Break Through Inertia: Strategies to Make Your Practice the Intervention

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We learned that we must require either a hardwired internet connect or calling in via a land line in the future – live and learn. I think that internet in general is having more issues due to so much use.

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About Today’s Presenters

**Eden Miller, DO** is a Family Practitioner at High Lakes Health Care in Bend, Oregon, where she shares a practice with husband, Dr. Kevin Miller. Over the past 20 years, Dr. Miller has cultivated a special interest in diabetes, after developing type 1 diabetes while in medical school. Out of that personal experience, her practice has extended into a subspecialty in diabetes and obesity care.

**Lucia M. Novak, MSN, ANP-BC, BC-ADM**, is a Nurse Practitioner, board-certified in both adult health and advanced diabetes management for over 20 years. She is a nationally recognized speaker and has authored numerous peer-reviewed articles, book chapters, podcasts, and webinars. She is also a veteran of the US Army Nurse Corp.
Learning Objectives:

● Identify ways to leverage the entire care team to help reduce therapeutic inertia.

● Understand how to structure an effective “Diabetes Only” visit to reduce therapeutic inertia.

● Improve understanding how effective care coordination can help overcome therapeutic inertia.

● Improve understanding of the optimal timeframe for scheduling a follow-up visit based on A1C and medication changes.

● Describe how virtual care can be utilized to help overcome therapeutic inertia.
Disclosures

Eden Miller, DO
Abbot, Eli Lilly, NovoNordisk, BT Astra, Neneca, Sanofi, Aventis, Merck
Advisory Board and Speaker, Pendulum Research

Lucia M. Novak, MSN, ANP-BC, BC-ADM
Promotional Speaker and/or Advisory Board Member and/or Consultant for: 1) Novo Nordisk; 2) Abbott Diabetes Care; 3) Xeris; 4) AstraZeneca; 4) Sanofi; 6) Janssen
Therapeutic Inertia is, in part, responsible for failure to meet goals.

THERAPEUTIC INERTIA: The failure to initiate or intensify (or sometimes de-intensify) the therapy regimen when a patient’s therapeutic goals are not met.

CLINICAL INERTIA: Includes underuse of therapies and interventions known to prevent or delay negative outcomes including DSMES, lack of screening, risk assessment, preventive measures, and referrals.
6 Months to Goal

1. Identify a Care Team for Your Practice
2. Do Diabetes Only Visits
3. Provide Diabetes Education
4. Be an Ally for Success
5. Leverage Virtual Care and Follow Up
Case Example - Joan

66-year-old female with Type 2 DM

Diagnosed 5 years ago and has noticed recently that “numbers have been slipping.”

Health reported as generally good…but she has hypertension, elevated cholesterol, and would love to lose a little weight.

Worried about the pandemic, and it has impacted her willingness to take her daily walks

Frustrated but decides to call the office for an appointment to get back on track
Poll Question 1:

In your practice setting, which of these do you use consistently: (check all that apply)
Processes and Approaches That Can Aid in Overcoming Therapeutic Inertia

1. Prioritize care coordination/team-based care
2. Incorporate “Diabetes Only” visits
3. Leverage remote monitoring and virtual care to increase touchpoints
4. Refer to DSMES, MNT, and other community services
5. Continuously assess and address social and emotional barriers
6. Have a Barrier Busting Mentality
Why are these concepts important?

• Spreads the workload
• Sets expectations and direction for the team
• Places emphasis and importance of diabetes care management as a stand-alone appointment
• Helps eliminate or at least address “inertia” on many levels of care intervention.
• Communicates importance of person with diabetes as a central part of the care team
6 Months to Goal

- Leverage the Care Team for Your Practice
- Do Diabetes Only Visits
- Provide Diabetes Education
- Be an Ally for Success
- Virtual Care and Follow Up
Who is on Team Diabetes?

- Person with Diabetes
- Family / Caregiver
- Clinician
- Pharmacist
- Nurse CDCES
- Registered Dietitian
- Medical Assistant
- Social Worker
- Dentist
- Case manager
- Exercise specialist
- Podiatrist
- Ophthalmologist
- Health coach
- Community health workers / Health Department
The Team Diabetes Office Staff at Work

Receptionist: Takes Joan’s Call and advises her...

“Our clinic has recently decided to begin making diabetes focused appointments where attention is placed specifically on diabetes and how it affects your overall health.

This appointment can be done in person in the clinic or virtually through a telemedicine platform. Which would you prefer?”

Task is sent to Medical Assistant to contact this patient for their in-person “Diabetes Only Appointment” for check list:

- Reminder call prior to appointment to get labs done prior to visit.
- Instruct patient to bring
  - Glucose/food/weight logs she may be keeping
  - Any technology such as a glucose meter, CGM receiver, or IDD.
  - Updated medication list
- Encourage patient to write down any questions or topics regarding your diabetes that you have and bring to your appointment.
Effectively Use Your Existing Space

- **Create a resource wall** for patients to freely access information
  - Coupons for medications
  - Information of local upcoming events
  - Community resources
  - Educational material

- **In waiting room**
  - **Reminder signs to bring diabetes related tools** and information to appointment
  - **Magazines and video educational material** for lobby wait times

- **In exam room**
  - **Informational posters and magazines** (e.g. Diabetes Forecast)
Leverage Your Office Staff Team to…

- **Gather vital signs** - including height, weight, BMI, blood pressure, pulse, and temperature.
- **Check medication list** - make sure it is correct and inquire about adherence.
- **Patient removes shoes**
- **MA downloads technology** and copies written log-books provided by the patient
- **MA performs the foot exam** (inspection, temperature, monofilament, vibration with a tuning fork) and documents the findings.
- **MA ensures the most current labs are in the chart** and determines if an A1c was done in the last 3 months. If not, or if Joan reports a recent change in her glucose, or if the last A1c was not at desired target then a point-of-care A1c is obtained.

**Setting EXPECTATIONS for all office staff and patients for DM-focus appointment**

**TRAINING** your staff to work to TOP of their scope/license/certification
6 Months to Goal

Leverage the Care Team for Your Practice

Do Diabetes Only Visits

Provide Diabetes Education

Be an Ally for Success

Leverage Virtual Care and Follow Up
Case Example - The “Diabetes Focused” Appointment

1. When Joan checks-in, receptionist knows that this is a diabetes-focused appointment and proceeds to ask Joan if she has everything with her from the medical assistant check list call.

2. Joan realizes she has forgotten her meter in the car and runs out to get it.

3. The receptionist collects everything from Joan and provides them to the medical assistant.
Joan’s “Diabetes Focused” Visit

Connect with the Person

- How is your diabetes control?
- Do you know your glucose targets?

Joan hasn’t been checking much but when she does, they are high, and she isn’t sure what targets she is shooting for.

Inquire about barriers and address them

- What are the biggest challenges to managing your diabetes?
- What one thing would make the biggest difference in allowing you to better care for yourself.

Joan has been getting takeout from restaurants for fear of going to the grocery store during the pandemic.

Assess current metrics and develop shared treatment plan

- Acknowledge concerns and provide suggestions for getting healthy food at restaurants, getting groceries for pick up or delivery, and reducing portions eaten.
- Inform Joan that rapid A1c today is 7.6% up from her 6.8% six months ago.

Prioritize glycemic control in next 6 months.
Focus on the ABC’s during in office appointment

- **HbA1c**
  - What is the targets A1c and time-in-range (TIR) for this person?
  - What is their current level of control for A1c and TIR?
  - Advance therapy and patient glucose awareness to reach target in the next 6 months

- **Blood pressure**
  - Current vital sign at target
  - Advance intervention, or therapeutic change to reach target

- **Cholesterol**
  - Is the current LDL at target for this person?
  - Intervene with lifestyle or therapy to advance toward desired target
Institute a Barrier Busting Mentality

Always ask about barriers – Never assume

“Can you tell me one the single biggest challenge in maintaining your health, an obstacle, or just something that plain old stinks when it comes to managing your diabetes and let’s see if we can address that today?”

Tackle barriers…deal with them or they will deal with us.

• Provide an intervention or new direction to overcome the barrier
• Avoid hyper-empathy or the desire to absolutely solve an issue
• Always do something to move closer to goal – avoid lack of progress

Screen for social and emotional barriers and diabetes distress.

• Consider incorporating a short social determinants of health screener for each patient
• Use a Diabetes Distress assessment [https://diabetesdistress.org/for-patients](https://diabetesdistress.org/for-patients)
Therapeutic Review

Inquire about drug adherence for each therapy:

- Side effects (positive and adverse)
- Cost: Co-pay, Deductible and Prior Authorization
- Attitude toward intensifying therapeutic intervention (increasing dosage or adding a med)
- Healthy lifestyle engagement and willingness to incorporate additional elements

How many times per week do you miss XYZ medication?
Poll Question 2:

Do you regularly incorporate continuous glucose monitors data in discussions with your patients?
Confirm Shared Glycemic Goal

1. Reminded Joan of the A1C target agreed on previously – in this case an A1C of less than 7% with minimal hypoglycemia.

2. Discussed whether she is having any trouble with medication adherence and refer to any information about missed medication captured by the MA.

3. Suggest meaningful SMBG (paired glucose testing) to help Joan understand the effects of meals, meds and movement activities on her glycemia.

4. Consider professional CGM to give her more in-depth lifestyle glucose information.
Lifestyle Prescription

• Weight management

• Healthy eating habits

• Exercise/physical activity
Glycemic Success Measures

1. Point-of-Care A1C if needed
2. Educate about when to SMBG – paired testing
3. Briefly discuss professional CGM & TIR (Reimbursement codes)
4. Download/review meter data Review logbooks
5. Query on hypoglycemia or medication side effects
6. Discuss medication adherence tricks
7. NOTE: Escalate or de-escalate therapy based on SMBG and CGM data as well as A1C
6 Months to Goal

Leverage the Care Team for Your Practice
Do Diabetes Only Visits
Provide Diabetes Education
Be an Ally for Success
Leverage Virtual Care and Follow Up
Joining with the patient, teaming up for success

1. Tall Joan…You want to help her get to her target as quickly as possible, and that diabetes is a progressive disease.

2. Clarify that…Staying in front of the progression can reduce complications and help her diabetes to stay under control longer.

   “There are various ways to get to target including the addition or adjustment of medication and lifestyle interventions such as dietary changes and increased exercise. What sounds like a good plan?”

3. Define and agree on a plan of action: What kind of interventions seem like a step she could take, and they jointly decide on the following plan:
   a. Increasing the medications she is taking to maximum dose
   b. Start having groceries delivered to the house allowing for healthier options
   c. Placing Personal/ Pro CGM for comprehensive evaluation of blood glucose patterns and TIR, or Increase SMBG to twice daily, incorporate PAIRED TESTING – one meal each day
Continue educating the person with diabetes

- Refer for DSMES - Regardless if concern regarding attending or coverage. If you don’t refer, it’s 100% certain that the person will not obtain the education.

- Four referral times for DSMES:
  1. New diagnosis of type 2 diabetes
  2. Annually for health maintenance and prevention of complications
  3. New complicating factors influence self-management
  4. Transitions in care with addition of new medications, insulin, continuous glucose monitoring or insulin delivery devices

Find a local ADA-recognized diabetes education program. These services focus on your concerns about diabetes. They will also empower you with the knowledge and skills to manage it. You can find a program in your area at [diabetes.org/findaprogram](http://diabetes.org/findaprogram).

The Association of Diabetes Care and Education Specialists (ADCES) also accredits diabetes education programs. You may be able to find additional programs at [diabeteseducator.org/find](http://diabeteseducator.org/find).
6 Months to Goal

Leverage the Care Team for Your Practice

Do Diabetes Only Visits

Provide Diabetes Education

Be an Ally for Success

Leverage Virtual Care and Follow Up
Be an Ally for Success

Within 1 week of appointment

• Reach out to patient via phone, secure e-mail or text
  - HIPPA-COMPLAINECE

• If no problems or concerns identified, contact patient in 2 weeks to verify
  - If still no concerns, remind patient of next appointment and any tasks required and ability to reach out if any questions, concerns before next appointment.

• If problems or concerns – address and re-connect weekly until patient is reporting doing well
  - Then again in 2 weeks to verify
6 Months to Goal

Leverage the Care Team for Your Practice
Do Diabetes Only Visits
Provide Diabetes Education
Forging Alliances
Leverage Virtual Care and Follow Up
It’s All in the Follow Up

• Establish next appointment at current visit
• Use a reminder tool such as an appointment or magnet card or follow up slip for the scheduler
• Agree on the action plan to be reviewed at next visit and inform the individual it will be documented in the patient record to refer to at the next visit
• Advise patient on where we are going to keep pace with their disease
• How and who to contact regarding glycemic results, effects of new therapeutic changes, and effects of intervention have
Clinical Use of CGM in Your Practice

Joan agrees to a Professional CGM study

- Place CGM in the office
- Two-week sensor return and upload
- Interpretation and pairing with activity
- Discuss in-person or via telemedicine and pair with activity
- Empower Joan to make meaningful changes
- Document treatment plan
- Follow up

Empower Joan to make meaningful changes
Poll Question 3:

What percentage of CGMs are downloaded and reviewed by HCPs?
Six Inertia Busters to Implement in Your Practice Right Now

1. Establish “Diabetes Only” visits that prioritize diabetes care assessment and intervention.

2. Refer all persons with Diabetes DSMES at least one time in their lifetime of treatment (irrespective of individuals’ likelihood to attend).

3. Develop a follow up interval based on target A1C or medication change for all patients.

4. Identify diabetes team members for your practice location and collaborate with them on patient care.

5. Aim to alter therapeutic intervention at all encounters when target is not achieved.

6. Make sure all office contacts (receptionist, medical assistants, nurses, and care coordinators) are aware of the inertia busters in place and reinforce them during patient interactions.
HCP Secrets for Success in Patient-level Inertia

1. You don’t know the inertia struggle unless you ask and evaluate for simple SDOH questions.

2. Have at least one answer for the greatest patient barriers you encounter.

3. Avoid hyper-empathy; it will wear you out.

4. Use shared decision making/good communication techniques.

5. Be a COACH for your patients, not a Referee…and use community you have built.

6. It’s a marathon, not a sprint.
Take Action - A job begun, is half done!

1. Pick two changes you will make in your office diabetes patient office workflow to help reduce TI

2. Find DMSES and community resources in your geographic area

3. Identify or create a referral process / form for patient services in your area
Conclusion

Never let therapeutic inertia be traced back to you!
Questions?
1. Download “Your Diabetes Care and Management Plan” to share with your patients

2. Download “7 Easy Strategies: Overcome Therapeutic Inertia Tomorrow” – Practice Action Checklist

3. Share the “Getting to Goal: Overcoming Therapeutic Inertia in Diabetes Care” fact sheet to share with all your clinic staff

4. Take the post-webinar survey – in your email box

Learn more at… TherapeuticInertia.Diabetes.org
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