Module 7 – Unit 4

Applying PCC in the Appointment

How should this end?
The end stages of the appointment

INSTRUCTOR'S GUIDE

idainstitute

Time for Unit: 1 hour

1. Goals
   - *Goal 1:* Understand how the clinician's communication can influence patient outcomes at the end stages of the appointment.
   - *Goal 2:* Introduce the key communication tasks (provide a clear diagnosis, encourage shared decision-making, and close the visit) during the end stages to facilitate person-centred interactions.
   - *Goal 3:* Create a safe peer-learning environment to practice communication skills and offer descriptive feedback.

2. Concepts to Master
   The final stages of the appointment are considered to occur after the completion of the assessments, whether it is a hearing test or fine-tuning of the hearing aids. Unlike the earlier stages of the appointment where our main emphasis is to gather information, we now transition into information provision and share decision making about management plans.

   The importance of this stage is to clearly explain the diagnosis and come to a collaborative decision with our patients on the management plan. Research has shown healthcare professional's communication to be a significant factor.

3. Reading
   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.

   Frankel, R. M., & Stein, T. (1999). Getting the most out of the clinical encounter: the four habits model. Perm J, 3(3), 79-88.

   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(1), 36-50.

   Krupat, E., Frankel, R., Stein, T., & Irish, J. (2006). The Four Habits Coding Scheme: validation of an instrument to assess clinicians' communication behaviour. Patient Education and Counseling, 62(1), 38-45.

   Meyer, C., Barr, C., Khan, A., & Hickson, L. (2017). Audiologist-patient communication profiles in hearing rehabilitation appointments. Patient Education and Counseling, 100(8), 1490-1498.

Sciacca, A., Meyer, C., Ekberg, K., Barr, C., & Hickson, L. (2017). Exploring Audiologists ' Language and Hearing Aid Uptake in Initial Rehabilitation Appointments. American Journal of Audiology, 26(June), 110–118.

Tai, S., Barr, C., & Woodward-Kron, R. (2019). Towards patient-centred communication: an observational study of supervised audiology student-patient hearing assessments. International Journal of Audiology, 58(2), 97-106.

Zolnierek, K. B. H., & DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: a meta-analysis. Medical care, 47(8), 826.Video Reflexivity Study. American Journal of Audiology, 27(2), 219-230.

4. Lecture

   PowerPoint: "How should this end? The end stages of the appointment"

5. Activities
   - Activity 1: Role-play

6. Homework
   Bring the video recording from unit 1 to class for discussion in the next unit.

Activity 1: Role-play

The goal of this activity is to practice the communication skills required to perform the final phase of the appointment. The communication tasks informed by The Four Habits are:

i. Delivering information

ii. Providing education and joint decision-making

iii. Closing the visit

Preparation

- The scenarios provided here are geared toward an audiology setting, but feel free to adjust the roles and story to fit your context.
- Ask the students to form groups of three: one student takes the role of the 'audiologist', one takes the role of the 'patient', and the third member takes the role of 'observer'.
- Provide students with a selection of main concerns, audiogram results and patient characteristics. Ask students to decide as a trio in which main concern(s), audiogram and patient characteristics they would like to role-play.

- The 'audiologist' will then leave the group for 5 minutes to prepare for his/her role using the communication tasks detailed in Initiating the Session and Information Gathering.
- The 'patient' and 'observer' will also have 5 minutes to discuss the case in more detail, prepare answers, and add their own flavor to the case.

Role-play

- The role-play should run for approximately 7-10 minutes.
- Provide the 'observer' with the feedback handout to prompt feedback to the clinician.
- If time allows, students can swap roles and do the second case scenario.

Role play options (select one from each category):

1. Main concerns
   - Onset of unilateral tinnitus
   - Deterioration in hearing
   - Sudden hearing loss
   - Onset of dizziness
   - Blocked ears
   - Difficulty hearing in background noise
   - Ear pain
   - Uncertain about hearing deterioration or hearing aids

2. Audiograms
   - Normal hearing
   - Mild to moderate mixed hearing loss in both ears
   - Asymmetrical sensorineural hearing loss
   - Unilateral mild conductive hearing loss
   - Bilateral moderate sensorineural hearing loss
   - Normal hearing in one ear, dead ear in the other
   - Sloping high-frequency hearing loss in both ears

3. Patient characteristics
   - Parent of a child with hearing loss
   - Angry patient
   - Anxious patient
   - Talkative patient
   - Patient in denial about hearing loss

Feedback Handout for Observer (continued on next page)

Areas to Improve	Good	Amazing!
Clinician frames diagnosis and information in terms that fit the clinician's frame of reference rather than incorporating those of the patient.	Clinician makes cursory attempt to frame diagnosis and information in terms of patient's concerns.	Clinician frames diagnostic and other relevant information in ways that reflect patient's initial presentation of concerns.
Clinician gives information and continues on quickly with giving patient opportunity to react (impression is that this information will not be remembered properly or fully appreciated by the patient).	Clinician pauses briefly for patient reaction, but then quickly moves on (leaving the impression that the patient may not have fully absorbed the information).	Clinician pauses after giving information with intent of allowing patient to react to and absorb it.
Information is stated in ways that are technical or above patient's head (indicating that the patient has probably not understood it fully or properly).	Information contains some jargon and is somewhat difficult to understand.	Information is stated clearly and with little or no use of jargon.
Clinician offers/orders tests and treatments, giving little or any rationale for these.	Clinician only briefly explains the rationale for tests and treatments.	Clinician clearly explains the rationale behind the tests and recommendations so that the patient can understand the significance of these management options.
Clinician makes no effort to determine whether the patient has understood what has been said.	Clinician briefly or ineffectively tests for the patient's comprehension.	Clinician effectively tests for the patient's comprehension.

Areas to Improve	Good	Amazing!
Provider shows no interest in having patient's involvement or actively discourages/ignores patient's efforts to be part of decision making process.	Clinician shows little interest in inviting the patient's involvement in the decision-making process, or responds to the patient's attempts to be involved with relatively little enthusiasm.	Clinician clearly encourages and invites patient's input into the decision making process.
Clinician offers recommendations for treatment with little or no attempts to elicit patient's acceptance of (willingness or likelihood of following) the plan.	Clinician makes brief attempt to determine acceptability of treatment plan, and moves on quickly.	Clinician explores acceptability of treatment plan, expressing willingness to negotiate if necessary.
Clinician does not address whether barriers exist for implementation of treatment plan.	Clinician briefly explores barriers to implementation of treatment plan.	Clinician fully explores barriers to implementation of treatment plan.
Clinician makes no attempt to solicit additional questions from patient or largely ignores them if made unsolicited.	Clinician allows for additional questions from patient, but does not encourage question asking nor respond to them in much detail.	Clinician openly encourages and asks for additional questions from patient (and responds to them in at least some detail).
Clinician makes no reference to follow-up plans.	Clinician makes references to follow-up, but does not make specific plans.	Clinician makes clear and specific plans for follow-up to the visit.

Adapted from: Krupat, E., Frankel, R., Stein, T., & Irish, J. (2006). The Four Habits Coding Scheme: validation of an instrument to assess clinicians' communication behavior. *Patient education and counseling*, *62*(1), 38-45.