HSP Review Response with Evidence Relevant to the Review Questions

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[redacted]

1. **Is there a need for clearer objectives for the program? In your view what should be included in any set of objectives**

Yes there is a need for clearer objectives to be defined and these should be client-centred, focusing on addressing the hearing and communication needs of people with hearing loss and their families, with the aim of improving quality of life for them. At the moment the brief aim describes 'reducing impact of hearing loss' by providing 'access to hearing services'. This may merely mean increasing the audibility of sound with amplification and the needs of people with hearing loss and their families are much broader than that.

Evidence of the impact of hearing loss is that it can be far-reaching with consequences both for the person with the loss and for those around them. For example, in our review of the impact of hearing loss for older adults (Laplante-Lévesque, Hickson, & Worrall, 2010a) the evidence was that the following activities are limited by hearing loss:

- Speech perception, especially in adverse environments with noise, reverberation, high speech rate, accented speech, and/or when the face of the person talking cannot been seen;
- Understanding of broadcast signals such as radio and television;
- Localization of sound sources such as footsteps and cars; and
- Detection of environmental signals including ringing telephones, doorbells, and alarms.

Participation restrictions caused by hearing loss include the following:

- Withdrawal from previous involvement in community life; and
- Avoidance of interpersonal interactions.

Broader impacts include:

- Reduced health-related quality of life
- Social isolation
- Anxiety and depression

Impacts on significant others have also been determined (Scarinci, Worrall & Hickson, 2009):

- Communication difficulties
- Negative relationship changes
- Reduced socializing
- Emotional responses e.g., frustration, feelings of burden

Of course, the information above relates to findings with various samples of people with hearing loss and their families (in research these samples are typically English speaking with relatively high education levels). The impacts on individuals vary and are influenced by a range of contextual factors (Meyer et al., 2016) e.g., living situation, ethnicity, other health conditions, cognitive function.

2. What changes if any should be made to the types of services that are offered under the Program and what would be the overall benefits?

My concern relates to the device-focused nature of current services to adults (children are better served because of the input of a range of health and education professionals eg teachers, speech pathologists, audiologists, family doctor).

In a video analysis of 62 initial consultations with people over the age of 55 years in Australian audiology clinics with 26 different clinicians (Grenness et al, 2015; Ekberg, Grenness & Hickson, 2014) we found:

- Clients' psychosocial concerns were rarely addressed and patients/companions (only attended 27% of the appointments) showed little involvement in management planning.
- The majority of audiologists' education and counseling utterances related to hearing aids; yet, only 56% of patients decided to obtain hearing aids at the conclusion of the consultation.
- Hearing aids were recommended in 83% of consultations where a hearing loss was diagnosed and alternative options were rarely provided.

Expanding on the types of services supported for all clients – beyond the fitting of devices – would be beneficial. When we offered options for treatment to 153 older adults with hearing impairment who had never done anything about their hearing before, we found that: 66 participants (43%) obtained hearing aids, 28 participants (18%) completed communication programs, and 59 participants (39%) decided to take no action (Laplante-Lévesque, Hickson & Worrall, 2012). Options were offered using a Decision Aid (Laplante-Lévesque, Hickson & Worrall, 2010b) which was very well received and appreciated by the participants. Those who chose hearing aids or communication programs achieved positive outcomes with the options they chose. There are two key implications of this research:

- approximately 1 in 5 new clients would opt do to a communication program rather than be fitted with a hearing aid, however, they are not offered that option.
- in current practice, some of the 1 in 5 new clients who would prefer a communication program may opt to take up hearing aids instead (as that is all that is offered) and the evidence is that they are much less likely to be successful with hearing aids in this instance. Motivation and readiness to accept hearing aids is a key factor in eventual success (Laplante-Lévesque, Hickson & Worrall, 2012; Ridgway, Hickson & Lind, 2015).

There is also evidence that many people fitted with hearing aids continue to have communication difficulties even with hearing aids. Communication programs (individual or group) (Hickson et al, 2007, 2019) are evidence-based options that can assist them and such an option should be provided to all clients, not just to new clients as is the case with RehabPlus at present. Copies of our group and individual communication programs are available for free download at: https://shrs.uq.edu.au/active-communication-education-ace

The device-focused nature of hearing services currently is also evident in the services provided to people with hearing loss living in aged care. This focus is not in line with the perspectives of residents, family and staff. In Bott et al (2020) we report findings from interviews with 23 participants across four stakeholder groups (audiologists, care staff, family members and individuals with dementia and hearing impairment living in aged care facilities). Thematic analysis revealed an overarching theme of "different priorities for managing hearing impairment". Essentially, audiologists, care staff and families prioritized different practices for managing hearing impairment: audiologists emphasized hearing aids while care staff and family emphasized communication strategies. Hearing aid use in aged care facilities is problematic for many reasons e.g., residents require staff support to manage them, staff workloads and lack of education about hearing aids means they are frequently unable to provide the support required, lack of clarity around responsibility and ongoing support for hearing aid use (Meyer & Hickson, 2020).

5. What is the right mix and range of services that consumers would benefit from under the program? How could consumers, families and friends, workplaces and others in the community, as well as taxpayers, benefit from a rebalancing of services?

Hearing loss causes communication problems and communication education should be integral to all hearing services, not an add-on for some. Following on from the evidence above, a rebalancing of services is needed to a more functional focus – that is, a focus on improving communication in daily life and addressing the psychosocial concerns of clients and families. At present, it is the measured impairment (loss of audibility) and how to improve the decibel level of perceived sound with the use of technology that receives the attention. This MAY result in improvements to communication but the link is assumed rather than assured for each individual client. For each client who indicates that they have hearing and communication needs, an individualized program of care should be

determined by the client and their significant others in a collaborative process of shared decision making with the clinician.

6. Do consumers receive sufficient information to make informed choices? Do they have adequate control and flexibility over the hearing services that would be in their best interests? What changes if any should be made?

It is clear from the research that choices provided to clients are typically not offered in a way that facilitates shared decision making (a central tenet of person- and family-centred care) and information that is provided focuses on the device alone and does not include communication education or counselling.

When interviewed about how hearing services can be person-centred (Grenness et al 2014), clients who were experienced users of audiological services said they wanted a therapeutic relationship with their clinician. They wanted to be informed, involved and they wanted individualized care. For example, one person said:

> *It's the level of interest in the person; I am not just some punter that's come through the door. I am a person who has needs, and the (audiologist) is trying to determine as best he or she can, what those needs are, and trying to find a solution for whatever my problem might be .* (Participant [redacted]; male, age 70).

This suggests a strong desire for 'control and flexibility' and the clients in the study could provide instances of when they had received such care and when they had not. For example:

> *He didn't talk about cost; he just said " For you, this would probably be the best sort " . It was very " okay, let ' s get on and get you a hearing aid, and get you out the door " . Maybe I just didn't feel comfortable with him as a person, but the approach made me feel " Oh dear, I don't think I want to come back here again " .* (Participant [redacted]; [redacted], age 71).

Shared decision making and informing clients appropriately could be facilitated by the introduction of Decision Aids in hearing healthcare. Decision aids are "tools that help people become involved in decision making by making explicit the decisions that need to be made, providing information about the options and outcomes, and by clarifying personal values." (Ottawa Hospital Research Institute, 2015, p. 1). They have been widely applied in healthcare and there are a number of studies on their use in audiology. They summarise intervention options and outcomes of each option according to recent scientific literature. Information is presented in a simple visual format adhering to health literacy principles. Excellent easy-to-use evidence based guidelines for Decision Aids are available from https://decisionaid.ohri.ca/

Options that should be presented to typical hearing services clients are: hearing aids and/or assistive devices and/or communication programs; or no action.

In a qualitative study of the use of a Decision Aid (Laplante-Lévesque, Hickson & Worrall, 2010c), participants talked about the value of the process:

I've never thought of other options: if you can't hear, you get hearing aids. (79-year-old [redacted]

I like to get an informed opinion, an educated opinion because I'm not the expert. (65-year-old [redacted]

I did go through it (decision aid) when I got home, showed my wife and talked about it. (77-year-old [redacted]

For me, this way of doing things (shared decision making) is part of the way of the future. (79-year-old [redacted]

That's a better thing: to make the patient decide, to give options. (81-year-old [redacted]

Another study relevant to this question about whether or not consumers receive sufficient information to make informed choices, we examined how information about the costs of hearing aids was presented to clients (Ekberg, Barr & Hickson, 2017). It was most common for audiologists to present one hearing aid cost option at a time, which led to multiple rejections from clients which made the interactions difficult. Alternatively, when audiologists offered multiple cost options at once (which occurred in 10 of the 46 appointments analysed in the study) this led to a smoother interaction. This suggests that consumers would benefit from a different approach to information provision than was typically observed in the study.

7. What are the advantages and challenges of having hearing appointments via telehealth?

A major potential advantage of telehealth is the inclusion of family members in the appointments. At present only approximately 30% of adult client appointments include a family member. Reasons are varied but one relates to the ability of family to attend face-to-face clinic visits. Telehealth can facilitate family-centred hearing care (Meyer, Scarinci & Hickson, 2019). This is important because of the impact of hearing loss of families and because of their key role in communicating with people with hearing loss.

8. Are hearing services accessible to those who require them, irrespective of where they live or the size of the consumer group with particular needs? Are the range and levels of government supports effective or are there further issues that need to be addressed?

The vast majority of people living in aged care facilities have hearing loss and their needs are complex because of the other health conditions they have and because of the environment in which they live. The needs of this population are currently not well served. Many of them are seen under the Voucher program which means that one facility may have to manage services for residents with numerous different providers. It seems clear that they should be considered as people with 'complex hearing or communication needs' and therefore covered by Hearing Australia's CSO obligations.

Having a single service support residents of aged care would likely go a long way towards improving coordination and quality of care to residents.

10. What data should be collected by the program? Who should hold the data? What data should be published and for what reasons?

It is essential that outcomes of the program are collected and that these are communication and quality of like outcomes. The focus of outcomes on measuring hearing aid use ONLY perpetuates hearing aids as the only option for clients. It is reasonable to measure hearing aid use and benefit in those who receive them but this should not be the only measure. My responses to question 1 show the likely impacts of hearing loss and improvements in these areas should be measured. In addition it would be useful to measure consumer satisfaction with the service provided. I have recently participated in a research study with the National Acoustics Laboratories and hopefully the review has access to this information.

The outcomes data should be collected and held by the government department that funds the program and the data should be made available to providers and published to inform consumer choice. Such publication of outcomes and satisfaction with a program are common place in other sectors eg the Quality Indicators for Teaching and Learning for higher education www.qilt.edu.au

References

Bott, A., Meyer, C., Hickson. L., & Pachana. (2020). "It's huge in a way." Conflicting Stakeholder Priorities for Managing Hearing Impairment for People Living with Dementia in Residential Aged Care Facilities. *Clinical Gerontologist*.

Ekberg, K., Barr, C., & Hickson, L. (2017). Difficult conversations: Talking about cost in audiology consultations with older adults. *International Journal of Audiology, 56*(11), 854-861. doi:10.1080/14992027.2017.1339128

Ekberg, K., Grenness, C., & Hickson, L. (2014). Addressing patients' psychosocial concerns regarding hearing aids within audiology appointments for older adults. *American Journal of Audiology*, 23(3), 337-350. doi:10.1044/2014_aja-14-0011

Grenness, C., Hickson, L., Laplante-Lévesque, A., & Davidson (2014). Patient-centred audiological rehabilitation: Perspectives of older adults who own hearing aids. *International Journal of Audiology*, 53 (S1), S68 - S75. doi:10.3109/14992027.2013.866280

Grenness, C., Hickson, L., Laplante-Lévesque, A., Meyer, C., & Davidson, B. (2015). The nature of communication throughout diagnosis and management planning in initial audiologic rehabilitation consultations. *Journal of the American Academy of Audiology*, 26, 36-50. doi:10.3766/jaaa.26.1.5

Hickson, L., Worrall, L., & Scarinci, N. (2007). A Randomized Controlled Trial Evaluating the Active Communication Education Program for Older People with Hearing Impairment. *Ear & Hearing*, 28(2), 212-230. doi:10.1097/aud.0b013e31803126c8

Hickson, L., Worrall, L., Scarinci, N., & Laplante-Lévesque, A. (2019). Individualized Active Communication Education (I-ACE): Another clinical option for adults with hearing impairment with a focus on problem-solving and self-management. *International Journal of Audiology*, 58(8), 504-509. doi:10.1080/14992027.2019.1587180

Laplante-Lévesque, A., Hickson, L., Worrall, L. (2010a). Rehabilitation of older adults with hearing impairment: A critical review. *Journal of Aging and Health*, 22, 143-153. doi:10.1177/0898264309352731

Laplante-Levesque, A., Hickson, L., & Worrall, L., (2010b). Factors influencing rehabilitation decisions of adults with acquired hearing impairment. *International Journal of Audiology*, 49 (7), 497-507. doi:10.3109/14992021003645902

Laplante-Levesque, A., HICKSON, L., & Worrall, L. (2010c). A qualitative study of shared decision making in rehabilitative audiology. *Journal of the Academy of Rehabilitative Audiology*, 43, 27-43.

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 & Hearing*, 33(1), 79-93. doi:10.1097/aud.0b013e31822c26dc

Meyer, C., & Hickson, L. (2020). Nursing Management of Hearing Impairment in Nursing Facility Residents. *Journal of Gerontological Nursing,* 46(7), 15-25. doi:10.3928/00989134-20200605-04

Meyer, C., Scarinci, N., & Hickson, L. Editors (2019). *Patient and Family-Centered Speech-Language Pathology and Audiology.* New York: Thieme. ISBN:978-1-62623-503-8

Meyer, C., Scarinci, N., Ekberg, K., Hickson, L & Grenness, C. (2016). The International Classification of Functioning, Disability and Health as a framework for providing patient- and family-centred audiological care for older adults and their significant others. *Seminars in Hearing*, 37 (3), 187-199. doi:10.1055/s-0036-1584411

Ridgway, J., Hickson, L., & Lind, C. (2015). Autonomous motivation is associated with hearing aid adoption. *International Journal of Audiology*, 54 (7), 476–484. doi:10.3109/14992027.2015.1007213

Scarinci, N., Worrall, L., & Hickson, L. (2009). The effect of hearing impairment in older people on the spouse: Development and psychometric testing of the Significant Other Scale for Hearing Disability (SOS-HEAR). *International Journal of Audiology, 48,* 671-683. doi:10.1080/14992020902998409