Role of the Speech-Language Pathologist in the Healthcare Triple Aim

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- [Amy] Once again, welcome to our webinar today: "The Role of the Speech-Language Pathologist "in the Triple Aim for Healthcare." Our presenter today is Katie Holterman. She is the Director of Clinical Education and Compliance for EnduraCare Acute Care Services. She is board certified in swallowing disorders and is a certified dementia care instructor through Dementia Care Specialists. She serves as a member of the Professional Development Committee for ASHA's SIG 13, is a member of ASHA's Healthcare Economics Committee and served as an advisor to American Medical Association's CPT Health Care Professionals Advisory Committee. Ms. Holterman has presented nationally on topics including dysphagia, health literacy and professional issues in rehabilitation, and we're very pleased to have her back here with us today to talk about the healthcare Triple Aim. Welcome, Katie.

- [Katie] Ooh, can you hear me? Thank you so much, sorry about that. Thanks, everybody. I'm so excited to be back here and talking about this topic today. I thought I would share with everybody just a little anecdote because, you know, you gotta love irony. So, right before this started, I thought, alright, let me get myself some, some water and I'm going to sit down and that way, you know, you always have to have water when you're speaking. So I drank my water and proceeded to aspirate the entire thing, and thought, well, that's appropriate if I'm speaking to speech pathologists. So we're going to go ahead and everybody's going to hear me cough throughout this whole thing while I try to clear my airway. So I apologize in advance. I'm really excited to talk about this topic today, and it's a topic that I think is one where, it's one I think people kind of roll their eyes at whenever they hear this kind of vague, you know, issue of a, what is the Triple Aim and b, how does it apply to us? I have a friend who, he listens to me speak quite often, goes, God love her, goes to pretty much every live presentation that I do and listens to these webinars ad nauseum, and she said to me, I think she's actually on today, she said to me, why are you picking this topic again? It's so boring. And that stuck with me, because I said, well, yeah, it's a little boring, but why? Why would you think it's, you know, why are we thinking this is boring? We're so

in tune with in our graduate curriculums and as we go on with continuing education to do these clinical topics. You know, how do we treat a patient? How do we diagnose a patient? How do we get to the crux of the intervention? It's really important to know the other side of things. How do we impact healthcare, and that's what we're going to talk about today. So, hopefully by the end you will be able to do the following: define the three components of the Triple Aim for healthcare, describe how the use of patient self reports, the ASHA NOMS and other outcome measurements can contribute to the Triple Aim, list at least two areas of focus, which enables a speech language pathologist to participate in improving the health of the overall population, and describe the connection between patient satisfaction and quality of care to reimbursement.

Disclosures that I would like to, to disclose. Financial disclosure, I am employed by EnduraCare Acute Care Services. I receive salary as an employee, and I am paid an honorarium fee by Continued for presenting this course. A non-financial disclosure, I am a member of the American Speech Language Hearing Association Healthcare Economics Committee. However, I am not presenting this topic today on the committee's behalf. I do present on the committee's behalf sometimes. This is not on their behalf today.

Alright, so let's get into the nitty gritty. This changing shift from volume to value. I think we hear about this a lot, right, we've certainly undoubtedly heard the phrase, we're moving from volume to value, and we have to sit back and question what does this mean? The problem with hearing this over and over again is that we don't see the immediate results. We quietly or slowly or piece by piece approach this shift as an industry, but it's not like boom, you know, today we collect payment for the volume of services that we provide and then tomorrow we're not going to do that anymore. We're going to go to a whole new system. For those of you working in the SNF industry, the skilled nursing facility, You know that there was kind of this boom shift with PDPM

being implemented October 1st, and that's a true, one day we're living by one reimbursement model and one day we're not. That shift occurred October 1st. That's part of this changing landscape. And I think that we hear so often, this shift from volume to value, and it becomes kind of this noise in our head. What does this mean if you're working in healthcare? And the Triple Aim is a really big part of that. It comprises so many components of that, and so while we want it to just kind of almost be over with already and so that we kind of know, okay now we're in this new era. This transition takes a long time and we've been living it for a while and we need to know what it's all about.

So, it simply used to be when we lived for so long in the fee for service model that we would provide a service, we bill for that service, we collect for that service. Very simple, but what we are moving toward is this pay for performance. And what does, what does that mean? How do we demonstrate what we do and the value involved in it? I don't know about any of you, but I am pretty sure that in my years of experience and doing what I do, I've never ended the day and said, you know, I gave every one of my patients really bad quality care today. I didn't do anything well. I didn't treat one patient the way they should have been treated.

You know, I gave really subpar performance today. I've never done that, and I don't think anybody's done that because we always give our all. We always try to demonstrate the value of what we do and we always try to make the patient better. It's why we got into what we do. Our patients make great results, and that's a great thing. But how do we demonstrate that beyond our own little clinic, beyond the patient relationship and beyond what we are doing? How do we measure it? So, you have a patient that comes in and you see that patient for an assessment, you do this great big evaluation and we all know that in our field our evaluations take a long time. And then you may measure that at the end, you may do a repeat assessment of what you did. Maybe you did a modified barium swallow in the beginning and a modified barium

swallow at the end, and so yes, your patient made good outcomes. Does it stop there? Are we the only ones that know that? How are we demonstrating what we are doing and does it have an impact in the greater picture of health care? We need to move out of the silo of just speech pathology and our own little realm of what we're doing. Not saying that our impact isn't valuable to the patients that we serve, but we have to be able to prove our value in the greater picture. The way that we do this is through contributing to our settings quality outcomes, our care models that we participate in, and becoming a partner in healthcare for within, again, our setting or our academic, the academic models that we have partnered with universities, we have to kind of think outside the box. So again, we're going to talk a little bit about this today, this is where we're going with this presentation. So what the heck is the Triple Aim? For those of you who don't know, how does it all relate to the Triple Aim? The Triple Aim is a framework that was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts and it was initially introduced in 2007. You may have heard it referred to in a number of different ways.

Most of the time, it is called the Triple Aim. Some people call it the Triple Aim initiative, the Triple Aim framework, things like that. There are different terminologies that have been extracted from the Triple Aim initiative, and patient satisfaction is a big one. So part of the Triple Aim is patient experience, but you'll hear patient satisfaction kind of relative to that. You'll also hear about reducing costs. But the important thing to remember is that Triple Aim actually is expanded on these things. The Triple Aim is not aimed at any specific one population or age group. It applies to patients of all ages and all healthcare settings, so no matter where you are in the healthcare continuum or who you treat, the Triple Aim has an impact. The three goals of the Triple Aim are to improve population health and with that includes improving quality of care, improving the patient experience and, again, quality of care falls into that as well as satisfaction, and then reducing costs on a per capita basis. And I love this graphic from the Institute for Healthcare Improvement because it shows to me, it depicts how the Triple Aim is not

kind of a depth-wise progression. It's not a, this has to happen first for this to happen. It's all kind of realmed together. It's an overlap. The summary, if you look at this picture, you'll see that if you put the patient in the middle where that dot is, then you look at improving population health, improving the experience of care for the patient and reducing the cost is all putting the patient at the center of everything. So, you know, the patient is really where, it's at the center of everything you're thinking about for all of these different components. If you, we can reduce health care costs while we improve quality of care, and then, as kind of a result, you will improve population health, but the results will also be by improving population health and improving the experience, you're going to reduce costs, so again, it is an overlapping feature, and that's important to remember.

So what is population health? We're just going to go through this term real quick. It's the health outcomes of a group of individuals, including the distribution of such outcomes within the group. What the heck does that mean? We'll go into that. It's different than public health, though. Public health is the science of protecting and improving the health of people in their communities. You promote healthy lifestyles, research disease and work on preventing infectious disease. Prevention does have a role in population health, but the two are not similar. I have a lot of people who have told me, oh yeah, population health is like improving the health of the population by, like, preventing disease. Well, yes and no. Preventing disease is part of it, but if, but it's not, it's not the main part, it's not the only goal, I should say. Okay, and again, public health, kind of what we do as a society to ensure people are healthy. Population health is really concerned with how are we measuring the health outcomes and the patterns of those factors that come into play with the health of a population. And if we look at the, what is involved in improving population health, there's a lot. We're looking at quality outcomes, clinical pathways, care models, quality measures. We're going to go into all of this in detail, but population health really encompasses what we do for the patient, how we improve their health. That's kind of the mantra I want you to think

about. What are we doing to the patient, how are we improving it and how are we measuring it? The Triple Aim also has to do with improving patient experience. And with that is not just satisfaction. Satisfaction is a component of it, but we're also looking at the use of electronic health records, the use of implementing care models. Are we doing patient centered care? Are we implementing patient centered care in our goal setting? Again, patient satisfaction, we're looking at outcomes with patient experience as well, patient reported outcomes and patient reported satisfaction. So where would speech pathology fit into all this now that we kind of have this broad overview of what the Triple Aim is?

And I know that the Triple Aim, the definition in and of itself is a little confusing. I think that when you start to look at yourself as a speech pathologist and say how can I fit into this, it begins to make a lot more sense. The first time I ever heard the term Triple Aim, it really, it kind of flew by me. I knew it was this healthcare concept. I knew that it was something that was important. I knew that it was an initiative that we kind of kept hearing about in the hospital that I was working in. But until somebody said to me, well, you're a part of this, it really didn't fit. And even when that phrase was said to me, it was in the context of a rehab department meeting where it was myself, physical therapist and occupational therapist, or sorry, physical therapy department and occupational therapy department.

And there was a lot of talk. And you, if you've ever been in a group with PTs and OTs, you know that there's a lot of PT and OT talk that goes into, into play, and you kind of go, where am I fitting, where does speech fit, you know? And you kind of want to do this, excuse me, where am I going to go here? The Triple Aim they were talking a lot about outcome measures and talking about how these outcome measures for PT and OT would come into play. They were talking about, you know, improving population health, they were talking about prevention, they were talking about screen, they were talking about prehab and prehab was all about joint replacements and how are we

going to get in and work on these pre-surgery classes for joint replacement? And I just, I tuned out. I thought this is so not speech pathology related. This is so, we don't have a place here, it's, if rehab has a place, it's all PT and OT. And it wasn't until I started to really think outside the box that I started to say, oh, wait a minute, we have a really, really big part of this, and we can fit easily into this puzzle. This puzzle piece is ours and we've got this. So I want, my goal today is to make sure that everyone on this on this webinar is walking away saying, you know, I can fit. And I really want people to think, as we're going through the next couple of slides, not only what I'm talking about and the ideas that have been generated through some of my work, but where can you fit this into your own setting? Where can you think about where you might fit? So we'll start with improving population health.

Again, population health is dealing with the overall improvement of the health of the population and that deals with how are we improving it, what are we doing to improve that, what are our outcomes, what are our interventions? Prevention is a part of it. Prevention has to do with that public health component, but it is a part of population health. So again, prevention. Speech pathology interventions really are reactive, when you think about it, right? A patient has a stroke, they have a swallowing issue, they have aphasia, we go in and we remediate. We're not proactively going to give aphasia therapy for somebody who might not need it.

So, again, it's this reactive kind of mode. But where can we fit into more of a proactive place where we're going in and we're advocating for the profession and promoting the profession and really getting getting in the face of some of our patients and saying we can help early intervention, we can get in there before either a problem actually begins, or just getting in to identify that early intervention, the earlier, identify the issue to go into early intervention. Screenings are a great way to do this. They can help prevent or even catch potential impairments. One of the things that we've really worked on in some of my former settings is the early development of vocal nodules. So, those of you

who work in voice, this is a great one where you can go not only educate the consumer, educate physicians, educate families on risks involved in things like vocal nodules, but identifying those signs and symptoms early enough. Same thing with dysphagia, you know, identifying those signs and symptoms early on. There's a lot of research involved in around early intervention and the impact and not so much in the realm of speech, but we can certainly, we can certainly tie it into speech pathology. I think there's more research to be done with this, but in rehab in general, there is a lot of research around the earlier that we get in to rehabilitate, the better the outcome. And then promotion and advocacy of the profession. So again, if we're looking at how we're going to be improving the health of our patients, we have to be in it to win it, and what I mean by that is we have to be able to have a patient who's having an issue say, I need speech pathology, they need to advocate for it themselves, but they don't know to advocate unless we're advocating for them to begin with. We need physicians to recognize the value of speech pathology services.

I was going to talk about this a little bit later, but this actually looks like it's a good time to talk about. I had a patient one time who was pretty in well into their Parkinson's diagnosis. Very difficult time in swallowing, very quiet, very disarthric. And he came to me and I said, you know, so, any interventions that you've done so far? And he said, well, I've had LSVT big for two years, and we were down the hall from that department, but the physician and the patient didn't know that there was an LSVT loud that would help him. So, that patient outcome could have been improved had we gotten in there a little bit earlier, or a lot earlier. So promotion and advocacy of the profession is really important when it comes to the Triple Aim. And then we have this concept of prehab or pre habilitation. And this is where I was saying, you know, a lot of the times, we think about the fact that this is very PT and OT related, but it really is, it really can fit for us. Prehabilitation is defined as a physical or lifestyle prep that happens before surgery and, the definition's before surgery, but it's really before any treatment intervention, because if you think about like a head and neck cancer, we're thinking about radiation

treatment, things like that. That is, prehab has a great role with that. It's designed to help patients regain function in less time. And so there's some main areas in which prehab would have come into play. Medical optimization of pre-existing conditions. There's a lot of talk with this in the management of the patient with diabetes. And so, optimizing the medical treatment for the diabetes prior to any kind of surgery or intervention lessens the chance of infections, post-op infections and things like that. Think about our role with the patient with, let's say reflux. There is, you know, there are some complications that come into play with reflux if they're not taking their medications appropriately prior to surgery and things like that. So, even wounds, we can have a direct impact if we work with a dietitian, any of those medical conditions that we can have a role in prior to them, to the patient going into either a surgery or a procedure, we need to identify where we can fit.

Physical fitness, you know, the better, the better fit the patient is, the better the recovery, so that, really we want to make sure we're identifying when we have appropriate referrals for patients for PT, if they're not are already receiving it. Nutritional status is a big one. So this is where we really, you know, our patients who are on modified diets, how often are we sitting here and thinking, alright, they're on puree and honey, but maybe they need to go for surgery for some reason. If they have poor nutritional status, it increases the likelihood that they will have a slower recovery.

How often are we taking a look and saying, how can we participate in the health of this patient and the outcome of this patient given their nutritional status? Are we working with the dietitian? Are we educating the patient? Are we saying, you know, make sure that you're getting enough hydration? Are they well prepared, you know, are we monitoring their nutritional status if they're on any kind of modified diets? We have a role with that and we need to make sure that we're taking an active role in there. And then psychological support. This comprises patients' cognitive and mental health prior to surgery, motivation and family support. Now I don't know about you, but I've had a

couple of instances in my career where I've seen a patient post-hip fracture. Otherwise healthy patient, but they come in with a hip frac, they have surgery, and lo and behold, all hell breaks loose. They're cognitively out of it. Their swallowing may be impaired. They're just having all of these speech issues, and we're thinking it's a hip fracture. How many of those patients had an underlying dementia or had an underlying cognitive decline that was occurring prior to surgery and the effects of anesthesia kind of perpetuated that? Now there's a delirium associated with that and it's not necessarily that we would go in and intervene afterwards for that specific dementia, because most of the time the delirium will make clear. But, how about just going in prior and identifying that that's an issue? How often are we going in and are having the opportunity to go in and do a baseline assessment, cognitive assessment? Some of these, in particular, that component may be a little bit difficult to implement in practice, and I realize that.

I'm a realist I'm not, you know, I'm not going to stand here and talk about this and say, well, this is so easy, everybody should be doing this. There, that's a difficult one to implement in a daily practice, but it's just one that I want everyone to start thinking about. How can we put this into practice? What can we do to talk with our care teams about how we may approach those patients? Along with improving population health is the development of clinical pathways, and I just gave some examples of clinical pathways. We're going to go into this a little bit. But the development and implementation of clinical pathways is really important. Okay, so why why would we develop these? By developing and implementing these it streamlines the delivery of the quality care in the most cost effective manner. I'm going to say that again: the development and implementation of clinical pathways, it streamlines the delivery of quality care in the most cost effective manner. So I want you to think about that. Anytime you can streamline something, right, it makes it easier for who? For everyone involved. And then putting something in a cost effective manner is obviously beneficial. So who can benefit? The patient, because they're getting the most standardized

treatment by putting together, by implementing a clinical pathway, they are getting standardized treatment that is hopefully evidence-based. The families have the adequate support. Continuum care, care partners along the continuum know that they are working in a team. They are being able to follow that pathway so that they know where the patient is in their continuum of care and how that patient is transitioning from setting to setting. What are clinical pathways comprised of? If you don't know a clinical pathway, this would be hard to follow. So a clinical pathway is usually comprised from a diagnosis or a diagnoses group, and it basically follows the patient diagnosis on how the treatment would be delivered, the assessment, the treatment along all of the touch points, all of the disciplines working together.

And we'll go into some examples about this. But basically, all settings can develop and implement pathways, clinical pathways. There are barriers, of course. There are barriers in everything that we do, it feels like, but all settings can develop these pathways. And what's great, as I said about the continuum care partners, you know, if we have a clinical pathway for, let's say, head and neck cancer. If you know that you're treating this patient and you're following the clinical pathway that's been developed, then the post-acute care setting and the acute care setting, the outpatient setting, everybody's on the same page.

Their approach may be a little bit different depending on your setting, but everybody would have kind of a heart in the game, and it provides the best care for the patient. Now some settings, it's a little bit more difficult to develop the clinical pathways based on the diagnosis. If you're in acute care, you may have a pretty solid clinical pathway developed for stroke, because that's kind of the most researched, it's more, there's been a lot of push as far as the Joint Commission, things like that in the development of a stroke clinical pathway. You may not have a clinical pathway for, you know, a head and neck cancer. If you're not head and neck cancer or if you're not oncology-based cancer center. So, again, it depends a little bit on your setting, but, you know, you have

to look at where you are and what you can do to participate in the development of the clinical pathways. Working with your administration, working with your leadership and saying how can we be a part of this puzzle? Can clinical pathways have an effect on cost? Absolutely. By developing clinical pathways, it's been shown that patients have a decreased length of stay in the acute care setting. There's a decreased readmission rate. And there's decreased cost and expenses. There's decreased labor, there's a decrease in the unnecessary testing. So there's a lot of effects that developing clinical pathways can have on the cost, and those are the types of things you want to bring to your administration when you're trying to look at how to develop that. Again, an example for a stroke. For an acute care patient in acute care, many of you may have order sets that when a patient comes in with a stroke, there's an order set that goes along.

The patient may have a CAT scan by a certain hour. Referral for speech, referral for PT and OT, referral for social work, and then everybody kind of goes into their mode of what they should be doing. There's a care team that's involved with that. And with every intervention there should, it should be backed by evidence-based practice or practice guidelines. So we knew that when developing stroke order sets that the CAT scan being done in a certain amount of time was going to improve outcomes. That was backed by evidence-based practice. Critical care management. There's a, I think this is one of the areas in which there's not a lot, it's a number of things. Either it's not a lot of clinical pathways that have been developed or we are not in that piece of the puzzle. We're not in that pie enough, and we need to be. There are so many avenues for developing clinical pathways for the different diagnoses that we see in critical care and speech pathology having a role in the early involvement, early ICU involvement, can really have a great impact on the patient. From a communication standpoint, if you think about the early ICU involvement for a patient who's intubated or has a trache. There's unnecessary costs involved in prolonging, potentially, the length of intubation, because the patient can't communicate as well as they need to or if they're newly

trached and they don't have a means of communication. If we're not involved early on, there is, there's this delay in care that people don't realize we can have an impact on. You know, thinking about just being a part of the respiratory team. Early improvement of cough response. How important is that in the ICU? And how many times do the critical care personnel realize that we can have an impact on that working together with our respiratory teams? Swallowing, obviously, you know we know that we get in there as early as we can, but, how many times is there kind of fear within the nursing staff, this fear of aspiration? And so, really working with educating the nursing care team in recognizing signs and symptoms and not being so fearful so that we can improve the patient outcome. Getting in there early, developing those pathways for each of those diagnoses and keeping in mind all of those areas in which we can work will have a great impact on the patient and the patient outcomes.

Okay, so patient centered outcomes. If we think about what patient centered outcomes are. Examples include quality of life survey. So, with outcomes you can have your own outcomes, how well did the patient do based on, you know, the assessments that you've done? But also how well is the patient doing in their own quality of life? How are they feeling, how are they thinking that they do? This also, again, remember all that overlap, remember that graphic, everything kind of overlaps, so this would also obviously have to do with the patient experience and patient satisfaction. But we need to measure not only for an outcome base how well the patient did, not only from our standpoint, you know, I the clinician think that this patient got better. But I the patient may not have thought I got better. We have to move toward this patient centered care, so using quality of life surveys, I feel, is so important with a patient, but including the results in our goals is even more important. I think that's where we kind of drop off. We may administer these quality of life surveys to some. But if we're not including it in the goals, then it's really not working. And remember that your goal may be different than the patient goals. So, if you feel like you want to get the outcome for this patient to be a certain level, that the patient never had that goal in place, it's not going to work, so

that's why patient centered goals and patient centered outcomes are just as important as our outcomes. And as we move toward how we're going to implement this, some of our own impact in the overall quality measures, that's going to be really important as we move on. Clinician based outcome measurement tools. Again standardized tests, things that we use for assessment, but a great source of this is ASHA's National Outcome Measurement System, or the NOMS system. For those of you who aren't aware of what NOMS is, it is made up from the use of functional communication measures, which are a series of disorder specific, it's a seven point rating scale, and it's clinician reported. The clinician reports at both admission and discharge. It is a member benefit, it is free to ASHA members through the American Speech and Hearing Association.

You do have to be registered user. The training is completed online. You get CEUs for it, yay. But the data is reported to national registry at ASHA. It's collected and then there's trends that are collected and reported on, different demographics and intervention patterns. It's a really great way to have this national comparison of how your interventions are working in comparison to national average, and it's really the best way to compare apples to apples in a disciplined, specific way. Okay, so that's really how we would measure from a speech pathology standpoint for the outcomes and quality. But again, how do we move out of that and move out of the silo and find our fit in kind of that greater picture? And this is where some of these hospital performance metrics quality measures are going to come in. Some examples that will talk about are re-hospitalization rates, length of stay, mortality rates and then CMS program performance. Okay, if you go on the CMS website, you can see all the quality initiatives and the patient assessment instruments that are used and you can see there is, this is only a snippet that I had screenshotted. There's so much involved in quality reporting from a CMS governed standpoint. We just wouldn't have time to go into everything today, and again, our goal is to look at how we're going to fit in this, but it's really important to have kind of this basic knowledge foundation of what this these

quality performance measures are, so I do encourage everyone to kind of go into CMS, navigate around and see what are the quality measures that are out there? Ask questions in your setting, ask your hospital, what are we participating in? How are we being measured? What are we doing with these quality measures? Ask your skilled nursing facility, you know, how can I be a part of this? An example, if you do go and say, you know, how are we measuring re-hospitalization and where do you see speech pathology fitting? They may say, well, you really don't.

And guess what, here, you can say, I really do. So re-hospitalization is a quality measure that is, it looks at the rate that a patient is hospitalized for the same condition within a 30 day timeframe. So, a key part of impacting re-hospitalization or making an impact on not having re-hospitalizations is discharge planning. And discharge planning, I always say it's not just social work and care coordinators, although they're an integral part of the overall discharge planning process, but we can't forget our role here. How many times have you had the experience, if you're in an acute care setting, where you get a call from the skilled nursing and they say I never got your speech notes, right, or you're in a skilled nursing setting or you're in outpatient, you're in home health and you're trying to work with a patient, you say I don't have the speech notes from acute care.

That transition, that care coordination is so important because if you decide to proceed without having any of that information, you're putting the patient at risk for a number of things, but if you're treating something that you're not sure what happened in the prior setting, you're going in blind, so you have to be part of coordinating that care. Coaching, educating, supporting the patient for self management. You know, if we're discharging a patient to home and we are discharging them, let's say, on a puree diet, honey thick liquid, and then we say okay, good luck. How many of those patients do we think may be re-hospitalized, and if they're hospitalized in the first place for, let's say, aspiration pneumonia, and then we're not giving them the adequate education and

they go home, guess what? They're going to be re-hospitalized for aspiration pneumonia. So, we have a huge role in this, in being able to really be a key part of the education team. Health literacy. How often are our patients understanding what's important in their health and their medication management, the instructions, the discharge instructions that they have. As communication experts, we have a huge role in ensuring that patients have an understanding of all of the discharge instructions. I don't think that our care partners see us that way. We need to advocate that we have, as communication specialists, we have a role in ensuring the health literacy of our patients. We talked a little bit about dysphagia preparedness and modified diets and an education plan for continued care. Make sure the patient knows what's going to happen, where they're going to go and what their follow-up plan is. You know, do they need additional services?

Do they need speech pathology in services in the home care setting? If they're receiving home care, make sure that it's set up for speech, not just PT and OT. Be an advocate for the patient, and you can help reduce re-hospitalization. And then talk to your administration and say, I'm a valuable part. I can do this. Length of stay. Again, this is a goal in the acute care setting. You're measured as to how long your length of stay is.

The goal is to reduce length of stay, and the reason for that is, a number of reasons, but reducing infection is a big one. The research has shown that the less time you're in the hospital, the least risk of infection, and so getting in early, again, for early intervention services help reduce that length of stay, reducing any delays along the clinical pathway. How many times do we have delays in radiology? What can we do to improve on that using all of our tools and resources that we have to ensure that the patient is moving in and moving toward the outcomes in a faster fashion than I think we're used to? Subacute, the times are changing with PDPM. You know, we used to have this, this kind of a increased length of stay, and now with PDPM, we're seeing a

whole shift with that. For those of you who are in skilled nursing environment, we know that there's a variable per diem adjustment now for PT and OT, meaning that there's a decrease in payment after a certain number of days. Speech stays steady, but that doesn't mean that we would keep them forever and ever. The patient, you know, they're looking at, CMS is looking at outcomes and how quickly are we able to move those patients along the continuum of care? How are we providing treatment? How intensive are our services? If we're only providing services four times a week then maybe five times a week would help the patient move along the continuum faster, more efficiently, get better outcomes.

Thinking about it in those terms is going to help. Okay, and again, I just did a screenshot for you to, you know, this is additional, the quality initiatives. Again, CMS, please go on and look at those. I think it's important. Again, along with the Triple Aim, the Improving Medicare Post-Acute Care Transformation Act, or otherwise known as the IMPACT Act, was implemented in 2014. This is part of the Triple Aim. It is working towards standardizing patient assessment data.

It's a way to compare apples to apples across the continuum. If we look at the IMPACT Act, there are certain measures that, for example, I'm sure for anybody in subacute you've heard of Section GG. This is implemented across all post-acute settings. It results in kind of a smoother patient transition between healthcare settings by using the same assessments and same coding systems, the same language. So, I know that if my patient needed x level of assistance in the skilled nursing environment, and it would translate to the same, the same language in a home care environment or an LTAH or an IRF. It improves the patient experience by having a universal system to measure across the continuum. I think the problem with the IMPACT Act is that the average SLP and a SNF doesn't see the impact for that, doesn't see where they fit or the worth. It's kind of this phrase, this terminology of what's used a measurement system for skilled nursing. And so, if you can, if you can look at how you would have an

impact in all of the measures that are collected for the IMPACT Act, you begin to see, oh, I do have, have a part of this. So this slide, I apologize, is a little blurry, but if you look at the CMS website, it's pulled directly from there. It talks about the IMPACT Act, there's different domains, and then what's being measured and which setting is adopting them. So, a large portion of what is measured is cognition plays a huge role, and so how can you as a member of the team say I can have an impact on the patient's cognition, I can help identify if there's a cognition impairment, and how that may impact the patient's score in this assessment. I think that that's an important concept in the fact that if you're not able to see where your role is in cognition. You know, one of the examples, let me go back.

And again, I don't know if you can see it, but one of the examples is looking at a fall rate, the percentage of residents with falls. Well, everybody thinks that may be mobility, but what about that confused patient, what about that patient who can't sequence appropriately when they're getting in and out of a chair when they're transferring? Our role is really important. We need to make sure that we are having a voice. Okay, and patient experience. Patient experience is basically the level of satisfaction that the patient felt with the care that they received. Patient experience is not only satisfaction, its quality, were the outcomes met? It's patient centered care. Are they engaged? Patient engagement is known to drive toward a complete patient experience. Are they involved in their goal setting?

Are they knowing their expectations? Are we providing adequate education? It encompasses the range of interactions that patients have with the healthcare system, so it includes ease of appointments, access to their information. Are we using an electronic medical record that allows us to talk amongst systems? Are we providing patient centered care? It involves health insurance, right? All the touch points of the interactions that patients have within the whole healthcare system. So think about health insurance. For those of you, either in private practice or even in an outpatient

setting, are we working with patients to help them understand their own health insurance? And more importantly, do we understand the health insurance? That helps with patient satisfaction and the overall patient experience. Patient experience versus satisfaction. So, in order to assess experience, we have to find out whether something that happened in a healthcare setting actually happened or how often it happened. Satisfaction is did we meet the expectations of that health situation that we met? So real quick, because we're running a little bit low on time, but the story of Bert and Ernie. Obviously aliases, but both patients had laryngeal cancer, both received prehab, both had clinical pathways followed, both had their pain managed, both moved from MPO to mechanical soft and fins and both had support groups. Same experience, however, Bert went in non-informed. He learned along the way. He didn't know what to expect. Ernie had a good friend who unfortunately went through the same thing, so he knew what to expect.

Their experience was the same, but their satisfaction was different because Bert was kind of, really not quite satisfied. He didn't know what what to expect and he felt confused by the whole situation. Ernie was more prepared, so his satisfaction was different. So, we need to know that we're looking at experience and satisfaction in two different ways and we can help navigate along the way by really becoming kind of a captain of that care team and navigating the patient experience in different situations. How do we measure patient satisfaction? Well, I'm sure, for those of you who work in hospitals or skilled nursing settings, you've heard about the satisfaction surveys. They attempt to translate these subjective results into data that's meaningful, quantifiable and actionable. Each satisfaction survey has a direct impact on reimbursement, and so we want to make sure that satisfaction is something that we are, you know, again it's patient perception, so what are we doing? What is our role in improving the patient satisfaction of the patient and the family members, and how are we communicating that to to everyone within our healthcare team? And finally, reducing cost. So, very simply, we need to have a financial awareness. We cannot be afraid of the p word, and

for those of you who I'm sure know what the p word is, that's productivity. It's not a negative word. It's not something we love to hear, but productivity does have a time and a place. We need to know what we cost, and productivity is part of what we cost as a profession, as labor cost. It is a business, okay? Healthcare is a business, so by having a financial awareness, it just elevates us to be able to say you know what, I need to deliver care in the most efficient and cost effective way for my patients, not only for the good of the patients, but for the good at the health care system that I'm working for. I need to be working at the top of my license. Am I doing skilled care all the time? That's what I'm being paid for. Is that what I'm doing? And reducing non-purposeful care.

Where's our evidence? Know your evidence-based practice. There's a great campaign called the Choosing Wisely Campaign. It is choosingwisely.org is the initiative of the ABIM Foundation. The mission is to promote conversations between clinicians and patients and help patients recognize and choose care that is supported by evidence, not duplicative, truly necessary. So, AOTA and APTA have really kind of taken on this Choosing Wisely campaign and promoted it within their profession, saying, you know, hey guys, get away from the cones and the pegs, right? We've all seen that with with a TNPT, but for speech I venture to say, get away from the paper and pencil tasks for cognition.

You know, make sure that what you're doing is applicable to the patient. And this Choosing Wisely campaign is one where the patient is, we're advocating for the patient to know what is non-purposeful care? What is evidence based care? Putting them in the driver's seat. I'm not gonna go through lean waste, just know that if anybody is interested, looking into Six Sigma Lean is a great way to look at how you can reduce costs. There's a whole program, many hospitals are using it, but I encourage you to take a look into that a little bit and say, you know, how can I fit as a speech pathologist into the the Lean Six Sigma system? I think that there is, you'll find some interesting

work with that. And again, reducing cost, just getting in there early, getting in there and making a difference early on. There's a lot of data to suggest that the earlier we can get in as a profession, the less cost per patient that there is, so advocating to your administration that the earlier you get into intervene, the better it is for the patient. And again, I started with this, and I'm going to end with this. Advocate for your profession. A higher visibility of services means increased referrals. Higher visibility of services for your consumer, you know, we're in a time of consumer driven healthcare, meaning that the patient decides where they're going. The patient decides that they're going to go to hospital a or hospital b.

They decide which outpatient setting they're going to go to. They're driving their own health care, and that's part of the Triple Aim in making sure that they are in the driver's seat. And we need to make sure that we're in there advocating for what we do to help improve the outcomes that they will have. And then again, physician education of services not well known, so get in there to your physicians and talk about how speech has an impact in improving the health of the patient, improving the outcomes and reducing the costs associated with some of these disease groups. Cardiac, pulmonary, neuro, orthopedic, get in there and talk about how we can really improve the overall patient experience.

Just one quick example, I know we're short on time. But I had a patient one time who had a c spine fusion and was having terrible swallowing difficulty. He came in for an MDS. Long story short, the patient swallowing was impacted from the surgery. And I developed this protocol with this referring surgeon, who we basically said, you know, we're going to get in and and work on prehabbing patients with c spine surgeries. We're going to get in and if there's any indication of symptoms, we're going to get in early, and we helped reduce the amount of complications, we helped get, we had a subgroup of patients where our patients were getting faster recovery from the surgery overall in comparison to those patients who were not receiving the same pathway. So,

it can work and we can have a critical role. We just have to look at where we fit and if we step outside of our box of just, you know, going in and doing clinical care, you will see that you have a great role in impacting the Triple Aim. I think that is it. List of references there. If anybody has any questions. I know we have just a few minutes, but I'm happy to take some.

- [Amy] Thank you so much, Katie. I'm going to give it a minute to see if anybody has any questions they want to put in a Q&A pod. I wasn't sure, who did you say, which foundation, what is it that that has the Choosing Wisely campaign?

- [Katie] So Choosing Wisely is, it's actually choosingwisely.org is the website. It is the initiative of the ABIM Foundation, and it's been implemented with, really, the AOTA has kind of taken it and moved with it from their professional organization. They've really implemented how to to use this campaign for occupational therapy and saying, you know, guys, put down the pegs, put down the cones and really look at function, and I think that speech needs to do a little bit more of that. And I think that if we kind of think outside the box, we can, cognitive impairment is I think a good example of how we can look to AOTA and Choosing Wisely and see how we can make that more functional.

- [Amy] Do you know if ASHA has any initiatives connected to that? I wonder if this is something that they're talking about.

- [Katie] Not that I'm aware of, but I certainly think that it's something that, you know, I know that they are looking at more inter-professional practice, and so if not that, maybe moving towards more functional goals. ASHA is very big on working at the top of our license and so that's part of this as well. Making sure that we're, part of working at the top of your license is making sure that you are providing only skilled services and functional services and creating goals that are functional.

- [Amy] Very patient centered as well.

- [Katie] Exactly, exactly.

- [Amy] Good, yeah, I've always found it interesting that when I was practicing clinically, the number and types of referrals I might get varied hugely from facility to facility, so I think there's still a lot of work for us to do as a profession in just promoting our own visibility, like you were talking about, and advocating for what we do and how we do it and our worth and value to perhaps a number of different areas of healthcare, that, I don't know, maybe doctors, nurses, insurance companies don't necessarily think of us as needing to be involved, but where we could play a role, so I really appreciate you being here to talk to us a little bit about that. It's certainly something we should all be keeping in mind in our work settings.

- [Katie] Yes, and I think that, you know, if you're not sure where to begin, I think the one thing that I would say is you have to start at the foundation, you have to start beginning and really kind of know what quality programs are out there, are being measured by CMS, by the Joint Commission, by all of these different organizations. You have to know what they are before you know where you can provide value, and so really starting at the beginning is important for everyone.

- [Amy] Okay, well, I'm not seeing any questions. We are a couple minutes over, so I think I'll go ahead and wrap it up here, but thanks so much for being here and thanks to our audience as well. Appreciate you spending an hour of your day with us. I will go ahead and close up the classroom, and I hope everybody has a great day and I'll see you back in another seminar before too long. Bye everyone.