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

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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?

Clinician communication
Client-centredness
Shared decision making

Adherence
Intervention outcomes
Satisfaction
Trust

Fiscella et al 2004; Lewin et al 2009; Zolnierek & Dimatteo 2009
Shared decision making

Clinician  Continuum of decision power  Client

Paternalistic  Shared  Informed

Partnership  Info exchange  Deliberation  Decision and action

Charles et al 1999
Montori et al 2006
A study of shared decision making in audiology
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
<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing aids</strong></td>
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<tr>
<td>![Hearing aid image]</td>
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<tr>
<td><strong>Communication programs</strong></td>
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<tr>
<td>![Communication program image]</td>
</tr>
<tr>
<td><strong>No intervention</strong></td>
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<td>![No intervention image]</td>
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</tbody>
</table>
Design

Adults ≥ 50 years old with hearing impairment and no previous hearing rehabilitation

Baseline measures

Presentation of intervention options with decision aid, deliberation (1 week) and decision

Hearing aids
Group program
Individual program
No intervention

Outcome measures # 1 (post-intervention)
Outcome measures # 2 (3 months post-intervention)

Study of experiences with SDM

Study of client decision factors
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
# My hearing options

<table>
<thead>
<tr>
<th>What is it?</th>
<th>Hearing aids</th>
<th>Group program: Active Communication Education (ACE)</th>
<th>Written program: Individualised Active Communication Education (I-ACE)</th>
<th>No intervention</th>
</tr>
</thead>
</table>
| **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 ✓ | ❑ | ❑ | ❑ | ❑ |
One of the research questions

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

Study of experiences with SDM

Adults ≥ 50 years old with hearing impairment and no previous hearing rehabilitation

Baseline measures

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)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency n (%)</th>
<th>Characteristics</th>
<th>Frequency n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td>Work status</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>15 (68%)</td>
<td>Work</td>
<td>10 (45%)</td>
</tr>
<tr>
<td>Female</td>
<td>7 (32%)</td>
<td>Retirement</td>
<td>12 (55%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public / private clients</td>
<td></td>
<td>Living situation</td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td>11 (50%)</td>
<td>Alone</td>
<td>6 (27%)</td>
</tr>
<tr>
<td>Private</td>
<td>11 (50%)</td>
<td>With other(s)</td>
<td>16 (73%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing impairment in better ear (0.5, 1, 2, &amp; 4 kHz average)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild (≤ 40 dB HL)</td>
<td>17 (77%)</td>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Moderate (&gt; 40 and ≤ 55 dB HL)</td>
<td>5 (23%)</td>
<td>50-65</td>
<td>8 (36%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; 65 and ≤ 80</td>
<td>12 (55%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; 80</td>
<td>2 (9%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td>n = 10 (45%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication programs</td>
<td>n = 9 (41%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No intervention</td>
<td>n = 3 (14%)</td>
<td></td>
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</tr>
</tbody>
</table>
Model of shared decision making in audiology

Decision making actors
- Family
- Me
- Health clinicians

Decision making processes
- Getting the full picture
- Having a decision to make
- Being informed
- Deliberating
- Understanding the chronic nature of HI

Decision making dimensions
- Type of decision maker I am
- General health care preferences
- Type of decision I am making
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)
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


What about the rest of the study?
Design

Adults ≥ 50 years old with hearing impairment and no previous hearing rehabilitation

Baseline measures

Presentation of intervention options with decision aid, deliberation (1 week), and decision

Study of experiences with SDM

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)
Research participants
n = 153

Intervention action
(6 months after intervention decision)

Hearing aids
n = 66
(43% of all participants)

Communication programs
n = 28
(18% of all participants)

No intervention
n = 59
(39% of all participants)

Intervention outcomes
(3 months after intervention conclusion)

Client-Oriented Scale of Improvement, International Outcome Inventory & Hearing Handicap Questionnaire
n = 91
(97% of all participants who completed an intervention)
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


To find out more

Extra resources (4) for your toolbox
Patient Engagement—What Works?

Angela Coulter, PhD

JOURNAL OF AMBULATORY CARE MANAGEMENT/APRIL–JUNE 2012
### What works?

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Potential Benefits</th>
</tr>
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</table>
| 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  

*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, MD, PhD; NORA MOUMJID-FERDJAOUI, MD, PhD; RENÉE DROLET, PhD; DAWN STACEY, RN, PhD; MARTIN HÄRTER, PhD; HILDA BASTIAN, PhD; MARIE-DOMINIQUE BEAULIEU, MD, MSc; FRANCINE BORDUAS, MD; CATHY CHARLES, PhD; ANGELA COULTER, PhD; SOPHIE DESROCHES, PhD; GWENDOLYN FRIEDRICH, MSc; AMIRAM GAFNI, PhD; IAN D. GRAHAM, PhD; MICHEL LABRECQUE, MD, PhD; ANNIE LÉBLANC, PhD; JEAN LÉGARÉ, Dr.H.c.; MARY POLITI, PhD; JOAN SARGEANT, PhD; RICHARD THOMSON, BA, BCH, MRCP, FRCP

Core competencies

1. Relational competency

2. Risk communication competency

Légaré et al 2013
Implementing shared decision making – Resource 3

PERSPECTIVE

Shared Decision Making: A Model for Clinical Practice

Glyn Elwyn, PhD\textsuperscript{1,2}, Dominick Frosch, PhD\textsuperscript{3,4}, Richard Thomson, MD\textsuperscript{5}, Natalie Joseph-Williams, MSc\textsuperscript{1}, Amy Lloyd, PhD\textsuperscript{1}, Paul Kinnersley, MD\textsuperscript{1}, Emma Cording, MB BCh\textsuperscript{1}, Dave Tomson, BM BCh\textsuperscript{6}, Carole Dodd, MSc\textsuperscript{7}, Stephen Rollnick, PhD\textsuperscript{1}, Adrian Edwards, PhD\textsuperscript{1}, and Michael Barry, MD\textsuperscript{8,9}
# Model for clinical practice

<table>
<thead>
<tr>
<th>1. Choice talk</th>
<th>2. Option talk</th>
<th>3. Decision talk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Step back</td>
<td>• Check knowledge</td>
<td>• Focus on preferences</td>
</tr>
<tr>
<td>• Offer choice</td>
<td>• List options</td>
<td>• Elicit preferences</td>
</tr>
<tr>
<td>• Justify choice - preferences matter</td>
<td>• Describe options</td>
<td>• Move to a decision</td>
</tr>
<tr>
<td>• Check reaction</td>
<td>• Explore preferences</td>
<td>• Offer review</td>
</tr>
<tr>
<td>• Defer closure</td>
<td>• Harms and benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide patient decision support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Summarise</td>
<td></td>
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</tbody>
</table>

Elwyn et al 2012
Implementing shared decision making – Resource 4

High quality care for all, now and for future generations

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

ii) Embedding Shared decision making in NHS systems and processes
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)
Client involvement and self-determination with a shared decision making model

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