

Bridging the Medical Technology Gap: The Impact of New Technology on Diabetes Management

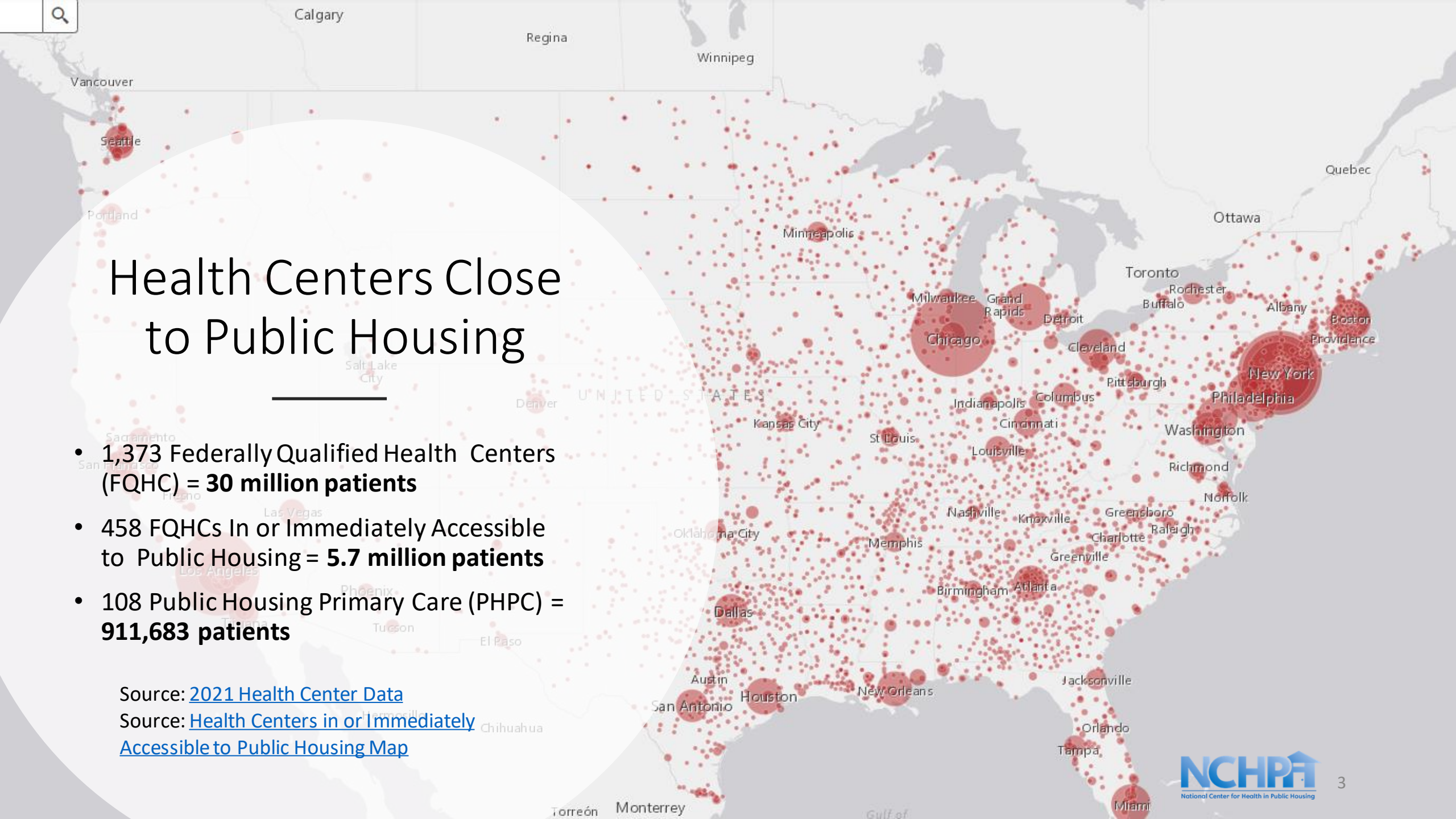
National Center for Health in Public Housing



National Center for Health in Public Housing

- The National Center for Health in Public Housing (NCHPH), a project of North American Management, is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for \$2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.





Health Centers Close to Public Housing

- 1,373 Federally Qualified Health Centers (FQHC) = **30 million patients**
- 458 FQHCs In or Immediately Accessible to Public Housing = **5.7 million patients**
- 108 Public Housing Primary Care (PHPC) = **911,683 patients**

Source: [2021 Health Center Data](#)

Source: [Health Centers in or Immediately Accessible to Public Housing Map](#)

Public Housing Demographics



1.5 Million
Residents



2 Persons
Per Household



38% Disabled



52% White



91% Low
Income



43% African-
American



26% Latinx



19% Elderly



36% Children

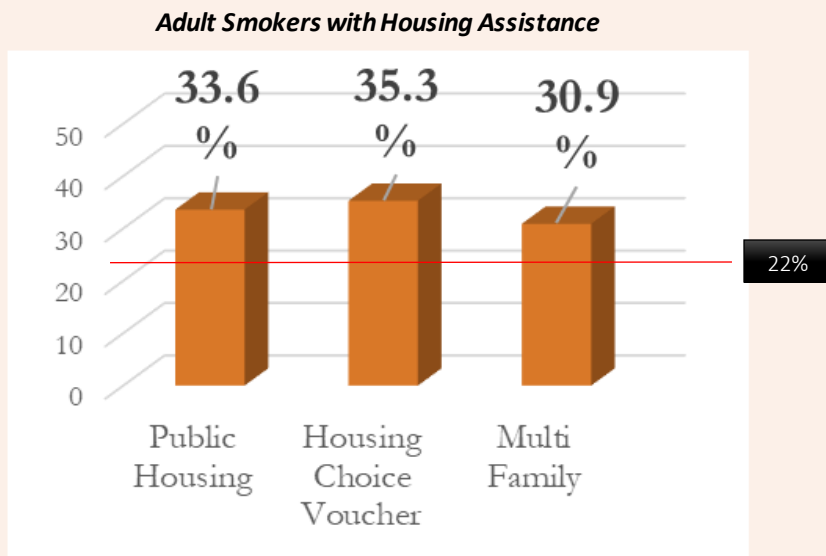


32% Female Headed
Households with
Children

Source: HUD 2023

A Health Picture of HUD Assisted Adults, 2006 -2012

Adults in HUD-assisted housing have higher rates of chronic health conditions and are greater utilizers of health care than the general population.



Source: [Helms, V. E., 2017, Sperling, J., & Steffen, B. L.](#)

	HUD-Assisted	Low-income renters	All Adults
Fair/Poor Health	35.8%	24%	13.8%
Overweight/Obese	71%	60%	64%
Disability	61%	42.8%	35.4%
Diabetes	17.6%	8.8%	9.5%
COPD	13.6%	8.4%	6.3%
Asthma	16.3%	13.5%	8.7%

Today's Speakers



Jose Leon, MD
Chief Medical Officer



Eric L. Johnson, MD
*Director of Interprofessional Education,
Education Resources*





Learning Objectives

1. Discuss blood glucose monitoring devices.
2. Compare insulin delivery systems.
3. Explain the use of digital health technology for people with diabetes.

Bridging the Medical Technology gap: The Impact of New Technology on Diabetes Management

Eric L. Johnson, M.D.
Assistant Medical Director
Altru Diabetes Center

Professor
University of North Dakota School of Medicine and Health Sciences
Grand Forks, North Dakota

Disclosure

- I have type 1 diabetes and I have used many of these devices
- I am not promoting any particular device(s)
- No other disclosures

Objectives

At the end of the webinar, participants will be able to:

1. Discuss blood glucose monitoring devices.
2. Compare insulin delivery systems.
3. Explain the use of digital health technology for people with diabetes.

Question #1

1. Insulin pumps and Continuous Glucose Monitors deliver fully automated insulin delivery:
 - A. True
 - B. False

Question #1

1. Insulin pumps and Continuous Glucose Monitors deliver fully automated insulin delivery:
 - A. True
 - B. False**

Question #2

2. Insulin pumps and continuous glucose monitors should only be used by people with type 1 diabetes:

- A. True
- B. False

Question #2

2. Insulin pumps and continuous glucose monitors should only be used by people with type 1 diabetes:

A. True

B. False

Question #3

3. Medicaid and Medicare don't pay for diabetes technology like pumps/smart pens/continuous glucose monitors (CGM's):

- A. True
- B. False

Question #3

3. Medicaid and Medicare don't pay for diabetes technology like pumps/smart pens/continuous glucose monitors (CGM's):

A. True

B. False

Many technologies

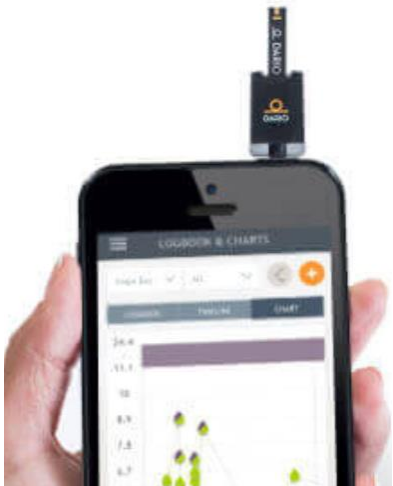
- Pumps
- CGM
- Smart Pens
- Smart Meters
- Apps
- Personal devices/trainers
- Open source DIY

Smart Meters, Apps, Fitness Trackers

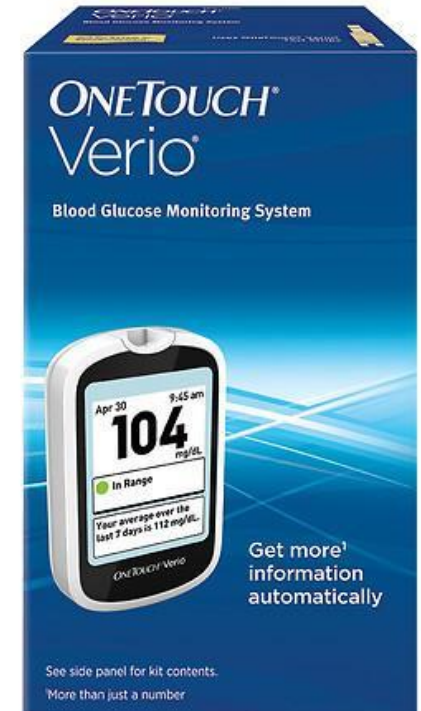
Smart Meters



Dario-clip on to smartphone



Contour



All are downloadable, some smartphone interface, track food, exercise, illness



MyFitnessPal

Calorie Counter &
Diet Tracker

GET

In-App
Purchases

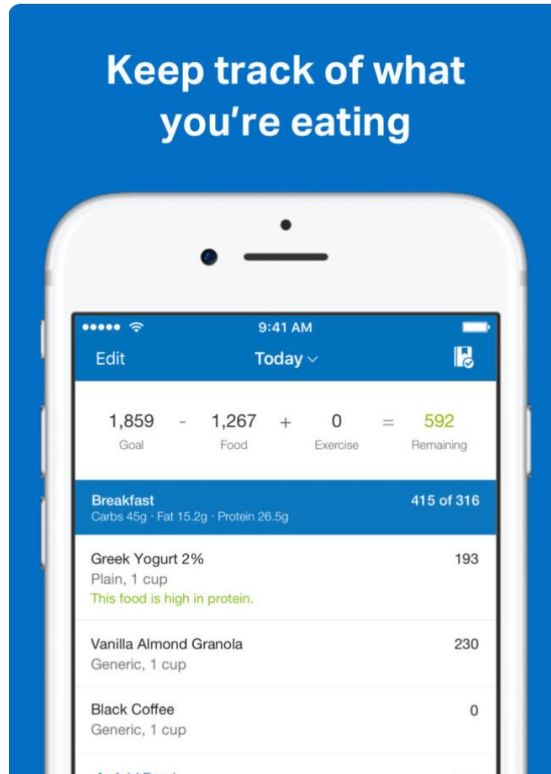


4.7 ★★★★★
328K Ratings

#3
Health & Fitness

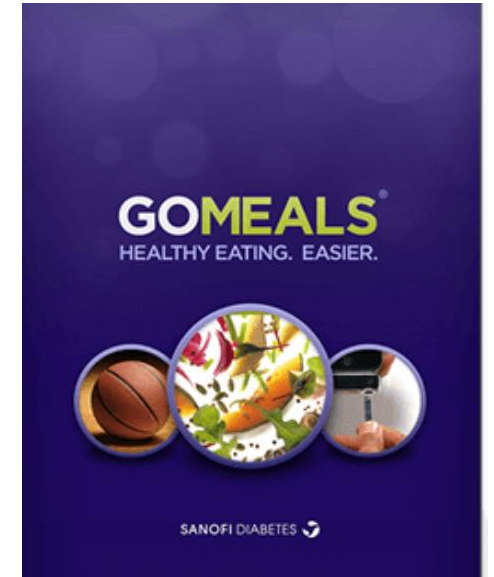
4+
Age

Apps



GLUCOSE BUDDY

MyNetDiary



Food, activity

*Look these up in the app store on your smartphone

Fitness Trackers

- Many devices
- Many applications
- Some have data sharing
- Challenge is integration of data meaningfully with EHR



Apple-use with Apple Watch



Fitbit



Continuous Glucose Monitoring (CGM)

CGM

CGM Professional

- CGM owned by the clinic placed by health professional to assess 7-14 days of blood glucose data
- We often do this for patients with variable blood glucose, difficulty achieving targets, A1C/BGM mismatches, or those considering a pump +/- CGM

CGM Personal

- CGM owned by person with diabetes
- Track data continuously
- Some integrate with insulin pumps, can also be used freestanding with injection insulin

CGM Systems*

Dexcom G6

- Does not require fingerstick blood glucose monitoring (BGM) for calibration
- Can be worn for up to 10 days
- Smartphone app
- Clarity platform
- Can share data with up to 10 people



New Dexcom G7 sensor is smaller than the G6 sensor. CGM and sensor are combined



Freestyle Libre 2 and FreeStyle Libre 3

- Do not require fingerstick BGM for calibration
- Can be worn for up to 14 days
- Smartphone app
- LibreLinkUp platform
- Can Share data with up to 20 people

Medtronic Guardian Connect

- Fingerstick BGM required for calibration
- Can be worn for up to 7 days
- Smartphone app
- Carelink platform
- Can share data with up to 5 people



*Can be used with insulin injections or pump therapy.

Implantable CGM

- Ascensia Eversense e3
- Requires fingerstick BGM for calibration
- Up to 6 months of use
- Has a phone app



Devices for Insulin Delivery

Devices for Insulin Delivery

- Insulin pens
- Connected or “smart” insulin pens
- Insulin pump (also called continuous subcutaneous insulin infusion)
- Often used with CGM
- Several different brands of each type of insulin delivery device

Connected Insulin Pens

Eli Lilly

Medtronic

Novo Nordisk



Each connect to various platforms

Sensor Augmented Pumps (SAP)

- Medtronic MiniMed 630G and Guardian CGM
- Tandem t:slim X2 Basal-IQ algorithm and Dexcom 6 CGM
- Omnipod DASH and Dexcom 6 CGM
- Not hybrid closed loop, but have low glucose suspend and alarms

Automated Insulin Delivery Systems

- Automated insulin delivery (AID) systems connect an insulin pump with a CGM system with a predictive control algorithm to automate insulin delivery based on real-time glycemic data.
- Commercially available systems are said to have “**hybrid closed-loop**” functionality because they automate insulin delivery in response to real-time glycemic data, but users must manually deliver mealtime bolus doses for carbohydrate intake.
- Fully closed-loop systems, when available, will be designed to automate all insulin delivery.
- Three AID systems are currently available in the United States.

AID Systems: Medtronic MiniMed 770G

- Tethered (tube and cannula) insulin pump
- Medtronic Guardian 3 CGM sensor (different-Bluetooth)
- Hybrid closed loop option
- Predictive control algorithm
- Dependent on user to enter carbohydrate intake and fingerstick glucose
- Fingerstick glucose needed for calibration
- Phone app can share data with up to five people
- Integrates with Accu-Chek contour glucose meter



AID Systems: Insulet Omnipod 5



- Wearable tubeless insulin pump (Pod)
- Dexcom G6 CGM sensor
- Predictive control algorithm
- Hybrid closed loop option
- Dependent on user to enter carbohydrate intake
- Handheld personal device manager looks more like a smartphone display
- Can also be operated with a compatible smartphone app
- Phone app can share data with up to 12 people

AID Systems: Tandem t:slim X2 with Control IQ Technology

- Tandem tethered (tube and cannula) insulin pump
- Dexcom G6 CGM sensor, can share with 10 other people
- Touch screen
- Predictive control algorithm
- Hybrid closed loop option
- Control IQ- gives correction boluses (60% of calculated)
- Automatically switches to 5 hours active insulin time on Control IQ
- Can also be operated with a compatible smartphone app



Other Technology

- DIY loops-open source algorithms
 - Not commercially sold, not FDA approved
 - Best for patients who are proactive, motivated, and tech-savvy
- Tidepool loop- has received FDA clearance, finalizing agreements with the various device manufacturers

Basal-Bolus Insulin With a Pump

- Only use rapid-acting insulin
- Small amount of insulin released every few minutes for basal coverage
- Larger amounts released for mealtime and correction bolus doses based on pre-programmed and user-entered data
- Pumps are like little computers; users/HCPs program the I:C ratio and insulin sensitivity factor, and users enter grams of carbohydrate so the pump bolus calculator can determine appropriate doses
- Calculator also takes insulin on board (remaining active insulin) into account
- AID systems handle basal insulin management automatically
- About 50% of TDD should be basal and about 50% should be divided among bolus doses, with some individual variation

Interpreting CGM Data for Clinical Decision-Making

CGM Data-Sharing Platforms

- All of the devices have proprietary platforms to upload/download data-Dexcom clarity, Medtronic carelink, tslim t-connect
- All have similar data reports
- I don't have a preference; they are all good
- In the era of telehealth, this ability to share and remotely monitor data is more important than ever
- Non-device specific platforms i.e., Glooko, Tidepool

Multisystem Downloading Platforms



Fitness +
Biometrics
Devices



Ambulatory Glucose Profile

AGP Report

Name _____
MRN _____

GLUCOSE STATISTICS AND TARGETS

26 Feb 2019-10 Mar 2019 **13 days**
% Time CGM is Active **99.9%**

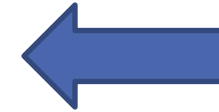
Glucose Ranges	Targets [% of Readings (Time/Day)]
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Above 250 mg/dL	Less than 5% (1h 12min)

Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.

Average Glucose **173 mg/dL**
Glucose Management Indicator (GMI) **7.6%**
Glucose Variability **49.5%**

Defined as percent coefficient of variation (%CV); target ≤36%

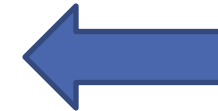
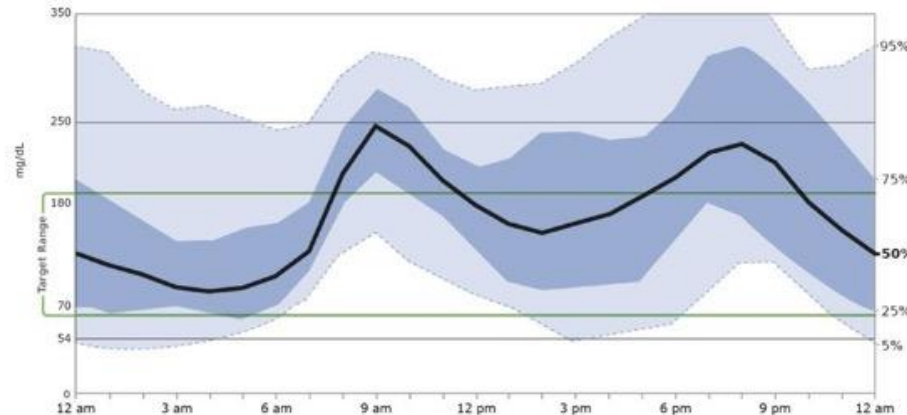
TIME IN RANGES



Look here first

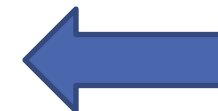
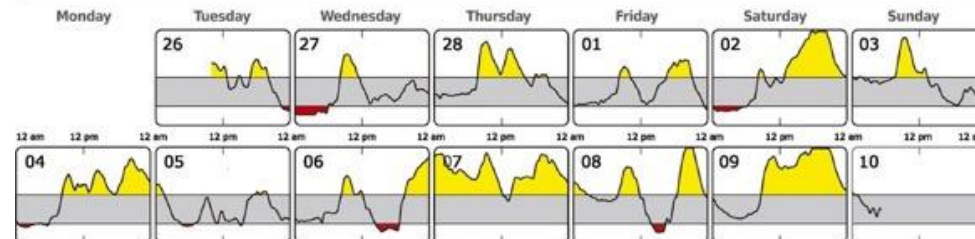
AMBULATORY GLUCOSE PROFILE (AGP)

AGP is a summary of glucose values from the report period, with median (50%) and other percentiles shown as if occurring in a single day.



7-14 day averages

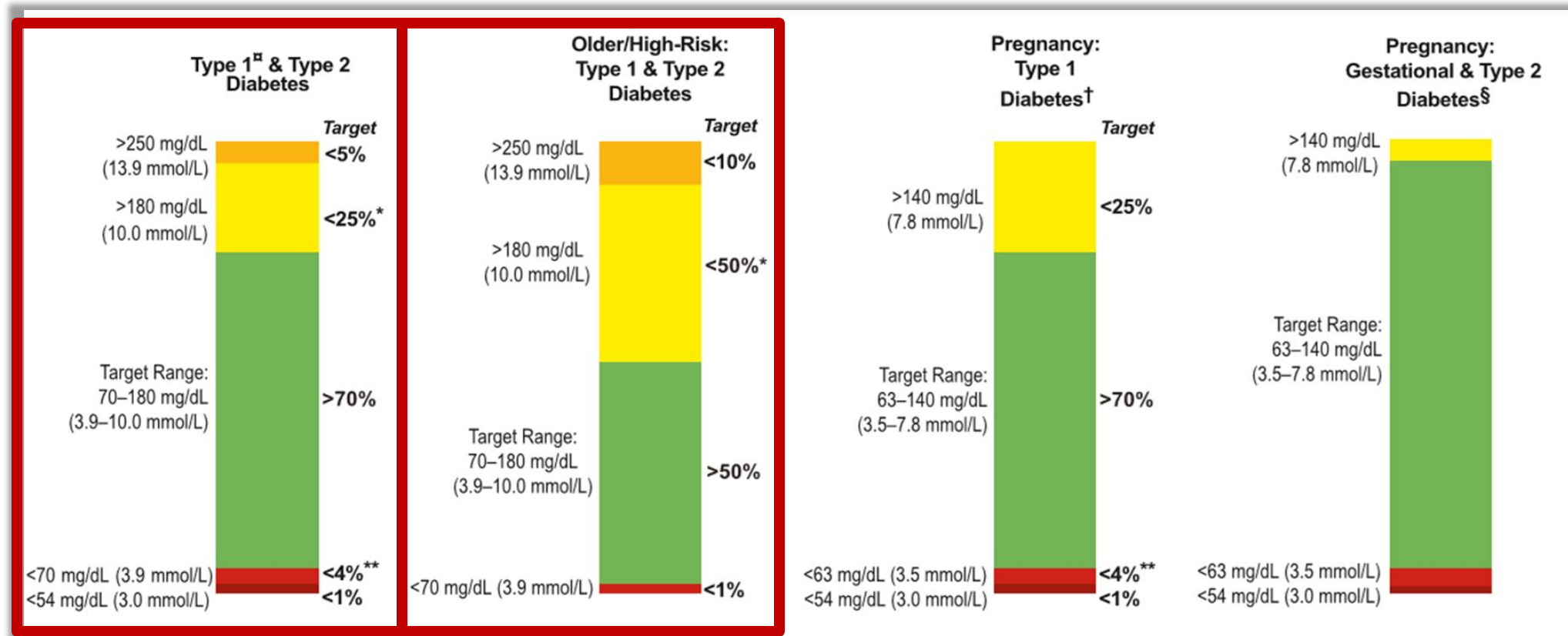
DAILY GLUCOSE PROFILES



Daily trends

Each daily profile represents a midnight-to-midnight period.

CGM Time in Target International Consensus Panel Recommendations



Who should have a pump and/or sensor?

Selection of Devices

- CGM: type 1 or type 2 on insulin
- Pump: type 1 or type 2 on multiple daily injections
- Shared decision making
- See ADA Standard of Care for more detail

Selection of Devices in My Practice

- Patients who are not meeting goals on multiple daily injections(MDI) with type 1 diabetes, some with type 2 diabetes on basal or MDI
- Patients who are good with followup (phone/text/in person/e-mail/appointments)
 - however, some “jump start” with some success with technology
- Patients with a lot of blood glucose variability
- Patients with asymptomatic hypoglycemia

Patient case

- 48 year old with type 2 diabetes of 7 years duration on metformin and basal insulin
- Based on this CGMpro data, what are some things we might do next?
- Is this patient a good CGM candidate?
- If yes, why?

AGP Report

March 31, 2020 - April 7, 2020 (8 Days)

GLUCOSE STATISTICS AND TARGETS

March 31, 2020 - April 7, 2020 **8 Days**

% Time CGM is Active **100%**

Ranges And Targets For		Type 1 or Type 2 Diabetes
Glucose Ranges		Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL		Greater than 70% (16h 48min)
Below 70 mg/dL		Less than 4% (58min)
Below 54 mg/dL		Less than 1% (14min)
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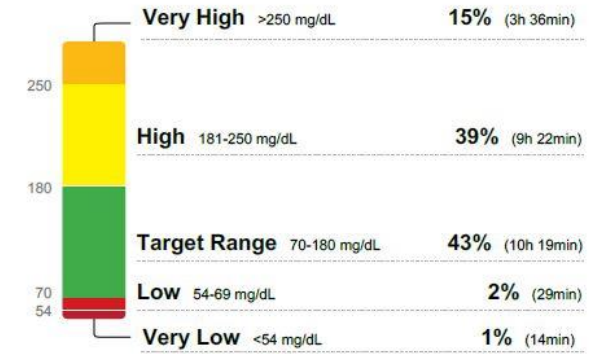
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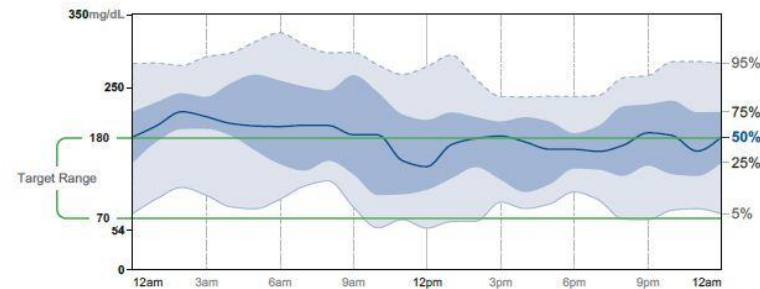
TIME IN RANGES



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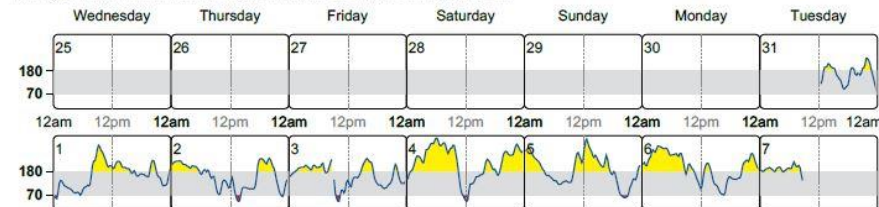
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DAILY GLUCOSE PROFILES

Each daily profile represents a midnight to midnight period with the date displayed in the upper left corner.



Getting Started

Think About Who Is On Your Team

- The primary diabetes provider
- Nurse
- Certified diabetes care and education specialist(CDCES)
- Nutritionist
- Advanced practice nurse or physician assistant
- Others (behavioral health, social worker)

Not every practice will have these team members

Get The Necessary Technology For Your Practice

- CGM's and Smart meters often have downloadable data sets
- The responsibility of downloading or compiling the data in-office can fall on a diabetes educator, but more likely in many primary care practices, a nurse or medical assistant can be trained to manage these devices
- All of the major device manufacturers have software that can be installed on an in-house computer where the data can be downloaded to paper or an electronic file (i.e., pdf) that may be uploaded into a medical record or uploaded to a commercial site
- Once you have done a few of these and develop a routine, the flow is usually good
- Doing in advance is best, but if done in office, may do encounter first and review data at end of appointment

CGM interpretation can be billed, many third- party payers cover such services

- What is included with CPT® code 95251?
- CPT® code 95251 is the analysis, interpretation and report for CGM for a minimum of 72 hours of data. An appropriate CGM analysis, interpretation and report should include the following elements:
 - Patient's name
 - Date of birth
 - Medical Record #
 - Indication for the device placement
 - Name/Type of device placed

Typical Ambulatory Glucose Profile interpretation template for electronic health record documentation may look something like this:

- Ambulatory Glucose Profile
- Dates of data review: ***
- Average SG: *** mg/dl.
- Coefficient of Variation (goal <36%): *** %
- *** % of time wearing CGM

- Glucose Ranges:
- SG below 54 mg/dl. (goal less than 1%) --*** %
- SG below 70 mg/dl. (goal less than 4 %) --*** %
- SG between 70-180 mg/dl. (goal is greater than 70%) --*** %
- SG above 180 mg/dl. (goal is less than 25%) --*** %
- SG above 250 mg/dl.(goal is less than 5%) --*** %

- Interpretation:
- ***

Medicare Coverage Requirements for Personal Therapeutic* CGM

- Have a diagnosis of diabetes, either type 1 or type 2
- Be treated with insulin
- Require frequent adjustments of the insulin treatment regimen, based on therapeutic CGM test results
- Have been seen in office within 6 months, and
- Continue to be seen at least every 6 months in order to continue to receive coverage

Patient case: Maria

Patient case: Maria

68 year old Hispanic female

- **Type 2 diabetes x 8 years**
- **Hx of HTN, dyslipidemia, albuminuria, transient ischemic attack**
- **GFR 45**
- **BMI 30**
- **A1C 8.5%**
- **Notes “lows”, often midday or overnight**
- **Medications**
 - **Atorvastatin 20mg daily**
 - **Lisinopril 10mg daily**
 - **Aspirin 81mg daily**
 - **Metformin 1000mg BID**
 - **Glimiperide 4 mg daily**
 - **Basal insulin 28 units hs**



Patient case: Maria

Which of the following glucose metrics is thought to be at least as important as the A1C level?

- A. Average glucose
- B. Percent of time sensor is worn
- C. Glucose variability measured by standard deviation or coefficient of variation
- D. Time in Range



Patient case: Maria

Answer: E All of the above when combined into a standardized CGM report



Patient case: Maria

- Individualizing A1C Goal -- factors to consider:
 - Support system
 - Vascular complications
 - Comorbidities
 - Life expectancy
 - Diabetes duration
 - Risks associated with hypoglycemia



Stop!

- What is going on with her?
- She has an elevated A1C with occasional lows
- What else in her history is concerning?
- What would be some good next steps?

Patient case: Maria

- Based on this CGMpro data, what are some things we might do next? (note- GMI is better than A1C?)
- Is this patient a good CGM candidate?
- If yes, why?

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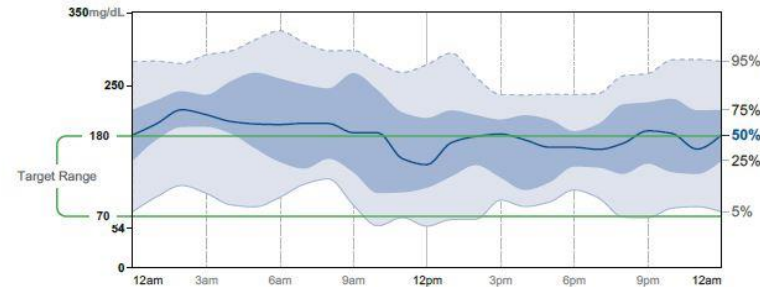
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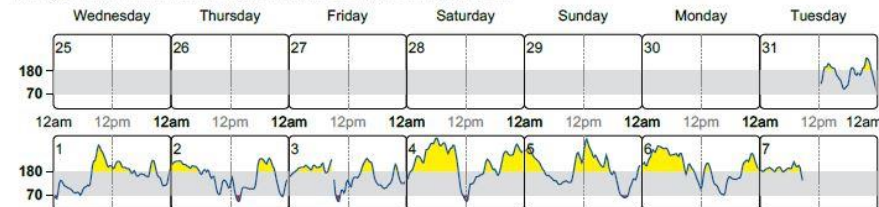
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Telehealth

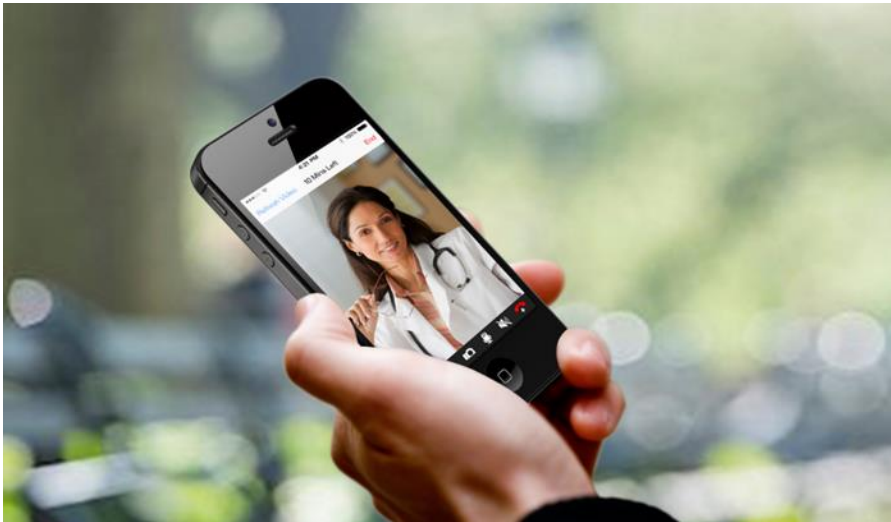
Essential Equipment for Success

- Good video source with best clarity and good lighting in the room
- Audio quality (headset, ear buds, or computer source)
- Secure high-speed Internet or cellular data capacity through secure hot spot
- Backup communication options (land line, cell phone)
- Computer, tablet, smartphone, or similar device
- Visual aids for patient education
- A secure, password-protected platform



Typical visits we are doing now from our diabetes clinic

Virtual Visits- device to device usually patient is in their home



Classic facility to facility telemedicine



Typical patient flow for a diabetes telehealth visit-

I can do these from home

Encounter “occurs” where patient is located

- **Telemedicine- patient in clinic-very much like a regular clinic visit**
 - Check in at reception at clinic in a remote site
 - Nurse or medical assistant gets vitals, reconciles medications, data management, etc
 - Nurse or medical assistant interacts with patient
 - Nurse or medical assistant stays in room for at least part of the visit to facilitate communication and engage with physician extender devices (stethoscope, ophthalmoscope, otoscope, etc
 - Charting very similar to clinic visit

Typical patient flow for a diabetes telehealth visit-

I can do these from home

**Encounter “occurs” where patient is located-
important for licensure**

- **Virtual (Video) visit-patient is on device to your device-usually from their home**
 - Patient electronically “checks in”- can do through electronic health record, secure password protected zoom meeting etc
 - Have the patient weigh themselves and check blood pressure if possible
 - Data available in advance if possible (remote cardiac monitoring, continuous glucose monitoring data, etc)
 - Select patients may have electronic stethoscope or other extenders
 - Charting very similar to clinic visit



AGP Report

GLUCOSE STATISTICS AND TARGETS

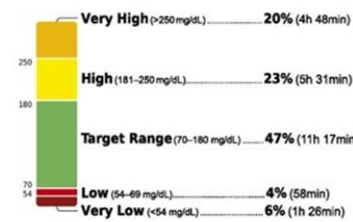
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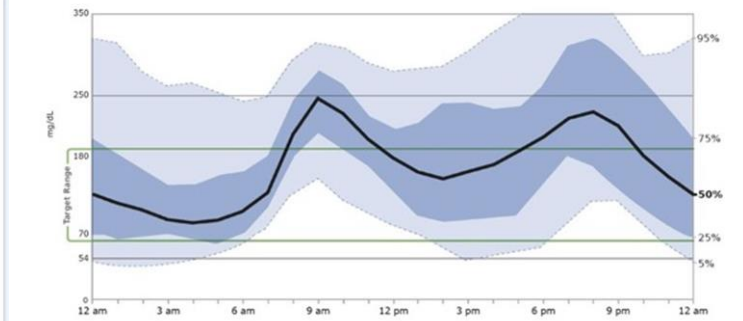
Name _____
 MRN _____

TIME IN RANGES

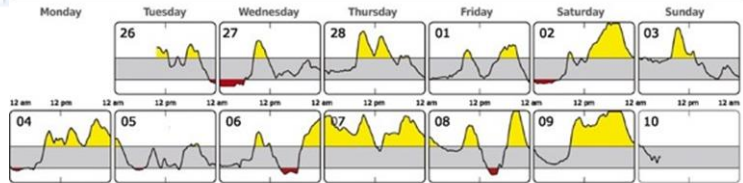


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DAILY GLUCOSE PROFILES



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- I prefer split screen- looking in the right direction while charting, reviewing data, writing orders, etc
- Can also do on multiple screens

Gaps in Technology Based Diabetes Care

- Availability of health care personnel familiar with devices
 - Pick a device like a CGM or a smart pen and get some experience with it
 - Who does telehealth? Can they link with your clinic?
 - Do you have community health care workers who can be familiar with devices?
 - It doesn't have to be all or none
- Payor variability, but we see a lot of Medicare and Medicaid coverage
- Provider biases
- Other social determinants of health
- Is technology widening the inequity gap?
- Who can make the leap in your practice?



Diabetes Care Is More Than Glycemic Management:
Addressing the Needs of the Whole Person

Avoiding Bias

- Be aware that coverage exists for diabetes technology, including Medicaid and Medicare-don't assume it won't be covered
- Racial and ethnic minorities and those of lower socioeconomic status have higher rates of diabetes, may have worse outcomes, and are less likely to be offered diabetes technologies
- Geographic disparities

Psychosocial Care

5.38 Psychosocial care should be provided to all people with diabetes, with the goal of optimizing health-related quality of life and health outcomes. Such care should be integrated with routine medical care and delivered by trained health care professionals using a collaborative, person-centered, culturally informed approach. **A** When indicated and available, qualified mental health professionals should provide additional targeted mental health care. **B**

5.39 Diabetes care teams should implement psychosocial screening protocols that may include but are not limited to attitudes about diabetes, expectations for treatment and outcomes, general and diabetes-related mood, stress and/or quality of life, available resources (financial, social, family, and emotional), and/or psychiatric history. Screening should occur at periodic intervals and when there is a change in disease, treatment, or life circumstances. **C**

Red letters are evidence grades. **A** = clear evidence from well-conducted, generalizable randomized controlled trials that are adequately powered. **B** = supportive evidence from well-conducted cohort studies. **C** = supportive evidence from poorly controlled or uncontrolled studies.

Psychosocial Care, continued

5.40 When indicated, refer to mental health professionals or other trained health care professionals for further assessment and treatment for symptoms of diabetes distress, depression, suicidality, anxiety, treatment-related fear of hypoglycemia, disordered eating, and/or cognitive capacities. Such specialized psychosocial care should use age-appropriate standardized and validated tools and treatment approaches. **B**

5.41 Consider screening older adults (aged ≥ 65 years) with diabetes for cognitive impairment, frailty, and depressive symptoms. Monitoring of cognitive capacity, i.e., the ability to actively engage in decision-making regarding treatment plan behaviors, is advised. **B**

Red letters are evidence grades. **B** = supportive evidence from well-conducted cohort studies.

[ADA Mental Health Provider Directory | American Diabetes Association](#)

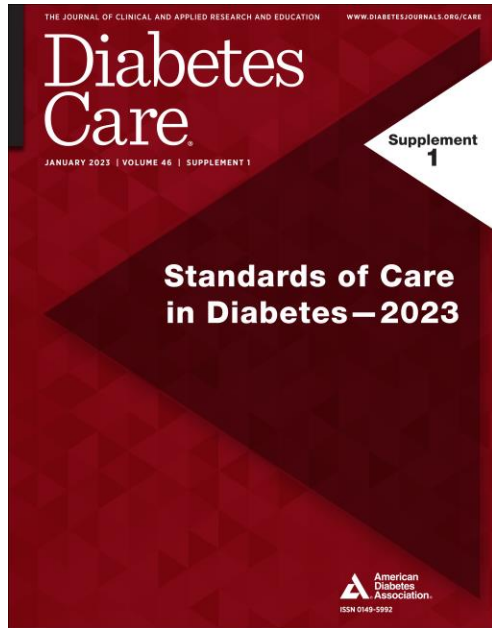
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**American Diabetes Association
Standards of Medical Care in Diabetes—2023
Abridged for Primary Care Providers**



<https://professional.diabetes.org/content-page/practice-guidelines-resources>



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The National Center for Health in Public Housing (NCHPH), a project of Health America Management, is supported in part by a cooperative agreement grant awarded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). To learn more about NCHPH, click here. To view our public housing demographics fact sheet, click here. What is the Health Resources and Services Address?



Health Behaviors and Public Housing
Health behaviors are detrimental actions that heightened the odd of illness and impede recovery. This map depicts some health behaviors by county and the location of PHPC health centers in the nation.

[VIEW MAP](#)



Health Outcomes and Public Housing
This interactive map explores the prevalence of diabetes, low birth weights, poor or fair health and HIV in the U.S. by county, so health centers can compare their performance measures and establish or modify health interventions addressing the health care needs of their communities.

[VIEW MAP](#)



Socioeconomic Health Factors and Public Housing
Social and economic factors are strong drivers of how well we live. Across the U.S., people who live in the bottom performance counties face higher rates of

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INTERACTIVE MAPS

The screenshot shows the NCHPH website with a navigation bar and a main content area. The main content area features a large banner for the 'PARTNERSHIPS TOOLKIT NOW AVAILABLE!' and three interactive maps. Each map has a 'VIEW MAP' button. The maps are titled 'Health Behaviors and Public Housing', 'Health Outcomes and Public Housing', and 'Socioeconomic Health Factors and Public Housing'. The website header includes the NCHPH logo and the tagline 'The National Center for Health in Public Housing - Enhancing Health Care Delivery for Residents of Public Housing'. The navigation bar includes links for HOME, TODAY'S AREA, RESEARCH & DATA, TRAINING & EVENTS, RESOURCE LIBRARY, ABOUT, and CONTACT US. The banner text reads: 'Check out our new partnerships toolkit, Healthy Together: A Toolkit for Health Center Collaborations with HUD-Assisted Housing and Housing Choice Voucher Program (in collaboration with HHS/CDC)'. Below the banner is a 'Welcome to The National Center for Health in Public Housing' message and an 'About' section with a link to 'What is the Health Resources?'. The maps are titled: 'Health Behaviors and Public Housing: Health behaviors are detrimental actions that heightened the odds of illness and impede recovery. This map depicts some health behaviors by county and the location of PHPC health centers in the nation.' 'Health Outcomes and Public Housing: This interactive map explores the prevalence of diabetes, low birth weight, poor or fair health and HIV in the U.S. by county, so health centers can compare their performance measures and establish or modify health interventions addressing the health care needs of their communities.' 'Socioeconomic Health Factors and Public Housing: Social and economic factors are strong drivers of how well we live. Across the U.S., people who live in the bottom performance counties face higher rates of...'

Complete Post – Evaluation Survey

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Thank you!

