MEALTIME REDISCOVERED

Collaborative Care to Families and Children with Pediatric Feeding Disorders

Skirboll Family Autism Conference 2023

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Disclosures

- Financial: I have no financial issues to disclose.

- Non-Financial:
  - I am director of Kimberly Brown PhD, Psychological Services, PLLC

  - I am a Clinical Associate Professor of Pediatrics at The University of Rochester
    - Voluntary Appointment

Outline

1. Definition of Pediatric Feeding Disorder
2. Models of care
3. Care team partners
4. Developing recommendations
5. Collaborative Care Model
6. Identifying solutions

Pediatric Feeding Disorder-New ICD10

Diagnostic Criteria

A. A disturbance in oral intake of nutrients, inappropriate for age, lasting at least 2 weeks and association with 1 or more of the following: medical, nutrient, feeding skills, and/or psychosocial dysfunction

AND

B. Occurs in the absence of the cognitive processes consistent with eating disorders, and the pattern of oral intake is not due to a lack of food or congruent with cultural norms. (Goday et al., 2019)

Pediatric Feeding Disorder-New ICD10

- Impaired oral intake that is not age appropriate and associated with one or more of the following:
  - Medical: cardiorespiratory or aspiration
  - Nutritional: malnutrition, nutritional deficiency, supplemental feeds
  - Feeding Skills: need for adaptive feeding strategies or equipment, texture modification
  - Psychosocial Issues: avoidance behaviors, "inappropriate caregiver management," disruption of social functioning, disruption of parent- child relationship around feeding. (Goday et al, 2019)

Clinical Care for Pediatric Feeding Disorders

1. Multidisciplinary care: Each team member sees the family individually and makes their own recommendations
1. Interdisciplinary care:
    a. Each team member sees the family individually, and makes group recommendations for each discipline.
    b. Try to be collaborative, but recommendations may not always be congruent
2. Transdisciplinary care: Indirect care model, with 1-2 primary therapists, teaching others to implement their recommendations.

Team Members

1. Speech Therapist
2. Occupational Therapist
3. Psychologist
4. Dietitian
5. Physician
6. Social Work

Who Is missing from the medical team?

1. Child's main pediatrician (obtain records)
2. Outside providers and other therapists working on feeding
3. Teachers, school staff
4. Family!!! – Not seen as part of the team, seen as the "patient"

Recommendations

We often have specific recommendations in mind for families

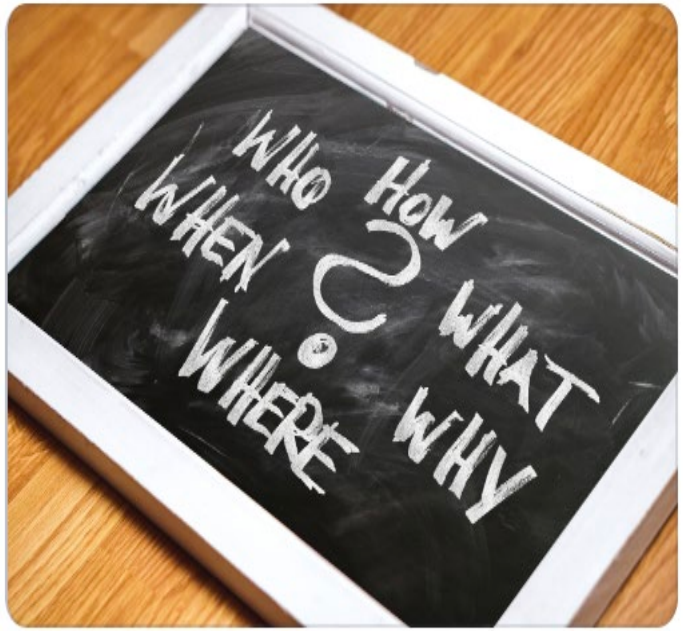
a. Scheduling and structure
b. Sitting for family meals
c. Presenting appropriate and nutritious foods
d. Management of GI symptoms
e. Oral motor exercises
f. Skill building for self feeding

Providing Recommendations

1. We make recommendations and provide them to parents
2. If therapy is recommended, they come back weekly to practice specific skills in clinic, then are sent home to practice.
3. What are some concerns with this method?

Problems with Typical Recs

1. Families are not always included in clinical practice, therapy
2. Families are receiving feeding therapy from other therapists
3. Recommendations don't generalize to the home setting
4. Other family members disagree with recommendations
5. Families may not have time or resources to carry them out



Including Families - Parents

1. Parents need to be educated about the child's condition in more detail than during a diagnostic visit.
2. Parents need to have a say in what they implement at home.
3. What are they capable of and what do they want to do?

- Analysis of providing parent education prior to feeding therapy:

Children were more likely to meet their feeding goals when parents set their own goals and chose recommendations they wanted to implement (Dahlman, unpublished thesis, 2021)

Including Families - Children

1. We are also often missing what the child wants and is capable of.
2. There is a lot of talk about children's autonomy in developing feeding skills.
   a) It is always the child's choice to say no
3. We cannot allow them to always make food choices, they are already making poor choices.
4. We can teach them how to make better choices, and feel comfortable trying new foods

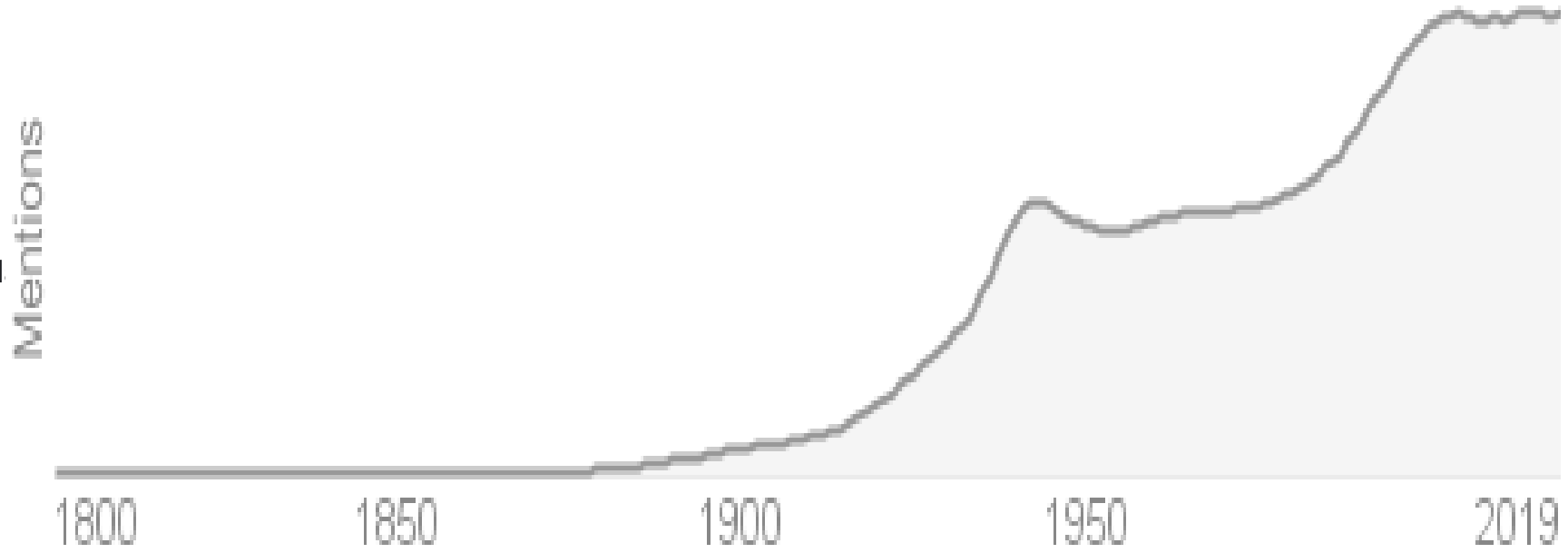
Including Families - Children

1. What their preferences are? Let them help us figure out where to start
2. What are they capable of?
3. When is it ok for them to say no, and when do they need a gentle push
4. Acknowledge sensory issues and anxiety as real, and learn how to address them first
5. Children may not like what we like or what we want them to like
6. Goal is to teach them to be able to learn to try new foods without stress. I cannot make children like foods, or enjoy eating
7. Recognize their need to function socially with eating, and how to make that easiest for them

Collaboration Definition

Collaboration: The situation of two or more people working together to create the same thing (Cambridge Dictionary).

Use over time for: coll



What does it mean to collaborate?

Synonyms	Antonyms
Alongside	Non-compatible
Allied	Divided
Cooperative	Peripheral
Cohesive	
Distributive	
Non-conflicting	

Collaborative Care Model

Orelove, Sobsey & Gilles, 2017)

1. Services are provided in a coordinated & comprehensive way
2. The team shares a framework to function effectively in
3. Goals ”belong” to the student and are based on functional life outcomes
4. Multidirectional and dynamic
5. Each discipline brings their own perspective but learn from each other
6. Acquire a shared understanding of each other’s expertise
7. Able to incorporate learned knowledge from others into own practice

Working across disciplines

- There is a divide in the field of PFD about who can provide the best care.
- The disciplines are sometimes in silos, defending their positions and strategies as better, more effective, or in some cases, more humane.
- There is a need for us to realize that we are working on the same goals, that we are providing very similar care, and that we have a lot to learn from each other.
- We do not all have the same amount of knowledge in a very complex field.

What are some solutions?

1. Formal collaborative training in PFD
2. Increasing data collection and group goal setting to demonstrate change in child and family function: this includes parent behavior
3. Co-treatments
4. Inclusion of EI and school staff in treatment planning
5. Allowing parents to participate in selecting recommendations and setting goals
6. Include child's abilities and desires to participate
7. Acknowledge and embrace all disciplines, and work together to find a common goal.

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