



Shoreline Speech Therapy

Communication Intervention for People with Dementia

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People with dementia (PWD) experience changes in their communication skills. All forms of dementia impact communication skills. These changes are related to linguistic impairments (e.g., remembering names of things), other cognitive deficits (e.g., attention, memory), and social communication skills (e.g., 'rules' of conversation). Communication is further affected by the physical environment (e.g., lighting, noise) and social environment (others' interaction styles and attitudes).

PWD may include trouble with¹:

thinking of words	meaningless or incomplete sentences	inappropriate conversation topics
understanding instructions	empty words ("the thing")	interpreting things literally
keeping a conversation going or talking too much	remembering what was said	saying things over and over
staying on topic	repeating questions	may be non-verbal in advanced stages
halting speech	reading and writing	
echoing others		

In combination with other cognitive difficulties, this communication impairment can affect a person's daily life in many ways. This includes:

Difficulty fulfilling basic needs:

- stating preferences and choices
- expressing pain, hunger, discomfort
- understanding care instructions

Trouble with personal relationships:

- participating in conversation
- repetitive comments and questions
- adhering to rules of social etiquette

- misinterpretation of the individual's verbal and nonverbal communication
- recognition and identification of people

Challenges with engagement in life interests:

- reading, puzzles, games, etc.
- roles in community (work, volunteer, family)
- entertainment (TV, movies, music)

Communication and Behaviour

The communication deficits of dementia contribute to 'responsive behaviours' such as repetitive calling out, agitation, wandering, and aggression. They also affect how we support PWD experiencing psychiatric symptoms such as hallucinations and depression. We can better support communication and behaviour by first understanding the person's strengths and areas of difficulty. This can be accomplished through comprehensive assessment (e.g., How much can the person read with understanding? What helps them communicate more effectively?), sharing the information revealed during the assessment (e.g., in a communication care plan), and seeking appropriate training from an S-LP. Second, once this understanding is gained, personalized recommendations can be made to use the person's strengths to compensate for their difficulties. For example, if procedural memory is relatively spared, this can be capitalized on in memory retraining interventions such as spaced retrieval training and vanishing cues (see below). S-LPs are the health professionals qualified to carry out such assessments and interventions.



What is the Role of S-LPs with Persons with Dementia?

Persons with dementia (PWD) of **all stages** can benefit from the specialized skills and therapeutic interventions provided by speech-language pathologists (S-LPs). All forms of dementia affect communication, whether by directly reducing linguistic skills, or indirectly through impaired

processes such as memory, attention, and reasoning. These difficulties are collectively termed 'cognitive-communication disorders'.

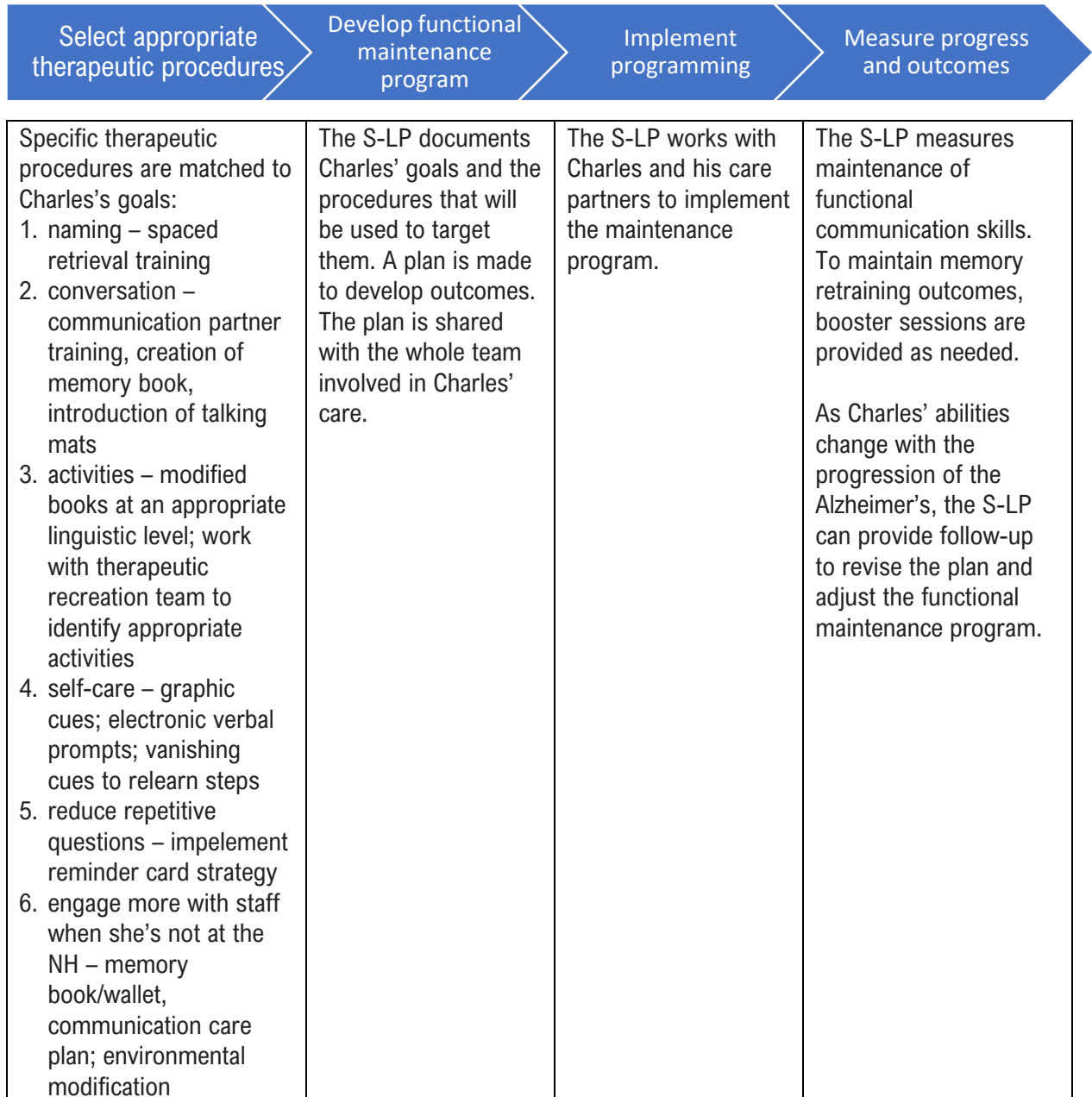
S-LPs can offer a range of clinical services to support PWD, their families, and their professional care partners (e.g., nurses, personal support workers, continuing care assistants)^{2,3}. The goal of treatment with PWD is to **maintain and maximize communication so the person can function optimally in their life**. Optimal functioning offers:

- maintenance of independence as much as possible,
- avoidance of creating 'excess disability' (reduction of ability when given unnecessary help with activities – e.g., ordering at a café for a PWD when they are actually able to do this themselves),
- maintenance of functional skills longer (e.g., greeting daughter by name, reading a menu, using signs to navigate a new environment),
- improving the efficiency of care staff's work (e.g., speaking in a way that the PWD can understand means they can follow the direction; having good feelings associated with the staff member and the routine means less resistance),
- reduced frequency and intensity of responsive behaviours,
- improved care (e.g., improved PO intake, pain management, personal care, assessment, wound care),
- greater staff satisfaction,
- more satisfying family relationships,
- increased participation and quality of life for the PWD, and
- dignity.

On the next page is a sample overview of a process of consultation with an S-LP.

Referral	Identify purpose of assessment	Assessment	Develop goals
<p>Charles (PWD) is admitted to a nursing home (NH). Communication challenges are apparent and frustrating for Charles, his family, and the care staff. Mary (substitute decision maker) discusses issues with Charles' doctor, who refers Charles and Mary to S-LP services.</p>	<p>The S-LP contacts Mary and sets up an appointment at the NH with her and Charles. Mary wants to know how to reduce Charles repetitive questioning, how to have nice conversations again, and if there's a way to work on remembering peoples' names. She wants to know how much he can understand and read – should she still bring the newspaper? The care staff want to know how to help maintain Charles's participation in care activities such as morning care.</p>	<p>The S-LP works with Charles, his family, and his care team to find out what his strengths and areas of weakness are in his spoken language, understanding, reading, writing, and cognitive-communication. She also screens for candidacy for various intervention procedures and approaches. The physical and social environment is also assessed for communication barriers and supports. The S-LP provides a detailed written report to share the findings with the family and care team.</p>	<p>Mary identifies specific goals to work on to maintain Charles functional communication skills:</p> <ol style="list-style-type: none"> 1. be able to say immediate family members' names 2. participate more in conversation 3. find activities he can enjoy (he used to love reading and playing cards) 4. be able to do more for himself for his care 5. reduce repetitive questions 6. engage more with staff when she's not at the NH

continued on next page



Below are some of the ways S-LPs are involved in the care of PWD. As with any kind of intervention, services are based on the **specific needs of a specific individual**. Not all interventions are appropriate for all persons, and no single treatment will address all issues. They are listed here to serve as an introduction to the possibilities that exist and of the services that have proved helpful to many PWD, their families, and their professional care partners.

Goals	Examples of Interventions
to facilitate recollection of personal facts (career, family, home life, travel)	memory book memory wallet conversation partner training reality orientation memory training
to improve ability to participate in, communicate, and follow directions during care activities (showering, dressing, feeding assistance)	conversation partner training visual aids verbal instruction via electronic device environmental modification
to recall factual information (person's name, names of objects, autobiographical information)	memory training procedures (e.g., spaced retrieval training)
to recall the steps in a task (making change, setting the table, making the bed)	memory training procedures (e.g., spaced retrieval training, vanishing cues)
to complete steps in a task	verbal instruction via electronic device
to improve orientation to person, place, and time (knowing the day, season, time, year)	reality orientation environmental modification
to reduce repetitive questioning	reminder cards memory wallet
to facilitate increased choice making	visual aids conversation partner training
to increase participation in conversation	conversation partner training memory book/wallet environmental modification
to increase on-topic conversation	memory book/wallet

Goals	Examples of Interventions
to improve topic maintenance and quality of conversation	conversation partner training memory book/wallet
to increase opportunities to engage in meaningful activities	conversation partner training memory book/wallet Montessori approach cognitive stimulation groups environmental modification
to reduce episodes of responsive behaviours	conversation partner training regular, appropriate, meaningful stimulation and purpose reminder cards environmental modification reminiscence videos
to improve responsiveness to episodes of repetitive vocalization/verbalization (“help, help, help”)	conversation partner training analysis of unmet needs regular, appropriate, meaningful stimulation reminder cards environmental modification reminiscence videos (if due to loneliness or boredom)
to support care partner coping skills related to cognitive-communication changes	care partner education and counselling
to understand the nature of cognitive-communication changes, identify specific communication strengths and areas of reduced ability, identify appropriate intervention approaches, identify appropriate strategies, measure outcomes, and document same	comprehensive cognitive-communication assessment communication care plan

ASSESSMENT AND CARE PLANNING

Comprehensive Assessment: Identify the Person's Strengths and Difficulties

What are the PWD's strengths and areas of difficulty?

How are these areas of difficulty impacting their functioning and participation?

A comprehensive assessment answers questions about the PWD's specific strengths and areas of difficulty. These questions may include:

- What does s/he understand when others speak?
- What can I do to make it more likely s/he'll understand?
- What length and complexity of reading material is s/he able to read with understanding (words, sentences, paragraphs)?
- I heard that using pictures can help him/her understand – what type of image is best?
- The way s/he talks has changed – how do you describe what I'm hearing?
- How do I help him/her to take part in conversations? How do we have enjoyable interactions when verbal communication is difficult?
- Sometimes s/he says inappropriate things. What can I do?
- What can we do to make sure s/he has something to do? That s/he's stimulated?
- S/he gets agitated and aggressive sometimes. Is communication contributing to these behaviours? How can I deal with these situations?
- S/he keeps asking the same questions over and over. What can I do?
- S/he keeps calling out. What can I do?
- S/he can't remember our family members' names. Is there anything we can do?
- S/he isn't eating. Is it because s/he's full? Doesn't like the food? How do I know?
- S/he keeps getting lost around the house/unit. What kind of things would help?
- Will his/her abilities keep changing?
- Other questions specific to your loved one.

Communication Care Plans: Document and Plan

Given what we now understand about this PWD's communication abilities, how do we maximize their functioning? How do we share this information with the whole team?

A communication care plan tells the health care team what a person's specific communicative strengths and areas of difficulty are and how to communicate most effectively with the individual. For example: how much a person can read with understanding, how to deliver instructions, how to offer choices. It involves a comprehensive assessment by an S-LP. These care plans benefit care partners by helping them to be more comfortable speaking with LTC residents with communication disorders, helping them to be more knowledgeable about an individual's communication abilities and difficulties, and can result in greater use of strategies⁴.

Below is a part of a communication care plan for a resident of a nursing home. This is for a resident whose ability to understand and use spoken language were severely reduced, but who made very good use of gesture to express himself, and of visual information to understand.

To maximize resident's expression:

- Give him your full attention.
- Watch his gesture, facial expression, and actions.
- Attend to his intonation.
- Follow his lead when able.
- Provide extra time for him to process your directions.
- Provide a visual choice.



CARE PARTNER COUNSELLING: COPE BETTER WITH DEMENTIA

How do I cope with what's happening to my relative?

For many family members and friends, being present during the course of dementia in a loved one is extremely challenging. An S-LP can support family to understand why their loved one is changing in their ability to communicate, how to make sense of new behaviours with a communicative basis, and how to move forward to make time with their loved one more satisfying.

COMMUNICATION PARTNER TRAINING

How do I have a conversation with my relative that we both can enjoy?

Communication requires at least two people who (ideally) take turns sending and receiving information. PWD cannot change the damage in their brains that has reduced their linguistic, pragmatic, and cognitive abilities. However, **we** can change our own behaviour to accommodate for this. We can use strategies and tools to reduce the occurrence of communication breakdowns and repair them more effectively when they do occur⁵.

We can support PWD to fulfill these needs of communication by:

- discovering and documenting the non-verbal ways they communicate (e.g., takes off pants when needs to urinate),
- proactively provide context and visual cues during conversation (e.g., when getting dressed, how to offer choice of clothing),
- reducing the processing demands by simplifying our language in specific but natural ways (e.g., limiting the number of directions or the complexity of a sentence),
- communicating respect to preserve dignity and community/family role as an elder and friend,
- framing our comments and questions to facilitate remembering,
- offering opportunities that are within their range of abilities (e.g., appropriate books, games, songs),
- preventing conversation from becoming a series of test questions (e.g., ‘do you remember Billy?’ ‘who’s this ma?’), and
- maintaining satisfying interactions if a person becomes non-verbal in the later stages.

People at all levels of severity (mild, moderate, and severe⁶) benefit when their care partners receive communication partner training (CPT) from an S-LP. This training is not the same as the general suggestions often offered as a part of caregiver training programs. CPT as delivered by S-LPs has a very specific focus on communication and behaviour. The most effective models also include direct coaching by an S-LP.

When conversing with a partner who has received training, PWD typically understand more, can express themselves better, can sustain topics of conversation longer, enjoy interactions more, and take a more active role⁷. There are also benefits for physical and mental health (food intake, pain assessment) and safety (reduced episodes of aggression, improved orientation). The benefits for care staff include improve effectiveness and efficiency in providing care, improved staff and resident safety, greater care compliance, and more satisfaction with their relationships with residents⁸.

Training and Counselling for Family Members

How does communication change with dementia?

What should I be doing so we can communicate better and have a good relationship?

Family and friends often struggle with the impact cognitive-communication symptoms have on their relationship with the PWD. They wonder how they can continue to have fulfilling interactions, or how to accommodate for these difficulties when they are providing care. Shoreline offers the *TARGETED Program*⁹ for family and friends of PWD. This program helps family to understand how dementia affects communication and what they can do to have enjoyable experiences together and to maintain a positive relationship. This program was developed at the University of British Columbia with collaboration between nursing and speech-language pathology. The content addresses the linguistic, cognitive, and relational aspects of communication breakdown in persons with dementia and provides training for participants in strategies to effectively compensate for reduced cognitive-communication skills.

Training for Professional Care Partners

What should I be doing so that we understand one another? How can I communicate better during care activities and social conversation? How do I handle repetitive questioning?

Nurses, continuing care assistants, and other staff in nursing homes and home care can develop skills to accommodate for residents'/clients' reduced communication ability. Staff complete their care tasks faster, residents receive better care (e.g., food intake, pain assessment), and staff and residents are more satisfied with their relationship. Shoreline offers an advanced training course for staff – *Successful Communication with PWD*¹⁰ which was developed by two S-LPs. This 12-part inservice addresses the linguistic, cognitive, and social reasons for communication breakdown and training for how care partners can apply specific strategies to maximize communication.

MEMORY TRAINING

Is he/she able to learn/re-learn information? How?

PWD can be trained to relearn names of people and objects, and steps in a sequence (e.g., safe swallowing strategies) using errorless implicit learning procedures¹¹ such as 'spaced retrieval training' (SRT) and 'vanishing cues'. An S-LP can screen for candidacy, select the appropriate procedure, and administer the treatment. SRT is described in greater detail here.

Spaced Retrieval Training: This procedure has been demonstrated to be effective for persons with mild¹² to moderate-severe^{13,14} Alzheimer's disease, vascular dementia, and mixed dementia¹⁵, in learning and relearning factual information such as face-name associations and object names or steps in a task such as making change. For this procedure to be appropriate, a person must not be agitated by repetitive questioning. Dosage for this approach as offered by Shoreline is 60 minute training sessions 3 days a week for a minimum of 4 weeks with follow-up every 6 weeks thereafter for booster sessions^{16,17}. A trained family member can administer 2 of these 3 weekly training sessions; 1 must be administered by the S-LP. One new target is worked on at a time in training sessions. Booster sessions cover multiple targets for maintenance. During training sessions, other

goals are also worked on such as developing visual aids, a memory book, reality orientation activities, cognitive stimulation, or additional memory retraining using other procedures.

MODIFYING THE ENVIRONMENT

How is the environment contributing to the PWD's difficulties? How can we make a more supportive environment to accommodate for the cognitive-communicative symptoms of dementia?

The physical environment is experienced differently by PWD. Things like lighting, noise, glare, sensory deprivation, sensory overload, signs, furniture placement, masking of exits, home-like décor, placement of interesting objects and activity opportunities, low visual contrast, and the presence of plants and animals can all affect how the person perceives, processes, and reacts to their environment. An S-LP can help with an environmental assessment and make recommendations on modifications, specifically those that impact communication.

Marion was a social woman with advanced dementia and a mild hearing loss. She was not verbal, but she loved people-watching, and was very expressive with her facial expression and posture. Marion required hand-to-mouth feeding assistance. Because she loved being with people, the unit staff placed her at a table with 3 other residents for meals. The server was nearby, and there was usually a television on in the background. Her intake at meals had become very poor and she was losing weight. Some people interpreted her behaviour to mean she disliked the pureed food that had been recommended. The nursing manager evaluated the situation and trialed a change. One staff member was assigned to feed Marion in her room. The curtains were opened to let the light in, her music was put on, and the staff member helped her to eat. The staff member would 'chat' with her about the food, weather, and music. If another staff member came in to change her roommate's bed, the two staff would chat, involving Marion in the interaction. Marion was much more engaged in this social situation than she had been at the table in the dining room. She began to drink and eat more and gained weight again. The nursing manager made some adjustments to the staff's work flow around the noon meal to ensure this intervention could be maintained.

EXTERNAL MEMORY STRATEGIES






Are there strategies to help him/her remember things?

For those with impaired short-term and long-term memory systems, external memory techniques work by *reducing the demands* being placed on the person's impaired memory system(s). Furthermore, they provide *cues* and *supports* to help people hold onto the information while working with it (such as during a conversation) and to help retrieve the information from long term memory.

Verbal Instruction Strategy

To give reminders when completing tasks that have multiple steps.

This strategy helps a PWD complete tasks with multiple steps (e.g., making a sandwich, brushing their teeth). The spoken steps are recorded into an 'electronic memory aid'. When activated, the steps are played, offering a guide while the person completes the task on their own. This strategy is helpful for people with mild and moderate dementia¹⁸.

How to make coffee	
1	 Pour 6 cups of water into the carafe.
2	 Pour the water into the reservoir.
...	
8	 Push the 'on' button.
9	 Wait until the coffee stops dripping.
10	 Pour the coffee into your mug. Enjoy!



Reminder Cards

To fulfill the need to know specific information that is asked for repeatedly.

This is a useful strategy when a PWD repeatedly asks the same question¹⁹. After answering the question the first time, the care partner prints the answer on an index card (or retrieves one if the situation comes up often), then the care partner reads the answer and gives the card to the person. When the PWD asks the question again, instead of answering again, the care partner says 'read the card'. This strategy is useful for information needed throughout the day (e.g., 'My daughter visits on Thursdays.') and for people with mild to severe dementia²⁰. This technique can be useful in many situations, such as:

- knowing where they live ('I live at St. Vincent's.')
- orientation to the day and important activities ('It is Wednesday. I go to church at 11am.')
- safety strategies – how to transfer from a wheelchair, safe walker use ('Nose over toes. '), swallowing strategies ('Take a bite. Tuck my chin. Swallow.')
- how to behave in a specific situation ('I'm in church. I should be quiet.')
- knowing where their partner is ('Linda is at home. She visits at supper.')
- coping with unfamiliar settings ('I'm at the dentist. The dentist will see me soon.')

Mr. and Mrs. C. were a close, active couple in their 60s when Mr. C. had a series of strokes and developed dementia. Whenever they went for a walk and had to wait for a red light, Mr. C. became extremely agitated and repeatedly demanded that they start crossing. Mrs. C. would say 'not yet' over and over as she tried to hide her embarrassment and as Mr. C. would start to become verbally and even physically aggressive. She learned how to rephrase 'not yet' as 'we can cross when the light turns green' and to use reminder cards in this specific situation. Mr. C.'s need to understand how to act in the situation was met, these episodes were more successfully managed so that Mr. C. did not escalate to agitation and aggression, these episodes become less frequent, Mrs. C. did not feel embarrassed, both maintained their dignity, and both enjoyed their walks together much more.

We cross the street
when the light is green.

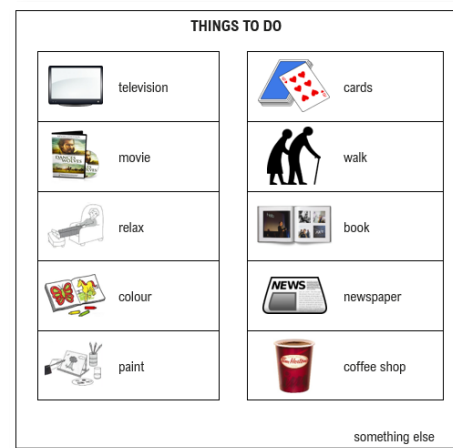


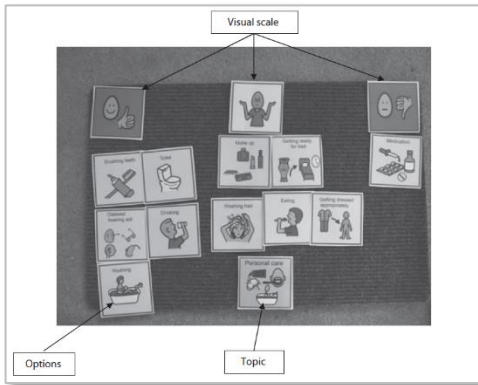
Visual Cues

Would pictures or photographs help him/her understand?

Visual cues can help a person to understand what you are saying to them. Dementia reduces a PWD's understanding of word meanings. If they also have aphasia from a stroke, or a hearing impairment, it can be even more difficult. Visual cues help them to understanding what's going on. For people who have difficulty expressing themselves verbally, they are also a way to express their choices. Visual cues can include signs, communication boards, and personalized cards that can be collected in a 'memory wallet'.

Harry was a friendly gentleman who had survived a series of strokes, had Alzheimer's disease, and had a severe hearing loss. For all these reasons, he had difficulty understanding others and expressing his own wishes. One of his strengths was using facial expression, gesture, understanding simple pictures, taking advantage of situation cues (e.g., when in the dining room, he expected routines related to meals), and reading single words. His companion knew what Harry liked and would offer him these activities. Harry was very accommodating and would always say 'yes' to whatever he was offered. His wife knew that he could have more control over his day if given a chance to make choices, and so asked the S-LP to help. They developed a small booklet of the activities that Harry liked, represented with simple line drawings and printed words (shown on right). The team was on board with the new strategy. Harry often chose activities that others would not have thought to offer – for example, he tended to chose art activities much more frequently than watching movies, which was most often offered previously.





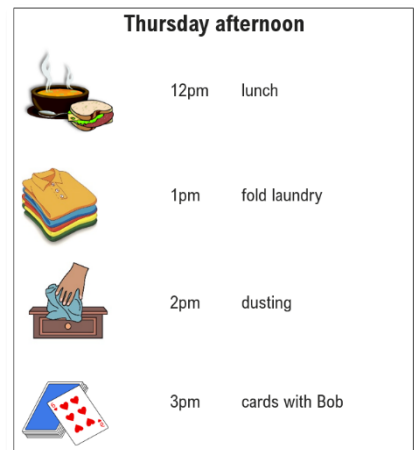
One approach to using visual cues in conversation is called ‘talking mats’²¹. Individual pictures are used by a PWD and their conversation partner to make choices, communicate their likes and dislikes, share their opinion, and even express their wishes related to health care decisions.

Left: Example of a Talking Mat from Murphy & Oliver (2013, p.174).

Visual Schedules

“When’s breakfast? What’s going on today?”

Visual schedules let a PWD know what to expect during a given day. A visual cue helps them understand the written words. These help a person to know what’s going to happen in a day. The PWD may need training to use such a schedule. On the right is an example of a schedule for a man with mild-moderate Alzheimer’s disease living at home with his wife.



Memory Books

What would help with participating in conversation?

A memory book tells the story of an individual's life, highlighting the most meaningful information. The purpose is to support and enhance communication between an individual with dementia and his or her family, friends, care partners, and fellow residents. Socializing and self-identity activities can be engaging to individuals with all levels of dementia.

When developing memory books, S-LPs work directly with the person with dementia and their family to create a book that is used by that person, including those with severe dementia²². This is possible when conversation and the memory book is at the right level for the PWD's linguistic, fine motor, and visual abilities. A memory book is adapted to a person's communication needs by modifying content, format, language, and including appropriate visual materials such as simple photographs.

Memory books help a person to retrieve information stored in long-term memory and to hold onto the information while they converse about the topic. The written and visual information helps them to share this information with others. The visual cue also helps PWD to stay on topic longer²³.



Above: Example of a memory book.

REALITY ORIENTATION


"Where am I? Where is my wife? What day is it?"

The purpose of reality orientation (RO) is to help a person recall or access information to help them orient to their reality of time, place, and person. It involves modifying the environment, providing visual aids, practicing important functional information, and having relevant features of the environment called attention to throughout the day. There are different approaches to RO. An S-LP can help evaluate whether RO would be an appropriate intervention, select goals, implement programming, and teach care partners how to adopt the approach.

Reality Orientation Groups

RO group intervention²⁴ can maintain, and in some persons improve²⁵, cognitive functioning level for those with mild to moderate dementia^{26,27}. In small groups (2-4 people) or individually, for 30-60 minutes, participants are presented with, practice, and use orientation information²⁸. The information that is chosen to practice must be functional for the individuals – what is meaningful for their daily life. It may include personal and current information such as the person’s name, where they are, date/season, and autobiographical information such as their hometown, family, and former occupation. If information is not functional for them (e.g., the specific date), then it should not be a goal of RO. The information that’s practiced doesn’t need to be information such as the date – this may not actually matter in the person’s daily life whether they know it’s April or May – but it may be helpful to know that it’s summer / winter if they like to go on walks outside. If RO practice would be frustrating or not enjoyable to an individual, then RO would not be an appropriate intervention.

RO group intervention should be supported with visual aids such as a ‘memory wallet’ (a miniature, portable memory book) that the person can keep with them during the day. RO sessions can be combined with reminiscence therapy or other programming. Family members can also be trained to provide such opportunities for practice at home. The minimum dosage should be 10 hours with *at least* one session a week²⁹.

<p>About Bill I live at Oceanview Place. I have Alzheimer’s disease. The nurses care for me. Joyce is taking care of our house. Joyce visits at supper time. Joyce loves me very much.</p>	
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Left: Example of a visual aid in a memory wallet to support reality orientation.

24-Hour Reality Orientation

Whereas RO group interventions are delivered during specific scheduled periods, 24-hour RO³⁰ is implemented by care partners at any naturally occurring opportunity throughout the day. This can include talking through care activities (e.g., what they want to wear, general conversation), pointing out things in the immediate surroundings (e.g., spring blossoms on a tree seen

through a window), incorporating references to current reality into conversation (e.g., commenting on the winter weather), labels on important rooms (e.g., washroom), a weather chart, a calendar, a daily menu, and a name tag on room door and place in dining room. 24-hour reality orientation is often implemented by nursing home staff.

The 24-hour RO approach should include use of visual aids such as a prominent 'RO board' (shown on right) in bed rooms / main areas or carried in a person's memory wallet. This approach may help to improve cognitive function in persons with mild to moderate dementia³¹. Use of strategies by a PWD such as referring to a RO board may require training.



Orientation throughout the day should be done in a gentle, respectful, natural manner that preserves dignity and pleasurable interactions. It is quite different than when done in a confrontational way that makes it clear what the person is *forgetting*. Sometimes it means entering the person's reality rather than insisting on establishing factual truth.

PWD: "I don't like January, it's so cold!"

Partner: "It's not January; it's December." (confrontational, corrective)

or

Partner: "Yeah, it is really cold out! Did you see all the snow??" (affirming, respectful)

To see how this approach can be used naturally in conversation, and hear what one woman has to share about learning to avoid corrective responses, watch: "Complaints of a Dutiful Daughter" (<https://www.youtube.com/watch?v=tN8Ku3tdS94>).

How do I Find an S-LP in Nova Scotia?

S-LPs who work with adults provide services through the public health system and in private practice. In the public system, services are provided by the Nova Scotia Hearing and Speech Centres (www.nshsc.nshealth.ca). Private practitioners work in clinics and/or see clients in their homes. They can be found through the Speech and Hearing Association of Nova Scotia (www.shans.ca/our-professionals/). Shoreline Speech Therapy is a private practice. Health insurance

plans often include coverage for private S-LP services. Patients can be referred by their doctor or can self-refer.

Resources

For a list of resources, please visit www.shoreline-speech.com/dementia.

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