# ASHA Changing Health Care Landscape Summit

## October 5–7, 2012

## <u>Executive Summary</u>

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## Introduction

It is widely acknowledged that health care, and especially the economics of health care, will be undergoing a dramatic change 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 Accountable 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, and
- 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, accountable 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. Independent of the results of the November 2012 presidential election or the legislative fate of the ACA, 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 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 risks.

Thus, ASHA convened a Summit on the Changing Health Care Landscape on October 5–7, 2012, to address the many present, pending, and proposed issues that face practitioners and the discipline of communication sciences and disorders. The purposes of the summit were as follows:

- 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.
- 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, and
  - dissemination of information that energizes individuals to become catalysts of change.
- Determine ASHA's role in proactively safeguarding the professions in light of the changing landscape in health care.

This summary highlights the key issues, implications, decision points, and recommendations for the practice of audiology and speech-language pathology identified during the summit to meet the challenges of a disrupted and evolving health care landscape.

# Audiology Summit Recommendations

## Introduction

On Day 2 of the summit (Saturday), the audiology participants met for a series of brief presentations, several group discussions, and five small group discussions related specifically to audiology and the changing health care landscape. That evening, those taking notes during the presentations and discussions distilled the discussions into a group of possible action items. These possible action items were discussed on Day 3 of the summit (Sunday). Once these items were discussed (and their wording changed based on audiology attendee input), these items were voted on for inclusion as formal action items. A 75% criterion was used for consensus to have been achieved (this could be 75% or more "yes" or 75% or more "no"). If 75% voted "no," the item was deleted from our list and from further discussion. If 75% said to keep the item, then three additional (secondary) actions were voted on for this item: (1) begin working on this item now (i.e., in the next year, approximately) or later, (2) this is a high priority item or low priority item, and (3) this is audiology only or both audiology and speech-language pathology. If any item did not reach consensus (i.e., the vote was between 25% and 75%, this item was typically discussed briefly, time permitting, and a second vote was taken). A failure to reach consensus resulted in that particular item being labeled as *no consensus achieved*. Failure to reach consensus never occurred for the primary vote to keep or eliminate a given action item, but it did occur in some cases for the secondary votes.

## Patient-Centered Care

As shown in Figure 1, the focus of much of our discussion was about, and promoted, patient-centered care. Patient-centered care has as one of its tenets that high-quality care must make the patient a central part of the health care team. Optimal patient-centered hearing health care must include clinicians (audiologists) who use best practices and who measure universally accepted outcomes.

- Promote patient-centered care, including what the patient wants/needs and incorporating the patient's goals [now; high; aud/slp].
- Incentivize audiologists to measure/value outcomes [now; high; aud/slp].
- Incentivize audiologists to consistently use best practices [now; high; aud].

## Education

Several presentations and discussion sessions focused on education. Education was discussed in the most general use of the term, and discussion addressed the education of virtually all stakeholders in hearing health care: the consumer, those making public policy, practicing audiologists, academic audiologists, other health care professionals, as well as our audiologists in training. Educational issues and action items were raised in most if not all discussions. A central theme of these discussions was that audiologists do not just deal with a patient during acute episodes of hearing/vestibular problems, but also provide hearing health care throughout the lifespan. The conversations about education were often focused on what ultimately became core summit

issues: patient-centered care, evidence-based practice, preferred practice patterns, online (or blended) learning, and interprofessional education.

<u>With a focus on patient-centered care, there is a need to:</u>

- Educate audiologists and students about
    - reimbursement models involved in bundling [now; no consensus; no consensus];
    - hair cell regeneration, vestibular prostheses, cell and gene therapy, and biotechnology with respect to potential changes in audiology practice and reimbursement [later; low; aud];
    - public health, epidemiology, health behavior, and the use of large data sets to evaluate clinical outcomes and hearing loss prevention [later; no consensus; no consensus];
    - using measures that go beyond audiometric measures that evaluate the impact of hearing loss on quality of life and communication functioning [now; high; aud];
    - outcome measures to evaluate impact of intervention and demonstrate value [now; high; aud/slp].
- Create academic training models where students learn preferred practice patterns [now; high; aud/slp].
- Develop an online or blended learning course (online plus live component) that addresses the changing landscape in health care (e.g., reimbursement issues, bundling) that universities can use to educate their faculty and students [now; no consensus; aud/slp].
- Encourage consistent use of agreed-upon definitions [now; no priority; aud].
- Educate primary care practitioners, nurse practitioners, and physician assistants about what audiologists do and about the value they add to the team, using data and information and data about cost reduction [now; high; aud].
- Incorporate interprofessional education [no consensus; no consensus; aud/slp]:
    - Encourage interprofessional education experiences.
    - Investigate use of simulation centers and standardized patient evaluations for interprofessional education.
    - Hold model workshops where teams with multiple disciplines that work together come together to learn and share with other institutions' teams their model and experiences.
    - Consider having the Council for Clinical Certification change certification standards to incorporate interprofessional education into standards and allow clinical hours supervised by professionals other than SLPs or audiologists.
    - Consider having the Council on Academic Accreditation in Audiology and Speech-Language Pathology change accreditation standards to incorporate interprofessional education into standards.

## Data and Databases

In multiple discussions, it was clear that there was a need for an extensive registry of patient data related to audiological services. This registry will be the key to developing defensible arguments about best practice, use

of patient outcomes, cost of services, and so forth. It was recognized that a centralized, accessible registry is not available. There are mineable electronic medical records and databases that are currently available, but these are proprietary within specific health care systems or institutions and, therefore, per HIPPA, not accessible to all potential end users who would have queries that need to be answered via such a data resource.

- Query existing databases/systems to inform health care policy development and practice [now; high; aud].
- Create an index of what is available in existing databases [now; high; aud].
- Create a centralized registry of de-identified audiologic data that is publically accessible for data input and data mining to be used to continually update best practices and demonstrate value in patient-centered care [now; high; aud]:
  - Encourage HIMSA to make NOAH data accessible in usable formats and make new fields available to capture outcomes.
  - Create a standardized data structure and fields prior to creating a centralized database.

## Recommended Actions

There was discussion that encompassed the need to develop tools that would allow practitioners to accurately collect and mine data related to patients' auditory and vestibular impairment. Those variables should include classification of the severity of the impairment, which must include the degree to which the impairment affects an individual's quality of life. The development of a model that would assist in the determination of the amount of care a patient requires from an audiologist is also needed. There are limited measures that could assist audiologists in the determination of which patients require additional auditory/aural rehabilitation (AR) in order to achieve targeted outcomes. There is a need to solicit feedback from patients who have utilized the services of audiologists, in order to assess, and ultimately improve, the effectiveness of those services. Participants discussed the putative relationship between hearing loss and depression/dementia, concluding that additional evidence could be provided by a systematic literature review.

- Develop a metric (single number) to classify severity of hearing loss [now; high; aud].
  - Modify *ICD-10* for audiometric classification.
  - Develop or adapt a functional classification with a focus on daily life activities.
- Develop and use a tool to triage patients and determine who would benefit from additional AR [now; no consensus; aud/slp].
- Administer surveys of the public to determine current effectiveness (quality of life, impact) of audiological services (get consumer perspective on service) [later; low; aud].
- Establish a standardized definition of value [now; high; aud].
- Conduct an item analysis of outcome questionnaires in audiology to develop a minimal set of questions that assess independent factors to be used in a central registry [no consensus; low; aud].
- Perform a systematic review of the literature to determine if there is supporting data on the impact of hearing loss on dementia and depression [later; high; aud].

## Other Areas (Legislative/Funding)

A number of the discussions and subsequent recommended actions addressed issues that would involve either legislative issues or substantial funding from an extramural agency. Unlike cochlear implants, we have no hard data that relate hearing aid use with an improvement in quality-adjusted life years. Under current health policies, a hearing aid is not available to everyone who needs one (or two). Medicare reimbursement is not available to audiologists for many aspects of their scope of practice. Third-party reimbursement is currently not widely available for audiology telepractice.

- Fund a multicenter, controlled study to show improvement in quality-adjusted life years in hearing aid use [no consensus; no consensus; aud].
- Develop a mechanism to make hearing aids available to everyone who needs them [now; high; aud].
- Change the Medicare reimbursement structure related to comprehensive care (prevention, identification, intervention, treatment, rehabilitation, and management) [now; high; aud].
- Work with Medicare to allow third party reimbursement for audiology telepractice [now; high; aud].

# SPEECH-LANGUAGE PATHOLOGY SUMMIT RECOMMENDATIONS

Like all health care professionals, speech-language pathologists are challenged by the changing health care landscape. The ASHA summit offered participants specific information about (a) the wider health care industry; (b) value-creation systems; (c) an update on the state of health care quality from the director of the federal Agency for Healthcare Research and Quality (AHRQ); (d) an overview of implications of accountable care for speech-language pathology services; (e) a primer on cost–benefit analysis; (f) an overview of the *International Classification of Functioning, Disability and Health* (*ICF*); (g) post-acute care imperatives; (h) perspectives on navigating change from executives of leading rehabilitation companies; (i) six specific aspects of outcomes measurement; and (j) an update on innovative approaches to academics and professional preparation. Participants were given the opportunity to discuss these topics in small group discussions and to provide written feedback regarding questions posed at the conclusion of the summit. Key areas of focus and recommendations are categorized and discussed below.

## Reconsider/Expand the Clinical Paradigm

- Move from a focus on deficits and impairments to context-based communicative effectiveness based on the formula developed by Kane: Outcome = f (baseline, patient factors, environment, treatment) and consistent with the new definition of "value" in health care: superior outcomes (reliable delivery of high-quality care) + patient-centered care (with personalized treatment plans) + efficiency (streamlined processes that reduce waste and lower overall health care costs).
- Fully develop ASHA's adoption of the *ICF* framework into speech-language pathology practice resources. Produce specific tools and resources for SLPs that are "wrapped around" the concepts of the framework—so that the *ICF* becomes a unifying language for clinical reasoning and problem solving across professional roles and venues. A unifying language for practice also enables cross-continuum inter- and transdisciplinary care. ASHA may want to consider describing clinical practice parameters in a dynamic document such as that developed by AOTA in its *Occupational Therapy Practice Framework: Domain and Process*.
- Expand the clinical paradigm beyond traditional CSD services to include patient–provider communication strategies, services to communication-vulnerable (not necessarily disordered) populations participating in health care services, and providing consultation regarding altering and enabling the communication environment in care venues such as ICUs and stroke units.

## Re-frame/Re-brand the Profession

- Position speech-language pathologists as the leaders in communication health.
- One participant stated the concept well: "ASHA needs to begin to lead by changing the vocabulary the field uses to describe value… be patient centered, not clinician centered… go beyond disability categories; talk about the critical importance of effective communication during health care encounters and the unique expertise available within the profession to meet patient and family needs, as well as support all stakeholders to deliver quality care within our country."

- Link communication outcomes to health care quality of life, including societal and personal costs and benefits, and frame the profession as part of primary health care, not as an ancillary specialty.
- Several participants advised that SLPs should be providing only high-level, "top of license" services (i.e., what CMS has always required: a "level of complexity and sophistication of service that only an SLP could perform"), working through others such as assistants and family members to provide practice and follow-up services.

## Quality and Outcomes Measurement and Management Needs

Several aspects of measurement were discussed during the Summit. The measurement of outcomes, data regarding the types of services rendered to different patient populations, and frameworks that are transparent and understandable across the continuum of care are important areas of need.

Recommendations were wide ranging:

- Speech-language pathologists need more specific guidance documents for optimal practice, such as condition-specific clinical guidelines, pathways, and protocols (pathways and protocols are typically developed by interdisciplinary teams, and SLPs need the knowledge and skills to incorporate goals and intervention parameters into these documents in local institutions and programs). Several participants stated that standards of care are required to reduce unwarranted practice variation, but also to identify care that should be individualized for specific patient needs: "standardize; then personalize."
- A keynote speaker suggested that ASHA consider developing "appropriateness criteria" similar to what has been developed by the American College of Radiology and the American College of Cardiology. Participants suggested enlisting the Special Interest Groups (SIGs), Related Professional Organizations (RPOs), ASHA expert consensus panels, and existing committees that focus on evidence-based practice parameters and tools in the effort to provide robust diagnostic and clinical intervention support tools. See the American College of Cardiology "Guidelines and Quality Standards" site to review how various support tools are presented: http://www.cardiosource.org/Science-And-Quality/Practice-Guidelines-and-Quality-Standards.aspx.
- Participants suggested that ASHA engage an external expert to evaluate the value and utility of NOMS. Does a NOMS functional communication measure level constitute an outcome? For example, what does it mean when a patient achieves a gain of one level after 15 treatment sessions? Needed enhancements to NOMS were identified including additional case-mix data and participation measures. If it is determined that NOMS is useful to quantifying outcomes, it must be funded accordingly, widely promoted, and used by practitioners. Outcomes measurement must be seen as integral to everyday clinical practice. Some participants expressed concern that NOMS is not accessible. In addition, there are many other outcome tools, including ASHA's own Quality of Communication Life Scale (ASHA QCL) that should be widely offered to clinicians to support outcomes measurement efforts.
- The importance of including patient-reported (and proxy-reported) outcomes in our outcomes measurement battery was stressed by presenters and participants.
- Some participants expressed the concern that ASHA does not seem to partner with other professionals to use one cross-professional outcomes tool. The interdisciplinary tools, CARE-C and CARE-F, created

through a CMS subcontract to Research Triangle Institute, in which ASHA participated and provided measures derived from NOMS, do not appear to be moving forward as a unified tool. Thus, it is critical that ASHA continue to find ways to integrate communication and swallowing measures into emerging instruments and databases. Is it feasible to continue to operate as if speech-language pathology is "different" and that we must have our own tools and not participate in interdisciplinary tools? What are the risks of not being adequately represented in cross-professional data sets?

- One presenter said that outcome metrics must focus on the ability of the individual to function independently and to live actively and productively. Outcome measures, critical case-mix data needed for risk adjustment, and resource utilization measures need to be available in the same data set so that the costs associated with health care utilization can be evaluated in relation to the benefits accrued (i.e., to conduct cost–benefit analyses). Professionals must focus on their "value-added" to *global* patient outcomes. Payers are looking for core outcomes data—not documentation—that can be efficiently processed and measures integrated into payment systems (claims data).

- One presenter, an expert on quality indicators, stated that meaningful functional measures are needed that can be translated into standardized data sets for sharing (e.g., within electronic health records [EHRs] and as part of health information exchanges). It was advised that the measures should be "technology agnostic" (inserted into any health data system and not restricted by proprietary barriers). Moreover, measures should be considered an essential component of EHR meaningful use transaction standards.

- Specific related research needs identified include comparative effectiveness, implementation research, and cost–benefit analyses and cost–resource use.

## Professional Preparation

Professional preparation was discussed and several innovative models were presented during the Summit. Preparation of SLPs who are competent and appropriately prepared and empowered to be leaders and effective partners in the health care delivery system is paramount. Recommendations included the following:

- Interprofessional education (IPE) to enable clinical practice focused on collaboration with other professionals and cross-continuum care coordination is a critical component of providing value-based health care. One presenter has established an IPE unit in a major teaching hospital.
- Prepare clinicians for evolving roles and expanded responsibilities in health care.
- Use new "active" approaches in education (e.g., simulation, case-based or problem-based learning) and more experiential learning to improve exposure to clinical practice early in the curriculum.
- Consider integration of the Clinical Fellowship Year into the degree program.

## Member Education and Widespread Dissemination of Information

Members of ASHA continue to participate in professional development activities that enhance their competency and preparedness to deliver high-quality services that yield significant outcomes for individuals with communication disorders. SLPs need information about the various changes in the health care landscape that will impact how services are provided and professionals are compensated. Moreover, information about

increasingly complex topics should be shared with members in clear messages that can be easily accessed and may also be shared with consumers as they seek services.

- Consider establishing an "open university" of online modules similar to the Institute for Health Care Improvement's Open School: http://www.ihi.org/offerings/IHIOpenSchool/Pages/default.aspx.
- Focus member education on topics related to "accountable care" such as systems skills; team science; care redesign (http://www.icsi.org/health_care_redesign_/ and http://www.hbs.edu/rhc/); cross-continuum care coordination; EHRs, automated clinical decision support tools, clinical analytics, and data management; and health care economics and business literacy.
- Consider requiring competency-based continuing education and possibly recertification examinations (similar to what is required of board-certified physicians).
- Participants stressed the importance of using a wide variety of educational tools and formats to disseminate information to professionals. In addition to conference and meeting presentations, offer webinars, YouTube video presentations, podcasts, Tweets, blogs, and a "value-based health care" Listserv. It was also suggested that ASHA offer modules for value-based care similar to the SERCU modules.

**Note**: Recommendations for speech-language pathology were developed by the planning committee based on the presentations, small group discussion comments, feedback recorded by participants at the conclusion of the summit, and extensive research conducted by the planning committee in the months preceding the summit. Some of the most salient advice was obtained from participants external to the organization. The format of the SLP segment did not lend itself to voting.

Figure 1
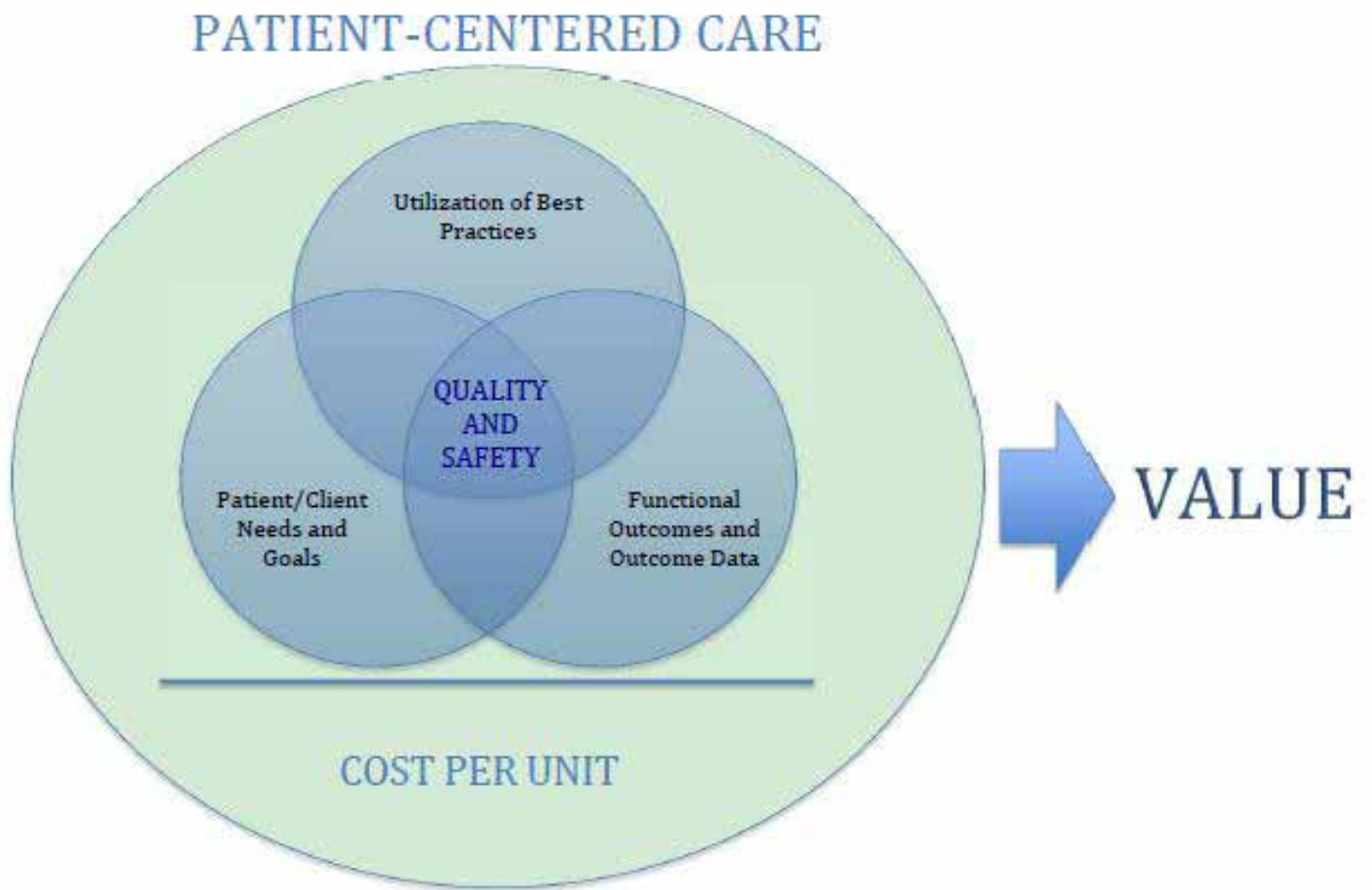


Developed by Wayne A. Foster (2012).