

Addressing Clinical Inertia in Diabetes Care

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Intensification of therapy in uncontrolled diabetes often is delayed for a variety of factors.

Understanding clinical inertia and its effect on patients with diabetes is important for clinicians. It helps address areas that may be contributing to delays in therapy escalation. Identifying and combating delays can improve patient outcomes by quickly meeting treatment goals.

Clinical Inertia and the Importance of Timely Therapy Adjustment

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. Despite numerous new diabetes treatment options since 2005, as well as leading diabetes organizations developing clear guidelines and treatment algorithms, there has been little to no measurable improvement in glycemic control among patients with diabetes in the United States.^{1,2}

Data show that early glucose management leads to a reduction in complications and improves long-term outcomes. In fact, this early achievement of glucose targets continues to reduce health risks many years later, even if the patient's A1C does not stay in range.^{3,4} Conversely, not reaching desired glycemic targets early on reduces a patient's chance of achieving targets further in their treatment.⁵

Despite frequent monitoring and guideline recommendations to escalate therapy,¹ intensification of therapy in uncontrolled diabetes often is delayed.⁶⁻⁸ Only two-thirds of patients ever reach their A1C goal, and only half of patients reach an A1C of <7%.⁹ There is a gap between what patients say they are willing to do to improve their A1C and what providers believe patients are willing to do to improve their A1C.¹⁰ In a survey of both patients and providers, it was found that providers can underestimate patients' willingness to make therapy changes.



Factors Contributing to Clinical Inertia^{9,11,12}

Three main categories that contribute to clinical inertia have been defined. These include system, provider, and patient related factors.

1. System Factors

- Insufficient team approach to care or care coordination
- Ineffective communication between clinicians and office staff
- Minimal to no active patient outreach
- Lack of data exchange between various providers and other health care services
- Health insurance coverage and variability of changing formularies or in-network providers
- Workforce capacity challenges



2. Provider Factors

- No initiation of new treatment
- Insufficient titration of treatment to goal
- Lack of clear treatment goals
- Insufficient time or competing demands
- Concern about patient resistance to changes in therapy
- Reactive rather than proactive care



3. Patient Factors

- Cost of medication
- Cost and availability of healthy food
- Medication side effects
- Regimen complexity; too many medications
- Forgetfulness
- Fear of needles
- Denial of disease or disease severity
- Absence of disease symptoms
- Mistrust of or poor communication with clinician
- Low health literacy
- Mental illness
- Social determinants of health



Tactics to Reduce Clinical Inertia^{2,13-15}

The following tactics can be incorporated into clinical practice immediately:


1. Schedule diabetes-only visits

- Schedule diabetes-only appointments to provide clinicians and patients adequate time to focus on current diabetes treatment, create a care plan, and address any changes in treatment in order to meet glycemic goals.
- Patients should bring items such as glucose logs, medications, and monitoring devices to these appointments for review.
- Utilize other health care disciplines with diverse expertise to provide additional touch points for timely changes in therapy.
- Set expectations with patients early to inform them that adjustments in therapy will be made from time to time, in order to optimize outcomes together.

2. Develop a personalized care plan

- A care plan should be created for each patient with specific and actionable goals to help achieve targets.
- The care plan should include an individualized A1C goal and take patients' concerns or needs into consideration.
- Patients who are engaged in their care produce better outcomes than those who are not engaged.
- Review and update this care plan at each appointment to ensure progress toward goals is being achieved in a timely matter.

3. Integrate screenings into every appointment

- Quickly identify and provide support for any barriers identified for patients.
- Barriers can include diabetes distress, low health literacy, depression, substance use, or health-related social needs.
- Resources to guide conversations with patients are available on the American Diabetes Association [website](#) 

4. Make quick adjustments in therapy any time A1C targets are not at goal

- Utilize other health care disciplines with diverse expertise to provide additional touch points for timely changes in therapy and utilize Diabetes Self-Management Education and Support (DSMES) services.
- Consider utilizing technology to make changes in therapy based on monitoring results when between A1C tests.
- Adjustments can include medication dose escalation, initiation of additional pharmacological therapy, nutrition, or lifestyle changes.

5. Schedule follow-up appointments according to A1C values in relation to A1C goals

- The further a patient's A1C is from their goal, the greater follow-up frequency is needed.
- Schedule appointments as follows:
 - A1C >9%: follow-up in 4 weeks
 - A1C 7-8.9%: follow-up in 2-3 months
 - A1C <7% or at personal goal: follow-up in 3-6 months

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