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Palliative Care across the Health Care
Continuum: The Role of the SLP in Each
Setting

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Palliative Care across the Health Care Continuum: The Role of the SLP in Each Setting

Katie Holterman, M.S. CCC-SLP, BCS-S

continued

Learning Objectives

- After this course, participants will be able to:
- List similarities and differences between palliative care and hospice care.
- Describe the role of maintenance therapy in palliative care.
- Identify ways rehabilitation can provide skilled therapy within the context of maintenance therapy.
- Identify opportunities for SLPs to participate in palliative care in the acute care, post-acute care and outpatient settings.

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Disclosures

- Renee Kinder, Employed at Encore Rehab Services, Received paid stipend from speechpathology.com
- Katie Holterman, employed at Care One Management, LLC. Received paid stipend from speechpathology.com

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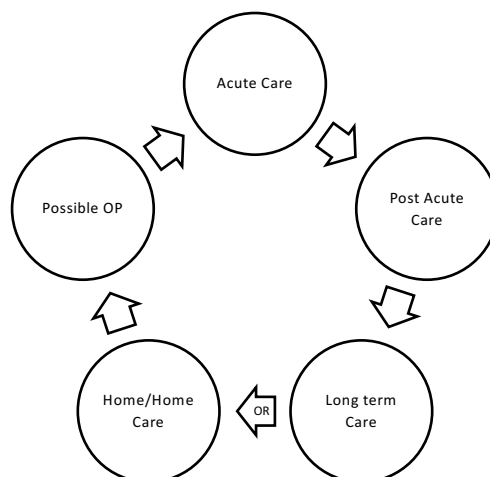
Palliative Care Across the Health Care Continuum

- Introduction and Definition and description of Palliative Care
- Palliative Care vs. Hospice Care
- SLP role in palliative care in acute care
- SLP role in skilled nursing rehab, long term care and OP/Home
- Advance directives, DNR's and those pesky waivers
- Rehab therapy defined- skilled to restore function and skilled to maintain function
- Conclusion and questions

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Healthcare Cycle

May skip, overlap, or stay in place



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Hospice vs. Palliative Care

- Hospice and palliative care both offer compassionate care to patients with life limiting illnesses
- Palliative care is always a component of hospice care HOWEVER a patient can receive palliative care without receiving hospice care.
- Palliative care is also focused on relieving symptoms associated with the patient's condition while receiving active treatment.

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Hospice vs. Palliative Care

- Hospice care is reserved for **terminally** ill patients when treatment is no longer curative assuming the disease takes its normal course.
- Palliative care can be rendered while the patient is continuing active treatment through different phases of their **life-threatening** condition

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continued

Palliative Care- Defined

- World Health Organization (WHO) definition:
- “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.”
- *Physical therapy, occupational therapy, and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills*
- **Medicare Benefit Policy Manual, Chapter 9 (Coverage of Hospice Services) Section 40.1.8 –**

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continued

Palliative Care- Described

- From Goldstein & Fischberg 2008:
- Comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients and their families with chronic, serious or life threatening illness.
- Allows the **potentially curative treatment** to continue where appropriate , while focusing on relieving/reducing symptoms that may be associated with disease progression or which may come from the curative treatments themselves.
- The focus is on quality of life, enhancing functional ability and facilitating decision making

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continued

Palliative Care- Goals

- Address for both the patient and caregivers
 - Emotional and spiritual concerns, cultural beliefs, preferences, wants and needs
- Coordinate Care /provide input and feedback to team
- Improve quality of life during illness

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continued

Benefits of Palliative Care

- Improved quality of life
- Reduced pain
- Possible shorter lengths of hospital stay
- Reduction of burden of care and emotional distress for caregiver
- Patient feels “in control”- improved mood/reduced depression

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Roles of SLP in All settings

Pollens (2004)

- To provide consultation to patients, families, and members of the team in the areas of communication, cognition, and swallowing function
- To develop, initiate and provide ongoing strategies in the area of communication skills in order to support the patient's role in decision making, to maintain social closeness, and to assist the client in fulfillment of end-of-life goals
- To assist in optimizing function related to dysphagia symptoms in order to improve patient comfort and eating satisfaction.
- Promote positive feeding interactions for family members

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Palliative Care Team

- Physician, nurse, social worker
- Chaplains
- Counselors
- Dieticians
- Pharmacists
- Physical and occupational therapists
- Music and art therapists
- AND, Oh yeah, Speech-Language Pathologists....

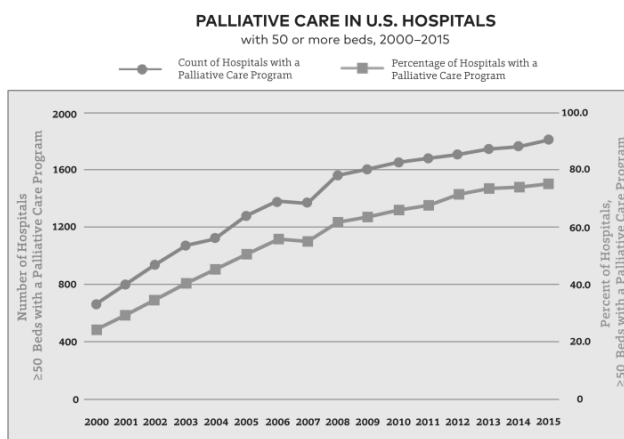


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SLP in acute care

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SLP in Acute Care



Source: Center to Advance Palliative Care, January 2017

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SLP in Acute Care

- Acute Care: The beginning? the middle? the end?
- Communication needs
 - Language and motor speech needs
 - Communication aids/alternative communication
- Dysphagia
 - Evaluations (also known as the revolving door of consults)
 - Recommendations and having a unified message
 - Feeding tubes
 - The Dilemma of the DNR

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SLP in Acute care

- Patient populations
 - Chronic Respiratory failures
 - CVA
 - Head and Neck Cancer
 - Neurological impairments/disease (Parkinson's and other.)
 - Heart Failure
 - Dementia

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continued

SLP Role in Acute Care

Communication and Cognition

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continued

SLP role in Acute Care- Communication

- Health Literacy-what is our role?
- Aphasia
 - Identifying wishes to address palliative care goals
 - Assisting with communication
- Communication aids/alternative communication
The role in ICU/CCU

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continued

SLP Role in Acute Care

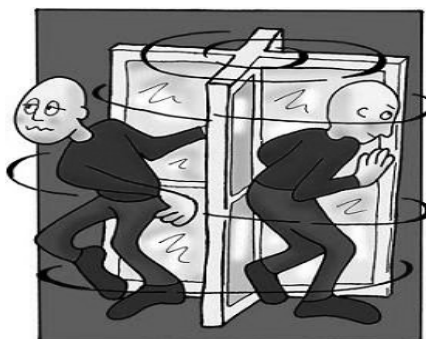
Dysphagia

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continued

SLP role in Acute Care- Dysphagia

- Evaluations....Stopping the REVOLVING DOOR OF CONSULTS



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continued

SLP role in acute care- Dysphagia

- Find out goals first
 - Goals of patient, family, nurse, physician and other team members
- Instrumental Assessments
- Do we go beyond being diagnosticians?
- Proving value as a key team member

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continued

SLP role in acute care

- Recommendations and having a unified message
 - The benefits and dangers of the changing recommendations
- "Safest diet"
- Remembering goals of palliative care
- Patient rights vs. SLP Ethical responsibilities
- **dysphagia is a manifestation of the patient's end-stage condition

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continued

SLP role in acute care- Feeding Tubes

- Dementia and the rest... where it gets tangled up...



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continued

Feeding tubes in Dementia

- In advanced dementia, studies have found feeding tubes do not result in improved survival, prevention of aspiration pneumonia, or improved healing of pressure ulcers.
- Feeding tube use in such patients has actually been associated with pressure ulcer development, use of physical and pharmacological restraints, and patient distress about the tube itself.
- Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems; in the final phase of this disease, assisted feeding may focus on comfort and human interaction more than nutritional goals

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continued

Feeding tubes and Palliative care- the when and the why

- Head and Neck Cancer
- Chronic Respiratory conditions*
- CVA

- The myth of temporary NG tubes vs
“permanent” PEG tubes

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continued

SLP in Post Acute Care

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continued

SLP in Post Acute Care SNF Part A

- Accessing SNF Benefit Requirements for Part A benefit
 - The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
 - The patient requires these skilled services on a daily basis (see §30.6); and
 - As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
 - The services delivered are reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity

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continued

Rehab Therapy Defined

- Rehabilitative/Restorative therapy includes services designed to address recovery or improvement in function and, when possible, **restoration to a previous level of health and well-being (i.e. PLOF).**
- Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment.
 - also be reasonable in terms of duration and quantity

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continued

Maintenance Therapy Defined

- MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

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continued

Is Palliative Care Allowed under Part A Benefit?

- Generally, palliative care is not a skilled service. However, if a palliative care resident is receiving a daily skilled service by Part A's definition and all other coverage criteria are met, then Part A will cover the resident just as any other resident meeting all of those criteria would be covered. The skilled services can be found in Medicare Benefit Policy Manual, Chapter 8.

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continued

SLP In Post Acute Care SNF Part B/Outpatient

- Reference “Requirements for Skill” slides
- Understand rehab versus maintenance

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continued

SNF RAI Definitions

- RAI- Resident Assessment Index
- Hospice: A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

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continued

“Terminally Ill”

- “Terminally ill” means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.
- Coding Section J1400 Prognosis

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continued

Determine Need for Skill: All Settings

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

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“Reasonable and Necessary”

Evidenced Based Practice

- *The services shall be considered under **accepted standards of medical practice** to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:*
 - Medicare manuals (such as this manual and Publications 100-03 and 100-04),
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd> and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

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“Reasonable and Necessary”

Complexity and Sophistication

- *The **services shall be of such a level of complexity and sophistication** or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist*
- *Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.*
- *If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

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continued

“Reasonable and Necessary”

Medical Diagnoses

- *While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a **beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled.** The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.*

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

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continued

“Reasonable and Necessary”

Determining Appropriate Frequency and Duration

- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and*
- *The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.*

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continued

Progressive, Degenerative, or Terminal conditions

- *Rehabilitative* therapy may be needed, and improvement in a patient's condition may occur, even *when* a chronic, *progressive, degenerative, or terminal* condition exists.
- For example, a terminally ill patient may begin to exhibit self-care, mobility, and/or safety dependence requiring skilled therapy services. The fact that full **(full movement from baseline to ploff)** or partial recovery is not possible does not necessarily mean that skilled therapy is not needed to improve the patient's condition *or to maximize his/her functional abilities*.
- The deciding factors are always whether the services are considered reasonable, effective treatments for the patient's condition and require the skills of a therapist, or whether they can be safely and effectively carried out by non-skilled personnel.

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continued

Post Acute Care SNF Requirements of Participation

Implementation Grid

Implementation Date	Type of Change	Details of Change
Phase 1: November 28, 2016 (Implemented)	Nursing Home Requirements for Participation	New Regulatory Language was uploaded to the Automated Survey Processing Environment (ASPEN) under current F Tags
Phase 2: November 28, 2017	F Tag numbering Interpretive Guidance (IG) Implement new survey process	New F Tags Updated IG Begin surveying with the new survey process
Phase 3: November 28, 2019	Requirements that need more time to implement	Requirements that need more time to implement



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SNF: PHASE 2 Requirements

- Behavioral Health Services
- Quality Assurance and Performance Improvements (QAPI Plan Only)
- Infection Control and Antibiotic Stewardship
- Physical Environment – smoking policies
- Resident Rights and Facility Responsibilities – Required Contact Information-
- Freedom from Abuse, Neglect, and Exploitation – 1150B
- Admission, Transfer, and Discharge Rights – Transfer/Discharge Documentation
- ➡ ▪ Comprehensive Person-Centered Care Planning
- Pharmacy Services – psychotropic medications
- Dental Services – replacing dentures
- Administration – Facility Assessment

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SNF Updates: Resident Rights

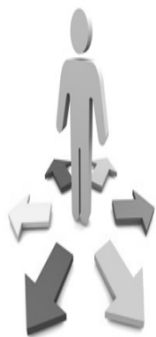
- The right to be informed in advance, by the physician or other practitioner or professional, of the **risks and benefits of proposed care**, of treatment and treatment **alternatives or treatment options** and **to choose the alternative or option he or she prefers.**
- The right to **request, refuse, and/or discontinue treatment**, to participate in or refuse to participate in experimental research, and to formulate an advance directive.



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continued

SNF: Person Centered Care Planning



- The right to participate in the development and implementation of his or her **person centered plan of care**, including but not limited to:
- The right to **participate in the planning process**, including the right to **identify individuals or roles to be included in the planning process**, the right to **request meetings** and the right to **request revisions** to the person-centered plan of care.

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continued

SNF: Goal Setting

- The right to participate in **establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.**



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continued

SNF: Person Centered Care Planning

- The right to be informed, in advance, of **changes** to the plan of care.
- The right to **receive the services** and/or items included in the plan of care.
- The right to **see the care plan**, including the **right to sign after significant changes** to the plan of care. "Allowing the resident to sign the care plan after changes are made documents the resident's involvement."

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continued

SNF: Person Centered Care Planning

- The facility shall inform the resident of the **right to participate in his or her treatment** and shall **support the resident in this right**. The planning process must--
- **Facilitate inclusion of resident and/or representative.**
- Include assessment of resident's **strengths and needs**.
- Incorporate resident's **personal and cultural preferences in developing goals** of care.
- The right to be **informed, in advance**, of the **care to be furnished and the type of care giver or professional** that will furnish care.

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continued

How to I honor Choice?

- Mr. Jones says, “I am not going to eat that puree crap”
- Mrs. Adams says, “I am safe to walk alone to the bathroom and refuse to wait for help”

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continued

Step 1: Identify Choice

- Talk with the elder and gather as much information about the nature of the choice that the person wishes to make. Repeat back to the person your understanding of what she or he desires to choose or refuse, to confirm both parties understand each other.

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continued

Step 2: Discuss Options

- Discuss potential positive and negative outcomes of respecting his or her choices, as well as the potential outcomes of preventing the person from acting on the choices. The care team should offer ways in which they can accommodate the choice and also mitigate potential negative consequences.

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continued

Step 3: Determine How to Honor Choice

- While some requests are potentially too harmful to other people to honor, many other requests can and should be honored by creating a plan to mitigate known potential negative consequences or offering a similar activity which has fewer potential adverse consequences. The team should compare the elder's choice to the person's condition to determine the nature of potential risks. If the requested action poses significant danger to others, the team should clearly explain why they cannot honor that particular choice.

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continued

Step 4: Care plan the Choice

- If a mutual decision is reached as to how the team will accommodate a choice to maximize the elder's well-being, the team will work out with the person the specific steps the staff will take to support that choice. The elder participates in the care planning process and is made aware of the steps of the plan.

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continued

Step 5: Monitor and Make Revisions

- If a mutual decision is reached as to how the team will accommodate a choice to maximize the elder's well-being, the team will work out with the person the specific steps the staff will take to support that choice. The elder participates in the care planning process and is made aware of the steps of the plan.

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Step 6: Quality Assurance and Performance Improvement (QAPI)

- The QAPI team should review trends related to resident choice and safety, particularly when elders are routinely denied requests, or when the team identifies patterns of community care practices that might be improved by performance improvement action plans.

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