

Eating, Feeding & Swallowing for children on the Autism Spectrum: Getting the info and figuring out what to do with it

Part 1: Assessment

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Dr. Sharon Smile, MBBS, DM, MSc



Pediatric Eating
And Swallowing

Holland Bloorview

Kids Rehabilitation Hospital

Welcome & Learning Objectives

- Discussion of important points to consider when assessing eating, feeding & swallowing with a child on the Autism Spectrum
- To understand how to bring together assessment information to form appropriate goals
- Case study presentation bringing together assessment details, synthesis of results and application to treatment



Associate Chief Medical Officer

Dr. Sharron Spicer

LAND ACKNOWLEDGEMENT



We acknowledge that what we call Alberta is the land of Treaties 6, 7 and 8. We are living and working on the traditional and ancestral territory of many peoples.

We acknowledge the many First Nations, Métis Settlements and Inuit who have lived in and cared for these lands for generations. We are grateful for the traditional Knowledge Keepers and Elders who are still with us today and those who have gone before us. We make this acknowledgement as an act of reconciliation and gratitude to those whose territory we reside on or are visiting.



We are currently working on the traditional territories of the Missasaugas of the Credit First Nation, the Wendat Nation, the Petun Nation, and the Seneca Nation, also a part of the Haudenosaunee Confederacy.

When we think of our commitment to reconciliation, we think of Indigenous communities with food insecurity, health inequities and limited access to medical services. We do a Land acknowledgement to renew our personal and professional commitment to work towards dismantling health inequities within these communities and other marginalized communities.

The image shows a screenshot of a Zoom Webinar Chat window. The window title is "Zoom Webinar Chat". A callout box points to the chat interface with the text: **For Comments**
Use the **Chat** and select "All panelists and attendees" for public comments.

Another callout box points to the Zoom control bar with the text: **For Questions**
Use the **Q&A** or **Raise Hand**. We will address them at the end of the presentation

The Zoom control bar at the bottom includes icons for "Chat", "Raise Hand", and "Q&A".



CERTIFICATE OF ATTENDANCE

Name

Attended the 1 hour webinar

Part 1: Assessment

**Eating, Feeding & Swallowing for children on the Autism
Spectrum: Getting the info and figuring out what to do with it**

offered on Oct 26, 2022

A handwritten signature in black ink, appearing to be "J. Turner", written over a horizontal line.

Dr. Justine Turner, MD PhD
On behalf of the PEAS Project



PEAS.Project@ahs.ca

Project Scope

The Pediatric Eating And Swallowing (PEAS) Project is a provincial **quality improvement** initiative with the purpose of developing a provincial eating, feeding, and swallowing **clinical pathway** to standardize and improve care for children with a **pediatric feeding disorder**.¹

Target population: Patients receiving care from provincial Outpatient Clinics, Home Care, or Community Rehabilitation

¹ Goday PS et al. *Pediatric Feeding Disorder: Consensus Definition and Conceptual Framework*. J Pediatr Gastroenterol Nutr. 2019 Jan;68(1):124-129.

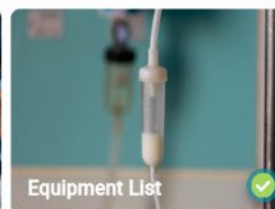
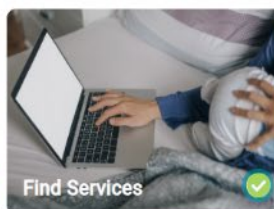
Find relevant information

For families and care providers of children with an eating, feeding and swallowing disorder

FOR FAMILIES

FOR PROVIDERS

Popular Resources for Families



peas.ahs.ca

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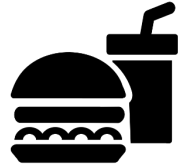
Presentation: Feeding issues in ASD



PREVALENCE

46% to 89% (Ledford & Gast 2006)

Variable presentation with variable prevalence: **13-95%**



FOOD PREFERENCE

Carbohydrates (William et al. 2005)

Crispy/crunchy snack foods (Schmitt et al. 2008)



FOOD DISGUST

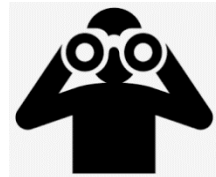
Fruits and vegetables (Aheam et al. 2001, Cornish, 1998; 2002)

Disruptive Mealtime Behaviours



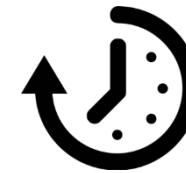
PREVALENCE

5 times the odds for children without ASD (5.11 (95% CI 3.74-6.97) (Sharp et al. 2013)



PROFILES

Texture: 69%, Appearance : **58%**, Taste **45%** Smell: **36%**, Temperature: **22%**, **Reluctant to try new foods: 69%** (William et al. 2000)



DURATION

Persistence of feeding challenges into adulthood- (Kuschner et.al. 2015)

Presentation: Feeding issues in ASD



COMORBIDITY

Prevalence of obesity: up to **30.4%**

Gastrointestinal problems: **49.3 to 82%**



WEIGHT VARIABILITY

Children 2-5yr: more likely to be overweight or obese

Children 6-11 yr: **underweight** than in matched cohort (Hyman et al. 2012)



NUTRIENTS

ASD consumed similar amount of nutrients/calories as control)



DEFICIENCIES

Iron deficiency: 24-32%, Iron deficiency anemia: 8-16%, Decreased bone mineral density

Low iron intake (Herndon et al 2009)

Low intake of Vitamin D, B12, protein and calcium (Zimmer et al 2012)

Vit C deficiency, Vitamin A deficiency, Rickets (McAlbee 2009, Stewart 2008)

The health status of adults on the autism spectrum

Lisa A Croen¹, Ousseny Zerbo¹, Yinge Qian¹, Maria L Massolo¹,
 Steve Rich², Stephen Sidney¹ and Clarissa Kripke³

Table 4. Prevalence of medical conditions among adults with ASD and controls.

Medical conditions	Adults with ASD (N = 1507), N (%)	Controls (N = 15,070), N (%)	Chi-square p value	OR ₂ (99% CI)*
Gastrointestinal disorders	523 (34.70)	4139 (27.47)	<0.001	1.35 (1.16–1.57)
Constipation →	67 (4.45)	210 (1.39)	<0.001	3.11 (2.13–4.54)
Diarrhea	79 (5.24)	510 (3.38)	0.002	1.41 (1.02–1.95)
Disorders of stomach or duodenum	20 (1.33)	220 (1.46)	0.68	1.00 (0.54–1.85)
Functional disorders	208 (13.80)	2075 (13.77)	0.97	0.96 (0.78–1.17)
GERD →	193 (12.81)	1161 (7.70)	<0.001	1.77 (1.42–2.21)
Gallbladder disorders	28 (1.86)	213 (1.41)	0.17	1.34 (0.79–2.28)
Lower GI	50 (3.32)	242 (1.61)	<0.001	1.92 (1.27–2.91)
Other disease of esophagus	69 (4.58)	421 (2.79)	<0.001	1.66 (1.17–2.35)
Diseases of rectum and anus	39 (2.59)	295 (1.96)	0.09	1.26 (0.80–1.97)
Hepatic disease	33 (2.19)	228 (1.51)	0.04	1.58 (0.96–2.60)
Upper GI motility	114 (7.56)	593 (3.93)	<0.001	1.85 (1.40–2.45)
Sleep disorders	265 (17.58)	1446 (9.60)	<0.001	1.92 (1.58–2.33)
Organic sleep apnea	64 (4.25)	404 (2.68)	0.005	1.54 (1.07–2.21)
Dyssomnia	236 (15.66)	1183 (7.85)	<0.001	2.05 (1.67–2.52)
Nutrition conditions	561 (37.23)	2821 (18.72)	<0.001	2.68 (2.29–3.12)
Symptom concerning nutrition metabolism and development →	524 (34.77)	2609 (17.31)	<0.001	2.62 (2.24–3.06)
Vitamin deficiency →	75 (4.98)	244 (1.62)	<0.001	3.25 (1.85–5.67)

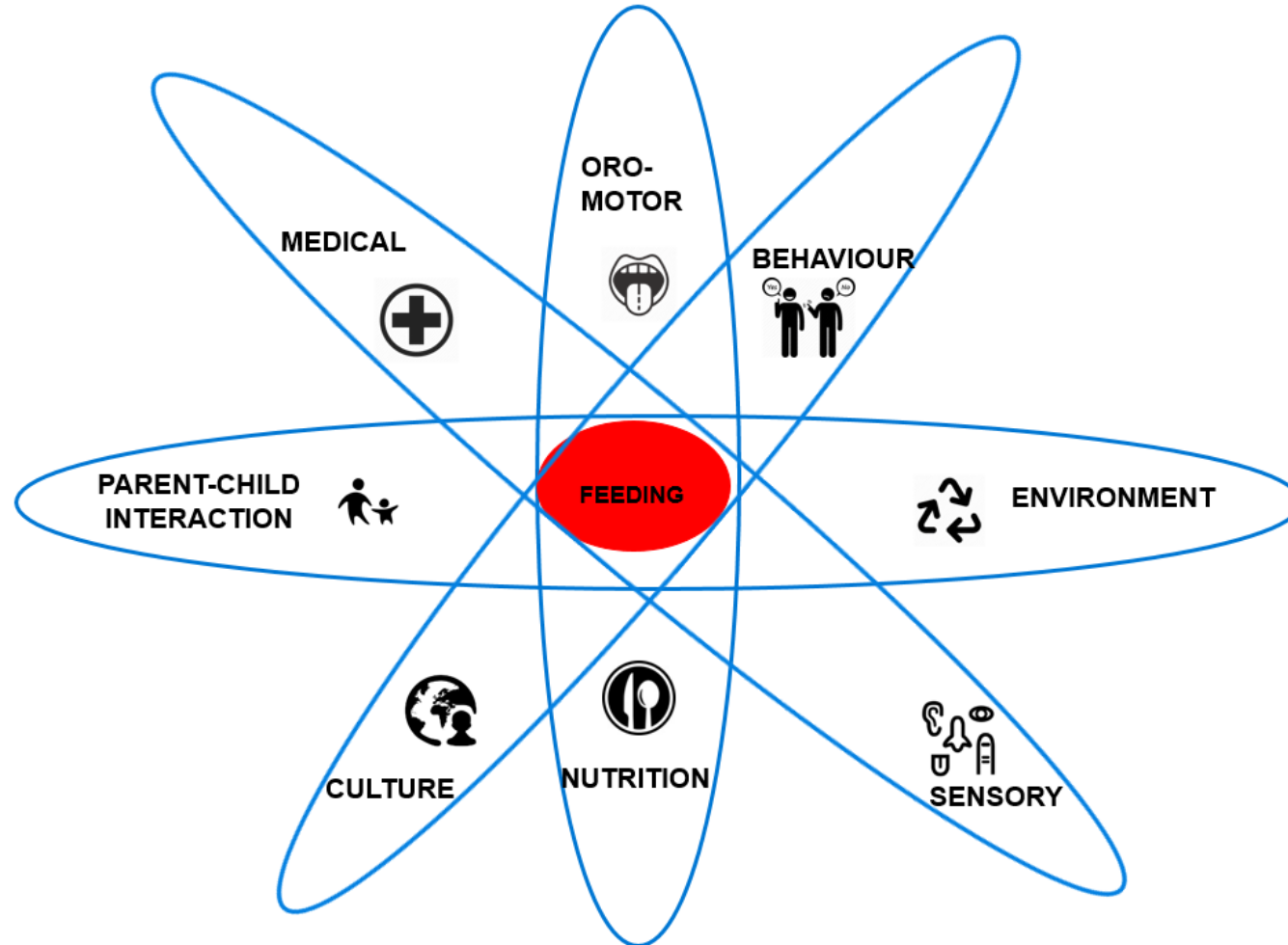
*Think of
feeding issues
as a
Medical issue
First*

“need for early and comprehensive medical investigation to determine if medical issues are contributing to the negative feeding behaviors for children with ASD”
(Rogers et al. 2012)

*Think of “feeding challenge” as a **SYMPTOM** not the problem*

- When a child presents with a cough, we don't just treat the symptom of a cough, we complete a comprehensive assessment of possible underlying causes of the cough and systematically rule out or rule in, each possible cause
- Obviously the more successful we are at identifying the underlying cause of the cough, the more successful our treatment will be

This same approach should be applied to assessing feeding challenges in kids with ASD



Smile, S., Raffaele, C., Perlin R. 2017.

The challenges:

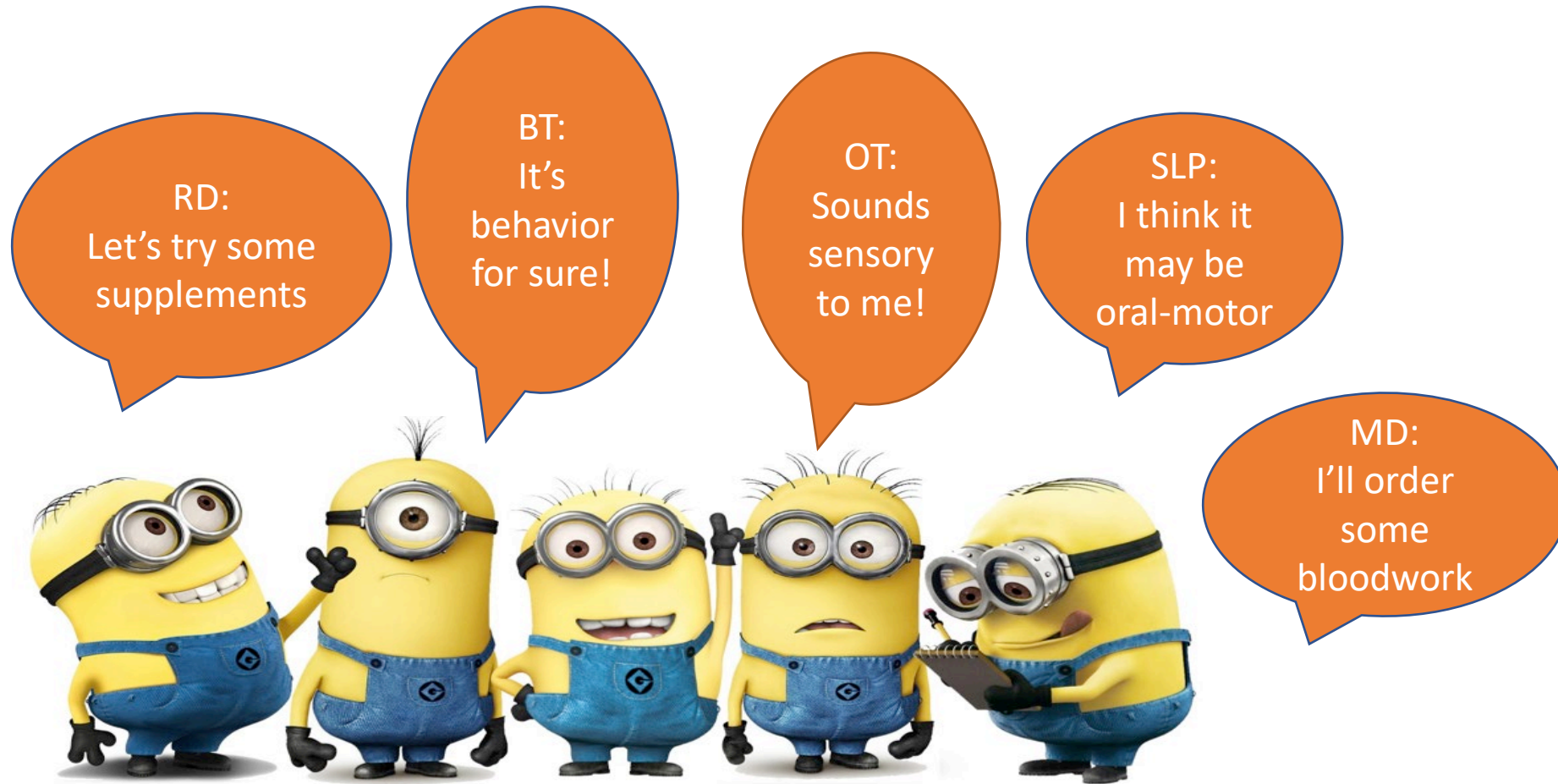


There is currently no established method guiding clinicians to complete a comprehensive assessment of all of the underlying factors contributing to a feeding challenge in a child on the autism spectrum

Without an adequate framework for assessment, clinicians are left to guess how to proceed



The current state of affairs:



For Example:

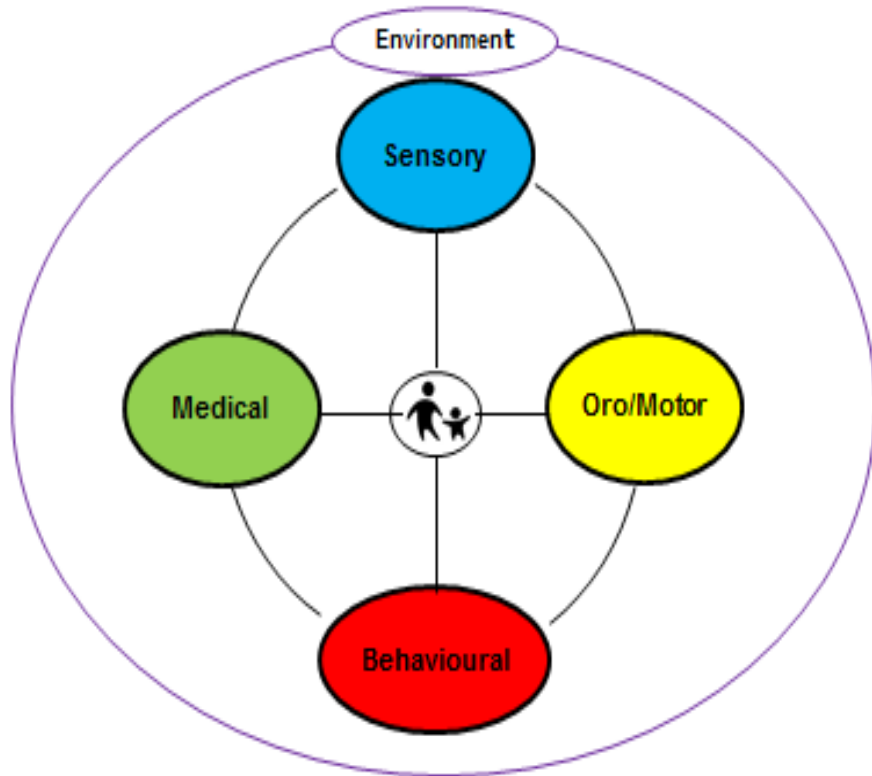
4 year-old boy with ASD presents with picky eating resulting in a limited diet of less than 15 foods. When new foods are presented, he cries and pushes the food away

He is referred to an OT who explains that the child has sensory feeding issues and designs an intervention to help desensitize the child to some target foods. After several months the child will touch and lick some new foods but has not added any new foods to his diet.

Here's what we're missing:

- He has significant issues with constipation
- He grazes all day, eats a few bites at a time
- He is fed by others while walking around or while watching TV
- His parents struggle with his poor compliance in all areas (sleep, dressing, bathing etc.)
- **Medical, environmental and other behaviour issues need to be addressed first**

Medico-oral-behavioural-sensory approach – MOBS^E approach ©



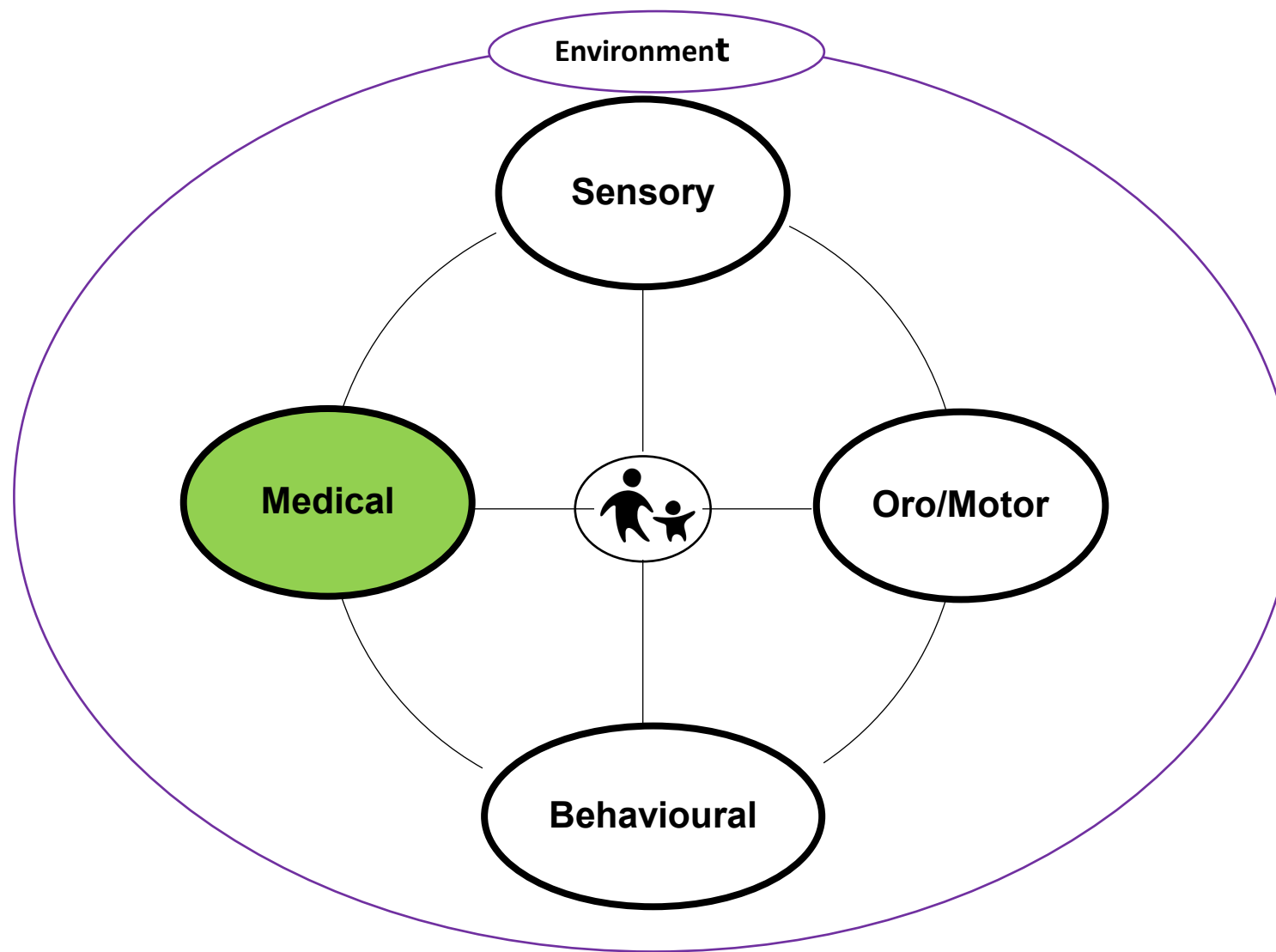
The MOBS^E framework is designed to guide clinicians through each factor: medical/nutrition, oral-motor, behaviour, sensory and environment to help properly identify the aetiology(ies) of a child's feeding challenge.

The framework is grounded in the premise that the parent child relationship impacts all aspects of feeding and requires consideration as clinicians move through each element of the framework.

Table 1. The tenets of the MOBS[®] approach©

Factor	Description	Red flags	Resources/team members
Medical/ Nutrition  	<ul style="list-style-type: none"> Identify common medical factors that may alter feeding behaviours such as: constipation, GERD, food allergies, gastritis, dysphagia (coughing, choking or drooling with meals) and medication such as stimulants or antipsychotic agents. Identify the child's developmental age and acquisition of appropriate feeding skills. Determine if the child is nutritionally stable as indicated by: weight, height, BMI, growth curve, hydration status, micro/macronutrient intake, HR, BP Document pubertal phase, peripheral stigmata of malnutrition or nutritional deficiencies 	<ul style="list-style-type: none"> Pain with feeding Recurrent vomiting and/or diarrhea Growth failure Pallor, lethargy Abdominal pain Hitting of abdomen (nonverbal child) H/O Aspiration Meets criteria for ARFID 	Feeding Handbook: See Buile et al. (2010) (16) and Smile (2019) (12) Consult a Dietitian and/or Gastroenterologist and/or Feeding specialist team as indicated
Oral-motor 	<ul style="list-style-type: none"> Identify any oral-motor challenges that may impact a child's feeding performance such as: anatomical differences (cleft, tongue tie, structure of mouth/teeth), delayed oral-motor skills (poor tongue lateralization, poor lip closure) leading to a mismatch of food offered not aligning with child's current oral-motor skill level. 	<ul style="list-style-type: none"> Drooling H/O gagging or choking Difficulty advancing textures 	Feeding Handbook: See Barton et al. (2018) (17) Consult a Speech and Language Pathologist as indicated
Behaviour 	<ul style="list-style-type: none"> Identify mealtime behaviours that may be contributing to a child's feeding performance such as: avoidance, refusal, tantrums, self-injurious behaviours Complete a functional behaviour assessment to determine the function of the disruptive mealtime behaviours 	<ul style="list-style-type: none"> Self-injurious behaviours at mealtimes Self-Induced Vomiting Inability to eat in different environments 	Consult a Behaviour Analyst as indicated
Sensory 	<ul style="list-style-type: none"> Determine whether the child is experiencing sensory processing differences that may be impacting on their feeding performance such as: sensitivity to taste, texture, smell, appearance, sound of foods, challenges sitting, challenges sensing hunger cues 	<ul style="list-style-type: none"> Anticipatory Gagging or Vomiting to certain scent or on seeing specific foods 	Feeding Handbook Consult an Occupational Therapist as indicated
Environment 	<ul style="list-style-type: none"> Assess environmental factors that may be contributing to a child's feeding performance such as: mealtime schedule, distractions, positioning, different feeders, seating 	<ul style="list-style-type: none"> Use of electronics to facilitate meal times Grazing 	Consult a Behaviour Analyst as indicated
Parent – Child Relationship 	<ul style="list-style-type: none"> Evaluate for parental anxiety around feeding Identify parent feeding style 	<ul style="list-style-type: none"> Force feeding H/O Depression or Anxiety (parent or child) 	See Hughes et al. (2005) (18)

Severe food selectivity: Consider if there is elimination of one or more food groups, consumes five or fewer foods.



Medico-oral-behavioural-sensory approach – MOBS^E approach ©

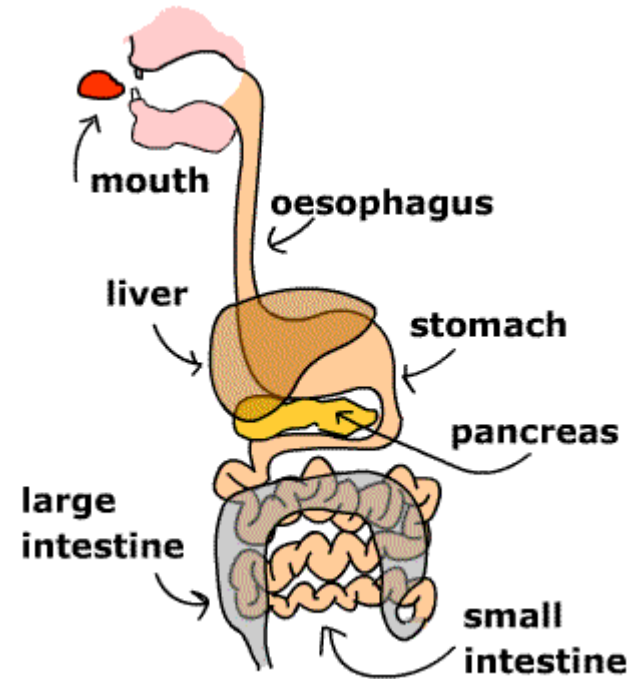
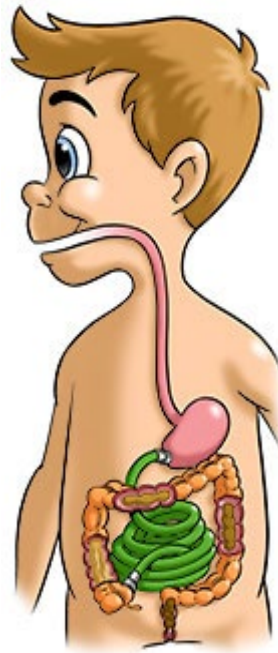
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Medical / Nutrition



- Identify common medical factors that may alter feeding behaviours such as:

- Dental Caries
- Dysphagia
- GERD
- Gastritis
- Constipation
- Food Intolerances
- Food Allergies
- Medication



Medical / Nutrition



- Determine if child is nutritionally stable as indicated by:
- Weight/height
- BMI
- Growth curve
- Hydration status
- Micro/macronutrient intake
- HR, BP
- Pubertal Stage

Medical / Nutrition



MOUTH



SWALLOW



FOOD ALLERGY

ABDOMINAL PAIN



CONSTIPATION



MEDICATION

Oral-Motor



- Identify oral-motor challenges that may impact a child's feeding performance such as:
- Anatomical differences (cleft, tethered oral tissues, structure of mouth/teeth)
- Delayed oral-motor skills (poor tongue lateralization, poor lip closure) leading to a mismatch of food offered not aligning with child's current oral-motor skill level

Oral-Motor



- Children with ASD reported to be later to transition to solid foods and to have more chewing difficulties than their matched peers (Nadon et al. 2011; Sahan et al. 2021)
- Some studies have reported higher prevalence of malocclusion in children with ASD compared to control group (Fontaine-Sylvestre et al. 2017) while others have found no significant difference (Barros et al. 2022)

Is it Sensory? Is it Motor?



- Is feeding difficulty really sensory based?
- Not accepting food (particularly gagging, spitting out) may not be sensory based rather:
 - Mismatch of child's mouth skills with food consistencies served
 - How fast they are being fed (pace)
 - How much they are being fed (volume)
 - Misunderstanding child's cues/behaviour

Is it Sensory? Is it Motor?

- A child accepting a wide variety of smooth pureed foods but refusing or spit/pull out harder solids
 - Suspect **oral motor difficulties** (ability) first before **sensory** or **behaviour**
- A child who willingly chews a selection of harder foods (e.g. skittles, smarties, gummies)
- Suspect **behaviour** and/or **sensory**, not **oral motor**



Is it Sensory? Is it Motor?

- Oral-motor delays can look like sensory issues-it is important to figure which is responsible for the challenges
- A child with oral motor issues needs to be fed foods that match their oral motor/developmental level, not necessarily their chronological age

If we offer foods that are too challenging we may see:

- Refusing food
- Refusing particular textures
- Coughing/choking
- Gagging/vomiting
- Swallowing foods whole
- Will chew on non food items/not food
- Putting foods in mouth-pulling/spitting out
- “feeding aversions”

•(Arvedson, 2013)



bwc5610181 Barewalls ©

•Averse to “feeding”? or averse to foods that are too difficult for their motor skills?

How do we know if a child's oral skills may be affecting their eating?

- Assessment is important!
- Gather information on
 - history of development of feeding skills
 - What foods does the child eat well/willingly-WHY?
 - What foods does the child refuse or not eat well-WHY?
- Physical assessment should include **observing feeding** preferably in person or virtually/by video as needed to evaluate:
 - Child's overall developmental level/motor skills
 - Oral mechanism structure
 - Lip/Tongue/Jaw movement/skill when eating
 - Current chewing pattern
 - Oral movements during speech

Based on the results of assessment-what strategies will work best to help this particular child be ready to work on chewing and to transition to greater texture?

Myth Buster

He's having trouble swallowing solids, I'll refer him to an SLP to assess his swallowing or to help him learn how to swallow solid foods



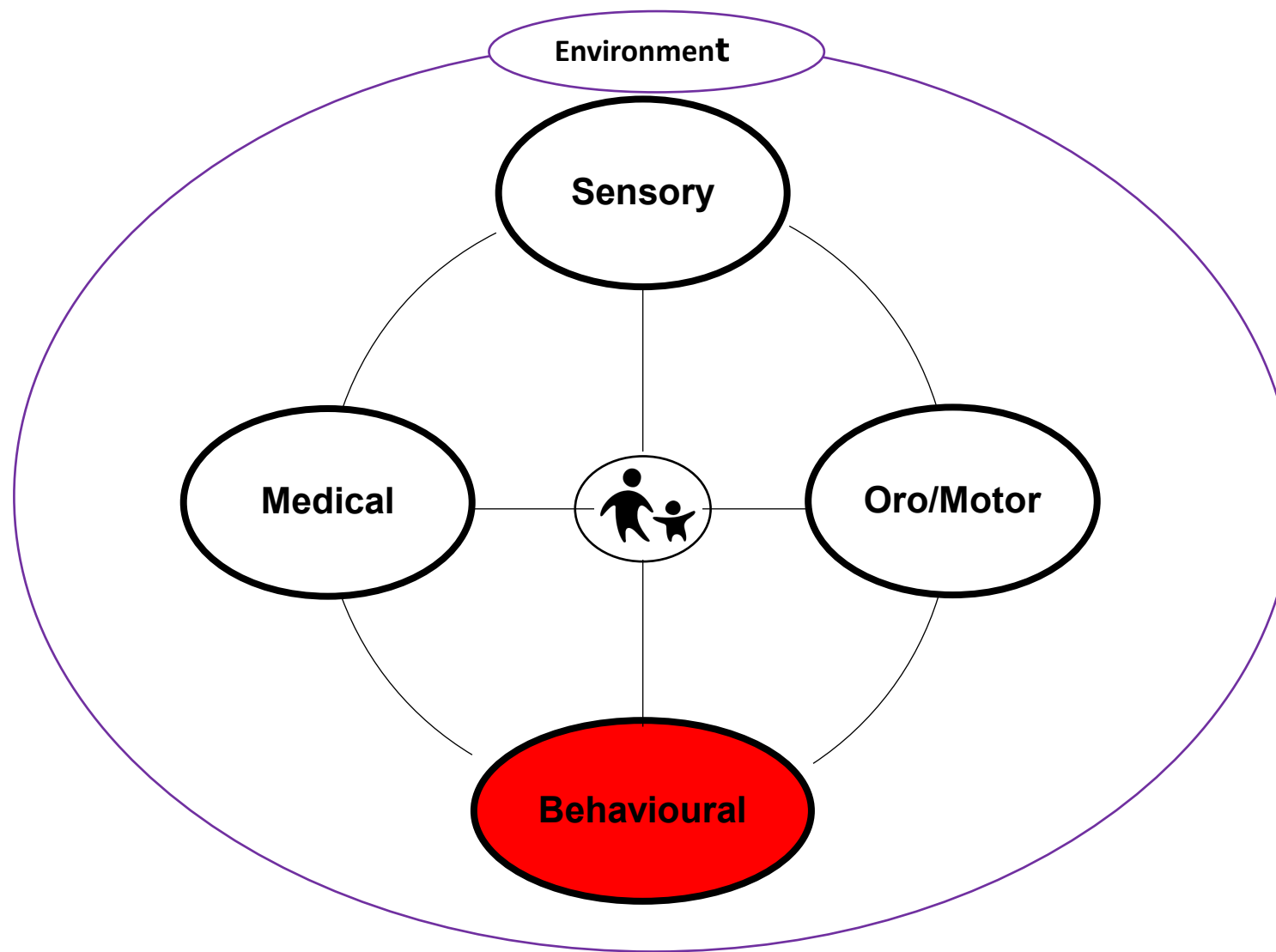
- But we don't "SWALLOW" solid food!
- We chew foods thoroughly to almost a puree before swallowing
- If liquids/purees swallowed well, it is likely not a swallowing problem, but a "CHEWING" problem
- Children may avoid foods that they cannot handle, so they accept soft or pureed foods, rejecting foods that require chewing but often can't tell us why
- If this is the case, we need to assess their **READINESS** to work on chewing and determine a treatment plan
- Children can (if needed) continue to thrive nutritionally with purees/liquids

Myth Buster

That spitting out foods sounds like a sensory feeding problem, I'll refer to an OT to help with that



- Spitting out foods could be sensory-but what if it is **ORAL-MOTOR**?
- Refusing particular textures, coughing/choking, gagging/vomiting, swallowing foods whole, chewing on non food items but not food, putting foods in mouth-pulling/spitting out
 - **Can make the case for an oral motor origin.**
- What if they are being force-fed?
- Mixed consistency (chunky) purees-PUREE SURPRISE!
 - puree elicits suckle-swallow pattern (Stolovitz & Gisel,1991) not chewing



Medico-oral-behavioural-sensory approach – MOBS^E approach ©

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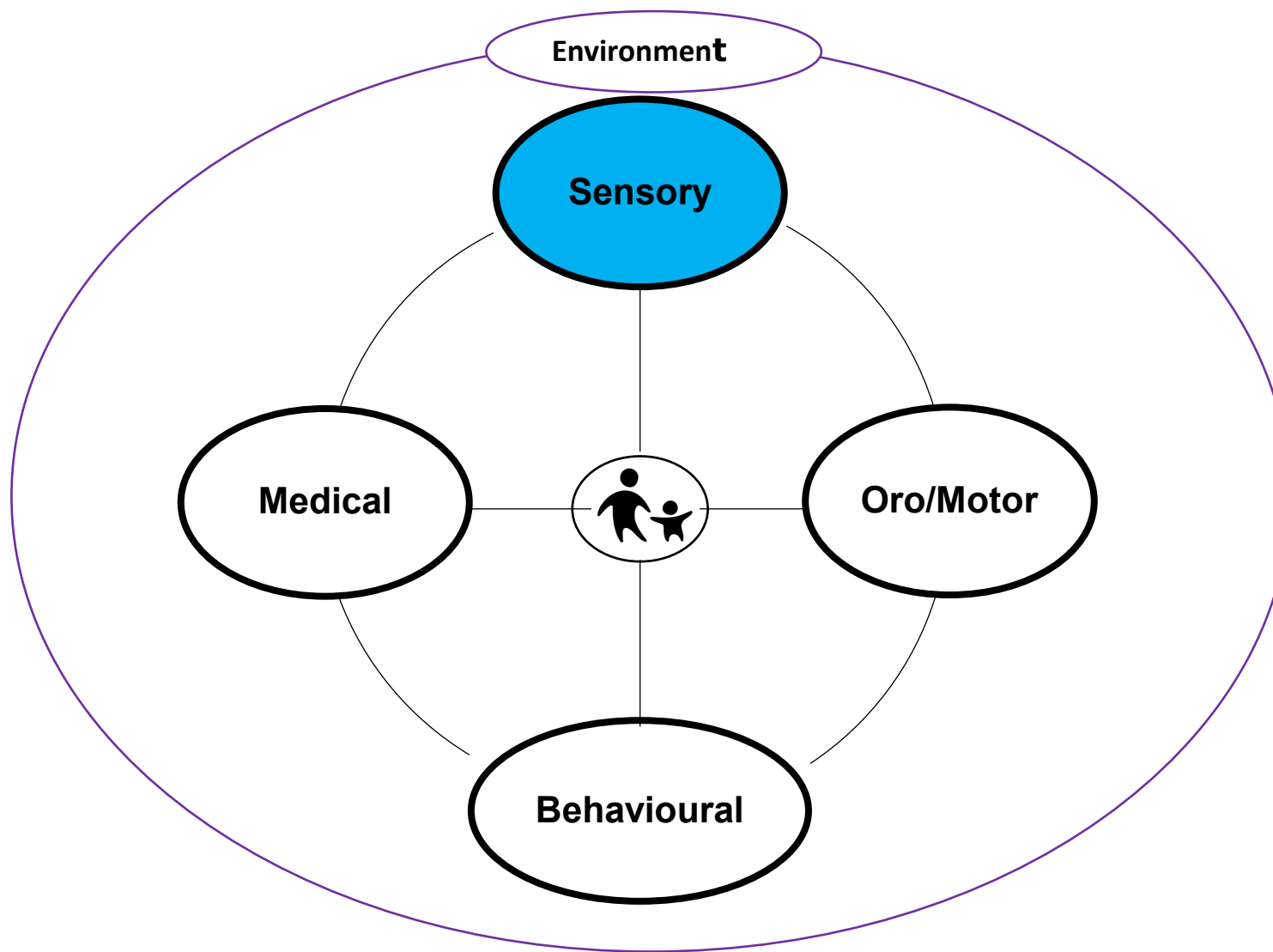
Behaviour



- Identify mealtime behaviours that may be contributing to a child's feeding performance such as:
 - Avoidance
 - Refusal
 - Tantrums
 - Self-injurious behaviours
- Complete a behaviour assessment to determine the function of the disruptive mealtime behaviours
- Is the child having behaviour challenges in other areas?

Remember, there are two behaviours to consider





Medico-oral-behavioural-sensory approach – MOBS^E approach ©

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Sensory



- Determine whether the child is experiencing sensory processing differences that may be impacting on their feeding performance such as:
- Sensitivity to taste, texture, smell, appearance, sound of foods,
- Difficulty staying seated for meals
- Challenges sensing hunger cues

Sensory



- We know that children with ASD can process sensory information differently as it is one of the diagnostic criteria for ASD in the DSM-V
- We also know that eating can be a very intense sensory experience that involves processing information from many different senses at one time
- Therefore, it would be easy to assume that most children with ASD have feeding issues as a result of sensory processing issues



Is the problem REALLY Sensory??

Many things can look like sensory issues, but they may not be:

- Spitting food out
- Gagging
- Pocketing or holding food in mouth
- Only eating a few bites
- Difficulty staying seated while eating



Ensure the issue is not a medical, oral motor or behavioural problem that just looks like a sensory issue

What if it is a sensory issue?

- There is no strong evidence to support that we can change how our brain processes sensory information related to feeding (i.e. you can't make someone like a taste or smell)
- Despite the existence of “sensory feeding” treatments such as the Sequential Oral Sensory (SOS) approach (Toomey, K & Ross, E., 2011) there is no strong evidence to suggest that sensory interventions alone are effective for treating all children with feeding challenges.
- There IS evidence to suggest that we can use behavioural and anxiety-reduction strategies to help kids learn to TRY new foods and to modify their reactions to unpleasant sensory input.

Interoception: A Hidden Sensory System



Interoception: A Hidden Sensory System

- Interoception is the awareness of our internal body states (Mahler, 2015)
- Interoception allows us the ability to “feel” the insides of our body including important sensations such as pain, body temperature, heart rate, **hunger, thirst**, sleepiness, need to use bathroom, and more (Craig 2002, 2003)
- The area of the brain that receives most of the information regarding interoception is the insular cortex (insula)

Several studies have demonstrated significant differences between the insula in autistic individuals and those without ASD (Garfinkel et al. 2016, DuBois et al. 2016)

Autistic adults report not feeling hungry, not attributing biological signs of hunger to needing to eat.

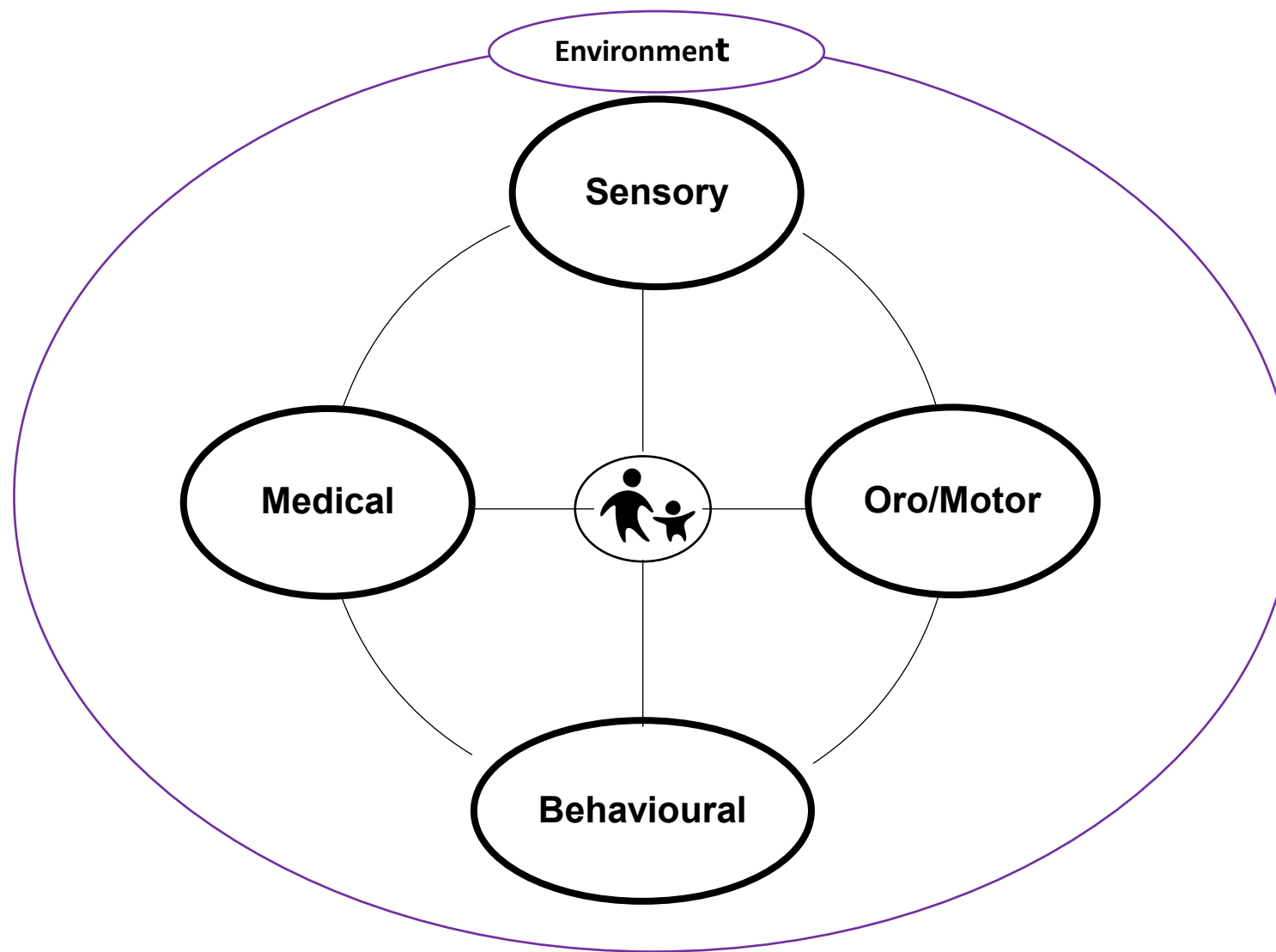
We can encourage kids to be hungry to encourage eating but can't rely on hunger as the sole treatment strategy

Myth Buster

Just stop giving him his preferred foods. When he gets hungry enough, he'll eat what you want him to. Kids won't starve themselves.



- Some kids with ASD may not feel hunger or may not connect the feeling of hunger with eating (differences with interoception)
- Some kids with ASD have extremely rigid behaviours that lead them to seek out familiar and fear anything new or even slightly different
- These children can restrict their intake to the point of becoming malnourished



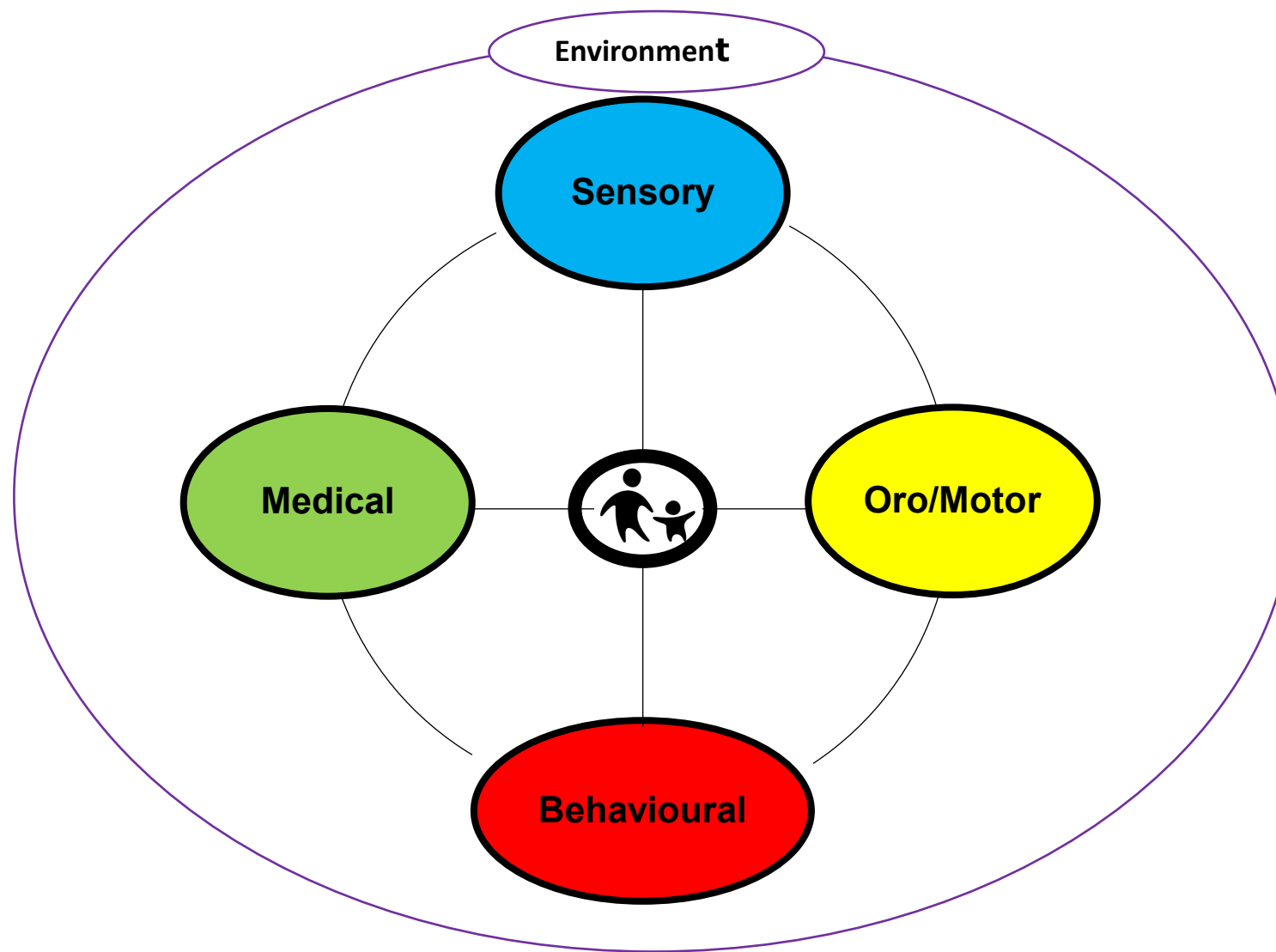
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Environment



- Assess environmental factors that may be contributing to a child's feeding performance such as:
 - Mealtime schedule /grazing
 - Distractions (tablet, TV, toys)
 - Positioning
 - Different feeders
 - Different locations



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Parent-Child Relationship

- Consider parental stress
- Consider parenting style with regards to feeding:



Parent-Child Relationship

- Be mindful of only gathering information from “parent report” (Vissocker et al. 2015)
- Important to gather information from parents/caregivers, preferably from multiple settings
- Also from child themselves if possible (Bitsika & Sharpley 2018)
- Observation is important to see the whole picture (Cermak et al. 2010)

Lots of children are picky eaters when they're young, he'll grow out of it

We'll recommend a nutritional supplement and vitamins and that will help

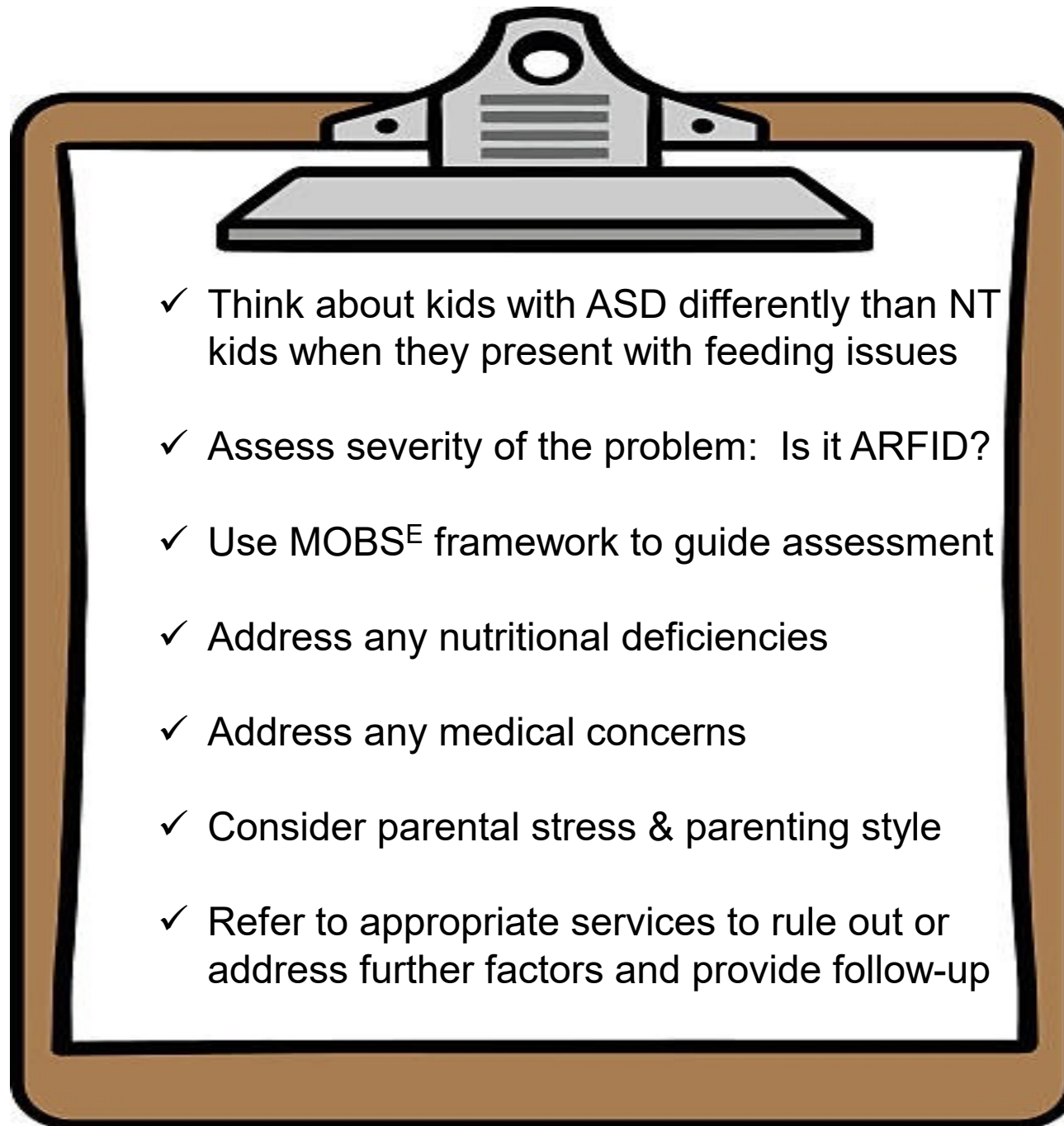
He won't eat solid foods. I'll refer him to an SLP to assess his swallowing and to help him learn how to swallow solid foods

A child's preference for "junk" food is usually due to poor parenting

Kids won't starve themselves. Just stop giving him his preferred foods. When he gets hungry enough, he'll eat what you want

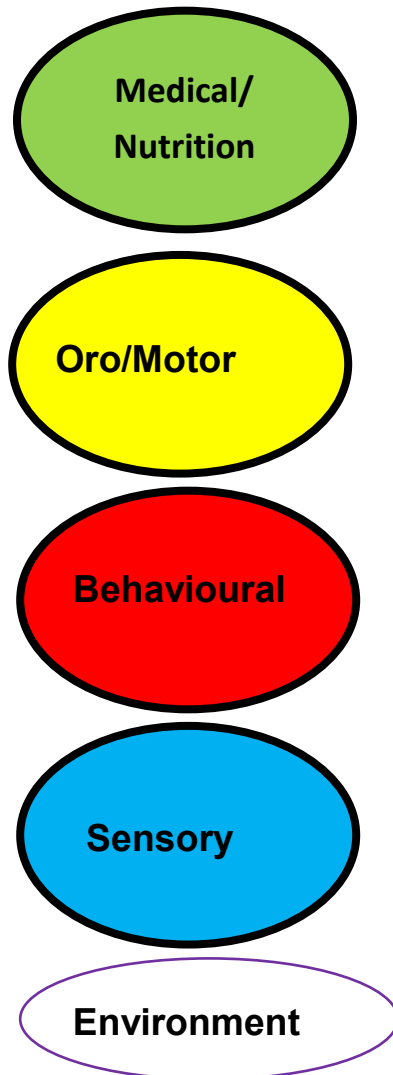
I've looked at his growth chart and his weight and height are fine, so no need to worry

That gagging and spitting out foods sounds like a sensory feeding problem, I'll refer to an OT to help with that



- ✓ Think about kids with ASD differently than NT kids when they present with feeding issues
- ✓ Assess severity of the problem: Is it ARFID?
- ✓ Use MOBS^E framework to guide assessment
- ✓ Address any nutritional deficiencies
- ✓ Address any medical concerns
- ✓ Consider parental stress & parenting style
- ✓ Refer to appropriate services to rule out or address further factors and provide follow-up

Medico-oral-behavioural-sensory approach – MOBS^e approach ©



- Contribution of medical issues?
- Assess nutritional status, should parents be concerned?

- Assess oral motor skills

- Analyze functional behaviours and caregiver
- Reason for refusal, which contexts?

- Assess sensory processing
- identify sensory sensitivities
- Interoception?

- Contribution?

! Evaluate Parent- Child relationship/ Parental Anxiety !

Glenrose Ax Format



Reason for referral



Parent/Caregiver Concerns & Goals



History



Oral-motor Assessment



Meal Observation/Food Play



How do we take the assessment info and decide on treatment goals?

Case Study
Emil



2 years 11 months



Referred for selective eating and limited food repertoire



Picky eating, nutrition concerns



Low dietary iron



Noted to have tongue tie



Not tolerating non-preferred foods on his plate

Recommendations:

- Tongue tie release
- Food Play for exposure
- Expanding Pediasure
- Iron supplement

3 years 10 months



Requested by parent



Re-ax oral-motor skills & nutrition, Strategies for expanding diet



Working with community teams, good strategy use at home



Improved tongue movement



Tolerating non-preferred on his plate, will touch dry non-preferred

Recommendations:

- Sensory exploration of non-preferred
- Introduce a reward system

4 years 10 months

VFSS



Parent Request



Nutrition concerns, OT requesting consult



OT working on food exposure, new GI concerns



Reduced tongue control, immature chewing pattern, drooling, low tone, dysarthric speech



Could tolerate some pudding on hands/arms but still hesitant

Recommendations:

- Referral to GI
- Refer for motor-speech Tx
- Work on OM control
- Continue diet expansion strategies

What Else???

Developmental
Pediatrician

Neurology

Peds
GI

Genetics

6 years old



Parent Request



Dropping foods



Taking some bites of new foods



? Mouth pain, difficulty with open cup



Exploring squishy texture with hands

Recommendations:

- Focus on spoonable foods
- Focus on goal foods, rather than general food play
- Refer to SROP for Feeding Treatment

Case Study Take-Aways

- Dynamic Process
- It's okay to back up and try something else
- Ask ***What Else?***





Questions & Comments?

The image shows a screenshot of a Zoom Webinar Chat window. The window title is "Zoom Webinar Chat". Inside the chat window, there is a dropdown menu for "To:" set to "All panelists and attendees" and a note that says "Your text can be seen by panelists and other attendees". Below the chat window, there is a toolbar with three icons: "Chat", "Raise Hand", and "Q&A".

For Comments
Use the **Chat** and select "All panelists and attendees" for public comments.

For Questions
Use the **Q&A** or **Raise Hand**. We will address them at the end of the presentation

Audio Settings ^

Chat Raise Hand Q&A

Eating, Feeding & Swallowing for children on the Autism Spectrum: Getting the info and figuring out what to do with it

Part 2: Treatment

Nov 2, 2022 | 10:30-11:30AM + Percolator 11:30-12PM

Joint Presentation by:
Glenrose, and Holland-Bloorview Rehabilitation Hospitals



Holland Bloorview
Kids Rehabilitation Hospital

The logo for Holland Bloorview Kids Rehabilitation Hospital, with "Holland Bloorview" in a bold green font and "Kids Rehabilitation Hospital" in a blue font below it.



Contact Us

PEAS.Project@ahs.ca

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QUICK LINKS

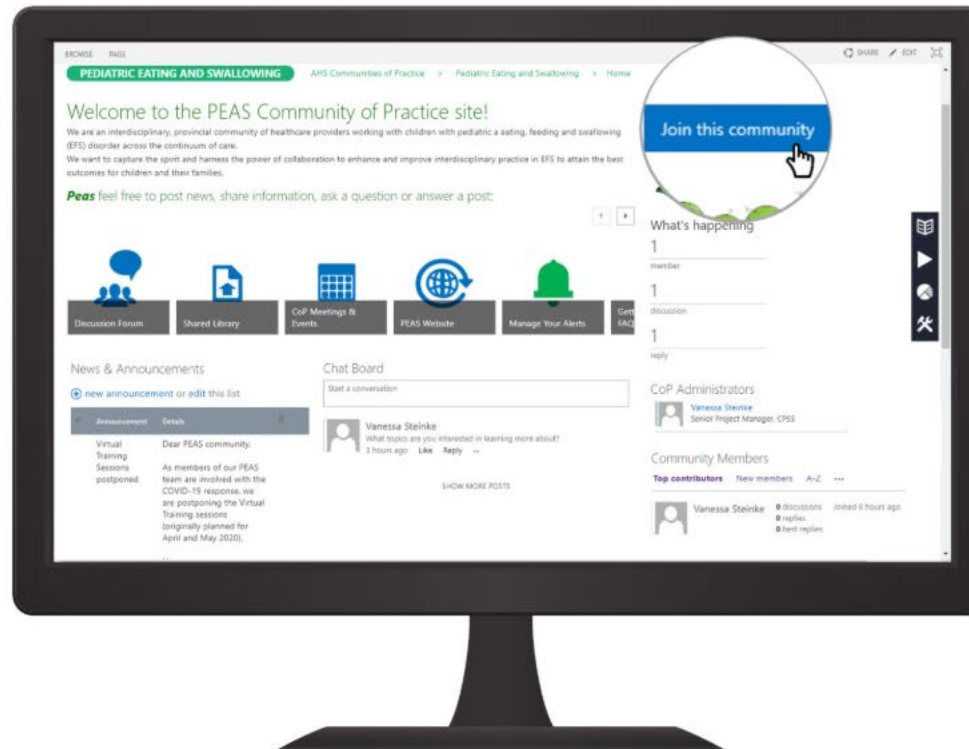
[✓ CPG QUICK REFERENCE](#)[✓ ORDER FORMS & HANDOUTS](#)[✓ FIND SERVICES](#)[✓ VIRTUAL HEALTH](#)[✓ EQUIPMENT & SUPPLIES](#)[✓ FUNDING INFORMATION](#)[✓ FOR FAMILIES](#)[✓ NEWS AND EVENTS](#)

Community of Practice

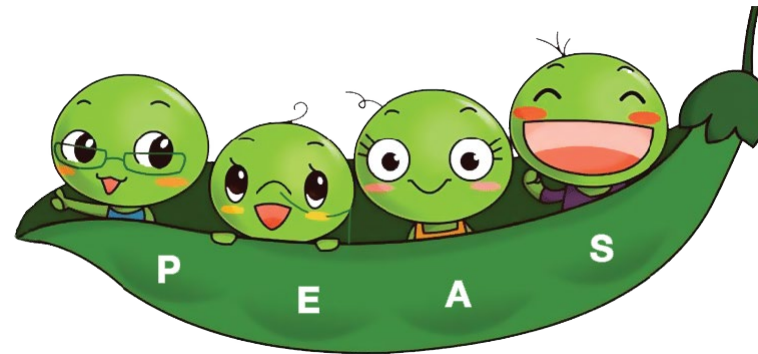
We have just launched the Pediatric Eating And Swallowing Community of Practice (CoP) for healthcare providers who work with children with a pediatric eating, feeding and swallowing (EFS) disorder. This virtual CoP is an interdisciplinary community of healthcare providers across the continuum of care in Alberta. The goal of this CoP is to capture the spirit and harness the power of collaboration to enhance and improve interdisciplinary practice in EFS to attain the best outcomes for children and their families.

To join the PEAS Community of Practice:

1. You must be a healthcare provider with an AHS account.
*See below for information on how to obtain an AHS account.
2. Go to the PEAS CoP website here: <https://extranet.ahsnet.ca/teams/CoP/PEAS/SitePages/Home.aspx>
If prompted, enter your AHS account name and password.
3. Click "Join this community" as shown below. That's it!



Thank you!



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<https://survey.ahs.ca/peas.autism1>

30 Min Percolator (optional)

Eating, Feeding & Swallowing for children on the Autism Spectrum: Getting the info and figuring out what to do with it

Part 1: Assessment

Christie Raffaele, MSc(OT), OT Reg. (Ont.)

Courtenay Mayowski, MSc, R.SLP (C)

Rebecca Perlin, M.Cl.Sc. SLP(C) reg. CASLPO

Dr. Sharon Smile, MBBS, DM, MSc



Pediatric Eating
And Swallowing

Holland Bloorview

Kids Rehabilitation Hospital

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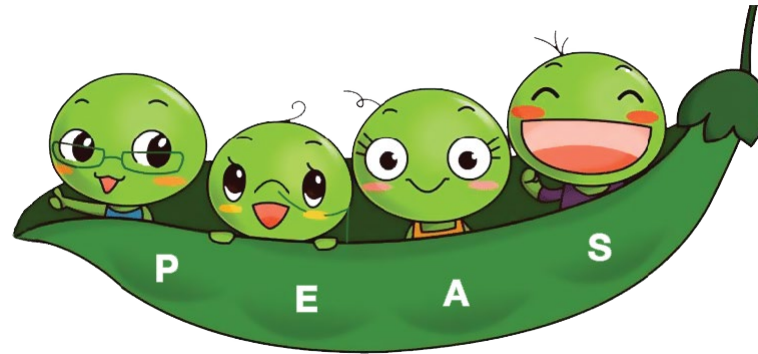
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Thank you!



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