TOWARDS CONSUMER DRIVEN IMPROVEMENT IN STANDARDS OF HEARING CARE: A NEW APPROACH

Isn't current communication technology wonderful?

Aren't we proud of Australian innovation and research in improving the lives of hearing impaired?

Aren't we lucky to have a government-funded hearing services program that is the envy of most of the world?

Isn't it great that we have fantastic programs for supporting people with hearing disabilities in their employment?

Aren't we fortunate to have more hearing care providers per head of population than most other countries? And that our providers are more well-educated than those in many other countries?

Yes. All this is good; very good. But we do have a problem. The current system for assisting those with communication problems caused by loss of hearing is failing to consistently deliver high standards of hearing care. Whatever interest in "Better Hearing" has brought you to this conference, we are all affected by this failure. This is a problem for the hearing impaired, their families and friends, their colleagues, and their consumer organisations. It is a problem for manufacturers of hearing devices, third party funders of hearing care, training institutions, professional associations and hearing care providers. It is a problem for the community. And it is a problem for our society. The financial and social consequences of poorly treated hearing loss was clearly demonstrated by the Access Economics report "Listen Hear!"[1].

I come from a background as a clinical audiologist. I've always had a keen interest in knowing "Have I done good?" In other words, how do I know whether my services have made a positive difference in the quality of life of the person who has relied on my professional expertise to help them overcome the problems caused by loss of hearing?

The key to knowing the answer to this question was to survey the opinions of those who had used my services.

"The successful provision of hearing health care ultimately comes down to each individual patient's satisfaction with his or her hearing aid outcome." *Jerry Northern, PhD*

This work eventually led to why I'm talking to you today.

I've been an audiologist since 1970 – over 40 years. In that time I have seen significant improvements in hearing science, in our understanding of hearing loss and its impact on peoples lives, in the education of hearing care providers and in technology (hearing aids, cochlear implants and assistive listening devices).

Have these improvements delivered better communication and life quality outcomes for people with hearing impairment? In the lives of many individuals living with hearing loss, they

have certainly made an enormous difference. But is the performance of the hearing care industry at a high enough level that people with hearing problems can have confidence that they have a high chance of obtaining the help they need?

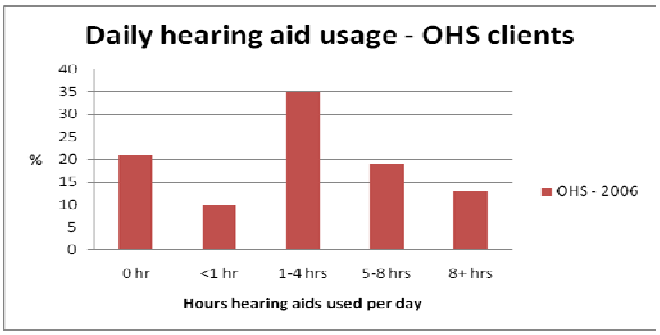
The "hearing care industry" is made up of six groups –

1. manufacturers (hearing aids, cochlear implants and assistive devices),
2. hearing care funders,
3. educational institutions,
4. professional associations,
5. consumer organisations and
6. hearing care providers.

Despite the best efforts of the first five groups, there is significant evidence that the last group holds the key to successful outcomes from hearing care, and that this group is failing consumers[2].

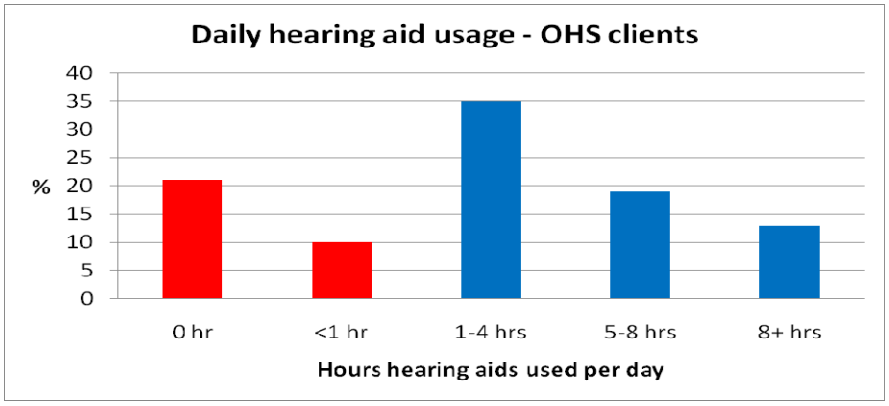
Successful outcomes from hearing aid fitting can be measured in a variety of ways. One simple measure of success is the average number of hours per day that people wear their hearing aids. The reasoning is simple. It is based on well established evidence that if hearing aids are fitted with good physical comfort and good hearing benefit they will be worn, and worn for most of the day. No matter how sophisticated the technology, if the aids are not physically comfortable they will either not be worn, or worn on a limited basis. And even if they are comfortable, if they are providing little help for the communication problems caused by loss of hearing, they will either not be worn, or worn on a limited basis.

In Australia, nearly 80% of hearing services are fully or partially funded by the Australian government under a Hearing Services Program administered by the Office of Hearing Services. Dr Harvey Dillon, Senior Research Scientist with the National Acoustic Laboratories, has measured daily usage of hearing aids fitted under this program[3]. He found that 21% of aids were never worn, and a further 10% were worn for less than an hour a day. In effect, nearly one third of people fitted under the OHS program were not using their hearing aids. This strong evidence indicates that the hearing care industry is failing those who depend on it to provide them with effective assistance for their hearing problems.



What happens when nearly one third of these aids are not worn? Firstly, it is a tragedy in the lives of those who have not obtained the assistance they needed. Secondly, it is a tragic failure of a generous government program designed to support the needs of hearing impaired people. But there is a third consequence for these poor outcomes.

Let's look at the 31% of people who got hearing aids, but who don't wear them (red bars).

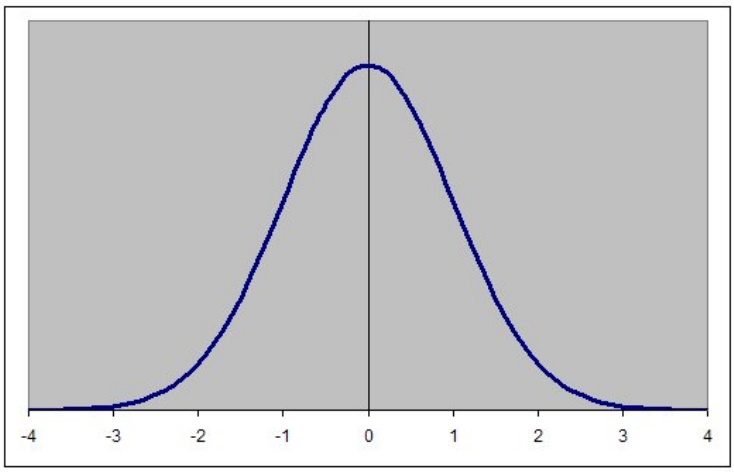


What are these unsuccessfully assisted people saying in their communities? "Hearing aids don't work." This develops into a negative stereotype of the effectiveness of hearing aids. Two independent studies[4,5] have found that 52% of those not seeking assistance for hearing problems give negative perceptions about the effectiveness of hearing aids as the reason ("Don't work" "Whistle" "Too much hassle"). These are from people who have never worn hearing aids! They can only have formed their opinions by observation/interaction with those who do have hearing devices. As Barbara Strauch reports in her recent book, "The literature is very, very clear on how much more potent the negative is."

So – if poor outcomes are delivered, the reputation for the effectiveness of hearing aids remains poor, and acts as a barrier to seeking hearing help. This goes a long way to explaining why, in Australia, nearly 2 out of 3 people who have hearing loss choose not to do anything about it.

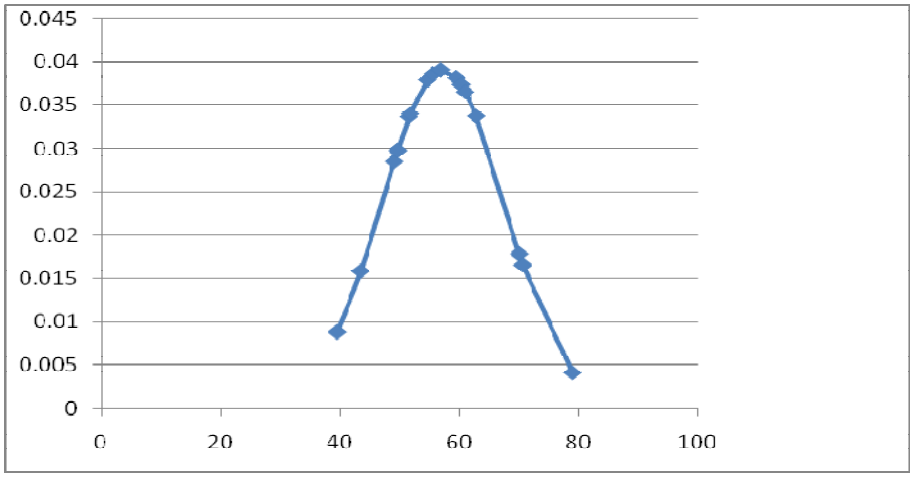
What can we do if improved education of dispensers, improved technology and improved government support for hearing services hasn't improved hearing aid outcomes? We need a new approach to lifting the standards of hearing care.

In his fascinating book "Better – A Surgeon's Notes on Performance" Dr Atul Gawande[7] examined the problems of health care delivery, and why there can be such a range of outcomes. Performance across a number of health areas (surgery, management of cystic fibrosis, immunisation programs) follows the normal distribution, the "bell curve", with some outstanding practitioners at the top end, some practitioners with very poor performance, and most practitioners falling within the middle "mediocre" middle range.



We all have ideas about what should happen with the poor performers. But what does it take to lift performance from the middle/mediocre to the outstanding? And how do patients choose who are the best practitioners?

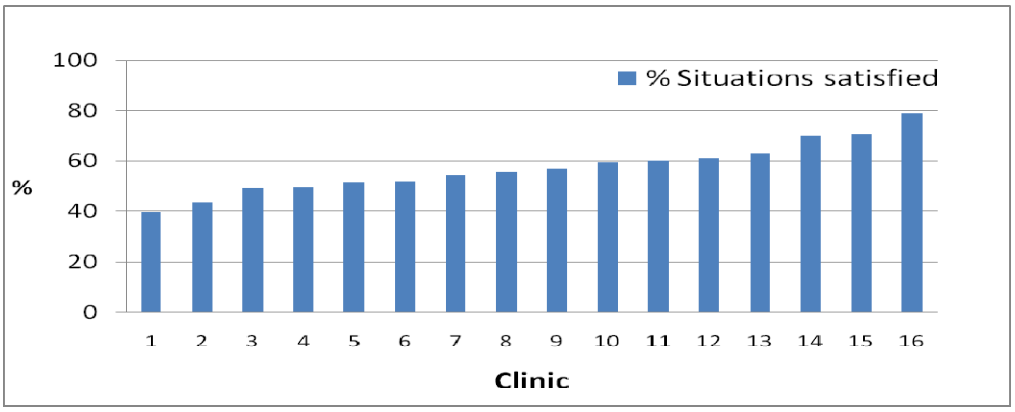
In hearing care, there is a similar distribution of outcomes.



This graph plots the percentage of situations in which clients are satisfied with their improved hearing, from 0% on the left, to 100% on the right hand side. Each point represents the performance of a single clinic. Some outstanding on the right hand side. Some poor performers on the left. But most are within the mediocre/middle range. Who wants "mediocre" in their health care?

How do we identify who are the best performers? And how can we help the rest to deliver better outcomes? Dr Gawande concluded that we cannot do "better" until we measure our performance, and compare it with the performance of others.

MarkeTrak and EARtrak are two client survey systems developed to measure the effectiveness of hearing aid outcomes. Data from both sources demonstrates that hearing aids do work – if fitted appropriately. But the data also highlights that there can be enormous differences between the results delivered by the best practitioners and "the rest". EARtrak shows the range of client satisfaction for having their hearing needs met varies enormously – from less than 40% to nearly 80%. These are not hearing aid issues. These are issues about how well services have been delivered that meet the individual client needs.

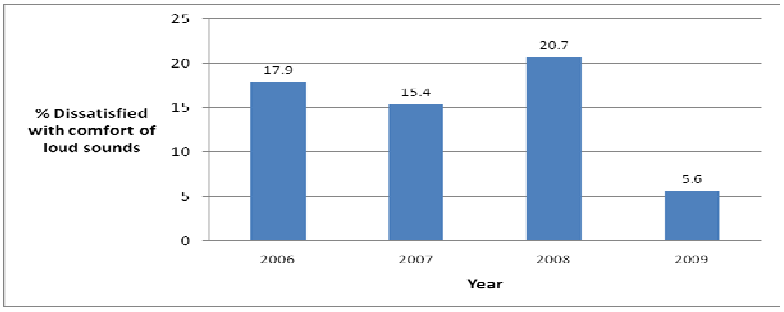


How do consumers identify which practitioner is most likely to deliver them a successful result? If you receive a voucher for hearing services from the government, you will see a list of service providers in your area. How do you know which is "the best"? And if you are funding your hearing care privately, how do you know where your funds should be spent to get the best value?

Up until now, positive word-of-mouth referrals from family or a friend has been found by many prospective clients to be the most effective way to find a good hearing care provider. What do you do if you don't know someone who can direct you to a good practitioner? Surveys by the Office of Hearing Services have found that the closest provider is usually the one most likely to be chosen when people are offered a choice. But is that provider going to give you the best results? I know I don't go to the closest doctor or the closest optometrist. What else can you do? Do you choose the largest organisation? The one with the biggest advertisements? The one that says they are the best? The one that promotes the latest technology? The one that rang you up to ask you to come in for a free hearing test?

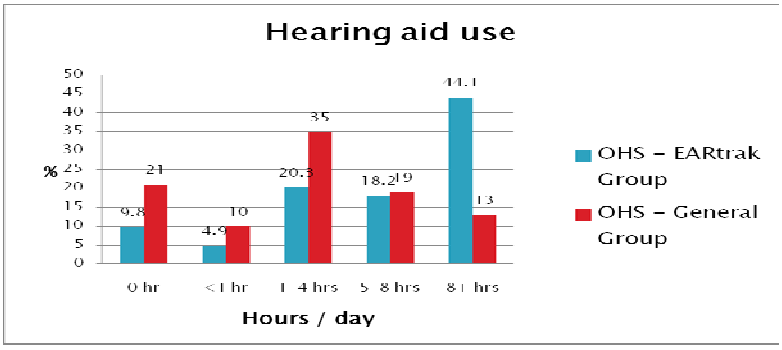
When choosing other products and services, consumers have access to independent reviews to help them make informed choices. For example, most of us know about the reviews reported by the Australian Consumers Association in "Choice". What is needed is a system to guide consumers to the "best" hearing care practitioners.

EARtrak was initially developed as a tool for clinics to measure their performance in hearing care delivery. These measurements are compared against national benchmarks. Clinics can identify exactly where their strengths and weaknesses are in comparison with other clinics, allowing them to focus on the key issues to be more effective. The system is based on surveys of hearing aid clients, sent to them by their clinic six months after new hearing aids have been fitted. Clients are asked specific questions about their experiences with their hearing improvement, device performance and the service they received. It's a comprehensive questionnaire. The completed surveys are returned by the client directly to an independent centre. EARtrak analyses the data and compiles regular reports for each participating clinic. So each clinic can compare their performance on a range of variables against the average performance on those same variables for the group of clinics. Clinics can easily see where they are performing well, and can identify areas where improvement is required. For example, in my clinical practice, we identified that many of our clients were uncomfortable with loud sounds. We have made modifications to our procedures to significantly reduce this problem.



This process of "detection and correction" of problems is a key component in implementing a system for Continuous Quality Improvement. But if no measures are made, problems go undetected and cannot be corrected.

The EARtrak system for performance measurement has been available since 2001. It has been conspicuous that uptake has been strongest by quality-conscious independent practitioners. For example, if we compare the results of the government-funded clients with those of the EARtrak user group, we see that clients of the practices using EARtrak have significantly better outcomes with regard to daily usage of hearing aids.



What is outstanding is that clients of this EARtrak group are more than three times more likely to using their hearing aids more than eight hours per day than the OHS-funded clients surveyed by Harvey Dillon. And clients of practices using EARtrak are less than half as likely to have their hearing aids "in the drawer". But use of this performance measurement system is till at a disappointingly low rate. Why?

The most common reasons given for not using an externally benchmarked system are:

1. The organisation does internally benchmarked surveys. Some individual practices and large dispensing organisations (private and government) have internal quality control measures in place. These measures do not provide independent benchmarking against other organisations. In other words, if they have no data against which to compare their performance, they remain unaware of areas where their performance may be below standard. This leaves them open to perpetuating systemic weaknesses.

2. The organisation "knows" they are delivering satisfactory services, based on their low rate of complaints from clients. Clients fitted with poorly fitted hearing aids rarely complain – they just stop using the aids, or use them on a limited basis. In 2001, OHS found that 62% of hearing aid users who had problems with the aids did not report these problems to their hearing care provider[8].

Dissatisfied clients are complaining. Not to their practitioner - but to their families, their friends, their colleagues, their doctors, their neighbours, their service clubs, their consumer organisations ... These complaints further reinforce negative stereotypes about the effectiveness of hearing aids.

Consumers deserve better from the hearing care industry and from clinical practitioners in particular. If improved technology and practitioner training have failed to deliver improved hearing aid outcomes, where do we go next? Strong advocacy by consumer organisations, such as BHA, have contributed to some improvement, but progress is slow. It is limited by the relatively minor number of consumers who actually belong to an organisation, and by the reluctance of consumers "to rock the boat". Consumers can play a major role in improving standards of hearing care, if their collective voice can be used. A way forward would be for consumers *of hearing services* to report their experiences *of hearing care* to an independent party. This would enable a profile of the quality of the work done by individual clinics to be built. These profiles can then be used to generate independent performance ratings for clinics, with this information accessible to potential consumers. Wouldn't such a system be a more reliable way of choosing a hearing care provider?

EARtrak has recently launched a ("Five star") performance rating system. Consumers have an easily recognisable method of identifying service quality. Clinics have an easily recognisable method of demonstrating their focus on good outcomes. Each star in the EARtrak rating is awarded for meeting performance benchmarks in five specific areas –

1. Use of an independent survey process to measure client outcomes.

2. Using the results to continuously improve service quality.
3. Client satisfaction with hearing improvement.
4. Client satisfaction with device performance.
5. Client satisfaction with service delivery.

A centralised process such as EARtrak allows calculation of star-ratings for a broad range of clinics if, and only if, there is sufficient consumer input. Consumer opinion can put upwards pressure on clinics to validate the effectiveness of their performance by surveying their clients, and listening to what they say. It also generates a valuable database which can be examined by researchers and consumer organisations interested in improving hearing care.

Consumers have considerable power to drive improved outcomes in hearing care, but only if their voice can be heard. The key is their systematic feedback about their experiences.

In an ideal world –

- Every person receiving hearing services would be surveyed about their experiences.
- The surveys would be sent to an independent organisation for analysis.
- That organisation would provide reports to individual clinics, comparing their performance against national benchmarks.
- Clinics would receive performance ratings, based on the quality of work they have delivered to past clients of their service
- Performance ratings would be available to consumers, to guide them towards those clinics delivering the best outcomes.

But we don't live in an ideal world. What can consumers do? For a start -

- When choosing a service provider, ask if they have an EARtrak quality rating.
- If they don't, search for one that does – or suggest that the clinic should be measuring their performance with an independent system such as EARtrak.
- If you have already been fitted with hearing devices, complete the EARtrak survey online (www.eartrak.com) or print out a copy of the survey and forward it to EARtrak.

In the US, Consumer Reports is the equivalent of our Australian Consumers Association. In 2009[9] they investigated the experiences of people purchasing hearing aids, and found it was really a matter of chance whether the individual got good outcomes, or not. It should not be left to chance whether Australians will get successful results from hearing care.

EARtrak is working to provide independent information to guide you towards those clinics with an established record for meeting the needs of their clients. We can only do this with the input of consumers.

To summarise. We have reached a critical point. Considerable advances in technology, training and hearing science have failed to deliver improved outcomes from hearing care. Although there is considerable good being done by the hearing care profession, a significant proportion of people do not receive adequate assistance. Hearing care professionals are unaware of their failures, and few are interested in measuring their performance. Consumers can play a vital role in giving feedback to the profession about the effectiveness of hearing care delivery. This feedback can help guide other consumers towards the professionals delivering the best outcomes from hearing rehabilitation, and contribute to improved standards of hearing care.

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