

### UPCOMING CONFERENCES

#### **April 18: McAllen, Texas**

(Rescheduled from March 7.)

*Reading the MBSS for Practical Application in the Long-Term Care Setting*; 3.0 CEUs

#### **April 24: Corsicana, Texas**

*Strategize with Strategies Cost:*

\$25.00 for Professional Imaging clients; 4.0 CEUs

#### **May 2: Houston, Texas**

*Deciphering Dysphagia with Estim*; 7.5 CEUs

(Filling up quickly! Please call to make a reservation.)

#### **May 30: Austin, Texas**

*Dysphagia Scene Investigators*, 6.0 CEUs

Please take time to come and learn with Professional Imaging. We welcome any suggestions you may have for conferences related to dysphagia and the care of our long-term care residences.

For more information, visit our website to download conference flyers and more.

[www.mbssonline.com/pi](http://www.mbssonline.com/pi)

Meet some of the Professional Imaging Team and see our mobile clinic, which will be on display at the **TSHA 53<sup>rd</sup> Annual Conference, April 2-4** in Austin. We look forward to seeing you there!

### Best Practices: Patient Care and Building Your Caseload in the Long Term Care Setting

Many of the facilities we service have difficulty building and maintaining a caseload in the area of speech pathology. This means that many SLPs have less work at a single facility and may need to supplement by working at other places. I met with some therapists who consistently have a full caseload to try and find out how they are reaching so many patients.

We all know that early detection of dysphagia can improve a patient's nutritional status and reduce the risk of aspiration. Also, it is important in helping to ensure patients are receiving meds in the most efficient, effective method, with the lowest risk for aspiration. This affords them the best opportunity for recovery from any other illnesses and increases the benefit received from intensive therapy for rehabilitation. Here are a few suggestions I found interesting, which may help you identify and treat patients with dysphagia as quickly as possible:

1. I meet with the medical director at my facility and set up a direct system to get an order for every patient with a high risk diagnosis for dysphagia upon admittance. I do my bedside the first day and schedule a MBSS with Professional Imaging. Within 24 to 48 hours of a patient being admitted, the MBSS is completed and I have a diagnosis of how severe the dysphagia is, what treatment is needed for the underlying pathophysiology, and a diet recommendation that is safest for the patient's nutrition/hydration with the lowest risk of aspiration.

*-SLP, Northeast Texas Facility*

2. I screen all long-term patients during my low caseload times, which occurs when we have few new admits. I get a baseline study, and pick them up immediately if they are severe. If they are mild, I pick them up as my caseload allows. However, I continue to screen them for changes so we can address them quickly, especially when it comes to the swallowing.

*-SLP, Houston Area Facility*

Many patients with dysphagia go undiagnosed because they are part of the overwhelming 40% who are silent aspirators (Logemann, 1993). Through Professional Imaging's QA program, we find that approximately 26% of the patients we see are silent aspirators, which may mean that there is a lower incidence than once thought, or we are missing many patients who are potential silent aspirators. Something to definitely think about as you manage patients in your long-term care facility.

### The Bernoulli Principle and the Swallowing Mechanism

Here is a quick review for all of you about the basic principle of the swallowing mechanism. As you all know the Bernoulli Principle is the high pressure/low pressure system by which the swallow mechanism functions. To initiate the swallowing, the base of tongue moves posteriorly to touch the posterior pharyngeal wall, and the velum lifts to close off the nasopharynx, which generates a build-up of pressure. Once the swallow triggers, as the bolus head passes the rami of the mandible, the larynx should lift the vocal cords close, and the epiglottis inverts over the laryngeal vestibule. The upper esophageal sphincter then opens, which has a lower pressure underneath than the pressure built by the above sequences to allow the bolus to be sucked -- yes that's right, just like a vacuum cleaner -- into the esophagus. If any one of these sequences is weak, delayed, or obstructed by changes in the cervical spine, it creates dysphagia.

The severity and underlying cause should be identified using the MBSS for appropriate treatment. The MBSS will identify any structural change -- which cannot be seen bedside -- and how it affects function.

Please ask any of our therapists if you have any questions as we perform the MBSS or after we perform the MBSS for better understanding of the diagnosis for the best treatment plan in relation to the identified pathophysiology.

The more you learn to better direct treatment plans, the better chances your patients will have to improve!

