

Diabetes and Telehealth

Iowa Diabetes Summit
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Telehealth Use to Support Patients with Diabetes

- Used for many years...various methods
- Not one "solution" or technology
 - Interactive video technology
 - remote patient monitoring tools/devices
 - virtual/e-visits
 - phone



Why/Which Telehealth?

Starting with the wrong questions...

TELEHEALTH



What is the care issue you need to address?

Identify your patients' or organization's needs and goals:

- Immediate (COVID-related? Seasonal?)
 - Reduce exposure
 - Maintain regular visits
- Longer-Term (from which perspective?)
 - Reduce re-hospitalization
 - Reduce overall cost of care
 - Improve resource (staff) use
- Improve upon care integration (PCP/Specialist)
 - On-going care management

How will you know that you were successful?

Various Modalities Used to Support Patients

- Video (traditional)
 - Patient Education Sessions - Registered Dietician
 - Group Sessions
 - Individual Counseling
 - Specialty Visits - Endocrinologist
- Remote Patient Monitoring
 - Data collection
 - Coaching/guidance
- Virtual Visits/eVisits (Phone)
 - As questions arise

Various Modalities Used to Support Providers

- Project ECHO
 - a tele-mentoring, educational opportunity
- Remote Patient Monitoring
 - Data collection / documentation
 - Enhances understanding of their patients' disease and challenges
- Virtual Visits/eVisits/Phone
 - increased communication opportunities

Example: Nebraska Medicine



A few more details about this program...

- Started off as a 3-year grant-supported project (2015)
- Patients with Type 2 Diabetes, following a hospitalization
- 955 participants, 3-month intervention
- Became integrated into their Patient-Centered Medical Home model
- Majority, younger than 65 (mean age=60, range=19-81)
- Involved daily uploading of HbA1c, weight, BP, plus weekly (minimum) phone calls from their assigned nurse coach
 - Additional calls made for urgent alerts resulting from the uploaded data
- Their Primary Care Providers not too engaged in the project, initially
 - Shifted as they saw results and impact to patients' overall health

Project Findings/Results:

- HbA1c -- Of the patients who had an HbA1c >9 at the the start of the program, 67% were ≤9 at the completion of the intervention
- Patient Activation -- Increased during the intervention
- Supports the "just in time" care approach -- meeting immediate clinical needs, prior to further deterioration of health

(See Reference Slide)

Highlights:

- NOTE: This was primarily a nurse-led program/intervention. Coaches created supportive relationships with their patients; they were "there" for these patients.
- Supports in-the-moment education opportunities and an improved understanding of the impact of daily choices on their diabetes. (Example)
- Took some of the pressure off the clinic staff; often these patients were needing frequent support and guidance

OMADA Study - also conducted out of UNMC

- Company-sponsored; randomized controlled trial
- Digital diabetes prevention program
- Patients with HbA1c values indicating prediabetes
- Participants reduced HbA1c by 23% (at 12 months), comparison group = 15%
- 58% (vs. 48%) reduced HbA1c to normal range at one year
- 48% (vs. 21%) achieved weight loss $\geq 5\%$
- Included devices, coaching, and tailored education

COVID-19 Brings Additional Considerations

- Certainly, an “at risk” population
- Reduce the exposure
- Home/School-based care options
 - Accessing care from where the patient is
- Support with telehealth, in various manners
 - Reduce missed/cancelled appointments
 - Virtual/e-Visits (including phone); Video visits
 - Also...use with patient portal
 - Patient Education/Preparation (supplies, etc)
 - Active support and observation of their monitoring

Special Points/Considerations

1. Greater flexibilities currently in place - regulations (PHE)
 - licensure
 - location of care
 - no differentiation between in-person and telehealth (mostly)
2. Focus / Goals of these flexibilities:
 - use limited resources wisely
 - reduce potential exposure - patient or provider
 - keeping people out of the clinic spaces for “regular” care
 - keep clinics functioning...and open
 - continue to support patients in the care they need...safely

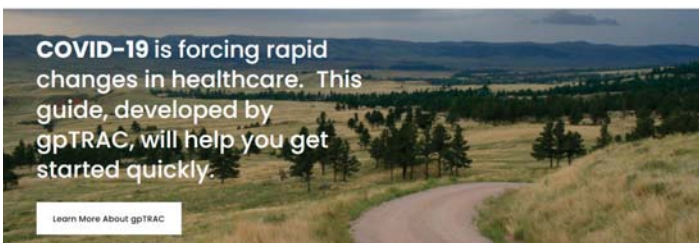
References:

- Michaud, T, et al. “Remote Patient Monitoring and Clinical Outcomes for Postdischarge Patients with Type 2 Diabetes”. *Population Health Management*, Vol 21:5 (2018) DOI: 10.1089/pop.2017.0175
- Rosenfeld, J. “Benefits to Remote Patient Monitoring.” *Medical Economics*, Vol. 97: 15, Nov. 5, 2020

gpTRAC.org



Resources: TelehealthQuickStart.org



Resources of Interest:

- Great Plains Telehealth Resource & Assistance Center (gpTRAC)
 - www.gptrac.org
 - Telehealth Quick Start Guide - COVID Resources, Federal and States
- National Consortium of Telehealth Resource Centers (NCTRC)
 - www.telehealthresourcecenters.org
 - Center for Connected Health Policy - 50 State Report
 - Telehealth Technology Assessment Resource Center
 - All 12 Regional Telehealth Resource Centers
- Telehealth: Health Care from the Safety of our Homes
 - www.telehealth.hhs.gov/
- Health Information Technology
 - www.ruralcenter.org/resource-library/health-information-technology
- Telehealth Use in Rural Healthcare - Topic Guide
 - www.ruralhealthinfo.org/topics/telehealth



Telehealth Stories

- gpTRAC is collecting stories to develop a library of anecdotal experiences with telehealth in our region.
- Do you have something to share?
- Do you know of a great story from your organization?
- ...from your community?
- **BONUS:** if gpTRAC was helpful, in anyway, would love to know that too!



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Thank you!