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.

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 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.

What’s next?

This is where we pick up today...

Once safety is established, then the swallowing and feeding team works to implement the plan with fidelity.

- Working with families
- 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.”

Working with the Medical Team

- Challenge because schools do not have the supports that are available in the Medical Setting.
- District must depend on the parents/guardians to communicate with the student’s physicians.
- Communication is essential to treating the student with dysphagia, especially when the student is medically fragile or when there are nutritional concerns.
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.

Collaborating with the physician

• Collaborate when there is a change in a student’s diet or to consult with physician about the student’s diet especially 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

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; syndromes, such as Down’s; developmental disorders and behavioral feeding.
• Majority of students are medically stable

Medical Setting
• Typically result of stroke, dementia, Parkinson’s and other adult onset disorders; or premature delivery and neonatal disorders.
• Many clients are medically unstable and are frequently recuperating from an illness.

Medical Support

One of the major differences between the educational setting and the medical setting when addressing dysphagia is 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

Percent of Workload

• 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 based team:

• Medical team members often include the following physicians as well as others: pediatrician, gastroenterologist, neurologist, pulmonologist, and ENT.
• Access to a dietician
• The hospital SLP – important to collaborate with the hospital SLP prior to the VFSS/MBSS
• Radiologist – will work with you during the VFSS/MBSS
Does the school district team need a physician’s script to modify a diet at school?

According to ASHA in regards to swallowing and feeding in the school setting:

“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

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.
• 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.

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).

School Health Records

• At the elementary or secondary school level, students’ immunization and 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.

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.

FERPA continued

• For instance, one of these exceptions allows schools to disclose a student’s health and medical information and other “education records” to teachers and other school officials, without written consent, if these school officials have “legitimate educational interests” in accordance with school policy. See 34 CFR § 99.31(a)(1).
• Another exception permits the disclosure of education records, without consent, to appropriate parties in connection with an emergency, if knowledge of the information is necessary to protect the health and safety of the student or other individuals. See 34 CFR § 99.31(a)(10) and 99.36.
**HIPAA**

- The HIPAA Privacy Rule requires covered entities to protect individuals’ health records and other identifiable health information by requiring appropriate safeguards to protect privacy, and setting limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

**FERPA/HIPPA Summary**

- School systems are bound by FERPA rather than HIPPA in most cases. When medical records are transmitted electronically it then becomes a HIPPA case.

Reference:

**When to contact the physician?**

- When you have a serious concern about the student’s health status
- To request a script for a VFSS/MBSS
- To request a change in diet orders for cafeteria (when a student does not have and IEP or the information needed on the IEP) or to consult with 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

**Levels of Management of Swallowing and Feeding**

**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

**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

**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.
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.

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

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
- Documenting trainings, observations, and feedback.
- Inquiring and listening to classroom staff regarding their observations and concerns.

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

Informing classroom staff and parents/guardians of 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?

*See Who and What handout

Collaborative Consultation: Training Classroom and School Staff

Training school staff on the swallowing and feeding plan
- Done prior to setting up a monitoring schedule
- Includes demonstration and modeling on how to safely 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.

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
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

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

Collaborative Consultation: Using Feedback

- Know what you want to address
- Know how it will be presented
- Know what the outcome should be
  Classroom staff needs:
  - Constructive and descriptive feedback
  - To hear the positive first
  - Follow up with a written summary of the observation and the suggestions.

Collaborative Consultation: Resolving Conflicts

- Talk to feeder first, explaining the importance of following the plan.
- If not resolved, talk privately with the classroom teacher.
- If not resolved, inform teacher that you must inform the principal
- Speak to principal
- If not resolved, contact the supervisor.

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, and data is taken to drive the treatment plan.

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.
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

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 out 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.

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.

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.

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).

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.
**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.

**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

**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)*

**Specificity of Learning: using food to target feeding skills**

- Specificity of learning; an easy eating task 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 performance and retention of skill (learning) are better in distributed practice. *(Schmidt & Lee, 1999)*
- An important advantage for advancing eating skills in the school setting is the multiple, daily practice opportunities that are available.

**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.
  So...if you want a child to learn to chew, he must have the opportunity to chew real food.

**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.
Documentation

- Documentation must be collected when using oral motor treatment plan to be sure that the program is being followed and that you are seeing positive changes. Data taking should be done at the beginning.
- 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
- Video child eating prior to start of plan, then again 6 months later.

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

School team works closely with parents/guardians and physicians to monitor and adjust to changes. Medical and school team collaboration is essential. Nurse is a major team member when working with a progressive disorder.

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.

Treatment principles

- Constant communication and collaboration with parents/guardians, classroom staff and medical team.
- Ongoing monitoring of swallowing and feeding skills with the expectation that there may be frequent changes and regression.

Treating Progressive disorders, cont.

- Highlighted importance of team effort at the school level including school nurse, principal, social worker, SLP, OT, and parents. In many cases the nurse becomes the Team Leader when a child is medically fragile.
- Providing support and information to parents/guardians, including important information on how the student is eating/functioning at school to the physician.
- School team members evaluate the student to determine if the way the student is being fed is the 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.
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

- Student is constantly sick or suddenly becomes sick
- May have difficulty getting the child to the point that you feel he/she is safe.

Following each illness:

- Adjust to swallowing and feeding 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 are 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.

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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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Transitioning To or From Tube Feeding

- 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.
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.

When does a child need tube feeding?

1. Child is unable to sustain nutrition orally but has a safe pharyngeal swallow. “Failure to thrive” and the child may be able to return to oral feeding. Oral feeding should continue.
2. Children are too sick to eat normally and are too fragile to risk surgical insertion of the PEG. Nasogastric tube is typically used.
3. Student has a high risk for aspiration that cannot be addressed with food alterations, positioning or feeding strategies. They receive no nutrition orally.

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, reported observations during school meals, strategies and modifications attempted and their results.
- 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.

Transition to tube feeding:

- A change in the student’s status indicates that he/she is losing 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.

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

- Physician and parents make the decision to transition from tube feeding to oral feeds.
- 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 will need to communicate with the child’s medical team. A release must be signed by parents to talk to the physician.
- Once the decision is made, the district team can help parents with the plan to gradually move to completely oral feeding.

Transition from tube to oral feeds:

- 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.
Transition from tube to oral feeds cont.

- Work closely with the parents/guardians and a dietician to ensure that the student is getting adequate nutrition
- Keep a food diary that charts:
  - Type and amount of food offered at school
  - Type and amount of food eaten at school
- Home and school follow the same program for introducing foods and textures.
- School district teams can be instrumental in students successfully making this transition!!

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

Taken from:

General guidelines for transition from tube to oral feeds cont.

- Some general guidelines for transiting student follow:
  - Begin with foods that the student already eats in the same texture, etc. as the student is accustomed
  - Work on only one change at a time – it may be adding taste or changing the texture
  - When you proceed to add different flavors, may experiment with different foods to find one that the student accepts

When transitioning to oral feeding:

- Some cases will make the transition very easily but other more involved cases may require the services of feeding specialists at hospitals, outpatient clinics, etc. We continue to be participants.

Behavioral Feeding Disorders

- District works to identify the underlying causes of the behaviors being observed and to address those issues as they are identified.
- 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.

5 Goals for Addressing Behavioral Feeding Disorders in the School Setting

1) To identify the underlying causes of the behaviors being observed and to address those issue as they are identified.
2) To decrease mealtime stress for the student, parents/guardians, and school staff members.
3) To decrease the incidence of problem behaviors at mealtimes in the school setting.
4) To increase the student’s participation in school by ensuring adequate nutrition and hydration
5) To advance the student’s diet to a more normalized diet for age and developmental level
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.

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.

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

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

Children with sensorimotor based behavioral feeding disorder may:

- Avoid eating certain food textures (crunchy, soft, chewy)
- Avoid eating food of certain temperatures (warm like oatmeal, cold like ice)
- Eat primarily only one color of food
- Eats only certain tastes (salty, sour, sweet)
- 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)
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?

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)
- 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.
- Pharmacology side effects
- Dental, etc.
- Food Allergies

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

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? The school and family must work together when approaching feeding with an extremely picky eater.

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.

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)

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.
Proactive approach to Picky Eating

• How a parent reacts to picky eating can have an affect on whether it evolves into problem feeding or eventually is no longer a concern. For example, preparing a separate meal may encourage picky eating in a young child.

(http://www.mayoclinic.org)

Problem Feeders (Extreme Picky Eaters)

Behaviors interfere with the getting a well-balanced meal at school and/or sufficient nutrition, as well as, interferes 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)

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.

Guidelines for beginning a feeding intervention program

• Mealtime 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.

Why pressure is not recommended.

• Kids learn to eat for the wrong reasons
• Pressure increases anxiety and decreases appetite
• Pressure makes children like food less.
• It makes children depend on you (or the parents or a device) for every bite. According to Rowell & McGlothlin (2015) “…behavioral modification often works best for more concrete tasks. …if you’re recognizing that rewards and bribes aren’t helping, honor your observations.”
Identify counter productive feeding tactics including pressure

1. Praise – verbal (I’m so proud of you for eating ___), sticker charts, clapping cheering
2. Shame or Guilt - (You asked for noodles, now eat them)
3. Bribes – (If you eat two bites you can have dessert), given a toy, or screen time.
4. Distraction – iPad, TV, toys
5. Threats or Force – restraint, force feeding, can’t leave the table
6. Pressuring therapy – kiss food, touch or paint with food when they don’t want to.
7. Nutrition admonitions – You need protein to be strong, It’s good for you

Rowell & McGlothlin, 2015, Feeding our Child with Extreme Picky Eating

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

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.

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)

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.

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.
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

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.

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 may 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)

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.
• 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

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

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