# Optimize Communications and Reduce Barriers to Diabetes Care for Patients With Limited Digital Access

**Contributing authors on behalf of Team Best Practices:***
**L. Austin Fredrickson, MD,** Northeast Ohio Medical University
**Seuli Brill, MD,** The Ohio State University
**Mary Joan Roach, PhD,** Case Western Reserve University
**Anne Gaglioti, MD, MS,** Case Western Reserve University
**Adam Perzynski, PhD,** Case Western Reserve University

Patients with barriers to care, including transportation and mobility issues and limited ability to use the internet, require targeted interventions to maintain consistent diabetes care.

Following are strategies to provide high-quality care for all patients, especially those with barriers to care.

## Clinic-Level Design for Patients With Limited Digital Access

Often, patients with limited digital access face compounded barriers to care, such as lack of access to reliable transportation, long travel times, lack of daytime flexibility to attend in-person appointments, or limited mobility or homebound status. To reduce the impact of transportation barriers, clinics should refer to the strategies below.

**Identify and document dual digital and face-to-face clinical care access vulnerabilities.**

- Conduct systematic social determinants of health (SDOH) screening and discussions to help identify patients with dual digital and face-to-face care barriers during brief or rare office encounters.

- Integrate SDOH screening into out-of-office outreach to help identify digital vulnerabilities (e.g., care coordination for patients with poorly controlled diabetes or patients with care gaps in diabetes management).

- Note that many SDOH screening tools do not include a question about digital access, therefore it may be necessary to ask about digital access separately. For examples of digital access questions, see the U.S. Department of Veterans Affairs ACORN Screening Tool.

**Respond to identified vulnerabilities.**

- Once vulnerabilities are identified, primary care team members can develop individualized approaches to overcome care gaps. If available, interdisciplinary clinical team members, such as social workers, can help develop these individualized care plans. For example:
  - Request that home health help support glucose monitoring.
  - Ask clinic staff to help patients identify labs open outside of business hours, within walking distance, or easily accessible by public transportation.
  - Involve caregivers who have digital connection resources.
  - Leverage the expertise of other team members, including diabetes educators, nutrition experts, and community health workers.
  - Coordinate with local senior services or non-profit organizations for grocery delivery.

## Design Clinical Systems that Promote Care Coordination

Make the most of every patient-initiated conversation, particularly telephone calls. Patients with limited digital access may be hard to reach with clinic-initiated outreach. As a result, strategies to consolidate clinic callbacks and maximize communication and planning within the patient-initiated outreach are critical.[1,2]

- **Assign patients who are not up to date with care to a clinical staff member (e.g., medical assistant or RN care coordinator) who is available to:**
  - Receive transferred patient calls from call centers, front desk, or triage.
  - Quickly identify care gaps and provide the patient with a real-time plan for meeting these care gaps (e.g., labs, prescriptions, glucometer, eye exam, and appointment scheduling).
  - Communicate with the patient's provider for timely signing of needed orders.
- **Create workflows for:**
  - Call transfers to the clinical staff contact.
  - Communication between real-time staff and primary care providers during encounters if urgent clinical needs arise.
  - Communication between real-time staff, pharmacy, and social work to address urgent barriers to care (e.g., prior authorizations, formulary medication checks, and financial barriers).
- **Create medical assistant or nursing pools (e.g., via electronic health records and telephone) to:**
  - Route calls and messages to allow for coverage during staff absences and turnover.

## Before an Office Visit

**Review patient records.**
- Flag charts of patients overdue for diabetes care (e.g., labs, visits, health maintenance, population health dashboards).
- Summarize care gaps using electronic health record functions (e.g., care coordination notes, the problem list, health maintenance tab, standing orders).
- Check when last labs were done. Can pre-visit labs still be ordered or obtained? If not, mark point-of-care testing to be ordered when rooming.

**BEFORE**

**Close gaps in information when the patient calls the office.**
- Have staff transcribe glucose readings into a grid and confirm medication taken. Staff scripts of what to ask patients are available in Cardi-OH's Diabetes QIP Toolkit (pp 18-21).
- Schedule overdue appointments.
- If possible, bundle appointments with related practitioners during the office visit (e.g., certified diabetes care and education specialist, dietitian). Engage the interdisciplinary care team, such as pharmacists and social workers, at the clinic.
- Have answers to condition-related commonly asked questions or required resources readily available when patients call to seek advice.[1]

**Ensure the patient is ready for the upcoming appointment.**
- Make sure the patient knows how the office phone number will display on the caller ID and is ready for a call from the office.
- Remind the patient to bring in or have available necessary items:
  - All medications, including insulin.
  - Any log recordings or devices: glucometer (with strips, if needed, to demonstrate technique), continuous glucose monitor (CGM) receiver, diet, blood pressure, and exercise.
  - Ask the patient to bring a support person or arrange to conference them into the appointment by phone or internet, if possible.
  - If the patient cancels, check to see if telehealth can be offered using a family member's device.

## During an Office Visit

**Conduct lab testing.**
- Collect point-of-care lab tests.
- Create requisitions for 'send out' venipuncture lab tests.

**Discuss glucose monitoring information.**
- Walk the patient through instructions for glucose monitoring and review targets at every visit.
- Consider CGM. Refer the patient to trained team members (i.e., pharmacist or certified diabetes care and education specialist) to assist with device selection; provide training; and, where feasible, facilitate remote monitoring.

**DURING**

- Review glucose logs. If no logs or reports are available, look at the glucometer or CGM receiver/app during the visit.
- If CGM is not available or preferred, provide a generic prescription for a glucometer so the pharmacy can fill the order based on insurance coverage and affordability.
- Offer the patient a generic paper chart/log in the office along with a schedule of testing, unless the patient has their own process.
- Optimize medication routines to promote consistent use.

**Screen for social needs and make referrals.**
- Clinics already screening for social needs can include screening questions about broadband connectivity and conduct rapid referrals to local resources (e.g., via EveryoneOn.org).

**Ensure access to needed medications.**
- Assess ability to receive pharmacy discounts via online-only discount programs.
- Have a stack of pre-printed information or printable electronic smart phrases about commonly used medicines. Also research less commonly used medicines and print relevant information.
- Leave printed materials on prescription-saving programs (e.g., GoodRx) at checkout window.

**Discuss follow-up care and next steps.**
- Establish clear patient and clinic responsibilities and expectations for the next steps in care (e.g., the patient will go to the lab within 48 hours, the patient will call the eye doctor to set up an appointment, the clinic will send a prescription for a new glucometer to [a specific pharmacy]).
- Use teach-back strategies to ensure the patient understands the follow-up plan and has buy-in.[2]
- Tell the patient if others will be contacting them to help address care gaps (e.g., "Someone from the scheduling center will call you in the next two days to set up an appointment with the kidney doctor. That person is not in our office but will work closely with us to help take care of you. If you do not receive a call in the next two days, please call the office and we will assist you further.")
- Confirm correct contact information for the patient and, if applicable, their caregiver. Get the phone number of the patient's trusted contact to help with follow up. (e.g., "Your doctor will need to communicate with you about your lab results and may need to change the medicine you are taking. What is the best way to contact you? Is there someone else we have permission to contact if we cannot reach you?")
- Make all needed follow-up appointments while the patient is in the office. Attempt to work around identified care barriers (e.g., early morning or end-of-the-day appointments can be challenging due to transportation challenges).
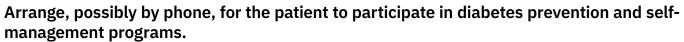
## After an Office Visit

**Encourage patients to check-in asynchronously with office staff between visits.**
- Be clear with patients that you want them to reach out to the office by phone or mail. For example, patients can report their glucose readings via phone to office staff.
- Use outreach methods to maintain communication with patients (e.g., reminder postcards, mailed letters, outbound phone calls).
- Mail "after visit" packets.

**Close gaps in care by scheduling outstanding appointments.**
- Have staff call the patient to schedule any remaining follow-up and specialty visits that were not scheduled when the patient was in the office (e.g., optometry, podiatry, nephrology). Schedule appointments for the same day as the next visit, if possible.

**AFTER**

**Arrange, possibly by phone, for the patient to participate in diabetes prevention and self-management programs.**
- Refer patients to in-person programs through the local YMCA, library-based programs, or social services.

**Make it easier for patients to do glucose monitoring without coming into the office.**
- Send CGM, glucometer, and blood glucose monitoring supplies to a pharmacy near the patient's home.
- Send a written glucose log with a self-addressed return envelope to make it easier for the patient to send back blood glucose readings.
- Promote the appropriate use of CGMs via smartphone app when connectivity and digital skills allow, or prescribe a separate reader.
- Identify a lab close to the patient for other monitoring (e.g., A1C, urine microalbumin, lipids) and send orders to this lab for blood draws.
- Encourage asynchronous check-in with office staff via telephone or mail.
- For patients reporting glucose readings:
  - Have patients share results with office staff via phone.
  - Encourage patients to call when values are out of range.
  - Encourage the provider to adjust insulin dosing over the phone.

## Additional Cardi-OH Resources

- **Addressing Clinical Inertia in Diabetes Care**
  cardi-oh.org/resources/addressing-clinical-inertia-in-diabetes-care
- **Navigating Barriers to Medication Access**
  cardi-oh.org/resources/navigating-barriers-to-medication-access
- **Optimizing the Telehealth Diabetes Visit: Glucose Monitoring Data**
  cardi-oh.org/resources/optimizing-the-telehealth-diabetes-visit-glucose-monitoring-data
- **Overcoming the Digital Divide**
  cardi-oh.org/resources/overcoming-the-digital-divide
- **Podcast 18 - Optimizing Telehealth for Diabetes Care**
  cardi-oh.org/resources/podcast-18--optimizing-telehealth-for-diabetes-care
- **Social Needs Screening Tools**
  cardi-oh.org/resources/social-needs-screening-tools
- **Supporting Patient Success With Continuous Glucose Monitor**s
  cardi-oh.org/resources/supporting-patient-success-with-continuous-glucose-monitors

### References

1. Due-Christensen M, Kaldan G, Almdal TP, et al. Out-of-office hours nurse-driven acute telephone counselling service in a large diabetes outpatient clinic: a mixed methods evaluation. Patient Educ Couns. 2015;98(7):890-894. doi:10.1016/j.pec.2015.03.014.
2. Hong YR, Jo A, Cardel M, et al. Patient-provider communication with teach-back, patient-centered diabetes care, and diabetes care education. Patient Educ Couns. 2020;103(12):2443-2450. doi:10.1016/j.pec.2020.05.029.

# Partners



**CASE WESTERN RESERVE UNIVERSITY**
**School of Medicine**

*In partnership with*

University of **CINCINNATI**
COLLEGE OF MEDICINE

**Northeast Ohio**
MEDICAL UNIVERSITY

OHIO UNIVERSITY
**Heritage College of Osteopathic Medicine**

**THE OHIO STATE UNIVERSITY**
COLLEGE OF MEDICINE

**UT** COLLEGE OF MEDICINE AND LIFE SCIENCES
THE UNIVERSITY OF TOLEDO

Boonshoft **School of Medicine**
WRIGHT STATE UNIVERSITY

OHIO COLLEGES OF MEDICINE
**GOVERNMENT RESOURCE CENTER**

**medtapp**
Medicaid Technical Assistance & Policy Program

**Ohio**
**Department of Medicaid**

The Ohio Cardiovascular & Diabetes Health Collaborative is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this document are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.

*Social Determinants of Health Working Group