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Final Report

Reframing the Professions of Speech-Language Pathology and Audiology

Ad Hoc Committee on Reframing the Professions

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Introduction

It is with a sense of urgency that the Ad Hoc Committee on Reframing the Professions submits this report to the ASHA Board of Directors for its consideration and immediate action. It is widely acknowledged that health care, and especially the economics of health care, will be undergoing dramatic changes over the next several years. Although momentum for these changes has been developing over the past decade, concrete changes in health care delivery and payment are imminent. Factors pressuring these changes include the unsustainably increasing cost of medical care, the Patient Protection and Affordable Care Act of 2010 (ACA), and the increasing demands for quality, efficiency, and accountability by regulators, health care rating organizations, accrediting bodies, employers, commercial payers, and the public. Changes are focused on achieving the Triple Aim, promoted by the Institute for Health Care Improvement (IHI):

➢ improving the patient experience of care (including quality and satisfaction),

➢ improving the health of populations,

➢ reducing the per capita cost of health care.

The Advisory Board Company, a national consulting firm in the health care industry, states that value-based, affordable care is patient centered, produces superior outcomes, and is delivered efficiently, streamlining care processes to increase access and reduce waste.

The concept of value in health care is featured prominently as a key part of health care reform. *Value* is defined as the ratio of quality and safety over total cost per unit. The formula used to calculate *value* is shown in Figure 1. The health care system in the United States is on a rapid course of change wherein payment will be based on results instead of on the volume of procedures, services, or interventions delivered. This change will affect all health care venues, systems, and practitioners—focusing all on determining what services have the highest impact on those we serve and can be delivered at the lowest cost. All professionals will need to develop strategies to achieve success in this transforming health industry. Providers must understand that they will be accountable for achieving outcomes with informed patients, balancing the "trifecta" of performance, utilization, and financial risk.

BACKGROUND ASHA ACTIVITIES

In October 2012, ASHA convened the ASHA Changing Health Care Landscape Summit, inviting leaders in speech-language pathology and audiology to meet over 3 days at ASHA's National Office (NO). Summit goals were to:

- Provide a forum for knowledge transfer, open discussion, and deliberation about the rapidly changing health care landscape
- Discern specific implications of health care reform with regard to all aspects of the professions of speech-language pathology and audiology and the discipline of communication sciences and disorders (CSD/CDS)

- Identify a set of options and seek consensus recommendations for a strategic course of action to respond to challenges and opportunities posed by health care reform in the areas of:
  - Professional practice
  - Research and data needs
  - Professional preparation
  - Member education and interprofessional education (IPE)
  - Dissemination of information that energizes individuals to become catalysts for change
- Determine ASHA's role in proactively safeguarding the professions in light of the changing landscape in health care

Recommendations from the Summit were divided by profession. The Speech-Language Pathology Summit recommendations centered around these issues:

- Reconsideration/expansion of the clinical paradigm
- Re-framing/re-branding the profession
- Quality and outcomes measures and management needs
- Professional preparation
- Member education and widespread dissemination of information

The Audiology Summit recommendations were organized around these topics:

- Patient-centered care
- Education
- Data and databases

The full report is available at www.asha.org/uploadedFiles/ASHA/Practice/Health-Care-Reform/Healthcare-Summit-Executive-Summary-2012.pdf#search=%22health%22.

AD HOC COMMITTEE

Early in 2013, the Board of Directors passed a series of resolutions to form the following ad hoc committees to further study the recommendations from the Summit and suggest specific actions:

- Ad Hoc Committee on Interprofessional Education
- Ad Hoc Committee on Audiology Outcomes
- Ad Hoc Committee on Developing Patient-Reported Outcomes
- Ad Hoc Committee on Developing a Taxonomy
- **Ad Hoc Committee on Reframing the Professions**

The Reframing Committee was charged "to identify specific elements that reframe the professions of speech-language pathology and audiology to meet the changing needs in both the health care arena and educational settings. The committee will determine overarching goals and strategies for implementation."

The Committee completed its charge with multiple conference calls and a face-to-face meeting during the spring, summer, and fall of 2013. Some of the work was done by the Committee as a whole; much was done by two subcommittees, defined by profession. As recommendations were developed, the Committee kept the Triple Aim as a focus. See Figure 2, which shows the relationship of each of the recommendations to the Triple Aim.

The Committee also discussed the differences in meaning of *reframing* as used within the Association versus the context of messages to external audiences. Committee recommendations address both contexts.

With the implementation of the Patient Protection and Affordable Care Act (ACA), the entire payment system for the health care industry began changing rapidly. As a result, reliance on the fee-for-service, volume-based system of payment/reimbursement is expected to be greatly reduced by 2020. With the change in the method of reimbursement, the model of service delivery must also change for all health care providers, including speech-language pathologists (SLPs) and audiologists.

OVERALL RECOMMENDATIONS FOR BOTH PROFESSIONS AND ALL SETTINGS

I. Immediate and significant need for education of membership: In order for any of these recommendations to be implemented successfully and embraced by ASHA members, the members must first understand the present and upcoming changes and the enormity of these changes. It does not seem that at present most members are aware of the impact that the changes in health care delivery and reimbursement will have on the professions. A knowledge gap exists that must be addressed. An appropriate action by a professional association is to be aware of changes that will affect its members—including members' preparedness to meet those changes and the substance of the changes—and to provide materials related to implementing changes.

Examples of some of the issues about which the membership would benefit from education include:

- Application of the International Classification of Functioning, Disability and Health (ICF) framework to goal setting and outcomes measurement, helping members focus on function
- Significant changes in payment methodologies
    - Bundled payments
    - Payment for outcomes
    - Value-based purchasing
    - Reduction or elimination of mandated state benefits
- What those payment methodology changes will mean to the way services are provided and the importance of demonstrating the efficacy of various service delivery models
    - Working at top of license
    - Use of alternative care providers and tiered service delivery personnel models
    - Interprofessional collaboration to achieve desired patient outcomes
- Specific legislative and regulatory changes
    - The Medicare Audiology Services Enhancement Act of 2013—H.R. 2330 (comprehensive benefit)
    - Unbundling of audiology services
    - Limited license physician status
    - Direct access

- Interprofessional Education (IPE) and Interprofessional Practice (IPP)

    Methods used to educate
    - o Resources on ASHA website
    - o Webinars
    - o Chats
    - o Conference presentations
    - o *ASHA Leader* articles
    - o *Perspectives* articles
    - o Materials to program directors
    - o E-mail

II. <u>Adjusting recommendations to meet needs of members in both professions and in multiple work settings</u>: Much of the change in health care reimbursement is currently occurring in the acute care arena, with a focus on keeping patients out of the hospital, which is the most expense care setting in which services can be provided. ASHA must consider how the following recommendations will need to be adjusted for SLPs practicing at all levels across the continuum of health care (e.g., acute care, inpatient rehabilitation, skilled nursing, home health, outpatient, early intervention, and private practice). Regardless of the setting, services will need to be provided in a different way. Some settings may offer unique opportunities to explore new avenues of service (e.g., private practice, outpatient centers). Because of variations in payment methodologies in different settings, the recommended actions may need adjustments to those levels of care.

The recommendations offered in this report relate most directly to how services are provided in health care settings. However, there are implications for service delivery model changes in school settings. For example, SLPs and special educators in public school settings were forced to reframe their services in response to reauthorization in 2001 of the Elementary and Secondary Education Act (renamed No Child Left Behind)—followed by reauthorization of the Individuals with Disabilities Education Act of 2004—that required Response to Intervention (RTI) as an eligibility consideration for the category of Specific Learning Disability. Special educators were charged with sharing strategies and interventions with general education teachers with the goal of preventing students from needing special education eligibility. The result was a huge need to train special educators and SLPs regarding "what was so special about special education," focusing on specialized instruction. Each recommendation should be considered by ASHA committees and NO units that work with members in school settings.

III. Translating the recommendations into specific actions needed in university settings: It should go without saying that these recommendations must be studied by members in higher education to determine the changes that need to be made regarding how we educate and train our students so that they are prepared to work and thrive in this ever-changing environment. To keep the educational model current, members in higher education must continuously analyze such external market changes and adjust the curriculum and clinic models accordingly. Students must be taught the business of our professions.

Overall Aim of Reframing the Professions: SLPs should provide value to individuals with communication and/or feeding/swallowing disorders and challenges—and audiologists should provide value to individuals with hearing and balance disorders—by delivering services that improve functional outcomes that matter to clients' everyday lives. This mission is carried out in a manner that results in a high degree of patient/family satisfaction and is cost effective. Both professions should look for opportunities to provide services related to primary, secondary, and tertiary prevention. Recent work coming out of the Institute of Medicine and the prevention science field is using a prevention framework that distinguishes among universal, selective, and indicated prevention. This may offer terminology that is transparent and easier to conceptualize.

SPECIFIC STRATEGIES RELATED TO EACH ASPECT OF THE TRIPLE AIM

STRATEGIES

I. Strategies to improve patient experience of care

A. Help members learn to develop functional goals:
- Develop simple modules to educate members on use of the International Classification of Disabilities and Function (ICF) framework to develop functional treatment goals and determine outcomes.
- Develop standard templates and examples of functional goals using the ICF framework.
- Promote use of the ICF frame work among members as the standard, acceptable practice in the treatment of communication and swallowing disorders.

B. Enhance, develop, and help members learn to use outcomes measures:
- Develop and/or improve and enhance clinical outcomes measures (per ASHA's National Outcomes Measurement System [NOMS]), so that they are both sensitive to change and able to document progress with therapy.
- Develop standards for the use of clinical outcomes measures (per NOMS or other tools), patient-reported outcomes (i.e., the Patient-Reported Outcomes Measurement Information System [PROMIS]), and quality-of-life measures (i.e., Health-Related Quality of Life [HRQOL]) to be used with individuals served.

- Develop or enhance a national outcomes database and develop patient registries in order to collect information about treatment needs and best practices for all populations served.
- Create easy-to-use dashboards with the information needed by clinicians and consumers to promote the use of best practices.
- Help members embrace technology and the power of data analytics.
- Collect data on the long-term functional and social implications of untreated communication and swallowing disorders on individuals and their quality of life.
- Collect data on the long-term costs to society of individuals with untreated communication and swallowing disorders versus the benefits to society of early treatment.

C. **Develop clinical pathways:**
- Develop clinical pathways for various diagnoses, conditions, and ages in order to standardize clinical practice and reduce unwarranted practice variations.
- Develop clear guidelines at different levels of care to help SLPs determine when formal therapy is not warranted, when to reduce the frequency of therapy, and when to discharge patients and transfer the responsibility to family.

D. **Focus on telepractice (telehealth, e-health, m-health) and other technological advances as a way to increase access to services for patients who live at a distance or cannot take off work or school to obtain services:**
- Provide resources for SLPs and audiologists who are interested in provision of services through telepractice.
- Promote legislative and regulatory changes to (a) allow the use of and reimbursement for telepractice in the provision of services, even across state lines, and (b) allow for telepractice for supervision, mentoring, and professional consultation.

II. **Strategies to improve the health of populations**

A. **Increase public knowledge of the various ways SLPs can participate in improving population health:** Develop documents, information on the website, and public service announcements about how SLPs are effective in a range of roles—including providing preventive, habilitative, and rehabilitative care and enhancing business communication effectiveness for hospitals and other organizations. Examples of slightly non-traditional activities/roles include:
- Provide early intervention services to develop prerequisite skills for communication and learning.
- Improve reading comprehension and fluency for children and adults.
- Enhance reading literacy skills and health literacy.
- Facilitate communication between health care providers and patients, so that patients can comprehend and participate more effectively in managing their medical conditions and care.
- Enhance medical environments (i.e., intensive care units, skilled nursing facilities, homes, etc.) for better communication.

- Train public servants (e.g., emergency responders and law enforcement agents) to recognize and appropriately respond to consumers with communication deficits.
- Enhance communication skills of employees for individual and organizational success by providing programs on accent modification, public speaking, voice improvement, business writing, accent learning (for actors), etc.

B. Expand audiology core competencies to include interventional care:

"Interventional audiology requires that audiologists and other hearing care professionals change their orientation toward patient care. Rather than centering on the dispensing of a hearing aid or medical device, interventional audiology revolves around the disease state of hearing loss and its relationship to the chronic medical conditions …" (Taylor & Tysoe, 2013, p. 16).

Interventional medicine focuses on prevention, early detection, and non-invasive alternatives to treatment, particularly as they relate to chronic health care conditions, such as heart disease and diabetes. Interventional audiology exists at the crossroads of hearing health issues and other co-morbid conditions that are likely to occur among patients seeking our services. The average age at which individuals purchase their hearing aids in the United States is 69, an age at which many Americans will likely be suffering from other chronic conditions.

Conditions and considerations for which audiologists need to expand their influence include (from Taylor & Tysoe, 2013):
- Dizziness: Intervention audiology can have an impact on reducing falls and subsequent costly hospitalization (from both a human and economic perspective).
- Diabetes: Intervention may reduce risk of falls secondary to diabetic neuropathy and reduce the impact of diabetes on progressive high frequency hearing loss.
- Cognitive decline: Evidence is emerging that hearing loss is independently associated with cognitive decline. There may be a benefit to intervening early in the course of age-related hearing loss in order to mitigate cognitive decline.
- Smoking: Evidence suggests that smokers are at a higher risk than non-smokers for hearing loss. In addition, second-hand smoke has also been implicated in hearing loss and the incidence of middle ear disease in children.
- Depression: The relationship between depression and hearing loss has been established in the research literature. Providing hearing health care early in the patient journey may reduce the impact of hearing loss on depression.
- Aging in place: There is a desire for most elderly to remain in their homes rather than be moved to an assisted living facility or become dependent on their adult children. Interventional audiology may provide these individuals with some of the tools necessary to live independently in their own homes without the fear of institutionalization.
- Healthy aging: One of the characteristic qualities of the baby-boomer generation is to remain active for as long as possible. Interventional audiology can provide these individuals the tools to stay connected with friends and family and to continue to participate in the social activities that they value.
- Hearing loss prevention across the life-span: Noise-induced hearing loss is entirely preventable. Consumer education must begin in pre-school and extend throughout the lifespan. Audiologists need to be recognized as THE voice for hearing loss prevention.

C. Utilize outcomes measures:

- Measure outcomes of professional services to assess and compare the effectiveness of diagnostic and intervention strategies. Use outcomes to build evidence-based practices and provide rationalization for effective assessment and treatment methods. Use standardized outcomes measures for audiology as a common means by which to evaluate the success of interventions and provide information on the quality of care for those receiving services.
- Develop functional and clinical outcomes measures for audiology that enable hearing care professionals to assess the quality of care delivered to clients/students/patients.

III. **Strategies for reducing per capita costs**

A. **Work at top of license:** SLPs should engage in only those patient care activities that require their level of expertise and skill. With our current model of service delivery, however, SLPs spend a great deal of therapy time "practicing" new skills that have been taught to the patient. This can and should be done by less skilled, and therefore less costly, individuals (i.e., assistants and/or the patient and family members). This would greatly decrease the cost of achieving outcomes (and also increase family satisfaction by decreasing the inconvenience, cost, and overall burden of care).
  - Develop an assistant role (e.g., for students who graduate with a bachelor's degree in speech-language pathology, but are not accepted into graduate school, or those who do not wish to seek a master's degree) so that assistants can be used to practice newly acquired skills with the patient at a far lower cost.
  - Develop teaching modules to help SLPs learn how to teach patients and their caregivers to self-manage/manage the disorder and work at home, provide consultative therapy for the development of new skills, and enhance their supervisory skills of support personnel.
  - Develop computer-based systems and mobile devices to assist patients in self-monitoring and recording practice.
  - Help employers understand that having the SLP work only at top of license is cost effective.
  - Develop measures of clinical productivity that still focus on cost per unit of service, and help employers understand the value of SLP activities to the organization that are not typically captured in current clinical productivity models.

B. **Market the profession of audiology as a uniquely qualified, cost-effective provider of care:** Marketing the profession of audiology is vitally important for the future growth and success of the profession. The public and allied health professionals need a full understanding of the unique contribution the audiologist can provide. They must understand when it is appropriate to utilize the expertise of the audiologist. Marketing the profession of audiology and the contribution of the audiologist will ensure that allied health and social service professionals have sufficient knowledge regarding the effects of impaired hearing and/or balance on patients and their families. They must be informed that audiologists are uniquely qualified to provide assessment and treatment for patients experiencing deficits of hearing or balance or the effects of tinnitus.

The public and health care providers need to be aware that, through education and training, audiologists are uniquely qualified to assess hearing and balance and to develop and administer a plan of treatment. Marketing efforts must be multi-tiered and include newsprint, television, radio, and the Internet. Appropriate levels of funding and expertise will be required.

The marketing should be produced on two fronts for two different audiences.
- Marketing to the general public
- Marketing to allied health professionals whose patients may be affected by hearing loss, tinnitus, vertigo

C. **Documentation:** According to the ASHA 2013 Healthcare Survey, SLPs spend about 20% of their time in documentation, the cost of which is paid by consumers. If asked, consumers would like to decrease the time and therefore the cost of this documentation. ASHA should:
- In terms of our documentation, determine what customers (physicians, patients/families, payers, etc.) actually want, need, and read.
- Develop templates to streamline all patient documentation (e.g., diagnostic reports, progress notes, discharge reports, etc.) in a way that meets the needs of all customers, yet is fast to generate and, therefore, less costly to produce.
- Educate SLPs on the need to document during the session and the fact that "more is not necessarily better."
- Maximize the use of electronic health records by working with developers to make changes in the tools to reduce time and effort.
- Work with test developers and publishers to make assessment tools easier to score online with results that automatically populate in reports.
- Monitor and help develop evolving technologies that will impact the management of communication and swallowing disorders.

D. **Eliminate waste in current processes:**
- Train SLPs to identify and eliminate waste in their processes by distinguishing value-added from non-value-added activities. Examples of the latter include charting the same information in multiple places and walking between treatment locations multiple times in a day.
- Develop recommendations to streamline diagnostic interactions so that unnecessary or redundant tests are not given and the necessary information is obtained in the least amount of time and at the lowest cost.

E. **Ensure patient/family engagement:**
- Develop online courses on self-management so SLPs can teach these skills to patients and families and make this a part of the graduate curriculum.
- Train SLPs to involve the patient and family in goal setting with a focus on function, the impact on the patient's ability to participate in life, and the outcomes that matter to patients.
- Train SLPs to shift the focus from providing direct service in so many visits to a consultative model where the patient and family are trained to practice at home between the visits.

F. **Encourage technology innovation and telemedicine**:
- Use data to determine and recommend the "best setting" (e.g., hospital, school, home care, etc.) for treatment of various disorders across the continuum so that there is not duplication of services and, thus, costs.
- Provide examples and instructions of how telemedicine can be used to provide shorter and more focused treatment, resulting in a lower per capita cost.

G. **Expand ASHA's responsibility in establishing standards for assistants; explore existing models (e.g., VA):**

As health care and education reform evolve, audiologists and SLPs need to question current practices and assess whether these practices are meeting the present and future needs. Our professions must deliver higher-quality services to increasing numbers of students/clients/patients, in spite of budget constraints and shortages of professionals in our field. With the increase in Medicare recipients due to the aging population and the growth of insured individuals due to health care reform, the need for services within the patient-centered medical home will increase. Furthermore, educational restructuring has increased the roles of the SLP and audiologist in providing services for greater numbers of children outside of the traditional special education environment. For these reasons, it is essential that the roles and credentialing of support staff be investigated by the Association. With the use of aides/support staff, audiologists and SLPs are able to work at the top of license and not be burdened with tasks requiring less complex skills. In addition, more students/clients/patients can be managed using a cost-efficient model.
- Investigate standards for speech-language pathology and audiology assistants with consideration given to how bachelor's-level graduates from CSD/CDS programs can be incorporated into this model.

H. Support research to examine evidence of equivalency of care (e.g., audiology vs. otolaryngology): In order for audiology to frame/brand itself as the premier provider for hearing and balance health care, the profession needs an evidence base that supports the assumption that hearing and balance services provided by audiologists yield better outcomes (objective, self-perceived, cost-effective, etc.) than those achieved by other providers of hearing and balance health care (i.e., physicians, physical therapists, technicians, hearing aid specialists, machines). Funding for such research should focus on the following:

- What services are likely to yield equivalent or superior outcomes at a lower cost if provided by an audiologist as opposed to other hearing health care providers?

Existing evidence: The only available evidence somewhat related to the question is an examination of the safety of audiology direct access for Medicare patients.

Pharmacists have done an outstanding job of evaluating the value of pharmacist-delivered care for a number of chronic conditions, including depression, adherence to antidepressants, cardiovascular disease, and diabetes. Pharmacists make a compelling evidence-based argument for why pharmacists belong in the Medical Home.

Sadly, audiology is light years behind pharmacy in developing such an evidence base or making a convincing argument for our role as the primary provider of hearing and balance health care. This contrast is even more disturbing when we consider that both the audiology and pharmacy professions moved toward requiring the doctorate as the entry level degree at about the same time.

Related recommendation not tied to the Triple Aim

Evaluate the appropriateness of the AuD educational model.

Starting with the Health Care Summit (October 5–7, 2012), education emerged as a topic in almost all discussions related to audiology. Education has two parts in the discussion: educating others about what audiologists do and educating new professionals in audiology. This committee, a subgroup of the larger Reframing the Professions committee, is composed of only audiologists; the committee addressed education—specifically, education of the future audiologist—using our current (almost universal) 4-year model for the entry-level clinical doctorate. This current model has the 4th year serving as an externship for clinical practice and, at this time, has no requirements/accreditation or regulations as to what encompasses the 4th year or the type of facility where the students are placed.

The AuD model has been around for approximately 20 years; not only is it timely to evaluate the model because of health care changes, but also because it is a relatively new model and periodic reviews are healthy to determine if changes are needed and/or to evaluate the impact on new graduates, the field itself, other professionals, and all consumers. Audiology is one of many clinical doctorates that have arisen over the past years, so evaluation may be informed by what others have learned. Several areas were identified and include:

- Number of students entering the program (e.g., What level/degree of growth is needed to sustain the profession?)
- Return on investment (ROI)
- Meeting the needs of students (e.g., Has there been a substantive change in training relative to the master's degree?)
- Meeting the needs of consumers (e.g., Are we serving consumers more effectively? Do consumers need better access to our services?)
- Adequately preparing students for the 2014 health care environment

1. Meeting needs of consumers

   o Meeting the needs of the consumer should encompass evaluation of accessibility, quality of care, and cost. Is there value to the consumer?

      ▪ At the core of moving to a clinical doctorate in audiology are the profession's self-serving reason (i.e., to increase autonomy in practice) and also the expanding breadth of practice that called for additional instructional time to teach basic skills within the profession. This is true not only for audiology but for other fields (e.g., physical therapy [PT]) as well and holds true for those professions with clinical doctorates as entry to the profession, not clinical doctorates as an option for advanced study (e.g., for nursing). In the context of an education review, we need to examine the notion or mindset that the degree (AuD) will increase autonomy (i.e., end the requirement for referrals from physicians) and potentially enable audiologists to charge more for services—thereby commanding respect from the medical field and from the public.

2. Number of students entering the field, ROI, and meeting needs of students

   o What impact is our current education model having on students, and can we sustain and attract high quality students to the field?

      ▪ If we are to encourage quality students to become audiologists, we need to evaluate cost. With health care changing and Medicare trying to reduce costs, we need to evaluate the cost of increasing professional education requirements. That is, the 4-year AuD degree is costly, but there is some expectation that earnings will offset that cost. (Cost should also be evaluated with respect to minority education and whether the educational costs are keeping minorities from entering the profession.) However, the expectations about compensation through educational costs are not directly related to reimbursement, especially by Medicare (exception to some services are those not covered by Medicare, such as hearing aid related services). Facilities/providers are reimbursed for the clinical service, not according to the highest degree held by the clinician providing the service. Salaries in health care do not always get elevated with advanced degrees. Many employers do not increase salaries if the scope of the work has not changed with the increase in degree

requirement. Often, salary changes have occurred not because of practitioners' increased education, but because of the growing shortage of clinicians that occurred because of the additional time needed to complete the degree (e.g., in the case of PT). Therefore, there is a disconnect between education cost and salary and reimbursement that needs to be evaluated.

3. Adequately preparing students for 2014 health care changes

   o Related to this issue are newer models of education that consider IPE. Are we educating within the models of health care that are emerging in IPP? Are we teaching students how to provide services that are
     - Patient/family centered
     - Community/population oriented
     - Relationship focused
     - Process oriented
     - Linked to learning activities, educational strategies, and behavioral assessments that are developmentally appropriate for the learner
     - Able to be integrated across the learning continuum
     - Sensitive to the system's context/applicable across practice settings
     - Applicable across professions
     - Stated in language common and meaningful across the professions
     - Outcomes driven

SUGGESTIONS FOR IMPLEMENTATION

- Because of the urgency of many of these recommendations, existing boards, committees, and NO units should be charged to implement as many of the recommendations as they can without delay.
- ASHA should collaborate with the Council on Academic Accreditation in Audiology and Speech-Language Pathology to implement suggestions in university training programs.
  o Develop a webpage and an online curriculum of educational materials for graduate schools and for practicing professionals regarding
    - changes in health care and why practice changes need to be made,
    - new practice models,
    - effective business practices in speech-language pathology.

- o Help faculty of various health care education programs work together to learn and be able to educate students regarding changes in provision of health care services and changes in reimbursement.
  - o Continue to monitor the preparation of students within the scope of practice so that future students are prepared to practice in the changing environment.
- Recommended changes should be translated into practice so that school-based SLPs and school-based audiologists can make the same changes. Practitioners in this setting are also being asked to do more things for more students with no additional resources. This will increase therapy effectiveness, decrease caseload size, and increase family satisfaction.
- There is a critical need that our members understand the magnitude of the changes taking place in health care, education policy, practice, and payment methodologies. Information provided by the national professional organization will ensure that members are receiving accurate and thorough information.
- Because reframing the professions is not a time-limited activity, the Association must continually respond to changes as they occur.
  - o Gather thought leaders for continued development of any of these recommendations that are determined to need further study. In addition, these thought leaders can help guide future actions of the Association as health care reimbursement models continue to change.
  - o Develop an ongoing health care advisory committee to evaluate the effect of bundled payments and other changes in reimbursement and care delivery that will affect the practices of speech-language pathology and audiology.
- Although the issue is not directly related to the Triple Aim, the committee recommends that the education and training of audiologists be examined at this time.

References and Resources for Reframing the Professions

The call for health care redesign and focus on value:

1. The Triple Aim—IHI www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx
2. Best Care at Lower Cost—The Path to Continuously Learning Health Care in America—Institute of Medicine (IOM) www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx
3. Healthy People 2020 Framework www.healthypeople.gov/2020/about/default.aspx
4. IOM Roundtable on Value and Science-Driven Health Care www.iom.edu/Activities/Quality/VSRT.aspx
5. What Is Value in Health Care? www.nejm.org/doi/full/10.1056/NEJMp1011024
6. Why Health Care Is Stuck and How to Fix It—Michael Porter and Thomas Lee http://blogs.hbr.org/2013/09/why-health-care-is-stuck-and-how-to-fix-it/
7. Redefining Health Care website www.hbs.edu/rhc/
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10. Care Redesign: A Path Forward for Primary Care Providers (presentation) www.centerforprimarycare.org/Summit_2012/Lee-Presentation.pdf
11. Disruptive innovation in health care http://hbr.org/web/extras/insight-center/health-care/will-disruptive-innovations-cure-health-care
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Team-based health care

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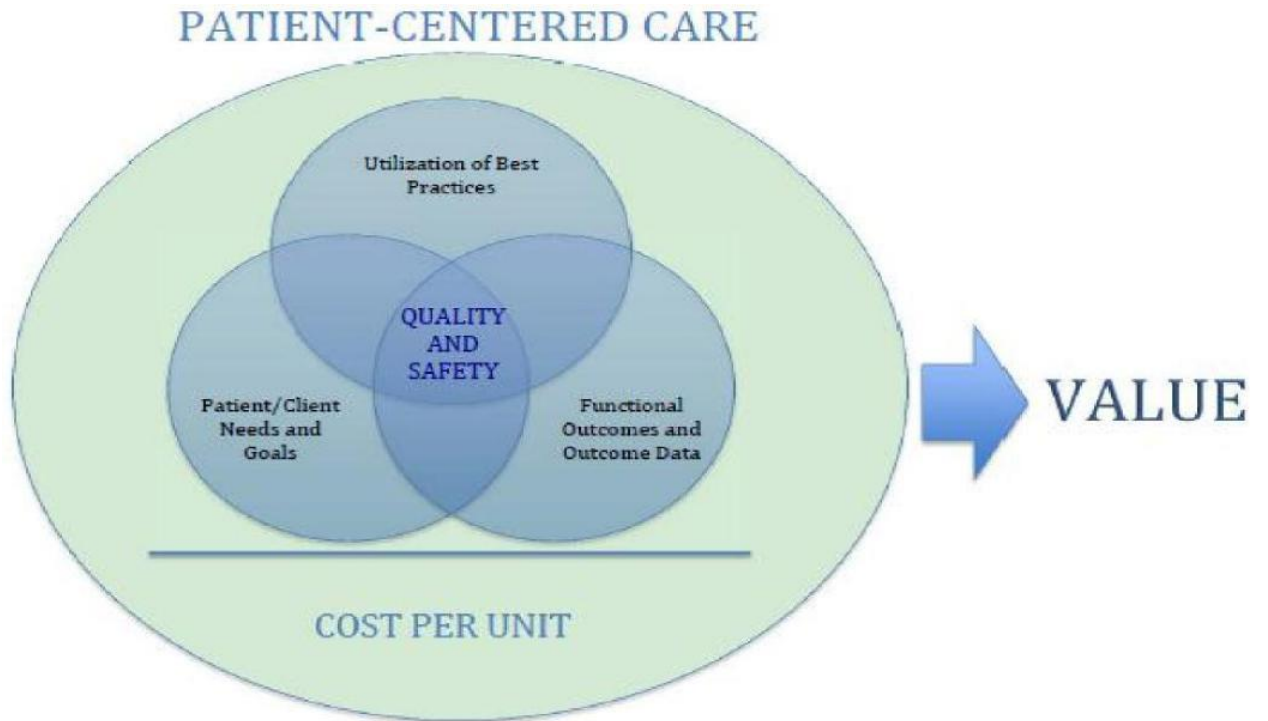
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Expand audiology core competencies to include interventional care

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FIGURE 1

PATIENT-CENTERED CARE

Utilization of Best Practices

QUALITY AND SAFETY

Patient/Client Needs and Goals

Functional Outcomes and Outcome Data

COST PER UNIT

VALUE

Developed by Wayne A. Foster (2012)

FIGURE 2

Triple Aim Framework

1. Improving the patient experience of care (including quality and satisfaction)

A. Help members learn to develop functional goals.

B. Enhance, develop, and help members learn to use outcomes measures.

C. Develop clinical pathways and clear guidelines at different levels of care to help SLPs determine when formal therapy is not warranted, when to reduce frequency, and when to discharge patients and transfer responsibility to the family.

D. Focus on use of telepractice and other technological advances as a way to increase access to services. Promote legislative and regulatory changes to allow (a) use and reimbursement of telepractice for provision of services, even across state lines, and (b) use of telepractice for supervision and mentoring.

2. Improving the health of populations

A. Increase public knowledge of ways SLPs can participate in improving population health.

B. Expand Audiology Core Competencies to include interventional care.

C. Utilize outcomes measures.

3. Reducing the per capita cost of health care

A. Work at top of license; engage in only activities that require SLP level of expertise and skill.

B. Market the profession of audiology as a uniquely qualified, cost effective provider of care.

C. Streamline documentation process.

D. Eliminate waste in current processes.

E. Promote patient/family engagement for self-management and to assist with functional goal setting and shift from providing direct service to consultative.

F. Utilize innovations in technology.

G. Expand ASHA's responsibility in establishing standards for assistants.

H. Support research to examine evidence of equivalency of care.

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