Diagnosis Dementia: Working with Patients with Dementia in Home Care under PDGM

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Presenter: Megan L. Malone, MA, CCC-SLP;
Jennifer Loehr, MA, CCC-SLP
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- [Amy] All right, I'd like to welcome everybody to our webinar today. We have Megan Malone and Jenny Loehr joining us to talk about Diagnosis Dementia: Working with Patients with Dementia in Home Care Under PDGM. Jenny Loehr is an SLP working for Encompass Health as a field integration lead training therapist and nurse in both the home health and hospice service lines on best practices, compliance, and documentation. She's the co-author of the book "Here's How to Treat Dementia" and has written and presented on the topics of home health service delivery and dementia for ASHA, the ASHA Leader, the National Association of Home Health and Hospice, Leading Age, and state association conferences. Megan Malone is also an SLP working as a clinical faculty member at Kent State University Department of Speech Pathology and Audiology and as a clinician and consultant in home health care. She is also the co-author of the book "Here's How to Treat Dementia." She has spoken numerous times at the annual conventions for ASHA, Gerontological Society of America, American Society on Aging, and the Alzheimer's Association, along with several state speech and hearing conventions. She has published articles in the "Journal of Communication Disorders," "Alzheimer's Care Quarterly," "The Gerontologist," and "Dementia." So welcome to both of you. We're so pleased to have you both with us today.

- [Jenny] Thanks for having us. We're always so grateful for the opportunity to present for you and really excited about giving some updated information for all of our listeners regarding working with dementia, and in this interesting environment with PDGM. So the topic is Diagnosis Dementia: Working with Patients with Dementia in Home Care Under PDGM. We are offering this slide to you, our disclosures. And they are spelled out for you here. And then we have some learning outcomes for you as well. After this course, we want you to be able to describe the PDGM model for reimbursement in home health care and its effects on speech-language pathology services. We want you to identify at least two strategies to implement when working with patients with dementia and their caregivers in the home health setting. And lastly, list two impact areas in which SLPs can demonstrate to agencies the value and need for their services. All right, I'm just gonna dig right in with some dementia facts for you. And this, all this information comes from Alzheimers.org association online. And this is the latest and greatest updates that they offer regarding what's going on out in the United States with Alzheimer's disease and other dementia diagnoses. 5.8 million Americans have been diagnosed with Alzheimer's or other dementias in 2019. And that's an indication that it's not going away, and it's not going away any time soon.

And so there will be a continued need throughout the years and decades for us to work with these individuals. $290 billion is the estimated cost for caring for individuals with Alzheimer's or other dementia types in 2020. And so that little fact lets us know also the increased burden on caregivers and family members, and the patients, for them to be able to live safely, as healthy as possible in the home. The next fact is that 25%, a quarter, of Medicare beneficiaries aged 65 and older with Alzheimer's or other dementias have at least one home health care visit during the year, so this is an average, compared with 10% of Medicare beneficiaries aged 65 and older without Alzheimer's or other dementias.

And what that little fact means is that most individuals who have this diagnosis of Alzheimer's or dementia are going to be seen, if they haven't already, by somebody from a home health agency. Home care isn't going away. It's going to be much more needed in the years and decades to come. And speech-language pathologists certainly will play a part, if not already, in dealing and working with individuals who have Alzheimer's and/or other dementias. So I'm also gonna give you some, just kind of a recap maybe of some home health facts for you. And most of the information, I think all of the information that I'm giving you on this slide, is old stuff, meaning it hasn't really changed. But it's still very, very important and critical that you be aware of the information on this slide if you're going to work in home health, in particular, with individuals who have a diagnosis of Alzheimer's or dementia, the first being that home health agencies have to adhere strictly to the Conditions of Participation, or the COPs, as we call them. The COPs are a set of rules and regulations that all home health agencies must adhere to if they are going to participate in Medicare reimbursement program. So if they wanna get monies from Medicare for the patients that they're seeing, they have to adhere strictly to all of the rules that are put forth in the Conditions of Participation. And these were just recently updated a while back with, they didn't take any out. They just lumped a whole bunch more COP regulations for us to follow. So we all should know the COPs. You don't have to have them memorized, but you should have a really good idea of what the rules are according to Medicare. And these are available to anyone online at Medicare.gov.

Home health agencies must ensure that patients meet eligibility criteria. So anyone who's going to see a home health patient needs to make sure that they meet these particular criteria. This patient has to show that there's a medical need. There has to be medical necessity. So they need to have a diagnosis, an illness, a disease that means that they will need skilled care. They will need medical care in their home. Patients also have to demonstrate that they are going to need skilled intervention for this illness, disease, or condition that they have.

And skilled intervention, that's the stuff that we do, speech-language pathologists, also our colleagues, our physical therapists, occupational therapists, registered nurses. Patients have to demonstrate that they're gonna need the skills that we have with our licenses in order to get home health services. And last, the patients have to be homebound. And there's a lot in the Conditions of Participation, there's a lot out there, about what homebound actually means for our patients. And there's always a lot of questions about homebound status when it comes to a patient that's suffering from dementia. In particular, maybe a patient who's got mild dementia who needs our care, or a patient who's got moderate to severe dementia who's under the care of a caregiver, and let's say the caregiver takes them out of the home. Well, we have to read the details about what homebound status means. And it's gotta be a taxing effort on that patient. Safety is a huge factor when it comes to everything homebound, sorry, home health-related. And if a patient is leaving home but they're not safe to do so, that still means that they're homebound. So it's important for speech-language pathologists to become really familiar with the homebound criteria moving forward. The Outcome and Assessment Information Set, or OASIS, that is the comprehensive assessment tool that is used in home health to determine eligibility. It helps determine how much service is going to be needed and provided to the patient. It's going to determine what kind of equipment is going to be needed for the patient, and also what kind of reimbursement is going to be given to the home health agency for the services provided. So the OASIS is really key to whether or not we're gonna get reimbursed for all of the services that we provide the patient.

And it is paramount to our success, and accuracy in completing the OASIS is paramount to the success of the home health agency. And we'll talk a little bit more about that. Home health agencies are still responsible for STAR ratings, for meeting patient satisfaction, for meeting those functional outcomes. Despite all the changes in our industry, we are still responsible for all of those things, which has become quite a challenge during this change in our reimbursement.

So we still need to be mindful and understand that each and every one of us, speech-language pathologists in particular, play a role in those STAR ratings and patient satisfaction and the functional outcomes. So those are still very, very important. I wanna talk about some myths. So PDGM came into play January 1. And prior to January 1, about November is when they came out with a final rule for PDGM. And there was still a lot of questions. Even Medicare still hadn't finalized how this was gonna play out. And so there were a lot of myths, a lot of urban legends going around, a lot of rumors about what's gonna happen with PDGM. And I wanna highlight some of the most popular myths out there that are still circulating today. And the first one is that

Medicare no longer reimburses for therapy services, SLP services in particular. And that is wrong. In fact, Medicare just put out, CMS, and I think that ASHA had a little something to do with this, but CMS just put out a little statement about the importance of therapy services, and it listed speech-language pathology services, with regard to taking care of patients who are homebound and playing a part in home health care services. So yes, Medicare still reimburses for therapy services. So that is a huge myth. The second one is Medicare no longer reimburses for a patient with a dementia diagnosis. That is wrong. Medicare has not changed in their eligibility criteria that I mentioned earlier. Prior to PDGM, Medicare paid for patients' services, even though had a diagnosis of dementia. So this was an urban legend long before PDGM. And they still continue to reimburse for patients with a diagnosis of dementia. And I will talk a little bit more in detail about that.

Medicare allows a set amount, Medicare is allowing for a set amount of therapy visits for patients per episode, and that is wrong. Medicare doesn't care at all how many visits a home health agency provides. If you provide three or you provide 300, they don't care. They're sticking with their reimbursement guidelines. That means it's up to the home health agency to determine how many visits should be seen, or should be provided to the patient. And we would hope that the home health agency leaves that to the clinician to make that decision, and ultimately the overseeing physician who signs the plan of care.

Medicare no longer allows the SLP to perform OASIS assessments, wrong, wrong, wrong. So speech-language pathologists are given the privilege to provide the comprehensive assessment and subsequent OASIS assessments during a patient's episode of care. And that is still the case. And I would even venture in to say that it's even more important now that the SLP take part in providing OASIS assessments moving forward. And the last one is Medicare will no longer reimburse maintenance therapy, and that is also incorrect. Now, more than ever, maintenance programs are important for our patients to keep them safe aging in place and maintaining at a level as long as possible despite having a chronic or terminal illness such as dementia. And Medicare continues to reimburse for maintenance therapy. Nothing has changed in that regard since PDGM came into play. So just some PDGM facts. In case you are aware of PDGM and how it works, this is the new method of reimbursement for Medicare for home health services that went into effect January 1, 2020. It is a significant, major shift in our reimbursement, the biggest shift we've had in about 20 years. And the way, the biggest part of this, the thing that is most significant to us in the home health industry is that prior to PDGM, home health agencies were reimbursed depending on therapy services.

So it was really therapy-driven reimbursement. The more therapy services that an agency provided, the more reimbursement the agency received. And so many agencies were incentivizing clinicians to provide more services. And then, all of a sudden, Medicare put on the brakes. And as of January 1, that is no longer the case. Now agencies are reimbursed depending on patient characteristics. So the next bullet kind of delineates what the characteristics or what the factors are for reimbursement, just in a very, this is a very broad explanation from 35,000 feet. PDGM is extremely complicated.

So I'm just making it really, really simple for you. The factors are the patient's diagnosis, what comorbidities there are for the patient, admission source, meaning where they came from to you in the home health agency. So if a patient came from the community, out in the community, being referred from their general practitioner, versus getting referrals from a hospital or acute facility. There's more reimbursement for somebody coming from the acute care rehab facilities, SNF facilities, than in the community. And then the timing, and that's pretty complicated. But it has to do with how many episodes the patient is receiving under the care of this home health agency. And then the functional score, and that comes from the OASIS. And there's a set number of factors from the OASIS that will determine what level of functioning the patient's currently at, whether they're low, medium, or high. Billing cycles have changed with PDGM. We now bill every 30 days as opposed to 60 days. Medicare has retained, for right now, episodes of care to be at 60 days. So it's a little confusing. Patient will be on service for 60 days with two separate billing periods within that episode. Accurate coding is very important. It's always been important, but even more so now, because reimbursement is dependent upon diagnosis and comorbidity. We have to be very, very accurate with regard to how we submit our claims to Medicare. So I mentioned previously the functional impairment levels, whether somebody is functioning at low, medium, or high.

That comes from certain OASIS items. These are the OASIS items that will determine functional level. And if you're not familiar with the OASIS, and I hope you will get really familiar with the OASIS moving forward, be the amazing SLP rockstar, do those OASIS. But they're called M questions, M1800, all the way down to M1033, grooming, dressing upper and lower body, bathing, toilet transfers, transferring in general, ambulation, and determining what their risk for hospitalization is. So the admitting clinician will get a baseline of these M items.

The next OASIS that is performed, whether that is a recertification for a new episode, or maybe a transfer to an acute care hospital, or maybe it's a discharge, the scores are gonna be compared from the first OASIS to the next OASIS. And that's how you get your determination for part of the reimbursement. One last fact, and it has to do with the coding of ICD-10 coding, I can't stress how important it is to code these documents accurately. We don't expect you to be an expert coder. And coders have to go through a certification program that is pretty rigorous. And you should be getting assistance from folks that are the experts at your home health agency. But accuracy is really important, meaning the SLP should be doing whatever they can, due diligence, to get the most accurate, up-to-date diagnosis coding for that patient. Dementia diagnosis can be added as a comorbidity, okay. But that, if it's just added as a comorbidity, it won't get as much reimbursement as if we used that dementia diagnosis as the primary diagnosis. But I do want you to understand, if you have a patient that you're seeing because they have a broken hip, and the physical therapist was in primarily to see the patient, yet they have a comorbidity of Alzheimer's dementia, Parkinson's dementia, that comorbidity will boost reimbursement a bit so that your services can be covered by Medicare. In order to count as that primary diagnosis to fit in the neurological reimbursement category, so there's only two out of 12 categories that take therapy services into account with regard to reimbursement. That's neurological and musculoskeletal.

And so some of your patients who have a primary diagnosis of dementia can be included in that neurological reimbursement category, meaning there is reimbursement considered for therapy services. Dementia diagnoses that are used for primary diagnosis have to be specific, though. So for instance, for dementia with Lewy bodies, and the code is G31.83. So it's very important that there is very much specificity with regard to that primary diagnosis. And that primary diagnosis really should come from a physician. We should try to get some documentation from the physician that that is, indeed, what the primary diagnosis is. That's just going to help you in getting reimbursed for your claim. And it's going to prevent an ADR, an additional documentation request from Medicare, meaning you've gotta dig into some back documentation to try to get everything that Medicare is looking for to cover that claim. So that's just some little-known facts about PDGM to help you get started here. So I'm gonna turn the mic over to my friend and colleague, the beautiful Megan Malone.

- [Megan] Thanks, Jenny, excellent information on PDGM. Appreciate all those facts and the latest figures. And I know it's been a complicated time for a lot of us trying to navigate PDGM and seeing how that affects our caseloads and how our agencies are handling that. And you know, I think we're all in it together, trying to kind of navigate this new terrain. But you know, I think what we're trying to do today, and hopefully our listeners will kind of hear that message, is that we really want to kind of clarify the facts, give some good direction, and also try to remind us all that our job hasn't changed. These patients haven't changed. It's the reimbursement that has changed. And unfortunately, sometimes we're seeing the effect of that, effects of all these reimbursement changes, coming down from our agencies and changing a little bit about the way that we work. You know, the hope is, is that with anything that's new, right, it takes some time to adjust, and that we'll see changes come down the pike even more as we move forward with this. But you know, I think, in terms of dementia care, really, the basics that we're gonna talk about today are the things that most SLPs have been doing with dementia patients forever. You know, the need for skilled services for our patients with dementia has not changed.

Again, it's just the mechanism for the reimbursement of those services that has undergone some changes as of January 1, 2020 with the advent of PDGM. But you know, we should continue to see our patients the same way that we have. That need for those patients to receive services that focus on cognition, strategies to assist with compensatory strategies for the effects of dementia, the importance of really training caregivers to change the way they communicate with their loved ones. You know, all of that education and all of that skilled treatment that we've been providing for years with these patients should still be in effect. We may just have to make a few concessions, a few changes based on kind of what's currently going on in terms of timing of things and how we set up our sessions and prioritize goals. And so that's gonna be the focus of this section of this course is just to kind of talk about, okay, how do we navigate this a little bit differently but keeping in mind, bearing in mind, that how we treat these patients and how we work with those caregivers remains the same? So we should still continue to evaluate and treat patients as ordered. Set goals and visit patterns that match the needs of the patient. I know there's a lot of discussion out there of sometimes agencies maybe dictating amount of visits that should be given to certain types of patients. At the end of the day, we really just have to keep in mind what our clinical judgment tells us to do, what our ethics tells us to do, make decisions based on that. Granted, we may have to make a few pivots in terms of amount of visits and how we kind of roll things out. And we'll talk about that as we go along here today. But in general, if you go in and do your evaluation, and you see certain priorities for this person to receive services from you, as a speech-language pathologist, and certain goals that will allow this person to remain safe within their home, being able to take medications safely, all of those kinds of things, then you would order your visits the same way that you always have. You would think about what the priorities are, about how long that would take. You would talk with your agency and the physician and get those approved, okay.

So those kinds of things aren't changing. Like we said, agencies should not be dictating the number of visits SLPs should be providing, as Jenny so eloquently put. Medicare doesn't dictate that either. So you know, if we're participating in those Conditions of Participation, and we're receiving, our agencies are receiving, reimbursement for services from Medicare, we go by their guidelines. They're saying that they don't dictate number of visits, so the agencies should also not be doing that either. So if you're kind of hearing that from your agency, those are discussions that need to be had. And I think we'll talk about some ways that you can have those discussions, how you can kind of navigate that kind of ethical dilemma of, you know, okay, well, this is what my agency's telling me to do, but this is what I feel my patient needs. Is there some compromise that we can have there? Can we look at things through a slightly different lens now and maybe have a few visits where we do some good training, either with those patients directly or with their caregivers, and then back out for a little bit, see how they're doing, and then come back in later? There might be some ways that we can do this. But in general, the rule is, is they should not be dictating the number of visits provided. But we may be asked, as SLPs, as clinicians, to improve our efficiency of care. So that's kind of what I'm talking about when we're saying, all right, we might have to kind of look at things through a slightly different lens. We might have to look at that, you know, the focus of the visits to be on those priority goals. What are the most important things this person needs to work on? And then that emphasis on patient and caregiver training and education, so that's a really big piece as well. How can we really use our expertise to provide instruction and demonstration to the caregivers on things that they can be doing. You know, based on what we see in evaluation and what these patients need, how can we provide that information in a shorter number of visits, perhaps? And then letting the caregivers kind of take the baton and run with it for a bit and see how things are going. So that's kind of the different shift that we might be looking at. Prioritizing goals, we always do that. But we might even have to look at that a little bit differently now.

Maybe number of goals might shrink a little bit and really focus on the ones that are gonna give us the biggest bang for the buck in terms of the person's safety overall and their communication needs, and then also that training piece. Okay, so when we're kind of trying to figure out how to do this prioritization of goals and making decisions about what's most important to work on, it's good to just kind of ask yourself some key questions. So you know, again, this isn't a change for PDGM. This is what we should kind of be focusing on is these kind of tenets of evaluation in home care. You know, what is this patient able to do? So can that patient communicate his or her very basic wants and needs?

So what are their communication strengths? What are their barriers or the obstacles that they have to communicating efficiently, either to their caregiver or to be able to maybe communicate pain or some other type of need, especially if they're having to communicate with, say, emergency personnel? Let's say something that was going on, we might have to teach the person how to get, you know, call 911 or talk to an ambulance or that kind of thing. So how would we evaluate the person's ability to communicate their basic wants and needs. So that would be a priority area. We always take a look at, of course, the patient's nutrition level, their hydration, and how they're doing with their medications. Are they taking those safely and in the right amounts, at the right time of day? So are they at any kind of risk for some type of deterioration due to lack of good nutrition, not getting enough liquids in, maybe at risk for some confusion related to their medications? So those would be super important things for us to evaluate. They really play into those functional outcomes and can be a really big impact area that SLPs can have on a case, if we are able to participate fully in helping a person to recall when to take their medications, what their medications are. This would also include things like dysphagia treatment.

So how is their swallowing? How they being able to take in food and drink safely? So we'd always wanna be evaluating that. And then we would wanna look at safety, of course. So is that person safe in their current living environment? What barriers are in the way there? Can we make some modifications or suggestions there? Or can we teach the person ways to remember how to remain more safe in their environment? So that could be anything from remembering to use their equipment, so making sure that they don't toddle into the kitchen without their walker or their cane if they need that, making sure that they're able to get off of their chair safely. And you know, you might think to yourself, well, that seems like that would be more of a physical therapy type of area.

But really, SLPs and PTs can work hand-in-hand in that. The PTs might be working on actual use of those walkers or that equipment, or those sit-to-stand types of strategies. But we, as SLPs, can work with the patient on how to remember to do those things and remembering to do them each time. And we could use different cognitive techniques or visual supports to help people to recall that they need to push off of their chair or to make sure that they have their walker before they begin to leave their chair or a certain room. So that's where we can kind of come in there. And then what kind of education or training is needed for the patient, the family, or the caregiver? So you know how those evaluations go here at home care. There's a lot of things that we're looking at. Obviously, first and foremost, that patient, but then we're also assessing that living environment. And who they're living with is included in that. And so sometimes we have caregivers who are kind of all in and really ready and willing to accept any recommendations that we give. They might even watch the sessions to try to learn what we're doing. And of course, that's the best case scenario. Sometimes we don't get that. And so we might have to think, okay, well, maybe this person needs a little bit more education on their need to kind of be involved in either observing some therapy or at least following through with written recommendations, maybe just even understanding the basic deficits the person might be dealing with. You know, a lot of this stuff is have second-hand for us, as therapists, but for family members who maybe have never had to deal with this before, it's a lot of stress and a lot of new things to learn. And some of these basics, like being able to shorten commands and questions to the person so that the person can actually pay the best attention to any verbal information that's coming in, that might be something that might not be kind of second nature to most people.

Being able to write down certain recommendations or things to remember for the patient might not be something the family member ever considered doing. So these are things that we can provide that education on, and we have to evaluate how willing and able that person is who's in the home, whether that's a paid caregiver or a family member, and then we have to then decide how long that type of training will take. Okay, so kind of moving into prioritizing goals, and we've kind of touched on this a little bit already. But I think it's always important for us to ask these questions in addition to the ones we just talked about. But again, what treatment areas will affect this person the most. What is the most important thing that this person needs to get out of therapy for right now? So that could be related to their safety. It could be related to to communication. It could be related to both. But what is gonna have the biggest impact? Also, what means the most to the patient to address? And I think that's always a huge piece of this. A lot of times in our evaluations, we're looking at documenting what the person-centered goal is. What is the person saying that they want to be addressing? And that's a huge piece of this. So we need to have those discussion, if possible, with the patient. You know, what do you really wanna get out of this? How can I help you? I always try to frame it in a way of, you know, if we could wave a magic wand and you could do something a little bit better or easier, and I can help you with that, let's talk about what that could be. And so sometimes that allows the person to start to really express what they would like to focus on in treatment. Sometimes you'll get those kind of dismissive responses. Oh, there's nothin' you can do for me, or not even understanding why you, as a speech-language pathologist, are there in the first place. You know, well, I have a memory problem, so I can say all my words fine. I just can't remember things.

And so sometimes we then have to do some explanation about even what speech pathologists do and what our scope of practice is and how working with cognition and memory and so forth is something that we are very well-equipped to do. And then we can explain to them some of the things that we might be able to assist them with. And that usually kind of brings people around a little bit better. You know, most are wanting to say, I'd love to be able to remember my loved ones' names. I'd love to be able to remember when I'm supposed to take my medication, things like that. What are some abilities or strengths the patient exhibits that can help them to successfully reach their goals?

I always feel that this is a huge piece, because a lot of times our evaluation measures are kind of seeking out the weaknesses, which, of course, the person is coming in with a diagnoses or a disorder, and they're needing therapy, it's to help improve an area that's not functioning as it typically would. But it's important for us to look at what abilities the person has as well. Because those are the things that are gonna be our strong foundation to assist with those weaker areas. So you know, what, is the person able to read, for one? You know, if their ability to read is still preserved, we can incorporate some use of visual supports. So that could be written cues that might be able to help. We might have to make some variations on those in terms of the print size or where they're located so the person can see them. But you know, if the person can read, that might be a way that we can compensate for those memory deficits, being able to remember, oh, yeah, I need my walker before I stand up and try to leave the room. Oh, yeah, I do need to take smaller bites when I'm eating. So we might be able to put a visual next to their plate at the the dinner table or put a reminder even on their walker directly in front of them that they need it to walk safely, things like that. So we always wanna look at strength and ability, so then we can figure out how to kind of circumvent the deficits that the person is exhibiting. And I find that this is a really, I don't know, it's really changed the way that I look at how I work with patients. Because I think it's just a more positive perspective to come from. You're looking at, okay, there's still abilities here.

Even if the person is pretty advanced with something like dementia, there's still often very much things that they can respond well to. That could be nonverbal cues. It can be music. It could be touch. Those kinds of things are still considered strengths the person may have. And so we might be able to capitalize on those. Or if they can't communicate very clearly verbally, maybe they still have the ability, their fine motor skills might still be intact, where then we can provide some communication cards or some kind of adapted augmentative communication, where then they can still express their wants and needs but use those cards to do so versus verbally expressing themselves. So there's always something to built on. And I think if we go from that perspective, it's just a lot more success-oriented both for us, as the therapist, and for the patients. Then we gotta look at how many therapy sessions we'll need to acheive these goals. And this is a tricky one. You know, I think it's always a little bit hard for us to make determinations about frequency and intensity of visits, how often we're going to be seeing them and for how long. You know, we have to kind of use our best educated clinical judgment to decide how long we think we need to see the patient for. But you know, under kind of this new reimbursement model, like we said, there might be some changes that might be asked of us. Your agency may say, well, can you do this a little bit more efficiently? Can you try to get done what you need to get done in a less amount of visits? And so in our minds, we're thinking, okay, well, what are the big priority things I can work on? About how many sessions will that take? Maybe there's gonna be some discussion back and forth between your agency about exactly what that will look like.

And then you get in there do what you need to do and try to get that caregiver training and that patient kind of up to speed. And then we see how it goes. You know, it doesn't mean that just because you're given a few visits initially to see a patient that you can't ever go back in and work with them, right. So it's more that we kind of look at things in that way, too. Maybe we can dig in early, get some things established, see how they're doing. You know, maybe the other disciplines that are involved in a case are keeping kind of tabs on that as well. And then we can always, as that skilled need shows up again, then we can be talking with the physician to be able to go back in and do additional visits, okay.

So we gotta still do that kind of planning that we've always been doing. But we might just be looking at it a little differently now. Okay, couple other things to keep in mind: Does the patient agree that they need therapy? That's always a fun one. Sometimes we get in there and people are more than willing to take the assistance that we can provide. Other times, they're not so keen on it. And I think it's always important to see what the patient is saying. See what they believe they need. Sometimes, I think, it's important for us to paint that clearer picture for them about what type of assistance, type of instruction, type of support that we can provide to them. And then I think that kind of changes their minds a little bit when they see how we can assist. Maybe even if we just have a couple of visits, and we can just open them up to the idea of, well, let's just try a few things. And then we can see what happens. And sometimes when they see that they're actually capable of doing some of these things or improving in some of these areas, they're more open to the process. So it's always important to have that discussion. Again, looking back at kind of what goals will help build patient success, thinking about what other disciplines are involved. So you know, it's always been tricky to schedule within home care and to kind of stagger visits and prioritize which disciplines should be involved at which points in a case. But it's always good to be weighing that into our decisions about what we are doing with the patient, what are the biggest priority areas, how many visits we're going to need. If there are several other disciplines involved, we may have to look at trying to stagger our sessions a little bit, things like that.

And then, are those patients, are caregivers willing to participate in treatment or carryover? So making sure that they are willing to do that. It's really important, as we're gonna see on this next slide here, that the caregivers are involved in that teaching and training, that they're also willing and able to do it. Here's a couple of examples of some teaching and training goals. So you know, it could be anything from the caregivers demonstrating how to safely thicken liquids to the recommended consistency, so we might have that as a priority goal.

Like, let's get in there and do some dysphagia treatment, but let's also make sure that those caregivers are up to speed on exactly what they need to be doing for thickening the liquids. It could be that the family members will demonstrate knowledge of different dementia resources. So maybe if we know we're only gonna be seeing the patient for a few visits and prioritizing some cognition goals, but then also that we want the family to know what they can do and how they can access information. Can they find those things in maybe a book that we create for them? Can the caregiver participate in training on different communication strategies? And can they teach that back? So maybe that's something like decreasing the length of those questions or commands, like I was saying a little bit ago, maybe just demonstrating that they can kind of change the way that they're communicating with their loved one, even getting on their level so the person can clearly see their face, maybe writing things down at times, especially if the person maybe has a hearing impairment, those kinds of things, or even things like listing the signs and symptoms of aspiration. So there's a lot of ways that the caregivers can be involving in being able to see the patient make progress and also maintain safety and function. Like we said, it's important that the caregiver or the family member states that they are willing to do therapy or willing to participate in caregiver training.

But it's also important that we ask them, and if they're unwilling to do so, that we document that as well. So you know, there's gonna be some that are gonna be willing and able, others who aren't. And you know, our key, just like with anything that we're doing, is to document that aspect. So if they're unwilling, we have to document that. Medicare won't reimburse for teaching and training of somebody who has stated they don't wanna learn. But they do definitely wanna see that we're doing that ongoing education and instruction and training with the caregivers. It's just key, if you can see here at the bullet here, that the training is documented, but also the caregiver's response to that training has to be documented.

So did they demonstrate understanding? Did they acknowledge the instruction that was given? Were they able to perform teach-back methods. So we need to be able to document that clearly so we're showing that that, that we're not just doing the education, but that actually the caregivers are following through on it. So if we have some limited visits, the key here is just to not limit our creativity. So some basic ideas, and this is something I've been doing for a while with a lot of my patients. Because I do feel like there's a lot to accomplish in a visit. And sometimes thoroughly educating the caregivers is something that can be a little time-consuming, and honestly, we may not have as much time to do. So I've created kind of resource or education toolkits that I kind of use with a lot of my patients. I just put together little handouts on a lot of the things that I typically teach on. So that could be cognitive strategies. It could be some of these communication strategies. It could how to make a good visual support, even different websites they can look at. So being able to provide that to the caregiver and talk them through some of that, show them, don't just hand them the book and expect them to read it. But maybe, oh, you know, today I thought we would just focus on this one page. This is what I was focusing on with your loved one. So these can be some things to keep in mind. And then maybe in that follow-up visit, asking if they had questions or if they were able to try some of those things out.

You know, a lot of times, if you kind of give a little bit of an assignment, people follow through. So, all right, next time when I come in, I wanna hear how those communication strategies went. You know, maybe just try it once when you are assisting in some of the ADL care, those kinds of things, see how that goes, if you kind of break down your directions a little bit, if the person, if your loved one does better. And then they kind of know, all right, they're expecting you to kind of come back in and ask about it. So you know, like anything, we follow through when we know we're gonna get asked about it.

So those might be some things you can try. Other suggestions would be using functional materials in the home that address the identified priority goals. This doesn't change in the advent of PDGM either. We should always be using functional things to help the patients follow through as successfully as possible. But you know, maybe those things are prioritized a little bit more now, where we're like, all right, I really need to make sure in these first couple of visits that you can show me how to use your cellphone in order to be able to contact family or emergency services or set medication time reminders, those kinds of things, okay. In terms of documentation, this doesn't change because of PDGM either. We wanna continue to use the ICF framework. So that's that International Classification of Functioning, Disability and Health. Great resources through ASHA on goal-writing. This one listed here, the PDF is specifically for dementia. It walks you through beautifully how to kind of use that framework for the different types of things you might be working on with a person with dementia. So that's a really more point. And then being able to kind of document honestly and ethically. So prioritizing goals, we might be able to see more positive outcomes even sooner if we're working on a little bit less. So those can be really positive things that could come out of this. But I think it's important to kind of keep communication open between yourself, your agency about documenting patient need for continuing care. It's really important that we realize that agencies need to demonstrate the need for therapy and the frequency and intensities based on need established by objective and measurable testing.

So it's all coming out of something that is data-driven. And then we have to make sure, as therapists, that we're documenting that ongoing need for treatment in every visit note. So not only talking about how the caregivers are following through with goals or how the patient is progressing, but how are they demonstrating a need for ongoing treatment? That needs to definitely be shown in all of our documentation. Okay, I'm not really gonna touch on these too deeply. But we did wanna provide a few examples of some goals that might relate to cognition and communication. These could be anything related to medication administration.

It could be something like responding to an alarm or something that might be set up to remind them when to take their medication. It could be we look at things like wandering if people were in a facility setting, or even maybe if they're at home and they're typically trying the wander out of the home, how we could work on that safety issue. So those might be real priority areas. Here's one related to the need to ambulate with a walker, so decreasing fall risk. So keep in mind that a lot of these goals are really not only expressing what we're gonna be working on but why it's important, how it's impacting safety or communication. So it's important to make sure that those are embedded in our goals. You know, here's the one, the second bullet is talking about recall and demonstrate hip precautions. So that might be something where the PT is really working on that rehab of that hip, but maybe we're working on them remembering what they can and cannot do as a result of their hip replacement, okay. So these are just some idea about some things that we can continue to be working on. Again, this hasn't changed based on PDGM. But we may look at prioritizing certain things or working on just a smaller amount of goals initially, and then being able to go back in and continue to work with patients as needed as that skilled needs arise. I'm gonna do a quick case study here just to kind of demonstrate these points. And so this patient is actually one of Jenny's.

And I think it's a really great illustration of working with a patient with dementia in a facility setting. This man was 75 years old, diagnosis of Alzheimer's dementia. Despite his dementia, he lived in an assisted living facility with fairly high-functioning residents. He was referred for speech therapy for wandering, which placed him at risk for his own safety and was also upsetting the other residents. So he was kind of getting quite around the community a bit, but also was at risk for leaving the facility and becoming lost, that kind of thing.

So his safety was definitely at risk. So the focus of the treatment was using a technique called the space retrieval technique and using visual cues. And I love this, because he apparently used to raise pigeons, so they used some visuals of some homing pigeons, pictures of those around the facility as his visual support reminder of where he was supposed to go and how to find his room and things like that. So initially, he was seen by speech-language pathology for 22 visits over two cert periods. So this was pre-PDGM. But we wanted to illustrate how the needs for these patients doesn't change, but we may prioritize things a little differently given some of the reimbursement changes we're seeing. He was also being seen by OT and skilled nursing. So we can see here that this kind of just talks a little bit more about some of the patient details, busy street, no locked exits, increased confusion for time and place, a score of a 20 out of 30 on the SLUMS evaluation. So we're definitely seeing some increased cognitive need going on with this gentleman. But he was also wandering into other residents' apartments, those kings of things, so definitely a skilled need for treatment here. So these were some of the goals that they addressed, being able to recall the strategy to locate his room. When you need to find your room, what do you do? And so I think he was looking for those pigeons, those pictures of the pigeons, which, again, just demonstrates how, if you prioritize meaning for a person, what do they need to know to keep them safe, but also what things mean something to them. Seeing a pigeon, a picture of a pigeon, probably wouldn't do that for me to find my room, but for this gentleman, it was something that had a lot of meaning for him.

So it was good to use something that would really stand out to him, and he'd be able to recall well, and then using those visual cues to locate different areas in the facility, like the dining room and his room, and then a goal for caregivers to show return demonstration of using these compensatory strategies. So again, these behaviors were compromising his ability to live in the least restrictive environment. The family and caregivers expressed that they're willing to participate. So again, key note here to document, that they were willing to participate in treatment.

And then the plan of care was discussed with the other people on the team. So when we wanna prioritize goals, so going back to those questions we were talking about a little bit ago, is the patient safe in his living environment? Nope, I think we established that. What kind of education or training is needed for the patient, family, or caregiver? So clearly, instruction on cuing for the patient and the use of the visual cues, and being able to cue the patient appropriately and frequently so he could recall it more accurately. And then we did establish that the caregivers are willing to participate. So under PDGM, we might look at this a little differently. They may have set the visit pattern based on the evaluation results and the time established to meet the goals. So we should always go in with that mindset. But if, for some reason, we are somewhat limited in visits or we wanna try to prioritize, or our efficiencies here, the way we would do that in kind of this new environment is to kind of focus on establishing those visual supports for the patient within the environment. So get those pigeon pictures up there. And figure out where the most important places are for those to be. Provide written supports or instruction to the patient's caregivers and family. So really doing that caregiver instruction piece would be huge if limited in visits to do those earlier. Work with the patient to establish the recall, so maybe establishing the space retrieval question, their recall of the response, teaching them to look for those visual supports, so getting them kind of a good jumpstart on things, so then, again, that baton could be passed to the caregivers. Document that progress using ICF, and then discuss with our agency the rational if more visits are needed, seeing of a compromise can be made, or if we can keep tabs on him with skilled nursing and OT being involved, and then bringing speech back in possibly at a later date if the patient needs more support or if the caregivers need more support. Okay, all right, so I'm gonna turn it back over to Jenny, and she's going to finish us out just discussing some ethical considerations and some SLP impact areas we can have.

- [Jenny] Thank you, Megan. Gosh, that was great information. And you know, just listening to what you were saying, really, what we do with our dementia patients hasn't really changed much over the years. It's just we need to be a little bit smarter, a little more efficient in what we do. So there's been a lot of ethical considerations going on since PDGM came into effect. And I might not go into detail with all of these, but some of the issues are home health agencies dictating the plan of care without input from the doctor, clinicians ask to see patients without proper orders being written, SLPs ask to perform functions that are not within the scope of practice, i.e. wound care, yes, this is an actual fact, or provide services without skilled service. I think you know in your gut, as a clinician, if something is right and something is wrong. So that's the main gist of this ethical consideration is to ask yourself, am I doing the right thing? Is this right for the patient? Is right for the industry? Are you setting a standard of working above board, being a role model for everyone else in the industry. One of the motivations for the changes in our reimbursement with PDGM from Medicare is that there's a lot of unethical behavior out there. And so we have the opportunity to set this right in turning it around. So don't hesitate to be vocal. If you're being asked to reduce your visits, if you're being told that the patient cannot be seen by the speech-language pathologist, number one, report your concerns to your immediate supervisor, okay. Number two, report your concerns to ASHA. Sarah Warren currently, as of this recording, is our healthcare regulatory advisor. So she's our Medicare expert.

And she wants to hear from you. So you can get in touch with her through ASHA. And she wants to hear if your position, if your job, if what you're doing is being compromised by PDGM. And then she will report to CMS on those stories that she hears from all of you. And then, of course, you can always report your concerns to CMS, to Medicare directly. Because they wanna hear, too. CMS has told all of the home care agencies, we're watching you. We're watching your behaviors. If you start to, if we start to see that all of the dementia patients are not being seen for therapy services under the home health agency's care, we're going to reach out to that home health agency, and there will likely be a penalty.

So it's important to be vocal so that everybody understands what's happening out there. How can you be an impact? Believe it or not, you're very, very valuable. That hasn't really changed, honestly, with PDGM. You've got unique skills and knowledge to impact many areas that are vital to home care. You can have an impact directly on improving outcomes, particularly in areas such as med management. That's a big one with Medicare. And that is actually one of the reimbursement buckets is medication management. You can impact and reduce falls. You can have a huge impact on reducing rehospitalizations. You can impact STAR ratings, which affects the agency referrals, and also reimbursement. So continue to provide that excellent care, encouraging completion of agency satisfaction surveys. You can participate in the agency's QAPI program, Quality Assurance Performance Improvement meetings. So you can have a real positive impact just by doing those things. You can show your value, number one, by starting to turn your mindset into demonstrating success through data. We need data to demonstrate to CMS, to everyone out there, how effective speech-language pathology services are. Data comes from evidence-based assessments and tools. It's used to demonstrate efficacy of treatment to CMS. And data leaves little room for question regarding impact. And so CMS took out a lot of questions on that OASIS document pertaining to speech-language pathology, communication, swallowing, et cetera.

And so now, more than ever, we're gonna have to use evidence-based tools, and we're gonna have to be able to report back to CMS how we're doing out there with our patients, showing your value through using data and evidence-based tools. Our role in the Conditions of Participation really hasn't changed. But once again, I'll say it a million times, SLPs need to be involved in completing that comprehensive assessment and all of the OASIS. Get the training that you need so that you can become involved. Our role is with coordination of care. We're involved in care planning, as I mentioned just previously, the QAPI program, ongoing interdisciplinary assessments, patient/caregiver counseling education, medication management. The way that we're gonna survive here is to become more involved than we ever were before. So we need to be really good at our care planning and utilization of the visits.

So I'm not saying cut your visits down, but really think hard, does the patient need, do all of my patients need two-week aids in an episode? Or should I be personalizing my plans of care to meet individual patient needs? And I would say yes, you do. Always perform at the top of your license. Do that OASIS. Take vital signs. Do med management. Collaborate and use a team approach. Step outside your silo. Work arm-in-arm with your PTs and OTs and your nurses. Consider telepractice. That's a big hot topic nowadays. And I highly recommend that you go to ASHA for resources and further opportunities for education on telepractice. I think it's gonna be huge in home health in the coming years. Once again, perform those OASIS and get involved in that med management. Wow, we did it. I wanna thank all of you for participating in this webinar. And we want to encourage you to reach out to us for any questions. We kind of zipped through a lot of slides. But I think we can embellish and give you so much more information if you need it. And so we always want, Megan and I always want, to encourage you to reach out to us using our emails addresses. And thanks, SpeechPathology.com, again, for having us. This has been a real pleasure.

- [Amy] Thank you, both of you, for joining us today. It's always our pleasure to have you with us. You always provide such incredible information, lots of practical advice and strategies, things to always be thinking about, and so current. So thank you to both of you for joining us today. And thank you to everybody who is participating and taking this course. We certainly do appreciate that and hope you have a great rest of the day. Thanks, everyone.