Department of Health Developmental Disabilities Supports Division Procedure	Procedure Number:
	Supersedes: Supporting People on the DD Waiver with Dysphagia/Risk for Aspiration Procedure (effective 11-1-04)
Procedure Title: Aspiration Risk Management Procedure	
Effective Date: Proposed August 16, 2010	
Approved: *Signature on file*	**Date:** 8-3-10

I. POLICY REFERENCE

Aspiration Risk Management Policy

II. PURPOSE OF PROCEDURE

This procedure clarifies the roles of interdisciplinary team members who support adults, age twenty-one and older, on the DD Waiver to identify and manage aspiration risk. These procedures supplement the current DD Waiver Standards.

III. APPLICABILITY

This procedure applies to all interdisciplinary team members who support adults on the DD Waiver.

IV. DEFINITIONS

Adults: Means individuals who are at least 21 years old and are no longer eligible for Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits through the Medicaid state plan.

Aspiration Coordinator: Means the Developmental Disabilities Supports Division staff person responsible for coordinating technical assistance and monitoring for adults on the DD Waiver identified as being at moderate or high risk for aspiration.

Aspiration: Means the act of food, saliva, liquids, phlegm or any other solid matter getting below the true vocal cords into the trachea. Aspiration is directly linked to dysphagia, but may also occur as a result of gastroesophageal reflux or other conditions.

Assessment: Process of gathering clinical information within a defined scope of practice resulting in recommendations for intervention, if warranted. In some cases assessment results may clarify that the individual does not need further intervention, even if screening results identified potential risk.

Competency Based Individual Specific Training: Means individual specific training with defined standards of performance, curriculum tailored to teach skills and knowledge necessary to meet those standards of performance, and formal examination or demonstration to verify standards of performance, using the established DDSD training levels of awareness, knowledge and skill. Training for awareness & knowledge may be provided in large groups. Knowledge shall be demonstrated via a written or verbal test of key content. Training for skill must be provided in small groups of DSP/IDT members or on a 1:1 basis using return demonstration with the individual or by practicing on each other. DSP may not implement each CARMP activity independently until they demonstrate a skill level of competence. DSP at the knowledge level of competence may provide supports only if they are working side by side with another DSP who has tested at the skill level.

- Reaching an **awareness** level may be accomplished by reading plans or other information. Verbal or written recall of basic information or knowing where to access the information can verify awareness.
- Reaching a **knowledge** level may take the form of observing a plan in action, reading a plan more thoroughly or having a plan described in detail by an experienced staff or therapist or nurse. Verbal or written recall may verify this level of competence.
- Reaching a **skill** level involves being trained by a therapist, nurse or experienced designated staff. The trainer should demonstrate the techniques according to the plan then observe and provide feedback to the trainee as they implement the techniques. This should be repeated until competence is demonstrated. Demonstration of skill or observed implementation of the techniques or strategies verifies skill level competence. Trainees should be observed on more than one occasion to ensure appropriate techniques are maintained and to provide additional coaching/feedback.

Comprehensive Aspiration Risk Management Plan (CARMP): Means a set of instructions regarding how an individual at risk for aspiration is to be supported as safely as possible during all daily routines including tube feeding and/or eating, bathing/hygiene, rest/leisure, and community outings. The plan will include clear instructions regarding adaptive equipment, proper positioning, tube feeding and/or assisted eating techniques and nutritional content, oral hygiene, medication delivery, relevant behavioral supports, and monitoring for signs and symptoms of aspiration related illness. Several different disciplines may be responsible for developing each element of the CARMP.

Continuum of Care (COC) Regional Medical Champions: Means the group of medical professionals who provide local support to interdisciplinary teams and health professionals serving individuals with developmental disabilities across New Mexico.

Decision Consultation Form: A form to guide and document team discussion in a manner that supports informed decision making and communicates the final decision to all team members.

Direct Support Personnel (DSP): Means the direct support staff members employed or subcontracted by an agency provider.

Dysphagia: Means difficulty swallowing and may involve one or more of the oral, pharyngeal or esophageal phases of swallowing. Dysphagia is a disorder that may contribute to aspiration risk.

Eating Specialist: Means an IDT member or professional who is knowledgeable and clinically competent in the area of evaluation and treatment of swallowing and feeding disorders and is able to take a leading role in supporting all team members through these processes with educational information, training, individualized written plans and referral sources. Historically, the speech, language pathologist has most often held this role in DD Waiver Services. The assessment and management of individuals with swallowing and feeding disorders is within the role of and scope of practice for certified speech-language-pathologists and occupational therapists, as identified by the American Speech-Language-Hearing Association (ASHA) and the American Occupational Therapy Association (AOTA), respectively. Certain nurses may also have developed particular expertise in this clinical area.

Evaluation: the documentation of an assessment process inclusive of recommendations. This document may also have other titles such as Assessment Report, Summary of Assessment Results, Annual Re-assessment or Annual Re-evaluation.

Gastroesophageal Reflux (GERD): Means the disease that is present with stomach/gastric contents back-up into the esophagus and pharynx or mouth. This action is not able to be controlled by the individual. Medical intervention is required. This is a risk factor for esophageal disease and for aspiration.

Health Decisions Resources (HDR): Means a group of volunteers from various professions who have experience in the field of developmental disabilities. HDR volunteers offer information and guidance about healthcare decision-making for individuals who have developmental disabilities.

Individual Advocacy and Assistance (IAA) Unit: Means a group of trained mediators with the Developmental Disabilities Supports Division who are committed to supporting and helping other individuals, teams and guardians resolve issues through consensus. The IAA specifically offers mediation, training, advocacy and technical assistance for those individuals who request help with dispute resolution.

Individual Service Plan (ISP): Means the individualized document or written plan developed by members of the IDT on an annual basis that identifies the individual's visions, desired outcomes and action plans with associated services.

Interdisciplinary Team Members (IDT): Means the team responsible for development of the individual service plan (ISP) and for identifying the agencies and individuals responsible for providing the services and supports identified in the ISP. The IDT shall consist of the following core members: the individual, case manager, guardian (if appointed by the court); "helper" chosen by the individual or their guardian if desired; key community service provider staff from residential and day services, including at least direct support personnel and the service coordinator; ancillary service providers such as nutritional services, physical therapy, occupational therapy, speech therapy, behavioral support consultation, substitute care, private duty nursing and other medical personnel (including agency nurse); others such as family members, advocates, and/or representatives of generic services.

Medical Emergency Response Plan (MERP): Formerly knows as medical Crisis Prevention/Intervention Plans (CPIP). These documents give instructions to direct support personnel regarding what signs to watch for that would indicate that a known medical condition is exacerbating into a life threatening situation and what to do when those triggers are observed.

NPO: Means "nothing by mouth", neither food nor fluids.

Positioning Specialist: Means either a licensed physical therapist or a licensed occupational therapist with specific knowledge in positioning for people with significant physical disabilities.

Primary Care Practitioner (PCP): Means the individual's primary medical care provider, usually a medical doctor, physician's assistant or certified nurse practitioner.

Reassessment: Process of gathering clinical information within a defined scope of practice, to determine the effectiveness of current strategies, identify clinically relevant changes in the individual's status and resulting in recommendations for revision of intervention, if warranted.

Risky Eating Behavior: behavior that causes the risk for aspiration or other medical complications to increase including but not limited to pulling on a feeding tube, rapid eating pace, taking too large of bites, not chewing thoroughly, PICA, not cooperating with positioning instructions or other recommended eating techniques.

Screening: Procedure applied to a group of individuals to identify those who need further assessment and possible intervention.

Significant Change of Condition: Means the individual has experienced one or more of the following: a decline in physical, cognitive or functional ability; a new diagnosis or event that requires a change in medication or treatment or requires creation or revision to a healthcare plan or MERP.

Significant Event: Means an event such as vomiting, rumination or choking that result in symptoms of respiratory congestion or infection; decline in responsiveness or function and requires intervention by the PCP or urgent care. This includes the use of antibiotics or respiratory treatments to treat a lower respiratory infection know or suspected to be related to an aspiration event. Such events shall be reported to DDSD per DDSD requirements.

Supports and Assessment for Feeding and Eating (SAFE) Clinic: Means a group of clinical professionals who have established a clinic that evaluates and recommends assistance for individuals with developmental disabilities, their families and care providers in improving safety for eating, health and nutrition. The clinic also provides the following:

- technical assistance
- support and continuing education for professionals involved in supporting eating for individuals with developmental disabilities throughout the life span
- pre-service education for graduate and undergraduate students in feeding/eating approaches for children and adults with developmental disabilities
- assistance and care to families and care providers in locating appropriate community resources for direct treatment, adaptive equipment and follow-up services

Tube feeding (gastrostomy, jejunostomy, or nasogastric): Means an alternative method of providing nutrition, hydration or medication through a tube that enters the body through the wall of the stomach, wall of the intestine or nose. A feeding tube may be the only method of intake or it may be combined with oral intake. Tube feeding may also be referenced as enteral feeding.

Video Fluoroscopic Swallowing Assessment (also known as VFSS, VSA or VSS): Means an assessment by video fluoroscopy in a medical radiology facility. The video fluoroscopy evaluates the person's swallowing mechanism by having the person swallow liquids, solids and/or medications mixed with barium. This allows for the dynamic evaluation of the oral, pharyngeal and upper esophageal mechanisms and identifies aspiration if it occurs. If abnormal swallowing is identified, the clinician determines the physiological area of abnormality and whether management strategies will help to minimize aspiration. This evaluation is most useful when performed collaboratively by a radiologist and an eating specialist.

V. PROCEDURE

	Responsible Party	Actions
A	Provider Agency Nurse	1. Identify individuals with a developmental disability as potentially at risk for aspiration through completion of the DDSD aspiration risk screening tool administered by the agency nurse. This screening tool shall be administered: a. To all adults served through the DD Waiver according to the implementation schedule for this procedure; b. annually at least two weeks prior to the annual ISP meeting, or upon significant change of condition, for all adults who were determined to be at low risk during their prior screening or assessment; 2. Notify case manager and therapists on the IDT of screening results within 48 hours. 3. If the screening results indicate potential for moderate or high risk the agency nurse shall contact the PCP within 2 business days of completing the screening to discuss the need for appropriate testing to verify the accuracy, etiology and severity of the potential risk. The nurse shall then collaborate with therapists to arrange for video fluoroscopy and/or other ordered diagnostic tests, if indicated. 4. If the individual is newly identified at moderate or high risk for aspiration, the nurse in collaboration with the Eating Specialist (when available) will develop an interim aspiration risk plan and train the DSP to implement within 72 hours. 5. Collaborate with IDT therapists to complete an initial aspiration assessment within 30 days following the date that the initial screening identified moderate or high risk. As part of this assessment, the actual level of risk will be verified. The assessment results shall be documented and include recommendations regarding any interventions warranted. 6. Annual reassessments will be conducted for all individuals at moderate or high risk for aspiration at which time a determination shall be made as to 1) whether the individual's risk level has changed, 2) whether risk management strategies implemented during the past year have been effective, and 3) whether intervention strategies need to be revised. The annual reassessment will be documented and distributed to IDT

		members two weeks prior to the annual ISP meeting. 7. If the individual has a significant change of condition, or hospitalization for pneumonia the nurse shall collaborate with IDT therapists to review most recent assessment and CARMP; revising as needed. 8. Develop a Medical Emergency Response Plan (MERP) for individualized aspiration risk factors for those at moderate or high risk. 9. Participate in the initial ARM IDT Meeting and collaborate with IDT to develop CARMP, with particular responsibility for sections related to medication delivery, weight monitoring, tube feeding, oral hygiene, monitoring pulmonary status and signs/symptoms of aspiration that require same day contact with the agency nurse, consistent with physician and dentist orders. In situations where the Community Living and Community Inclusion are different provider agencies, the Community Living Nurse shall collaborate with the Community Inclusion nurse during CARMP development and determine how training will be handled in each setting. 10. If the case manager identifies discrepancies between sections of the CARMP, confer with relevant disciplines to resolve such discrepancies and revise the CARMP within 5 business days. 11. Deliver competency based training for DSP and other relevant IDT members regarding sections of the CARMP authored by the nurse as well as regarding implementation of the MERP within 30 days of the completion of the CARMP, with a refresher annually. Maintain original copies of training rosters and provide copies of training rosters to the agencies that employ the DSP for their files. Nurses may designate a specific individual on the team who is competent to both implement the plan and train on it to train in their place; such designation must be made in writing and included in the individual specific training section of the ISP. 12. For individuals at high risk for aspiration, conduct monthly face to face visits until the individual is stable and implementation of supports is verified to be consistent; thereafter frequency shall be at least quarterly to monitor for signs/symptoms of aspiration/respiratory illness. If the individual is tube fed, the tube site shall also be assessed at these visits. Relevant findings from these monitoring visits as well as frequency of reported individualized signs/symptoms shall be included in quarterly reports.

		13. For individuals at moderate risk for aspiration, conduct quarterly face to face visits to monitor for signs/symptoms of aspiration/respiratory illness and to verify that supports are being implemented as trained. Relevant findings from these monitoring visits as well as frequency of reported individualized signs/symptoms shall be included in quarterly reports. 14. Receive and respond in timely manner to reports from any IDT member of signs/symptoms of aspiration or illness of any kind. Response method shall be based upon nurse clinical judgment given the nature of the report and circumstances and shall be documented in nursing notes. The person who reported signs/symptoms must be notified regarding action to be taken. 15. Serve as the lead for communicating with each individual's primary care practitioner and other physician(s) related to aspiration risk management activities. 16. Consistent with E.3 and E.8 of this procedure, when an individual has been recommended to receive nothing by mouth (NPO), but the individual/guardian chooses to continue oral eating, the nurse shall help the individual/guardian to seek a second opinion as needed/desired and shall support the individual/guardian to work with the physician to retract any NPO orders written in order to allow the team to honor this health decision. 17. Participate in annual ISP Meeting to discuss effectiveness of current CARMP and any needed revision based upon annual reassessment results, status of Individualized Outcomes and frequency of signs and symptoms observed over the past year.
B	Individual/Guardian/ Designated Health Decision Maker	1. Express the wishes/desires of the individual regarding aspiration risk management. 2. Become informed/educated on aspiration risk and options for safe nutrition and hydration as well as other strategies for minimizing risk factors. 3. Participate in medical appointments. 4. Advocate for the individual's needs, wishes and civil rights. 5. Make informed healthcare decisions after consideration of risks, benefits and impact on quality of life from recommended aspiration risk management strategies using Decision Consultation Form process as needed. (See E.3 and E.8 of this procedure). 6. Participate in development and review of the CARMP

		including identification of measurable indicators of CARMP effectiveness.
C	Therapists & Behavior Support Consultants (BSC)	For an individual newly identified at risk for aspiration: 1. In collaboration with Nurse, the Eating Specialist will develop and train DSP to implement an interim aspiration risk management plan regarding minimizing aspiration risk related to dysphagia, within 72 hours. 2. If ordered by physician, the Eating Specialist will collaborate with the nurse to arrange for video fluoroscopy and/or other diagnostic tests. 3. Collaborate with nurse, other disciplines and DSP in completion of an initial face to face aspiration assessment in the individual's natural setting(s) within 30 days of the date the initial screening identifying moderate or high aspiration risk. As part of this assessment, the actual level of risk will be verified. The assessment results shall be documented and include recommendations regarding any interventions warranted. For individuals who already have a BSC on the team, any risky eating behaviors shall be assessed by the BSC within this timeframe. For individuals who do not have a BSC on their team, other disciplines should notify the Case Manager of the need for a BSC assessment if risky eating behaviors are observed during their assessment, so that the Case Manager can work with the individual/guardian to chose a BSC for this purpose. Teams may need to seek interim consultation from the DDSD Office of Behavioral Supports while selection of a BSC and processing of the ISP budget revision is in process. 4. If during the aspiration assessment needed changes to the interim aspiration risk management plan are identified, revisions will be made immediately, initialed and dated by the relevant discipline(s) and DSP instructed regarding the change. 5. For individuals already identified as at risk for aspiration complete a discipline specific annual aspiration reassessment for all individuals at moderate or high risk for aspiration at which time a determination shall be made as to 1) whether the individual's risk level has changed, 2) whether risk management strategies implemented during the past year have been effective, and 3) whether intervention strategies, including behavioral strategies, need to be revised. The annual reassessment will be documented and distributed to IDT members two weeks prior to the annual ISP meeting.

		6. Participates in IDT meetings: a. Present assessment or reassessment results and recommendations for aspiration risk management strategies; b. Provide information regarding risks, benefits and alternatives for recommended strategies to aid the individual and guardian in making related health decisions; and c. Develop/revise assigned components of the CARMP collaboratively, using CARMP template for strategies. d. Distributes template portions to case manager within 10 business days following the IDT meeting. 7. If the case manager identifies discrepancies between sections of the CARMP, confer with relevant disciplines to resolve such discrepancies and revise the CARMP within 5 business days of the case manager notice of such discrepancies. 8. Deliver competency based training for DSP and other relevant IDT members regarding sections of the CARMP which they have authored within 30 days of the completion of the CARMP. If multiple authors collaborated on a single section, those authors may agree upon which author(s) will be designated in the CARMP Lead Contact column to train that section. Authors shall maintain original copies of training rosters and provide copies of training rosters to the agencies that employ the DSP for their files. Therapist/BSC may designate a specific individual on the team who is competent to both implement the plan and train on it to train in their place; such designation must be made in writing and included in the Lead Contact column of the CARMP. 9. Provide and document observation/monitoring of CARMP implementation, providing constructive feedback to DSP as warranted. Such observation shall be monthly until stable and alternate between home and day settings with no less than a quarterly visit for each site thereafter. Observation is intended to determine if CARMP implementation is consistent, correct and effective, as well as to check on the current status of the individual.
D	Registered Dietitian (RD)/Nutritionist	1. Complete an assessment regarding nutritional intake within 30 days of the date the initial screening identifying moderate or high aspiration risk. The assessment results shall be documented and include

		recommendations regarding any interventions warranted. 2. Complete an annual reassessment regarding nutritional intake meeting for individuals already identified as at risk for aspiration. Distribute reassessment results to all IDT members at least two weeks prior to the annual ISP. 3. Participate in IDT meetings: a. Present assessment or reassessment results and recommendations for aspiration risk management strategies; b. Provide information regarding risks, benefits and alternatives for recommended strategies to aid the individual and guardian in making related health decisions; and c. Develop/revise assigned components of the CARMP using CARMP template for strategies. d. Distributes template portions to case manager within 2 weeks. 4. Deliver competency based training for DSP and other relevant IDT members regarding sections of the CARMP which they have authored within 30 days of the completion of the CARMP. Maintain original copies of training rosters and provide copies of training rosters to the agencies that employ the direct support personnel for their files. RD/Nutritionist may designate a specific individual on the team who is competent to both implement the plan and train on it to train in their place; such designation must be made in writing and included in the Lead Contact column of the CARMP. 5. Monitor the nutrition portion of the CARMP a minimum of four times a year, revise and re-train as necessary.
E	Case Manager (CM)	1. If the individual does not receive either Community Living or Community Inclusion services and therefore there is no nurse on the IDT, the case manager shall work with the individual and their family/guardian to complete the aspiration risk screening tool consistent with A.1.a & b. Individuals who do not receive either Community Living or Community Inclusion are not required to complete a CARMP. Therefore, if the screening tool indicates moderate or high risk, the case manager will inform the individual/guardian of the opportunity to: a. be referred to the SAFE clinic for assessment, and/or b. consult with their PCP for alternative further evaluation of the aspiration risk and/or physician orders for managing that risk, and/or,

		c. select relevant disciplines from secondary freedom of choice forms and then add them to the ISP budget in order to conduct an aspiration risk assessment, develop aspiration risk minimizing strategies, train strategies and monitor implementation, as appropriate. 2. If any IDT member disagrees with a "low risk" finding on the screening tool, the case manager will convene and facilitate an IDT meeting so that the team can go through the tool together to confirm the appropriate risk level. 3. Upon notice from the nurse of initial aspiration risk screening results indicating moderate or high risk for aspiration, the case manager will notify the individual, guardian and other IDT members within two business days, and begin to arrange an IDT meeting to develop a CARMP. This CARMP development meeting must occur after the aspiration assessment is completed by the clinicians on the team and not more than 45 days from the screening date. IDT Agenda for this initial ARM IDT Meeting shall include: a. review results of the aspiration assessment and strategies recommended by those conducting that assessment; b. discuss whether further collaborative assessment is needed in order to complete strategies for the CARMP; if so, relevant IDT members schedule such collaborative assessment to occur within 10 business days, inclusive of strategy development; c. discuss risks and benefits of recommended strategies as well as alternatives, (depending upon the nature of recommended strategies the IDT may use the DDSD Decision Consultation Form to guide this discussion); d. If there is a recommendation for a feeding tube, use of the DDSD Decision Consultation Form is strongly encouraged. In addition, the case manager shall provide the individual/guardian a copy of the pamphlet "Should I Get a Feeding Tube? Questions & Considerations for Individuals and Their Healthcare Decision Makers". If the individual or guardian does not agree with a recommendation for a feeding tube, a discussion to insure informed decision making with documentation on the DDSD Decision Consultation Form is required. e. completion of the Statewide Aspiration Risk List (SARL) Referral Form;

		f. completion of as much of the CARMP template as possible, clarifying who will complete remaining sections of the CARMP template within 10 business days (including completion of the "Lead Contact" column of the CARMP), and clarifying schedule for individual specific training to occur regarding CARMP implementation. g. Discussion of where the completed CARMP will be available in each location where the individual participates in any daily activities affected by CARMP implementation (e.g. separate binder that goes on all/certain outings versus labeled section of larger health and safety related binder and where that is kept in the home and day program). Note that the CARMP is to be kept intact and the sections shall not be separated into different locations. h. Within 72 hours following this meeting, the individual's ISP shall be revised to reflect the individual's risk for aspiration as follows: a. reference risk for aspiration in the Health & Safety Narrative; b. reference development of the CARMP on the Health & Safety Action Plan; i. Once the individual's initial CARMP is **in place**, an ISP revision must be done to delete any boxes previously checked in the Individual Specific Training section of the ISP for Mealtime Plan, Tube Feeding Protocol and/or Nutritional/Dietary Plan and instead check the "other" box under the Support Plan column, specify CARMP and insert "refer to CARMP" in the "Who Provides Training" column. (The CARMP will specify training responsibility for each **section** of the CARMP in the Lead Contact column.) Complete "Who Receives Training", "Urgency" and "Type" columns as usual. 4. Provide the individual/guardian with secondary Freedom of Choice form for any needed clinical discipline not already on the team to help assess, design and implement a CARMP, and revise the ISP budget to reflect the addition of such discipline(s). If no provider from the needed clinical discipline is available, contact the Aspiration Coordinator at DDSD. 5. Submit SARL Referral to Aspiration Coordinator within five business days following the meeting. 6. Once all sections of the CARMP are completed and submitted to the case manager (within 10 business days

		of the IDT meeting), the case manager shall review the entire CARMP within 3 business days to determine if there are any discrepancies between sections. If discrepancies are identified, refer back to the relevant authors to submit revisions to resolve those discrepancies within 5 business days. 7. Ask authors any questions the Case Manager has regarding CARMP content that arise while they are conducting the review in #6 above to assure their own awareness level of competence. 8. Review CARMP with the individual/guardian once all elements of the CARMP are complete (and any discrepancies resolved). If the individual/guardian does not agree with the content of the CARMP, in whole or in part, the CM will: a. Explore with the individual/guardian the reasons for disagreeing with aspiration risk management strategy(ies); b. Convene a meeting with the IDT members and relevant consultants to 1) discuss recommended strategies and concerns of the individual/guardian and 2) to complete a DDSD Decision Consultation Form, (if the individual/guardian objects to multiple strategies within the CARMP, more than one form may be needed); c. Coordinate implementation of the Action Plan; section of the DDSD Decision Consultation Form, including any resulting revision to the CARMP itself; and d. Submit a SARL Referral form requesting "Deferral status", indicating date DDSD Decision Consultation Form was completed. 9. Distribute final CARMP to all IDT members, including each agency providing direct services to the individual. 10. Convene an IDT meeting whenever necessary to assure ongoing risk minimizing strategies are being implemented; revise and submit updated SARL Referral forms when there is a significant change of condition that results in a higher or lower level of aspiration risk. 11. If any of the following conditions exist an IDT meeting shall be called immediately to ensure that adequate health and safety measures are in place, any existing CARMP is revised as warranted and a SARL update submitted; (the agency nurse is required to attend this meeting): a. Discharge from hospitalization due to aspiration or

		choking incident. b. Unexplained weight loss of greater than 10% of body weight or 10 pounds in 6 months. c. Initiation of a feeding tube. 12. During site visits, look to make sure the current, intact CARMP is readily available to DSP at the service delivery site. 13. During subsequent annual ISP Meetings, include the following items on the agenda and facilitate discussion of those items: a. Status of Individualized Outcomes in the CARMP, any barriers to their achievement which have occurred and any appropriate changes to those outcomes needed; b. Review frequency of individual signs and symptoms over the past year, concerns related to that frequency and any needed changes to that list; c. Review of current strategies in the CARMP and whether changes are needed based upon authors' findings during monitoring visits, their annual re-assessment results, Individualized Outcome status or changes warranted given frequency of signs and symptoms; d. Discussion of whether additional assessment or medical referral is needed related to the individual's aspiration risk and results of a-c above; if so reflect this on the Action Plan for Health & Safety Related Supports page of the ISP; e. Agree upon assignments and method to complete any changes resulting from discussion of a-d above within 10 business days following the meeting. 14. The Case Manager shall repeat steps 6 through 8 above for the revised CARMP each year following the annual ISP Meeting.
F	All IDT Members	1. Observe the individual for signs and symptoms of aspiration, calling the agency nurse if noted. 2. Participate in CARMP planning. 3. Implement their responsibilities within the CARMP in a consistent correct fashion. 4. Contact Regional Office nurse, Office of Behavioral Supports or Aspiration Coordinator for assistance if needed.
G	Provider Agency,	1. Notify the CARMP authors immediately when new DSP

	House Lead/Manager, Day Program Supervisor or Service Coordinator	begin working with the individual and therefore need to be trained. 2. Arrange/schedule individual specific training with authors or designated trainers for various elements of the CARMP. 3. Identify DSP assigned to implement various aspect of the CARMP and ensure that no staff assists an individual with eating or tube feeding until they are deemed competent by the relevant trainer(s) at the skill level. 4. Attend IDT meetings and offer input. 5. Arrange for active DSP participation in aspiration risk assessment and CARMP planning. 6. Monitor DSP for consistent, correct implementation of the CARMP. Contact the relevant author(s) for retraining if implementation concerns are identified. 7. Observe the individual for signs and symptoms of aspiration, calling the agency nurse if noted. 8. Report Significant Events to the Regional Office per DDSD requirements. 9. Assure that a current, intact CARMP and MERP are readily available to DSP in the service delivery site at all times. 10. Assure that all outdated aspiration related plans superseded by the CARMP are removed from service delivery sites to avoid any confusion. Such outdated plans should be archived at the agency's main office. 11. Maintain all training roster copies related to the current CARMP in the agency office.

VI. LIST OF ATTACHMENTS

Aspiration Risk Screening Tool
Nurse Aspiration Assessment Tool
Statewide Aspiration Risk List Referral Form
Comprehensive Aspiration Risk Management Plan template and instructions
"Should I Get a Feeding Tube? Questions & Considerations for Individuals and Their Healthcare Decision Makers" pamphlet
DDSD Decision Consultation Form
Medical Emergency Response Plan Policy