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*School of Occupational Therapy*

Development of a Consulting Program: Improving Access to Feeding Therapy Services and  
Increasing Health Literacy for Caregivers of Children with Eating Difficulties

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### **Abstract**

Feeding and eating difficulties can occur in typically developing children as well as children with disabilities, which can negatively impact the feeding process and increase caregiver stress. After conducting a needs assessment at Feeding Friends Children's Feeding Clinic and Therapy Services, it was determined there was a need for increased access to feeding therapy in rural areas, as well as a need to address the lack of accessibility to feeding resources and tools. The purpose of this doctoral capstone project was to provide consultation opportunities and easier access to additional resources for caregivers living in rural areas who have a child with feeding and eating difficulties to improve health literacy and provide a better quality of life for their child(ren). The program included seven handouts, each created to meet a need discovered during the initial needs assessment. The handouts included information pertaining to oral sensory delay, oral motor delay, when to be concerned, difficulty with transition, a consent form, intake forms, and how to prepare for a virtual consult. A paper questionnaire was distributed to collect feedback from parents and caregivers on suggestions for the consulting branch, as well as what additional information they might find helpful regarding feeding and eating. To determine if needs were met, a pre- and post-informal interview with the co-owners of Feeding Friends was completed. To examine efficacy of the program once launched, a plan was developed and discussed with both co-owners on how to collect data and continue to gain feedback on the program. Overall, it was determined that the information provided in the consulting branch, as well as additional information had met the needs of the site and both co-owners.

Development of a Consulting Program: Improving Access to Feeding Therapy Services and  
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**Introduction**

Some form of feeding issues can be apparent in around 30% of typically developing children but can increase to 80% in children with developmental disabilities (Mascola et al., 2010). Successful treatment of feeding disorders is often dependent upon initiating a new, and positive, learning experience with eating that involves both the child and caregiver (Greer et al., 2007). Occupational therapists have had a long-standing role in the treatment of feeding and eating problems because of their importance as a primary self-care occupation, and eating is crucial to an individual's health and well-being throughout the lifespan (An, 2013). The purpose of this doctoral capstone experience (DCE) is to create a consulting branch of a pediatric feeding clinic, as well as include additional information on feeding issues, with the goal of increasing health literacy for caregivers and families of children who experience feeding and eating difficulties.

**Feeding and Eating**

Pediatric feeding disorders (PFDs) are “impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction” (Godoy et al., 2019, p. 125). The International Classification of Functioning, Disability, and Health (ICF) framework considers having a holistic understanding when working with PFDs and knowing how they can impact both the psychological and functional characteristics of an individual (Godoy et al., 2019). The ICF also highlights how PFDs can include “impaired mechanisms, environmental barriers, and facilitators and, most importantly, the impact on participation in daily family and community life” (Godoy et al., 2019, p. 125).

In its simplest form, eating is defined as “the ability to keep and manipulate food or fluid in the mouth and swallow it” (AOTA, 2014, p. S19). Eating is an essential part of a human’s daily occupations that begins at infancy and continues to develop throughout their lifespan (Absolom & Roberts, 2011). Feeding is described as the “process of setting up, arranging and bringing food (or fluid) from the plate or cup to the mouth; sometimes called self-feeding” (AOTA, 2014, p. S19). Swallowing is defined as “moving food from the mouth to the stomach” and goes through three phases: the oral, the pharyngeal, and the esophageal (AOTA, 2014, p. S19; Morris & Klein, 2000). For the purposes of this paper, unless otherwise specified, the process of feeding, eating, and swallowing will be referred to as eating.

### **Eating Development**

The process of developing feeding skills is complex and can be influenced by many factors (Le Révérend et al., 2014). Eating is a demanding physical task that requires involvement of all the body’s organ systems including the brain, cranial nerves, heart, skeletal muscles, and the vascular, respiratory, endocrine, and metabolic systems (Toomey, 2002). Any issues or impairments that arise involving these systems can have an impact on a child’s relationship with food and mealtimes (Morris & Klein, 2000). Children require the experience and developmental readiness to advance their eating skills and once those new eating movements have developed, then they depend on sensory input from their environment, food, and the utensils used during eating tasks (Morris & Klein, 2000). There are multiple barriers that could be limiting the development of a child’s feeding skills including structural, physiological, wellness, experiential, and environmental limits (Morris & Klein, 2000).

**Structural limitations.** The development of feeding skills relies on the support from multiple interconnecting systems that each have their own structure, which in turn helps keep the

total system at work while eating (Morris & Klein, 2000). During the feeding process, the movement, timing, and coordination of each structure is dictated by neurological programming that is specific to that structural system (Morris & Klein, 2000). Therefore, any changes or limitations of this structural system will influence the other systems and cause problems with an individual's eating (Morris & Klein, 2000). An example of this is when an infant has a cleft lip or cleft palate resulting in an opening in their lip or hard palate, which can then cause limitations in that infant's feeding patterns (Morris & Klein, 2000).

**Physiological limitations.** During the process of chewing, multiple physiological factors influence the efficiency of a munch/chew pattern including the number of teeth the child has, occlusion contact area, bite force, ability to control masticatory muscles for efficient contraction, and control of soft tissues to manipulate the bolus and placing of bolus in occlusion area (Le Révérend et al., 2014). The physiology of eating is also influenced by the neural, hormonal, and neurotransmitter systems that work together to control and monitor the transition of food from one system to the next (Morris & Klein, 2000). Additionally, this involves the respiratory and cardiac systems to assist with feeling comfortable and safe while eating (Morris & Klein, 2000). Aspiration is a common example of a physiological limitation that can occur during eating because it is a result of the upper channels and valves not working well to carry food from the mouth to the stomach (Morris & Klein, 2000). Another frequently seen example of a physiological limitation is gastroesophageal reflux (GER). This can result from the lower esophageal sphincter malfunctioning, which then causes the contents of the stomach to backwash into the esophagus, leading to reflux (Morris & Klein, 2000).

**Wellness limitations.** Wellness limitations cause an individual to lack the balance between their physical, emotional, and spiritual health (Morris & Klein, 2000). These three

aspects of an individual's health and wellness are important because they are intertwined and influence both the individual's self-care and overall well-being (Grover, 2018). An example of a wellness limitation can be something as simple as a food or environmental allergy, which may not cause an individual to be sick, but they might not feel well due to the effect their allergy can have on other body systems like respiratory and gastrointestinal (Morris & Klein, 2000).

**Experiential limitations.** Each individual has their own experiences relating to food, eating, drinking, and mealtimes, and some of these experiences are more memorable than others (Morris & Klein, 2000). A common negative experience that children have at a young age is the use of an orogastric or nasogastric tube for feedings (Morris & Klein, 2000). Tube feedings are invasive and can be uncomfortable for children. Therefore, when anything is approaching their nose or mouth, they sometimes determine that this is equally as threatening and uncomfortable as their tube feedings (Morris & Klein, 2000).

**Environmental limitations.** Environmental limitations can include socioeconomic factors or mental-health factors relating to the family (Morris & Klein, 2000). Issues with poverty or inconsistency with mealtimes and caregivers often hinder a child's ability to learn valuable feeding skills (Morris & Klein, 2000). Both caregiver and child enter the feeding environment with set predispositions and abilities that build overtime with every interaction, which can have a negative effect on the child's feeding development if the environment is not consistent or stable (Davis et al., 2006).

### **Eating Concerns**

Common feeding concerns that are seen during childhood include picky eating or selective eating, food refusal, manifestation of negative affect and negative behavior during eating, exceedingly slow eating, and having a tantrum or angry outbursts during mealtime

(Lewinsohn et al., 2005). According to Bernard-Bonnin (2006), “About 25% to 40% of infants and toddlers are reported by their caregivers to have feeding problems, mainly colic, vomiting, slow feeding, and refusal to eat” (p. 1248). In some cases, parents and caregivers may be unintentionally contributing to the feeding problems their child is experiencing (Lewinsohn et al., 2005). It can be difficult to identify feeding issues considering most children experience them as a result of both medical and behavioral influences (Greer et al., 2007).

### **Impact on Caregiver and Family**

Feeding and eating problems are one of the most common topics parents discuss with their pediatricians (Gueron-Sela et al., 2011). Increased levels of stress on parents and caregivers can occur when their child has a feeding difficulty, which can result in a strained parent-child relationship and overall negative well-being for both the child and caregiver during their feeding process (Greer et al., 2007). Craig et al. (2003) conducted a study on parental perceptions of gastrostomy feeding and found that parents felt more at ease with this because they were assured that their child was receiving nutrients; however, other concerns were raised such as the negative impact it might have on oral feeding, the stigma around tube feeding and negative public view, possible language difficulties, and overall health and nutrition concerns. Caregivers of children with feeding concerns also feel a personal responsibility for why their child is experiencing these eating difficulties due to the fact that providing nourishment is one of the primary responsibilities for caregivers when their children are young (Craig et al., 2003). Children absorb a great amount of information when they are young, and a lot of their behaviors and actions are modeled by their caregivers’ behaviors and actions. Therefore, when a caregiver starts to show signs of stress or frustration during mealtime, this visible sign can cause the child to avoid meals even more and

continue in a negative cycle until caregivers are given direction and proper intervention for their child's feeding difficulties (Greer et al., 2007).

### **Rural Access to Therapy**

When there's a lack of healthcare professionals working in rural areas, this will inevitably have an impact on the how individuals with disabilities receive therapy services, as well as how timely and effective those services are (Dew et al., 2013). Early therapy intervention has proven to be beneficial for individuals with a disability, regardless of age, and it improves family and community participation in activities to enhance quality of life (Dew et al., 2013). There are other extrinsic and intrinsic barriers affecting access to therapy services in rural areas. Extrinsic barriers may include the decreased number of community hospitals in remote areas, lack of healthcare specialists in rural areas, decreased incentives for therapists to take on work in rural areas, and rural healthcare policy (Osborne, 2008). Intrinsic barriers decreasing access to therapy in rural areas can involve the cultural perceptions an individual has about their community or personal health, geographical isolation, differences in technology access in rural areas, and an individual's lack of health insurance and low-income status (Osborne, 2008).

### **Telehealth & Consulting**

According to the Institute of Management Consultancy (IMC), consulting can be defined as "the service provided to business, public, and other undertakings by an independent and qualified person" (Ajmal et al., 2009, p. 524). Furthermore, consulting is about developing a relationship with the client to offer expertise about a particular issue that the client is experiencing, then providing possible solutions to that problem as well as ways to adapt both the clients internal and external environment in hopes of improving their situation (Dean et al., 2011). Telehealth services are an efficient way for providing consultations to potential patients,



so they can gain easier access to care, reduce costs of services, and decrease wait times for those needing immediate therapy services (Renda & Lape, 2018). During therapy sessions, it is important to find what is motivating for each individual client and take that into consideration when using telehealth and a technology design (Burrige et al., 2017). The application of virtual services is continuing to expand with the changing trends in how individuals have access to healthcare including user preference, managing acute and chronic conditions at the right time and place, the movement of care from hospitals to the patient's home setting, and the use of mobile devices (Burrige et al., 2017). The key to an effective consultation is a shared commitment to change between the client/caregiver and the consultant, and what that change process entails (DeBoer, 1986; Jaffe & Epstein, 1992; Murray et al., 1993; Rainville et al., 1996).

### **Occupational Therapy's Role**

Occupational therapy (OT) practitioners have advanced knowledge in activities of daily living (ADL) such as an individual's ability to participate in eating (AOTA, 2017). Occupational therapists have the ability to provide comprehensive management of eating problems, as well as provide interventions that focus on facilitating an individual's participation in eating that often involves both the individual and their family or caregiver (AOTA, 2017). OT practitioners are distinctively qualified to address eating difficulties because they look at "not only the physiological factors, but also the psychosocial, cultural, and environmental factors involved with these aspects of daily performance" (AOTA, 2017, p. 1).

## **Methods**

### **Project Site**

Feeding Friends Children's Feeding Clinic & Therapy Services is a privately co-owned outpatient pediatric clinic in Indianapolis, Indiana that began providing services in May of 2007

(Find Health Clinics, n.d.). The clinic moved to its current location off of Binford Avenue in 2016. The clinic provides developmental therapy, occupational therapy, physical therapy, and speech therapy through outpatient and early intervention—locally called First Steps—services. Feeding Friends is one of the premier feeding programs in the greater Indianapolis area and strives to provide therapy services to children of all ages through one-on-one and small group settings (Feeding Friends, 2020). For the remainder of this paper, Feeding Friends Children's Feeding Clinic & Therapy Services will be referred to as Feeding Friends unless otherwise specified.

The OT department at Feeding Friends consists of twelve occupational therapists, all of whom are passionate about providing services to kids and utilizing their own unique treatment styles and various experiences to do so. There are a total of ten speech therapists (ST's) working for Feeding Friends who are equally passionate about providing speech therapy to kids. Approximately eighty percent of the kids on the OT caseload at Feeding Friends are being treated for eating difficulties, which includes a variety of diagnoses and conditions at various age ranges. Around sixty percent of the kids on the speech caseload are being treated for eating difficulties. Each OT and ST eating appointment is generally one to two times a week depending on the severity of the eating issue, and last anywhere between 30 and 60 minutes. Typically, children are seen by one therapist; however, some sessions may overlap with other treating therapists.

## **Purpose**

My primary focus was to develop a program that included consulting and what that entails for Feeding Friends, as well as additional information regarding feeding and eating, to improve health literacy for caregivers and provide a better quality of life for their child(ren). This

includes developing a business model with what consulting will look like for Feeding Friends in terms of the delivery, approach, frequency of meetings, allocating time for payments, and more. Additional information will be made available through the Feeding Friends website that includes handouts, feeding tools and devices, professionals typically worked with, and support groups. The purpose of this doctoral capstone project was to provide consultation opportunities and easier access to additional resources for caregivers living in remote and rural areas who have a child with feeding and eating difficulties to help guide them through this process, help them understand what their options are, and let them know that they are not alone.

### **Theoretical Framework**

The approach of this consulting branch of Feeding Friends is guided by the Person-Environment-Occupation-Performance (PEOP) model, including Niklas Luhmann's social systems theory, as well as the sensory integration (SI) and behavioral frames of reference.

**Person-Environment-Occupation-Performance model.** Feeding and eating difficulties are often a result of the child's characteristics (physiological, psychological, sensory-perceptual) the child's environment (internal and external), and the caregivers involved. The Person-Environment-Occupation-Performance (PEOP) model demonstrates how the interaction between a person's abilities, the environmental factors involved, and the task demands of certain occupations have a direct influence on performance outcomes (Cole & Tufano, 2008). The PEOP model has a client-centered focus on occupations (valued roles, tasks, and activities) and performance (Cole & Tufano, 2008). This model uses the top-down approach and can assist therapists with identifying enablers and barriers to an individual's occupational performance and participation (Wong & Fisher, 2015).

Understanding the interaction between a child's abilities, the environmental factors, and the demands of the task during eating, as well as identifying where there are barriers to successful performance or participation can then be addressed in the intervention process and help enhance the child's role functioning (Cole & Tufano, 2008). For example, for some toddlers, it's not the type of food that's causing an eating issue, but rather the size or portion of that food and the higher demand it is requiring from that child to munch/chew and swallow successfully. The presentation of foods is extremely important to ensure the task is possible for that child, so providing smaller portion sizes, as well as smaller bites, will match the child's eating skills and remove the high physical demand of the task.

**Niklas Luhmann's social systems theory.** Luhmann's social systems theory looks at consulting in a non-traditional way with focusing on the boundaries of communication and preventing any unintentional misunderstandings (Mohe & Seidl, 2009). Furthermore, to avoid any miscommunication, Luhmann suggests identifying one individual who is in charge of the contact system, which is the main form of communication between the client and consultant (Mohe & Seidl, 2009). Additionally, this theory utilizes a systemic consulting approach that emphasizes the importance of the client during the consulting intervention process (Mohe & Seidl, 2009). When the client is at the center of the intervention process, then they are responsible for what they decide to do with the input given to them by the consultant (Mohe & Seidl, 2009).

Providing consultation options through telehealth is a non-traditional environment, and therefore requires the client to take on more responsibility with the intervention plan in order for there to be success without hands-on treatment from the consultant. Therefore, it is the consultant's responsibility to focus on the client and build an effective form of communication

and teaching style that will best assist the client so they can have success with the intervention process. For my project, this means describing feeding and eating interventions in a way that the client understands the demands of the task, as well as providing effective examples if needed for further explanation. Following Luhmann's social systems theory, the consulting branch for Feeding Friends will include defining the specific roles of both co-owners in the communication process to ensure organization and increase the success of the session for both client and consultant.

**Sensory integration frame of reference.** Sensory Integration (SI) is based on the way the brain receives sensory input from the environment and organizes it so that the body can respond with action (Cole & Tufano, 2008). This frame of reference is aimed at remediation of the sensory integration challenge, then improving the client's ability to integrate that sensory information by changing the organization of the brain (Cole & Tufano, 2008). Occupational therapists can use this information to develop an intervention plan by identifying the client's sensory needs or intensity of sensation that is specific to each client, then help them normalize their sensory processing needs and produce an adaptive response (Cole & Tufano, 2008). This is true for environmental adaptations as well. To begin facilitating a change for these children with eating difficulties, the OT will need to provide guided sensory input in a context that works best for each child (Cole & Tufano, 2008). For a child to be successful with eating, all the sensory systems must be integrated, as well as the lesser-known senses of balance, body awareness in space, and information received from one's joint's (Toomey, 2002). For example, when a young toddler is munching/chewing table foods, their head will naturally move with every munch/chew, so it's important for that child to adjust their sense of balance when munching or chewing to be successful with eating table foods (Toomey, 2002).

**Behavioral frame of reference.** The behavioral frame of reference focuses on desired behaviors through defining goals and working toward those goals utilizing skilled instruction, modeling, coaching, and behavioral reinforcement (Cole & Tufano, 2008). The best way to promote desired behaviors is through intermittent positive reinforcement (Cole & Tufano, 2008). Behavior is learned and can be remodeled with reinforcement (Cole & Tufano, 2008). For eating problems, the desired action (eating) requires shaping, which can be done by reinforcing a desired behavior continuously until the child learns the action (Cole & Tufano, 2008). For example, this can be demonstrated with a series of steps that are often used when introducing a new food to kids such as telling them to first smell it, then touch it, and so on until the child gets more comfortable with the new food, with the end goal being they eventually eat the new food.

### **Screening and Evaluation**

My project began with a needs assessment at Feeding Friends. The assessment included observing multiple feeding sessions for both occupational and speech therapy, as well as conducting unstructured interviews with the speech and occupational therapists on staff in addition to the co-owners of Feeding Friends. Unstructured interviews allow for a more natural conversation than structured interviews because the questions are spontaneous and the interview relies on the social interaction between researcher and informant (Patton, 2002; Zhang & Wildemuth, 2007). Also called informal interviews, unstructured interviews provide more flexibility with questions, allow for in-depth conversation, and increase validity through a deeper understanding of the situation (McLeod, 2014).

I utilized a survey methodology in the form of a paper questionnaire to collect feedback from parents and caregivers on suggestions for the consulting branch, as well as what kind of additional information they might find helpful regarding feeding and eating difficulties. This

method was chosen because it allowed for a cost-effective and simple process for gaining information from parents/caregivers (Picincu, 2018), and allowed for the opportunity to compare and contrast the information that was collected (Gaille, 2020). The questionnaire was developed based on findings in the literature review and therapist expertise from both co-owners who are a speech and occupational therapist. We developed questions to explore parent/caregiver views on the Feeding Friends website and if they had utilized it before, resources they wish they had access to like handouts or feeding support groups, and recommendations for the consulting branch. The caregiver questionnaire was reviewed by both co-owners before distribution. Based on their feedback, a 6-item questionnaire was finalized that included closed and open-ended questions. See Appendix A for the finalized caregiver questionnaire. The finalized questionnaire was distributed to parents/caregivers of existing eating therapy clients at Feeding Friends, ages 0-6 with a variety of diagnoses or impairments. Ten questionnaires were distributed, however only four contributors responded.

### **Targeted Population**

There are two groups of clients that made up the DCE targeted population: the OT and speech therapists at Feeding Friends and the population of children with eating difficulties as well as their family. Results from the needs assessment identified two themes for the clients being served: the need for increased access to feeding therapy in rural and remote areas and the need to address the lack of accessibility to resources and tools through the Feeding Friends website.

### **Implementation Phase**

A consulting branch of Feeding Friends, as well as additional information about feeding and eating, was developed utilizing telehealth resources created throughout the course of the

pandemic. Feeding Friends is looking to expand their services across the state of Indiana, specifically to rural and remote areas to address the lack of feeding services available to individuals in those areas. Part of this development includes creating and implementing handouts with valuable information on feeding and eating difficulties, as well as what to look for during the eating process and when to seek help.

### **Developing handouts.**

Each handout was created after a thorough review of the literature on that specific topic and relevant information was compiled. Handout topics were decided upon based on the literature, feedback from the caregiver questionnaire, and therapist expertise. Some handouts were formed based on information and resources the speech and occupational therapists had on hand in the clinic, with certain adjustments made to fit each handouts criterion for the project. A rough draft of each handout was created, then reviewed by the occupational and speech therapist co-owners of Feeding Friends.

Once the above steps were completed, each handout was re-evaluated again, first by myself and then by both co-owners. Any necessary changes were made, then the revised handouts were piloted by three caregivers who are current clients at the feeding clinic. Verbal feedback was received from all three caregivers who piloted the handouts, and possible changes were discussed among myself and the co-owners of Feeding Friends, and appropriate changes were made after the discussion if necessary.

A final needs assessment was conducted to ensure the information on each handout met the needs of the co-owners and potential clients of Feeding Friends. It was determined that no additional handouts or information was needed. This was done in the form of an informal interview with both co-owners of Feeding Friends.



**Handout details.**

A total of seven handouts were developed. Each handout was created to meet a need discovered during the initial needs assessment. These handouts were designed to increase health literacy and overall knowledge on feeding and eating difficulties, as well as preparation recommendations for a consultation. The handouts include information pertaining to oral sensory delay, oral motor delay, when to be concerned, difficulty with transitioning, a consent form, intake forms, and how to prepare for a virtual consult.

***Oral sensory delay.*** This handout defines oral sensory delay and what are common indicators of a sensory issue. This includes sensory avoidance and sensory seeking behaviors that can be observed during eating tasks. This handout serves to inform parents/caregivers on potential signs and symptoms of oral sensory delay. The oral sensory delay handout can be found in Appendix B.

***Oral motor delay.*** This handout defines oral motor delay and common signs to look for during eating tasks that could be indicative of an oral motor delay. It contains safe feeding practices, as well as what can happen as a result of poor oral motor skills. This includes the definitions of dysphasia and aspiration, which are two common terms associated with oral motor delay. Additionally, the handout lists common signs of swallowing problems. The oral motor delay handout serves to inform individuals on what oral motor delays could potentially look like, as well as safe ways to participate in feeding and eating tasks to decrease the likelihood of a problem with swallowing. The oral motor delay handout can be found in Appendix C.

***When to be concerned.*** This handout includes two lists of tasks and skills that a child might be struggling with or have not yet developed, which could suggest the need for therapy services. Both lists were already developed and available through the Feeding Friends website

under the appropriate therapy provider (occupational, speech, developmental, and physical therapy). For the purpose of this project, we are focusing on the occupational and speech therapists' lists. There will be a statement included under the new additional information tab on the website about how to access these lists. The handout that outlines both lists for occupation and speech therapy can be found in Appendix D.

***Difficulty with transitioning.*** This handout discusses the correlation between a child's medical history and having trouble with the process of transitioning to new foods whether that transition is from breast/bottle to purees or purees to table foods. It includes common signs that can be observed when working on transitioning to new foods. It also has a list of strategies to attempt to increase success with transitioning. The handout for difficulty with transitioning can be found in Appendix E.

***Consent form.*** This form has already been developed for telehealth therapy utilized during the pandemic. The consent form has since been updated due to changes in the regulations regarding the use of telehealth to provide therapy services. As of June 9<sup>th</sup>, 2021, telehealth services provided by both occupational and speech therapist in the state of Indiana is now permitted. The consent form is an agreement between the therapist and client to freely discuss medical information/history during the sessions. Additionally, the consent form allows for the delivery of early intervention services virtually and that the therapist or First Steps organization is not responsible for any technical issues or security complications. The consent form can be found in Appendix F.

***Intake forms.*** The intake forms were also previously developed; however, the co-owners were in the process of revising the questions and information obtained through these forms during my DCE. These forms are given to the parent(s)/caregiver(s) before the evaluation or

consultation. Additionally, the forms provide the therapist with comprehensive information about the child's medical history, as well as insurance information, fee for service agreement, attendance policy, and release of information agreement. This allows the therapist to review the forms and gain some understanding of the eating difficulties the child is experiencing before the initial session, so they can ask further questions during the evaluation or consult. The revised intake forms can be found in Appendix G.

***How to prepare for a virtual consult.*** This handout includes information for the parent(s)/caregiver(s) on what to attempt before the consultation meeting, so they are better prepared, and in turn help the consult go more smoothly. This handout includes eliminating distractions, being well rested if possible before the consult, and planning the session during a time that the child typically eats a meal or has a snack. The handout regarding how to prepare for a consult can be found in Appendix H.

### **Staff development.**

To ensure the staff at Feeding Friends developed a good understanding of each handout, a brief training session was held at the clinic. This session provided education and training to both the occupational and speech therapists on staff. Education included an overview of each handout and its purpose, as well as how their clients could benefit from each form. The session involved an open conversation with the therapists and answering any questions or clarifications needed. Since the staff being trained were therapists familiar with eating therapy, only one session was necessary to demonstrate sufficient staff development about the use of each handout and its overall purpose regarding feeding and eating. Additionally, the therapists who attended the session demonstrated verbal understanding of each handout at the end of the discussion. This guaranteed that the therapists had an opportunity to evaluate the handouts and

understand the content on each of them. Therapists were given access to the handouts through the Feeding Friends Dropbox.

### **Administration.**

Administration can be defined as “a process of systematically arranging and coordinating the human and material resources available to any organization for the main purpose of achieving stipulated goals of that organization” (Amadi, 2008, p. 5). In other words, administration helps a business or organization achieve a set of defined objectives (Amadi, 2008). Occupational therapists as an administrator includes overseeing other occupational therapists in a department and are responsible for program planning, management, policy development and budget separation, educating the staff and clients, and personnel management (What is OT, 2021).

During my doctoral capstone experience, I was able to utilize and acquire many of the traits associated with being an effective administrator to ensure the success of the program. I increased my knowledge not only in eating interventions but in program planning and development. I successfully educated the Feeding Friends staff on the purpose of each handout and benefits of the consulting branch. In addition to utilizing both co-owners of Feeding Friends, I also included the occupational and speech therapists on staff throughout the phases of this project to help contribute to the development of the program and overall goal for their business.

Four additional skills that I often utilized throughout the development of the program included communication, flexibility, leadership, and organization. Communication played a major role in the development of the program, especially in the implementation phase to ensure consistency among the staff at Feeding Friends. I remained flexible with the direction that the program was going, as well as changes that were made or suggested throughout the DCE. I also

demonstrated flexibility regarding meeting times with the co-owners and staff at Feeding Friends, since their schedules are all different and they change frequently in an outpatient setting. I conducted an educational training session for the staff demonstrating the value and importance of the program, as well as the handouts. My leaderships skills were tested due to the ever-changing schedules of the co-owners and staff and having to take initiative to establish times to discuss the program. I stayed focused and organized throughout the DCE and program development, which gave me the chance to make the most of my time when I had the opportunity to discuss topics with the co-owners or other staff. All of these skills and traits allowed me to effectively assume the role of an administrator and successfully implement the consulting branch, as well as additional information on feeding and eating.

## **Results**

### **Program Evaluation**

Once each problem had been identified and addressed during the implementation phase, I began to evaluate the program. I repeated an informal interview with the co-owners of Feeding Friends to discuss the finalized product and ensure the materials included in the program met the needs of both clients. Additionally, a plan was developed and discussed with the co-owners on how to assess efficacy of the program once implemented.

**Project outcomes.** After conducting the final informal interview, it was determined that the information had met the needs of the site and both co-owners. This included an easy way to sign up for a consult either virtually or in person with one of the co-owners, forms and handouts with important information regarding feeding and eating difficulties, how to prepare for a virtual consult, feeding support groups, feeding devices/tools with picture examples and the resources that the Feeding Friends typically uses to find those devices/tools, and a statement about the

importance of teaming and a list of healthcare professionals that Feeding Friends typically works with.

Since Feeding Friends will be implementing the program after I'm no longer on site, both co-owners have been educated on how to examine efficacy of the program once implemented. First, we discussed possible ways to collect data on the new sections of the website once it is launched. This included setting up a way to monitor how many people access either the additional information or the consulting branch on the website. By doing this, it would allow the co-owners to keep track of the number of views that occurred on those two tabs. Additionally, the co-owners plan to record the number of consults they accumulate through the website and whether the consult was virtual or in-person. Collecting this data will help determine the effectiveness of the program and if it is expanding Feeding Friends' business. Next, a trial run of the new Feeding Friends website was discussed and agreed upon. The co-owners plan to utilize two of the four caregivers who responded to the caregiver questionnaire and have them perform the trial run of the new website, as well as two of the therapists on staff at Feeding Friends. This ensures that both targeted populations will review the information before it is launched and address any final concerns or suggestions that they might have. There is also a plan to develop a handout for potential clients to fill out before a consultation along with the consent form and intake forms. This handout would ask for brief information such as name, date of birth, contact information, diagnosis, reason for referral, other services being received or have received, do you want the consult to be virtual or in-person, and how did you hear about Feeding Friends. Again, by asking how these individuals heard about Feeding Friends, this would allow for the co-owners to see the most consistent way that caregivers and families are seeking therapy services from

Feeding Friends. Whether it's from the website, a physician, word of mouth, Facebook, or other resources.

### **Societal Need**

Around 25% to 40% of infants and toddlers are reported by their caregivers to have feeding problems such as colic, vomiting, slow feeding, and refusing to eat (Bernard-Bonnin, 2006). Through my DCE, I address the societal need regarding the lack of access to feeding therapy services and how that is impacting both the child and caregiver or family. I addressed this need through the development of a consulting branch, as well as including additional information on feeding and eating. I created handouts to educate caregivers and provide assistance to therapists during their feeding intervention process, as well as assist caregivers in preparation for a virtual or in-person consultation. All of this will help increase health literacy and overall knowledge on feeding and eating difficulties. Ideally, this will provide easier access to feeding therapy services and decrease the effects that eating difficulties can have on both the child and the caregiver/family, therefore reducing the societal challenge of pediatric feeding disorders (PFDs).

### **Quality Improvement**

To ensure quality improvement of the project was sustained, continuous adjustments and evaluations were completed throughout each phase of the DCE. During the evaluation phase, both the Feeding Friends staff and caregivers of clients were encouraged to discuss what their needs were and any suggestions regarding the consulting branch or additional information that was going to be added to the Feeding Friends website. After completion of the evaluation phase, a few minor suggestions were discussed and implemented during the implementation phase. This included the possibility of holding group feeding therapy opportunities in a central location for

the individuals in remote and rural areas, in order to capture more people at one time. The implementation phase continued with no other issues identified. After evaluating the program again, I met with the co-owners of Feeding Friends one final time to ensure no further issues arose and all suggestions had been addressed; no additional issues were identified.

### **Sustainability**

Sustainability of the program is probable given that both co-owners and the additional occupational and speech therapists on staff are familiar with virtual sessions and have been using telehealth services for over a year now. Additional steps have also been taken to ensure sustainability such as completion of the training session on the handouts prior to implementation of the program to warrant consistency among therapists. Electronic versions of the handouts will be available through the Feeding Friends Dropbox, also a hardcopy version of each handout is available in the staff office to all therapists at the clinic. Copies of those handouts can be made as needed. By providing possibilities on how to examine efficacy of the program once it is launched, this further assists with sustaining the program after I am no longer on site.

### **Discussion and Overall Learning**

During my entire doctoral capstone experience I gained a great deal of knowledge and experience that will help me become a better future OT practitioner. This includes learning how to develop and implement a program successfully, as well as advancing my clinical skills. I have expanded my knowledge regarding pediatric occupational therapy, specifically related to children with eating difficulties. I was able to learn new strategies when addressing difficult child behaviors, also methods to use when involving the caregiver(s)/parent(s) in the intervention process or treatment session. Additionally, I was exposed to a variety of diagnoses and



impairments and developed a better understanding of how that might affect a child's oral motor development or eating habits.

In addition to increasing my knowledge base, I have been able to grow professionally as well. I was able to observe flexibility during a treatment session and with daily scheduling. I watched the benefits of teamwork among co-workers, as well as working with additional healthcare professionals to provide the best care for each child. Additionally, I witnessed effective communication, the importance of evidence-based practice, and the value in building rapport. Many of these experiences work hand in hand together to create a positive work environment and accomplish tasks.

### **Effective Communication**

Throughout my DCE, I had multiple opportunities to observe and interact with other healthcare professionals in addition to the clients I worked with. Particularly in a healthcare setting, working together with an interprofessional team allows for different perspectives and different aspects of health to provide the best treatment plan for the client (Eaton et al., 2017). Effective communication is a critical part of obtaining success and reaching the desired goal(s) when working with members of an interprofessional team (Shoham et al., 2016). I was able to engage in written communication, as well as verbal and nonverbal communication during my doctoral capstone experience. Additionally, it was important for me to stay aware of my body language and how I was stating things during verbal communication to ensure I was remaining professional, and my demeanor was true to what I was attempting to communicate.

Occupational therapists need to have good communication to ensure patient satisfaction, adherence to treatment, and an overall positive health outcome (Borghi et al., 2016). For example, an occupational therapist can utilize their questioning skills to build an occupational

profile for that client, which includes acquiring information about the client's medical history, daily activities they participate in, what interests and values they have, what does their support system look like if they have one, and what are their desired goals or outcomes for therapy.

Completing an occupational profile is an important part in creating an effective treatment plan/intervention for the client. Building rapport is another important aspect when working in a professional health setting because it creates a sense of trust between the therapist and client. Therefore, occupational therapists need to utilize good communication skills in order to build that rapport and develop a healthy relationship with the client (Price, 2017). In a pediatric setting, it was not only important for me to build rapport with the clients that I was seeing, but also with their caregiver(s). A lot of the children I was working with were too young or sometimes unable to communicate their experiences with me, so I needed to be able to effectively communicate with their caregiver to gain that information and understand what goes on in that child's daily life.

Overall, there were three key parts of communication that I learned and was able to further develop during my doctoral capstone experience. First, I realized the importance of good verbal and non-verbal communication when interacting with others such as an interprofessional team, the client, or the client's caregiver(s). This will also assist in building a positive relationship during the therapy process and allow for optimal treatment and intervention. Second, building confidence when speaking to others can lead to better confidence overall in both my communication skills and therapeutic knowledge, which allows me to feel confident when sharing my ideas and thoughts about a client. I will continue to improve in this aspect through practice. And third, when working with other healthcare professionals and participating in collaborative work, this can help produce the best treatment plan and outcomes for the client.

**Development of Leadership and Advocacy Skills**

I have utilized and developed many professional, leadership, and advocacy skills throughout the different stages of this DCE.

**Leadership skills.** I was able to increase my knowledge and experience regarding eating difficulties, development and implementation of a program, and increasing my communication skills. By taking on the role of a leader in certain aspects of this doctoral capstone experience, I was able to self-direct myself and further develop my confidence and initiation skills. I improved my collaboration skills with other disciplines including physical therapists, speech therapists, and developmental therapists by communicating with them outside of therapy sessions. Additionally, I increased my knowledge and experience with professional writing and research. By continuing to grow and develop my leadership skills, among other skills, I will develop into a better future OT practitioner.

**Advocacy skills.** According to the third edition of the Occupational Therapy Practice Framework (OTPF), “Occupational therapy practitioners can indirectly affect the lives of clients through advocacy” (AOTA, 2014, S11). Advocacy supports “health, well-being, and occupational participation at the individual or systems level” (AOTA, 2014, S30). During this DCE, I had the opportunity to advocate for the OT profession, my clients at Feeding Friends, my program development, and myself.

When advocating for the OT profession, this included educating the client’s families, as well as the staff at Feeding Friends. I was able to educate both parties on the purpose of OT, especially when addressing feeding and eating. This helped me gain experience with advocating, which allowed me to better describe the OT profession and enhance my explanation after each discussion.

I advocated for my clients at Feeding Friends, including those who were experiencing eating difficulties and those who were not. I educated and collaborated with clients and their families to ensure the best care was provided and everyone's goals were being met. Additionally, I provided education to families and caregivers on how they can advocate for their child(ren) to receive the benefits and accommodations that are available to them in order to improve their participation in occupations. This included discussing possible equipment and tools available to them, community-based services available where they lived, and insurance benefits/restrictions. Although I did not have the opportunity to discuss the impact of eating difficulties with the public, I often discussed the topic with caregivers during sessions or in between sessions whenever the topic was brought up. In addition to some of the handouts that were developed regarding oral sensory delay, oral motor delay, when to be concerned and seek a referral to therapy, and difficulty with transitioning are all ways to increase advocacy and awareness of eating difficulties.

I advocated for the consulting program, along with additional information on feeding and eating, by initiating conversations with the co-owners of Feeding Friends, other staff members, and families of clients. After the program was developed, I educated both the occupational and speech therapists on the handouts developed, the purpose of the program, and how to advocate for it's use. Additionally, I collaborated with the co-owners to develop a plan for implementation and examining efficacy of the program once I am no longer on site.

During my doctoral experience, I had multiple opportunities to advocate for myself. I reached out to therapists about opportunities that benefit my learning experience and increase my knowledge about pediatric OT. This included observing multiple treatments and evaluations performed by different therapists including occupational, speech, and developmental therapists. I

had the opportunity to observe a different setting that incorporated equine-assisted therapy, which involved activities with horses. Advocating for myself allowed me to grow professionally and further develop my leadership, communication, and advocacy skills. I also encountered barriers to my growth and development of these skills, however, I was able to overcome those barriers to complete my program and become a better professional and future OT practitioner.

### **Summary**

Throughout my experience at Feeding Friends, I was able to accomplish many things. This includes evaluating, interpreting, and resolving some of the needs of Feeding Friends by creating a consulting program that can be easily implemented and maintained once I am no longer at their site. I was able to gather additional information for the Feeding Friends website, which included developing relevant handouts, providing suggestions for eating devices/tools as well as the links for where you find those devices/tools, and specify feeding support groups in and around Indianapolis. I also expanded Feeding Friends' eating therapy opportunities and increased health literacy for potential feeding clients. I have developed many skills and abilities during this DCE experience and have grown both professionally and as a future OT practitioner. I have advanced my clinical skills and experiences through this DCE opportunity and feel that it has not only helped me prepare to become an occupational therapist but has also allowed me to grow as an individual.

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Appendix A  
Finalized Caregiver Questionnaire

## Feeding Friends

### Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

#### Caregiver Questionnaire

Feeding Friends is looking to expand their services across the state of Indiana, specifically to rural and remote areas. There's a lack of healthcare professionals working in rural areas and this is negatively impacting how individuals receive therapy services, as well as how timely and effective those services are. Feeding Friends plans to create a consulting branch for individuals seeking a consult for feeding and eating difficulties. Additionally, we are trying to grow our website by including additional information on feeding equipment, handouts, and update our annual paperwork. Feeding Friends values any feedback or recommendations regarding our website, annual paperwork, and future consultation branch.

1. Have you used the Feeding Friends website before? If so, what did you like about it? Any recommendations for the website?
2. Are there any handouts regarding feeding information that you wish you had access to?
3. Would you benefit from having additional information about common adaptive equipment/devices used with feeding difficulties, as well as the resources where you can obtain that equipment?
4. Would you like information on feeding support groups? If you already utilize a feeding support group, if you don't mind sharing, which one(s)?
5. Do you know anyone who would benefit from a consultation from Feeding Friends but cannot complete the consult at the clinic due to distance, medical concerns, etc.?
6. Is there any advice you could provide for the consulting branch if you needed services but did not live in the area or could not come in person?

Appendix B  
Oral Sensory Delay Handout

## Feeding Friends

Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

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### Oral Sensory Delay

The mouth tissues perceive sensory information such as the taste, temperature, and texture of food. Some children can have a feeding aversion to how foods feel or taste.

### Common Signs of Oral Avoiding Behaviors

- Refusing entire categories of food
- Avoids certain texture of foods
- Difficulty with new foods
- Gags, chokes or drools often
- Difficulty using a straw
- Refusing to eat foods that touch
- Refusing to touch or explore foods
- Crying during mealtimes

### Common signs of Oral Seeking Behaviors

- Strong brand preference
- Craves certain foods
- Prefers spicy or hot foods
- Bites frequently
- Bites/Chews nails
- Mouths non-food items
- Chews furniture, toys, pencils, etc...

Appendix C  
Oral Motor Delay Handout

## Feeding Friends

### Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

#### Oral Motor Delay

The suck-swallow-breath pattern in infants may be poorly developed. Muscles of the tongue, jaw and lips may be weak with underdeveloped chewing patterns.

#### Common Signs of Oral Motor Delay

- Poor lip closure or latch
- Weak sucking/chewing skills
- Overstuffing/pocketing food
- Limited tongue movement
- Immature chewing pattern
- Difficulty transitioning from bottle to table foods
- Coughing or choking
- Low intake of food (child may not consume enough calories because it takes so long to eat)

#### Safe feeding practices

A swallowing problem means that one or more of the phases of swallowing are not functioning well, also call dysphagia. Dysphagia can interfere with a safe swallow which can cause aspiration. Aspiration is the term used to describe food or liquid entering the airway. Most often, when aspiration occurs you will see the following signs. However, a child can silently aspirate (fluid/foods going into the lungs without coughing or choking)

#### Common signs of Swallowing Problems

- Coughing during and following eating/drinking problems
- Unexplained low-grade fevers
- Sneezing following eating
- Reoccurring respiratory infections and/or pneumonia
- Choking during mealtimes
- If infant, bottle or breast refusal, pulling away from nipple
- Noisy or wet upper airway sounds and/or poor voice quality (hoarse, weak, wet) during and following eating/drinking
- Difficulty with food transitions (puree to solids)
- Poor saliva control
- Poor chewing skills
- Multiple swallows to clear bolus (residue left on posterior portion of tongue)
- Poor weight gain
- Nasal regurgitation

## Appendix D

## When to be Concerned Handout

**When your child might need to be referred to Occupational Therapy.**

## Fine Motor/Gross Motor/Play Skills

- If your child is only using one hand to complete tasks
- If your child is not being able to move/open one hand/arm
- If your child is uncoordinated or displays jerky movements during activities
- If your child is over or under-shooting the intended object when reaching
- If your child is not using the appropriate force to complete a task (too rough/gentle)
- If your child has fisted hands past 6 months
- If your child is not bringing hands to midline by 10 months of age
- If your child is not releasing an object deliberately by 12 months of age
- If your child is not scribbling on paper by 15 months of age
- If your child is not imitating writing lines by 26 months of age
- If your child is not using scissors by 30 months of age
- If your child is not able to dress themselves by 4 years of age
- If your child has difficulty engaging in this tactile play
- If your child is constantly in motion
- If your child is fearful of movement
- If your child covers their ears to avoid sound
- If your child likes to crash into or push objects, furniture, and other people
- If your child is not able to feed themselves with their fingers or with a spoon by 12 months of age

**When your child might need to be referred to Speech Therapy.**

## Receptive (understanding of language)

- Your child does not respond to their name
- Your child does not follow age-level directions (1 step 18-24 months, 2 step related 24-30 months, 2 step unrelated 30-36 months)
- Your child does not identify body parts or common objects/pictures
- Your child has limited play with toys

## Expressive (spoken language)

- Your child does not babble or jabber (0-18 months)
- Your child is not able to combine words in phrases (24-36 months)
- Your child uses words and/or phrases but is not functional in their language use
- Your child has a limited use of actions, adjectives and pronouns (27-36 months)
- Your child expresses extreme frustration or negative behavior

## Articulation/Speech (how clearly your child is understood)

- Your child uses the same sound attempt for most words
- Your child demonstrates labored speech or will grope for words
- Your child has a limited ability to combine syllables in words/phrases
- Your child is unintelligible (24 months 50%, 36 months 80%)
- Your child has delayed age-level sounds (p/b/m/n/t/d/h/w/y)
- Your child's vocal quality is nasally or raspy

## Orally

- Your child drools a lot, shirt is wet, need to keep a bib on your child during non-mealtime
- Your child keeps his/her mouth open (mouth breather)



Appendix E  
Difficulty with Transitioning Handout

## Feeding Friends

Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

### Difficulty with Transitioning

Infants and children with a history of gastrointestinal difficulties (reflux, constipation, delayed gastric emptying), food allergies, and/or developmental delays may experience increased difficulty transitioning from breast/bottle to purees and table foods.

### Common Signs of Problems with Transitioning:

- Refusing the spoon
- Immediately spitting food out
- Etc.

### Try These Strategies:

- Use spoon to present a preferred food (applesauce, yogurt)
- Use spoon to stir or “draw with” a puree on tray or table; encourage imitation
- Allow time for child to get comfortable with the puree and interact with spoon and/or puree before presenting a bite
- Present the spoon to lips and keep it there until child open mouth for it
- Remain calm and use a soothing voice; limit verbal cues and use brief statements like “bite” or “more yogurt”
- Provide praise after taking a bite, opening mouth, etc. whether it was independently taken or adult led
- Keep mealtimes fun!
- Allow for messy play with food as this helps with sensory development and to prevent oral aversion
- Limit cleaning of the face and avoid “scraping” lips with the spoon to clean off excess food

Appendix F  
Consent Form Handout

## Feeding Friends

Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: feedingfriends@hotmail.com

**Indiana First Steps  
Informed Consent for the Use of Virtual Early Intervention**



Child Information		
Name of child	Child ID #	Date of birth (mm/dd/yyyy)
Street address	City	Zip code
Early Intervention Service Type		
This consent is to be used for one (1) service type. Please complete additional consents for each service type.		
<input type="checkbox"/> Service Coordination <input type="checkbox"/> Evaluation and Assessment <input type="checkbox"/> Ongoing IFSP Service(s)		
Acknowledgement and Statement of Consent		
<p>I understand that my child and family may receive early intervention (EI) services through virtual visits. I also understand that federal and state laws require I consent to the following:</p> <ol style="list-style-type: none"> <li>1. I consent to the delivery of EI services by virtual visits over a computer, tablet, or smart phone between Indiana First Steps EI professionals and my family/child. I understand that the availability of virtual visits will depend on the type of technology, devices, or system requirements used.</li> <li>2. I understand that EI professionals will have the same licensure/certification and apply the same standard of care as EI professionals during an in-person visit.</li> <li>3. I understand that not all EI professionals are able to provide virtual visits due to licensure/practice act restrictions.</li> <li>4. I will have access to all EI records and information resulting from the sessions conducted through virtual visits as I would during in person visits, and as provided for by law.</li> <li>5. As with any internet-based communication, I understand that risks include the possibility of technological problems which may result in poor quality or disconnection from the virtual visit, as well as a security breach without the appropriate protections. To help mitigate security risks, it is recommended I take steps to protect my personal device and data including using a secure Wi-Fi network with password and using a videoconferencing platform with end-to-end encryption to participate in virtual visits.</li> <li>6. I understand that Indiana First Steps is not responsible for my device security and acknowledge and knowingly accept the risks of accessing service(s) via virtual technology.</li> <li>7. I understand that, in addition to the EI professional, other individuals may be involved in the virtual visit to operate or repair the video or audio equipment. If this occurs, these individuals must be identified to all parties</li> <li>8. I understand that I am responsible for the cost of technology associated with receiving EI services through virtual visits (e.g. data/internet plans, personal device)</li> <li>9. I understand that the use of virtual visits are only allowable at this time due to COVID-19 and are not a permanent service delivery option. This temporary policy will be in effect until May 31, 2020, or when Indiana's public health emergency is lifted, whichever date is soonest.</li> </ol>		
Signature of parent/guardian/caregiver		Date (mm/dd/yyyy)
Verbal Consent		
If consent for the use of virtual early intervention is obtained verbally, documentation of consent must be included in the child's EI record.		
<input type="checkbox"/> Consent was received via phone. Documentation of the conversation is included in the child's EI record		
<input type="checkbox"/> Consent was received via text message. A copy of the conversation is included in the child's EI record.		
<input type="checkbox"/> Consent was received via email. A copy of the conversation is included in the child's EI record.		
Signature of EI professional		Date (mm/dd/yyyy)

Appendix G  
Intake Forms

# Feeding Friends

## Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: feedingfriends@hotmail.com

Section I:	Patient Information	Date _____
Name: _____ Prefer to be called: _____		
Phone: (____) _____ Date of Birth: _____		
Primary Address: _____ City: _____ State: _____ Zip: _____		
Secondary Address: _____ City: _____ State: _____ Zip: _____		
Child Resides with: _____ Both Parents _____ One parent (please name: _____)		
Person to contact in case of emergency: _____ Phone: _____		
Email Address: _____		
Primary Physician: _____ Phone: (____) _____		

Section II:	Insurance Information
Policy Holder: _____ DOB: _____ Relationship to Patient: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Social Security # _____	
Name of Employer: _____	
Insurance Company: _____ Insurance Co. Phone: _____	
ID#: _____ Group #: _____ Plan/Program Name: _____	
----- DO YOU HAVE ANY ADDITIONAL INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, COMPLETE THE FOLLOWING	
Name of Insured: _____ DOB: _____ Relationship to Patient: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Name of Employer: _____	
Insurance Company: _____ Insurance Co. Phone: _____	
ID#: _____ Group #: _____ Plan/Program Name: _____	
Parent/Guardian	
1. Name: _____ Relationship to Patient: _____	
DOB: _____ Social Security #: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Phone: _____ Email address: _____	
2. Name: _____ Relationship to Patient: _____	
DOB: _____ Social Security #: _____	
Address: _____ City: _____ State: _____ Zip: _____	
Phone: _____ Email address: _____	

**Section III:****Medical Release of Information**

✓The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Feeding Friends, Inc. I understand that I am financially responsible for any balance. I also authorize Feeding Friends, Inc. or the insurance company to release any information required to process my claims.

Insurance Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA/FERPA**

✓HIPAA is a Federal law that requires companies to maintain strict confidentiality for client information specifically the clients' private health information (PHI). I have reviewed and understand Feeding Friends Inc.'s HIPAA policy, including how my PHI may be shared, stored, and displayed. I understand my HIPAA rights.

Insurance Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

✓FERPA is a Federal law that protects the privacy of student education records and gives parents certain rights with respect to their children's education records. Since we often receive education documents, we are required to protect these documents as well. I understand my FERPA rights.

Insurance Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

✓I have read HIPAA and FERPA; **however I choose to waive my rights** and continue to allow Feeding Friends Inc. to access all medical records of the above patient.

Insurance Subscriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fee for Service Agreement**

This agreement stands between Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. and the patient listed below for the duration of the current year. Please initial by each line to indicate understanding and agreement.

\_\_\_\_\_ Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. will assist the patient in the filing of insurance claims if we are in-network with the provider. Please remember the only services eligible for insurance reimbursement are occupational/physical/speech and language therapies. Unfortunately, developmental therapy is ineligible for insurance reimbursement.

\_\_\_\_\_ It is understood by both the insurance subscriber and Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. that if the therapy fees are not covered under the patient's insurance plan, the insurance subscriber will be responsible for payment of these service fees.

**As a reminder, the patient's family is responsible for monitoring the number of visits allowed per coverage year and must notify their therapist AND the front office immediately if the limit has been exceeded to discuss continuing services.**

\_\_\_\_ We will file your therapy services through Medicaid if we have received your insurance information to complete an authorization. You are responsible for notifying Feeding Friends if you are using Medicaid insurance in other therapy locations. Medicaid will often not pay for multiple therapy sites for the same service. If Medicaid does not cover your claims, you will be responsible for payment of these fees.

\_\_\_\_ We will continue to use telehealth services as appropriate. Insurance companies vary with their allowance of these services. We will work with you to determine if your insurance company will allow telehealth. Families are responsible for payment if the telehealth services are not covered.

\_\_\_\_ The insured will be responsible for notifying Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. when there is a change in insurance coverage. If new insurance information is not provided in a timely manner, the family will be responsible for unpaid services due to lack of timely filing. Per our contracts with our insurance companies, we must submit claims within 30 days. **In addition, families will be charged \$20.00/claim if we must refile claims due to new coverage.**

Parent Signature/Date: \_\_\_\_\_

Child's Name \_\_\_\_\_

## Feeding Friends

### Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

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#### Attendance Policy (CLINIC)

Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. is committed to providing quality and consistent care of your child. We want your child and family to achieve the goals and outcomes that you have decided upon. In order for this to happen, we need consistent care and therapy time so that we can assist you in making these great changes in your child. Below is our attendance policy for all therapy services offered through Feeding Friends, Inc. Please initial to indicate that you understand the policy.

\_\_\_ If you need to cancel therapy services, we would appreciate a 24-hour notice. Although, we do understand that illnesses are unpredictable, the earliest notification possible will allow us greater flexibility in rescheduling your appointment.

\_\_\_ If a family cancels within 2 hours of the scheduled appointment time, this therapy visit will be considered a "no -show" appointment. The only exception to this rule will be if your child's appointment is prior to 10 am. Three no -show appointments will lead our therapists to discharge your child from our services.

\_\_\_ If a family cancels therapy without attempts to reschedule the appointment 4 times within a 3-month period, the therapist reserves the right to fill your spot and a new day and time will be assigned to you.

\_\_\_ If your family plans an extended time off from therapy services due to illness, hospitalization, or vacation, you will need to notify your provider. Your therapy time may not be held by the provider.

\_\_\_ If your therapist needs to cancel or reschedule an appointment due to illness or vacation, we will reschedule with you at a time that is convenient for both the family and therapist. If a therapist will not be able to provide services for greater than two weeks in a row, we will offer a substitution therapist to cover your child's services.

Please sign below indicating that you understand Feeding Friends Children's Feeding Clinic and Therapy Services attendance policy.

\_\_\_\_\_  
Parent signature and Date

\_\_\_\_\_  
Therapist Signature and Date

\_\_\_\_\_  
Child's name

# Feeding Friends

## Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

### Release of Information

I, \_\_\_\_\_ agree that Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. can relay information about my child, \_\_\_\_\_ in the following manner:

<input type="checkbox"/> Voice Mail Message	<input type="checkbox"/> Text Message	<input type="checkbox"/> Email
Using the following #s:	Using the following #s:	At the following address(es):

I, \_\_\_\_\_ agree that Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. can release information about my child, \_\_\_\_\_ in regards to his/her progress and skills observed by any of our therapists. Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. may establish contact with the following:

Name:	Phone #:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

(continue on the back if necessary)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

### Photography Release

I, \_\_\_\_\_, give permission for Feeding Friends Children's Feeding Clinic and Therapy Services, Inc. to use photographs of my child, \_\_\_\_\_ for the purpose of marketing both in paper publications and internet use and for the purpose of (history, journaling, scrapbook, etc.).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Feeding Friends

Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

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### Directions to Feeding Friends

6330 E. 75<sup>th</sup> St., Suite 206, Indianapolis, IN 46250

From Greenwood Area:

1-465 E to Shadeland Ave/ 56<sup>th</sup> Street Exit 40. Keep left to take Shadeland Ave/ 1-465 N ramp. Keep Left to merge onto N Shadeland Ave. Turn left onto E 75<sup>th</sup> Street then turn Right on Knue then Right again before the Railroad Tracks. Suite 206 will be directly in front of you.

From Carmel/ Zionsville/Westfield Area:

1-465 S to 1-69 S via Exit 37A toward Binford Blvd/Indianapolis. Take a Right onto E 75<sup>th</sup> Street then Right on Knue then Right again before the Railroad Tracks. Suite 206 will be directly in front of you.

From Fishers/Noblesville Area:

IN-37 to 1-69 S towards Binford Blvd/Indianapolis. Take a Right onto E 75<sup>th</sup> Street then Right on Knue then Right again before the Railroad Tracks. Suite 206 will be directly in front of you.

Leaving Feeding Friends heading towards Greenwood:

East on E 75<sup>th</sup> Street towards Binford Blvd to Right on N. Shadeland. Keep Left for ramp for I-465 S



Appendix H  
How to Prepare for a Virtual Consult Handout

## Feeding Friends

Children's Feeding Clinic and Therapy Services, Inc.

Phone (317) 284-1166 --- Fax (317) 284-1559 --- Email: [feedingfriends@hotmail.com](mailto:feedingfriends@hotmail.com)

### How to Prepare for Virtual Consult:

- Try to limit distractions
  - Put pets up
  - Remove any additional electronics from room
  - Set up meeting at dinner table or where mealtime typically takes place
  - Set up in a room away from other children/siblings
  - If needed, utilize toys that are used during mealtimes only
- Be well rested
  - Try to get a good night's rest before the consult
  - If possible, plan session after the child's naptime
- Plan the session during a time that your child typically eats a meal or snack
  - This will provide the greatest opportunity for the therapist to observe your child's eating habits and/or concerns