this? And it's kind of an OTC type of question, if you will, can patients fit themselves and way to

understand this really with differences in technology between prescription and OTC hearing aids is to make sure that you're using the same devices.

And so in this study the same prescription devices were used for all of the treatment conditions. So it gets rid of the effect of the technology per se and really focuses in on the care model. So in this study there were three groups of patients. One group was an audiologist fit group. The other was a group called otc, meaning that they were patients were fit with OTC like devices.

Meaning prescription devices that were designed to be fit as if it were. An OTC did have some audiologic support, but it was more of an express type of fitting really, just designed to provide them the minimum support they needed to get started. And then there was a true OTC group where it had pre set programs in the hearing aid. So if they were in the audiology fit group, they had a pure tone audiogram. With the audiologist, they had a complete hearing aid fitting session, the meet time of which in the study ended up being 92 minutes, hour and a half.

They did a cozy unaided quicksand, loudest discomfort levels. The audiologist selected the acoustic coupling. The aids were programmed to NAL and L2 and were verified using real ear measurements. They had an orientation counseling, written support and website based support as well. They had a one week follow up that was automatically scheduled and then they received additional support as needed.

So this is something that we might consider to be just a good, thorough, audiometric, audiologic based approach to care. Probably looks very familiar to you. In the OTC group these folks did still have a pure tone audiogram. With the audiologist they had a very truncated fitting session that was limited to 30 minutes. The audiologists selected the best preset program in the hearing aids.

So the hearing aids had these preset programs based upon several different types of common audiogram, common audiometric configurations. So there were different gain levels available based on

that. And then the audiologist would tell them, this is the one that's most appropriate for you. The audiologist selected the acoustic coupling and then hearing aid adjustments were made by the person in real life using a smartphone app. They also provided written instructions and could access the website.

They were actually allocated up to two 15 minute follow appointments as needed. And patients did take advantage of that in the study. And then in the OTC group you had these precept programs. In the hearing aid, the patient used a kiosk application on a tablet computer to listen to various sounds. And based on the responses from the patient, it recommended one of the presets to be provided to the patient.

So then they received their hearing aids and accessories. During the trial, the patients could request a preset reselection if they found that it wasn't working for them. Or they could also request hearing aid replacements if they encountered device issues. And you can imagine this is what might happen in a true over the counter hearing aid scenario where if it's not working, they could switch it out for something else. And they also had written instructions and website based support included in this study were adults 55 to 85 years old and they had bilateral mild to moderate sensorineural hearing loss of a particular configuration and degree.

And so the only real exclusion criteria in this study were that they, they needed to have the right hearing loss and they were excluded if they were a non native speaker of English or if they had prior hearing aid experience. So these were again all new users. What was interesting is when you look at the total number of patients or subjects that were assessed for eligibility in the study, 40% or 41% of the subjects were excluded due to not meeting criteria. And this is really interesting to me because I've been looking at this over time in other studies and the number that actually keeps coming up is around 40%. When you look at studies that are really designed to evaluate the patient population that is meant

to be fit with OTCs that mild to moderate sensorineural hearing loss group, when you look at these studies and you look at who volunteered and say, yes, I meet these criteria, but then they were actually screened for their degree of hearing loss.

Around 40% of them in most studies are found not to be candidates based on their audiologic status or some other important criteria that would make them really not the ideal population for OTC hearing aids. So this was yet another study that came up with around this 40% number, which is interesting. So let's get into the results here. The outcome measures that were used in the study were interesting in that they included two different ways of measuring the same test. That test is the Glasgow Hearing Aid Benefit Profile, and it was administered in two ways.

In one case, it was administered following a period of hearing aid use, like a traditional outcome measure that you might be used to. In another case, it was administered using what's called ecological momentary assessment or ema. So with ema, the participants were prompted on their smartphones periodically for a week to give feedback on the hearing aids in the moments that they were experiencing it. So they were the same types of questions as the retrospective gfab. But the people were able to respond in the moment and those in the moment scores were then averaged to give a total outcome score.

What was really interesting finding is that it showed that when subjects were asked about their outcomes that really mattered, the group that was fit by the audiologists showed greater usage when using the EMA version of the GFAB compared to both of the OTC groups, even those people who were assisted in an express fashion by the audiologist. They also showed a better global outcome when using this EMA metric. That's in contrast though to the retrospective version of the same questionnaire. So it appears that the test was made more sensitive to patient experience by asking the subjects about their experiences in real time, rather than asking them to remember that experience later on. They also

saw a significant difference on the saddle, which is a more traditional measure.

What we see from this randomized trial, it does show very clearly that appropriate audiologic care, like a traditional model of audiologic care, can have tremendous benefit to the patient and that the sort of express version of care really doesn't provide the same outcomes. So I think it does answer that original question is, does the care that you provide matter? The answer is yes, it absolutely can matter. If it's done in a way that can absolutely impact the patient and some forms of care don't necessarily provide that same outcome, then my follow up question to that would be, does your care matter as a patient or as a provider? This study provided had a protocol that was very thorough and adhered to a strict protocol.

What does that mean for you and your average patient that you're seeing on a day to day basis? My guess is that you are probably providing excellent patient care. But do you know that for sure? And even if you do, can you prove it? Can you explain what your approach to care is?

Can you explain if it's unique in any way? And are you working with any payers that might be interrupting this care process in some way that might not be beneficial to the patient? So these are again more questions that are food for thought. So keep thinking about. All right.

Another important question is whether patients care about care. So even if we know that they have superior outcomes, do they actually care about getting this excellent care that is required to do that? Another really cool study that was done recently was by Anna Marie Gilla and colleagues Lamar University and the University of Oklahoma. They actually asked experienced hearing aid users about their willingness to pay for devices, over the counter devices and hearing care. Very interestingly, when they asked this group of experienced users what their willingness was to pay for OTC devices, the median cost was $0.

So they just simply were not willing to even take OTC devices as experienced users. When they asked these experienced users about what they referred to in the study as advanced digital technology, it was somewhere between $1,000 and 2,000 dol per ear for device that they were expressed willingness to pay. And you can imagine that this is probably very consistent with what their actual experiences were in obtaining hearing aids previously. Right? So their perception of how much they were willing to pay was probably pretty closely anchored to what they actually would have paid in real life.

However, when they were asked about being willing to pay for hearing care services, things got very interesting. Because they were willing to pay, the median willingness to pay was $250. What that says to me is that patients do care about care, but not until they actually do. So they really do care about it, but they probably don't necessarily know it when they see it. With this group, they were willing to pay for the devices, but it was probably presented to them historically in a bundled model, right.

That where they were paying for the devices and the care together. And so if you look at their overall willingness to pay, if it was $1,500 per year, that's $3,000 overall. And then you add in this extra amount that they were willing to pay for care of another $250, that might be closer to what they actually paid as a bundled model. And they weren't necessarily splitting it out in their minds what was the value provided by the devices versus what was the value provided by the care? So it does seem that they were, you know, absolutely willing to pay for care.

But how much of what they were paying for did they identify as care and would they know it, what that care looks like when they see it? I think a lot of times what we perceive as professional care, a lot of times our patients feel or perceive as being nice to them, that we're good people and we listen to them and we take their concerns seriously. But I think in a lot of cases, they just simply don't quite know that care when they are experiencing it. And so I think it's one of the things that we could really do for patients to be helpful to them is to be explicit about the care that we're providing. That when I'm having

this discussion with you about your hopes and dreams and needs, it's really about providing you with care, professional care that you deserve to be compensated for, rather than simply being a nice to have.

So my guess is that you've all had, as I have had in the past, had patients ask us why they should choose us and why they should come to us over another provider. And this is a question that sometimes can be off putting as a professional, because it can feel like they're skeptical of us or maybe doubting our abilities. But I would urge you, if it does feel that way, to think about it a little bit differently. We'll ask this question. I think that it's really a sign that they are highly invested in their care and they're looking for validation from us that they've made the right choice in coming to us, they want to be successful.

But if they're asking that question, it also tells us that they haven't yet had that made explicit to them. And so if that's the case, it's certainly they have a good reason to ask this question. Right. And so we should really be able to describe to them what it is that we're gonna provide from a care perspective. And so one of the things that can be very beneficial to us as clinicians is to, you know, when you're asked patient or proactively be able to explain to a patient what's the philosophy that you are approaching their care?

Do you have a philosophy? Can you describe it? How are they going to know and have confidence in the fact that they're in good hands getting their care from you?

One great answer to this question is being able to describe a person centered care approach to your diagnosis and treatment. The definition of person centered care here came from the work conducted by the IDA Institute. It describes care as being designed around the individual, with the audiologist treating the patient as an equal and active partner in decision making and goal setting and being respectful of their preferences. Person centered care has been shown to have numerous outcomes for both

individual clinicians and for our practice. So it's not just all about the patient having a better experience with it.

It turns out as providers, when we provide person centered care, we have more meaningful interactions, we have greater job satisfaction, we have less burnout. So there's actually a selfish component to this in addition to having better outcomes for patients. But of course, it also results in better patient and family outcomes when it comes to treatment as well. And that's true across all of healthcare and hearing care as well. Now, there are numerous elements of person centered care, including the manner in which we communicate and how we determine the best course of action to take when treating patients.

I'm mostly going to focus on that treatment planning components, but I'll touch a little bit on the communication as well as we go through this. My personal belief is that one of the best ways to both demonstrate the value of your career and to ensure that you have a process in which person centered care is practiced is to have a formal treatment plan. I know that we all learned about treatment planning when we were in school, but it's not very common to see a formal treatment plan completed in audiologic practice right now. And so I would encourage you to consider, you know, is this something that if you're not currently doing. Is that something that you might want to implement with your patients?

And I'm going to explain why I think that's helpful. Just one way in which you can show the patient what they are receiving from you and that this care is focused on their needs and wants and expectations so they clearly know what it is that they're paying for and clearly understand that it is centered around their needs. One of my favorite quotes is attributed to the Art of War. It's that strategy without tactics is the slowest route to victory. Tactics without strategy is the noise before defeat.

And so when I think about that treatment plan, I think of it as the strategy, how or what's our route to victory here for this patient? But you also need to have some tools to implement that plan to get you to

where you need to be. So I'm hoping that the rest of this presentation offers a little bit of both strategy and tactics for you to use. As far as tools, OTICON does have several counseling tools to help support you. If you feel that these tools would be at all helpful to you, you can access them as a handout with this session or you can contact your OTICON representative for hard copies of these.

One of these counseling tools is meant to help describe your practice to your patients. It's meant to help patients understand what to expect from the diagnosis and treatment process. And it highlights the care that you're providing rather than highlighting the technology itself. So here the technology is portrayed as an enabler of your treatment, which of course is exactly what it is. Now, what you see here is a fairly generic tool.

It's meant to work for a variety of practices. If you already have a tool like this, that's awesome. If this tool inspires you to create your own practice specific tool, that's great as well. So please feel free to use it as you would like to, sort of. Well, when it comes to treatment planning, the first step is obviously to diagnose the problem.

So let's talk a little bit about diagnosis. Whether we like it or not, the fact is that almost nobody wants hearing aids. They might need them, but for some reason in general, people feel bad about the idea of it. I think we've all experienced this, right? So in large part, if somebody is sitting in your office, the likelihood is that something bad happened.

Something happened that made them feel worse than not wanting hearing aids. So they are sitting in your office not hoping that you'll provide the right amplification and the right technology. They're hoping that you will make that bad feeling go away. But if we're going to do this, we really have to allow them to tell us what it is that's bothering them. It's important to recognize that as an audiologist, you are likely one of the only people that they will meet who both understands what they are experiencing as a result of their hearing loss and who also cares about it.

Their friends and family may care, but they won't necessarily understand. Their other doctors have time for something that they wrongly consider to be less significant. Right. So they're lacking the real care part of that. Right.

You are the only person who will both listen to and understand their story. And if we don't give them the opportunity to do this, that patient is unlikely to have that opportunity anywhere else. So think about that for a moment. It is a fleeting moment in time where we can make a huge difference to someone who may they very well be in pain. My experience is that this is also a moment in time where we can create substantial trust.

If we demonstrate to the patient that we care enough to ask those difficult questions and to take the time to listen to the answers, they're likely to be your patient for the rest of their lives. They're not going to necessarily go out and start looking for other care providers when they know that you are actually there to listen and take care of them. You can really establish a strong bond by giving them that opportunity to tell their story.

All right. So to the patient, hearing loss is first and foremost a communication disorder. That said, we do need to understand the underlying pathology so that we can treat it effectively and if necessary, refer for medical care. But then we, in addition to that, need to understand the communication disorder aspect of it. Because most of the time when they're in here, most of the time when that bad thing happened that made them not feel great, a lot of times it came down to some communication disorder, some misunderstandings, some difficulty in a relationship caused by not being able to communicate effectively.

So we need to understand both pieces of that diagnosis. As far as diagnosing communication disorder, super threshold tests in noise can be quite helpful. Obviously, the audiogram is extremely helpful in

understanding audibility, but those super threshold tests can help us further understand the person's need. One of the newer tests that I just want to call out is the ACT test. Audible contrast threshold.

It provides a very quick language independent assessment of hearing ability and or ability to hear in noise, and that can be predictive of aided speech and noise performance. So the ACT test can be used for diagnosis and then for counseling. And then specifically right now In Oticon hearing aids, it can be used to prescribe the noise reduction features in the hearing aids to match the needs of the patient. So once we've gathered this information diagnostically with their audiogram and, and our testing, we should take a moment to consider what's most important to the patient. One of the things that happened to me in clinical practice was we were working with some audiometers and we're going from a traditional paper based, using a GSI audiometer.

And because we're using an electronic medical record system, we were experimenting with some computer based versions of audiometers. And what I found in doing that was if I wanted to get a copy of the person's hearing test, after having done that, done the hearing test, I actually needed to print it out and go down to the end of the hallway in a busy ENT clinic and hope that the printer cooperated that moment, which you know how printers can be sometimes they don't work like we would like them to. So that took more time than I was interested in committing to go down there and get that audiogram. So instead of bringing that audiogram back into the sound booth with me, I just went in without it. And without that audiogram, I was actually able to have a much more constructive, person centered conversation with the patient than I had been when I had that audiogram in my hands.

When I went in without the audiogram, I just was able to say, you know, yes, you're right, you do have a mild hearing loss or moderate hearing loss or whatever it is. I can see where you would be having the trouble that you're having that you've told me about. And so let's talk about what you might want to do about that. Right. Rather than getting into all of the details of what we've gathered, when you think

about how long it took us as professionals to learn to interpret and understand an audiogram, I think we ask a lot of patients to try to walk through that experience with us.

And even if we're really, really good at trying to make it simple for them, I think one of the questions is how much do they care about people? Absolutely may care about that, but I think on the whole, most people are really just interested in, you know, is this a problem? Should I do something about it? And so it's something to be thinking about. The other times that I think we need to be thinking about.

What patients want to know about is when they turn out to be the unicorn. Right. And they are not the typical age related, gently sloping, mild to moderate sensorineural hearing loss that we wish they were. Frankly, almost all the research that we have on how to fit hearing aids is based on a typical hearing loss group. So to the extent that your patient has other issues going on, such as medical causes for hearing loss, we tend to get further and further away from our evidence base for how to fit hearing aids, and we begin to get a little bit more into the arts than the science of it.

And then there are some patients who have really different issues, really challenging, really complex hearing losses. But the thing about all of these folks is they almost never really know that their experience with hearing loss is different than the other 20 patients who came in before them. As far as they're concerned, they don't know that they're different than everybody else. They might believe that their situation is typical. And so for those people, I think we need to help set expectations, right, that in fact, they don't necessarily have that typical hearing loss.

They may be. And I used to tell people this, you're a unique unicorn, and it's not necessarily something that you would want to hear from your provider, but reason I'm telling you this is that I want you to know that your hearing loss and your issues are a little bit more complex than what we typically see, and we don't necessarily have the same evidence space to rely upon for how to treat that. That said, I will do the work that's needed in order to make sure that we do the best we can for you. And your job is to be

patient while we work through that and to give me honest feedback about what you're experiencing so that we can work together to get you what you need as a special, unique unicorn. All right, next step is really to define the problem.

So we've diagnosed the hearing loss per se, and we've listened to to the story, but what are the unique problems that the patient is experiencing? Again, I'd like to offer up some tools and options for you in case this is helpful, because I think in some cases, it can be difficult for patients to articulate what their specific needs are. It can be, in some cases, challenging for providers to elicit those things as well. So sometimes a tool can be helpful to facilitate that conversation. This is a tool that was based on, again, some work that was done from the IDA Institute, and it really gets into, you know, what are your communication needs?

Why are you looking to seek care? How important is it for you to improve your hearing in this situation, and how difficult is it for you to communicate in that situation? And this One is using situation specific in order to, again, just help facilitate conversation. So this is not meant to be something where the patient fills this out on their own. It's meant to be a conversation with a patient.

This counseling tool provides various scenarios of situations. So again, it's very situation specific, but the goal is to really help this person be able to articulate the experience that they have in these situations. What are they thinking, what are they feeling, what is happening, relationship wise, communication wise in those types of settings so that we can get them to articulate the challenges that they're having. There is a tear off pad version of this communication needs assessment where they can actually go through and as an individual, be able to mark the importance of those particular situations. And there's space to provide notes of, again, what is very specifically going on in those situations so that we can understand what needs to happen to help.

And then I'm going to talk about this a little bit later. There's also some hearing aid preferences that we might be able to put in front of people to get them to think about their needs. But I'll come back to that part later. Next up is really setting meaningful goals with a patient. So when we think about meaningful goals, I mean, I think that we really want to get to, you know, it's sort of a form of cognitive behavioral therapy where the question really is, how are we going to know success when we see it?

How are we going to know that you've been successful with your hearing aids? What does that look like and feel like to you? So if we could fix all of the problems that brought you in the door, what does that look like? And helping the patient to have an opportunity to think that through, I think goes a long way to, again, making this very person centered. But it also allows us the opportunity to set some meaningful goals.

And that is important because a lot of times what will happen when we fit hearing aids is that a person will come back and they will have a better experience, but they won't necessarily be focused on what was actually solved, because hearing aids can have some drawbacks and can have some inconveniences for people. And so they might kind of gloss over the fact that they've had improvements in the most important areas that they came in for, but then they tend to focus on some of these other small, smaller inconveniences or things that they notice rather than being focused on what the improvements were that they were looking for. Right. And it kind of gets back to that first study that I showed where you Know, if you ask, you know, after the fact, you know, what did you experience improvements here? They may or may not remember those things, but if we can make it really specific to them, really concrete to them about what this matters, you know, what matters most to you, then we can reference that back later on.

Say, you know, is this, did we achieve this or not? So it's a very useful exercise. It's also a very useful exercise in setting expectations for patients. Right. A lot of things we can accomplish using the

technologies that we have available to us and the communication strategies and so on.

But there may be things that require other types of intervention and we need to be able to help create appropriate referrals or set expectations in that way way. Once we understand their big picture goals, right. We can start to break that into objectives. So again, kind of think back to your early treatment planning experiences back when you were in school and think through, you know, you have your goal, but what are the steps that we're going to take in order to achieve that goal? When you break into objectives, we want to make them smart.

And so those that would refer to things that are specific, measurable, achievable, realistic and timely. I'm sure you've all heard of smart goals before, but I think it's really important to create a situation where the patient firmly identifies this is what we are trying to achieve. We want to be able to sit and have a nice peaceful meal at my dining room table when the family is over for this birthday party where my two grandkids are there. And I want to feel like I'm not having to ask what all the time. So I would like to decrease the frequency that I'm saying what or missing out.

And something like that makes this a very concrete type of situation. Now, do you have to be able to measure everything, like quantify it per se? Not necessarily, but we want it to be concrete. We want them to be able to know it when they see it. Right.

One really useful tool for accomplishing this is the cosi, the Client Oriented Scale of Improvement. The COSI is available in, in the questionnaire module in noaa. So if you don't have otherwise use it or have access to it, it's available there for you. And with the cozy you have, I really like it because it's very versatile. You can use the cozy in a lot of different ways.

One way could be just to actually get to their specific need and record it. But I, what I like about it is that in addition to the specific need, you could actually just Change that into a treatment goal. You can take

the problem that they're having, which is, you know, maybe that I, you know, we keep having arguments over the volume of the TV when we're watching TV together at night. Okay? So let's take that specific need and turn that into a treatment goal.

So what you would like to see is that when you are watching your television show, and let's be really specific, what television show do you have the most trouble with? Well, maybe I have the most trouble with Wheel of Fortune. Right. Because they're throwing all these letters out there without context and those are hard to hear. Right.

So maybe we're watching Wheel of Fortune and having trouble with understanding that. So what we would like to see is that when we are watching Wheel of Fortune together at night in the living room, I do not have to feel uncomfortable. The volume of the TV can be at a level that's comfortable for my partner. And we have a nice time. And I, we don't have frustration over my inability to hear as well as I would like, and we don't have any arguments over the volume of the tv.

Achieving that is a really specific thing, Right. This person can understand it, they can visualize it, they'll know it when they see it. Right. So we could do something like that. We could also prioritize these.

And so you could, if you wanted to assign different levels of priority to different goals. And so one goal might be very important such that it brought them in, like maybe they had a bad experience where it was something that caused them an embarrassing situation and so that was something they never want to have happen again. That was sort of the precipitating event that made them pick up the phone and call you and make an appointment. But it might not be the biggest priority from a day to day life perspective. Right?

It might be an important priority, but it turns out that once they've really made that appointment, well, there's also stuff that's happening every single day that's bothersome to them. And you know, big

picture wise, this would be the most important thing. Priority can be important because we want to know what is most important to the patient in the event that we need to make any compromises. Right. With the care.

And so understanding what is most important to them is very critical. With the cosi, you can also look at a degree of change and a final ability. So you can look at it as an outcome measure. From a final ability perspective. You can look at it as a progress metric for degree of change.

So degree of change Theoretically you could look at, when they come back for their follow up appointment, you could say, okay, because of the new hearing instrument, I now hear worse. No difference. Slightly better. Better, Much better in this specific situation, right? Once we know what we want to see, how are, how are we doing getting there?

This could be really important for making changes to our treatment strategy. Maybe the person couldn't tolerate as much gain as they could benefit from during that first appointment. And so maybe they're not doing as well as we would like. Maybe they need more gain, maybe they need some adjustments to their noise settings, maybe they need some accessories that they hadn't considered yet, right? Maybe they need a new instrument altogether.

There are things that we can address by understanding what their specific scenarios were. And then you can also use it for final ability, right? You can be able to demonstrate to yourself, to the patients, to payers, how much success they had. And so that's where we, you know, again, can, can we measure it? Can we demonstrate our benefits to patients?

And the other cool thing about this final ability though is that you can also use it to set objectives or set expectations, I should say. So when you create the specific goal for the person or this objective for the person, one of the things that I think is important is like okay, you say you want to be able to do this, sit

in the living room, be able to watch Wheel of Fortune and so on. How important is, is it to you to be able to do this all the time, half the time, hardly ever. Where do you want to see yourself? Right?

Is it absolutely critical that this happens all the time or is most of the time acceptable? And that's important because it might come to a situation where maybe if they are needing and wanting to watch TV and be able to hear, hear almost always, maybe a TV adapter would be a good solution for this person. Maybe if it's that they want to hear almost always in religious service, maybe they're going to need remote microphone technology, right? And if they choose not to do that, and we find, you know that well, there's going to be some limitations to what the hearing aid alone can do that maybe some accessories could be helpful. Maybe using the hearing aid alone would get you there most of the time.

And if you want to get to all the time or almost always, you might need some additional support that is something that you can have a really meaningful discussion about when you are setting those expectations and doing that goal setting. So I just think it's a really versatile tool and can be used in such a good variety of ways. And of course, it is very person centered. You are creating an outcome metric while you are creating a treatment plan. And you are creating both a treatment plan and an outcome metric that are specific to this patient.

It is a very person centered approach to care. All right, so let's talk about the next step. Right? Is that's where you're selecting the appropriate intervention. And in my mind, you know, I just.

When I think about going to a physician nowadays, one of the things that I am very concerned about is making sure that my physician understood what I have a problem with, did their diagnosis correctly so that they can recommend an appropriate treatment option. I do not need for them to be extremely involved in the treatment option. I don't need them to know. I don't need personally to know how it works. Sometimes it's a pill that they can give me me or a shot that they can give me to make me feel better.

Sometimes it might be more involved than that. But what is most concern to me is that they got the diagnosis right and they understand my needs so that they can make the appropriate treatment recommendation. And so I think that we need to be really focused on how can we understand truly the needs of this person. And then when it comes to the treatment recommendation, I'm far more likely to be comfortable and trust that this provider is giving me what I need because they truly understood what my needs are. So one of the things that I showed you on the tool before, in addition to really getting to those communication needs and relationship needs in specific scenarios, is a component where we look at the person's preferences when it comes to hearing aids.

So when we have hearing aid options nowadays, there are a lot of potential features that our patients could benefit from. This is a counseling option that we can put in front of people to really just understand what their preferences are. What is it about hearing aids that they feel is going to be most important? Is it a sound quality issue? Or maybe clarity is more important than sound quality to them?

How important are reliability or durability to them? Maybe they've had experiences in the past where they've struggled with reliability or seen somebody who's had trouble in the past. How important is that as a factor to them? We might assume that reliability and durability are important to everybody. And of course they are.

But relative to everything else, where is that reliability and durability? Where is that sound quality? Where is that clarity? A lot of new users and many previous users have appearance as a concern cosmetics. And again, we see many people who have that Concern.

And so we kind of have a tendency to assume that everybody has that concern, and everybody might have that concern to some degree. But again, where is it relative to everything else? Do they care that they can control their device with a smartphone? Do they care about having an app? Or would they

prefer to just leave it and not have to deal with deal with it?

Are accessories important to them? Do they want to be able to have additional tools in their tool belts to manage things, or are they going to need that based on your communication assessment? Dexterity obviously can be an important issue for patients, and we want to help them understand where that is in terms of importance for them. Ability to connect to other devices. Do they stream or not?

A lot of times people will look at a smart device and say, well, is it compatible or not? Well, it only matters if it matters to the patient. We need to be able to think through what are options. Budget is on here. And I think this is a critical component to the conversation and to have early on in the conversation, sometimes people see this and they shy away from it a little bit because they really want to be able to demonstrate the benefits of devices to the patient beforehand before discussing budget.

And a lot of times people look at this and say, well, budget's important to everybody. And I agree that budget is important to everybody somewhere, but it's not necessarily the thing that is most important. It might be the third most important thing or the ninth most important thing to the patient, or it might be, you know, somewhere in between. Right. So we need to understand how important finances are to a patient when we have this discussion with them.

And we should not assume that budget is a major priority. We should not assume that it is not a priority. We need to have that conversation to understand so that we can provide. Knowing all of this, knowing their communication needs, knowing what their goals are, knowing what their preferences are, then we can make a very strong recommendation. And the patient can feel confident in our recommendations because we have listened to.

To them. And I think that this is a really important gift that we give to people. There is a book that. Looking for the author here, Sorry. Barry Schwartz, who is a psychologist, wrote a book called the

Paradox of Choice.

And he talks about a study that was. That took place where they actually sold jam to flavor different flavors of jelly to students at the mall. And on the first day they sold three flavors of jelly, and on the second day they sold seven flavors of jelly. And thinking that, you know, it was kind of an interesting question, you know, when are you going to sell more of These jelly jars, and they actually sold more jelly when people only had three choices rather than when they had seven choices. And they surmised that really people become paralyzed to some extent when they have too many choices to make.

They doubt or second guess their decision decisions. And in addition to not being able to make a choice, even if they are able to make a choice, research has shown that they are less satisfied with that choice if there are too many other options presented to them. And so as healthcare providers, sometimes people say, well, it's my job to put all the options in front of them and let the patient decide. That is one school of thought. But at the same time, I think the, that if we have truly listened to our patients, we have earned the rights to make a recommendation for them.

And I think that in doing so, making a recommendation of maybe 1, 2, 3 options to a patient, we can help them make a decision. We can help them move forward with their decision. And if the number of options is not that high, they are likely to be more satisfied with their decision. And so we need to be able to think, take into account a person's psychological response to having a lot of options available to them and to help them be able to make good choices.

And then in addition to that. So, like, once we have created this treatment, once a person is on the verge of sort of making a decision about moving forward with treatment, I think that we should have a very frank conversation about are they ready? How do you feel about this? How confident do you feel about your ability to manage this? Do you foresee any barriers that we should address?

We should give them an opportunity to reflect, to think through the answers and to give us feedback about this recommendation. A lot of times we kind of want to fill in silence, but the fact is that, that people need a moment to digest what we've told them. People need a moment to think through what this is going to look like for their life. And so we need to give them that space. We need to give them the time to think that through.

You could even say, I'm going to give you a minute or two to think this through. Think through any questions that you might have, maybe even walk out the door for a minute and come back. Would you like, would you like a glass of. I'm going to go get a glass of water or a cup of coffee. Could I get you something while you think this through for me, A minute would be a great way to give them the space to do that.

And frankly, if they're not sure, if they don't know where to go with that. When you come back, you can ask them these questions. How do you feel about this? How confident are you about this? Do you foresee any barriers?

Because that'll get us to where we need to go next.

And then, of course, once we have selected an appropriate intervention and agreed upon that with the patient, we can have these process progress metrics. So again, the COSI allows us to do that. You've got your degree of change, you've got your final ability. We can use this treatment plan to absolutely just document this is how we're doing. We can modify our treatment accordingly as needed.

If the person is not making the progress that is needed for that treatment plan, plan. And then of course, we're going to review and adjust this as needed, right? So if a person has experiences over time, we may need to kind of almost start over again. Hearing loss is a chronic disease, and so is a chronic disorder. And we need to treat it that way and consider our patients over the course of their lifespan.

I remember having patients who came in with one specific type of hearing loss and then something else happened, right? They had a sudden hearing loss on top of it, or they had a stroke or something happened where their needs changed. And whether those were dexterity needs or vision needs or hearing needs or some other life event that occurred, we needed to start over, right? We needed to go back and adjust our treatment plan. We needed to rediagnose, we needed to redefine the problem, have new goals, select the appropriate intervention, and so on.

Cause it is a chronic disorder and we need to treat it as such. So. So think about it as sort of a big circle when it comes to that treatment planning that we're never quite done until we're done. So with that, I just want to share a reference slide here and I would encourage you to take a look at any of these. The articles that I started are open source.

And then there's a really nice book chapter in Patient and Family Centered Speech Language Pathology and Audiology by tima. The book Paradox of Choice is a very interesting, interesting read that you might get some benefit out of. And so with that, I would welcome any questions or comments that you have. Please don't hesitate to reach out to me. My email is viraticon.com and please feel free to utilize any of the counseling tools as would be beneficial to you.

And again, reach out to your OTICON representative if you would like to get copies of these so that you could use them in your clinical practice. So with that, I just want to thank you for your time and attention and hope that you have great success.