



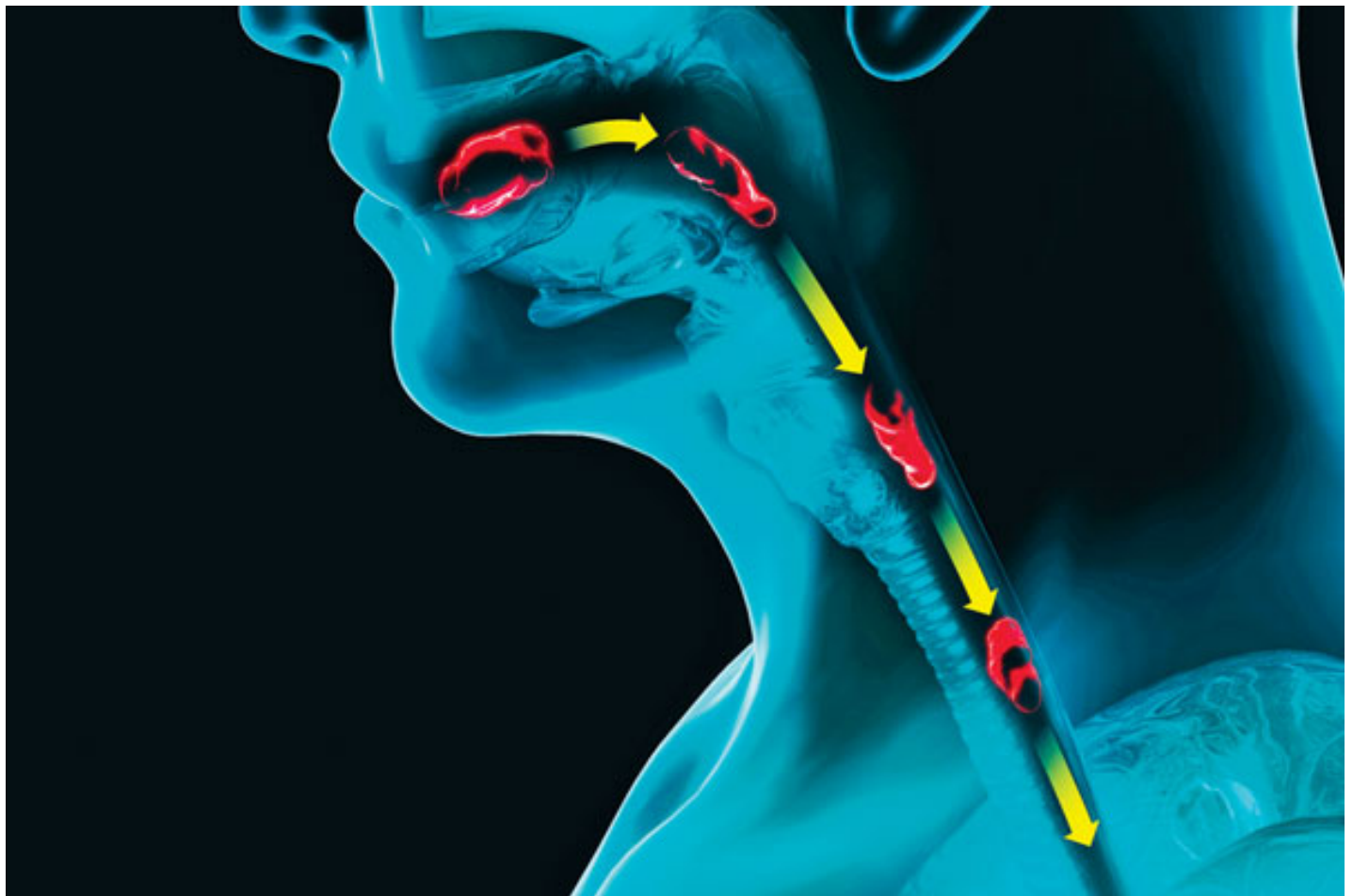
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## The Case for Instrumental Assessments

Pointing out cost savings may help convince administrators at post-acute care settings of the value of instrumental swallow studies.

By George Barnes

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Fred, 87, has been unable to eat or drink by mouth since his stroke, and is craving a sip of water. But the speech-language pathologist in the skilled nursing facility denies his request

because of his dysphagia, saying, “I’m afraid that you may end up getting pneumonia if you aspirate on water, given that you’re so weak.”

Fred is unconvinced that he will get pneumonia or even aspirate, noting an improvement in his swallowing. But the SLP has no access to an instrumental swallow exam for Fred—she has only the results from the hospital videofluoroscopy done immediately post-stroke, which showed silent aspiration.

Fred needs an instrumental assessment of swallowing to determine whether thin liquids are safe, but his skilled nursing facility (SNF) will not authorize the expensive procedure.

What the SNF may not realize is that investment in FEES (fiberoptic endoscopic evaluation of swallowing) or videofluoroscopy for their residents with dysphagia can cost less than keeping them on texture-modified food and liquids they may not need.

## Access

Ensuring access to instrumental assessments of swallowing is one of the most important ways SLPs can advocate for patients with dysphagia. SLPs report that many post-acute care settings, particularly SNFs, lack easy access to videofluoroscopy (typically done as an outpatient procedure at a hospital) and FEES, which can be done in the patient’s facility or as an outpatient at a hospital. SLPs may encounter resistance from administrators in post-acute care settings such as SNFs and home health because of the costs incurred for instrumental assessments of swallowing by the facility/agency in the context of consolidated billing (see [“Instrumental Assessments: Importance, Value, and Payment”](#)).

Without access to an instrumental assessment, we are completely blind to the anatomical and physiological characteristics of the swallow—making it nearly impossible to accurately assess risk and create an effective plan of care.

## Widespread problem

From [7% to 40% of patients in SNFs may have dysphagia and 12% to 54% may be malnourished as a result of the dysphagia](#), according to a 2015 systematic review. These alarming numbers speak directly to our responsibility in this setting. SLPs work hard—really hard—but we don’t have X-ray vision. There is only so much the SLP can do to assess risk and function on a non-instrumental clinical assessment of swallowing.

[The methods we use to detect aspiration and diagnose pharyngeal dysphagia at bedside have poor sensitivity.](#) If the information we are getting is poor, then the decisions we make based on that information will inevitably be poor. Bad decisions lead to bad outcomes—and [with dysphagia, these could be life-altering.](#)

What does someone do when they can’t see what’s going on? Think about driving in the fog: You move slowly, conservatively, and limit risk however you can. This defensive practice may

work well for driving, but not for managing dysphagia. [SLPs may over-diagnose dysphagia in as many as 70% of non-instrumental evaluations.](#)

Being overcareful—implementing conservative measures without instrumental assessments—is often misguided. For example, recommending thickened liquids based on a non-instrumental swallowing assessment alone—a commonly used treatment approach—may:

- [Increase the risk of silent aspiration](#), making the SLP blind to being blind.
- [Increase the risk of aspiration pneumonia](#), ultimately defeating its intended purpose.
- Affect dehydration and medication management, among other risks (See ASHA's [adult dysphagia practice portal page](#) for a discussion under “diet texture modifications” within the treatment section).

But being blind at bedside is a double-edged sword. We could also be underdiagnosing. [Silent aspiration may occur in 60% of all incidents of aspiration.](#) Further, [silent aspiration is particularly concerning in terms of aspiration pneumonia risk.](#)

## Show me the money

Ready to start advocating for a swallow study? The most important information you need is the numbers. Being aware of the financial impact on our patients and facilities makes a stronger starting point for advocacy.

### Cost

Accurate diagnosis—rather than over-diagnosis—of dysphagia means we could be saving our facility significant costs associated with the condition (for example, thickened liquids, food preparation, staff support, tube feeding). This is no small number. For example, [research from Denmark tells us that costs for patients with dysphagia](#) may be \$4,282 (\$5,138 today, adjusted for inflation) higher per year for those in the hospital and \$7,209 (\$8,650 today) higher for those in the community for just one person compared to those without dysphagia. Further, patients required to be NPO with a feeding tube may cost the facility \$31,832 (\$54,114 today) per year.

These numbers may include modified diets, staffing needs, and feeding-tube formula, but also common medical complications (such as aspiration pneumonia, malnutrition, weight loss, and dehydration) that often arise from mismanaged dysphagia.

### Hospital readmission

SNFs want to avoid patients being readmitted to hospitals, so focusing on how dysphagia may affect that may help the cause. A 2016 study found that [general readmission to the hospital quadruples the risk of mortality within six months.](#) Some of the top causes, such as pneumonia, sepsis, and electrolyte imbalance, are directly related to dysphagia, aspiration, and

dehydration. And, under changes in health care regulations, readmissions are associated with increased costs to SNFs and hospitals.

## Cost calculation

So how can you calculate the costs related to dysphagia and readmission rates specific to your facility?

Talk to your **admissions coordinator**, **billing specialist**, and/or **administrator** to find the general distribution of payers of patients in your facility over a pre-defined period (for example, a year), as payers have different policies. For example, services for Medicare Part A beneficiaries are paid for from a shared pot of money (consolidated billing); Medicare Part B beneficiaries are billed for each service rendered (typically with an associated co-pay).

Find out from your **billing specialist** how much the facility has been paying recently for instrumental assessments of swallowing as outpatient services. Make sure that you are counting all of the costs related to obtaining the test—including transportation and staff assistance.

Go back to your **caseload records** to determine the number of patients who, during that same pre-defined period of time:

- Had dysphagia.
- Were on thickened liquids.
- Were on texture-modified diets.
- Had dysphagia and diagnoses of malnutrition, dehydration, weight loss, and meal supplements.

Talk to the **kitchen manager** to estimate the costs of buying pre-thickened liquids and/or thickening agents for the facility. Estimate costs for labor for diet texture modifications for the number of people on altered diets in the facility.

Find out from the **admissions manager** how many patients with dysphagia had hospital readmissions, and estimate costs of lost revenue and any financial penalties from the payers.

**Pull these together** to create an analysis of dysphagia costs versus costs of instrumental assessments to make a case for the return on investment.

Yes—it does take some sleuthing and record-keeping to build your case. But the returns are well worth the effort. You are also building relationships through this data hunt: You are establishing yourself as an ally who wants to save costs for the facility and the patient, while optimizing patient care and outcomes.

## X-ray vision

As we know, one way to get X-ray vision is to ... use an X-ray. Videofluoroscopy is still the go-to for many facilities. However, many facilities (especially SNFs) do not have the equipment to do this procedure easily and efficiently. Instead, patients are transferred to a nearby hospital (in some rural facilities, "nearby" could be 50 miles away). This process is expensive—in addition to the videofluoroscopy, it involves costs for medical transportation services, radiology charges, hospital SLP charges, barium costs, and someone to accompany the patient. These costs typically aren't neatly organized on an itemized list, so talk to the department or staffer who handles the facility finances to get a sense of these specific numbers to fully paint the picture for the administration.

## **An alternative solution**

FEES is an excellent alternative to videofluoroscopy. Cost is just one advantage. If videofluoroscopy costs \$1,500, a FEES typically costs less than a third of that (\$400–\$500). And with mobile services, the patient doesn't have to travel out of the facility, taking time away from rehab and other treatments.

Going to the hospital can also be uncomfortable for a patient who is frail, has wounds, and/or has difficulty sitting upright in a stretcher for long periods. FEES also does not require radiation exposure—so it can include multiple trials and strategies in a variety of clinical scenarios.

[Videofluoroscopy and FEES both have benefits and weaknesses](#) and one may provide more valuable information than the other, depending on the patient's condition. However, both are now considered gold-standard evaluation studies and both provide clear information regarding the safety and efficiency of your patient's swallow.

## **Use a team approach**

Who are your champions? Consider discussing all options for instrumental assessments with your rehab director, director of nursing, and the billing department for their input before scheduling a meeting with your administrator. By clarifying how the benefits of the different options resonate with each department head, you can get their approval and incorporate them into a formal proposal. You will be able to present a multifaceted solution to a multifaceted problem that is supported by multiple departments.

## **Talking points**

When advocating for an instrumental study with your facility's leadership team, consider the following:

- Dysphagia and malnutrition are huge issues for SNF patients. An instrumental study can make a meaningful difference in improving functional outcomes and reducing costs.
- A non-instrumental assessment is not enough to manage dysphagia accurately and effectively.

- Dysphagia costs money. Figures from the Denmark study indicate a [patient with dysphagia can cost a facility \\$5,000–\\$10,000 more than a patient without dysphagia](#); getting a patient off NPO status may save the facility more than \$50,000 each year.
- Mobile FEES may be a viable alternative to hospital-based videofluoroscopy to alleviate cost-related concerns.

The SLP is responsible for making life-changing decisions regarding a patient's swallow. The only way to visualize the swallow accurately is through an instrumental study. Costs are always going to be a concern, so it's important to convey the potential savings the facility may realize by using an instrumental swallow study—and to emphasize that the patient's quality of life, values, and preferences are critical. Shared decision-making is vital to achieving the best possible care for each patient.

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Swallowing, Dysphagia & Feeding Disorders

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## Additional Resources

### We recommend

Build a Case For Instrumental Swallowing Assessments in Long-Term Care

Rinki Varindani Desai, The ASHA Leader, 2019

Clinical Swallow Assessments Do Not Assess Swallow Function

The ASHA Leader, 2020

When a Child Needs an Instrumental Swallowing Assessment

Jenny Reynolds, The ASHA Leader, 2020

Speak the SNF Lingo to Show the Need for Instrumental Assessments

Stephanie Watson, The ASHA Leader

Instrumental Assessments: Importance, Value, and Payment

Tim Nanof, The ASHA Leader, 2022

Validation of the 3-oz Water Swallow Test for Aspiration Following Stroke [↗](#)

Kathleen L. DePippo, JAMA Neurology, 1992

Preventing Aspiration Complications: Implementing a Swallow Screening Tool [↗](#)

Gina Pifer, American Journal of Occupational Therapy, 2019

Identifying Aspiration Among Infants in Neonatal Intensive Care Units Through Occupational Therapy Feeding Evaluations [↗](#)

O. Jayne Bowman, American Journal of Occupational Therapy, 2020

Aspiration and Relative Risk of Medical Complications Following Stroke [↗](#)

Marlene A. Holas, JAMA Neurology, 1994