



DDSD-Clinical Services Bureau Therapy Updates

MARCH, 2009

VOLUME 1, NUMBER 2

Have you attended the required ISP Person-Centered Planning training?

If not, there is a special one day ISP PCP Training especially for therapists and BSCs.

When: 4/30/2009

Where: Bank of the West Building at 5301 Central, 11th floor conference rm.

Register at:

www.trainnewmexico.com

This course is free and required of all therapists and BSCs per the DD Waiver Standards. If you have attended in the past, you are not required to attend again. You can attend any 1-day PCP class listed on www.trainnewmexico.com

Questions? Contact:
Brienne Conner @
841-5533 or
brienne.conner@
state.nm.us

What's New with Aspiration Policies/Procedures?

DDSD has carefully reviewed all feedback on the draft Aspiration Policies/Procedures and has decided to take a more moderate approach than proposed in the recent drafts. In order to manage aspiration risk effectively without undue burden to the system or intrusion on the individual themselves, our proposed approach will be as follows:

- a. Screen all adults participating in the DD Waiver for aspiration risk as part of their annual health screening and whenever the individual has a significant change in health condition.
- b. Group individuals, based upon screening results into low, moderate and high risk categories.
- c. Individuals at both moderate and high risk will continue to be tracked on the Statewide Aspiration Risk List (SARL).
- d. Those at low risk will continue to be monitored by their IDT for the emergence of signs and symptoms of aspiration; if in the future they become moderate or high risk, they will be added to the SARL at that point.
- e. Individuals at moderate risk will be supported in a fashion very consistent with our current 2004 Aspiration Policy and Procedures.
- f. Individuals at high risk will move into a model more consistent with the proposed drafts recently circulated, saving this intensity of service and intrusion for those most likely to develop aspiration pneumonia.

Criteria for the high risk category will include: use of a feeding tube; hospitalized for aspiration pneumonia within the past 3 years; treated on an outpatient basis for pneumonia in combination with observable signs/symptoms of aspiration within the past 12 months; or chronic lung disease, immunosuppression, severe GERD, or frequent rumination or vomiting, in combination with moderate to severe oral or pharyngeal dysphagia.

The current Aspiration Policy and Procedure does not call for 24 hour positioning plans. However, we intend to include consideration of positioning needs in activities other than mealtime as a requirement for those at both moderate and high risk. This does not mean that a positioning plan must be created that gives instructions for 24 hours of every day, rather it requires the team and positioning specialist to consider what other activities that the individual regularly engages in that may have an element of aspiration risk and might benefit from particular positioning. The need for any positioning programs for other than mealtime will be determined on an individual basis and include additional considerations such as skeletal deformities, oxygen transport problems, and skin integrity.

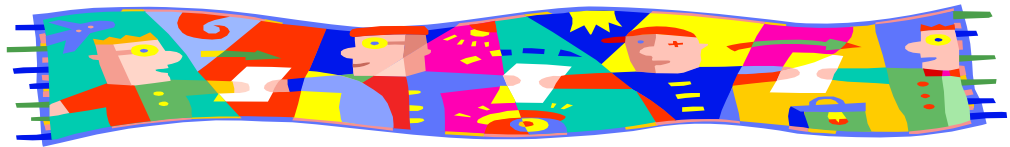
We are now in process of developing a rule, associated protocols, a screening tool, SARL referral form, and other guidance materials. Once the rule and protocols are ready, a public hearing will be conducted consistent with state requirements for promulgation of rules/regulations.

Aspiration Risk Management Training – Hold These Dates!!!

Date	Location	Date	Location
4/24/09	Roswell	5/14/09	Santa Fe
4/30/09	Las Cruces	5/15/09	Albuquerque
5/1/09	Las Cruces	5/21/09	Albuquerque
5/7/09	Farmington	5/22/09	Albuquerque
5/8/09	Gallop	7/10/09	Albuquerque

Aspiration Risk Management Training will be provided by the Clinical Services Bureau beginning in late April. DD Waiver Therapists are required to attend this training on one of the above dates. You will be receiving an official notice soon. Meanwhile, go to www.trainnewmexico.com to check for updated information and to register for these training opportunities. Information should be posted by April 10th or sooner. As usual, FREE CEU's will be offered. Registration will begin at 8:30 AM. The training will begin at 9AM and end at 4PM.

Please contact Jeana at 575-528-5190 or your regional training coordinator for further information.



CLINICAL TAKES: POSITIONING AND ASPIRATION FOR DD WAIVER PHYSICAL THERAPISTS

You may be scratching your head lately trying to decide how to deal with recommendations from the Community Practice Review and/or the Aspiration Clinical Team regarding positioning for individuals who are at risk for aspiration. Let me tell you some of the things I've been hearing and maybe we can have a dialogue about these issues. I would like to see if the Clinical Services Bureau can be of assistance in this area of your PT practice.

First, you need to know that poor positioning has been sighted for some individuals for whom aspiration was identified as a contributing factor in their death. This has increased the state's interest in addressing positioning for all individuals on the DD Waiver.

So what else have I been hearing? Some physical therapists are uncomfortable with the task of identifying positioning recommendations around aspiration. Some PTs have told me that they do not feel positioning to address aspiration is within their scope of practice. To this I would point out that the New Mexico Physical Therapy scope of practice is intentionally broad and in my opinion, the first 2 points in the scope certainly cover developing a positioning program to reduce the risk of aspiration. I've printed those points below:

I. "practice of physical therapy" means:

- (1) examining and evaluating patients with mechanical, physiological and developmental impairments, functional limitations and disabilities or other health-related conditions in order to determine a physical therapy diagnosis, prognosis and planned therapeutic intervention;
- (2) alleviating impairments and functional limitations by designing, implementing and modifying therapeutic interventions that include therapeutic exercise; functional training in self-care and community or work reintegration; manual therapy techniques, including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive and adaptive devices and equipment; bronchopulmonary hygiene; debridement and wound care; physical agents; mechanical and electrotherapeutic

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modalities; and patient-related instruction.

I would also ask that you consider a statement I ran across in an article in last month's journal Physical Therapy by Gwendolen Jull, PhD, FACP who is a professor of Physiotherapy at The University of Queensland, Australia and President of the Australian College of Physiotherapists. In her invited commentary Dr. Jull says, "Continuing education and professional development are hallmarks of professional practice. The concept of the 5-year half-life of knowledge in health care professions is well recognized, as is the fact that tertiary professional (entry-level) education does not fully prepare or equip new professionals for lifelong practice."

So, you may not have studied positioning to address aspiration in your PT education. This is certainly true for me. However, our profession, and the medical world, is changing rapidly and I think that it would most short sighted of us to limit ourselves to what was contained in our entry level program.

Also, I have found at least 5 practice patterns in the Guide to Physical Therapist Practice which speak to physical therapists addressing positioning for functional activities or positioning to improve physiological function. Two of these practice patterns list aspiration pneumonia as a diagnosis addressed by the pattern.

I've also heard that some PTs feel that it is the SLP's job to develop a positioning program. Certainly, all members of an individual's team should work together to develop the best plan possible. However, the SLP's training allows them to give very general recommendations around positioning and eating (for example-everyone should be sitting completely upright). For some individuals this may be adequate. However, for individuals who have fixed deformities or who have additional areas of concern (more about this below) the SLP will not be able to develop the most appropriate plan. If we are talking about an individual who is fed by tube the SLP has no responsibility for aspiration risk management.

What else do we need to talk about? Well, I think PTs may be looking for an assessment tool to assist them in development of a good positioning program. I'm looking for that tool also. If you find one be sure to let me know so the rest of us can stop looking.

Until we come up with the assessment tool I'm suggesting an outline for thinking about positioning in a holistic manner. Beginning in April of 2009 the Clinical Services Bureau and other DDS related staff will be giving a series of workshops around the state to help everyone with aspiration risk management. I trust that I will see you in one of those workshops and we can continue our conversation. In the meantime let me suggest these steps in assessing an individual for a positioning program. I have used a lot of Elizabeth Dean's work as I have thought about positioning and aspiration. I was first introduced to Dr. Dean's work when I attended a workshop here in Albuquerque taught by Mary Massery, PT. several years ago. Dr. Dean has written and edited material on a wide range of topics. Cardiopulmonary Physical Therapy is one of her areas of interest.

Here's an outline of things you might consider:

Is the individual at risk for aspiration and are there recommendations regarding positioning?

- o Identified by PCP or other physician
- o Identified by Video swallow study or other diagnostic procedure
- o Identified by history
- o Other

Do these recommendations appear to you to be appropriate?

- o If the recommendations appear appropriate use them to develop a positioning program for the individual
- o If you do not believe the recommendations are appropriate contact the person who gave the recommendation and attempt to reach an agreement – if you are not able to reach agreement and still believe the recommendation is not appropriate – get with the individual's case manager to complete a Decision Justification Form stating your rationale.

This issue's
"Clinical Takes"
article was
written by:

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CSB PT
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If there are no recommendations?

- Use any video swallow study as an opportunity to gain objective information about how positioning affects swallowing
- Use your ability as a PT to observe the impact of positioning on signs of aspiration. (Be aware that just because an individual does not demonstrate signs of aspiration, that does not mean that the person is not aspirating)
- Use expert opinion to develop a program (more about this below)
- Consider what you know in the following areas as you are developing the positioning program
- Is the individual fed via tube (G or J)
 - When is the individual fed
 - Where is the individual fed
 - Research (with individuals who are vent dependent and have tubes) reports a reduction in aspiration when the individual's trunk is no lower than 30 degrees
 - Having a tube does not mean the individual will not aspirate
- Is this individual at risk for skin breakdown? If so consider what trunk elevation above 30 degrees will do to skin. Also consider how limiting the number of positions the individual may use may impact the person's skin integrity.
- Is this individual at risk for oxygen transport problems? What positions will be most beneficial and which positions will be the least helpful?
- Does the individual have limited range of motion or fixed deformities? Here are some examples:
 - Consider how much hip flexion an individual has when you are recommending upright sitting for reducing the risk of aspiration. If the individual's hip flexion is limited, assess the spinal curves and the position of the individual's head when the individual is sitting.
 - Consider what a fixed kyphosis does to an individual's ability to transport food from the front of the mouth to the back when you recommend the person be fully upright. Also, watch the person assisting the individual with the meal. Does the person assisting lift the person's head to get the food into the mouth? Is this hyperextending the cervical spine and opening the individual's airway?
 - Consider how a scoliosis you can observe from the outside may signal a change in the internal structures. Is straightening the external body causing difficulty with the esophagus?
 - What happens to hip flexion when the recommendation is that an individual never have the trunk lower than 30 degrees?
 - Can an individual with a fixed kyphosis sleep with their trunk elevated 45 degrees? You might want to observe an individual for an hour positioned at any angle you recommend.
 - Look at where the ribs are resting when an individual is sitting or in bed with the trunk elevated. Is the degree of elevation causing the ribs to press on the stomach? Does this pressure have an impact on symptoms of reflux?

I think it is important that we identify individuals whose risk for aspiration requires that we specify positioning throughout the day. Every team serving an individual at risk for aspiration should have this discussion. Some individuals need this level of positioning intervention, some do not. This decision should be made on an individual basis. As I have alluded to above in the things to consider when developing a positioning program there can be some unwelcomed side effects if positioning options are limited.

When you are thinking about positioning throughout the day, may I suggest that you consider some of these issues:

- Does this individual have difficulty handling oral secretions?
- Does this individual have reflux?
- Can this individual change their position without assistance?
- Is this individual NPO? How is oral care managed? Do they try to

A REMINDER:

Please remember to include a list of AT items that you monitor in your Therapy Progress Report! You should also include where the item should be available (IE: home, day site, work?).

Thanks so much!

- drink shower water or water in the swimming pool?
- Does this individual have habitual postural or muscle tone problems that increase the risk of aspiration? For example:
- Cervical hyperextension
- High extensor tone
- Reversed lumbar curve
- Lack of hip flexion
- Kyphosis with forward head
- Does the individual use forward flexion of the head to deal with oral secretions?

Now, I have to say that one of the problems I hear about the most is that positioning recommendations from different members of the team do not match. Working on the DD Waiver is an exercise in teamwork. Please find a way to communicate with the rest of the team about what you are recommending and assure that all recommendations match.

And one final thought, remember that family members and direct care staff may need some extra training about how to tell when an individual is sitting the way you think is safest. Also, being able to tell when someone's trunk is elevated 30 degrees or 45 degrees is not always easy for the average person providing care. I suggest that you mix your formal training on positioning with a healthy dose of monitoring what is really happening.

Here are some resources to find those expert opinions I mentioned above:

1. E Dean. Oxygen transport deficits in systemic disease and implications for physical therapy, *Physical Therapy* 1997,77: 187-202
2. Smith Hammond CA, Goldstein LB. Cough and aspiration of food and liquids due to oral-pharyngeal dysphagia: ACCP evidence-based clinical practice guidelines. *Chest* 2006 Jan;129(1 Suppl):154S-68S.

I would like to hear from you about your experiences with positioning and aspiration. I am available to consult with you on specific individuals if you think that would be helpful. Feel free to call me at 505-841-5224 or e-mail me fran.dorman@state.nm.us I look forward to continuing this conversation.

ORAL HYGIENE AND ASPIRATION

Saliva can be aspirated just like food and liquids. We all have a certain amount of bacteria in our mouths. Poor oral hygiene can lead to a high bacterial load. If there is excess bacteria in the mouth, saliva aspirated is MUCH more likely to progress to pneumonia. Oral hygiene is also essential for edentulous people and those who are tube-fed. Research has shown that proper oral hygiene reduces illness and death from aspiration in vulnerable populations.

Therapists should take an active role in tooth-brushing issues. Things to consider:

- Is the individual orally sensitive? Does this make oral hygiene difficult for the individual and staff? Would an electric toothbrush or a different toothbrush help? Would a desensitization program help? Is a bite block needed?
- Is the person positioned properly during oral care? Can the person spit out excess saliva? Is too much toothpaste being used? Toothpaste is not essential for good plaque removal. Is suction or a toothette needed to help clean out excess saliva?
- Does the person pocket food? Would visual checks be helpful to make sure food is cleared from oral sulcus areas? Would alternating recommended food and liquids help?

These are just some of the issues to consider in helping individuals and staff with a good oral hygiene program. Individuals should visit their Dentist on a regular basis. Therapists should make an effort to find out if the Dentist had any special recommendations and partner with the Dentist and Nursing to develop good oral hygiene plans. Effective oral hygiene is an essential element of good health and aspiration risk prevention.