

REVIEWED FEBRUARY 2024 – CAPSULE 13

# Strategies to Reduce Clinical Inertia in Patients with Diabetes

**CONTRIBUTING AUTHORS:** Bree Meinzer, PharmD, BCACP, University of Toledo; Colin Crowe, MD, Case Western Reserve University, on behalf of Team Best Practices

Clinical inertia is a lack of timely adjustment to medication and/or lifestyle therapy when a patient’s treatment goals are not met. It is a major contributing factor to hyperglycemia in patients with diabetes. Data show that early glucose management leads to a reduction in complications and improves long-term outcomes. Conversely, not reaching desired glycemic targets early on reduces a patient’s chance of achieving targets further in their treatment.<sup>1</sup> Despite frequent monitoring and guideline recommendations to escalate therapy,<sup>2</sup> intensification of therapy in uncontrolled diabetes often is delayed.<sup>3-5</sup>

## Strategies to Reduce Clinical Inertia in Practice<sup>6</sup>

**Take the following actions to begin addressing clinical inertia:**

- Schedule diabetes-only visits to allow adequate time to discuss diabetes specific goals or questions patients may have about their care. Utilize other health care disciplines and Diabetes Self-Management Education and Support (DSMES) to improve touch points and diabetes education.
- Develop a personalized care plan that takes patient concerns, wishes, and needs into account. Review this care plan regularly and update it at each visit.
- Integrate screening for behavioral health and social barriers and identify support for patient.
- Make quick adjustments in therapy any time a patient’s A1C targets are not at goal. This includes medication dose escalation, initiation of additional pharmacological therapy, and nutrition or lifestyle changes.<sup>5</sup>
- Schedule follow-up appointments according to how close the patient’s A1C is to goal. Utilize technology, such as telehealth and electronic medical records, to create more patient touch points.

For more information, access Cardi-OH’s expanded resource on [clinical inertia](#).



### Schedule follow-up appointments based on patient’s A1C:

- Every 4 weeks for those at 9% or higher
- Every 2 to 3 months for those between 7 and 8.9%, and
- Every 3 to 6 months for those <7% or at their personal target<sup>6,7</sup>

#### References

1. Matthews DR, Paldanius PM, Proot P, et al. Glycaemic durability of an early combination therapy with vildagliptin and metformin versus sequential metformin monotherapy in newly diagnosed type 2 diabetes (VERIFY): a 5-year, multicentre, randomised, double-blind trial. *Lancet*. 2019 Oct 26;394(10208):1519-1529. doi: 10.1016/S0140-6736(19)32131-2.
2. American Diabetes Association. Standards of Care in Diabetes. *Diabetes Care*. 2023;46(Suppl 1):S1-S282. <https://doi.org/10.2337/dc20-Sint>.
3. Pantalone KM, Misra-Hebert AD, Hobbs TM, et al. Clinical inertia in type 2 diabetes management: evidence from a large, real-world data set. *Diabetes Care*. 2018;41(7):e113-e114. doi:10.2337/dc18-0116.
4. Khunti K, Gomes MB, Pocock S, et al. Therapeutic inertia in the treatment of hyperglycaemia in patients with type 2 diabetes: a systematic review. *Diabetes Obes Metab*. 2018;20(2):427-437. doi:10.1111/dom.13088.
5. Pantalone KM, Wells BJ, Chagin KM, et al. Intensification of diabetes therapy and time until A1C goal attainment among patients with newly diagnosed type 2 diabetes who fail metformin monotherapy within a large integrated health system. *Diabetes Care*. 2016;39(9):1527-1534. doi:10.2337/dc16-0227.
6. American Diabetes Association. Getting to Goal: Overcoming Therapeutic Inertia in Diabetes Care. [https://professional.diabetes.org/sites/default/files/media/overcoming\\_therapeutic\\_inertia\\_factsheet\\_final.pdf](https://professional.diabetes.org/sites/default/files/media/overcoming_therapeutic_inertia_factsheet_final.pdf). Accessed March 12, 2024.
7. Hu M, Zhou Z, Zeng F, Sun Z. Effects of frequency of follow-up on quality of life of type 2 diabetes patients on oral hypoglycemics. *Diabetes Technol Ther*. 2012 Sep;14(9):777-82. doi: 10.1089/dia.2012.0037.

The Ohio Cardiovascular and Diabetes Health Collaborative is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this document are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.

For more information head to [Cardi-OH.org](https://www.cardi-oh.org).

© 2021 Cardi-OH