



Deriving Value: Live Visits in the Context of a Changing World

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As described in a “Quality Improvement Success Story” published in this issue (1), Lauren Oshman and her colleagues implemented and studied the effect of an intervention called diabetes-focused visits (DFVs). These intensive, deliberately designed live office visits ultimately succeeded in reducing therapeutic inertia and helped patients get to glycemic goals. In reading the words written by these researchers *and* understanding what they left *unsaid*, it becomes evident that we have an opportunity to rethink our approach to diabetes and the role of “live” visits in the context of a rapidly evolving diabetes landscape in which the new focus must be on providing whole-person care and meeting people where they are.

For patients who are attending live, in-person visits with their diabetes care provider, how do we maximize the value of patients’ time? How do we build services around our patients that make it easy and efficient for them to engage in optimal diabetes self-care and actively collaborate with us on their diabetes management? When patients increasingly are finding online health care options acceptable or even preferable, how do we make in-person appointments both appealing and rewarding for all parties?

Before each DFV, the staff of the clinic profiled by Oshman et al. used pre-visit planning to prepare for their encounters with patients. The pharmacists on the team reviewed patient charts and made medication recommendations to the physicians. The American Medical Association’s STEPS Forward module on pre-visit planning (2) is an example of material that clinicians can use to learn about and implement the pre-visit planning technique and thereby increase the likelihood that the

care team will be prepared and the live visit will be valuable.

As Oshman et al. demonstrate, when pre-visit planning is complemented by the creation of real, team-based care that includes pharmacists, supervising endocrinologists, and other health care professionals who use clinical decision support and algorithms in the provision of diabetes care, therapeutic inertia lessens, treatment is intensified, and glycemic goals can be met more easily.

Patients in the clinic described by Oshman et al. came from a geographical area with a high social deprivation index. Their reality should give us pause and encourage us to reflect on how well our own clinics are screening for, and addressing, social determinants of health (SDOH) among our patients. These SDOH related factors can exist, of course, even for patients who do not reside in a zip code region labeled as socially deprived. To derive value for both in-person and telehealth visits, we should ask whether we are systematically screening for SDOH factors. Are we using tools such as the National Association of Community Health Center’s PRAPARE (Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences) tool (3), or are we taking a haphazard approach? Are we doing this screening to “check the box” for an insurance company, or are we doing it to ensure that we are really listening to and soliciting the needs of our patients in a meaningful effort to transition to whole-person care? Are we positioning ourselves in our clinics, our health systems, and our clinically integrated networks and accountable care organizations with the right personnel, including social workers, navigators, and care managers? Do these professionals have access to community resource referral websites such as Find Help (4), WellSky (formerly Healthify) (5), and other platforms to connect patients to services?

As part of live, comprehensive care, the design of Oshman et al.’s DFVs incorporated time with a certified diabetes care and education specialist (CDCES). This design was a result of patients reporting time, financial, and opportunity cost barriers to scheduling additional visits beyond the primary care provider appointment for diabetes education. These barriers led the clinic team to redesign its approach and implement the provision of

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same-day, truncated diabetes self-management education and support within the DFVs. Although this was a patient-centered and logical decision, it raises questions about how effective and durable such truncated education will be over time. An evaluation of patient knowledge and skill retention would answer that question.

Many organizations and companies such as Livongo (6), Lark (7), Welldoc (8), and others are trying to re-imagine a relationship with patients as one that is longitudinal and continuous and allows for education, coaching, and real-time decision support offered through telehealth platforms, Internet bots, live health coaches, and online classes with CDCESs. The future of diabetes education will be increasingly delivered online, at scale, and in a manner that will ensure that patients are not talked to, but rather are talked with and that their questions are answered, their competency and knowledge are assessed, and they have resources to turn to when day-to-day questions arise. Organizations considering implementing DFVs would be well served to develop a strategy that takes advantage of the myriad existing companies and partners that can support both patients and providers. There will always be a role for both in-person and technology-enabled health care services, and it is up to us as health care leaders to build an ecosystem that derives the most value from both approaches.

Organizations looking to recreate the success of Oshman et al. with DFVs are encouraged to include highly reliable screening tools for depression (e.g., the Patient Health Questionnaire-2 [9]), anxiety (e.g., the General Anxiety Disorder-7 instrument [10]), and diabetes distress (e.g., the Problem Areas in Diabetes scale [11]). Managing a population of patients with diabetes without attention to behavioral health will lead to suboptimal outcomes. Being sensitive to the same types of barriers that Oshman et al. found that limited robust in-person CDCES visits will also be necessary to ensure that patients are able to access behavioral health practitioners to address these highly prevalent, but still underdiagnosed, conditions. Increasingly, these services are being offered via telehealth as a preferred option.

Additional examples of redesign to increase the value of live office encounters include screening for diabetic retinopathy through office-based cameras. These handheld or desktop-mounted cameras can be operated by staff with a few hours of training, and images can be uploaded and read by board-certified experts. Emerging artificial intelligence technologies exist and are being refined to allow for even easier automation of screening

in the primary care setting. Patients gain the benefit of having the screening done during the clinic visit, often without additional copays and burdens of traveling to another location for care. The fact that Oshman et al. did *not* see an increased rate of completed retinopathy screening after implementing an “enhanced checkout process” (1) that incorporated systematic referral for this screening further corroborates the notion that these screenings should be done during the DFVs, if possible.

Similarly, patients who have not had an opportunity (for whatever reason) to obtain recent laboratory tests can have point-of-care A1C and urine microalbumin screening during DFVs, yielding immediate, valuable data that will affect the treatment plan during the live encounter. These laboratory results will simultaneously help providers close quality gaps in care, which will yield additional resources through better performance in value-based incentive contracts that then can be invested back into the clinic.

The live visit increasingly needs to be one in which providers identify patients who can benefit from remote patient monitoring (RPM)—involving data from continuous glucose monitoring or other emerging technologies. These live visits can be used to place devices, provide patient education, review data, and refine care planning. As an example, patients with poorly controlled diabetes are at great risk for limb-threatening foot ulcers. Clinicians in live visits increasingly (through partnerships with companies such as Podometrics [12] and Arche [13]) will be able to identify patients who are candidates for RPM for tissue changes in the feet. These emerging RPM options can predict the development of foot ulcers weeks to months before they emerge (14,15). Instead of clinicians performing monofilament and vascular exams—both of which are performed with great variability of effectiveness in the primary care setting (16)—they will review RPM data from sensors embedded in footwear. These data can affect care plans and help providers ensure aggressive management and referral for advanced care from a podiatrist or vascular specialist when warranted to ensure that risks are mitigated before complications emerge.

In the end, health care is local. Thus, it is up to local leadership to devise local systems, with live visits that provide the greatest value, using the right technologies and connected to the ever-expanding global list of partners and stakeholders that can assist in the care of patients with diabetes. This future is for us to build, together.

DUALITY OF INTEREST

No potential conflicts of interest relevant to this article were reported.

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