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## Refusing Telemedicine – Can Patients Opt-out of Remote Care?

With the sweeping rise of COVID-19, telemedicine has taken healthcare by storm. During the local surges, this served as a mandated way of maintaining safe distancing. But as things come back to a new normal and as we decide where telemedicine fits in to a clinic structure, it might be worth asking: Should patients have the option for in-person care? Is refusing telemedicine in favor of being physically seen a choice patients should be able to make? As we begin to settle in to a fixed role for telemedicine in the post-COVID world, centers are beginning to shape processes around telehealth.

Three assumptions that we make about patients and virtual encounters give shape to our policies:

### ASSUMPTION OF APPROVAL

We assume that telemedicine is what patients prefer. The belief that patients prefer to be cared for in the context of their home isn't always the case. There may be sensitive issues or a hidden agenda that doesn't show well across a screen.

### ASSUMPTION OF EQUIVALENCE

We assume that telemedicine is as good as in-person care. There is a bias to try to assess virtually some conditions that may best be assessed in real life. But, sometimes, medicine needs to be inconvenient.

### ASSUMPTION OF CAPACITY

We assume the patient is able to participate in a virtual visit. Some families lack Internet access and equipment to complete a telemedicine visit. Tech insecurity is a bigger issue than thought initially when we started doing telemedicine.

There are many reasons why a patient may prefer an in-person visit. Our assumptions about the magic of telemedicine are not always right. While we should work to accommodate the preferences of the patient, patients need to understand that there are conditions and circumstances where an in-person visit is not necessary. And patients should be offered the right of refusing telemedicine.

Will our telemedicine policies pull us back to an imbalanced doctor-patient relationship? After the COVID dust falls, we need to create more structure that respects the interests and will of the patient. Telemedicine is a moving target. What works or doesn't work today may have a very different solution or experience a year from now. Flexibility and rapid reiteration of our processes will be critical to successful adjustment and growth.

Visit [3charts.com](http://3charts.com) to read the full article.



## Involving Youth in the Decision to Initiate CGM Device Use Improves Treatment Adherence



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Involving children and adolescents in the decision to initiate the use of a continuous glucose monitoring (CGM) device is necessary to achieve maximum clinical benefit, explains Victoria A. Miller, PhD. "If youth are not directly involved in the decision to start the device, they may be less successful with it, which would lead to a missed opportunity to receive the clinical benefits of consistent CGM device use," Dr. Miller says.

### Laying the Groundwork for Increased Responsibility

For a study published in *Diabetes Care*, Dr. Miller and colleagues sought to identify factors that facilitate long-term use of CGM. They examined whether youth involvement in the decision to start CGM predicted device use and whether this relationship was mediated by CGM self-efficacy and satisfaction. "This study supports my prior research, which demonstrated that greater youth involvement in discussions with parents about type 1 diabetes (T1D) management is associated with improved treatment adherence,"

Dr. Miller notes. "Being empowered to participate in such decisions lays the groundwork for increased responsibility and effective self-management as children mature."

In this study, parent-child dyads from an academic endocrinology clinic completed assessments prior to initiating CGM, including a measure of the child's involvement in the decision to start. Two months into CGM use, young people completed measures of CGM self-efficacy and satisfaction. Adherence to CGM use between weeks 5 and 12 was assessed via a cloud-based data repository. Hypotheses were tested with linear, mixed effects models.

### Empowering Young Patients

CGM use in 108 dyads (youth mean age, 13.4; 73% white) was positively predicted in a baseline parent report of youth involvement in the CGM decision. In addition, this relationship was mediated by the youths' perception of CGM self-efficacy and hassle. When youth shared their opinions about CGM with parents and participated in the decision to start, they perceived higher self-efficacy and lower hassle at the 2-month follow-up, which predicted more days of use (Figure). This pattern held in models adjusting for youth race, sex, and family income. "This finding is consistent with prior research

showing the importance of self-efficacy for successful diabetes management in youth," Dr. Miller notes.

The qualitative data that the team are working on suggest that some parents may put pressure on their children to agree to start the device, which may backfire if a child is hesitant or feels as if they don't have ownership over the decision, she adds. "There are multiple ways to engage youth in discussions about CGM, such as asking about their questions or concerns, showing them the device in the physician's office, and asking their opinions about whether or not they wish to proceed," Dr. Miller says. "These actions can go a long way in helping young people feel empowered regarding decisions about their T1D management and their general overall health."

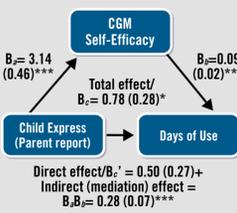
### Important Implications

Dr. Miller suggests that future research in this area should target more racially and ethnically diverse samples to determine whether and how processes related to CGM decision making differ in more vulnerable subgroups of youth with T1D. "We are also in the process of documenting additional analyses from the study, focused on semi-structured interviews with a random subset of youth and parents at both baseline and follow-up. This will give us a more in-depth understanding of their experiences with decision making and device use," she adds. "In addition, future research can expand on this study by developing and evaluating intervention strategies to enhance youth involvement about other T1D-related decisions."

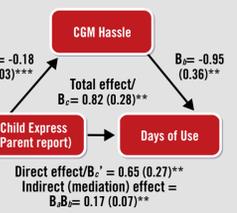
The most important message Dr. Miller seeks to convey to endocrinologists and pediatricians is that children and adolescents should be the primary drivers of the decision about whether to start CGM. "Young people who were more involved in the decision used the device more consistently, which is important to achieving maximum clinical benefits of CGM," she explains. "For many families, the decision about CGM was discussed and revisited over a long period before deciding to use the device."

### Figure Mediation Analysis

#### A: CGM self-efficacy as the mediator.



#### B: CGM hassle as the mediator.



Note: +  $P < 0.10$ , \*  $P < 0.05$ , \*\*  $P < 0.01$ , \*\*\*  $P < 0.001$ . Values are from unadjusted models. Pattern of findings was the same in models adjusting for child sex, race, and income. Source: Adapted from: Miller V, et al. *Diabetes Care*. 2020;43(10):2355-2361.

## Medical Economics

SMARTER BUSINESS. BETTER PATIENT CARE.

### Why We Need a One-to-Many Telehealth Model of Care

This article was originally published in *Medical Economics* and is written by Jon Bloom, MD.

One thing the COVID-19 pandemic has made clear is that telemedicine is a public health necessity. However, real-time, or synchronous, telemedicine isn't sustainable or scalable. We're already seeing synchronous telemedicine practiced on a small scale put a strain on our healthcare system during COVID-19.

For telemedicine to work at scale, it must also have a one-to-many component. In this model, data can be remotely gathered and consistently monitored over time and then used for timely and targeted communication between patients and providers. This allows care to scale from one-to-one to one-to-many.

Fortunately, a model already exists for how we can use asynchronous, one-to-many remote monitoring at scale for even the hardest-to-reach patients.

The health system overseen by the VA is now successfully using asynchronous telehealth to ensure patients who cannot or should not visit a VA facility are still able to get the frequent care they need from a distance.

One such example is the effort to remotely monitor veterans at risk for diabetic amputations. Veterans place their feet on the Podometrics SmartMat for just 20 seconds a day in their home, and the temperature data captured is automatically sent to a care management team to monitor. When early signs of issues are detected, patients and providers are notified so clinical action can be taken quickly, helping to prevent more serious complications.

Such large-scale preventive care could not be achieved through synchronous, one-to-one telemedicine. There simply are not enough doctors available to check in with every patient for even 1 minute every day. However, remote asynchronous systems can gather data over time to help prioritize synchronous telemedicine, ensuring patients receive the care they need when it matters most.

A key takeaway of the current pandemic has been the importance of telehealth; however, for it to be sustainable, we need a combination of synchronous and asynchronous patient monitoring tools that allow for targeted communication. We should expect more healthcare providers to incorporate this kind of model to offer access at scale and save lives.

To read the unabridged version, visit [www.medicaleconomics.com](http://www.medicaleconomics.com).

## In Case You Missed It

### Self-Monitoring Important for Intermittently Scanned CGM Users

The need for continued self-monitoring of blood glucose (SMBG) testing remains important for all intermittently scanned continuous glucose monitoring (isCGM) system users and may affect overall cost-effectiveness of isCGM, according to a study published in *Diabetes Technology & Therapeutics*. With hypoglycemia-prone patients with type 1 diabetes who use isCGM systems shown in previous research to spend approximately 5 hours per day in states during which SMBG is indicated, investigators estimated the need for SMBG testing by retrospectively analyzing isCGM data from a cohort of real-world isCGM users. Participants spend a mean of 3.18 hours per day in a SMBG-indicated state, with a mean of 3.86 transitions to an SMBG-indicated state per day. The median frequency of clinically important hypoglycemia episodes per week was 1.5, among which only 50% were associated with a scan during the episode and the average duration was 75.2 minutes per episode. "Impaired awareness of hypoglycemia and incidence of asymptomatic hypoglycemia may be underreported [among] real-life isCGM users in clinical practice," write the study authors.

### Early Insulin Pump Therapy Improves Outcomes in Children With T1D

"Our findings provide evidence for improved clinical outcomes associated with the early initiation of insulin pump therapy in children with type 1 diabetes," write the authors of a study published in *The Lancet Child & Adolescent Health*. With insulin pump therapy shown in prior research to be associated with improved metabolic control when compared with multiple daily insulin injections in children with type 1 diabetes (T1D) but no clear evidence on when it is best to initiate such therapy following diagnosis, the study team aimed to compare the outcomes between early and delayed start of insulin pump therapy in young patients with T1D. They reviewed data on 8,332 patients aged 6 months-15 years at diagnosis who started insulin pump therapy either within the first 6 months (early treatment group) or in the second to third year (delayed treatment group) after diabetes diagnosis, and who were treated with insulin pump therapy for at least 1 year. When compared with the delayed treatment group, the early treatment group had significantly lower estimated A1C values (7.9% and 62.6 mmol/mol vs 8.0% and 64.1 mmol/mol), as well as lower rates of hypoglycemic coma (incidence risk ratio [IRR], 0.44) and hospitalization (IRR, 0.86). Although the early treatment group had better mean systolic blood pressure (117.6 mm Hg vs 118.5 mm Hg) and HDL cholesterol (62.8 mg/dL vs 60.6 mg/dL) levels, diastolic blood pressure levels, estimated BMI standard deviation scores, and concentrations of LDL cholesterol, non-HDL cholesterol, and triglycerides did not differ significantly between the groups during follow-up.

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