The Lewin Group
Diabetes Care Assessment, Planning, and Management during COVID-19
May 5, 2021

Alana Nur: Thank you so much. My name is Alana Nur, and I'm with The Lewin Group. Welcome to our webinar today, Diabetes Care Assessment, Planning, and Management During COVID-19.

Today's session will include a presenter-led discussion followed up with time for questions and answers. The session will be recorded. The recording and a copy of today's slides will be available at ResourcesforIntegratedCare.com. There are two ways to listen to the audio for today's presentation. Audio should be streaming automatically through your computer's speakers. Make sure that your computer is connected to reliable internet, and that your speakers are turned up.

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And for those who are interested in continuing education, please do note the requirements for completing the post-test, as well as the pre-test and the post-test with a passing score by 11:59 p.m. tomorrow.

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At this time, I'd like to introduce our moderator, Lola Akintobi, the consumer and community engagement consultant at Community Catalyst. She provides training and coaching services that help develop and implement effective systems of consumer and community engagement in healthcare. Lola?

Lola Akintobi: Thank you, Alana. Next slide, please. So, I am pleased to join you today to be able to introduce our wonderful presenters. The first presenter that you will be hearing form is Dr. Vivian Cheng. Dr. Vivian Cheng is a primary care clinical pharmacy specialist at Bowdoin Street Health Center. She will be discussing clinical management today.

Next, we will be joined by Nicole Kohler, clinical design specialist, and Katie Sheridan, case management. The two are from Gateway Health, and they will be discussing how Gateway Health has supported dually eligible individuals from a health plan perspective. Next slide, please.

And then our final presenters are Dr. Vivian Nnacho Ayuk, chief executive officer from Sorogi, and Ms. Fontella Young from Sorogi. Together, the two will be discussing self-management, and Ms. Young will be discussing her experience as a participant in Sorogi. Next slide.

By the end of today's webinar, we are hoping that you will come away with the following learning objectives. The first is describe the disproportionate impact of COVID-19 on dually eligible individuals with diabetes, particularly those from communities of color. Identify approaches to providing both clinical management and self-management education and support, while adhering to physical distancing protocols.

Recognize barriers to telehealth for some members, and identify ways to successfully overcome them, and finally, name strategies for effectively connecting members to resources and supports, including food, medications, and supplies during COVID-19. Next slide, please.

So, today's webinar, we will have the following parts. We will start today's webinar off with a poll that will begin briefly, and then I will go into an overview of diabetes management, and then we will have our first presentation by Dr. Cheng, where she will be presenting diabetes care management and the clinical pharmacist's role during COVID-19.

Then we will have Nicole and Katie discuss this diabetes management and interventions, followed by Dr. Ayuk and Ms. Young discussing diabetes care and telehealth. We will then close out with an audience Q&A and an evaluation. Next.

So, our first poll has the question, which of the following best describes your professional area. You have the options of health plan case manager or care coordinator, health plan customer service, health plan administration and management, medicine, nursing, physician assistant, other provider, pharmacy, social work, advocacy. Please find the option that best describes you, choose that, and then we will see where the majority of our attendants are.

So, we'll give that a few more seconds. Okay. And can we advance to the results? Great, thank you very much. So, the majority of you, at roughly half, 48.2%, are health plan case managers and care coordinators, followed by health plan administration and management. We have 12.5% of you in medicine, and 1.2% in pharmacy, 14% of you are social workers, and 8% of you are doing advocacy work. Wonderful to have all of you on today's webinar.

And then we have one more poll question. In what setting do you work? Health plan, ambulatory care setting, long-term care facility, home care agency, community-based organization, consumer organization, academic research, other. And we'll take a few seconds for you to be able to respond to that.

All right, and can we advance to the results? Thank you; 66% of you work in health plans, 15.8% are in community-based organization, 11.5% are in other, and the last few percentages are in ambulatory care settings, long-term care facilities, and home care agencies. As you all can see, we have a wide breadth of professionals on today's webinar. It is a pleasure to host all of you.

And so now we'll go into an overview of diabetes management. So, because all of you are from different fields and have different levels of experiences with dually eligible individuals, with diabetes management, with health plans, it's important for us to start at the same place in understanding dually eligible individuals with diabetes.

When we look at the dually eligible population, we see that 23% of those ages 21 to 64 and 25% of those 65-plus have a diabetes diagnosis. For dually eligible individuals, there is a disproportionate impact by COVID-19, where case rates are 2.6 times higher than Medicare-only recipients. Diabetes rates for people of color ages 18-plus are up to three times higher than their white counterparts.

Diabetes management is important because uncontrolled diabetes can lead to poor health outcomes, such as cardiovascular disease, nerve damage, and damage to various organs. Uncontrolled diabetes is also associated with poor COVID-19 outcomes. Next slide.

And so, in today's webinar we will be discussing the importance of diabetes management, and to put it into context, when blood sugar is elevated and that persists, nerves, blood vessels, and other organs can be damaged. Controlling blood sugar requires both diet and exercise, and may require oral or injectable medications, such as insulin. People with diabetes need to control their blood pressure and cholesterol in order to be able to reduce their cardiovascular risk, resulting in such things as heart disease or stroke.

And finally, the hemoglobin A1C blood test is the best measure of blood sugar control over the last three months. It should be monitored at least two times a year. So, without further ado I will pass it to our first presenter, Dr. Vivian Cheng, who is a primary clinical pharmacy specialist, and she will be discussing diabetes care management and the clinical pharmacist's role during COVID-19. Dr. Cheng.

Vivian Cheng: Thank you so much, Lola. Good afternoon, everyone. Next slide, please. So, the Bowdoin Street Health Center was founded by community residents in 1972, and is located in Dorchester, Massachusetts, which is Boston's largest and most diverse neighborhood. We are licensed under the Beth Israel Deaconess Medical Center system, and we are also a member of the Beth Israel Lahey Health Performance network, which is a clinically integrated network focused on population health and providing value-based, cost-effective care.

We are very proud to serve all patients, regardless of insurance, immigration status, and we have a diverse staff who speak many languages, such as Spanish, Portuguese, Haitian Creole, and Cape Verdean Creole. And some of our services that we provide include, but are not limited to, adult and family medicine, mental health, pediatrics, and community health programs. Next slide, please.

So, a brief snapshot of our patient demographics that are available. A little over 15% of our adults have type II diabetes and two-thirds of our patients reside locally in the Dorchester neighborhood. As you can see, over half of our patients are Black and then 22% of those patients are actually Cape Verdean, so we have a very specific and unique patient population here. Additionally, the vast majority of our patients are adults over 18 years of age, and we have about 15% of our patients who are 65 years and older. Next slide, please.

So, at Bowdoin Street we have different diabetes initiatives, but primarily we are taking a population health approach to managing diabetes. The goal of population health is to try to proactively connect with patients who have uncontrolled diabetes and either engage them or reengage them, for patients who are overdue for follow up. And another goal is to also identify ways to better optimize the diabetes care.

And specific activities that help support these initiatives include staying up to date on certain evidence-based diabetes medicines. And so over the last five to 10 years, we've had a bit of an explosion in different diabetes medicines, both oral and injectable, available to us, and many of them confer additional benefits beyond helping to lower blood sugar, such as cardiovascular benefits, renal protective effects, and we want to try to prioritize those as well.

We also try to keep up-to-date on insurance formulary changes and costs for medicines, and we analyze data from our electronic health records system, and we can generate patient-level reports to identify potential waste to improve patients' diabetes medicine. And especially during COVID-19, having this proactive approach and using the lens of population health management has been super important for helping to identify our patients who have uncontrolled diabetes.

Our patient population has been disproportionately impacted by the COVID-19 pandemic, and many patients who may still be hesitant to come into the clinic are at risk for continuing to go without care. Furthermore, this proactive outreach itself is critical, because some patients may have challenges in getting to the office, whether it's

scheduling appointments via phone, transportation issues, and so having this proactive approach is -- you know, we can still keep a handle on some of our patients who are so important to us. All right, next slide, please.

So, at Bowdoin Street, we have complex care management teams, and so we take a multidisciplinary, patient-centered approach, and so some of the members of my teams include myself as the clinical pharmacist, nurses, community health workers, behavioral health specialists, and others.

Additionally, pre-COVID we had programs such as diabetes group classes and the diabetes prevention program. We also have a wellness center located in the health center, which includes two exercise and activity rooms, and a demonstration kitchen, shown here in this picture. And so these resources were able to provide health education, physical activity, and also a feeling of community and support for our members and patients. Next slide, please.

And so to highlight a little bit more about what I do as a clinical pharmacist, so, I have a collaborative practice agreement with the Bowdoin Street physicians, and when they refer patients to me, I'm able to help co-manage patients with diabetes, hypertension, and high cholesterol. And so I hold my own appointments with patients via telehealth and in person, where I adjust and optimize medicines that align with both best-practice guidelines, but also considering individual patient preferences and needs.

So, the more I can help triage questions and concerns related to medication costs and formularies, order pertinent lab work that may be overdue, and also provide patient and provider education. Next slide, please.

So to step back and talk about the impact the COVID-19 pandemic has had on patients with diabetes, it's impacted them in a lot of different ways, the first being with gym closures and especially over the winter, there's been less physical activity, which can lead to weight gain and worse blood sugar control. There has been less access to healthy foods, both due to financial stressors and potentially reduced access to grocery stores.

Those financial stressors can also prevent people from accessing needs like medications, diabetes testing supplies, doctor visit copays, transportation to clinics. Additionally, fears and hesitancy about COVID-19 exposure can result in less people wanting to come into the health center for appointments, and additionally, we've seen a lot of different offices have either closures or restricted in-person hours as well, which can reduce access.

Furthermore, during the pandemic we've seen the rise of technology and telehealth. However, many patients have either lack of access to certain technologies or have barriers to using a technology which can impact their ability to engage in telehealth services.

And finally, we also have to be mindful of the impact of the pandemic on mental health. So, the isolation, the lack of social connections, it adds on the stress of managing chronic diseases like diabetes. It can all take a toll. Next slide, please.

So, at Bowdoin Street, for some supports for people who have diabetes, first is conducting visits through telehealth. We primarily conduct most of our telehealth via phone at this time, but we are rolling out virtual platforms to engage in video visits. We also perform telemonitoring of home blood sugars and blood pressures, and right now this is just having patients either check their sugars or blood pressures on the phone while in the telehealth appointment, or having them go through their machines to report back numbers.

Additional, we've been providing free blood pressure machines for patients with uncontrolled hypertension who may not be able to afford one on their own. And then to work around following up on lab appointments for blood work, we've been scheduling patients for lab slots instead of having walk-ups, to follow social distancing recommendations.

Furthermore, we have weekly exercise classes via Zoom, and so we have HIIT training classes, Zumba, and Cardio Blast to help provide members and patients some structured activity. In the fall we also hosted a virtual wellness fair called Healthy at Home, where we covered topics such as better understanding the COVID-19 pandemic, better understanding how to check their sugars and blood pressures at home, and some nutrition tips and tricks.

At Bowdoin Street we are also very fortunate to have a community health worker who specializes in nutrition and food access, and so she helps connect our members to SNAP benefits, our Fresh Truck, and enrolling patients in medically tailored meal delivery programs, if they're eligible. Next slide, please.

And so next, I wanted to spend some time talking about considerations for the clinical management of diabetes that I think are particularly important. And so first, as background, as a pharmacist, my specialty area is in medications, and per the 2021 American Diabetes Association guidelines, we should be prioritizing medicines that confer those additional benefits that I mentioned earlier--the cardiovascular, immunoprotective effects.

Those should be prioritized first, because they provide those additional benefits beyond just lowering sugar. Additionally, we also have to consider patient-specific factors. And so looking at patients' past medical history -- for example, if someone has chronic kidney disease or a history of a heart attack, that may push me to use a certain medication over the other.

I also have to think about dexterity, for patients' ability to check their sugar or administer insulin. If they had visual impairments or had really bad arthritis, that may impact my

recommendations for how frequently they should test the sugars, or if you can even use insulin at all.

And then finally, we also have to take into consideration the patient's preferred language, literacy, and health literacy levels. For example, patients who have low literacy and health literacy, using patient handouts with written information may not be as valuable for them.

Next, this may seem obvious, but I think it is so important to ask questions and confirm understanding rather than make assumptions. And so if you are able, it's important to double-check refill histories, to confirm if perhaps medication nonadherence is an issue. We also want to ask open-ended questions, and avoid leading questions.

So asking questions like in the last two to three weeks, how many times did you maybe forget to take a medicine. It forces the patient to give us a number. And avoid leading questions, such as you don't forget to take your medicine, do you, which sets up the patient for the desired answer, not necessary the truthful answer.

And finally, it's so important to use teach-back technique to verify patient comprehension. There have been many instances where I teach patients how to use a glucometer or an injectable medication, and once I put the device in their hands, they don't know where to start.

We also need to have shared decision-making discussions with patients when we're setting their goals and choosing medications. You know, I may think that a certain medicine that's an injection is the best medicine for a patient, but if they are adamant and refuse injections, then we have to shift and pivot.

And finally, it's extra-important, especially during the COVID-19 pandemic, to be flexible and empathetic. Remember, we have to treat the patient. We are not treating the A1C, we are not treating the blood pressure, we are treating the patient as a whole. Next slide, please.

And then finally, a couple considerations for patients who may be blind or visually impaired, or deaf or hard of hearing. This may require some more creative workarounds, such as getting permission to work with a family member or visiting nurse to track home blood sugar and blood pressure readings.

I think at this point it's also important to simplify medication regimens and use medicines with a lower risk for causing hypoglycemia. And then we can also be a little bit more creative with our glucose monitors as well.

There are monitors that can verbally read out the sugar reading, for those who may be visually -- who have visual impairment, and then if possible we can also consider using continuous glucose monitors to reduce need for frequent finger-sticks. However,

insurance coverage can be tricky for continuous glucose monitors, and they can also present a technological difficulty for certain patients as well. Next slide, please.

So, I wanted to next highlight a couple cases from Bowdoin Street. So, first is Mr. M. He is a 56-year-old Indian male, and his last A1C was 10.3% back in February. And he also has a strong personal and family history of cardiovascular disease. Due to these co-morbidities he was fearful about going back into the office, due to the risk of coronavirus exposure.

But we were able to reengage Mr. M. via telehealth follow up, and we actually learned that he was only checking his sugars when he felt unwell. He wasn't checking them every day or necessarily even every week. And then there was also some sporadic medication adherence, because the medicine brand he was prescribed for his diabetes, it wasn't covered by his insurance and so it was extremely expensive, so he was only picking it up occasionally.

Through these frequent telehealth check-ins, we were able to provide education on the importance of checking his sugars daily, importance of improving his diet and adding in more exercise, and we also adjusted his medication to a formulary agent from his insurance to help improve adherence. And after all of that, we actually were able to improve his sugar control. His A1C improved by about 2 percentage points as of March 2021. Next slide, please.

And next in our final case example is Ms. B. She is a 65-year-old Cape Verdean woman who lives by herself about an hour away from the clinic, so it can be difficult for her to travel to doctors' visits. Her last A1C was around 10.9% in July of 2020, and she cannot read or speak English.

She also had a lot of difficulty checking her sugars. First she had difficulty using the device, and she also didn't quite understand what the numbers meant when she did check her sugars. She also struggled with taking her medications as prescribed. Using the injection medicine that she was prescribed, it was a daily injection where she had to select the dose, and she just also didn't like doing injections every single day, which led to some missed doses.

So we engaged Ms. B. through both telehealth and in-person visits, using an interpreter. We were also able to connect with her daughter, with the patient's permission, who was able to help provide a little bit more support in helping her mom stay on top of taking her medications daily and check and understand her sugar readings.

We also were able to involve the patient in our medication adherence packaging service, which is a monthly delivery of weekly adherence packages to help simplify her regimen a bit. And we also switched her from a daily injection to a once-weekly injection, where the device was much easier to use. She doesn't have to select a dose, and it was only once a week.

And so with all of that, we were able to improve her fasting blood sugars down to around 140 mg/dL, which is about an estimated A1C of around 6.5%. We were very pleased with her progress. Next slide, please.

And so moving forward, as we hopefully transition into a post-pandemic world, some of our plans for diabetes care management include re-instituting in-person diabetes group classes and nutrition classes. We will continue to offer telehealth options, because telehealth looks like it's here to stay. It's becoming more popular and integrated, and this can be very convenient for a lot of patients who maybe have transportation difficulties to get to their office.

We can continue to follow up on their blood sugars and blood pressures from afar. We're also very excited in that there are plans to build an on-site clinic pharmacy on the first floor, which will hopefully make it easier for a lot of patients to get their medicines. Because currently our clinic is located in a bit of a pharmacy desert.

And that, I believe, is the end of my presentation. And so now I will pass it on to Nicole and Katie from Gateway Health, who will present on diabetes management intervention during COVID-19.

Nicole Kohler: Thank you, Vivian. Good afternoon, everyone. I'm Nicole Kohler. I will be speaking first, and then I'll be kicking it off to Katie Sheridan. Next slide, please.

Before diving in a little bit, just to provide a little background about Gateway Health. We serve over 340,000 members across Pennsylvania through our dual eligible special needs plans, or D-SNPs, as well as our Medicaid plan. We are headquartered in Pittsburgh, Pennsylvania, with over 1,500 associates that support our mission to care for the whole person in all communities where the need is greatest. Next slide, please.

As many of you are aware, managing and treating diabetes requires a multidisciplinary care team, and we here at Gateway feel no different. We have a diabetes workgroup that strategizes the interventions and initiatives to improve the access, address disparities, and covers the overall spectrum of diabetes are, and including barriers of social determinants of health.

Making up this disciplinary care team are multiple departments. We have myself in strategy and innovation; we have clinical improvement, really pushing on those performance measures; medical management, for clinical oversight and guidance; case management for intervention, support, and feedback; pharmacy, to address medication-related needs, as well as coverage; analytics supports us with data. We can move to the next slide.

Case management provides the timely coordination to address our members' healthcare needs, which as you can imagine required some ingenuity and persistence during the pandemic. Katie will speak to those in a few moments. The case manager here is really key in our integrated care model, and may be a registered nurse or a social worker.

They collaborate with our members for care coordination, care transition, disease education, needs assessment, for identifying barriers, and support goal-setting and adherence to treatment plans. Many of our case managers work with our members through telephonic outreach. We also have dedicated field-based teams that work with our members face-to-face, in-person, in the community.

Prior to the restrictions from COVID-19, these field-based case managers literally met the members where they are. Whether that was within their doctor's appointment, at a hospital, within the member's home, or another safe and secure place within the community.

During COVID-19 and currently we've developed processes and implemented them to support the members that were used to this, the providers that were also used to having our case managers there to work remotely until we're able to resume working back in the field.

All of our case managers work closely with the providers and community partners to support the needs. Members that require additional assistance with diabetes may be referred to our certified diabetes care and education specialist, CDCES wellness coach. Members are also able to refer themselves 24 hours a day, seven days a week, through our online member portal. Next slide.

So, what does wellness coaching through our CDCES look like? It really focuses on a lifestyle improvement through education and counseling. To use those assessments and clinical judgment to set realistic goals with the member. Diabetes self-care behaviors -- you know, healthy eating, physical activity, self-monitoring, problem-solving, risk reduction, healthy coping, are really at the forefront of the conversations and are incorporated into all coaching sessions to help members achieve their goals.

And members with diabetes are at various points of their diabetes journey. So, engagement with our CDCES really reflects that. Some interactions are short, which may be completed in a single session; others require multiple sessions over several months. Our CDCES may also screen for diabetes distress, to uncover any distress that is caused by the burden of having diabetes or the day-in and day-out care for managing diabetes. There is a link with more information on the diabetes distress screener in the Resources section at the end of the presentation. Next slide.

As with every aspect of our lives, the public health emergency really necessitated our adjusting. So, early on in the pandemic, the work -- we had workgroups that were really created to focus on COVID-19, promoting the outreach and education on CDC guidelines. As the vaccines became available and were rolling out, a vaccine workgroup was created to really ensure we were strategic in our approach to get as many members vaccinated as possible.

This workgroup worked to develop -- excuse me -- content that was available telephonically over (inaudible), or even online, so we can engage our members and educate them on the vaccine. We also really worked to partner with our providers, community partners, and other key stakeholders within the community to align on vaccine events to then get our members scheduled and ultimately vaccinated.

Early on and periodically throughout the beginning of the pandemic, we made some proactive call campaigns to our high-risk members, really informing them of the risks of contracting COVID-19 as well as encouraging adherence to the CDC guidelines. In addition to our dedicated COVID-19 workgroups, the diabetes workgroup that we have incorporated discussions to work through barriers that members were facing, specifically around access to testing as well as medical appointments as a result of the closures.

Members who are having a difficult time getting an A1C test or a screening test for nephropathy to test for impaired kidney function were mailed at-home test kits. Within these kits there were instructions of how to complete the test, as well as directions on how to return the completed test for processing.

The results were then shared with the member's primary care provider that we had on file for any necessary follow-up. And as you can imagine, as we started to work remotely, we had to engage our members a little bit differently as well. So one of our community engagement teams that really works with our practices to schedule appointments for members that are overdue for any type of appointment or test had to be -- adapted their workflow.

One thing they found is offices were operating differently, or short-staffed, so they worked in collaboration with some provider practices to develop workflows that are allowing members who are not able to connect with their provider to work with us, and we were able to transfer the members to their provider for follow-up care. Another community engagement team developed virtual events that also enabled them to continue their work just a little bit differently. And now, I'll turn it over to Katie.

Katie Sheridan: Thank you, Nicole. It is important for our case managers to stay engaged with our members during this difficult time. They were tasked to complete outreach calls to identify any barriers that our members may have been experiencing during the COVID-19 pandemic. During the initial lockdown phase, we were specifically targeting members that were at high risk of a COVID-19 hospitalization, including our members that have diabetes.

These calls gave our case managers the opportunity to provide COVID-19 education and information from the CDC, assess needs around social determinants of health, barriers to care, and physical and behavioral health needs, review plans for our members with diabetes, if they were to quarantine or contract the virus, making sure they would have enough food or insulin for at least 14 days, and lastly, over the recent months, providing information on COVID-19 vaccines, addressing vaccine hesitancy, and scheduling agreeable members, as well as their families, for a vaccine appointment.

During our outreach calls, the case managers discussed and identified several barriers to care, and most important to note that COVID-19 was its own separate barrier to navigate that presented new challenges to overcome. Specific to this presentation, I will discuss the concerns, potential impact and interventions with each barrier for our members who have diabetes.

The potential concerns are much the same with each barrier. We wanted to avoid unstable blood sugars that could result in an inpatient hospitalization, and a decline in a member's overall health and wellbeing. Next slide, please.

Transportation was a common barrier. Members were scared to use shared rides or be exposed by a driver. Members were social distancing from families who normally provided transportation for them, or transportation options were just limited. We wanted to ensure our members' needs were being met, that they were attending their doctors' appointments, had enough medications, and had adequate food supplies, and had transportation options to obtain a COVID-19 vaccine in the more recent months.

The case managers provided education on their supplemental benefit vendor. Our Medicaid members qualify for an allotted amount of rides per year to medical appointments. That includes the pharmacy also. Connecting our insulin-requiring members to their supplemental benefits, which include transportation to non-medical appointments, going to the grocery store, food banks, and educating our members on the use of their medical assistance transportation options. Also educating our members on telehealth visits, home delivery options, and where and how to seek care. Next slide, please.

Food access and availability has been a strain for most people during this pandemic, whether it be limited food options at the store, fear of being exposed, or loss of job and income, making it difficult for adequate nutrition. Our goal was to offer education on diet for diabetes, healthy eating on a budget, and accessing food bank resources. We were helping our members find food banks in their area, setting up appointments to pick up their food, referring members to our wellness coach for further education and planning, and using home delivery options, if applicable. Next slide, please.

Provider availability has been a struggle, as you've heard during this presentation so far. Limited office hours, limited office staff, and limited options. During the initial phases, providers were not regularly having those in-person visits to assess a member's status. Some members also lacked smartphone or computer internet access to make or access telehealth appointments, and the lab closures made getting blood work done more differently.

Case managers were providing support to our members by encouraging member, provider, and caregiver collaboration, providing education for telehealth options, either by video if the member had that capability, or by phone, if there was no video option.

Then the provider and member could decide the next steps, if a provider felt the member needed to be seen in person.

We were also assisting and arranging for SafeLink phones if a member qualified, sending members at-home hemoglobin A1C testing kits via mail, and in the more recent months, utilizing our new connection centers for technology access in the Pittsburgh and Harrisburg areas.

We were encouraging our members to discuss electronic medical record options with their providers, if appropriate. Also providing education on Gateway Health Plan's 24/7 nurse line availability for non-emergent needs. Next slide, please.

Our objective was to ensure that our members' needs were met, and obtaining their medication would not be a barrier or something that they would have to stress over. It was significant to inform our members of their options if they were avoiding exposure by leaving their home or had any transportation concerns.

Gateway had increased the allowance to be filled for a 90-day supply for all medications. This also included testing supplies for diabetes, copays and fees were waived for diabetic testing supplies in 2020, and there were no copays and fees for diabetic testing supplies in 2021. Arranging for pharmacy delivery of at-home medication packs, either with their own preferred pharmacy or utilizing a mail-in pharmacy.

We were also encouraging our members to speak with their providers regarding glucose monitoring options. It was discovered that members were testing their blood sugars more during lockdown, and running out of testing strips. So, just having open communication with their provider regarding their best options. Next slide, please.

Mental health is its own separate barrier, much like COVID-19. Our concern was members were at risk for increased depression and anxiety related to the pandemic. Fear of exposure and increased social isolation, increased depression and anxiety with a member who has diabetes can lead to a lack of testing, poor nutrition, lack of exercise, and not taking medications appropriately.

Our case managers were arranging telehealth visits to talk with their providers, providing education on coping skills, connecting members to behavioral health providers, and referring members to virtual support groups. We also utilized our governor's mental health resources and their 24/7 support line that became available during the COVID-19 pandemic.

We had definitely seen an increase with our engagement rate with our members during the lockdown phase. They were more responsive and willing to work with our case managers to find assistance. Next slide, please.

So, lack of exercise -- the gyms have closed down, and there were limited options for members due to social distancing. The concerns that we had in regards to lack of exercise

was weight gain, decrease in mobility, and at-risk for developing hypertension or any diabetic complications.

Our case managers were referring to at-home options and virtual classes, encouraging at-home exercise and increased communication with their providers regarding exercise capability. Next slide, please.

Okay. So, please note that the names and any identifying information have been changed to be in compliance with HIPAA guidelines. This is just one example of a success story between the Gateway Health Plan case manager and one of our dually eligible members.

So, a member dually eligible for Medicare and Medicaid was referred to case management after a recent in-patient hospital stay for uncontrolled diabetes with osteomyelitis of her foot. She shared that her health had declined since the start of the COVID-19 pandemic. She was in fear of leaving her home until she ended up being hospitalized.

An initial assessment, including conversations with the member and the Gateway case manager and her home health aide identified needs, barriers, and possible interventions. She also identified a lack of transportation as a barrier to attending provider appointments, and indicating discomfort related to frequent blood sugar testing. Next slide, please.

So, our case manager worked with Kendra during this case. She was able to arrange bathroom safety equipment for her, which is one of our supplemental benefits to reduce her fall risks associated with her osteomyelitis. She was able to arrange transportation, so she was able to get to her endocrinologist appointment and her follow-up surgeon appointment. The case manager also provided education around alternative glucometers, including continuous glucose monitoring to address her discomfort related to frequent testing, and a diabetic diet and other information around maintaining a healthy lifestyle at home during COVID-19.

Kendra has since switched to continuous glucose monitoring and implemented small changes in her diet, including using a food log and has reported her regular blood sugar monitoring as normal blood sugar range. That concludes my part of the presentation. I would next like to introduce Dr. Vivian Ayuk and Fontella Young, discussing diabetes care and telehealth during COVID-19.

Lola Akintobi: Dr. Ayuk, if you're there, I don't think we can hear you. Dr. Ayuk or Ms. Young, we can't hear you. You might be muted. Apologies, everyone. Let's see if we can get this technical glitch worked out. We know we heard you earlier.

Vivian Nnacho Ayuk: Hello?

Lola Akintobi: All right, I think we can hear you now.

Vivian Nnacho Ayuk: Can you hear me?

Lola Akintobi: There was a bit of an echo.

Vivian Nnacho Ayuk: All right, I apologize. I'm not sure exactly what happened, but we'll take it from here. Good afternoon, everyone. I am Vivian Nnacho Ayuk, and I'm CEO of Sorogi. Thanks for the opportunity to share our experience providing diabetes care and support during the COVID-19 pandemic. And I'm also joined by Ms. Fontella Young, who was a participant in our program, and you'll get to meet her shortly. Next slide, please. Next slide.

A little bit about Sorogi, and we will get into the patient participant demographics. Sorogi is actually a health and wellness company out in Washington, DC. That's where we're located. And most of the participants that we serve come from wards seven and eight. We primarily provide education and support to people who live with diabetes or hypertension or have hypertension.

And we also support the providers who care for them by providing them with education opportunities on how to work best with community organizations such as ours. Like I mentioned, the majority of the participants that come into our programs are from wards seven and eight, and we have eight wards in Washington, DC.

And if you look at the map on your right, you will see that wards seven and eight have the highest percentage of residents who have diabetes. Overall in the district, 9% of the population do, but in wards seven, eight, and also in wards five and six, you see that we do have double-digit numbers.

The majority of the participants in our programs do identify as African-American, and also wards seven and eight, which is where we get a lot of referrals from, have the highest percentage of food desert -- over three-quarter of the total food desert in DC. are located in wards seven and eight.

In addition to that, we also have limited education and support programs for people with diabetes. At last count we did have about 17 total programs in the district, and only four of those programs are located in ward eight and seven. The majority of them being in ward one and two. So, there is a lot of disparities in the district. Next slide, please.

In terms of age distribution, we have 68% of our participants fall between the age of 35 and 64. Less than 6% are less than 35 years of age; 26% are over 65 years. Gender-wise, 80% of them are female, and we only have about 20% of them as male. Previously mentioned, we have majority of our participants identified as African-Americans, and 24% of our total participant population are dual eligible for Medicare and Medicaid. Next slide.

In terms of programs, we do have the Diabetes Self-Management Education and Support program, which is our signature program we get the most referral for. That's the one that

we get a lot of referral from primary care providers and also specialty. In addition to that, we also provide the diabetes prevention program, which is a CDC program for people with pre-diabetes, who are diagnosed with pre-diabetes.

Also in addition to that we also have the remote patient monitoring, which is a new program that we put in place to be able to have specifically generated data from their Bluetooth devices, and incorporate that in the care that we provide for them. Next slide, please. Next slide.

Lola Akintobi: I believe we're on the slide with the diabetes care management model, with the picture of the patient there.

Vivian Nnacho Ayuk: All right. In terms of diabetes care management model, the model that we use, actually, is a more -- it's an inter-disciplinary approach in how we provide care for our participants in our program. We do have a nurse, a dietitian, pharmacist, a peer support facilitator, and a certified lifestyle coach.

We do believe that this is the best approach to providing education and support for people with diabetes out in the community setting. In addition to that, members, depending on where they are and the goals that they're working on, get to pick which member of the care team they can work with to be able to achieve the goals that they're working on. We make sure that we have that shared decision process in place, we talk about all the different style behaviors.

And in particular, we make sure that goals are set together with the participant and they understand and are ready to be able to make the change, the lifestyle change that is needed to improve their overall care. But throughout the program, as we teach the group sessions or in-person, we make sure that everyone is actually sticking to what they are an expert on, and the participant gets to benefit from having this interdisciplinary team, even out in the community setting. Next slide, please.

Our team, as mentioned before, the interdisciplinary team, but that said, the certified diabetes care and education specialist takes the lead role in managing the overall care for our participants. This is the person that would actually make sure that they conduct the initial assessments, make sure that, you know, we have all the required labs, make sure that we also go and work with a patient hand-in-hand to develop the short- and long-term goals.

So, this is who actually set up everything that then happens in the program. And in addition to that, we have a registered dietitian, and if the patient's immediate needs are nutrition, figuring out how food affects your blood sugar, all of that, we do have a registered dietitian that they can have group sessions with, or one-on-one, and they're able to create personalized meal plans for them.

Our registered dietitian is also able to provide medical nutrition therapy in the community setting. Our pharmacist is in charge of the medications. We don't make changes to

medication therapy, but we make sure that our participants understand how taking their medications really affects their overall care, making sure that we don't have non-adherence issues.

If there are barriers to access to medications, those are the things that the pharmacist will address. And we're in constant communication with the referring providers to make sure that if there are any gaps in care, if there are any medications that are missing that are required, that we bring this to the attention of the providers, and that it's addressed.

Our peer support coach is there to facilitate the peer support session, to just make sure that it is a welcoming space, the participants feel comfortable sharing, and everyone feels respected in that environment. So, it's not a really structured program, but it's more so that the participants can learn from each other and they're there to make sure that it's a very respectful space and everyone gets an opportunity to share and get something useful out of those sessions. We do have the lifestyle coach, who facilitates the diabetes prevention sessions, and also supports our certified diabetes care and education specialist. Next slide, please.

So, a little background. Sorogi actually started out of Flexcare pharmacy. The pharmacy created a diabetes program to address the needs of its patrons, and over time, due to challenges in space and staff, we made the decision to actually create Sorogi that was going to be solely responsible for the education piece.

But both organizations still work hand-in-hand, and the pharmacy has been a great referral source for Sorogi. A lot of the times we find out that the changes in therapy or changes in status or when someone is newly diagnosed, we don't find out until they show up at the pharmacy to actually pick up a prescription. And that's a really great opportunity the pharmacist to now refer them into the Sorogi program, for them to get the additional support that they need.

The pharmacy also fills 20% of the scripts from long-term care facilities, and we have centers. So when we have transition of care and patients are going from long-term facilities or rehab back into their home, they're going in with a lot of insulin that was being managed perfectly when they were in the rehab center. Then when you're going home, we want to make sure that they're going to be able to safely administer insulin, to safely check their blood sugar at home.

That they do understand when to call their doctor or their education specialist for additional support. So, when we fill those prescriptions at the pharmacy, the pharmacy then makes sure that there is a follow-up happening in 72 hours, checking in and making sure that family members and the patient themselves know that they do have additional support, and they can self-enroll in these programs as well.

And when the participants are in our program, during our sessions with them we sometimes find out that they're having difficulties accessing medication, and that's when they get sent back to the pharmacy. Then we check on formulary, making sure if it's a

prior authorization issue. We do handle that. And making sure that they have access to the medications that they need. So, Sorogi and Flexcare really work well together, not just for the referral but also addressing needs that are identified. Next slide, please.

Now, during COVID-19, we had some unique challenges at Sorogi. We had really prided ourselves that we had an in-person program where, you know, we really valued that connection that we've created with our participants. They're able to come in, we're able to provide a face-to-face interaction, and a lot of opportunities for teach-back.

We found out that a lot of time we give instructions, people think they know how to do it, but if they don't take the opportunity to show you so you can correct any mistakes, they go home and they're still confused for instance how to check their blood pressure or how to check their blood glucose, or even how to administer insulin or other injectables.

So, it was really a great opportunity that we had, and we really value that in-person connection. But with COVID-19 and that being done, there was a lot of fear about how we keep participants engaged during a virtual session. We are also worried about the fact that other programs also were being discontinued. There were a lot of programs that have closed down, and if we also shut down our program, then we were really limiting access to education and support.

And a lot of frustration on that end, communicating with healthcare providers, there were offices that were closed, and most of them were working remotely. And with reductions in the staff were not able to assess blood labs the way we used to, communication around refills. All the things that were important in managing the patient's care were being lost.

So, these were the challenges that we faced with COVID in our program, but we still made the decision that it was better for us to try to figure out ways to move forward and not shut down the program completely because of COVID. So, we made the decision that we were going to move everything to a virtual program. Next slide, please.

Given the challenges that we're already facing in the community, we did not think that shutting down our program was a wise decision. So, we had to find a way to move forward, and to do that we had to adopt telehealth. And we made sure that our diabetes prevention program, the diabetes self-management and support, including all the activities that support those programs, were all available to our participants now through a virtual platform.

And we talk about activities like how to check your blood glucose, you know, we could do all that through -- I'm sorry, a telehealth platform. We were able to do cooking demonstrations, even grocery stores, we could also do that during -- using our virtual platform.

In addition to that we also created our first virtual support group for our participants in our diabetes programs. There's a lot of concern around, you know, stress, there was a lot about just dealing with the day-to-day challenges or having a chronic illness, and this has

been a really big success to our program. Having this extra support for these participants has made a huge difference. Next slide, please.

One of the benefits of actually have it move from a virtual platform is that we're able to also handle the challenges of transportation. When we were meeting in person, a lot of the times our participants struggled with transportation. That was a major barrier for coming to classes.

And moving into the virtual platform really was very helpful, because now they can be home and not have to miss any class at all. So, that was really helpful, and we also went further to make sure that participants who did not know that they had benefits such as shared rides, that we were able to let them know. But in terms of COVID, having the telehealth as an option was very helpful, especially for those who were already having transportation issues.

Education around effective use of devices, that was really great. Because we had, you know, situations in the pharmacy, or even in our program, where participants were provided with blood glucose machines, and they go home and we never hear back from them. And, you know, you have canceled appointments, and you're never quite sure if the participant knows how to do it well at home, and they were doing it accurately.

But having that telehealth, and being able to have that video option to watch them do it, we at least can guarantee that the participants were doing it correctly and they were checking their blood glucose at home. And also, we were able to provide blood pressure monitors through agreements with local insurance plans, and that was also important because now the participants also had a blood pressure monitor that could support telehealth.

We provided grocery cards to help with fresh fruits and vegetables, and as previously mentioned, the virtual tours were really helpful with the cooking demonstrations as well. In addition to that, we worked really hard with our local insurance plans to make sure that devices that participants need, such as BGMs or blood pressure monitors, that they were able to have access to that.

We would work through prior authorizations as needed for our participants, so they had access. And finally, we also contracted with a local fitness instructor who was able to provide weekly virtual physical activity sessions. Next slide, please.

Now, in terms of barriers to telehealth, the initial one that was very -- something we had to really work on was technology. A lot of our staff members were not familiar with the telehealth platform, and it was a learning curve. So, we had to spend the first few months making sure that everyone was comfortable with the technology that we had adopted, and also to make sure that we were going to be able to change our curriculum so that it could fit, and something that we could deliver in a very engaging way, virtually.

So, we spent approximately two months or so making those adjustments. In addition to that too, our participants were not very familiar, too, with this technology, so we spent a lot of time creating workflow, you know, guides for them, to make sure that before you had an in-person -- I'm sorry, not in-person -- a one-on-one visit with either the registered dietitian or the certified diabetes care and education specialist, that there was a pre-appointment call where we checked and made sure they had the right technology, they were comfortable, they knew the link and what time the appointments were.

And when we put that in place, it was very helpful and it made sure that we had really good conversations with the participants when they finally joined. So, a lot of work had to go in to making sure that not only was staff comfortable with the technology, but participant as well, and they were -- they had the right cellphone or smart devices to be able to connect.

One of the challenges to that we found is that not all the participants had the right technology. Not every one of them had a smartphone. One of the way we dealt with that was that we just would call them over the phone. We have to meet people where they are. It was either that or there was nothing for them, and we felt like calling them -- you know, and a lot of times, they just had questions and we were able to address those over the phone. So, it was not perfect, but it kept them connected, it still kept them engaged in the program, and we could still provide some level of support. Next slide, please.

Engagement in our program, one thing we worried about before -- you know, during COVID was how were we going to be able to manage that group dynamic, especially when you're on a virtual platform. There's a lot of distraction, background noise -- how were we going to do that and still keep it a very productive session?

So, one thing we did was we made sure that we reduced the curriculum to 30-minute sessions. We used to have it as an hour and a half, and we break it down to 30 short minutes, practical things that people needed. We included a lot of visuals, and having a lot of PowerPoint slides. You know, plenty of opportunities for questions and for participants to share their personal experience as well. We found this to be really helpful and really kept them engaged as compared to having them to be really long hour or hour-plus sessions.

Another barrier that we discovered in our program which we did address was also to create, which I already discussed, that peer support group, because there was a lot of demand for a space where people could just come in and share and not feel pressure depending on what they were going through. Just listening to each other, knowing they were not alone in this journey, and that there was support out there in the community that they could access virtually. Next slide, please.

At this point I'm going to bring in Ms. Fontella Young. She actually was referred to our program. She self-referred into our program during the COVID-19 pandemic, and we were able to successfully on-board her. And at this point I'll let her share her experience, what she's gained by being part of our Sorogi program. Ms. Young?

Fontella Young: Hello, my name is Ms. Young. I got diagnosed with type II diabetes. I had a doctor that did a conference visit. She did not know how to shoot the pen. I didn't know anyone, anyone to talk to, or anyone that had diabetes. So, after we fooled around with the pen for a little while, she didn't know how to use it, and was trying to tell me how to use it. Flexcare pharmacy called me, and when they called me they showed me how to shoot myself, they showed me what was good numbers, what was bad numbers. We had meetings, we had support groups, we had grocery shop, going to grocery stores.

It was really helpful, and I really loved it, and I promoted it in the medical field where I went to the doctor, and it was real helpful for my community. And I love everything about this, and I just pray to God that we'll just keep this program.

Vivian Nnacho Ayuk: Thank you, Ms. Young. Next slide, please. And Ms. Young -- just to share a little, I know we're almost out of time -- she came in like that, really not knowing anything about diabetes, and through this program was able to get the support that she needed.

Now, we're talking about lessons learned. I would say for our program, trying to reach, you know, really hard communities that are not engaged in care, I would say, for us, lessons we have learned is that it starts with building trust. And we have been in the community for a while, both from the pharmacy and also now as Sorogi.

They need to know that you're here and you're here for them. Once you have that, which is what we've been able to build through our pharmacy and now through Sorogi, is that you leverage that. They come in to your pharmacy, always have participants or patrons that come in more frequently that they see their primary care provider.

So, having that great relationship with our community pharmacy, people are able to now easily come into the program believing that it's there, they're willing to listen, and they're willing to participate. Also, when we have them in our program, we want to make sure we address their immediate needs. You have to meet people where they are and address what is of most concern to them.

When we do that, we find out people are much more receptive to hear more and to do more to improve their overall health. Another lesson we learned with this is that you have to make sure that your team has the right tools and resources to be able to do the work. And it starts with re-evaluating your workflow, making sure that you have the right technology available for them to do their work by telehealth.

We also make sure that we collaborate with other programs also, in case our program does not address every need, such as mental health is something that our program still struggles with. We are looking into partnering with other organizations in the community where we can refer our participants out and they get that extra support beyond the peer support group.

And of course I mentioned our continuing education for the staff, making sure that they are up to date with treatment guidelines, the new research, and making sure that we're providing services in a way that is very respectful of the community and the things that are important to them. Next slide, please.

One more thing we're going to get with telehealth is that we're able to go beyond our wards seven and eight residents. We're now able to see participants now in all the eight wards in DC, and also see participants from Maryland as well. This technology has been really helpful in, you know, helping us to really expand our programs beyond wards seven and eight.

And we do believe that there is a role that technology plays in diabetes self-management and can be very, very beneficial. So, we are looking also at how do we extend our peer support group so we don't just have females like we have right now, and opening it up as well so we have maybe a senior virtual support group, or one for children or high schoolers or, you know, people in college.

Having different platforms where people can actually come in, feel comfortable, learn from each other, and improve their overall health. We truly believe that if you're going to do telehealth, diabetes self-management, education and support programming, that a team-based approach is still the best way to go. Next slide, please.

Going forward for Sorogi, we are going to continue with telehealth, but it's going to be more of a hybrid model now, because we do recognize that this was great, it worked during the pandemic, but we did lose some participants as well who did not have the right technology, and we could not provide what was needed for them to be able to join the classes online. So, we believe that a hybrid model is the best way to move forward.

And also, we are going to be sharing the findings from our program with important stakeholders in the community, like our DC department of health and also the managed care organizations, so that this--what we found out during COVID can be used to improve care for the residents of DC.

And I mentioned earlier were looking at partnering with behavior health specialists so we can easily refer -- not just refer, but also get feedback and follow up as to how the participants are doing, and how we can continue to support them in our programs as well. We're looking at partnerships with our libraries and our rec centers as avenues where we can continue to provide in-person education and support when everything opens up again, and also looking at piloting an in-person peer support group. Next slide.

Well, thank you very much, and I really do apologize for the tech issues we were having. But I really did appreciate the opportunity to share what we're able to do during COVID. And I'll hand it back to you, Lola.

Lola Akintobi: Thank you, Dr. Ayuk. All right, so at this time we have some time for questions and answers, so first, just thank you so much, Vivian Cheng and Nicole and

Katie and Dr. Ayuk, Vivian Ayuk, and Ms. Young. Thank you so much for sharing all your perspectives so far.

So, we've had some folks chatting in some questions already, so we'll get started with a few of those. But for anyone in the audience listening, if you have questions now that have come up or you think about them now, please do submit them using the Q&A feature on the lower left of the presentation screen. If you type your comment at the bottom and press Submit to send it, we'll be looking through those questions and asking them to our speakers.

So, I will start with a question -- Vivian Cheng, I think this is for you. You'd mentioned the mental health impacts as well as the challenges of our people with diabetes who also have depression. How have you focused -- in what ways have you focused on supporting people with diabetes who also have depression during COVID-19?

Vivian Cheng: Absolutely, that's a great question. And I think for my role, I work closely with our clinic psychiatrists and our behavioral health workers, and so making sure that I try to help triage the patients and connect them with the resources they may need. Additionally, if they have depression or other mental health disorders, I definitely do take that into consideration when I'm helping to co-manage their diabetes.

I may relax how quickly or how aggressive I am in trying to lower their sugars or A1C, I may try to act almost as just a sounding board for patients who may have to express their frustrations with everything going in the pandemic or their lives, and maybe that day diabetes isn't the focus of our call.

And so just trying to be flexible, validate that they're going through a difficult period, and validate that. Depression and diabetes are closely associated and can often cause for both to be not well controlled. So, just kind of serving as that additional resource and connecting patients to our mental health providers.

Lola Akintobi: Thank you so much, Vivian. Ms. Young, we had some questions for you from your perspective. You mentioned that you were newly diagnosed with diabetes during COVID. What should providers and health plans know about how to support someone who's receiving a new diagnosis, especially during COVID? Ms. Young, if you're speaking, you may be on mute. I don't think I can hear you.

Fontella Young: Could you repeat the question?

Lola Akintobi: Yes, absolutely. So, you mentioned you were newly diagnosed with diabetes during COVID. What should a provider or a health plan staff person know who's supporting somebody who's newly diagnosed? What was helpful for you in terms of the support that you needed?

Fontella Young: Support that I needed was Sorogi and Flexcare pharmacy, they called me to show me how to do what I needed to do to shoot myself, to the support groups, to

calling, checking, and seeing if I knew what to do, gave me a book, showed me. That really helped me a lot. The walking -- I didn't know anything, anybody, anything.

Lola Akintobi: Thank you, that's really helpful. Dr. Ayuk, I might also, as a follow-up, ask if there's anything that you do specifically when you're thinking about supporting someone who's receiving a new diagnosis.

Vivian Nnacho Ayuk: Absolutely. For the primary care providers, it helps if they're aware of all the support programs that are available in the community for the participants. It helps that once someone is diagnosed they have that initial education that happens in-clinic, that they do get a referral to see a certified diabetes care and education specialist.

Because a lot of time we'll be finding in our programs that people come in and they don't remember what the doctor said, they're all confused, there's a lot of distress, a lot of emotions involved. It really helps when they get that referral. So, I would encourage any primary care provider it's not enough to just say hey, we're going to prescribe medication, go to the pharmacy and pick it up. It must be followed up with a referral to a diabetes program, so that the participant or the patient does get the support that they need in-between those office visits.

Lola Akintobi: Thank you. That's very helpful. So, in Vivian Cheng's presentation, she mentioned supporting an individual with diabetes who had a family member who was providing support, and we know that many individuals with diabetes, including older adults, have family or friends that provide important care. They may help them monitor glucose or administer insulin or other medications.

And I was wondering, Katie and Nicole, or Vivian Ayuk, if you have anything to add about any strategies that you might -- that you particularly use to support and work with family caregivers of people with diabetes. So, Katie or Nicole, maybe I'll start with you.

Katie Sheridan: Yeah, hi, this is Katie. So, as long as we have appropriate consents on file or a verbal consent from the member, we can provide the same level of support and education to assist the family caregiver. So just encouraging blood sugar logs, educating for diet for diabetes, and then just encouraging a diabetes plan with the provider.

Lola Akintobi: Thank you, Katie. And Vivian Ayuk, do you have anything you would add about supporting or working with family caregivers?

Vivian Nnacho Ayuk: Absolutely, and same here -- as long as we have that consent, we open up our program so they can attend a group session as well. And we've had several family members take advantage of that, and they get to learn a little bit more about the condition. They get to know how best to support the person, being a little bit more patient, knowing that, you know, it's a process, it's not something that you can take a Tylenol for and it's over.

But just getting to learn how best to support the person, how to ask, for the person who has diabetes, how they want to be supported. And also, we make sure that they know that they also need to take care of themselves as well, and what we find out is that behavior changes works well when, you know, it's incorporated by the whole family. When we talk about healthy eating, it's not just for the person with the diabetes, it's much more successful when it is a team approach, when the whole family is involved in it. They're much, much likely to be more successful.

And finally, tell them they need to take care of themselves as well. They need to be able to recognize when there is stress, there's anxiety, and to seek help with that. In addition, we open up our support group too, and I think those few family members who have really taken advantage of it, they feel more comfortable now, they feel like they have a better understanding of what they need to do to support their loved one.

Lola Akintobi: Thank you so much. All right, so I want to get a chance to have you all reflect for us. So, I'll ask each of you this question. What's one lesson learned in terms of diabetes management during COVID, or a change that you made to your approach to diabetes management during COVID that you want to see continue in your program? And Vivian Cheng, maybe I'll start with you.

Vivian Cheng: Sure. I think, coming from my training as a clinical pharmacist, we are so kind of numbers-oriented. We are go, go, go, let's get these sugars down, let's get these blood pressures down, calling patients every three to four weeks. But with the pandemic, you know, that's forced everyone to have to shift a little bit. I think something I'll carry into the post-pandemic world is it's okay to slow down sometimes and take your time in establishing a trust with the patient, establishing a relationship. And you know, it's okay to take your time to work with the patient to get them to their goal A1C or goal blood pressure.

Lola Akintobi: Thank you, Vivian. That's wonderful. Katie and/or Nicole, if either one or both of you would like to share about a lesson learned or a change that you've made to your diabetes management approach during COVID.

Katie Sheridan: Yeah, I think one thing that we've noticed was the eagerness for our membership to embrace some of the technology that was available, and using the technology, specifically telehealth, that was available, I think that was something that was refreshing that we were seeing, and hope to be able to use that in different ways as we move forward outside of the pandemic as well.

Lola Akintobi: Great, thank you. Vivian Ayuk, I'll also ask this one to you. What was a change or a lesson learned that you made to your diabetes management program during COVID that you'd like to continue?

Vivian Nnacho Ayuk: I would say it would be the incorporation of technology and the benefits that we have seen with it. It's been really helpful. I don't think we could still have had a program, an active program, if we had not switched to telehealth. And we also

recognize that technology's great, but it has to be the right technology at the right time for the right person. So, those were all lessons learned, and things that we plan to build on as we move forward post-pandemic.

Lola Akintobi: Wonderful. Well, thank you all so much, and thank you to everyone who has been chatting in questions as well. We'll certainly take a look at those and follow up with everyone. At this time, though, please do send any additional questions. If you have any, you can email us at RIC@Lewin.com.

And we'll just remind everyone that the slides for today's presentation, a recording, and a transcript are going to be available on the Resources for Integrated Care website shortly. As a reminder, if you are interested in earning an NASW CEU or the continuing nursing education contact hours, please take the post-test. You must take the post-test by 11:59 p.m. Eastern time tomorrow, Thursday, May 6, with a passing score. You can also take the post-test multiple times to earn this score.

We also wanted to let everyone know that additional resources, some of which we were sharing during the webinar, they're all included on slides 60 and 61 at the end of this presentation. You'll be able to see those if you download the slides from the website as well. And we've included a number of resources, like I mentioned, that were mentioned during the presentation.

Well, we're now at the end of our presentation today. Thank you so much for joining us. Please do complete our brief evaluation so that we can continue to deliver high-quality presentations. If you have any questions, please don't hesitate to email us at RIC@Lewin.com. And just thank you so, so much again, Vivian Cheng and Nicole and Katie, and Vivian Ayuk and Ms. Young for sharing your perspectives.

I know that your perspectives have been very valuable, and we all learned a lot today. Thank you, everyone who joined and tuned in today. Have a wonderful afternoon, and thank you so much for your participation.