FEEDING, EATING AND SWALLOWING SPECIALTY CERTIFICATION
Occupational Therapist

Table of Contents: ACTIVITY EVIDENCE FORMS

- Below is one example for each type of form, not for each criterion. The examples are to help you understand how to complete each form, regardless of the criterion.
- The forms that are included are hyperlinked in the table of contents below.
- Please note that these are examples only to help guide you in the type of information to include. For many reflections, your style may be different; for example, more narrative or more bulleted.
- Note that unused forms (pages) are not included in this document. Please do the same with the final set of evidence forms you submit with your application.

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- Formal Learning– Minimum 10 contact hours needed
- Independent Learning–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

Criterion 2: Knowledge: Evaluation
- Expert Witness
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- Independent Learning–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

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- Independent Learning–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

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- Presentation
- Public Awareness Effort
- Volunteer Leadership
Criterion 1 – Knowledge: Diagnostic Considerations

Demonstrates knowledge of primary and secondary conditions that impact occupational engagement related to feeding, eating, and swallowing.

Guidelines

- Examples of peer-reviewed publication include journals such as *AJOT* or *OTJR*.
- May include a chapter in an occupational therapy or related professional textbook, if chapter has gone through peer review (a process in which subject matter experts, using a formal system and defined guidelines, provide content guidance to an author and recommend publication, revision, or rejection of a work).

1. Submit APA reference for the publication. For in-press publication, also include a verification letter or e-mail identifying applicant and anticipated date of publication.


2. If applicant is not identified as first or second author, please describe your contribution/involvement in the development of the publication. (*average word guideline=200*)

   **Author.**

3. Provide a reflection indicating why this publication was chosen to represent "knowledge of primary and secondary conditions that impact occupational engagement related to feeding, eating, and swallowing." (*average word guideline=200*)

   This publication helped me to refine my skills in the treatment and evaluation of geriatric clients with dysphagia. The focus of the geriatric population also means looking at common diagnoses that may put a geriatric patient at a higher risk for dysphagia, such as stroke; brain injury; spinal cord injury; multiple sclerosis; muscular dystrophy; post-polio syndrome; cerebral palsy; Parkinson’s disease; amyotrophic Lateral Sclerosis; Alzheimer’s disease and other forms of dementia; arthritis; head, neck and esophageal cancer; head or neck injury or surgery; decayed or missing teeth; poor fitting dentures; endotracheal intubation and tube feeding. Some of the larger areas of concern that I became more familiar with (when thinking about dysphagia and the geriatric population) included: oral care, polypharmacy, quality of life, and dehydration. My increased awareness of the issues concerning the geriatric population in a long term care facility enabled me to develop the best care plan to address a client’s dysphagia concerns.

   Through the research I conducted when writing this chapter, I feel more competent in my understanding of secondary conditions that impact the occupation of feeding, eating, and swallowing and I am better able to provide appropriate information regarding decisions for safe and adequate nutrition.
EXPERT WITNESS/TESTIMONY

Criterion 2 — Knowledge: Evaluation

Demonstrates knowledge of relevant evidence specific to evaluation in feeding, eating, and swallowing.

Guidelines

- Serving as an expert witness in a civil or criminal legal case court or in arbitration.
- Providing expert testimony in official hearings at the local, state, or national level.

1. Describe the expertise which you were able to share relevant to feeding, eating, and swallowing. (average word guideline–200)

I testified as an expert witness for the state during a custody arbitration on pediatric dysphagia. The family involved in this case was charged with endangering the child by withholding medically indicated treatment. The child was diagnosed with severe, chronic aspiration requiring medical insertion of a gastric feeding tube for nutrition and hydration. The family continued to feed the child orally, resulting in multiple hospitalizations for pneumonia.

A modified barium swallow study was performed at a regional medical center by the hospital occupational therapist and radiologist. The recommendation by the medical center team was for the child to receive no food by mouth since oral feeding was identified as a risk for aspiration and pneumonia.

As an expert witness in the evaluation of pediatric dysphagia, I was asked to view the modified barium swallow study and provide an interpretation of this dysphagia assessment. I confirmed that the study demonstrated consistent aspiration below the vocal folds with all textures of solids and liquids, and bolus pooling in the area of the vallecula.

I provided testimony for the state that the typical intervention for dysphagia of this severity for a child this age is feeding via a nasal gastric tube and subsequent placement of a gastric feeding tube if the condition does not resolve.

2. Describe how the knowledge acquired from this activity “demonstrates knowledge of relevant evidence specific to evaluation in feeding, eating, and swallowing.” How did the activity influence the way you practice, or how did it affect your client outcomes? (average word guideline–200)

As an expert witness, my participation in this arbitration hearing demonstrates my expertise in evaluation of feeding difficulties, namely the assessment of dysphagia. While the evaluation of feeding difficulties requires comprehensive assessment methods, confirmation of aspiration is generally made through diagnostic assessment such as a modified barium swallow study, video fluoroscopy, or fiber optic endoscopic evaluation study (FEES). My training in these assessment methods has classified me as an expert in swallowing evaluation.

In preparation for the hearing, I performed a literature review to verify that I was using the most current and evidence-based knowledge regarding interpretation of diagnostic swallowing assessments and making subsequent recommendations based on diagnostic findings.

Participation in this activity influenced my practice by reminding me to consider the implications of my recommendations based on these diagnostic assessments for children and their families, particularly for the difficulty families may face in accepting and following recommendations for no oral feedings. It affected my client outcomes by reminding me to continue to be client-centered and when recommendations of this nature are made, to ensure that families have the information, support, and resources needed to care for their child.

3. Submit verification of activity as a separate attachment. May include any 1 of the following:

- Transcript of the testimony.
- Notice of deposition.
- Letter from the attorney.
**Formal Learning**

*Back to Criteria*

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**Criterion 3 — Knowledge: Intervention**

Demonstrates knowledge of relevant evidence specific to *intervention* in feeding, eating, and swallowing.

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**Guidelines**

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

**Please identify the type of activity in which you participated:**

- ☐ AOTA CE: Participation in Self-Paced Clinical Course or CE Product from the list of AOTA offerings approved for this certification. *Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.*
- ☐ Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.
- **X** Participation in post-professional academic coursework. *Attach unofficial transcript.*

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1. **Activity information.**

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>University XYZ– Foundations in Feeding, Eating, and Swallowing for the Adult with Neurological Impairments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider/Instructor</td>
<td>Jane Doe, PhD, OTR/L, SCFES</td>
</tr>
<tr>
<td>Activity Date(s)</td>
<td>06/10/XX to 08/30/XX</td>
</tr>
<tr>
<td>No. of Contact Hours</td>
<td>3 College Credit hours—45 contact hours</td>
</tr>
</tbody>
</table>

2. **Activity Learning Objectives. *List up to 5.***

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A)</td>
<td>The learner demonstrates knowledge of neurological disorders impacting swallowing for adult clients.</td>
</tr>
<tr>
<td>B)</td>
<td>The learner demonstrates knowledge of the normal and abnormal stages of oral, pharyngeal and esophageal components of swallow.</td>
</tr>
<tr>
<td>C)</td>
<td>The learner demonstrates knowledge of three intervention techniques to be used with adult clients exhibiting neurologically-related swallowing disorder.</td>
</tr>
<tr>
<td>D)</td>
<td>The participant will demonstrate knowledge of a topic related to intervention to present to the class.</td>
</tr>
<tr>
<td>E)</td>
<td></td>
</tr>
</tbody>
</table>
3. Describe the relevance of the activity to your practice in feeding, eating, and swallowing. *(average word guideline–200)*

One third of my outpatient caseload consists of older adults, aged 70-90+ years with a diagnosis of Parkinson’s disease. These patients suffer from a variety of issues compromising their swallowing from their neurological diagnosis and from aging-related problems. My patients relate the impact their feeding, eating, and swallowing problems have on their daily intake of food, fluids, and medication. Their problems range in severity from embarrassment, resulting in withdrawal from social events surrounding dining, to that of compromised energy and health. Research articles I read on intervention of swallowing problems in this population tend to focus on one treatment approach over another. This course offered additional knowledge and intervention techniques, as well as opportunities to present and gain feedback from instructors and class participants concerning interventions for this population.

4. Describe how the knowledge acquired from this activity “demonstrates knowledge of relevant evidence specific to intervention in feeding, eating, and swallowing.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

The course presented the treatment of oral, pharyngeal, and pharyngo-esophageal components of Parkinson’s disease and related disorders that I routinely apply to my patients. I found use of techniques for oro-pharyngeal sensory stimulation and lingual strengthening to be very beneficial in improvement of timing and clearing during swallowing. These improvements were verified clinically with decrease in coughing during treatment sessions, and by the videofluoroscopy swallow study following the conclusion of treatment sessions.

The course also presented information related to psycho-social impact of swallowing disorders in this population. Many clients feel embarrassed to use recommended techniques or fear they will always be required to use them. This attitude can set up negative interactions between clients and caregivers who encourage the use of recommended strategies. I am better able to communicate to my clients and their caregivers the benefit of compensatory methods to provide relief from aspiration and choking during meals as a short-term method, as we work on the neuromuscular strengthening exercises and activities during treatment and home program. By clarifying the 2 approaches and educating both the client and caregiver, our client compliance is improved as the caregiver burden is lessened.

5. Submit documentation that verifies completion of the activity, such as certificate of completion or unofficial transcript. *Not required for AOTA courses.*

For this example, verification is not included but should accompany this activity if submitted.
INDEPENDENT LEARNING  
Back to Criteria

Criterion 3 — Knowledge: Intervention

Demonstrates knowledge of relevant evidence specific to intervention in feeding, eating, and swallowing.

Guidelines

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

Please identify the type of independent learning activity in which you participated:

- [ ] Independent reading from AOTA-Approved Independent Learning List in feeding, eating, and swallowing.
- [x] Independent reading of recent peer-reviewed, professional articles, or chapters in textbook not associated with a formal learning course.
- [ ] Independent review of professional electronic resources (e.g., NIH, CDC, CanChild).
- [ ] AOTA Journal Club Toolkit (reading & discussion time). Must be AOTA member to access the kit.
- [ ] AOTA Critically Appraised Paper (CAP, includes submission to the AOTA Evidence Exchange).

1. Why did you choose this activity?

- [x] Clinical reference for specific population, program, or individual
- [ ] Invited peer review of scholarly work or publication (print or online)
- [ ] Preparation for poster or presentation
- [ ] Preparation for academic lecture
- [ ] Literature review for research project
- [ ] Preparation for serving as a mentor
- [ ] Other, please specify:____________________________________________________________

2. Bibliography of select item(s) used for independent learning. *List in APA format.*

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fraker, C., Fishbein, M., Cox, S., &amp; Walbert, L. (2007)</td>
<td>Food Chaining: The proven 6-step plan to stop picky eating, solve feeding problems, and expand your child’s diet. (Chapters 6, 7, and 8 pages 177-304)</td>
</tr>
</tbody>
</table>
3. **Date(s) of independent learning**

   July 10th, 20XX  
   July 17th, 20XX  
   July 19th, 20XX  
   August 6th, 20XX  
   August 16th, 20XX

4. **Time spent engaged in independent learning.**
   - For reading, estimate 8–12 published pages/hour. *Not required for AOTA-identified independent learning list of resources.*
   - For journal club, discussion time counts toward 10-hour requirement.

   Reading the resources listed above amounted to 14 hours of independent study.

5. **Describe the relevance of the independent learning activity to your practice in feeding, eating, and swallowing.** *(average word guideline–200)*

   While working in an early intervention practice setting, I received an increasing number of referrals for OT evaluation and intervention for children described as picky eaters. Concerns were consistently noted regarding limited food intake and food selectivity. I wondered what the literature had to say regarding the issues of picky eating and food selectivity in terms of recommended intervention practices for children with these concerns.

   I took many continuing education courses with a focus on OT intervention, and wanted to investigate literature outside the OT field to determine if there were additional factors that had not specifically been addressed in my continuing education coursework.

   The question that guided my investigation was “What factors may impact children with picky eating or food selectivity, and what strategies may be helpful in intervention?”

6. **Describe how the knowledge acquired from this activity “demonstrates knowledge of relevant evidence specific to intervention in feeding, eating, and swallowing.” How did the activity influence the way you practice, or how did it affect your client outcomes?** *(average word guideline–200)*

   There were 2 significant take-aways for me through this independent study:

   First, there are numerous feeding disorder categories in which a child’s symptoms might be classified. Knowledge of these various categories was important to better focus my intervention strategies, and to communicate more effectively with other team members concerning these strategies.

   Secondly, the readings emphasized the importance of individual and family relationships with food. As a result, my intervention approach has shifted to incorporate a more relationship-based approach to feeding, and to focus on the relationships that the child and family have with food, as well as with each other, particularly in relation to mealtime participation.

   I found that families are very responsive to the change of focus from simply “eating” to mealtime as a whole. They report progress and changes in areas such as: family meal routines, more pleasurable experiences around food, and more focus on exploration on food as meals.

   Through my independent learning, I discovered reading resources that are parent-friendly and can be shared with families. They are then empowered to ask questions, as well as collaborate more fully in the intervention process.
**Criterion 5 — Evaluation: Performance Skills**

Administers standardized assessments specific to feeding, eating, and swallowing, consistently integrating clinical observations throughout the evaluation process.

**Guidelines**
- Must represent a **minimum of 10 hours** over a minimum of 2 months.
- Does **not** include supervisory relationships.
- Relationship must have occurred in the past 5 years.

1. Dates of mentoring relationship
   
   April 20XX - June 20XX

2. Approximately how many hours did this represent in total?
   
   40 Hours

3. Applicant’s goals for mentoring relationship. **Goals must have been met by time of application. List no more than 3.**
   
   A) Demonstrate competency in performing the clinical dysphagia blue dye (“grape juice”) test.
   
   B) Increase my video fluoroscopy skills to include competency in swallow studies with clients who have a tracheostomy tube.

4. 

<table>
<thead>
<tr>
<th>Mentor</th>
<th>Mark Therapist, MS, OT/L, SCFES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position/Role of Mentor</td>
<td>Clinical Supervisor</td>
</tr>
<tr>
<td>Workplace of Mentor</td>
<td>Anytown Clinic</td>
</tr>
<tr>
<td>Contact Information for</td>
<td><a href="mailto:Mark.therapist@email.com">Mark.therapist@email.com</a></td>
</tr>
<tr>
<td>Mentor (email or phone</td>
<td></td>
</tr>
<tr>
<td>number)</td>
<td></td>
</tr>
</tbody>
</table>

5. State why the mentor was selected to help you meet the goals identified above relative to the criterion. *(average word guideline—50)*

   Mark is a recognized dysphagia expert in our facility. He provides dysphagia training throughout the region for all diagnoses, including those with tracheostomy tubes. He has been AOTA specialty certified in feeding, eating, and swallowing for 2 years.
I provided dysphagia intervention for 10 years; however, I had limited experience with clients with a tracheostomy tube. Following my mentoring relationship, I am more confident and thorough with client dysphagia evaluations and in my ability to administer video fluoroscopy for clients with tracheostomy.

The blue dye/grape juice test is an assessment I now use as part of my clinical dysphagia evaluation. I can determine whether or not suspected aspiration is observed. The client swallows food or liquid with the blue dye added (or just grape juice), and after a short period of time, the nursing or respiratory staff provides suctioning through the tracheotomy. If there is any discoloration of the client's secretions that resemble the blue dye/juice, I can determine that aspiration is occurring. This information helps me make decisions for diet recommendations or the need for further evaluation with a video fluoroscopic swallow study. I am able to independently complete a video fluoroscopic swallow study for more complex clients with a tracheostomy tube.

By using the “grape juice” test I am able to:

- Determine the most appropriate consistency with which to begin the video fluoroscopic swallow study.
- Determine which compensatory techniques can be trialed during the video fluoroscopic swallow study.
- Determine if suctioning through the tracheotomy is necessary following oral intake.
CRITICAL REASONING SCENARIOS
Back to Criteria

Criterion 6 — Evaluation: Critical Reasoning
Synthesizes and interprets assessment data and clinical observations related to the client, context, and performance in feeding, eating, and swallowing.

Guidelines

- Applicant chooses 2 assessments and completes this 2-part form relative to the application of each assessment tool with a client. Selected tools can either have been used with the same client or different clients.
- Assessment tools may be identified from the list, or applicants may submit an assessment that is not listed.
- For each assessment, answer the following questions by reflecting upon a case from your practice. You may choose to use different cases for each assessment tool.

**Part I**

**ASSESSMENT 1** (Part 1 of 2)

1. Name of assessment.
   
   **Canadian Occupational Performance Measure (COPM)**

2. Describe the client, client factors, and case contexts that contributed to your selection of the assessment for the identified case.

   “Andy” is a 20 month old male referred to me by the Early Intervention (EI) evaluation team for weekly OT services to address the primary family concern of feeding difficulties. Andy had a history of failure to thrive, weak upper esophageal sphincter muscle, gastro-esophageal reflux, and a significant respiratory event that resulted in his mother calling 911 and performing CPR. The multidisciplinary EI evaluation report noted intact oral structures and oral functions for eating and swallowing, including a rotary chew for higher textures. Andy’s preferred foods included: yogurt, applesauce, mandarin oranges, peanut butter, crackers, grilled cheese, chicken nuggets, fish sticks, and a supplemental drink. Development was within an age expected range in the areas of motor, communication, and social skills. The EI evaluation report indicated possible impairments in sensory processing, particularly tactile processing, based on observations during the evaluation.

   In addition to the EI evaluation findings, I decided to administer the Infant/Toddler Sensory Profile to gather more information on how Andy’s sensory processing may be influencing his feeding and eating behaviors. I also administered the COPM to help gather further information concerning satisfaction and performance of family occupations. Administration of the COPM revealed the following: 1) Andy’s mother had a history of an eating disorder, 2) the mother had fearfulness with feeding Andy due to the past respiratory event, and 3) there was a lack of consistent mealtime routines at home due to parent work schedules.

3. What considerations regarding reliability, validity, relevance, and currency did you consider when selecting this assessment?

   Due to the family-focus of EI services, the COPM was a relevant tool for better understanding family satisfaction and performance of feeding and eating occupations, and their difficulty balancing these occupations with the work of the parents. Andy’s mother completed the COPM based on self-perception of her overall occupational performance. Psychometric studies show the COPM to be a reliable and valid measure of occupational performance. The purpose of the COPM is to show change in satisfaction and occupational performance; therefore, it was a helpful tool for measuring change in how Andy’s mother perceived family participation and performance of mealtime occupations following several months of intervention.
4. Describe the assessment results, including those gathered through clinical observation, and what these results told you about the client's occupational performance.

   Based on the initial administration of the COPM, Andy’s mother rated “lack of a mealtime routine at home” as her most important problem related to occupational performance. She also identified “long commute to work and long work hours” and her own “avoidance of preparing meals for herself and her family” as other priority problems. Andy’s mother was particularly upset that on most days she could not pick Andy up from daycare until 6 PM, which meant he was very hungry and snacked on preferred foods like crackers during the car ride home and then refused to sit down for dinner with the family at 7 PM. The results from the COPM completed by Andy’s mother helped to confirm information gathered from interviewing and observation of family routines.

5. Describe how and why you integrated these results into the client's intervention plan.

   The integration of multiple assessment results helped me to further understand Andy’s challenges with occupational performance of feeding and eating, given his sensory processing needs and the lack of mealtime routine in the home environment.

   The integration of the COPM with the other assessment results helped to further develop an intervention plan focused on creating mealtime routines at home that supported Andy’s performance of feeding and eating, and also fit with his family’s busy lifestyle. My approach included the suggestion that Andy eat a small, healthy meal at daycare around 5-5:30 PM before his mother picks him up to help decrease her stress about him being hungry and needing to rush to get dinner prepared. The family sat down together for an evening meal around 7-7:30 PM that initially included at least 1 of Andy’s preferred foods. This enabled the family to slowly establish a routine of sitting down together on weeknights and having a meal where Andy eats something and could participate successfully. My intervention approach focused on helping Andy’s mother recognize these small successes and also supporting her in creating more significant, structured mealtime routines on the weekends.

**Part II**

**ASSESSMENT 2** (Part 2 of 2)


7. Describe the client, client factors, and case contexts that contributed to your selection of the assessment for the identified case.

8. What considerations regarding reliability, validity, relevance, and currency did you consider when selecting this assessment?
9. Describe the assessment results, including those gathered through clinical observation, and what these results told you about the client’s occupational performance.

10. Describe how **and** why you integrated these results into the client’s intervention plan.
**Criterion 6 — Evaluation: Critical Reasoning**

**Synthesizes and interprets assessment data and clinical observations related to the client, context, and performance in feeding, eating, and swallowing.**

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**Guidelines**

- *Program development* refers to the creation of a new program or development of an evolving program.

1. **Dates of program development**

   December 20xx to June 20xx

2. **Briefly describe the program purpose, services offered, and clients served. (average word guideline–250)**

   I developed the Rehabilitation Dining Group program in our facility to increase the following with our clients and caregivers:
   - Independence in self-feeding skills, including appropriate use of adaptive equipment as needed, identification of strategies for meal set up, and appropriate positioning and cueing.
   - Socially appropriate eating abilities, with cuing assist as needed.
   - Consistency and follow through with dysphagia recommendations, including diet modifications and compensatory techniques to reduce aspiration.

   OT staff trained in feeding, eating, and swallowing, are present during each group and implement established intervention plans and provide additional education/training in feeding techniques, therapeutic functional activity, diet modifications and therapeutic exercise as needed.

   The program is targeted for adults with neurologic diagnoses in the in-client rehabilitation program. Group size does not exceed 4 clients.

3. **Describe how this program development activity, including description of resources used, demonstrates your ability to "synthesize and interpret assessment data and clinical observations related to the client, context, and performance in feeding, eating, and swallowing." (average word guideline–500)**

   Since we cannot always assign clients with FES needs to a therapist who is specifically trained in this area in our facility, I developed the Rehabilitation Dining Group Program to better meet the needs of various clients in an occupationally relevant situation.

   As part of program development, I identified standard assessments for all group leaders to use that appropriately grade function in feeding, eating, and swallowing according to a client’s diagnosis. One assessment I have become familiar with and now use frequently is the Edinburgh Feeding Evaluation in Dementia Questionnaire (EdFED-Q). This feeding assessment, originally designed for clients with dementia, helps determine the need for possible psychosocial and clinical interventions that may be needed during mealtime.

   During mealtime, I am able to use my professional observation skills and integrate therapeutic use of self when addressing the psychosocial needs of clients related to FES. I can provide education concerning meal choices and discuss resources such as those from the American Dietetic Association. I instruct clients on compensatory techniques that facilitate greater independence, and I teach how to advocate for their feeding, eating, and swallowing needs.

   With regular involvement by practitioners who are trained in feeding, eating, and swallowing, we are better able to observe progress toward goals and modify the care plans accordingly. My skill in performing swallowing evaluations has become more refined, as I am present during an entire meal and can observe limitations in activity tolerance. I also make recommendations in real-time...
during a meal and observe if these changes decrease signs of aspiration or increase a client’s level of independence in feeding.

Data being gathered includes number of program participants, diagnoses and measurement of the functional oral intake scale to document improvement. This data gathering is beneficial to demonstrate how OT intervention can be supported in research to show how best practices can be developed for feeding, eating, and swallowing concerns. During the first 3 months of the program there was an average of a 1 level improvement on the functional oral intake scale.

References

Elaine J. Amella, P., APRN, BC, FAAN, Medical University of South Carolina College of Nursing and James F. Lawrence, PhD, APRN, BC, Evercare. (2007). Eating and Feeding Issues in Older Adults with Dementia: Part I: Assessment. Best Practices in Nursing Care to Older Adults with dementia

SELF-ANALYSIS OF VIDEO RECORDING

Criterion 7 — Intervention: Performance Skills
Performs interventions that are unique to feeding, eating, and swallowing while integrating impact of varying client factors and contexts.

Guidelines
- Submission of actual video recording is not required for application; however, appropriate permissions should be obtained by applicant whenever engaging a client in a video-taped session.

1. | Age of Client | 87 years old |
   | Client Diagnosis(es) | Dysphagia from aging-related weakness |
   | Setting for Evaluation | Outpatient Clinic |
   | Date of Video Recording | November 19, 20XX |

2. Provide a brief summary of the video contents and how it demonstrates your ability to “perform interventions that are unique to feeding, eating, and swallowing while integrating impact of varying client factors and contexts.” (average word guideline–200)

This video portrays treatment for my client using several interventions including the use of swallowing strategies for airway protection to be utilized during meals and those to be used for specific swallowing muscle group strengthening. The video demonstrates my use of the NMES VitalStim™ modality along with postural training, targeted exercise interventions and patient/family education. It demonstrates progression of treatment from internal oral sensory and motor stimulation, to specific exercises targeting base of the tongue and laryngeal elevation muscle groups, and finally to swallowing strategies used during meals. This particular patient was inconsistent in her ability to perform exercises without moderate cues.

While generally tolerating the treatment interventions well, the client is noted to have limited ability to integrate a specific, complex muscle strengthening exercise which results in confusion of this exercise with another and it is therefore discontinued from her program.

3. After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your practice related to intervention. (average word guideline–400)

After reviewing the video, I realized I was too focused on an attempt to achieve several treatment “goals” in this particular session. While my initial thought was that this was an effective treatment session, with all of the proper components flowing in a good manner, I discovered that the patient was confusing components of several exercises, and I needed to provide additional training/education for family members supporting the home program.

- My patient was holding his breath in a Valsalva maneuver instead of using a pause and effortful swallow. Use of the Valsalva maneuver causes an increase in thoracic pressure and can alter blood flow circulation which was not desirable for my patient. I was able to correct this during the next treatment session with patient and family member education.

- The patient used more shoulder/trunk movement than neck turn to complete the head turn posture to support airway protection. For subsequent treatment sessions, I added additional manual neck muscle techniques to improve neck range motion.
When the desired strategy was use of the neck turn as stated above, the patient had greater eye contact with the family member seated across from him. This was difficult to change since our treatment area is tiny and I want to be in a position to palpate his neck muscles, requiring me to sit on the side of the neck turn. After video review, I decided to try to move the water cup to the side of the desired direction of the neck turn, and to add an amusing decal on the cup to assist in visually cuing the patient. I then engaged the patient and his family member in further discussion concerning their home seating arrangement thereby encouraging a change to better improve his neck turn during meals through visual cues rather than verbal “nagging”.

By analyzing the video recorded intervention, I recognized that I place too much emphasis on components of the intervention gathered from the assessment rather than client factors. My practice has changed by improving the structure and pacing of client treatment sessions for maximal OT intervention. Video recordings of intervention sessions is a tool I plan on using to help improve my intervention skills.
Guidelines

- This should not be confused with consultation that is part of the ongoing services provided in your routine job duties but is a request to address a particular issue at a particular site, either external or internal.
- Consultation may include (but is not limited to) developing or evaluating a program or service, developing a strategy for long-term planning, establishing outcomes measures, incorporating national guidelines into internal policies and procedures, assessing and addressing staff educational needs, assessing and addressing resource needs, and validating program/service delivery with current evidence.
- Applicant must have had a minimum of 10 hours working with the site.

1. Entity for Which Consultation Was Completed
   Therapy Kids: Anytown Division

2. Date(s) of Consultation
   November 1, 20XX; December 12, 20XX

3. No. of Hours Completed During Consultation
   24

2. Objectives for consultation. Objectives must have been met by time of application. Please list no more than 3.

   A) Identify areas for service delivery improvement for Therapy Kids High Risk Feeding Program.

   B) Provide education and training for staff regarding the neurodevelopmental process of feeding skill progression for high-risk clients.

   C) Provide an opportunity for observation of skilled feeding intervention with a neonate.

3. Summarize the consultation results. (average word guideline – 200)

   I was asked to assess the current Therapy Kids High Risk Feeding Program. I completed a systematic review of records, interviewed stakeholders, observed the identified lead therapists, and interviewed past clients to determine outcomes. Through this process, I discovered that therapists were not competently delivering services, nor assessing the effectiveness of their interventions. As a result, outcomes were over-inflated.

   I identified the following areas for development:

   1. Establish feeding competency guidelines and a monitoring/tracking system for competency development.
   2. Provide education and training on best practices for infant feeding intervention.
   3. Establish a resource for evidence-based practice that is updated regularly.

   To begin addressing these areas, I first established a formal education and training event. The training event included a preparatory learning activity, attendance of a didactic lecture with group discussion, learning activities, a lab for critical thinking development, and a follow up field
application activity.
After the lecture was completed, the therapists selected a client for me to consult on and provide hands-on demonstration of assessment and intervention strategies that were discussed. Intervention skills I modeled included: bottle selection based on assessment of neurodevelopmental phase of suck progression, external pacing, positioning, and energy conservation techniques. Participants asked questions and challenged intervention strategies. After the session was completed, resources were provided to justify selected intervention strategies and for further case review. Changes were seen in the participating therapists through a pre- and post-test case analysis, and through my observation of several intervention sessions.

4. Summarize how this professional development activity influenced your ability to "select, plan, and modify interventions in feeding, eating, and swallowing based on evidence and evaluation data." (average word guideline–400)

This activity enabled me to assess benefits of various intervention strategies as a third party, rather than from my perspective only. Observing strategies used by other clinicians also enabled me to expand my critical reasoning strategies.

For example, several clinicians failed to identify areas of weakness, despite having poor outcomes. Through observation and documentation review, it became clear that they were relying on intervention strategies, such as oral motor exercises for babies under 3 months of age, without empirical evidence. I was able to respond by gathering research, preparing an educational experience, and then demonstrating direct application through intervention with a baby on their service. After the baby’s needs were identified through a comprehensive feeding assessment, which included suck evaluation, bottle trials, extensive chart review, and caregiver interview, I was able to facilitate the team’s critical reasoning for intervention.

Throughout this experience, I was repeatedly challenged to select, plan, and modify intervention strategies while using evidence-based practice guidelines. I gained skill in the following areas: observing others for effectiveness of intervention strategies, dissemination of information based on the learner’s needs and client’s response to intervention, and ability to modify intervention strategies while meeting the needs of the learner and the client.
**Research**

**Criterion 8 — Intervention: Critical Reasoning**

Selects, plans, and modifies interventions in feeding, eating, and swallowing based on evidence and evaluation data.

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**What type of research was conducted? Please choose 1.**

- **X** Scientific inquiry—Qualitative, quantitative, or mixed-methods approach.
- ☐ Methodological research/instrument development—Scientific inquiry to establish psychometric properties of (1) a new tool, (2) an existing tool with a new population, or (3) an existing tool translated to a new language.
- ☐ Systematic review of the literature—Comprehensive search, review, and analysis of the existing literature to answer a focused question.

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1. **Title of research conducted**

   Mothers’ Perceptions of Their Occupations when Mothering a Child with Feeding Concerns.

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2. **Mechanism of dissemination:**

   - **X** Publication
   - ☐ Evidence-Based Practice
   - ☐ Peer-reviewed presentation
   - ☐ Project Web site
   - ☐ Grant funding
   - ☐ Dissertation/thesis
   - ☐ Critically Appraised Topic (CAT, e.g., AOTA)

**Citation:**


---

3. **Role of applicant in the research. (average word guideline—25)**

   This article was the result of work completed as part of my PhD dissertation. I was the principal investigator.
4. Purpose and rationale of the research. *(average word guideline–250)*

The purpose of this study was to gain insight regarding mothers’ perceptions of their occupations when mothering a child with feeding and eating difficulties. In particular, the issue of mothers’ perceptions of life satisfaction was explored along with how women perceive the issue of stress. Gaining a better understanding of these phenomena may be important in designing and providing appropriate support to mothers, which in turn may assist in their ability to succeed within their daily occupations.

Three specific factors were addressed in this study: feeding, stress, and life satisfaction. The literature revealed that there are many reasons for concerns to exist regarding a child’s feeding that may relate to client factors (difficulty swallowing) or contextual factors (low socioeconomic status or a mother’s inexperience). In addition, concerns related to feeding can influence occupational performance in mothering occupations related to nurturing and caring for a child. This in turn may lead to feelings of stress or decreased life satisfaction.

5. Describe how this research demonstrates your ability to “select, plan, and modify interventions in feeding, eating, and swallowing based on evidence and evaluation data.” *(average word guideline–400)*

In conducting this research, I gained a better understanding of mothers’ perceptions of concerns they experience relative to FES, as well as their perceptions of the services they did or did not receive. This improved my ability to select, plan, and modify OT FES interventions.

As a result of this research, I was able to identify several factors that influence mealtime outcomes for clients: stress of moms; service delivery; and a child’s body functions, performance skills, performance patterns, and contexts as they relate to the mealtime process.

Using this data, I tailored my interventions and addressed issues of maternal stress by demonstrating a greater sensitivity to how mothers may be feeling and how they are coping with their concerns about feeding and eating, even if they may not identify these feelings as stress during an evaluation. I now spend additional time asking questions that focus more on coping strategies and considering how families are dealing with mealtime difficulties.

My practice is influenced by the finding that several of the moms I interviewed felt that the system was not responsive to their needs. I now spend more time on mentoring and teaching that directly reflects the issues of family-centered care and listening to the concerns of the families. As a result, my interventions along with the interventions of those I work with in the clinic, and those I teach in the classroom, are also influenced by the research findings.
.getClientBasedCaseStudy()

Criterion 9 — Psychosocial Critical Reasoning

Recognizes immediate and long-term implications of psychosocial issues related to conditions found in clients with feeding, eating, and swallowing needs and modifies therapeutic approach and occupational therapy service delivery accordingly.

Guidelines

- Client-based case study should not include any form of standard client documentation (e.g., evaluation summary, discharge plan) or identification of client name(s) or facility information.

1. Date(s) case study represents

   August 03 - Sept 28, 20XX

2. Describe the client, client factors, and case contexts for the identified case. The context of the case should be adequately communicated so that relevance and merit of the case to the criterion is easily determined. (average word guideline-500)

   Tommy was 11 years, 2 months and had significant medical and behavioral challenges. He was referred for home health feeding therapy due to an extremely limited diet and high levels of family stress at mealtimes. The initial evaluation revealed a complex medical and psychosocial history including the following diagnoses and manifestations: history of severe reflux resulting in indirect aspiration and upper respiratory infections (URIs), delayed gastric emptying, failure to thrive (FTT), history of physical abuse through toddlerhood by his biological father (who is now incarcerated), developmental delay, cognitive delay requiring special education, opposition defiant disorder (ODD), attention deficit disorder with hyperactivity (ADHD), body dysmorphia, bulimia, violent tendencies, and suicide attempts.

   Tommy was recently discharged from an in-patient behavioral feeding program, where he had been seen to address his weight gain, but he refused to participate, and a nasogastric tube was used for weight gain. Tommy and his mother were separated throughout the hospitalization with the exception of 2 hours daily for visiting. She ultimately requested early discharge due to psychological concerns for her child. Within 48 hours of discharge from this facility, Tommy experienced a psychotic breakdown and was hospitalized at the state mental hospital for 6 weeks.

   I completed an initial feeding evaluation 10 days after discharge from the state hospital. Testing included the Parent Stress Index, Pediatric Evaluation of Disability Inventory (PEDI), skilled feeding trial, and interview of the mother and child. According to the parent interview, Tommy’s mother revealed feelings of helplessness, powerlessness and extreme fear regarding her child’s refusal to eat. She responded to these feelings by offering food constantly and adhering to any demands Tommy expressed in regards to what foods he desired, and when and where he chose to eat. He was significantly delayed in self-care (including feeding), due to complete refusal to participate, and he used manipulation and control strategies to maintain a power position during mealtimes. Frequently, a meal was prepared by his mother only to be refused or destroyed, and then another meal was demanded. Violent outbursts were common at mealtimes. It was clear to me that Tommy’s challenges did not lie in the acts of physically eating and swallowing, but rather in his relationship with food and those who participated in this relationship.
Although Tommy’s feeding challenges were initially medically-based (severe vomiting and poor gastric motility), I discovered his longstanding negative experiences with food, coupled by psychological imbalances, led to an inappropriate use of food for control and manipulation. He did not present with sensory or oral motor challenges, and it became quite clear as I worked with the family that the main issue was psychosocial in nature. This child had very little experience using cooperation and positive interactions to participate in functional roles such as student, child, friend, grandchild and ultimately eater. As past treatments failed to address his core challenges, Tommy had been trained to use food refusal for control of others, and without psychological and therapeutic feeding support, he ultimately may have needed long term supplemental nutrition to prevent future disability.

I was able to recognize these immediate and long term complications through ongoing interactions with Tommy, open communication with his psychologist, spending time with the family, and participating in mealtime routines. Immediate negative consequences were seen in the loss of trust between mother and child, negative emotional exchanges over meals, and feelings of anger, fear, and sadness. Long term consequences were seen in lack of growth velocity for Tommy, inability to control his behavior at school (in part due to prolonged fasting intervals), and a high risk of relapse into bulimia. The family was at high risk for secondary psychosocial issues, such as abuse and neglect without support.

In order to address these complications, the family dynamic at mealtime was looked at. Tommy was included as an equal partner in determining his role in eating and meal preparation. The family was taught the Division of Responsibility, by Ellyn Satter, and received training on how to offer food pleasurably without contingencies. Treatment sessions focused on supporting Tommy in executing control in an appropriate manner, while maintaining an age-appropriate role at home. He participated in grocery shopping, food prep, and serving others. As a result, stress decreased, and his interest in eating within a social environment increased dramatically. I engaged Tommy with empowerment strategies, such as giving opportunities for daily success through independent ADL and play activities, which also resulted in his increased desire to try new foods. More importantly, I partnered with his psychologist to establish a long term plan for follow-up on mealtime strategies. Psychological support of both the child and mother was needed for long term success and behavior modification. The family was followed by psychology on a weekly basis, and was seen monthly by a behaviorist. Lastly, I introduced Tommy’s mother to a domestic abuse support group to address her psychosocial health.
**ETHICAL PRACTICE SCENARIO** (Part 2 of 3)—Fiscal & Regulatory

**Criterion 10 — Ethical Practice: Fiscal & Regulatory**

Identifies ethical implications associated with the delivery of services in feeding, eating, and swallowing and articulates a process for navigating through identified issues.

**Guidelines**
- The applicant identifies ethical implications associated with the delivery of services and articulates a process for navigating through the identified issues.
- The applicant shall review the AOTA Code of Ethics and Ethics Standards and align the dilemma with the ethical principle(s) that is/are challenged.

**Ethical Scenarios**

**Scenario #4**

**Scenario #5**

A new edition of a commonly used standardized assessment is released with new normative data, updated procedures, and better reliability and validity than the former edition. This updated assessment has been purchased by the facility. The OT is asked to use the new edition, but continues to use the former edition since the OT is more familiar with it.

**Scenario #6**

1. To which scenario are you responding? 5
2. From the AOTA Code of Ethics and Ethics Standards, which ethical principle(s) has/have been challenged in this scenario? Select the top ethical principle(s) that apply, up to a maximum of 3.

- ☑ 1. Beneficence
- ☐ 2. Non-maleficence
- ☑ 3. Autonomy, Confidentiality
- ☑ 4. Social Justice
- ☑ 5. Procedural Justice
- ☐ 6. Veracity
- ☐ 7. Fidelity
3. Describe how you would apply the ethical principles identified above to guide you toward a resolution for the concern noted. (average word guideline—500)

The therapist has an ethical obligation to be proficient in the administration of the updated edition of the test, and use the most current scoring tables when reporting results.

AOTA Code of Ethics and Standards (2010)

Principle 1: **Beneficence** states that OT personnel shall:

D. Avoid the inappropriate use of outdated or obsolete tests/assessments or data obtained from such test in making intervention decisions or recommendations.

G. Take responsible steps (e.g., continuing education, training) and use careful judgment to ensure their own competence.

Principle 4: **Social Justice** addresses the importance of limiting the impact of social inequality on health outcomes.

F. Provide services that reflect an understanding of how occupational therapy service delivery can be affected by factors such as economic status, age, ethnicity, race, geography, disability, culture, and political affiliation.

Principle 5: **Procedural Justice** states that we have a professional obligation to:

F. Take responsibility for maintaining high standards and continuing competence in practice, by participating in professional development and educational activities to improve and update knowledge and skills.

The reliability and validity of any test will depend, in part, on the characteristics of the normative sample participating in the standardization process. The second edition of a test will incorporate better representation (e.g. geographical, age/gender, numerical) from the diverse populations we serve. Some shift in the normative data will occur as broader demographics are incorporated. If this standardized tool is being used to determine a client’s need for therapy service, then the use of outdated norms might inappropriately deny service to some.

The practitioner needs to learn the updated test administration and scoring procedures. The practitioner can engage in self-study and practice the new procedures with colleagues or with those with a typically developed swallow until he or she feels competent. If support from colleagues is not available, the practitioner should pursue a formal professional development activity or a mentor who can support this learning.
**PRESENTATION**

*Back to Criteria*

**Criterion 11 — Establishes Networks**

Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of feeding, eating, and swallowing.

**Type of presentation:**

- **X** In-service to professionals
- ☐ Academic program lecture
- ☐ Professional level workshop (e.g., state conference)
- ☐ Community

1. Presentation information.

<table>
<thead>
<tr>
<th>Title</th>
<th>Uses and Alternatives to Thickening Agents for Medically Fragile Infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audience</td>
<td>Pediatric Nutrition Network - a group of registered dieticians in the Anystate central region serving medically fragile infants. Although this group is potentially a good source of referrals, they are not widely known in the therapy community.</td>
</tr>
<tr>
<td>Date and Time of Presentation</td>
<td>August 8, 20XX</td>
</tr>
</tbody>
</table>

2. Brief description of the presentation, including content focus. *(average word guideline–50)*

This was a 45 minute presentation to meet the objectives listed below with an opportunity for open discussion and questions and answers. Content focused on the current use of thickening agents and their alternatives for swallowing support in medically fragile infants. Contraindications to intervention with thickening agents were outlined and references/resources were included.

**Presentation Objectives**

1. List diagnoses and describe feeding presentation of infants who would benefit from thickener usage.
2. Summarize current research on risk of commercial thickeners and limitations of MBSS to diagnosis dysphasia.
3. Describe at least 3 alternatives to commercial thickeners for reducing dysphagia risk.

3. Applicant’s objectives for networking. *Objectives must have been met by time of application. Please list no more than 3.*

| 1. Increase referrals for OT from the Pediatric Nutrition Network. |
| 2. Strengthen connections with area dieticians who may be able to serve my clients. |
| 3. Market to relevant stakeholders that my home health agency follows best practices relative to feeding, eating, and swallowing. |
Since I am recognized by other OTs in the region as a specialist in feeding, eating, and swallowing, I was invited to present through a contact with the Pediatric Nutrition Network (PNN), which was a potential referral source not being utilized in the community. In preparation for the presentation, I surveyed several NICU feeding specialists in the immediate area for general philosophy on thickener use. As a result, I strengthened my local NICU contacts and was exposed to a variety of thickening protocols. Quickly it became apparent that thickeners were utilized by these specialists as a primary intervention strategy when other feeding practices were not in place and/or when the staff was unsupported by ancillary services. In response to area practices, I modified my presentation to include alternatives to thickening and the use of a multi-disciplinary approach to establish support networks.

After my presentation, I fielded questions and networked with dieticians. One of the dieticians I met had the capacity to serve many of the children on our service. Dietary services are lacking in our agency. A few months later, I scheduled a meeting with her to further investigate how we could bring feeding and nutrition services together. As a result of this meeting, our agency has completed an OT education class guided by the RD. Our therapists now have an RD to refer clients to who are in need of help with tube weaning and basic growth needs.

According to feedback I have received since the presentation, RDs in attendance have submitted thickening alternative references and resources to their own places of business. They can offer families more choices and advocate better for alternatives. Without this presentation, I would not have had the opportunity to educate others on alternatives to commercial thickeners or have been able to expand the services I offer to my clients.
**ADVOCACY EFFORTS**

Criterion 12 — Advocating for Change

Influences services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities.

**Guidelines**
- Active involvement in or facilitation of advocacy activities at the local, regional, state, or national level for the purpose of influencing decision-makers about policy, procedures, services, reimbursement, or occupational justice issues.
- Merely serving as a participant does **not** constitute advocacy efforts.
- **Minimum of 10 hours** over at least 2 months.

**Type of advocacy activity:** *(check all that apply)*
- Development and dissemination of advocacy materials (e.g., letters, brochures, websites, podcasts)
- Lobbying to/education for policy-makers
- Organizer of community event (e.g., fundraising, health fair)
- Subject expert in media interview (e.g., radio, television news, newspaper)
- **X** Presentation to stakeholder
- Other

1. | Description of Activity | Target Audience | Date(s) | No. of Hours Involved |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Presenter/Panelist at the Children’s Health Consultant Advisory Committee Meeting</td>
<td>OTs, RNs, MDs, non-profit health organization representatives, local and state health organization and government officials</td>
<td>November 10, 20XX and January 22, 20XX</td>
<td>10 hours, including preparation, presentation, and meetings</td>
</tr>
</tbody>
</table>

2. **Applicant’s objectives for advocating for change. List no more than 3.**
   
   A) Increase awareness of our state’s public health insurance program’s process for getting therapeutic formulas to WIC participants and to simplify the application process.

   B) Facilitate awareness of the role of OT in feeding, eating, and swallowing, and the impact delayed access to therapeutic formulas makes on low income families.

   C)
I have many children referred to me with feeding, eating, and swallowing deficits who are diagnosed with “failure to thrive” (FTT). These children and their families are Women Infants and Children (WIC) participants who are part of the public health system. During OT evaluation and treatment sessions, they often reported significant difficulty accessing the therapeutic formula being prescribed by pediatricians. The formula that is recommended is denser, ensures increased caloric intake, and is easily digestible. Lack of earlier access to this formula delays progress related to OT outcomes.

The formula is typically paid for by public assistance; however, the WIC program in our area traditionally assisted families in completing the application, which included an interview. I spoke with a local WIC coordinator and was informed that the system is flawed, and due to decreased resources, the application process is often delayed. One solution discussed is that the application could be completed by the referring physician or an RN.

I decided to advocate for this by reaching out through the local Children’s Health Consultant Advisory Committee, a non-profit health organization that provides services and programs financed by Any State to low income families.

I participated in 2 meetings. During the first meeting, I clarified the role of OT with feeding, eating, and swallowing through discussion on how the lack of access to therapeutic formulas impacted our client’s progress and ability to achieve goals, as the children continued not to feed using the current formulas. During the second meeting, I facilitated a round table discussion with various health care providers and other stakeholders, including our state’s representative, regarding the application process.

As a result of this advocacy effort, the application and request can now be completed during the child’s actual pediatrician visit and can be sent electronically to our state’s public health insurance agency in order to expedite a family’s access to therapeutic formulas. Access to the formula in a more timely fashion, gives me the ability to provide comprehensive OT services with use of an optimal formula as part of the feeding, eating, and swallowing intervention, sooner rather than later, thereby maximizing therapeutic outcomes.
I provided OT services once a week through Early Intervention for Alex, an infant with a history of premature birth at 34 weeks gestation, to address acquisition of developmental skills for feeding, play, and other childhood occupations. At the chronological age of 3 months, his mother returned to work outside the home, and Alex attended the local daycare 10 hours each day, 5 days a week. I provided OT services for Alex in the daycare setting. While Alex had early feeding difficulties due to an uncoordinated suck-swallow-breath pattern and poor endurance for breastfeeding, by the time he started at the daycare he was feeding orally by breast and bottle for his entire nutritional intake. His mother identified the goal of continuing to exclusively breastfeed for the recommended duration of 6 months before introducing solid foods, even though establishing and maintaining routines to support continued breastfeeding would be difficult with her return to work.

During a phone update with Alex’s mother, she reported frustration over the daycare’s lack of support for breastfeeding. She reported feeling embarrassed when she came over during her lunchtime to breastfeed, as the daycare room did not have any quiet, private area. Alex’s mother was also upset because the daycare often fed her son a large bottle of formula right before she arrived to pick him up, even when she called to say she would arrive momentarily to breastfeed him. She became further distressed when the daycare staff urged her to start spoon feeding cereal to Alex at around 4 months of age. I identified the need to educate the daycare Director and staff about creating an environment and routines at the daycare that supported continued breastfeeding for this client.

My efforts to influence change focused on educating the Director and staff of the daycare concerning environmental modifications and establishing routines to support continued breastfeeding. Advocating for change in this daycare setting was necessary for providing family-centered occupational therapy to my client. In speaking with the Director, I learned that very few infants at the daycare received bottles of expressed breast milk, and that Alex’s mother was the first to visit her child during the day to breastfeed. The staff in the infant room also expressed a lack of knowledge about breastfeeding and misconceptions that breast milk alone wasn’t enough to satiate the hunger of a 3 to 4 month old infant.

I provided the Director with information from the World Health Organization and American Academy of Pediatrics recommending exclusive breastfeeding until 6 months of age to help dispel the misconception that younger infants who are breastfed need supplementation. I also shared a list of resources developed by national and local child care organizations explaining recommendations for successful support of breastfed infants in daycare settings.
3. Describe the change outcomes or progress toward change as a result of your efforts. *(average word guideline–200)*

As a result of my efforts, the Director of the daycare arranged for a staff in-service on breastfeeding promotion to be presented by a nutritionist and lactation consultant, who were able to answer questions concerning storing breast milk, feeding expressed breast milk, and offer strategies to support mothers who desired to continue breastfeeding. The Director asked me to participate during the in-service by providing recommendations on how to set up a space for mothers desiring to breastfeed at drop-off or pick-up.

I consulted with the staff in the infant room and recommended moving a rocking chair into a quiet, dark corner of the room. In addition, I recommended that Alex’s mother purchase a washable nursing pillow to have available for her use when breastfeeding at drop-off or pick-up. My weekly OT sessions at the daycare also included staff education concerning infant hunger cues and support for establishing a feeding routine for Alex that enabled his mother to breastfeed him during her lunch hour and at drop-off/pick-up from daycare.

In a follow-up conversation, Alex’s mother reported feeling less stressed now that the daycare had a better understanding of the benefits of continued breastfeeding and why it was important to the mother as a child-rearing occupation.

4. Articulate how this case demonstrates your ability to "influence services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities." *(average word guideline–500)*

This case required reflection on my part concerning my role as an OT relative to health promotion. Alex had the developmental skills required for continued breastfeeding and he and his mother had a well-established routine at home. In order to provide client-centered care, my OT intervention approach required changing the daycare environment to create support for this family’s preferred feeding method.

While an environmental modification such as creating a quiet space at the daycare for feeding is not outside the scope of OT, I had to respect the culture of the daycare organization and gain trust in order to advocate for change. By initially approaching the Director rather than the staff, I was able to maintain a strong, collaborative relationship with the staff and avoid causing them to think I was criticizing their knowledge or practices. Further, by advocating for change at the Director level, I created an opportunity for the daycare to institute new policies and procedures for infant feeding that benefited others besides my client. Finally, by influencing infant feeding practices at this daycare, my advocacy efforts enabled other infants at this daycare to partake in the health benefits of continued breastfeeding.
PUBLIC AWARENESS EFFORTS

Criterion 12 — Advocating for Change

Influences services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities.

Guidelines
- Development of public awareness media for a broad audience to promote topic(s) relevant to the specialty area.

Type of media developed: (check all that apply)
- [X] Presentation to potential referral source audience
- [☐] Presentation to potential clients
- [☐] Participation in community event, such as health fairs
- [☐] Speaking to community groups
- [☐] Development and dissemination of marketing materials (e.g., brochures, websites, podcasts)
- [☐] Participation in media interview (e.g., television news, newspaper)
- [☐] Other

1. Target audience(s) of public awareness.

<table>
<thead>
<tr>
<th>Target Audience of Public Awareness Efforts</th>
<th>Referral sources for OT FES early intervention services, including: pediatricians, gastroenterologists, residents, nutritionists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date(s) of Public Awareness Activity</td>
<td>January, March, June, and September 20XX</td>
</tr>
<tr>
<td>Approximate Total Hours Engaged in Public Awareness Activity(ies)</td>
<td>Series of 4 one hour presentations with 8 hours of preparation = 12 total hours.</td>
</tr>
</tbody>
</table>

2. Brief Summary of the Public Awareness Message (average word guideline – 50)

I contrasted typical and atypical development for children under age 3 and provided information concerning when an OT referral would be appropriate to provide intervention and maximize meal participation. We also discussed how to move forward with a referral for FES services from an OT in an early intervention setting, as well as how to reach an OT in other practice areas.

3. Applicant’s objectives for advocacy/change. List no more than 3.

| A) Provide resources to physicians regarding typical expectations for young children related to feeding and eating. |
| B) Facilitate awareness regarding the types of services available to children and families when concerns regarding feeding and eating arise. |
| C) Improve awareness of how to refer to therapy services to support children and their families when feeding and eating concerns are present. |
I work in a community-based early intervention setting and have expertise in FES with young children. Due to this expertise, I was introduced to a local developmental pediatrician who was concerned with understanding where children could be referred for FES support. She had an 18-month waiting list, and expressed concern that several families (who could have been referred for FES services with OT by the regular pediatrician but were not), were complaining that they could not access services to meet their needs. Her concern was that due to the waiting list, families were not being seen early enough for support since other physicians did not know how to access these services.

I met with the developmental pediatrician and we concluded that education with referral sources needed to be done in order to meet the needs of these children. She helped me schedule a series of educational sessions at the regional grand rounds. Grand rounds were chosen since this was an opportunity to reach the largest number of referral sources at one time. Individuals attending grand rounds are direct sources of referrals for OT and FES support. The goal of the presentations was to advocate with attendees for FES services referrals.

As a result of these presentations, we saw an increase in calls regarding questions on feeding, eating, and swallowing. We also saw an increase in evaluation referrals through our office to address these areas of need. Recently, our EI office has been receiving more calls from other EI offices in the state asking for support concerning feeding, eating, and swallowing, which has led me to site visits and consulting with other providers concerning assessment and intervention for feeding, eating, and swallowing. The increase in referrals has led to more requests for support in this area of practice which in turn is improving client access to appropriate FES services in the area.
**Volunteer Leadership**

**Criterion 12 — Advocating for Change**

Influences services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities.

**Guidelines**
- Service with a local, state, national, or international agency or organization that has relevance to the criterion.
- **Minimum of 25 hours** for at least 1 year.

1. **Name of organization**
   
   Family Center Outreach

2. **Dates of service**
   
   Two years, from January 1, 20XX – January 1, 20XX

3. **Approximate number of hours of service**
   
   80 hours

4. **Identification of the volunteer leadership role served (must be leadership in nature, e.g., officer, chair, committee member, board member)**
   
   Early Intervention Committee member

5. **Describe how this leadership activity helped you “influence services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities.” (average word guideline–400)**

   **Family Center Outreach (FCO)** is a non-profit organization that provides training and resources to parents of children with special needs. FCO received a grant to conduct a 10 month program to provide education and guided learning instruction to parents and caregivers of children ages 3-5 with G-tubes (children with other types of feeding tubes were not included in this program). The program was designed to supplement the child’s current hospital-based OT program for feeding, eating, and swallowing.

   As a volunteer with feeding, eating, and swallowing expertise, I was asked to create and deliver an educational and hands-on program for stakeholder groups, specifically with parents and primary caregivers. I worked with the FCO staff to design a pre-weaning program based on current literature that clearly defines weaning preparation. The goal of the program was to educate parents and caregivers, and to provide easy-to-implement sensory activities. Parents were asked to share the provided suggestions and educational handouts with the pediatrician and hospital-based OT. The families attended for 2 hours once a week, and the program ran for 12 consecutive weeks. Anecdotally, parents reported to FCO staff that due to this program, their children were demonstrating better outcomes with already established OT goals. We were able to conduct three 12-week sessions during the 10 month grant period.

   Through this volunteer effort I was able to provide research and educate FCO policy makers and funders about OT involvement in the G-Tube weaning process. As a result of parental feedback and formal assessment of the program, FCO applied for and was awarded additional grant funds to support another 10-month pre-weaning program, which included hiring a part-time OT.