Components of Successful Dysphagia Intervention for the SLP in the Skilled Nursing Facility (SNF) Setting

Speech and Hearing Association of Alabama (SHAA)

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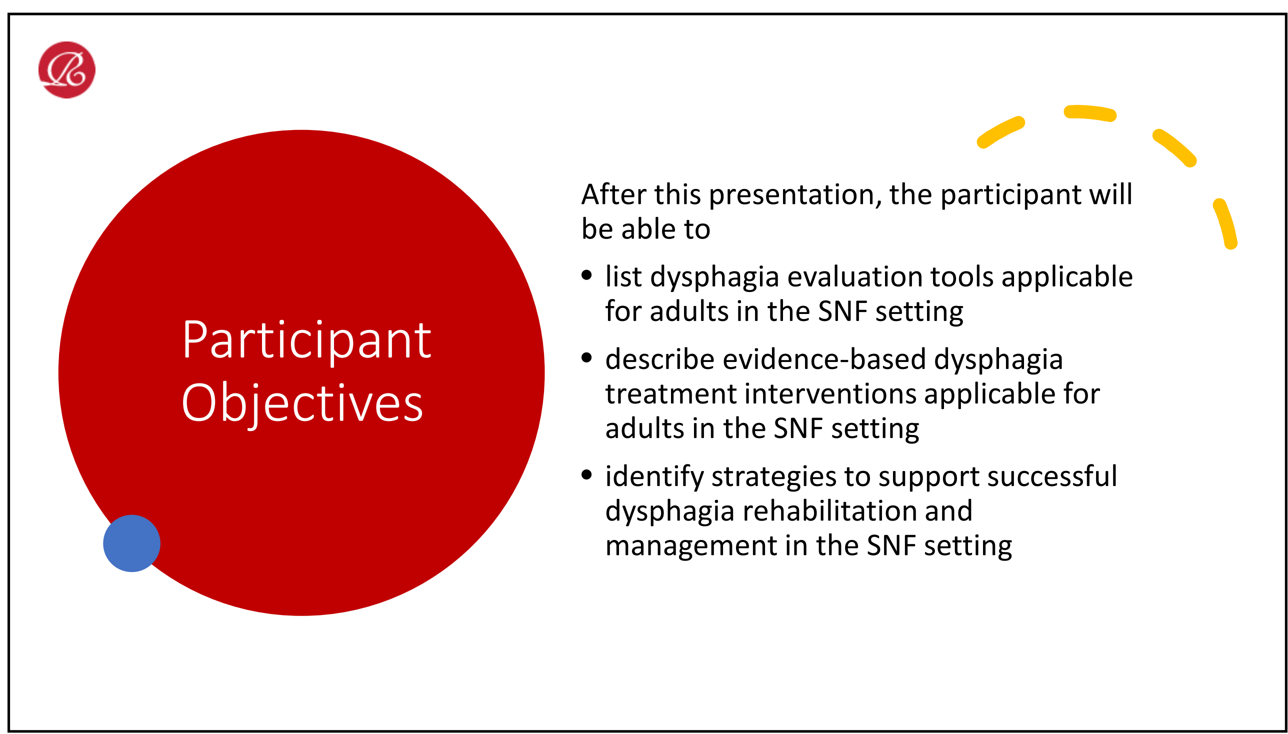


Continuum of Care: Post-Acute

After Discharge from Acute Care Hospital – What next?

POST-ACUTE CARE SETTINGS

LONG-TERM CARE HOSPITAL

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods

INPATIENT REHAB FACILITY

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery

SKILLED NURSING FACILITY

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services

HOME HEALTH & HOSPICE

Consists of services provided to beneficiaries in their homes as well as palliative and support services for beneficiaries who are terminally ill

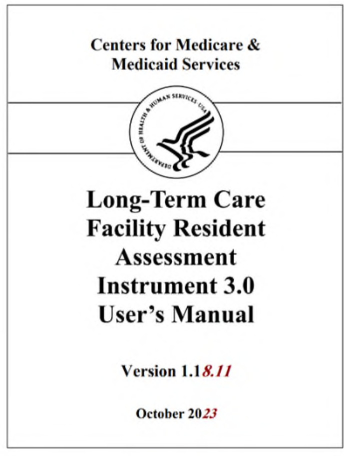
UNSKILLED HOME CARE

In-home support services to assist patients who suffer from injuries or health conditions that impair their ability to perform daily living activities

Federal Guidelines: OBRA 1987

- Omnibus Budget Reconciliation Act (OBRA) of 1987 (The Federal Nursing Home Reform Act (NHRA) – **created a minimum set of standards of care and rights for people living in certified nursing facilities.**
- Long term care facilities accepting Medicare or Medicaid funding are to provide services **so that each resident can "attain and maintain the highest practicable physical, mental, and psycho-social well-being" (basic objective of the reform)**
- **SLPs in the SNF setting assist residents with achieving and maintaining their highest level of function and quality of life.**

CMS RAI Manual: Minimum Data Set (MDS) 3.0 Resident Assessment and Care Planning



CMS RAI Manual: Minimum Data Set (MDS) 3.0 Resident Assessment

- Screening, Clinical and Functional Status Data Elements
- Common Definitions and Coding Categories
- Comprehensive Assessment
- Conducted on a Set Schedule (e.g. Quarterly)

CMS RAI Manual: Minimum Data Set (MDS) 3.0 Resident Assessment

Section	Description
Section B:	**Hearing, Speech and Vision**
Section C:	**Cognitive Patterns**
Section GG:	**Functional Ability and Goals**
Section K:	**Swallowing and Nutritional Status**
Section L:	**Oral/Dental Status**

CMS RAI Manual: MDS 3.0
Section K: Swallowing/Nutritional Status

SECTION K: SWALLOWING/NUTRITIONAL STATUS

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

K0100: Swallowing Disorder

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

↓ Check all that apply	
☐	A. Loss of liquids/solids from mouth when eating or drinking
☐	B. Holding food in mouth/cheeks or residual food in mouth after meals
☐	C. Coughing or choking during meals or when swallowing medications
☐	D. Complaints of difficulty or pain with swallowing
☐	Z. None of the above

CMS RAI Manual: MDS 3.0
Section K: Swallowing/Nutritional Status

Coding Instructions

Check all that apply.

- **K0100A, loss of liquids/solids from mouth when eating or drinking.** When the resident has food or liquid in *their* mouth, the food or liquid dribbles down chin or falls out of the mouth.
- **K0100B, holding food in mouth/cheeks or residual food in mouth after meals.** Holding food in mouth or cheeks for prolonged periods of time (sometimes labeled pocketing) or food left in mouth because resident failed to empty mouth completely.
- **K0100C, coughing or choking during meals or when swallowing medications.** The resident may cough or gag, turn red, have more labored breathing, or have difficulty speaking when eating, drinking, or taking medications. The resident may frequently complain of food or medications "going down the wrong way."
- **K0100D, complaints of difficulty or pain with swallowing.** Resident may refuse food because it is painful or difficult to swallow.
- **K0100Z, none of the above:** if none of the K0100A through K0100D signs or symptoms were present during the look-back *period*.

Dysphagia Epidemiology

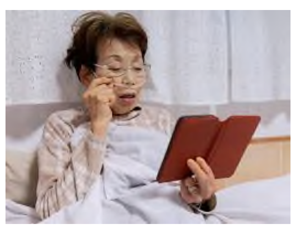
- Prevalent in elderly and persons with complex medical conditions, significantly higher prevalence in nursing homes when using screening compared to patient report.

Hospital setting	**36.5%**
Rehabilitation setting	**42.5%**
Nursing home setting	**50.2%**

Prevalence of Oropharyngeal Dysphagia in Adults in Different Healthcare Settings: A Systematic Review and Meta-analysis;
Rivelsrud, Maribeth C. et al, Dysphagia(2023) 38: 76-121

Consequences of Dysphagia in Elderly

Malnutrition	**Pneumonia**
Dehydration	**Frailty**
Choking	**Chronic Lung Disease**
Compromised General Health	**Social Isolation**



Source: ASHA Adult Dysphagia Practice Portal

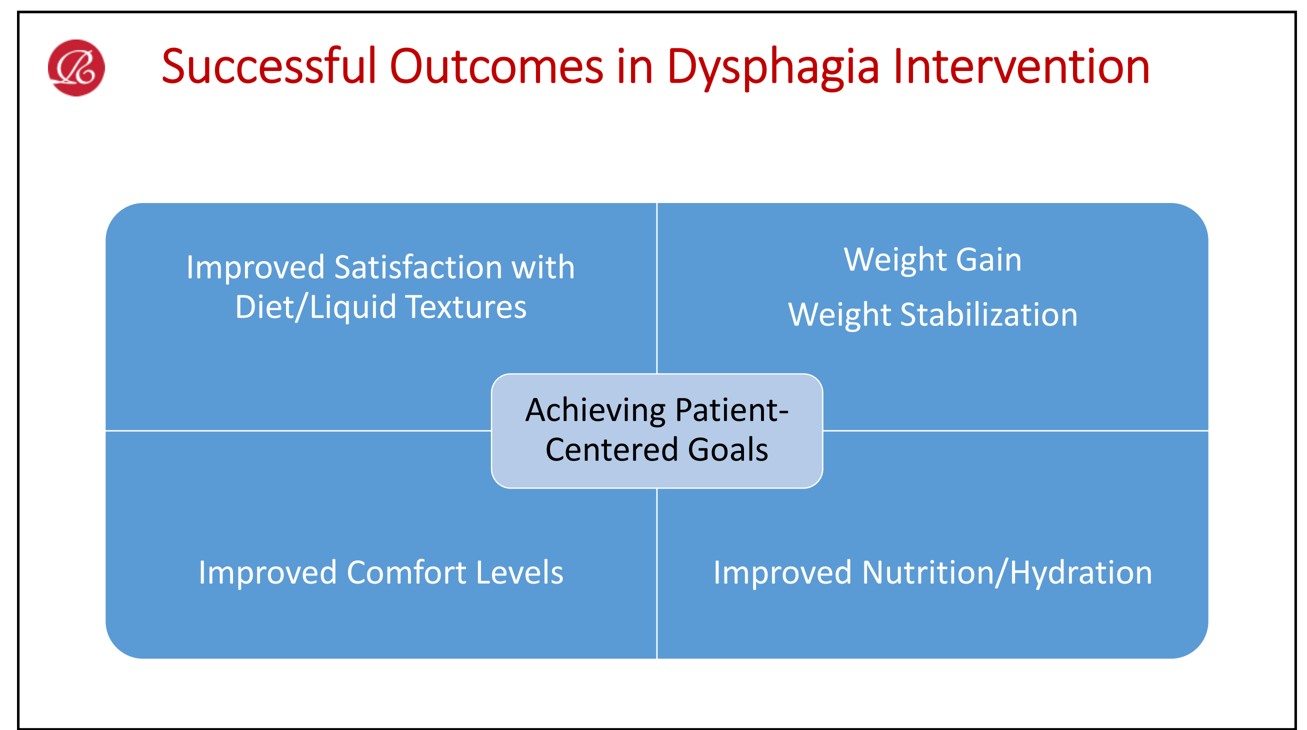
Aspiration Pneumonia

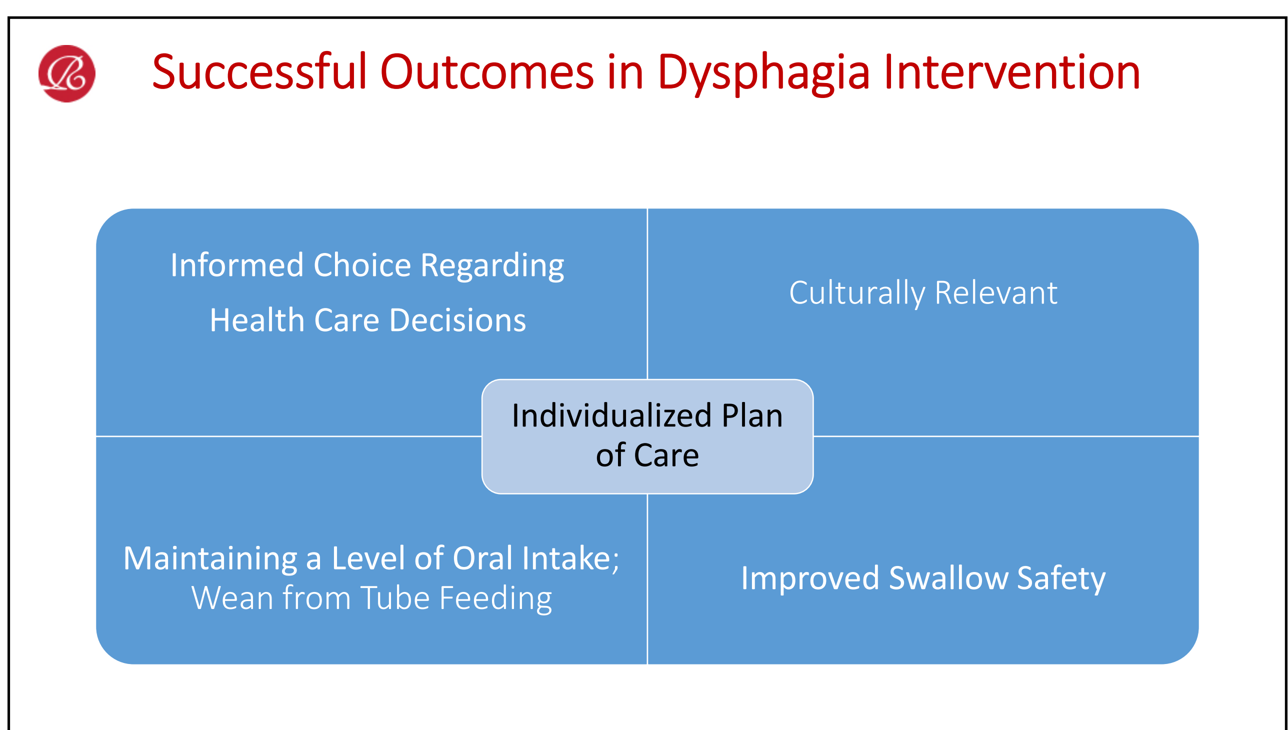
Langmore, Susan E. Ph.D., et al. "Predictors of Aspiration Pneumonia: How Important is Dysphagia?" Dysphagia 13: 69-81 (1998).

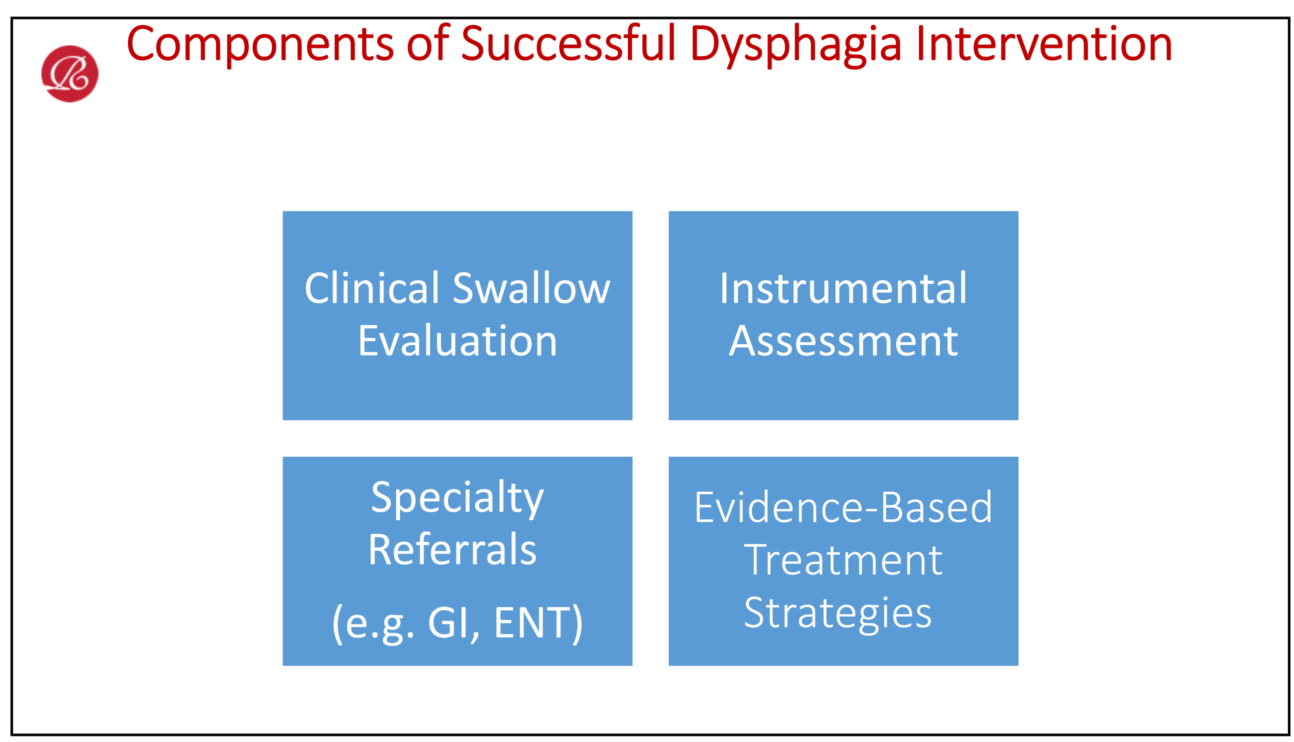
Of the 189 elderly subjects in the study, those most likely to develop aspiration pneumonia included:

Dependent for Feeding	Multiple Medications
Dependent for Oral Care	Smoking
Number of Decayed Teeth	Bed Bound
Tube Feeding	Reduced Activity Levels

Successful Outcomes in Dysphagia Intervention




Successful Outcomes in Dysphagia Intervention
Informed Choice Regarding Health Care Decisions
Culturally Relevant
Individualized Plan of Care
Maintaining a Level of Oral Intake; Wean from Tube Feeding
Improved Swallow Safety


Components of Successful Dysphagia Intervention
Clinical Swallow Evaluation
Instrumental Assessment
Specialty Referrals
(e.g. GI, ENT)
Evidence-Based Treatment Strategies

Dysphagia Evaluation Tools for Adults in the SNF Setting (Clinical Swallow Evaluation, Instrumental Assessments)

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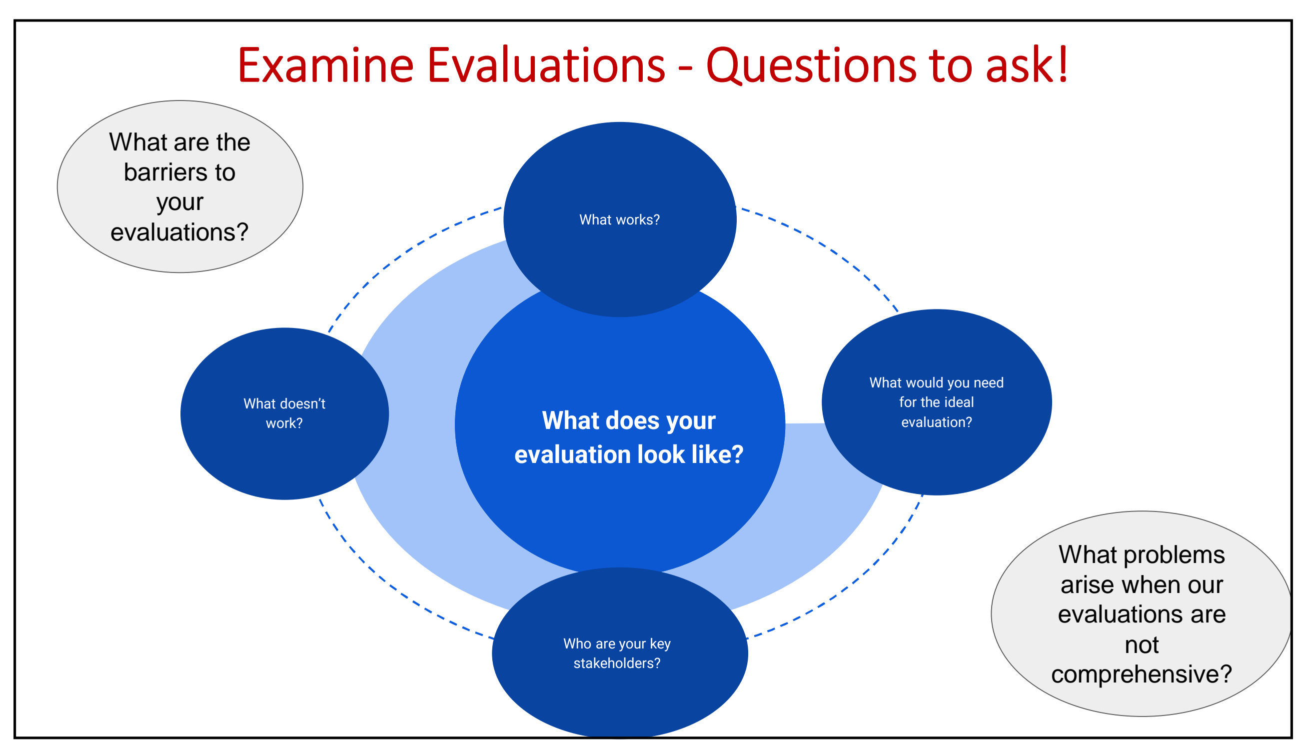
Examine Evaluations - Questions to ask!

What are the barriers to your evaluations?



What problems arise when our evaluations are not comprehensive?

Evidence-Based Practice in Dysphagia Evaluation

Understanding Evidence-Based Practice as a tool to create comprehensive interventions for **all** patients using **all** components:

- Empirical evidence
- Clinical expertise/expert opinion
- Patient Perspectives (to include cultural or personal perspectives and values)

VS

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Why Perform an Assessment

As Speech-Language Pathologists, the basis of our profession is investigative in nature and should provide insight for the patient's clinical picture.

- Clinical competence is predicated on the ability to investigate to provide best practice to our patients.

"Every sleuth evaluates **all of the evidence**." Dr. James Coyle

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Discrepancies in Evaluation Practices Among Clinicians

While examining the many discipline-specific processes and procedures, there seems to be lack of consistency with many variable related to completing initial dysphagia evaluations:

- The purpose for the initial dysphagia evaluation was left to interpretation providing differences across clinicians with the same level of experience.
- Standardized assessments exist; however, not all are norm-referenced for all populations/settings.
- Many clinicians utilize a variety of tools in order to complete the dysphagia assessment.
- Clinicians have found valuable information in the initial assessment that drives future interventions.

(Mathers-Schmidt & Kurlinski, 2003)

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Dysphagia Evaluation Tools for Adults in the SNF Setting

Screening	Non-Instrumental Assessment (i.e. Clinical [Bedside] Swallow Evaluation)	Instrumental Assessment
Utilized to determine the need for further assessment. ASHA suggests that a screening could be; • Questionnaires or interviews • Monitoring the presence of swallowing difficulties • pt/caregiver reports • Standardized screening tool	Assessments are used to determine presence of signs/symptoms of dysphagia. Often inferences can be made related to the reported difficulties. Provides insight into the need for further evaluation through instrumental assessment.	These assessments are used to examine the oral, pharyngeal, laryngeal, and upper esophageal areas of the swallow and to assess the effectiveness of treatment strategies.

Screenings

The purpose of the screening is to understand if dysphagia exists. When performed correctly, the screener is able to provide information on next steps.

- The screening process helps to identify people who are at high risk for developing disease.
- The screening can be performed by the SLP or a trained provider to include nurses or physician.
- The observer is looking for particular behaviors during eating/drinking.
- The screening is not an authorized means to determine aspiration.
- Screenings may yield recommendations for additional screenings, additional services, and/or additional referrals.

(ASHA, n.d.& Coyle, 2015)

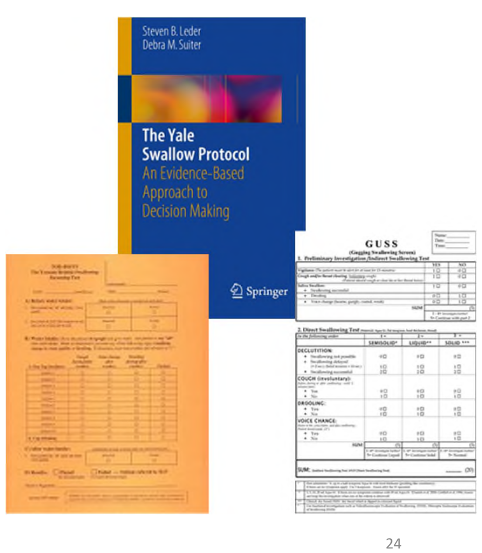
Examples of Standardized Screenings

Screening Water protocols

- Yale swallow protocol
- 3 oz. water challenge
- GUSS Test-The Gugging Swallowing Screen
- Timed water test
- MWST-Modified Water Swallowing Test
- Burke Dysphagia Screening Test

Other swallowing screening tools:

- Toronto Bedside Swallow Screening Test (TORBSST)
- The Dysphagia Standard Assessment (DSA)



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Non-Instrumental Assessment

The purpose of the non-instrumental assessment is to fully examine the reported or observed signs/symptoms of dysphagia.

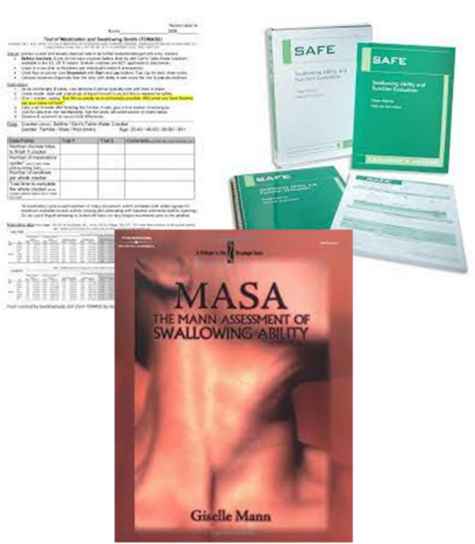
The clinician should have a basis of knowledge and skills to include, but not limited to:

- Understanding of diagnoses when examining the patient medical record;
- Typical and atypical function of the swallowing mechanism
- The impact of the patient's ability to perform the functional oral, pharyngeal, laryngeal, and esophageal tasks or limitations in performing the task of swallowing;
- Understanding the barriers and effects of the limitations on the patient's overall quality of life.

The non-instrumental assessment will assist the clinician in:

- Creating a clinical picture in order to establish a plan of care.
- Informing of the potential for interventions.

Examples of Standardized Non-Instrumental Assessments



- Test of Mastication and Swallowing Solids (TOMASS) (Normed for the oral phase)
- Swallowing Ability and Function Evaluation (SAFE)
- Mann Assessment of Swallowing Ability (MASA)
- Cranial Nerve Assessments

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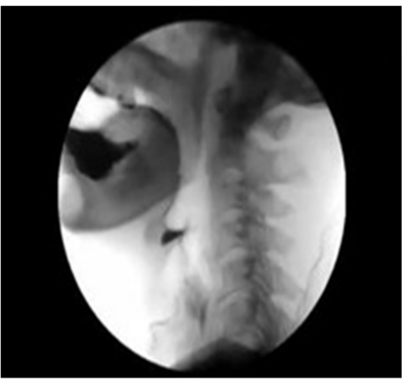
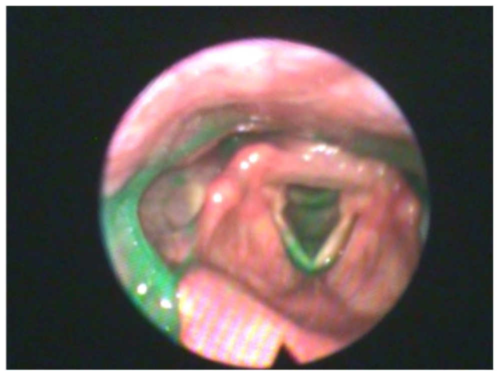
Instrumental Assessments

"It is impossible to determine pharyngeal and laryngeal anatomy and physiology, bolus flow characteristics, or presence of silent aspiration, based on a clinical swallow evaluation (CSE) alone."
(Leder, 2014)





Why Instrumental Assessments?

Research has documented that 40-60% of those who aspirate may not be identified by the clinical (bedside) swallow examination alone.

- Consider an x-ray obtained when evaluating a suspected fracture: instrumental assessments aid in more clearly defining the nature/extent/severity of the impairments in swallowing and in considering treatment interventions.

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Why Instrumental Assessments?

Treatment on the bases of physiology always allows for the appropriate intervention based on need and prevents:

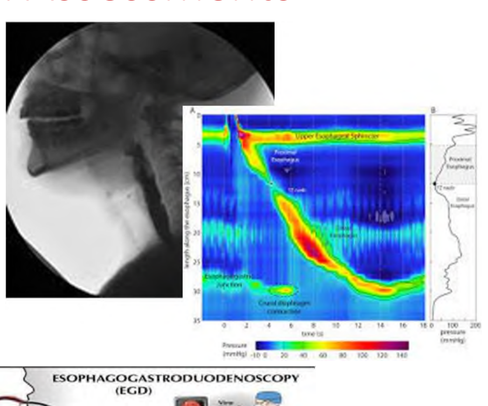
- Misdiagnosis- which occurs when only utilizing non-instrumental assessments without visualization of the swallow structures.
- Over treating- often occurs when providing inappropriate interventions or prolonged interventions if unsure of the physiological issue.

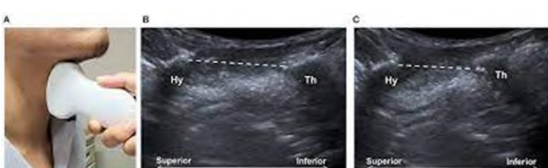
Treatment on the bases of physiology encourages:

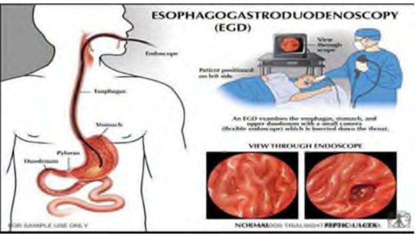
- Appropriate, targeted treatment techniques.
- Reassessment focus.
- Cost-effective for the patient.

Examples of Instrumental Assessments

- Fluoroscopy (Modified Barium Swallow Study, Upper GI/Barium Swallow)
- Endoscopy (FEES, EGD, TNE)
- Ultrasound
- High Resolution Manometry (HRM)(Pharyngeal, Esophageal)
- High Resolution 3-Dimensional CT Scan







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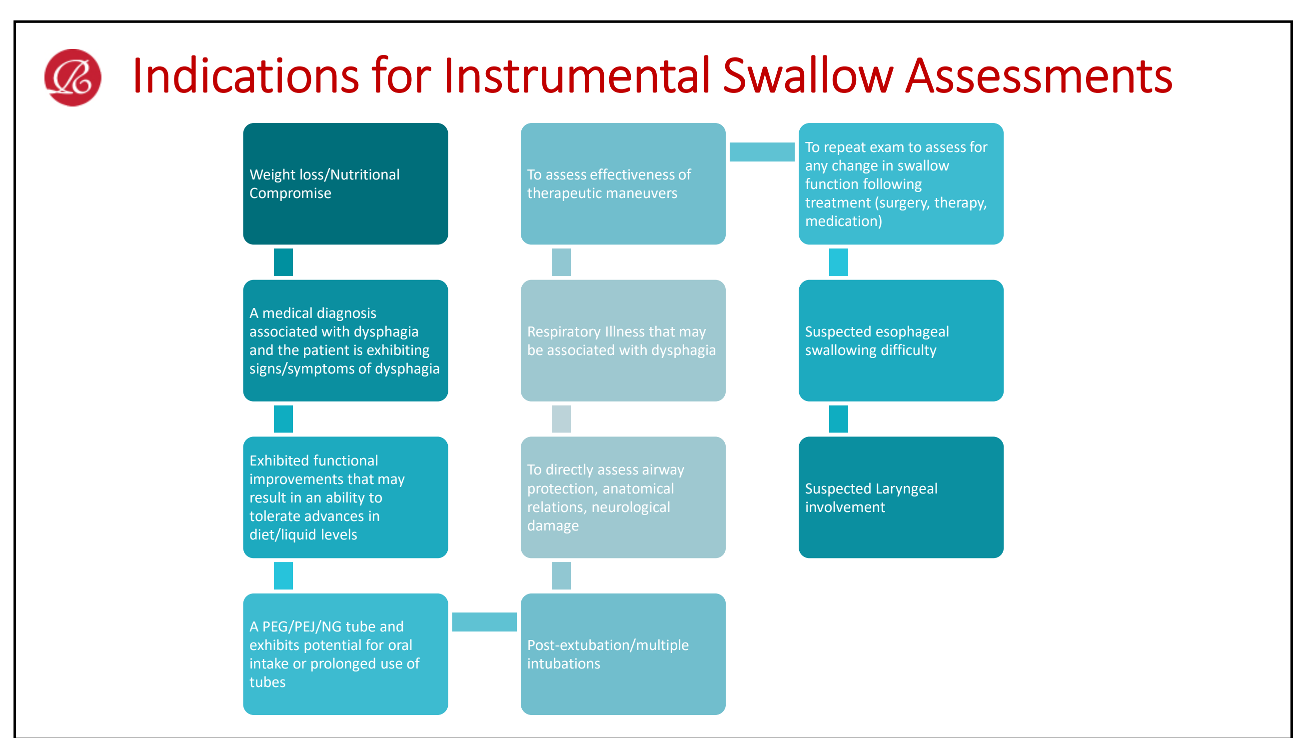
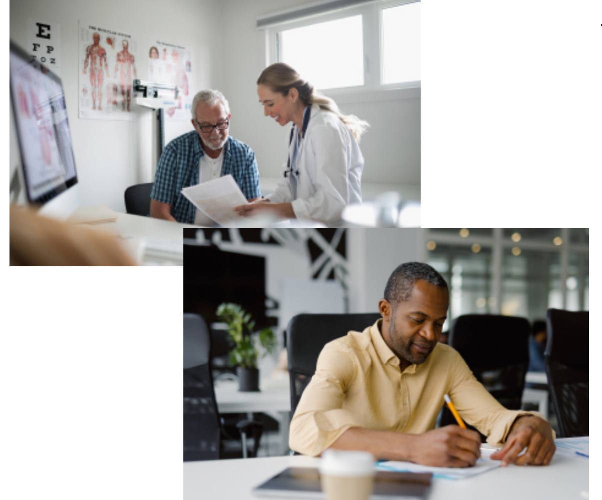
Indications for Instrumental Swallow Assessments



Additional Assessments



Utilizing additional assessments assists the comprehensive evaluation to add ratings from clinicians or other trained professionals and the patient/caregiver perspective.

- Trained Observer Rated Clinical Assessments
- Patient Reported Outcome measures (PROM)

Trained Observer Rated Clinical Assessments

Observer-Rated Clinical Assessments are beneficial for adding to the comprehensive dysphagia assessment.

- Observer ratings are scores given using units of measurement that are defined by the researchers (Meagher, 2009).
- Provides more insight into the clinical bedside swallow assessment and instrumental assessment.

Trained Observer Rated Clinical Scales

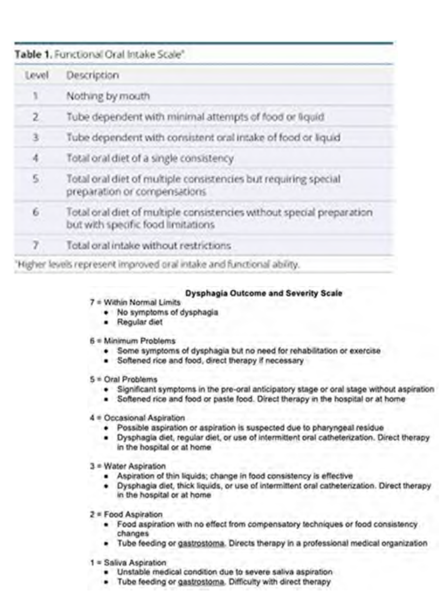


Table 1. Functional Oral Intake Scale*

Level	Description
1	Nothing by mouth
2	Tube dependent with minimal attempts of food or liquid
3	Tube dependent with consistent oral intake of food or liquid
4	Total oral diet of a single consistency
5	Total oral diet of multiple consistencies but requiring special preparation or compensations
6	Total oral diet of multiple consistencies without special preparation but with specific food limitations
7	Total oral intake without restrictions

*Higher levels represent improved oral intake and functional ability.

Dysphagia Outcome and Severity Scale

7 = Within Normal Limits
- No symptoms of dysphagia
- Regular diet

6 = Minimum Problems
- Some symptoms of dysphagia but no need for rehabilitation or exercise
- Softened rice and food, direct therapy if necessary

5 = Oral Problems
- Significant symptoms in the pre-oral anticipatory stage or oral stage without aspiration
- Softened rice and food or paste food. Direct therapy in the hospital or at home

4 = Occasional Aspiration
- Possible aspiration or aspiration is suspected due to pharyngeal residue
- Dysphagia diet, regular diet, or use of intermittent oral catheterization. Direct therapy in the hospital or at home

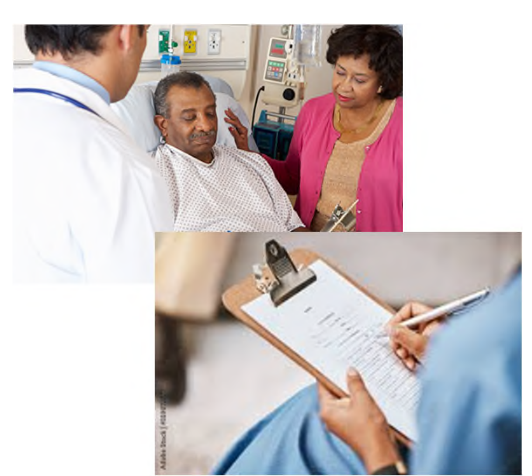
3 = Water Aspiration
- Aspiration of thin liquids; change in food consistency is effective
- Dysphagia diet, thick liquids, or use of intermittent oral catheterization. Direct therapy in the hospital or at home

2 = Food Aspiration
- Food aspiration with no effect from compensatory techniques or food consistency changes
- Tube feeding or gastrostoma. Directs therapy in a professional medical organization

1 = Saliva Aspiration
- Unstable medical condition due to severe saliva aspiration
- Tube feeding or gastrostoma. Difficulty with direct therapy

- Functional Oral Intake Scale (FOIS)
- The Dysphagia Outcome and Severity Scale (DOSS)
- The Dynamic Imaging Grade of Swallowing Toxicity (DIGEST-H&N Cancer)
- Bolus Residue Scale (BRS)
- Yale Pharyngeal Rating Severity Scale(Observed during FEES)
- Performance Status Scale (H&N Cancer)
- Penetration Aspiration Scale (PAS-Observed During FEES or MBS)
- Reflux Finding Score (RFS)

Patient Reported Outcome Measures (PROM)



Patient Reported Outcome Measures (PROM) are patient ratings that provide insight into:

- Best way to solicit and measure perspectives
- Cognitive awareness through comprehension
- Informing and facilitating clinician/client communication about goals
- Monitoring changes for intervention (Cohen & Hula, 2020).

Patient Reported Outcome Measures

- Eating Assessment Tool (EAT-10)
- M.D. Anderson Dysphagia Index (MDADI)-H&N Cancer
- Quality of Life in Swallowing Disorders (SWAL-QOL)
- Swallowing Quality of Care (SWAL-Care)
- Sydney Swallow Questionnaire (SSQ)
- The Dysphagia Handicap Index (DHI)
- Reflux Symptoms Index (RSI)
- Dysphagia Numerical Rating Scale (Dysphagia NRS)

Tips for a Successful Referrals

- Consult with the patient's CRNP vs MD regarding the patient's s/s consistent with dysphagia, as well as recommendations for Dental/GI/ENT consultation
- Choose practitioners that are familiar with and supportive of speech-language pathology and that are knowledgeable of various diagnostic and treatment procedures
- Communicate the reason for referral prior to the patient's scheduled appointment (i.e. phone call, fax copy of the FEES/MBS)
- Share SLP contact information with the physician/physician's office and request results from the evaluation

Dysphagia Treatment and Management for Adults in the SNF Setting

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Dysphagia Treatment

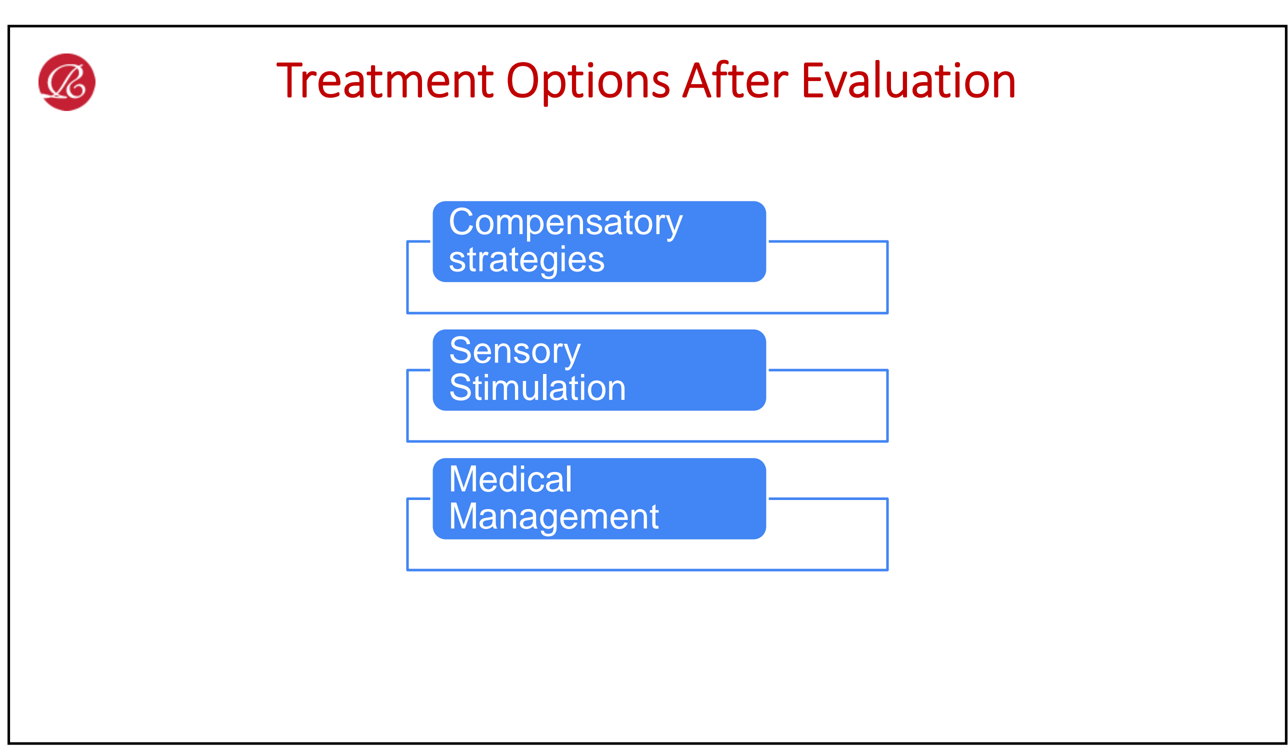
- Dysphagia Management
- Dysphagia Rehabilitation
- Combination

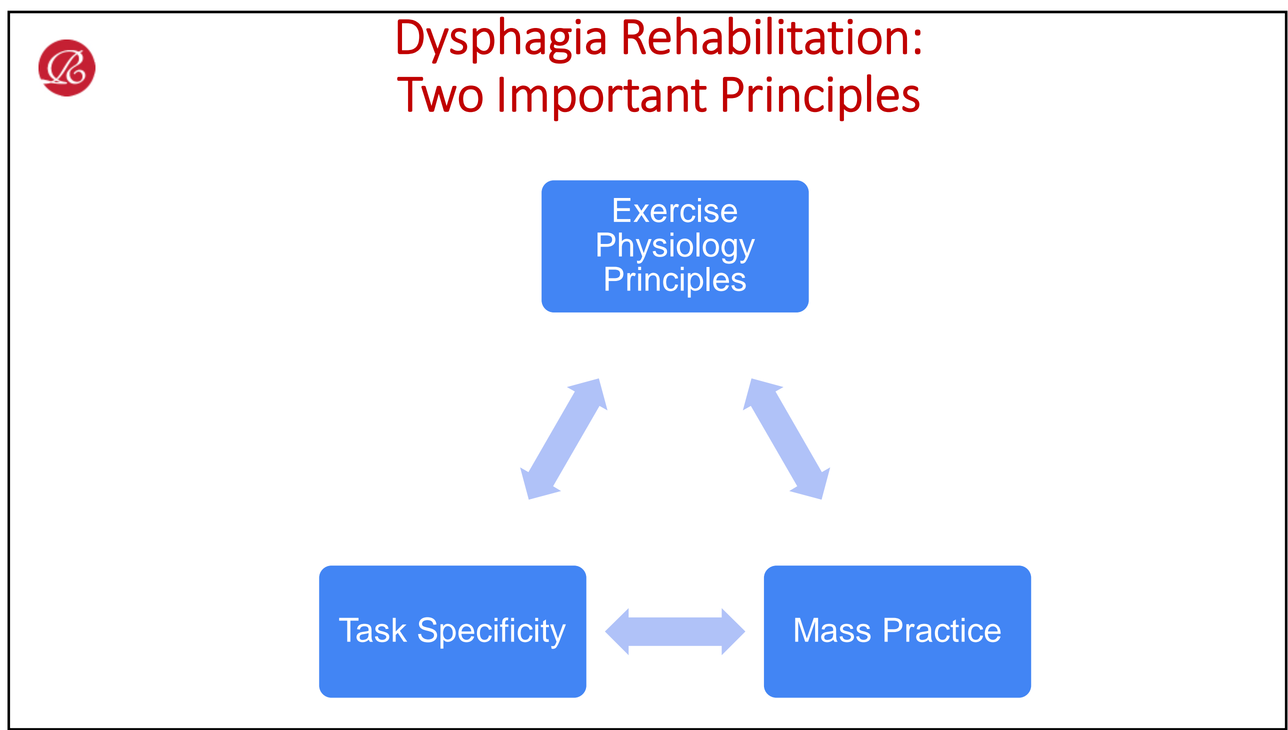
Dysphagia Treatment After Evaluation

"Upon completion of the clinical and/or instrumental evaluation,
the clinician should be able to use the acquired data to
identify which treatment options would be most beneficial.

Treatment options should be **selected on basis of evidence-based practice,** which
includes a **combination of** the best available evidence from
published literature, the patient's and family's wishes, and the clinician's experience."

(ASHA, n.d.)


Treatment Options After Evaluation
Compensatory strategies
Sensory Stimulation
Medical Management


Dysphagia Rehabilitation:
Two Important Principles
Exercise Physiology Principles
Task Specificity
Mass Practice

Dysphagia Rehabilitation: Task Specificity

- Exercises should be swallow-driven!
- Include dysphagia tasks and compensatory strategies as part of the instrumental assessment in guiding your treatment plan.

"We don't want to be doing exercises on the wrong impairments or even worse on ones that need medical intervention from ENT or GI before we start our treatment"
–Theresa Richard, Medical SLP 2022

Dysphagia Rehabilitation: Strength

- When the focus **is to increase muscle strength**, there must be a systemic increase in resistance (load bearing or intensity) to increase muscle size and strength.

Dysphagia Rehabilitation: Strength

- **Intensity** of exercise refers to the amount of load, volume, and duration of the exercise stimulus. Muscle size is one factor that influences force production for swallowing. **To elicit strength gains**, one should provide a load or resistance of 60-70% of maximum capacity.

(Coyle, James L. SiG 13, www.asha.org)

Dysphagia Rehabilitation: Progression

- Activity that does not force the body beyond its usual level of activity will not result in neuromuscular adaptation (Pollock, et al, 1998).
- Depending on etiology of deficits, often the focus of exercise should be on working to the point of fatigue instead of simply performing a specific, routine number of sets and repetitions (i.e. exceptions would include diagnoses such as ALS, Myasthenia Gravis, post-Covid syndrome, etc.)

Dysphagia Rehabilitation: Example Exercises

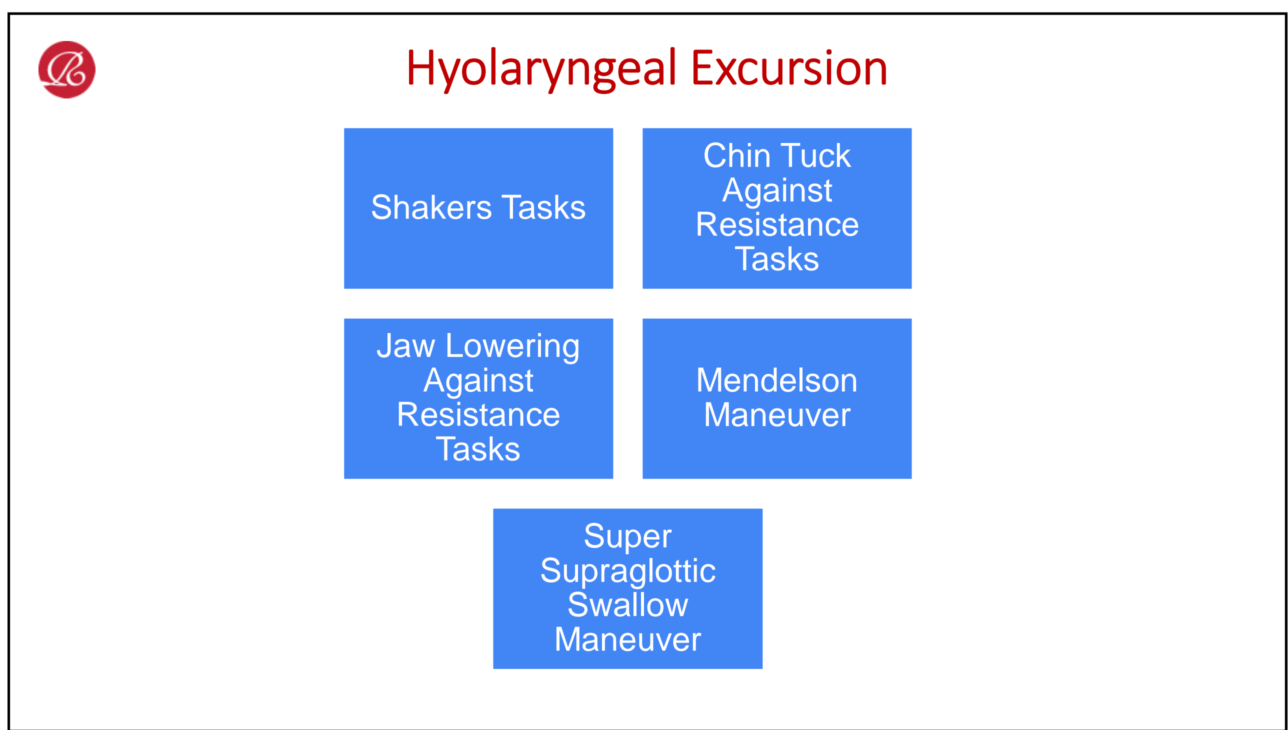
- Inspiratory/Expiratory Muscle Strength Training
- Effortful Swallowing Tasks
- Hyolaryngeal Excursion Tasks
- Pharyngeal Constriction Tasks
- Vocal Function Tasks
- Lingual Press Against Resistance
- Bolus Mastication Tasks
- Resistive Labial Strengthening Tasks

Respiratory Muscle Strength Training

www.EMST150.com

www.aerobika.us

www. pnmedical.com



Effortful Swallow with Tongue Press Technique

- Can Improve:
  * tongue to palate contact
  * increased base of tongue (BOT) retraction
  * contact with the posterior pharyngeal wall (PPW)
  * hyolaryngeal elevation and excursion vocal fold closure
  * pharyngeal constriction, and opening of the upper esophageal sphincter (UES)

(Huckabee et al., 2005)

Biofeedback in Dysphagia Rehabilitation

"Biofeedback incorporates the patient's ability to sense changes and aids in the treatment of feeding or swallowing disorders. For example, patients with sufficient cognitive skills can be taught to interpret the visual information provided by these assessments (e.g. sEMG, ultrasound, FEES, use of mirror, etc.) and to make physiological changes during the swallowing process."

Adult Dysphagia Portal www.asha.org

Guardian Aspire2

Vital Stim Plus

Synchrony sEMG

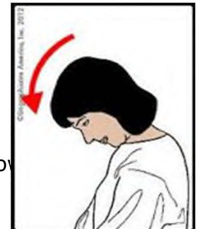
Neuromuscular Electrical Stimulation (NMES)

- Small electrical impulses delivered through electrodes attached to the skin.
- NMES is applied in conjunction with traditional exercise therapy.
- Some brands of NMES for swallowing include: VitalStim, e-Swallow, Guardian, AmpCare. Requires training. Various protocols and electrode placements.

Sun, S.F. et al, Combined Neuromuscular Electrical Stimulation (NMES) with Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and Traditional Swallowing Rehabilitation in the Treatment of Stroke-Related Dysphagia.

Dysphagia Management
Compensatory Swallowing Safety Strategies

- Postures
  - Chin down
  - Head turn to right or to left
  - Sit upright
- Other
  - Liquid wash
  - Lingual sweep
  - Hard Throat Clear and Re-Swallow
  - Lingual Bolus Placement



Compensatory Strategies: Diet and Liquid Modifications

- Diet and liquid consistencies
- What is the difference between diet analysis and diet trials?
- Promotes safety and/or efficiency with oral intake.

Diet and Liquid Modifications: What about these "other" consistencies?

- Many items do not have the viscosity labeled from the manufacturer
- Consider using the IDDSI flow test, spoon-tilt test or fork-drip test to objectively measure liquid viscosity or food textures
- Consider including the following items during instrumental assessment as appropriate:
  - Carbonated Beverages
  - Liquid supplements (e.g. Boost, Ensure, health shakes, etc.)
  - Buttermilk
  - Mixed consistencies

Compensatory Strategies: Utensils

Esophageal Dysphagia

- Normal swallowing requires the close functional coordination of the mouth, pharynx, and esophagus, and if one of these components becomes functionally impaired, it is likely that the others may be affected
  Triadafilopoulos et al., 1992, "Oropharyngeal and Esophageal Interrelationship in patients with Nonobstructive Dysphagia". Digestive Diseases and Sciences, Vol. 37, No. 3
- Familiarize yourself with the signs and symptoms of esophageal dysphagia vs GERD and LPR.
- Could the patient benefit from a referral to GI?

Signs/Symptoms of GERD

Heartburn	Chest pain	Breathing problems
Hoarseness	Throat pain	Dry throat
Bronchitis	Belching/ hiccup	Difficulty swallowing
Halitosis	Sour taste	Recurrent pneumonia
Spitting	Chronic dysphonia	Intermittent dysphonia
Vocal fatigue	Voice breaks	Chronic throat clearing
Chronic Cough	"Postnasal drip"	Excessive throat mucus
Drooling	Regurgitation	Unexplained weight loss
Globus sensation in throat or chest		Changes in dietary habits

CMS RAI Manual: MDS 3.0 Section K0300: Weight Loss

K0300: Weight Loss

K0300. Weight Loss

Enter Code: Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. No or unknown
1. Yes, on physician-prescribed weight-loss regimen
2. Yes, not on physician-prescribed weight-loss regimen

DEFINITIONS

5% WEIGHT LOSS IN 30 DAYS
Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.

10% WEIGHT LOSS IN 180 DAYS
Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.

Unintentional Weight Loss: The SLP's Role

*Is there an underlying cognitive/communication deficit which needs to be addressed?

- -Memory Deficits
- -Attention Deficits
- -Problem Solving Deficits
- -Expressive Communication Deficits

*Don't forget the oral phase!

Oral Care in the Skilled Nursing Setting

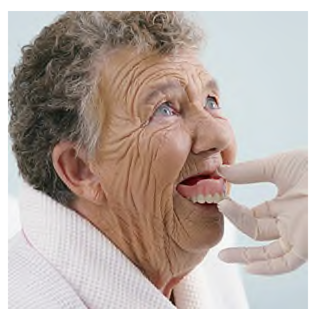
- Minimally once every 24 hours but optimally 2-3 times a day
- There is strong evidence to support toothbrush use (soft pediatric, electric, and/or suction toothbrush) over other options such as oral sponges or lemon-glycerin swabs for effective dental plaque removal.
- Dentures should be removed daily and soaked in water.
- Make referrals for dental consultation as necessary to social services and/or nursing.

Oral Health

Consider denture fit with oral health

Ill-fitting dentures can cause problems with oral intake, such as:
Tongue thrust

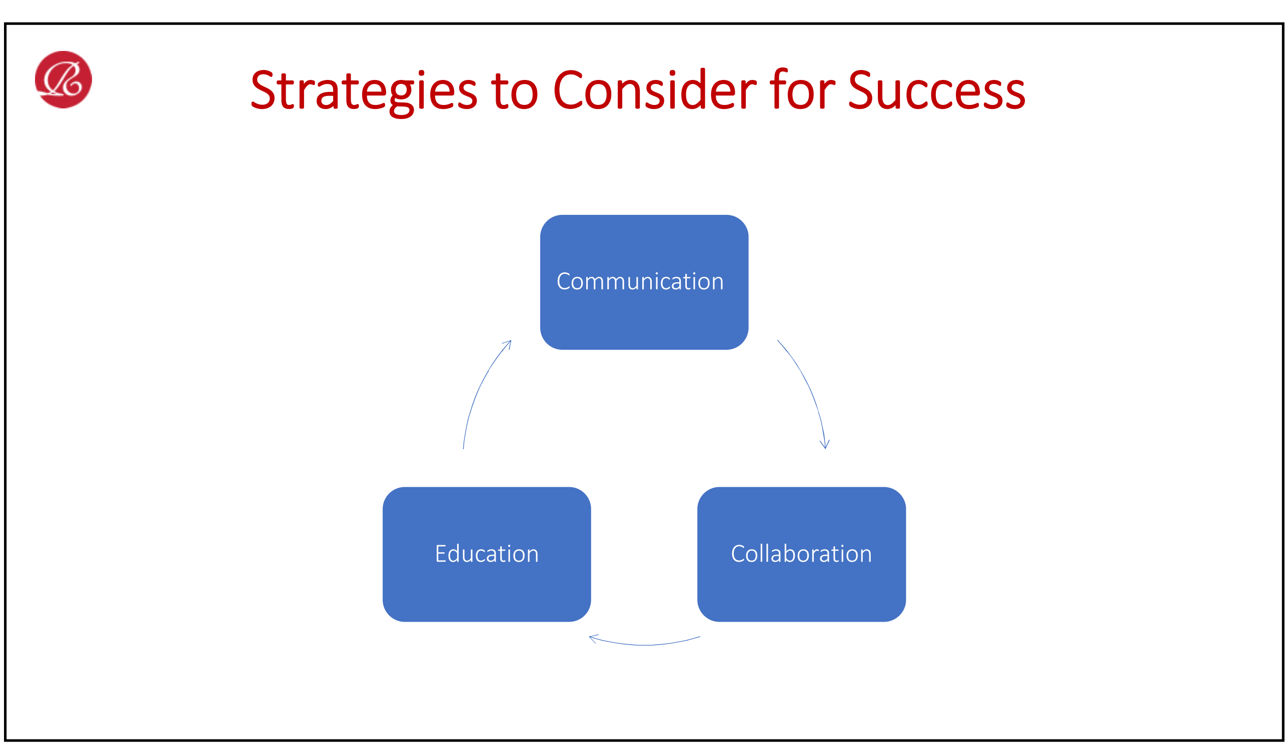
- Loss of oral motor control
- Delayed swallowing reflex
- Gagging
- Drooling

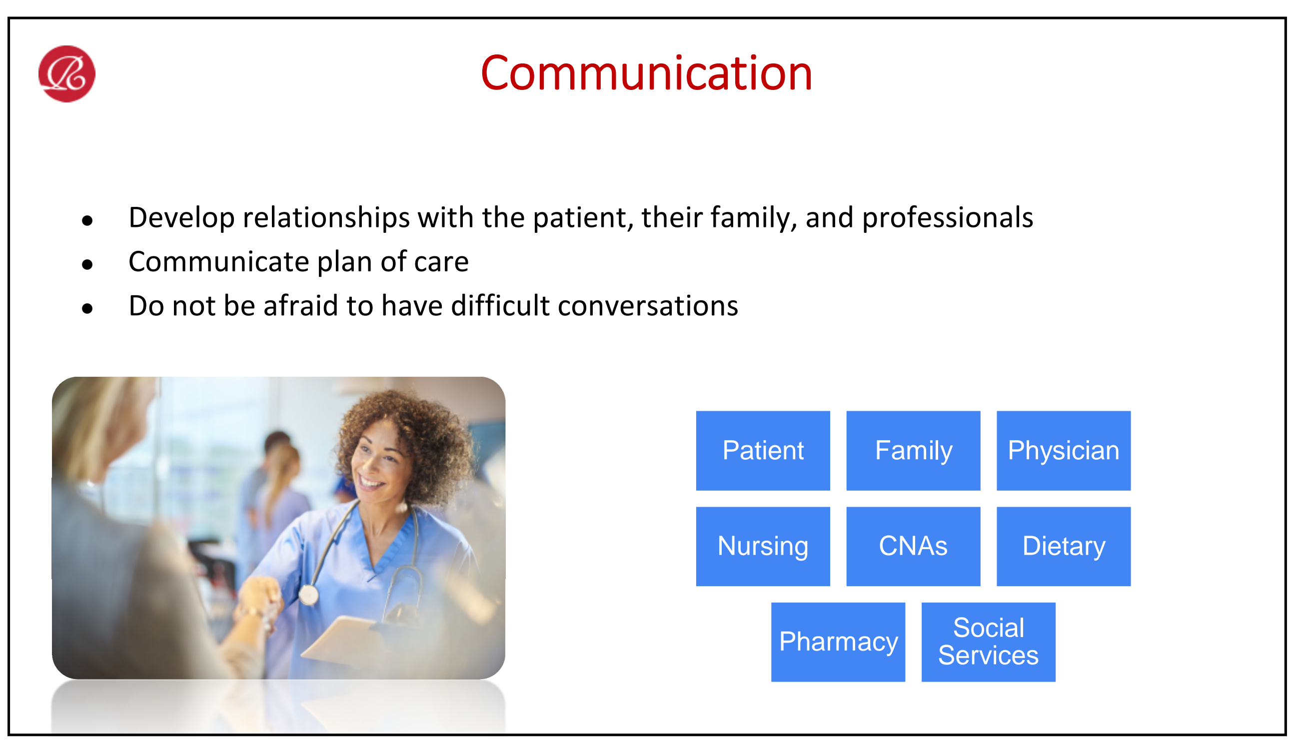


Dentures may also be present, fit well, but not worn.

Case Studies 1-4

Strategies to Promote Successful Dysphagia Rehab and Management in the SNF Setting


Strategies to Consider for Success
Communication
Education
Collaboration


Communication
Develop relationships with the patient, their family, and professionals
Communicate plan of care
Do not be afraid to have difficult conversations
Patient
Family
Physician
Nursing
CNAs
Dietary
Pharmacy
Social Services

- Director of Nursing (DON)
- Assistant Director of Nursing (ADON)
- Unit Manager
- Rehab Nurse
- Staffing Nurse
- MDS Coordinator
- Charge Nurse
- CNAs

Collaborating with Other Professionals: Certified Nursing Assistants

Certified Nursing Assistants and Nursing Aides (CNAs) are integral to the meeting the basic needs and wants of the patient.

Tips to assist with better collaboration

- Do what you can to make their job easier.
- If you have time to help them out, take that minute.
- If you see them implementing something you recommended, thank them.
- Give them the opportunity to share their knowledge of the resident. They spend more mealtimes with resident than we do.

Collaboration with the Multidisciplinary Team

The care plan process lends itself to therapy referrals due to changes in the resident. Let's remind them that there is more to identifying potential swallowing problems that coughing and choking.

- Change in respiration during po intake
- Recurrent pneumonia
- Decline in po intake or interest in eating
- Weight loss
- Complaints of food becoming lodged in the throat, globus sensation, pain when swallowing, or frequent regurgitation

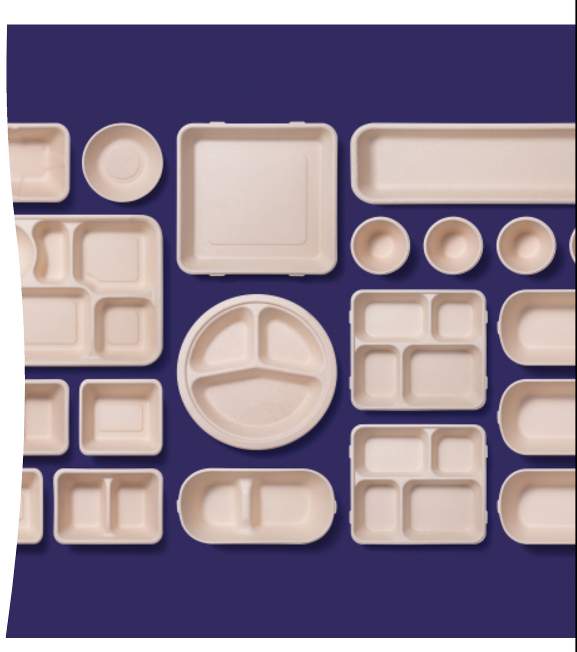
Reason for Referral: Ask Specifics

Many of the referral and screening tools utilized are simple checklists. Ask specifics about:

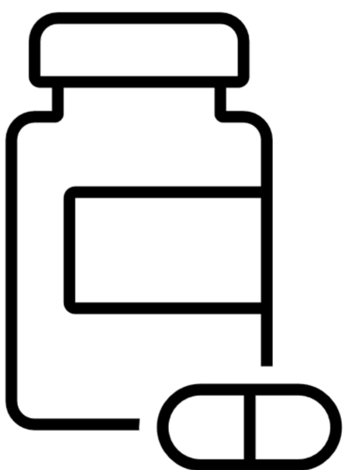
- Positioning: Bed or chair
- Occurrence: Frequency of episodes
- Duration: How long has this been happening (i.e. days, weeks, etc)?
- Progression: Is it better or worse?

Collaborating with Other Professionals: Dietician

- Diet and liquid consistency modifications
- Weight loss
- Tube feedings (bolus or continuous)
- Individualized considerations
- Maximizing caloric intake



Collaborating with Other Professionals: Pharmacist



- Xerostomia
- Level of alertness
- Coughing, etc.

If these issues are significant and potentially reversible, the pharmacist may recommend alternative options to the MD to offer some relief to the resident.

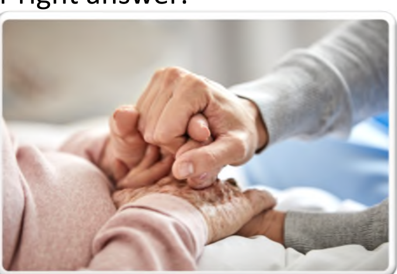
Collaborating with Other Professionals: Social Services/Discharge Coordinator

- Serve as informants regarding the resident's living environment.
- Refer residents who may be experiencing worsening depression or anxiety
- Give insight to the resident's DC plans
- Assistance with transitioning care (i.e. Home Health, Outpatient services)

Having Difficult Conversations

- When we know that our residents are not candidates for skilled intervention, are not consuming adequate po intake and are unable to safely tolerate po intake, what do we do?
- When caring for frail elders, there is often no clear right answer.

Pioneer Network, New Dining Practice Standards (2011), 26



Important Terms to Understand

- **Protein calorie malnutrition**
  - Inadequate intake of food caused by infection, inflammation, wound healing, fever, shivering, malabsorption, hypermetabolism, and inadequate caloric intake.
- **Failure to Thrive**
  - A state of decline that is multifactorial and may be caused by chronic diseases, functional impairments, dementia, and depression.
- **Anorexia in Aging**
  - Defined as age associated changes in the regulation of appetite and the lack of hunger. It is multifactorial and includes a combination of physiological changes related to aging, pathological conditions, and social factor

National Institutes of Health (.gov) www.ncbi.nlm.nih.gov>articles>PMC4772033

What does this mean?

With age:

- Activity decreases, metabolism slows, the need for energy decreases and people eat less
- Ability to absorb and utilize nutrients becomes less efficient resulting in a greater need for nutrients
- Chronic conditions, medications, and psychosocial conditions can affect nutritional requirements

Board, N., et al. Providing Health and Safe Foods As We Age: Workshop Summary EBSCO eBooks.

Alternative Means of Nutrition

- Tube feeding may be clinically appropriate in certain circumstances, but it should not be an automatic next step when other feeding strategies have failed.

- Before deciding to initiate tube feeding, the interdisciplinary care team should meet with the patient and responsible party/health care proxy to carefully consider the risks vs benefits of tube feeding and the patient’s preferences.

Consider the Research

- "Evidence suggests that nutrients neither prolongs nor improves life for many elderly patients with anorexia-related malnutrition at the end of life, with weight loss and cachexia frequently persisting despite interventions."

  Friedrich, L., & RD, C. (2013). End-of-life nutrition: is tube feeding the solution?. Annals of Long-Term Care, 21(10).

- “Studies have shown that feeding tubes are of unproved benefit in ensuring adequate nutrition, preventing pressure sores, preventing aspiration pneumonia, providing comfort, improving functional status, or extending life in patients with advanced dementia. The procedure can be burdensome through tube-related complications and the use of restraints.”

  Li I. Feeding tubes in patients with severe dementia. Am Fam Physician. 2002 Apr 15;65(8):1605-10, 1515. PMID: 11989637

  (Cassaret, Capo, Kaplan, 2005; Friedrich, 2013)

Legal Considerations

- Living Wills and Health Care Proxy
  - Living will - legal document detailing a person's desires regarding their medical care in circumstances in which they are no longer able to make decisions or express informed consent
  - Advance Directive - guides choices for physicians and caregivers (e.g. terminally ill, seriously injured, coma, late stages of dementia or end of life)
  - Health care proxy - legal document that names someone to act as proxy or agent, to express wishes and make health care decisions if the ill or injured is unable to do so (i.e. durable medical power of attorney)

Patient/Family Desires to Continue PO Feeding

- SLP Role:
  - Explain risks that may be associated with continued PO intake
  - Recommend the safest consistencies
  - Educate on benefits of good oral care
  - Educate on best practice for feeding and safety strategies with chosen diet

- PO intake in conjunction with tube feedings:
  - If appropriate this may be 1 meal/day, 1 small snack/day, or simply ice chips throughout the day
  - Need: supporting documentation that shows the resident may benefit from limited amounts of PO intake to help maintain quality of life, maintain oral and pharyngeal musculature, and to help prevent the risk for aspiration

Hospice or Palliative Care

- Purpose: to make the patient feel more comfortable and improve their quality of life
- Includes:
  - Holistic end-of-life (EOL) care focused on providing mental, emotional, social and spiritual support
  - Comfort medication
  - Medical equipment and supplies
  - Care in facility or at home
  - Support for caregivers

Keys to a Successful CF Experience in the SNF Setting

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Workforce Trends

ASHA SLP Healthcare Survey Report 2005-2021

Employment Status

- In 2021, **overall, 72% of SLPs who were employed worked full-time—**up gradually from 62% in 2005.
- From 2005 to 2021, SLPs in home health care settings were the most likely, or among the most likely, to work part-time.
- In most survey years between 2005 and 2021, **SLPs in skilled nursing facilities were more likely than SLPs in other health care settings to work full-time**.
- In 2021, 83% of SLPs in skilled nursing facilities worked full-time—up slightly from 80% in 2019.

Workforce Trends

ASHA SLP Healthcare Survey Report 2005-2021
Job Openings

- In 2021, **36% of SLPs reported** that **job openings outnumbered job seekers** in their type of employment facility and geographic area, **similar to recent past years** (28%–37% from 2011 to 2019).
- From 2005 to 2021, **SLPs who worked in rural areas were more likely than SLPs who worked in suburban and city/urban areas to report that job openings** outnumbered job seekers in their type of facility and geographic area.
- Job Openings by Health Care Setting From 2005 to 2021, SLPs in home health care settings, outpatient clinics or offices, and skilled nursing facilities **were more likely than SLPs in hospitals** to report that job openings outnumbered job seekers in their type of facility and geographic area.

Considering a CF Placement in SNF?

- Do you enjoy the medical side of speech-language pathology?
- Are you open to working with the adult and geriatric population?
- Are you interested in advancing your clinical skills for the adult population with dysphagia, cognitive and memory deficits, aphasia, and hearing deficits?
- Are you willing to be an advocate for patient’s needs? (i.e. Communicating with physicians, nurses, administrators, family members)

Considering a CF Placement in SNF?

- What does a typical day look like at this facility?
- Will I be traveling to other facilities to provide evaluations or treatment? How much of my work day or week will be spent traveling?
- What will the availability of my supervisor be to answer questions and provide mentorship on-site?
- Is there a CF training program available at this facility?
- Are there systems in place to make sure training minimums are being met for ASHA and your state licensure requirements?

Considering a CF Placement in SNF?

- In your opinion, what are important qualities that you are looking for in a candidate for this position?
- What do you enjoy about working for this company?
- What challenges do you see existing in this role, and what do you see as necessary to overcoming them?
- What degree of flexibility will I have in my work schedule?
- Is there a weekend or holiday on-call rotation?

Considering a CF Placement in SNF?

- How is productivity calculated? What activities count in productivity calculations? Are those targets achievable?
- What does on-boarding and mentorship look like at first hire and later on? Are there other SLPs in the building?
- How does the compensation and benefits package compare to other options?
- What sets your company apart from others? (Young, J., 2023)
- How would you describe overall company culture? (Young, J., 2023)

Working in a Skilled Nursing Facility… Is It Right for You?

- Article in The ASHA Leader June/July 2021 by Monica Sampson and Jamila Harley state that **"Like any work setting, a skilled nursing facility is better-suited for some prospective employees than for others."**
- The authors encourage you to **ask questions** of employers including:
  - How long has the rehab provider contracted with this facility?
  - What systems are in place to ensure that patients have access to instrumental swallowing assessments within a reasonable time frame?
  - Is this position a growth position (adding new staff) or is this to replace a vacated position? Why did the last person leave?

Considering a Placement in a SNF? What Credentials Does the CF Supervisor Need?

- A clinical fellow must be supervised by a speech-language pathologist who holds a valid ASHA Certificate of Clinical Competence (CCC)
- The clinical fellow may be required to extend their clinical fellowship if the CF supervisor does not keep their certification status up to date-make sure to validate the supervisor's CCC status
- It is the supervisor's responsibility to maintain certification during the entire clinical fellowship period through timely payment of annual dues and fees

Considering a Placement in a SNF? What Credentials Does the CF Supervisor Need?

- The supervisor must have 9 months of full-time experience working as a speech-language pathologist after being awarded the CCC-SLP
- 2 hours of professional development must be completed by the supervisor in the area of supervision at least once after being awarded the CCC-SLP
  - Elements of Effective Supervision and Mentoring (CEU 360)
  - https://www.asha.org/professional-development/supervision-courses (ASHA)
- ASHA Certification Online Verification Portal
  - https://www.asha.org/certification/cert-verify

How Long Does the Clinical Fellowship Last?

- **36 weeks of full-time** (35 hours per week) experience (or the equivalent part-time experience), **totaling a minimum of 1260 hours**
- Part-time work can be counted, as long as the CF works more than 5 hours per week
- **80% of time must be spent in direct clinical contact** (assessment/diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling)
- **Travel, lunch, vacations/holidays, leaves of absence, and other forms of paid or unpaid time off cannot be counted in your number of toward the minimum number of CF hours**

Clinical Fellowship Supervision: Minimum Requirements

Segment 1	Segment 2	Segment 3
6 hours of direct observation	6 hours of direct observation	6 hours of direct observation
6 hours of other monitoring activities	6 hours of other monitoring activities	6 hours of other monitoring activities
Complete Clinical Fellowship Skills Inventory (CFSI)	Complete Clinical Fellowship Skills Inventory (CFSI)	Complete Clinical Fellowship Skills Inventory (CFSI) *The Clinical Fellow must receive a score of "2" or better on all skills on the CFSI during the final segment of the CF experience

Questions about this presentation?

Email us at:

rts.questions@restoretherapy.com

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