

Challenges and Opportunities for Speech-Language Pathology Programs in a Changing Healthcare Environment

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Financial and Nonfinancial Disclosures

- None relevant to this presentation

Learner Objectives

Participants will be able to:

1. Describe the basic changes in the United States healthcare system that affect the practice of speech-language pathology
2. Discuss strategies to improve the outcomes of our treatment and increase patient/family satisfaction
3. List strategies to decrease cost of care and programmatic costs

Introduction

My Professional Journey

- School SLP in North Carolina- 1973-76
- Cincinnati Children's- 1976-current
 - Became Director of SLP in 1981
 - Became Senior Director in 2005
 - Program grew from 3 SLPs to over 130 SLPs with 20 more in affiliated programs



Cincinnati Children's SLP Program

Current status: We think we are...

- The biggest pediatric SLP program in the country
- One of the best pediatric SLP programs in the country
- Positioned for future changes in the healthcare environment

Cincinnati Children's

- How did we become the biggest?
- How did we become one of the best?
- How did we become positioned for changes in the healthcare environment?

Objective #1

Participants will be able to:

- Describe the basic changes in the United States healthcare system that affect the practice of speech-language pathology

What do most Americans know about our current healthcare system?

Everyone has opinions!



Everyone wants it all!

- Low cost
- High quality

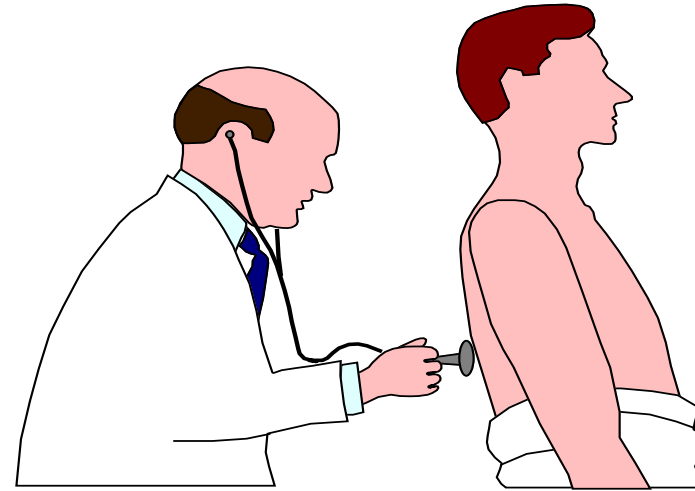


"Well here's your problem, you're both a beggar and a chooser."

Why is a change in our healthcare system needed?

Our *healthcare system* is not particularly...

- healthy,
- caring,
- or even a very good system.



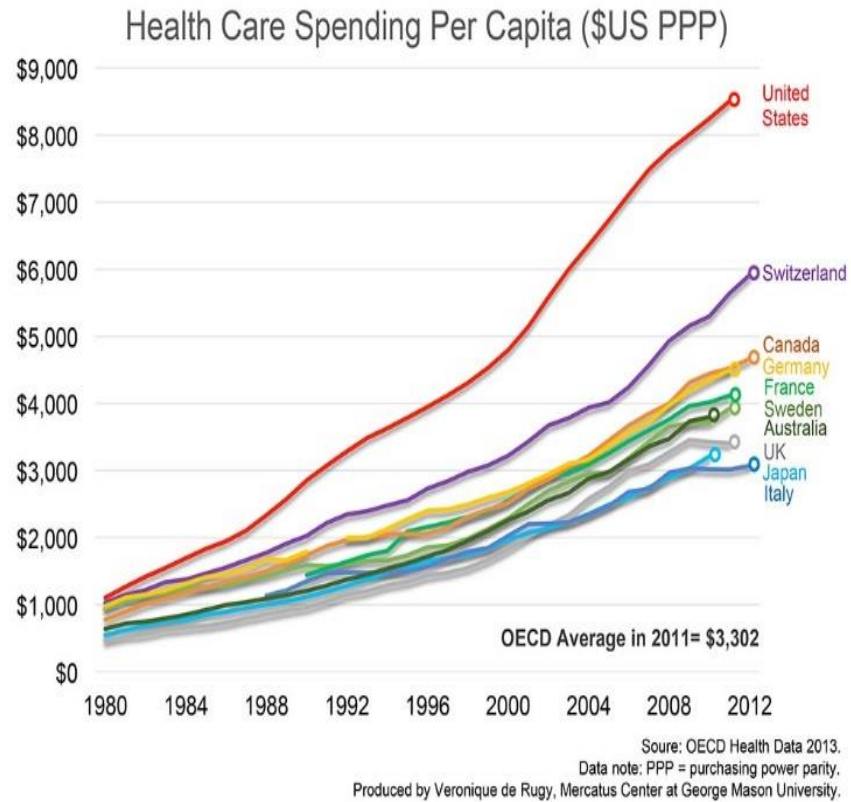
Why is a change in healthcare system needed?



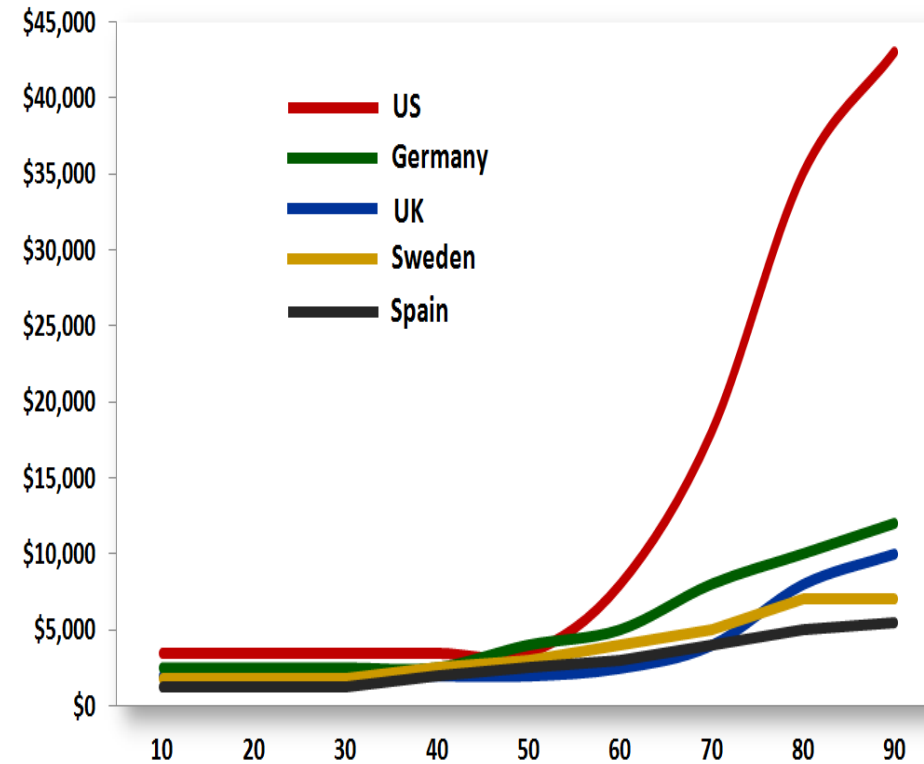
1. High Costs

Current Trends in Healthcare Spending

Healthcare Spending per Capita is on the Rise



Annual Per Capita Healthcare Costs by Age



US Healthcare: Skyrocketing Costs

Average Cost of Delivering a Baby:

- **2004:** \$7,700
- **2014:** \$32,000
- More than 300% increase in 10 years!!!
- Highest cost in the world!

Source: NBC Nightly News, March 4, 2014



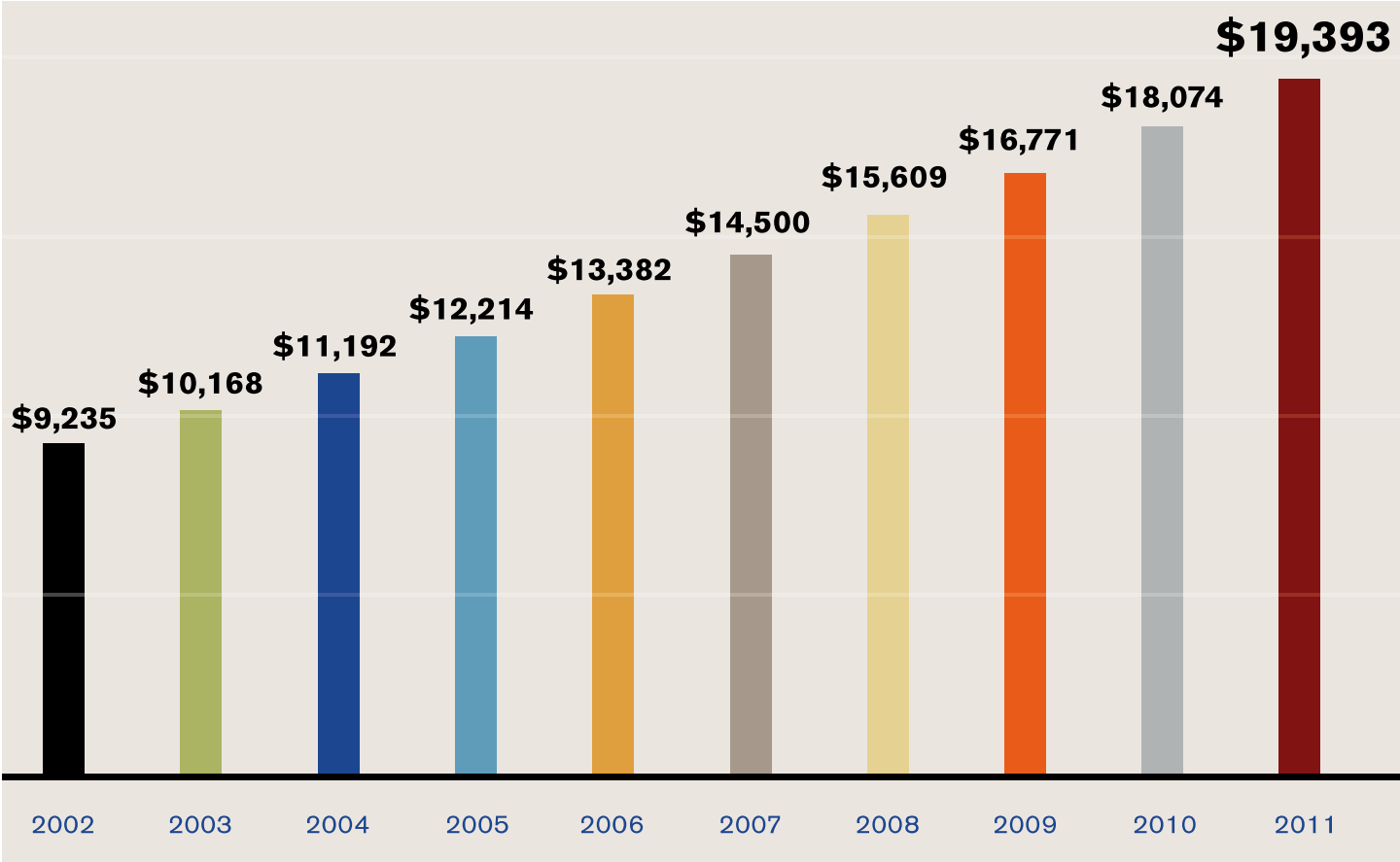
US Healthcare: Skyrocketing Costs

Cost of delivering a baby in California in 2014:

- Anywhere between \$3,000 and \$37,000

Source: NBC Nightly News, March 4, 2014

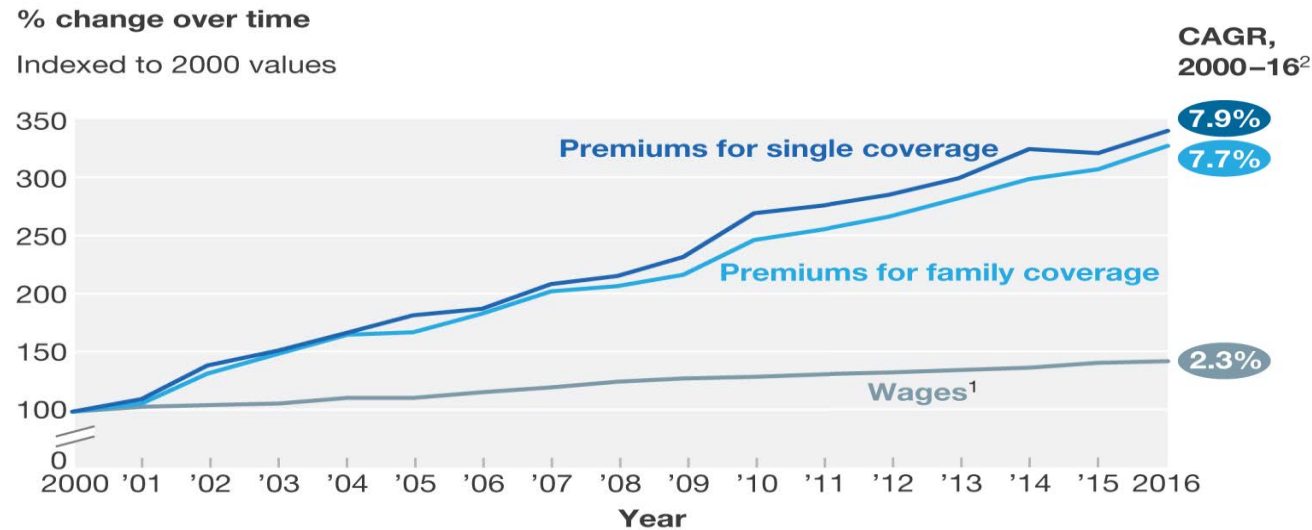
US Healthcare: Costs for Families



Source: Milliman Medical Index

Cost of Premiums

Since 2000, employees' premium contributions have increased more than three times faster than wages



CAGR, compound annual growth rate.

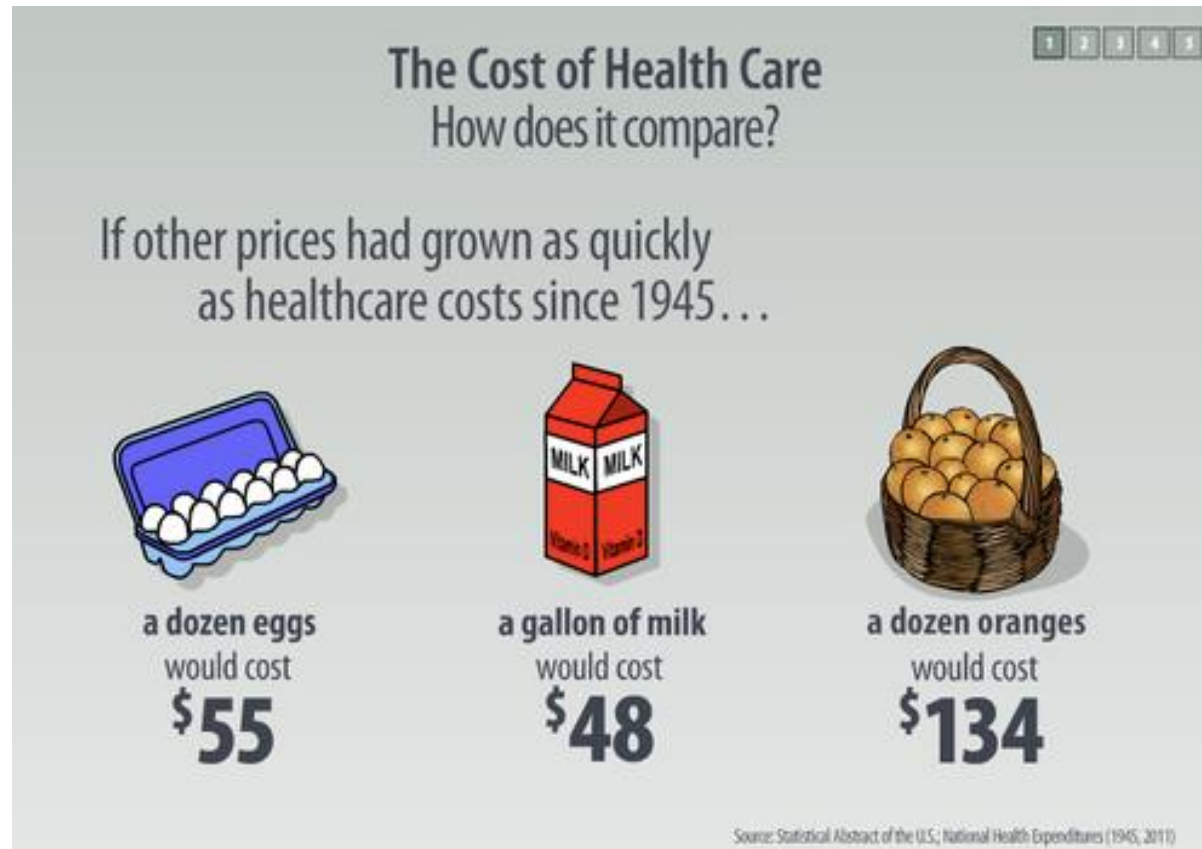
¹Projected for 2016 based on three-year CAGR trend.

²For wages, CAGR is based on latest available data from 2000–15. CAGR for 2016 was projected on CAGR from the three previous years.

Source: Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey; Bureau of Labor Statistics

McKinsey&Company

Is this different than inflation in general?

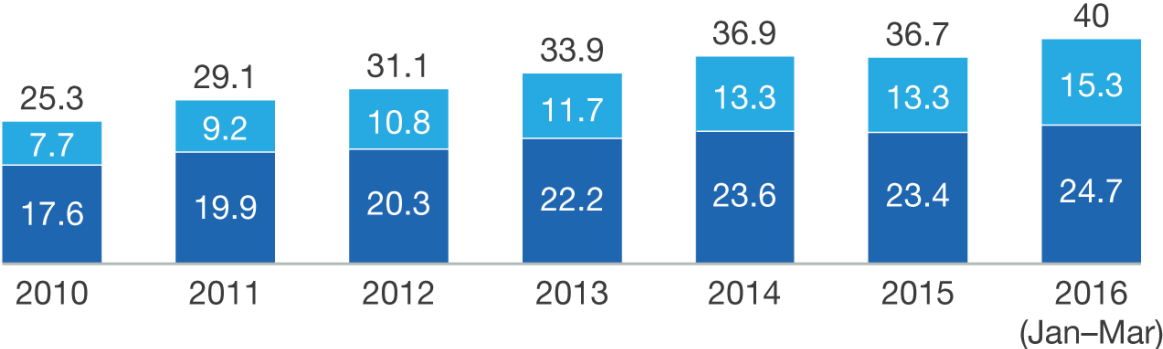


High-Deductible Plans

An increasing number of consumers are enrolled in high-deductible plans

% of people under age 65 with private health insurance who are enrolled in a high-deductible health plan (HDHP)

■ CDHP (HDHP with HSA) ■ HDHP without HSA

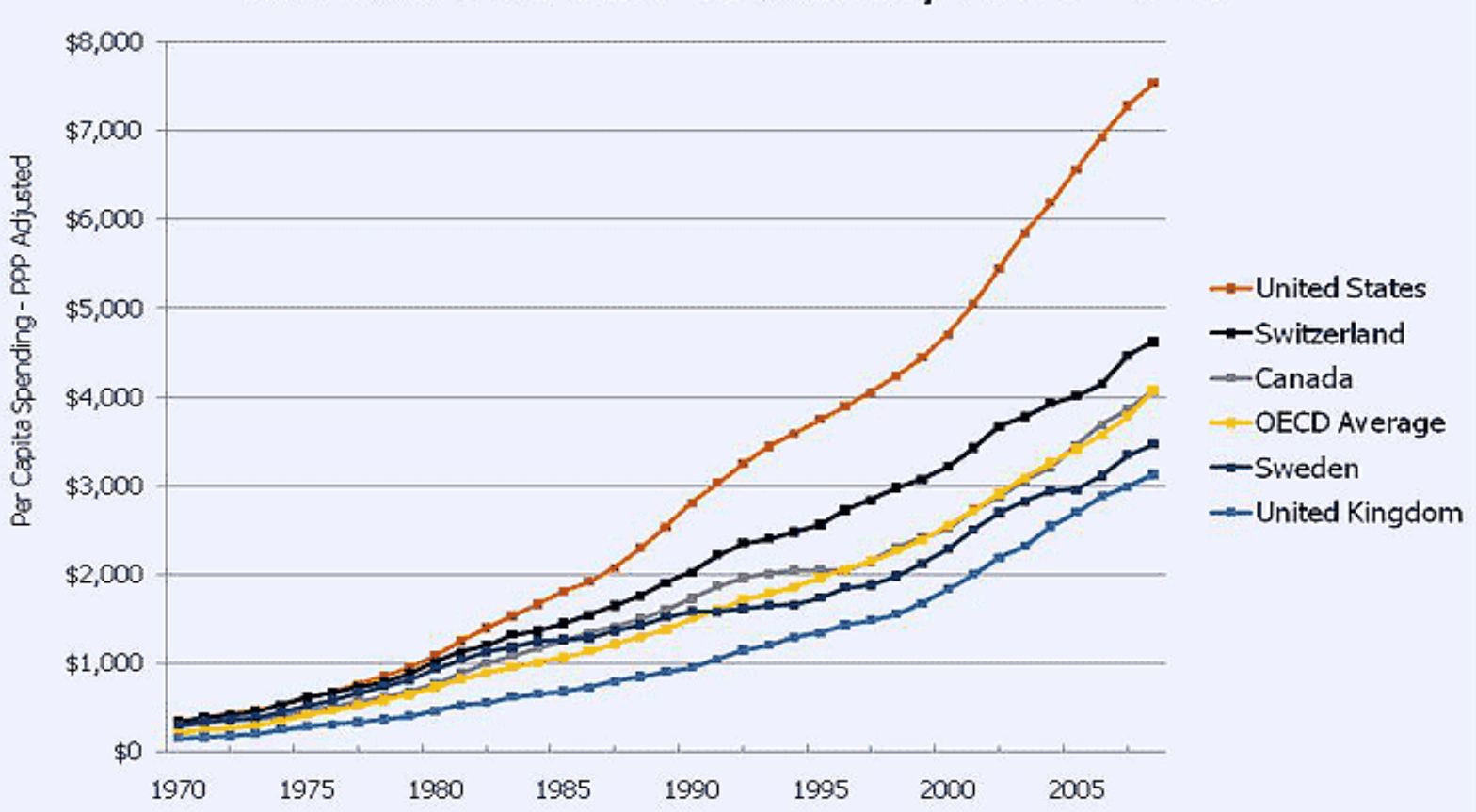


CDHP, consumer-directed health plan; HSA, health savings account.

Source: Health insurance coverage; early release of estimates from the National Health Interview Survey, January–March 2016; National Center for Health Statistics, September 2016

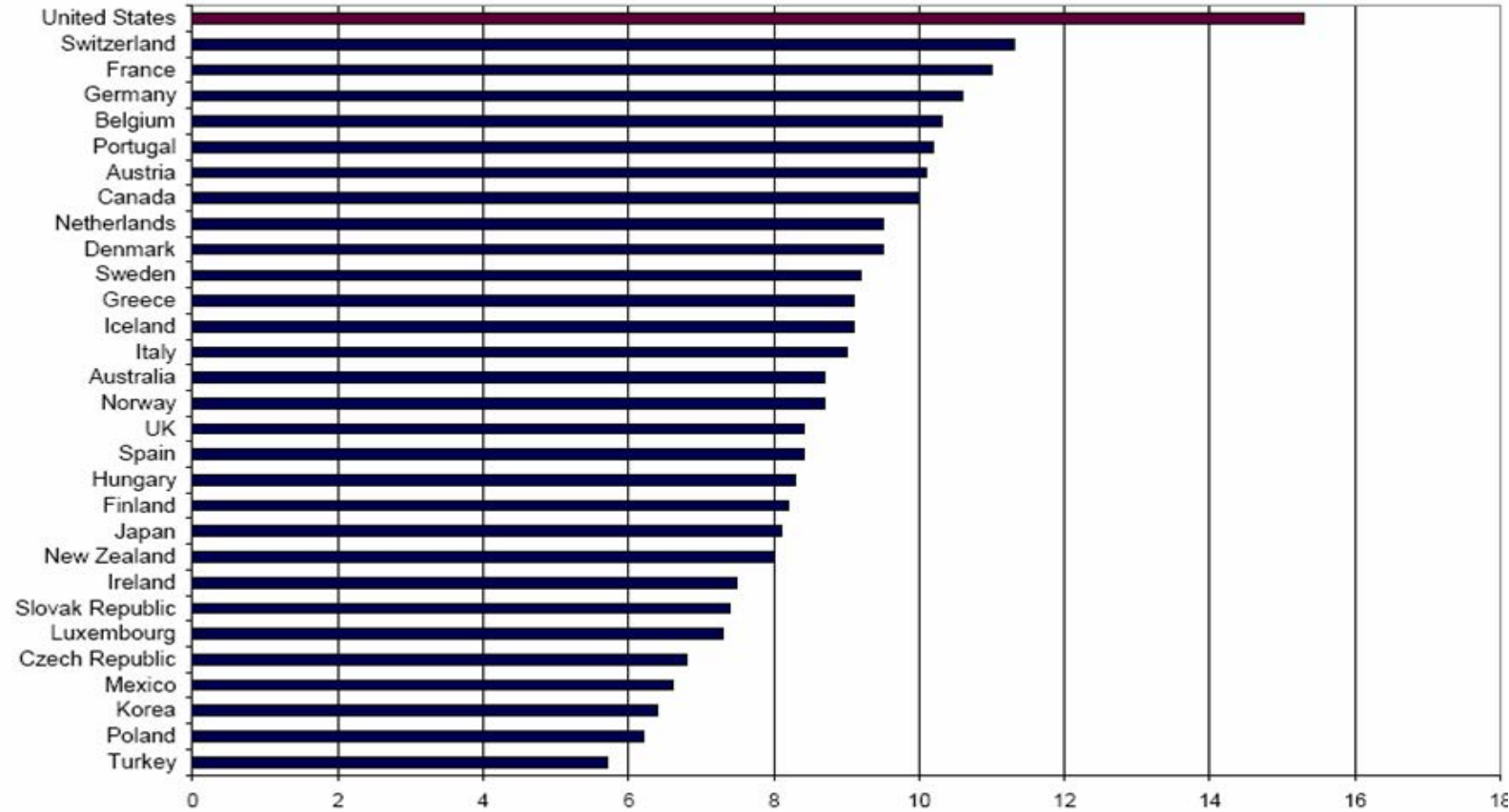
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Per Capita Spending for OECD Nations



Source: Kaiser Family Foundation

Healthcare as Percentage of GDP



Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).

Note: For countries not reporting 2006 data, data from previous years is substituted.

US Healthcare: Most Expensive

- The US spends 2.4 times more per capita on healthcare than the average spent in other developed countries
- Estimated that billions are spent on non-value-added expenses



US Healthcare: Most Expensive

The cost is killing us!!!

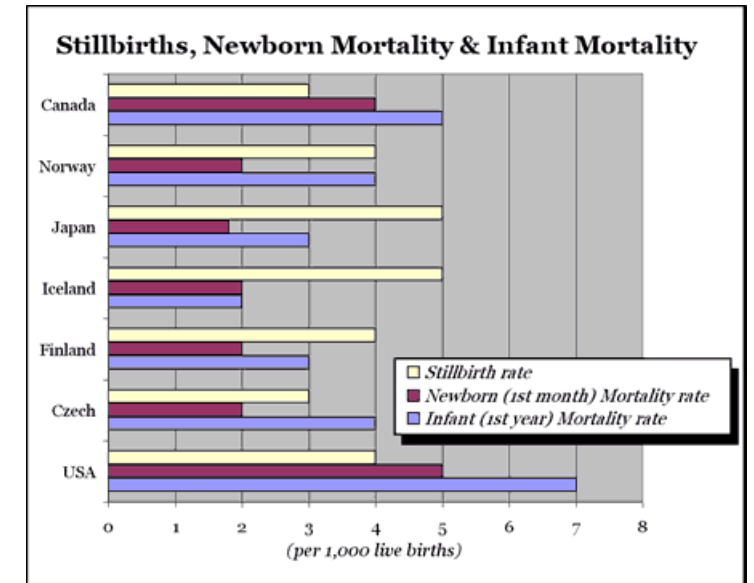


"My doctor told me to avoid any unnecessary stress, so I didn't open his bill."

2. Questionable Quality

US Healthcare: Not that Good

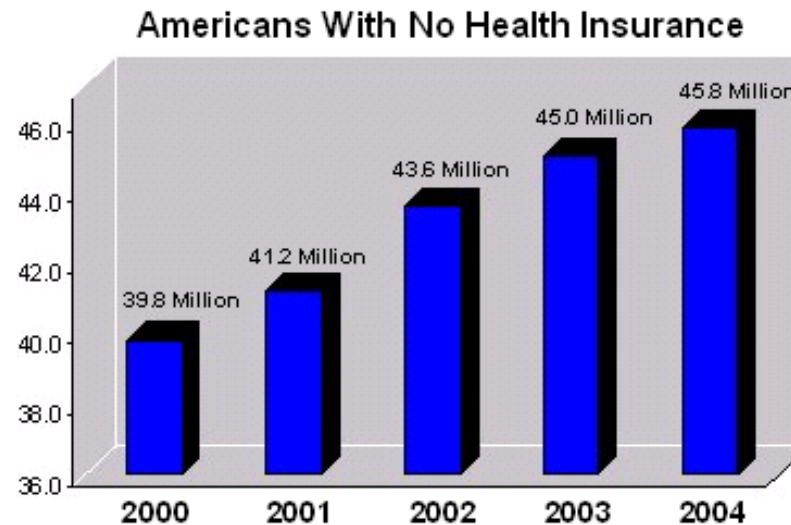
- US is ranked as 37th best healthcare system in the world
- Infant mortality rate is better in many other countries, including: Korea, Lithuania, New Zealand, Portugal, Singapore, Spain, Slovenia, Sweden, Switzerland, Uruguay, and others



Source: WHO, 2013 World Development Indicators

US Healthcare: Not that Good

- There is a lack of affordable care for a significant number of Americans
- Many Americans have NO insurance and therefore, little to NO healthcare



Source: U.S. Census Bureau

US Healthcare: Not that Good

Many studies have reported:

- Pervasive problems with quality of care
- Uncertainty about best practices that work
- Lack of evidence for many popular procedures and services
- Widespread clinical practice variation
- Significant disparities in the access to care

US Healthcare: Not that Safe

Landmark reports published by the Institute of Medicine (IOM) in 1999 and 2001:

- **Published report:** *To Err is Human: Building a Safer Health System* and *Crossing the Quality Chasm: A New Health System for the 21st Century*
- **Conclusion:** There are major issues with quality and safety in US healthcare across the country.



US Healthcare: Need to Decrease Costs

- Increase in cost of medical care each year is unsustainable
- No one is arguing for status quo
- Everyone who pays for healthcare (employers and consumers) wants to figure out how to pay less!

US Healthcare: Need to Increase Quality (Outcomes)

- Advocated by regulators, healthcare rating organizations, accrediting bodies, employers, commercial payers, and the public

The ABCs of the Affordable Care Act (ACA)



Affordable Care Act (ACA)

AKA Obamacare

- Healthcare reform was signed by President Obama in March 2010.
- It's actually two separate pieces of legislation:
 - The Patient Protection and Affordable Care Act (PPACA), and
 - The Health Care and Education Reconciliation Act

Triple Aim of Healthcare Reform

- 1. Improve the patient/family experience** (e.g., increasing quality, outcomes, and satisfaction)
- 2. Improve the health of populations** (which includes expanding coverage to more people)
- 3. Reduce per capita cost of care**



Changes for Consumers... at least for now

- Cannot be denied for pre-existing conditions
- Removal of lifetime limits
- Children under age 26 can stay on their parent's plan
- Preventative care is covered
- Individual mandate for coverage
- Health insurance marketplace for low cost plans

Changes for Consumers

Ultimate Goal:

- High quality universal healthcare coverage



Changes for Providers

New focus on:

- Value
- Comparison of outcomes
- Bundled payments



What is value in healthcare?



Value in Healthcare

- Value is the cost/benefit ratio of care



Value in Healthcare

$$\text{Value} = \frac{\text{Benefit (quality, outcomes, and satisfaction)}}{\text{Cost}}$$



To increase value: We need to increase the benefit and decrease the cost.

Value in Healthcare

- Value is what really matters to patients
- How do we address value in our services?

Value in Healthcare

Benefit: Patient/Family Satisfaction

- We need patient-centered care with personalized treatment plans
- We cannot be clinician-centered or organization-centered

Value in Healthcare

Costs

- We need decrease costs through increased efficiency and streamlined processes

Value for Patient/Family

- Families are “shopping” for healthcare and are considering costs more than ever due to:
 - High co-pays and very high deductibles
 - Indirect costs (i.e., time from work, gas, parking, etc.)
- Information about cost and quality will become more readily available



Value for Patient/Family

We need to consider the following:

- What influences families' "willingness to pay"?
- What is the priority and the value to the patient?
- For an activity to be considered *value-added*, the customer must **want it AND be willing and able to pay** for it

Value for Patient/Family

What do you think our patients/families are willing to pay an SLP to do?
Yes, No, Maybe

- Your expertise, opinions, and advice
- Your time writing a report
- Your time scheduling an appointment
- Your time practicing a skill that the patient can perform

Value for Referral Sources

Physicians will be asking the following questions:

- Does your service provide a difference that is of value to the patient and family?
- Is your service worth the cost?

Value for Referral Sources

- We need to educate referral sources about what services we can provide, and how they add value to the patient that is worth the cost.
- It's time to do lots of lectures!



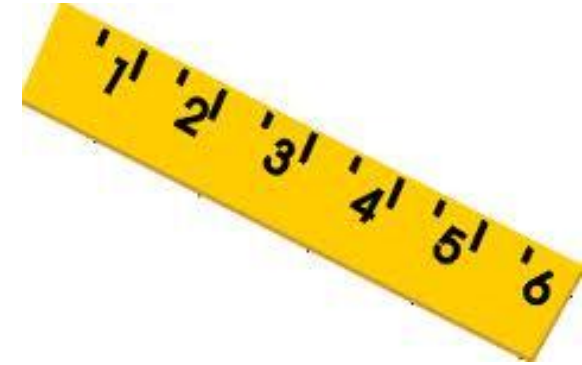
Value for Payers

- Payment will be based on:
 - Results (instead of the volume of services delivered)
 - Patient satisfaction and experience
 - Compliance with standard protocols



Value for Payers

- Payers will measure performance, compare hospitals and providers, and adjust payments
- Hospitals will have metrics to receive full reimbursement



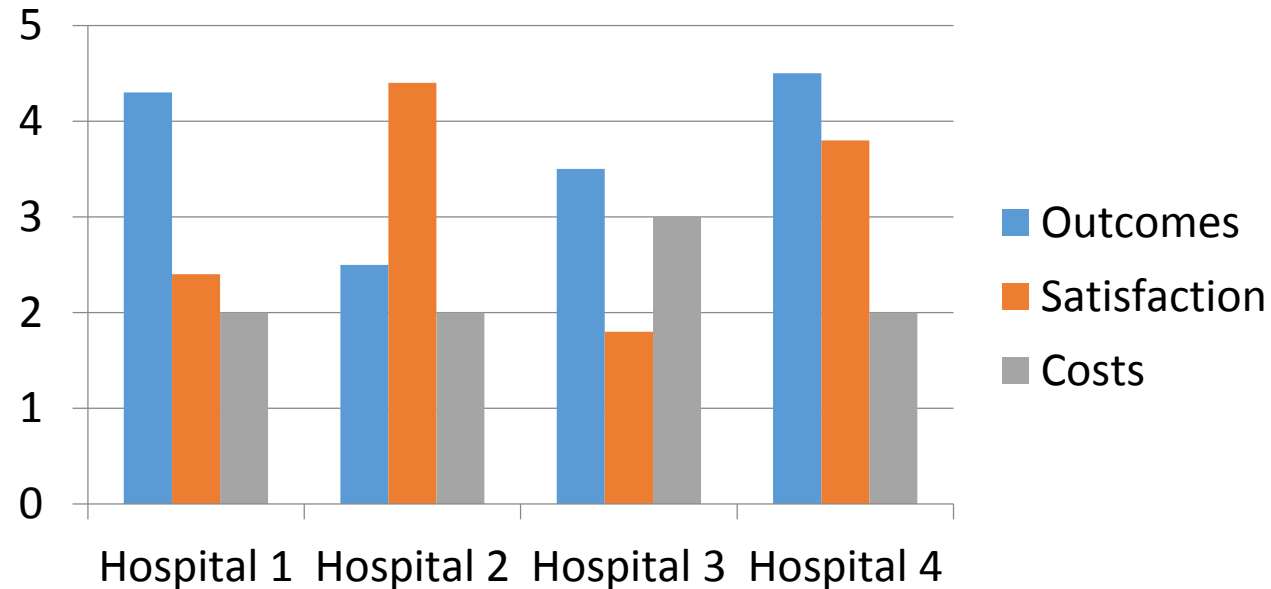
Value for Payers

- At Cincinnati Children's, Medicaid reimbursement is linked to quality targets and outcomes
- Metrics include:
 - Hospital acquired infection
 - Readmission for asthma
 - Ventilator assisted pneumonia

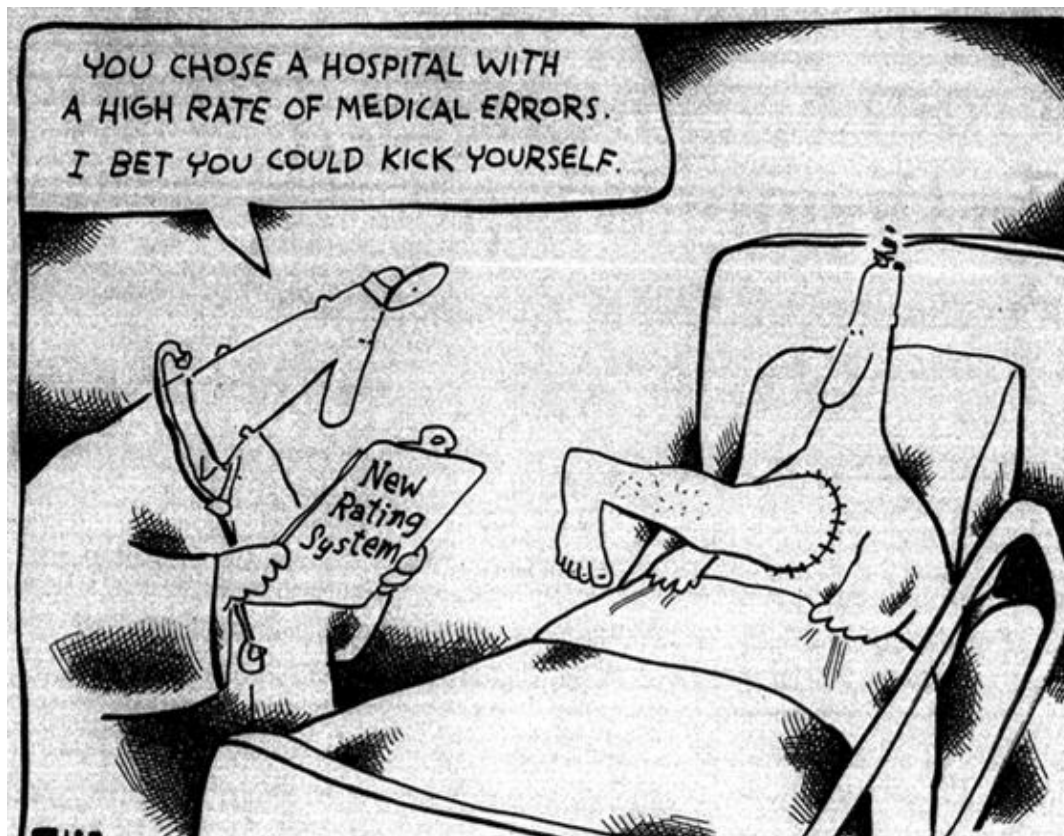


Value for Payers

- Ultimately, payers and consumers will be selecting preferred providers based on ratings of value (outcomes, satisfaction, and costs)



Value and Outcomes



Bundled Payments



Bundled Payments

- Meant to replace fee-for-service
 - Fee-for-service rewards high volume (lots of tests and procedures with a fee for each)
 - Providers usually don't know the cost of the tests and treatments that they order



Bundled Payments

- Bundled payment: Reimbursement for a diagnosis (i.e., diabetes, cardiac care, stroke, etc.)
- Reimbursement based on median costs of procedures “typically done” for a diagnosis

Bundled Payments

- Rewards achieving outcomes with less service (e.g., costs)
- Physicians will care about costs (and therefore, order fewer services) because they will affect his/her reimbursement
- Can that affect SLP services???

Bundled Payments

- Although reducing costs is emphasized, there are penalties to cutting corners on care or poor quality under bundle payments
 - Example: Penalty for hospital re-admission within 30 days

Bundled Payments

- Coordinated care plans will be important, particularly for chronic care patients
- Hospitals will look at systems and duplication or overlap of services
- Providers with the highest quality and lowest cost will thrive



Bundled Payments and SLP

Less will be best!

- Need to achieve quality results with less care (expenditure of resources)
- Team care and collaboration will be critical



Objective #2

Participants will be able to:

- Discuss strategies to improve the outcomes of our treatment and increase patient/family satisfaction

Improving Outcomes

Do outcomes really matter?

Great technique! Well done indeed.
It's a shame the patient died.



Clinical Guidelines Improved Outcomes

- Need to to standardize clinical procedures that are evidence-based
 - Increases efficiency
 - Reduces variations and processes that do not add value (and increase cost)



Outcomes Research and Measures

- Needed to determine which treatments work, for which patients, and with what kind of trade-offs



Outcomes Research and Measures

Example:

Which type of therapy will result in the fastest progress and therefore, the lowest cost for correction of a speech sound disorder?

- 20 sessions of oral-motor therapy
- 20 sessions of sound placement therapy with targeted practice

Functional Goals



Functional Goals

- Need to focus our practice on function goals
 - Goals that are important to the patient/family
 - Goals that will make the biggest impact in improving function

Task-Based Treatment vs. Functional Outcome-Based Treatment

Task-Based Treatment

- Assesses the patient's impairments
- Organizes the treatment around patient limitations

Outcome-Based Treatment

- Assesses the patient's functional needs
- Organizes treatment around skill requirements needed for effective function

Task-Based vs. Functional Outcome-Based Treatment

Task-Based Treatment

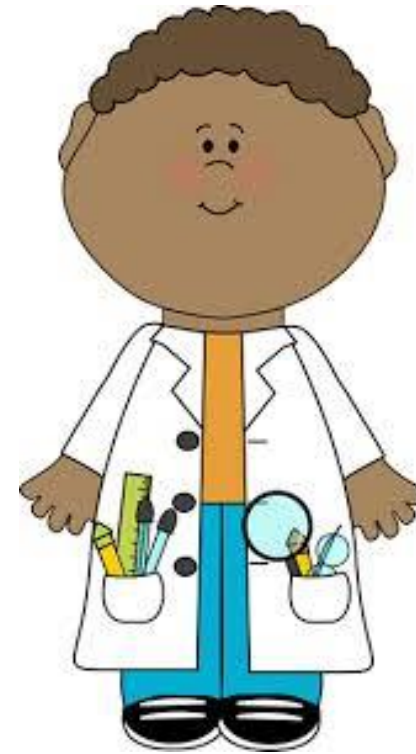
- Focus is on reduction of impairment
- Focus is on correction first
- Provides family teaching at the time of discharge

Outcome-Based Treatment

- Focus is on functional skill acquisition
- Focus is on compensation first
- Provides family teaching throughout treatment

Specialization

- Have staff specialize in areas of interests to increase the quality (and efficiency) of care



Improving Patient/Family Satisfaction



Consumers Want Convenience

- Women account for 51% of the workforce in the US (US Dept. of Labor).
- Kids over the age of 3 are in school
- Recurrent therapy appointments from 9:00 to 5:00, Monday through Friday, are not convenient for MOST families



Consumers Want Convenience

- To increase patient/family satisfaction (and obtain a competitive advantage), services should be offered in the evenings and on weekends.



Objective #3

Participants will be able to:

- List strategies to decrease cost of care and programmatic costs

Old Model of Healthcare Financing

Increase revenue

- See lots of patients
- Provide lots of services to each patient

New Model of Healthcare Financing

Decrease costs

- Need to reduce nonclinical activities (nonbillable) to see more patients (billable)
- Need to achieve good outcomes and high patient/family satisfaction with less service (less cost) per patient

Strategies to Decrease Costs

1. **Top of License**

2. **Documentation**

3. **Productivity**

4. **Scheduling**

} Decrease non-clinical/non-value-added time

} Increase clinical/value-added time

What is the biggest cost in an SLP program?

Salary!!!

- To reduce the cost of care...
 - Can cut the salary (cost per hour) of SLP OR
 - Reduce the amount of time spent by the SLP for each patient



1. Top of License



Top of License

- More cost-effective to have lower paid, less skilled people (i.e., administrative staff) to provide support services
- HC provider can see more patients (increase access), and generate more revenue

Top of License Examples

- For MDs, expanded services are now provided by:
 - Nurse practitioners
 - Physician assistants
 - Pharmacists
 - Social workers
 - Administrative staff



Top of License for SLPs: Admin Support

- Paid admin assistants, schedulers, insurance specialists
- SLP undergrad and grad students
- Volunteers



Top of License for SLPs: Clinical Support

- SLP assistants
- SLP undergrad and grad students
- Volunteers
- Parents/family members



Top of License

- To increase support and decrease your costs, develop a **Student Volunteer Program**
- Students provide support to the staff, but also get to observe



Top of License

Student volunteers can help to :

- Set up and clean up
- Organize materials and cabinets
- Make copies
- Run errands
- Call families
- Make communication boards, handouts, etc.
- Take a history over the phone
- Do literature reviews

Question about Clinical Care: True or False?

- A. Progress will usually be faster with *intensive therapy*.
- B. Progress will usually be faster with therapy as needed and *intensive practice*.

Consider the theories of motor learning (and cognitive learning)

Top of License: Clinical Support

- Motor learning is dependent on:
 - instructions,
 - trial and error, and
 - feedback
- Motor learning is what needs to be done in therapy.



Top of License: Clinical Support

- Motor memory is dependent on practice
- Practice develops the automaticity of the movement and ultimate “carry-over”
- Practice does NOT require “skilled” work
- Practice should be done primarily at home, and not in the therapy session

Top of License for SLPs: Clinical Support

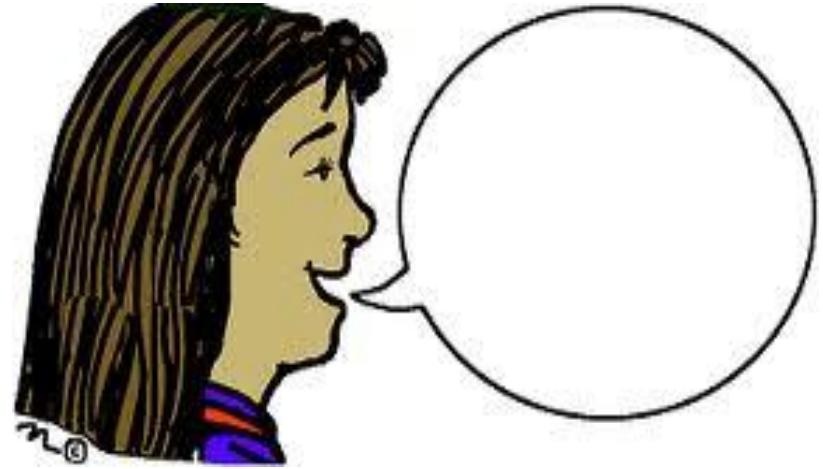
Speech therapy is like taking piano lessons...

If you just go for the lesson but don't practice at home, you don't learn to play the piano!



Top of License for SLPs: Clinical Support

- Learning a second language requires instruction and study and then practice
- Language learning for the first time also requires practice



Family Involvement

- For fastest progress in the least amount of time, the patient needs to practice daily and frequently
- The family must be part of the treatment team
- Family needs to ensure regular therapy attendance, but also frequent practice at home



Top of License for SLPs: Clinical Support

- To engage families to work with the patient, it helps to use principles of **self-management**, including **motivational interviewing**



What is the biggest non-billable cost in an SLP Program?

- Documentation!



Documentation

Advance Magazine Survey, 2003:

How much of your time is devoted to paperwork? (N = 251)

Percent of Respondents	Percentage of Time
1%	Less than 1%
34%	10-25%
43%	26-50%
18%	51-75%
4%	More than 75%

Documentation

ASHA Healthcare Survey, 2013

How much of your time is devoted to clinical documentation? (N = 595)

Average Percentage of Time: 20%

Documentation

Advance Magazine Survey, 2003

What factor causes the most stress for you in your job? (N = 219)

Percent of Respondents	Category
30%	Caseload size
49%	Paperwork
5%	Difficult patients
5%	Turf battles
11%	Work environment

Documentation

Why do we spend so much time in documentation?



Documentation

- Because we have all had an old professor who told us to!

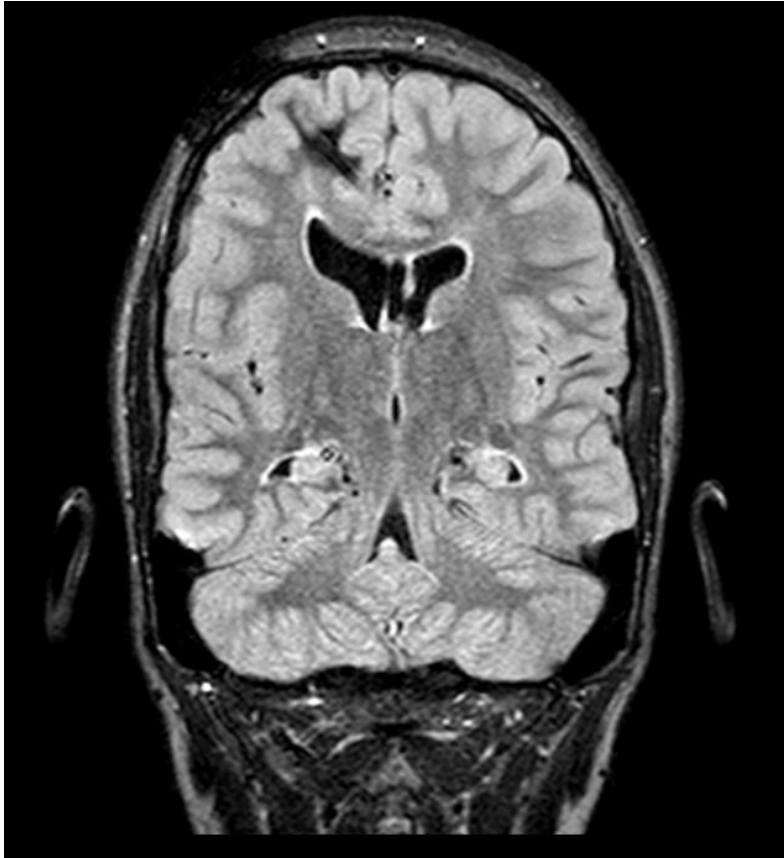


Staff Comments

- If the report isn't long, the family and payer will think that they were overcharged.



Cost of Getting an MRI



MRI Charges

Procedure Name	Technical Charge	Professional Charge	Total Charges
Brain MRI	\$3,325.00	\$869.00	\$4,194
Abdominal MRI	\$3,644.00	\$364.00	\$4,008

Bowel MRI Report

CLINICAL HISTORY: Patient with chronic abdominal pain, mouth ulcers, ulcers in transverse colon.

COMPARISON: Abdominal ultrasound 2/13/2014, showing renal stones, bladder debris, and prominence of common bile duct.

PROCEDURE COMMENTS: MRI of the abdomen and pelvis was performed with and without Magnevist intravenous contrast. VoLumen was used as the oral contrast agent. One 0.3 mg dose of glucagon was administered subcutaneously at the beginning of the exam, and a second 0.3 mg dose of glucagon was administered intravenously prior to gadolinium injection.

FINDINGS:

LOWER THORAX: Normal.

LIVER AND BILIARY SYSTEM: Normal.

SPLEEN: Normal.

PANCREAS: Normal.

ADRENAL GLANDS: Normal.

KIDNEYS, URETERS, AND BLADDER: Normal.

BOWEL: Normal. There are segments of proximal jejunum and terminal ileum which are poorly distended. Within these limitations, no mucosal hyperenhancement, mural stratification, bowel wall thickening, strictures, or fistula. The bowel peristalses normally. The terminal ileum is normal.

PERITONEAL CAVITY: Normal. No inflammatory stranding, lymphadenopathy, engorged vasa recta, fatty proliferation, or abscess. No free fluid, focal fluid collection, or free air.

UTERUS AND OVARIES: Normal.

VASCULATURE: Normal.

LYMPH NODES: Normal.

ABDOMINAL WALL: Normal.

OSSEOUS STRUCTURES: Normal.

IMPRESSION:

Essentially normal MR enterography without findings of inflammatory bowel disease. There are segments of terminal ileum and proximal jejunum which are poorly distended, but no secondary findings of inflammation are present.

Brain MRI Report

CLINICAL HISTORY: New head tilt. Questionable new onset nystagmus. Rule out structural lesions.

COMPARISON: None

PROCEDURE COMMENTS: MRI of the brain was performed before and after administration of intravenous contrast.

FINDINGS:

The ventricles and extra-axial spaces are normal in size and shape.

There is no mass lesion or evidence of intracranial hemorrhage.

Parenchymal signal and morphology are normal.

There are normal flow voids in the intracranial vessels.

There are no foci of abnormal enhancement.

There are no regions of restricted diffusion.

A few small mucous retention cysts are seen within the adenoids.

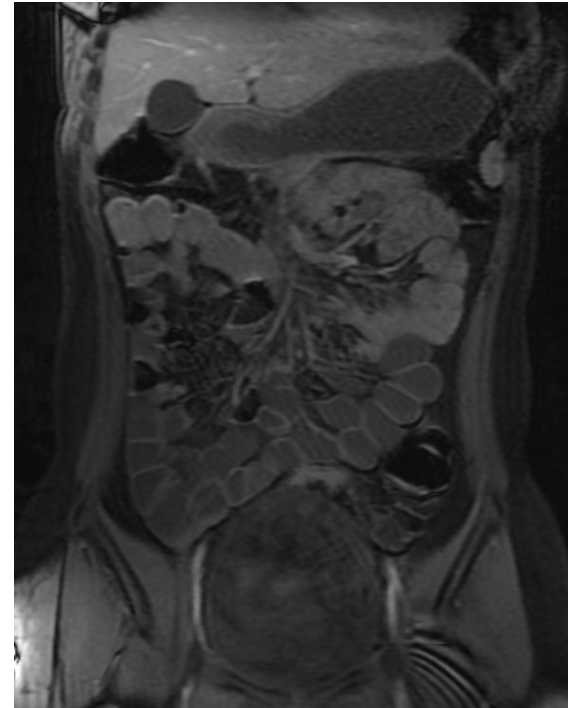
IMPRESSION:

Normal MRI examination of the brain without and with contrast.

Cost of Getting an MRI

MRI charges are based on:

- Time spent
- Degree of clinical expertise
- Cost of equipment
- Additional overhead



Staff Comments

- A report has to be long to convey all the necessary information for our customers.



Documentation

- If you get a psych report, what do you read?
- What do you remember?
 - History
 - Examination and test results
 - Summary
 - Recommendations

Documentation

- Have you ever received a formal written report from your primary care doctor?
- If so, was it in paragraph format?
- How many pages was it?

Documentation

- How much are patients/families willing to pay for a professional to compose a report?
- What do our customers (referral sources, families, other SLPs) really want and need from our documentation?

Documentation

Based on a survey of customers at Cincinnati Children's:

- **Doctors:** want summary of findings and recommendations
- **Patients/families:** want info about the diagnosis and what can be done about it
- **SLPs:** need the eval data presented concisely (no verbal vomit!)
- **Payers:** want to see the CPT code and ICD-9 code for auths and evidence of progress for reauths

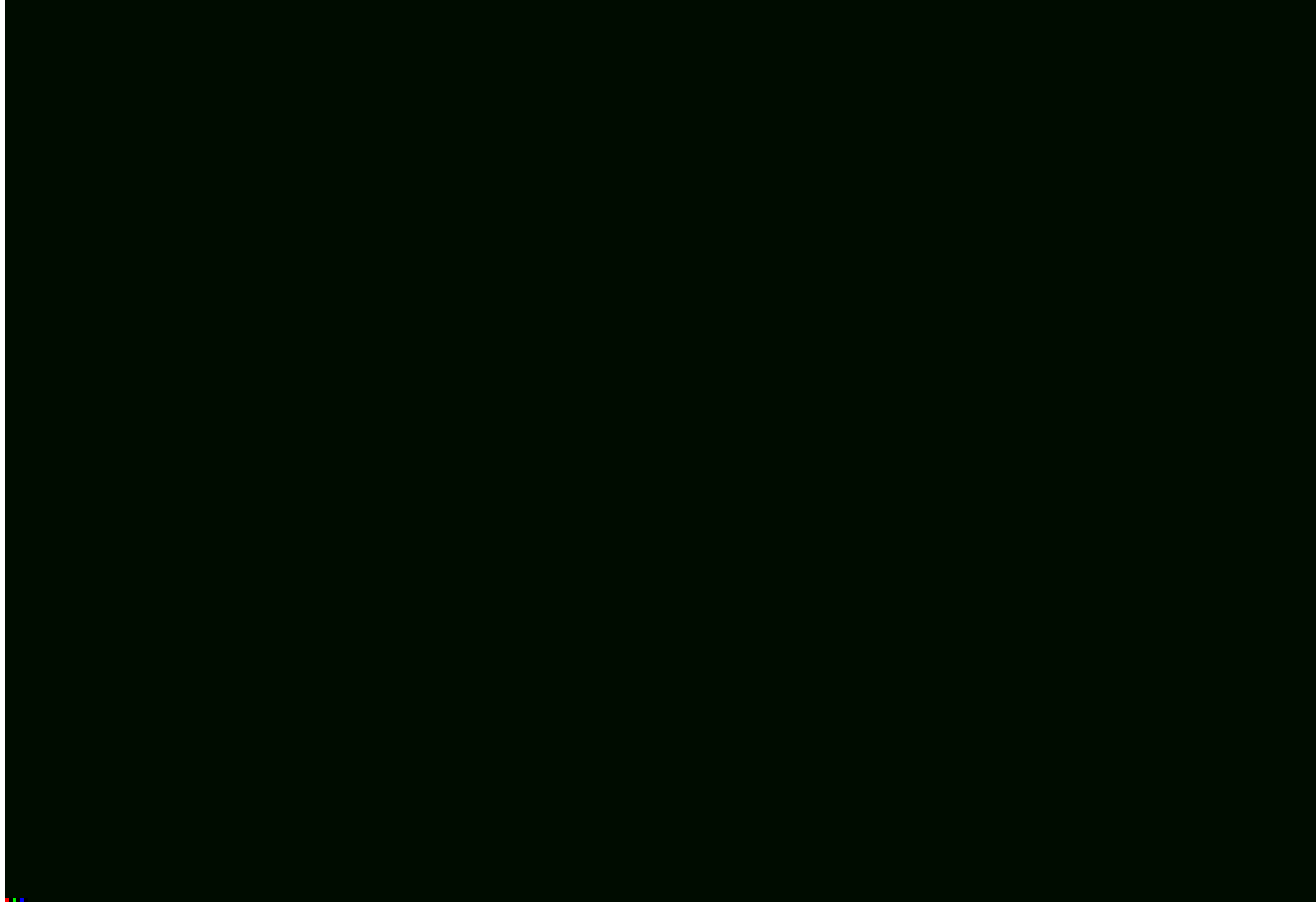
Documentation

- Cutting total time documentation:
 - Decreases the cost (i.e., time and salary), and
 - Increases clinical time (e.g., access for more patient and more revenue)
 - Decreases SLP stress and increases SLP satisfaction

3. Productivity

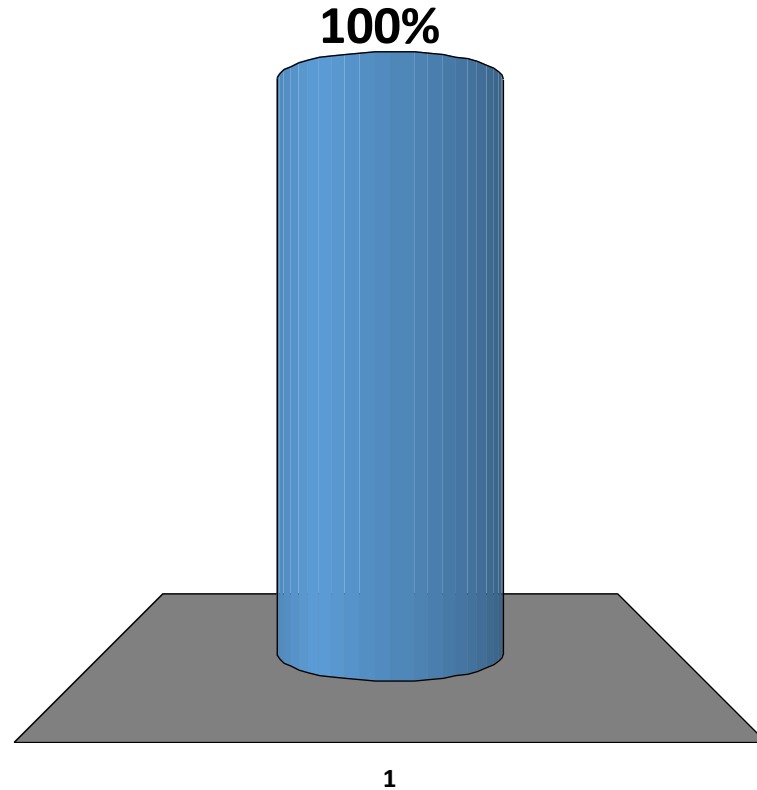


Productivity Business Model



SLPs should be held responsible for their productivity?

1. True
2. False



Productivity and Scheduling

- *Productivity* is a HUGE stressor for SLPs!



Productivity and Scheduling

- Scheduling should NEVER be done by SLPs.
- If all scheduling is done by the admin staff, SLPs should not be responsible for productivity.



Productivity and Scheduling

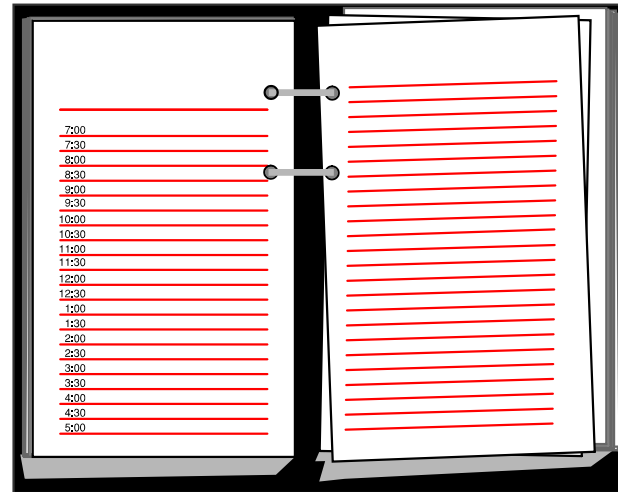
Business argument:

- Professional schedulers are cheaper and do a much better job of it
- SLPs will be able to see more patients, and generate more revenue
- SLPs will be happier, which makes them provide better service

Productivity and Scheduling

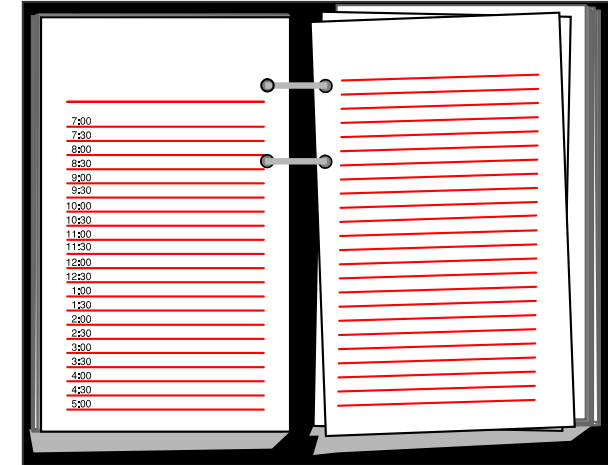
- Make sure SLPs manage their caseloads appropriately and don't keep patients that don't show or no longer benefit
- Should hold support staff accountable for ensuring full schedules

4. Scheduling



Scheduling

- Schedule to compensate for cancellations and no-shows
- If the goal is 65%, schedule at 82%



Therapy Scheduling Options

- Consultative scheduling
- Block scheduling
- FIT scheduling
- Family-friendly appointments

Consultative Scheduling

- SLPs design the treatment plan and teach the skill
- SLPs train the parents/family members to work with the patient at home
- Patient returns for a therapy session when ready for the next step

Block Scheduling

- Patient is seen for a block of sessions (i.e., 4, 8, or 12 sessions) and then off for a block
 - Short-term blocks increase commitment and attendance
 - Allows more practice and habituation of skills at home
 - Allows other patients to receive therapy in the alternate block

FIT Scheduling

- Develop a Family Initiated Treatment (FIT) Program where families call in to schedule individual appointments at their convenience
 - Some families cannot commit to a regular weekly time due to their changing schedules, transportation issues, etc.
 - This increases the ability to keep full schedules (which indirectly reduces costs).

Family-Friendly Appointments

- Provide evening and weekend appointments.
- Ask staff to work one night per week and then take Friday afternoon off to compensate
- This is more family-centered care and increases access for many patients.



Scheduling: Long-Term Patients

- Some disorders cannot be corrected with therapy, but instead will be a chronic life-long condition
- When is it time to quit?
- We devalue the profession by “practicing” with patients or keeping patients in therapy who are not making progress

Scheduling: Long-Term Patients

- Research shows that most progress is made in the initial stages of therapy
- Long-term therapy can:
 - overburden the family emotionally and financially
 - overburden the healthcare system with minimal benefits

Scheduling: Long-Term Patients

- Parents/family members are more likely to disengage
- Patients are more likely to cancel
- If there is a wait list, it deprives other patients from receiving services

Scheduling: Long-Term Patients

What we can do for chronic conditions?

- Consider short episodes of care rather than continuous care
- Spread out sessions to allow more practice between sessions
- Work on realistic, functional goals and then discharge
- Recheck patient periodically
- Discharge from therapy if there has been minimal or no progress
- Do not allow parents/family members prescribe treatment or dictate the “dose”

Scheduling: Long-Term Patients

Consider the ASHA Code of Ethics:

SLPs should not deliver therapy without a reasonable expectation of achieving an outcome.

Cincinnati Children's SLP Program

- How did we become the biggest?
- How did we become one of the best?
- How did we become positioned for changes in the healthcare environment?

How did we become the biggest?

- Cincinnati is not the biggest metro area in the US
 - We are the 28th biggest in the US
- Cincinnati doesn't have more children with communication/swallowing disorders than other areas

How We Became the Biggest

So how did we get so big?



How did we become the biggest?



How did we become the biggest?

- The main reason is that we became profitable!
- Because of this, we were allowed to grow.



How did we become the biggest?

Reduced unnecessary, non-patient care (e.g., non-billable) work

- Support staff (including schedulers and insurance specialists)
- Effective scheduling procedures
- Reduced time spent in documentation
- Virtual meetings and staff bulletins

How did we become one of the best?



How We Became One of the Best

- We developed a Vision Statement:
We will be THE leader of pediatric SLP in the world
- We developed strategies to meet the vision



How did we become one of the best?

- Because we are so big, we have a lot of intellectual capital
 - Staff to specialize and participate in leadership
 - We provide education and mentoring for baseline and specialty competencies



How did we become one of the best?

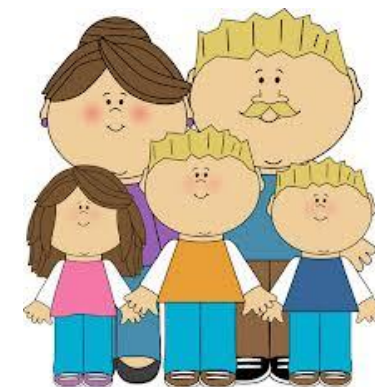
- Service guarantee: Every patient is seen by a specialist in his/her disorder

How did we become positioned for changes in the healthcare environment?



How are we positioned for change?

- We have reduced cost and increased productivity.
- We now receive our better outcomes in fewer visits (with less cost) because we engage families.



Conclusion

- There are many challenges, but also many opportunities for speech-language pathology programs in this changing healthcare environment.
- We need to take advantage of opportunities to increase patient/family satisfaction and outcomes, while decreasing the cost of care.
- If we are willing to make some changes for the benefit of all, we will be prepared for the future.



**The future belongs to those who
prepare for it today.**

Malcolm X

