Welcome to conversations about care, a podcast for pediatric clinical providers.

For today’s episode of Conversations and Care, I’m lucky enough to speak with three colleagues about how obesity care is being adapted and delivered by Telehealth during these unprecedented times. It’s important to remember that these are stories from the field that focus on real time experiences and lessons learned as we transition and adopt the care we provide during this pandemic. These stories are not being shared as best practices, nor are they meant to be interpreted as direct medical advise. They merely reflect real time perspectives that can help in former approaches as we all grapple with how to best support our patients with obesity and adopt care delivery during COVID-19. Thank you for listening and I hope you enjoy these conversations.

Sandy: Hi everybody, this is Sandy Hassink and today we’re going to be speaking with Sarah Armstrong, a pediatrician in North Carolina about Sarah’s experiences with Telehealth. I want to welcome Sarah to our conversation and just ask you Sarah, can you tell us a little bit about your practice. What kind of practice you have, who you work with, and what the kids are like.

Sarah: Sure! Thank you Sandy for having me and for doing this series. It’s great to start this succession given transitions to new ways of delivering care for children and teenagers with obesity. So, the practice that I see patients at here at Duke University is a tertiary care pediatric weight management program. It’s very similar to many others around the country. We have a team of medical providers, a mix of MD’s, PA’s and NP’s. We have two registered dieticians, and three physical therapists. We also have a licensed professional counselor who is able to see patients to do one-on-one therapy sessions with the family or the child directly. So, typically our protocol, similar to other practices, is we do a comprehensive intake of children with obesity or with a BMI at or above the 95th percentile. We don’t have any requirement for comorbidity, although we often see them. We do a comprehensive screening and take and describe the program offerings and then try to see the patients back about once a month face-to-face, at least in the old days for motivational interviewing driven goal-setting sessions. We also in recent years as advanced treatment has become more available for children, we do counsel families about the options for medication or weight loss surgery, and we have an adolescent certified program through the MBSAQIP program here at Duke for adolescents 14 and older with severe obesity. So, we do offer those treatment options as well for families with children who qualify and who express interest, and that sort of thing.

Sandy: So Sarah, it’s been a challenging time to say the least for all of us and you have a very comprehensive program. I understand you’re implementing Telehealth for the first time. Just a couple thoughts, how did you start, who did you start it with (your whole team or just a part of your team?), how are people adjusting? Can you just say a few words about how that rolled out for you?

Sarah: Yes! Well I expect, like for many people, this was something we had considered doing for a long time and certainly would see the value for families and being able to do at least a portion of these visits from home where not only it eliminates the need for travel and much less of a time commitment, but also the opportunity to meet families truly where they are, which is what we always try to aspire to. But really, in their own home environment and be able to work through some challenges given the situation quite literally we could see. So, we’ve been contemplating it for many years. In North Carolina it hadn’t been approved as a reimbursable service, so with the onset of COVID, that policy changed rapidly. We first, in the early weeks were told that telephone visits were going to receive some minimal reimbursement and so really within a week we converted over all of our providers to doing 100 percent telephone visits for all follow up patients. We decided to defer new patients until we were back in clinic, but as this … for the parents, this was not going to be a one week out of clinic sort of situation and as the payers in North Carolina quickly amended their policies, now all payers, including Medicaid, will reimburse for video visit services at the same rate as in person services, which is remarkable. We have moved toward converting toward video visits. Now this has been a process, as you can imagine and I’m sure many people are experiencing. There are several logistical barriers. So, the providers all need to get trained and what we found is while the MD’s were high up on the list for the institution to train, the dieticians were lower down on the list. So, we couldn’t get everyone trained all at the same time. So, we were going to have to do this piece meal, which is a challenge if you have a patient that has a nine o’clock appointment with the medical provider and a 9:30am with the nutritionist, and they have to do one by video and one by phone. It just get’s complicated. So, that’s one hurdle that we’re close to over at this point. One of the other big hurdles is on the patient side because, at least in the Epic EHR that we use, patients have to be signed up for the patient-facing version called My Chart in order to access the video visit. That’s challenging. It requires all sorts of access that we know many of our or most of our at risk families just don’t have a laptop or phone and Internet that is reliable. Being able to have someone in the house that can read in English enough to sign them up for My Chart and read the instructions. They have to get on the phone with one of the information technology staff to walk them through the process of getting on the video visit. So, it’s no small task. That part, however, I have come to view as a real silver lining because patients who are able to access their own electronic health record are more informed and they are more able to drive their own care and ask informed questions. So, I view it as somewhat of a blessing that we had this situation that forced sort of attention to families to help them get access to their own health record. So, that’s been an ongoing process for getting families up and running. So, I would say most of the challenges at this point have been logistical, but when it’s worked, and we’ve now had … every week we have more and more of these that are working well. I would say overall families and kids really like the opportunity to connect. They are very grateful for not having to travel or expose themselves to a healthcare facility right now. They also have a lot of questions that are different right now on how do I keep my child active when we’re not really supposed to be around other people and we don’t have a big yard to play in? How do I keep my children emotionally and socially connected to their friends when they’re really not allowed to see them right now? People worried about food shortages, people who were facing food insecurity before hand and now it’s even more of a concern with their children not receiving school meals, and uncertainty on where to find food. So, these questions are really personal and private and being able to discuss them in the comfort of their own homes has really been an upside.

Sandy: And Sarah, it sounds like the tenor of the visit, by the nature of the fact that it is a video visit and not an in person visit, but also the tenor of the visit, the kind of things you’re discussing are different, how is it working with you seeing a child with a parent? Do other family members come along for the ride so to speak?

Sarah: That’s been another interesting facet of it. So, I know for many of us who have worked in weight management for a long time, often you get the situation where a mom brings a child and says, “If only I could get the dad to XYZ,” like stop bringing Pepsi into the house, or stop taking her to Bo jangles on the way to school. Well, in these situations we’ve sometimes seen that the before mentioned accused parent is often there as well. So, it really does open up this opportunity to express concerns about the child’s health in a way that allows everybody to express what their concerns are. So, I’ve heard perspectives from people that I don’t always hear their perspectives. That has been really interesting. Another situation that has come up that has surprised me and has been something else to cope with is when the child is not there. So, somewhat often I think parents are either confused or are just trying to make it work and they’re taking the video call from work on a break and they say how great this is that they can talk about their child’s health and they don’t have to be distracted by their child being there, or I’ve had a couple times where it’s been an early morning video call and the teenager is still soundly asleep. The parent would prefer not to go wake up their grumpy teenager at 8:00am. So, that has required a little bit of flexibility I think to best understand what are the regulations, but also understand what is ethical, what’s appropriate to be done directly with the parents if the child is not part of that conversation. So, that’s been another interesting twist.

Sandy: So, there are many things that are said that might not be said in an in person visit such as more family members, or more concerns immediately about the COVID situation. Do you think there’s anything that they are not saying to you that they might have said to you in an in person visit?

Sarah: That is a great question! You know, it’s always more difficult the more degrees, in my opinion, the more degrees in separation we have. The way I was trained was to look at all of the information you get from an encounter with a patient, which includes body language; it includes how they look at each other when they are talking about things. Some of that is really hard to capture by video and I will say I sometimes end visits and I think there was more to that story than I got. But, hopefully the new, they keep saying this, the new normal, whatever that’s going to mean could entail a combination of visits that can be done remotely, but not to fully replace the in person. I really do believe that that relationship and that in person bond is important for getting at those things that they are probably just not saying when you’re face to face with them.

Sandy: Sometimes we take the physical examinations for granted and I know I always examined every patient all the time and people would say, “Sandy, why are you doing that?” I said, “Well, you get a lot of information. The factual information about what the physical status is and you just get information when you interact with the patient around the physical exam.” Is there anything that you have missed or thought that we should pay extra attention to because we don’t have that physical exam right now at our disposal?

Sarah: Yes, it is a great question and it’s one that worries me a little bit. So, there’s actually a whole category of things that I sort of feel like are reasons to bring somebody in anyways, despite the risk. Fortunately, I think we can pick up clues of those things through the video visits, so it’s not like we are missing them entirely. But, I do think we need to pay attention and say, “You know what, this child, I really need to see them in clinic. So, let’s schedule a follow up appointment.” That basket of things includes some vital signs. So, if I have a patient who has a history of high blood pressure and perhaps they are on medication that could worsen that, or they’re on antihypertensive, but I was still tinkering with the dose. That might be somebody that I might say it’s time to come in and get that checked. Certainly, I’ve had a lot of patients, I don’t personally and I think this is probably for each person or each provider to decide their own comfort level, but I personally don’t ask patients to self-weigh at home and report that weight on a video visit. However, a number of them do anyways. So, sometimes, you get a little bit of information about how things are going based on that information that people give you, but if it does seem like things are really off track coming into recheck the body mass indexes is probably not unreasonable, especially if it hasn’t been done in some time. Labs that have probably been the most frequent reason I’ve had people come in for a follow up visit. So, in particular if I had somebody who had a borderline hemoglobin A1C and they’re reporting any kind of symptoms, concerning for polyuria, polydipsia, I just had one of these patients last week, a 10 year old who is over 300 pounds and was waking up at night to drink and go to the bathroom and had an A1C three months ago of 6.2. So, I said, “You know what, this is worth the risk! You’re coming in.” So, I think those are ones that we do have to pay special attention to and be willing to say there is no … we don’t have an algorithm, we don’t say this number of risk factors should come in and this doesn’t because it’s all clinical judgment, but I think we all have to be willing to do that. The last situation is if we’re monitoring them for advanced therapy, so if they’re on a medication for weight loss or they are on track for bariatric surgery, we are still bringing those kids in to have their vital signs measured because we don’t want them to have to come off the medicine or start over or be irresponsible about managing dosage estimates without data. So, those are the cases where we do bring them in and that’s where that physical exam piece could come in. If there’s something concerning on an exam that the family is not sure about, that might be another (and you can’t see it). Our physical exam on the video visit consists of acanthosis plus or minus, we also do have patients walk for us, just walk down the hallway and walk back because you can get a good assessment of gait as well as any [inaudible00:17:22] or [inaudible00:17:23]. So, that’s something you can ask about pain symptoms, but that’s kind of the extent of the physical exam for us at this point.

Sandy: Well Sarah, you’re brining up a really good point about the nature of obesity medicine because clearly we’re treating a chronic disease, but acute problems have raised [inaudible00:17:42] of chronic disease and I think it’s worth all of us spending a moment to recognize that we’re doing chronic disease follow up, but all the examples in that context acute problems, both related to obesity and actually may be unrelated to obesity can arise. So, I think it’s worth reflecting on that and being ready to act on the acute problems when we need to. Is there any specific, as we wrap up, advice you would give practitioners? You’ve given us so much really incredibly useful information. Any other advice or council you would give practitioners in this time of Telehealth visits or their patients with obesity?

Sarah: Thanks so much for saying that, Sandy. I feel more like we’re all learning together and it’s great to have so many people in this tight knit community of childhood obesity clinicians that we can all kind of share our experiences and learn together. I guess the one other thing that I would add is that I think being gentle with ourselves and with out patients as we all learn this new way of interacting together. For my very first video visit, I’ll just share that I had a patient who knew that it was my first time doing the video visit and they were so supportive of me. The patient kept saying, “You’re doing great Dr. Armstrong! You can make your way through this!” Just having the support for each other to recognize that this is new and that I might press the wrong button and we’re completely logged out and then I have to figure out how to get back in, and to be able to just laugh about that and not get too worried is really I think the way that we’ll learn okay and we’ll make it through this together.

Sandy: Sarah, it’s been such a pleasure and I know you’re outside in the beautiful North Carolina weather. We can hear the birds chirping and you’re modeling the way for all of us. Thank you so much for sharing your time and expertise with us as you continue on the Telehealth journey. So, thanks a lot Sarah!

Hello and welcome to our podcast today on delivering Telehealth visits to children with obesity and I have today with me Dr. Sarah Hampl from Kansas City, Missouri who provides care for children with obesity in an obesity treatment programs out of Children’s Mercy Hospital. Sarah’s been involved in obesity research, prevention, and treatment for many years and we look forward to her perspective on the use of Telehealth with our patients.

Sandy: Sarah, I know if you would like to start by introducing yourself and tell us a little about your patients and your weight management program.

Sarah H: Sure! So, as Sandy said I’ve been working in weight management for about 20 years now seeing kids with obesity and their families. I work with a great team of individuals, medical providers, dieticians, social workers, wonderful nurses, administrative assistants and evening group education coordinators who teach our group programs. So, our clinical program consists of weight management clinics as well as group programs for kids, families, and our clinics. We have kind of a main weight management general management program called Fit Kids Weight Management Clinic, and then we have a couple specialty clinics for kids in weight management one. It’s for kids with special healthcare needs and obesity lead by my colleague, Dr. Meredith Dryer-Gillett, and our other specialty clinic is lead by Dr. Brook Sweeney and she’s our medical director for weight management and she and colleagues operate our metabolic bariatric clinic which is for kids that are on the surgical track for bariatric surgery and recovering from bariatric surgery. Our group programs are for younger kids, again lead by Dr. Dryer-Gillett up to the age of nine and then we have a little longer program for kids between the ages of 10 and 18 called [inaudible00:22:11] Kids Evening Group. It has been a challenge during the pandemic. What we have found so far is that it’s actually working quite well, there is definitely a learning curve, but it’s working quite well to see our families in our clinics through Telehealth. I’m glad to talk with you more about that Sandy.

Sandy: So, Sarah, have you used Telehealth before the pandemic started?

Sarah: Yes, so we, Children’s Mercy has four different regional clinics. Two in Kansas and two in Missouri and we were accustomed to seeing kids in outlying areas who would come to our regional clinics. We would be at the main Children’s Mercy campus and see them by Telehealth and it would cut off several hours from their travel if they were to just go to one of our regional facilities. We have technology such that we are able to do not only the interview and the history, but also the physical exam with the help of nurses at those facilities who have equipment that enables us to do the physical exam. So, we were accustomed to doing initial visits as well as follow-up visits for both ourselves and our dieticians and social workers were doing that. So, that made it a little easier to transition into the Telehealth mode. How we are doing that is basically through a platform called Microsoft Teams, families are contacted, they give their permission, their consent for a virtual visit, and that’s documented. The families receive an email with instructions about how to prepare for the visit. Then on a mutually agreed up date and time then we contact the family.

Sandy: So Sarah, what are the main differences you’re seeing between your previous Telehealth visits and the visits you’re doing now with your families?

Sarah: That’s a good question! I think there are multiple differences, some can be viewed as kind of barriers or limitations, but others can be reframed into strengths. So, maybe starting out with the strengths I think we are all getting a unique incite into families living at home and being able to talk with them in their home environment. That’s a real privilege, so even when our families were going to our Telehealth facilities, again it was a medical facility and not a home. So, being able to see the patients in their homes you can kind of complement them on different things like I had a child yesterday show me these really great posters that she had been making with her mom. You get to see a little bit different aspect of their lives that’s life that is more real so I really appreciate that. I think too we are limited again by the fact that we can’t do a physical exam, but we are I think able in some ways to be a little bit more relaxed with families. We want to put them at ease right away and just acknowledge what a tough time this is for everyone. So, I think some of the main differences can be reframed as strengths. I think also, I know there have been sometimes some concerns among families about just life in general and routines. I think just as important as us trying to talk with families and set goals with them collaboratively, it’s probably just as important to ask them how they are feeling about adjusting to this time and just setting up family routines and are they able to do that with ease or is it really a challenge for them. That is where the AAP and other resources have come in so handy in just general life and parenting and stress management in this time because we’re finding a lot of families struggling with how to get their kids on a routine to do their school work, to have regular meals and snacks, and to have regular bedtimes. I think that’s been one thing that I’ve really been struck with is sleep hygiene and sleep habits are really off during this time.

Sandy: So Sarah, have your families had any difficulty connecting with you or do you feel that your no show rate is so to speak is any different from what it was when you were seeing them in clinics?

Sarah: I think our no show rate has decreased so I am really grateful for that. Most of the families that have been contacted, do you get a reminder within 48 hours of the time that I’m going to be calling them. So, we were doing that before, but it seems like our attendance rate in the virtual clinic is better than it was in the face-to-face clinic. I think in terms of other connectivity issues, we’re finding that most of our families do have cell phones and they are able to download the app that it requires to be able to visit with us face-to-face on a screen. There have really only been a handful of families that we had to do just a straight telephone visit rather than actually be able to see them either through their computer or their cell phone.

Sandy: That’s really reassuring that most families one way or another have access to you in the clinic. Can you tell me, have you done anything with your group visits through Telehealth?

Sarah: We have done some individual phone calls with families that were in our group programs at the time the pandemic required us to stop the in person visits. We have not yet been able to restart or start a virtual group where everybody would see each other and that’s on the screen unfortunately. We do have a colleague that is doing that as part of the federally funded research study. So, we’re learning from her as much as we can, but we haven’t been able to really continue our groups, which is very … we feel really bad about that and are very anxious to explore other opportunities to do that.

Sandy: Sarah, I know that in Telehealth the physical exam component is the most challenging one because we don’t have access, two our ability to do a physical exam. How are you coping with that and have you found anything that helps you assess the physical?

Sarah: So, one thing that we have started doing is sending out information to parents ahead of time with that electronic invitation to have them get the child’s height and weight at home. There’s a really nice guide that comes in English and Spanish on the CDC website that gives parents guidance and it even includes some visuals for parents about how to do their child’s height and also how to weight their child if they have a scale. So, those are things that we’re doing. In addition to that as far as other physical exam findings, we’re not trying to assess for acanthosis or anything, but definitely on those initial visits if a parent has a concern about a certain sign or symptom that the child is experiencing, we do go through our review of symptoms and we’re asking those questions and encouraging those parents to speak up if they’ve noticed anything.

Sandy: That’s great and I think that we’re all feeling the challenge of giving a complete exam in a visit as we possibly can, so thank you very much for those insights on how we can move forward doing just that.

 So, we’re all thinking about the challenges and opportunities as you think forward maybe past the epidemic, do you think that you will be increasing your Telehealth use and maybe even expanding it to groups as you understand the technology better?

Sarah: I do! I think it has been an eye opening experience and we’re learning as we go with it. I think that we are in agreement as a team that this really has increased convenience for families quite a bit. Also, our show rates are better which is very important, and again with learning from others just like you’re trying to spread the knowledge here today, Sandy, and also just learning from our colleagues around the country and through email and so forth, I think that’s been a really valuable experience. We learn how other people are doing it and other places, and can apply those emerging best practices to our clinic and group situation. I think now more than ever it’s really important to be patient and family centered and recognize that we and they are going to have to adapt to expectations from what we might do in a face-to-face clinic visit to just be more acknowledging of the tough time that this is and being able to support families in more of those general routine settings and scheduling types of ways than maybe we were accustom to in the past.

Sandy: Sarah, to sort of elaborate on that, have you found that during this time you’ve changed either your approach or the kinds of goals families want to be setting at this time? What has been your feeling about how your goal setting is going with the families?

Sarah: You know, we’re trying to remain as patient centered as possible. I think one thing that has changed is we tend to not push for very many goals. We didn’t really before really either, but maybe where we would have set two or three goals, we might set one goal not, and it may not be as directly related from the outside looking in to healthy eating or active living, but we know it’s something that directly relates whether it be helping them set a schedule or working on better sleep habits. So, we’re really trying to be patient and parent driven with it still, but I think we’re also not wanting to overwhelm them with this just like they may be feeling overwhelmed in other areas of their home life and their work life. We’re really kind of keeping it lighter so to speak. I think we’re also maybe even pushing, not pushing but encouraging technology more than perhaps we had before. First of all we’re definitely, especially this time of year, kids please go outside, please get the fresh air and that exposure to nature and how good it is for their emotional health as well as their physical health. Then again, we’re also realizing that some parents may not want their kids to be outside if they are not home if they are a parent that is still continuing to leave the home for work. So, to keep the kids active during the day, giving them some brain breaks in between assignments and so forth. We’re recommending some websites to look into and also getting the kids more involved in being able to do some healthy food preparation.

Sandy: Clearly you’re really patient and family focused. Have you had any feedback from your Clinic for your children with special healthcare needs about how that is going with their Telehealth visits?

Sarah: You know, I have not directly, and I should have asked my colleague before today’s call, I do think the one thing that I have heard from her doesn’t necessarily or isn’t necessary exclusive to kids with special healthcare needs, but just parents who we might recommend will pick up a jump rope for your child or something relatively inexpensive to help facilitate physical activity. Parents are really needing to make difficult choices. Yes, they would like to do that, but they also need food and so we’re really being careful about screening for food insecurity and being able to refer to area resources for that. All of our school districts are continuing to supply meals for breakfast and lunches for kids that qualify.

Sandy: You know, it’s so important as you have outlined so well how you need to be attuned to situations families are actually in and what the challenges are of our daily life as well as weight management during this time. What impact do you think this may have, if any, on the relationship that you have with your patients?

Sarah: I’m hopeful that it will, for families that we’re seeing for the first time via Telehealth, I hope that we are able to convey well enough how much we care about them and how much we are looking forward to being able to see them in person and continue to work with them and support them. So, maybe kind of an engagement tool in a way for those families that we’re seeing for the first time over the screen. And for families that we already know, I think it goes a little easier on our end. I think we feel a little bit more comfortable because we already have a rapport established with those families, and just encouraging them to hang in there, we are planning on seeing you again face to face, but we’re also realizing how much of a convenience factor this does add for families to be able to do these visits this way. So, we’re trying to kind of leave the door open for either modality when we conclude the call.

Sandy: Does your families, are families taking to this and preferring it or do you think that they’ll just say that when this is over we’d rather come in? What is sort of the mix of feelings you’re getting from your families about preferring one modality over the other, if they do?

Sarah: I think for our families that we’re seeing for the first time by Telehealth, I’ve heard from several of those families that they really are looking forward to meeting the rest of our team in person. For the families that we already know and have been working with longer term, I think that for the most part they’ve been pretty flexible with whatever can work. So, I think that they’ve shown some interest in continuing phone visits if possible, but I think everybody’s a little bit stir crazy these days and we welcome the chance, when possible, and actually see people face-to-face.

Sandy: Right! So, Sarah, this has been really a wonderful snap shot of how things are going with you and your patients. Is there anything you’d like to tell our audience about Telehealth visits or encourage them in any way before we wrap up here?

Sarah: I think that one thing I might mention is that we do have the opportunity to prepare families to some degree before our initial visit with them because we’re sending out this email invite. We can also give them the heads up that we may want to speak to the parent privately so that they’ll know in advance and give them some ideas about how that could be done. I’ve had parents be okay with us starting out with the parent and child and then at the point, or if there’s a point at which we really want to talk to the parent by themselves, they’ve gone out in their car if they have a small home or an apartment, and spoken with us there. That’s fine too, but I think the more that we can give them in terms of information to help them prepare for the visit, the better. I think the other thing that’s been really been helpful is encouraging families to sign up for our existing parent portal where we can share information back and forth with them, and be able to provide, again, as may resources as we can that we could send in an email with links so they would just have to click on it to be able to see it. So, I guess for my colleagues out there I’d say, “Please try it and also reach out and ask for help or ask for suggestions. If you have questions, I know there are some informal kind of networks that are already developed through Power and Compass, a section on obesity, and then the Coach Program. I think that there are some ways that you can get your question out there for others to respond to.” I think this is a great time for us to be sharing what we have found to be successful.

Sandy: So Sarah, I’d like to thank you very much for your time and your expertise and wish you and your team well as we’re all taking this journey together. We really appreciate you coming on for this podcast.

Sarah: Thanks for the opportunity!

So, welcome everybody to my conversation with Dr. Tori Rogers from Maine about Telehealth in general and how Telehealth is being used by the doctors in Maine to take care of the children with obesity that they follow.

Sandy: So, welcome Tori!

Tori: Hi Sandy! Thanks for having me here!

Sandy: I wanted to start, Tori, by just sort of talking a little about your work in Maine and about the practices that you work with in general to acquaint us with what’s going on up there.

Tori: Sure! So, in Maine we run a program called 5-2-1-0 Let’s Go where we work throughout our communities of Maine and in Carroll County, New Hampshire to make it easier for kids to eat healthy and move more. Like many people doing around the Country, we’ve been doing this for about 12 to 15 years. Really the last 10 we’re really focused on this multi setting environment where we work with doctors to make sure they’ve got consistent messaging and appropriate tools and resources to talk to patients about the prevention and management of treatment of obesity. We also work with schools, and school cafeterias, and early care in education sites to make sure that they have healthy foods there. We’re really excited about the really promising work that’s been happening in Maine. Environments are changing, policies are being written that are very strong and implemented, and behaviors are improving, and our obesity rates appear to be stabilizing. So, we’re very excited about that. We work with about 200 healthcare practices throughout the state of Maine, and as I said, I’m in Carroll County, Hampshire, and the practices are school based health centers, federal qualified health centers, family practices, pediatric practices. We actually work with about 40 to 45 practices that care for adults too. So, when we work with those practices we provide them with the 5-2-1-0 tools about having good conversations around healthy eating and active living. We also ask them to actually weigh and measure the patients starting at birth and going until two. You and I have had many conversations about if we could identify these kids early on, their weight for length, and their abnormal weight for length, we can make a quick intervention, we hope. I shouldn’t say it’s quick, but we can make an earlier intervention. So, we do that, we also, as we’re working in these sites, our healthcare sites focus on that now, we train our doctors to use motivational interviewing techniques to have respectful conversations with their patients and families, and we’ve been doing a lot of work on this and we’re really excited. We’ve done webinars on motivational interviewing and trainings. I go around to many practices and do trainings on this, but in our typical fashion, it’s like the typical encounter you have with your pediatrician and the patient, and the patient may be in the family. It’s in the room and you have these conversations about how things are going, if they’re on medications, how are the medications going, all within the exam room. So, when COVID-19 came, we all had to change how we were interacting personally, and professionally, we started thinking at how are we going to be able to have these 5-2-1-0 conversations. So, I’ll tell you a little bit of how we’re doing it around prevention, and then I’ll tell you about how our colleagues who are treating patients, how they are doing it. So, our 5-2-1-0, as we all know, that well visits are on hold except for kids. In Maine it’s at birth to about six months was still doing the well visits. They are doing well visits in person, so it’s zero to six, and then we’re doing well visits six months on Telehealth, and 5-2-1-0 comes in there. So, what we’re finding is that we’re able to have those conversations, sometimes the NA will get on first and do the rooming in with the Zoom or whatever technology you’re going to use and do screening questionnaires. So, they’re doing the screening questionnaires right there. So, we’re able to still have those preventative conversations around obesity. So, before I go into the specifics of how we work with patients with obesity, Sandy, do you have any questions about anything I just said?

Sandy: So Tori, are you seeing any variability in how the different kinds of practices are implementing Telehealth or see any in general specific or general challenges in their implementation just of this technology?

Tori: Of the technology, absolutely! So, What we’re seeing is that some practices were ahead of the game on this. We’ve got a practice, Val O’Hara up in Northern Maine, she’s been doing Telehealth from her practice to other practices because Maine is a very rural state. So, patients, instead of driving three hours to see Val for a visit, the patient would go into their primary care practice and Val would Telehealth from her office to the primary care practice office and the patient was there. So Val has been doing Telehealth for a while so people like Val, this was a no brainer. Instead of doing it from her office to another office, she was just doing it from her office to home. So, a couple things I will tell you about what people are saying is that a lot of people are using Zoom, a lot of people are using different formats, a lot of people are doing the whole visit at the same time where the patient will get roomed in by a MA. Sometimes [inaudible00:46:36] a couple days before hand. So, I think it really depends on the technology you’re using and it also depends on the provider’s ease of the technology. We started doing this pretty rapidly about four or five weeks ago and now people are going, “Oh, what we did four weeks ago isn’t working as well as what we do now.” A couple things I’ll say about it is that a couple people have said to me that, “You know when you have your doctors appointments, you know it’s a Tuesday at 10:00am. So, it’s on your calendar, it’s Tuesday at 10:00am and that’s all great. But when you’re working from home or you’re studying from home and you’re doing laundry, and then you’re jumping on a call, the Tuesday at 10:00am doctors appointment can get lost.” So, sometimes the docs have had to call up and say, “Hey, are you ready to get on the Zoom call?” The patient is like, “Oh my gosh, I’m so sorry, I forgot. Yes, I’ll get right on it.” So, there’s been more of those. That said, there’s been less of the no shows! So, it’s really interesting. We’re also finding that about 50 percent of the patients, these are from the patients who are being seen for obesity care, 50 percent of them love this technology and it’s the adolescents are eating it up, they know it, they’ve been doing this for awhile. Fifty percent of them say, “I want to do this after COVID.” Then 50 percent say, “I’m happy to do this now, but I think I’d rather see you in person.” So, from a technology point of view, I think it happens lots of different ways for lots of different reasons. I will say people are talking about post-COVID; absolutely this will be part of your repertoire or part of your menu of how you see patients. We used to have nurses do phone follow up; my guess is we will be doing some Zoom follow-ups. We’ll be doing … this is part of how we do things. So, that’s a little of the technology. One thing I want to say about the technology that I find fascinating, I had a bum elbow and I had to do a follow-up visit with my orthopedic surgeon, my sports medicine guy, and I was excited mostly because I wanted to see how the technology would work for me as a patient, and he used something very similar to Zoom. What was fascinating to me was normally when you’re in the doctor’s offices you’re not absolutely looking straight ahead at the doctor, right? He or she might be at the side or maybe they’re typing or maybe they’re looking away, or you might be looking away. When you’re doing Telehealth, you’re seeing the patient, or the provider right in front of you. What I felt was an incredible encounter because I was like, “He’s listening to me because he’s looking at me.” We actually talked about it because I know him. I was like, “Listen, this is absolutely incredible.” I thought this was a great experience. It was quick, he was looking at me and I’ve had other people say the same thing. They feel a different connection because we’re looking at the computer and you see that person straight on. So, when you think about the technology and the format that also can be difficult. Obviously when you’re having some difficult conversations you may want to look down or to the side and that’s still okay, but when you really want to try and get the attention of your provider or your patient, you have this opportunity that you may not have had in the exam room in the same way. So, from a technology point of view, that’s sort of what we’re finding.

Sandy: I think it’s fascinating because I think the opportunity to have that connection and to foster that connection is still there with the technology because I think people sometimes thing, “Well, we’re using technology so how can I have a warm connection? How can I foster my relationship?” I think they’re pointing out that the opportunity is there to foster this relationship with your doctor or your provider. Do you want to talk a little bit now and we can circle back on the technology, but talk a little bit now about the folks doing obesity treatment and how this is working out for them.

Tori: Yes, absolutely! So, when this first came out, my colleague Carrie Gordon, who is an extraordinary clinician, she’s a nephrologist who is now just doing solely obesity medicine, she was on it right when we were told to go home and cancel patients. She was like, “I’m not cancelling, I’m just going to call them.” We were like, “Just Zoom them.” She was like, “This is great!” So, she was ahead of the game and a couple things that we’re finding that are surreal wins. In a rural state like Maine, this is a huge win. There are so many patients that are like, “Oh wow! I can jump on this and it’s not going to be four hours out of my time. Two hours at the doctors office, maybe an hour there and then two hours back to our home.” So, that would have been five hours. That happens a lot in our state. There are people who definitely travel more than an hour or two to see the doctor for 30 minutes. So, that’s the first thing she realized was that all these people who were no shows, now they’re very willing to jump on a Zoom call. People are really excited! They’re in your home so you can sort of see their home, so people are excited about that. They’re more relaxed, Carrie is finding and I can understand that! They’re in … you know when you go into a doctor’s office and sometimes it’s associated with a hospital, it’s got a sterile feel to it, right? So, often times when the doctors are doing the Telehealth, they may be doing it from their home right now or they may be doing it from one exam room. It just has this different feel to it. There are a couple things that have been real wins, as Carrie said. There’s a couple times where people have said, “Oh man, I wanted to bring you my prescription bottle because there’s something written on it.” Well, now Carrie can say, “Well, go get it! Let’s just take a look at it.” One patient said, “My dad’s on this medication for weight loss and I was interested in it.” Carrie was like, “So, go get your dad’s medication!” Carrie has been able to see some … as she’s talking to the parent’s sometimes in the background, the kids who may be on the spectrum, the autism spectrum, or jumping around in the background, and she’s like that’s great because they probably couldn’t be doing that in the exam room. But, in the back of the living room as the mom is having this conversation, or dad; the kid is doing what he or she needs to be doing to stay focused. The other thing that she’s finding is the patients are incredibly grateful. Incredibly grateful for people reaching out at this time because we’re all sort of in need of connections. For folks who are dealing with chronic disease like obesity, that connection is even stronger. So, Carrie is finding that her patient’s are so grateful that Carrie is there and taking this time. A couple other things before I get into the challenges, mostly what she’s been doing right now is talking about mental health because probably of COVID, right? So, understanding that when you do these visits, as you would any visit, you have to sort of see what the patient brings in with them and craft the visit around that. She does use medications for a number of her patients so she is able to work on those kinds of things. She’s done new patients, she’s done sick patients, and she’s done follow-up. She thinks she can do it all. Her MA goes in a couple days before and does the check in and does all the screening and then Carrie goes in and does it. A couple challenges though is that for the less verbal kids, this is hard. So, kids who may be more introverted or shy, this can be hard because the doc is staring straight at you. It might be hard for some of the kids on the autistic spectrum, but the other thing that we’ve talked about is privacy. So, at the beginning of each Telehealth, Carrie has to say, I’m in a room, I’m all by myself, there’s nobody here, nobody can hear you, but in all honesty, we have to disclose that. On the other end, we’ve talked about it as sometimes the patient may be in a place that’s not very private. So, Carrie always says, “Do you want to have conversations about XY or Z, or I’d like to talk a little more about somethings that may be uncomfortable. Are you in a place that we can talk about that?” You can envision that many of our patients and families may not have many close places to go for private conversation. So, that’s definitely a challenge. She hasn’t seen it, but we acknowledge that it could potentially could be a challenge on that. What she’s also said is that sometimes then you need to say, “Hey, we’ll put that off until I can see you in person.” A couple things, as I think everybody knows, the insurance companies have agreed to reimburse for Telehealth for this period. I know the American Academy of Pediatrics is actively looking at this issue and we hope that continues. Right now Carrie is just billing for time. She sees a lot of our Medicaid kids, so that’s fine. Lastly, I was just going to say that she’s so excited about this. She thinks this is just going to be definitely part of how she does medicine. Lastly, I’ll say, we’re very excited. We’ve done this not just in our obesity work, but also in our children’s hospital, but often times we’re having primary care providers Zoom in with the patient and the specialist, and that’s an opportunity for everybody to learn. For the specialist to maybe learn a little bit more about the primary care provider and the relationship for the primary care provider to understand what the specialist is doing. I think that potentially you could see how the primary care provider could do some of these visits on his or her own. So, another really positive thing that I think will continue onward.

Sandy: Well Tori, that’s such a great summation of sort of the state of the art right now and how it’s evolving. A couple questions because I’m fascinated with the connection between the providers, say the primary and the specialist, and the live connection so to speak and how important and fruitful that could certainly be. You’re doing so much work in the community. Maybe not now in this epidemic, but do you see a potential for connection with the provider and the community, the school, early education or the community services, do you see opportunity there?

Tori: Yes, absolutely! We had already been doing a bit of that, which was great, so I’ve connected very much to Headstart, to WIC, and to our schools. We work with I think 65 percent of all of our public schools we’re affiliated with, so we’ve reached out and our colleagues across the states have reached out to the superintendents and said, “Hey, how can we help.” So, we think this is the beginning and with mostly, in all honesty around COVID and some issues around school closing, but to me I saw the opportunity of getting pediatricians more involved with school health. So, I think … and this idea that we can do more and more with this Telehealth piece. It’s easier, people are getting very comfortable with this format and it’s easier for us to say like, “Hey, let’s just jump on a call.” What I’m finding is that the more you can see somebody, the more you can be like, “Hey, that’s Jill! I know Jill now! We can make the connections and I think we can all sort of see … as we’ve always said it at Let’s go, “If the healthcare provider does his part, and the superintendent does her part, and the ECE and early care does her part, and out of school does his part, before we know it, we have surround sounded this child with messaging in environments that are healthy. I think going forward there are many, many lessons from COVID, but one of them is that we can all work together and find a space to do that in.

Sandy: It’s so important because this again, they present an opportunity to make those connections that I think all of us so deeply desire to make with the support systems in the community. A couple other thoughts that I had is that I wonder if the frequency of visits has changed or revisits has changed for people, maybe increased or decreased, and what about the length of these follow-up visits or new visits. Any feedback from your providers about that?

Tori: Oh yes, the frequency. People want to do more and more of it. They’re very interested and there is space in people’s calendars to do more of it. So, yes, the frequency, people want to do more of it. The length is usually about 30 minutes. Some of the new patients were 45 minutes, and as Carrie says, “It’s just like when you’re in the exam room with a patient and you’re feeling like it’s a really positive interaction for the patient and family, you just stay longer.” It kind of screws up a little bit of your next couple patients, but that’s what they are finding with Zoom. You do know that depending on the technology, you have to close that one encounter out and then start the next one. We do have many Zoom or Telehealth accounts that people can use, so I think the frequency is that people want to do more of it and the length can vary from a quick 15 minute one to up to 30 or 45 minutes. I would say more than 45 minutes is tough anyways. I think there’s a limit that you have to put on this. We are finding that right now providers are primarily doing this, but in our obesity clinic, we have social workers and dieticians who also potentially are going to be doing this. Lastly, this is sort of into Telehealth, but we’ve been doing some work with our medical students and residence around culinary medicine and teaching them how to cook. We’re going to continue to do that work and potentially also as we’re thinking about doing sort of cooking classes for our medical students and residents, thinking about how we bring in some of our patients and families into those cooking classes. Whether they’ll be the same cooking classes or separate, most likely separate right now, but using Telehealth to do things that you were going to do anyways. It will be a different experience, but we’ll find some things that are positive and some things that are challenging.

Sandy: So, you know I think it is so exciting in the midst of all the stress to have some excitement about the potential of this methodology. In my mind I was thinking, “Gee, the patients could get to the point where they’ll just call their doc and say hey could we have FaceTime?” I think that we’re going to see a lot of change that will benefit people that are working, people in rural states, people that just want more frequent visits and can’t have them because of the travel. So, Tori is there anything that you’ve learned from your providers that you’d like to offer to our audience as we wrap up? Any piece of advice or encouragement that you’d like to offer?

Tori: What I have learned from my providers is that they’re incredibly resilient and they were quick to jump on how do I make sure that I just take care of the pediatric patients and the immunizations and making sure that we don’t lose all of that really amazing preventative care that we give. They also realized that we definitely have vulnerable populations. People with obesity seem to be doing worse with COVID and so they’re realizing that we need to be going forward in our prevention measures around obesity work, and also working with our patients with obesity. So, they feel very strongly that … for pediatrics we’re not on the front lines of dealing with COVID-19 to the extent as our adult colleagues. That said, we should stay on the front lines of pediatric child health and this is a great way to do it. I also … so much in medicine people can get kind of disenfranchised and get a little jaded. This is really energized people! People have been really energized by it because I think their patients have been energized and so that’s exciting to see. Again, we’ve been doing this for four weeks and so I’m sure there is so much more to learn and we’ll adapt to it, but again, the resiliency of our providers and our provider teams to continue to do the hard work that they need to do is just great! So, thank you for the opportunity to share our main experience.

Sandy: Tori, thank you very much and we hope we can get opportunities to continue to share and learn about your journey in Telehealth and with obesity prevention and treatment. I want to thank you very much for sharing your time and expertise with us.

Tori: Anytime!

The views, information, resource, or opinions expressed during the Conversations About Care Podcast Series are solely those of the individuals and do not necessarily represent those of the American Academy of Pediatrics. The topics included in these podcasts do not indicate an exclusive course of treatment or services standard of medical care. Variations taken into account individual circumstances may be appropriate. The primary purpose of this podcast is to explore common themes related to quality pediatric care from the prospector of clinicians. This podcast series does not constitute medical or other professional advise or services. This podcast is available for private, non-commercial use only. Advertising, which is incorporated into, placed in association with, or targeted toward the content of this podcast without the expressed approval and knowledge of the American Academy of Pediatrics podcast developers is forbidden. You may not edit, modify, or redistribute this podcast.