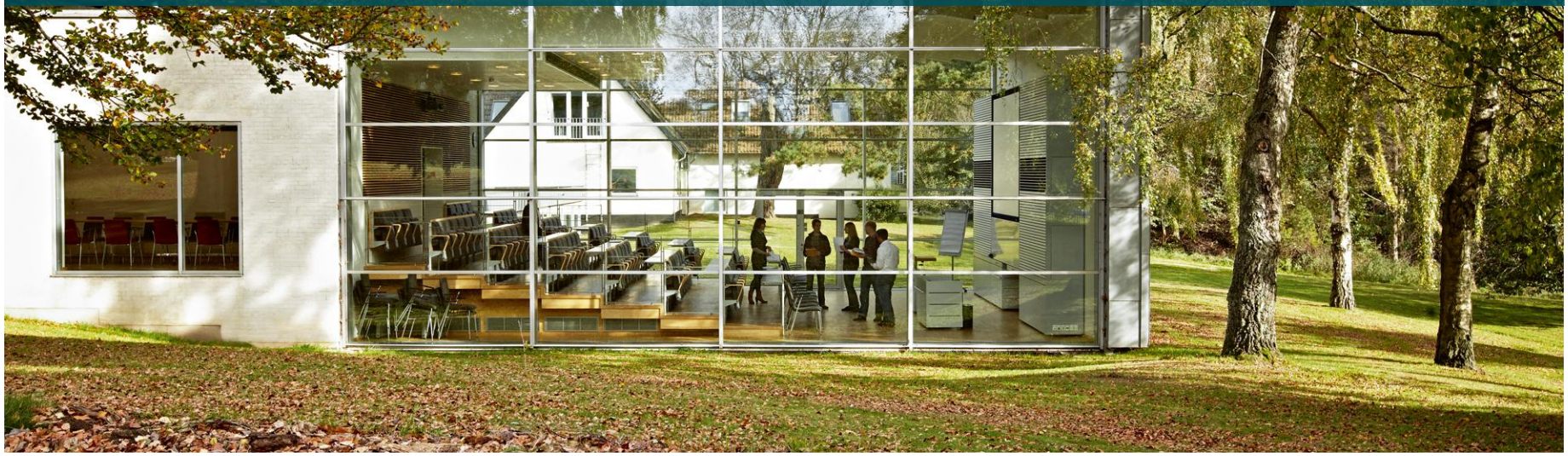
Inspiration til fremtidens hørerehabilitering, 21 February 2014

Client involvement and self-determination: A shared decision making model



Louise Hickson, PhD
Linda Worrall, PhD

Ariane Laplante-Lévesque, PhD

The University Of Queensland
AUSTRALIA

EriksholmResearchCentre
PART OF OTICON


ONE SIZE FITS ALL.
Except for you,
of course.

Decision making in audiology

Why

- “Any or all of the following: education and counseling, communication strategies, individualized auditory training, hearing aids, assistive listening devices, and group education and therapy” (Sweetow 2007 p.26)

What

- Cognitive process leading to selection of course of action among several alternatives (Albert 1978)
  - *Do I feel I have a hearing loss?*
  - *Who should I go to?*
  - *Will I wear hearing aids?*

Intervention decision making in audiology

- Adults and older adults with acquired hearing impairment
- What are intervention options for them?

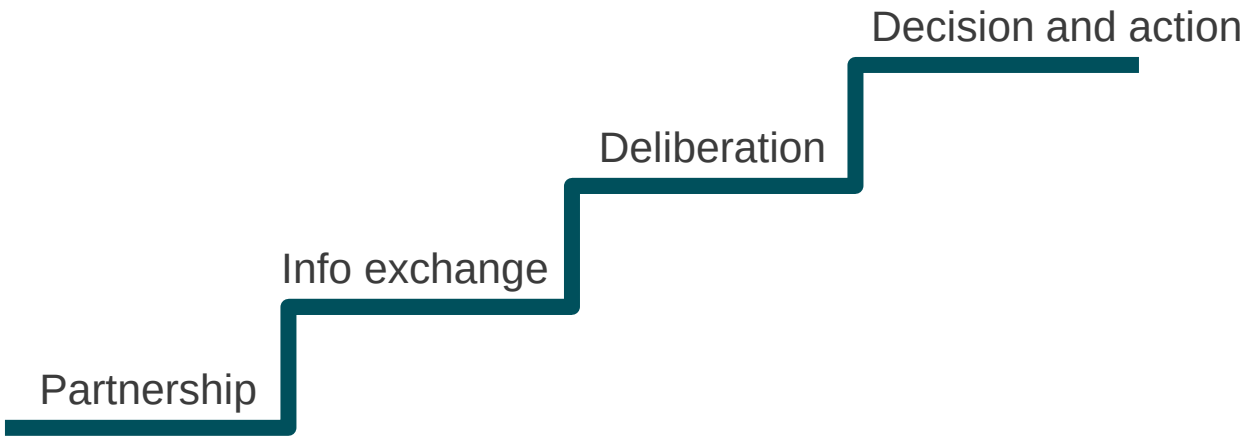
Why match evidence with client preferences?

Fiscella et al 2004; Lewin et al 2009;
Zolnierek & Dimatteo 2009

Shared decision making

Clinician — **Continuum of decision power** — Client

Paternalistic — **Shared** — Informed



Charles et al 1999
Montori et al 2006

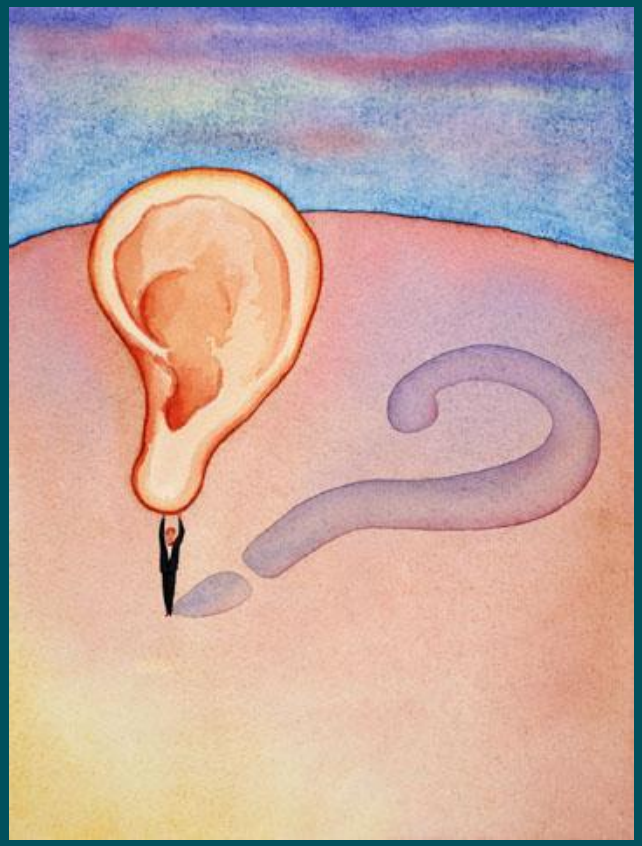
A study of shared decision making in audiology

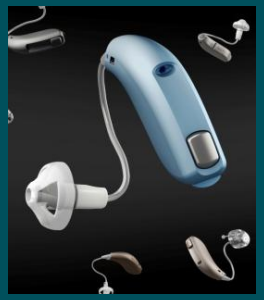
EriksholmResearchCentre
PART OF OTICON

Research aims

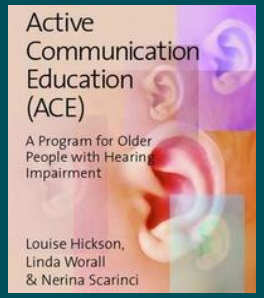
- Offering intervention options to adults with acquired hearing impairment seeking help for the first time, using shared decision making
- Exploring their experiences with shared decision making
- Identifying predictors of intervention action and successful outcomes

Interventions





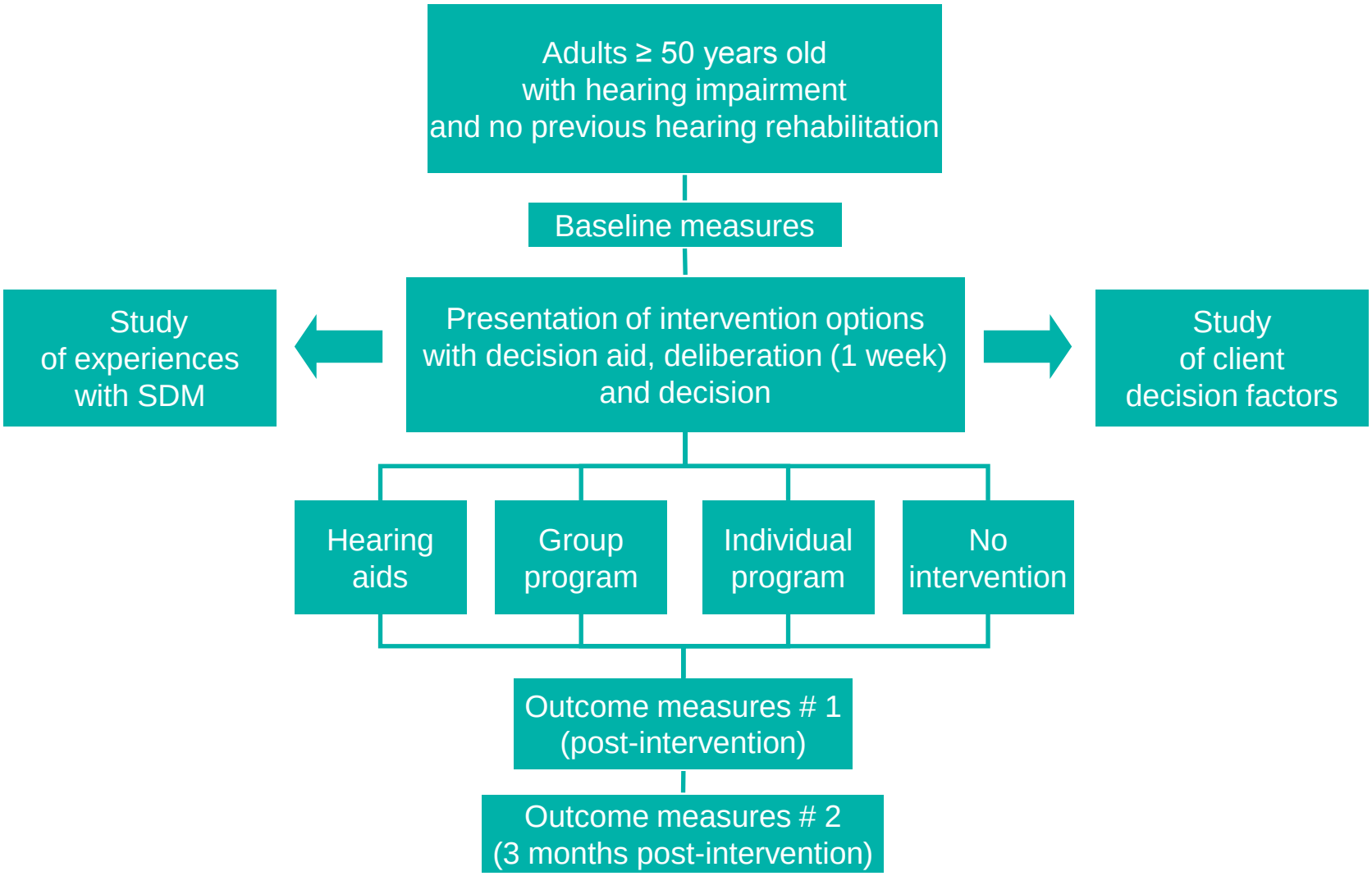
Hearing aids



Communication programs

No intervention

Design



EriksholmResearchCentre
PART OF OTICON

Sampling and recruitment

- 153 adults ≥ 50 years with acquired hearing impairment (average of air conduction thresholds at 0.5, 1, 2 & 4 kHz > 25 dB HL in at least one ear) and who had not previously received audiological services
- Recruitment via public hearing services, print and electronic media, notice boards, and word-of-mouth

Decision aid

- “Evidence-based tool designed to prepare clients to participate in making choices among healthcare options […] Supplements (rather than replaces) clinician’s counselling about options”(O'Connor et al 2009 p.3)
- Summary of intervention options and their outcomes according to research evidence
  - First page providing overview of intervention options
  - One page with details for each of the intervention options
- Readability: Flesch-Kincaid Grade Level of 5.3

Decision aid - first page

My hearing options

What is it?	Hearing aids	Group program: Active Communication Education (ACE)	Written program: Individualised Active Communication Education (I-ACE)	No intervention
What is involved?	• Being fitted with hearing aids. • Wearing the hearing aids to help with my hearing problems.	• Participating in group sessions to learn ways to cope with my hearing problems. • Using the information to help with my hearing problems.	• Reading chapters at home to learn ways to cope with my hearing problems. • Using the information to help with my hearing problems.	• Keeping on going the way I am at the moment.
FIRST STEP Options I want to know more about ☑	☐	☐	☐	☐
SECOND STEP Options I will think about ☑	☐	☐	☐	☐

Communication Disability Centre, 2008

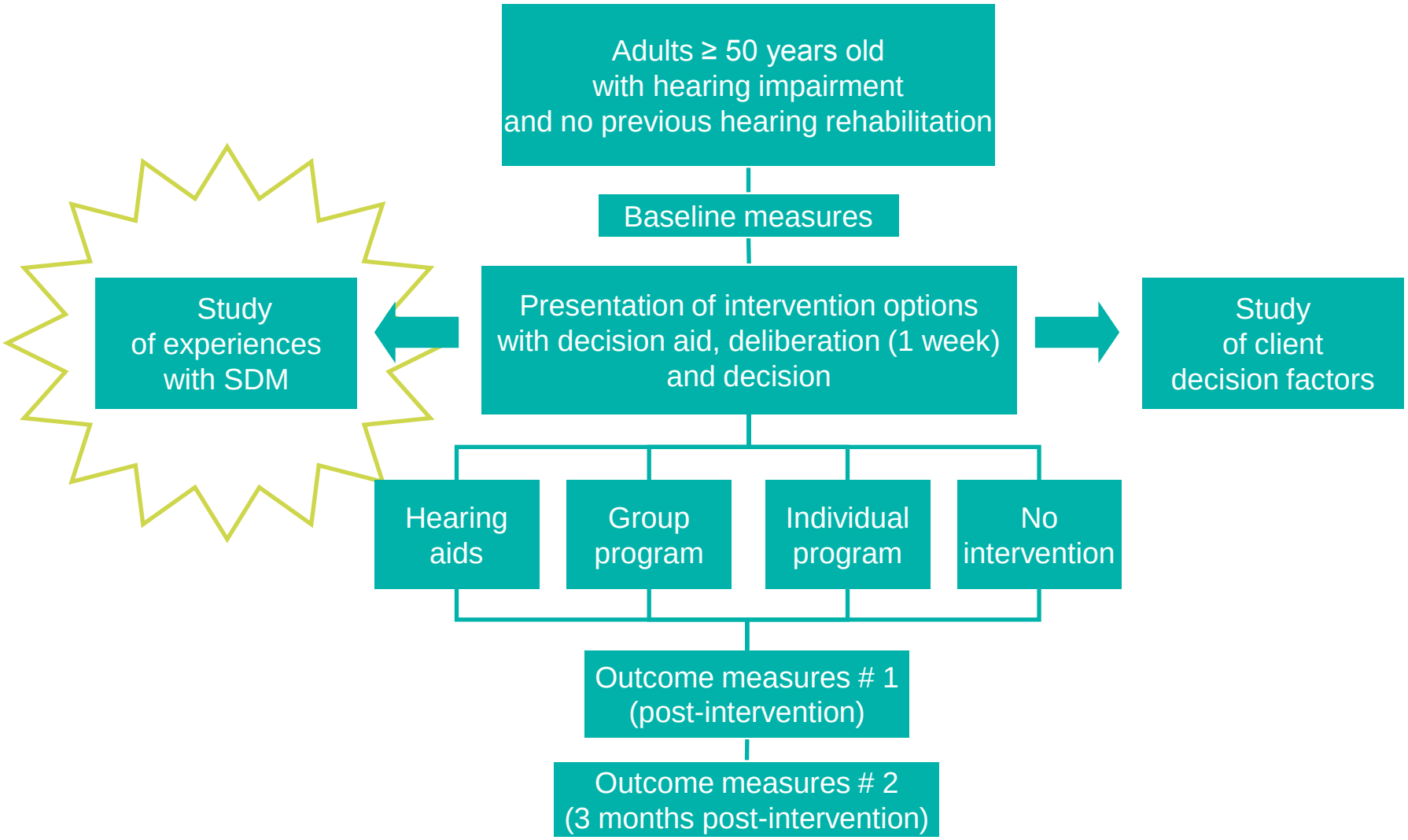
The University Of Queensland

EriksholmResearchCentre
PART OF OTICON

One of the research questions

What are the experiences of adults with hearing impairment with shared decision making in audiological rehabilitation?

Design


Adults ≥ 50 years old
with hearing impairment
and no previous hearing rehabilitation
Baseline measures
Study
of experiences
with SDM
Presentation of intervention options
with decision aid, deliberation (1 week)
and decision
Study
of client
decision factors
Hearing
aids
Group
program
Individual
program
No
intervention
Outcome measures # 1
(post-intervention)
Outcome measures # 2
(3 months post-intervention)

Sub-sample (n=22)

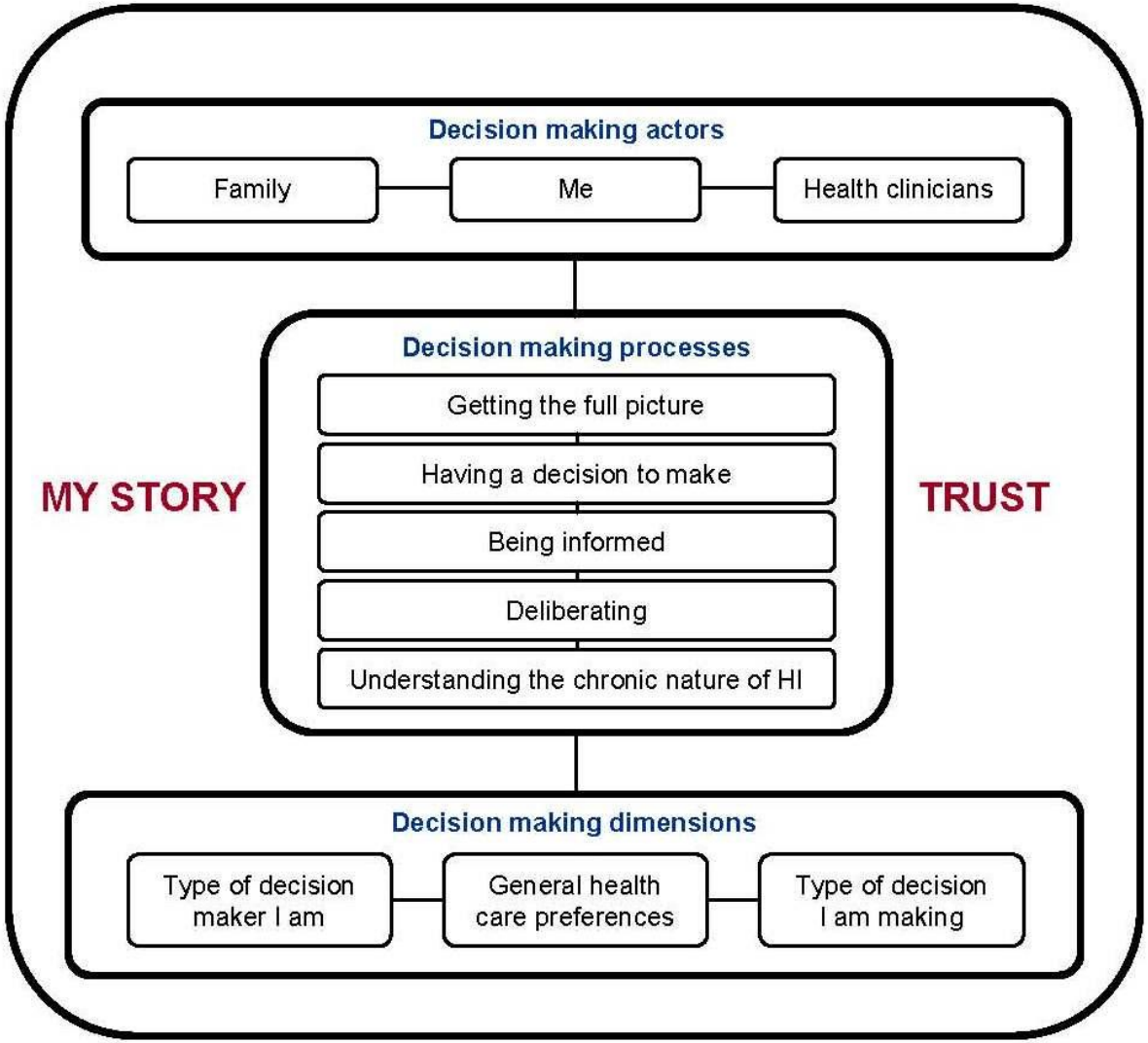
Characteristics	Frequency n (%)	Characteristics	Frequency n (%)
Gender		Work status	
Male	15 (68%)	Work	10 (45%)
Female	7 (32%)	Retirement	12 (55%)
Public / private clients		Living situation	
Public	11 (50%)	Alone	6 (27%)
Private	11 (50%)	With other(s)	16 (73%)
Hearing impairment in better ear (0.5, 1, 2, & 4 kHz average)		Age	
		50-65	8 (36%)
Mild (≤ 40 dB HL)	17 (77%)	> 65 and ≤ 80	12 (55%)
Moderate (> 40 and ≤ 55 dB HL)	5 (23%)	> 80	2 (9%)

Hearing aids
n = 10
(45%)

Communication programs
n = 9
(41%)

No intervention
n = 3
(14%)

Model of shared decision making in audiology



My story

- *It's a good question to ask: "What is it that you miss with your hearing loss?" I think specific questions in that regard are important. "Do you feel at a total loss when you're watching a play?"* (81 year old person)
- *My experience has been overwhelmingly good. I've found people in the medical profession who'll listen. You have to go against their grain initially, but I've found people that will listen.*
  (79 year old person)

Eriksholm Research Centre
PART OF OTICON

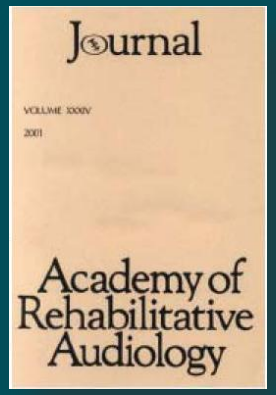
Trust

- *I will be led by them (audiologists). After they test me, they're there to advise me and I'll be taking their advice.* (65 year old person)
- *In the last couple of years, they seem to become big, hearing aid clinics. I'd never seen them advertised the way they do and they're always very swish looking setups. That's what made me cynical about it.* (55 year old person)
- *I won't go to one of these (hearing aid clinics) that offer free hearing tests because they're not interested in your hearing from your health point of view. [...] It's a business to them and they're just interested in selling you the hearing aid.* (63 year old person)

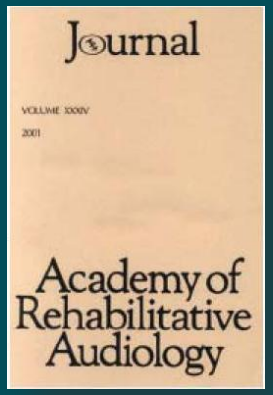
Clinical implications

- Take into account our client's story
  - Client-centred consultation does not take longer than biomedical consultation (Levinson & Roter 1995)
  - Client-centred consultation achieves better treatment adherence than biomedical consultation (Haskard Zolnierek & DiMatteo 2009)
- Build trust in the client-audiologist relationship (McKinstry et al 2009)
  - Knowledge
  - Ethics

To find out more about shared decision making

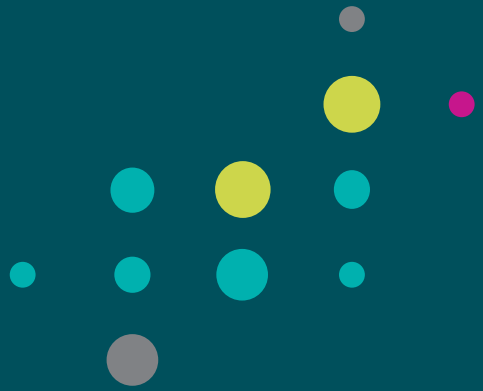


Laplante-Lévesque A, Hickson L, Worrall L. 2010. Promoting the participation of adults with acquired hearing impairment in their rehabilitation. *Journal of the Academy of Rehabilitative Audiology*, *43*, 11-26.



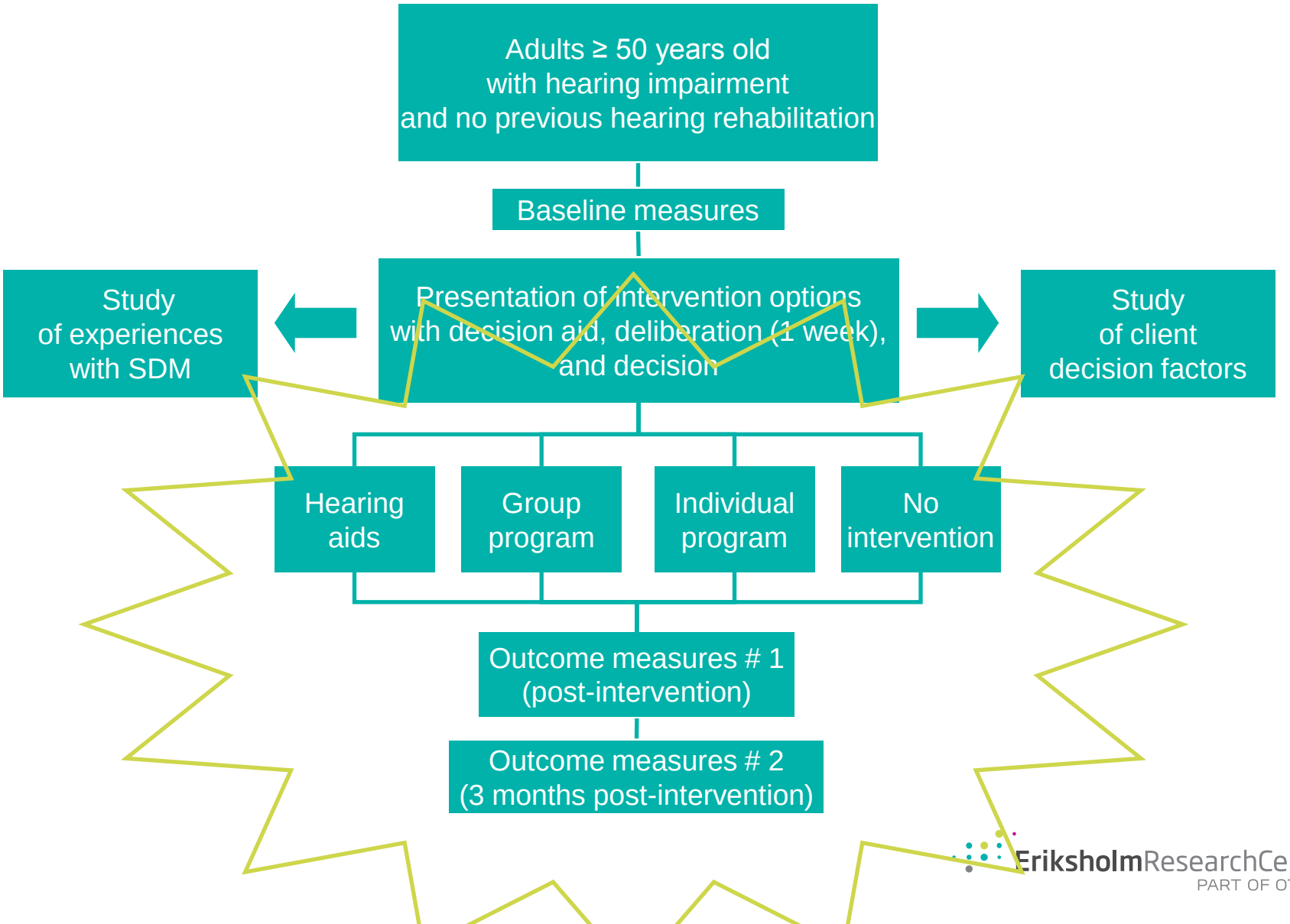
Laplante-Lévesque A, Hickson L, Worrall L. 2010. A qualitative study of shared decision making in rehabilitative audiology. *Journal of the Academy of Rehabilitative Audiology*, *43*, 27-43.

What about the rest of the study?

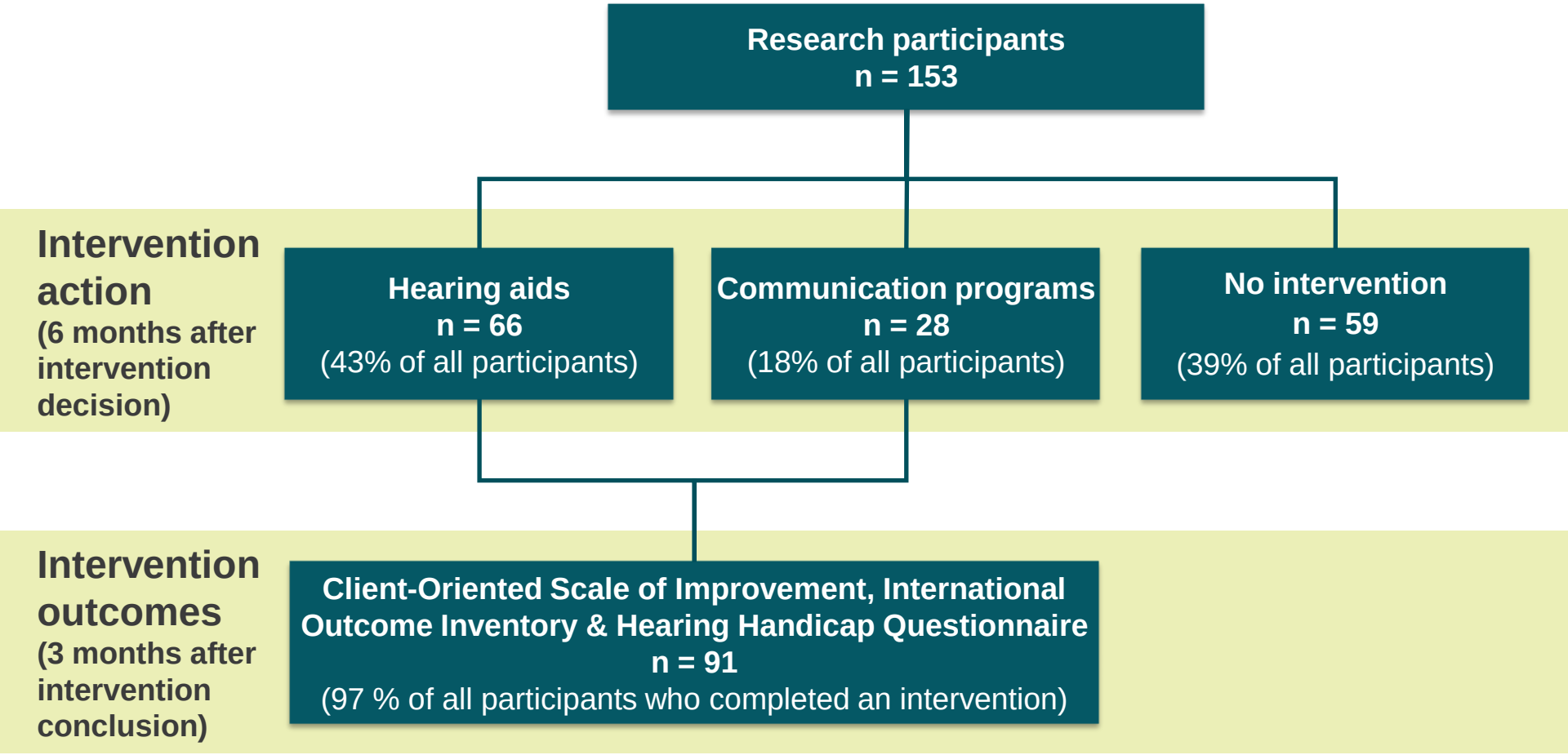


Eriksholm Research Centre
PART OF OTICON

Design


Adults ≥ 50 years old
with hearing impairment
and no previous hearing rehabilitation
Baseline measures
Study
of experiences
with SDM
Presentation of intervention options
with decision aid, deliberation (1 week),
and decision
Study
of client
decision factors
Hearing
aids
Group
program
Individual
program
No
intervention
Outcome measures # 1
(post-intervention)
Outcome measures # 2
(3 months post-intervention)

Intervention action and outcomes



Potential predictors investigated

- Demography
  - Age
  - Gender
  - Living situation
  - Education
- Hearing impairment
  - Hearing impairment (pure-tone audiometry)
  - Time since hearing impairment onset
- Psychology
  - Self-reported hearing disability
  - Stage of change
  - Locus of control
  - Communication self-efficacy
  - Greater perceived suitability and effectiveness of communication programs

Predictors: Results

Not significant

- Demography
  - Age
  - Gender
  - Living situation
  - Education
- Hearing impairment
  - Hearing impairment (pure-tone audiometry)
  - Time since hearing impairment onset

Significant

- Psychology
  - Self-reported hearing disability
  - Stage of change
  - Locus of control
  - Communication self-efficacy
  - Greater perceived suitability and effectiveness of communication programs

Clinical implications

- Offer intervention options
- Discuss the predictors identified here with clients:
  - Self-reported hearing disability
  - Stages of change

To find out more

Laplante-Lévesque A, Hickson L, Worrall L. 2010. Factors influencing rehabilitation decisions of adults with acquired hearing impairment. *International Journal of Audiology*, *49*, 497-507.

Laplante-Lévesque A, Hickson L, Worrall L. 2011. Predictors of rehabilitation intervention decisions in adults with acquired hearing impairment. *Journal of Speech, Language and Hearing Research, 54, 1385-1399.*

Laplante-Lévesque A, Hickson L, Worrall L. 2012. What makes adults with hearing impairment take up hearing aids or communication programs and achieve successful outcomes? *Ear and Hearing, 33,* 79-93.

To find out more

Laplante-Lévesque A, Hickson L, Worrall L. 2013. Stages of change in adults with acquired hearing impairment seeking help for the first time: Application of the transtheoretical model in audiologic rehabilitation. *Ear Hear*, *34*, 447-457.

EriksholmResearchCentre
PART OF OTICON

Extra resources (4) for your toolbox

Eriksholm Research Centre
PART OF OTICON

Implementing shared decision making – Resource 1

J Ambulatory Care Manage
Vol. 35, No. 2, pp. 80–89

Patient Engagement—What Works?

Angela Coulter, PhD

JOURNAL OF AMBULATORY CARE MANAGEMENT/APRIL–JUNE 2012

What works?

Table 3. Promising Interventions to Support Shared Decision Making[a]

Intervention	Potential Benefits
Patient decision aids	• Increased patient involvement in decisions • Better understanding of treatment options • More accurate perception of risks • Improved quality of decisions • Appropriate impact on uptake of screening • Does not increase patient's anxiety • Reduces use of elective surgical procedures • *May* be cost-effective
Health coaching	• Reduced mortality • Reduced risk factors • Improved health status • *May* be cost-effective
Question prompts	• Increased question asking in consultations • *May* increase patients' knowledge and understanding • *May* empower patients and improve satisfaction • Does not necessarily increase length of consultations
Self-management education and support	• Improved patient knowledge and understanding • Improved confidence and coping ability • Improved health behaviors • Improved social support • *May* improve adherence to treatment recommendations • *May* improve health outcomes • *May* reduce hospital admission rates • *May* be cost-effective

[a]Where the evidence is less strong, this is indicated by including *may* in the list of potential benefits.

Coulter et al 2012

Implementing shared decision making – Resource 2

Core Competencies for Shared Decision Making Training Programs: Insights From an International, Interdisciplinary Working Group

France Légaré,[1] MD, PhD; Nora Moumjid-Ferdjaoui,[2] PhD; Renée Drolet,[1] PhD; Dawn Stacey,[3] RN, PhD; Martin Härter,[4] PhD; Hilda Bastian,[5] PhD(c); Marie-Dominique Beaulieu,[6] MD, MSc; Francine Borduas,[7] MD; Cathy Charles,[8] PhD; Angela Coulter,[9] PhD; Sophie Desroches,[1] PhD; Gwendolyn Friedrich,[10] MSc; Amiram Gafni,[8] PhD; Ian D. Graham,[3] PhD; Michel Labrecque,[1] MD, PhD; Annie LeBlanc,[11] PhD; Jean Légaré,[12] Dr.h.c.; Mary Politi,[13] PhD; Joan Sargeant,[14] PhD; Richard Thomson, BA, BCh, MRCP, FRCP[15]

JOURNAL OF CONTINUING EDUCATION IN THE HEALTH PROFESSIONS, 33(4):267–273, 2013

Core competencies

1. Relational competency

2. Risk communication competency

Légaré et al 2013

Implementing shared decision making – Resource 3

JGIM

PERSPECTIVE

Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD[1,2], Dominick Frosch, PhD[3,4], Richard Thomson, MD[5], Natalie Joseph-Williams, MSc[1], Amy Lloyd, PhD[1], Paul Kinnersley, MD[1], Emma Cording, MB BCh[1], Dave Tomson, BM BCh[6], Carole Dodd, MSc[7], Stephen Rollnick, PhD[1], Adrian Edwards, PhD[1], and Michael Barry, MD[8,9]

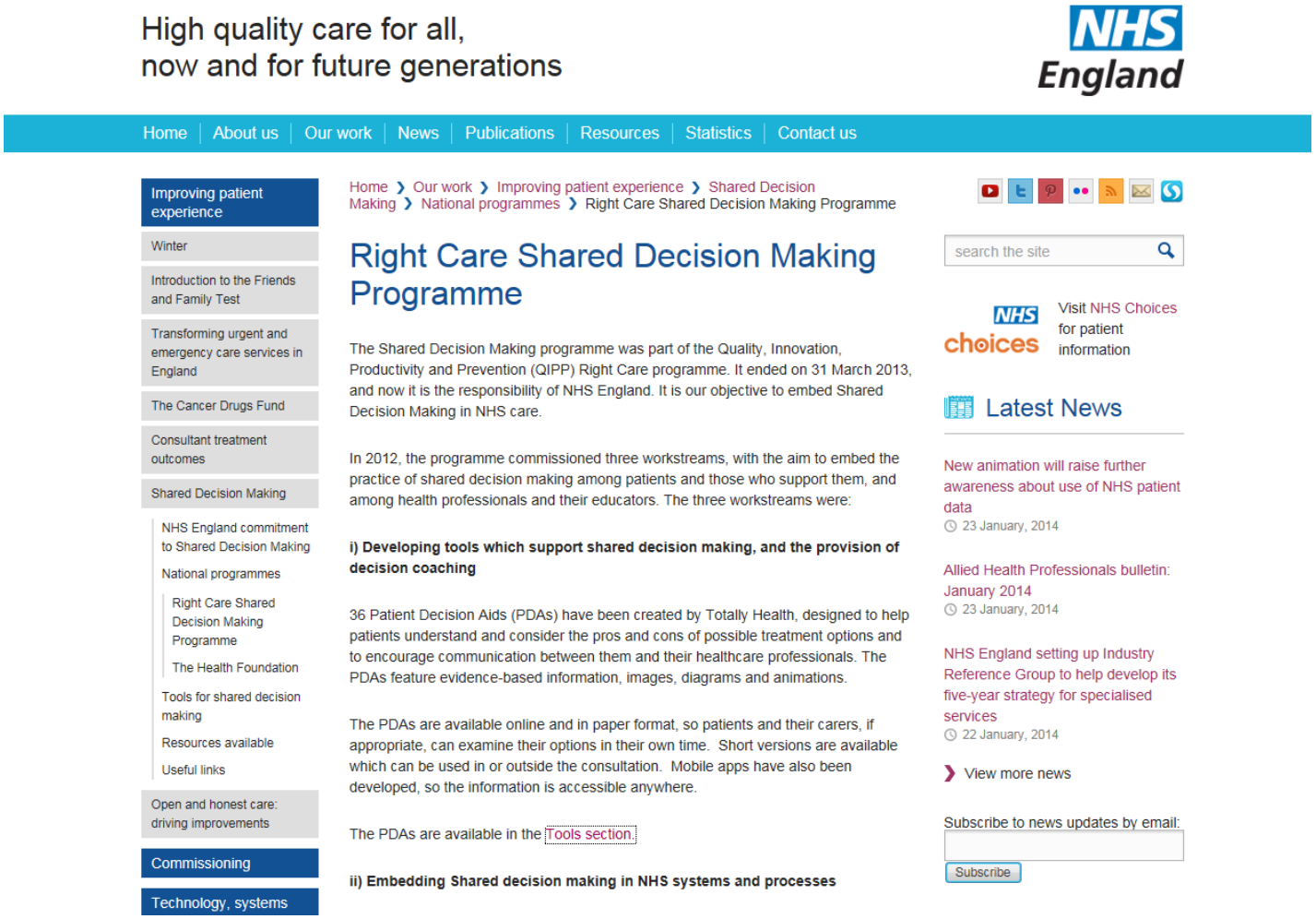
EriksholmResearchCentre
PART OF OTICON

Model for clinical practice

1. Choice talk	2. Option talk	3. Decision talk
• Step back • Offer choice • Justify choice - preferences matter • Check reaction • Defer closure	• Check knowledge • List options • Describe options explore preferences • Harms and benefits • Provide patient decision support • Summarise	• Focus on preferences • Elicit preferences • Move to a decision • Offer review

Elwyn et al 2012

Implementing shared decision making – Resource 4



High quality care for all,
now and for future generations

NHS England

Home | About us | Our work | News | Publications | Resources | Statistics | Contact us

- Improving patient experience
  - Winter
  - Introduction to the Friends and Family Test
  - Transforming urgent and emergency care services in England
  - The Cancer Drugs Fund
  - Consultant treatment outcomes
  - Shared Decision Making
    - NHS England commitment to Shared Decision Making
    - National programmes
      - Right Care Shared Decision Making Programme
      - The Health Foundation
    - Tools for shared decision making
    - Resources available
    - Useful links
  - Open and honest care: driving improvements
- Commissioning
- Technology, systems

Home › Our work › Improving patient experience › Shared Decision Making › National programmes › Right Care Shared Decision Making Programme

Right Care Shared Decision Making Programme

The Shared Decision Making programme was part of the Quality, Innovation, Productivity and Prevention (QIPP) Right Care programme. It ended on 31 March 2013, and now it is the responsibility of NHS England. It is our objective to embed Shared Decision Making in NHS care.

In 2012, the programme commissioned three workstreams, with the aim to embed the practice of shared decision making among patients and those who support them, and among health professionals and their educators. The three workstreams were:

i) Developing tools which support shared decision making, and the provision of decision coaching

36 Patient Decision Aids (PDAs) have been created by Totally Health, designed to help patients understand and consider the pros and cons of possible treatment options and to encourage communication between them and their healthcare professionals. The PDAs feature evidence-based information, images, diagrams and animations.

The PDAs are available online and in paper format, so patients and their carers, if appropriate, can examine their options in their own time. Short versions are available which can be used in or outside the consultation. Mobile apps have also been developed, so the information is accessible anywhere.

The PDAs are available in the Tools section.

ii) Embedding Shared decision making in NHS systems and processes

search the site

NHS choices Visit NHS Choices for patient information

Latest News

New animation will raise further awareness about use of NHS patient data
23 January, 2014

Allied Health Professionals bulletin: January 2014
23 January, 2014

NHS England setting up Industry Reference Group to help develop its five-year strategy for specialised services
22 January, 2014

› View more news

Subscribe to news updates by email:

Subscribe

EriksholmResearchCentre
PART OF OTICON

Acknowledgements and final words

- Research participants
- Profs. Louise Hickson and Linda Worrall
- Australian Department of Science, Education and Training

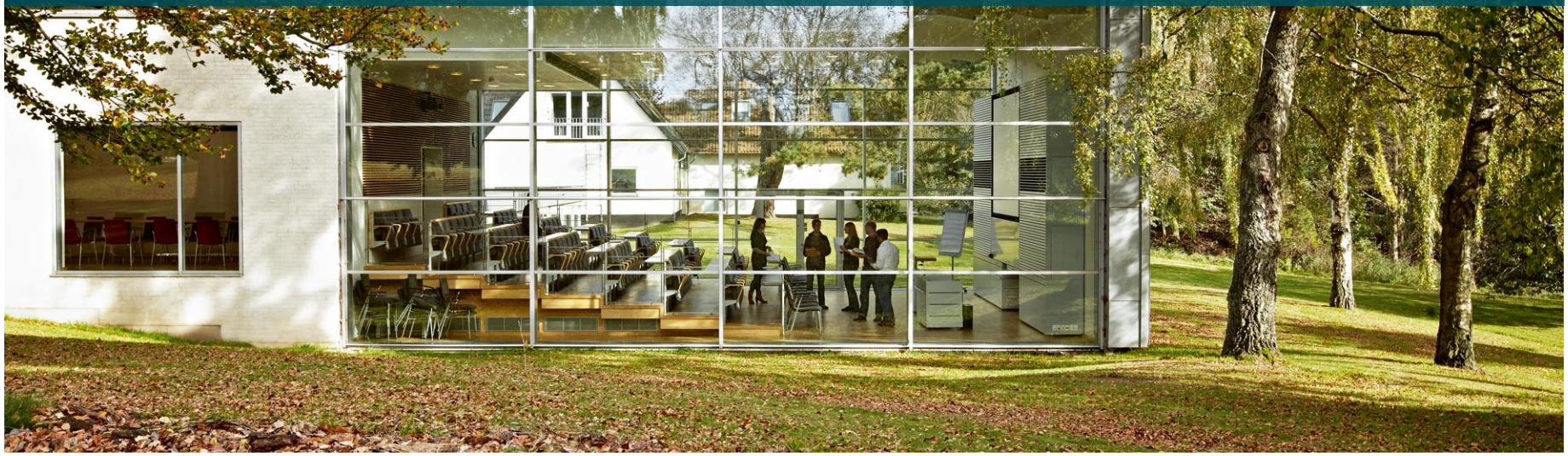
That's a better thing: to make the patient decide, to give options. (81 year old person with hearing impairment)

For me, this way of doing things is part of the way of the future. (79 year old person with hearing impairment)

EriksholmResearchCentre
PART OF OTICON

Inspiration til fremtidens hørerehabilitering, 21 February 2014

Client involvement and self-determination with a shared decision making model



Louise Hickson, PhD
Linda Worrall, PhD

Ariane Laplante-Lévesque, PhD

The University Of Queensland
AUSTRALIA

EriksholmResearchCentre
PART OF OTICON