Improving Hearing Aid Outcomes Through Adoption of Patient-Centered Care

By Caitlin Turriff

Hearing aid technology has improved tremendously in recent years. Available devices are sleek, fast, adjustable, "smart," and provide excellent benefits to individuals with hearing loss.

Despite these advances, the number of individuals with hearing loss who wear hearing aids remains small. According to MarkeTrak VIII, about 25 percent of adults with hearing loss are fit with hearing aids. Even though that percentage remains small, patient satisfaction toward hearing aids is improving (Kochkin, 2010). Incorporating patient-centered care elements into a hearing aid practice could help raise the adoption rate and continue to improve the patient's perceived success with hearing aids.

What Is Patient-Centered Care?

Patient-centered care is becoming common in the medical community. It is defined as "providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001). According to MarkeTrak VIII, certain behaviors exhibited by an audiologist can improve hearing aid user success. These attributes include being knowledgeable, establishing realistic expectations, exhibiting empathy, explaining care, the quality of care, and being professional (Kochkin et al, 2010). Audiologists should especially strive to recognize and validate emotional responses from patients, as this can be an important component of patient-centered care.

Empowering the patient by engaging in conversations that address both the clinician's and the patient's goals is the main aspect of patient-centered care. Patient appointments tend to focus on the clinician's goals—identifying and managing hearing loss—often disregarding the patient's emotional response to the hearing-loss diagnosis (Eckberg et al, 2014). This can be a challenge to providing patient-centered care because the patient's concerns might not be fully recognized and addressed.

A way to incorporate patient-centered care would be to provide the hearing-loss diagnosis, engage the patient in a discussion about their hearing loss, their attitude toward hearing loss in general, and to then determine rehabilitation options (Eckberg et al, 2014). For example, ask the patient open-ended questions regarding his or her feelings about the hearing loss diagnosis after providing results of the audiogram and before discussing hearing aid options.

After addressing the emotional response, the discussion can shift to topics such as the patient's lifestyle, attitudes toward hearing loss and assistive technology, their support system, dexterity, visual acuity, and cosmetic preferences, as these are all reported challenges to successful hearing aid fittings (Kochkin, 2007).

When the audiologist strives to balance his or her goals with identifying and addressing the goals of the patient, higher satisfaction and better hearing aid outcomes can be

achieved. This shared decision making will help the patient feel more empowered, and the audiologist can have a clearer sense of how to direct the rehabilitation.

After the Hearing Aid Fitting

Patient-centered care does not end after the selection and purchase of hearing aids, it also extends to follow-up appointments, and using an outcome measure is a way to achieve this. The Abbreviated Profile of Hearing Aid Benefit (APHAB) and the Satisfaction with Amplification in Daily Living (SADL) are two subjective measures that identify some of the known challenges to hearing aid success—satisfaction with overall performance and device cost (Kochkin, 2010).

The APHAB can be used to identify the patient's benefit from his or her hearing devices. This test consists of 24 items that measure communication ability in common situations with subscales addressing ease of communication, reverberation, background noise, and negative reactions to environmental sounds (Cox and Alexander, 1995). The questions are answered for both aided and unaided situations and the patient will choose a response on a seven-point scale ranging from always to never. The results will identify the patient's perceived hearing aid benefit and can open communication to address any challenges that may be occurring such as difficulty understanding speech in loud environments.

Determining the cost-benefit relationship also can be evaluated with an outcome measure. The SADL achieves this by evaluating hearing aid user satisfaction and the service and cost of the hearing aid. This questionnaire consists of 15 questions divided among four topics: positive effects, service and cost, negative features, and personal image (Cox and Alexander, 1999). The patient records his or her answers on a seven-point scale ranging from "not at all" (one point) to "tremendously" (seven points), and these responses are then averaged to determine the global score, which decides the patient's overall satisfaction (Cox and Alexander, 1999). The score can then be used to discuss whether the patient feels he or she is receiving adequate benefit in relation to hearing aid cost.

The results of these outcome measures can prompt discussion regarding ways to identify and address remaining challenges. For example, the audiologist may need to provide additional counseling on communication strategies to help the patient strengthen self-advocacy and improve interactions with family and friends.

Conclusion

By focusing on both the clinical aspects of hearing health care (identifying and recommending solutions for hearing loss) and the individualized needs of each patient, a more meaningful patient–provider relationship can be established. This mutually beneficial appointment and communication structure should continue into subsequent appointments. Ultimately, allowing patients to feel that they can be active participants in their hearing health care can help improve patient satisfaction and ensure positive hearing aid outcomes.

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