

Ep 145 Episodes of Care

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Um, 4s welcome to the SLP Happy Hour podcast. I'm Sarah an SLP. Working in private practice in Oregon. I also design materials on Teachers pay teachers. You can click on SLP Happy Hour Store@teacherspayteachers.com, and my products focus on childhood apraxia speech. Today on the podcast, we have Kristen and Christy here to talk to us about implementing episodes of care versus speech and language therapy with planned therapeutic breaks, including the benefits of such a model and the details of how it's implemented at Children's Hospital of Richmond. So let's introduce you to our experts today.

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Hey, I'm Kristen Monroe. I'm an SLP at the Children's Hospital of Richmond at VCU in Richmond, Virginia. You might hear us refer to it as Chore. I'm a part of the Assistive Technology team, and I'd say about 50% to 60% of my caseload involves working with AAC users in some capacity, like through AAC evaluations, equipment checkouts, and trainings and follow up trainings each week. I'm also heavily involved with training and mentoring staff regarding at and AAC and have presented nationally on AAC and caregiver training topics. And I'm also working on my clinical doctorate through Nova Southeastern University. I also want to disclose that any information or opinions I share on this podcast are my own personal and professional opinions and don't necessarily reflect the opinion of Chore. Hi, I'm Christy Pop. I'm a speech language pathologist at the Children's hospital of Richmond at the VCU in Richmond, Virginia. I have worked at Tor for over ten years and I'm part of the Assistive Technology team as well as the VCU Cranny Facial Care team. In many ways, I feel very fortunate to be able to combine my love of treating individuals with complex communication needs as well as cranny facial anomalies using AAC. I complete AAC evaluations and equipment checkouts as well as see clients with complex communication needs using AAC and ongoing therapy. I also complete speech language screenings, evaluations and see clients and ongoing therapy with cleft, lip and palate and or craniofacial anomalies. As part of the VCU Craniofacial team, I'm passionate about identifying solutions to facilitate long term AAC use across the lifespan and formulating an effective approach for training and implementing AAC post checkout of an AC equipment purchase. I assist with training staff members regarding ATAC

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and have recently presented nationally on AC, Episodic care and caregiver coaching. I also want to disclose that any information or opinions I share on this podcast are my own personal and professional opinion and do not reflect the opinion of Chore at VCO.

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So I was fortunate enough to see your presentation at Atia. And for those listening, it's a yearly AAC conference in Florida where you discussed episodes of Care. And as an aside, my friends who are SLPs are kind of tired of hearing me talk about it, but they're like, wow, Sarah, you're really into this. And I'm like, yes. So thank you for presenting. And can you, for those listening, define find what an episode of Care is? And I want to mention to listeners that lots of other professions, especially within the medical setting, are already implementing episodes of care, so SLPs didn't make it up. So that said, I noticed that with SLPs, kids tend to stay on caseloads for a long time and not graduate unless they meet age level expectations. Well,

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thank you so much for coming to our presentation and providing us with this exciting opportunity to speak on your podcast. In short, an episode of Care is a period of therapy intervention with defined beginning and end dates that focus on specific and realistic goals that are formulated with the individual and their family. The idea is that individuals with chronic conditions, such as those with complex communication needs, would participate in several episodes of therapy intervention across the lifespan. So breaks in therapy intervention would allow families to practice therapeutic techniques at home, allow time to participate in community events or programs that could assist with implementation, and participate in other therapies that could complement and enhance skills learned in one therapy or another. Examples could include participation in occupational therapy, physical therapy, Aba therapy, music therapy, and more. Incorporating episodic care assists with increasing caregiver participation through identifying the family's priorities when formulating goals, creating caregiver buy in, and motivation when provided specific beginning and end dates of therapy episodes and making the caregiver feel like an integral part of their child's therapy journey by including them in sessions. An analogy I like to use when discussing the benefits of incorporating episodic care to improve therapeutic outcomes with parents and caregivers is working out at the gym. Going to the same cycle class once a week for a year will only provide so much improvement to your overall cardiovascular fitness and strength. However, when you incorporate multiple types of training into your fitness routine over short increments of time, you not only see improvements in your large muscle groups, but also your small muscle groups as well. Isn't it also easier to commit to going to the gym each week when you have signed up for an eight week class schedule versus a twelve month subscription? Speech therapy can be seen as one part of the client's entire fitness routine and taking breaks to pursue other community opportunities or therapies or simply taking a break because client and parent burnout is real can enhance the clients learn skills and help refocus priorities. In regards to determining length of an episode, bales and colleagues at Cincinnati Children's Hospital Medical Center, Division of Occupational Therapy and

Physical Therapy develop four modes of intervention frequency across care from inpatient to outpatient, that range from intensive so more than three times a week weekly, which includes one to two times per week or every other week, monthly, and then consultative. The type of frequency that is recommended is determined by several factors related to the individual's readiness for intervention based on their diagnosis or prognosis, the critical period for skill acquisition or potential regression, and level of support or training needed from the skilled clinician to obtain desired skills. Working in outpatient Pediatrics most of my clients fall within the weekly or bimonthly therapy frequency because my clients are making progress towards goals, they are determined to be within a critical period of achieving new skills or possibly regressing if therapy stopped. They require clinical reasoning skills for a large portion of the therapy program and a high level of support is needed to attain these goals. Now, Hansen and all then modified these therapy frequency guidelines by adding duration guidelines for each treatment frequency. So intensive frequency rate indicates the shortest duration of care of two to six weeks in length, while weekly and bimonthly services range from four weeks to twelve week episodes. The duration of therapy intervention increases for monthly or periodic, such as three to six months and consultative, which is scheduled on an as needed basis. Based on these guidelines combined, my clients are often scheduled for twelve week episodes and seen one to two times per week or on an every other week scheduled basis. Specific therapy goals are formulated in collaboration with the client and their family while considering their priorities. They're created to be achievable within the length of the therapy episode and designed to be measurable to adequately mark progress over the episode. Our episodes can be extended or shortened based on the client's progress in therapy. For example, if the client is meeting multiple short term goals and the family is comfortable with carrying over targets to home around halfway through the episode, then we would start the discussion about ending an episode and moving towards a therap therapeutic break prior to twelve weeks. If the client is making great progress but still needing consistent support and critical reasoning skills from the clinician to troubleshoot problems, as well as continued caregiver support and training to implement targets at home, then we may look into extending the episode for a few more weeks if needed.

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That was really good, Christie.

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Thank you. But I'm going to have lots more questions. So what are some benefits

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of implementing an episodes of care model for kind of everyone involved? And in other words, why would you do this? Why not just see the same kids every week forever? Not why should we try this? Because we're not telling anyone to try this. But why might we want to try this, which I am trying this.

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Well. Firstly, I'll start by saying that the research is still very much needed in regards to the effectiveness of both episodic care and continuous care models of therapy. The University of Puget Sound published an article in 2016 by Rebecca Newman, Kimberly McGarvey and Laura Hope from the School of Occupational Therapy titled Episodic versus Continuous Care in outpatient pediatric clinics that investigated the effectiveness of episodic care in comparison to continuous care. Based on their research findings, no significant reduction or regression in the child's baseline functional status was noted when provided with episodic care versus continuous, less intensive care. In 2017, Justice annull published a research article in the American Journal of Speech Language Pathology titled Algorithm Driven Dosage Decisions Optimizing Treatment for Children with Language Impairment. The research article aimed at providing guidance on identifying the appropriate therapy intensity for children with language impairment. They discussed the long standing evidence regarding the benefits of distributing learning opportunities over time, such as allowing for therapeutic breaks can assist with increasing generalization of skills and overall engagement in our outpatient practice setting. Very long wait lists, frequent no shows or inconsistent attendance insurance limitations, as well as overall family scheduling conflicts all really negatively impact a child's ability to effectively receive continuous therapy. Episodic care can be beneficial to a variety of individuals within the client's therapy journey for the client and their families. Episodic care allows the family to become more involved in their child's therapy journey by actively participating in therapy sessions, collaborating with goal setting with their priorities addressed, and providing specific beginning and end dates, which assists with caregiver buy in and financial planning for services. Families are often surprised and even disheartened when alerted about the therapy center's long waiting list. After attending an initial evaluation and being told that their child needs ongoing therapy services with Episodic care, clients are able to be seen much sooner due to the cyclical nature of the therapy process. Families may feel relief in knowing that they won't have to wait six months to a year or more before their child starts receiving therapy. When implementing episodes of care within your therapy practice, multiple children are able to receive services within the same day and time over the course of the year in comparison to one child receiving continuous care at the same day and time for a year. Alleviating waitlist woohoo. By implementing episode of care as a speech language pathologist, you have opportunities to connect and create buy in with caregivers in regards to their child's therapy journey, which ultimately leads to increased carryover of targets at home. You also see measurable gains in therapy based on the specific goals you've created with the family. You have opportunities to enhance your critical thinking skills by applying evidence based practice into your therapy intervention in order to problem solve issues that arise and need solutions within a short time frame. And lastly, hopefully you find that implementing episodic care reduces overall therapist burnout. It is easy to fall into routines seeing the same clients for years and years, slowly making gains towards long and short term goals. The faster paced and cyclical fashion clients are seeing in episodic care can add excitement to your day and certainly keep you on your toes with problem solving issues needing resolution within a short period of time.

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Something that I've started doing with my families at the beginning of the episode or when we're deciding whether or not we want to take a break or continue our episode is say so twelve weeks from now or however long we've decided our episode is going to be, I'll say, how are you going to know that therapy is working? Is Because then it moves. I think almost every speech therapist has had that parent who's walked in and you're like, what's bringing you in? And they say, Well, I want my child to talk more, but you're never going to get to that point where more is enough. But if you can get them to state a specific behavior, then you get that, AHA, I know that therapy is working. So by asking that question of how are you going to know therapy is working, it gives you that small step, tangible goal that is family centered and kind of gives you direction for collaborating on other goals too. And we wanted to have a model that fit within the bounds of evidence based practice and clinical reasoning. So just like any other treatment approach, one single episode can't be a one size fits all. So with our programmatic approach, at first everybody is scheduled in a max of twelve week blocks. At the beginning of each episode, the therapist and Caregiver collaboratively set priorities for the episode, and the episode uses a combination of child directed and parent directed intervention like coaching to address the priorities. Is And then two thirds of the way through the episode, what we would call a checkpoint therapy session, the therapist and caregiver collaboratively decide on the next steps of the episode. At this point, the therapist and caregiver can decide to either, one, extend the direct intervention episode, two, take a therapeutic break with specific goals to work on while taking a therapy break, or three, decide that they're ready for discharge from services. And that's something that the caregiver and therapist collaboratively decide. So it really becomes a cycle of intervention where the child's moving through periods of direct intervention with practice breaks in between to work on skills targeted during the direct intervention period. Though

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it sounds like you're doing a lot of joint planning with parents, and parents are really involved. So I have to ask, are parents required to sit in for sessions? So most of the parents that come into my clinic, for example, do, but there are a few who are like Sarah, caring for a child with multiple disabilities is exhausting. I need to just sit in the waiting room or sit in my car and look at my phone. So how do you handle that? Do parents have to sit in? Well, I wouldn't say it's required, I would say it's strongly encouraged. But that's with the caveat that if I'm asking the parent to sit in, I really want to make sure it's worth their time. I'll talk about this more when we talk about coaching, but by sidelining parents in therapy sessions or by not cluting them at all, having them sit out, or just having them passively watch on the side, we're sending the message that I'm the expert and you can't do what I'm doing. And that's totally not the message that we want to be sending people that we're trying to empower. The reason for asking parents to sit in is so that we can engage in productive parent directed teaching, so that they can carry over what we're doing in settings outside of a quiet and frankly unrealistic therapy room setting. And I want to make sure that what I'm doing has relevance in the real world. And I can't guarantee that if I don't have the parents input on the regular. So while I do respect that being a parent of a child with special needs can be exhausting and demanding, I would want to make sure that I'm helping them fill their cup when they're coming to our therapy sessions by giving them tools that will be useful throughout the week rather than asking them to disengage during the therapy session. If they're needing a break from parenting, then I might try to help them find resources that are a better outlet for taking a break from the demands of parenting, like support groups or other extracurriculars for their kids only

had a handful of people who are adamantly resistant to it. Honestly, most parents are refreshed by it rather than feeling burned out we try to focus on building habits in a specific routine and then generalizing those new habits to other routines so that way the skill is more manageable. So when coaching, the parents and I work through a routine where we only focus on one or two of our goals with one or two new skills, and then we kind of collaborate on creating a strategic approach to working on those goals. So, for example, with a kid who just got a new AAC device, if a parent says they want to work through the bedtime routine, then I might have the parent list out different steps of the routine. And then I would have the parent tell me phrases on their communication device that they can model with their child during the different phases of the bedtime routine. So that way it's a bite size manageable home program that they only have to do during a routine that they're already doing anyway. So that way it's not just one more thing we're adding to their list. On another note, something I try to be sensitive of is cultural differences. If a cultural or linguistic difference is why they're resistant to coaching, then that's a whole different conversation. Cultural humility could be a topic for a whole other podcast, but that's always an important aspect to consider, not just with coaching, but with any treatment approach.

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I definitely say caregivers prioritize therapy sessions when they know there is an end date in sight. Anecdotally I can say that I've had less cancellations and no shows since starting this model. I think this happens for two reasons. One, when caregivers know there's an end date, they're like, okay, put me in coach. What do I need to do to help my child at home? They don't want to miss out on a chance to learn something to help their child. Second, kind of going back to that gym analogy. If I'm doing a hard workout in a class at a gym, and the trainer is like, okay, only 20 more seconds in my mind, I'm like, yeah, I can do anything for 20 seconds. Let's do this. And I've kind of noticed that with our caregivers too. They're like, okay, I can handle just three months. And I even did have one caregiver say to me, oh, yeah, twelve weeks. We could totally do that. And just three things like that I can handle. That buy in has been greater, and attendance has been better because it just feels more doable. And as a therapist, I can feel it too. We've probably all had those clients on our case load where we're like, okay, I know you need therapy, but where the heck do we start? And using collaborative goal setting with short term, family centered input has made my therapy feel so much more purposeful and rewarding. It's nice to just have a specific target that I know is meaningful for the family. Is something that I began noticing when I first began completing assistive technology evaluations a few years ago was the number of clients and their families returning for subsequent evaluations maybe a year or two after their checkout appointment of the purchase. Assistive technology equipment stating that the individual's AC equipment has been left in a closet, is no longer working properly, and technical support was never contacted, used maybe only a few times, or unable to use because the caregivers were unfamiliar with how to set up or mount the device on the individual's different seating arrangements. How could something so detrimental to providing a voice and a greater quality of life just sit on a shelf or used only a handful of times? It appeared to me that so much time, effort and support was spent identifying the perfect AC device that fits the individual's cultural and linguistic needs as well as fit within the family dynamics and their priorities. However, it seemed that very little training and support was provided post checkout of the assistive technology equipment. This motivated me to formulate a post checkout episode of Care Protocol to ensure consistent and effective carryover of prescribed at equipment across multiple

environments. This episode of Care Protocol provides additional training appointments after attending a checkout appointment for a Received At or AC equipment. At the time of the checkout appointment, the therapist discusses the option for attending a post checkout episode of Care to provide additional training and support of the prescribed AC device to assist with implementing at home. If the family expresses interest in pursuing the post checkout episode of Care, then the therapist will outline goals for the episode of Care, discuss the attendance policy, and determine number of therapy sessions and frequency rate based on the family's comfort level with the AC device and their availability. I created a checkout Caregiver checklist to go over during the checkout appointment to make sure all the elements of the AEC device, such as the setup, programming and implementation, are demonstrated during this appointment for the family. I've also created pre and post episode of Care surveys to serve as internal measures that serve as a checkpoint during the therapy episode. The surveys consist of several questions using a five point Likert scale related to the caregiver's comfortability, with modeling on the individual's device to indicate a variety of pragmatic functions, their comfort level with setup and programming on the AEC device, and understanding steps to take when the AC device is not functioning properly. The survey helps guide the development of functional and realistic goals, as well as identifies areas needing additional code training or support. In my own experience with this protocol, I often see clients from eight to twelve weeks and vary the service delivery methods to help with implementation at home. For instance, I may see a client with their new AAC device for in person sessions at our outpatient clinic for four to eight weeks, incorporating the family and sessions using both direct and parent coaching to ensure familiarity with the device, and modeling. Then, towards the end of the episode, I like to shift to telehealth visits if the family is agreeable and interested to make sure skills learned in a very controlled outpatient clinic setting with limited distractions can be carried over to the home environment. This is when I discussed that participation in a few telepractice sessions would help provide more insight into barriers of AAC implementation at home and allow me to identify possible solutions or strategies to incorporate at home. I've also encouraged telepractice sessions when there are multiple caregivers at home that want to be part of the client's therapy sessions. However, they cannot to attend their ongoing sessions, maybe due to scheduling conflicts. I saw a client using an AC device accompanied by his mother for in person therapy sessions where we focused on caregiver training and how to model usage of the device at home. His mother reported that he also had a nurse at home during the day. However, her shift would end by the time he came in to see me for therapy.

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So we scheduled some telehealth appointments that included both his mother and nurse present at home so that way they could practice modeling on the individual's device during daily routines, activities requiring nursing attention and just becoming more comfortable with setting up, mounting the device, and different seating arrangements during the day. I like

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how fluid this model is. I think as I was learning it, in my mind, it was always twelve weeks, once weekly. Parent coaching, but what I'm hearing is there's a lot happening, and I can definitely see the benefit of this model. And I'm curious about the telepractice piece, especially post COVID, and if that's a hard sell for families, because for some families, they're telling me we don't

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do video.

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So what language do you use to describe why you want to try telepractice with families? I It

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helpful to at least begin with in person sessions to establish that connection with the client and their family, be able to provide hands on expertise to troubleshoot issues, as well as evaluate the client and their family to determine if they would be a good candidate for shifting to telepractice. This can include other family members, such as grandparents or personal aides, nurses, and more. I also find it helpful to at least begin with in person sessions to establish that connection with the client and their family, be able to provide hands on expertise to troubleshoot issues, as well as evaluate the client and their family to determine if they would be a good candidate for shifting to telepractice. Let's

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talk a little bit about the goals. So I'm used to writing, you know, year long goals. So how do you develop goals for an episode of Care? Or maybe what are some examples that you've used for a twelve week episode for students of different needs? When

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formulating goals over over the episode of Care, we follow the smart principle, meaning that the goals must be specific they're measurable attainable realistic and timely. We are aware that we may see a child multiple times for different episodes over the course of the year. Therefore, we can use long term goals to support this length. However, we want to create short term goals that are specific to the child's needs and family priorities are able to be achieved within the episode length and are able to be measured. For

example, I saw a client with a speech sound disorder characterized by the phonological process of gliding as well as a few other phonological processes. The family's main priority was for their child to be able to say his name, which began with the letter L. During the evaluation, he was stimuable for L in isolation syllables with moderate supports, however very emerging at that word level. So I formulated a goal for the production of initial L at the word level. So example could be client will produce initial L at the word level with 90% accuracy given minimal cues. I would hope that within twelve weeks I could achieve this goal. However, if I wasn't getting close to meeting this goal by that two thirds checkpoint, then that would alert me to take a step back, reevaluate my therapeutic strategies used in sessions. I was able to add goals as his episode continued to include all positions of words as he was meeting this goal in the initial position of words fairly quickly. By the end of this episode, he had mastered the sound and a therapeutic break was recommended to encourage carryover to home at that sentence and conversational level. He was then recommended to return within six to twelve weeks to target another phonological process or address any other potential issues with generalizing ill into connected speech for our early communicators will often use the goal client will use symbolic rather than non symbolic behaviors to make either a request or terminate Greek caregivers. And 80% of opportunities given minimal cues from the clinician. This goal allows for usage of a variety of total communication modalities to communicate something specific that maybe was identified by the caregiver and includes a specific measurement to determine if that goal has been achieved over the twelve week period. I think a good takeaway to reshaping goals to fit Episodic care is focusing on making them specific and attainable versus using language that may be too vague or ambiguous. This is where the family's input is especially valuable as they are the key components of identifying specific goals to fit their priorities, as well as assisting with goal attainability through their carryover at home, which we know won't be achieved if they're not motivated or included in the goal formulation process. By breaking down the overall skills to be attained in therapy into more specific and achievable goals, we set the child and the family up for success by showing them each week how much closer they are to meeting their goals within a short period of time. If a child has difficulties with the production of KN and is not stimuable for these phonemes in isolation or syllables during the evaluation, then I would begin there and avoid creating a broader goal for producing these phonemes at that word, sentence and conversational level, as this may not be attainable by the end of a shorter episode.

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As far as workload is in episodes of Care model more work for the SLP overall because talking with friends like I have been about it, they're concerned that you would basically be doing totally new evals every twelve weeks and that it would be a lot of onboarding and connecting with new children and doing new report writing and writing new goals. So they're worried it would take a lot of time and that this model would

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increase their workload. To be honest, it's hard to say because I think each SLP's experience will be different depending on the treatment setting in which they're working. Christie and I have the benefit of working for a large organization, so we share that workload with other therapists and billing specialists and patient access staff. And also Episodic care doesn't necessarily mean that your caseload is completely turning over every twelve weeks. It kind of naturally gets staggered. At Tour we kind of did our own staggered start so that we wouldn't have that like, oh, we're at twelve weeks time for everybody to turn over. But I think the initial change to an Episodic care model could be a lot of work up front, but like with any change, once you find your rhythm, you can figure out how to build in safeguards to protect yourself from burnout and overworking yourself. And I found too now as people start coming back in, I've done the legwork of teaching them, like doing a lot of the parent training in the first episode, so when they come back, it's more like a quick update like the parent has that groundwork laid and we can really jump in and focus on specific skill. US. And you mentioned at your presentation that parent coaching is a key part of

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this episode of care for students, especially who use AAC. And so why did you choose parent coaching? That's a

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good question. I think it'd be best to start by defining coaching. Because something I've noticed with reading coaching literature and attending presentations about coaching and presenting about coaching and talking to others about coaching is that everybody's got a different definition or understanding of what coaching is. So just to get us on the same page, when I'm talking about coaching, I'm talking about a capacity building, strengths based approach to caregiver instruction that incorporates adult learning, principles of self directed learning, active observation of specific therapeutic techniques, guided practice, ^{1s} and feedback. So our presentation highlighted coaching principles such as joint planning, active observation, guided practice, reflection and feedback. ^{1s} I think there's a misconception that if you're kind of standing on the sidelines telling someone what to do, that's coaching. But that's just one element of coaching and really an element that should really only be used minimally. So when it comes down to it, I think coaching is guiding the learner towards a solution that is meaningful for their situation. So to get back to your original question about why I chose parent coaching as treatment approach for Episodic care, something I mentioned in the presentation is that we want to think of intervention as two experts coming together to work towards a common goal. Like I mentioned before, when the parent isn't actively participating in the therapy session, either by sitting outside the room or just passively sitting in the room, we're unintentionally sending that message that I'm the expert and you aren't. However, we want caregivers to be key decision makers in their child's care. They're the ones who spend the most time with their child. And just because Christie and I work a lot with AAC, especially looking at the AAC literature, it tells us that if we aren't actively involving end users and their caregivers in the evaluation and decision making process, then the AAC device may not be successfully

used. And the literature also tells us that parent implemented intervention results in greater communication outcomes for end users. But we're still not using coaching. It's a huge research practice gap. And I think now that we know that coaching is evidence based, our field in general, not just with AAC, but we need to start working clinically to close this gap.

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So when you talk about there's a gap between research, which really is very parent coaching, communication, partner training, this is what's going to give us the best bang for our buck. Why do you feel like that might not be happening and is part of it the systems we work in? Because I'm just thinking, like, I worked in schools for 14 years. I didn't want to give the teacher one extra thing to do. And I didn't have a lot have access to parents in private practice. I would say like parents are burned out and kind of disconnected from therapy sometimes based on just how parenting is going for them, how their life is going for them. And those are the barriers that I've seen. But do we know what the barriers are?

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Off the top of my head, I don't know exactly what the literature would say. Anecdotally 2s I would say that coaching

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can feel awkward at first and I think it's hard for. 2s It's hard for somebody who may be newer to the field too. I mean, just like we've been talking about earlier, it feels awkward to say, how can I be helpful to you? Because it makes us feel like we're not the expert, and it makes us think that others are questioning if we're the expert. And we, as SLPs who are type A educated people, will don't want to act or appear like we don't know what we're doing. So I think there are elements of coaching that can feel awkward. I think there are certain skill sets too, like relational skill sets and counseling skill sets that are kind of prerequisite to being a successful coach. So an analogy I'm thinking of if I'm trying to get out the door, but I'm also trying to teach my child how to tie their shoes. It's going to be so much easier for me to just put the shoe on and do it myself versus stopping and taking that extra time to teach my child how to tie their shoes. So there's a lot of work up front that happens. But if I do stop and take the time to teach my child how to tie their shoes down the road, that skill is going to serve them in a much better capacity.

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Yeah. And I think there's also, like I had a, you know, one semester counseling class

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in grad school, but reading about how to do counsel, you know, like parent coaching and doing it is totally different. Like, when I'm actually doing parent coaching, the parent will say something and I'll be like, okay, Sarah, Summarize, or ask a clarifying question or an open ended question. It's one of those things that I thought

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when I was in grad school would be really easy, but then once I actually started to implement it, I was like, this takes a lot of skills that I need to learn.

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Yeah, I think it's a collaborative decision when you're looking at a coaching cycle, you don't have to do every single element. Like when I first described joint planning and active observation and reflection and feedback. You don't have to do one of those cycle or an entire cycle every single time. Most caregivers are hesitant with different elements of coaching, especially the guided practice phase. Like, who wants to have someone watch them try something new? Definitely not me. If we've done the work of establishing rapport and making the treatment space a safe learning space, then most caregivers eventually become comfortable with that part of coaching or other elements of coaching. So I'm not ever going to force someone to do something they're not comfortable with. And if someone doesn't want to engage in the coaching model, I think some detective work as to why they're resistant needs to take place. Because if they don't want to use coaching, then I need to respect that and find a way to provide education in a way that they're willing to receive it. In my experience, if I try to tell someone something they don't want to hear or teach them in a way they don't want to be taught, we kind of just end up spinning our wheels. So instead of telling them what I think needs to be done, I try to take time to listen and understand where they're coming from and meet them somewhere in the middle.

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Yeah. And ^{2s} this makes sense. And I also want to say I'm thinking about, like, school

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SLPs who work for public agencies. I did that for 14 years and I was allowed to do monthly minutes or yearly minutes. So whatever your setting is, maybe there's something you can take out of this episode, whether it's I'm going to involve the Caregiver more or I'm going to write some short term goals that I'm sure the team understands. I feel like you're doing a lot of things besides the episode of Care. Does that make sense? It's like episodes of Care is wrapped up in a big package that comes with a lot of other things, which is why I think at points I've had trouble understanding it. Like it's a very big present, like maybe in a refrigerator box. But there are things that there are lots of things that we can take away from this conversation and start implementing. So if someone listening has something that they would like to ask you about or contact you about, how can they do this?

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I'd say pick someone who you have good rapport with, who you know would be game. When I first started trying out coaching, I asked certain caregivers if they'd be willing to switch it up while we try something that would be new for both of us. And taking that approach to the coaching conversation put us on a level playing field because we were both doing something new. I think sometimes us type SLPs are afraid of showing ourselves as learners to our clients because we want to present ourselves as the experts. But I think when we're honest about topics that are new or uncomfortable to us, it can actually lend us more validity and credibility because then they really trust us when we're showing our comfortable areas. Also, when trying out episodes, I'd say have a clear plan for how you're going to implement it, but also be willing to be flexible. Most caregivers who are new to episodes but familiar with ongoing therapy are hesitant to shift to episodes of care because they're afraid they won't be able to get back in or their child might lose skills. For example, something we do with our at team is we have specific block slots for eye gaze episodes of care, so we have a rough idea of when spots will become available. And I've

U3

40:06

also had some great success with starting the discussion of episodic care with new clients during the evaluation. So during the evaluation, so much information is thrown at caregivers about their child's, current skills, things they're having difficulties with, potential therapy goals, treatment options, and more. When families hear specific beginning and end dates and this helps reduce the overwhelming thoughts that the caregivers might have streaming through their brains, such as how am I going to take time off work for this session every week for the unforeseeable future? Or how much school will they have to miss to receive these services? Can I even afford this therapy long term? How many copays will I have? So I've received very little pushback from families about episodic care during the evaluation, and maybe this is purely because they're unfamiliar with the varying treatment frequencies available at different settings. You have to start the therapy intervention cycle somewhere in order for episodic care

to be successful, so why not with someone new and fresh on the scene? With some of my clients I've seen for longer periods of time? Honestly, this conversation has been tough. However, after discussing some of the benefits of episodic care and taking therapeutic breaks, they're also comforted by the fact that the door is not permanently closed at the of the therapy episode. They like the idea that by the end of the episode a plan is in place to return within a certain time frame for another episode of care. So that way it's not necessarily goodbye, it's just

U2

41:34

see you later.

U1

41:36

Bye.

U2

41:43

You. 2s First of all, Sarah, thanks for having us on your podcast and for your thoughtful questions. I really appreciate the work you're doing for our field. So thank you so much for the time you put into the SLP Happy Hour. If anyone listening wants to know more, you can email me at kristen monroe. That's kristenmonro@vcuhealth.org. I'd be happy to share some of my formative and influential resources. Also, if you reach out to me at my email address, I'm currently working on an online continuing ed module that will be coming down the pipe, so I'd be happy to share that information with others when it's available. And I'm also happy to just informally chat with anybody that wants to know more. Yes, and thank you so much, Sarah, for providing us this opportunity to speak on your podcast. I truly appreciate all the valuable time and effort and dedication that you poured into the SLP Happy Hour. I would love to hear everyone's thoughts and perspectives on this topic as well. You can email me at christine Pop so it's Christine Pop@vcuhealth.org. I'm happy to share my handouts and surveys for the post checkout episode of Care Protocol or answer any questions you may have. I'm also very interested to hear from those already utilizing Episodic Care and discuss any and all successes and or roadblocks.

U3

43:17

Thank you again for lending us your ears.

U1

43:19

I would love to hear from people about this and if they've tried it. So I am at Slphyour@gmail.com. So thank you both for being on the podcast. If you're listening in, thank you for tuning in. I hope that this was a helpful episode where you learned just one thing, even that you can take away and apply in your practice. I know I have. So on behalf of SLP Happy Hour, thank you for listening. I hope this episode was a little slice of an SLP Happy Hour for you. And until next time.