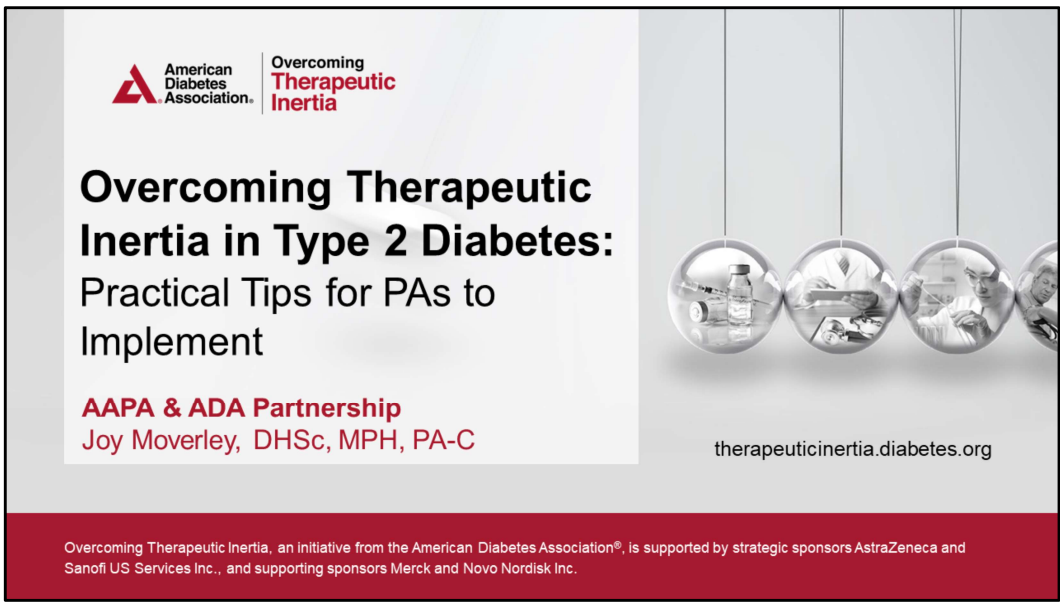


The purpose of this presentation is to guide individuals and organizations in developing identify and address the problem of therapeutic inertia in the people with type 2 diabete which they care.

Objectives

1. Learn how to leverage the best practices framework to improve diabetes care for your patients
2. Describe the evidence for failure to advance or de-intensify treatment and the impact on clinical outcomes
3. Identify contributors to therapeutic Inertia in a clinical practice

American Diabetes Association. | Overcoming Therapeutic Inertia

OVERCOMING THERAPEUTIC INERTIA®

Current Challenges

Despite the influx of new and improved diabetes therapies, including technologies, the majority of people with diabetes are still not meeting treatment goals nor are able to maintain stable glycemic control. In fact, a *New England Journal of Medicine* study reported that glycemic and blood pressure control declined in adults with diabetes in the 2010s (while lipid control leveled off).[1]

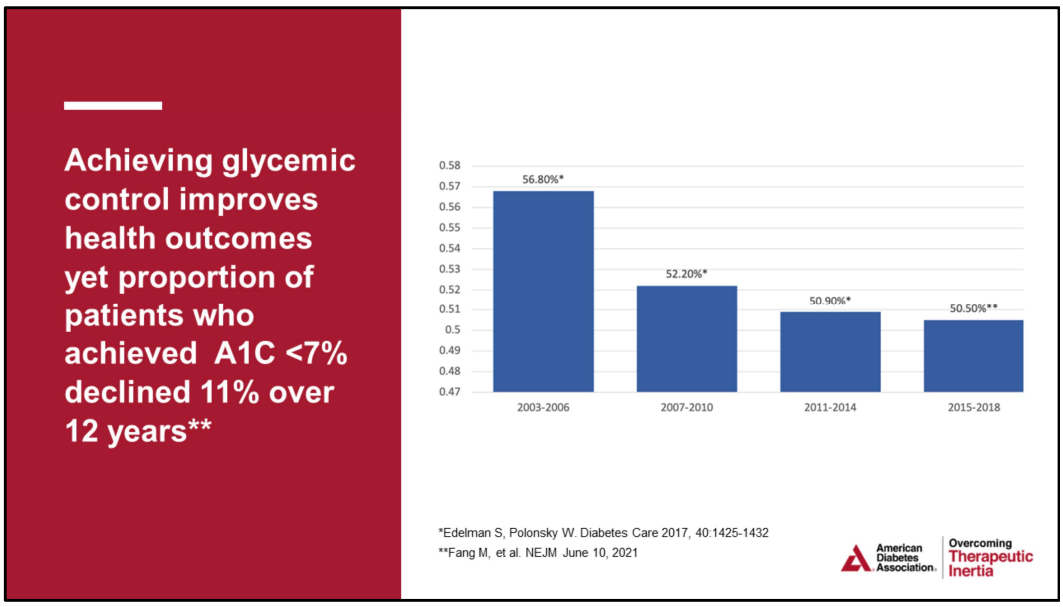
This, in turn, puts people at risk of fatal short-term complications, such as diabetic ketoacidosis (DKA), and devastating long-term complications, including heart disease, vision loss, and kidney failure.

[1] *N Engl J Med* 2021;384:2219-28. DOI: 10.1056/NEJMsa2032271

American Diabetes Association. | Overcoming Therapeutic Inertia

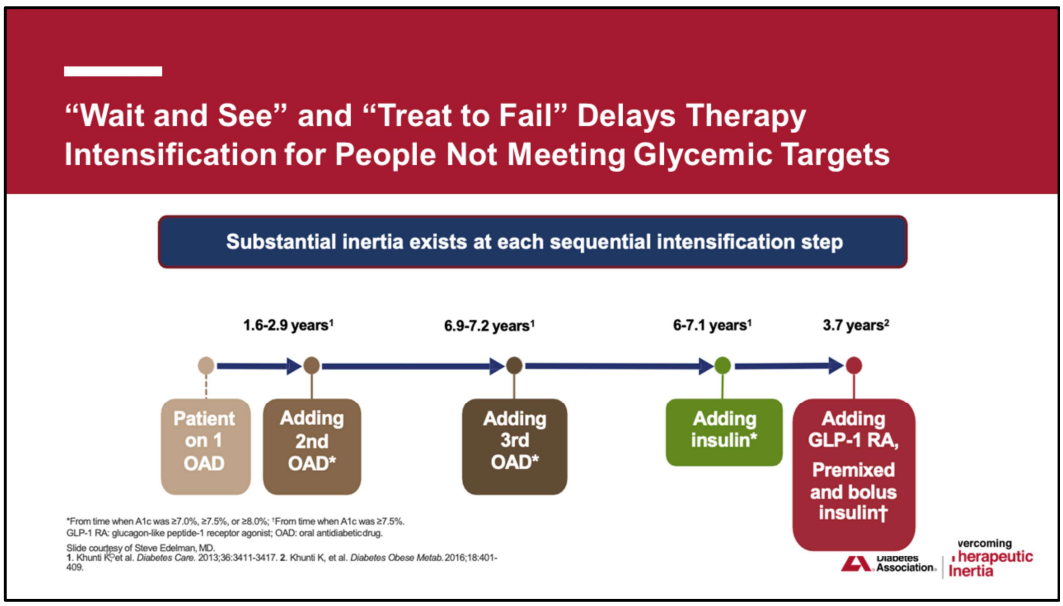
More than 40 new diabetes treatment options since 2005, as well as advancements in guidelines and treatment algorithms, we still have not made a meaningful difference in improving glycemic control in people with type 2 diabetes.

In fact, between 1999 and 2014 the percentage of patients with diabetes with an A1C over 9% actually increased. This phenomenon is known as therapeutic inertia—delay or inaction to initiate or intensify therapy when glycemic treatment goals have not been met.



Diabetes control in the U.S. population has steadily declined over the past 20 years, as gold-standard measure of A1C.

The figure on the screen shows that only 50.5% of people with diabetes meet the goal



The timeline on the screen shows that substantial inertia exists in years–not months at step in the patient's therapeutic journey.

The wait-and-see approach, or treat until the medication, for example, oral anti diabetic insulin fails, can mean that people with type 2 diabetes (PWT2D) spend years in hyperg

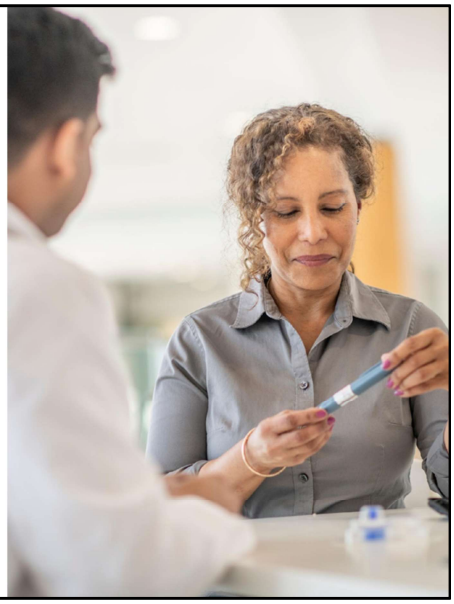
The "Wait and See" and "treat until a medication fails" approach often happens AFTER been delayed or considerable inertia has occurred in initiating a medication.

Therapeutic Inertia in Type 2 Diabetes

The failure to initiate, intensify, or de-intensify medication therapy when therapeutic goals are not met, despite:

- Clear definition of appropriate targets
- Benefits of achieving targets
- Available effective therapies
- Clinical guidelines/algorithms

Therapeutic inertia can occur at all stages of treatment intensification.



One of the reasons WHY glycemic control in the US population with diabetes has been stagnan worsened over the last 2 decades is Therapeutic Inertia (TI).

TI is the failure to initiate, intensify or de-intensify medication therapy when therapeutic goals could include starting a medication, changing a medication, modifying a dose, combining medi intensifying therapy if patient goals are not being met.

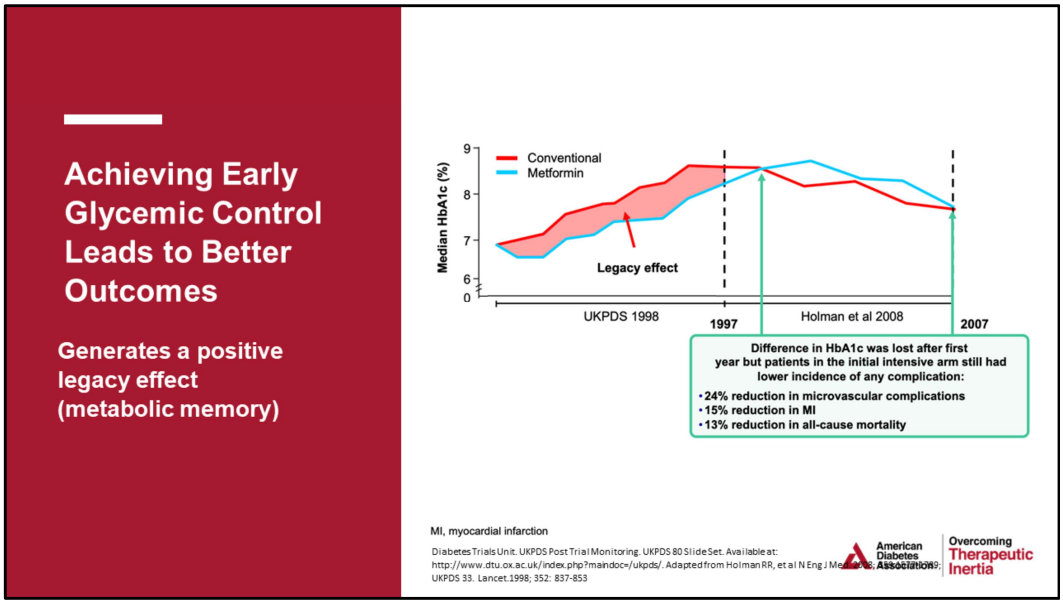
TI can be present at diagnosis or at any stage along the patient's treatment journey.
TI is occurring despite:

- Clear definition of appro

targets exist

- Benefits of achieving glycemic targets are well established
- Effective therapies are available
- Evidence-based clinical

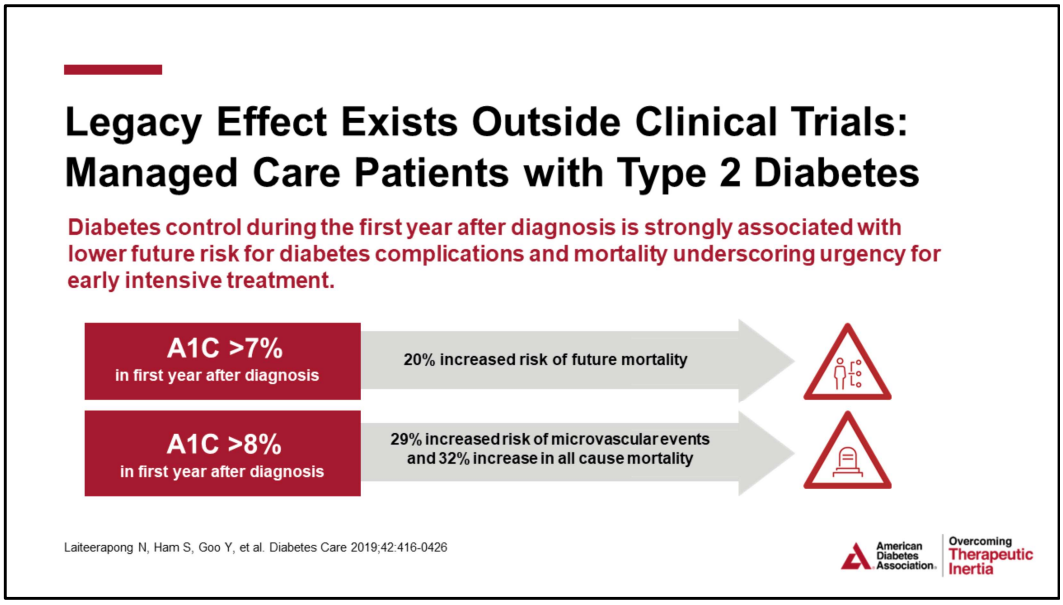
guidelines/algorithms are widely disseminated



The initial study period of the UK Prospective Diabetes Study (UKPDS) showed that pat treatment with lower A1C had significant reductions in microvascular complications. Hov significant reductions in cardiovascular complications.

Interestingly, follow up studies showed that even though differences in A1C were lost ov the initial intensive arm continued to have significant microvascular complications and s in cardiovascular complications.

UKPDS and other landmark trials showed early glycemic control creates a legacy of bet health outcomes, even after glycemic control wanes.

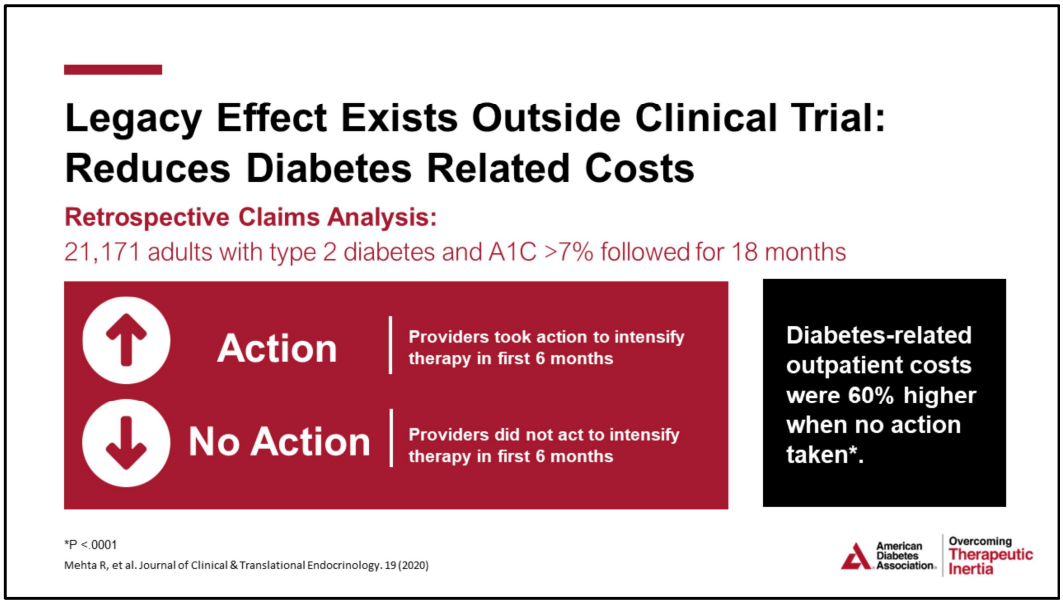


Real world data supports UKPDS clinical trial data. In a cohort study of over 34,000 pec diabetes (PWD) in a managed care population in northern California, patients were follc following diagnosis. The impact of glycemic burden was evaluated at various points.

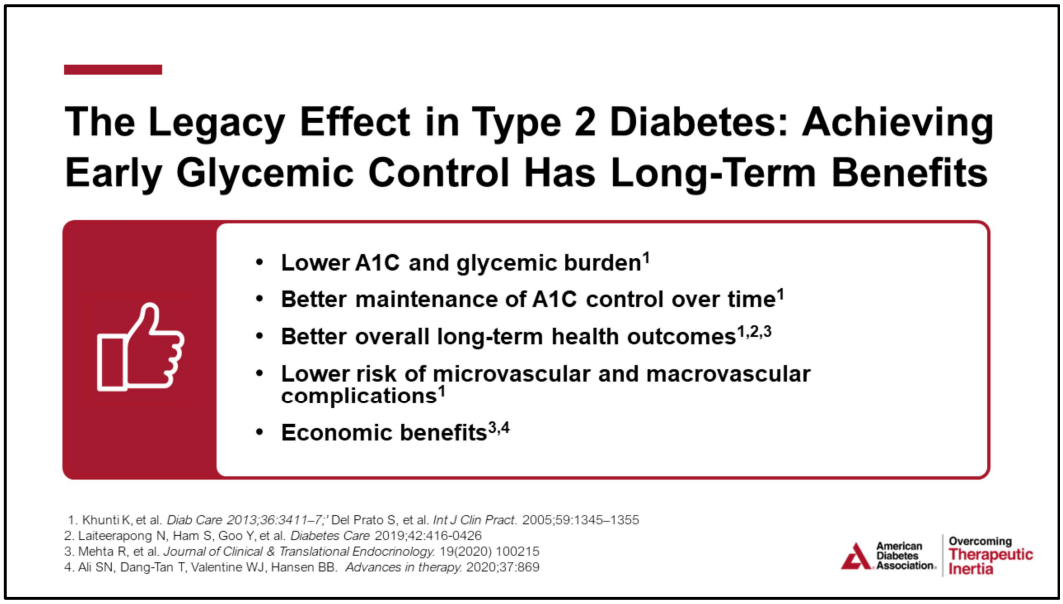
Among patients with 10 years of survival after diabetes diagnosis, the results showed the follov

- A1C levels ≥7.0% (≥53 mmol/mol) for the 1st year after diagnosis were associated with an in future mortality.
- Increasing periods of exposure to A1C levels ≥8.0% (≥64 mmol/mol) were associated with a microvascular events and mortality.

This study suggests that the legacy effect exists outside of trial populations. It begins as early as diagnosis and depends on the level of glycemic exposure. These findings underscore the urgenc of diabetes and the future consequences of failing to achieve near-normal glycemia soon after diagnosed with diabetes.



A retrospective claims analysis of >21,000 adults with type 2 diabetes (T2D) followed fo
that if their providers did not take action to intensify therapy within the first 6 months of t
outpatient costs were 60% higher than when providers acted in the first 6 months to inte



Achieving glycemic targets has many health benefits

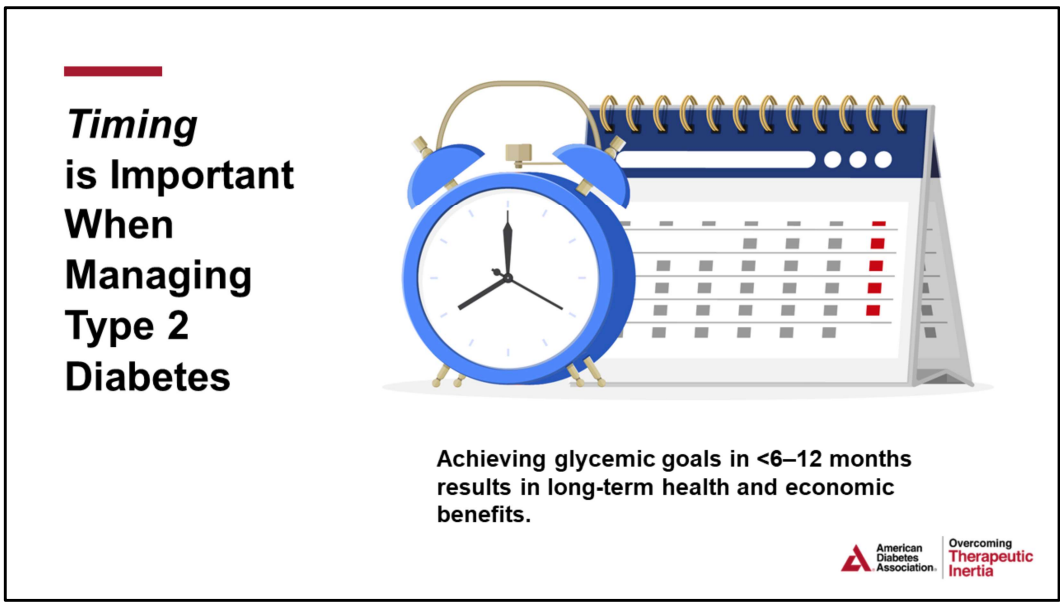
And…achieving goals **early in treatment** leads to the additional benefit of developing a

This legacy, first Illustrated by the UK Prospective Diabetes Study (UKPDS) in 1998 wh intensive treatment arm who achieved target goals of A1C <7% in first year had signific micro and macrovascular complications in the 10-year follow-up study …Even though d were lost over time.

UKPDS and other studies show early glycemic control creates a legacy of metabolic me better long-term health outcomes.

- Lower glycemic burden
- A1C maintained at near target over time
- Better over all long-term health outcomes because it lowers the risk of complic
- Reduced hospitalization and outpatient costs

S Khunti, K Khunti, et al.; Therapeutic inertia in type 2 diabetes: prevalence, causes, consequences and methods to overcome inertia; Ther Adv Endocrinol Metab; 2019, Vol. 10: 1–11

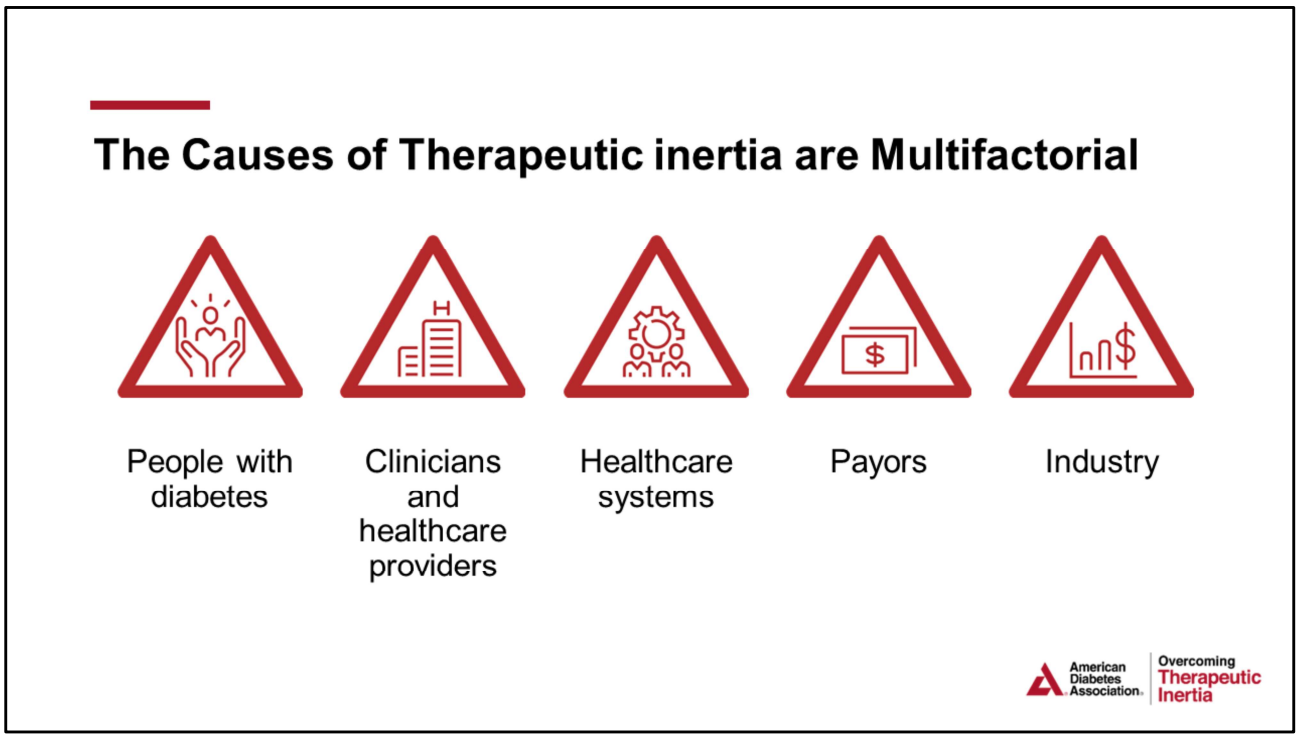


Timing is everything in type 2 diabetes treatment. The key concept in therapeutic inertia is acti
achieve glycemic targets and A1C goals within 6 months to 1 year of treatment.

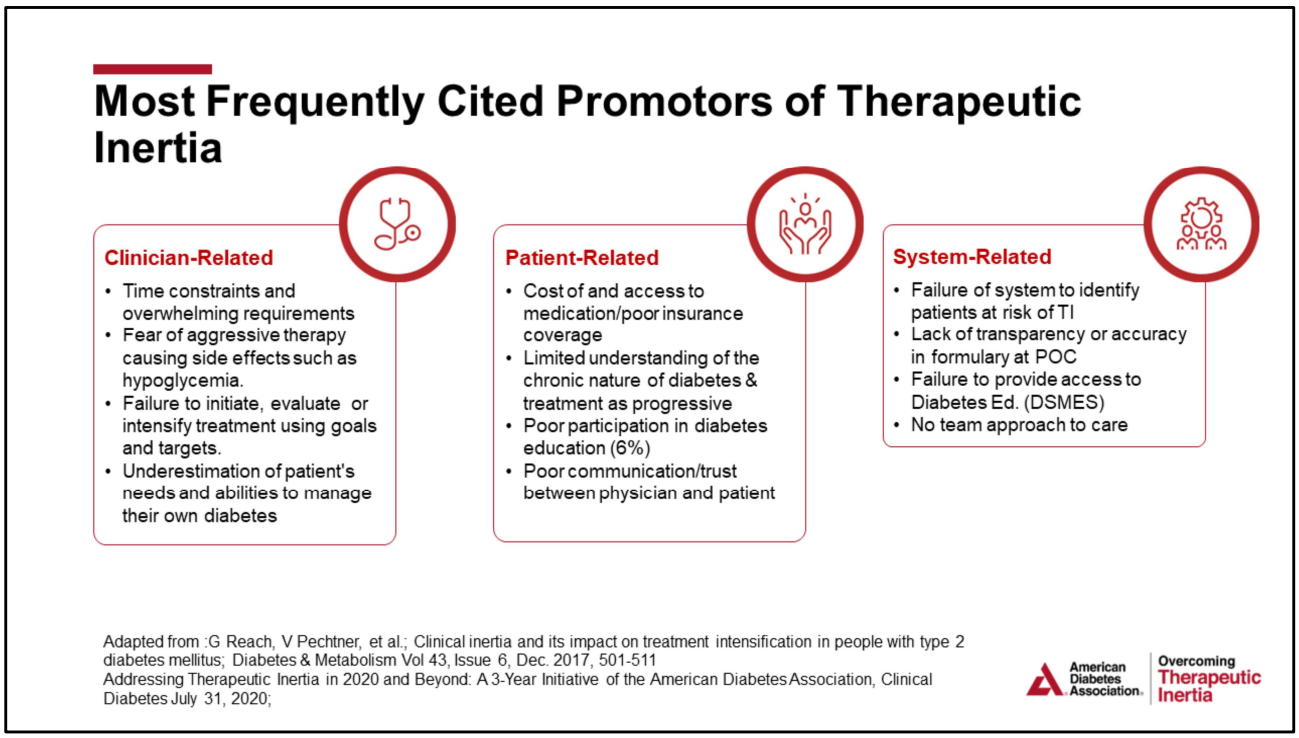
Recent studies in real world populations support the value of adopting this sense of urgency –6
providers who take treatment action within 6 months provide patient health and economic be

The potential glycemic and financial burden to individuals and our healthcare system ca
through health economic modeling. DELAYING intensifying treatment by 1-year results
costs in loss of lives and resources.

Contributing Factors to Therapeutic Inertia

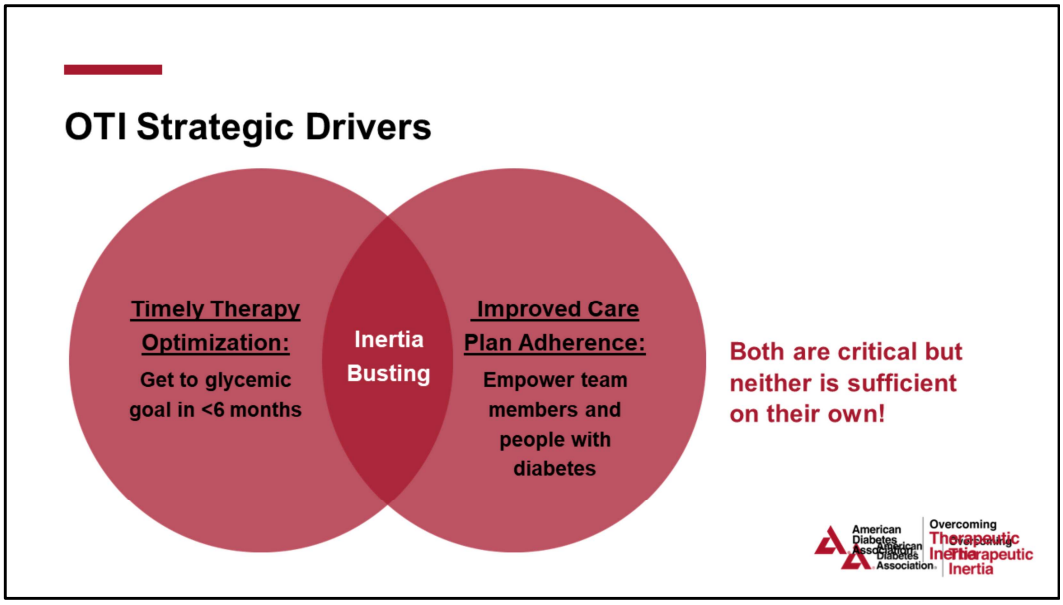


Key message: There are multiple stakeholders involved which necessitates a multipronged approach to overcoming therapeutic inertia.



Key message: There are many, many contributing factors to TI that need to be addressed.

Patient related are largely 2/2 SDOH



Timely therapy optimization is critical to overcome therapeutic inertia. It starts with iden diabetes who are at high risk. Set treatment goals with shared decision-making. Modify timely.

Focus on improved care plan adherence: Ask about barriers and find solutions together diabetes.

Clinicians should reflect on this question every visit and in between: Have I done everyt to tackle therapeutic inertia?

ADA's Overcoming Therapeutic Inertia Initiative

American Diabetes Association. | Overcoming Therapeutic Inertia

Overcoming Therapeutic Inertia®

ADA launched this effort in 2018 to identify barriers in diabetes care and develop solutions leading to improved, timely treatment modification and improved glycemic control in people with type 2 diabetes.

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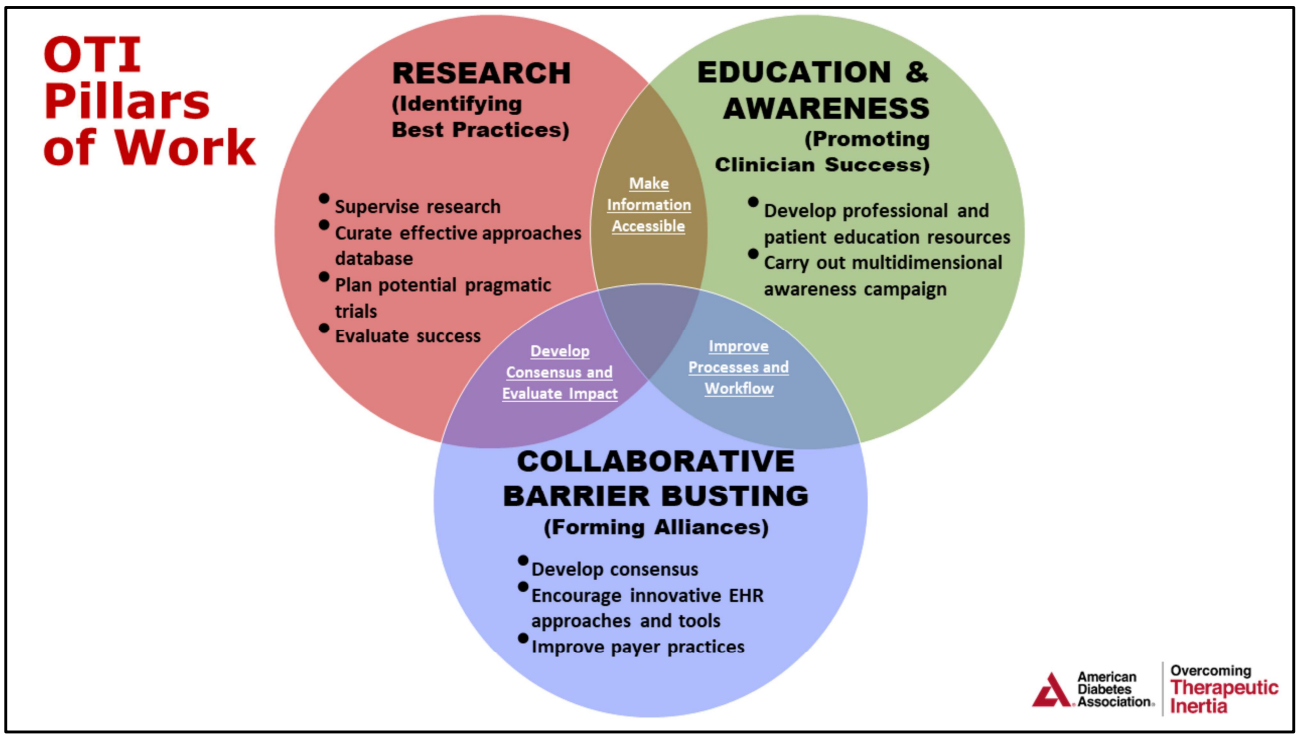
OTI Pillars of Work
RESEARCH
(Identifying Best Practices)
Supervise research
Curate effective approaches database
Plan potential pragmatic trials
Evaluate success
EDUCATION & AWARENESS
(Promoting Clinician Success)
Develop professional and patient education resources
Carry out multidimensional awareness campaign
Make Information Accessible
Develop Consensus and Evaluate Impact
Improve Processes and Workflow
COLLABORATIVE BARRIER BUSTING
(Forming Alliances)
Develop consensus
Encourage innovative EHR approaches and tools
Improve payer practices
American Diabetes Association.
Overcoming Therapeutic Inertia

ADA OTI Partnership

OTI Alliance Partners:

- Association of Diabetes Care and Education Specialists (ADCES)
- AMGA (American Medical Group Association)
- American Association of Nurse Practitioners (AANP)
- **American Academy of PAs (AAPA)**
- American Association of Pharmacists (APhA)
- American Society for Health System Pharmacists (ASHP)
- Sanofi

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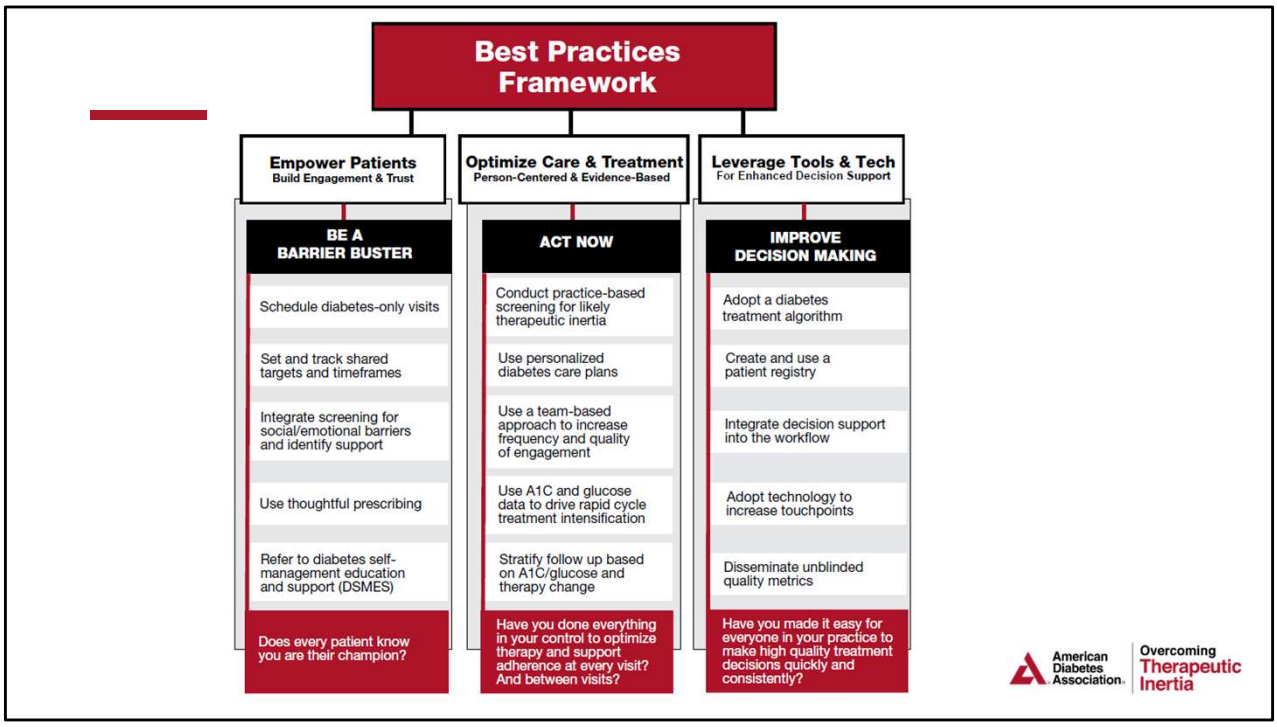
Best Practices Framework
Empower Patients
Build Engagement & Trust
Optimize Care & Treatment
Person-Centered & Evidence-Based
Leverage Tools & Tech
For Enhanced Decision Support
BE A BARRIER BUSTER
Schedule diabetes-only visits
Set and track shared targets and timeframes
Integrate screening for social/emotional barriers and identify support
Use thoughtful prescribing
Refer to diabetes self-management education and support (DSMES)
Does every patient know you are their champion?
ACT NOW
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Have you made it easy for everyone in your practice to make high quality treatment decisions quickly and consistently?
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Empower Patients

Schedule diabetes-only visits

- At least 1 appointment per year
- Shared decision making and patient-centered care.
- Sets the stage and importance of managing diabetes to your patients.

Nuti, L, Turkcan, A, Lawley, MA, Zhang, L, Sands, L, McComb, S. The impact of interventions on appointment and clinical outcomes for individuals with diabetes: a systematic review. *BMC Health Serv Res* 2015;15:355. https://doi.org/10.1186/s12913-015-0938-5.

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1.All too often, urgent and emergent challenges take precedence during office visits.

2.assessing barriers, evaluating gaps in current diabetes knowledge, and building rapport and trust.

3.These appointments will also serve to deliver the message about the importance of managing diabetes to your patients.

CARDIOVASCULAR DISEASE AND RISK MANAGEMENT

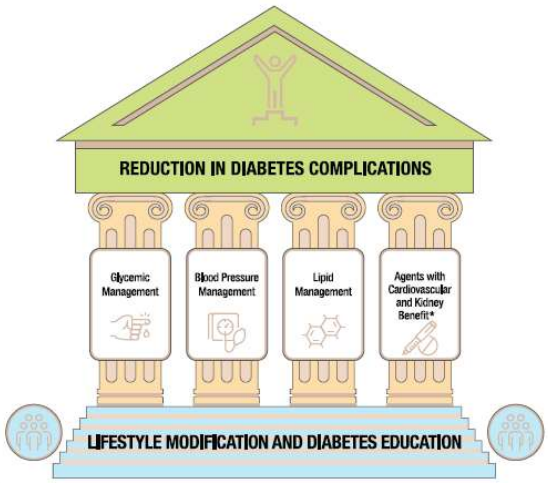

Figure 10.1—Multifactorial approach to reduction in risk of diabetes complications. *Risk reduction interventions to be applied as individually appropriate.

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2022. Diabetes Care 2022;45(Suppl. 1):S144-S174

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Amy Butts

Set and track shared targets and timeframes

- Realistic and personalized goals with buy-in from the person with diabetes.
- Cultural and personal preferences is important to obtain acceptance and willingness

Levengood, TW, Peng, Y, Xiong, KZ, Song, Z, Elder, R, Ali, MK, et al.. Team-based care to improve diabetes management: a community guide meta-analysis. *Am J Prev Med* 2019;57:e17–26. https://doi.org/10.1016/j.amepre.2019.02.005.

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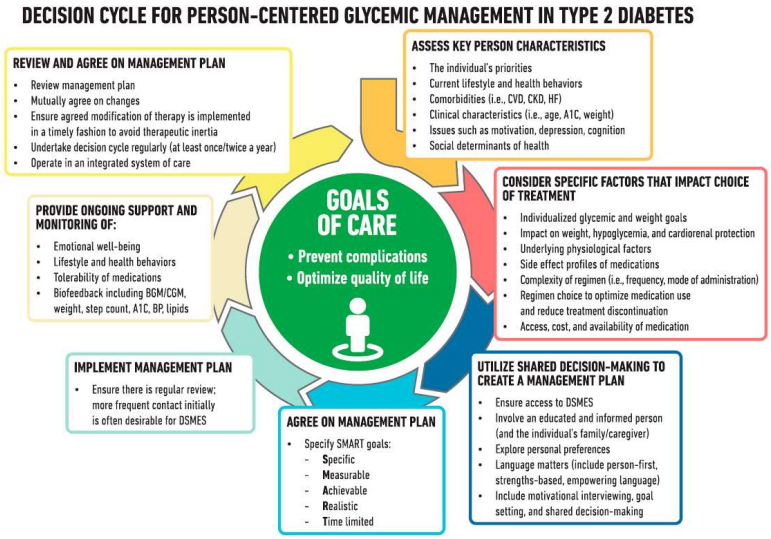
In addition, creating a realistic timeframe for obtaining these goals is important for the positive legacy effect [10].

COMPREHENSIVE MEDICAL EVALUATION AND ASSESSMENT OF COMORBIDITIES



Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Care in Diabetes - 2023. Diabetes Care 2023;46(Suppl. 1):S49-S67

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Appendix: Patient Self-Assessment Tool

Your Type 2 Diabetes Treatment: Get Ready for Your Visit

Your diabetes care team can help you find a diabetes treatment plan that works for you. Take a few minutes to answer these questions so your care team will know how to make the most of your visit.

First, let's see where you are in your diabetes journey.

1 How long have you had diabetes?
- ☐ Less than 1 year
- ☐ 1 to 5 years
- ☐ 6 to 10 years
- ☐ More than 10 years

2 How do you think your diabetes treatment is going?
- ☐ Great—I'm totally on top of it
- ☐ Okay—but it could be better
- ☐ Not so good—something needs to change

Now let's find out how you're doing with specific parts of your care.

3 Many people take more than 1 medicine to treat their diabetes. Are you okay with the idea of taking more than 1 medicine?
- ☐ Yes
- ☐ No
- ☐ I'm not sure

4 Do you take your medicines on schedule and as prescribed?
- ☐ Yes
- ☐ No
- ☐ Sometimes

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Appendix: Patient Self-Assessment Tool

5 Do you check your blood sugar on schedule?
- ☐ Yes
- ☐ No
- ☐ Sometimes

6 The last time you got your A1C checked, were you meeting your goal?
- ☐ Yes, my A1C was where it needs to be
- ☐ No, my A1C was too high
- ☐ I'm not sure

7 What do you do when you need help managing your diabetes?
- ☐ I call someone on my care team, like my doctor, nurse, dietitian, or pharmacist
- ☐ I call my diabetes educator
- ☐ I ask friends and family
- ☐ I go to an organization in my community
- ☐ I look on the internet
- ☐ I don't know what to do—I feel like I'm in this alone
- ☐ Other: _____

8 What are the biggest challenges you have in managing your diabetes?
- ☐ My treatment plan
- ☐ Sticking to my treatment schedule
- ☐ Paying for my medicines, devices, or supplies
- ☐ Getting to my appointments
- ☐ Eating healthy
- ☐ Getting enough physical activity
- ☐ Feeling overwhelmed or depressed about my diabetes
- ☐ Other: _____

9 What other things would you like to talk about?

_____

_____

_____

Great—now share your answers with your diabetes care team during your visits. That way, they can help you get the information and support you need to keep your diabetes treatment on track to meet your goals.

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Overcoming Therapeutic Inertia

Integrate screening for social or emotional barriers and identify support

- Ask why
- Consider the social determinants of health (SDOH)
- Psychosocial considerations – diabetes distress, depression, and anxiety
- Diabetes literacy and numeracy
- Food insecurity should be assessed
- Once barriers are identified, locate support services in your community and make referrals.
- Consider ways to leverage existing staff to help with this task.

American Diabetes Association Professional Practice Committee. Facilitating behavior change and well-being to improve health outcomes: standards of medical care in diabetes – 2022. *Diabetes Care* 2022;45(1 Suppl):S60–82. https://doi.org/10.2337/dc22-s005.Search in Google Scholar

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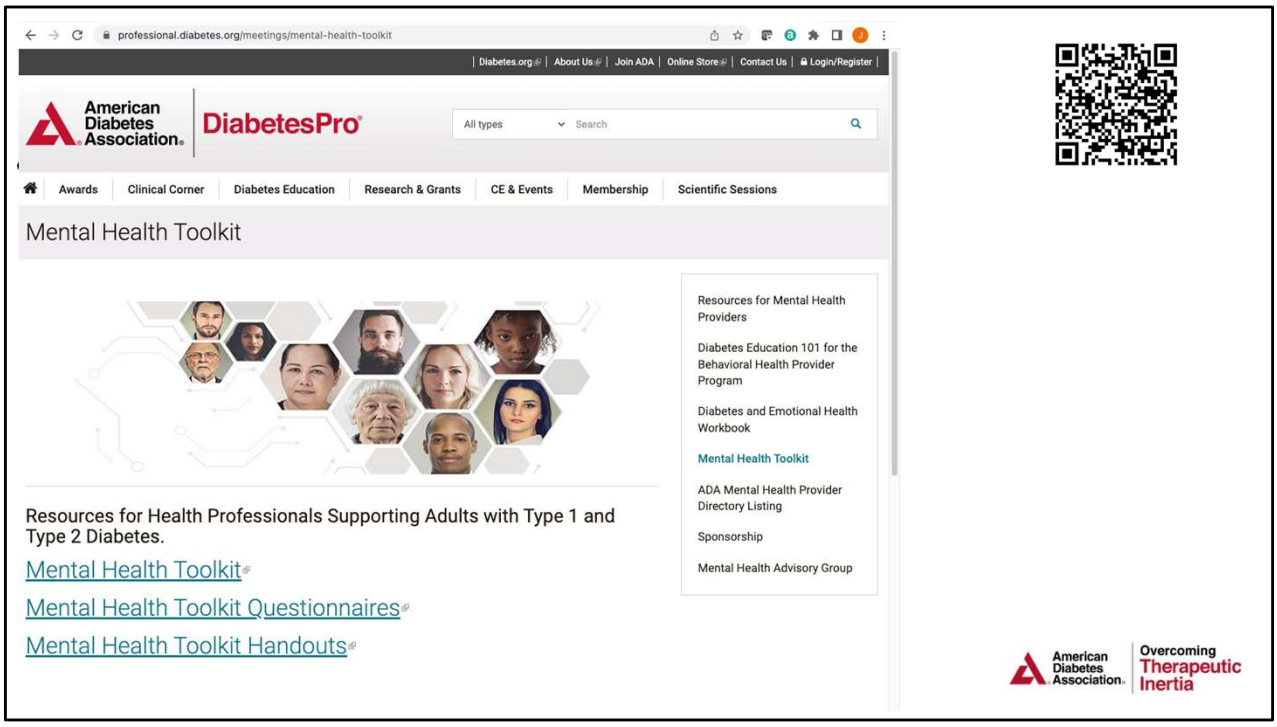
- Ability to keep appointments
- Childcare, work
- Transportation, cost, insurance



Amy Butts
https://professional.diabetes.org/meetings/mental-health-toolkit

Use thoughtful prescribing

- Cost, fear of injection, personal preference
- Shared-decision making central to OTI

American Diabetes Association Professional Practice Committee. Facilitating behavior change and well-being to improve health outcomes: standards of medical care in diabetes – 2022. *Diabetes Care* 2022;45(1 Suppl):S60–82. https://doi.org/10.2337/dc22-s005.

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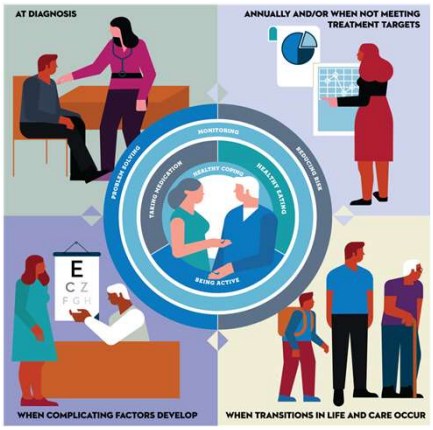
The choice to take medication can be impacted by many factors including cost, fear of injection, and personal preference [10, 17]

Refer to diabetes self-management education and support (DSMES) services



1) At diagnosis.
2) Annually and/or when not meeting treatment targets.
3) When complicating factors develop.
4) When transitions in life and care occur.

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020
ADCES. AADE7 Self-Care Behaviors, The Diabetes Educator, 2020

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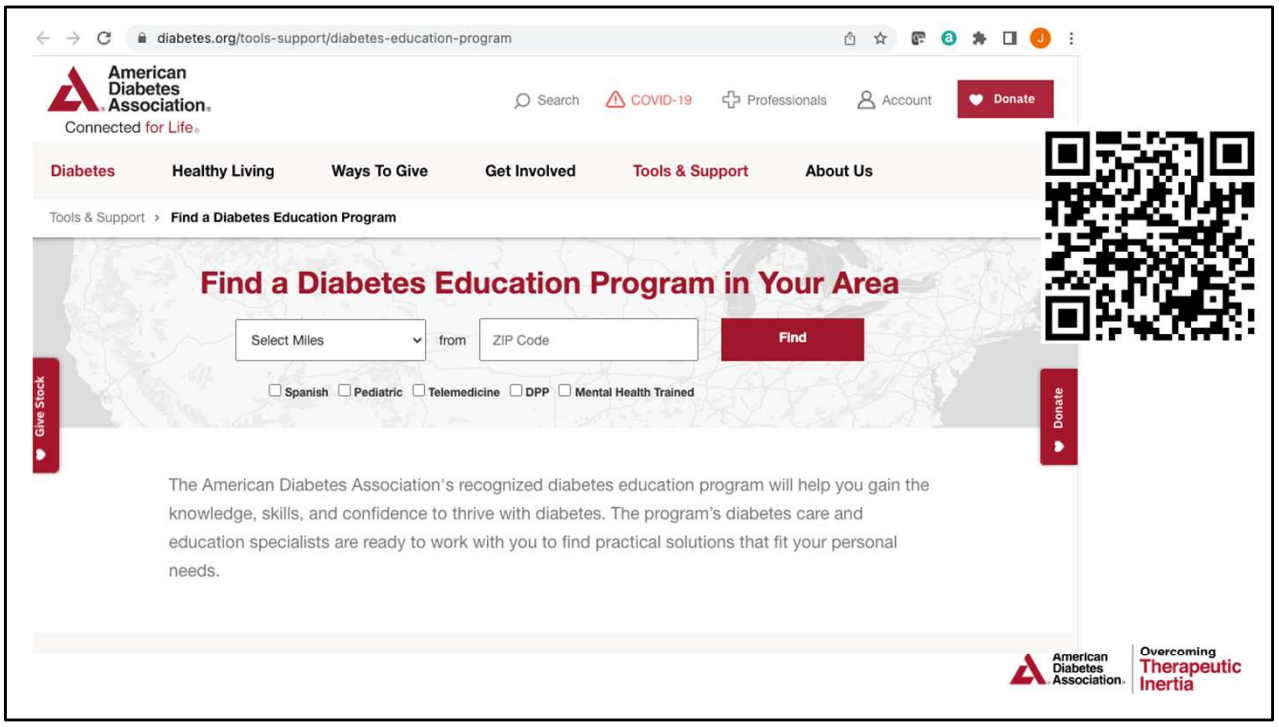
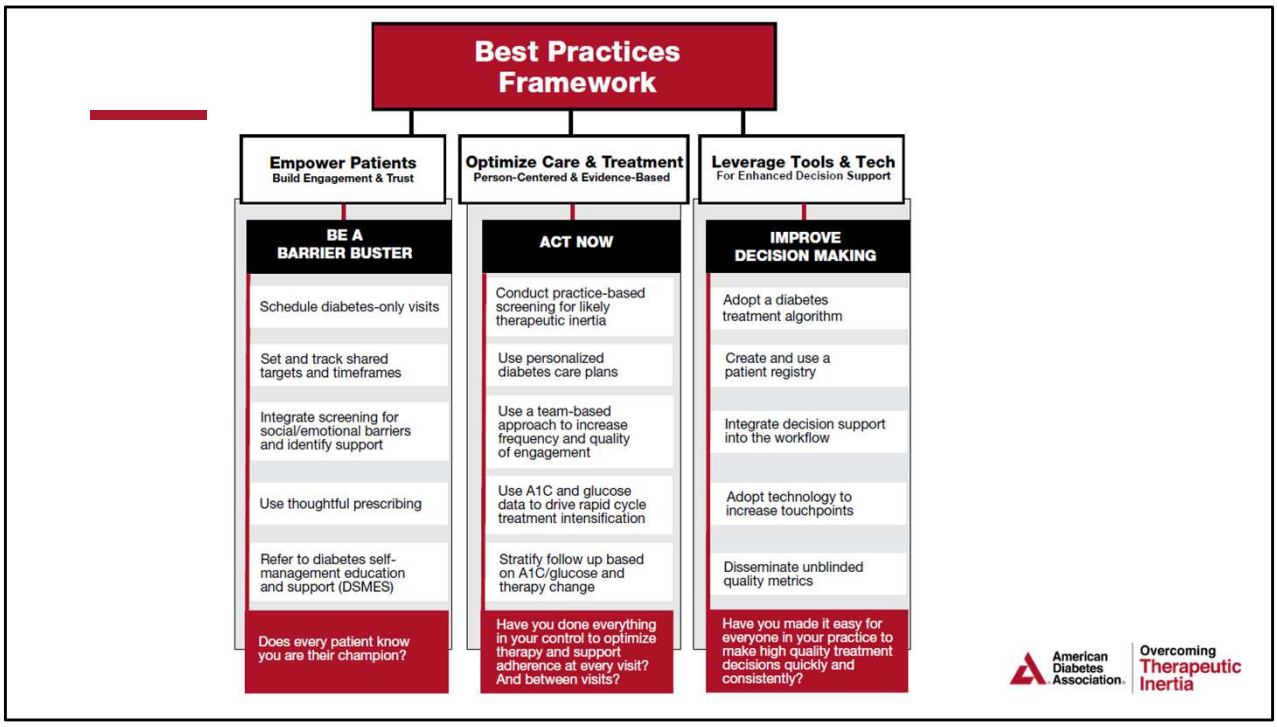
DSMES = medication

In addition, consider Shared Medical Appointments or “group visits”



***Ellen - experience; slide from DM Educators? (ADCES)
Need to confirm this slide w/ Ellen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Optimize Care & Treatment

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Use personalized diabetes care plans

- Include glucose targets and timeframes to reach targets
- Shared decision-making approach to consider personal preferences
- Motivational interviewing/open-ended questions

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Allow patient to help set the agenda
“What are your goals for today’s visist”

personal preferences, values, strengths, and medical, social, and psychological needs when developing or updating the care plan.

Use a team-approach to increase the frequency and quality of engagement

Besides the usual healthcare team members consider:

- Community health workers, mental health specialists
- Online coaches
- Religious leaders
- Friends, family, co-workers
- PA students (and Pre-PAs)
- Medical assistants!

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Empower your Medical Assistants

- Patients receiving care in primary care clinics utilizing MAs as health coaches showed significant improvement in A_{1c} and cholesterol levels when compared to usual care (48.6 vs. 27.6%, p=0.01).
- Both quality of care and patient satisfaction were also increased when patients received health coaching [1]. This is especially true for patients who do not speak English.
- MAs are often racially, ethnically, and linguistically concordant with the patient population compared to HCPs [2]. For example, Spanish-speaking MAs can overcome cultural and language barriers with Spanish-speaking patients through health coaching.

1Willard-Grace, R, Chen, EH, Hessler, D, DeVore, D, Prado, C, Bodenheimer, T, et al.. Health coaching by medical assistants to improve control of diabetes, hypertension, and hyperlipidemia in low-income patients: a randomized controlled trial. *Ann Fam Med* 2015;13:130–8.
2Thom, DH, Hessler, D, Willard-Grace, R, DeVore, D, Prado, C, Bodenheimer, T, et al.. Health coaching by medical assistants improves patients' chronic care experience. *Am J Manag Care* 2015;21:685–91.

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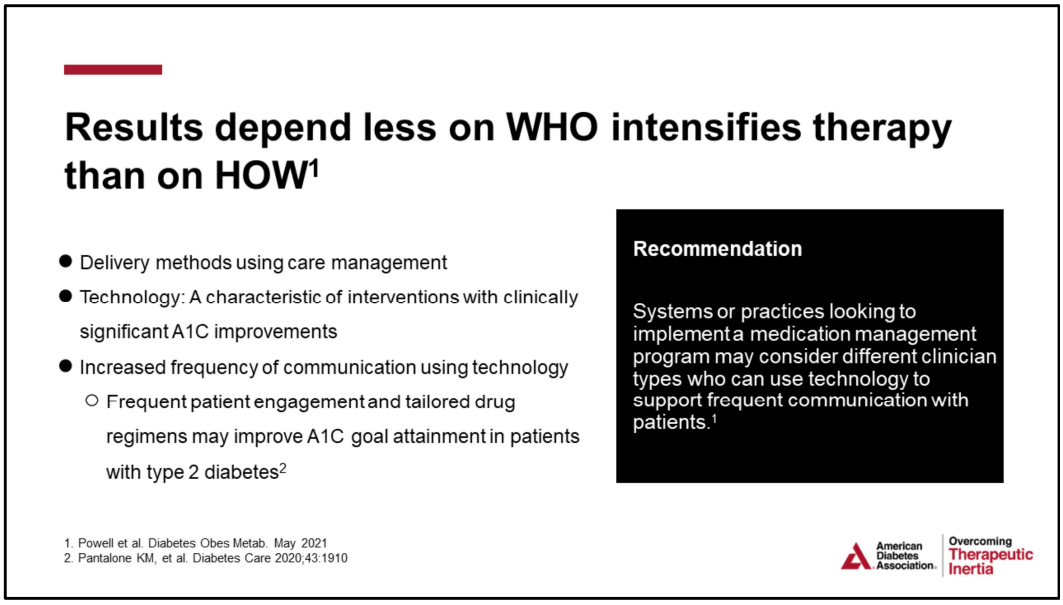
Another way to include your MA as part of the team is to have them reach out to patients 1 or 2 weeks after the appointment to ascertain questions or concerns. Engaging MAs in this fashion helps integrate them as members of the diabetes care team.

anecdotal feedback from their staff that they believe that they are recognized as integral members of the team. They are also able to develop a trusting rapport with the patient that not only reduces delays in care but also

improves patient satisfaction.

When our patients are more engaged, they are provided an opportunity to self-advocate and report that they feel genuinely cared about by the entire office staff.

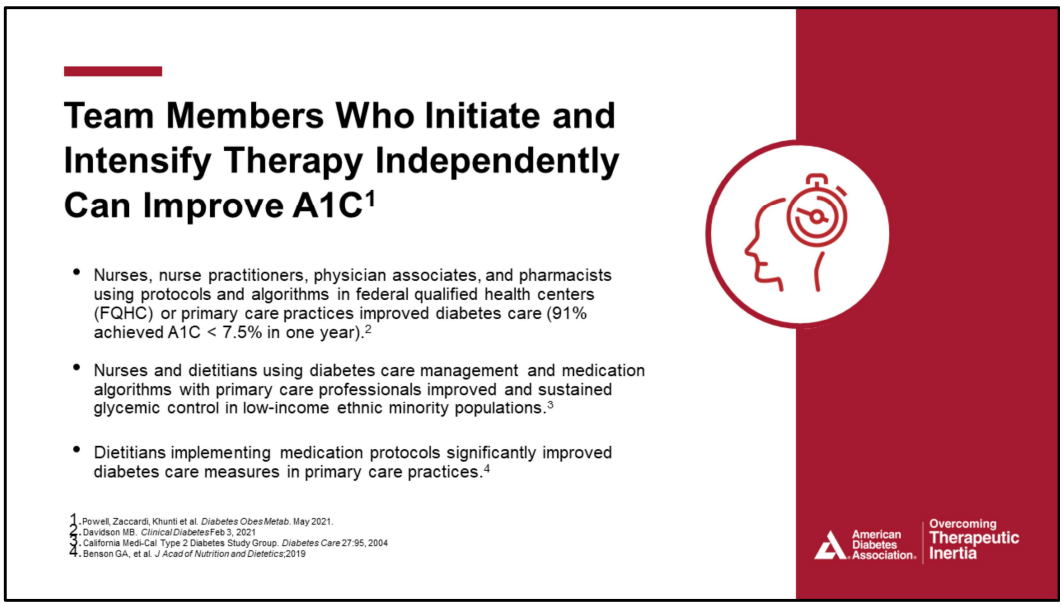


No single provider type was associated with improvements. Results may be less dependent therapy but rather HOW in terms of…

- Delivery methods using care management
- Technology: A characteristic of interventions with clinically significant A1C improvemen
- Frequency of communication important outcome of technology use

Other studies also demonstrate that frequent patient engagement and tailored drug regim A1C goal attainment in persons with type 2 diabetes.

Systems or practices looking to implement a medication management program may consid types who can use technology to support frequent communication with patients.



Several other small studies utilizing diabetes specialist team members support the meta systematic review revealed that empowering team members to modify medications is e efficient for achieving AIC targets. Here are examples of studies:

- M Davidson reviewed the eleven studies he has conducted since late 90's illustrating tha Nurses, NPs, PAs, Pharmacists using protocols and algorithms in FQHC/primary care prac diabetes care (91% achieved A1C <7.5% in one year).[2]

- California Medi-Cal type 2 diabetes study group nurses and dietitians using diabetes care medication algorithms with primary care providers improved and sustained glycemic con ethnic minority populations.[3]

- A study by G Benson illustrated that Dietitians implementing medication protocols in PC Minnesota modest but significantly improved diabetes care measures in primary care pra

Use A1c and glucose data to drive rapid-cycle treatment intensification

- Leverage point-of-care A1c testing
- Continuous glucose monitors
- And/or self-monitoring of blood glucose data

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Stratify follow-up based on A1c/glucose and therapy change:

- More frequent visits based on glucose therapy data, side effect profile impacting consistency, complexity, etc.
- Leverage telehealth

HbA_{1c}	Frequency of follow-up visit[a]
<7%	Every 6 months
7–8%	Every 3 months
8–9%	Every 6 weeks
9–10%	Every 4 weeks
>10%	Every 2 weeks
Hypoglycemia	Within 2 weeks

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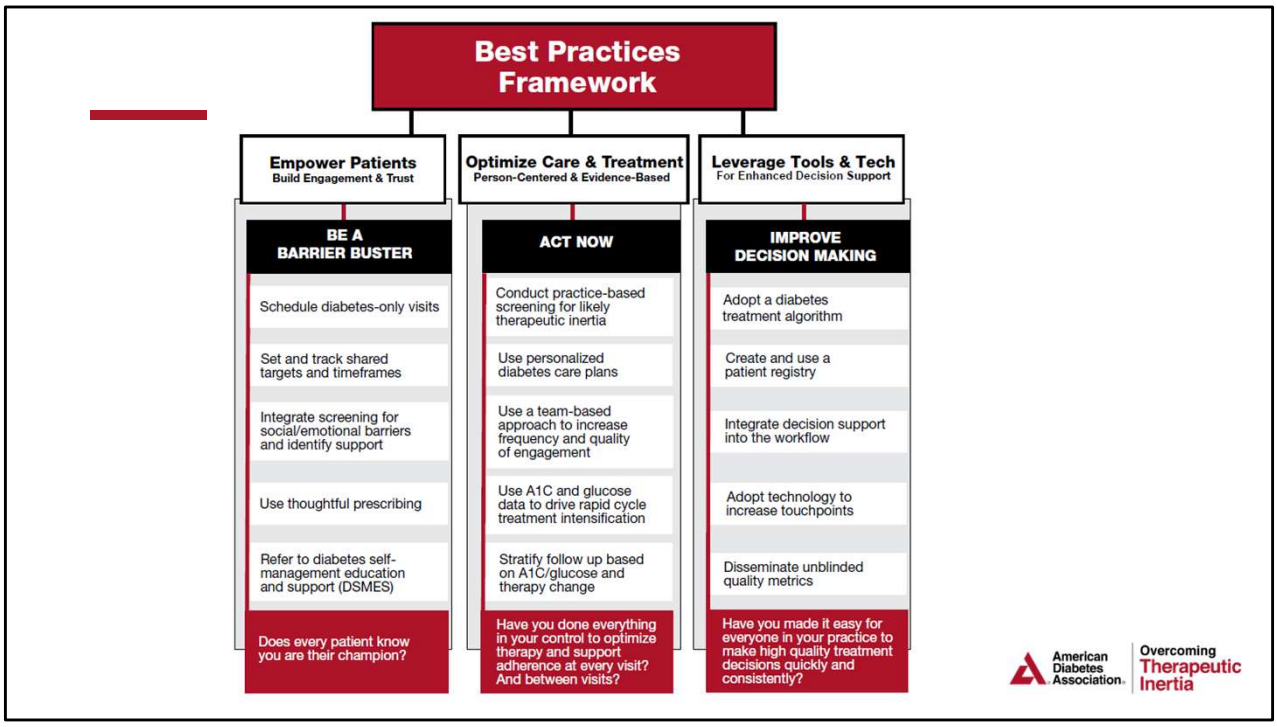
Best Practices Framework
Empower Patients
Build Engagement & Trust
Optimize Care & Treatment
Person-Centered & Evidence-Based
Leverage Tools & Tech
For Enhanced Decision Support
BE A BARRIER BUSTER
Schedule diabetes-only visits
Set and track shared targets and timeframes
Integrate screening for social/emotional barriers and identify support
Use thoughtful prescribing
Refer to diabetes self-management education and support (DSMES)
Does every patient know you are their champion?
ACT NOW
Conduct practice-based screening for likely therapeutic inertia
Use personalized diabetes care plans
Use a team-based approach to increase frequency and quality of engagement
Use A1C and glucose data to drive rapid cycle treatment intensification
Stratify follow up based on A1C/glucose and therapy change
Have you done everything in your control to optimize therapy and support adherence at every visit? And between visits?
IMPROVE DECISION MAKING
Adopt a diabetes treatment algorithm
Create and use a patient registry
Integrate decision support into the workflow
Adopt technology to increase touchpoints
Disseminate unblinded quality metrics
Have you made it easy for everyone in your practice to make high quality treatment decisions quickly and consistently?
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Leverage Tools & Tech

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Adopt a diabetes treatment algorithm

- Standards of Care app
- Laminated copies
- Protocols for nurse and MA staff

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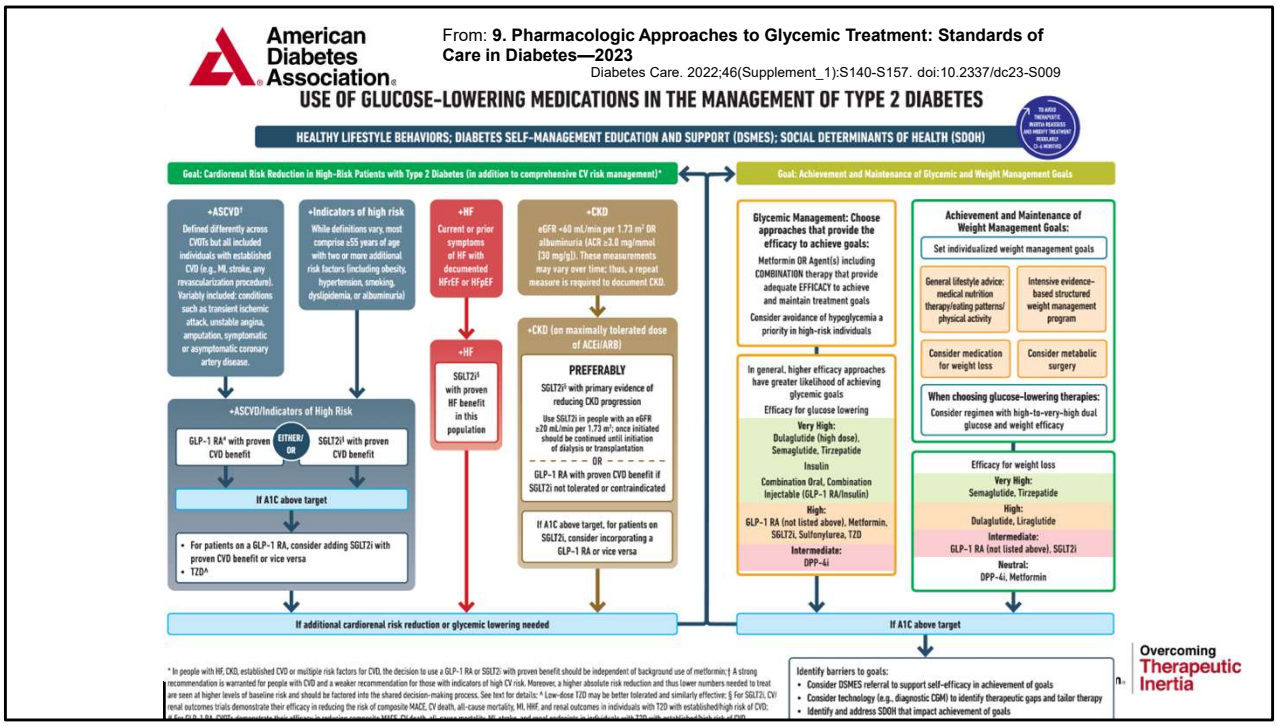
An example could be that any patient found to have their most recent A_{1c} over 3 months ago would automatically receive a point-of-care test by the MA prior to being seen. Other protocols could include vaccinations (e.g., influenza, pneumococcal), yearly dilated eye exam referrals, DSME referrals, and identification of annual screening labs such as random urine albumin/creatine ratio.

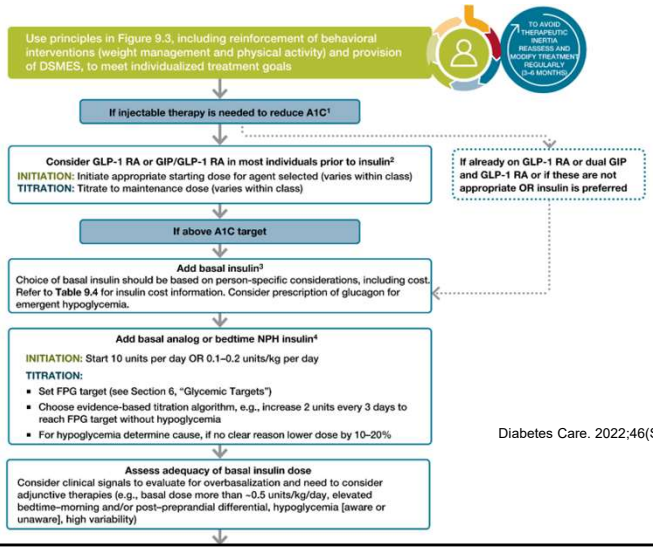


Pharmacologic Therapy for Adults with Type 2 Diabetes Recommendations

•**9.4c** Pharmacologic approaches that provide adequate efficacy to achieve and maintain treatment goals should be considered, such as metformin or other agents, including combination therapy (Fig. 9.3 and Table 9.2). **A**

•**9.5** Metformin should be continued upon initiation of insulin therapy (unless contraindicated or not tolerated) for ongoing glycemic and metabolic benefits. **A**

Intensifying to injectable therapies (1 of 2)



Diabetes Care. 2022;46(Supplement_1):S140-S157. doi:10.2337/dc23-S009

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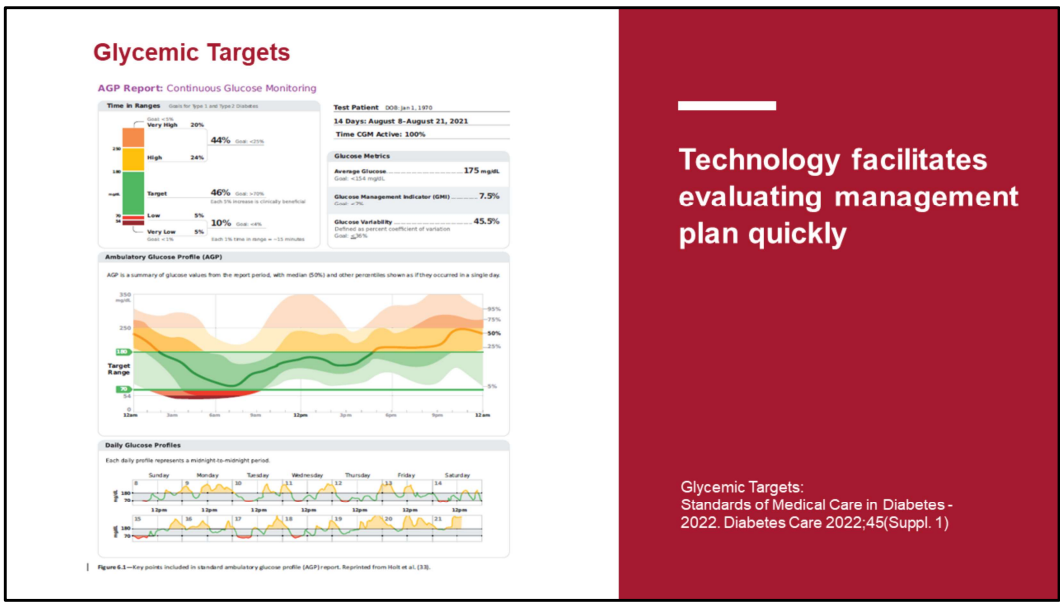
Adopt technology to increase touch points

- Daily text messages to support patient self-care behaviors
- Telehealth visits
- Patient portal
- Continuous glucose monitors

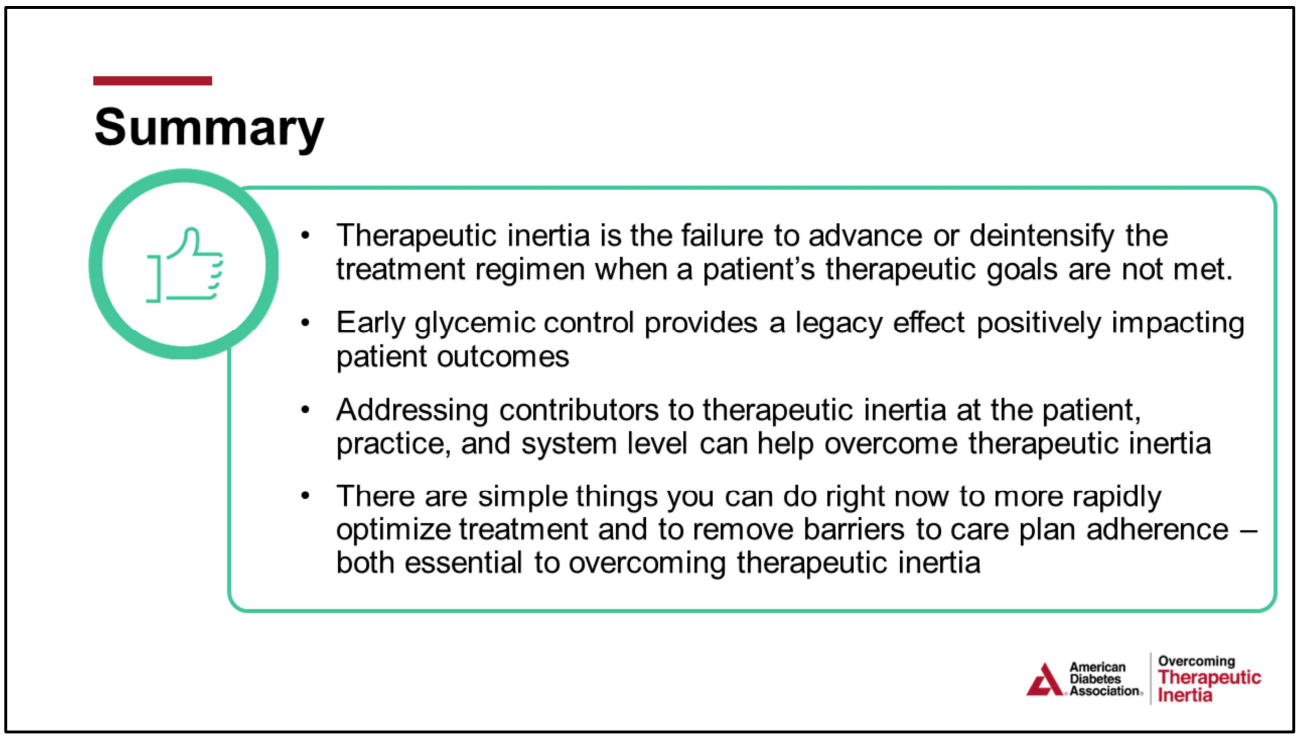
Watterson, JL, Rodriguez, HP, Shortell, SM, Aguilera, A. Improved diabetes care management through a text-message intervention for low-income patients: mixed-methods pilot study. *JMIR Diabetes* 2018;3:e15. https://doi.org/10.2196/diabetes.8645.



On the screen is an ambulatory glucose profile (AGP) report from a continuous glucose mo
Continuous Glucose Monitoring or blood glucose monitoring meters allows for quicker
effectiveness of medication(s) without waiting for a 3-month A1C measurement.

Increased communication between patients and care team members and use of technolog
characteristic of nearly all clinically and statistically significant care management and ed
interventions in the meta-analysis. CGM is increasing rapidly and is a technology that is
making rapid therapy changes even in T2D.

- Telemonitoring
- Texting
- Virtual visits using cloud-based technology
- Mobile applications supporting automated coaching
- Self-tracking tools



Key messages:

- Therapeutic inertia is the failure to establish appropriate targets and escalate treatment to achieve treatment goals
- The data showing delays in the intensification of therapy are compelling
- Early control provides a legacy effect positively impacting patient outcomes
- Reimbursement models are changing – don't be left behind
- Multiple stakeholders - People with diabetes, providers, healthcare systems, payors, industry – necessitates a multipronged approach

OTI Website

A repository or OTI-related resource for health care professionals and people with diabetes

therapeuticinertia.diabetes.org

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https://www.therapeuticinertia.diabetes.org/practice-improvement-resources

Therapeutic Inertia in Clinical Practice: Self-Assessment

Use this tool to measure how often therapeutic inertia occurs in your practice and to identify contributing factors. This tool can also be used to help detect therapeutic inertia between visits.

Take the Survey →

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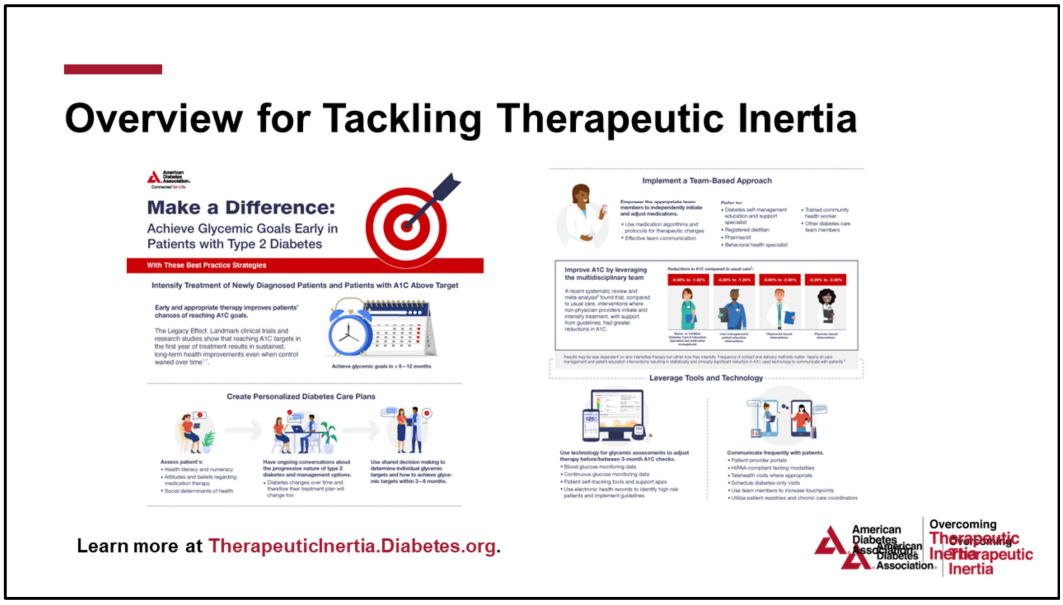
We will generate and share with you a confidential report that includes a set of personalized recommendations based on your survey responses.
Your name, email and any identifying information will be kept confidential. However, the de-identified data generated maybe used for future research, ADA assessment purposes and we may contact you for opportunities to participate in further research and training.



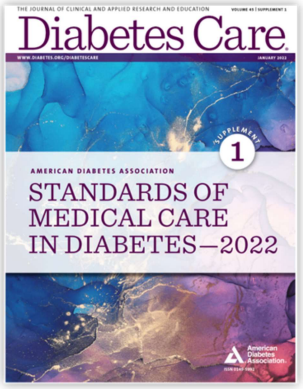
Here is a one-page infographic that outlines steps you can take to overcome therapeuti
Share with your organization or teams.

The ADA's *Standards of Care*: Always Up to Date and Ready to Use

Approach to Medication Therapy in Type 2 Diabetes

- Algorithms
- Guidelines for intensification of therapy
- Customized Protocol

Check out the app at professional.diabetes.org/SOCApp!



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The ADA Standards of Care is available and always up-to-date with treatment algorithm intensifying therapy and customized protocol.

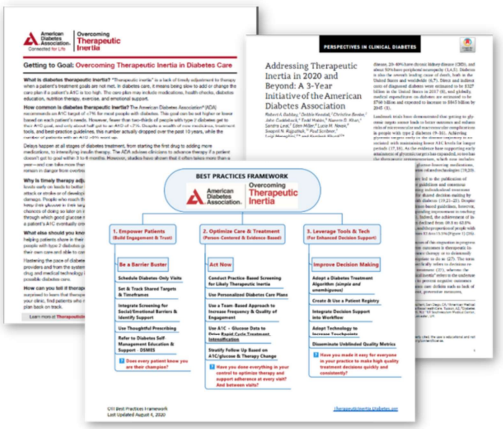
The web app is also available for easy to use.

OTI Initiative: Patient, Provider, and Practice Resources

Download and share:

- OTI Fact Sheet: Getting to Goal: Overcoming Therapeutic Inertia in Diabetes Care
- OTI Best Practices Framework
- OTI White Paper—Addressing Therapeutic Inertia in 2020 and Beyond
- Strategies to OTI: Systematic review
- Patient toolkit
- Webinar series

Learn more at TherapeuticInertia.Diabetes.org.



Take the TIQ self assessment of your level of understanding related to how therapeutic clinical practice.

Download OTI 1-pager and share with members of your team.

Identify at least 1 modifiable strategy to improve TI in your organization and who needs success.

Questions?

jmoverle@touro.edu

American Diabetes Association.

Overcoming Therapeutic Inertia

therapeuticinertia.diabetes.org