Busting Inertia: Identifying and Engaging High-Risk Patients

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We learned that we must require either a hardwired internet connection 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.
About Today’s Presenters

**Kevin Pantalone, DO, ECNU, FACE** is the Director of Diabetes Initiatives for the Endocrinology and Metabolism Institute at Cleveland Clinic. He is a board-certified endocrinologist. From 2014-2019 he served as the Director of Clinical Research for the Department of Endocrinology. Dr. Pantalone has authored numerous publications on the topic of therapeutic inertia using the enterprise-wide electronic health record at Cleveland Clinic.

**Chhavi Mehta, MD** is Associate Medical Director of Quality and Ambulatory physician lead for the Sutter Diabetes Clinical Improvement Community and has been part of the Diabetes Research Institute at Mills Peninsula Medical Center since 2014. She has developed and worked on quality improvement projects related to diabetes, including integrating the diabetes educators within the primary clinics and developing a tele-medicine system for high-risk patients with diabetes.
Learning Objectives

• Improve understanding of the importance of identifying patients likely affected by therapeutic inertia (TI)

• Increase confidence in identifying patients experiencing therapeutic inertia through the use of electronic health record queries and other methods

• Increase confidence in ability to utilize patient dashboards and best practice alerts as tools to overcome TI

• Ability to list at least 3 patient engagement tactics that can be utilized within a practice to help overcome TI and improve treatment adherence
Disclosures

Kevin Pantalone, DO, ECNU, FACE

In the past 12 months, I have received

- Research support from Bayer, Merck, and Novo Nordisk
- Speaker honoraria from AstraZeneca, Merck, and Novo Nordisk
- Consulting honoraria from AstraZeneca, Bayer, Corcept Therapeutics, Merck, and Novo Nordisk
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.
At the Heart of Overcoming Therapeutic Inertia

All Strategies Must Drive Either...

Timely Therapy Optimization
Do something at every visit over target

Improved Care Plan Adherence
Continuously assess and address barriers

Inertia Busting

Both are critical...

But neither is sufficient!
Why is early identification important?
In Caring for Type 2 Diabetes, *Timing* is Important
Duration of Glycemic Burden

Few Patients Have A1C Evaluated & Addressed in a Timely Manner

Percentage of Uncontrolled Patients Returning for Follow-Up A1C Testing per ADA Guidance (N=82,675)\textsuperscript{a,b}

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<td>2.9</td>
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<tr>
<td>Full Adherence</td>
<td>6.8</td>
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Proportion of Uncontrolled Patients Who Had Treatment Modified

- No modifications (95,330): 38.6% of 36,823
- Modified therapy (95,330): 61.4% of 58,507

3% of patients met testing frequency and treatment modification guidelines. Those patients were \textasciitilde5X more likely to achieve A1C \textless7%.

\textsuperscript{a}Based on retrospective analyses of claims data from a large US health insurance company.

\textsuperscript{b}To be considered adherent to the ADA testing guideline, patients were required to have had a follow-up A1C test within 3 months (+/15 days tolerance) of the index test date or any follow-up test with an A1C value \textless7% or within 6 months (+/15 days tolerance) of a follow-up A1C test value of \textless7%. In order to be considered fully adherent over the 1-year time frame, patients must have had all recommended A1C tests, as determined by their A1C values.

T2D is a Progressive Disease

T2D Disease Progression Over Time

Representative depiction of the natural progression of T2D (time course and function).¹

IGT = impaired glucose tolerance.
In Caring for Type 2 Diabetes, *Timing* is Important

**Physiology and Psychology**

- Glycemic burden
- Loss of beta cell function
- Risk of complications
  - Macrovascular (cardiovascular)
  - Microvascular (renal, retinal, neural)
- Natural tendency to deny and defer

**Philosophy and Approach**

- Act with *urgency*
- Act *aggressively*
- Address risk of cardiovascular disease
- Address risk of chronic kidney disease
- Screen for retinopathy, neuropathy
- Understanding: this is a progressive disease
- Expectation: need to advance therapy
Poll #1:

Does your practice have a tool to quickly identify patients who are experiencing therapeutic inertia?
Historical “Treat to Failure” Approach

Case 1 - “Treat to Failure” example

NINE MONTHS AGO:
64-year-old woman. A1C = 7.7%.
Metformin 500 mg once daily. Had nutrition consult and DSMES consult 4 years ago, near the time of diagnosis
Increase in metformin dose and additional medications were recommended at this visit
Patient was adamant about not wanting to change anything and plan was to return in 3 months for repeat A1C. She says she will get “back on track” with diet and exercise

TODAY:
Missed 3-month appt. Repeat A1C 8.6%. Blames the higher A1C on the holiday season. Again, she states she will get back on track and does not want to initiate another therapy

As the clinician, what do you do?
“Treat to Target” Approach

Case 2 – “Treat to Target” example

TODAY:
43-year-old man. A1C 10.0%.

Has been on metformin intermittently for about 4 years

Says his A1C was 8.2% at diagnosis

Admits he did not take his disease seriously until his feet started to get numb a few months ago

Wife made the appointment today

As the clinician, what do you do?
Case 2 – “Treat to Target” – cont’d

Simply resuming metformin was not felt to be adequate

Metformin 1000 mg twice daily resumed

Dulaglutide .75 mg once weekly initiated

One-month f/u noted his average blood glucose had improved, but was still hovering around 150 mg/dL on average

Rather than wait for A1C, dapagliflozin 10 mg po daily was initiated. Dulaglutide also increased to 1.5 mg once weekly.

Follow-up A1C 5.7%

A1C has remained ~6% for the past 2 years
Proactive, Early, Aggressive Intensification: The Future

• “Treat to Failure” – Waiting for A1C to rise above goal before making change – has not worked!

• The guidelines have evolved, but translation of new recommendations into clinical practice is often delayed

• Recommendation for initial therapy:
  - Lifestyle Modification
  - Lifestyle Modification + Metformin
  - Lifestyle Modification + Metformin + Drug B
In Caring for Type 2 Diabetes, *Timing* is Important

**Physiology and Psychology**

- Glycemic burden
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**Philosophy and Approach**

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Intensification Inertia – Choosing Interventions That Have Little Likelihood of Success

• A1C 9.2%

• Doubling the dose of metformin from 1000 mg to 2000 mg is not going to get A1C to target

• Increasing insulin glargine from 22 to 28 units is not going to get A1C to target

• Must select interventions that are meaningful, impactful, with high likelihood of success
In Caring for Type 2 Diabetes, *Timing is Important*

**Physiology and Psychology**

- Glycemic legacy
- Loss of beta cell function
- Risk of complications
  - Macrovascular (cardiovascular)
  - Microvascular (renal, retinal, neural)
- Natural tendency to deny and defer

**Philosophy and Approach**

- Act with *urgency*
- Act *aggressively*
- Address risk of cardiovascular disease
- Address risk of chronic kidney disease
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- Understanding: this is a progressive disease
- Expectation: need to advance therapy
Identifying Therapeutic Inertia in Your Practice & Improving Patient Engagement
Disclosures

Chhavi Mehta, MD

I have no relevant financial interest or other relationship with any manufacturer of commercial products or services.
Screening Strategy for Use in Practice

• To identify patients at risk, think **high sensitivity**
  Ensure you don’t miss any patients who may be experiencing therapeutic inertia
  (few false negatives)

• Different from research studies and quality measures for accountability, where high **specificity** is important
  Ensure the patients you’re studying really are experiencing therapeutic inertia
  (few false positives)
Focus on Two Groups of Patients

1. **Patients you are seeing:** Assess for risk of therapeutic inertia
   
   Patterns of behavior and glycemic control *over time*
   
   - Does the patient have an individualized A1C target and a plan of care?
   - Medication adherence, diet, exercise, interaction with healthcare system

   Other risk factors
   
   - Lack of knowledge or understanding (glycemic legacy, progressive disease)
   - Diabetes distress
   - Social issues
   - Insurance coverage
   - Gaps in refill history (pharmacists can check)

2. **Patients you’re not seeing**

   Use a patient registry to look across a population → outreach to those at risk

   - A1C above individualized target or no recent A1C
   - No recent check-in or pattern of regular interaction with the healthcare system
   - Fear of hypoglycemia – allowing glucose to run high intentionally
The Diabetes Care Cycle
Visit Pre-Work

- Orders placed
- Reminders for care gaps in EHR
- Flag “potential therapeutic inertia” – use a registry
- Standard MA work

Care of the patients who do not have an appt.
Dashboards and Physician level reports
Care of the patient at the time of the visit
Identifying TI in the Patients You’re Seeing

**Office visit**

HbA1C ≥ threshold

- Individual target
- 8.0 percent (population)

3 mo.

Earlier HbA1C < threshold → continue to monitor
Earlier HbA1C ≥ threshold → intensify therapy again
No earlier HbA1C → therapeutic inertia

Recheck in 3 mo. (after this visit)

Intensify therapy, recheck in 4 to 6 wks.

Intensify?

HbA1C < threshold

- Refer for DSMES (CDE)
- Refer to clinical pharmacist
- Refer for nutritional counseling or weight management
- Refer to diabetes specialist/expert for consult
- Advance the dose of a current medication
- Add a new medication
- De-escalate therapy, if high A1C is due to hypoglycemia and missed doses

HbA1C ≥ threshold

- Refer for DSMES (CDE)
- Refer to clinical pharmacist
- Refer for nutritional counseling or weight management
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- Advance the dose of a current medication
- Add a new medication
- De-escalate therapy, if high A1C is due to hypoglycemia and missed doses

No HbA1C or no action

- therapeutic inertia

Diagnosis established at least 3 mo. prior to this visit
Pop-up in EHR: “Best Practice Alert” in Epic (BPA)

1) Age ≥ 18 years
   AND
2) A1C ≥ 8 in the past 6 months
   AND
3) No current T1D on the Problem List
   AND
4) Patient is not currently Pregnant
The Diabetes Care Cycle
Care at the Time of the Visit

- Care of the patients who do not have an appt.
- Visit Pre-work
- Care of the patient at the time of the visit
- Dashboards and Physician level reports

• Orders placed
• Reminders for care gaps in EHR
• Flag “potential therapeutic inertia”
• Standard MA work

• Close care gaps
• Use team-based approach
• Follow guidelines
Close Care Gaps: ADA Standards of Care App

Standards of Care App

Download the Updated ADA Standards of Care App

Get the Standards of Care App in the App Store for iOS or Google Play for Android to get the most up-to-date Standards along with interactive tables and algorithms. You can also access the Web App online.

This video walks you through how to use the Standards of Care app when caring for patients:

https://professional.diabetes.org/content-page/standards-care-app-1
Team Based Approach

Clinical Team
(MD, NP/PA, MA, RN, Pharmacist, RD, Social Worker/Psychologist)

Diabetes Care and Education Specialist

Quality Teams

Patient
### Team Based Approach – A Diabetes Team

**Visit Prep**
- EHR identification of visit as diabetes care visit
- Care gaps that needs to be addressed

**Medical assistant**
- Pend labs per health maintenance reminder on the EMR
- Update micro albumin and eye exam screen
- Blood pressure check and repeat if the first measure is high
- Pend immunizations

**Physician NP/PA**
- Address therapeutic inertia – treatment intensification per guidelines
- Address all care gaps (A1C, statin, retinopathy, nephropathy)
- Frequent follow-up by PCP and extended care team members (Pharmacist) until A1C under control
- Refer to diabetes education, linked visits with diabetes education. Patient seen the same day
- Assess for diabetes distress/depression and refer to mental health specialist
- Refer to other extended care team members like pharmacists
- Refer to diabetes specialist/expert
- Refer to obesity programs
The Diabetes Care Cycle
Care for Patients with No Appt.

- Give feedback to physicians
- Seek positive deviants (outliers)

Care of the patients who do not have an appt.
- Orders placed
- Reminders for care gaps in EHR
- Flag “potential therapeutic inertia”
- Standard MA work

Visit Pre-work

Care of the patient at the time of the visit
- Close care gaps
- Use team-based approach
- Follow guidelines

Dashboard and Physician level reports

Patient
Disseminate Unblinded Quality Metrics

Find the positive deviant!
There’s variation in performance by care team, within every organization.

Figure out who is getting it right and learn from them!

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<th>A1C 6 MO</th>
<th>A1C &lt;8</th>
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<th>BP 1 YR</th>
<th>BP GOAL</th>
<th>Eye Ex 2 YR</th>
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<td>96.0%</td>
<td>76.0%</td>
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Run Date: 15-April-2019
The Diabetes Care Cycle
Dashboards and Physician Reports

- Care of the patients who do not have an appt.
  - Use a population health approach
  - Leverage EHR registry and strategic outreach

- Visit Pre-work
  - Orders placed
  - Reminders for care gaps in EHR
  - Flag “potential therapeutic inertia”
  - Standard MA work

- Dashboards and Physician level reports
  - Give feedback to physicians
  - Seek positive outliers

- Care of the patient at the time of the visit
  - Close care gaps
  - Use team-based approach
  - Follow guidelines

- Patient

American Diabetes Association
Overcoming Therapeutic Inertia
Risk Stratification

High risk
A1C > 9%
(20%)

Moderate Risk
A1C 8-8.9%

Intermediate risk
A1c 7-7.9%

Low risk
A1C < 7%

Predictive Analytics
- Male with obesity and on Insulin or 2nd line treatment
- Baseline A1C 5.5 - 6.9
Use a Diabetes Registry

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<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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</table>
Don’t be intimidated. You don’t need to log in.

This is a great resource for helping practices get a registry report out of whatever EHR they have.

This resource can help you use the population health tools in your specific EHR to identify those who have not reached their target and those who may have uncontrolled diabetes:

https://www.novomedlink.com/practice-resources/EHR.html
Practical Patient Engagement Strategies

• Consider scheduling diabetes-only visits at least annually, especially for patients with multiple chronic conditions. Focus on diabetes-related issues such as A1C goal attainment, medication compliance, diabetes distress, and diabetes-related health maintenance.

• Arrange more frequent office visits based on A1C and recent treatment change. For example, every six to eight weeks for those at 9% or higher, every two to three months for those between 7 and 8.9%, and every 3–6 months for those <7% or at their personal target. Leverage telehealth to make it easier.

• Adopt technology to increase touchpoints and improvement engagement. When it comes to engagement, both quantity and quality matter. Frequent touchpoints are important for optimizing disease management.

• Use a team-based approach to increase frequency and quality of engagement. Leverage each member of the care team at the top of their license. Tap medical assistants and care managers to provide active follow up. Engage qualified nurses, CDEs, RDs and pharmacists to ensure that people with diabetes have their treatment evaluated and goals reinforced at every possible opportunity.
Other Considerations & Tips

• Refer to Diabetes Self-Management Education and Support (DSMES) – It Works!
  A 2015 systematic review (1) of DSMES found robust data that engagement in DSMES
  results in a statistically significant decrease in A1C levels…and more is better!

• Integrate screening for social and emotional barriers contributing to therapeutic inertia – and identify community support resources.

• Use Thoughtful Prescribing - Consider the cost of prescribed medications and insurance coverage. Patients may be reluctant to admit they can't afford the medications you prescribe. If uninsured, consider connecting patient with patient assistance programs (PAPs), or use the “if cost is a major issue” path in the ADA Standards of Care (Figure 9.1 in 2020)

Poll #2

What engagement strategies are you most likely to implement in next 3 months?
Summary

• Therapeutic inertia is the failure to initiate or intensify (or sometimes de-intensify) the therapy regimen when a patient’s therapeutic goals are not met.

• Timely, early, and aggressive intensification of therapy is required – treat to target.

• Early control provides a legacy effect that positively impacts patient outcomes.

• Identify TI in your practice – in those you are seeing and those you are not.

• A team-based approach that leverages community resources is critical – people with diabetes, caregivers, care team, pharmacist, dietician, social worker/psychologist, DSMES, etc.

• Use a variety of strategies to improve quantity and quality of engagement – diabetes only visits, technology, more frequent follow up.
Questions?
Your Action Assignment - Should you choose to accept it!

1. Choose 1 item from the “Identifying and Engaging Patients Experiencing Therapeutic Inertia” Practice Action Checklist.

2. Complete the “Act Now – Therapeutic Inertia in Clinical Practice: Self-Assessment.” Pull records and see where TI shows up.

3. Share the “Overcoming Therapeutic Inertia Fact Sheet” with all your clinic staff

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

Learn more at... [TherapeuticInertia.Diabetes.org](http://TherapeuticInertia.Diabetes.org)
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<th>Date</th>
<th>Webinar Title</th>
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<td>Leveraging Personalized Diabetes Care Plans to Overcome Therapeutic Inertia</td>
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<td>Break Through Inertia: Strategies to Make Your Practice the Intervention</td>
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<td>1/27/2021</td>
<td>Engaging Your Community as an Inertia Buster</td>
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<tr>
<td>3/10/2021</td>
<td>Optimize the Patient Journey: A Case-Based Approach</td>
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Other Therapeutic Inertia Components Coming Soon…

1. Practice Pearls videos series on overcoming therapeutic inertia

2. Free Online “Diabetes Consumer Guide Tool” – compare devices, drugs and more!

3. Patient & Provider Conversation Guide and Toolkit

4. Customizable Patient Care and Treatment Plan
Become an ADA Professional Member Today!

- Enhance your patient care with ADA’s COVID-19 resources
- Regular webinars led by today’s experts on vital topics
- Popular discussions in the DiabetesPro Member Forum
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