Influencing Population Health for Adults with Chronic Dysphagia Related to Postural Impairment

Presenters: Jeanne Copeland, M.S., CCC-SLP & Alyssa Thrush, DPT, GCS, CEEAA

Contributing Author: Jarrod Nichols, DC

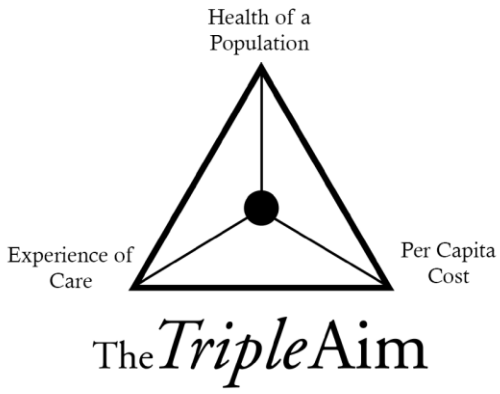
Saturday, September 23rd, 2017, 10:30am – 12:00pm

Thought-provoking questions

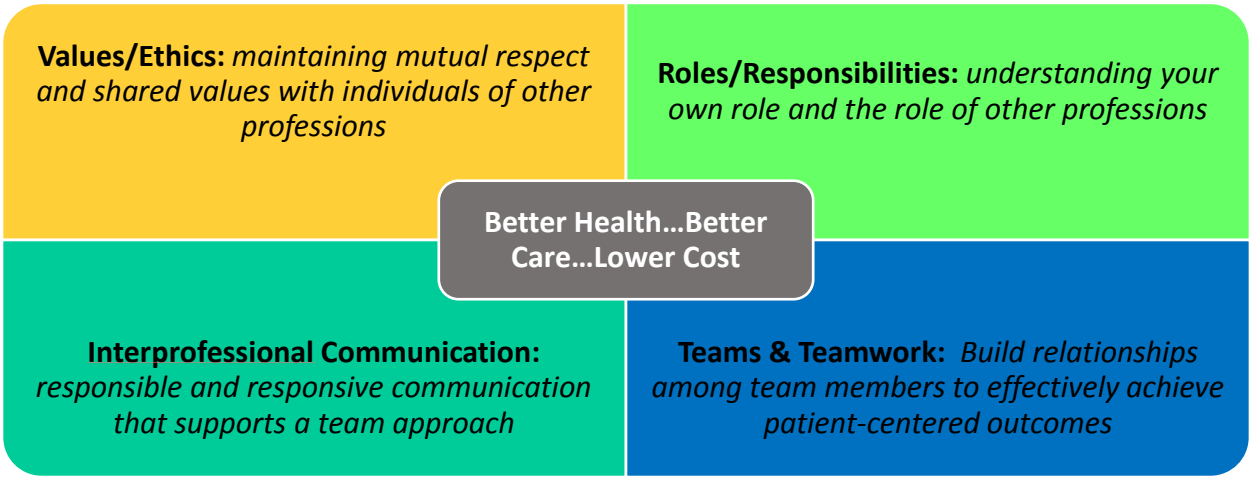
- How can posture positively and/or negatively affect your outcomes for dysphagia treatment?
- How does interprofessional practice influence your clinical decision-making for dysphagia treatment?
- How can your daily practices for dysphagia treatment affect the overall health of the population?

Value-Based Care Key Concepts

1) The goal of Value-Based Care is "The Triple Aim:" Better ***Health***, Better ***Care***, Lower ***Cost.***



2) Achieving Value-Based Care is based on the successful integration of these components:
   a. Interprofessional Practice (IPP)
   b. Top of License Practice
   c. Evidence-Based Care
   d. Patient Activation and Engagement
3) Interprofessional Practice Model:



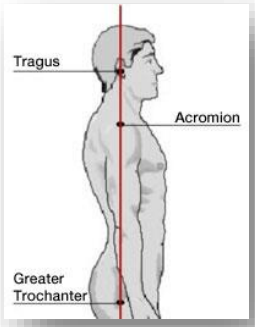
4) Population Health
    a. Definition = “Health outcomes of a group of individuals, including the distribution of such outcomes within the group.” (David Kindig, MD, PhD)
    b. Determinants / Factors
        i. Health Care
        ii. Individual Behavior
        iii. Social Environment
        iv. Physical Environment
        v. Genetics
5) Relevant outcome measures
    a. Population Health outcomes
    b. Therapeutic outcomes
    c. Interdisciplinary outcomes
    d. Patient-centered outcomes

Postural Key Concepts

1) Posture affects many different systems, including:
    a. Respiratory
    b. Digestive
    c. Musculoskeletal
    d. Nervous system

Hyperkyphotic posture (Forward Head Posture) is associated with a greater rate of mortality. (Kado, et al, 2004)

2) “Good” posture is defined as ears aligned with the shoulders and the shoulder blades retracted.



3) According to Davis’ Law, soft tissues will adaptively shorten, tighten, and weaken due to poor posture.

The connection between Dysphagia and Posture

1. The primary factor contributing to dysphagia in the elderly is age-related disease (Sura, Madhavan, Carnaby, & Crary, 2012)
2. Conditions which contribute to dysphagia in the elderly fall into four main categories (Groher & Crary, 2010)
    a. Neurologic disease (Dementia, TBI, Stroke, etc.)
    b. Progressive disease (Parkinson’s Disease, Huntington’s Disease)
    c. Rheumatoid disease (Progressive systemic sclerosis)
    d. Other (Medication-related, radiation, chemotherapy, respiratory compromise)
3. Changes in posture occur in conjunction with many of the diseases that contribute to dysphagia in the elderly.

SLP Assessment with a focus on Population Health and Dysphagia

1) Complete chart review focusing on identification of diseases and conditions that may have implications for posture and dysphagia (see above)
2) Observe physical symptoms related to posture (e.g., asymmetry, chronic open mouth posture, reduced eye contact, etc.)
3) Identify and assess general dysphagia symptoms related to posture (e.g., presence of temporomandibular joint dysfunction, bruxism, chewing only on one side, fatigue during meals, etc.)
4) Identify and assess oral and pharyngeal symptoms related to posture (e.g., xerostomia, anterior bolus loss, increased risk of penetration and/or aspiration, etc.)
5) Recognize that other less-obvious symptoms may also be related to posture and dysphagia (depression, decreased wound-healing ability, reduced eye contact)
6) Develop a patient-centered plan of care that addresses the root cause(s) of the dysphagia impairment to achieve better overall outcomes

Interprofessional Practice Application to Treatment of Dysphagia and Population Health

How can we utilize all of the resources at our disposal, combined with a focus on patient-centered care, to help our patients achieve maximal and long-lasting outcomes?

1) Is a referral to other therapy disciplines needed?
2) How can we communicate and collaborate with other therapy disciplines to maximize treatment outcomes for dysphagia?
3) Is a medication review needed?
4) Is a physician referral (GP or specialist) indicated?
5) When is the right time to develop and train for HEP/RNP/FMP?
6) How can we activate and engage our patients and their families to take an active role in their treatment?

Selected References:

- Groher ME, Crary MA (2010). *Dysphagia: Clinical Management in Adults and Children.* Maryland Heights, MO: Mosby Elsevier.
- Kagaya, Hitoshi et al, (2011). Body Positions and Functional Training to Reduce Aspiration in Patients with Dysphagia. *JMAJ 54(1):* 35-38.
- Rofes L, Arreola V, Almirall J, et al. (2011). Diagnosis and management of oropharyngeal Dysphagia and its nutritional and respiratory complications in the elderly. *Gastroenterol Res Practice.* doi: 10.1155/2011/818979.
- Sura, L., Madhavan, A., Carnaby, G., & Crary, M. A. (2012). Dysphagia in the elderly: management and nutritional considerations. *Clinical Interventions in Aging*, *7*, 287–298. http://doi.org/10.2147/CIA.S23404