Overcoming Therapeutic Inertia: Clinical Workshop

Chicago, IL
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American Diabetes Association®

Overcoming Therapeutic Inertia

Optimizing Diabetes Care to Avoid Therapeutic Inertia

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American Diabetes Association®

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!

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

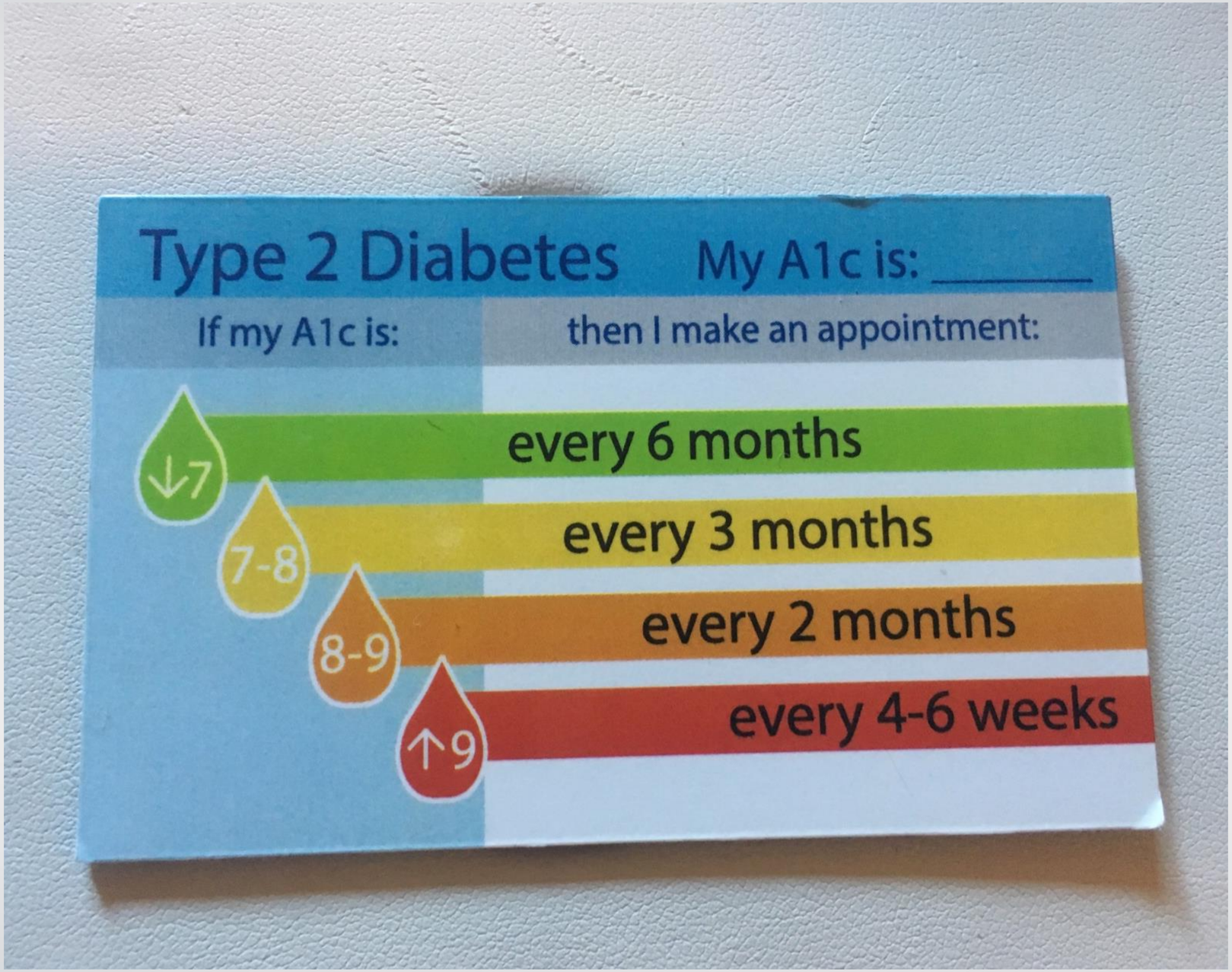
Utilizations of Technology for Individuals

- 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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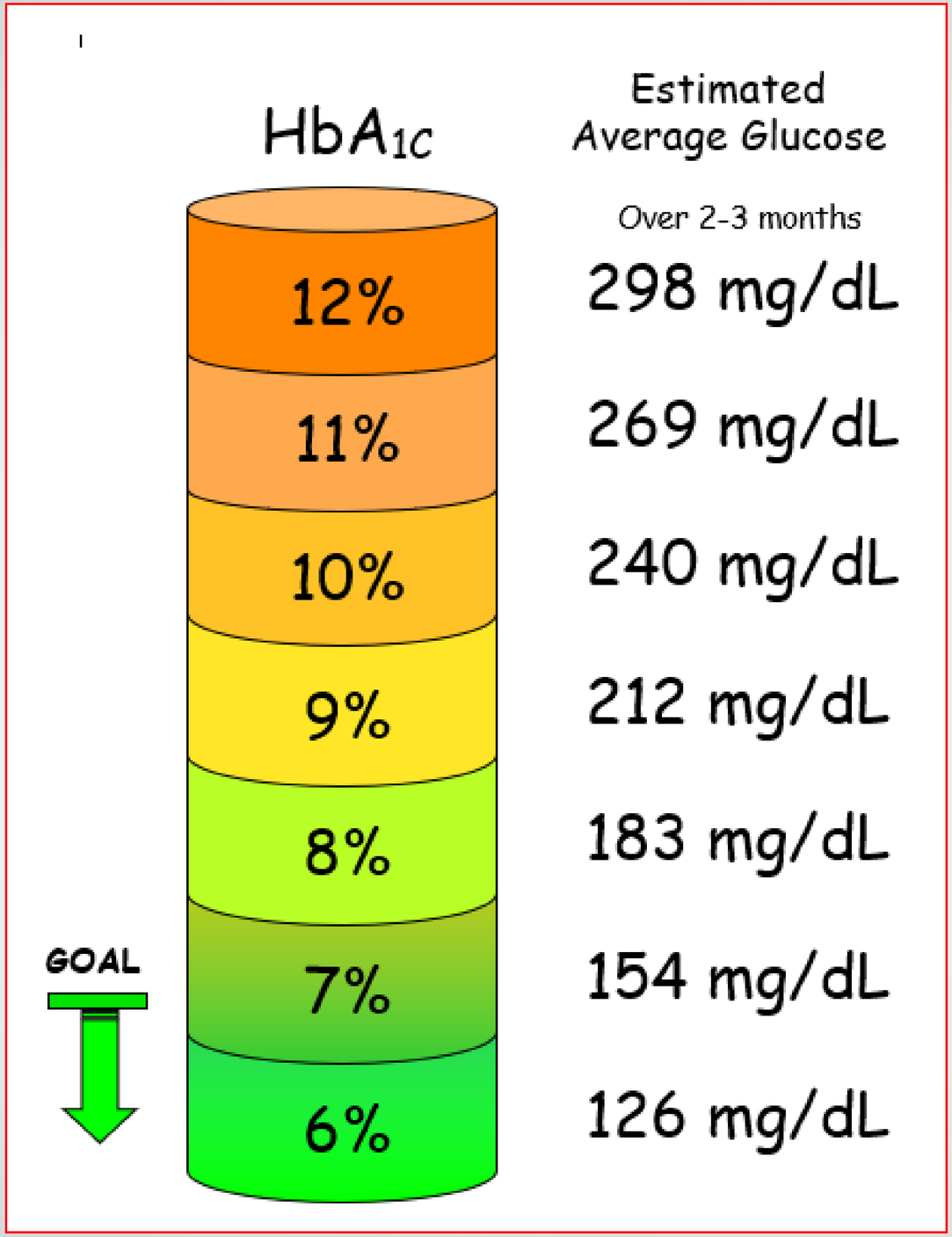
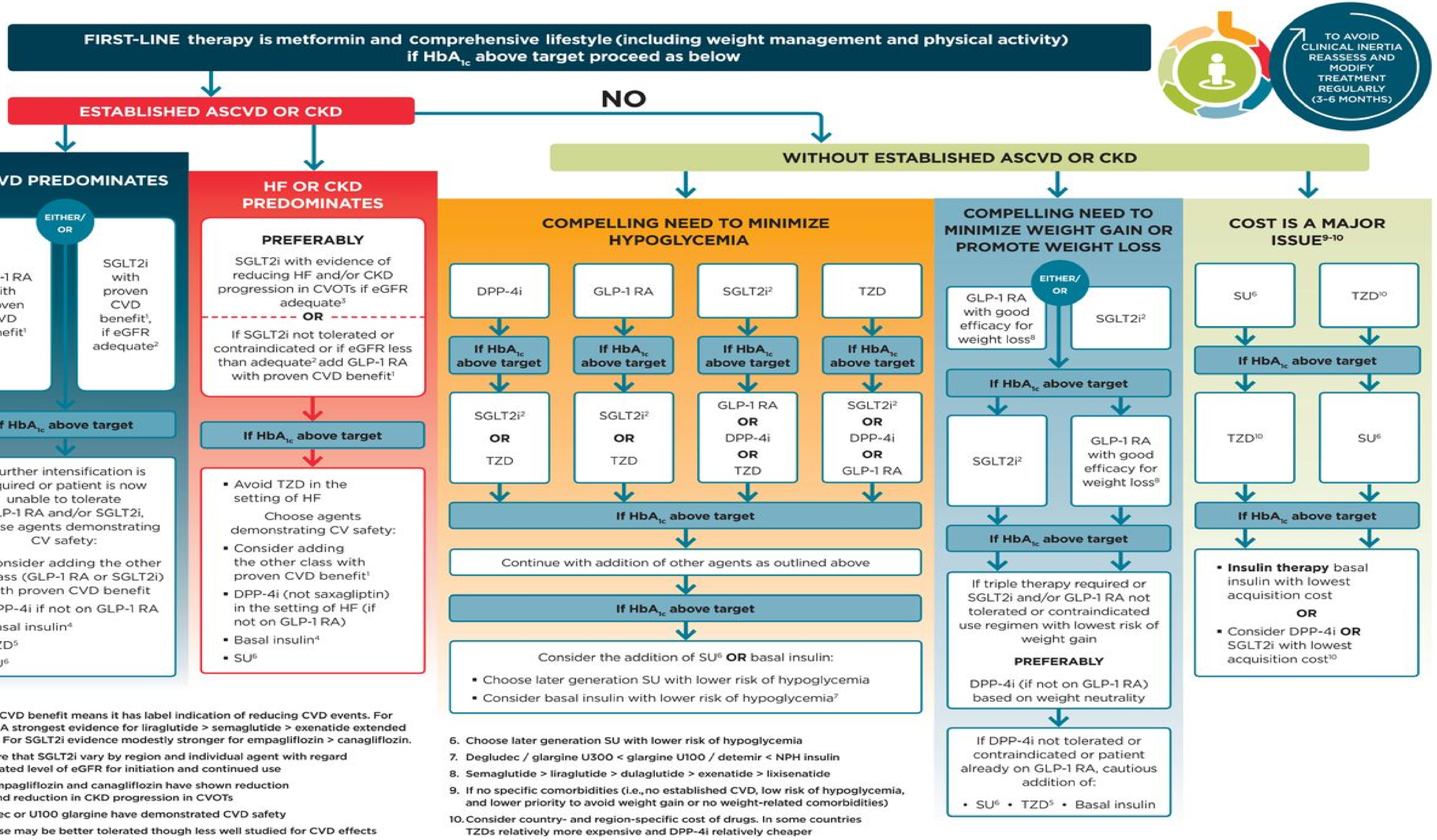

HbA1c
Estimated Average Glucose
Over 2-3 months
12%
298 mg/dL
11%
269 mg/dL
10%
240 mg/dL
9%
212 mg/dL
8%
183 mg/dL
7%
154 mg/dL
6%
126 mg/dL
GOAL



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 months 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”
- Your list of those at 9% or greater is your priority list for follow up
- Your data is worthwhile, and you 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

Questions?

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?

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Addressing Barriers to Self-Care that May Impact Therapeutic Inertia

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Disclaimer

I have no conflicts of interest in relation to this presentation.

Learning Objectives

- Improve awareness of basic motivational interviewing techniques for increasing patient activation
- Increase awareness of psychosocial barriers that can contribute to therapeutic inertia
- Improve assessment of health literacy as a barrier to self-management

Bedside Manner

- Active listening
- Sit down and sit close
- First impressions matter
- Take out the medical jargon
- Lead a productive conversation
- Nonverbal communication for you and the patient
- Value your patient’s time as much as your own
- Validate your patient’s concerns

Developing Good Bedside Manner: 9 Tips for Doctors. St. George’s University. 2019. Retrieved from https://www.sgu.edu/blog/medical/how-to-develop-good-bedside-manner/

Show Mutual Respect

- Address patient with preferred pronoun, name, gender identity
- Utilize translation services in patient's preferred language
- Address the patient as a whole, not a diagnosis
- Allow time built into the appointment for patient to ask questions

Developing Good Bedside Manner: 9 Tips for Doctors. St. George's University. 2019. Retrieved from https://www.sgu.edu/blog/medical/how-to-develop-good-bedside-manner/

Steurer K and Davis K. Respecting Gender Identity in Healthcare: Regulatory Requirements and Recommendations for Treating Transgender Patients." *American Bar Association*. 2017. Retrieved from www.americanbar.org/groups/gpsolo/publications/gpsolo_ereport/2017/march_2017/respecting_gender_identity_healthcare_regulatory_requirements_recommendations_treating_transgender_patients/

Characteristics of Adult Learners

- Draw upon their experiences as a resource
- More motivated in learning by doing versus memorizing
- Need to know *why* they are learning something
- Learner role is secondary
- Must fit their learning into life's "margins"
- Lack confidence in their learning
- More resistant to change
- Must consider physical and mental aging in learning

Kuhne G. 10 Characteristics of Adults as Learners. Retrieved from http://ctle.hccs.edu/facultyportal/tlp/seminars/tl1071SupportiveResources/Ten_Characteristics_Adults-Learners.pdf on 27 September 2019.
Corley, MA. Teaching Excellence in Adult Literacy 2011. Teal Center Staff. Adult Learning Theories. Adapted from the CALPRO Fact Sheet No.5, Adult Learning Theories.

Healthy People 2020: Social Determinants of Health (SDOH)

Healthy People 2020. Social Determinants of Health. Retrieved from www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

SDOH Screening Tools

National Association of Community Health Centers (NACHC):

- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

  → Free templates for Epic, eClinicalWorks, GE Centricity, and NextGen

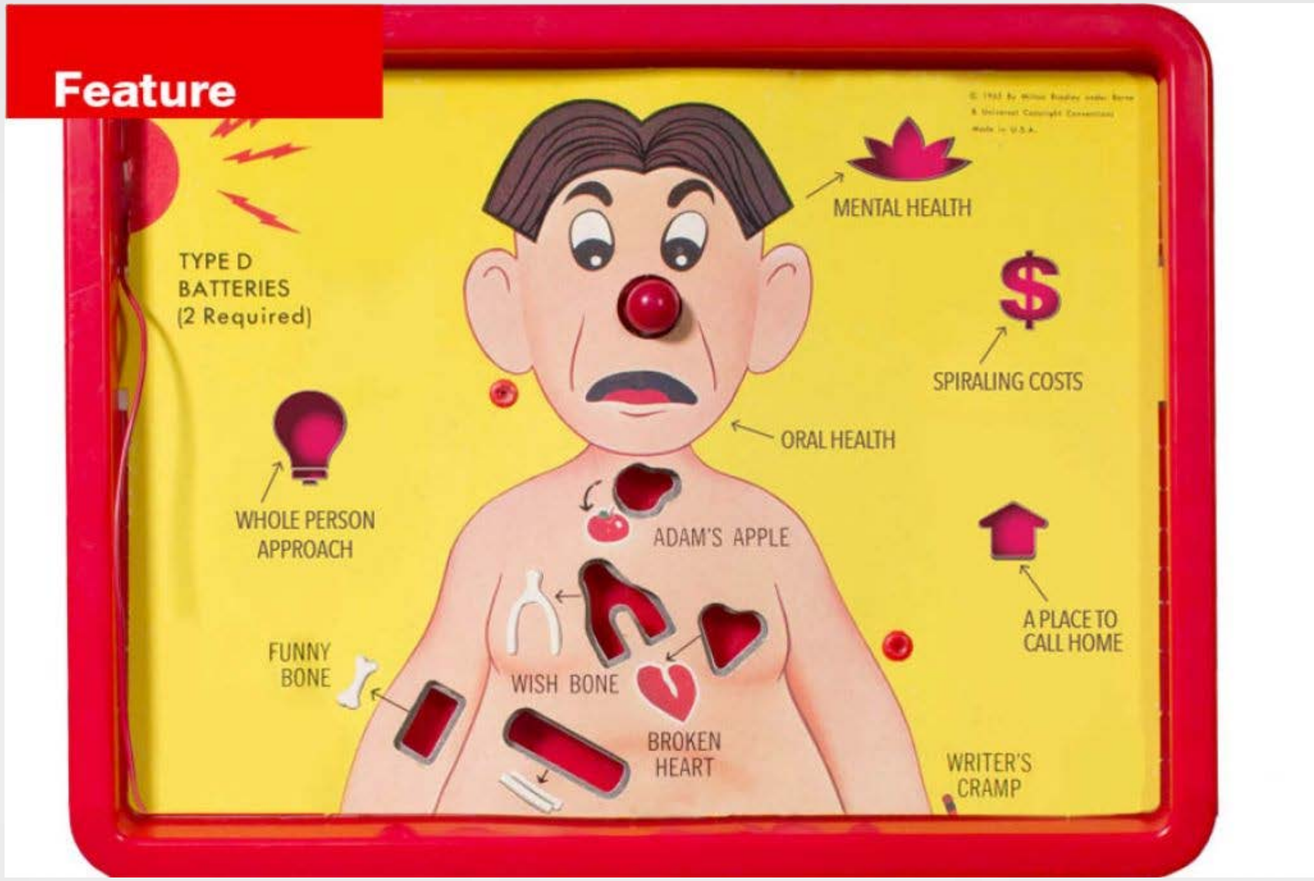
Centers for Medicare and Medicaid Services (CMS):

- Health-Related Social Needs (HRSN)

PRAPARE. Implementation and action tool kit. National Association of Community Health Centers. March 2019.

The Accountable Health Communities Health-Related Social Needs Screening Tool. Centers for Medicare and Medicaid Services. Retrieved from https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

What Can YOU Do as a Healthcare Professional?



Milhstein, Amy. Heal Thyself. Oregon Business, July 3, 2019.
https://www.oregonbusiness.com/article/health-care/item/18802-medicaid-heal-thyself

Motivational Interviewing

- Always ask permission before giving information
- Express empathy
- Support self-efficacy
- Roll with resistance
- Cognitive dissonance

OARS:

Open-ended questions, **A**ffirmations, **R**eflective listening, **S**ummaries

Chesanow N. For Noncompliant Patients, a Fix That Works. Medscape. 2014, https://www.medscape.com/viewarticle/825594.
Biglow M. Applying motivational interviewing strategies and techniques to psychiatric pharmacy practice. *Mental Health Clinician.* 2012, Vol. 2, Issue 4.

“BATHE” Method

- **B**ackground: “What is going on in your life”
- **A**ffect: “How do you feel about that”
- **T**rouble: “What troubles you the most about this?”
- **H**andling: “How are you handling that?”
- **E**mpathy: “That must very difficult for you”

Lieberman JA 3rd, Stuart MR. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. *Prim Care Companion J Clin Psychiatry.* 1999. Apr;1(2):35-38.

Case

68 year old presents for diabetes follow-up

CC: fatigue despite using CPAP

Current hemoglobin A1c 9%

PMH: T2DM- uncontrolled for 10 years, CKD Stage 3, hypertensive CKD, Dyslipidemia, OSA on CPAP, BMI 48, neuropathy, iron deficiency anemia, moderate persistent asthma

Due for depression screening, influenza vaccine, fall risk assessment

Case

Patient Health Questionnaire (PHQ) is 12 today.

- Denies SI/HI
- Does endorse stress at home and at work
- Recognizes she is not taking care of herself

What now?

Individualized, Comprehensive Care

- Discuss the diagnosis, allow time for questions
- Individualize hemoglobin A1c goal
- Discuss preventative care as part of diabetes management
- Utilize your available team members
- Trust your team

Billing

Bill for the complexity of your visit

- Z codes available for social determinants of health

Patient-driven Care

- Same day appointments
- Allow for overbooking
- Telehealth?
- Text reminders

Medium. At a Glance: New Z-Codes for SDOH. Patchwise Labs Retried from medium.com/patchwiselabs/at-a-glance-new-z-codes-for-sdoh-5368f354c769.

Lagasse J. AMA, UnitedHealthcare Team up on Billing Codes That Address Social Determinants of Health. Healthcare Finance News, 2 Apr. 2019. Retrieved from www.healthcarefinancenews.com/news/ama-unitedhealthcare-team-billing-codes-address-social-determinants-health.

Brandenburg, L., P. Gabow, G. Steele, J. Toussaint, and B. Tyson. 2015. Innovation and best practices in health care scheduling. Discussion paper. Washington, DC: Institute of Medicine. http://nam.edu/wpcontent/uploads/2015/06/SchedulingBestPractices.pdf

Addressing Barriers seen from Outside of the Clinic

- Get to know resources in the community
- As a healthcare professional, how do you stay informed about resources in the community?
- Monthly staff in-services
- Other ideas?

Health Literacy

Federal Agency for Healthcare Research and Quality's (FAHRQ) definition:

- The degree to which an individual has the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

U.S. Department of Health and Human Services. Healthy People 2010. Washington, DC: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In National Library of Medicine Current Bibliographies in Medicine: Health Literacy. Selden CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

Health Literacy

Red flags:

- Patients may know what they are taking solely by the color, shape, size of the pill if unable to read
- Phrases: “I am too tired to read” “I will read this when I get home” “ I do not have my glasses”
- Rehospitalizations

Health Literacy

How can you assess for low health literacy?

- Ask your patients to read their prescription bottles and then have them explain how they take their medication.
- Teach back method: Let them show you how they draw up insulin to the correct line on the syringe.

Howe CJ, Walker D, Watts J. Use of Recommended Communication Techniques by Diabetes Educators. *Health Lit Res Pract.* 2017 Oct 10;1(4):e145-e152.

Case

52 year old patient with type 2 diabetes

CC: frequent hypoglycemic episodes

Taking glipizide IR 5mg PO BID and metformin 1000mg PO BID

Current hemoglobin A1c 10%

Food Insecurity

Definition: the unreliable availability of nutritious food and the inability to consistently obtain food without resorting to socially unacceptable practices

Ask your patient the following 2 questions:

- Within the past 12 months, were you worried that food would run out before you had money to buy more?
- Within the past 12 months, did you feel that the food you purchased did not last and there was no money to purchase more?

ADA Standards of Medical Care. *Diabetes Care.* 2019;50-60
Hill JO, Galloway JM, Goley A, et al. Scientific statement: socioecological determinants of prediabetes and type 2 diabetes. *Diabetes Care.* 2013;36:2430–2439
Seligman HK, Schillinger D. Hunger and socioeconomic disparities in chronic disease. *N Engl J Med.* 2010;363:6–9

Food Insecurity

If using a sulfonylurea, change to an alternative oral option

- If no other alternative, choose glipizide. Consider long-acting formulation

If patient is in need of insulin, pen preferred:

- Rapid acting insulin administered after first bite
- Long-acting basal insulin

Local resources: food banks, food pantries, Supplemental Nutrition Assistance Program (SNAP), Women Infant Children (WIC), Community meals

ADA Standards of Medical Care. *Diabetes Care.* 2019;50-60
Hill JO, Galloway JM, Goley A, et al. Scientific statement: socioecological determinants of prediabetes and type 2 diabetes. *Diabetes Care.* 2013;36:2430–2439
Seligman HK, Schillinger D. Hunger and socioeconomic disparities in chronic disease. *N Engl J Med.* 2010;363:6–9

Case

Pt taking metformin and glipizide after meals.

Not willing to start insulin at this time but is willing to see what an injectable pen looks like.

Willing to start taking metformin with meals. Would like to stay on glipizide but would like to change to ER formulation.

Patient thought iced tea was good for you. Willing to change to unsweetened iced tea.

Medication Health Literacy

Organize the prescription label in a patient-centered manner

- Simplify language
- Give explicit instructions
- Include purpose of use (i.e. indication)
- Limit auxiliary information
- Comment for dispensing in preferred language
- Improve readability

❌ Metformin 500 mg tablet # 60 1 refill Take one tablet by oral route twice daily

✔ **Metformin 500 mg tablet #180 3 refills Take 1 tablet by mouth 2 times daily with breakfast and dinner for diabetes**

Prescription Container Understanding Labeling. USPC 36. Retrieved from https://www.nmpharmacy.org/Resources/Documents/USPC_Labeling_Guidelines[1].pdf.

Smart Prescribing

- De-prescribe
- Minimize polypharmacy
- 90 day supply of medication
- Prescribe generic
- Get to know the formularies for common insurances you encounter
- Ask patient to bring medication bottles to appointment for reconciliation, especially if they are seen by outside providers.
- Pen formulation for visual or dexterity impairments
- Minimize use of sliding scale insulin

Castro-Rodríguez A, et al. Factors Related to Excessive Polypharmacy (≥15 Medications) in an Outpatient Population from Colombia. *Int J Clin Pract.* 2018 Sep 30:e13278.
Marcum ZA, Hanlon JT, and Murray MD. Improving Medication Adherence and Health Outcomes in Older Adults: An Evidence-Based Review of Randomized Controlled Trials. *Drugs Aging.* 2017 Mar;34(3):191-201.
ADA Standards of Medical Care. *Diabetes Care.* 2019;50-60

Demonstrations

- Pen formulations
- Insulin syringes
- Teach-back technique
- Food models
- Glucometer and/or blood glucose logbook
- Phone apps

Take Away Points

- Motivational interviewing does not require more time than you have but can save you time while helping your patient.
- You can help minimize barriers to health care through bedside manner and smart prescribing.
- In-clinic demonstrations are your most valuable tool to assess for health literacy.
- It is up to you to find resources in the community to help you and your patient work through barriers outside the exam room.

Questions?

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