Overcoming Therapeutic Inertia: Clinical Workshop

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American Diabetes Association®

Overcoming Therapeutic Inertia

Optimizing Diabetes Care to Avoid Clinical Inertia

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Overcoming Therapeutic Inertia

Its not about working harder

Its about working *Better*

Take the time to develop a system to tackle inertia in your practice.

If you don't deal with inertia, it will deal with you.

Scheduler or Front office

- Try to have Diabetes only appointments and keep them sacred
- 24 hr. Reminder Phone call to bring in log books, medication list, and technology
- Follow up Appointments at the discretion provider or…..
  - A1c 9 or greater then 6-8 week
  - A1c 7 to < 9 then 2-3 mos
  - A1c < 7 then every 3 mos or Q 6 if a1c stable less than 7
- Implement a triage system for Diabetes related questions especially hypoglcemia

Medical Assistants / Back office staff

- Enter Vital Statistics
  - BP, Weight, BMI, Waist Circumference, Tobacco Status
- Reconcile Medication List and Dosing
  - Inquire adherence of therapy

"How many times in a week to you miss a dose of XYZ therapy"

- Foot Exam Vibration, Monofilament, and Temp
  - Leave Shoes off if providers needs to see the feet
- Rapid A1c per office protocol- Affinion or cassette
- Micro albumin urine- at time of visit

Medical Assistants / Back Office Staff

- Download technology, SMBG device, or copy of log book
- Familiarity with delivery devices and in office demonstration capability
- In office location resource wall for patient handouts and coupons
- Maintain sample area for medication and refrigerated products

It is your license that obtains these, the decision is yours,

but you don’t want to create strife

If these wall could talk…
You have the space, use it

- In room resources to pass the time
  - A1c Thermometer poster
  - Symptoms of Hypoglycemia
  - MOA medication video resources
  - How to Inspect your feet poster
  - Any other patient resource that is helpful (Medicare info, Patient Assistance….)
- Office magazines
  - *Diabetes Forcast magazine*
  - Cook books, *Eat this not that (this one tends to mysteriously disappear)*
- Information wall
  - Disease state handouts, Co-pay cards, Community resource information, business information for nutritionist, fitness, and foot care

The Diabetes Review Appointment

Know your ABC's

- **A1c**
  - Individualized Goal, **if not there change something**
- **Blood Pressure**
  - less than 140/90
- **Cholesterol**

Tackling barriers

Can you tell me one thing that is really disruptive, a barrier, or just plain old stinks when it comes to treating your diabetes and lets see if we can address that today?

I can do that…

Take-away or home work for the next visit

Glycemia and A1C

- Point of care A1c options for patients for those with lab inertia
- Address medication adherence
    - Trash day is Trulicity day, On the weekend is Ozempic……..
    - Metformin ER in the am
    - What does with food mean
    - What if I miss a dose
- If the A1c is not at goal add another therapy or titrate one directed at the targeted glycemic control desired
- Negotiate no more than 4 weeks to 3 months depending on current control

Weight Reduction

- Even 3-5% reduction in bodyweight has an impact
- Mention to patients when they don’t gain weight
- Remember it is several factors that go into this
  - Eat during daylight hours
  - The body defends its weight set point
  - Intake the majority of calories prior to 3pm
  - Carbs best at lunch (least insulin resistance)
  - Get plenty of sleep, leverage weight reduction diabetes therapies, & stress reduction

Exercise

- Ask your patient… “what do you think I mean by exercise more?”
- I want you to move your body more than you currently are. How do you think you could do that?
- Strength training is so forgotten
- At least stretch, everyone can do that!

Improved Eating habits

- Keep it simple- only forbidden food is liquid carbohydrate *unless treating a low blood sugar*
- Quantity is the first step, purchase a kids plate with dividers
- Nothing white except for Greek yogurt, and maybe Jicama
- Try to get your FIVE (Fruits and Veggies)
- Eat more intact foods *(rice-a-roni doesn't grow out of the ground)*
- Have the individual determine which foods are just not worth it
- Is it carb worthy?

Motivational Encouragement

- Start each visit with a positive comment regarding the patient engagement
    - Even if it is…"glad to see you are here today"
- Use common everyday things to educate and inspire
    - Automobiles, activities of daily living, and cell phones make great analogies
- Never emotionalize having diabetes
    - Remind them they can have the disease instead of it having them
- Screen or inquire regarding mental health state and past trauma

Use Your Community

- Senior Councils
- Local Health Department; many are implementing Pre-Diabetes and Local Diabetes Intervention programs
- Churches, Places of worship, and community centers events
- Find out what theses organizations are doing, refer, advertise, and carry their resources

Secrets of Success with Patient Inertia

- You don’t know the inertia struggle unless you ask
- Have at least one answer for the greatest patient barriers you encounter
- Avoid hyper-empathy; it will wear you out
- Be a **COACH** for your patients, not a *Referee*
- It’s a marathon, not a sprint

Prior Authorizations

- Anticipate them and dictate into encounter note
- Document a patient-centered narrative and the patient needs
- Cite Standards of Care
    - ADA Treatment Algorithm
    - FDA Indications
    - Secondary Benefits Desired
    - Cardiovascular or Renal Benefit
- Stand Firm in you Professional opinion
    - Liability for denied therapies is not transferred to the provider
    - Coverage for therapeutic options it is dictated by the payor…call it out if it goes against your medical judgment

The Co-pay Conundrum

- Increase communication between prescribers and dispensers of medication
- Utilize co-pay assistance cards
- Half pill program
- Concentrated Insulins
- Cash Pay Question
- OHHH Canada!!!!
- Patient Assistance Medicare and Uninsured

Utilizations of Technology for Individuals

- Use it to lessen disease burden, increase patient engagement, and improve outcomes
  - Continuous glucose monitoring
  - Insulin Deliver Devices
  - Apps for carb counting, weight reduction
  - Step counters or fitness pals
  - Smart Watches
  - Challenge patient to find one they like and show it to you

You don’t need to know all of the options,

but be familiar enough with one to have a resource

In Office Tools

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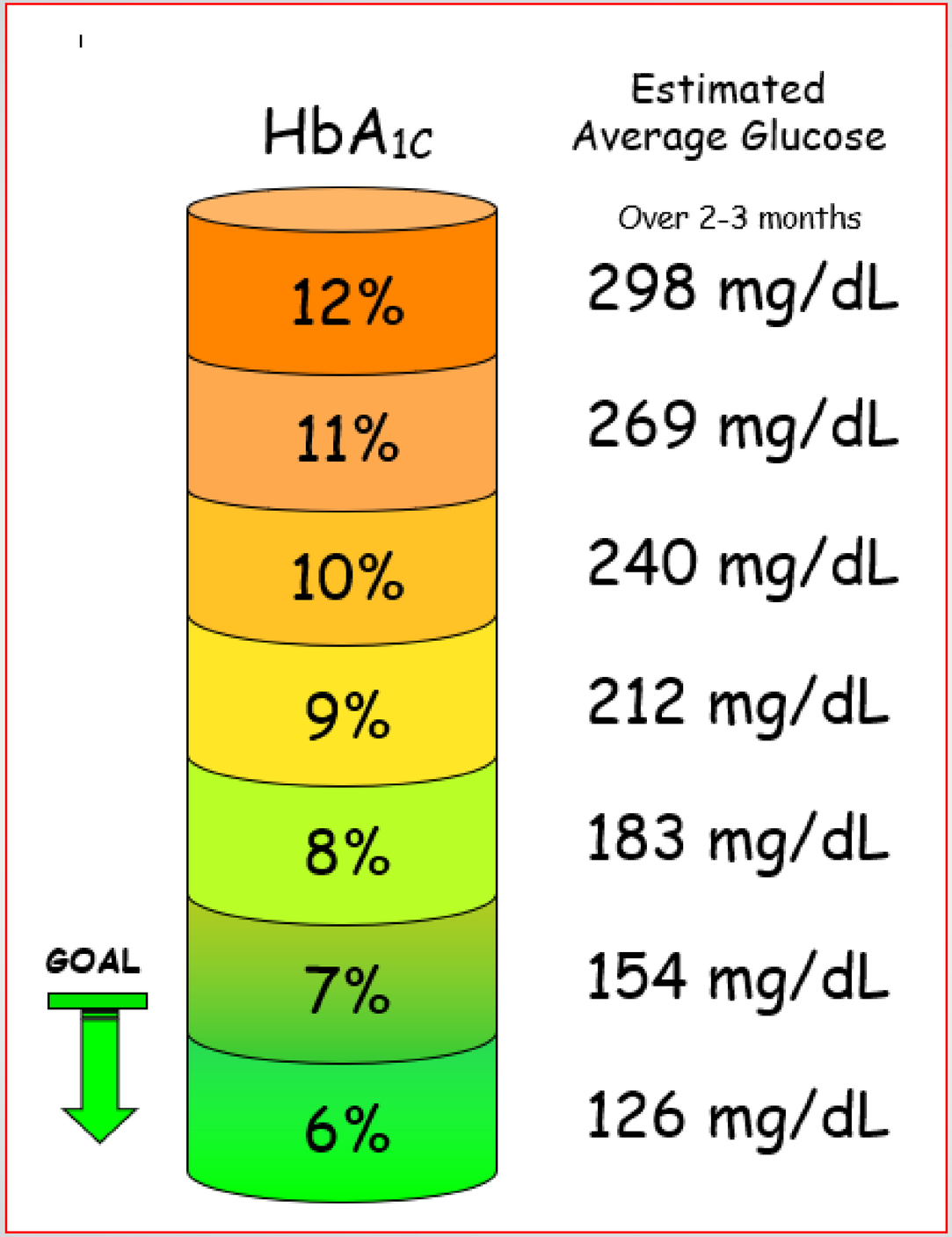
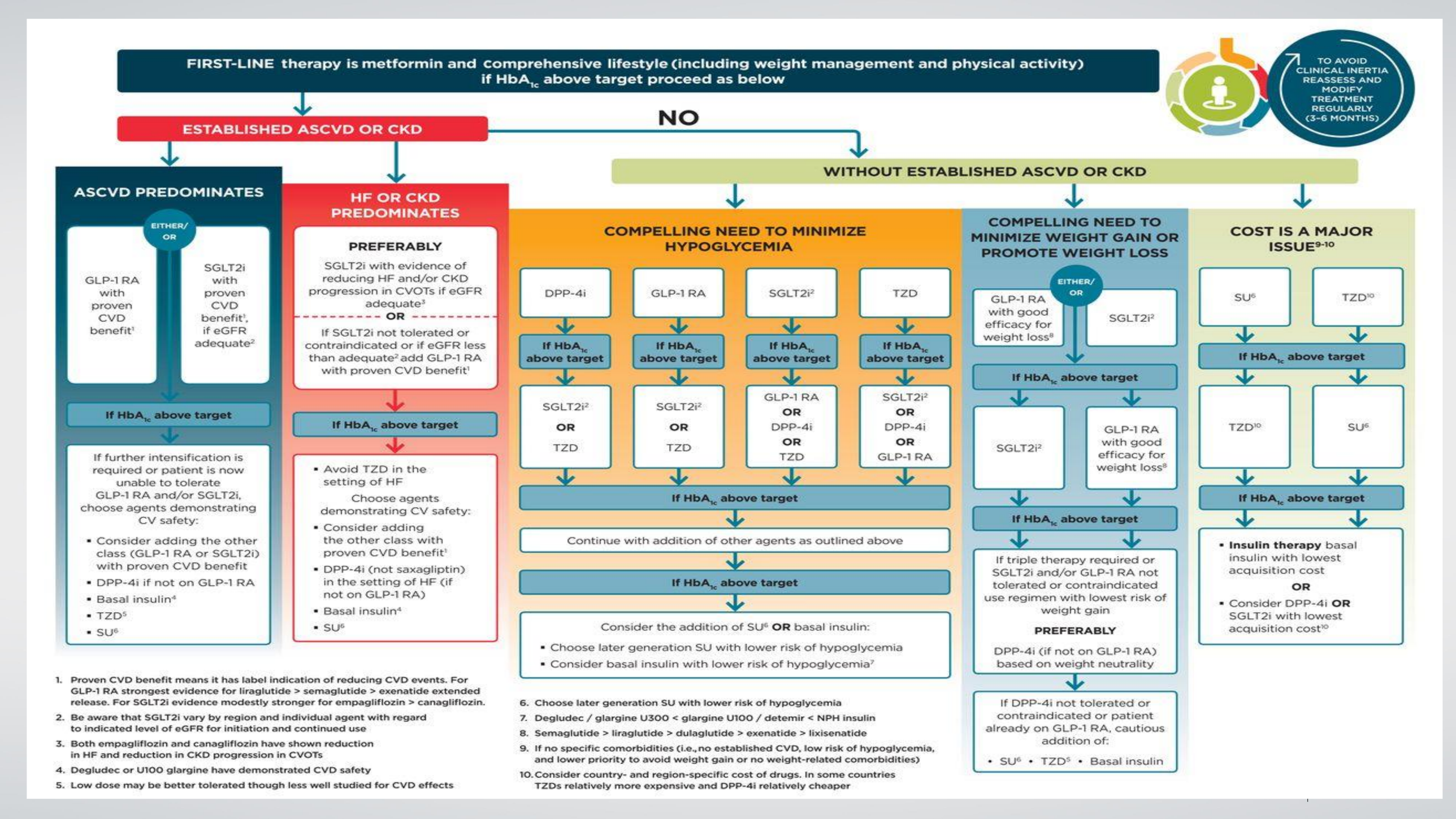

HbA1C
Estimated Average Glucose
Over 2-3 months
12%
298 mg/dL
11%
269 mg/dL
10%
240 mg/dL
9%
212 mg/dL
8%
183 mg/dL
7%
154 mg/dL
6%
126 mg/dL
GOAL



1. Proven CVD benefit means it has label indication of reducing CVD events. For GLP-1 RA strongest evidence for liraglutide > semaglutide > exenatide extended release. For SGLT2i evidence modestly stronger for empagliflozin > canagliflozin.
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Both empagliflozin and canagliflozin have shown reduction in HF and reduction in CKD progression in CVOTs
4. Degludec or U100 glargine have demonstrated CVD safety
5. Low dose may be better tolerated though less well studied for CVD effects
6. Choose later generation SU with lower risk of hypoglycemia
7. Degludec / glargine U300 < glargine U100 / detemir < NPH insulin
8. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
9. If no specific comorbidities (i.e., no established CVD, low risk of hypoglycemia, and lower priority to avoid weight gain or no weight-related comorbidities)
10. Consider country- and region-specific cost of drugs. In some countries TZDs relatively more expensive and DPP-4i relatively cheaper

Know Your Data

- Every 3 month query your ICD10 for diabetes and those with A1c ≥ 9 and those above 7
    - If no EHR keep a running list of individuals on paper “poop list”
- With that list of those at 9 or greater priority list for follow up
- Your data is worthwhile, can apply for NCQA diabetes recognition and leverage with payors

Diabetes Nation
educating. inspiring. encouraging.

DIME Program™ Care Model

Diabetes Intervention and Management with Excellence

LDL Cholesterol Reduction Table

STEP 1 Chose Desired LDL Reduction

LDL GOAL	Acutal LDLmg/dl =	70	80	90	100	110	120	130	140	160	170	180	190	200
LDL 100 mg/dl →	% Reduction Needed =	0	0%	0%	0%	9%	17%	23%	29%	38%	41%	45%	47%	50%
LDL 70 mg/dl →	% Reduction Needed =	0	13%	22%	30%	36%	42%	46%	50%	56%	59%	61%	63%	65%

STEP 2
Select Agent and Dose
LDL-Lowering AGENTS

DESIRED % REDUCTION

Generic	Trade	20%	30%	40%	50%	60%
		Approximate LDL Reduction by Dose				
Ezetimibe Simvastatin	Vytorin				10/10 (45%)	10/10 (52%)	10/40 (55%)	10/40 (60%)
Atorvastatin	Liptor			10mg (39%)	20mg (43%)	40mg (50%)		80mg (60%)
Rosuvastatin	Crestor				5mg (45%)	10mg (52%)	20mg (55%)	40mg (63%)
Simvastatin	Zocor		10mg (30%)	20mg (38%) 40mg (41%)		80mg (47%)		
Niacin Simvastatin	Simcor						2000/400 (56%)	
Niacin Lovastatin	Advicor		2000/20 (30%)	2000/20 (36%)	1500/40 (37%)	2000/40 (42%)		
Fluvastatin	Lescol	20mg (22%)	40mg (25%)		80mgXL (35%)			
Lovastatin	Mevacor Altoprev	10mg (21%)	20mg (27%)	40mg (31%)	20mgBID (34%)	40mgBID (40%)		
Pravastatin	Pravachol	10mg (21%)		20mg (32%)	40mg (34%)	80mg (37%)		

Please refer to the package insert (PI) of each medication for full prescribing information and indications. Most LDL Reductions obtained from PI's.
Further information on medications, doses, and titration can be found in the detailed DIME Program™ Care Model Manual.

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Diabetes Benchmarks

- HbA1c
  - ? 15% = Poor Control >9.0%
  - ? 40% = Control <7.0%
- LDL Cholesterol
  - ? 37% = LDL ? 130 mg/dl
  - ? 36% = LDL < 100 mg/dl
- Blood Pressure
  - ? 35% = ? 140/90 mmHg
  - ? 25% = < 130/80 mmHg
- Retinal Screening
  - ? 60% Documented Dilated Retinal exam
- Tobacco Status & Cessation Advice
  - ? 80% (Non smoking or Advice/Cessation documented)
- Nephropathy Assessment
  - ? 80% (Yearly proteinuria assessment)
- Foot Examination
  - ? 80% Yearly evaluation for lesions and evaluation with a
    - minimum of one clinical test performing either:
    - a 10-g monofilament exam
    - temperature discrimination
    - vibration perception (using a 128-Hz tuning fork)

Questions Regarding Medication Approval

We have ordered a new medication for your medical condition. Often these medications require additional work from our office and the pharmacy in order to have the treatment approved by your Insurance Company. Below is a few things to keep in mind while are trying to get your medication.

Medication

Sometimes there is a generic alternative that works in the same manner and is a less expensive, but not always. We generally chose this in the beginning but things change rapidly **so ask the Pharmacist if there is one available.**

Insurance companies often have preferred drugs within each group of medications that treat a certain condition. In the office we will often see this ahead of time but please inquire at the **Pharmacy if a preferred alternative is recommended.**

Co-pay and Out of Pocket

The amount you pay for your prescriptions at the Pharmacy are determined by a great deal of factors. When you are given an amount and there are questions, ask the following clarifying questions.

Is this amount my co-pay?
Do I have a deductible?
Have I entered into the "doughnut hole"?
Has this medication been sent for a prior authorization?
Are there any coupons I can get online or at my Doctors office to help with the co-pay amount?

Prior Authorizations

In some cases, permission from the insurance company is needed in order to get medications authorized by the insurance. This takes time and a group effort help speeds up the process. Start by making sure the Pharmacy has asked for the Prior Authorization. Make a list of all medications, and adverse reactions you have had with previous treatments for your condition, and make our office aware of these. Be patient, check back every 2 weeks to see if we have made any progress.

Last Ditch effort

Medications not covered by Insurance, can often be purchased out of Canada using ***Planetdrugsdirect.com***. We have used this site for several years and there is a high level of patient satisfaction.

It’s All in the Follow Up

- Establish the next appointment at the current visit
- Agree upon the action plan to be reviewed at the next appointment
- Advise your patients were are going to keep pace with their disease

Barriers and Solutions
Peer Learning Exercise

- What is the biggest barrier to reducing TI in your practice or experience?
- What strategies, mentioned here or otherwise, have you found that work to address your top barrier? Or, maybe you haven't found solutions and want advice from others?

Questions?