
DYSPHAGIA IN MOTION CAN HELP SOLVE SEVERAL PROBLEMS IN YOUR FACILITY:

Problem #1: Hospital MBSS appointment times can be anywhere from 2-6 weeks away.

- Radiology directors reserve a few hours per week in the radiology suite for outpatient MBSSs. If several SNFs are sending their residents to the same hospital, depending on the availability of the SLP and radiologist, the MBSS can be pushed out several weeks.
- Once the MBSS is completed, the SLP and radiologist each have to write their reports, and they may not be completed for a few days. The facility SLP is responsible for tracking down the report through medical records and having it faxed to the appropriate nurse's station, oftentimes taking a week to receive the report with results.

Solution #1: Dysphagia in Motion will be at your facility within 1-2 business days of receiving the physicians order.

- We can be reached via phone, email, text, or request through our website.
- We can also schedule a time that is most convenient for the facility SLP and the family, so that everyone can be consulted to make the most appropriate patient-centered recommendations.
- We carry a mobile printer and print the full-color report and still images of the study and leave them in the facility that same day.
- Our full-color study videos are provided on a flash drive to facilitate easy review by the SLP, family members, and physicians.
- Results can be implemented immediately into the resident's treatment plan to expedite and maximize the ability to achieve their highest level of functioning, and reduce the risk of dehydration, malnutrition, and pneumonia.

Problem #2: Disagreement regarding evaluation recommendations

- Your SLP does not have X-ray vision. There is a 70% error rate with clinical bedside swallowing evaluations where SLPs have made over-restrictive recommendations while also missing silent aspiration.
- Additionally, MBSS studies are time-limited due to radiation exposure which often results in fewer boluses and compensatory strategies being tested, giving an incomplete picture of the patient's functioning. Incomplete studies are more likely to result in recommendations for thickened liquids, mechanically altered diets, and NPO/PEG.

Solution #2: At Dysphagia in Motion, we take the time to incorporate multiple components into our assessments to ensure that the safest, least restrictive recommendations are made. Our assessment includes:

- Chart Review:
 - Our endoscopist will look at the patient's advance directives, medical history, general health trajectory, lab values, x-ray reports, and medications to ensure that all risk factors for development of aspiration pneumonia have been identified
 - We take into account the patient's wishes and advance directives to ensure that our recommendations make sense for the facility, patient, and their family.

- Comprehensive Assessment:
 - While MBSS studies are often limited to 4 minutes or less due to radiation exposure, FEES studies have no such restriction and can last an entire meal if necessary.
 - MBSS studies involve constantly stopping/starting the recording, FEES provides a continuous full-color recording of the swallowing physiology.
 - Because of the lack of time restrictions, FEES allows for testing of many more bolus presentations as well as use of compensatory and therapeutic strategies and exercises which provides a more complete understanding of the patient's functional level.
 - We review every single study frame-by-frame (at the industry standard 30 frames per second) following the study to ensure that we didn't miss swallow events.
 - Most MBSS providers do not review their studies prior to writing the report, despite this being recommended as an industry standard.
 - Our reports include clear, concise descriptions of bolus movement and related swallowing physiology impairment to help provide guidance for treatment decisions.

- SLP/Facility Consultation:
 - Our endoscopists are highly educated regarding current best practice in dysphagia compensation, exercise, dysphagia physiology, billing, and the informed consent process.
 - We provide assistance and mentorship to SLPs new and old to ensure that your facility is using the most current evidence-based practice in assessment and treatment.

Problem #3: MBSS Barium Choice May Affect the Study Results:

Many MBSS providers use powdered barium (EZ-Paque) in order to save money. The only barium product currently FDA approved for use in MBSS is Varibar. Use of powdered barium in a swallow assessment may lead to:

- Inconsistent viscosity frequently occurs due to lack of precise measuring of the powder being added to test consistencies and can lead to poor test-retest reliability
- Powdered barium is designed for GI use to **COAT STRUCTURES** to make them more visible during GI studies such as esophograms. This may lead to false positives regarding residue in the pharynx and ultimately modified diets for no reason.
- Powdered barium has an unpleasant taste/texture. Research has shown that aversions to taste and texture may negatively affect a patient's swallowing pattern.

Solution #3: Dysphagia in Motion uses real foods that are up to IDDSI standards to ensure test-retest reliability.

- We add a small amount of non-toxic food coloring as contrast which has no impact on flavor or viscosity. If your patient has special dietary requirements, we are prepared to bring special items with us for testing to ensure that both IDDSI standards and your patient's needs are met.
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Problem # 4: Cost of re-hospitalizations

The following five conditions account for 78% of all 30-day SNF re-hospitalizations, and have all been deemed as potentially avoidable:

1. Congestive Heart Failure (CHF) - can be reduced by adherence to any fluid or dietary restrictions.
2. Respiratory infections - may be reduced by following appropriate positioning of residents with swallowing problems to avoid aspiration that could lead to pneumonia.
3. Urinary Tract Infection (UTI) - can result from dehydration or poor nutrition, which may be prevented with careful monitoring of patient fluid and nutrient intake.
4. Sepsis - same as above
5. Electrolyte imbalance - same as above

Solution #4: Dysphagia in Motion is able to test a variety of compensatory strategies to determine the least restrictive diet that the resident will be compliant with.

- The procedure is performed in the resident's natural environment and position to ensure accurate recommendations.
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Problem #5: Increased operating costs with thickened liquids

Many residents are assessed with a modified barium swallow study (MBSS) at the hospital when they are acutely ill. Once their condition has improved, they are sent back to the SNF. It has been found that 80% of residents have improved after discharge back to the SNF to the point that they no longer need the thickened liquids, but are never re-evaluated.

- It costs the facility on average \$7,000 per resident to be on nectar thick liquids for 1 year.
- Research shows that having a resident on thickened liquids can greatly improve the risk of dehydration and pneumonia, and decrease their quality of life.
- The more residents that are on thickened liquids, the higher the risk for CNAs to make an accidental error when passing fluids, leading to a DOH tag.

Solution #5: Dysphagia in Motion is able to test a variety of compensatory strategies to determine the least restrictive diet/liquid consistency that the resident will be compliant with.

Problem #6: A hospital MBSS costs approximately \$1200-\$1800 and affects the productivity of OT/PT/SLP and the associated RUG levels.

- There are several charges tied in to the cost of an MBSS - the cost of the speech-language pathologist to perform the study, the cost of the radiologist/radiology tech, radiology suite charges, barium cost (which has tripled in recent years), cost of transportation to the hospital and a companion or CNA to go with them. These charges are all fluid, and subject to change. They are not all billed at once per patient and usually are all included in one bill annually from the radiology department to the SNF.
- The MBSS procedure itself takes 4 minutes to perform, however the average length of time the resident is gone from the facility is 4 hours. While the resident is gone, OT/PT/SLP all miss out on designated treatment minutes for the day affecting productivity, and ultimately affecting the RUG level.

Solution #6: Dysphagia in Motion charges one low all-inclusive rate per procedure. This is well below the national average and we do NOT charge for mileage regardless of the distance to your facility.

- If results are not obtained, the facility is not charged.
- The facility SLP is able to bill their therapy treatment code while assisting with the procedure which will NOT disrupt productivity for skilled residents or result in a denial of facility SLP claims for managed care residents.
- The facility is able to receive the procedure allowable back for LTC residents.
- We will work with your reimbursement/billing team to ensure that your facility is able to maximize all appropriate reimbursements for our service.
- We do not charge a cancellation fee if we arrive and your patient is out of the facility due to unforeseen circumstances.

References:

Bedside clinical swallow exams by SLPs have proven to be under-estimating and over-estimating aspiration; therefore, the use of instrumental swallow evaluations is imperative.

- O'Horo, John C. et al. (2016). Bedside Diagnosis of Dysphagia: A Systematic Review.
- Gerrie J.J.W. et al. (2008). Bedside Screening Tests vs. Videofluoroscopy or Fiberoptic Endoscopic Evaluation of Swallowing to Detect Dysphagia in Patients with Neurological Disorders: A Systematic Review.

MBSS is not the only "Gold Standard" in dysphagia assessment and management; FEES is just as accurate and with even better sensitivity and specificity than MBSS.

- Leder, S.B. & Murray, J.T. (2008). Fiberoptic Endoscopic Evaluation of Swallowing.
- Kelly, A.M. (2007). Assessing Penetration and Aspiration: How Do Videofluoroscopy and Fiberoptic Endoscopic Evaluation of Swallowing Compare?

The rate of complications associated with FEES is less than 1% overall.

- Nacci, A., et al. (2016). Complications with Fiberoptic Endoscopic Evaluation of Swallowing in 2,820 Examinations.
- Aviv, J.E., et al. (2005). Flexible Endoscopic Evaluation of Swallowing with Sensory Testing: Patient Characteristics and Analysis of Safety in 1340 Consecutive Examinations.

Studies show that endoscope placement does not adversely affect swallow function.

- Suiter, D. M., & Moorhead, M. K. (2007). Effects of Flexible Fiberoptic Endoscopy on Pharyngeal Swallow Physiology.