Maintaining Safety, Managing Feeding, and Improving Functional Eating Skills in the School Setting

EMILY M. HOMER, CCC-SLP
STUDENTS EAT SAFELY, LLC, CONSULTANT
VOICE OF THE MOUNTAINS CONFERENCE
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Disclosures

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Previous courses we…

- Defined dysphagia and feeding disorders
- Identified the signs and symptoms and the students who are high risk
- Discussed the benefits of a system-wide procedure and educational relevance of addressing swallowing and feeding in the school setting
- Reviewed legal and ethical considerations
- Sorted through team approach and team models
- Discussed preparing a proposal for your district
- Went through the "Students Eat Safely: Follow the Forms" procedure.

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Procedure

- Referral
- Parent/Guardian Interview
- Interdisciplinary Observation
- Swallowing and Feeding Plan/Classroom Staff Training
- Individualized Health Plan/Emergency Plan
- Cafeteria procedure
- IEP
- Pre MBSS/VFSS Referral Form
- Revision of plan and training on revisions
- Ongoing monitoring/consultation and Therapy

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Is the procedure done?

You have **established safety** by writing a student specific swallowing and feeding plan that details how a student should be fed or eat at school.

You have **trained the classroom staff** on how to feed the student and have observed them to make sure they understand how to implement the plan.

You **have primary feeders and back-up school staff members trained** in the implementation of the swallowing and feeding plan and they have signed verifying that they were trained.

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What's next?

Once safety is established, then the swallowing and feeding team works to implement the plan with fidelity. Today we will talk about:

Working with the medical team

Implementation monitoring

Program management

All done to meet the goal of ***"establishing and maintaining safety during meals and snacks at school."***

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Working with the Medical Team

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Medical/School Differences: Type of Cases

We know that the majority of cases in the medical setting are either elderly or newborn/preschool, however, that is only one of the differences in the types of cases that each setting is responsible.

School Setting

Typically result of neurological disorders, such as cerebral palsy: neuromuscular disorders, such as Muscular Dystrophy, syndromes, such as Down's; developmental disorders and behavioral feeding.

Majority of students are **medically stable**

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Difference: Types of cases

Medical Setting

Typically result of stroke, dementia, Parkinson's and other adult onset disorders; or on the other end of the spectrum, premature delivery and neonatal disorders.

Many clients are **medically unstable** and are frequently **recuperating from an illness.**

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Medical Support

School Setting

Difference in access to **medical support**. School districts **rely on parents** for the following:

Student's medical history

Permission to speak to physicians

Request to physician for a script for a swallow study

Medical Setting

The medical setting has easy access to physicians and nurses and other medical professionals.

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Percent of Workload

School Setting

Dysphagia is a **low incidence disorder** in the schools and as a result is a very small part of the school-based SLPs workload. This results in minimal experience on a daily basis with a disorder that requires specialty.

Small percentage of school-based SLP's job

Medical Setting

Large percentage of hospital and medical SLP's caseloads are dysphagia.

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Collaboration with the physician

Extremely important to collaborate when there is a **change in a student's diet or to consult with physician about the student's diet** when

- they receive part or all of their nutrition or hydration via enteral or parenteral tube feeding
- there are medically complex conditions
- the medical status is a significant variable for determining the appropriate assessment and treatment strategies

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Medical based team:

Medical team members often include the following **physicians** as well as others: pediatrician, gastroenterologist, neurologist, pulmonologist, and ENT.

Access to a **dietician** (some districts employ dieticians)

The **hospital SLP** – important to collaborate with the hospital SLP prior to the VFSS/MBSS

Radiologist – will work with you during the VFSS/MBSS

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Working with the medical team, cont.

The school-based team is responsible for establishing a safe feeding plan based on information gathered from the parents/guardian, physicians (when possible) and the team assessment of swallowing and feeding.

When the team obtains a script from a physician, they must **consider the script** but are not bound by it. The district maintains the **obligation to secure safe feeding** for the child at school.

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Does the school district team need a physician's script to modify a diet at school?

"Although SLPs do not require a medical prescription or other form of medical approval to perform **clinical evaluations** or **implement intervention programs**, there are instances when a prescription, referral, or medical clearance may be requested from the student's primary care physician or other health care provider (e.g., when requesting VFSS or FEES evaluations)." "This request may be made through the family or directly to the provider (after discussion with the family), when the school has **approval for direct communication with the health care providers**."

Reference: ASHA Practice Portal: Pediatric Dysphagia

https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589934965&section=Assessment

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Why doesn't a school-based team need a physician's referral for diet modification, clinical evaluation, etc.?

Ultimate responsibility for student safety at school lies with the school system. (remember Parentis Loci from course 1)

If a parent or a physician recommends a diet that the team decides is harmful to the student, they will not be able to honor that script. We cannot intentionally feed a child in a manner that we know, based on professional knowledge, skill, and evaluation, to be harmful.

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FERPA

FERPA is a Federal law that protects the **privacy of students' "education records."** (See 20 U.S.C. § 1232g; 34 CFR Part 99). FERPA applies to educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education.

This includes virtually all public schools and school districts, most private and public postsecondary institutions, including medical and other professional schools.

If an educational agency or institution receives funds under one or more of these programs, FERPA applies to the recipient as a whole, including each of its components, such as a department within a university. See 34 CFR § 99.1(d).

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School Health Records

At the elementary or secondary school level **students' immunization other health records that are maintained by a school district or individual school**, including a school-operated health clinic, that receives funds under any program administered by the U.S. Department of Education are "education records" subject to FERPA, including **health and medical records maintained by a school nurse** who is employed by or under contract with a school or school district.

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FERPA cont.

Parents have a right under FERPA to **inspect and review** these health and medical records because they are "education records" under FERPA. See 34 CFR §§ 99.10 – 99.12.

In addition, these records may not be shared with third parties without **written parental consent** unless the disclosure meets one of the **exceptions** to FERPA's general consent requirement.

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When does a school district team contact the physician?

- When you have a serious concern about the student's **health status**
- To request a **script for a VFSS/MBSS**
- To **consult with the physician about the student's diet** especially when the student is moving from tube to oral (script required) or if student is sick.
- When you are concerned about a child's **nutritional intake**
- To get a more thorough **medical history**

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Management of Swallowing and Feeding

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Levels of Management

Collaborative Consultation for all students.

Levels of Management

1. Direct therapeutic intervention to improve **oral phase dysphagia and sensory issues**
2. Intervention with the student with a **progressive disorder or is medically fragile**
3. Treatment with the student **transitioning to or from tube feeding**
4. **Behavioral** feeding disorders

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Where does evaluation end and intervention begin?

The process of identifying the swallowing and feeding disorder, establishing and implementing a safe swallowing and feeding plan is **dynamic** with intervention melding with evaluation and visa versa.

The implementation of the plan becomes a part of the therapeutic process and also involves ongoing evaluation of the child's swallowing and feeding.

Example: student with 1:1 monitoring

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Collaborative Consultation

- **All** students being followed by the swallowing and feeding team receive ongoing consultative/ collaborative services.
- It is the **primary intervention model** for students because it not only establishes and continues safety during meals but it addresses the student's weaknesses by regular implementation of compensatory procedures.

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Collaborative Consultation

Consultant:

Knowledge and skills to mobilize other professionals in the treatment or handling and specific and mutually defined problems.

Serves as a resource to professionals who actually deal with the problems

Gives **professional advice or services based on their knowledge** on the subject matter

Relays a desire to help and to work together for the benefit of the student

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Collaborative Consultative Level of Treatment

1. **Monitoring** the implementation of the swallowing and feeding plan.
2. **Sharing information** with swallowing and feeding team members including teachers, paraprofessionals and parents.
3. **Coordinating services** of swallowing and feeding team members, as well as, the student's progress with feeding.

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3. **Providing feedback** to feeders to direct them toward safe and efficient feeding practices.
4. **Resolving conflicts** when they occur, throughout the process

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Collaborative Consultation: Monitoring

Monitoring is directed toward the **implementation** of the swallowing and feeding plan.

Observing the student being fed or eating including:

- Positioning during meals
- Food preparation
- Feeding equipment being used
- Correct food presentation

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Documenting trainings, observations and feedback.

Inquiring and listening to classroom staff regarding their observations and concerns.

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Collaborative Consultation: Sharing Information with Team Members including classroom staff and parents

Informing classroom staff and parents/guardians of the signs and symptoms that may indicate that the plan is not effective or that the student's swallowing and feeding skills are changing.

Educating school personnel on the disorder
Who and What of Swallowing and Feeding Disorders

- What is the disorder?
- Who is at risk?
- What are the signs and symptoms?
- What are the complications?

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Collaborative consultation: Training

Training school staff on the swallowing and feeding plan.

- Done prior to setting up a monitoring schedule
- Includes **demonstration and modeling** on how to safety feed the student.
- **May include parents/guardians** who may demonstrate how student is fed at home and be trained in how the school staff will feed the student.
- There must always be **alternate feeders** trained in the event that the regular feeder is out.

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Examples of monitoring activities include:

- Educating staff and parents
- Observing the staff providing intervention using the feeding and swallowing plan and Individualized Health Plan upon completion of training
- Modifying any interventions or equipment
- Documenting current feeding status and progress of the student
- Documenting and researching any complications in the feeding progress

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Monitoring continued

- Observing the student feeding in several settings at school (example: cafeteria, snack time in the room)
- Developing a new feeding and swallowing plan as needed
- Serving as a resource to the staff and parents about feeding issues

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Collaborative Consultation: Coordinating Efforts of Swallowing and Feeding Team Members

Regularly scheduled meetings

Email correspondence

Conference calls

Weekly or monthly updates in a log or notebook

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Collaborative Consultation: Using Feedback and resolving conflicts

Feedback: classroom staff needs

Constructive and descriptive feedback

To hear the positive first

Follow up with a written summary of the observation and the suggestions.

Conflicts:

Follow this chain of command: feeder, teacher, principal, coordinator, supervisor.

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Direct Therapeutic Intervention to Improve Oral Phase Dysphagia and Sensory Issues

Oral motor treatments are done to improve oral preparatory and oral transit phases and functional eating skills.

Parents and school staff are trained

Exercises are specific to the child's weaknesses

Exercises are done frequently and repeatedly with fidelity

Data is taken to drive the treatment plan.

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Therapy to improve oral motor functioning

Should be based on **clinically observed deficits** in the child *(Edwards, 2013).*

Should focus on **specific skills that are functional and meaningful** such as spoon feeding, biting, chewing, etc. *(Edwards, 2013)*

Oral motor skills should be **trained in the order they normally develop** *(Sheppard, 2005)*

Oral motor program should be **intensive and systematic** with the goal being to progress to a more normalized diet.

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Common milestone sequences for eating development described in the literature include:

Transition between type of foods (i.e. liquids to soft solids to chewable foods of various levels of difficulty).

Types of utensils (i.e. bottles to spoons and forks to cups and straws)

Independence (i.e. holding bottle, feeding with fingers, and independent use of utensils)

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Primary eating milestones are:

Nippling

Eating from a spoon

Drinking from a cup

Sipping from a straw

Biting

Chewing

Self-feeding

Sheppard, J. (2008), Using motor learning approaches for treating swallowing and feeding disorders: a review. *Language, Speech, and Hearing Services in Schools,* 39 (2), 227-236.

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Therapy that fosters feeding independence and a more normalized diet

Spoon feeding

Biting

Chewing

Drink to bite ratio

Swallowing before taking another bite

Appropriate amount placed on eating utensil

Adequate amount of chewing before swallowing

Alternating a variety of foods at each meal

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Goals for independent spoon to mouth eating

Given a ½ spoonful of preferred food, the student will bring the food to his/her mouth when **prompted**, 8 out of 10 trials.

Given a ½ spoonful of preferred food, the student will bring the food to his/her mouth with **faded cues**, 8 our of 10 trials.

Given a ½ spoonful of preferred food, the student will bring the fool to his/her mouth with **no prompts or cues**, 8 out of 10 trials.

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Goals for increasing chewing skills and lateralization

Given a **chewy tube** placed on the student's molars, the student will chew 3 times on each side when prompted by the therapist in 10 practice trials. Repeat exercise 10 times each session.

Given **cheese wrapped in cheesecloth**, the student will chew 3 times on each side when prompted by the therapist in 10 practice trials. Repeat exercise 10 times each session.

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Goals for drink to bite ratio

Given a meal and drink, the student will take 1 drink when **prompted** 100% of the time after 3 bites of food.

Given a meal and drink, the student will take a drink after 3 bites of food with **minimal cueing.**

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Oral Massage, Oral Stimulation and Vibration to Facilitate Movement

Oral massage may be used to increase oral awareness, decrease tonic bite, decrease hyperactive gag reflex and decrease tooth grinding *(Bahr, 2001).*

Massage and stretching exercises may be successful in promoting awareness of oromotor structures, facilitating symmetrical movement and improving feeding *(Edwards et al, 2013).*

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Vibration and oral stimulation

Vibration can be used each day to desensitize and "wake up" muscles of the oral mechanism

Vibration can be accomplished using mouth massagers and vibrators

Can also use vibrating toothbrush

Can use vibration on tongue, cheeks, inside and outside of mouth

* Do not use vibration with students who have a history of seizure disorders.

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Jaw Work

Exercises directed toward jaw stability, strength, and function are used to encourage and practice biting and chewing to prepare a student for new food textures.

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Therapist Manipulated Exercises

Therapist manipulated exercises are used to activate muscle contraction, desensitize orally defensive children and to provide movement against resistance to build strength. Useful for student who do not have the cognitive ability to perform therapist-directed exercises. *(Beckman, et al, 2004)*

Provide assisted movement:

- Lips
- Cheeks
- Jaw
- Tongue

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Goals for therapist manipulated exercises

The student will tolerate 4 reps of 3 lip closure stretching exercises. (Baseline data indicates that the student will only tolerate 1 rep of the 3 lip closure exercises)

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Specificity of learning: using food to target feeding skills

Specificity of learning: "an easy eating task that is performed in a typical eating environment for the child will be more effective in terms of performance and retention of skill than one that is modified for "rehearsal".

Results of this research demonstrate consistently that practice experiences that result in the fastest learning and best retention of skill are those that **most closely approximate the movement coordination and the environment** of the target task, as well as, the **typical conditions** in which it will be performed. (Schmidt & Wrisberg, 2004, Sheppard, 2005)

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Specificity of Training: Using food to target motor skills

Select exercises that closely match the target function.

Train as close to the desired mealtime target as possible using successive approximations.

Essentially, **specificity training** means that you must perform the skill in order to get better at it.

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Goals for Specificity of Learning

Given a saltine cracker placed on the student's molar, the student will chew the cracker 3 times in 8 out of 10 trials.

Given a saltine cracker, the student will bite a small piece and chew it 3 times in 8 out of 10 trials.

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Documentation

Documentation must be collected when using an oral motor treatment plan to be sure that you are seeing positive changes. Data taking should be done at the beginning and throughout.

Be sure all parties are aware of how often exercises must be completed. All personnel should be trained in the same way by the same SLP.

Have a documentation sheet that is used each time exercises are completed.

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Intervention with the Student with a Progressive Disorder or is Medically Fragile

- The school team works closely with parents/guardians and physicians to monitor and adjust to changes in the student's condition.
- Medical and school team collaboration is essential.
- The nurse is a major team member

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Treatment with a child with a progressive disorder or who is medically fragile

Students in school districts throughout the country have a variety of disorders and syndromes that result in regression over time.

Treatment approach may be different for the child who is regressing or who is sick.

Goals turn to **maintaining skills and adapting as the student regresses**.

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Communication and Collaboration	Monitoring	Importance of Team Effort
• Constant • Parents and Medical Team	• Ongoing • Expectation that condition will change and regressions	• Enhanced team: SLP, OT, nurse, social worker, principal, so on. • Provides support and information to parents and physicians

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Treating Progressive disorders: when there is medical instability

School team members evaluate the student to determine if the way the student is being fed is contributing to the instability.

A swallowing and feeding plan is written based on the student's ability and is frequently monitored and adjusted as the student's feeding status changes. Classroom feeding staff are trained on each revision.

Following the procedure continues to be extremely important. (medical referrals, updating swallowing and feeding plan, cafeteria procedure, ongoing monitoring)

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When making decisions regarding the student's ability to eat at school, use the resources within your district

- Nursing staff
- Social worker
- Principal
- Special education administrators
- Legal staff for district

- School will need to have a plan for emergency services such as when is EMS called? When are the parents called? etc. Doing this ahead of time prevents confusion when there is an event.

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Student becomes medically unstable

May have difficulty getting the child to the point that you feel he/she is safe.

Following each illness:

Observe the student's swallowing and feeding skills and react to changes by answering the following questions:

- Can the student continue to eat safely at school?
- If so, what changes need to be done to the plan?
- Does the student need an alternative method of receiving nutrition?
- Is the student so sick that hospital/homebound services may be indicated?

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Communication with student's physician

The school district's team will need to speak directly to the student's physician when the decision is being made for the medically unstable student to remain at school or to return to school.

Follow your district's policies regarding when a student may return to school after an illness and when the student is placed on hospital/homebound.

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Treatment with the Student Transitioning To or From Tube Feeding

School team shares information regarding swallowing and feeding status with parents/guardians and physicians and works closely with them to make the transition.

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Tube Feeding: general information

2 most common types of tubes:
- Nasogastric
- Gastrostomy

All use a high-calorie liquid food mixture containing protein, carbohydrates (sugar), fats, vitamins and minerals.

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Nasogastric Tube

Through nostril to the pharynx into the esophagus.

Child's condition is likely to improve and child will return to oral feeding.

Movement of child can displace the tube.

Nurse must be involved in the assessment and the placement of the tube.

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Percutaneous Endoscopic Gastrostomy (PEG) Tube Feeding

Most common tube feeding seen in schools.

Placed in stomach and nutrition is received directly into the stomach.

Feeding may be on a typical meal schedule or a slow continuous feed.

Depending on the state regulations the school nurse will administer the tube feeds or trains classroom staff on how to feed the child.

Child may or may not be an aspiration risk.

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When does a child need tube feeding?

1. **Child is unable to sustain nutrition orally but has a safe pharyngeal swallow.** Child referred to as "under nourished" or "failure to thrive". The child should be able to return to oral feeding, so ral feeding should continue.
2. **Student has a high risk for aspiration** that cannot be addressed with food modifications, positioning or feeding strategies. They receive no nutrition orally (NPO).

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3. **Children are too sick to eat normally and are too fragile to risk surgical insertion of the PEG.** Nasogastric tube is typically used temporarily.

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District's role in moving a student from oral feeding to tube feeding

Decision is with the parents and the child's physician

School team may play an important role in supporting or seeking a decision.

School team will serve as an information source to the student's physician, reporting their observations during school meals, strategies and modifications attempted and the results.

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Regardless of parent's or physician's decisions, the school district must ensure the safety of the student at school and cannot feed the student in a way that the school team determines is unsafe.

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Transitioning to tube feeding: the districts role

A change in the student's status indicates that he/she is loosing weight, there is a change in their structures that may be affecting oral intake or that is causing a concern of aspiration.

School team works closely with the student's parents/guardians and physicians (need release).

School-based team can serve as a support and information source for the parents/guardians.

Potential legal and ethical dilemma if parents/guardians do not agree with the concerns of the school team.

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District's role in moving a student from tube feeding to oral feeding

Physician and parents make this decision

School team provides the physician and parents information on the student's oral feeding status at school.

When there is a disagreement as to the ability for a child to safely be fed orally, the school team communicates with the child's medical team. A release must be signed by parents.

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Transition from tube to oral feeds:

Once the decision is made, the district team can help parents with the plan to gradually move to completely oral feeding.

Ongoing consultation and collaboration with the student's medical team and parents is essential.
A **medical script** is necessary stating that the student is safe to return to oral feeding at school.
School district does NOT have total responsibility for this transition but can assist and facilitate the process during school feedings

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Transition to oral feeds from tube feeding

Is child ready for transition to increased oral feeding?

Medical stability

Nutritional stability

Volume tolerance

Oral motor safety/skills

Let's eat: pediatric nutrition, behavioral and oral sensory motor issues. ASHA convention handouts, Arvedson, et al., 2008.

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Behavioral Feeding Disorders

Must be **approached differently** than those with a strict safety concern.

Rarely occur on their own and often have other accompanying disorders which can affect a student's feeding status.

Core team members include the SLP, OT, nurse and a **behavioral specialist**.

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Goals for School-based Behavioral Feeding

1) To identify **the underlying causes of the behaviors** being observed at school.
2) To **work with families and physicians** on identifying any medical issues that may be affecting the student's eating
3) **To identify any swallowing (dysphagia) concerns** and address them.

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3) **To identify sensory motor issues** and provide intervention if appropriate.
4) To **determine if the student has adequate nutrition and hydration** to access his/her curriculum.

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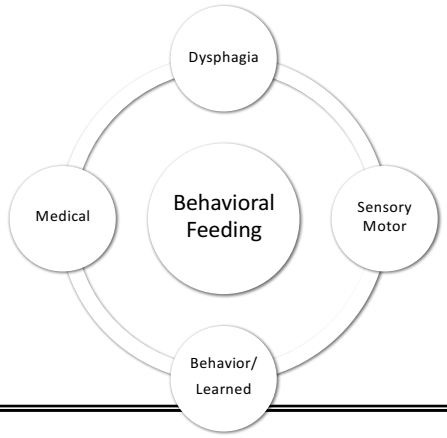

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What is a behavioral feeding disorder?

- When a child has a response to foods, liquids, and/or mealtimes that interferes with his or her ability to function in normal, daily living activities both at home and in the school setting (Homer, 2016).
- May include an aversion to food and mealtimes
- May have a special education classification such as other health impaired, developmental disabilities or autism.
- May be a student with early medical conditions that interrupted normal eating development.

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Behaviors Frequently Associated with Behavioral Feeding Disorders:

- Oral defensiveness
- Oral Hypersensitivity
- Picky-Eating
- Feeding Aversion
- Feeding Jags (eats only one thing)
- Limited Eating (only eats a certain amount)
- Food Refusal
- Vomiting

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Teachers and parents may report:

Throwing food or utensils
Screaming and/or crying in the presence of food
Self injury
Flopping or falling to the floor in the presence of food
Leaving the area
Closing mouth or head turning
Spitting
Overstuffing
Aggression (biting, scratching, head butting, etc. in an attempt to hurt the feeder)
Self induced gagging or vomiting

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Identification requires a process of looking at each of the following areas:

The student's **level of development** in feeding skills.

Medical issues associated with swallowing and feeding including dysphagia concerns including if the child's feeding development was interrupted.

Sensorimotor issues which may be contributing to observed behaviors.

The **consistency** of the student's observed behaviors throughout the day.

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Level of Development

Poor, weak oral facial musculature

Hypotonia – reduced tone of jaw, lip, cheeks, and tongue may result in disorders of mastication, speech and swallowing.

Student may be eating at the level that he/she feels safe, refusing foods that do not feel safe.

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Example:

- Inadequate chewing results in the student choking on a chopped consistency food.
- Student becomes fearful and avoids textured foods.
- Parents become concerned about nutrition and give child only pureed foods, preventing the student from developing oral motor skills for chewing.
- Student not only is resistive to texture but also does not develop the motor skills to chew.

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Begin with why is the child having trouble chewing?

Considerations include multiple factors when we complete a differential regarding lack of chewing skill:

- history and medical co-morbidities (prematurity, GI, respiratory, neuro, etc.)
- variances in developmental domains (gross motor, fine motor, cognitive, sensory, oral-motor)
- nature of the child's feeding environment (exposure, parental understanding and approaches, feeding history to date), to oral structural differences, to current level of lingual and cheek/lip skills
- swallowing integrity for less challenging feeding tasks. (Shaker, 2018)

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Determining Medical/Health Concerns

Health issues may be affecting the student's desire to eat. In order to accurately diagnose a student's feeding behaviors such as food aversion and avoidance it is necessary to rule out health issues that could be contributing such as:

- GER or GERD (spitting up, vomiting, persistent sore throat, persistent cough, choking or gagging when eating)

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- Idiopathic Eosinophilic Esophagitis (IEE) – coughing, gagging when eating, vomiting, poor weight gain, food caught in esophagus, and others.
- Acute painful swallowing – food refusal
- Motility related GI conditions – diarrhea, constipation, bowel obstruction
- Cyclic Vomiting Syndrome (CVC) – sudden rapid, frequent and intense vomiting, abdominal pain, weakness and more.

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Managing Medical Concerns

When there is a concern about a medical condition the school nurse will review the student's medical history and talk with parents/guardians. In addition the nurse may implement:

- Medical referral/recommendations
- Nurses evaluation
- Growth profile
- Baseline weight measure
- Weekly physical/weight measures

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Sensory Feeding Problems

These are problems where something about the way food looks, tastes, smells, or feels is overwhelming or uncomfortable to a child.

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Children with sensorimotor based behavioral feeding disorder may:

Avoid eating certain food textures (crunchy, soft, chewy)temperatures, colors or tastes.

Does not notice food left on his/her face (low tone)

Gags easily when eating or when using utensils

Resists tactile exploration of food

Enjoys playing with food but does not eat it

Mouths, licks, or chews non-edible items

Routinely smell things (food and non-food items)

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Determining Sensory Issues

Typically the OT is responsible for conducting a sensory screening to look for the following:

- Oral Defensiveness
- Oral Hypersensitivity
- Oral Hyposensitivity
- Significant sensitivity to textures
- Significant sensitivity to temperatures
- Significant sensitivity to tastes
- Significant sensitivity to color

Are the sensory issue pervasive or only related to feeding?

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Strategies for Sensory Feeding Problems

A sensory diet is a daily routine of sensory experiences.

Sensory de-sensitization is the process of reducing a child's reaction to sensory stimuli.

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Working closely with parents/guardians:

Throughout the process it is essential to work with families to determine:

What are the family dynamics in regard to the feeding disorders?

- Gathering information from the family
- Issues for the family
- Family centered care

What are their concerns and goals for the student?

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General treatment goals often include:

Decreasing behavioral problems at meals

Decreasing parent stress

Increasing pleasurable parent-child interactions

Increasing oral intake or variety of oral intake

Advancing texture

Increasing the structure and routine of mealtime

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Additionally, specific behaviors are often chosen and targeted for increase or decrease/ extinction. Thus, detailed behavioral programs are designed to address individual behaviors as well as to further the general goals of treatment.

Fischer, E. & Sliverman, A. (2005) Behavioral treatment of feeding disorders. SIG 13 Perspectives on Swallowing and Swallowing Disorders (Dysphagia), October, Vol. 14, 19-24. doi:10.1044/sasd14.3.19

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3 Tiered Hierarchy Approach to Classifying Behavioral Feeding

There are different levels of behavior feeding concerns. Some levels are established feeding disorders and will need direct intervention. Other levels will be normal developmental processes or emerging feeding disorders.
Each level in the school setting may be addressed by the swallowing and feeding team.

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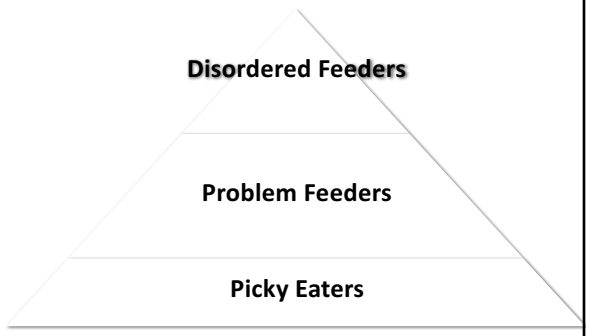

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Picky Eater
Proactive Preventive Approach

- Tolerate new food on the plate
- Usually touch or taste new food
- Eating at least one food from most food textures
- **Basically balanced diet-** eating from all 4 food groups
- Consuming small amounts of food
- Found in **25-35%** of typically developing children (Rogers, Magill-Evans, Rempel, 2012)

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Typical feeding development

Around 12 to 18 months normal developing children begin to lose their appetite and may start refusing foods.

At 18 -24 months they develop clear food preferences and may exhibit some “picky eating” tendencies.

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Proactive approach to Picky Eating

District may provide consultative services to parents who report picky eating in their 3 – 5 year olds. They can provide the following as a service and preventative measure:

- General information on dealing with a picky eater
- List of websites offering suggestions
- List of children books that address the topic of picky eating in a fun and entertaining way SLP may demonstrate to parents/guardians reading a story that encourages positive food attitudes.

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Problem Feeders (Extreme Picky Eaters)

Behaviors interfere with getting a well-balanced meal at school and/or sufficient nutrition. They interfere with academic and social programs at school. Student may:

- Cry or act out when presented with new food
- Refuse entire categories of food textures
- Avoid one or more food groups
- Exhibit unusual aversions
- Demonstrate tactile and oral defensiveness
- Run or tries to escape from the food or from eating *(Weaver, 2008)*

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Addressing Problem Feeders in the School setting

May need direct therapy and intervention to address sensory and motor issues which may be contributing to the feeding behaviors.

District team **works closely with parents/guardians** to provide feeding and behavioral strategies to address behaviors.

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Guidelines for beginning a feeding intervention program

Mealtimes and food experience in general should be **pleasant and stress free**. *"Parental stress does not help to get a child to eat more" (Arvedson, 2017)*

Goals should focus on adequate nutrition and hydration for health and growth.

Mealtime environment should initially be quiet and distraction free. School may need to provide a quiet place for the student to eat and then work toward eating in cafeteria.

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Mealtime Routine

Establishing a regular mealtime routine is a **key component** of most feeding plans. It teaches children a regular routine and also provides opportunities for teaching positive mealtime behaviors. Mealtime routines include serving meals at roughly the same times each day and involving the children in developmentally appropriate tasks, such as: setting the table, bringing food to the table, helping to clear the table, etc.

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2 Types of Therapies

Systematic desensitization therapy:
Internally driven
Model and Play
Bottom up
Speech and OT therapists approach

Operant conditioning therapy:
Externally driven
Eat more food
Reduce refusal behaviors
Typically clinic based, intensive behavior modification

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Techniques and procedures

Some popular programs and approaches to treating behavioral, sensory and motor feeding disorders:

Food Chaining - Cheri Fraker/Laura Walbert http://cheriandlaura.blogspot.com/

Helping Your Child with Extreme Picky Eating – Katja Rowell & Jenny McGlothlin (2015) www.extremepickyeating.com

Sequential Oral Sensory (SOS) approach to feeding – Kay Toomey https://sosapproach-conferences.com/

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Sensory motor approach – Lori Overland

http://www.talktools.com/a-sensory-motor-approach-to-feeding/

Applied Behavioral Analysis - http://www.centerforautism.com/aba-therapy.aspx

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Disordered Feeders

Behaviors are **severe, consistent**, and often have the potential of affecting the student's health.

Students are at a greater risk for failure to thrive.

Health risks are present and the district works with the family and physician to support a feeding program.

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Disordered feeders

- Refusal behaviors are more severe than in problem feeders
- Possibly failure to thrive- below 5th percentile
- Can occur with other conditions including cerebral palsy, autism or other developmental delays
- Can affect student's participation in educational setting by disrupting classrooms
- Can be caused by physical and structural problems as well as behavioral and anxiety issues.

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Nutrition Issues Caused by Eating and Feeding Disorders

- Inadequate nutrition is detrimental to a student's physical and mental health resulting in poor school performance *(Fiese, Gudernson, Koester & Washington, 2011)*
- Inadequate nutrition is also a problem for children with ASD with poor eating behaviors such as food selectivity and fear of trying new foods *(Cornish, 1998)*

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Nutrition Issues (cont.)

- Long term under-nutrition permanently affects cognition and language.
- It is best practice that school therapy practitioners support students in the educational setting to promote success in achieving educationally related and functional goals including ADL's such as feeding and eating.
- Effective interventions can include **behavioral strategies, oral-motor therapy, sensory sensitivity strategies, and social stories**
- Collaboration with family, school, and medical community is necessary.

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Disordered Feeder

Student may need marked assistance to transition from G-tube feedings

Student may need marked assistance to transition to solid food.

Student may require marked assistance to transition from private hospital feeding program

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What Can a District Do?

Evaluate their resources and determine the level of intervention that they are able to provide. (ex. A district may need to contract with a BCBS to help establish a behavior plan)

Provide services that ensure that students are able to access their curriculum, thus providing a free and appropriate public education (FAPE).

Serve as a support to the home and to medical programs that the students receive outside of the school setting.

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Students you may see:

Student is extremely picky and lunch consists of the same thing everyday and is very limited nutritionally
- If this student is getting adequate nutrition to access their curriculum then therapeutic intervention may not be indicated.

Student will take a school lunch but will not eat anything or will only eat a specific color item, etc.
- May be a candidate for sensory motor intervention

Student refuses all food and will not go into the cafeteria.
- If these behaviors carry through all day then a behavior plan my be indicated

Student disrupts the class by running away, pushing food aside, etc.
- Identify food which the child will tolerate and begin with that. Gradually add similar foods (can be done therapeutically and reinforced by the teacher)

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St. Tammany Parish Survey

81 SLPs and OTs responded

58 students with swallowing and feeding disorders

Refer to handout titled:

Who are the Behavioral Feeding Students on Your Swallowing and Feeding Caseload?

Results:

25% of total swallowing and feeding caseload.

No severely violent or refusal behavior reported.

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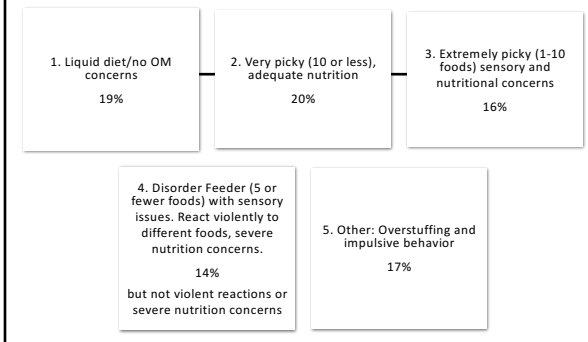

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Summary

Children with swallowing and feeding disorders are in every district.

When students do not received adequate nutrition and hydration they are not able to adequately access their curriculum, attend school or socialize.

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Summary

There are many compelling reasons why a district should adopt a procedure for swallowing and feeding:

- Keep students safe at school
- Supreme court and state court cases
- IDEA and providing FAPE
- Ethical responsibility of professionals
- Food and nutrition program standards and requirements

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Summary

A system approved procedure that provides the steps necessary to establish and maintain competency is recommended.

This procedure should include:

- An interdisciplinary team approach
- Clarification of roles and responsibilities of team members.
- Accompanying forms that provide documentation throughout the procedure.
- A system for working with the cafeteria program to provide the recommended diet

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Summary

- A process for maintaining safe feeding through collaborative consultation

Once safety is establishing and there is a system for maintenance, therapeutic intervention may help to improved student's swallowing and feeding skills.

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For more information, electronic copies of the forms, and/or questions contact:

Emily M. Homer

emijhom@gmail.com

www.emilymhomer.com

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