Division of Special Education/Early Intervention Services

Feeding and Swallowing Policies and Procedures

The purpose of this document is to provide guidance to address the issues and procedures for meeting the needs of children and students with feeding and swallowing disorders within the early intervention/education setting.

1. Is there a range of feeding and swallowing disorders?

Yes. Feeding and swallowing problems “can be wide ranging and may include physical difficulty (e.g., bringing food to the mouth), processing food in the mouth (e.g., motor or sensory deficits), dysphagia, psychosocially based eating disorders (e.g., food obsessions, maladaptive eating habits), dysfunction related to cognitive impairments (e.g., understanding nutrition or food preparation), surgical intervention, and neurological impairments, as well as positioning problems that affect feeding, eating, and swallowing” (AOTA, 2007).

Dysphagia is a feeding and swallowing problem, and is defined as “dysfunction in any stage or process of eating. It includes any difficulty in the passage of food, liquid, or medicine, during any stage of swallowing that impairs the client’s ability to swallow independently or safely” (AOTA, 2007. P. 634). ASHA uses “swallowing and feeding disorders” when referring to dysphagia and delays/disorders in the development of eating and drinking skills, which are common in varied pediatric populations. Swallowing and feeding skills include the introduction, preparation, transfer, and transport of food and liquid from the mouth through the esophagus into the stomach. Feeding and swallowing skills also include management of saliva and oral intake of medications.

Swallowing and feeding disorders vary considerably in their characteristics and severity. Children may demonstrate choking and aspiration, oral sensorimotor impairments, maladaptive behaviors during eating, refusal to eat, and may only accept a restricted variety of food and liquid. Anatomic, neurologic, and/or physiologic impairments may affect a variety of skills, including, but not limited to, motor planning, postural control and oral-pharyngeal motor skills, sensory processing, respiration, and digestion. Students with severe disorders may experience deficiencies in nutrition and hydration, as well as reduced respiratory health.

2. Do local lead agencies (LLAs)/local school systems (LSSs) have any legal obligations related to feeding/swallowing?

Yes. In order for the child/student to be eligible for early intervention services or special education/related services in the area of feeding and swallowing, the child must first be identified as having a developmental delay or a disability related to education which makes the child/student eligible for early intervention/special education needs. While feeding and swallowing disorders are not a specific eligibility category for early intervention/special education, children/students with other disabilities may have feeding and swallowing as an accompanying disorder.

The Individuals with Disabilities Education Act (IDEA) includes provisions that children/students with health related issues be provided services in order for the child/student to participate fully in their educational program. In Maryland, a child with feeding and swallowing concerns may qualify for Part C if the child has either a 25% delay in one or more areas of development; atypical development in one or more areas of development; or a diagnosed medical condition where the child has a high probability of experiencing a developmental delay.

Providing services for children/students with feeding and swallowing concerns in the school or community setting will support the child/student’s access to a free appropriate public education (FAPE) by:

- Promoting safety and success of children/students during mealtime. This includes the availability of food and the development of procedures to minimize risks for choking and aspiration during oral feeding. Training of personnel should include first aid, CPR, Heimlich, signs and symptoms of aspiration, and procedures specific to individual children/students.
- Promoting participation and/or independence for children/students with mealtime issues.
- Promoting nourishment and hydration for optimal health and participation.

In order to ensure safe mealtime participation, all information related to feeding and swallowing needs to be available to all members of the school or early intervention team. In some instances, providers may determine that additional medical clearance is required prior to oral feeding. Permission/release of information forms need to be included in the child’s early intervention record or school health file in order to share information related to feeding and swallowing concerns as part of any needed medical care.

IFSP/IEP teams will determine, based on identified needs, the appropriate professional(s) with the expertise to address an individual child’s/student’s feeding and swallowing concerns. However, a collaborative effort is required by all team members.

[20 U.S.C. 1401(1); 34 CFR §300.5; 34 CFR §300.8(c).]
3. **Is there a difference between the medical and the early intervention/educational models related to feeding and swallowing issues within the home, community or education setting?**

Yes. Medical/clinic-based services provide medically ordered diagnostic evaluations of feeding and swallowing concerns and often develop a feeding protocol that can be safely implemented at home and at school. Medically-based services include but are not limited to: advancing textures, behavioral feeding programs, specific caloric intake, transitioning to oral feeding.

School-based services focus on the development and implementation of a safe feeding protocol at school in order for the student to have the necessary hydration and nutrition in order to access instruction. School-based services may also include but are not limited to: staff development and training, monitoring, data collection related to participation in natural learning environments, and student skill development. Student skill development may include advancing in textures, advancing in intake methods re: dining equipment, and possible transition to oral feeding. Early intervention services address the concerns of families and other caregivers as they relate to the developmental aspects of mealtime participation by using treatment strategies based on scientific research, to the extent practicable.

Children/students will benefit from collaboration between early intervention/school-based and medical-based service providers. This collaborative process should address the differences between the medical and the early intervention/educational models related to the individual feeding and swallowing issues within the home, community or education setting as appropriate to the needs of the individual child/student.

4. **Are feeding and swallowing issues the responsibility of any single profession or discipline?**

No. It must be recognized that each discipline/profession encompasses separate and distinct knowledge, expertise and skill sets for addressing the unique needs of children/students with feeding and swallowing disorders or needs. These roles and expectations should be determined following local policies and procedures, as the IFSP or IEP process may vary by local Infants and Toddlers Program/LSS. The IFSP/school team may include: Parents/guardian, child care provider, classroom teacher, paraprofessional, speech-language pathologist (SLP), occupational therapist (OT), psychologist, cafeteria worker, nutritionist, nurse, physical therapist (PT), and additional adult support.

Parent/caregiver input and participation should include:

- Providing medical and feeding history including food allergies, dietary restrictions, medications, and any medical/diagnostic reports related to feeding and swallowing;
- Sharing knowledge of the child’s/student's feeding skills/habits, food preferences, and mealtime environment;
- Sharing cultural routines and practices related to foods and eating;
- Implementing swallowing and feeding goals and strategies in the home and community environments.
- Participating as members of the team to support the management of their child’s/student’s
feeding and swallowing.

- Collaborating with team members and outside providers to ensure consistent management of feeding and swallowing strategies at home and school

IFSP/IEP team input and participation should include:

- Determining a point of primary contact among early intervention/education staff to coordinate, collaborate, and disseminate information among the parent, team and outside providers:
- Participating as a member of the team to support the management of the child/student’s feeding and swallowing:
- Ensuring safe feeding practices:
- Providing assessment and intervention strategies/techniques to address related needs:
- Establishing a safe swallowing and feeding protocol and/or an Individualized Health Plan (IHP) (emergency plan):
- Monitoring the child’s/student's safe swallowing and feeding protocol:
- Reviewing child’s specific feeding and swallowing issues to address the child’s/student’s response or reaction to feeding and swallowing e.g., vomiting in response to a particular food smell:
- Training early intervention/school-based personnel and the parent/caregiver as needed.

5. **Do feeding services for the infants/toddlers (IDEA Part C) population differ from those provided to the age three to twenty-one year old population (IDEA Part B)?**

Yes. Early intervention services (IDEA Part C) are provided to infants and toddlers age birth to kindergarten age, effective 12/1/2011 this becomes birth through three years of age, in conformity with an IFSP and are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child’s development. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. Early intervention services are provided to the extent necessary to meet the unique needs of the child and family and to achieve the outcomes identified by the IFSP team and the family. These services are to be based on scientific research, to the extent practicable.

Students with disabilities, three through 21 years of age (IDEA, Part B) may require the provision of specialized instruction in order to receive a free appropriate public education (FAPE). The special education and related services a student with a disability may require is determined by the student’s IEP team. Related services may include transportation, developmental, corrective, and other supportive services as may be required to assist a student with a disability to benefit from special education. In accordance with 34 CFR §300.8(a)(2)(i), if a student has one of the disabilities listed in 34 CFR §300.8(a)(1), but only needs a related service, the child is not a child with a disability under the IDEA.

The educational relevance of providing services for students with feeding/swallowing concerns in the school setting may include but is not limited to:

- Promoting safety and success of students during mealtime. This includes the availability of
appropriately prepared food and the development of procedures to minimize risks for choking and aspiration during oral feeding. Training of personnel should include general first aid, CPR, Heimlich, signs and symptoms of aspiration, and procedures specific to individual students.

- Promoting participation and/or independence for students with mealtime issues.
- Promoting nourishment and hydration for optimal health and participation.
- Ensuring student safety while eating in school by providing the appropriate staff, food or procedures required to reduce the choking and aspiration risks of students while eating.
- Enabling full participation in the student’s educational program by ensuring that the student be appropriately hydrated and nourished.
- Developing the skills necessary to become independent, to the extent possible, at mealtimes in order to participate safely with non-disabled peers.

[20 USC 1431 §631(a); 34 CFR §303.12(a); 34 CFR §303.12(b)]

6. Are early intervention/school based staff allowed to refuse to carry out specific feeding and swallowing services they may feel are unsafe or inappropriate?

If the service provider believes that oral feeding is unsafe and has clearly documented these findings, he or she should consult with the nurse and notify his or her supervisor, the IFSP/IEP team and/or the child’s outside provider(s). Licensed professionals on the early intervention/education team (SLPs, OTs, PTs, nursing, and psychologists) are bound by state regulations and discipline-specific codes of ethics to take every precaution to avoid harm and to discontinue immediately a procedure which is contraindicated. A team meeting needs to be convened as soon as possible to address these concerns as related to FAPE.

In John A. v. Howard County Board of Education, 400 Md. 363 (2006), John A. alleged the school system failed to implement his daughter’s IEP. His daughter received, as a related service, administration of three psychotropic medications prescribed by the family’s psychiatrist from the school nurse. The psychiatrist told the school nurse never to withhold the medications even if the child appeared lethargic or drowsy. The child was observed after receiving the medication to be drowsy and to have an atypical pulse. The nurse consulted with the school health services manager, who was also a registered nurse. The school health services manager reviewed treatises on the medications used, consulted with Maryland Board of Nursing, and attempted to consult with the family psychiatrist. Because the school health care providers were not able to communicate with the psychiatrist on the effect of the medication, the providers found it would be inappropriate to provide the medication as directed. The school offered to have the parents administer the medication.

When confronted with medical ethics issues such as those in John A., reconvening the IEP team is always appropriate. At the IEP meeting, the team can discuss related services and other issues and where necessary modify the IEP.

[COMAR 10.41.02.02, 10.46.01.03, 10.38.03.02]
7. Are services related to feeding and swallowing considered to be medically reimbursable?

Yes. Services provided to students with feeding and swallowing concerns are medically reimbursable if the therapy is part of the SLP, OT, and PT related services provision within the IFSP/IEP. However, Medicaid will not reimburse for daily feeding unless a nurse is providing tube feeding.

8. Can feeding and swallowing services provided within the early intervention/education setting be required by a physician’s order?

A physician’s order may be considered when developing, reviewing, or revising the IFSP/IEP but is not controlling. Eligibility for the related services to address the child’s needs relevant to feeding and swallowing concerns is an IFSP/IEP team decision. A physician cannot order services be provided as part of the IFSP/IEP process.

For more information, call 410-767-0858

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