FEEDING, EATING AND SWALLOWING SPECIALTY CERTIFICATION
Occupational Therapist Assistant

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.

**Criterion 1. Knowledge: Diagnostic Considerations**
- Formal Learning-- Minimum 10 contact hours needed
- Independent Learning--Minimum 10 contact hours needed
- **Publication** – Peer-Reviewed

**Criterion 2. Knowledge: Assessment**
- Formal Learning--Minimum 10 contact hours needed
- Independent Learning--Minimum 10 contact hours needed
- Publication – Peer-Reviewed

**Criterion 3. Knowledge: Intervention**
- **Formal Learning**--Minimum 10 contact hours needed
- **Independent Learning**--Minimum 10 contact hours needed
- Publication – Peer-Reviewed

**Criterion 4. Knowledge: Regulation & Payers**
- Formal Learning--Minimum 3 contact hours needed
- Independent Learning--Minimum 3 contact hours needed
- Publication – Peer-Reviewed

**Criterion 5. Assessment: Performance Skills**
- Client-Based Case Study
- **Mentee** (does not include supervisory relationship)
- Self-Analysis of Video Recording

**Criterion 6. Intervention: Performance Skills**
- Client-Based Case Study
- Mentee (does not include supervisory relationship)
- Self-Analysis of Video Recording

**Criterion 7. Intervention: Critical Reasoning**
- Client-Based Case Study
- **Formal Specialized Consultation for Intervention**
- Mentee (does not include supervisory relationship)
- Program Development
- Research

**Criterion 8. Psychosocial Critical Reasoning**
- **Client-Based Case Study**
- Formal Specialized Consultation for Psychosocial
- Mentee (does not include supervisory relationship)
- Program Development
- Research

**Criterion 9. Ethical Practice**
- **Ethical Practice** – The 3 ethical practice scenarios are found within the application itself.

**Criterion 10. Establishes Networks**
- Formal Specialized Consultation
- **Marketing Activities**
- Presentation
- Volunteer Leadership

**Criterion 11. Advocating for Change**
- **Advocacy Efforts**
- **Advocacy Case Study**
- Presentation
- **Public Awareness Efforts**
- 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)

   Co-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 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.

   Due to the review of the evidence we 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 assistance with decisions for safe and adequate nutrition.
Criterion 3 — Knowledge: Intervention

Demonstrates knowledge of relevant evidence specific to \textit{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 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. \textit{Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.}

X Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.

☐ Participation in post-professional academic coursework. \textit{Attach unofficial transcript.}

1. Activity information.

<table>
<thead>
<tr>
<th>Activity Title</th>
<th>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>08/29-30/XX</td>
</tr>
<tr>
<td>No. of Contact Hours</td>
<td>12</td>
</tr>
</tbody>
</table>

2. Activity Learning Objectives. \textit{List up to 5.}

| A) | Understand the normal and abnormal stages of oral, pharyngeal and esophageal components of swallow. |
| B) | Understand the psychosocial impact of swallowing disorders for persons with Parkinson’s disease. |
| C) | Identify 3 feeding, eating, swallowing intervention techniques appropriate for use with clients who have neurologic conditions. |
| D) |
| E) |
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, including the neurological diagnosis and from aging-related problems. Their problems range in severity from embarrassment, resulting in withdrawal from social events surrounding dining, to that of compromised energy and health.

In working with my supervising OT, we reviewed the current literature and found that intervention for swallowing problems in this population tend to focus on one treatment approach over another. We decided to attend this course together, and it 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 esophageal components of Parkinson’s disease and other related disorders, and the OT and I routinely apply these with our patients.

One of the more important discussions at this course for me was the information related to psychosocial 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

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(s)</th>
<th>Title</th>
<th>Journal/Course Info</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>
<td></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 and discussion with supervising OTR amounted to 20 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, the OT department was receiving 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. In discussion with my supervising OTR, we 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.

   My supervisor and I have taken many continuing education courses with a focus on OT intervention in the area of FES. We wanted to investigate literature outside the OT field to determine if there were additional factors that had not specifically been addressed in the continuing education coursework we had already taken.

   The questions that guided my investigation were: “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)*

<table>
<thead>
<tr>
<th>There were 2 significant take-aways for me through this independent study consisting of reading and discussion:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 ability to discuss possible intervention strategies with my supervisor. This also led to more effective communication with other team members regarding intervention and goal setting.</td>
</tr>
<tr>
<td>Secondly, the readings emphasized the importance of individual and family relationships with food. As a result, my ability to actively engage in discussions regarding intervention planning has broadened. Overall, the approach to intervention 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.</td>
</tr>
<tr>
<td>I found that families are very responsive to the change in focus from simply “eating” to instead “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 of food at meals.</td>
</tr>
<tr>
<td>Through my independent learning, I discovered resources that are parent-friendly and can be shared with families. Families are then empowered to ask questions, as well as collaborate more fully in the intervention process.</td>
</tr>
</tbody>
</table>
Criterion 5 — Assessment: Performance Skills
Administers standardized assessments as delegated by the supervising occupational therapist specific to feeding, eating, and swallowing, consistently integrating clinical observations.

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

3. Applicant’s goals for mentoring relationship. **Goals must have been met by time of application. List no more than 3.**
   - A) Successfully identify the different types of tracheostomy tubes.
   - B) Demonstrate competency in follow through of safe feeding in clients that have a tracheostomy tube.
   - C) Increase my skills in communicating and documenting possible need for diet advancement in clients with a tracheostomy tube.
   - D) Increase awareness for using the Edinburgh Feeding Evaluation in Dementia (EdFED) assessment.

4. Mentor | Mark Therapist, MS, OT/L, SCFES
--- | ---
Position/Role of Mentor | Clinical Supervisor
Workplace of Mentor | Anytown Clinic
Contact Information for Mentor (email or phone number) | Mark.therapist@email.com

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.
6. Briefly describe how the knowledge acquired from this mentoring activity influenced how you “administer standardized assessments as delegated by the supervising occupational therapist specific to feeding, eating, and swallowing, consistently integrating clinical observations.” (average word guideline=200)

I provided intervention for clients with dysphagia for 10 years; however, I had limited experience with clients with a tracheostomy tube. Following my mentoring relationship, I am more confident working with clients who have a tracheostomy tube.

During mealtimes I can observe how well clients are handling their secretions, check for any aspiration signs or symptoms, and see how the client is tolerating the recommended diet. I have learned when to communicate the possible need for diet modification.

With proper observation and guidance during a client’s mealtime, I have learned to:

- Communicate to the supervising OT any signs of aspiration during mealtimes for a client who has a tracheostomy tube.
- Recognize the different types of tracheostomy tubes.
- Document clearly the observed dysphagia status, including type of diet and any signs of aspiration.
- Recognize the need to use the EdFED feeding assessment.
FORMAL SPECIALIZED CONSULTATION FOR INTERVENTION

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Criterion 7 — Intervention: Critical Reasoning

In collaboration with the supervising occupational therapist, selects, plans, and modifies interventions in feeding, eating, and swallowing based on evidence and evaluation data.

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
---|---
Date(s) of Consultation | November 1, 20XX; December 12, 20XX
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 assist my supervising OT in assessing the current Therapy Kids High Risk Feeding Program. I participated in a systematic review of records, collaborated with stakeholders, observed the two OTAs on staff while my supervising OT observed the lead OTs, and interviewed past clients to determine outcomes. Through this process, we discovered that the practitioners were not competently delivering services, nor were they assessing the effectiveness of their interventions. As a result, the OT determined that outcomes were over-inflated.

   We 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 regularly updated.

   To begin addressing these areas, we 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. I delivered relevant content to the OTAs.

After the lecture was completed, the OTAs selected a client for me to consult on and provide hands-on demonstration of intervention strategies that were discussed. After consultation with my OT, the intervention skills I modeled included: bottle selection (based on my OT’s 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 our observations of several intervention sessions.

4. Summarize how this professional development activity influenced your ability to “collaborate with the supervising occupational therapist 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 OTAs also enabled me to expand my reasoning skills.

For example, several OTAs failed to identify areas of weakness in their service delivery, 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. The OT and I responded 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 completed by the OT, which included suck evaluation, bottle trials, extensive chart review, and caregiver interview, I was able to facilitate the OTA’s reasoning for intervention.

Throughout this experience, I was repeatedly challenged to select 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.
PROGRAM DEVELOPMENT

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Criterion 7 — Intervention: Critical Reasoning

In collaboration with the supervising occupational therapist, selects, plans, and modifies interventions in feeding, eating, and swallowing based on evidence and evaluation data.

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 collaborated with the OT in the development of a 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 cueing assist as needed.
• Monitoring of dysphagia recommendations, including diet modifications and use of compensatory techniques to reduce risk of aspiration.

OT assistants trained in feeding, eating, and swallowing (FES), are present during each group and monitor plans for 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-patient 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 “collaborate with the supervising occupational therapist to select, plan, and modify interventions in feeding, eating, and swallowing based on evidence and evaluation data.” (average word guideline—500)

Since an OT cannot always be present at our feeding group, it was important for me to work collaboratively with the OT in developing my skills to identify signs of aspiration, use of compensatory techniques for safe swallow, and ways to recognize possible progress within the established plan of care.

In working with the OT, I increased my ability to use delegated sections of the standardized assessment tool for feeding called the Edinburgh Feeding Evaluation in Dementia Questionnaire (EdFED-Q). With this tool, I can gather data to contribute to the comprehensive OT evaluation.

I am able to provide education concerning a client’s current diet recommendation and follow through with monitoring use of compensatory techniques and swallowing exercises that are needed.

With my consistent presence within this feeding group, I became better at observing signs of progress and could communicate more effectively with the supervising OT when there may be a modification in the care plan or if reevaluation should occur.
Criterion 8 — Psychosocial Critical Reasoning

In collaboration with the supervising occupational therapist, 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

   September 10, 20XX - January 16, 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)

   **Initial Evaluation History:** This child was initially evaluated by the occupational therapist at 5 months of age due to poor weight gain and suspected torticollis. She presented with labored respiration, a weak nutritive draw, poor tongue cupping, and delayed anterior posterior bolus transit resulting in inefficient feeds and risk of aspiration. The occupational therapist recommended positioning changes, flow management and external pacing. Her 19 year old mother and 20 year old father where not concerned with her feeding status and felt she would get better with time.

   **Treatment History:** I began with parent training on the feeding recommendations issued by the occupational therapist. While the mother was able to learn to feed the baby safely, the baby continued to lose weight and her feeding pattern did not improve even with skilled intervention and transition to a special needs feeder. After teaming with the physical therapist, who had concerns regarding the child’s lack of muscle tone and general weakness, she was referred to the neurologist. Within 2 months of her initial evaluation she was diagnosed with Spinal Muscular Atrophy (SMA) Type 1, a rapidly progressing terminal muscular disease that would ultimately result in her inability to contract any voluntary muscle.

   **Psychosocial:** The parents were not accepting the child’s prognosis and felt a cure would be found and the child would return to developing normally. Feeding was seen as her greatest pleasure and most advanced skill. The parents repeatedly referred to her feeding skills as proof that she was doing well and that she simply needed more physical therapy to address her loss of motor skills. They refused all testing, including a Modified Barium Swallow Study (MBSS), which might reveal poor function, and refused to participate in a home program that was not focused on oral feeding.

   **Feeding/Eating/Swallowing:** The child needed to be able to feed as safely and pleasurably as possible, a preferred activity for her and her parents. Frequent re-assessment by the occupational therapist was needed for plan of care revision to account for her rapidly declining status. The parents needed support in understanding why the child’s feeding ability was changing without loss of attachment to their child. As the disease progressed she needed a gastrostomy tube and tracheostomy with ventilator support to sustain life. Feeding intervention shifted to pleasurable oral activities and a focus on temporomandibular joint (TMJ) range of motion so she could continue her oral hygiene program. Integration of her parents into her feeding activities remained challenging.
This case demonstrates my ability to recognize immediate implications of psychosocial issues related to this client and the impact of feeding, eating, and swallowing recommendations. My recognition of the family’s psychological state was primary in determining intervention. They were in the denial stage of grieving and needed time to process the child’s diagnosis while focusing on valued intervention strategies to build compliance. I began by focusing on safe oral feeding (the parents’ primary goal) while planning for future modifications. I also recognized that oral feeding brought the child great pleasure. While she was still strong enough to swallow without aspirating, I maximized her pleasure by providing techniques to maintain safe suck, swallow and breathe while conserving her energy.

This case demonstrates my recognition of long-term implications of psychosocial issues related to conditions found in clients related to feeding, eating, and swallowing as well. I knew this child would be unable to maintain safe oral feeds as she lost her ability to swallow and breathe independently. I slowly integrated pleasurable oral experience and touch into her oral feeding routine. When a gastrostomy tube was placed she and her parents could still participate in the feeding routine as she received her gastrostomy feeding. I also stressed the importance of an oral hygiene routine for sustaining lung health, and worked towards training her parents on delivering this routine even when she was still eating by mouth. From the moment I initiated treatment, I remained cognizant of the child’s terminal status and the family’s needs for ongoing emotional support as their child declined. In an effort to address these emotional needs, I introduced the family to our company’s social worker, who provided resources for support groups and counseling.

This case required me to modify the therapeutic approach and OT service delivery due to the degenerative nature of SMA Type 1. The family’s acceptance of the child’s changing needs, without loss of interest in their child, was paramount to treatment success. I celebrated the child’s abilities to participate in the feeding routine, and later oral hygiene routine, without focusing on loss of function. Rather, through activity analysis I found elements of each activity that she could perform herself. As her family witnessed her pleasure in these activities they began to willingly participate in her feeding, eating, and swallowing plan. I was able to establish myself as a team player and build rapport and trust. The positive nature of this relationship enabled me to stay active in the home as the child declined. The family trusted me to advocate for their needs so I was able to change my approach to one of palliative care. I continued to guide positioning changes for secretion management, the oral hygiene routine for lung protection, and oral play activities needed for AROM of the jaw to reduce pain. Through therapeutic use of self and ongoing respect for the changing psychosocial needs of the family, I continued to engage the child and family in safe and meaningful activities for feeding, eating, and swallowing.
ETHICAL PRACTICE SCENARIO (Part 2 of 3)—Fiscal & Regulatory

Criterion 9 — 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

<table>
<thead>
<tr>
<th>Scenario #4</th>
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<tr>
<th>Scenario #5</th>
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</thead>
</table>

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 OTA is asked to use the new edition, but continues to use the former edition since the OTA is more familiar with it.

<table>
<thead>
<tr>
<th>Scenario #6</th>
</tr>
</thead>
</table>

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
- 4. Social Justice
- 5. Procedural Justice
- 6. Veracity
- 7. Fidelity

- 2. Non-maleficence
- 3. Autonomy, Confidentiality
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 practitioner has an ethical obligation to be proficient in the administration of the updated edition of the assessment, 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 assessment will depend, in part, on the characteristics of the normative sample participating in the standardization process. The second edition of an assessment 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 assessment administration and scoring procedures. The practitioner can engage in self-study and practice the new procedures with colleagues, the supervising OT, or with those with a typically developed swallow until he or she feels competent. If support is not available, the practitioner should pursue a formal professional development activity or a mentor who can support this learning.
MARKETING ACTIVITIES

Back to Criteria

Criterion 10 — 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 media used for marketing: (check all that apply)

☐ 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 _____________________________________________________________________

Target Audience of Marketing

- Parents
- Administrators and teachers in private and public schools, Pre-K through Grade 5

Date(s) of Marketing Efforts

July 10, 20XX

Approximate Total Hours Engaged in Marketing Activity

10 hour preparation
2 hour event

1. Provide a brief summary of the marketing activity. (average word guideline–50)

I collaborated with my OT supervisor as part of my city’s summer day camp event, supported by our local school district. This one-time summer event’s theme was Healthy People 2020 (HP2020).

I engaged the children in activities that provided sensory exposure to nutritious foods. The OT identified children that demonstrated significant tactile, visual, and gustatory aversions during the activities. Adults accompanying these children were given brochures that included information concerning OT along with a checklist of potential behaviors that might trigger the need to seek an OT referral from a pediatrician. Our contact information was also included.

2. Applicant’s objectives for the marketing. List no more than 3.

A) Educate our target audience on age-appropriate feeding behaviors, the overall developmental process for appropriate food transitions, and sensory activities for problem eaters.

B) Increase client referrals to our practice by 10% for children with feeding, eating, swallowing needs.

C)
3. Describe how this marketing activity demonstrates how you “establish and collaborate 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.” (average word guideline–200)

During this event, we increased potential referrals by facilitating awareness of the role of OT in feeding, eating, and swallowing, and we were able to identify children with feeding issues that might benefit from OT services.

We engaged several spectators on the role of feeding and swallowing OTs, and the benefit of early recognition of poor feeding behaviors in young children to initiate early OT intervention. The teachers and parents reported that they appreciated education in this area, as they sometimes identify feeding problems that they are not sure how to address.

As a result of this marketing activity, the number of referrals we received increased, and we began communicating with and establishing a professional relationship with pediatricians that were not initially in our network.
**PRESENTATION**

**Back to Criteria**

**Criterion 10 — 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.

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**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)**

My supervising OT and I gave a 45 minute presentation to meet the objectives listed below. There was 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.**

A) Increase referrals for OT from the Pediatric Nutrition Network.

B) Strengthen connections with area dieticians who may be able to serve my clients.

C) Market to relevant stakeholders that our home health agency follows best practices relative to feeding, eating, and swallowing.
Since both the OT I work with and I are recognized by other practitioners in the region as feeding, eating, and swallowing specialists, we were 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 this presentation, we surveyed several NICU feeding specialists in the immediate area for general philosophy on thickener use. As a result, we strengthened our local NICU contacts and were 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, we modified our presentation to include alternatives to thickening and the use of a multi-disciplinary approach to establish support networks.

After our presentation, we fielded questions and networked with dieticians. One of the dieticians we met had the capacity to serve many of the children on our service. Dietary services are lacking in our agency. A few months later, we 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 we 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.
**Criterion 11 — 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)
- ☒ Presentation to stakeholder
- ☐ Other

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

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)
3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you “influence services for clients (person, organization, population) relative to feeding, eating, and swallowing through independent or collaborative education or advocacy activities.”

Our practice has many children referred to OT 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.

After consulting with the OT, 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.
**ADVOCACY CASE STUDY**

**Criterion 11 — 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**

- Efforts toward change that influence access to services or promote the health and occupational engagement of clients.
- This should **not** be confused with routine job duties associated with expected occupational therapy service delivery. For example, submitting letters of necessity for equipment would not meet intent.

1. Describe the client (person, organization, population) or program and the context as it applies to an identified need for change. *(average word guideline—100)*

   I collaborated with an OT to provide services for Alex, an infant with a history of premature birth, to address acquisition of developmental skills for feeding, play, and other childhood occupations. He was seen by OT through an early intervention program once a week. 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.

2. Summarize your efforts to influence change. *(average word guideline—200)*

   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 continued 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 collaborated with the OT, and based on our discussion, 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 OTA 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 11 — 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)

- 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)

In collaboration with my supervising OT, 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. I work closely with my supervising OT who also has expertise in this practice area. Due to this expertise, we were 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 my supervising OT regarding the developmental pediatrician’s concerns. As a result of the meeting, we concluded that education with potential referral sources needed to be done in order to meet the needs of these children. The developmental pediatrician assisted us in the process of scheduling 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 service 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. 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.
**Criterion 11 — 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 work with an OT consultant to create and deliver an educational and hands-on program for stakeholder groups, specifically for 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 worked with the OT and 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.**