ACCELERATING DIABETES CARE FOR_LIFE

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Therapeutic Inertia: An Endocrinologist's Perspective*

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*Input from several colleagues including clinic director

How is therapeutic inertia impacting the practice/organization/group?

- Unnecessary referrals
  - PCPs don't have time to deal with complex social and clinical cases, endo referral seen by them as solution
  - Many people need DSMES more than specialist MD
- Patients with persistent poor control, recurrent hypoglycemia, self-care barriers have worse outcomes (ER, hospitalizations, etc.)
- Provider burnout
- Not meeting benchmarks for quality measures: potential reimbursement implications

What is the practice/organization/group doing to address therapeutic inertia?

- "Best practice" advisories in Epic
  - Turned on Spring 2018
  - Primarily process measures (eye exams, foot exams, urine alb)
  - One for A1C >9% two quarters in a row
  - Progress being tracked by powers that be
- Goal is to have more documentation/ordering done by non-provider staff in future
- Attempts to triage referrals more and also get appropriate people back to primary care (so we can focus more on people who need endocrinologist)

What are the barriers?

- Not enough time (during visits and between visits)
- Multidisciplinary clinic, but work in silos; difficulty with same-day visits
- Difficult to keep chronicity in mind with intermittent visits
- Geographically distributed patient population
- High rates of comorbidities, competing priorities
- Social determinants (poverty, un- or underinsured, poor health literacy, NC diet…)
- Competing priorities/fears: lower A1C or avoidance of hypoglycemia (different values between person w/diabetes, PCP, other specialists)
- Formulary confusion

What has been successful? What was done, why did it work?

- Data:
  - POC HbA1c
  - Downloads of pumps, CGM, meters by triage staff; pulled up in room
- Formulary Search app
- Two CDEs in office (especially for type 1, pump/CGM)
- PharmD with prescribing privileges in practice
  - More availability for frequent follow-up
  - Longer visits with focus on med adherence and education
  - Ability to trouble shoot cost, formulary issues
- Epic BPAs: uptick in some measures being met (may not be sustained)

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What has not been successful? What was done, why did it not work?

- Group classes
  - We have them, but underused (1-4 patients/monthly series)
  - Transportation issues, dispersed population
- CDEs have separate schedule; difficult to have same-day appointments.
- Much focus on T1D, technology and less on DSMES for type 2s in particular
- No MNT options affiliated with clinic
- BPAs are easy to ignore. Ways to resolve them are not helpful

What does the practice/organization need from other stakeholder groups to address therapeutic inertia?

- More integrated DSMES and MNT
- Support staff who can offload tasks from providers (documentation, standing orders, simple education) so we focus more on therapy
- Address and provide support for PCPs
- More information about and integration of community resources
- Financial, social support for our patients (Medicaid expansion!)