Interprofessional Practice In The Post Acute Setting: Reducing Hospital Readmissions and Promoting Health Literacy

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Objectives

- Understand the Triple Aim Framework, and its impact on care planning in the post acute setting
- Define Health Literacy and its impact on SLP practice
- Define the WHO ICF models
- Define the role of SLP in Care Management
- Understand CMS 5 Star Rating
- Identify key Quality Measures and how the interprofessional team can impact the metrics
- SLPs role in reducing re-hospitalizations

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Value Based Care

Triple Aim

Lower Cost to the Health Care System

Better Care Experience

Better Population Health

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Better Care Experience

- Review evaluation findings with the patient -communicate strengths and weaknesses
- Create goals with the patient, have a joint vision
- Participate in interprofessional collaboration to create a patient centered
- Communicate clearly and often regarding the purpose of each treatment intervention and its impact on function
- Consider patient preferences including appointment times, privacy, and desire for feedback
- Use each progress report as an opportunity to engage the patient
- Ensure transition planning is comprehensive and all information is understood
- Provide opportunities to practice skills in functional contexts

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Better Population Health

Can our patients navigate the healthcare system?

- Make appointments, arrange transportation
- Locate providers and services, specialists, and preferred hospitals
- Calculate premiums, copays, deductibles
- Complete complex forms
- Share accurate personal information, such as health history
- Understand both lay person and professional content related to medical conditions
- Effectively communicate concerns and questions
- Engage in self-care and chronic-disease management
- Understand mathematical concepts such as probability and risk

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Bridging the Gap

"Too often, there exists a chasm of knowledge between what professionals know and what consumers and patients understand. *Basic health literacy* is fundamental to the success of each interaction between health care professionals and patients—every prescription, every treatment, and every recovery. *Basic health literacy* is fundamental to putting sound public health guidance into practice and helping people follow recommendations."

--Howard K. Koh, M.D., M.P.H., US Assistant Secretary for Health

(Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). National Action Plan to Improve Health Literacy. Washington, DC: Author.)

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What is Health Literacy?

Health literacy is the degree to which individuals have the capacity to <u>obtain, process</u>, and <u>understand</u> basic health information and services needed to make appropriate health decisions

Definition by the National Institute of Health

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Health Literacy Defined

World Health Organization *"The cognitive and social skills which determine the motivation and ability of individuals to gain access to understand and use information in ways which promote and maintain good health"*

American Medical Association *"The ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment."*

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Key Concepts for Health Literacy

Cultural and conceptual knowledge and listening, speaking, arithmetical, writing, and reading skills

(Health literacy: a prescription to end confusion. Edited by: Nielson-Bohlman L, Panzer A, Kinding D 2004.)

Identifies reading and numeracy skills as the defining attributes, but adds comprehension, the capacity to use health information in decision making, and successful functioning in the role of healthcare consumer.

(Speros C: Health literacy: concept analysis. 2005)

Health literacy information is divided into health related print literacy and health related oral literacy

(Baker DW: The meaning and the measure of health literacy. 2006)

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How Does Low Health Literacy Impact Health?

Individuals put their health at risk when they do not understand their health information. The following are common challenges:

- Limited access to information and services
- Poor knowledge of risks associated with diagnosis
- Poor utilization of preventive care resulting in increased emergency room visits
- Poor self report of health conditions resulting in delayed medical care
- Poor knowledge of choices and consequences of each choice
- Less knowledge of and poor adherence to medication management
- Less follow through on important self care practices for chronic conditions
- Poor health outcomes and higher medical costs

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Why Health Literacy Matters

- 12% of Americans have proficient health literacy (Agency for Healthcare Research and Quality, 2013)
- 50% of the American adult population experiences challenges applying health information (Nielsen-Bohlman, Panzer, Hamlin, & Kindig, 2004)
- 71% of older adults over 60 had difficulty using printed materials (National Assessment of Adult Literacy)
- 68% of older adults had difficulty interpreting numbers and doing calculations (NAAL)

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National Assessment of Adult Literacy

Types of Literacy

- Prose literacy—ability to search, comprehend, use and interpret text
  - Example: pharmacy insert, magazine articles, instructional materials, brochures
- Document literacy—ability to search, comprehend, and use non-continuous text
  - Example: Interpret a map, schedule or read a food or drug labels
- Quantitative literacy—ability to identify and perform computations either alone or sequentially, using numbers embedded in printed materials
  - Example: reading pill labels, calculating a tip, balancing a checkbook

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West Virginia : Who Are We Treating?

The U.S. Department of Education estimated that 17 percent of West Virginia adults have significant difficulty with literacy tasks relating to everyday life and work.

Literacy is unevenly distributed across the state, generally improving from south to north and reflecting the education levels and relative affluence of West Virginia counties

The National Center for Education Statistics' report says 13 percent of adults in West Virginia did not have the basic prose literacy skills (the ability to read material arranged in sentences and paragraphs, like newspaper articles, brochures or even the instructions for over-the-counter medicines)

SLP Role in Health Literacy

Service delivery domains

- Collaboration
- Counseling
- Prevention and Wellness
- Screening
- Assessment
- Treatment
- Modalities, Technology, and Instrumentation
- Population and Systems

Collaboration

- Partner with other professionals on the interprofessional team
- Share responsibility with the team for functional outcomes
- Partner with patient and family to establish common goals
- Focus on sustainability of progress

Counseling

- Provide education and support to patient and family re: diagnoses and impact on communication, cognitive communication and or swallowing disorders
- Review risk factors and empower informed decision making
- Support patient and family in advocacy efforts
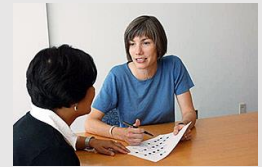
Prevention and Wellness

- Identify new disorders/ disease
- Mitigate impact of disorder or disease on participation in meaningful tasks
- Enhance function and quality of life
- Identify high risk behaviors and educate to increase awareness
- Provide alternative choices

Screening

- Select evidence based and appropriate screening tools
- Use data to make informed choices regarding health of patient /population
- Review results and make referrals as needed
- Inform patient of findings and next steps

Assessment

- Provide comprehensive assessment utilizing evidence based tools that are standardized and criterion referenced
- Evaluate body function, structure, activity and participation, within context of environmental and personal factors (ICF models)
- Use chart review, pt interview, skilled observation and dynamic assessment


Treatment

- Consider appropriate dosing including frequency and duration of care
- Create goals that are meaningful, and relevant for patient
- Address functional impairments
- Use researched, evidenced based treatment approaches
- Design, implement and document skilled services

Modalities Technology and Instrumentation

- Consider need for Instrumental assessment
- Use all technology that will enhance outcomes (AAC, biofeedback, APPS, computer based programming)
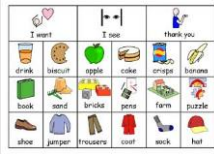
Population and Systems

- Use plain language to facilitate clear communication
- Provide patient family and or Caregiver education and training
- Seek return demonstration of skills
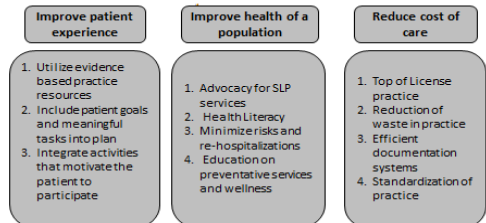- Collaborate with other professionals to maximize outcomes

Assessment and Treatment in the Post Acute Setting

- **Language skills**: Receptive Language: auditory comprehension, reading comprehension
- **Language skills:** Expressive Language: verbal expression, written expression
- **AAC:** low tech/ high tech
- **Aural Rehab:** Speech, language, communication, and listening skills impacted by hearing loss

- **Cognitive Communication**: Attention, Memory, Problem solving, Executive Function skills
- **Swallowing:** Oral phase, Pharyngeal phase, Esophageal phase
- **Speech Production**
- **Voice:** Phonation quality, pitch, loudness, alaryngeal voice
- **Resonance:** hypernasality, hyponasality

Triple Aim Framework

Improve patient experience
1. Utilize evidence based practice resources
2. Include patient goals and meaningful tasks into plan
3. Integrate activities that motivate the patient to participate

Improve health of a population
1. Advocacy for SLP services
2. Health Literacy
3. Minimize risks and re-hospitalizations
4. Education on preventative services and wellness

Reduce cost of care
1. Top of License practice
2. Reduction of waste in practice
3. Efficient documentation systems
4. Standardization of practice

Clinical Reasoning in a Value Based Setting

- Integrate standardized tests and measures
- Utilize evidence based resources to guide decision making throughout the care process
- Understand the patients' functional needs
- Activate and engage patients in taking responsibility for their own results
- Define, measure and achieve outcomes
- Ensure sustainability of skills, generalization and carryover

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ICF of Health and Disability Published by the World Health Organization WHO (2001)

The International Classification of Functioning, Disability and Health Framework

KEY POINTS

- Stress is on health and functioning, rather than on disability
- F*unctioning* refers to all body functions, activities and participation
- *Disability* is a term for impairments, activity limitations and participation restrictions
- Lists environmental factors that interact with all these components
- ASHA incorporated ICF framework as relates to conditions addressed by SLPs such as voice disorders, dementia and aphasia

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WHO ICF Models
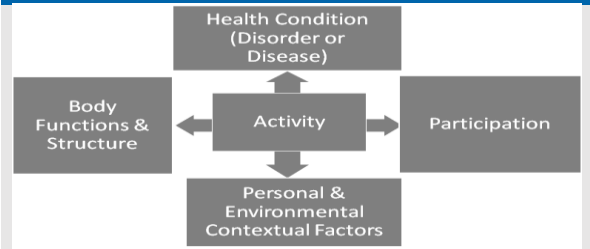
ICF Concepts

Contextual Factors include:

- **Environmental Factors**—factors that are not within the person's control, such as family, work, government agencies, laws, and cultural beliefs.
- **Personal Factors—**include race, gender, age, educational level, coping styles, etc. Personal factors are not specifically coded in the ICF because of the wide variability among cultures. They are included in the framework, however, because although they are independent of the health condition they may have an influence on how a person functions.

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ICF Concepts

Functioning and Disability Includes:

- **Body Functions and Structures—**describes actual anatomy and physiology/psychology of the human body.

- **Activity and Participation—**describes the person's functional status, including communication, mobility, interpersonal interactions, self-care, learning, applying knowledge, etc

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What is Care Management?

"Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services."

(Adapted from R. Mechanic, "Will Care Management Improve the Value of U.S. Health Care?")

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What is Care Management?

"Care management is a promising team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively. It also encompasses those care coordination activities needed to help manage chronic illness"

(Adapted from R. Mechanic, "Will Care Management Improve the Value of U.S. Health Care?")

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Role of Therapist in Care Management

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Care Management: Advocacy

- How can we be better advocates for our patients?
- Does our screening process allow us to "screen in" vs "screen out" for services?
- What could the patient do before that he cannot do now?
- Can we help the patient by reducing risk and improving function?
- Did we analyze the root cause of all functional impairments?

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Care Management: Comprehensive Assessment

- What is the discharge disposition/next level of care for this patient?
- What are the communication demands placed on this patient? Who are their communication partners? Communication environments?
- What meaningful, functional tasks must they demonstrate in order to transition to the next level of care safely?
- Have standardized tests and measures been utilized to identify and address root cause of functional limitations?
- What does the patient hope to achieve as a result of treatment?

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Comprehensive Assessment

- Western Aphasia Battery
- Ross Information Processing Assessment Geriatric (RIPA- G)
- Rivermead Behavioral Memory Test
- Arizona Battery of Communication Disorders of Dementia (ABCD)
- Frenchay Dysarthria Assessment
- CAPE V

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Comprehensive Assessment: Discharge Planning Day 1

- Identify and address all barriers for safe transition
  - Is the patient at risk for: re-hospitalization, falls, medication management mistakes or errors
  - Is the discharge environment safe/appropriate?
  - What strategies and or environmental modifications enhance success?
- Functional level required to safely transition
  - What was the residents PLOF?
  - What tasks will they need to complete independently?
  - What training is required to ensure a safe and sustainable discharge?

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Care Management: Communication with Team

SLP can support and impact PT/OT goals
- Determine length and complexity of input
- Appropriate cueing hierarchies
- Enhance recall of target strategies or sequences
- Co treatment with other disciplines

Care Extenders and Family
- Who will support this patient's meal prep/ diet orders
- Opportunities to practice HEP/ communication strategies
- Education and awareness of re-hospitalization risk

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Care Management: Treatment Progression

- Are the interventions rooted in evidence- based practice and require the skills of a therapist?
- Do we utilize all delivery models to ensure the patient receives effective and efficient care?
- Do we provide individualized, patient-specific analysis of the POC and make modifications and adjustments as necessary?
- Is functional improvement and risk reduction evident by meaningful progress in outcome measures and timely goal progression?

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Treatment Progression: Mode of Therapy

Billing Mechanism as per 3rd Party Payer Arrangement/Contract	Individual Therapy	Group Therapy	Concurrent Therapy	Co-Treatment	MDS Completion – Section O0400 (Only Required for Patient Care in Skilled Nursing Facilities)
RUGs IV (Medicare A and Managed Care A RUGs)	100% of treatment minutes allocated to RUG level	As per Med A group definition (see below). 25% of treatment minutes allocated to RUG level by the MDS software.	50% of treatment minutes allocated to RUG level by the MDS software.	100% of treatment minutes allocated to RUG level	Input total minutes for each mode of therapy. MDS software calculates allocation of minutes for RUG level total as per RAI Manual and RUGs IV classification system
Managed Care A - Level of Care (e.g. SNF or sub-acute level of care OR Level I, II, etc.)	100% of treatment minutes count toward level of care	100% of treatment minutes count toward level of care unless limited by contract	100% of treatment minutes count toward level of care unless limited by contract	100% of treatment minutes counted toward level of care unless limited by contract	Input total minutes for applicable mode(s). No allocation of minutes required.
Medicare B or other payers with reimbursement via CPT codes (including applicable Managed Care B contracts) *Recommend clinicians review CPT code	100% of treatment minutes count toward treatment time	As per Med B group definition (see below). 100% of treatment minutes count toward treatment time	Only applicable for the capture of skilled services of 'unattended' or 'supervised' CPT codes	Time must be divided between the two disciplines OR one clinician must bill for the entire service. (Refer to co-treatment note below)	Input total minutes for applicable mode(s) of therapy. No allocation of minutes required.
Managed Care B per visit rates or capitated contract	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	Input total minutes for each mode of therapy. No allocation of minutes required.
Other Payers with reimbursement via session/visit or a flat rate	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	100% of treatment minutes count toward treatment time	Input 100% of minutes for each mode of therapy. No allocation of minutes required.
Medicaid	For guidance, recommend rehab review of State Regulations. If none, then follow the guidelines as per the applicable billing mechanism in column one of this table.				

(1) RAI Manual, Chapter 3, page O-17; (2) Medicare Benefit Policy Manual, 100-2, Chapter 15, sections 220 and 230, page 194 and (3) RAI Manual, Chapter 3, page O-22

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Treatment Progression: Modes of Therapy

With the effective use of concurrent and group therapy modes of care delivery where indicated and allowed, clinicians are able to provide clinical care to more patients in need

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Mode of Therapy: Targeting Skill Progression Speech Intelligibility

- Use **individual therapy** sessions to focus on education of strategies and drilled practice in structured setting with SLP
  - Target Skills:
    - Repeating phrases and short answers to personal questions with use of pacing board to achieve slow rate of 1 word per second.
    - Emphasis on diaphragmatic breathing and inhalation at beginning of each utterance.
    - Education on strategies to self monitor and adjust as needed

- Use of **group therapy** to introduce new communication partners who are unfamiliar listeners
  - Target Skills:
    - Provides patient with real time feedback, new environmental demands, and opportunities to self-monitor and self- correct
    - Return to SLP individual sessions to address weaknesses and provide additional practice

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Modes of Therapy: Targeting Skill Progression

- Use of **concurrent therapy**
  - Pair this patient with another patient who is functioning at a supervision level
  - Target Skills:
    - Independent use of strategies and ability to repair communication when needed.
    - Recognize opportunities for environmental modifications
- Tasks: Patient expected to independently use intelligibility strategies to request personal banking information in noisy environment via phone
  - Patient expected to adjust as needed to enhance intelligibility at conversational level in real time

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Care Management: Outcomes

- Use of objective measures, collecting data, trending data
- Use of discipline specific outcome measures to show changes in function (NOMS)
- Use of functional outcomes with improved performance on targeted tasks that are meaningful to the patient
- Evidence of patient/ family/ caregiver education and return demonstration

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Outcomes: National Outcomes Measurement System

- ASHA tool to demonstrate value and effectiveness of Speech Language Pathology services provided to adults and children
  - Identify trends
  - Improve quality of services
  - Expected outcomes
- It uses a disorder specific, 7- point rating scale called Functional Communication Measures (FCMs) to rate various communication and swallowing abilities at both evaluation and at discharge from SLP services
- Significant change is exhibited with 1-2 point improvement

https://www.asha.org/noms/national-outcomes-measurement-system/

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Outcomes: Eating Assessment Tool

- The Eating Assessment Tool (EAT-10) is a validated self-administered survey that provides a subjective assessment of dysphagia
- Used at evaluation to document the patient's perception of their dysphagia severity, and again at discharge to monitor patient response to treatment and perception of improvement
- The mean EAT -10 score of the patients with dysphagia improved by an average of 5-7 points after treatment

Belafsky PC, Mouadeb DA, Rees CJ, Pryor JC, Postma GN, Allen J, Leonard RJ. Validity and Reliability of the Eating Assesment Tool (EAT-10). Annals of Otology Rhinology & Laryngology 2008;117(12):919-924.

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EAT- 10

To what extent are the following scenarios problematic for you?

Circle the appropriate response	0 = No problem		4 = Severe problem		
1. My swallowing problem has caused me to lose weight.	0	1	2	3	4
2. My swallowing problem interferes with my ability to go out for meals.	0	1	2	3	4
3. Swallowing liquids takes extra effort.	0	1	2	3	4
4. Swallowing solids takes extra effort.	0	1	2	3	4
5. Swallowing pills takes extra effort.	0	1	2	3	4

Belafsky PC, Mouadeb DA, Rees CJ, Pryor JC, Postma GN, Allen J, and Leonard RJ. Validity and reliability of the Eating Assessment Tool (EAT-10). Ann Otol Rhinol Laryngol 117: 919-924, 2008.

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Outcomes: Swallowing Quality of Life Questionnaire

- The SWAL-QOL tool is a 44 item, standardized, dysphagia specific questionnaire
  - Consists of a series of questions, and provides a 5 point scale ratings system to allow for rated responses which relate to quality of life
  - Used in conjunction with other assessments and interventions, to assess treatment effectiveness, patient satisfaction, and improvements in quality of life for Individuals with dysphagia

McHorney CA, Bricker DE, Kramer AE, Rosenbek JC, Robbins J, Chignell KA, Logemann JA, Clarke C. (2000).The SWAL-QOL outcomes tool for oropharyngeal dysphagia in adults: I. Conceptual foundation and item development. Dysphagia 15 (3): 115- 21.

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SWAL-QOL

2. Below are aspects of day-to-day eating that people with *swallowing problems* sometimes talk about. In the last month, **how true** have the following statements been for you?

(circle one number on each line)

	Very much true	Quite a bit true	Somewhat true	A little true	Not at all true
Most days, I don't care if I eat or not.	1	2	3	4	5
It takes me longer to eat than other people.	1	2	3	4	5
I'm rarely hungry anymore.	1	2	3	4	5
It takes me forever to eat a meal.	1	2	3	4	5
I don't enjoy eating anymore.	1	2	3	4	5

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Outcomes: Patient Specific Functional Scale

- PSFS
  - Patients report 3 functional activities that are important in their daily lives.
  - Patients rate their ability to complete these functional activities on an 11-point scale at a level experienced prior to injury or change in functional status.
  - Patients select a value that best describes their current level of ability on each activity assessed

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PSFS

Functional Activity 1

What activity is important to you in your daily life that you are having difficulty with now?

Please circle **one** number indicating your ability to complete this activity now:

0	1	2	3	4	5	6	7	8	9	10

Unable to perform activity like I could before my injury or problem.

Able to perform activity at the same level as before my injury or problem.

Adapted from: Stratford, P. (1995). "Assessing disability and change on individual patients: a report of a patient specific measure." Physiotherapy Canada 47(4): 258-263. Patient Specific Functional Scale: © 1995, P Stratford, used with permission.

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The SLP's role in Interprofessional Practice: Working in a Post Acute Setting

- Assessment and treatment of the short term to home patient
- Assessment and treatment of the long term care patient
- Establishing Restorative Plans and or Functional Maintenance Plans
- Clinical Programming initiatives
- Obtaining AAC devices
- Making referrals as needed (ENT, Audiologist)
- Care planning and team approaches to care
- Serving as a resource for end of life decision making
- Education and training of pt/ staff/ and or family members

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CMS Five Star Program Overview

Background

- CMS created the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily and to help identify areas about which they may want to ask questions.
- The Centers for Medicare & Medicaid Services (CMS) calculates a star rating (Between 1-5) for 3 sources, along with an overall rating.

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3 Components of 5 Star Ratings

- Nursing Home Compare features a star rating system that gives each facility a rating between 1 and 5 stars. The nursing home star ratings come from:
  - Health inspections
  - Staffing
  - Quality of resident care measures

Health Inspection Rating

Based on deficiencies identified during the three most recent annual inspection surveys, and findings from the most recent 36 months of complaint investigations

- All deficiency findings are weighted by scope and severity
- Most recent survey findings are weighted more than the prior year
- Measure takes into account number of revisists required to ensure deficiencies have been corrected

Staffing Ratings

Based on two measures:
- RN hours per resident day, and
- Total staffing hours per resident Day
- Staffing rating is changing to provide more emphasis on RN staffing
- Staffing ratings set to one star that report four or more days in the quarter with no RN onsite
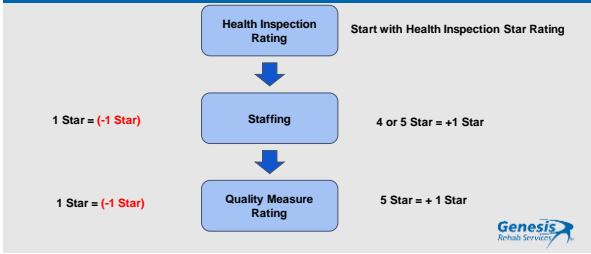

Quality of Resident Care

Quality Measures (QMs) ratings are based on MDS and claims-based quality measures

Based on performance on **16** of the 24 QMs that are posted on NH Compare site
- ➔ Based on MDS 3.0 assessments
- ➔ Also based on hospital and ED claims
- ➔ Includes **nine long-stay** and **seven short-stay** measures

Calculating the Overall Rating

| Health Inspection Rating | Start with Health Inspection Star Rating |

1 Star = (-1 Star) | Staffing | 4 or 5 Star = +1 Star

1 Star = (-1 Star) | Quality Measure Rating | 5 Star = + 1 Star

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Long Stay Measures

- Percentage of residents whose need for help with activities of daily living has increased
- Percentage of residents whose ability to move independently worsened
- Percentage of high risk residents with pressure ulcers (sores)
- Percentage of residents who have/had a catheter inserted and left in their bladder
- Percentage of residents who were physically restrained*
- Percentage of residents with a urinary tract infection
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents experiencing one or more falls with major injury
- Percentage of residents who received an antipsychotic medication

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Short Stay Measures

- Percentage of residents whose physical function improves from admission to discharge
- Percentage of residents with pressure ulcers (sores) that are new or worsened
- Percentage of residents who self-report moderate to severe pain
- Percentage of residents who newly received an antipsychotic medication
- Percentage of residents who were re-hospitalized after a nursing home admission *
- Percentage of residents who have had an outpatient emergency department visit *
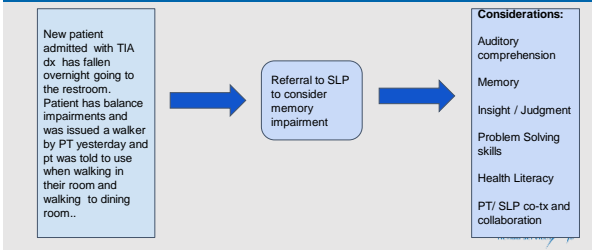- Percentage of residents who were successfully discharged to the community *

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802 Report

Making a Difference - Falls

Quality Domain	PT	OT	ST
Falls	• Fall Risk Identification • Gait/Assistive Device Retraining • Mobility Retraining • Balance Retraining • Compensatory Strategy Training • Progressive ROM/Strength Training • Dual Task Training • Pain Management • Posture • Flexibility • Neuromuscular & Vestibular Rehab	• Environmental Modifications • Continence Management • Pain Management • Low Vision • Wheelchair Positioning • ADL Training • Cognitive Strategies for ADL's • Home Safety Strategies	• Cognitive Retraining • Attention • Spaced Retrieval for Memory • Communication of Needs • Topographical Orientation • Task Remediation • Aural Rehab Interventions • Safety Awareness

SLP Case Study

New patient admitted with TIA dx has fallen overnight going to the restroom. Patient has balance impairments and was issued a walker by PT yesterday and pt was told to use when walking in their room and walking to dining room..

→ Referral to SLP to consider memory impairment →

Considerations:

Auditory comprehension

Memory

Insight / Judgment

Problem Solving skills

Health Literacy

PT/ SLP co-tx and collaboration

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Making a Difference - Pain

	PT	OT	ST
Pain	• Root Cause Assessment • Progressive ROM/Strength Training • Physical Agent Modalities • Manual Therapy • Cognitive Behavioral Therapy • Collaboration of Med Schedule • Neurorehabilitation • Contracture Management	• Contracture Management • Strengthening/ROM • Adaptive Equipment Training • Seating and Positioning • Training in Body Mechanics/Ergonomics • Cognitive Behavioral Therapy • Collaboration of Med Schedule • Health/Medication Management • Manual therapy • Physical Agent Modalities • Contracture Management	• Communication Training • Swallow Therapy • Collaboration of Med Schedule • Health Literacy • Executive Function • Problem Solving

SLP Case Study

A long term care resident with a diagnosis of Dementia, GDS 6 recently fell without injury. She is now demonstrating "behaviors" after lunch each day including standing up from chair and trying to walk away from it, yelling out obscenities, rocking at times and at risk to tip her chair

→ Referral to OT fpr positioning, OT asks SLP for input →

Considerations:
Medication schedule and pain mgt
Unmet need underlying behavior
Non verbal communication attempts
SLP / IDT collaboration

Making a Difference - ADL's and Mobility

Quality Domain	PT	OT	ST
ADL & Mobility Changes	• Progressive ROM/Strength Training • Mobility Training • Balance Retraining • Pain Management • Assistive Device Prescription Positioning • Activity Tolerance Training • Contracture Management • Coordination/motor control	• Individualized MBI Reports • ADL/IADL Retraining Compensatory ADL Training • Adaptive Device Assessment/Training • Task Analysis • Self-Feeding • Continence Management • Strength/ROM/Positioning • Balance During Functional Task • Energy conservation/Work Simplification • Contracture Management • Coordination/motor control	• Cognitive Retraining • Spaced Retrieval Techniques for Task Specific Memory • Safety Awareness • Communication Skills Training • Swallow/Dysphagia Therapy • Breath Support Training

SLP Case Study

Patient was in a MVA dx with concussion with LOC. Pt has been on PT OT ST and is now walking 500 ft so insurance is recommending DC. Patient has significant attention and memory impairments, difficulty reading print and lives alone with no support

→ SLP providing education to patient re: diagnosis and anticipated barriers →

Considerations:
STM deficits impact medication mgt/ follow up appts
Attention deficits may impact IADLS and safety
Health Literacy
SLP IDT collaboration

Making a Difference - Skin Integrity

Quality Domain	PT	OT	ST
Skin Integrity	• Direct Wound Care* (Selective Sharps Debridement, Physical Agent Modalities) • Positioning (Bed/Wheelchair) • Mobility Training • Edema Management • Contracture management	• Positioning (Bed/Wheelchair) • Edema Management • Mobility Training • Health Management • Contracture Management • Continence mgt	• Swallow/Dysphagia Therapy • Communication Skills Training • Memory, Remediation, Compensation

SLP Case Study

Long term care resident with a diagnosis of late stage Dementia and several CVAS has developed a red area on her buttocks. She often gets up and leaves the table at meals and is not easily redirected, therefore her intake of both solids and liquids is poor.

→ Referral to OT for new wheelchair cushion, OT refers to SLP after dining room observation →

SLP targets trials of finger foods and small bowls, SLP collaborates with dietician to order snacks and supplements to boost caloric intake. SLP educates nursing re: risk of dehydration. Family provides large sip cup with family dog's pictured on it

Making a Difference - Rehospitalization

Quality Domain	PT	OT	ST
Re-hospitalization & Successful Discharge to the Community	• Fall Risk Management • Community Mobility Training • Mobility/Gait Training • Patient/Caregiver Education • Health Literacy • Wellness • Home Exercise Program • Home Assessment • Transition Planning	• Medication/Health Management • ADL/IADL Retraining • Driving & Community Mobility** • Patient/Caregiver Education • Health Literacy • Home Exercise Program • Home Assessment & Modification • Transition Planning	• Cognitive Retraining • Communication Skills Training • Health Literacy • Patient/Caregiver Education • Transition Planning

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SLP Case Study

Patient is an 70 year old man with COPD and PD. He has demonstrated SOB at meals and moderate oral dysphagia. He has poor coordination between swallowing and respiration. Patient has been educated to soft diet/ use of smaller bites and rest breaks between bites to minimize choking risk.

→

Patient at risk for respiratory compromise. Pt verbalizes to that he is overwhelmed by new diet and strategies

→

Emphasis on Health Literacy

Education and training re: anatomy and physiology

Focus on selecting food choices in alignment with recommended diet

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Hospital Readmission Reduction Program

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value based purchasing program that reduces payments to hospitals with excessive readmissions

This program supports the national goal of improving healthcare by linking payment to quality of hospital care

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Excess Readmission Ratios

CMS used ERR or Excess Readmission Ratios to measure performance of these conditions/ procedures in the program

Acute Myocardial Infarction

Chronic Obstructive Pulmonary Disease

Heart Failure

Pneumonia

Coronary Artery Bypass Graft

Elective Primary Total Hip Arthroplasty and or Total Knee Arthroplasty

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SLP Role in Treating Patients with Cardiac Conditions

The Basal ganglia and hippocampus (subcortical structures known to contribute to cognitive functioning) appear particularly vulnerable to CVD-related atrophy. (Lim et al., 2004; Verhaegen et al., 2003).

• Prior to a CVD diagnosis, having more than one risk factor can jeopardize an individual's cognitive and communicative abilities (Hassing et al., 2004; Pavlik et al., 2005). Impairments are common in the following areas
• Attention deficits including sustained attention, processing speed, and attention switching
• Memory deficits including immediate and delayed verbal recall, visual memory, and learning efficiency
• Executive functioning impairments, including inhibition, planning, reasoning, and cognitive flexibility
• Health Literacy for medication/ pharmacotherapy and lifestyle changes

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SLP Role in Treating Patients with Respiratory Conditions

• Total swallow duration and swallow apnea duration increase with age and in patients with lower lung volumes
• Risk for inspiration after swallow/ aspiration
• Impaired mucociliary clearance
• Decreased vital capacity/ breath support
• Diminished cough effort
• COPD pts may be at higher risk for mild cognitive impairment (MCI)

Gross, R. D., Atwood, C. W., Jr., Grayhack, J. P., & Shaiman, S. (2003).
Singh et al (2014)

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SLP Role in Treating Patients with Orthopedic Conditions

Approximately 10% of elderly surgical patients develop Post Operative Delirium rising to 30–65% after certain types of surgery, such as hip fracture, cardiac and emergency surgery (Ansaloni et al 2010)

Postoperative delirium is an acute organic brain syndrome that usually develops within the first few days after an operation

POD's core symptom is inattention, but other cognitive changes are also common, including memory deficit and disorientation

Post Operative Cognitive Dysfunction- results in prolonged impairment (weeks or months)

 Range from mild limitations in memory, intellectual ability and executive function to pronounced inability to concentrate, process information or execute formerly uncomplicated tasks

Conclusions

- Focus on the value based care framework and ICF models will ensure patient treatment programs are patient specific, meaningful and valuable to the patient
- SLPS should consider and address health literacy skills within the context of assessment / treatment and transition planning process
- SLPs play a key role on the interprofessional team to support many of the quality measures that impact overall patient safety and health
- The use of outcome measures will enhance SLP practice and supports documentation and value of services

Questions

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