Tutorial

Using Backward Design in Dysphagia Management: A Paradigm Shift Toward More Culturally Responsive Care

Kevin Renz Ambrocio[a] iD and **Samantha E. Shune[b]** iD

[a] Department of Speech Pathology & Audiology, University of South Alabama, Mobile [b] Communication Disorders and Sciences Program, University of Oregon, Eugene

A B S T R A C T

Purpose: Marginalized communities have an increased predisposition to disease where dysphagia is often associated. While commonly used as paradigms in health care and dysphagia management, the biomedical model and forward design do not adequately support equitable, inclusive, and quality care for individuals of culturally and linguistically diverse (CLD) backgrounds. A more-narrow focus on curative and impairment-based management may actually be detrimental to patients' personal and cultural identities. Therefore, it is crucial to broaden the focus of service delivery to provide culturally responsive, patient-centered care. This tutorial describes the application of backward design to dysphagia management, with practical strategies and tools offered to increase the quality of care for persons of CLD backgrounds.
Conclusion: Clinicians need to prioritize the individual cultural dynamics of each patient. Personalized ethnocentric care requires clinicians to become aware of their own worldviews and biases while understanding better their patients' identities. Clinicians should consider adopting a more holistic lens and beginning the dysphagia management process with the patient's end goal in mind. Through this critical first step, clinicians will be better equipped to inform appropriate assessment and intervention selections that leverage all aspects of the biopsychosocial framework, helping to reduce health disparities in CLD populations.

Dysphagia is a swallowing disorder that involves the aerodigestive tract. It can lead to significant health consequences, such as malnutrition and dehydration (Carrión et al., 2015), aspiration pneumonia (Feng et al., 2019), decreased psychosocial well-being (Moloney & Walshe, 2018), and caregiver burden (Namasivayam-MacDonald & Shune, 2018; Nund et al., 2014; Shune & Namasivayam-MacDonald, 2020). Working with people who present with dysphagia in order to maximize functioning and minimize risk requires extensive knowledge and clinical skill (Caesar & Kitila, 2020). Recent advances in the dysphagia literature and, subsequently, dysphagia management have more appropriately recognized the complexities involved, reflected particularly in the shift from focusing only on considering airway invasion to better understanding the underlying physiology. For instance, increased standardization for assessing videofluoroscopic swallow studies using the Modified Barium Swallow Impairment Profile (MBSImP) has added value to how speech-language pathologists (SLPs) communicate information practically and more consistently (Martin-Harris et al., 2017). Overall, these advancements have stimulated large-scale research efforts that better inform assessment utility (Clain et al., 2022), and the implementation and appropriate use of these tools have improved diagnostic accuracy, for example, early detection of esophageal motility disorders (Watts et al., 2019) and treatment effectiveness (Balou et al., 2019).

Correspondence to Kevin Renz Ambrocio: kra2121@jagmail.southalabama.edu. **Disclosure:** *The authors have declared that no competing financial or nonfinancial interests existed at the time of publication.*

The increased attention on swallowing physiology is well aligned with the biomedical model of medicine, a traditional and dominant approach of diagnosing and managing disability and illness (Farre & Rapley, 2017). Using this model, SLPs emphasize the impairment and how to "fix" it. With respect to SLPs' increased understanding of the biophysical aspects of dysphagia, SLPs have come a long way from simply managing airway invasion through compensatory approaches toward restorative management practices. Yet the restoration of impaired or lost function is, or should be, only one consideration within management. Given the nature of the traditional medical approach and the currently available literature specific to dysphagia management, patient values and preferences are often overlooked compared to the other tenants of evidence-based practice (EBP). An imbalance also exists as dysphagia research lacks attention on ethnocultural and patient-focused considerations (Koidou et al., 2013). This gap may contribute to the disproportionate health and health care disparities experienced by persons from culturally and linguistically diverse (CLD) backgrounds, which is defined as U.S. Census–designated individuals whose cultural values or ethnic background is distinct from mainstream society and individuals who belong to a home where a language other than English is spoken. Exploring these topics may foster a more culturally responsive health care system better equipped to reduce cross-cultural issues, improve health care outcomes, and ensure equitable and quality care.

Health care more broadly is slowly becoming more conscious of its consumers. Pivoting from a sole emphasis on curative treatment as the marker of successful medical management, there is a growing call for treatment to instead focus on understanding, strategizing, and executing effective plans that integrate and maximize patient experience, empowerment, goals, and preference (Ben Natan & Hochman, 2017). This perspective is well aligned with the International Classification of Functioning, Disability and Health (ICF) framework, which views impairment of body structure and functions in the context of an individual's biopsychosocial factors, allowing for increased flexibility and promoting a greater consideration of the whole person (World Health Organization, 2001). Such an intentional focus on the individual within context is crucial to quality care in our increasingly diverse society.

Persons from CLD backgrounds are particularly vulnerable, but highly prevalent, populations (Cadoret & Garcia, 2014), making up nearly half of the U.S. population today (U.S. Census Bureau, 2019). In addition to the known disparities across marginalized groups regarding health care access and disease impact (Ellis & Jacobs, 2021), some evidence indicates health disparities may also exist surrounding persons with dysphagia. Hispanic and non-White stroke survivors, including Asian, Black or African American, and Native Americans, are often more predisposed to dysphagia, with individuals of Asian descent having the highest rate (Bussell & González-Fernández, 2011). Feit et al. (2020) indicated disparities between dysphagia and percutaneous endoscopic gastronomy tube placement based on race, ethnicity, and socioeconomic status. Furthermore, food and eating are intricately tied to culture, necessitating recognition of the role culture plays when treating dysphagia. Food and mealtime have various meanings for people and are often symbolic of one's identity (Almerico, 2014). These concepts reflect social order and community (Ochs & Shohet, 2006) and allow people to maintain their cultural practices (Kenny, 2015). Ochs and Shohet (2006) state that, "mealtimes are both vehicles for and endpoints of culture" (pp. 35–36). Therefore, not only certain populations may be at greater risk of developing dysphagia, but also required mealtime adaptations may lead to permanent changes detrimental to their cultural and/or personal identity.

Differing systems and values related to health, wellness, and illness are apparent across cultures, including how persons from CLD backgrounds understand and respond to treatment and lifestyle recommendations. Cultural rules and conventions are often considered a "way of life" and deeply rooted in generational history, particularly food and eating. For example, an ethnographic description of a Chinese cancer support group's discussions displays how their food-oriented culture strongly views food as a way to maintain human connections and improve health by "fighting" their disease with foods that are "cancer destroying" and avoiding those perceived as "cancer causing" (Bell et al., 2009). Additional work with Chinese nursing home residents highlights the cultural value of collectivism that is also present during eating-related activities (Wu & Barker, 2008). Unfortunately, SLPs frequently impose change on an individual's eating practices that may conflict with one's food culture and behavior, such as the use of texture-modified foods and liquids. This common practice may not only reject the beliefs of culture-sharing groups but also lead to a host of consequences, including loss of autonomy, meaning, values, and sense of self (Genoe et al., 2010).

Additionally, creating new experiences that promote changed behaviors and routines could increase stress and result in a lack of adherence to treatment recommendations, leading to poorer health outcomes (Genoe et al., 2010). It is also possible that patients from CLD backgrounds may have disproportionate health literacy and may encounter communication disparities with SLPs or have difficulty understanding information related to the plan of care (Ribeiro et al., 2021). This issue may be common in dysphagia management, given that dysphagia is complex and often a novel topic, thereby potentially prohibiting patients of CLD backgrounds from advocating

for themselves and thusly labeling them as noncompliant. Recall the Chinese cancer support group and nursing home residents' meaning of food (Bell et al., 2009; Wu & Barker, 2008) and imagine an SLP who recommends that a patient of these culture-sharing groups refrain from eating in a room with other people to limit distractions. By following this recommendation, the patient may decrease participation in the collective family meal, choosing to either eat alone or not eat, resulting in reduced quality of life and, possibly, health and nutritional consequences. Yet if the patient were to choose to continue eating with family members, this decision would oppose the SLP's recommendations and expectations, and the patient may be labeled as noncompliant.

Decisions made in dysphagia management, such as alternative means of nutrition, diet modifications, use of compensatory strategies, and environmental adaptations, should be met with an understanding of the patient's cultural attitudes and values as some cultures have different inherent beliefs (Kenny, 2015; Watson & Bell, 2014). SLPs play a critical role in managing the mealtime experience, but there may be a lack of consideration for these decisions' adverse impact on one's personal and cultural identity. SLPs must help their patients weigh the benefits and consequences of the choices made to yield functional outcomes that are significant to the patients. Ultimately, there is an opportunity and need for growth in dysphagia management to better incorporate ethnocultural considerations.

Despite the increasing awareness and value of a more holistic management approach, several barriers exist for the successful implementation within the scope of dysphagia. First, dysphagia practice undoubtedly necessitates a substantial understanding of swallowing physiology in the context of various disease processes. This focus naturally emphasizes the biomedical model to achieve accurate diagnosis and effective treatment. Biomedical factors are also more tangible and quantifiable than ethnocultural issues, so clinicians are likely to make provisions for the former (Koidou et al., 2013). Persons from CLD backgrounds may not ascribe value to or may have apprehensions about Western biomedical practices, which typically shape and align with the clinician's epistemology, expertise, and worldview. Decentering the clinician and their opinions by listening and attempting to understand the patient's perspective seems like a reasonable solution. However, clinicians may not be adequately equipped with a structured framework on how to maximally center their clinical practices on the multidimensional cultural systems of patients who belong to CLD backgrounds, especially within dysphagia management.

Although cultural considerations have gained attention more recently, cultural sensitivity and competence at the individual and organizational levels across health care are far from exemplary, considering the ongoing health disparities persons of CLD backgrounds frequently experience. Since the biomedical model has been the dominant approach to health care, changing fixed practices requires time and a conscious effort. The literature also lacks attention on cultural issues surrounding dysphagia and its management (Koidou et al., 2013). For instance, dysphagia research has predominately focused on quantitative physiological outcome-based studies as compared to cultural implications and outcomes associated with dysphagia. Furthermore, a gap in the dysphagia literature exists regarding qualitative explorations of the experiences, perspectives, and behaviors of individuals from CLD backgrounds. Although quantitative research is crucial to the field's understanding of dysphagia, the latter would provide complementary and comprehensive context to better explain the phenomenon under study, which often cannot be explained solely by quantitative measures.

As the Western society continues to transform, so should clinicians' perspectives and practice patterns. Addressing these barriers will help reframe dysphagia practice. This transformation will require a paradigm shift in order to enable more effective person-centered care for CLD groups of persons with dysphagia in the context of EBP. This tutorial proposes and describes a paradigm shift using a more backward design in dysphagia management to meet the individual needs of persons of CLD backgrounds. With the vast majority of health care focusing on "cure" rather than "care," this tutorial offers clinicians a framework and practical strategies to facilitate a starting point for this shift and to put the "care" back in "health care."

Backward Design

Backward design is a result-focused instructional planning method that starts with the end goal (Wiggins & McTighe, 2005). It includes three stages:

1. identifying the desired results (outcome),
2. determining appropriate and meaningful ways to evaluate skill attainment (process), and
3. planning specific learning experiences (content).

This approach leads to active learning and engagement because it promotes a dynamic partnership between the instructor and learner, which challenges the traditional learning model (Wiggins & McTighe, 2005). Stage 1, identifying the desired results, establishes the course and learning outcomes, as well as priorities that participants should master. At this early stage, instructors should think about the big picture, including what is essential to know and understand, and meaningful skills that one should be able to perform. Student engagement and feedback in goal

setting provides a foundation for active learning. Stage 2, determining appropriate and meaningful ways to evaluate skill attainment, involves choosing acceptable evidence forms that demonstrate student learning (e.g., quizzes, tests, assignments, projects, labs, simulations). Stage 3, planning learning experiences, involves determining how the concepts will be taught, what learning strategies will be used, and the resources and materials needed to successfully deliver meaningful learning experiences (Wiggins & McTighe, 2005).

Backward design is the opposite of the traditional "forward design" paradigm, which is content focused, linear in fashion, and mainly targets how the information will be presented. Forward design focuses on inputs, such as class activities and instruction at the onset, rather than prioritizing the output or the intended outcome (Slavych, 2020). This traditional form of learning promotes the passive acquisition of information. It places instructors at the core of the learning process, as the "sage on the stage" or learning authority, who choose the subjects to be covered, plan the lesson sequence for the topics, and develop assessments to determine students' understanding.
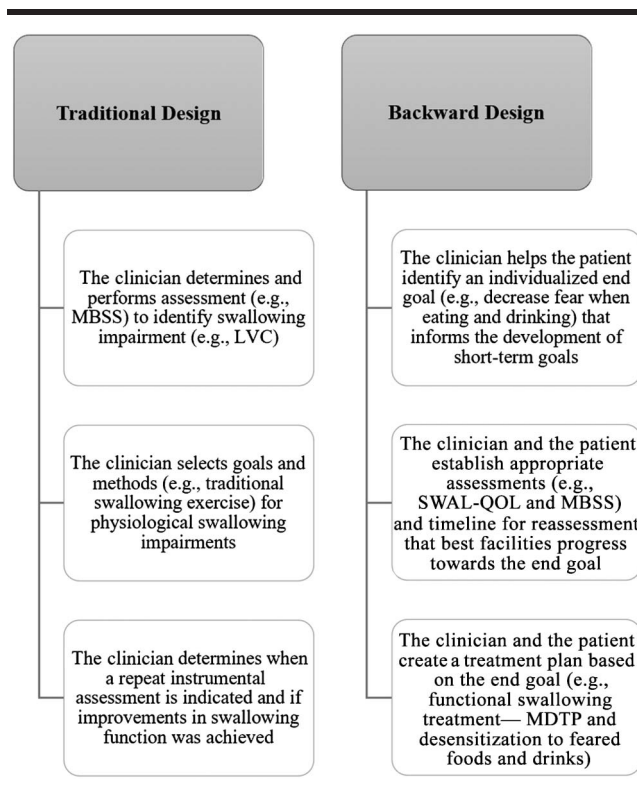
Backward Design and Dysphagia Management

Much of dysphagia practice today mimics this traditional forward paradigm. Clinicians start by identifying the impairment, determine what is most important in treatment, plan how to treat the impairment with a therapeutic regimen, and reassess the swallowing mechanism using instrumental tools when they deem it appropriate. The clinician is viewed as the expert. Patients are led to believe that the clinician's knowledge and expertise are at the core of the treatment process, thereby creating the image that a patient's progress and success depend significantly on the clinician. Notably, when clinicians prescribe treatments without consideration of patients' perspectives that then fail to achieve positive outcomes, patient nonadherence is often regarded as the issue (Stamer et al., 2013). Importantly, patient treatment adherence depends not only on their health and personal factors but also on contextual factors (Krekeler et al., 2020). Contextual factors include caregiver and social support, which are largely related to patients' cultural systems and dynamics. Caregivers are also key to treatment success for many patients, but their role, often informally bestowed upon them, can lead to significant burden, thus calling attention to greater consideration of patients' unique ethnocultural and social schema (Shune & Namasivayam-MacDonald, 2020). By considering the patient and their contextual factors at the forefront and center of dysphagia practice, clinicians may

better capture the individual needs of patients from CLD backgrounds.

The principles of backward design could be applied to dysphagia management, including for individuals from CLD backgrounds, as this paradigm promotes individual variability and a person-centered approach. Figure 1 displays a comparison of traditional and backward design in the context of dysphagia management. In the backward design model, direct patient involvement would occur at the outset of the evaluation process and during intervention, which could drive patient goals and outcomes more effectively. Treatment would specifically address the problems that the patients care about most. Clinicians would be better positioned to empower patients to become equal partners during evaluation and treatment. Mirroring the principles of backward design, the purpose of a well-planned rehabilitation program is to have the end in mind before establishing specific treatment protocols (Wiggins & McTighe, 2005). Prioritizing the patient's goals and preferences through patient engagement and learning about their cultural identities shifts the focus away from solely building a plan based on impairments. The remainder of this tutorial will describe crucial aspects of dysphagia

Figure 1. Comparison of dysphagia management using traditional and backward designs. LVC = laryngeal vestibule closure; MBSS = modified barium swallow study; MDTP = McNeill Dysphagia Therapy Program; SWAL-QOL = Swallowing Quality-of-Life questionnaire.

management within each stage of backward design. Table 1 provides an outline of the different techniques relative to the stages of backward design that will be discussed. In order to demonstrate the application of backward design to dysphagia practice, particularly with patients from CLD backgrounds, a case study is presented below that will be further embedded throughout the discussion of each stage.

Consider Ms. H, a 52-year-old bilingual Tagalog- and English-speaking (L1 > L2) Filipina who was referred to an outpatient clinic after sustaining a pontine stroke. She presented with right facial asymmetry, right upper and lower extremity weakness, dysarthria, mild cognitive dysfunction affecting memory and information processing, and dysphagia. A modified barium swallow study revealed deficits in mastication, anterior–posterior lingual transfer, tongue base retraction, and laryngeal vestibular closure. These deficits contributed to oral residue with solids and consistent aspiration of thin liquids with reduced ability to eject the material from the airway with a reflexive and volitional cough. A puree and nectar-thick liquid diet was recommended by the SLP at the hospital. Ms. H's family reported that the SLP who performed the modified barium swallow study strongly urged the patient to consume this modified diet to prevent the development of aspiration pneumonia. During the SLP evaluation at the outpatient clinic, the family indicated that they were concerned about the patient choking and not eating enough due to disliking the new diet and that they felt unequipped to financially manage their loved one's dysphagia as they come from a relatively low socioeconomic background. Ms. H specified that she was afraid of missing out on social functions, which are vital to her way of life, because she feels embarrassed about her diet restrictions. She also reported that she misses eating her favorite food, "Halo-

Halo" (a traditional Filipino dessert with several mixed consistencies, such as jelly, ice cream, syrup, and flan).

Stage 1: Identifying the End Goal

The first stage of backward design begins with identifying the end goal. It involves asking the patient essential questions that help the clinician to better understand the patient's worldview, values, preferences, and desired outcome, in order to inform successful goal setting. Given that people have unique cultural identities that impact their view on health and illness, the priorities of the patient and the clinician may be different. For example, a patient may prioritize their quality of life over swallowing safety, whereas their SLP's values may be the opposite. Clinicians can be more prepared to work in tandem with their patients by knowing their patients' specific end goal before beginning the management process.

Shared Decision-Making

Shared decision-making empowers patients to be active collaborators in making their health care decisions and goals (Elwyn et al., 2017). Shared decision-making encourages clinicians to acknowledge their patients' values, builds awareness of others, helps honor cross-cultural differences, and promotes cultural humility or the lifelong commitment to building self-awareness and understanding of others (Derrington et al., 2018). The Agency for Healthcare Research and Quality (AHRQ; 2020) outlines a five-step process for shared decision-making called the SHARE Approach, which emphasizes open discussion between the clinician and the patient in order to identify what is meaningful to the patient. The SHARE Approach is made up of the five steps below (AHRQ, 2020).

1. **S**eeking the patient's participation
2. **H**elping the patient explore and compare treatment options
3. **A**ssessing the patient's values and preferences
4. **R**eaching a decision with the patient
5. **E**valuating the patient's decision

Step 1 of the SHARE Approach involves making the patient aware that their active participation in their care is critical, as some patients do not know that they can and should engage in the decision-making process. Step 2 pertains to the clinician's role in helping the patient navigate the risk and benefits of care plan options by using the current best evidence. Step 3 involves communicating with the patient regarding their values and preferences to determine what matters most to them and what outcomes they hope to achieve. Step 4 represents a joint decision between the patient and the clinician about the plan of care only after the patient has received adequate information about all

Table 1. Techniques for achieving stages of backward design.

Stage	Techniques
1. Identifying the desired results	• Shared decision-making • Motivational interviewing • Ethnographic interviewing
2. Determining appropriate and meaningful ways to evaluate skill attainment	• Goal attainment scaling • Patient-reported outcome measures

3. Planning specific learning experiences	• Passive learning
	  o Acquiring information
	• Active learning
	  o Observing
	  o Doing
	  o Reflective open dialogue

their options. Step 5 signifies the ongoing assessment of the shared decision and adjusting the care plan to impact the patient's life and health positively.

Implementation of shared decision-making is a deliberate process. It is helpful to have personal buy-in and have organizational support (AHRQ, 2020). A practical suggestion for gaining organizational buy-in is finding a respected champion within the health care team who understands the value of patient-centered decisions. One should share a clear written vision statement for why shared decision-making matters and how it could impact outcomes. For successful implementation, clinicians must gain experience with the tenants of shared decision-making (AHRQ, 2020). The process of implementing shared decision-making could begin with even smaller steps, such as beginning a patient interview with an open-ended question and listening actively or making sure to check-in with the patient periodically to ensure understanding. In traditional interviewing, the clinician approaches the discussion with a preconceived notion about the patient, their problems, and what is best for the patient; this approach is very clinician centric. Communication breakdowns because of power dynamics and linguistic differences between clinicians and patients from CLD backgrounds may exacerbate health inequities and distrust of the medical system. More comprehensive interviewing styles, such as motivational interviewing and ethnographic interviewing, allow the patient to lead and actively contribute to the dialogue and establish their individual plan of care.

Motivational Interviewing

Motivational interviewing is a person-centered, goal-oriented technique that promotes empathetic and reflective listening to help patients explore their behaviors and values to create goals and an action plan (Resnicow & McMaster, 2012). There is adequate evidence suggesting the positive outcomes of motivational interviewing across various patient populations and clinical settings (Lundahl et al., 2013). Motivational interviewing provides clinicians with the ability to interact with patients from diverse cultures purposefully in a manner that help patients voice their thoughts and concerns openly and empowers them to build confidence to achieve their goals (Szczekala et al., 2018). Motivational interviewing is based on the following guiding principles:

- expressing empathy,
- facilitating modifications in behavior,
- promoting autonomy to reduce resistance, and
- supporting self-efficacy.

The specific techniques used in motivational interviewing include asking open-ended questions, providing affirmations, showing empathy, and summarizing ideas relevant to the patient during the interview (McFarlane, 2012). See Table 2 for examples of each motivational interviewing skill applied to the dysphagia aspects of Ms. H's case. Implementing these techniques during the first stage of backward design in dysphagia management could facilitate a dynamic patient–clinician relationship. Culturally responsive SLPs should use motivational interviewing to learn about the patient's views on their health, health care, and their dysphagia. Motivational interviewing can be used to better understand the patient's culture (e.g., beliefs, customs, religion, cuisine, social habits, and family norms) that could shape the course of dysphagia treatment.

Ethnographic Interviewing

Ethnographic interviewing is a patient-centered approach used to understand a person's sociocultural patterns and perspectives by empowering them to share their experiences (Namasivayam-MacDonald & Riquelme, 2019; Riquelme

Table 2. Motivational interviewing techniques as applied to dysphagia management.

Technique	Examples
Open-ended questions	• "How do your swallowing problems impact your life?" • "Tell me about how your modified diet has impacted your daily life." • "How do you learn best?" • "What does health/illness mean to you?"
Affirmations	• "You seem very motivated to get back on your previous diet and participate in your social functions. Therapy is challenging work, but your eagerness will help us during this process." • "Thank you for expressing your concerns about the burden your swallowing issues have caused you and your family. I have a better understanding of how to help you."
Reflective listening	• When listening to a patient, repeat their words periodically to show you are actively listening. • Describe observations you make about the patient's behaviors using statements like "I sense you getting [type of emotion]." • Reframe the patient's words by making statements like "Let's think about reasonable steps to get you back to eating Halo-Halo."
Summarizing	• "Let's finish our evaluation with a recap of what we've discussed about your swallowing and your ultimate goal of being able to eat Halo-Halo with your family the next holiday." • "To make sure we're on the same page, eating Halo-Halo with your family by your next birthday is what you want to achieve. You also want to decrease the feeling of fear you get when eating and drinking."

& Rosas, 2014; Westby et al., 2003). It allows the clinician to obtain a rich collection of patient information that can be used to bridge cultural difference gaps, help establish dynamic patient–clinician relationships, and better inform decision-making (Riquelme & Rosas, 2014). Its key features include accepting a learning stance using descriptive and structural questions, and exploring social context (Westby et al., 2003).

To obtain a vivid account of the patient's life experiences, clinicians should view the patient and caregiver as experts of their own cultural system, including their view of health and health care. Clinicians who assume that they understand the patient and their cultural beliefs and experiences may bias the patient's responses and distort the course of the interview and future interactions. Like motivational interviewing, ethnographic interviewing emphasizes open-ended questions (Westby et al., 2003). Descriptive and structural questions are specifically used in the latter interviewing approach. Descriptive questions aim to explore a broad idea of how the patient views their world and problem in a nondirective manner (Westby et al., 2003). For example, the SLP evaluating Ms. H can begin a conversation with a broad grand-tour question to learn about the patient's general experiences, such as "describe a typical day in your life." The clinician then probes deeper by asking descriptive mini-tour questions, which focus on specific activities. For example, to elicit information about the task of eating and drinking, the SLP can then ask Ms. H, "Describe your typical experience during mealtime before your stroke" and "How has it changed after your stroke?"

As the clinician actively listens to the patient's response, the clinician should take note of keywords that the patient uses (e.g., the patient describes the experience as "scary" and uses the word "fear"), as these words or problems will be used to form follow-up structural questions. Structural questions aim to focus on the patient's perception of the experiences and gain more specific information that will inform treatment planning (Westby et al., 2003). Although more focused, structural questions should remain open ended. For instance, the SLP could ask, "Tell me about the reasons eating is scary," or "How do you manage these fears when eating?" Throughout the conversation, the clinician requests examples of the experiences specified by the patient. It is also vital to obtain information about the social context of the experiences introduced by the patient (Westby et al., 2003) and be mindful of the environmental setting and external factors that could affect the interview process. For instance, creating an inviting and culturally sensitive physical space for Ms. H may involve inquiring about her culturally accepted norms and preferences, such as acceptable proxemic space when interacting with others, which could help her feel more comfortable sharing valuable information if applied. Ultimately, comprehensive interviewing techniques

would be useful for gaining in-depth information about the lives, experiences, and perceptions of patients who are members of CLD backgrounds in a nondirective manner and promote trust between the patient and SLP. Clinicians may also find these strategies beneficial to use with caregivers to gain more context about patients' values and behaviors, as well as the impact of the dysphagia on the larger family system.

Stage 2: Determining Appropriate and Meaningful Ways to Evaluate Skill Attainment

The second stage in backward design is determining appropriate and meaningful ways to evaluate skill attainment, which is accomplished through assessment. Clinicians must assess patient-centered outcomes to learn more about patients' goals, progress, and worldview. Providing culturally sensitive patient-centered care goes beyond learning about individual patient factors as described in Stage 1 of backward design. Assessment of patient-led outcomes should be ongoing throughout the plan of care. Furthermore, the assessments that clinicians choose should be responsive and flexible to meet the diverse cultural and social realities of patients from CLD backgrounds.

Goal Attainment Scaling
A method of assessment that can be used during Step 2 in backward design for dysphagia management is goal attainment scaling. This scale is a patient-specific, criterion-referenced outcome measure for detecting meaningful and realistic change (Shankar et al., 2020; Turner-Stokes, 2009). Measurable and objective patient-centered goals are first identified through, for example, motivational interviewing as described above (e.g., Ms. H identifying her desire to eat the same traditional Filipino dinner as her family—increase range of foods, including Halo-Halo). Secondly, the patient and the clinician establish expected outcome descriptions and rating scores (e.g., Ms. H consistently using 2/4 swallowing techniques in order to increase safety with more textured foods as the expected outcome). See Table 3 for an example of a defined expected outcome rating scale. Baseline scores should then be taken for each goal. Lastly, ratings for each goal are captured during the intervention, and progress is compared to the baseline ratings on a reasonable date (Turner-Stokes, 2009). The benefits of goal attainment scaling include its ability to capture the individual's needs, measure functional goals at various levels of ability, and promote shared goal setting (Turner-Stokes, 2009). Functional progress should be tracked throughout the intervention.

Patient-Reported Outcome Measures
Success in dysphagia management is often measured by valid and reliable impairment-based outcome measures.

Table 3. Example of defined expected outcome rating scale for goal attainment scaling.

Achievement description	Achievement rating
Achieved expected outcome much less than expected (decline)	-2
Achieved expected outcome somewhat less than expected (baseline)	-1
Achieved expected outcome at expected level	0
Achieved expected outcome somewhat more than expected	+1
Achieved expected outcome much more than expected	+2

SLPs are often well acquainted with and use clinician-driven outcome dysphagia and bolus flow measures in conjunction with instrumental evaluation, for example, the Penetration–Aspiration Scale (Rosenbek et al., 1996), the Dysphagia Outcome and Severity Scale (O'Neil et al., 1999), and the Yale Pharyngeal Residue Severity Scale (Neubauer et al., 2015). The frequent use of these measures is well aligned with the current primary focus of dysphagia management being the improvement of observable kinematics and timing—impairment-level approaches. Although several impairment-based dysphagia outcome measures are available and critical to the evaluation process, few valid and reliable tools emphasize all aspects of the ICF, particularly contextual and environmental factors (Nund et al., 2019).

Patient-reported outcome measures (PROMs) can be useful for addressing all aspects of the ICF as PROMs identify patients' direct perceptions about their health condition, independent of clinician input (Patel et al., 2017). Some robust PROMs exist (see Table 4), which clinicians can use to build an understanding of the unique realities of persons from CLD backgrounds, thereby promoting cultural competence. A variety of PROMs have been validated across a number of diverse groups, such as the Dysphagia Handicap Index (DHI) for Italian adults with swallowing impairment (Ginocchio et al., 2021), the Eating Assessment Tool (EAT-10) for Brazilian inpatient adults (Gonçalves et al., 2013), and the Swallowing Quality of Life questionnaire (SWAL-QOL) for Greek adults with dysphagia

(Georgopoulos et al., 2018). However, many CLD groups remain unrepresented, and the development of a PROM specific to cultural considerations in dysphagia should also be a consideration for future research.

Although cultural competence may help clinicians increase their understanding of the unique realities of patients from CLD backgrounds, this process may remain static based on clinicians' judgments regarding when and how to conduct swallowing assessments. However, cultural humility necessitates one's ability to continuously learn from others. The dynamic utilization of proper tools, chosen purposefully based on information obtained during the patient interview as previously discussed, is critical to measure patient outcomes during the therapeutic process. A continuous effort to learn from others enables clinicians to collaborate with their patients about the outcome they wish to achieve. This collaborative approach better informs clinical decision-making, including the types of tools that may best capture patients' progress toward their intended outcome, and provides a foundation to construct a person-specific therapeutic timeline.

PROMs can also address unobservable qualitative information (Cohen & Hula, 2020). For example, in the case of Ms. H, the SLP can use the SWAL-QOL (McHorney et al., 2002) to quantify how her dysphagia currently contributes to her fear of choking, missing out on social functions with her culture-sharing group, and the financial and family burden mentioned during the interview process, as well as dysphagia's impact on her life after a course of therapy. PROMs highlight biopsychosocial factors that may impact patient problems and allow clinicians to evaluate the treatment process' functional efficacy from the patient's perspective. Most importantly, PROMs provide clinicians a way to check that the patient remains at the center of the therapeutic plan (Kingsley & Patel, 2017).

The American Speech-Language-Hearing Association's (ASHA) 2013 Health Care Survey showed that approximately 17% of respondents implemented PROMs in their practice (ASHA, 2013). This statistic shows how historically underutilized PROMs have been within the SLP scope of practice, which calls to question whether SLPs are able to demonstrate their value in impacting functional patient change or delivering all components of EBP. It

Table 4. Examples of patient-reported outcome measures (PROMs) for dysphagia.

PROM	Outcomes assessed	Reference
Dysphagia Handicap Index (DHI)	Physical, emotional, and functional impact of dysphagia and quality of life	Silbergleit et al. (2011)
Eating Assessment Tool (EAT-10)	Symptoms-specific swallowing difficulties	Belafsky et al. (2008)
Reflux Symptoms Index (RSI)	Symptom severity in laryngopharyngeal reflux	Belafsky et al. (2002)
Swallowing Quality of Life questionnaire (SWAL-QOL)	Quality of life related to swallowing	McHorney et al. (2002)
Swallowing Quality of Care questionnaire (SWAL-CARE)	Patient opinions on the clinical care and patient satisfaction	McHorney et al. (2002)

would also be beneficial to combine the data obtained from the PROMs with the information gathered using instrumental assessment (as appropriate) and the interviewing techniques described previously. The triangulated information obtained across these comprehensive sources would improve the clinicians' ability to report the overall meaningfulness and impact of the treatment process toward the established goals unique to the patient's circumstances and contextual factors.

Stage 3: Planning Specific Learning Experiences

The last stage of backward design involves planning specific learning or treatment experiences that work toward the patient's end goal in the context of the whole person and disease process. This stage in backward design is purposefully placed at the end of the framework because the activities chosen during the therapeutic process should be driven by the end goal. From a biomedical standpoint, it is known, and arguably critical, that dysphagia intervention should incorporate impairment-specific factors necessary to create physiological change. However, successfully balancing the biomedical aspects of intervention with the patient's unique personal and contextual factors can be challenging. This stage necessitates careful consideration of the patient's learning style and preferences, as culture is tied to learning variations and styles (Chang & Kelly, 2007; Huang et al., 2020). For example, race and gender differences have been linked to differing preferences for abstract conceptualization versus concrete experiential learning (Omidvar & Tan, 2012). Such preferences should be explicitly considered, and patients can be asked how they best learn during the interviews described above. This stage of backward design is a dynamic process that often can involve both passive and active learning approaches, which may help capture the cultural and personal differences of individual patients (Fink, 2013; MacDonald & Frank, 2016). The former implies more traditional learning as it entails receiving information from another source in a didactic manner, such as lectures, video demonstrations, and informational handouts. The latter represents observing, doing (i.e., practicing and applying skills), and engaging in reflective open dialogue (Fink, 2013).

Some of these concepts may not be new to clinicians as they are naturally incorporated in the therapeutic experience. For example, clinicians often provide educational training in dysphagia-related material, such as handouts in the patient's native language informing them about thickening liquids, strengthening exercises, and oral care. In addition, clinicians typically provide demonstrations and models for performing impairment-specific exercises, which patients observe and subsequently replicate. However, clinicians

should intentionally implement various experiences across these learning domains, with a greater focus on active learning experiences when appropriate (Fink, 2013). Although these concepts are used primarily in education, they enable clinicians to select and structure experiences that promote maximal learning, using strategies like reflective open dialogue, which is uncommon in dysphagia practice but could be easily applied. Therefore, the remainder of this section will focus on describing this procedure.

Reflective Experiences

Although learning about the unique characteristics of a particular culture and the individual patient's needs is vital to planning specific therapeutic experiences for patients from CLD backgrounds, cultural humility necessitates ongoing self-critique on the part of the clinician in order to challenge one's biases. Aiming to be culturally competent is not merely enough, as it is impossible to fully understand all dimensions of other cultures. Therefore, lifelong self-assessment is necessary to create meaningful and culturally responsive therapeutic experiences for patients of CLD backgrounds. Self-assessment represents the complex process of thinking intentionally and critically about one's thoughts and actions. It involves becoming mindful about how and why individuals perceive themselves in the context of the world around them. The purpose of self-reflection is to use reflective thinking to transform personal abilities (Nguyen et al., 2014). Self-assessment in health care has been used as a framework to improve professional practice patterns by identifying individual strengths and shortcomings and promoting self-empowerment. This process has also improved decision-making and reduced health care errors through debriefing (Mantzourani et al., 2019).

Building clinician reflective experiences. Utilizing reflection could increase cultural responsivity in clinical practice. However, it is important to recognize that the concept of self may challenge the implementation of reflective practice. Broadly, cultures are often typologized as either collectivists or individualists. The former perceives themselves in their family or culture-sharing group, valuing interdependence, whereas the latter has a strong concept of self, valuing their own desires, attitudes, and beliefs (Bhawuk, 2017). Collectivists may be less inclined to naturally engage in self-reflection because they tend to conform to the needs of their social circle. Individualists may be more accustomed to pursuing their own goals and live by ideals that benefit themselves. Therefore, they may constantly have to self-assess to best position themselves toward goal attainment. Although collectivism and individualism are often defined as two distinct constructs, clinicians need to adopt flexibility in their service delivery to

patients from CLD backgrounds, becoming aware of their own worldview.

It is critical to address personal and institutional attitudes, values, abilities, and biases (Olson et al., 2016) that could influence patient care decisions for people of CLD backgrounds with dysphagia. For example, most SLPs commonly use a spoon and fork to administer a bolus to patients; however, certain cultures might use chopsticks or their hands. This assumption that all individuals perform equally with one standard method can alter performance, which could be perceived as an impairment. Therefore, SLPs must build their willingness to learn and accept differences in order to reduce bias. According to Hall and Johnson (2020), reflecting on one's biases and others' perspective promotes clinicians to gain a comprehensive understanding of the patient's worldview, thus resulting in greater responsivity toward the patient's needs instead of catering to the clinician's ego and agenda. As described by the National Center for Cultural Competence (NCCC), self-assessment marks a crucial step for developing cultural humility (Goode, 2010).

However, self-assessment can be complex for many service providers as they may have had limited exposure to developing and engaging in metacognitive practice during their education and training. ASHA provides cultural competence checklists to heighten the everyday clinician's cultural awareness and sensitivity (see Table 5). These resources, Cultural Competence Check-Ins (Self-Reflection, Culturally Responsive Practice, and Gender Inclusivity), facilitate self-assessment and identification of clinicians' perspectives, biases, and practice patterns toward persons of CLD backgrounds (ASHA, 2021a, 2021c, 2021d). For example, clinicians must understand and respect how various cultural norms or sexual orientations impact patient interactions and decisions. ASHA also has a checklist (Policies and Procedures) that helps businesses assess how their practice methods affect individuals from CLD backgrounds (ASHA, 2021b). The NCCC (n.d.) also has more extensive self-assessments that promote cultural competence and diversity for primary health care providers and programs. These tools focus on assessing cultural and health disparities, cultural appropriateness, policy, and equity.

Building patient reflective experiences. Koidou et al. (2013) state that therapeutic intervention plans can include various modalities, such as restorative or compensatory approaches for swallowing, often based on what the clinician identifies as the swallowing impairment and how to minimize health risks. However, an overly simplistic care plan based on impairment alone can lead to the broad application of standardized therapeutic recommendations and regimens. This approach resembles traditional education, which has historically viewed curriculum development as centered on the instructor's values, using one standard teaching approach, and implementing the same classroom activities for all learners (De Jesus, 2012). Yet similar to students, patients have various learning styles and preferences (visual–spatial, body-kinesthetic, musical, interpersonal, intrapersonal, linguistic, reasoning) that shape their learning ability and the types of support mechanisms they need (De Jesus, 2012; Omidvar & Tan, 2012). De Jesus (2012) indicates that students who are nonmainstream language speakers, who are from diverse backgrounds, or who have disabilities may not benefit from traditional learning due to their different perspectives and life experiences. Traditional learning also does not permit the learner to actively engage with the content at their own level, lacks flexibility, may not be meaningful to the individual, and utilizes low-level cognitive processes (De Jesus, 2012). Therefore, clinicians who impart this type of methodology may not achieve patient buy-in and motivation, resulting in poor patient outcomes and skill carryover. Planning successful therapeutic experiences not only requires careful consideration of cultural differences, for example, one's motivation for learning, health literacy, language (Huang et al., 2020), but should also aim to promote the active acquisition of meaningful skills that can be transferred to several situations (Wiggins & McTighe, 2005).

Grocott and McSherry (2018) report that outcomes improve when patients feel involved in their care. Using a reflective framework typically facilitates active patient engagement and could provide clinicians insight into a patient's desired therapeutic experience, which can inform an action plan. Patient experience surveys have become an important metric used in health care. Clinicians could incorporate this tool as a systematic way for patients to communicate support mechanisms they need, allowing clinicians to focus and allocate therapeutic resources appropriately (Grocott & McSherry, 2018). For example, Ms. H's SLP could develop an initial experience intake form

Table 5. American Speech-Language-Hearing Association (ASHA) cultural competency check-ins.

Resource	Website
Self-Reflection	https://www.asha.org/siteassets/uploadedfiles/multicultural/self-reflection-checklist.pdf
Culturally Responsive Practice	https://www.asha.org/siteassets/uploadedfiles/multicultural/culturally-responsive-practice-checklist.pdf
Gender Inclusivity	https://www.asha.org/siteassets/uploadedfiles/multicultural/gender-inclusivity-self-reflection.pdf
Policies and Procedures	https://www.asha.org/siteassets/uploadedfiles/multicultural/policies-and-procedures-checklist.pdf

that encourages Ms. H to reflect and share her expectations of and preferences for the intervention process. This initial survey could be used to obtain information, such as Ms. H's likes and dislikes, her communication style, preferred pronouns, and care coordination preferences (e.g., scheduling). Clinicians could also implement a clinical effectiveness survey throughout the intervention sessions to gather patient perceptions related to process improvement (Grocott & McSherry, 2018).

Furthermore, clinicians can directly apply reflective strategies in therapy to promote active learning when appropriate. This procedure may include a combination of active forms of learning, such as behavioral analysis, mindfulness, problem solving, and planning, which utilize high levels of cognition and are often advantages of differentiated learning (De Jesus, 2012; Krathwohl & Anderson, 2010). Medina et al. (2017) specifically encourages targeting metacognitive skills, such as reflection, in student learning to facilitate the development of higher level learning. Although the study discusses the importance of self-assessment in the context of higher education (Medina et al., 2017), one could apply its principles to increase active learning in therapy. For example, the SLP working with Ms. H may apply tongue exercises using the Iowa Oral Performance Instrument (IOPI Medical, LLC, 2020) in therapy to target tongue strength. To facilitate active learning, the SLP might ask her to simulate mashing a piece of Halo-Halo jelly using the IOPI tongue bulb and document her experiences troubleshooting tongue placement and strength to achieve maximum tongue pressure. Instead of the SLP immediately providing feedback, the patient has more opportunity to understand the concept and its relevance, as well as acquire and carry over the skill beyond intervention cessation (Uemura et al., 2021). Although active forms of learning have proven beneficial to skill attainment, these principles should be weighed in the context of the patient's cultural differences as some individuals may value other learning styles.

Unifying the Patient–Clinician Treatment Plan

Historically, health care providers were perceived as having professional control in selecting treatment options. Previous research has found that there may be a mismatch of clinical prioritization when managing dysphagia, with clinicians more focused on swallowing safety and patients valuing more psychosocial factors (Martino et al., 2009). In the context of health care moving toward greater patient involvement, the gap between patient and clinician perspectives raises concern for failing to achieve the patient's desired treatment outcomes. Therefore, treatment planning should consider patient performance and objective benchmark data in the context of qualitative data, such as the patient's experiences, satisfaction, concerns, and ability to adapt as new circumstances and insights emerge. Table 6 provides

Table 6. Suggestions for increasing qualitative data in speech-language pathology.

- Encourage partnerships between researchers and working clinicians who manage dysphagia daily
- Draw inspiration from disciplines with robust qualitative studies (e.g., sociology, anthropology, implementation sciences)
- Promote tracking of clinical data, including PROMs and patient and caregiver free-text question surveys
- Encourage semi-structured patient and caregiver interviews
- Increase clinicians' presence in translatable research via publishing case studies
- Document and track patient complaints, perceptions, and feedback on daily or progress notes

Note. PROMs = patient-reported outcome measures.

practical tips for increasing qualitative data in speech-language pathology clinically and in education and research.

A well-crafted, person-centered, and flexible treatment plan requires an ongoing shared partnership between patients and clinicians. It is also advantageous to approach dysphagia management with a polyocular view driven by not only the patient and the clinician, but also all the stakeholders involved in the health care team as different perspectives often facilitate a better management plan (Hall & Johnson, 2020). As outlined previously, it is recommended clinicians utilize shared decision-making. Implementing shared decision-making in the final step of backward design will likely lead to increased patient collaboration and buy-in regarding the treatment experience. It is also important to note that there must be a balance between patient preferences and professional expertise and control. Creating balance may be achieved by having a clear sense of the tenants of shared decision-making and understanding that this shift does not imply the complete dissolution of previous practice patterns or professional expertise. Rather, it suggests clinicians and patients should rationally deliberate after all treatment options have been presented equally and thoroughly. Clinicians should also empower patients to make informed decisions with their professional guidance.

Conclusions

This tutorial outlines a paradigm shift in dysphagia management using the methodical steps of backward design: identifying the desired results, determining appropriate and meaningful ways to evaluate skill attainment, and planning specific learning experiences. The application of backward design in dysphagia management moves away from the more traditional biomedical model and aligns well with EBP and person-centered care. Given the increased recognition of health disparities and inequity in the context of the growing CLD population, it is crucial that SLPs providing

dysphagia services continue to improve their ability to deliver equitable, inclusive, and quality care. Although person-centeredness is not a new concept to SLPs, further research should be conducted in patient-centered dysphagia service delivery and cultural considerations in dysphagia management. For instance, the application of PROMs and qualitative data in addition to impairment-based outcome measures should be implemented more widely in dysphagia research. Incorporating mixed-method designs could facilitate contextualized information that captures more aspects of the biopsychosocial framework. Research into the application of the concepts listed within this tutorial (e.g., shared decision-making, goal attainment, and active learning) to dysphagia management is also needed. Ultimately, the ideas discussed in this tutorial are intended to help SLPs serving patients with dysphagia reflect on their current practice patterns and maximize their ability to deliver individualized, culturally responsive, and goal-centered care.

Data Availability Statement:

Data sharing is not applicable to this article as no data sets were generated or analyzed during this study.

Acknowledgments

References

Agency for Healthcare Research and Quality. (2020). *The SHARE Approach—Essential steps of shared decision making: Expanded reference guide with sample conversation starters.* http://www.ahrq.gov/health-literacy/professional-training/shared-decision/tool/resource-2.html

Almerico, G. M. (2014). Food and identity: Food studies, cultural, and personal identity. *Journal of International Business and Cultural Studies, 8,* 1.

American Speech-Language-Hearing Association. (2013). *SLP health care survey 2013 outcome measures report.* https://www2.asha.org/uploadedFiles/2013-SLP-Health-Care-Survey-Outcome-Measures.pdf

American Speech-Language-Hearing Association. (2021a). *Cultural competence check-in: Culturally responsive practice.* https://www.asha.org/siteassets/uploadedfiles/multicultural/culturally-responsive-practice-checklist.pdf

American Speech-Language-Hearing Association. (2021b). *Cultural competence check-in: Policies and procedures.* https://www.asha.org/siteassets/uploadedfiles/multicultural/policies-and-procedures-checklist.pdf

American Speech-Language-Hearing Association. (2021c). *Cultural competence check-in: Self-reflection.* https://www.asha.org/siteassets/uploadedfiles/multicultural/self-reflection-checklist.pdf

American Speech-Language-Hearing Association. (2021d). *Self-reflection: Gender inclusivity.* https://www.asha.org/siteassets/uploadedfiles/multicultural/gender-inclusivity-selfreflection.pdf

Balou, M., Herzberg, E. G., Kamelhar, D., & Molfenter, S. M. (2019). An intensive swallowing exercise protocol for improving swallowing physiology in older adults with radiographically confirmed dysphagia. *Clinical Interventions in Aging, 14,* 283–288. https://doi.org/10.2147/CIA.S194723

Belafsky, P. C., Mouadeb, D. A., Rees, C. J., Pryor, J. C., Postma, G. N., Allen, J., & Leonard, R. J. (2008). Validity and reliability of the eating assessment tool (EAT-10). *Annals of Otology, Rhinology & Laryngology, 117*(12), 919–924. https://doi.org/10.1177/000348940811701210

Belafsky, P. C., Postma, G. N., & Koufman, J. A. (2002). Validity and reliability of the reflux symptom index (RSI). *Journal of Voice, 16*(2), 274–277. https://doi.org/10.1016/s0892-1997(02)00097-8

Bell, K., Lee, J., & Ristovski-Slijepcevic, S. (2009). Perceptions of food and eating among Chinese patients with cancer: Findings of an ethnographic study. *Cancer Nursing, 32*(2), 118–126. https://doi.org/10.1097/NCC.0b013e3181982d36

Ben Natan, M., & Hochman, O. (2017). Patient-centered care in healthcare and its implementation in nursing. *International Journal of Caring Sciences, 10*(1), 596.

Bhawuk, D. P. (2017). Individualism and collectivism. *The International Encyclopedia of Intercultural Communication, 2,* 920–929. https://doi.org/10.1002/9781118783665.ieicc0107

Bussell, S. A., & González-Fernández, M. (2011). Racial disparities in the development of dysphagia after stroke: Further evidence from the Medicare database. *Archives of Physical Medicine and Rehabilitation, 92*(5), 737–742. https://doi.org/10.1016/j.apmr.2010.12.005

Cadoret, C. A., & Garcia, R. I. (2014). Health disparities and the multicultural imperative. *Journal of Evidence Based Dental Practice, 14,* 160–170.e1. https://doi.org/10.1016/j.jebdp.2014.02.003

Caesar, L. G., & Kitila, M. (2020). Speech-language pathologists' perceptions of their preparation and confidence for providing dysphagia services. *Perspectives of the ASHA Special Interest Groups, 5*(6), 1666–1682. https://doi.org/10.1044/2020_PERSP-20-00115

Carrión, S., Cabré, M., Monteis, R., Roca, M., Palomera, E., Serra-Prat, M., Rofes, L., & Clavé, P. (2015). Oropharyngeal dysphagia is a prevalent risk factor for malnutrition in a cohort of older patients admitted with an acute disease to a general hospital. *Clinical Nutrition, 34*(3), 436–442. https://doi.org/10.1016/j.clnu.2014.04.014

Chang, M., & Kelly, A. E. (2007). Patient education: Addressing cultural diversity and health literacy issues. *Urologic Nursing, 27*(5), 411–417.

Clain, A. E., Alkhuwaiter, M., Davidson, K., & Martin-Harris, B. (2022). Structural validity, internal consistency, and rater reliability of the modified barium swallow impairment profile: Breaking ground on a 52,726-patient, clinical data set. *Journal of Speech, Language, and Hearing Research, 65*(5), 1659–1670. https://doi.org/10.1044/2022_JSLHR-21-00554

Cohen, M. L., & Hula, W. D. (2020). Patient-reported outcomes and evidence-based practice in speech-language pathology. *American Journal of Speech-Language Pathology, 29*(1), 357–370. https://doi.org/10.1044/2019_AJSLP-19-00076

De Jesus, O. N. (2012). Differentiated instruction: Can differentiated instruction provide success for all learners? *National Teacher Education Journal, 5*(3), 5–11.

Derrington, S. F., Paquette, E., & Johnson, K. A. (2018). Cross-cultural interactions and shared decision-making. *Pediatrics, 142*(Suppl. 3), S187–S192. https://doi.org/10.1542/peds.2018-0516J

Ellis, C., & Jacobs, M. (2021). The complexity of health disparities: More than just black–white differences. *Perspectives of the ASHA Special Interest Groups, 6*(1), 112–121. https://doi.org/10.1044/2020_PERSP-20-00199

Elwyn, G., Durand, M. A., Song, J., Aarts, J., Barr, P. J., Berger, Z., Cochran, N., Frosch, D., Galasiński, D., Gulbrandsen, P., Han, P. K. J., Härter, M., Kinnersley, P., Lloyd, A., Mishra, M., Perestelo-Perez, L., Scholl, I., Tomori, K., Trevena, L., . . . Van der Weijden, T. (2017). A three-talk model for shared decision making: Multistage consultation process. *BMJ,* j4891. https://doi.org/10.1136/bmj.j4891

Farre, A., & Rapley, T. (2017). The new old (and old new) medical model: Four decades navigating the biomedical and psychosocial understandings of health and illness. *Healthcare, 5*(4), 88. https://doi.org/10.3390/healthcare5040088

Feit, N. Z., Wang, Z., Demetres, M. R., Drenis, S., Andreadis, K., & Rameau, A. (2020). Healthcare disparities in laryngology: A scoping review. *The Laryngoscope, 132*(2), 375–390. https://doi.org/10.1002/lary.29325

Feng, M.-C., Lin, Y.-C., Chang, Y.-H., Chen, C.-H., Chiang, H.-C., Huang, L.-C., Yang, Y.-H., & Hung, C.-H. (2019). The mortality and the risk of aspiration pneumonia related with dysphagia in stroke patients. *Journal of Stroke and Cerebrovascular Diseases, 28*(5), 1381–1387. https://doi.org/10.1016/j.jstrokecerebrovasdis.2019.02.011

Fink, L. D. (2013). *Creating significant learning experiences: An integrated approach to designing college courses.* John Wiley & Sons.

Genoe, R., Dupuis, S. L., Keller, H. H., Martin, L. S., Cassolato, C., & Edward, H. G. (2010). Honouring identity through mealtimes in families living with dementia. *Journal of Aging Studies, 24*(3), 181–193. https://doi.org/10.1016/j.jaging.2010.02.001

Georgopoulos, V. C., Perdikogianni, M., Mouskenteri, M., Psychogiou, L., Oikonomou, M., & Malandraki, G. A. (2018). Cross-cultural adaptation and validation of the SWAL-QoL questionnaire in Greek. *Dysphagia, 33*(1), 91–99. https://doi.org/10.1007/s00455-017-9837-8

Ginocchio, D., Ninfa, A., Pizzorni, N., Lunetta, C., Sansone, V. A., & Schindler, A. (2021). Cross-cultural adaptation and validation of the Italian version of the Dysphagia Handicap Index (I-DHI). *Dysphagia, 37*(12), 1120–1136. https://doi.org/10.1007/s00455-021-10369-2

Gonçalves, M. I. R., Remaili, C. B., & Behlau, M. (2013). Cross-cultural adaptation of the Brazilian version of the eating assessment tool—EAT-10. *CoDAS, 25*(6), 601–604. https://doi.org/10.1590/S2317-17822013.05000012

Goode, T. D. (2010). *A guide for using the cultural and linguistic competence family organizational assessment instrument.* National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

Grocott, A., & McSherry, W. (2018). The patient experience: Informing practice through identification of meaningful communication from the patient's perspective. *Healthcare, 6*(1), 26. https://doi.org/10.3390/healthcare6010026

Hall, K. D., & Johnson, L. W. (2020). The three CCCs of dysphagia management: Culturally competent care. *Perspectives of the ASHA Special Interest Groups, 5*(4), 1000–1005. https://doi.org/10.1044/2020_PERSP-19-00112

Huang, C.-D., Tseng, H.-M., Jenq, C.-C., & Ou, L.-S. (2020). Active learning of medical students in Taiwan: A realist evaluation. *BMC Medical Education, 20*(1), Article No. 487. https://doi.org/10.1186/s12909-020-02392-y

IOPI Medical LLC. (2020). *Iowa Oral Performance Instrument.* https://iopimedical.com/

Kenny, B. (2015). Food culture, preferences and ethics in dysphagia management. *Bioethics, 29*(9), 646–652. https://doi.org/10.1111/bioe.12189

Kingsley, C., & Patel, S. (2017). Patient-reported outcome measures and patient-reported experience measures. *BJA Education, 17*(4), 137–144. https://doi.org/10.1093/bjaed/mkw060

Koidou, I., Kollias, N., Sdravou, K., & Grouios, G. (2013). Dysphagia: A short review of the current state. *Educational Gerontology, 39*(11), 812–827. https://doi.org/10.1080/03601277.2013.766518

Krathwohl, D. R., & Anderson, L. W. (2010). Merlin C. Wittrock and the revision of Bloom's taxonomy. *Educational Psychologist, 45*(1), 64–65. https://doi.org/10.1080/00461520903433562

Krekeler, B. N., Vitale, K., Yee, J., Powell, R., & Rogus-Pulia, N. (2020). Adherence to dysphagia treatment recommendations: A conceptual model. *Journal of Speech, Language, and Hearing Research, 63*(6), 1641–1657. https://doi.org/10.1044/2020_JSLHR-19-00270

Lundahl, B., Moleni, T., Burke, B. L., Butters, R., Tollefson, D., Butler, C., & Rollnick, S. (2013). Motivational interviewing in medical care settings: A systematic review and meta-analysis of randomized controlled trials. *Patient Education and Counseling, 93*(2), 157–168. https://doi.org/10.1016/j.pec.2013.07.012

MacDonald, K., & Frank, M. C. (2016). *When does passive learning improve the effectiveness of active learning?* Proceedings of the 38th Annual Conference of the Cognitive Science Society, Austin, TX, 2459–2464.

Mantzourani, E., Desselle, S., Le, J., Lonie, J. M., & Lucas, C. (2019). The role of reflective practice in healthcare professions: Next steps for pharmacy education and practice. *Research in Social and Administrative Pharmacy, 15*(12), 1476–1479. https://doi.org/10.1016/j.sapharm.2019.03.011

Martin-Harris, B., Humphries, K., & Focht Garand, K. L. (2017). The modified barium swallow impairment profile (MBSImP) —Innovation, dissemination and implementation. *Perspectives of the ASHA Special Interest Groups, 2*(13), 129–138. https://doi.org/10.1044/persp2.SIG13.129

Martino, R., Beaton, D., & Diamant, N. E. (2009). Using different perspectives to generate items for a new scale measuring medical outcomes of dysphagia (MOD). *Journal of Clinical Epidemiology, 62*(5), 518–526. https://doi.org/10.1016/j.jclinepi.2008.05.007

McFarlane, L.-A. (2012). Motivational interviewing: Practical strategies for speech-language pathologists and audiologists. *Canadian Journal of Speech-Language Pathology & Audiology, 36*(1), 8–16.

McHorney, C. A., Robbins, J., Lomax, K., Rosenbek, J. C., Chignell, K., Kramer, A. E., & Bricker, D. E. (2002). The SWAL-QOL and SWAL-CARE outcomes tool for oropharyngeal dysphagia in adults: III. Documentation of reliability and validity. *Dysphagia, 17*(2), 97–114. https://doi.org/10.1007/s00455-001-0109-1

Medina, M. S., Castleberry, A. N., & Persky, A. M. (2017). Strategies for improving learner metacognition in health professional education. *American Journal of Pharmaceutical Education, 81*(4), 78. https://doi.org/10.5688/ajpe81478

Moloney, J., & Walshe, M. (2018). "I had no idea what a complicated business eating is…": A qualitative study of the impact of dysphagia during stroke recovery. *Disability and Rehabilitation, 40*(13), 1524–1531. https://doi.org/10.1080/09638288.2017.1300948

Namasivayam-MacDonald, A. M., & Shune, S. E. (2018). The burden of dysphagia on family caregivers of the elderly: A systematic review. *Geriatrics, 3*(2), 30. https://doi.org/10.3390/geriatrics3020030

Namasivayam-MacDonald, A. M., & Riquelme, L. F. (2019). Presbyphagia to dysphagia: Multiple perspectives and strategies for quality care of older adults. In *Seminars in speech and language* (Vol. 40, No. 3, pp. 227–242). Thieme Medical Publishers.

NCCC. (n.d.). *Self-assessments*. National Center for Cultural Competence, Georgetown University. Retrieved February 20, 2022, from https://nccc.georgetown.edu/assessments/

Neubauer, P. D., Rademaker, A. W., & Leder, S. B. (2015). The Yale pharyngeal residue severity rating scale: An anatomically defined and image-based tool. *Dysphagia, 30*(5), 521–528. https://doi.org/10.1007/s00455-015-9631-4

Nguyen, Q. D., Fernandez, N., Karsenti, T., & Charlin, B. (2014). What is reflection? A conceptual analysis of major definitions and a proposal of a five-component model. *Medical Education, 48*(12), 1176–1189. https://doi.org/10.1111/medu.12583

Nund, R. L., Ward, E. C., Scarinci, N. A., Cartmill, B., Kuipers, P., & Porceddu, S. V. (2014). Carers' experiences of dysphagia in people treated for head and neck cancer: A qualitative study. *Dysphagia, 29*(4), 450–458. https://doi.org/10.1007/s00455-014-9527-8

Nund, R. L., Brown, B., Ward, E. C., Maclean, J., Roe, J., Patterson, J. M., & Martino, R. (2019). What are we really measuring? A content comparison of swallowing outcome measures for head and neck cancer based on the international classification of functioning, disability and health (ICF). *Dysphagia, 34*(4), 575–591. https://doi.org/10.1007/s00455-019-10005-0

Ochs, E., & Shohet, M. (2006). The cultural structuring of mealtime socialization. *New Directions for Child and Adolescent Development, 2006*(111), 35–49. https://doi.org/10.1002/cd.154

Olson, R., Bidewell, J., Dune, T., & Lessey, N. (2016). Developing cultural competence through self-reflection in interprofessional education: Findings from an Australian university. *Journal of Interprofessional Care, 30*(3), 347–354. https://doi.org/10.3109/13561820.2016.1144583

Omidvar, P., & Tan, B. H. (2012). Cultural variations in learning and learning styles. *Turkish Online Journal of Distance Education, 13*(4), 269–286.

O'Neil, K. H., Purdy, M., Falk, J., & Gallo, L. (1999). The dysphagia outcome and severity scale. *Dysphagia, 14*(3), 139–145. https://doi.org/10.1007/PL00009595

Patel, D. A., Sharda, R., Hovis, K. L., Nichols, E. E., Sathe, N., Penson, D. F., Feurer, I. D., McPheeters, M. L., Vaezi, M. F., & Francis, D. O. (2017). Patient-reported outcome measures in dysphagia: A systematic review of instrument development and validation. *Diseases of the Esophagus, 30*(5), 1–23. https://doi.org/10.1093/dote/dow028

Resnicow, K., & McMaster, F. (2012). Motivational interviewing: Moving from why to how with autonomy support. *International Journal of Behavioral Nutrition and Physical Activity, 9*(1), 19. https://doi.org/10.1186/1479-5868-9-19

Ribeiro, U. A. S. L., Vicente, L. C. C., & Lemos, S. M. A. (2021). Functional health literacy in adults and elderly with dysphagia. *Audiology: Communication Research, 26*. https://doi.org/10.1590/2317-6431-2020-2351

Riquelme, L. F., & Rosas, J. (2014). Multicultural perspectives: The road to cultural competence. In *Language development: Foundations, processes, and clinical applications* (pp. 255–256). Jones and Bartlett Learning.

Rosenbek, J. C., Robbins, J. A., Roecker, E. B., Coyle, J. L., & Wood, J. L. (1996). A Penetration–Aspiration Scale. *Dysphagia, 11*(2), 93–98. https://doi.org/10.1007/BF00417897

Shankar, S., Marshall, S. K., & Zumbo, B. D. (2020). A systematic review of validation practices for the goal attainment scaling measure. *Journal of Psychoeducational Assessment, 38*(2), 236–255. https://doi.org/10.1177/0734282919840948

Shune, S. E., & Namasivayam-MacDonald, A. (2020). Dysphagia-related caregiver burden: Moving beyond the physiological impairment. *Perspectives of the ASHA Special Interest Groups, 5*(5), 1282–1289. https://doi.org/10.1044/2020_PERSP-20-00067

Silbergleit, A. K., Schultz, L., Jacobson, B. H., Beardsley, T., & Johnson, A. F. (2011). The dysphagia handicap index: Development and validation. *Dysphagia, 27*(1), 46–52. https://doi.org/10.1007/s00455-011-9336-2

Slavych, B. K. (2020). Designing courses in communication sciences and disorders using backward design. *Perspectives of the ASHA Special Interest Groups, 5*(6), 1530–1541. https://doi.org/10.1044/2020_PERSP-20-00053

Stamer, M., Schmacke, N., & Richter, P. (2013). Noncompliance: A never-ending story. Understanding the perspective of patients with rheumatoid arthritis. *Forum: Qualitative Social Research, 14*(3). https://doi.org/10.17169/fqs-14.3.1932

Szczekala, K., Wiktor, K., Kanadys, K., & Wiktor, H. (2018). Benefits of motivational interviewing application for patients and healthcare professionals. *Polish Journal of Public Health, 128*(4), 170–173. https://doi.org/10.2478/pjph-2018-0034

Turner-Stokes, L. (2009). Goal Attainment Scaling (GAS) in rehabilitation: A practical guide. *Clinical Rehabilitation, 23*(4), 362–370. https://doi.org/10.1177/0269215508101742

Uemura, K., Kamitani, T., Yamada, M., & Okamoto, H. (2021). Longitudinal effects of active learning education on lifestyle behavior and physical function in older adults. *Journal of the American Medical Directors Association, 22*(2), 459–463. https://doi.org/10.1016/j.jamda.2020.05.014

U.S. Census Bureau. (2019). *Race and ethnicity in the United States: 2010 census and 2020 census*. Census.Gov. Retrieved from https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html

Watson, N., & Bell, C. (2014). Cultural considerations in tube feeding decision-making. *Division 14 Newsletter, 21*(2), 63–73. https://doi.org/10.1044/cds21.2.63

Watts, S., Gaziano, J., Jacobs, J., & Richter, J. (2019). Improving the diagnostic capability of the modified barium swallow study through standardization of an esophageal sweep protocol. *Dysphagia, 34*(1), 34–42. https://doi.org/10.1007/s00455-018-09966-5

Westby, C., Burda, A., & Mehta, Z. (2003). Asking the right questions in the right ways. *The ASHA Leader, 8*(8), 4–17. https://doi.org/10.1044/leader.FTR3.08082003.4

Wiggins, G. P., & McTighe, J. (2005). *Understanding by design* (2nd ed.). ASCD.

World Health Organization. (2001). *International classification of functioning, disability and health: ICF.*

Wu, S., & Barker, J. C. (2008). Hot tea and juk: The institutional meaning of food for Chinese elders in an American nursing home. *Journal of Gerontological Nursing, 34*(11), 46–54. https://doi.org/10.3928/00989134-20081101-11