Questions/Answers from Becky Dorner & Associates 3/21/19 Webinar

IDDSI: Teamwork from Regulatory Requirements to Successful Implementation

Our sincere thanks to Karen Sheffler, MS, CCC-SLP, BCS-S and Brenda Richardson, MA, RDN, LD, CD, FAND for sharing their time to answer the questions that we did not have time to answer during the live webinar. There is also an extensive Question and Answer document from Webinar 1: The International Dysphagia Diet Standardisation Initiative: The Who, Why, What & How*. In addition, IDDSI.org has a page of FAQs. Remember that the IDDSI.org website is a living site and continues to change as information becomes available. These questions were answered using the information that was available at the time of the document's publication (3/28/19).*

Question: We are confused as we have never triggered therapeutic diet defined by the MDS as a mechanically altered diet. For example, a regular diet, puree consistency diet would trigger mech altered diet but not a therapeutic diet.
Answer: The Resident Assessment Instrument (RAI) does not define an altered food/fluid consistency as being a therapeutic diet for MDS coding. On the other hand, the CMS State Operations Manual (SOM), Appendix PP includes altered consistency as being a therapeutic diet in guidance to the surveyors. So even though it is not coded on the MDS form, surveyors will be reviewing mechanically altered diets as therapeutic.

Question: Our facility is based on the household model with CNAs and nursing staff serving residents in their individual kitchens and dining rooms. Any suggestions on how to initiate training on these diets for nursing staff?
Answer: Training will be similar to that of most facilities. You will have to analyze what they are serving out of the kitchens and teach them the testing methods to make sure they do point of service food and liquid testing.

In general, help nurses and other staff know **why** you are changing to IDDSI. Go to theIDDSI.org website and click on the IDDSI Resources tab. Review the first two Presentations listed. You can easily give 10-15 minute presentations on the importance for patient safety and consistency across institutions. Stress the fact that we are going from systems that were ***subjective*** and not based on good evidence to a system that is objective and based on evidence. The subjective methods of the past caused dysphagia diets to vary greatly, even between two institutions in the same town. Labels of "honey" and "nectar" have always been confusing for nurses, so I like to tell nurses right away that all the labels make sense now with IDDSI (e.g., we know what "mildly thick" and "moderately thick" mean. We know what "minced and moist" means, as the label itself is descriptive, whereas the old term of "mechanical soft" was vague and did not have consistent meaning across facilities). The added bonus is that IDDSI has translated labels and descriptions across many languages, so nurses can give information in multiple languages to meet their patients' needs.

Start promoting that this will be helpful and easy, how it will improve patient safety and take the guess-work out of what nurses have had to do for years. It will also help them avoid liability in instances of choking and choking deaths. Following a standard will be better for all.

Question: I would be interested to learn if there are any participants who are part of large hospital groups that are beginning the transition. We are in a group of 15 hospitals and it is overwhelming to think about the coordination. Each hospital has its own menu, but the EMR is common among all. It is going to be a project to have each hospital working on the implementation at the same time the entire system working in a coordinated way.
Answer: The problem is that each facility is doing its own thing with its own diet labels, descriptions and different menu items. We need standardization so that we can all communicate effectively together. Imagine one person going from a smaller hospital in that group and getting transferred

to a bigger hospital, and none of the diet labels were the same. The doctors and patients are left confused, and people can choke and die with these kinds of set-ups for major errors. A common language is the goal of IDDSI for patient safety.

Start with presentations and letters to the administration to help get buy in from the top-down. Maybe some higher up administrator has had experience with dysphagia diets with a loved one and can understand safety needs. Don't be "that hospital" that only gets involved with improving patient safety AFTER a sentinel event related to diet errors.

Years ago, Karen was part of an effort to get 6 hospitals in one system to reach consensus on the National Dysphagia Diet (2002). **It can be done!** IDDSI is a better system with much better evidence to change to.

A large healthcare system here in Boston is in a similar situation, having many hospitals under one entity. The RDNs are starting to talk amongst hospitals at their monthly EPIC meetings. RDNs and SLPs are meeting individually at the separate hospitals. They noted the difficulty of having different kitchens and different menus. They like the idea of one of the smaller hospitals within the big network to try to implement IDDSI first, and then expanding that model to the larger system. You need to find champions across the system to pull things together. It was similar to when these big systems changed over to the EPIC computerized documentation - they needed specific champions/experts and lots of training. First train the trainers and then expand.

Of course, it was easier to change one hospital at a time (e.g., our story at Beth Israel Deaconess Medical Center, Boston, was written up in the April 2019 ASHA Leader). Also see the presentation by SLP and RD from University of Michigan on IDDSI's YouTube channel.

Question: Could a patient be on pureed solid foods and thin liquids? Or, regular foods and extremely thick liquids at the same time?
Answer: Yes. As noted in the webinar, you do not have to be on combinations that appear to be connected (i.e., Puree level 4 with extremely thick liquid). Those levels are just connected in the framework because they act the same in the mouth.

The SLP will select least restrictive/safer diet options within the SOLIDS and within the LIQUIDS. There are many different combinations, like puree and thin liquid or minced and moist and mildly thick liquid. The texture and liquid will depend on the pathophysiology of the person's dysphagia (what is wrong with the swallow structure and function or with the person's attention/cognition/safety awareness). If you are an RDN or an RN, do not try to guess which consistencies are best. The SLP should do full evaluations to determine what solids and liquids are the best. For example, thicker is not always better. Many nurses automatically tell people to chin tuck, but sometimes the chin tuck can make the swallow worse and cause aspiration!

Dysphagia is often complex and multifactorial, and it frequently needs instrumental evaluations (videofluoroscopic swallow studies / modified barium swallow studies and/or fiberoptic endoscopic evaluations of swallowing / FEES) to determine the best diet for the patient. If you are an RDN or RN, please support the SLPs in advocating for extra testing for patients to determine best solids and liquids. Sometimes sending patients out for these tests or getting the exams brought to them is difficult to pass through the doctors and administration.

The tests are so important (ask: would you decide NOT do an x-ray if someone fell? We need to visualize the swallow to determine the best diet, as we don't have x-ray vision). These

instrumental evaluations not only help guide what diet to start on, they also help target therapy to what part of the swallow needs rehabilitating.

Question: It looks like the texture and thickness of liquid are automatic? What would the numbers be for a puree with thin liquids?
Answer: Not sure what you mean by "automatic." As noted above, the solids and liquids are selected carefully based on an individual patient's needs.

Puree is level 4. Thin liquid is level 0. There are 8 levels total with liquid through solids (from 0 to 7). The numbers are just one indicator of that level, as well as the label, the color and the right-side up or upside down triangles. These are just multiple visual indicators to recognize the diet and level.

Karen likes this IDDSI handout as it shows how the clinician will fill in the person's food and liquid in the handout - inside the triangles:
http://ftp.iddsi.org/Documents/Backpage_consumer_handout_Adult_What_is_the_IDDSI_Framework_30Jan2019.jpg

Question: Have you implemented this language into your electronic health record and how is that done?
Answer: At Karen's hospital, they have not yet switched over the labels in the EMR yet. It will vary based on your record system. Talk with your IT people. It will also require training the physicians, NPs, PAs who write orders. Make sure to use drop-down menus that make the medical team select a solid and a liquid separately. Please also see the presentation on the IDDSI YouTube channel from the group at the University of Michigan.

Also refer to the IDDSI website Resources tab for Abbreviations suitable for food service software.

This would also apply to long term care or any setting using electronic medical records.

Question: Do you have a recommendation on equipment to modify textures/blenderize small portions (~10 servings at a time)?
Answer: It depends on the type of food that needs to be modified. Blixers do a nice jog of pureeing foods. Food processors would work well for other textures. Blenders work well for liquids.

Question: The biggest challenge is getting the food in the appropriate textures. This is not a simple allowed/not allowed issue. It will be challenging to convert current menus and recipes to comply with the new criteria. Any suggestions for resources on how to do this?
Answer: Use the tools provided at IDDSI.org along with food distributor and manufacturer recommendations for specific recipes. You may want to consult with menu companies that are in the process of converting their current menus.

Question: Will we be able to recommend a liquidized diet that's thinned further, to Mildly Thick 2 level if patients cannot handle thick foods and need something more drinkable?
Answer: They would be on a full liquid - mildly thick level 2 diet without solids. You will have to make sure that the liquids are all high calorie and all soups, cream of wheat, etc. are at a mildly thick level. This diet is actually quite typical for people who suffer with the effects of head and neck cancer and subsequent chemo/radiation treatment. Aspiration of thin liquids is common, but textures that are too thick (moderately thick or extremely thick) may get stuck in the throat.

Question: Would you recommend that the RDN write an order for a diet upgrade? For example, upgrade from pureed to mech soft? Or upgrade liquids?
Answer: I don't fully understand your question, but here are some thoughts. RDNs and SLPs can only write diet orders in facilities where they have written policies to do so.

In many places, the diet order needs to come from the doctor, NP or PA. Typically, nurses can downgrade for safety, but an upgrade is different, as it could cause serious consequences like choking. Diet upgrades are typically based on a full evaluation by an SLP, who is trained to consider the oral, pharyngeal, and esophageal ramifications of a diet upgrade. We can also finally stop using that vague term: "mechanical soft."

If the RDN thinks a person can be upgraded off a pureed diet, then the RDN should recommend an evaluation by an SLP. Often, people are downgraded to pureed diets when they are very sick, but then no one remembers to order the SLP swallowing re-evaluations to see if they can be upgraded off puree. We all want people to be on the least restrictive diet with the best quality of life, while meeting patient safety standards. We all know that we cannot prevent aspiration and/or a choking event 100% of the time, but we can take reasonable measures to reduce risks, as long as the patient and/or healthcare proxy agree with the plan of care. Sometimes a person's goals of care dictate that he/she does not want extreme measures of downgrading the diet and liquids. Then we offer some feeding/swallowing strategies to make that diet as easy as possible. Again, we cannot dictate a diet upgrade or downgrade, but we can provide options for the patient/family to make informed decisions. However, we need good documentation and communication across staff.

Question: I read that different syringes are giving very different results - will it be necessary to buy a specific syringe?
Answer: Please make sure that your syringe measures 61.5mm from 0 to 10. Karen has found that "slip tip" syringes give slightly different results than the "luer lock" syringes, but very slight. Karen has used 10ml BD syringes as shown in the presentation.

The specific reference number of the BD slip tip syringe that Karen uses is REF 303134. The BD Luer Lock reference number is 302995. IDDSI says that calibration of a syringe should show that water at Level 0 should run through the syringe in 7 seconds.

Question: Are there resources on how to create a consistent Liquidised texture? How do we know how much liquid to add?
Answer: You can flow test the results to make sure it is Moderately thick or less. You can use the spoon tilt test and Fork Drip tests for this texture too. Make sure to not just add water, as that would dilute the nutritional content.

Question: How do you handle diet orders if the diet manual being used does not include IDDSI terminology?
Answer: Diet manuals are being revised to include IDDSI. Again, this is a process, and IDDSI realizes that it will take 1-2 years at least. The Academy and ASHA have set that May 1, 2019 date to make sure that people are *starting* the process - like you all are now.

Question: How practical is it to have to use the flow tests, fork/spoon tests or the fork pressure tests when you are preparing meals/drinks for more than 1 person?

Answer: One kitchen in our facility could be preparing dysphagia meals/drinks for 10-15 people at the same time. Once you make up a recipe and plan, you should not have to test every single tray for every patient.

See the IDDSI.org website for Audit Sheets (Under Implementation section in Resources tab). I'm sure in the past you have done quality control testing with sample trays and random samplings on your tray line. Now you have the Audit Sheets to help cooks do these quick testings to make sure that the meals are accurate.

The tests are meant to be handy POINT OF SERVICE testing methods. Everyone has a spoon or a fork on the tray. The CNA or nurse upon serving the food can also double check / make sure the food is moist and soft enough with accurate particle sizes. For example, the 4mm particle size of Minced and Moist is the size that would fit between two tines of a fork. The 1.5cm particle size of Soft and Bite-Sized is about the distance across a dinner fork or the size of the patient's thumbnail.

The spoon tilt test can be easily done at the table with the patient, making sure that the purees are moist and slide off a spoon easily. Not sticky, thick, dried out edges that could cause choking even with a puree.

Regarding drinks: industry partners are starting to make sure that their products fall in line with IDDSI. If you purchase pre-thickened liquids, you will not have to retest the liquid viscosity every time. However, the SLP and RDN can team up to flow test all the supplements that your facility offers, so that you know which ones are really Mildly thick/nectar thick and which ones are too thin for Mildly thick. Test them when they are cold and room temperature, as colder liquids are thicker, but often liquids sit on trays and do not stay cold. This is really important to test all supplements (sample at least three times per type of supplement). You can see Karen's flow test results at www.swallowstudy.com, searching for IDDSI Resources blog.

Question: What are the anticipated increased costs with this transition? As healthcare moves towards more value based care models, can you speak about quality metrics for SLP and dietitians related to this topic?
Answer: Think about the savings in risk management. You now have a new standard based on good objective evidence rather than poor subjective diet descriptions that are not easy to definitively define in a court of law. Patient safety is paramount.

The preparation and testing of these diets does not require any fancy equipment. That was the idea of IDDSI - to make all testing methods easy. You do not have fancy viscosity equipment, but obtaining syringes in healthcare is easy and affordable. A syringe is as fancy as IDDSI gets. You can do testing with fingers, spoons, forks, chopsticks and your eyes.

All IDDSI resources are free and available to the public. Implementation has started around the world in countries with fewer resources than ours.

"Dysphagia has a substantial health and cost burden on the US healthcare system," per Patel, et al. (2018). See: https://www.ncbi.nlm.nih.gov/pubmed/29155982. Maybe with increased efficiency with IDDSI, these costs can be brought down! IDDSI finally allows hospitals, rehabs, nursing facilities and home health care to talk the same language. If you have a swallow study at one place and you are given a diet with clear IDDSI labels, the next facility may not have to

completely re-evaluate so thoroughly as that facility will understand the standardized diet that the patient is on.

Question: Is it recommended to test pre-thickened liquids before service?
Answer: Once you have a company that you trust, then you should not always have to retest every cup of liquid before service. Many industry partners of IDDSI have already started to tweak their formulas for better consistency/accuracy with IDDSI. Some are starting and others may not have started yet. You need to analyze the products in your facility as you learn more about IDDSI.

Test all the liquids that you get from your current pre-thickened liquid supplier. There are companies that have no consistency among the different juices that they provide. One has "nectar thick" cranberry at a much thicker level than the apple. Test it all - the water, the apple, orange, cranberry, milk. When you test the liquids from a company and find discrepancies, call that company and ask what they are doing to ensure that all their liquids test consistently within IDDSI expectations for Mildly thick and Moderately thick. If you are not satisfied with that company, push to change companies in your facility. Additionally, push for switching to the "clear" xanthan gum formulas, as we now know that is better than the corn starch based thickeners for maintaining thickness in the mouth and cup once saliva and amylase mixes with it. Clinicians can push industry to take notice and improve products for patient safety for all.

Question: What desserts will work for levels 5 & 6?
Answer: We have to get creative. IDDSI will be sharing recipes in the future. I could imagine a fruit cobbler (peach cobbler) would be good with a soft topping rather than the crispy/crumbly topping.

Some people have found that the particle size requirements of Level 5 (4mm) and Level 6 (1.5 cm) are quite restrictive and cause a lot of menu items to be eliminated. That is one reason why people asked for that Level 7 Easy to Chew diet - which is soft but does not have the very small bite size of level 6.

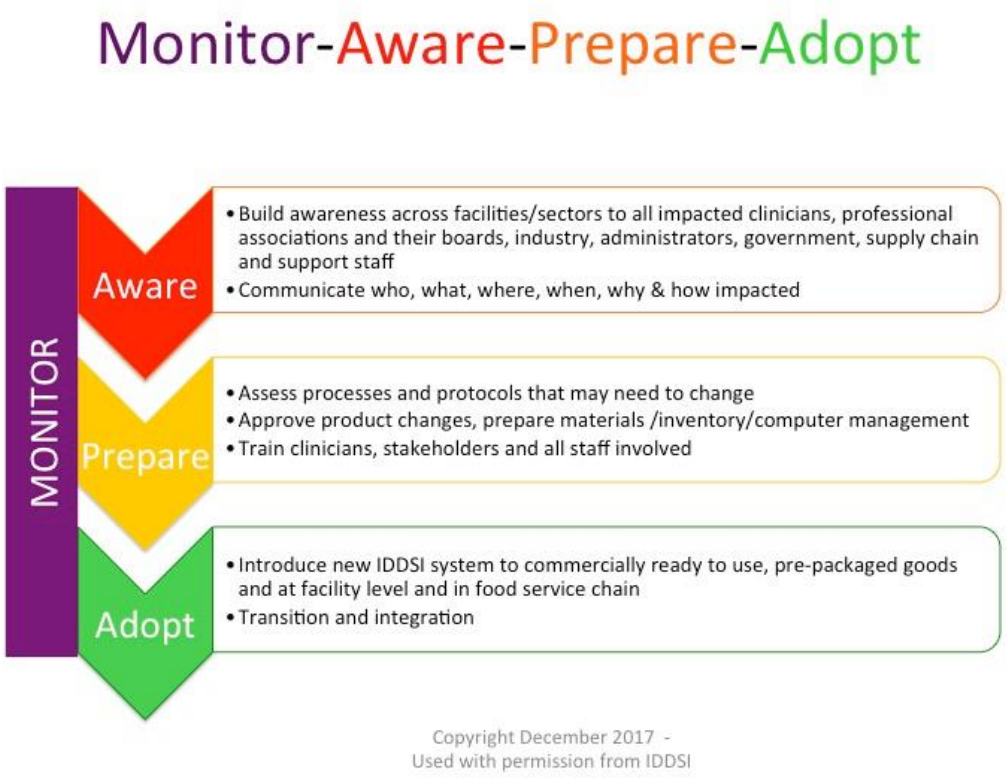
Question: Do you have to follow testing methods for Easy to Chew or are they optional and it is more just to make sure the food is soft and moist?
Answer: Easy to Chew would use the Fork Pressure Test as its main testing method. Please see 4 pages of descriptions of this diet on the IDDSI website under "Consumer Handouts" section:
http://ftp.iddsi.org/Documents/7_Easy_to_Chew_p1_Adult_pg1_consumer_handout_30Jan2019.jpg
http://ftp.iddsi.org/Documents/7_Easy_to_Chew_p1_Adult_pg2_consumer_handout_30Jan2019.jpg

Make sure foods are moist and soft. Here is a full description of it from IDDSI:

- "Soft, but not necessarily bite-sized."
- Does not prevent choking.
- Normal everyday foods of soft/tender textures only, that are developmentally and age appropriate.
- Requires biting & chewing ability.
- Foods are naturally moist, and NOT:
    - Hard, chewy, fibrous, stringy, and
    - No seeds, bones, gristle.
- For patients with some weakness and/or who tire easily.
- Mixed consistencies may be okay.

Question: What is the timeline for the transition from NDD to IDDSI. Is the deadline May 1, 2019?
Please do not think of this May 1, 2019 date as a ***deadline***. It is the beginning of the transition to IDDSI. The beginning of the Implementation. IDDSI Implementation Guides are 12 month calendars that start with just building awareness in yourself and at your facility. This is like a kick-off.

IDDSI has been published since 2016, but only now have the Academy and ASHA come together to really expect its members to start this implementation. Implementation has to start with Awareness. Some people are already at the adoption phase, but start where you are. Ultimately, just start. If you get started with Implementation Guides, then if you are asked in 6 months by a surveyor, you can at least show them where you are in the process and speak clearly on the need for IDDSI and your plan. This is IDDSI's concept:



Question: Can you give a couple examples of naturally occurring slightly thick liquids?
Answer: Ensure and Nepro supplements are only slightly thick, for example. Also, likely most tomato juices and eggnogs are slightly thick, but you will have to flow test them to make sure.

In a blender, you can make all kinds of smoothies, adding yogurt, banana, avocado as natural thickening agents. But flow test the results. Send patients home with syringes to keep flow testing their blender creations.

The area of "slightly thick" is potentially exciting. If you have a patient who is particularly not going to drink that liquid that is nectar thick/mildly thick, then test them with the instrumental evaluation with slightly thick liquids. Maybe he only needs a liquid that is a little thick, and not necessarily all

the way to a nectar thick/mildly thick. Please see IDDSI Resources tab under "Print and Display" section for the conversions or "mapping" to Varibar barium. This provides ideas on how to make a slightly thick barium liquid for your testing.

Question: Will Barium swallow tests delineate texture/consistency using IDDSI guidelines?
Answer: They should. Barium liquids map over to the IDDSI levels fine. See that section I mentioned above. Here is the link: https://ftp.iddsi.org/Documents/Mapping_Varibar_to_IDDSI.pdf

Karen has started to dual label in my reports. As an SLP, you should start recommending diets that map over to IDDSI labels. For example, if you are recommending a moist ground and nectar thick liquid, but put in parentheses "aka, Minced & Moist, Mildly thick liquid according to IDDSI.org guidelines". That way facilities that are already moved over to IDDSI know what you are recommending.

Karen has already started using the super helpful food testing methods to teach out-patients about "soft" foods after their VFSS/modified barium swallow studies. In the past, we never had an objective way to describe "soft." Now everyone understands the fork pressure test. Additionally, to prevent choking, it is easy to describe to the patient to cut foods to the size of your thumbnail - to make sure you do not block off your airway/trachea. The bite size of 1.5cm is supposed to fall through the opening of the airway rather than block it off. An adult thumbnail or a child's pinky nail are about the sizes that you want of the food to make sure it does not block their airways. Info from April 2018 webinar 1 on BeckyDorner.com:

Adult	Pediatric

• Bite-size = 1.5 x 1.5 cm
  ○ Adult thumb nail
  ○ About the width of fork
• AVERAGE ADULT AIRWAYS:
  ○ Male = 21.5 mm
  ○ Female = 17 mm
	• Bite-size = 8 x 8 mm
	• PEDIATRIC AIRWAY = 8 mm
	• INFANT AIRWAY = 6.5 mm

Question: Shouldn't speech pathologists lead this implementation since it is their expertise with orders originating from their evaluations?
Answer: SLPs could not do it without RDNs! RDNs have the food service connections, and RDNs can make sure that the modified foods have sufficient nutrients. Imagine if liquidized level 3 was just created by adding water! How diluted would the nutrients be? Supplements are recommended by RDNs (based on comprehensive nutritional assessment), and together with the SLPs, you can make sure you are recommending the right supplement for the right person.

Question: Are any foodservice companies adding these diets to their spreadsheets?
Answer: Yes, some food service/distributing companies have begun to change their menus. Check with your vendor for more information.

Question: How is the food production department in long term communities preparing for this many consistency of diets? They typically aren't staffed like a hospital.

Answer: The implementation process is different for each location and this is where the IDDSI.org implementation resources become a valuable tool. This tools also can be a part of the QAPI program.

Question: In the Soft & Bite sized and Minced & Moist diets, it says with no separate liquid. Does this mean there should be no beverages served with meals?
Answer: No. This means that there should be no mixed consistencies (i.e., soups with chunks plus liquids, cold cereals with milk), unless cleared by the SLP. It takes extra skill and control to manage a mixed consistency. Sometimes we test these specifically on our instrumental exams.

Also, the stews should not separate with a thin liquid leaching out.

Please continue to think of diets as a prescription of a solid and a liquid separately. The patient may be on Soft & Bite-Sized and Mildly thick liquid, and may not tolerate any thin liquid so mixed consistencies are not served.

Question: What is best practice to document patients who refuse diet modification however are at high risk for choking?
Answer: Of course, these lengthy topics on ethics, quality of life and patients' rights were not addressed in our presentation. Therefore, we will only briefly touch on this issue. It is important to note that when we as clinicians provide recommendations, they are only that - recommendations. The physician (and/or NP or PA) ultimately sign off on orders. The entire medical team needs to make goals and decisions WITH the patient or healthcare proxy. We cannot mandate a diet on the patient. That just leads to us saying that they are "non-compliant." We need to stop using that term, "non-compliant." People have the right to direct the course of their treatment. We can also learn to improve documentation.

There are some excellent resources available from the Pioneer Network to assist in assessing risk vs benefit (www.Pioneer.net). Another great resource can be found at http://www.justiceinaging.org/giving-elders-a-voice-in-their-own-care-person-centered-care-and-choice/ which includes a report on how to create true person-centered care in the context of a long-term care environment. The report was a result of The Rothschild Person-Centered Care Planning Task Force, sponsored by the Hulda B. and Maurice L. Rothschild Foundation, in which Justice in Aging participated.

Question: If a resident in long term care voices their dislike of being ordered a pureed diet for dysphagia and we let the MD know and he refuses to write the order to upgrade what do we as a facility do in that case?
Answer: We have to follow the MD order. There should be good communication among the whole team, with patient or healthcare proxy included in any discussions. The MD may have sound rationale for being cautious. However, the MD needs to be documenting clearly what his rationale is for going against the patient's wishes. For example, "after long discussion of the risks and benefits, the patient and the team have decided…."

If the MD continues to essentially ignore the communications from the rest of the team and from the patient/healthcare proxy, then the facility needs to document thoroughly in case the issue ends up in a court of law. Potentially, the patient or healthcare proxy could decide to change physicians as well, as that does not seem to be a reasonable or prudent manner to make healthcare decisions.