A QUICK DOSE OF CE

MLI's Podcast for Healthcare Professionals

EPISODE #3 – Diabetes Management Through Telehealth: Helping Clinicians Feel Confident Managing Their Patients via Tele-Health – Interview with Dr. Marie McDonnell

Transcript

***Kristin*:** Hi, and welcome to another episode on "*A Quick Dose of CE."* I'm Kristin Gusack and today I'm joined by Dr. Marie McDonnell, Chief of the Diabetes Section and Director at Brigham Health Diabetes Program at Harvard Medical School in Boston, Massachusetts.

Our discussion today will cover teleconference-specific communications skills in diabetes management, strategies for pharmacotherapy management and devices that can be used to manage patients with diabetes as their needs evolve, strategies for treatment adherence, and identification of potentially underserved populations.

Hello and thanks for joining us, Dr. McDonnell, today. How are you?

***Dr. McDonnell*:** I'm fine, thank you, Kristin. It's really lovely to be here with you.

***Kristin*:** Telehealth is certainly not new to us in diabetes care and it's almost like you guys are the model for how to do it right. I would find it very difficult to establish rapport with a patient over the phone. Are there any techniques that you found have been working after doing this for so long?

***Dr. McDonnell*:** Yeah. It's such a great question, Kristin. And you're right—we started to do this in 2016 with gusto. And, you know, as we find now, there's really no good training on that

on how to do it, but I think actually we're seeing a little bit more of that just coming out of the pandemic.

But I will tell you that, first of all, if the patient sees you in-person first, the rapport is much more easily established and then maintained with virtual care. So, we still encourage that. Although, of course, that was truly suspended—appropriately so—during the pandemic. But establishing a relationship virtually I find still difficult. I would say on the phone the approach you have to distinguish yourself away from, say, a cold call or somebody who's trying to sell something to the patient. You really need to be warm—very warm—immediately and ask them how their day is going or tell them that you're really happy to be talking to them to talk about their health. Just establish right away what your goal is but also that you're there to help them.

And then, I think on video it's much easier than phone because you can comment on, you know, where the patient is, just have sort of an icebreaker, "How's it going?" and "It looks like you're in your living room," or something. Something just commenting on their background and then it sort of lightens the mood. That's just really an opener for the conversation establishing the relationship, I think. You have to go to the next level for sure.

***Kristin*:** Right. Do you think that you set agendas or expectations differently via a telehealth call than you would if somebody was in your office?

***Dr. McDonnell*:** Well, I've learned to do that because what we always said from the beginning is that it's virtual care, but it's not virtual time. It's real time. And you actually need time and space to do it. And so we learn that, you know, since there's no sort of natural flow that you get in the clinic where a patient is expecting to wait—you know, the nurse, the medical assistant comes in, does the vital signs, and then the medical assistant leaves. And the patient knows there's a gap in there all the time and they know the doctor's coming in soon. That gap does not exist anymore. In fact, our medical assistants will call the patients hours before our actual visit to prep them for the visit.

Long story short, Kristin: It is important to set the goal of the visit right upfront so that everyone knows that this is not a time to just discuss the whole kind of cache of issues. But, you know, sometimes I say, "Well, you know, we have 20 minutes. We're going to make the most of it today." I do say that even though in medical school we were taught never to tell patients how much time we have so that they don't feel rushed. But sometimes in telemedicine, it's better for them, I think.

***Kristin*:** Yeah. I think that would be challenging as well and especially with a patient where you feel like there might be some concerns or emotions that you need to kind of delve a little deeper in to try to keep and set that expectation. Any strategies you have when you get in a situation with somebody where you realize that they might need a different, a more empathetic response?

***Dr. McDonnell*:** Yeah. For sure. And, you know, we're seasoned clinicians, and we know to pick up on cues. And you can do that by looking at a patient virtually but also on the phone you can sense sometimes that a patient is either upset about a certain subject or they're just going to need a different approach, and you can let them take the conversation where they need it to go. And we know that that's also therapeutic for a lot of patients just to feel like they have somebody listening to them. And, boy, during the pandemic that was a major theme of my visits were patients were lonely.

***Kristin*:** Yeah!

***Dr. McDonnell*:** And they wanted mostly to talk. And I would say 5 of the 20 minutes or 30 minutes, if I was lucky, was spent on actual medical management.

***Kristin*:** Wow!

***Dr. McDonnell*:** And the rest was on counseling. And management involves that too, you know, "What are you able to eat? What foods are you accessing? Are you able to limit that takeout?" Things like that. But, yeah….

***Kristin*:** Yeah.

***Dr. McDonnell*:** It was a lonely time.

***Kristin*:** And that was going to be, actually, my very next question is conveying complex information maybe about medication changes or something that, you know, really,

traditionally you've been able to be in person. Has that changed at all via telehealth? Do you feel that people are more, it's more difficult to?

***Dr. McDonnell*:** For sure. So, in the office most clinicians do explain a complex either physiology or just maybe steps that we want the patient to take in order to determine the best eventual final strategy. We would write them down. We would take a pen and draft a nice sometimes a graphic for patients to understand. Or we would utilize some graphics we have in the office that tell the story. In diabetes education, that's a common tool. So, virtually we have to use other strategies.

I have often shared my screen to display either the glucose data they've sent to me so we can talk about it or even just to pop up a Word document. And I know Zoom actually has a blackboard or a whiteboard that you can use. That was disabled in the version that we were able to use, but you can share a Word document. And I would write out the steps for them and type them out for them and then send that document to them. And I would have to make the print a 30 font so they could see it. But, yes, I do think that explaining step complex management strategies was hard.

The thing I will say, though, is that that depended a lot on the distractions at home. That you could argue that maybe with somebody with their headphones on and focused on the screen that maybe they were more focused on what you were saying. And some patients probably really heard nicely what to do next, and I know I had many patients do well. But then if some

folks did not find a quiet place in their home or they didn't emphasize that part of the visit, that the no-distraction rule, then the visit was lost. Much of the value was lost.

***Kristin*:** Yeah. That's an excellent point, too. I think that people probably vary in how casual to how strict they are in their telehealth appointment, which is as important as it was if it was in person. And that would be tough. The mom who has children in the background and is trying desperately to listen to you but maybe can't.

***Dr. McDonnell*:** I know, and that happens in the clinic, too. But typically the child can be distracted by watching me in the office.

***Kristin*:** Interesting.

***Dr. McDonnell*:** Or I find that somehow when mom's at home with the child, mom really can't focus. It's just not going to happen.

***Kristin*:** Yeah.

***Dr. McDonnell*:** So, yeah. And in patients who don't quite understand the point will answer the phone while they're in line at the grocery store and say, "Can I have few minutes? I'm just checking out here" and just not seeing it. This isn't a real visit. This is just my doctor calling me.

***Kristin*:** Right.

***Dr. McDonnell*:** That understanding and expectation really has to be communicated by the clinic staff.

***Kristin*:** Yeah.

***Dr. McDonnell*:** That should be all settled before you get on the line with them.

***Kristin*:** That's a great point.

***Dr. McDonnell*:** Yeah.

***Kristin*:** Switching over to something that you mentioned earlier about, you said when you put up their numbers on the screens. So diabetes, obviously, you've been getting numbers electronically from patients. This is kind of common practice. So, what do you see continuing, you know, something that has maybe gotten better with telehealth with information you're getting from a patient?

***Dr. McDonnell*:** Yeah. Well, for sure. I would say that patients were pushed beyond what they saw as their boundaries before in terms of technology. So, just simply taking a photo of your glucose log that you write down with a pen and paper and knowing how to upload that into the patient portal—that was a huge deal for patients. I had patients who downright just refused to do that before. But now with a pandemic they had to do it for their bank statements or their taxes or like lots of things when they were working with their accountant or forms they had to fill out for their kids' school. I mean everybody learned how to scan an email and

upload. So, that's a big deal because now we really have limited, we still have barriers there. Not every person, you know. We have a lot of patients who are socioeconomically challenged and also just challenged in other ways where they don't have access to that.

And then as far as Bluetooth®-enabled devices, we're now seeing there's really only one commonly used glucose meter that is not Bluetooth®-enabled in the US. So, the call was heeded by the companies and if providers choose to, they really have an easy time now sharing their patients' glucose data.

***Kristin*:** So, switching gears a little bit: Has there been a change in the devices that you see patients are using now in kind of this new normal?

***Dr. McDonnell*:** Right. Yeah, it's such a good question. So, I would say coupled with this surge in telemedicine, just prior to this year we saw companies really up their game in terms of connectability—of built-in connectability—of their devices and also companies eager to get into kind of the mHealth or mobile health area where they could help people manage themselves. So, with all of that, we see patients realizing that people are interested in their glucose data, and they are more interested in seeing it.

And so, we're seeing more commercials on TV of the continuous glucose monitors, for example. And in the end, patients want these devices that don't require a finger stick. Totally understandable need to avoid self-harm or hurting themselves to monitor their disease. I mean we're all very supportive of this concept. It's just that the cost is high for a lot of people,

but we are seeing an increased demand. And I am hoping that the insurers will pay attention to this consumer demand and the advocacy coming out of the professional groups afford these patient-centered devices and will allow the companies to if they will pay for them. And hopefully the companies will be able to enter the market more strongly and lower their cost, because my understanding is the device is not that expensive to make anymore. Because they've been on the market for quite a while.

***Kristin*:** Yeah, and I can see how this would just have such an improvement on medication adherence and…

***Dr. McDonnell*:** Oh yeah, right.

***Kristin*:** …treatment plan adherence and linking what patients are doing to what is happening with their devices and the numbers that they're getting. So….

***Dr. McDonnell*:** That's right. And people call that empowerment, which is sort of an old term now, but I still like it because that's exactly what people look like and feel like when they know what their numbers are. They feel in control, and that's the name of the game.

***Kristin*:** I agree. So, as far as pharmacotherapy, are there any decision points that you look out for? And how do you communicate kind of changing that during a telehealth visit?

***Dr. McDonnell*:** Right. Actually, telehealth is a great way to keep a patient engaged on step therapy when we realize, and we communicate to the patient ahead of time, that we're likely

going to need to add this medication or titrate this one and then decide if we need to add the second or third medicine. And telemedicine can be so focused so easily because everybody's really interested, I think, in defining a specific period of time where they will get on the video or phone.

So, what I like to do a lot is to establish a step, potential steps. I actually will write them out. Step one is we're going to start this medicine. If this doesn't do the trick, we're going to do step two. And if you have trouble with step two, here is the optional step three. And I write it out, and then we have actually rapid follow-up visits that might be just ten minutes. Could be two weeks to four weeks away where the whole goal is to see where they're at.

What we find is that if we give them these steps. And we kind of say, "See you in 3 months." Then nothing happens, and we miss the opportunity to engage with them on the steps that we created together. And sometimes if they don't show up for the 3-month visit, the whole thing falls apart. So, in telemedicine there's a better opportunity because you can find that quick time usually on your schedule just to do those check-ins. And I do think, you know, someone asked about having an agenda for your telemedicine meeting, like we do in business. And it's probably the right thing to do in a lot of cases just to set it up. So, we're going to check in in 2 weeks on where you are in the steps, so….

***Kristin*:** I think that's very powerful too, to be able to check in kind of more frequently because everybody's routine is off. Everybody's doing different things. Maybe we've all

started to redefine that since we've been doing this for so long. But it's to have the ability to check in more often is helpful.

***Dr. McDonnell*:** The other thing I'd like to mention, though, is that we were less incentivized to check in frequently before because the insurance companies were not paying for—very easily anyway—remote management. And that's changed now. And if we can find the time and the energy and we get enough support from our staff, we can design a real feasible clinical program for ourselves and our patients so that they get what they need.

***Kristin*:** Yeah. Do you see any other factors that we've all experienced with, you know, weight gain or stress? Those sort of things kind of wreaking havoc on people's diabetes treatment plans?

***Dr. McDonnell*:** For sure, yes. At our institution, so if you look at all of our hospitals in what we call the NGB system in Boston, we had a clear decline in the number of people who were achieving what we call glucose control or good control, which is an A1C less than 7. And sadly, we weren't surprised. But sadly, the folks who fared the worse were those who did not speak English and those who were nonwhite, specifically black people. And that, I think, calls attention to what we already know: that there are some populations that were just more sidelined by COVID. And they really had to focus on survival of themselves, yes, but also their family beyond what is clearly something that cannot always be prioritized, which is their health.

So, it tells us that we need to prepare our patients for a crisis, and we have done that in ways that might be more focused on natural disasters. So, the American Diabetes Association has a nice set of patient guidelines on that, but maybe we should talk broadly about that with our patients. What's would happen if one day you had some event where you couldn't walk anymore? Or what kind of preparation are you going to have for being mindful about your own health if your world gets turned upside down?

I don't know. We haven't figured this out yet, but I do know that preparedness is part of this.

***Kristin*:** And maybe that's the silver lining in all this is that we do think as we go forward there's going to be a hybrid model like what you mentioned about insurances changing—things being covered now, devices that people are using more often. They're learning how to do a lot of things online. This is all the silver lining of what everybody's been through. And I've seen certainly too with disability, people that are hearing impaired and being able to do closed captioning via a telehealth visit. Are there any other...

***Dr. McDonnell*:** Interesting.

***Kristin*:** …kind of newer technologies that your institution is using to help people?

***Dr. McDonnell*:** Yeah. You know, I haven't seen the use of technology that helps the blind and the deaf yet, not in our practice. What we have done is basically support and make sure that there are other people in the person's life who can be in the visit just like we would do normally in person. But, yeah. I do have many, not many but I have several who are

extremely vision impaired. And telemedicine has helped them pretty substantially because the idea of being safe at home is attractive to them, and they don't get very much visual stimuli or visual feedback. So really, what they need is good audio and a good conversation, and they need somebody to be able to see them. So, the video care is good for them because they're able to not have to navigate the world to get to me, and we can generally have a very effective session.

But hearing impairment I think is a big challenge, and we need to use the technology that exists because I know it does.

***Kristin*:** Okay, so now that patients really have been through this for a year or more, what do you find is the right thing to counsel them on? They've obviously overcome this. What are some of the things that they should do, maybe some of the things that they shouldn't do that you've seen that maybe they have been doing?

***Dr. McDonnell*:** Yeah. This is going to be a big learning exercise and a time for reflection for many people. I don't know when that time will be when people will feel like this is sort of over and we're going to then look back. But it's happening now. And what I think is very important is to help people/patients reflect on what choices they did make around food and exercise and how they let stress invade their health and how we can prepare them for that.

There's some really decent evidence in diabetes for mindfulness training so that what it delivers to the individual taking the training are tools they can use in times, especially when

they're off track or there's increased stress, to remind themselves of who they are and what their real goal is and where health fits into their priorities.

And then, you know, the other thing is to make sure patients always do have their supplies, because you never know when things will be interrupted. So, don't let your glucagon, which is lifesaving therapy for people with severe hypoglycemia, don't let that expire. Remind your doctor to refill it for you.

If you have an insulin pump, make sure you always have backup—what we call backup basal, which is a long-acting insulin that you can use in the event you can't receive your pump supplies. And that's happened several times with the hurricane in Puerto Rico. There was a dramatic impact on supply of one pump company because there was a big warehouse in Puerto Rico. So, it was a disaster for so many patients and a lot of them did not have backup insulin.

And then the third thing is to not imagine that people aren't caring about you just because they're not calling to find out if you're okay. So, for example, if you need insulin therapy for survival and you don't have it, call. Call your doctor. Don't just ask your family to put up money for you. Make sure your doctor knows that you're in this trouble because often there are things that the healthcare team can and would love to do for you as a patient, including finding samples and talking to industry on your behalf.

So, I did find some patients who ended up rationing their insulin and getting into trouble. And they never called because they felt like every doctor was so overwhelmed that their problem was so small when everyone was dying from COVID, which is the words that came from my patient's mouth. And I said, "No, you are important too. Even when there's a disaster, you are important too to so many people."

***Kristin*:** Well, thank you so much. There's been so many helpful tips and insights that you've given us. I really appreciate your time with us today.

***Dr. McDonnell*:** Oh, you're so welcome, Kristin. Thanks for giving me the time, too.

***Kristin*:** Thank you all for listening in. This episode has been a collaboration between Medical Learning Institute, Inc., and The Endocrine Society.

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