Telemedicine Pearls and Perspectives from a Pediatric Feeding Team and Parent

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Covid-19 has undoubtedly impacted all aspects of practice for health care professionals. The UNC Pediatric Feeding Team has not been immune to the growing pains of telemedicine. Sharing both frustrations and funny anecdotes about our experiences with telemedicine has replaced previous discussions pertaining to live visits. Patients connecting while shopping, driving their cars, or even without their child present are just some of the scenarios we have had to navigate. Also challenging have been those frustrating moments during evaluation when the speech therapist is intently watching a toddler chew and swallow, looking for any signs of coughing/choking or other subtle swallowing concerns, only to be suddenly cut off due to glitches in cyberspace.

However, many unexpected positive aspects of patient care have also evolved from the use of telemedicine. While working through the "bumps", more optimistic questions began to arise. Might telemedicine provide unexpected benefits for our special population of patients? Might patients and parents alike prefer to engage in feeding therapy from the comfort of their home feeding chair? Could we see a better overall picture of a child's availability to food and assess nutrition effectively at home? The goal of this article is to offer some practical "pearls" regarding our experiences along with the experience of one parent on the receiving end of telemedicine.

A Medically Complex Patient's Journey from Diagnosis to Telemedicine

Four-year-old Beckett first came to our clinic at 17 months old. He first presented to our team with multiple food allergies, vomiting, gagging, and coughing with eating and drinking and significant refusal behaviors such as swatting and head turning when anything was introduced into his mouth. He was still breastfeeding at that time and refused to suck a bottle. His diet consisted of a limited amount of carbohydrates, fruits, vegetables and some proteins, fortified cereal with coconut oil added into each puree due to failure to gain adequate weight. He was constipated and had symptoms of reflux. We started medical treatment for both and as he showed some improvement, we implemented feeding therapy.

He slowly progressed with oral intake but not to the point that nutrition and growth were optimal. After further work up, he was diagnosed with Eosinophilic Esophagitis (EoE) by upper endoscopy and was subsequently treated with swallowed steroid slurries. His symptoms significantly improved and we again initiated feeding therapy.

Feeding therapy with the SLP continued on an outpatient basis every two to four weeks, while our feeding team met with him every two to five months for nutritional monitoring and medication management. He showed slow and steady progress with a hybrid sensory-behavioral feeding therapy-based technique prior to the COVID-19 Pandemic in March of 2020.

COVID-19 brought about a rapid transition to telemedicine which required transitioning Beckett's therapy techniques. Beckett was a particularly sensitive patient with known underlying sensory aversions and preferences. Because of this, the SLP needed to "re-group" and adapt his therapy to what she felt would be most achievable through the platform of telemedicine. In his case, she chose an exposure, sensory based approach, facilitated through parent coaching. As this had not been previously trialed with Beckett, the therapist was uncertain about efficacy and outcomes of the sessions. As evidenced by his progress with food variety and acceptance, the strategies were successful. An interview with Beckett's mother describing the teletherapy experience is outlined in table one.

Interdisciplinary Feeding Team Transition from In-Person Team to Telemedicine Visits. The Interdisciplinary Feeding Team is comprised of Pediatric Nurse Practitioners, Speech and Language Pathologists (SLPs) and Registered Dietitians. All three providers see each patient at every visit using an interdisciplinary team approach. While the UNC Feeding Team was well versed in treating a multitude of underlying gastrointestinal disorders, we did not know that those same conditions would be later identified as more amenable to the telemedicine platform (Berg, 2020). As we have been able to offer our patients appointments with all three disciplines simultaneously via telemedicine, we have successfully treated constipation, GERD, feeding difficulties and poor growth via telemedicine with the benefit of live in-person visits if needed for "red flags" such as ongoing GI discomfort, weight loss or negligible progress with oral feeding issues.

As there has been no prior precedent for the sudden spike of telemedicine visits conducted, the team developed strategies through "trial and error" that ensured the visit was efficient for the team to obtain needed information and the family to receive the best possible care. We found having one individual oversee the time and technical issues was most efficient. Beginning with the feeding therapy portion of the feeding team visit was most beneficial in capturing our pediatric population's best attention span. We utilized schedulers to call our team patients ahead of the visits to ask that the patient be placed in the feeding chair with food in place, ideally ready to eat at the beginning of the encounter. Our SLP then conducted a feeding therapy session while the child was most engaged with the visit.

Following the therapy portion of our team visit, we next conducted the physical examination with parent assistance. Though skeptical at first, we soon realized the value of the video screen and were able to assess overall appearance, mental status, activity level, body habitus, oropharynx, cyanosis, respiratory effort, abdominal girth or distention, muscle wasting, extremity swelling or clubbing, skin rash or pallor, visible neurologic deficits, emotional affect, and presence of medical devices including gastrostomy tubes and nasogastric tubes (Berg, 2020). We then asked medication and nutritional questions, very much enhanced by the ability to see medications, vitamins and formula bottles and containers, and made necessary adjustments to the plan of care together.

We did utilize a virtual "pause" at times on the more complex cases and would ask the parents to allow us a moment to discuss our plan while on mute. Parents were very receptive and welcomed our team back after a brief consultation where we would then present our plan and allow time for questions within the 60-minute allotted time frame for the visit. (Table 2)

Wrap Up

Although telemedicine and teletherapy were certainly not on our immediate radar to provide healthcare, the Covid-19 pandemic launched us out of our comfort zone and as the saying goes, we had to “sink or swim”. The needs of our pediatric feeding team population appeared to be magnified as many other support systems (school, home therapies, daycares) were temporarily suspended during the beginning of the pandemic. As hospital clinicians, taking a pause to regroup was not an option.

As a result, we have grown immensely as a team. We have identified most pertinent information to obtain during modified video visits and can now identify which types of patients have the most potential to succeed in the telemedicine platform. We have been able to provide continuity of care, preventing potential malnutrition, GI discomfort and feeding issues in our pediatric population. We have also become more resilient, patient and creative. We hope our experience and pearls of wisdom can help you when working with your pediatric telemedicine patients as individuals and as a part of a team.

Parent Perspective of the Pros and Cons of Telemedicine/Teletherapy

Please share your experience with telemedicine during the COVID-19 pandemic.
Telemedicine has been extremely helpful during the COVID19 pandemic. We have been able to stay connected to our health team, while remaining safe at home.
Do you think feeding team visits are more or less effective over telemedicine?
The only thing that makes them less effective than in-person visits is not being able to get his weight and height. We have had interim in-person visits or check ins with his pediatrician.
Do you think virtual feeding therapy is as effective as in person therapy?
Yes. He has really enjoyed the virtual therapy. I think he is more comfortable at home. He also isn't as tired during therapy from the drive/walk to the hospital. We also continue to work after we finish the video visit.
Does Benny seem to prefer teletherapy or live visits for therapy?
He likes both! He seems to enjoy the teletherapy. He gets excited to set up his work space and gather his supplies. He does ask when we can go see his feeding therapist in person. So, I think he would benefit from having a once a month or once every other month in person visit.
What are the biggest challenges with teletherapy? (cons)
Sometimes it is hard to hear or the video might be choppy. Just dealing with connection issues.
What are the biggest benefits to teletherapy? (pros)
Staying safe at home and not having the commute with two toddlers every other week.
What can you share about your experience that you believe would help other patients get the most out of their telemedicine experiences?
Prepare any supplies for therapy in advance. I set out a variety of fruits and vegetables on the counter so that I can grab what we need during therapy. Find a quiet place in the house to take the meeting/call. Have something to write down any changes to plan or goals we need to work on. Arrange that no one else in the house is streaming from a device or in a virtual meeting. We notice that this helps establish a better connection.

Table 1

Telemedicine/Teletherapy Lessons Learned from the UNC Interdisciplinary Feeding Team

	• Requires more structure and preparation by caregivers and clinicians. • Visit time limited by screen fatigue and attention span of young patients. • Alternative to in-person visits during pandemic/cold/flu season promotes patient safety and health. • Patients traveling from a distance are able to maintain normal daily activities (work, school) and keep appointments without lost wages or education time. • Interim "check in" appointments can be offered, improving overall continuity of care. • Identified leader beneficial for efficiency of appointment. • Although physical examination is limited, key components are able to be assessed and hold value. • Patients can provide medication bottles with concentration and dosages. • Insurance reimbursement comparable to in-person visit with proper documentation. • Access to food allows better discussion when looking at labels, ingredients and variety. • Provides opportunity to address food safety issues by viewing mixing and storage of infant formulas. • Use of home or PCP scale to monitor weights should be interpreted cautiously, but allows for adjustments during telemedicine visits. • Parents have access to foods they would like to practice with and are able to change food plan easily if needed. • Providing patients with the same materials that are used in therapy ahead of time is effective for mirroring activities. • Assessment of food insecurity. • Parents and children have added benefit of uninterrupted time together, having fun with food in their own environment.

Table 2

Reference:

Berg, EA, Picoraro JA et al. Covid 19- A Guide to Rapid Implementation of Telehealth Services: A Playbook for the Pediatric Gastroenterologist. *J Pediatr Gastroenterol Nutr.* 2020 Jun; 70(6): 734–740.