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Together at the Table: Working with Teams

Stephanie Cohen, M.A., CCC-SLP, CLC
Karen Dilfer, M.S., OTR/L

1

Disclosures

- Karen and Stephanie are co-directors and founders of the Chicago Feeding Group, a 501(c)3 organization
- Karen Dilfer maintains a private practice in Illinois.
- Stephanie Cohen maintains a private practice, Cohen Speech and Feeding Solutions, PLLC, in Illinois.

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Learning Outcomes

As a result of this course, participants will be able to:

- Participants will be able to list at least three professionals who may be part of a feeding team.
- Participants will explain the importance of knowing different professionals' areas of expertise.
- Participants will be able to list at least three strategies to improve collaboration on therapy teams.

3

Trust on Teams

- Teaming is best practice
- Respect
- Communication

(Edwards et al., 2017; Kazak et al., 2017)

4

Teams Support Families

- Parents feed responsively when they:
  - Feel supported
  - Understand the plan of care
  - Trust their providers
  - Have confidence in their ability to parent
  - Are not operating out of fear or anxiety

(Park, Thoyre, Estrem et al., 2016; Black & Aboud, 2011; Sanders & Hall, 2011)

5

Teams Exist in Different Forms

- Hospitals
- Clinics
- Virtual teams
  - Formal
  - Ad hoc
- Early Intervention/home-based teams

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Telepractice/Telehealth

- AOTA defines telehealth as the application of evaluative, consultative, preventative, and therapeutic services delivered through information and communication technology.
- Clinician to patient, clinician to clinician
- Must be equivalent to the quality of services provided in person
- Synchronous, asynchronous, or hybrid
- Adhere to code of ethics
- Can facilitate parent/child connection because we are NOT at the table.

https://www.asha.org/Practice-Portal/Professional-Issues/Telepractice/

https://ajot.aota.org/article.aspx?articleid=2719223&_ga=2.182232679.1144319333.1585573477-963233035.1582922516

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Netcoaching

- Available through hospitals and independent companies
  - Telemedicine
  - Mealtime Coaching/Consulting
  - Tube weaning
- Can be valuable resources, especially in under resourced areas
- Important to understand the role of netcoaching service in collaboration with the child's team

(Marinschek et al., 2014)

8

Feeding is Complex

Feeding issues are complicated.

Children need to FEEL GOOD before they can eat.

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CONTINUED

First Steps

Recognize what's hard

→ Help a child feel good & resolve medical issues

→ Responsive feeding practices

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Team Considerations

- Making referrals
- Communication
- Integrating recommendations
- Managing conflict
- Creating the best experience for the family

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Who Might Be on the Team?

- **Family/Caregivers**
- Extended family members
- Pediatrician
- Social worker
- Registered dietician
- Speech-Language pathologist
- Occupational therapist
- Childcare educator
- Gastroenterologist
- Allergist
- ENT
- Pulmonologist
- IBCLC
- Nurse
- Psychologist
- Service Coordinator/ Case Manager

Q9

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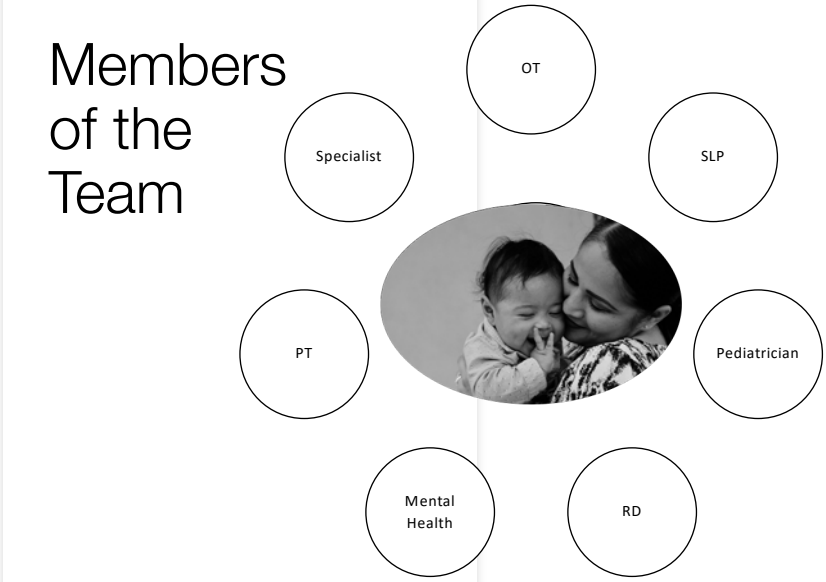
Members of the Team



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Teaming and Collaboration

A multidisciplinary team can holistically address a child's health and well-being:

- Medical management
- Sensorimotor skill building
- Behavioral support
- Hunger provocation
- Pain management
- Sensory integration difficulties

(Edwards et al., 2015)

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Teaming and Collaboration

Families felt part of the team when medical professionals:

- Accepted their assessment of the child's condition
- Listened to them

(Thomlinson, 2002)

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CONTINUED

Know Your Fellow Providers

- Seek connections
- Introduce yourself to others
- Ask questions about areas of specialty
- Share your perspective, understand theirs
- Build your referral list

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CONTINUED

Continuum of Treatment Philosophies

Child Motivated

Adult Motivated

Self-feeding

Force-feeding

(Klein, 2012)

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Responsive Feeding Strategies:

- Modeling positive eating behavior at mealtimes (Harper, 1975)
- Encourage shared mealtimes (Verhage C, Gillebaart M Van der Veek S et al, 2018)
- No pressure (Galloway et al., 2006)
- Offering enjoyable foods to encourage internal motivation
- Avoid using food as rewards for eating other foods (Finnanne et al, 2017)
- Respond promptly to child's cues of hunger and satiety (Black & Aboud 2011)

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Responsive Feeding Strategies are NOT:

- Adult controlling presentations of food
- Verbally directing child eat one food before another or larger quantity of a food
- Overly focusing on quantity of intake and neglecting skill development
- Tangible reinforcers for tastes/bites taken
- Using food as rewards for eating other Foods ("If…then") (Finnanne et al, 2017)
- Separating child from family mealtimes or from parents in sessions (Verhage C, Gillebaart M, Van der Veek S et al, 2018)

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Case Study: Addison

Medical History

- Left Hypoplastic Heart Syndrome
- Global delay
- Eight months old
- Had upcoming heart surgery

Feeding

- NG tube fed
- Safe to eat by mouth
- Very cautious of mouth
- Parents interested in transitioning off of feeding tube

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Case Study: Addison

Early Intervention:

- Occupational Therapist
- Speech-Language Pathologist
- Physical Therapist
- Registered Dietician

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Case Study: Addison

Intervention:

OT:	SLP:
• Build comfort around mouth • Introduce straws/cups • Introduce tastes and flavors	• Emphasis on quantity • Emphasis on parent-driven interventions vs. child led

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Case Study: Addison

Intervention Breakdown

- Goals of parent vs. team
- Difference in philosophy of providers

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Who Should be Present at an Evaluation?

- What is best for this family?
- Share options available
- Evaluators should have specialized expertise
- Best practice is a multidisciplinary perspective
- Team evaluation not always possible

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Considerations

- Age of child
- Family dynamics
- Child and family's past experiences
- Complexity of the case
- Time frame
- Environment
- Location (telehealth vs. on-site)
- Roles of different providers

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CONTINUED

Case Study: Max, 5 weeks

- Concerns:
  - Noisy breathing with feeding
  - Slow weight gain
- Initial evaluation with SLP
  - SLP recommended ENT consult and swallow study
  - Implemented strategies to slow the flow from the bottle and offer pacing
- ENT → dx. mild laryngomalacia, no VFSS needed
- Parent expressed confusion with different recommendations.

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CONTINUED

Case Study: Max

- SLP acknowledged differing recommendations with parents and with the pediatrician.
- Pediatrician took team leader role, synthesized information and helped family make decisions.
- Additional conversation with to ENT to build the relationship and share information/education
- Asked parents what THEY wanted and offered education

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Building Trust: The Team

Photo by fauxels from Pexels

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Team Collaboration & Communication

TRUST FIRST

Communication, not conflict

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Team Collaboration & Communication

- All team members understand the plan of care
  - Goals and indicators of progress
  - Therapeutic strategies/intervention
  - Home program
- Regular check-ins
- Connect with team members outside of your clinic/setting

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Share the mealtime information

- Medical providers may not be able to conceptualize what happens at home
  - Emotional climate
  - Mealtime dynamics
- Intentional collaboration
  - Verbal
  - Written
- Encourage parents to share video

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Collaboration: Making it Happen

Written documentation	Phone calls	Text messages
Email	Virtual meetings	Co-treating
Attending doctor appointments	Attending diagnostic testing	

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Photo by **mododeolhar** from **Pexels**

Quality vs. Quantity

Quality→ Quantity!

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Teaming and Collaboration

Can you think of a time when you collaborated with another member of the team in a way that benefitted the family?

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What Gets in the Way? Barriers to Trust on a Team

- Location
- Different philosophies
- Inconsistent communication (leads to caregiver confusion)
- Lack of time/productivity demands
- Mixed/Incomplete messages
- Emotional reactions
- Asynchronous collaboration

Q10

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Handling Conflict

Photo by Christina Morillo from Pexels

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Handling Conflict

- Trust First
- Know Your Team

Photo by LinkedIn Sales Navigator from Pexels

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When in Conflict

Ask questions

Actively listen

Educate

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Case Studies

CONTINUED

Case Study: Charlie

- **History:** Severe hypotonia, slow weight gain, significant motor planning impairments for feeding, delayed feeding milestones (chewing, utensil use, straw use, and open cup)
- **EI Team:** PT, OT, DT, SW, SLP, RD

e Study: Charlie

CONTINUED

Case Study: Charlie

Collaboration:

- **ST and OT** to determine best utensils for Charlie
- **ST and RD** to determine best textures and combinations of food to maximize nutritional intake in the context of slow rate of intake and decreased endurance
- SW and other therapists to help manage flow of recommendations, support family through seeking a diagnosis
- Regular full team meetings
- Therapists and physicians to share concerns and progress

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Case Study: Charlie

Photo by Migs Reyes from Pexels

History:

- Born at 40 weeks IUGR
- Cardiac anomaly, repaired via surgery at 4 months of age

Concerns:

- Poor weight gain, dream feeding, poor transition to solids
- Developmental delay

Treatment

- Hospital SLP → Home based OT
- Feeding clinic, team GI doctor → G-Tube
- EI team: RD, SLP, OT, PT

: Ben

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Case Study: Charlie

Photo by Migs Reyes from Pexels

- Collaboration:
  - **OT and GI:** helped GI understand feeding skills
  - **ST, OT, RD** to determine how to help Charlie
    - Participate in family mealtimes
    - Develop comfort with new foods
    - Develop feeding skills
    - Transition off of his feeding tube

: Ben

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Parent video
Charlie

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Successful Implementation of a Responsive Feeding Approach

- Children need to feel good
  - Physically
  - Emotionally
- Parents need to:
  - Develop confidence
  - Build trust in their children and providers
- Providers need to:
  - Support relationships between parents and children
  - Build trusting and collaborative teams

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Thank You!

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CONTINUED

Questions

- Karen Dilfer: karen@eatwithkaren.com

- Stephanie Cohen: Stephanie@cohenspeechandfeeding.com

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CONTINUED