Addressing the Elephant in the Room: Sales in a Clinical Profession with Andreas Seelisch – 1PM ET

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CAA Webinar

Addressing the Elephant in the Room: Sales in a Clinical Profession

Andreas Seelisch, M.Sc., B.H.Sc. (Hons), Reg. CASLPO , Director of Audiology, Hearing Solutions

April 22nd, 2021

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Canadian Academy of Audiology is a professional association dedicated to enhancing the role of audiologists as primary hearing health care providers through advocacy, education and research.

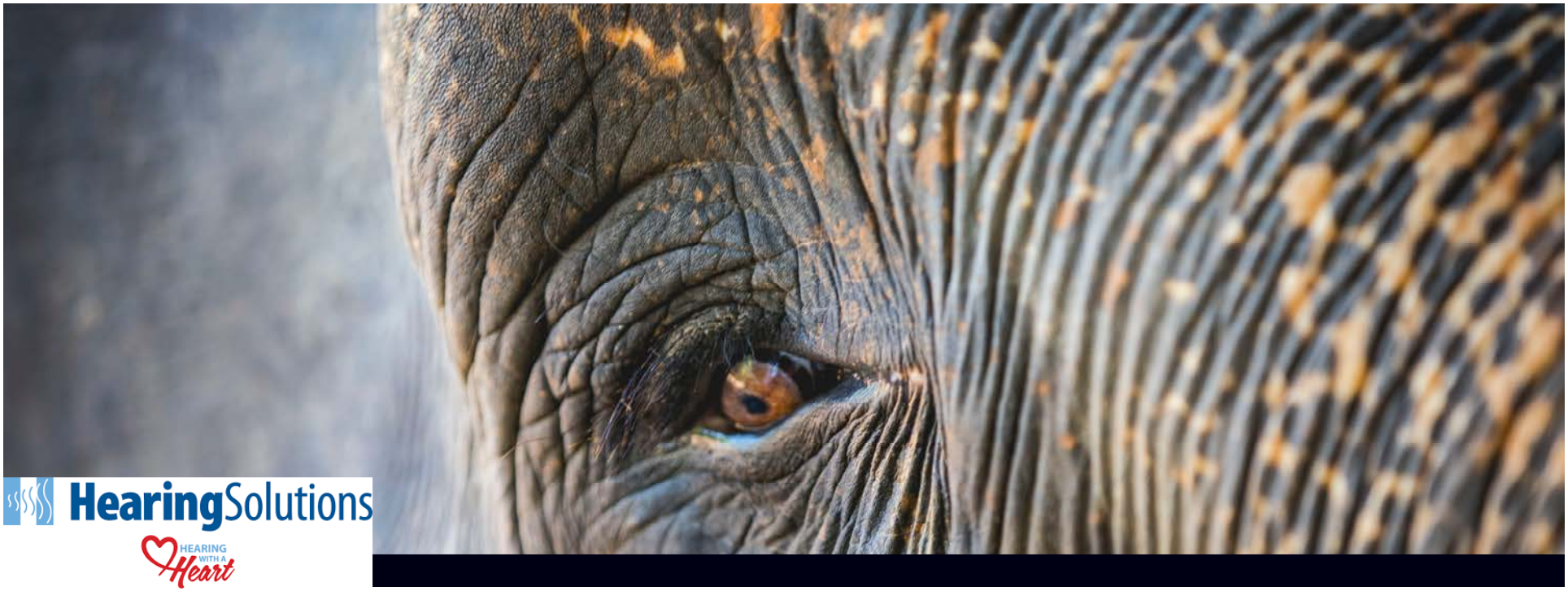
Host - Salima Jiwani

Salima Jiwani is the Director and Lead Audiologist at AudioSense Hearing & Balance, an audiology clinic in Toronto. She is also an Adjunct Lecturer in the Department of Speech-Language Pathology at the University of Toronto, and past-president of the CAA. Salima works with children and adults of all ages, and provides her patients with industry-leading audiological care for hearing, balance, and post-concussion services by leveraging her clinical, research and industry experience. Salima earned her Ph.D. in 2015 in Auditory Neurophysiology and Neurosciences at the University of Toronto's Institute of Medical Sciences and the Cochlear Implant Lab at The Hospital for Sick Children, after completing her Master of Science in Audiology degree at Dalhousie University.

Speaker: Andreas Seelisch

Andreas Seelisch is the Director of Audiology at Hearing Solutions, the largest independently owned and operated hearing aid retailer in Ontario. He graduated from Western University with a Masters in Communication Sciences and Disorders in 2008 and completed his thesis work at the National Centre for Audiology on the sound quality impact of frequency compression technology.

His current research focus is on clinically applicable topics such as clinical practice guidelines and exploring barriers to hearing aid uptake.



Addressing the Elephant in the Room:

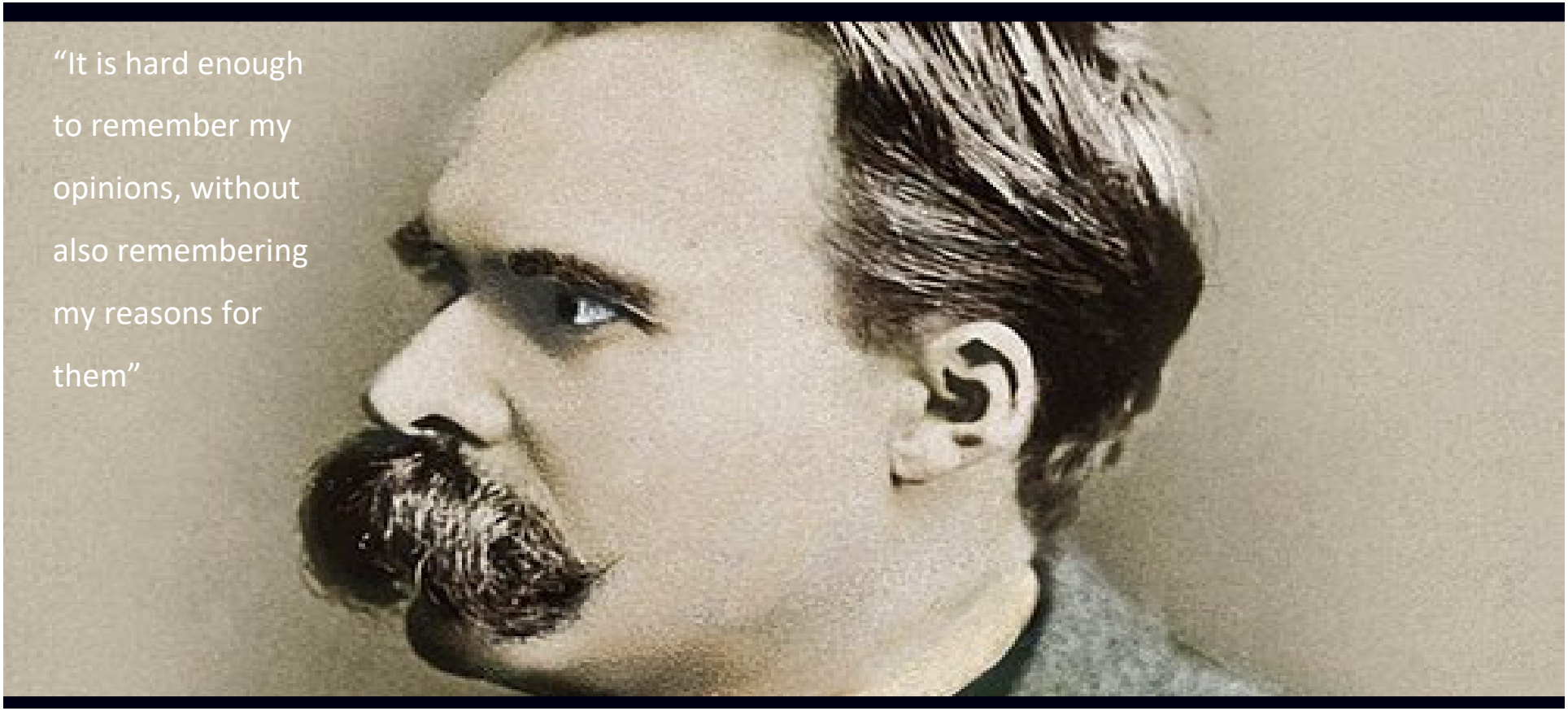
an introduction to sales in a clinical environment

Andreas Seelisch, M.Sc., B.H.Sc. (Hons), Reg CASLPO
Director of Audiology, Hearing Solutions

Agenda & Learning Objectives

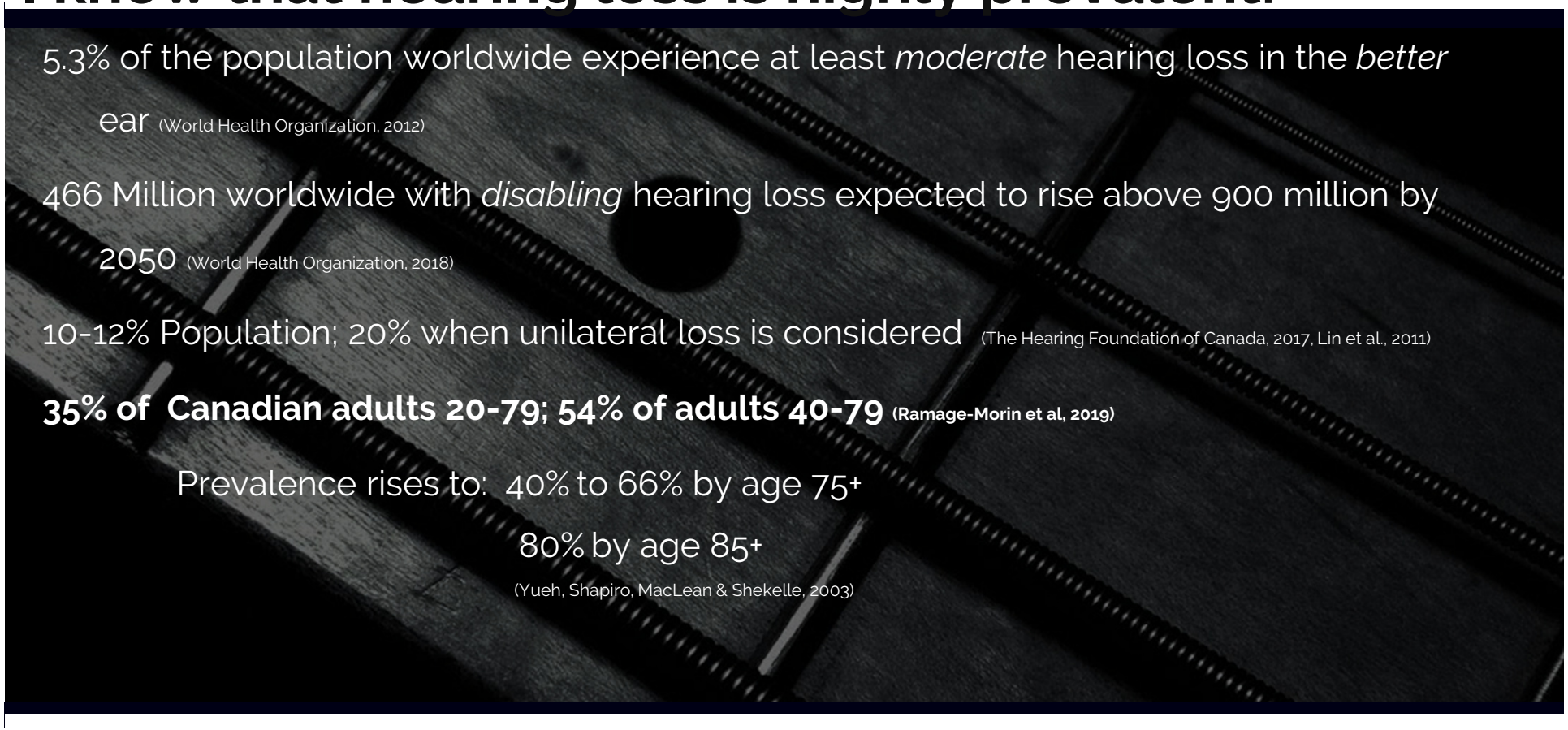
1) Challenge your personal belief system & explore what it means to be a “salesperson”
2) Consider counselling techniques and tools to support driving behavior change
3) Confronting biases in order to more effectively manage objections and understand our patients

What motivates you to do your job? Do you love your chosen profession? Why?



Friedrich Nietzsche (1844-1900)

I know that hearing loss is highly prevalent:



5.3% of the population worldwide experience at least *moderate* hearing loss in the *better* ear (World Health Organization, 2012)

466 Million worldwide with *disabling* hearing loss expected to rise above 900 million by 2050 (World Health Organization, 2018)

10-12% Population; 20% when unilateral loss is considered (The Hearing Foundation of Canada, 2017, Lin et al., 2011)

35% of Canadian adults 20-79; 54% of adults 40-79 (Ramage-Morin et al, 2019)

Prevalence rises to: 40% to 66% by age 75+

80% by age 85+

(Yueh, Shapiro, MacLean & Shekelle, 2003)

I know that hearing loss is associated with a wide variety of negative outcomes:

Linked with issues such as dementia and cognitive decline
(Granick, Kleban, & Weiss, 1976; Gussekloo, de Craen, Oduber, van Boxtel, & Westendorp, 2005; Lin et al., 2011a; Lin et al., 2011b; McCoy et al., 2005; Valentijn et al., 2005)

Increased listening effort
(Bernarding, Strauss, Hanneman, Seidler, & Corona-Strauss, 2013; Kramer, Kapteym, Festen, & Kuik, 1997; Tun, McCoy, & Wingfield, 2009)

Profound psychological consequences including: depression, isolation, anger, exhaustion, anxiety, insecurity, despair, negative self-image, inability to relax, loss of group affiliation, paranoia, and loss of intimacy (Trychin, 1993).

Impacts to quality of life as well as economic, behavioral, emotional and psychosocial domains
(Dalton et al., 2003).

Risk of falling
(Girard et al., 2014; Lin & Ferrucci, 2012; Lopez et al., 2011).

I know hearing aids can improve outcomes:

Systematic Reviews have show that hearing instruments improve health related quality of life
Chisolm et al. (2007)

Hearing instrument use also appears to attenuate the accelerated cognitive decline associated with hearing loss (Ameiva et al, 2015; Dawes et al, 2015).

Hearing instruments enjoy high rates of satisfaction (81% and 91% with technology purchased in the last year) (Abrams & Kihm, 2015).

Hearing instrument owners report improved relationships, work performance, communication abilities and overall quality of life (Abrams & Kihm, 2015).

Lancet Commission found Hearing Loss to be the #1 modifiable risk factor for dementia and recommends the treatment of Hearing Loss as a Preventative Measure(Livingston et al, 2017).

I know that hearing instrument uptake remains both low delayed:

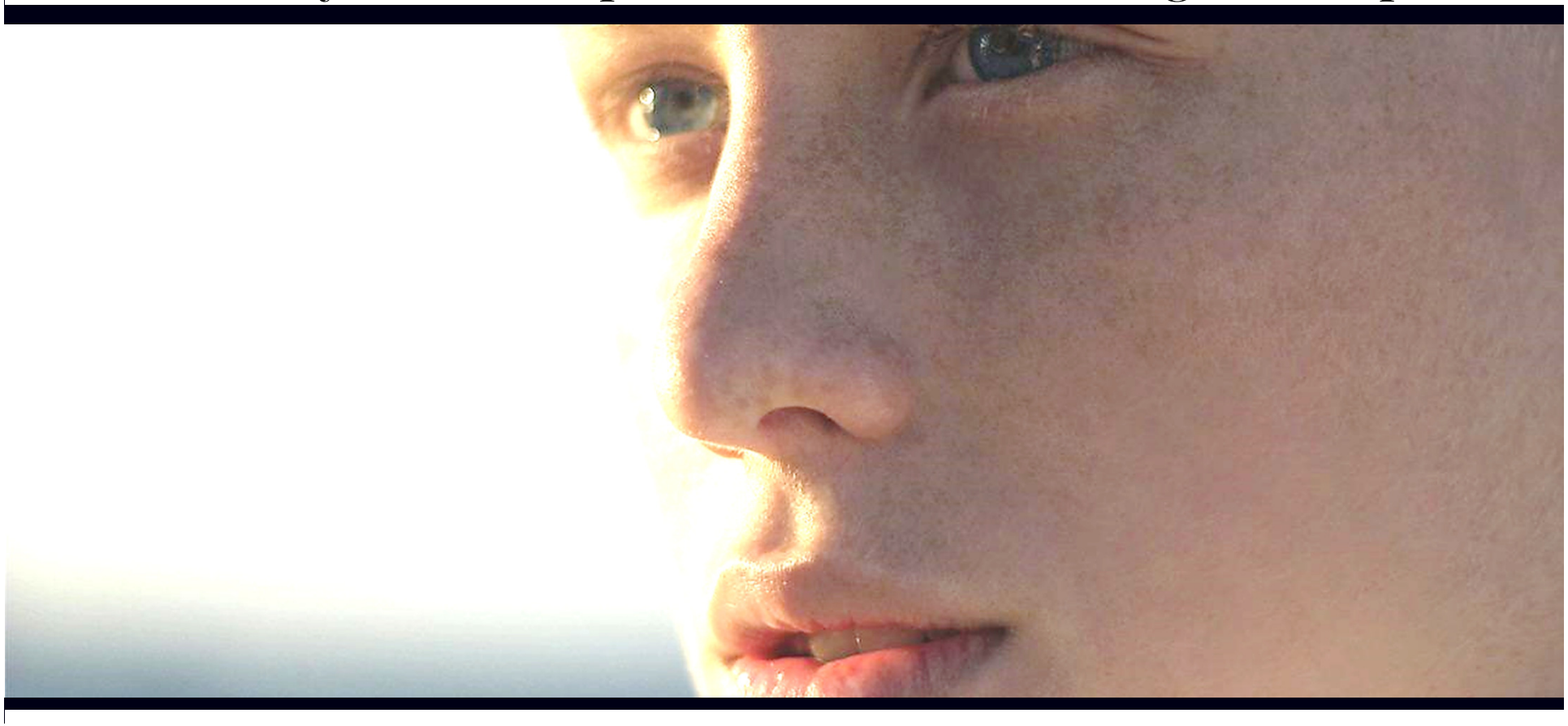
Hearing instrument penetration rates in the United States are estimated at between 25-33% (Amlani, 2010; Abrams & Kihm, 2015; Grundfast and Liu, 2017).

Non-Hearing aid owners have been aware of their hearing loss for 9.5 and 12.4 years (Abrams & Kihm, 2015, Kochkin, 2013)

Only 30% of those with self reported hearing difficulties are hearing aid owners (Abrams & Kihm, 2015)

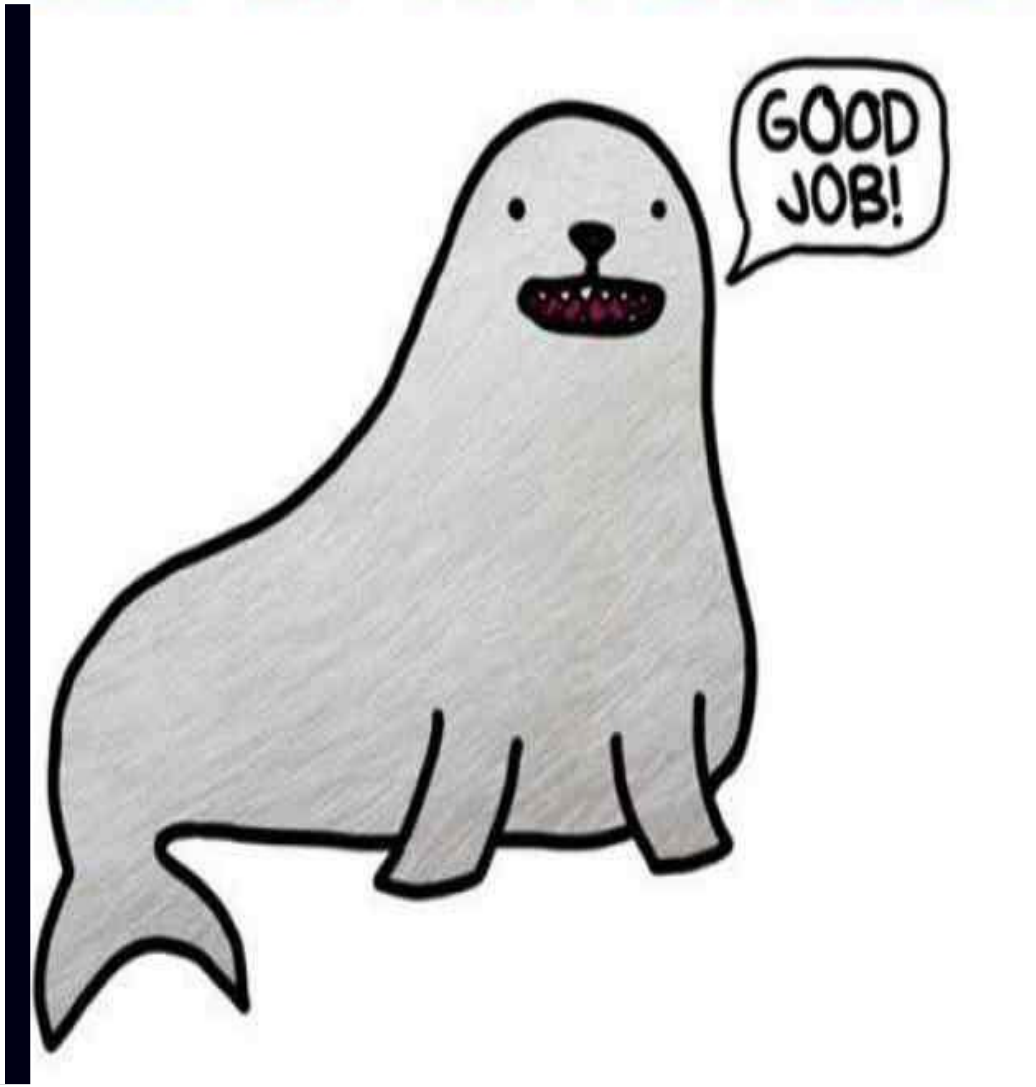
Hearing aid owners waited between 6.7 and 13 years before pursuing treatment (Abrams & Kihm, 2015, Kochkin, 2013)

Therefore, my vision is to promote increased hearing aid acceptance:



Simon Sinek - Start with Why

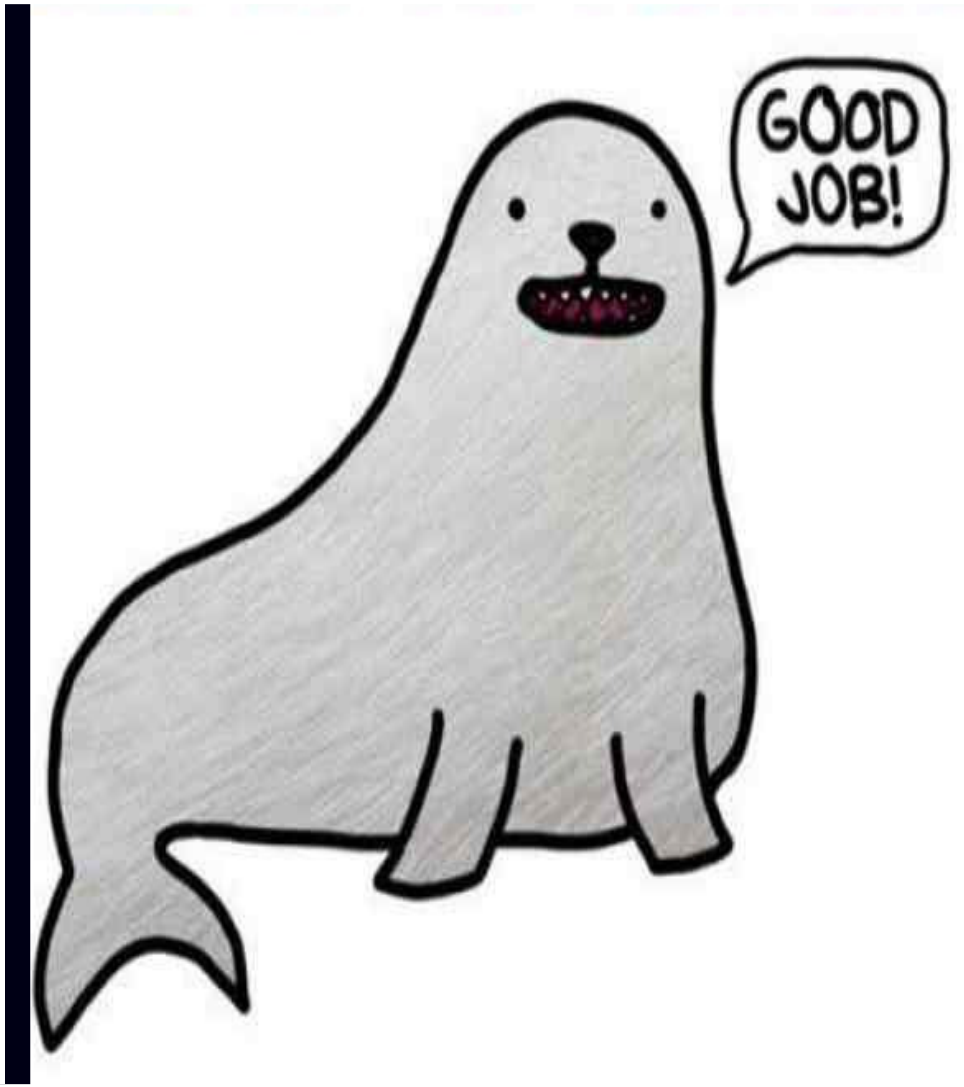
How do I fulfill my vision?
How do you know your doing a good job?



Examples:

1. Subjective reports (Patients seem happy etc.)
2. Validation Tools (COSI, APHAB, IOI-HA), Verification
3. Key Performance Indicators (KPIs)

- Unit Sales / Targets
- Closing Ratio/Conversion, Return Ratio, Binaural Rate, Referral rate Average Selling Price etc.



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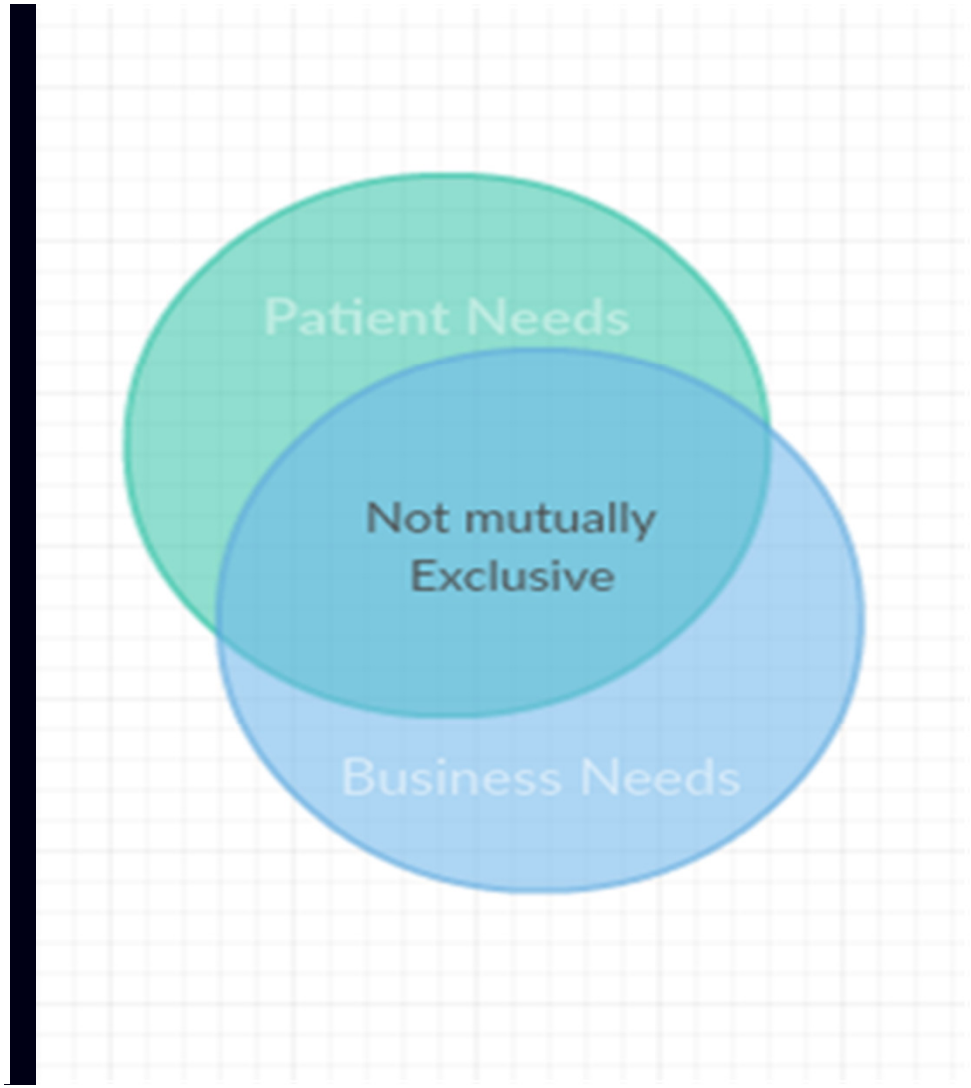

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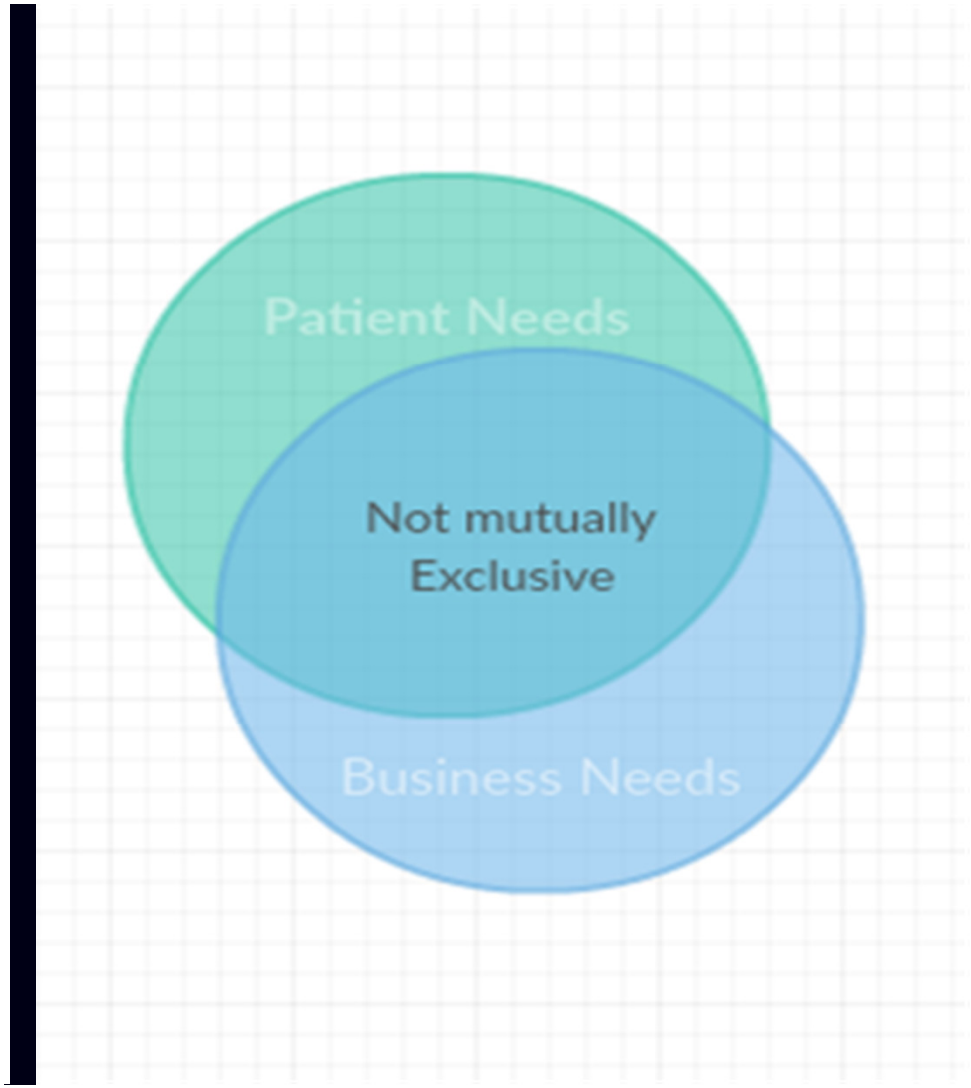


Examples:

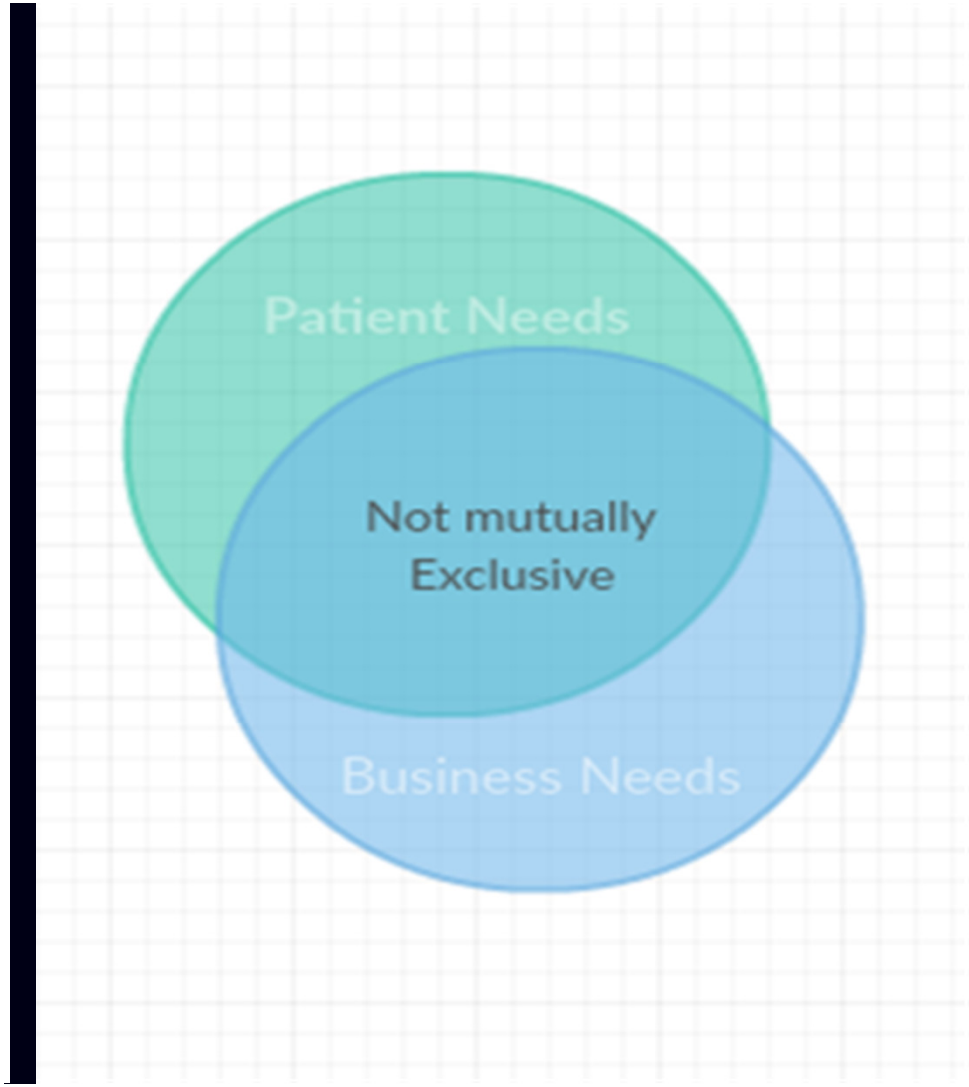
Verification/Targets: (Valente, Potts and Valente, 1995, Valente 2019)

BR: (Holmes, 2003)

ASP: *Industry E.g."Ria vs. Alta"*

Conversion: My vision

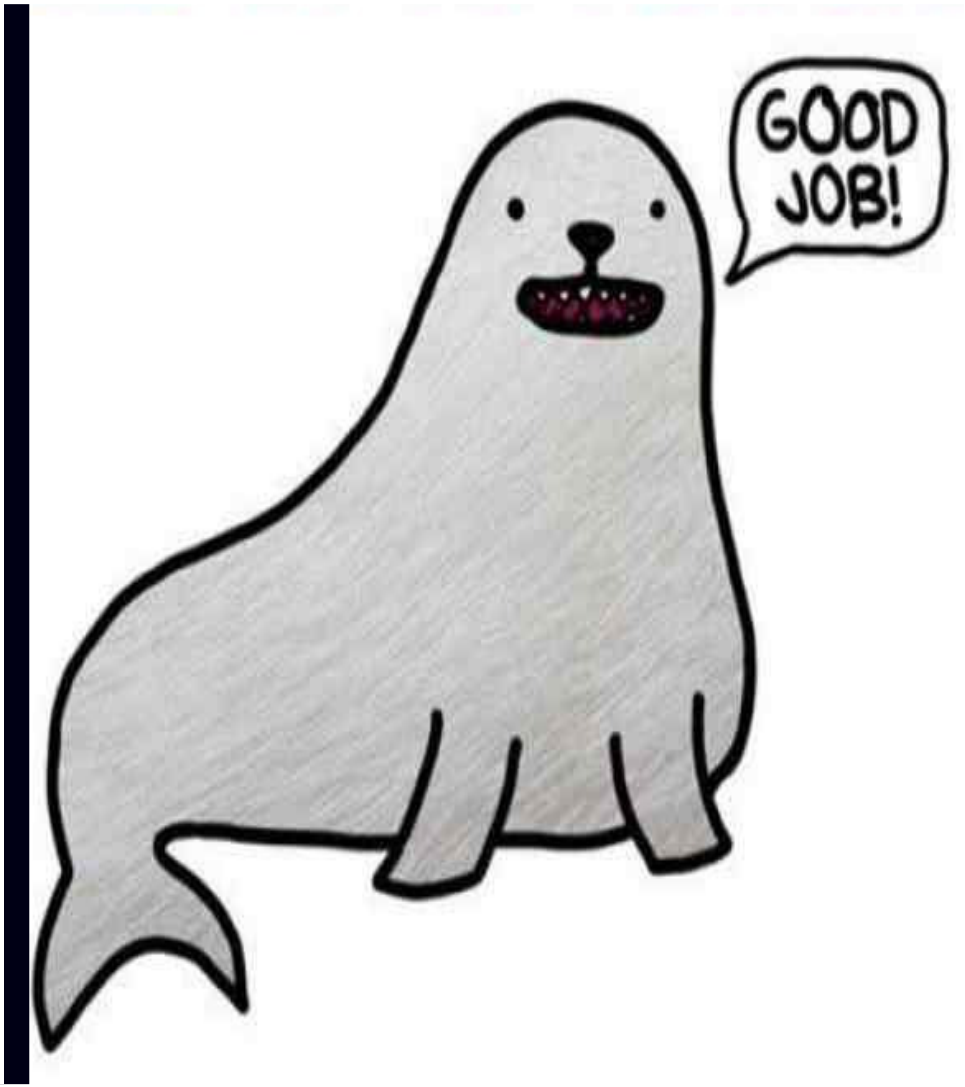
Market Share: Demonstration



Core Purpose: HearingSolutions

HEARING WITH A Heart

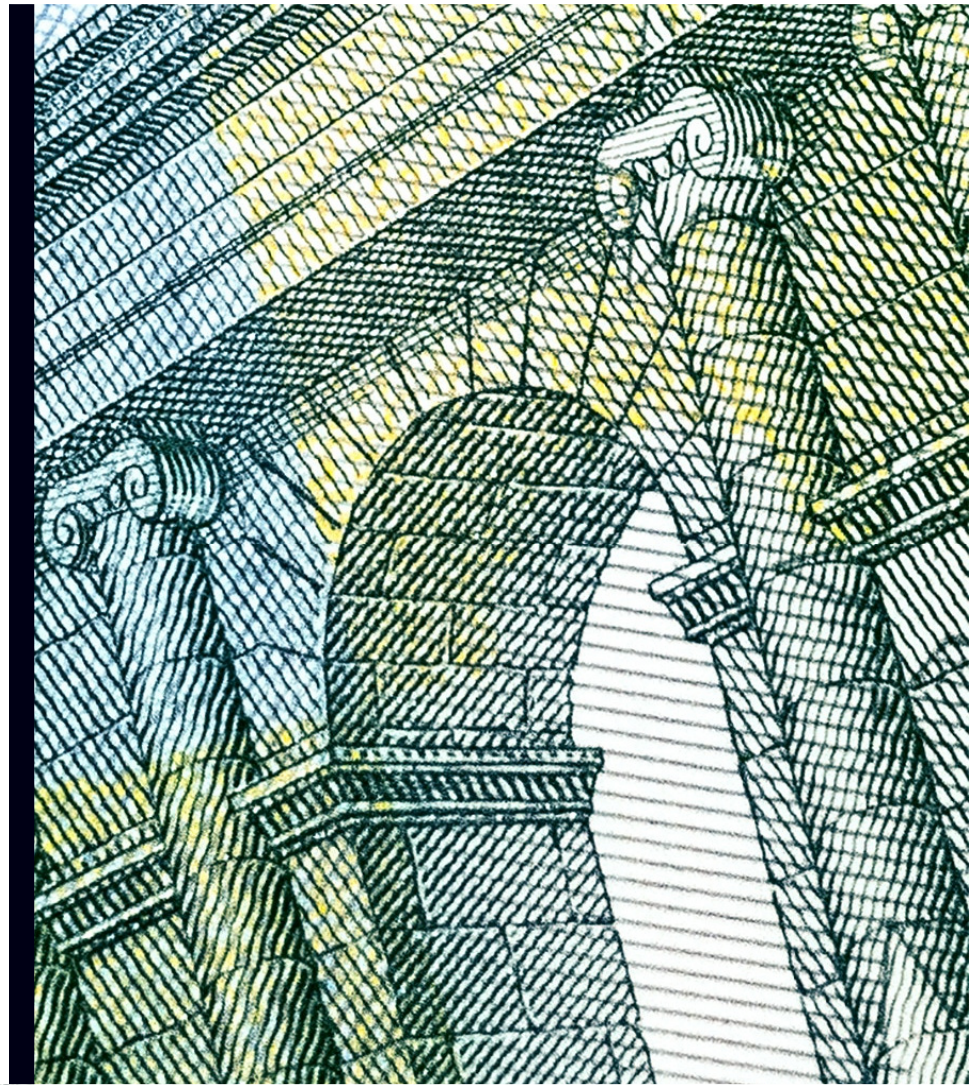
"We motivate individuals to proceed with the ideal hearing solution that's just right for them, and that in turn helps them hear what matters most in life."



What is the problem then with sales?

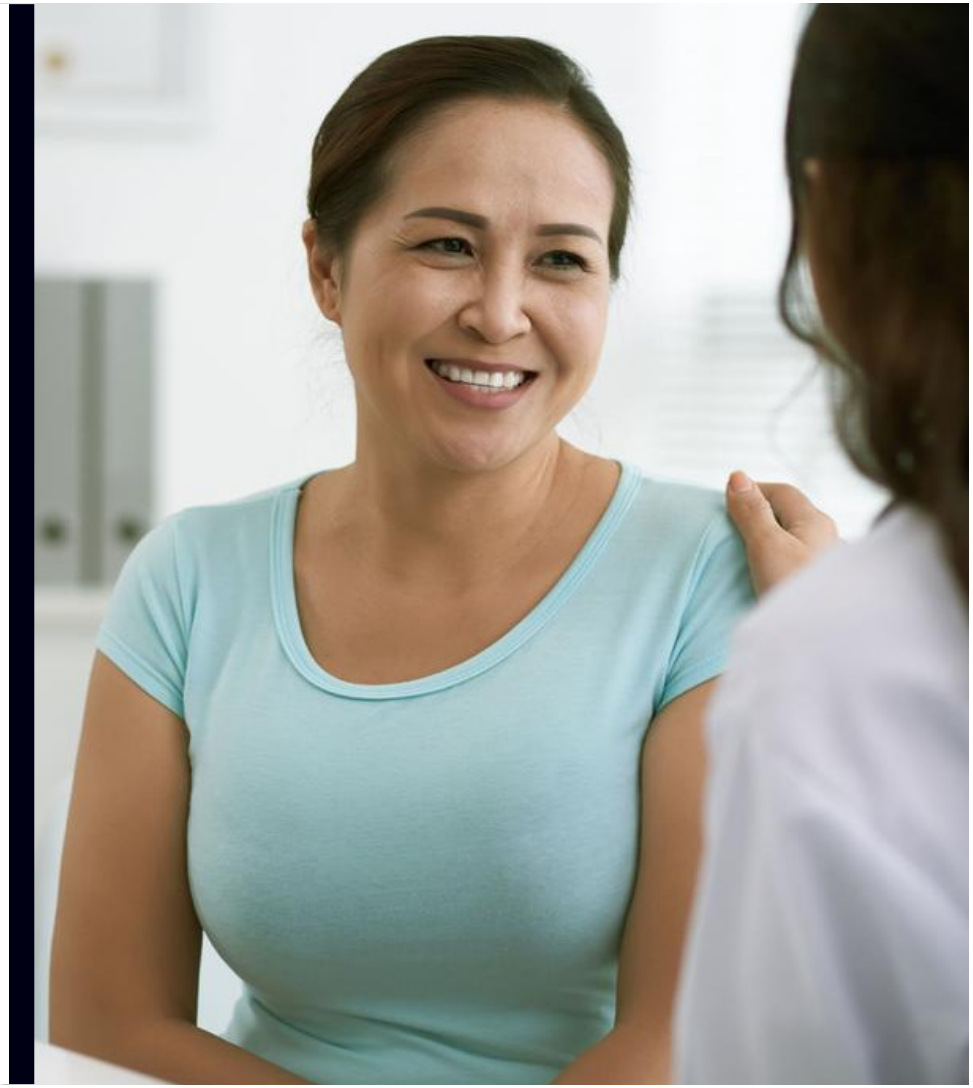
1) Are hearing aids free? Are your services free? Should they be?
2) Does selling *enable* or *prevent* you from doing what motivates you?

What do you think of when I say sales, selling, salesperson?



What do you think of when I say sales, selling, salesperson?

"You know what…**you are a good salesperson**"



Consider for a moment other industries:

Medical

Optical – Check ups, Limited ongoing Care

Dental - material vs. time, check ups, Cost over 3yrs

Trades/Skills

Audio - $95/hr & 100% markup on accessories, undisclosed markup on primary devices

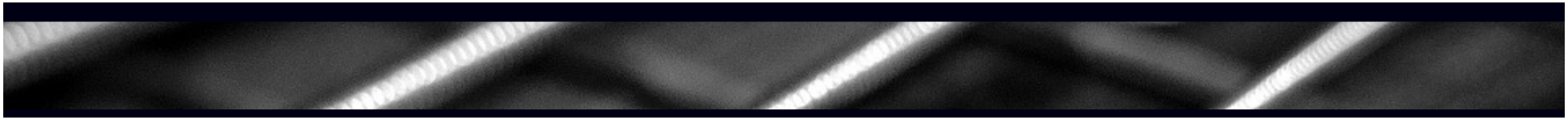
Mechanic – $125/Hr

Economic Maxim:

"No such thing as a free lunch"

- Clinician Level: Education, Expertise, Salary
- Clinic level: Retail Space, Staff, Equipment, Ongoing Care, Leads etc.
  - VF2, Probe tubes, shipping
  - $300-800 Cost per lead Hearing Review (2021)
- Manufacturing Level: R&D (Phone Industry), Ongoing Care (Staff)

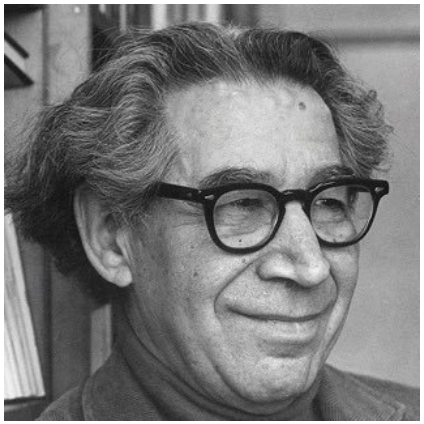
Perhaps selling is just doing our job well…



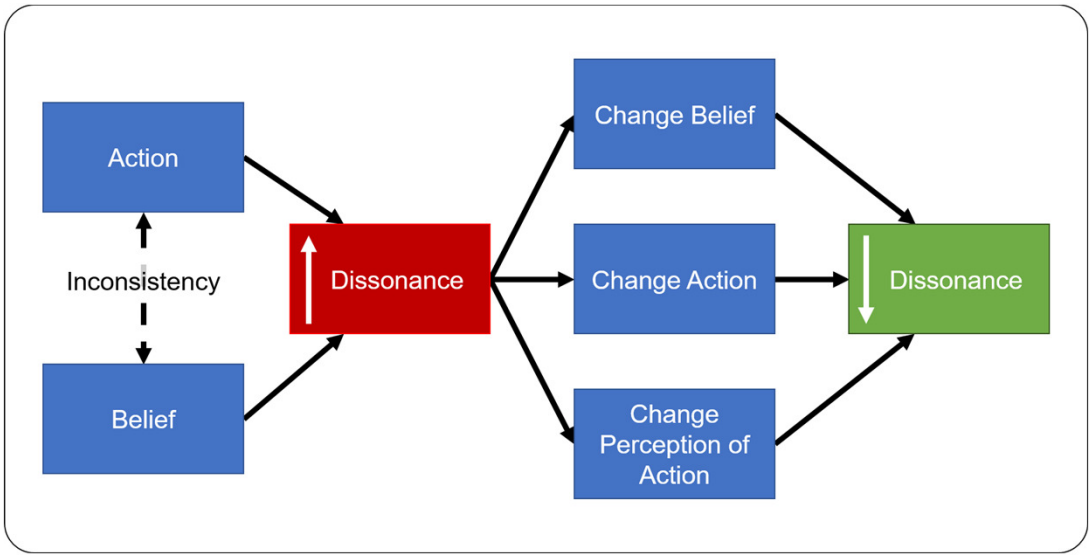
- We need to take away the concept of being a salesperson that brings guilt or anxiety, and focus on what you really are – an agent of change. (Hecker, 2015)
- How well are we helping a patient by doing a hearing test, identifying them with a hearing loss, and then sending them home?

We want to move these patients forward because we believe its in their best interest and will make their life better **(even if they don't know it yet)** and so we should be as good at it as possible!

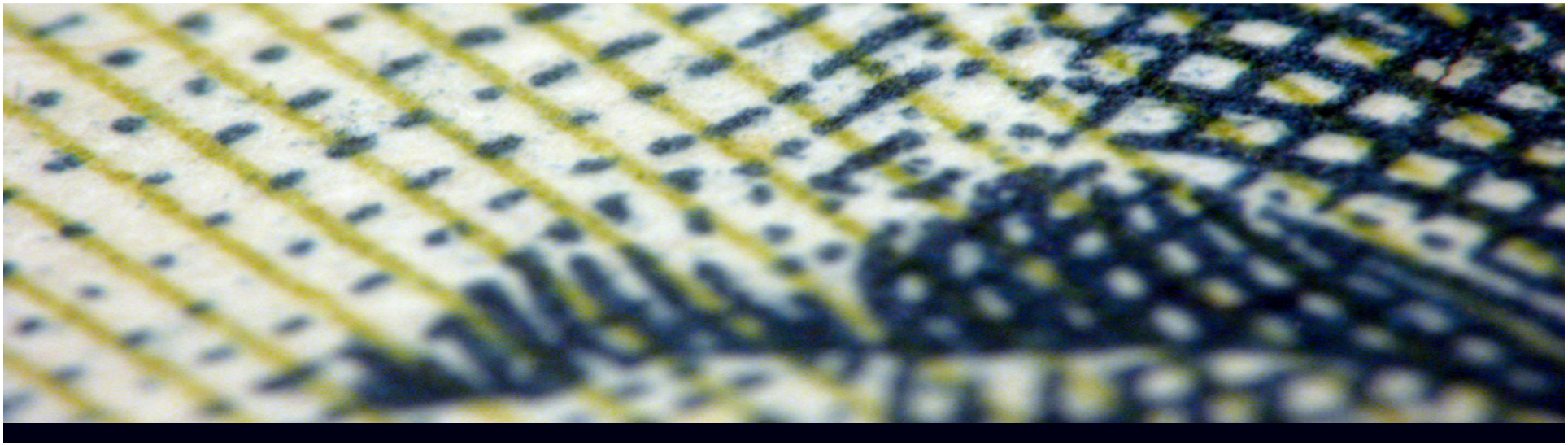
Cognitive Dissonance



In the late 1950's American psychologist Leon Festinger extensively described cognitive dissonance in where opposing actions and beliefs cause causing psychological distress.



“Reconciling your belief system”

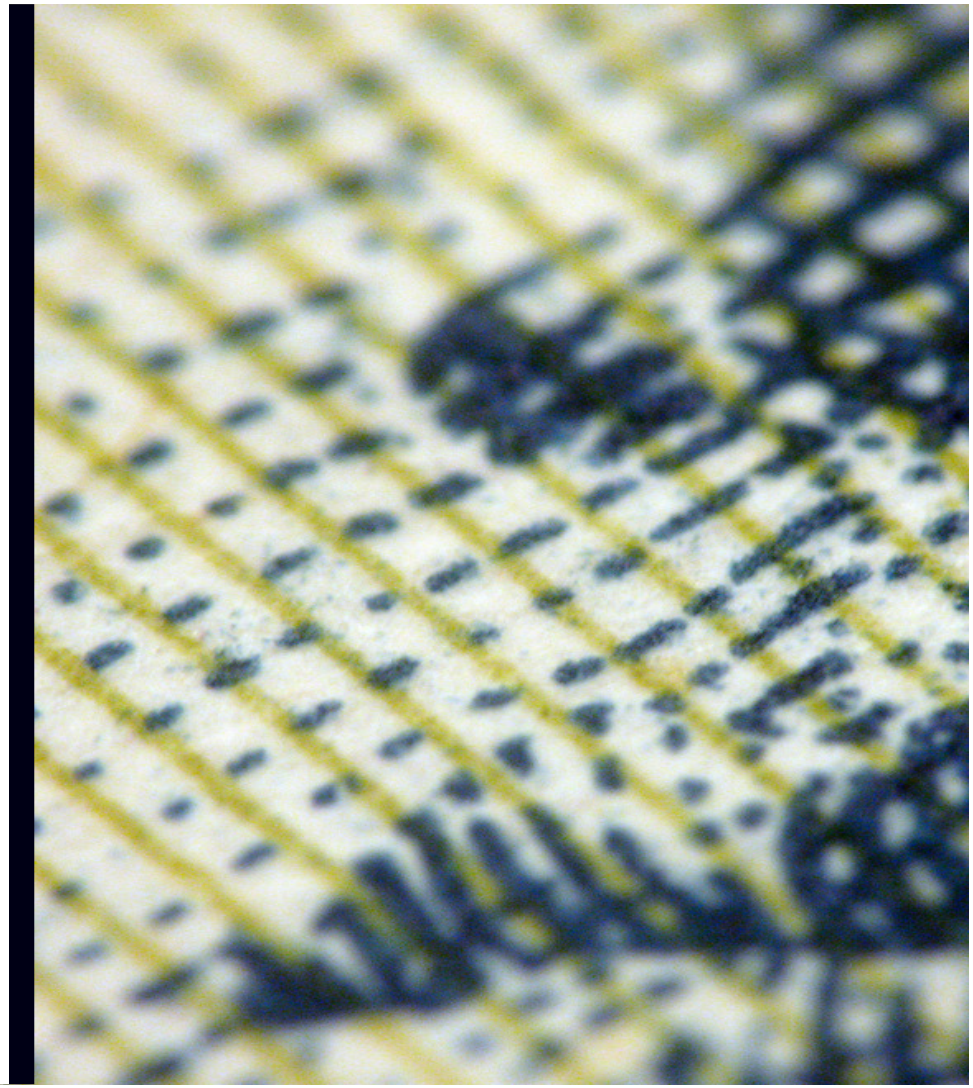


2 The tools and counselling techniques that will support driving behavior change

Motivational Interviewing…

…is a directive, client-centered counselling style for eliciting *behavior change* by helping clients to explore and resolve ambivalence.

1. Express Empathy
2. Develop Discrepancy
3. Deal with Resistance
4. Support Self-Efficacy



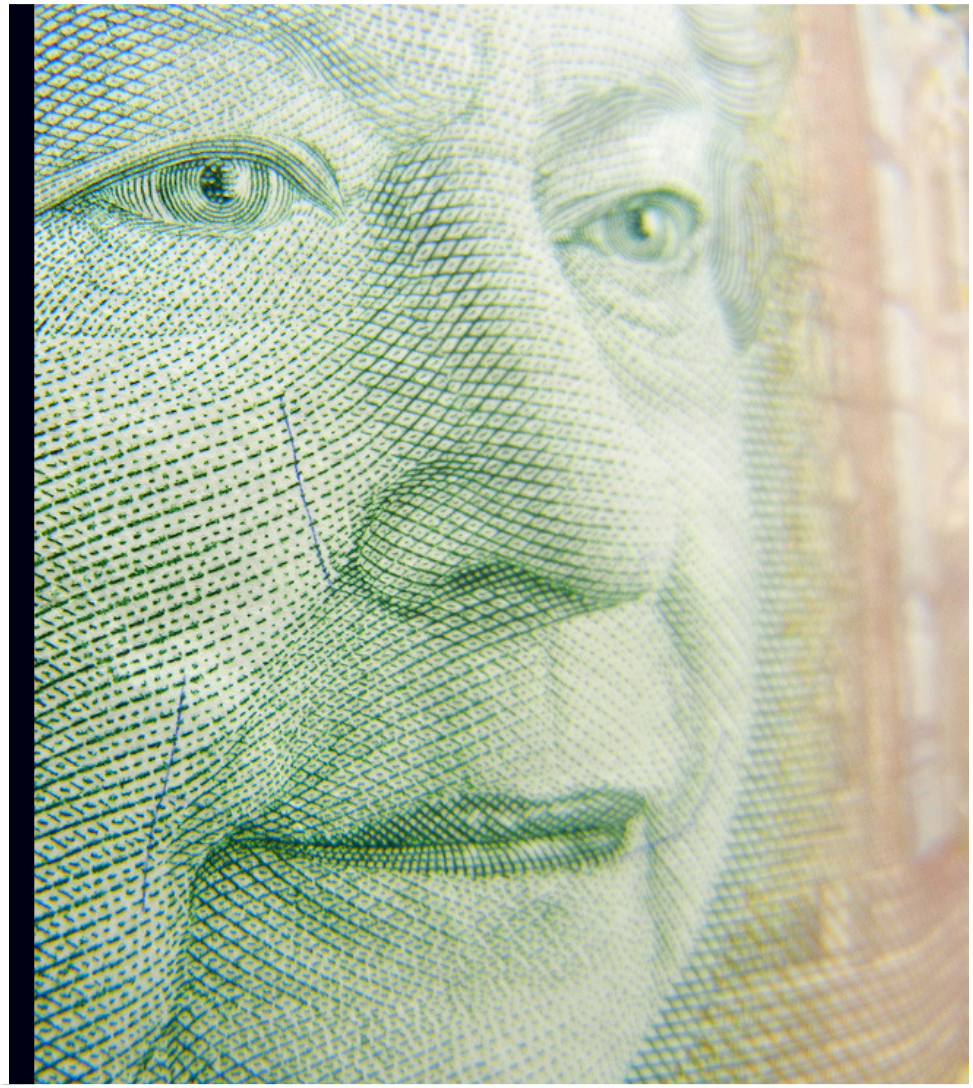
Discovery, Gap Analysis, Intelligence Gathering

Patient History

Foundation in Discovery Phase

- Seek to understand
    - PCC/FCC
- Motivational Interviewing
    - Reflective Listening
    - Open ended Questions
        - Effective probing
        - Talk less and listen more
    - Rapport Building

Promote understanding and evoke emotion

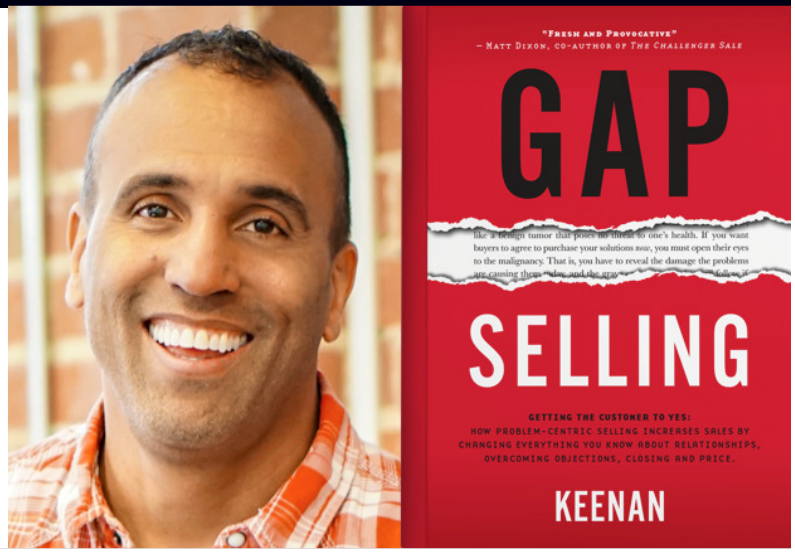


Gap Selling

Asking questions, discovery, putting your customer first,

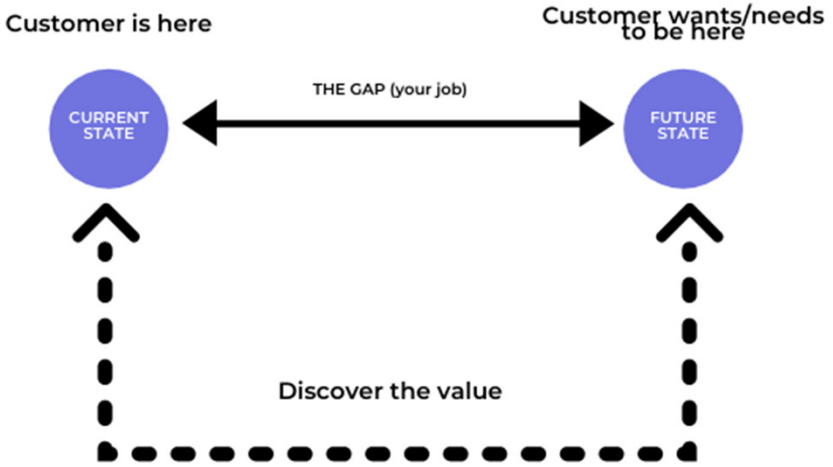
influence customer to want a solution to their problems

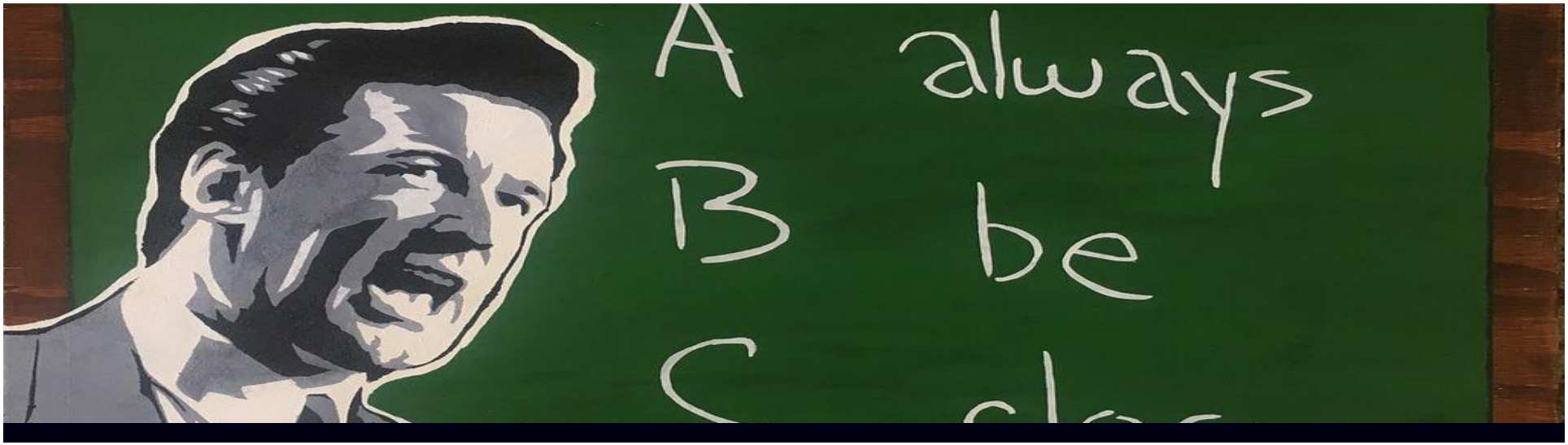
(even if they ***don't know they have a problem yet***)



Gap Selling

2. Develop Discrepancy





Gap Selling

Orlob (2018) in an analysis of 1,000,000 sales calls found closing calls have little to no difference in outcome while **questions** during discovery calls and more **listening vs. talking time** did

Mastering the Complex Sale –Jeff Thull

Through “diagnostic” **questioning** designing a complex solution to a complex problems (complex sale is where the customer requires your expertise)

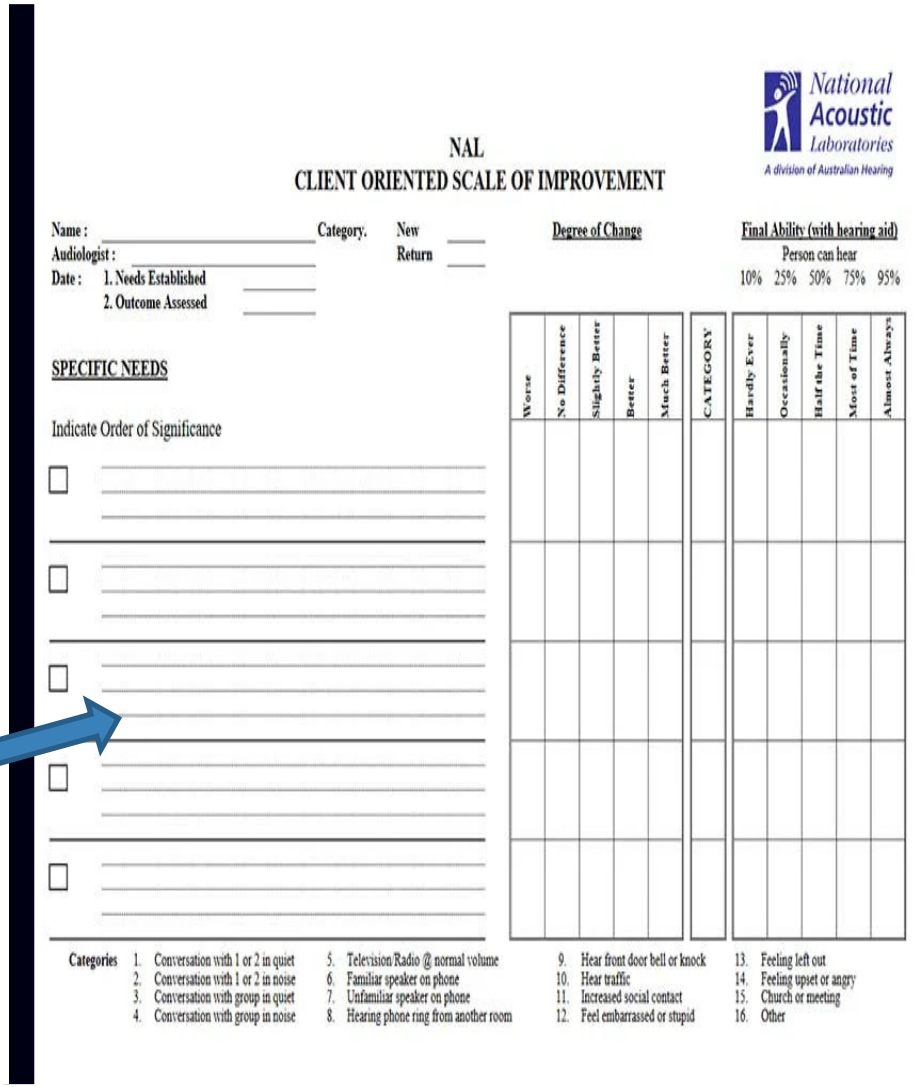
Patient Motivations

- E.g. COSI
  - Grandchildren
- E.g. 2 Tinnitus

2. Develop Discrepancy

Or

"The Gap"



National Acoustic Laboratories
A division of Australian Hearing

NAL
CLIENT ORIENTED SCALE OF IMPROVEMENT

Name : _____ Category. New ____
Audiologist : _____ Return ____
Date : 1. Needs Established ____
2. Outcome Assessed ____

Degree of Change

Final Ability (with hearing aid)
Person can hear
10% 25% 50% 75% 95%

SPECIFIC NEEDS

Indicate Order of Significance

	Worse	No Difference	Slightly Better	Better	Much Better	CATEGORY	Hardly Ever	Occasionally	Half the Time	Most of Time	Almost Always
☐											
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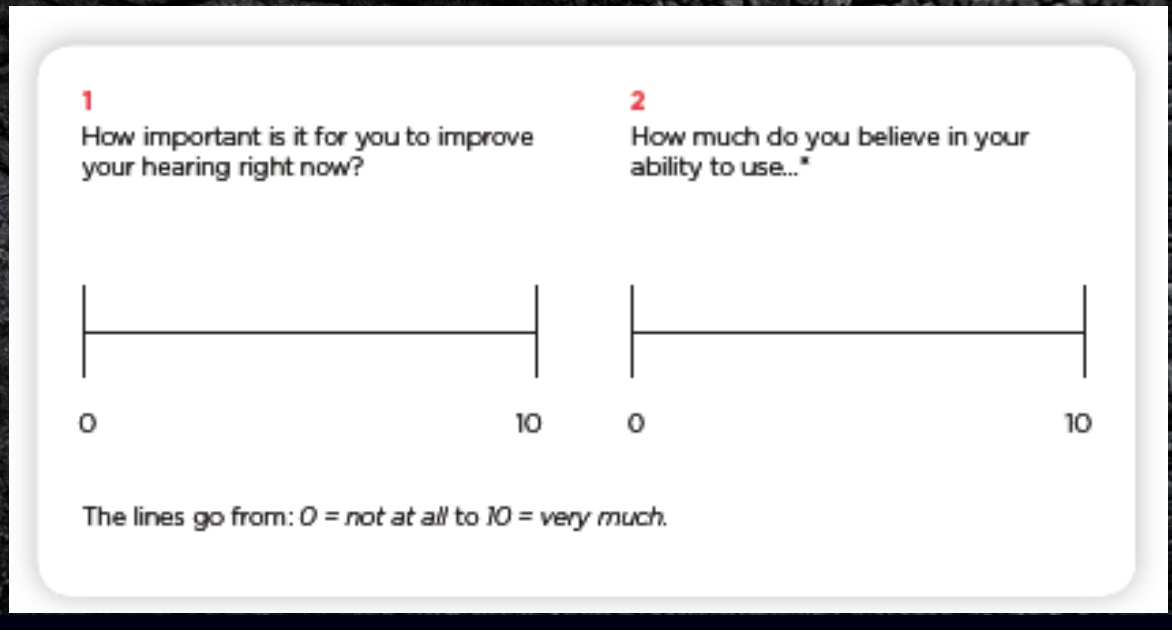
Categories
1. Conversation with 1 or 2 in quiet
2. Conversation with 1 or 2 in noise
3. Conversation with group in quiet
4. Conversation with group in noise
5. Television/Radio @ normal volume
6. Familiar speaker on phone
7. Unfamiliar speaker on phone
8. Hearing phone ring from another room
9. Hear front door bell or knock
10. Hear traffic
11. Increased social contact
12. Feel embarrassed or stupid
13. Feeling left out
14. Feeling upset or angry
15. Church or meeting
16. Other

Ida Institute - “The Line”

2. Develop Discrepancy
3. Deal with Resistance
4. Support Self-Efficacy



Ida Institute - “The Box”

2. Develop Discrepancy
3. Deal with Resistance

1 ADVANTAGES	2 DISADVANTAGES
The advantages of continuing as you do today	The disadvantages of continuing as you do today
No need to hear anymore than I do now!	**I can't really think of any**
Are there any situations you avoid because of your hearing difficulties?	*You never feel exhausted when you are in group contexts?*
Have you considered that your communication partners may be unhappy or dissatisfied because you miss out on things?	*Would your communication partners agree to that?*
I do not have a hearing problem!	**I will feel excluded from social contexts**
You never find that people mumble?	*In which situations do you feel excluded?*
Have you experienced any situations in which it is difficult to hear?	**I might lose my job!**
	Is it only in job situations that you have hearing problems?

1. Express Empathy (& Reflective Listening)

Need to listen to emotion, not just the content.

"that must be difficult…" –JGC

"Would that be good?"
"What would it be like if?"
"What would it take?"

Studies suggest patients perceive audiologists as insensitive or indifferent
(*Clark and English, 2013)*

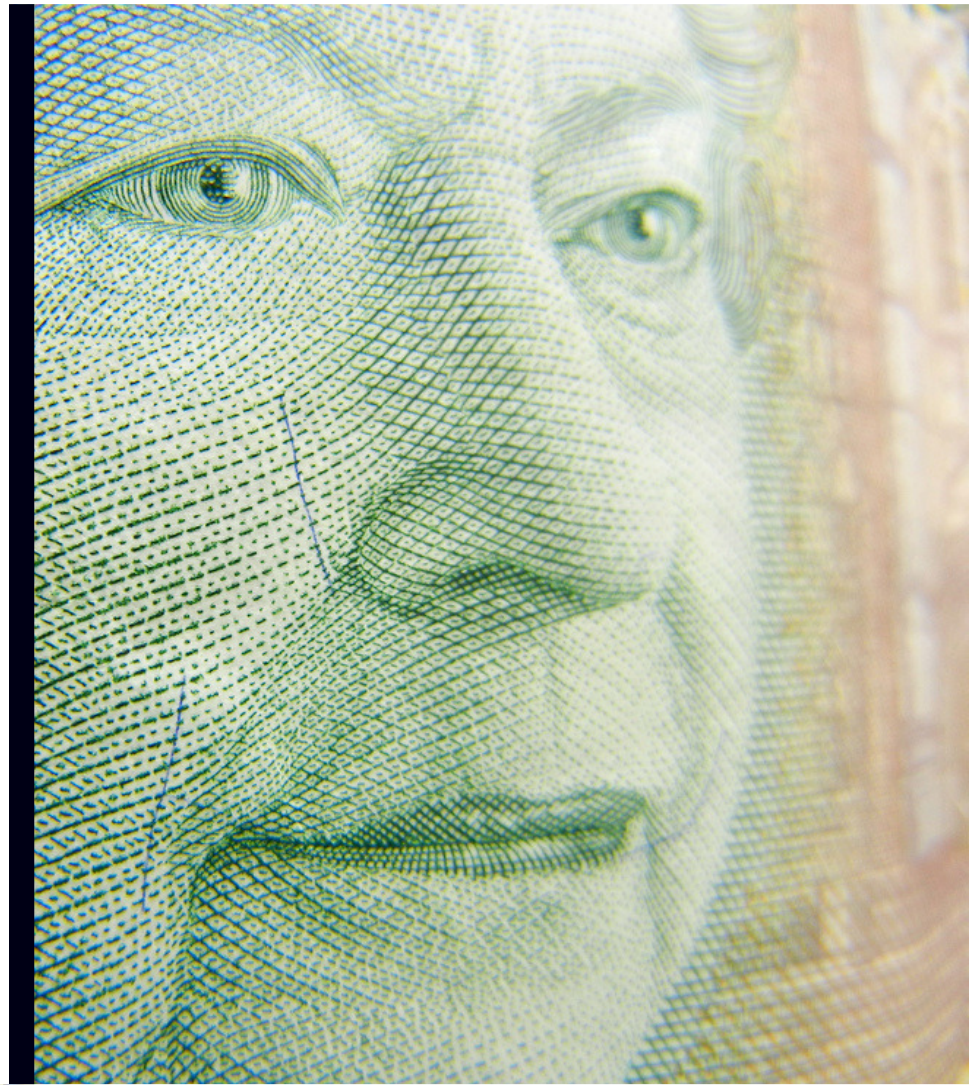
1% die

4% move

11% competition

16% dissatisfied with product

68% because of an attitude of indifference by someone in the practice (Staab, 2000)



- “they don’t have much care…they test your hearing and what levels you’ve lost and then its straight away its on to hearing aids”
- “Technical audiology skills are assumed…interaction skills are valued”

“If it’s a human being that I can relate to then its so much better…if its comes to cost then I’m willing to pay 10 or 20% more.”

“…I feel an element of frustration that I’m not really being listened to”

“the audiologist telling me what I need doesn't cut it anymore”

-Greness et al 2014

- Interviewed 22 first-time patients about shared decision making and reported that *adults valued trust in the audiologist* and *wanted the opportunity to share their story with the clinician*.

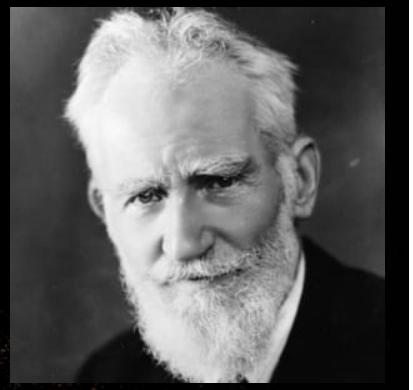
-Laplante-Levesque et al (2010)

"Saves time, less expensive and allows for a higher degree of accuracy with patients"

-Rutherford (2018)

“The problem with communication…is the illusion that it has been accomplished.”

-George Bernard Shaw



Transparency

- Candor, Bluntness, Radical Honesty…
- means getting curious, seeking to understand, asking potentially uncomfortable questions
- Reflective listening (Let me see if I have this right…)

Examples:

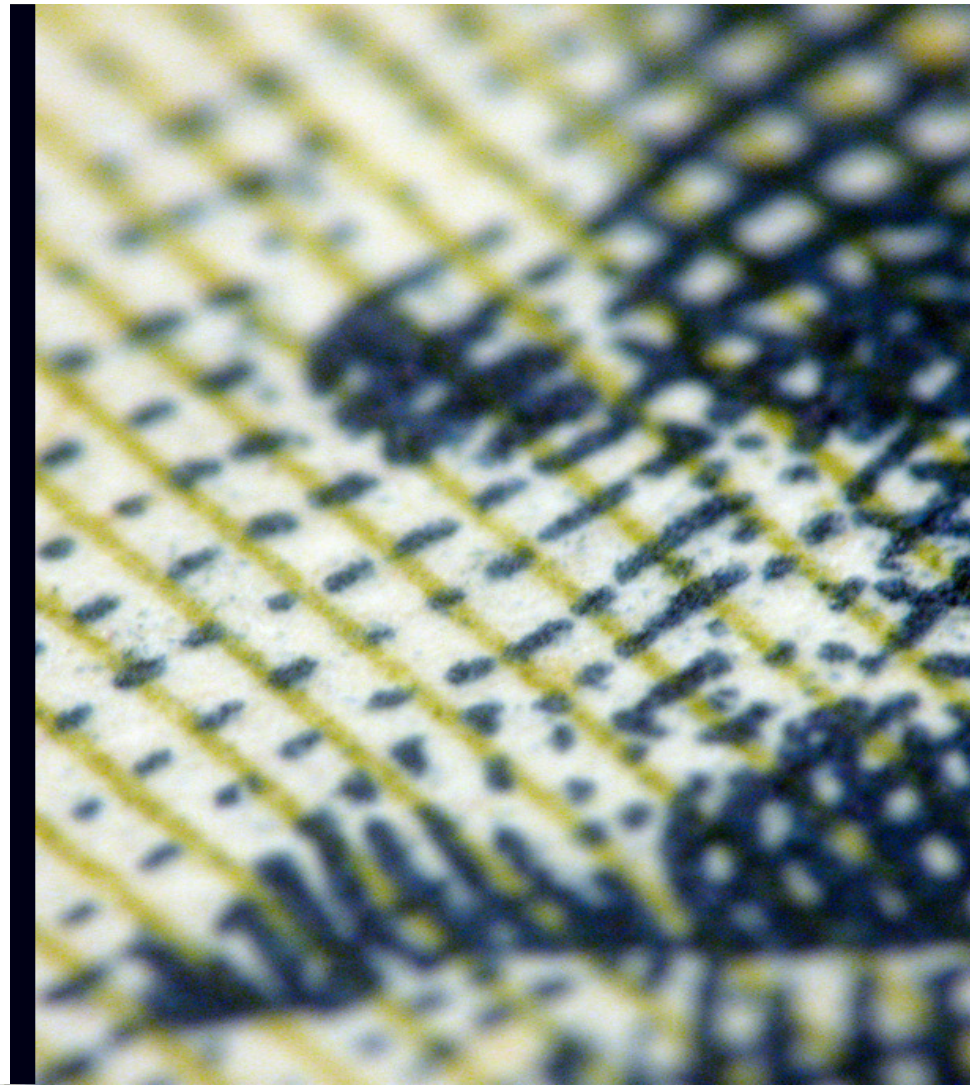
1. *Introducing cost early*
2. *asking for sale/commitment*
3. *Probe barriers*

- Balancing act:

Need to avoid Paternalism/Content Counselling while providing clarity in what we *believe* is the right action, they are coming to use for guidance. Can't expect them to "decide" if its not something they are equipped to make a decision on. As such we also need to be cautious of an overly passive approach that is vague or unclear.

"Guide on the Side"
vs
"Sage on the Stage"

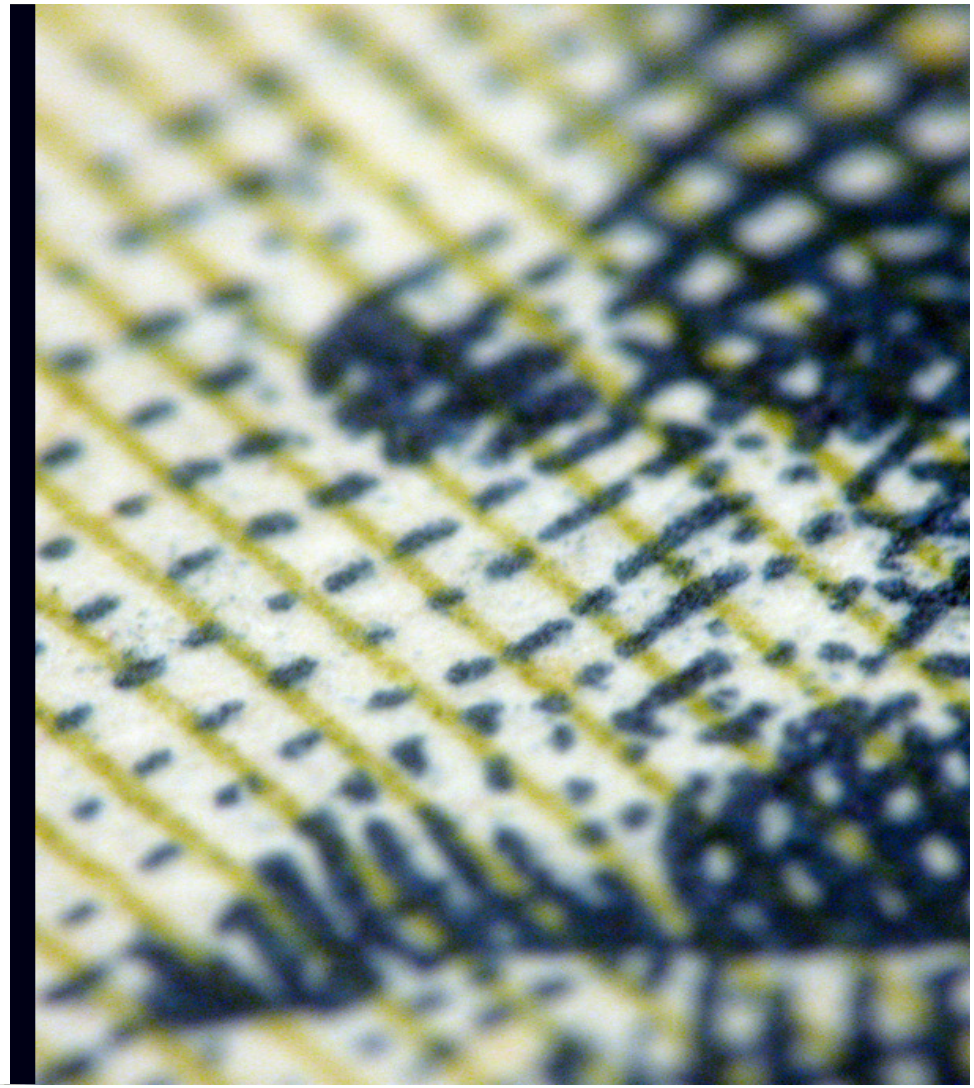
- E.g. #1 Content Trap
- E.g. #2 Dr. Google
- E.g. #3 Dr. GP or ENT



Paradox of Choice:

- Famous “Jam Study”
- 401k Study
- Surgery vs Novel Medication

“Guide on the Side”
vs
“Sage on the Stage”



Clinician perspectives on barriers to hearing aid uptake and how they might influence decision making.

Andreas Seelisch[1]
Jeff Crukley[2,3]
Stella Ng[2]
Emilia Kangasjarvi[2]

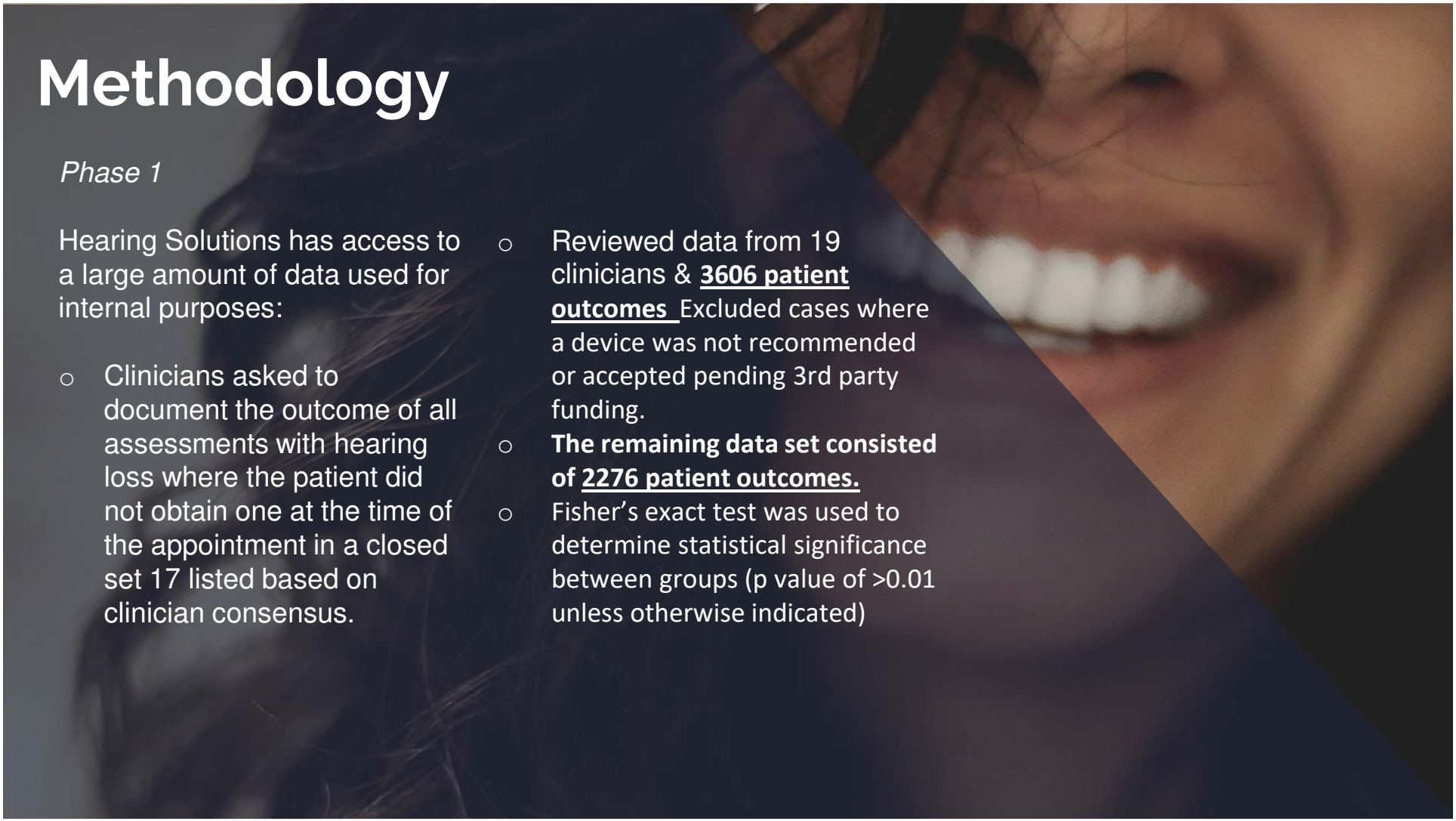
1. Hearing Solutions, Toronto, ON
2. Department of Speech Language Pathology, University of Toronto, Toronto, ON
3. Starkey Hearing Technologies, Eden Prairie, MN

Methodology

Phase 1

Hearing Solutions has access to a large amount of data used for internal purposes:

- Clinicians asked to document the outcome of all assessments with hearing loss where the patient did not obtain one at the time of the appointment in a closed set 17 listed based on clinician consensus.
- Reviewed data from 19 clinicians & **3606 patient outcomes** Excluded cases where a device was not recommended or accepted pending 3rd party funding.
- **The remaining data set consisted of 2276 patient outcomes.**
- Fisher's exact test was used to determine statistical significance between groups (p value of >0.01 unless otherwise indicated)



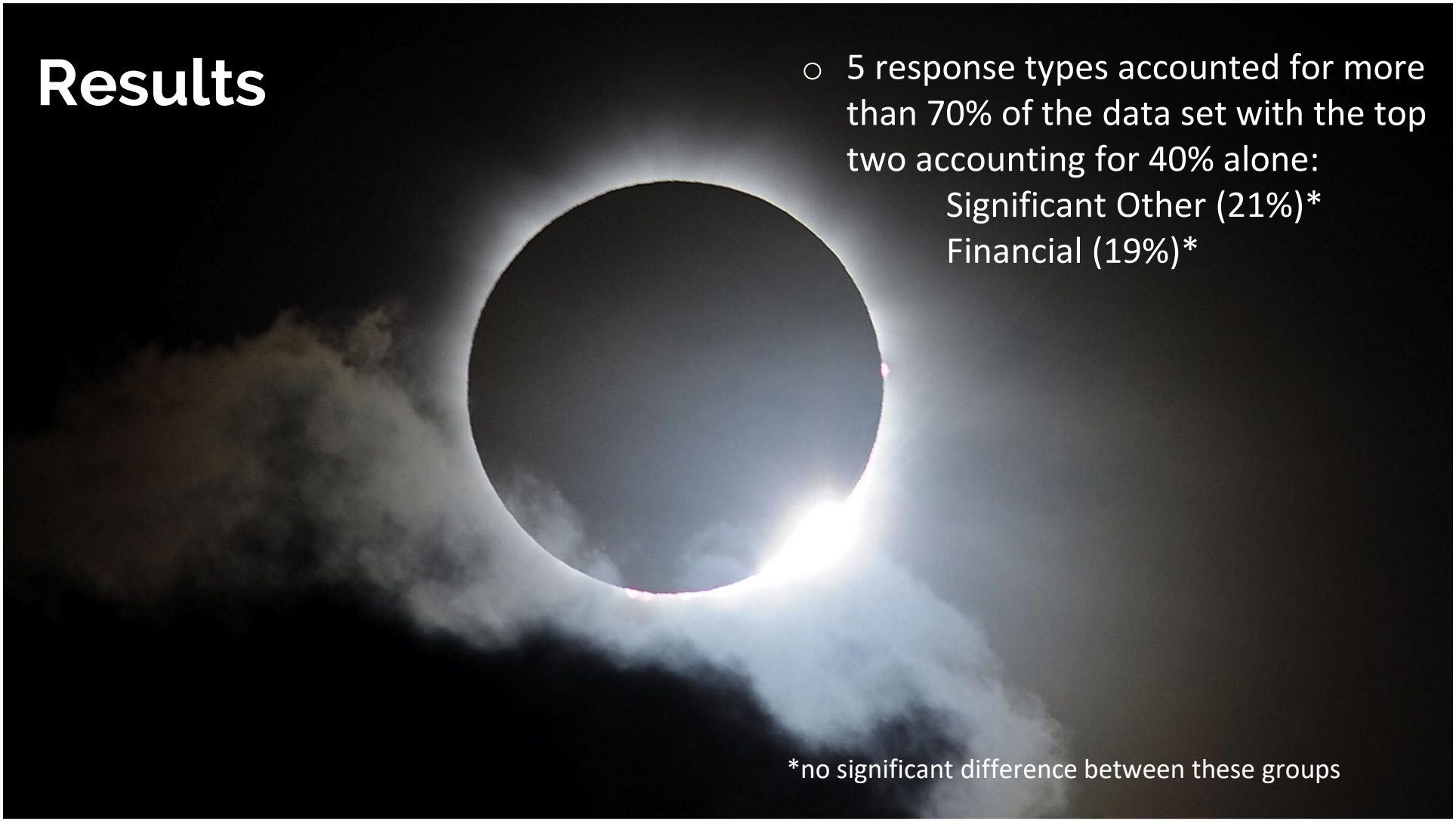
Methods

- *Phase 2*
- 10 of those 19 clinicians were interviewed by telephone
- asked to describe their approach with patients to communicating results, recommendations and overcoming objections.
- Interviews were transcribed and analyzed; meaningful units coded and counted

HearingSolutions
HEARING WITH A Heart

Results

- 5 response types accounted for more than 70% of the data set with the top two accounting for 40% alone:
  - Significant Other (21%)*
  - Financial (19%)*



*no significant difference between these groups

Results

5 response types accounted for 70% of the data set:

- Thinking about it (11%*)
- Denial (10%*)
- Happy with current aids (10%*)

*no significant difference between these groups

Consulting with significant other

Majority of cases, significant others contributed to **acceptance**

Minority of cases a significant other risked being **unsupportive**

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*They **usually come back after they've talked to their family…they just need to hear it from people that they love,*** not people in an office. (Interview#2)

"

If they're not willing to accept it, um ... Sometimes I've found ***the leading cause for that is not having somebody present in the appointment***, so they need another opinion. Usually another loved one's opinion ***because they don't want to be making a big purchase without consulting with somebody they trust.*** (Interview#6)

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Research:

A significant other provides aid and pressure to seek help and offers support when making decisions.

A significant other is often more aware of how the hearing loss is impacting the person needing hearing-aids and this reinforces the idea that family and significant others should be involved in the discussion making process and probably the initial appointment itself.

- Singh and Launer, 2016; Duijvestijn et al, 2003; Meyer, Hickson and Fletcher, 2014

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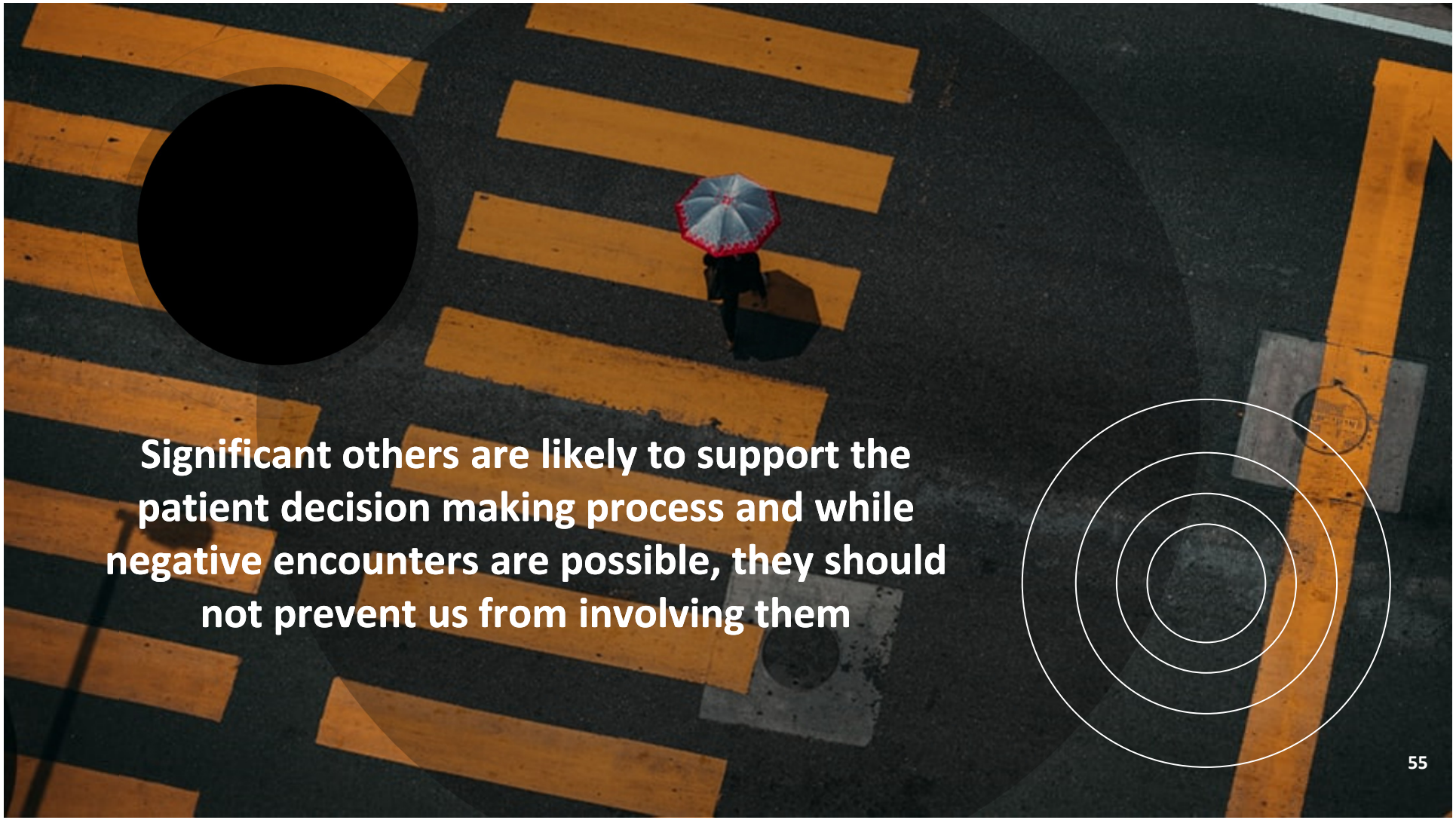
N.b. see how this ties into motivational interviewing


Significant others are likely to support the patient decision making process and while negative encounters are possible, they should not prevent us from involving them

Financial

Some clinicians viewed cost as a definitive **barrier**

Other clinicians had a more nuanced approach viewing cost as a **source of hesitation**

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"Um, well it could just be like pricing. They take a look at the pricing and ***they feel like it's too expensive***." (Interview#3)

"Um, but usually most of it's uh ***usually cost***. Um, yeah." (Interview#5)

"And of course, there's the um issue when it comes to motivation of um, you know, there's the issue of finances because they're not, ***hearing aids aren't cheap***." (Interview#9)

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Delving Deeper

- There's so many um, ***so many reasons for um, not purchasing a hearing aid*** (Interview#4)
- Sometimes cost, but ***that's pretty rare… We can work around cost*** (Interview#6)

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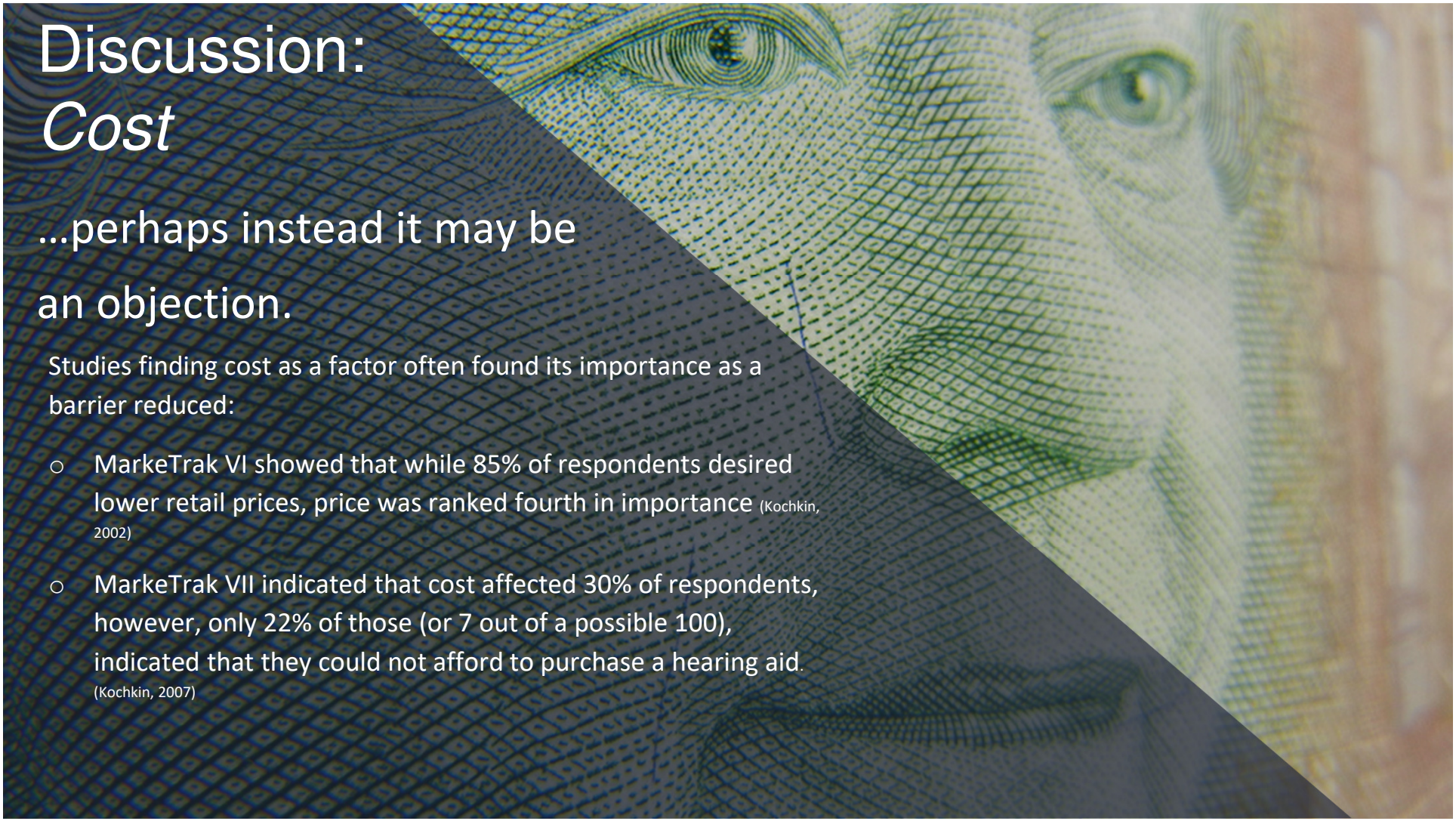
Discussion: *Cost*

Results clearly indicate that there is a **belief** among clinicians that cost is a leading barrier…

Cost is a recurring theme in literature as a suggested barrier to hearing instrument acceptance.

(Grundfast and Liu, 2017; Fischer et al., 2011; Franks & Beckmann, 1985)

Discussion: *Cost*



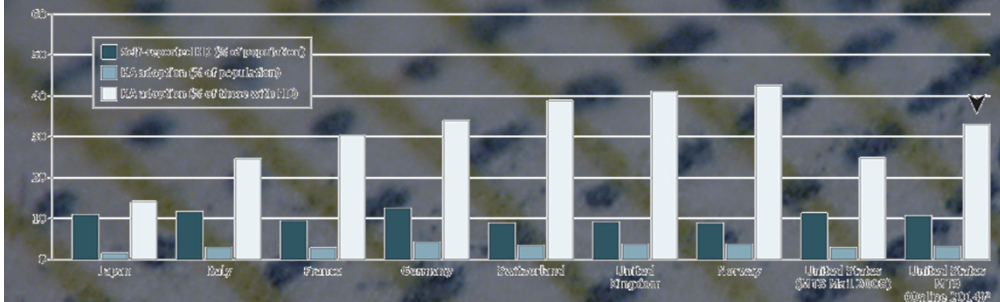
…perhaps instead it may be an objection.

Studies finding cost as a factor often found its importance as a barrier reduced:

- MarkeTrak VI showed that while 85% of respondents desired lower retail prices, price was ranked fourth in importance (Kochkin, 2002)
- MarkeTrak VII indicated that cost affected 30% of respondents, however, only 22% of those (or 7 out of a possible 100), indicated that they could not afford to purchase a hearing aid. (Kochkin, 2007)

Discussion: *Cost*

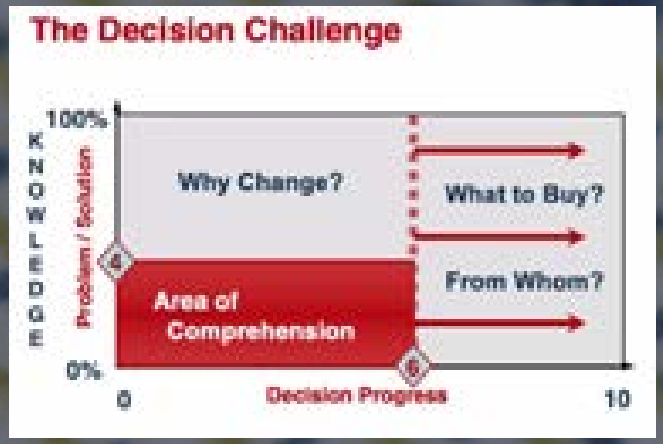
Publicly funded systems see only a modest *increase in hearing instrument penetration rates* from 25-33% to 33-45%. (Amlani, 2010; Abrams & Kihm, 2015; Amlani, 2010; Abrams & Kihm, 2015; Grundfast and Liu, 2017).

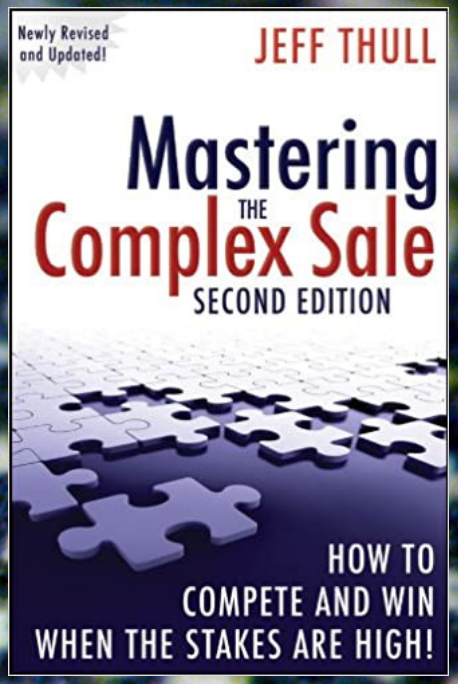


Evidence to suggest that the hearing instrument market is inelastic to price reductions <u>especially at low costs</u>; even if hearing aids were offered at no cost, the acceptance rate in the US would increase from 24.6% to approximately 34% (Amlani, 2010).

In 2007 the US showed significant economic slowdown, despite this, unit sales continued to grow. If price were a major driver economic instability should have resulted in a drop in sales. (Amlani, 2010).

Jeffery Thull: *Mastering the Complex Sale*

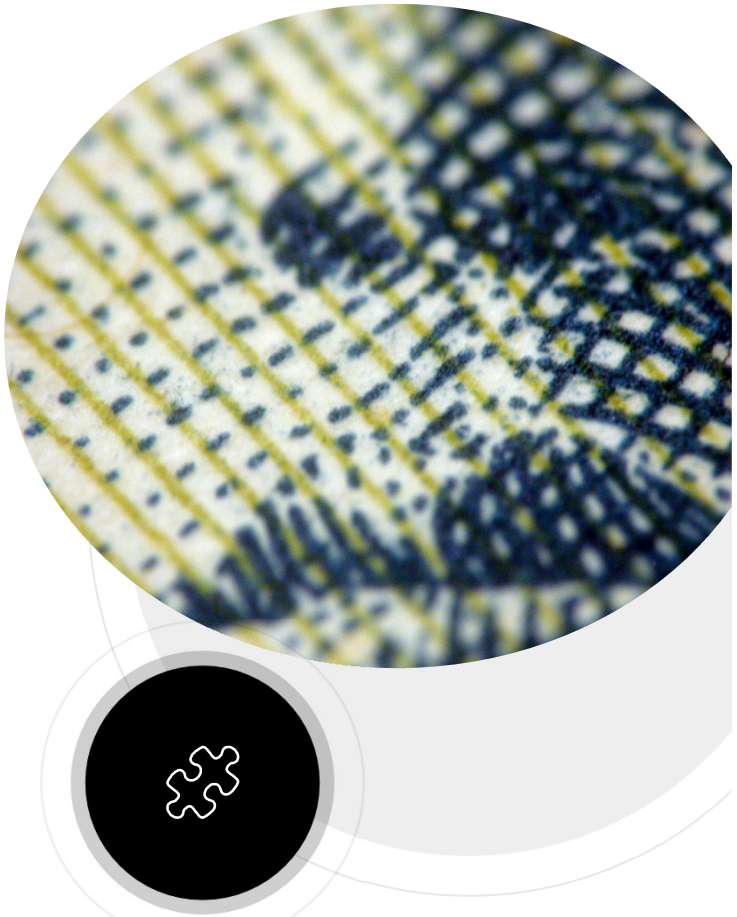




"Majority of no decisions are premature solutions who have not yet decided to change!"

Research

- Only 35% of non owners would accept an invisible free hearing aid (Aaron, 1978).
- “Simply a convenient form of denial” (Kochkin, 2007).



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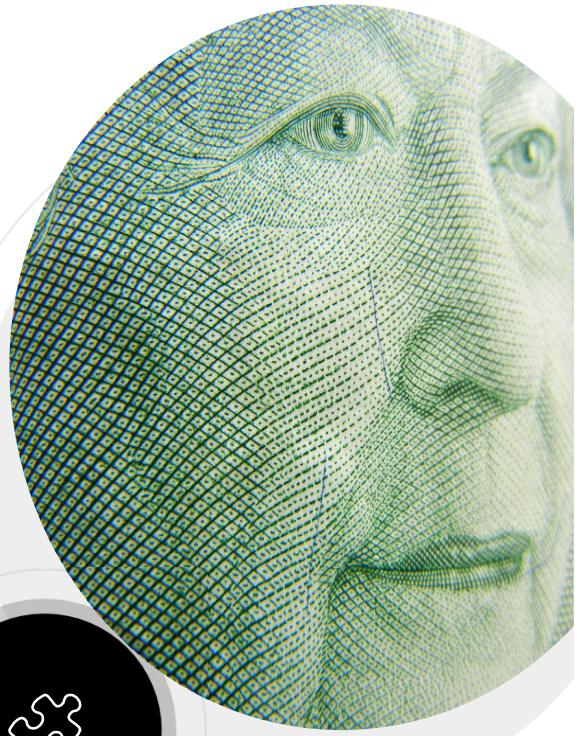
Research

Patients who perceive benefits to outweigh barriers are more likely to accept hearing aids. Meyer and Hickson (2012)

42% of non-owners who were recommended a device reported they were too expensive vs 26% who reported they could not afford them (Powers and Rogin, 2019)



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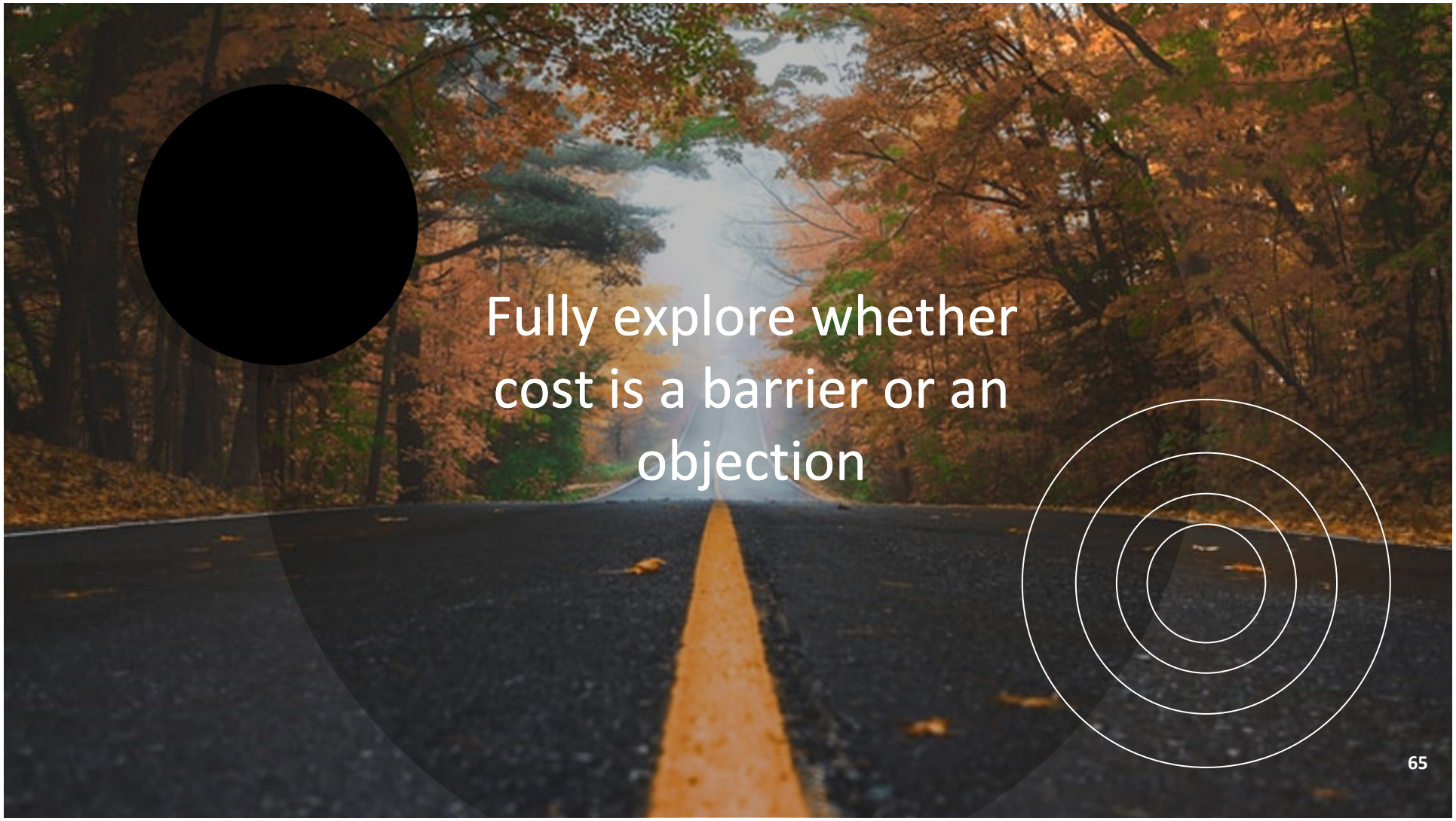

Fully explore whether cost is a barrier or an objection

Discussion: *Denial*

- The 10% response rate of denial clearly implies that there is a difference between clinician perspective and patient perspective that we minimally need to be sensitive to and probably need to investigate further.

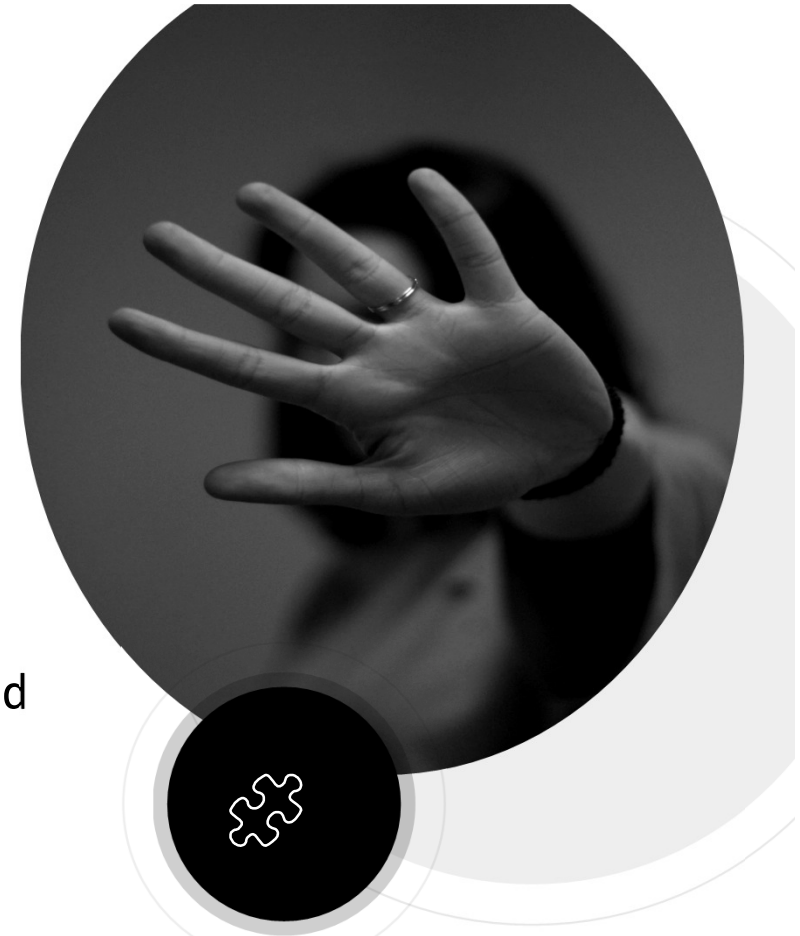
Denial

Conversation Closer

denial is often left unpacked by providers

Delving Deeper

We can better understand patients' needs and goals



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I think the ***most surprising ones*** are, like, the ones who come in and ... are, like maybe they're really ***in denial*** or they're really, like, adamant, like, "I don't need those, I don't need those.

> Sometimes, though, you hit ***a roadblock you can't get past.*** (Interview #1)

So, um if somebody comes in and, and they've made an appointment, and then they, ***their body language***, and everything they've written on their intake form, and the ***interview is very closed off***, and like shut down. And they don't open up, and of course I have ***a gut feeling they're in denial.*** (Interiew#8)

Yeah, if they're just not ready, ***they're just not ready, so ...*** (Interview#5)

Spectrum

> “So um, but sometimes it takes time if they're in denial, like if it's a, a denial patient***, it takes them time to, to come around.”*** (Interview#4)
>
> But if they just have that difficult closed personality where this is not something they want to even engage in, then it's really hard***, or takes a long time to get there.*** (Interview #2)

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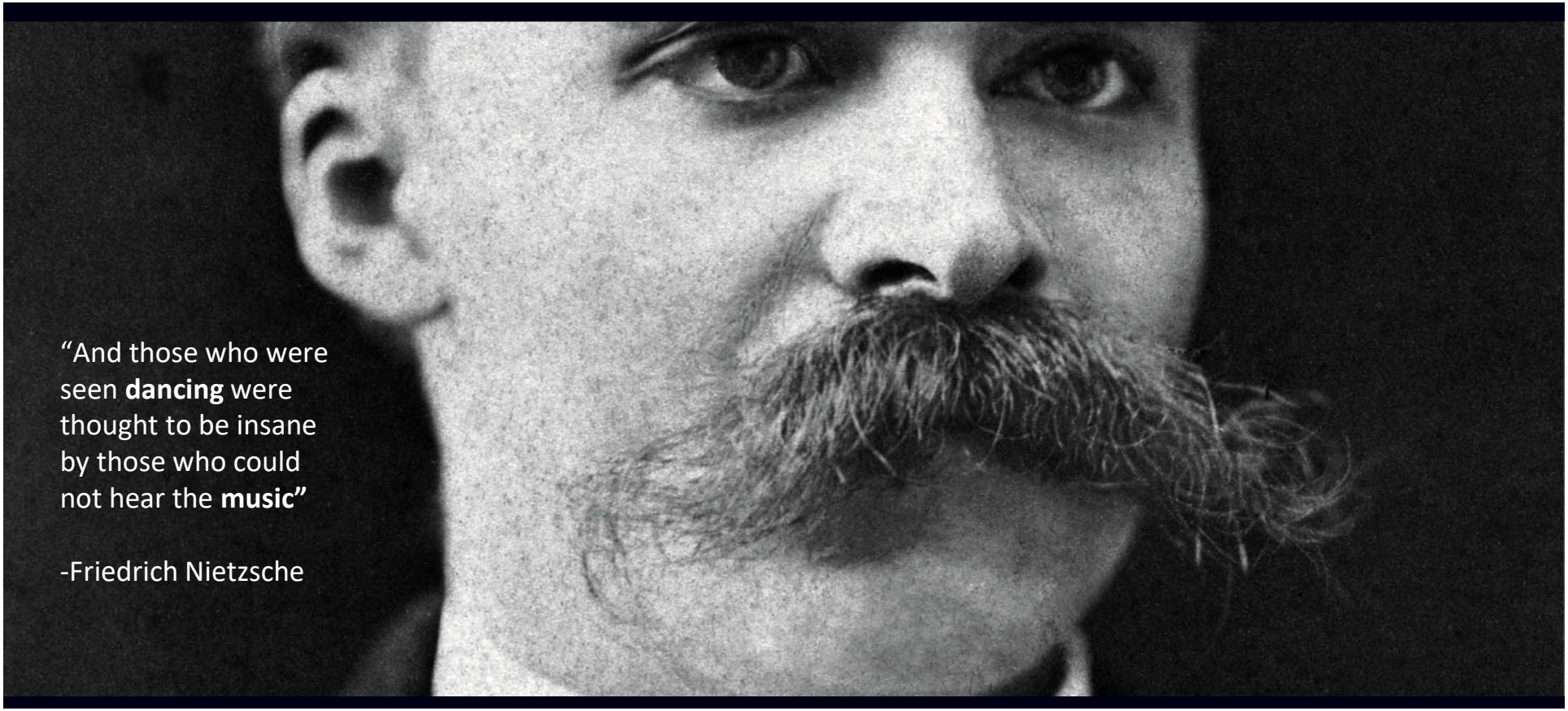
Delving Deeper

> Just kind of ***digging into why you need to think about it. What is it that's holding them back*** from going ahead. And then, usually ... this has happened before with me, then they'll usually ***tell you what the issue is.*** It usually comes out after a couple of follow-up questions; but you have to be able to ask those questions in a manner that doesn't offend them, I guess. (Interview#6)

Delving Deeper

> Their fears or their, their apprehension with hearing aids. So um, just to try and dig ***deeper a little bit to see why***. Like what, what's bothering them. What's kind of like why are they scared of, of the process and everything like that. (Interview#7)


Don’t limit our own
prospective


"And those who were seen **dancing** were thought to be insane by those who could not hear the **music"**

-Friedrich Nietzsche

Thanks!

Any questions?

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Questions?

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Thank you