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In This Issue

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Saving Larry's Life
The Story of a "Nagging" Wife

Tamara B. Cranfill, PhD, CCC-SLP
KSHA President

The radiologist said I saved Larry's life. I am not certain that is true, but I am thankful I have enough knowledge and experience to recognize the possible influence his reflux disease was having on his pulmonary status.

During the summer of 2013, my husband nearly died due to a progressive decline in his lung function. I'd like to share part of his story as a "case report" to encourage SLPs to be cognizant of the influence reflux has on our clients (and family) with swallowing disorders and recurrent pneumonias.

Larry has a significant medical history for lung disease. He experienced what has been described as "severe asthma" as a child. He ultimately "grew out of it" per his parents during his elementary school years. As a young adult, he was a smoker for nearly a decade without notable lung illness. In the 1980s, Larry was "gassed" while leveling silage in a silo on our farm. As corn cures, it produces a highly toxic gaseous by-product. He was wrongly informed that it was safer to go into the silo after three days (supposedly to permit the gas to dissipate out of the silo) rather than immediately following the silo fill. This resulted in a severe bilateral pneumonia from which he recovered, but the experience appeared to re-open the asthma "wound." He subsequently developed pneumonias each winter and experienced exercise induced asthma requiring inhaler management. It is important to note that throughout his life Larry has been an athlete. He played football in high school and became an avid runner for several decades until knee and heel injuries slowed the number of miles he could tolerate per week. He then moved to biking and swimming, again until a shoulder injury nagged him, resulting in expanding his current passion, golf – a much less active sport with regard to influencing lung capacity.

As he has decreased his aerobic activity, his weight has increased. He has gained approximately 25 pounds in the past five years. This is not to say he is obese, simply not at his "fighting weight." As his wife, I recognized increased symptoms of GERD; he belches frequently following meals, has increased bad breath, vocal hoarseness,

Continued pg. 3

Focused Initiatives for 2014-15:

1. **Expansive improvements to the KSHA website.**
2. **Increased focus and a new look for our quarterly newsletters.**
3. **Continued efforts to gain new members among students and associates, to reach potential members moving into the state and retain current members.**
4. **Appointment of a student representative to the Executive Council (rotated annually between university programs).**
5. **Development of interprofessional practice "day" at KSHA for 2016 in conjunction with KPTA and KOTA (topics relevant across disciplines).**
6. **Expansion of interprofessional practice activities in Frankfort through joint legislative advocacy efforts; advance public policy agenda on reimbursement, regulatory issues and EBP.**
7. **Continue to support advocacy efforts and training at all levels; increased role of PAC Chair.**
8. **Increased regional communication throughout the year via "Coffee Chats" with Executive Council members.**
9. **Apply to host the Council of State Speech-Language Hearing Association Presidents spring 2017 Conference.**
10. **Support Executive Council members in their efforts to build working committees that encourage increased leadership and participation in KSHA.**

President's Message

"Action expresses priorities." – Mahatma Gandhi

Tamara Cranfill, PhD, CCC-SLP
KSHA President

The stated mission for KSHA is "to promote and support the highest standards for professionals in speech-language pathology and audiology, provide professional development and advocate for legislation and regulations necessary for members to provide quality care for individuals with communication disorders." Note the action words: promote, support, provide and advocate. During my 35-year career, KSHA has certainly done just that, growing into one of the most efficient and effective associations in the nation. I hope to continue those actions during my tenure as President. My view, as modeled by those before me, is to be a servant leader. I have no great skills in speaking or motivation to offer. My intelligence does not strike awe in the hearts of my colleagues. While I don't take myself too seriously, I take my work very seriously. I offer my sincerest commitment to represent and work toward excellence in the profession for all consumers KSHA serves (clients, families, communities, students, colleagues). I will keep KSHA's mission at the heart of all I pursue this year and encourage our Executive Council members to do the same.

The past year has included approximately 815 hours of service by multiple members of your Executive Board; this does not include travel-time to and from various events. Hours were spent physically in Frankfort and/or in other meetings advocating for the salary supplement, promoting clarity of Response to Intervention roles, supporting legislation for consistent service reimbursement and providing guidance in development of a meaningful professional assessment for school practitioners. Hours were spent in ongoing efforts to collaborate with the Kentucky Physical Therapy Association (KPTA) and the Kentucky Occupational Therapy Association (KOTA) in political advocacy actions as well as future interprofessional practice CE offerings. Hours were spent developing, organizing and fine-tuning the Convention to meet needs of practitioners in all settings. As you go through your day-to-day schedules, you likely don't think about the colleagues who volunteer their time and talents for the Association. This is done in addition to their jobs, families and other commitments. I am always humbled by the selfless action of our leadership for KSHA … for you.

Action is required on every front if KSHA is to continue to meet its mission. KSHA is more than an annual Convention. Action cannot occur without YOU. KSHA is a volunteer organization; it is not a business. We, the Executive Council, need you to be engaged in promoting, supporting, providing and advocating for the profession across the state. We plan to be accessible and transparent in our work this year. Feel free to contact any member of your Council to offer your expertise on topics of interest to you. No offering of time is too small and each is appreciated. Let us know what you value, where the needs are, and when battles need to be fought or victories celebrated.

Saving Larry's Life

Continued from pg. 1

daily voice fatigue and complaints of heartburn. He was prescribed Prilosec, which he took as needed. I also noted increased snoring, coughing during sleep and episodes of sleep apnea. He also began to have 1-2 glasses of red wine in the evenings "for (his) heart." Also important to note is that Larry's father died of cancer that developed from Barrett's esophagus.

As a dutiful wife, I began to nag him when I noted chronic episodes of congestion and coughing. Larry would call his primary physician who would prescribe a quick fix for the asthma symptoms, symptoms would improve, and he would continue his same behaviors. Larry could not understand any possible relationship between reflux and his lung status despite my informed nagging. The slope became very slippery in the summer of 2013 beginning in June. His sensitivity to asthma triggers increased significantly; his cough was chronic rather than episodic. He was coming home early from work to sleep. Perhaps, most frightening (at least to him), he was not able to complete 18 holes of golf. The decline was occurring even with the usual prednisone course. He ultimately went for a pulmonology consult and was quickly recommended for a pulmonoscopy. Following the procedure, the pulmonologist described Larry's lungs as the "worst pair of lungs" she had seen in her many years of practice. She was unable to vacuum his lungs because she could not see, the tissue was inflamed and breaking away. A round of IV antibiotics and steroids were prescribed for a three week period with a second pulmonoscopy to follow. During the second procedure, his lungs were improved to the point they could be suctioned and cultures obtained. Results from the cultures were reported as "normal flora" and "nothing unusual." For me, that was a red flag despite relief that cancer was not a player. I received minimal to no response from the primary physician and the pulmonologist when I raised the question with regard to his GERD history. Might he be aspirating in his sleep? No worries; increased doses of Prilosec.

Larry followed up in August with the pulmonologist's office. He was better, but not well. His oxygen levels were better, but not normal. He was not coughing as much, but was coughing daily. During his visit, he was seen by the nurse practitioner. I again raised my concern that I believed Larry was aspirating during his sleep secondary to his GERD. She heard me. She referred to the GI who ultimately referred for what I thought would be a barium swallow.

I was thankful to be given permission to observe his barium swallow. They had orders for a modified barium swallow only. Pharyngeal function was not the concern for me. I was able to gain an addendum order to include a barium swallow. As expected, Larry's oral and pharyngeal functions were normal. No s/s of aspiration. However, his barium swallow revealed gross regurgitation to the level of the vestibule, poor peristaltic wave and reflux on every bolus/bolus stream. The radiologist supported my every nag without even knowing it. Elevate the bed. No late meals or snacks before bed. No alcohol immediately before bed. Lose a few pounds.

"His barium swallow revealed gross regurgitation to the level of the vestibule, poor peristaltic wave, and reflux on every bolus/ bolus stream."

We elevated the head of the bed and his reflux medicines were changed and increased. Larry's lung status improvements were marked once he demonstrated increased compliance with reflux management recommendations. He was compliant with his asthma medications and GI medications, continuing to take them even though he was feeling better. Since approximately December 2013, his improvements have been steady. Like many of us, though, he tends to think himself invincible when he begins to feel better. When he falters on his precautions (late night snacking, for example), his cough will become more congested, not to mention increased coughing and snoring while sleeping. It is a battle.

My purpose for sharing this intimate story is to reinforce the need for us as professionals to perk our ears when our clients report a history of or symptoms of reflux disease especially if they also have voice, COPD, and/or dysphagia complaints. I am absolutely convinced that Larry's ability to tolerate any aspiration, whether his stomach contents or normal flora/saliva, is compromised secondary to his respiratory history. The two conditions, compromised lung health and reflux disease, were a fierce combination overlooked by his medical practitioners. They were not considered related until I raised the questions and voiced (repeatedly) my concern.

The radiologist said I saved Larry's life. I am not certain that is true, but I am thankful I have enough knowledge and experience to recognize the possible influence his reflux disease was having on his pulmonary status. It didn't hurt being a bit of a nag either. [I only said "I told you so" once.]

Connect With KSHA

Visit the KSHA website, www.ksha.info, and make sure your KSHA membership is up-to-date. Log on to the Member Center of the website, enter your Last Name and your Member Number. Once logged in, you are able to edit your membership information, such as mailing address, email address, professional information and more.

The Member Center also gives you access to renew your membership, register for an event at the member discounted rate, search for a member, access member-only resources and print your membership card.

Be sure to check out the **Full-Color *KSHA Communicator*** online at www.ksha.info.

Follow KSHA on Twitter at https://twitter.com/kyspeech and Facebook at https://www.facebook.com/KYSPEECH.

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The SLP's Role in End of Life Care

Jo Shackelford, EdD, CCC-SLP

Owner, Connections Speech & Language Services, LLC

As rehabilitation therapists, SLPs spend most of their clinical efforts helping patients acquire new skills, reacquire lost skills and work toward independence. But our role differs sometimes, when we work with people who are nearing the end of their life because of terminal illness or aging. Therapists who work in settings such as long term care, hospitals, home health or hospice often need to make an adjustment in how they view their contributions to a patient's quality of life.

The main goals of a palliative care team, which supports a person with chronic illness or who is near the end of life, are to manage symptoms and complications, provide social and emotional support, and to include the patient and family in decisions as they need to be made (Pollens, 2012). We have a great deal of knowledge that can be an asset in achieving these end of life care goals and are increasingly a part of the interdisciplinary team of professionals who work in palliative care. Facilitation of communication and dysphagia management are two areas in which we can play an important role (ASHA, 2014).

Facilitating Communication

In the final weeks and days of life, communication of messages becomes increasingly important. There is a need to understand now, not later. Through evaluation of retained communication abilities, the SLP can support the patient in communicating wants and needs. Simple low-tech alternative communication techniques can be used to allow a person to indicate food choices, ask for another blanket, spell out a message guiding a medical decision and express love to family members. When communication abilities decline, use of supported communication techniques can decrease frustration by helping the patient and family engage in successful conversations.

Maintaining Nutrition and Hydration

Being able to eat comfort foods can be important emotionally in a person's final weeks of life. For the family, ways to show love and nurturing become more limited when a person begins to withdraw. Being able to provide a few bites of a favorite food in a manner that minimizes additional risk or discomfort can be one way to care for a loved one. SLPs can conduct a non-invasive bedside swallow evaluation to determine safest food consistencies and liquids. We can identify strategies to make swallowing more comfortable and can make dietary modifications as the person's strength and alertness decline.

SLPs also assist the care team in educating the patient's family about the swallowing process and how to minimize discomfort during oral intake. We support caregivers in their often-difficult decisions about use of supplemental feeding methods. When caregivers are struggling with their decision to not use a feeding tube, a trusted voice saying, "You're doing the difficult thing, the right thing" can be a great comfort.

HOPE, DIGNITY, LOVE.

ASHA provides a wealth of information related to end-of-life. Read more about our role in palliative care, needed competencies and cultural considerations at http://www.asha.org/slp/clinical/endoflife/.

Dr. Jo Shackelford is owner of Connections Speech & Language Services, LLC in Bowling Green, Kentucky. Connections specializes in accent modification and adult communicative, cognitive and swallowing disorders. You can contact her at http://connectionsspeech.wordpress.com or ConnectionsSpeech@gmail.com for more information.

References

ASHA. (2014). End-of-life issues in speech-language pathology. Retrieved from http://www.asha.org/slp/clinical/endoflife/

Pollens, R. D. (2012). Integrating speech-language pathology services in palliative end-of-life care. Topics in Language Disorders 32(2), 137-148.

Raising Awareness of the Cancer Burden in Appalachia

Vrushali Angadi, MS, CCC-SLP

PhD Candidate in Rehabilitation Sciences at the University of Kentucky

Appalachian/rural Kentucky, like other Appalachian regions in the United States, has been identified as an underserved region in terms of healthcare due to limited access to tertiary healthcare centers, low levels of literacy and poor socio-economic conditions.[1] The cancer burden in Appalachian Kentucky has been a serious ongoing issue for many years, with the region demonstrating a high incidence of lung, colorectal, breast and head and neck cancers (HNC). With an annual incidence of 14.01 per 100,000, the state of Kentucky has one of the highest incidences of HNC in the United States.[2] More alarming is the rising trend in the incidence of these cancers.[2] While the national trend shows an overall increase of 0.3%, Kentucky shows an increase of 2.17% of head and neck cancers since 2001.[2]

As a speech-language pathologist at the UK Voice and Swallow Clinic serving the Markey Cancer Center at the University of Kentucky, my interest is to understand the HNC population of our state. To that end, we conducted a study to characterize and investigate distribution trends in the treatment seeking population for head and neck cancers at the UK Head and Neck Cancer Clinic from 2007 to 2010. The study categorized the patient population by site and stage of cancer, type of treatment(s), basic patient demographics and the county wise distribution. Through this study we found comparable numbers of HNC in both Appalachian and non-Appalachian counties. A majority of the patients seeking treatment, both rural and urban, also had advanced disease stages. These results were consistent with state head and neck cancer statistics that demonstrate that rural/Appalachian regions of Kentucky have a higher incidence of HNC as well as cancer related mortality as compared to urban regions.[3] Fifty-four of Kentucky's 120 counties are included in the Appalachian region. According to the present census report, urban counties have a larger population count, almost double, as compared to the rural/Appalachian regions.[4] However, with respect to head and neck cancer incidence, the numbers are comparable. Due to educational, economic and geographic challenges, Appalachian regions in Kentucky are disproportionally faced with health disparities as compared to urban counties. These disparities often result in limited public awareness of basic health information and delayed or limited access to health care. Consequently, the people of rural Kentucky face widespread and life threatening health challenges that are often not detected or treated until the later disease stages.

Efforts are being made to reduce health care disparities and to improve the health of all Kentuckians. For example, the Appalachia Community Cancer Network (ACCN) presently has programs in place for prevention and treatment of lung, cervical and colorectal cancers. Considering the high incidence of HNC, similar efforts are needed to reduce the incidence, increase awareness, and improve the overall treatment outcomes for head and neck cancers.

Like most cancers, head and neck cancers are best treated in their early stages. Treatment in early stages not only improves chances of survival but also minimizes the level of treatment-associated morbidity. In fact, five year survival outcomes for treatment for early stages of head and neck cancers vary between 90-95%, which are very encouraging statistics to seek treatment early. Unlike lung cancer, breast cancer or colorectal cancers, detection techniques for HNC are fairly accessible and require little use of sophisticated instruments. A routine head and neck examination as performed regularly by a primary care physician, otolaryngologist, dentist, physician's assistant or nurse practitioner can help detect HNC. The decreased need for sophisticated instrumentation to screen for HNC makes planning outreach programs less challenging. Health professionals involved in screening can travel to underserved regions to reach out to individuals who may not otherwise have the means or the resources to seek medical help. With early identification, these individuals can be successfully treated, thus minimizing health care costs by preventing long-term health issues related to cancer treatment.

References:

1. ACCN. Addressing the cancer burden in Appalachian communities. 2010.
2. Registry KC. Age adjusted invasive cancer rates in Kentucky. 2013; http://cancer-rates.info/ky/index.php. Accessed 31st May 2014, 2014.
3. Registry KC. Cancer Mortality Rates. 2013; http://cancer-rates.info/ky/index.php, 2014.
4. Commission AR. Census Population change. Appalachian Regional Commission.

To read the FULL article, go to the KSHA Communicator online at http://ksha.info/communicator.html where the author describes head and neck cancer in Kentucky and provides information regarding the cancer screening initiative. Please don't miss this important information!

Convention Directors

Heather Gaddis

Ann Miller

2015 KSHA CONVENTION

COMMUNICATION

THE POSSIBILITIES ARE ENDLESS

February 25-28, 2015 Louisville, KY

Before we know it, Convention time will be upon us, and we ask that you join us for the 2015 KSHA Convention in Louisville, Kentucky, February 25-28. The 2015 KSHA Convention Committee is already recruiting top speakers to make this Convention the best yet. In the world we live today, ***possibilities are endless*** and the same is true regarding our profession as speech-language pathologists and audiologists. When it comes to bettering someone's communication disorder or other deficits, we need to be all in, open minded and willing to try anything. Whether it's a child with articulation errors, an adult stroke patient with aphasia, a child getting his first cochlear implant turned on or even a geriatric Parkinson's patient trying to improve her voice, the possibilities are endless. We hope that as you mark your calendars for this upcoming Convention, you think about our profession and ***Communication*** and that ***the Possibilities Are Endless!***

CALL FOR POSTERS

KSHA is now accepting proposals for poster presentations for the 2015 Convention. This is the perfect opportunity to share your research or creative activity with the membership. Presenters are able to briefly talk to small groups and receive feedback. Let's make 2015's Poster Session excellent! Submit your proposal today!

Deadline: January 15, 2015

Student Scholarships and Research Funding for 2015

It's that time of year again. Deadlines for KSHA student members to apply for a research grant or one of the scholarships listed below are fast approaching! KSHA funding is a great way to support your educational endeavors relating to our professions.

Applications and instructions are available online at www.ksha.info.

STANLEY and STECKOL AWARDS—Student Scholarships – *Deadline to submit: November 15*

Awarded: At Convention

Two Awards, each up to a maximum of $2,000.

The Steckol Memorial Fund and the Bev Stanley Award are awarded by the Scholarship Committee to a graduate student majoring in audiology or speech-language pathology at a university in Kentucky accredited by the Council on Academic Accreditation of the American Speech-Language-Hearing Association. The $2,000 award is intended to help defray educational costs. The student must demonstrate both academic excellence and need.

STUDENT RESEARCH GRANTS

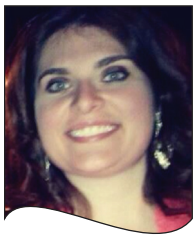
Deadline to submit: April 30

Awarded: June 1

Two Grants, each up to maximum of $500.

Grant money is available! We invite you to apply for available funds to help defray the costs of your research project. If KSHA provides funding for your student research, then you and the research team agree to recognize such support in any presentation or publication pertaining to this research study. The student also agrees to write a comprehensive article for the *KSHA Communicator* upon completion of the research study.

Please contact Donna Goodlett-Collins at donna.goodlettcollins@brescia.edu.



10 things

I wish someone had told me before my First Day

Alesha McPeak, MS, CCC-SLP

As a graduate, you walk across the stage and are handed that coveted diploma, the key to your future. You are ready to save the world with all of your newfound knowledge and excitement. Prepare yourself my friend; the real world isn't all fairy tales and roses. You'll win some and you'll lose some. For every wonderful victory you will have some devastating losses. Here are 10 pieces of advice from wise, experienced clinicians that I wish someone would have told me to ease the transition into reality.

1. **Nobody really knows what it is you do for a living.** You will be educating others on the need for your services. Patients, families, teachers, principals, doctors and nurses will all require your assistance in understanding your awesomeness. Hang in there! Keep a positive attitude with your coworkers; they will be your lifeline to a full caseload.
2. Yes, you do have the latest knowledge of your field just waiting to be tapped into, but remember: **You do not know everything about everything.** Ask for help! Don't become so overwhelmed that you put your patients at risk.
3. **People don't care what you know until they know that you care.** Look people in the eye, smile and be nice. When you enter the room to work with a new patient, introduce yourself and tell them why you are there.
4. **Death is a part of life.** It isn't predictable, but it is something you can expect to happen from time to time with your patients. Even if you deal with death fairly regularly in the medical setting, your patients will likely not have the same familiarity with it. Remember you are working with people, not just diagnoses. Take time to sit down with the 90-year-old man who is watching his wife of 68 years die before him because she has lost all ability to safely eat anything by mouth. Listen to his love story, you might just find a renewed strength and desire to fight for your patient's fullest potential.

"Listen to his love story, you might just find a renewed strength and desire to fight for your patient's fullest potential."

5. **Never stop being a student of your field.** Constantly seek new ways, better ways, and just different ways of pursuing therapy techniques. There are billions of people in the world and not every method will work for every person. Always seek your creative side and be open to new techniques. Never forget: if you can't do an hour session with just a shoe string and newspaper, then you aren't thinking creatively enough.
6. If possible, try and **do something for yourself every day.** When you start working, the pursuit for the almighty dollar will become front and center as your student loans come due. You will want a new car, a new house—your hair professionally dyed red so you stop having to hope it doesn't turn out orange again because you used the box—and all of these precious things take money. But trust me; money cannot buy health or true happiness. Volunteer your time, go for a run or finally spend time with your ageing relative that you have been meaning to visit. Just doing something that isn't in the pursuit of that dolla dolla bill will make you less stressed and ultimately a better person.
7. **Write EVERYTHING down.** This cannot be stressed enough and you have probably heard this advice during school. If you don't write something down, then it absolutely did not happen. You have to think, "If I'm going to have to read this in two years and understand it to support my decision at that time, then I had better be writing everything down."
8. **Sometimes you are the only fighting voice a patient will have.** If you are working with children, then never stop working towards getting them the latest and greatest materials possible. If that means you have to pursue your supervisor to approve your materials list, then do it!
9. Remember that **you have a wonderful support system in your past professors and fellow classmates.** I even contacted some wonderful former classmates to aid in the writing of this awesome Top 10 list. These people know you, they were there for you at two o'clock in the morning when you hadn't even started that 10-page paper and they will continue to be there for you as sounding boards about patients or a shoulder to cry on when you need someone to understand what you're going through.
10. Lastly — and perhaps most importantly — **be absolutely in love with what you do.** If you ever stop caring about your patients, then get your booty out of that setting. If you don't care, then you will be of absolutely no good to anyone.

There you have it, ladies and gentlemen! Get out there and make a difference in your patients' lives. You have the knowledge and the drive, now go show it to people and get them excited about speech-language pathology and audiology!

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Upcoming Events

November 2014

Stanley and Steckol Awards
Deadline to submit
November 15, 2014

December 2014

Membership Renewals
Deadline
December 31, 2014

February 2015

KSHA Convention
Louisville, KY
February 25-28, 2015

April 2015

Student Research Grants
Deadline to submit
April 30, 2015

tell us what YOU THINK

The *KSHA Communicator* would love to hear from you!

Tell us what you think about our new style.

Tell us what you want to READ about in the upcoming issues.

If you have or are currently working as an audiologist or speech-language pathologist in a medical setting, we would love for you to tell us what we should write. … Or better yet, go ahead and write about your story, your favorite new clinical strategy or your amazing mentor!

Send your feedback, ideas, suggestions for improvement and writings to **write4ksha@gmail.com** today!