

## Aspiration Risk Management FAQs

**Age:** Does this manual apply to persons under age 21?

*No. These individuals will be provided services through their Medicaid card under EPSDT services.*

**Age:** ASP Policy states that this applies to adults 21 years and older. What about 18 years old who receive community living services? Don't they need to be on the SARL? *Individuals eighteen to twenty-one continue to be eligible for medically necessary therapy supports until their 21<sup>st</sup> birthday. As of 8-28-09 only one individual in this age group were both on the SARL and served in Supported Living. The few others in this age group were all in Family Living model. Eighteen year olds living in the community are not required to be on the SARL, but the team should access needed therapy supports through the Medicaid state plan EPSDT program to address implementation of a Mealtime Plan and other Aspiration risk management measures following accordance with their Doctor's orders.*

**ARM subcommittee:** Who are the clinical members of the team?

*Nurses, therapists (OT, PT, SLP and BSC's) and dieticians may all be clinical members of the team. In addition, other clinical staff may participate such as dentists, specialists or the PCP.*

**ARM subcommittee:** Who can sit on the ARM subcommittee? How many people are required?

*The IDT will determine who is on the ARM subcommittee. It is anticipated that the clinical members of the team will be on the subcommittee since aspiration risk management plans will be in their area of expertise. There is no minimum or maximum number. It is expected that the IDT members will step up and contribute their expertise for the benefit of the individual. The individual, guardians, family members, support personnel, case managers, and other members of the team are welcome to be members of the ARM subcommittee.*

**ARM subcommittee:** Where will the ARM subcommittee information be maintained?

*With the ARM subcommittee chairperson and in the Comprehensive Aspirations Risk Management Plan (CARMP).*

**ARM subcommittee:** Please provide information on practical implications for organizing meetings. It is difficult to get people together for meetings now.

*The team will determine how they meet. This may include but is not limited to traditional face to face meetings; conference calls; email or videoconferencing if available.*

**ARM subcommittee chair:** What if no one assumes the ARM chair responsibilities?

*It is the expectation of the team that they will provide appropriate, professional supports to the individuals they serve. The ARM subcommittee chair is essentially an*

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*organizational and facilitative function. It is anticipated to require more time at the beginning of the committee but that demands will decline over time.*

**ARM subcommittee:** How frequently does the ARM subcommittee meet?  
*The ARM subcommittee will meet at 6 months, annually and as needed after hospitalization or acute condition change.*

**Assessments:** Will the SLP/Eating Specialist have any input into the decision of obtaining a Modified Barium Swallow or is this a decision of the Doctor and nurse?  
*The SLP/Eating Specialist will have input into these decisions as they do now.*

**Assessments:** Who does the assessments? Nurse; Doctor; SLP/Eating Specialist or who?  
*The physician or PCP may order a variety of tests but most typically orders a Video fluoroscopy; a barium swallow with or without an upper GI and they may order other tests such as chest x-rays or lab work. The SLP or Eating Specialist may complete a bedside swallow assessment, oral hygiene assessment and saliva management assessment, or request tests such as a VSA or barium swallow. The PT will complete positioning assessments, at a minimum. The OT will assess oral hygiene practices with other members of the IDT and adaptive equipment needs and sensory issues. The BSC will complete an assessment of challenging/risky behaviors that may impact aspiration risk. The nurse will complete the New Mexico DDS aspiration screening tool. They may complete other risk screens such as fall risk or pressure ulcer risk assessments as appropriate. The nurse and therapists will complete any needed routine nursing/therapy assessments.*

**Aspiration Health care plan:** Who writes this plan if there is no nurse?  
*See NURSE*

**Aspiration checklist:** Must the aspiration checklists be used?  
*The moderate and high aspiration checklists are no longer in use as the Standards have been revised and the lists are no longer necessary.*

**Budget:** Nursing hours is bundled at 3 hours per person per month. This new model seems to overburden the busy system.  
*DDS has begun to discuss methods by which hours may be increased for specific disciplines. However, nurses are already completing the Health Assessment tool (HAT) and have been responsible for health care planning related to aspiration for many years. The HAT is the overall annual health assessment. The aspiration screening tool should be seen as a component of the HAT and is designed to be completed with the HAT annually and for change of condition. The difference in aspiration screening is that it should also be completed for reported Signs and symptoms of aspiration that may indicate a needed change in treatment or care planning.*

**Budget/hours:** Will therapists get added hours for this work? Many therapy caseloads are very full. It seems like the added tasks will take up therapy time.

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*At this time, case managers may approve up to 58 hours for therapy services. If 58-72 hours are needed, the therapist completes a clinical exception request. The newest Clinical Exception Request Form includes an abbreviated process if the therapist is actively contributing to ARM strategies for the individual. These requests are processed as quickly as possible. The therapy exception request was edited to expedite aspiration needs several months ago. There have been circumstances that require more than 72 hours of therapy service. In these circumstances, the therapist may submit a request for additional hours that requires review and authorizing signature of a DDS Deputy Director. An upcoming revision of the DDW standards will include any changes to the budgeting process.*

**Case management:** Will hours be increased for case managers if they are the ARM chair?

*DDS has begun to discuss methods by which hours may be increased for specific disciplines.*

**Case management quarterly monitoring:** If a Doctor orders NPO and the SLP/Eating Specialist withdraws their mealtime plan, how does this change the case manager's quarterly monitoring?

*From July 1, 2009 to July 1 of 2010, the case managers will be transitioning their monitoring from the quarterly process identified in the 2004 policy to that of the 2009 ARM Manual. This is based on IDT dates that fall after August 1, 2009. However, if an SLP/Eating Specialist withdraws their MTP plan, the nurse would work with the Doctor to identify what the diet texture would be, knowing that the person or guardian has refused to consider a feeding tube. Many physicians will revert back to the previous diet texture order. An RD can also be a helpful member on this team.*

**Case Management:** How can CMs be responsible to ensure that all staff is trained? The rosters are not at the houses/sites. CMs should not have to go the agency office to review them.

*Clearly, CM'S cannot have primary responsibility to ensure that staff is trained, but they should ask staff on site, and document this clearly in their site visit form/notes. Case Managers can and should ask the staff working at site if they have been trained- ask questions from the CARMP/MTP (on site) Additionally, CMs monitor that the CARMP(MTP) is present at the Day and Residential sites quarterly. If the CM notices that staff are obviously not implementing the plan appropriately, they should address this with the staff and alert the service coordinator or nurse, if necessary, and the plan author, that added training is needed.*

Even if the rosters are received from the agency and therapists- how can the CM verify that all staff is on the rosters? This is only at that moment in time, and new staff come and go constantly. *CMs can call the agency nurse or service coordinator and ask whether all staff have been trained, and document this in their notes. Training rosters that document training completed throughout the year will be provided to the residential and day activity service coordinators.*

**Diagnosis:** Who makes the diagnoses of dysphagia?

*The SLP/Eating Specialist or physician/PCP makes this diagnosis. Dysphagia and esophageal dysmotility should be included on the list of medical diagnoses or problems in the individual's record.*

**Distribution:** Case Mgrs would like clarification of who is responsible to distribute what documents.

*Therapists are responsible to distribute their therapy plans and reports including any additional assessments completed as a result of the identification of moderate or high risk of aspiration. For high risk, the ARM Sub-committee Chairperson is responsible to distribute the CARMP to the case manager, residential and day activity service coordinators, the guardian, and all sub-committee members. The agency nurse is responsible for conveying information regarding the contents of the CARMP to the PCP. The case manager will distribute it to any additional entities. For moderate risk, the MTP is reviewed for consistency among the different parts by the case manager- who notified the authors if there are potential discrepancies conflicting instructions to address, then it is distributed to the entire team by the case manager. The case manager is asked to look for discrepancies. They are not asked to make a "clinical" judgment to correct these conflicts – just to be sure that the authors coordinate their plans and that the final plans are consistent. Inconsistent plans should not be distributed. Case managers may call the CSB Regional office for assist or submit a RORI in extreme circumstances.*

**Doctors:** How can you get Doctors to attend meetings regarding deferred status?

*Deferred status will often be used for those individuals who are not willing to have a feeding tube inserted despite high aspiration risk. These are pivotal conversations and many physicians are willing to attend these critical discussions since they often lead to end of life planning. Meetings should be scheduled at times and places that will support the physician attending either in person or by phone. In other cases, the individual/family/guardian may need to make an appointment at the doctor's office in order to discuss the issue with their doctor. Many times families, guardians, case managers and nurses will be pivotal in working with the Doctor to attend.*

**Doctors:** It seems like there are lots of calls and meetings. What do we tell the Doctor when they ask about billing for consultation?

*PCP's will be contacted for orders or revisions after a screening tool is completed. This is like any other call to the Doctor's office to provide updated information on a client and is usually not billed. The only meeting where the Doctor would be asked to attend would be in the case of deferred status and the person is not going to follow the physician's orders for following a mealtime plan or agreeing to have a feeding tube. These are significant issues and most physicians would try very hard to be at these meetings where their medical recommendation and orders are not going to be followed. Doctors routinely bill for meetings with patients and families and their offices know how to accomplish this. .*

**Eating Specialist:** Who determines who the eating specialist or positioning specialists are on the team?

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*Clinical members of the team will take on roles that are within their scope and area of expertise. PT's and some OT's are positioning specialists. SLP's and some OT's are eating specialists. This should be discussed in the context of the IDT.*

**GERD:** Who determines that the person has “poorly controlled GERD”?

*Poorly controlled GERD means that, despite receiving medication, the person still exhibits signs and symptoms of reflux. Input regarding this may be gathered from the staff. Clinicians on the team will observe possible symptoms and then discuss this with the nurse.*

**Independent living:** Does this apply to those in independent living?

*Yes- this applies to all adults on the DD Waiver.*

**Initial IDT – Identified High Risk:** What if the evaluations and PCP recommendations are not completed within 2 weeks following the initial identification of at risk? Does the team meet anyway – or wait for the results?

*If the evaluations are within a few days of 2 weeks, the IDT can be scheduled then. If longer, the IDT should meet and review the current status and safety, and re-meet when the evaluations have been completed. The nurse will have developed an interim plan which can be edited if needed and extended if needed until all the assessments are completed and orders are received.*

**IST:** Who is responsible for individual specific training?

*The authors of the plan will be responsible for delivery of individual specific training. Providers are responsible to facilitate the participate of direct support personnel in that training.*

**ISP:** Will those on the SARL need health visions and outcomes in the ISP?

*This will be determined on an individual basis but these issues will likely need to be addressed in the ISP. Aspiration risk impacts all areas of life and the decision to eat or not eat is also enormous.*

**Jackson:** Should we complete the screens for all JCM's first in order to get ready for the Audit cycle?

*NO- the nurses should complete the screens for all individuals according to the schedule of the persons annual IDT. This process takes effect for IDT meetings that are scheduled after August 1, 2009.*

**Meetings:** If PT (or any team member) is unable to attend a meeting in person can they attend by phone?

*Yes - the IDT determines how the team will meet and interact. Due to therapy shortages, some therapists are only able to attend meetings by phone.*

**Mi Via:** Does this apply to persons on the Mi Via waiver? **No**

**Monitoring:** How often does the team meet and review the monitoring plan?

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*For individuals at high risk, with a CARMP, the team meets annually, 6 months after the annual and as needed after hospitalization or acute condition change to review the monitoring plan.*

**Monitoring:** Who monitors the elements of the Comprehensive Aspiration Risk Management Plan (CARMP) for consistency?

*Since the CARMP is only for those at High Risk, the ARM subcommittee chairperson will do this review and work with the authors to assure the various sections of the documents are not in conflict.*

**Monitoring:** Who makes sure the staff person continues to apply the strategies when the “trainer” is not present.

*Provider agencies are responsible for assuring that the direct support personnel are continuing to apply the strategies. House Supervisors are critical to this effort.*

**Nurse:** What if there is no nurse on the team since the person only receives limited services?

*The agency nurse is responsible for completing the aspiration risk management screening tool. The hierarchy that is in the 2007 DDW standards will be followed. If no services are provided that require a nurse, the case manager will complete this tool as a default. The case manager may contact the regional office nurse or CSB for questions in completing the tool. However, if a person has high acuity needs, the team may determine that different services are needed on the budget.*

**Nutrition:** What is the role of the nutritionist in the MTP?

*The nutritionist or dietician will give input about the individual’s nutritional needs for oral food or tube feedings. This is based on a clinical assessment of the person’s nutritional needs including a review of weight, laboratory values, likes/dislikes; metabolic needs or potential food/drug interactions. Dieticians/nutritionists will create diets based on individualized nutritional needs and can advise on the needed texture modifications of meals and fluids.*

**Oral Care Plans:** How is the best way to document tooth brushing and assistance with oral care?

*Agencies have their own methods for documenting providing or assisting with personal care. Sign off sheets similar to the MAR (such as a treatment or ADL sheets) might be considered.*

**Oral Care:** Do oral care plans need to be signed off by the dentist?

*No. Oral plans may be basic or complex based on the individual’s needs. These plans will include any orders or guidance from the Doctor, Dentist or Hygienist that have been provided. Oral care plans may refer to oral hygiene strategies such as OT Sensory Support Plans or Positioning Support Plans. PT plans for positioning during oral hygiene and SLP plans to minimize the effects of dysphagia during oral hygiene.*

**Oral Care:** If the person is NPO and cannot spit out toothpaste, should it be discontinued?

*The use of toothpaste is not proven to remove oral bacteria. Toothpaste does freshen the breath. The action of the brush on the teeth and gums removes bacteria and plaque. Options might include: using low-foam toothpaste, using a dry brush, using a brush rinsed in water or mouthwash and shaking any excess fluid off, etc. Options should be individualized. The nurse may contact the dentist for input as needed.*

**Oral Care Plan training:** Can we have some ideas for developing and training oral hygiene plans?

*First determine the level of support the individual needs with oral hygiene. They will vary from being independent (likely no plan needed – state on the CARMP that the individual is independent for tooth brushing), needing reminders/cueing, having learning needs or needing maximum assist/being totally dependent for all oral care. The plan will be based on the person's needs and the quality of their oral care. For those who need total assistance, the nurse and direct support staff can glean advice from the dentist. Those dentists who are experienced in DD dentistry will be more likely to provide teams with guidance on providing oral care at home. Oral care can be provided in a variety of places – not just the bathroom. The key to oral care is consistency. In addition, collaboration and input from other team members such as behavior support consultants or occupational therapists is very helpful in dealing with behavioral or sensory issues. Nursing may develop a basic plan that addresses oral care and refers to more in-depth and specific plans developed by the therapists and/or the BSC. Many long term direct support staff knows exactly how to best assist or provide oral care; incorporating their ideas into the care plan allows newer staff to benefit from their experience and creates the consistent delivery of supports. Authors of the plan are responsible for the individual specific training. Contact CSB for information about generic materials related to delivery of oral care supports*

**Planning:** Does the comprehensive aspiration risk management plan (CARMP) replace the MTP; HCP and crisis plan?

*No. The CARMP is comprised of these various plans which are all related to the management of aspiration risk. This comprehensive plan reflects the interdisciplinary and collaborative process for creating an individualized plan.*

**Plan Reviews:** Who monitors the components of the CARMP for consistency? As a case manager, we don't have the clinical skills to do this.

*The case manager will monitor the elements for those at moderate risk; the ARM chair will monitor for those at high risk. The case manager is **not making** clinical decisions. They are merely looking for inconsistencies and letting those authors know that **THEY** need to assure that the strategies in the plans are not in conflict. The plan authors are responsible for assuring that their plans are not in conflict. CSB stands ready to assist with consultation for IDT members as needed.*

**Planning/Documentation:** The requirements for documentation seem burdensome and may take away the focus on quality care and meaningful day.

*When the person is seen in a Wholistic manner, physical needs, including health and the ability to breathe is a basic need that that must be met. If you have difficulty breathing or are ill, it is difficult to fully participate in your life activities. There will be some increase in meetings and documentation for those at high risk; however the implementation of consistent preventive measures and more vigilant staff will enhance quality care and allow for a more meaningful life.*

**Planning:** If the case manager reviews the meal time plan for consistency but they don't match and one of the therapists refuses to change their plan would the next step be a RORI?

*Hopefully a simple conference call between the authors of the plans would resolve the issue. A Regional Office Request for Intervention may be filed and support for resolution will be provided by the regional office. In addition, the therapy consultants working with the clinical services bureau would be available to advise the team therapists and Individual Advocacy is available for team conflict resolution. If there are clinical reasons for neither therapist wanting to change their plan and additional information would be helpful, a referral to the SAFE clinic may be an option.*

**Plans:** Is it possible to download the aspiration risk management tool?

*The original sample aspiration risk management plan was distributed statewide and posted on the DDS website in August of 2008. This plan may be used as a sample for content or can be used and edited as needed by provider agencies. More updated versions of this and other plans will be posted. The DDS Aspiration Risk Screening Tool is also available on the DDS website.*

**Positioning:** Should we see positioning protocol for mealtimes, bathing, relaxing, etc when there are positioning difficulties? Is a checklist okay?

*The intent of this process is that the team or ARM subcommittee will develop an individualized plan that is based on clinical assessments. A checklist might serve this purpose but will need to be individualized in order to meet the person's specific needs.*

**Pilot:** Why is the State piloting this project?

*DDS will run this pilot through December, 2009 in order to gather information from all providers before finalizing language for regulation. It is best to test this program before it becomes regulation.*

**SARL:** If aspiration is diagnosed by the Doctor, do we need to monitor or put the client on the SARL?

*Yes. The screening tool will be used to determine the level of risk and the protocols to be used.*

**SARL:** What if someone develops aspiration pneumonia while in the hospital for another reason? Do they need to go on the SARL?

*The nurse will complete the screen and, based on the results of the screen the person may need to be referred to the SARL. A recent episode of aspiration pneumonia is a high risk factor and that person would be placed on the SARL.*

**SARL:** Is there a form for deferred status?

*Yes the SARL referral form has a section for the deferred status and the required documentation that needs to be provided.*

**SARL:** If someone is already on the SARL how will they be sorted for moderate or high risk?

*Screens will be completed for ISP meetings held after August 1, 2009. Individual's level of risk will be determined at that time.*

**SARL:** Will the SARL change to reflect level of risk?

*Yes. This was addressed in all trainings. The next year will be a gradual conversion from the current SARL with new SARL elements.*

**SARL:** What is the procedure for taking off someone who is under 21? What documentation is needed?

*Case Managers should complete the current quarter's aspiration quarterlies and attach a note with them when submitting them to CSB/their RO, noting this person is under 18 and should be removed from the list. If someone is turning 21 between August 1, 2009 and July 1, 2010, we would advise completing the screening tool and if at moderate or high risk just leave them on the SARL rather than taking them off the SARL just to put them back on in 6 months.*

**Screening:** Who is responsible for the screening tool? Will a hierarchy be developed for that role?

*The nurse is responsible for completing the screening tool. The hierarchy that is in the 2007 DDW standards will be followed. This means that, for individuals who do not receive service types that include nursing, the case manager will complete this tool as a default.*

**Screening tool:** Do we use the old or the new aspiration screening tool?

*The new screening tool ("DDSD Aspiration Risk Screening Tool") will be used to screen all adult DDW participants whose IDT is scheduled after August 1, 2009. It may be downloaded from the DDSD website. There was a prior tool that has been an optional assessment for aspiration risk. Providers are advised that this old tool is no longer to be used.*

**Therapy:** What if there is no PT/OT or BSC on the team? Is that ok?

*The IDT should consider which assessments are needed and who is qualified to complete those assessments for the individual to address aspiration risk management adequately. Case Managers may need to adjust the budget and FOC may need to be signed to add needed team members. If no therapists are available in the area, the person may be seen in SAFE or the team may contact Clinical Services Bureau or the Office of Behavioral Supports for consultations.*

**Therapy Hours:** How will some therapists have enough hours to complete this protocol, when they are already in exception hours?

*The team should discuss this, and strategize. If there are additional hours needed, and the therapist is in exception hours already- they should contact the CSB, as their may be additional funding that can be sought, in certain circumstances. Therapists are asked to contact CSB if they have exceeded 72 hours and need additional time. In these cases review of justification and authorizing signature by a DDS Deputy Director is required.*

**Training:** Who can be a designated trainer for the MTP? We were told only SLP/Eating Specialist can do this.

*The SLP/Eating Specialist must conduct an initial training of the MTP. Following that training, the clinician can designate a trainer that is competent in delivering the services and teaching the services. The author of the plan may designate all, none or part of the plan to be trained by someone who is competent in delivering and teaching that portion of the plan. Designation is entirely at the discretion of the plan's author.*

**Training:** Can a designated trainer be used for initial Direct Support Staff trainings?  
*No. The initial training must be done by the author of the plan.*

**Training:** Who is going to train case managers on writing HCP and do aspiration reviews when there is no nurse?

*The case manager will be writing the Health Care Action Plan in the ISP, but not the Healthcare Plan. If someone needs a health care plan developed due to aspiration risk, it is strongly recommended that the case manager arrange to have Private Duty nursing added to the budget to develop these plans if the individual is not in either Community living or Community Inclusion services.*

**Therapy:** If the OT can do positioning and the person has a PT, what is the need for the PT?

*Occupational therapists may provide positioning services that they feel fall within their training, skill set, and scope of practice. Not all OT's have the necessary skills to meet complex positioning needs. Physical Therapists have the skills and training to address positioning issues related to multiple health issues.*

**Therapy:** How do teams address issues and tasks if no therapist or nurse is available?

*Agencies are required to have nurses on staff or on contract. Some areas of the state are enduring a severe shortage of therapists. If there are no therapists in the area to support the person or the team, the team may contact the SAFE clinic for evaluation and support or the Clinical Services Bureau. Technical assistance can be provided by experienced clinical therapists.*

**Timelines:** There are timelines for document submission that are not followed now. Will these timelines be enforced?

*Yes. If team members are not submitting documents in a timely manner a RORI may be submitted and the Regional Office may intervene as the Regional Director deems appropriate*

**Time Frames:** What is the suggested time frame for case managers to review all the plans for consistent information?

*At the moderate risk level, authors of the MTP must submit their written elements within 10-days of the IDT meeting to address aspiration risk. The case managers shall review the elements of the MTP for consistency and assure that the inconsistencies are corrected within 15-days of the IDT meeting to address aspiration risk. The MTP will be distributed within 15-days of the IDT meeting to address aspiration risk. The case managers just have to review the components of the MTP for consistency – not compare it to all other plans – so we are talking MTP singular not plural. Authors are responsible to make sure any other plans they write are consistent with the MTP – however, if a CM notices a discrepancy say between MTP and HCP they should of course point that out to the author*

**Training:** Is a client specific video training sufficient for initial and or annual training? *Client specific video training may be used for refresher training. It may not be used for initial training.*

**Training Verification:** some therapists only see their client every other week- or less- how will therapists verify training? *This should be discussed in the IDT meeting, and a plan to address this should be agreed upon and documented. They shouldn't need to go weekly to verify training...they should just check for correct implementation periodically following the training.*