

Overcoming Therapeutic Inertia: Clinical Workshop



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Overcoming
**Therapeutic
Inertia**

Understanding Therapeutic Inertia in 2019: Why should you care?

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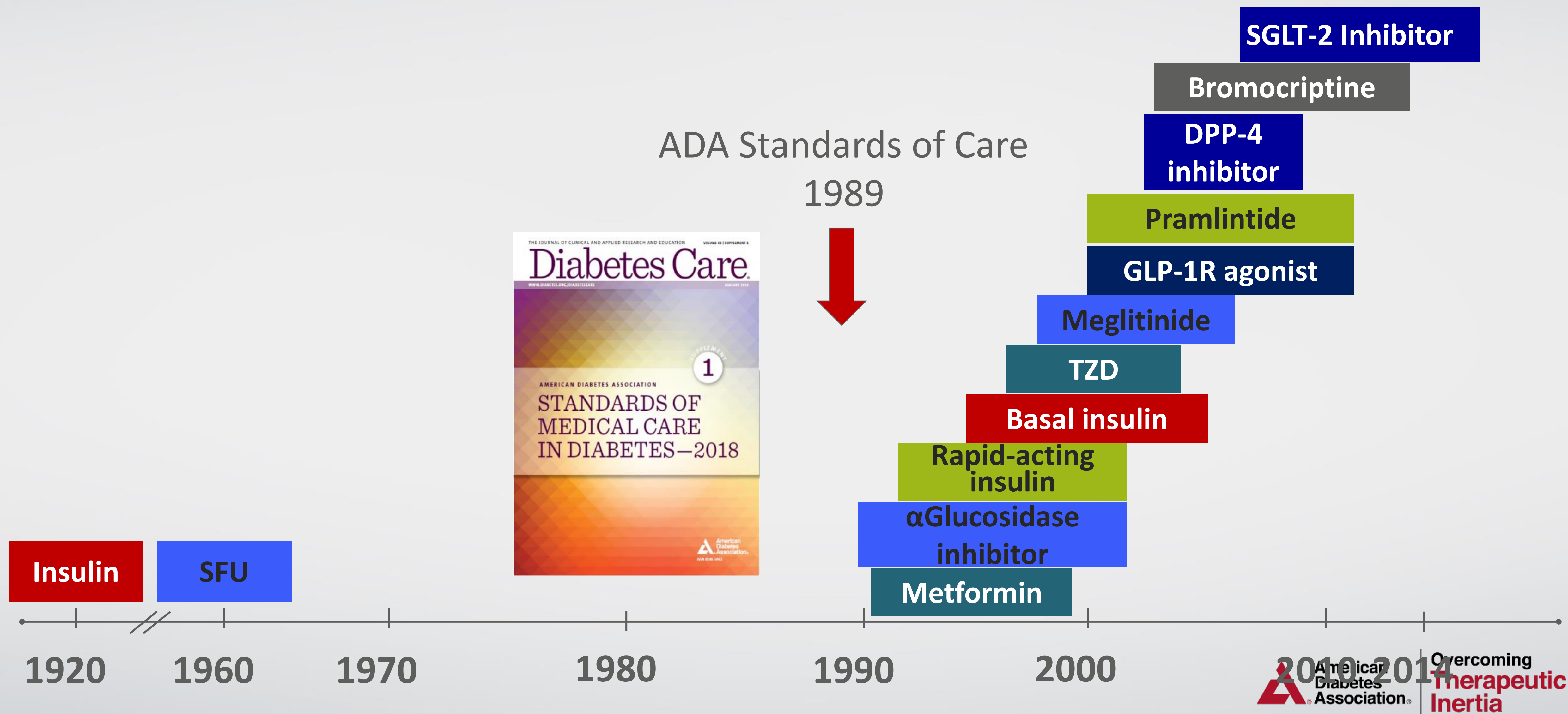
Economic Costs of Diabetes in the US in 2017

- ***327 billion were spent in 2017 on diagnosed diabetes.***
 - \$237 billion in direct medical costs and \$90 billion in reduced productivity
- ***Direct medical costs represent a 26% increase (adj for inflation) since 2012*** (increased prevalence and the increased cost per person affected)
- **More than 300 million work days are lost to the economy due to diabetes**
- **Diabetes resulted in 277,000 premature deaths.**

Economic Costs of Diabetes in the US in 2017

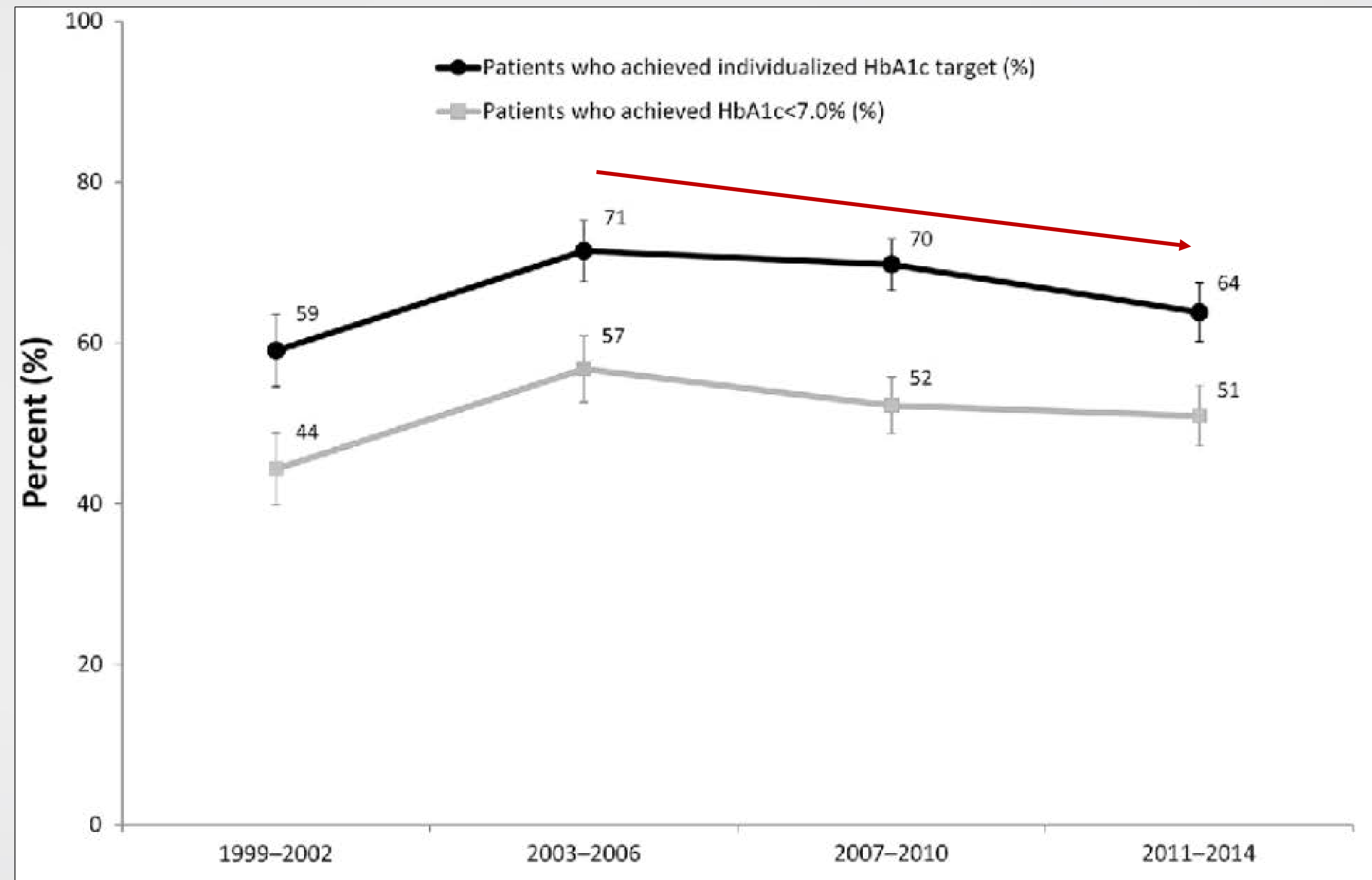
- Medications directly used to treat diabetes = \$31 billion, \$15 billion of which is for insulin.
 - Increased by 45% over 5 years after adjusting for inflation
- **1 in every 4 health care dollars** spent (24 percent) was for the care of people with diabetes

Therapeutic Advances Over Past 20 Years



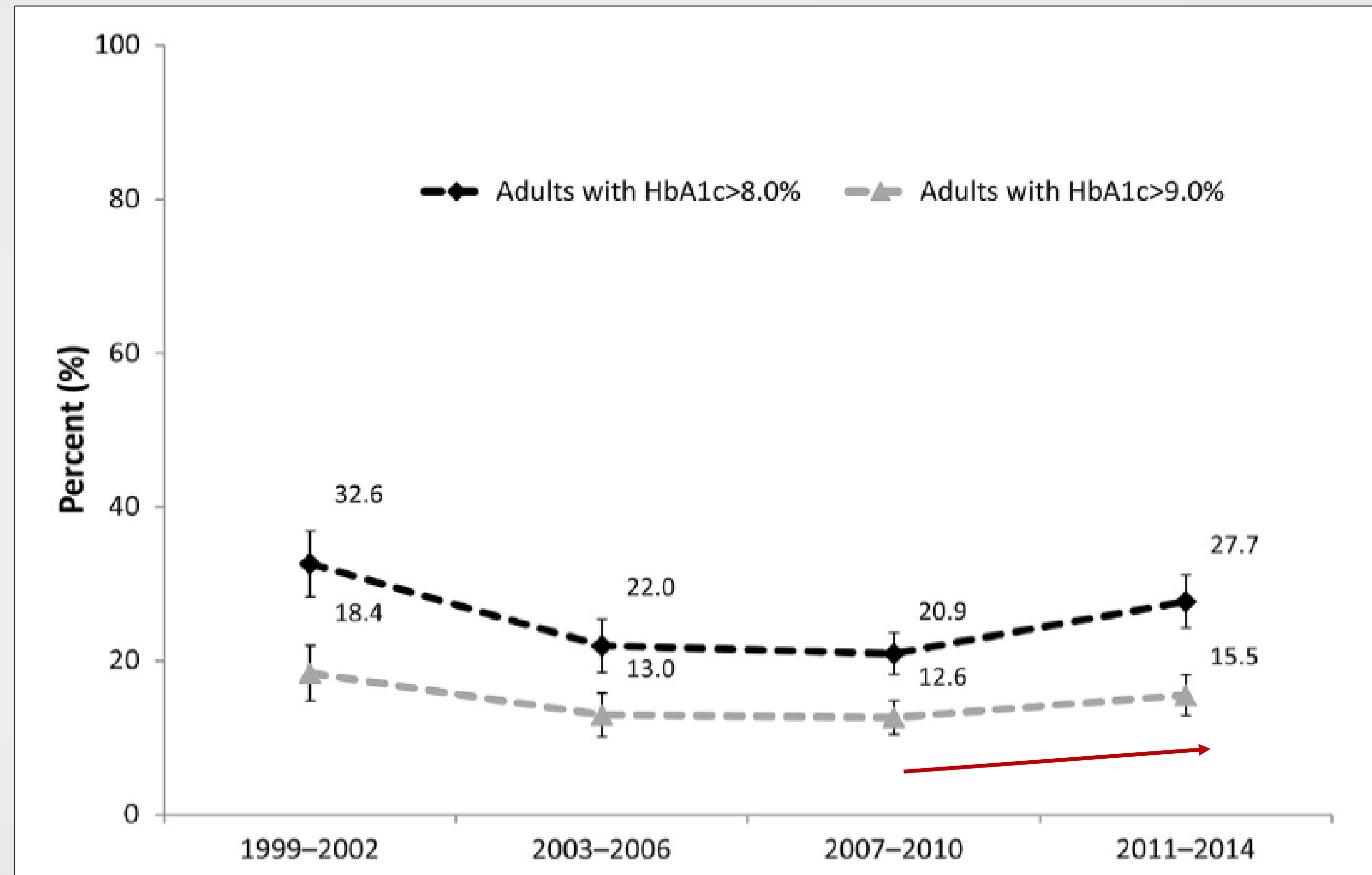
Despite increasing number of new diabetes medications and technologies ...

- Achievement of individualized targets declined from 69.8% to **63.8%**



Despite increasing number of new diabetes medications and technologies ...

- The percentage with HbA1c >9.0% increased from 12.6% to **15.5%**



What's wrong with this picture?

- Decline in % of patients at HbA1c <7%
- At best, only about 50% of patients at Goal
- Increase in % of patients with very poor control
- Unacceptable level of morbidity and mortality
- Diabetes-related costs to society are tremendous



ALL THIS DESPITE MORE THAN 40 NEW T2D
TREATMENT OPTIONS APPROVED SINCE 2005

The root of the problem ...



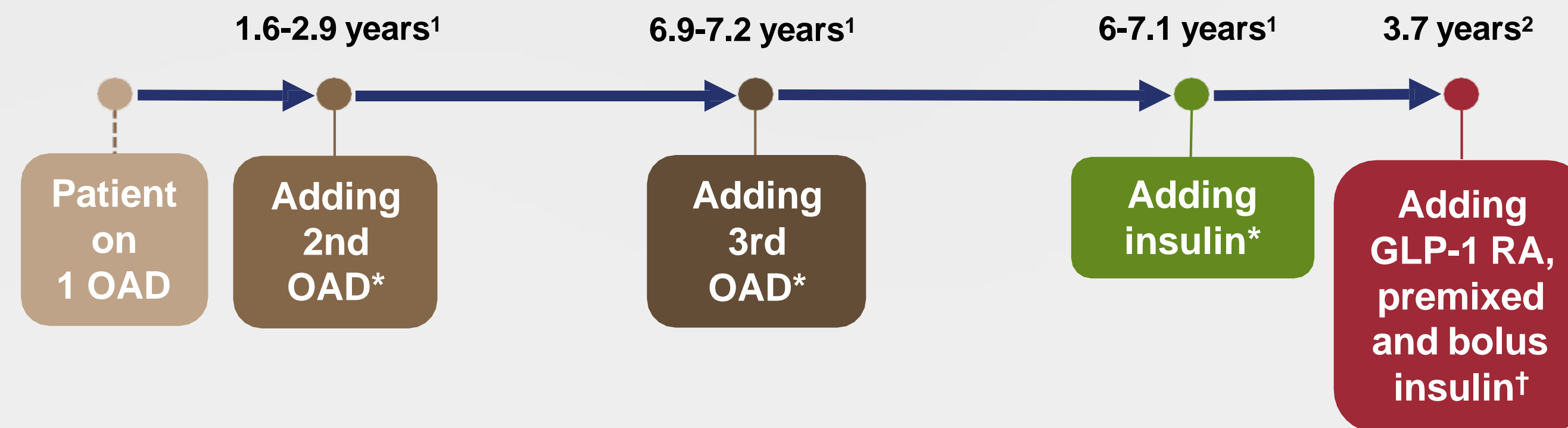
Therapeutic Inertia

Therapeutic Inertia: Rational and Clinical Relevance

- The failure to establish appropriate targets and escalate treatment to achieve treatment goals
- Responsible for substantial, preventable complications of diabetes with the associated excess in direct and indirect health care costs

Clinical Inertia Plays an Important Role in Delaying Intensification of Diabetes Therapy

Substantial inertia exists at each sequential intensification step



*From time when A1c was $\geq 7.0\%$, $\geq 7.5\%$, or $\geq 8.0\%$; †From time when A1c was $\geq 7.5\%$.
GLP-1 RA: glucagon-like peptide-1 receptor agonist; OAD: oral antidiabetic drug.

Slide courtesy of Steve Edelman, MD.

1. Khunti K, et al. *Diabetes Care*. 2013;36:3411-3417. 2. Khunti K, et al. *Diabetes Obes Metab*. 2016;18:401-409.

Our view ...

- Although therapeutic inertia impacts all populations, targeting individuals with **type 2 diabetes** is our first priority
- The causes of clinical inertia are multifactorial, with contributory elements from five stakeholder groups:
 - People with diabetes
 - Clinicians and other healthcare providers
 - Healthcare systems
 - Payors
 - Industry

Promotors of Therapeutic Inertia Often Cited...

Healthcare

Clinician-Related

- Insufficient time
- Failure to set clear goals
- Failure to initiate treatment
- Failure to titrate treatment to achieve goals
- Failure to identify and manage comorbidities (e.g. depression)
- Patient 'highjacks' the clinical encounter
- Reactive rather than proactive care
- Underestimation of patient's need

Patient-Related

- Denial of having the disease
- Denial that the disease is serious
- Low health literacy
- High cost of medication
- Too many medications
- Medication side-effects
- Poor communication between physician and patient
- Lack of trust in physician
- SDOH, Depression or substance abuse
- Lifestyle factors
- Absence of symptoms

System/Practice –related

- No clinical guidelines
- No disease registry
- No visit planning
- No active outreach to patients
- No decision support
- No team approach to care
- Poor communication between physician and staff

What else is important to know about therapeutic inertia?

- Early tight control leads to longer term maintenance of glycemic control.¹ – A legacy effect.
- Therapeutic inertia leads to a reduced likelihood of achieving target levels later in the disease trajectory.²
- Early intensification of treatment, in appropriate patients, is associated with a shorter time to subsequent glycemic control.³
- Therapeutic inertia has been associated with a reduced quality of life for the patient, along with increased risks of morbidity and mortality.

1. M Abdul-Ghani, C Puckett, *et al.* Initial combination therapy with metformin, pioglitazone and exenatide is more effective than sequential add-on therapy in subjects with new-onset diabetes. Results from the efficacy and durability of initial combination therapy for type 2 diabetes (EDICT): a randomized trial. *Diabetes Obes Metab* 2015; 17: 268–275.

2. D Mauricio, L Meneghini, *et al.* Change in insulin dose and HbA1c by geographical region—results from the diabetes unmet need with basal insulin evaluation (DUNE) Study. *Diabetes* 2018; 67(Suppl. 1). DOI: 10.2337/db18-1037-P.

3. U Desai, NY Kirson *et al.* Time to treatment intensification after monotherapy failure and its association with subsequent glycemic control among 93,515 patients with type 2 diabetes. *Diabetes Care* 2018; 41: 2096–2104.

What can you expect from this workshop?

- Practical advice from real-world settings
- Case-based presentations that will provide ideas for:
 - Optimizing your practice workflow
 - Addressing communication barriers
 - Dealing with patient self-care/self-management resistance
- Opportunities to discuss and share both your biggest challenges and solutions that work for you
- Leave with Ideas you can use in your practice right now that could make the measurable difference in reducing TI in your practice.

Today is about...

- Solutions
- Discussion
- Sharing
- People with Diabetes

It is not about...

- Finger-pointing
- Blame
- Ego
- Self-interest



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