



DMS NEWS AND REVIEWS

A DYSPHAGIA MANAGEMENT SYSTEMS PUBLICATION

June 2015

► IN THE NEWS

“The Revolving Door: A Report on U.S. Hospital Readmissions”

Lavizzo-Mourey R (2013) The revolving door: A report on U.S. Hospital Readmissions. Robert Wood Johnson Foundation. Dartmouth Atlas Project: 1-60.

“The US health care system suffers from a chronic malady— the revolving door syndrome at its hospitals. It is so bad that the federal government says one in five elderly patients is back in the hospital within 30 days of leaving.

Some return trips are predictable elements of a treatment plan. Others are unplanned but difficult to prevent: patients go home, new and unexpected problems arise, and they require an immediate trip back to the hospital.

But many of these readmissions can and should be prevented. They are the result of a fragmented system of care that too often leaves discharged patients to their own devices, unable to follow instructions they didn’t understand, and not taking medications or getting the necessary follow-up care...”

The federal government has pegged the cost of readmissions for Medicare patients alone at \$26 billion annually, and says more than \$17 billion of it pays for return trips that need not happen if patients get the right care.

► ON PAGE 3:

Dr Jeanna Winchester PhD & Carol G Winchester MS SLP CCC provide a literature review focusing on “Repeat Hospitalization,” proving further explanation on the relationship between reducing repeat hospitalization and effective dysphagia management.

► DID YOU KNOW?

In hospital discharge communications, even in patients identified as having dysphagia, 45% of patient discharge summaries **omitted all dysphagia recommendations** made **within the SLP notes**

More than 40% of hospital discharge communications **omitted at least one** (but not all) **of the SLP’s recommendations**.

Only 13% of all hospital discharged patients with dysphagia had hospital discharge summaries that **included all of the SLP’s dysphagia management recommendations**.

General **food** recommendations **omitted roughly 60%** and **liquid consistencies** other than “thin” were **omitted 22%** of the time.



Hospital Readmission:

- The detection of aspiration is a predictor of pneumonia risk and/or probability of re-hospitalization in nursing home residents.
- Instrumentation has an 82% rate of predicting hospital readmission.
- An unmanaged dysphagia diagnosis in a rehabilitation setting is associated with a 13-fold increased risk of mortality with 1yr.
- The most frequent reasons for hospitalized Centenarians included sepsis, aspiration pneumonia and acute myocardial infarction, with mortality ~10%.
- There was a 93.5% increase in hospitalized older patients diagnosed with aspiration pneumonia while other types of pneumonia in the elderly decreased.

Cichero & Altman, 2012; Croghan et al, 1994; Mandawat et al, 2012; Rofes et al, 2010



Monthly Free Course

Repeat Hospitalization & the Dysphagia Link

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The Speech Pathologist is integral in the prevention of repeat hospitalization of the nursing home resident. This literature-based review presents a plethora of data that can be used in patient advocacy, SNF staff education, and Physician discussion.

Dysphagia Management Services tracked 5 facilities across the country, looking at a variety of factors that are indicative of repeat hospitalization for respiratory complications. Three facilities had a 14 month pre-program and 22 month post-Comprehensive Dysphagia Management program, providing endoscopic services and basic education/training. Two facilities were provided with the same 14 month pre-program and a 22 month interdisciplinary comprehensive education/training team approach, including comprehensive endoscopic swallowing tests (FEES) as their means of instrumentation.

In the facilities that provided **basic** education/training and endoscopic services, **the reduction in repeat hospitalization was 26-36%**. In those that combined endoscopic services with **comprehensive interdisciplinary dysphagia management** education/training and a team approach, **repeat hospitalization reduction was 62-66%**.



INTRODUCING: Jennifer Bland MEd SLP CCC

Jennifer Collins Bland graduated from Meredith College with a Bachelor's Degree in Communications. After graduating from North Carolina Central University with a Master's Degree in Communication Disorders in 2001, Ms. Bland's focus was with the geriatric population where her passion for dysphagia management set her path. She quickly fell in love with the diagnostic side, specifically fiberoptic endoscopy, as a way to manage her patients' dysphagia in the Skilled Nursing and Long Term Care settings. Ms. Bland is currently employed by Dysphagia Management Systems, LLC as a Director of Clinical Practice with a focus on Clinical Mentoring.



Repeat Hospitalization & Effective Dysphagia Management

Dr. Jeanna Winchester, PhD, Clinical Scientist

Carol Ghiglieri Winchester, MS SLP CC, President of DMS LLC

Between 2010 and 2030, the geriatric population will dramatically increase, with estimates of upwards of 70 million elderly residents by 2030; representing nearly 20% of the total American population. Centenarians, e.g. individuals living beyond 100yrs, are the fastest and largest growing population in America, with a projected 735% increase in the population between 2010 and 2050, totaling beyond 600,000 centenarian Americans by the year 2050 (Mandawat et al., 2012). It is expected, by the year 2030, that 10-15 million Americans will be in the 85+ age range (U.S. Census Bureau, 2012), an age group consistently afflicted by progressively deteriorating dementia and other chronic diseases such as cardiovascular disease, cancer, stroke, chronic lower respiratory diseases, influenza, pneumonia and diabetes mellitus; diseases associated with an increased likelihood of hospitalization.

Repeat hospitalizations are known to be frequent, quite costly, largely preventable and potentially associated with negative health outcomes (Lanspa et al., 2013). This topic is important because less time between hospitalizations was associated with severe physical or cognitive impairment, partial restraints (bedrails alone or trunk, limb and chair alone), the use of a feeding tube or intravenous drop for nutrition as well as the presence of certain co-morbidities (e.g. CHF, diabetes mellitus, unstable conditions and cancer). Overall, a shortness of breath and vomiting were the symptoms associated with the greatest risk of repeat hospitalizations (O'Malley et al., 2011). Several factors indicative of repeat hospitalizations are also associated with a patient's likelihood for recovery. In the following article, we demonstrate that effective dysphagia management is the key to reducing repeat hospitalization.

The repeat hospitalization statistics are staggering. For example, among all hospitalized Medicare beneficiaries, nearly 1 in 5 were readmitted to the hospital within 30 days of admission and over 1/3 were readmitted within 90 days of admission. In this scenario, individuals were more likely to have multiple medical co-morbidities, greater length of stay during the index hospitalization, and additional recent hospitalizations. They were also likely to be discharged to a skilled nursing facility, and this discharge was significantly correlated with re-hospitalization at a later date. Over the entire population, the mortality rate within 1yr of hospitalization was 15.7%, and for those with early readmissions it was 38.7% (Lum et al, 2012).

In addition to mortality rate, time between hospitalizations was also an indicator of patient outcomes. For example, in a study of new admits to 677 nursing homes over a period from 1998 to 2004, among the more than 680K new residents, 408,534 were hospitalized, and ~50% were first-time hospitalizations (O'Malley et al., 2011). O'Malley

and colleagues found that the time between hospitalizations decreased markedly as the number of previous hospitalizations increased, the shortest time between hospitalizations occurred between the first and second hospitalization for these residents and that, there afterwards, the time between hospitalizations was consistently decreasing as successive hospitalizations continued to increase (O'Malley et al, 2011).

Successfully managing dysphagia is critical to reducing repeat hospitalization. Unfortunately, though, the treatment for dysphagia amongst the myriad of long-term care settings varies greatly (Loeb et al., 2003). Severe consequences of dysphagia can include dehydration, malnutrition, aspiration, choking, pneumonia and death (Barer et al, 1989; Clave & Cichero, 2012; Gordon et al, 1987). In elderly patients with oropharyngeal dysphagia, aspiration pneumonia occurs in 43-50% during the first year, with mortality of up to 45% (Loeb et al, 2003).

The varying approaches to Dysphagia Management in long-term care may be related to the inconsistency of hospital discharge communications when a patient leaves the hospital setting and is transferred to long-term care; even in patients identified as having dysphagia in the hospital. Upwards of 45% of patient discharge summaries **omitted all of the dysphagia recommendations made within the SLP notes**, upwards of 42% omitted at least one (but not all) of the SLP recommendations, but **only 13%** of hospital discharged patients with dysphagia had hospital discharge summaries that **included all of the SLP's dysphagia management recommendations** (Kind et al, 2011). Additionally, 47% of patients with dietary recommendations and restrictions made by the SLP were completely omitted from their discharge summary. Of the types of dietary recommendations omitted from discharge summaries from the hospital, tube feeding recommendations were the least commonly omitted, however, all other types of dietary recommendations and restrictions were completely omitted >54% of the time. Shockingly, **general food recommendations omitted roughly 60%** and **liquid consistencies other than "thin" were omitted 22%** of the time (Kind et al 2011).

When successful management of dysphagia occurs, there is a dramatic increase in safety and a reduction in penetration and/or aspiration, providing a strong logical basis for utilizing dietary modification in patients at risk for aspiration pneumonia. In addition, managing the risk factors associated with the five systems of dysphagia (muscular, neurological, respiratory, cognitive and gastrointestinal) results in a better-stabilized patient, thus reducing their risk of return to hospital for many co-morbidities.

My name is Carol Ghiglieri Winchester and I'm the Founder and President of Dysphagia Management Systems, LLC, and its predecessor company BEST Dysphagia Management. More importantly, I am a Speech-Language Pathologist who is a Daughter, Granddaughter, Mother, and Sister. Being a family member is the most precious and important role that I have, and it drives me to be great at what I do, or at least to try my best every single day. I find that belonging to a strong family unit drives my advocacy for others on a daily basis. I always tell my employees that at a 'minimum', we need to care what happens the Patient that relies on our expertise. It should not be based on whether it suits our convenience, how difficult a journey it may be to get them the services they need, or how many folks we have to convince that they will benefit from the services of an SLP. It should be because we KNOW we can help the quality of their life and that we BELIEVE in what we do. It should be because we CARE.

I have performed over 10,000 endoscopic swallowing studies over the years and am constantly amazed by the comprehensive dysphagia evaluation and what positive patient changes result from the plethora of information gained. My bulletin board is covered many times over with the thank you notes from Speech Pathologists, Patients and Families whose lives I, and my employees, with the expertise of the staff SLP, together have touched. It is a daily reminder of why I continue to work so hard to get the word out about how vital and valuable a Speech Pathologist is. I continue to carry on with my mission to educate folks about why they need to work with their SLP, sometimes educating only one person at a time!

How can I be so focused? Its simple - family! The story of my inner strength began with my Grandmother. Isabelle Harrison was a vibrant, intelligent, funny 87 year old who spent her days playing bridge, shopping, visiting friends, and enjoying her children, grandchildren and great grandchildren. Her husband, my Grandfather had passed away several years earlier after suffering 9 strokes (recovering from 8) over the course of thirty years. There was nothing 'old' about this woman. She was still driving and even walking without the aid of a cane until Thanksgiving of her 87th year when she slipped in the kitchen of her home while cooking spaghetti sauce, falling and breaking her hip. She was hospitalized a few days before the holiday and had surgery to repair her hip. The surgery had to be repeated a second time the next day due to a repair fault, and as such she had anesthesia twice in 48 hours. With the holiday approaching, my Grandmother was sent to the rehab facility in her hometown in order to get a few days of Physical Therapy prior to going home to modifications that would enable her to use a wheelchair and walker in her home. The problem with this picture was the skeleton staff on duty over the holiday, and the lack of time for an SLP to do more than a clinical bedside evaluation. The SLP quickly determined my Grandmother to be safe for a regular diet with thin liquids, not having taken into consideration the loss of sensation and decreased muscle movement that accompanies two surgeries, anesthesia, and 87 years of life. An MBS was to be performed in about a week. She didn't make it that long. My Grandmother was moved to the rehab unit of the SNF on Saturday, without any precautions from the SLP, and she was fed a dinner of regular texture with thin liquids. She died of suffocation in her sleep, her lungs full of turkey and dressing according to the autopsy. It was unnecessary for this vibrant woman to go this way, and it happened just as I had started this company in rural Indiana, a mere four hours away from where she lived. It was avoidable. This spark lit the fire in me that said ' we need to all work together to assure that we are educated about the risks of inattention to detail, and how it affects a patient that someone loves very much!'

My company evolved over many years with success stories that would bring tears to your eyes. Patients who had returned to the hospital three and four times, and finally when that pesky reflux was identified (for example), and better managed so that it didn't keep falling into the lungs causing pneumonia, stopped their repeat hospitalization and stabilized! We were providing services that seemed to mean something and we were touching real lives. Our reports were comprehensive and detailed, and we were confident that we were passing along the information to everyone that needed to know how to more safely participate in the patient's life. I thought that I was doing enough, however all of that changed when my Mom was diagnosed with ovarian cancer just after her 70th birthday.

Dorthiana Harrison Ghiglieri had just returned from a golfing trip to Florida, where she spent her days rotating among the 4 golf courses, and then enjoying the nearby restaurants with friends. She loved golf, bridge, and spending time with her family. I had seen her during her trip to Florida, a mere hour and a half away from my home in Sarasota. She complained of a mild back ache, but she thought she had strained it playing too much golf. That was her only symptom until she was diagnosed with Stage 4 ovarian cancer. She returned to Florida to stay at my home and she began a regimen of chemotherapy at a local cancer center that was renown for great results. She tolerated the first series of treatments and seemed to be making progress until low blood pressure demanded that I rush her to the ER. It was there that the final, unnecessary chapter began.

The statistics in our literature review this month talked about the lack of communication within disciplines, and that a whopping 45-47% of the time there are mis-communications and/or complete lack of communication within hospitals, and between hospitals and SNF's. Although this seems astounding, we experienced this first-hand when my Mom was admitted from the ER to the hospital for observation overnight. While in the ER she was treated for a reaction of the chemotherapy on her GI system, and the significant burning that that reflux was causing in her chest and throat. Once she was stabilized in her room, she asked me to run to the mall and pick up a few items that would make her more comfortable once she came back to my house. I was gone for less than an hour, but during that time the nurse came into the room and asked her if there was anything she needed. My Mom said that she had just had a dream about sitting under a tree, drinking a chocolate milkshake, and that it tasted so good! The nurse said that she'd call down to the kitchen and see if they could whip her up a chocolate milkshake and within a few minutes my Mom was enjoying her treat. Unfortunately, within moments of drinking less than half of her milkshake, the reaction of the milk and chocolate on her already tender GI system was enough to induce reflexive vomiting. Having not reviewed the ER notes concerning my Mom's treatment, and with me out of the room for but a few moments, this well meaning nurse contributed to the downward spiral from which her weakened immune system would not recover. I received a frantic call from my Mom from her cell phone telling me that she had vomited, aspirated, and was immediately thrown into an inability to breathe. She was very very scared and wondered if I could get right back to her room as she was pushing the nurses button but no one was responding.

I rushed back to the hospital to be greeted by a team of professionals surrounding my Mom's bed. Her oxygen level was falling as it was determined that she had indeed aspirated acid reflux of her stomach contents, and she was suffering from an abrupt reaction to the acid falling into her lungs. The outlook was grim, and the pattern that followed was textbook. Because of her depressed immune system, she appeared unable to fight what was happening to her body internally. By coincidence, my Brother and Sister were in the air, flying in to Sarasota after a call from me earlier in the day concerning her low blood pressure. They arrived at the hospital in time to be included in a conversation with the Pulmonologist and I, discussing the potential of putting her on a respirator to see if it would help stabilize her condition. As we were speaking outside her room, her condition began to worsen. She was very afraid until they gave her some medication to ease her transition from life to death. “It didn't need to happen today”, I told my siblings. It just didn't need to happen on that day when she was awake, alert and laughing— until she wasn't.

(Continued on next page...)

► A JOB WELL DONE!

Lauren Busby MS SLP CCC - Antioch TN

Lauren Busby has been a practicing SLP since 2010 and working at a SNF in Antioch, TN for the past three years. Her dedication to her patients and motivation to improve their function through focused treatment is at the core of her patient approach. Lauren recently referred a patient who had been hospitalized due to a bio-prosthetic aortic valve replacement and required subsequent tracheostomy and PEG placement to serve as the patient's primary means of nutrition. He was admitted to Lauren's SNF on 3L of oxygen and NPO status. Shortly following her evaluation, Lauren referred to DMS for a DST to be performed, to assess swallow safety. It was evident following the DST that the patient was not safe for food and could only tolerate ice chips in small amounts. Due to the presence of a pacemaker, the patient was not a candidate for NMES (Vital-Stim) and was therefore able to utilize only oral-motor exercises for dysphagia rehabilitation. Lauren realized the hard work and strong level of commitment that rehabilitating the patient's swallow function would require. In order to get the patient on-board with a strict oral-motor exercise program, Lauren carefully and thoroughly reviewed the results of the DST with the patient, and stressed the importance of consistently sticking to the treatment program. As she put it, Lauren “focused on the ‘why’s’” in order to make the treatment approaches meaningful to the patient. Soon, the patient began to affectionately call Lauren “Mamma Hen” for her structured, encouraging, and gently persistent approach. After several weeks of intense speech therapy, the patient was ready to receive a DST reassessment. The results showed incredible improvement in function and cleared him to begin food trials with Lauren. According to Lauren, having access to instrumental swallow assessments helps her manage risk in her patients since “even though everything might look great on the outside, the patient might not be doing well on the inside.” Ultimately, the patient was discharged from her service, only requiring oxygen at night, and on a diet of mechanical soft foods and thin liquids. She and the patient were thrilled. It is because of Lauren's advocacy for, and commitment to, her patients that we would like to highlight her today as an outstanding SLP. Thank you for all you do to improve the lives of others everyday! Job well done Lauren!

My Mom died 13 years ago today, as I am writing this OP-ED. I am shaking my head as I write this, repeating that it just didn't need to happen this way. Would she have survived Ovarian Cancer? Probably not. But that was her fight to fight, and because of lack of attention to detail, in the absence of a family member to advocate for her, she didn't get that chance. Because of this, I immediately changed the DMS reports to be easier to read and find the recommendations, and mandated that the report be in the hand of the staff prior to my staff leaving the patient's bedside. I mandated that they tell everyone who will listen what is safe for the patient, and that they take the extra time to be sure that the SLP is on the same page. I ask myself daily, “Why are we even bothering to do this job if we aren't going to advocate for the Patients we serve in a way that really means something?”

What drives you to be an SLP? I'm sure you have your stories of what motivates you. I wanted to share mine in memory of two women that I loved very much, who just didn't need to die of complications of dysphagia. I am committed to telling anyone who will listen that dysphagia management and attention to detail saves lives. It just does!

- Carol G Winchester, MS SLP CCC

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COMING NEXT MONTH!

DMS is committed to providing Continuing Education Events to the Speech Pathologists in the facilities we serve. In next month's issue, we will have sign-up information to attend these FREE educational experiences along with the potential to earn ASHA CEU's!

Did you know that by **simply identifying your patients at risk for Dysphagia** complications that you can **positively affect the budget in your facility** in multiple cost centers? The SLP that is astute at knowing the value of his/her service is well prepared to proactively advocate for those patients that need care

Learn more about the relationship between reducing costs to your facility and effective dysphagia management. Next month's issue will include a review of the evidence and provide you, the interdisciplinary team, with a guide to reducing overall costs to your facility with a comprehensive dysphagia management plan!

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