A Day in the Life of an Outpatient SLP in a Medical Setting

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The Texas Speech-Language-Hearing Association (TSHA) Medical Speech Pathology Committee has been working hard to keep you all up-to-date with current practice information and education. One project we have been working on is compiling resources for speech-language pathologists (SLPs) who are looking to transition into the area of medical speech pathology. Presented to you in this issue of the Communicologist *is a "Day in the Life" summary that aims to depict what you might expect to come across working in an adult medical outpatient setting. This information along with other resources can be found on the Medical Setting Resources page in the Practice Resources section of the TSHA website. This will be the first in a series of articles on days in the life in different medical settings, so keep an eye out and stay tuned for more in future issues of the* Communicologist*.*

Working in an adult outpatient setting is not as streamlined as you would imagine it to be. There are always surprises. There is no predicting what type of patients are going to enter your facility each week. In a way, outpatient SLPs are expected to be highly proficient in every aspect of our field. Aphasia and cognitive deficits—of course, you will see that. Motor speech issues—do you know the difference between apraxia and dysarthria? Dysphagia and voice disorders—be prepared to bring your "A" game! Adult fluency cases—it's okay; those are still scary for me too.

I have been practicing in outpatient settings for 12 years and still feel challenged regularly. If you enjoy working closely in a team and building long-term relationships with individuals, working in an outpatient setting may be for you. As you read through a day in my typical work life, take a moment to reflect on who you are as an SLP, your skill set, and if you can see yourself preparing to meet the demands of the setting.

7:30 a.m. My work day does not officially start until 8 a.m.; however, I always like to get a jump on the day. I typically arrive 20 to 30 minutes early to review the day's caseload. I also use this time to gather and print out materials I will be using for the day in order to prevent having to utilize treatment time to do so. At our facility, we have hour-long slots blocked for each patient. Most of the speech therapy (ST) outpatient billing codes are untimed, but I still see my patients for 50 to 60 minutes. I typically have eight patients scheduled for the day—four in the morning and four after lunch. The day will be long, but I am looking forward to it as all of my favorites are coming in today.

8 a.m. Clocked in and ready to go! I eagerly check our electronic check-in system to see if my first patient, Victoria*, has arrived. She is a 45-year-old educator who has been diagnosed with muscle tension dysphonia. I walk up to our front lobby to greet her and escort her back to my treatment room. We catch up on current events and then get to work focusing on relaxation exercises, diaphragmatic breathing, and conversational training therapy. I also complete some manual therapy focusing on decreasing laryngeal tension. About 20 minutes until the top of the hour, she lets me know that she needs to leave early to make another appointment. This works out great for me because I have an initial evaluation scheduled for the next hour, and I have no idea what the diagnosis is. We wrap up the session at 8:45 a.m., and I walk her out.

8:45 a.m. I walk with purpose back to my computer hoping to find out as much as I can about the new evaluation (Frank*). By now, the patient has finished his registration so I can see that he is 62 years old and has a diagnosis of cerebrovascular accident (CVA). Fortunately for me, he was recently discharged from our hospital's inpatient facility. I am able to review his evaluation and progress notes from his chart on our hospital-wide electronic medical record (EMR) system. I take note of his medical history and that while in inpatient they were targeting cognition and speech intelligibility in his speech sessions.

9 a.m. I walk out to the lobby and greet Frank* and his wife. After my introductions, I guide them back to the treatment room and commence with the evaluation. Even though I was able to obtain a substantial amount of information from his chart, I begin with a thorough case history. I then complete an oral motor/cranial nerve exam and briefly screen speech, voice, and language functions. The evaluation is progressing pretty quickly, so I decide I have enough time to complete a longer cognitive exam such as the Cognitive Linguistic Quick Test (CLQT) rather that something short and sweet like the Montreal Cognitive Assessment (MOCA). The CLQT ends up taking a little longer than expected, but I complete it and quickly score it. Based on the results of the evaluation, I make my recommendations to the patient and his wife. We discuss treatment plans, and I then provide education and an initial home exercise program. We make our way to scheduling to get the patient scheduled for his follow-up visits. As we are exiting my treatment room, I notice that my 10 a.m. patient finished her physical therapy (PT) session and is waiting for me in a chair right outside my office.

10:10 a.m. By the time I walk back, Amie* (a 26-year-old female) has made her way into my treatment room. She was involved in a motor vehicle accident (MVA) and suffered a moderate traumatic brain injury five months ago. As I greet her, I attempt to quickly gather the evaluation materials from the last hour's evaluation and place them out of sight. This current patient has progressed exceptionally well with treatment. Treatment has focused on cognitive functions through both a restorative and compensatory approach. She tells me that she has awesome news for me. She goes on to say she wants to go back to school to get a nursing degree and that she recently took her entrance exam and did exceptionally well! A proud moment for both of us. We get some work done, and I escort her at the top of the hour to her PT session. I provide some hand-off communication to the physical therapist, and I am off.

11 a.m. I have another evaluation this morning, but in this case, I was aware of the reason for the patient referral. I had been in contact with a local head and neck surgeon over the past week regarding the case of Edgar*, a 58-year-old male who is to undergo a total laryngectomy. The purpose of this evaluation visit is to provide pre-counseling before the surgery and to provide the patient and family with education on what to expect after the surgery. We discuss the anatomical and physiological changes caused by the surgery and their effect on communication, swallowing, and respiration. A good amount of time is spent on the subject of voice restoration. The family has an immense amount of questions, and I make sure to clearly answer each one. We plan to follow up a few weeks after surgery. I call the referring surgeon to let her know how the evaluation went.

12:05 p.m. Lunch time! Before clocking out for lunch, I quickly reanalyze the day's schedule to decide if I should take my full hour or just a 30-minute lunch. I am behind on documentation, and my afternoon patients generally have excellent attendance. I decide that a 30-minute lunch is most appropriate. Fortunately, I brought my lunch today, so I take a seat with my coworkers in our lounge and relax for a bit.

12:35 p.m. I complete my documentation with a peppy playlist in the background.

1 p.m. I managed to complete the 9 a.m. CVA evaluation report, but I am still pending the other evaluation and notes. It's time to start seeing patients again. This hour, I have a re-evaluation scheduled. I have been working with Evelyn, a 25-year-old female, for about six weeks, and she has about two visits left on her certification period. This patient suffered a CVA while working outdoors and now presents with expressive aphasia and apraxia of speech. Today, her husband and her mother are with her. We speak for a while, and they update me on the progress they have seen in the patient. To follow up from the initial evaluation, I administer the Western Aphasia Battery (WAB). The patient exhibited excellent progress, increasing her overall aphasia quotient by 30 points. I discuss the results with the patient and family, and I escort them all the patient's occupational therapy (OT) re-evaluation.

2 p.m. Miguel*, a 52-year-old male, is transferred to my treatment room via a wheelchair after his OT session. He presents with pharyngeal dysphagia characterized by reduced hyolaryngeal excursion and reduced pharyngeal constriction. After he arrives, we get him transferred to an adult-sized positioning chair and commence with treatment. I complete some manual therapy to engage supra- and infrahyoid musculature, and then I get the patient hooked up to a two-channel surface electromyography EMG (sEMG) unit. The surface sEMG unit provides visual and auditory feedback to the patient as we work on improving hyoid elevation and pharyngeal constriction for the remainder of the session. The patient is off to physical therapy next. I quickly talk to the physical therapist and ask if he can incorporate some push/pull exercises in treatment to aid in glottic closure.

3 p.m. I get notified by the front office staff that my 3 p.m. patient is running around 15 minutes late. I try and use this time to close some notes from earlier in the day.

3:20 p.m. My seventh patient of the day, Cassandra*, finally arrives. I go to the lobby to greet her and her son. Cassandra* is a 48-year-old female who suffered an L-side CVA around seven months ago. Initially, she presented with global aphasia but has considerably improved her receptive language skills. Unfortunately, progress has been limited in her expressive speech. Earlier in the week, we initiated a month-long trial with an Augmentative and Alternative Communication (AAC) Device. The patient arrived with her device, and we immediately get to work. We utilize the first half of the session to input more personal information into her trial device. Today, we input the names of family and friends that were provided by her son as well as information related to her church. For the second half of the session, we practice identification and answering basic questions with the device. At the end of the session, I escort her back to the lobby and give homework to take pictures of family members, rooms around their home, and church.

4 p.m. On the way back to my treatment room, I am stopped in the hallway by an OT to let me know that my 4 p.m. patient is being sent to see his physician due to exceedingly high blood pressure. I sit down at my desk ready to catch up on documentation when one of our schedulers knocks on my door. She lets me know that a patient got confused with his schedule and came in today instead of tomorrow. (This happens way more often than you would think.) The patient is asking if we can accommodate them, and I agree. My final patient for the day is Mario*. He is a 69-year-old male presenting with hypokinetic dysarthria secondary to Parkinson's disease. In the session, we focus on being loud. To achieve this, we target proper posture, respiration, phonation, and behavior modification. The patient has been doing well with treatment. After the session, I speak with his wife, who tells me the patient has been generalizing the strategies learned in therapy well and that the family is understanding him better at home.

5 p.m. The workday is officially over. I am pending some documentation, but I am unable to stay late today to finish it up. My daughters have ballet in 20 minutes. I take a quick look at tomorrow's schedule and see I have all treatments and no assessments. I also notice that my 9 a.m. patient cancelled and that my clinical supervisor blocked that slot for documentation. I will have some time to catch up! I gather my things and head for the door reflecting on the day.

**To protect patient confidentiality, all identifying information has been changed.*

I hope you enjoyed the summary. If you have any questions for the Medical Speech Pathology Committee, please feel free to contact co-chairs **Suzanne Bonifert** (Suzanne.Bonifert@cookchildrens.org) or **Shannon Presley** (Shannon.Presley@unt.edu). The Medical Speech Committee is here to serve you!