BRIEF OR NEW

A Multidisciplinary Approach to the Development of Competency Standards and Appropriate Allocation for Patients With Dysphagia

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Current Medicare guidelines stipulate that dysphagic patients can be treated by either an occupational therapist or a speech pathologist. Reimbursement for dysphagia therapy is provided for occupational therapy as long as it is medically "reasonable and necessary" and for speech therapy as long as it is "reasonable and necessary and only if there is a communication disorder" ("Dysphagia Evaluation," 1983, pp. 11-12). The application of these guidelines may be confusing in certain clinical settings and situations.

Confusion arose in our facility, Cedars-Sinai Medical Center, Los Angeles, California, about cases in which the speech pathologist was treating communicative as well as swallowing deficits and the communication problem was resolved. We also questioned whether an occupational therapist or a speech pathologist should treat a patient discharged from both services due to a lack of progress when a reevaluation of swallowing was ordered. In 1987, our facility developed a flowchart as a guideline to allocate dysphagic patients to either an occupational therapist or a speech pathologist. The flowchart follows Medicare guidelines and has been accepted by our clinicians as a fair means of allocation.

Simultaneously, in recognizing that dysphagia management is often not covered in occupational therapy or speech pathology curricula, our facility developed competency standards to prepare the staff to work with dysphagic patients. Both the flowchart and the standards may be useful for those hospitals in transition from a unidisciplinary to a multidisciplinary approach to the management of patients with dysphagia.

Historical Perspective

The most important factor in dysphagia management is the therapist's skill and knowledge. Occupational therapy is a health profession whose purpose is to enable the patient to achieve a maximal level of independent living by developing those capacities that remain after disease, accident, or deformity.

Because feeding is a primary self-care activity, occupational therapists traditionally have played an active role in feeding programs. Eating, according to the American Occupational Therapy Association (AOTA), is "the skill and performance of sequentially feeding oneself including sucking, chewing, swallowing and using appropriate utensils" (AOTA, 1979). The assessment and treatment of swallowing problems have been addressed in the occupational therapy literature for over 40 years. In the 1940s, Margaret Rood described detailed procedures to stimulate swallowing (Rood, 1956). During the 1950s, feeding and swallowing techniques were an integral part of therapy.
component of therapy for children with cerebral palsy (Holser Buehler, 1966) and for postpolio patients. In the 1970s, swallowing therapy techniques were initiated with adults with such disabilities as stroke and head injury (Silverman & Elfant, 1979).

Further development of dysphagia management continues, as described by Cromwell (1986) and Asher (1984). In addition to these descriptive papers, studies related to feeding have been published by Stratton (1981) and Rogers and Snow (1982).

The American Speech-Language-Hearing Association (ASHA) defines *dysphagia* as “a swallowing disorder characterized by difficulty in oral preparation for the swallow or in moving material from the mouth to the stomach” (Staff, 1987, pp. 57-58). Traditionally, speech pathology has focused on the oral and laryngeal anatomical structures and their function in speech production. Because the structures used for speech are also essential for swallowing, speech pathologists acquire a basic knowledge of deglutition.

Historically, swallowing function is mentioned in speech textbooks as early as the 1930s (Travis, 1931). These early efforts focused on children with cerebral palsy. More recently, speech pathologists have become involved in the management of swallowing disorders resulting from stroke, head injury, and other neurological disorders. For example, Logemann (1983) developed the modified barium swallow as a diagnostic tool for use with these patients. Many dysphagic patients have concomitant speech-language disorders. Often, the swallowing problems temporarily take precedence over speech-language disorders, at least until the patient can safely and adequately manage food by mouth.

**Clinical Training**

The occupational therapist’s role in treating patients with dysphagia is based on the therapist’s frame of reference and educational background. In a telephone survey that we conducted of the three undergraduate and graduate occupational therapy programs in Southern California, we found that although the course content may or may not specifically address the diagnosis and treatment of dysphagia, these three schools teach the primary skills needed to work with patients with this condition. Each school’s curriculum addresses aspects of the anatomy and neurophysiology of swallowing. In addition, three major occupational therapy textbooks (Hopkins & Smith, 1983; Pedretti, 1985; Trombly & Scott, 1982) briefly discuss basic therapy for feeding and eating problems, including the importance of patient food positioning, food consistency, and monitoring for aspiration during swallowing.

Speech pathology curricula vary among schools, but all cover the anatomy and physiology of speech mechanisms as well as the evaluation and treatment of communicative disorders (e.g., articulation, language, fluency, cognition, and pragmatics). In a telephone survey that we conducted of four randomly chosen speech pathology programs in Southern California, we found that three of the four provided some training specifically for dysphagia management. Two schools included dysphagia within a course such as “Voice and Articulation” or “Neuroanatomy,” but one school had a specific course entitled “Dysphagia and Cognition.”

Limited coverage of specific dysphagia management in the formal education of occupational therapists and speech pathologists coupled with the increased demand for dysphagia services has created a situation that encourages the acquisition of additional knowledge through continuing education. Currently, no professional discipline has a known certification program for dysphagia management.

**Competency Standards**

The coordinators of the dysphagia program at our facility adapted and modified ASHA’s competency standards for clinical preparation (Staff, 1987) as prerequisites for working with patients with dysphagia (see Figure 1). The prerequisites include required readings (e.g., Logemann’s [1983] *Evaluation and Treatment of Swallowing Disorders* and a procedural manual created by the dysphagia coordinators at Cedars Sinai Medical Center), the acquisition of fundamental knowledge about dysphagia, and supervised clinical experience with patients with dysphagia.

Speech and occupational therapists at our facility who are interested in dysphagia management can acquire specialized knowledge, skills, and clinical expertise through workshops and under the guidance of one of the two dysphagia program coordinators. Therapists are allowed time to attend in-house and outside workshops as well as to observe and practice videofluoroscopic swallowing studies. The required readings are done on the therapist’s own time. Upon completion of prerequisite clinical training, the therapist must be able to do the following:

1. Identify the necessity for evaluation and refer the patient to the appropriate team member.
2. Administer and interpret bedside swallowing evaluations and videofluoroscopic swallowing studies with the radiologist.
3. Document the evaluation results and recommendations in a concise and timely manner.
4. Develop dysphagia treatment plans.
5. Recognize when it is appropriate to terminate therapy.

As of this writing, five speech pathologists and nine occupational therapists have been trained for...
Feelings of territoriality between the two disciplines are minimized, thus resolving the problem of cross-coverage during periods of high census at the hospital, especially when either discipline receives multiple requests for dysphagia treatment.

### Allocation of Patients With Dysphagia

Figure 2 shows the clinical framework used to allocate patients with dysphagia to either occupational therapy or speech pathology services. The primary division occurs with the presence or absence of communicative disorders. If the patient with dysphagia has a concomitant communication disorder, then the speech pathology service provides the dysphagia intervention. If the patient does not present a communication disorder, then the occupational therapy service provides the intervention.

If speech services are discontinued due to a lack of progress and yet a reevaluation of swallowing is ordered, the occupational therapist involved in the case would administer the reevaluation even if a speech pathologist performed the initial evaluation. If an occupational therapist had not been on the case, however, then the speech pathologist would continue to provide dysphagia services.

These allocation guidelines are modified depending on the number of therapists available, the patient census, or both. When the census is high, patients are assigned on the basis of the availability of therapists from either discipline. Medicare guidelines

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**Figure 1.** Competency standards for occupational and speech therapists interested in dysphagia management. CSMC = Cedars-Sinai Medical Center, Los Angeles, California.

**Figure 2.** Clinical framework by which patients with dysphagia are allocated to either occupational therapy or speech pathology services. D/C = discontinue; O.T. = occupational therapist.
allow for a speech pathologist to treat a patient for a communication disorder while an occupational therapist treats the dysphagia.

Future Directions

ASHA and AOTA are currently addressing dysphagia issues. In 1987, ASHA’s Ad Hoc Committee on Dysphagia passed a resolution recommending that speech pathologists be allowed to treat dysphagic patients with or without a communication disorder (Staff, 1987). As of April 1989, Medicare had not yet reached a decision regarding this recommendation. In 1986, ASHA and AOTA met to form the Joint Ad Hoc Committee to discuss dysphagia issues and concerns common to both professions. Long-term plans include collaborative research in dysphagia and improved clinical expertise among members.

Effective August 25, 1989, speech pathologists can provide services to Medicare patients with dysphagia regardless of a communication disorder. At the time of this writing, the dysphagia coordinators at Cedars-Sinai Medical Center continued to use the above guidelines as a fair means of allocation of patients with dysphagia.

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References


