

SLPs and Hospice Care

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SLP Roles

- Speech-language pathologists, and rehabilitation professionals in general, are being recognized more frequently as valuable members of a palliative care team.
- However, even with a high incidence of patients with cognitive-communicative, motor speech and swallowing disorders in hospice, SLPs are underutilized
- Palliative care emphasizes improving quality of life through pain and symptom management, communication, and coordinated care.

SLP Roles

- SLPs are firmly established with patients with head and neck cancer
- Physicians and other referral sources may not recognize our role with other types of cancer, with respiratory disease, motor neuron disease, and neurological diseases.
- Treatment for cancer and the nature of the disease process often results in at least mild cog-communication and swallowing deficits

SLP Roles

- Weakness and wasting from terminal disease also predispose patients to respiratory disorders, dysphagia, and dysphonia.
- SLPS may determine the safest diet and make adjustments as the disease progresses, teach swallowing compensatory strategies, educate caregivers about safe feeding assistance techniques, and teach about ANH options.

SLP Roles

- Families often welcome information about dying and comfort care and those times when feeding someone is not a priority.
- SLPs can provide education about oral care and keeping the mouth comfortable and clean.

Communication Interventions

- Many options for readily available high and low tech AAC devices exist
- Patients and families can access options more easily now due to the influx of smart phones and tablet computers.
- These devices may be more socially acceptable to augment communication skills.
- Quick acquisition and affordability are important with a shortened lifespan or poor prognosis

Communication Interventions

- Communicating immediate wants and needs about pain, discomfort, medical treatment, and emotional status are all critical for a patient during terminal illness.
- Other pressing needs for communication include living wills, power of attorney, and health care proxy decisions.
- Individuals may also have unresolved family issues or concerns to communicate.

Issues specific to cancer

- Feeding tubes are used frequently in patients with cancer regardless of swallowing status to maintain weight and adequate nutrition.
- SLPs can provide education about ANH and teach oral motor exercises in patients with head and neck cancer undergoing radiation.
- SLPs also teach patients and families about what they can eat and drink to maintain pleasant oral experiences and avoid disuse atrophy that occurs with ANH and lack of oral activity.

Rehabilitative Focus

- Many patients on hospice are not imminently dying, and may benefit from a more rehabilitative focus for aphasia, dysarthria, or dysphagia.
- Individuals with brain tumors often have a variety of cognitive linguistic deficits which may prevent return to work or communication with family and friends.
- Individuals may be too ill to use a tracheoesophageal prosthesis immediately after laryngectomy and may have to progress through a series of communication options like artificial larynges and AAC .

Rehabilitative Focus

- Other patients with head and neck cancer usually have some type of dysphagia and need swallowing rehabilitation.
- Patients with neurological diseases like Amyotrophic Lateral Sclerosis and Progressive Supranuclear Palsy may live for several years with changing communication and swallowing needs and appear at different times on the SLP's caseload.

Patient examples: Brain cancer

- 72 YO male pt had received radiation and chemo for brain tumor after surgery
- Resultant aphasia as effect of treatment
- Pt very physically active and had goal of improved receptive/expressive aphasia
- Pt seen in home for physical and speech therapy for 60+ days until max benefit reached
- Pt lived about 6 months after ST discharge

Patient example: ALS

- 70 YOF, recent diagnosis ALS, on hospice 1 month, rapid decline. PEG tube but eating also
- Pt very weak, continuous oxygen required, assist 1 person to transfer
- Speech clear; dysphagia present
- Family satisfied after swallow eval and teaching and no additional therapy desired
- Pt died 6 weeks after evaluation

Patient example: Progressive Supranuclear Palsy

- 78 YOF with PSP, had been on hospice 8 months
- Poor endurance but ambulated without assist
- Functional swallowing skills but underweight
- Moderate-severe dysarthria with rapid fatigue
- Interested in inexpensive AAC & given information
- Pt died 2-3 weeks after evaluation

Patient example: Laryngeal cancer

- 64 YOM with laryngeal cancer, vocal folds present, metastases to multiple organs
- Pt NPO and receiving palliative care only
- Pt could wear one-way speaking valve short periods while supervised to communicate
- Family trained to place valve when visiting or pt indicated desire to communicate
- Pt died while on service

Patient example: ALS

- 39 YOM with ALS, NPO with PEG tube
- Physically weak, using wheelchair, frequent falls
- Speech unintelligible
- Pt had Dynavox but preferred phone app on Android with voice output to communicate
- Educated family on other AAC options when pt could not type, evaluation only

Clinical wrap-up

- Many pts/families are relieved to know that “normal” oral intake is not a goal of hospice care especially if pt has a method of ANH
- Many pts will deteriorate quickly and need access to quick and easy AAC like a phone app or IPAD
- Many pts on hospice will live for fairly long periods of time and benefit from traditional aphasia or dysarthria therapy

Clinical wrap-up

- SLPs are often not called in to see patients in hospice until they are near death
- Our colleagues, especially nursing, need to be educated about what we can do to help patients earlier in their care

Conclusion

- SLPs play an important and under-recognized role with patients on hospice and can address speech, swallowing, and cognitive-communication skills.
- Education can be our most important service assisting both patients and caregivers in feeling more comfortable dying at home.
- Being able to eat and drink a little and communicate with family and friends is critical.