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

https://youtu.be/eHNaCZIr6vM
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 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 ≥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:


gpTRAC.org

Supporting Your Telehealth Journey

Helping You Make Telehealth Happen

How We Can Help ➤
COVID-19 is forcing rapid changes in healthcare. This guide, developed by gpTRAC, will help you get started quickly.

Learn More About gpTRAC
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!
CONTACT INFO

Jonathan Neufeld, PhD
Executive Director
574-606-5038
jneufeld@umn.edu

Mary DeVany, MS
Associate Director
605-360-6279
medevany@umn.edu

Zoi Hills, MS
Program Manager
612-625-9938
hills069@umn.edu

www.gptrac.org
Thank you!