

## Clinical Inertia and the CDE: How long does it take to go from 0-88?



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## Objectives

1. Define the term Clinical Inertia
2. Explore barriers of patient support within the medical team
3. Review the role of the CDE and scopes of practice to support initiation of therapy changes
4. List techniques/approaches used to help reduce CDE inertia
5. Create change – decrease clinical inertia

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The back story.....



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### 1. Clinical Inertia – What is it?

The big picture:

*In the context of diabetes, clinical inertia is when patients do not begin or intensify treatment despite not achieving their A1C goal*

inertia

in·er·tia  
Noun

1. A tendency to do nothing or to remain unchanged.

2. PHYSICS

a property of matter by which it continues in its existing state of rest or uniform motion in a straight line, unless that state is changed **by an external force**.

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In this presentation I will provide an overview of clinical inertia in terms of the clinical management of diabetes. I aim to provide suggestions for Certified Diabetes Educators in identifying and overcoming aspects that may have a negative impact on our patients and our specialty.

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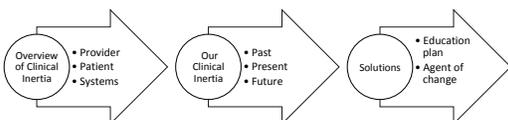
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The journey:




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The problem:

- Despite the increase in the availability of antihyperglycemic medications and evidence-based treatment guidelines, the proportion of people with diabetes (T2) who fail to achieve glycemic goals continues to rise. One major contributor is a delay in treatment intensification despite suboptimal glycemic control; referred to as clinical inertia.
- The presence of clinical inertia appears to hinder escalation of treatment from OADs to insulin therapy, with delays of approximately 6 to 8 years.
- Failure to intensify treatment may also occur in patients who are optimized on basal insulin, but still fail to reach A1C targets despite achieving fasting plasma glucose (FPG) within target ranges.

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The studies:

- A retrospective cohort study involving 11,696 patients with T2D in the UK Clinical Practice Research Data-link database reported that only 30.9% of patients with A1C of at least 7.5% (i.e., eligible for treatment intensification) had their treatment regimen intensified with bolus or pre-mix insulin or a glucagon-like peptide 1 receptor agonist (GLP-1 RA), and the median time to intensification was 3.7 years
- A study on a large cohort of patients with T2D followed over a period of 22 years showed that a 1-year delay in treatment intensification in patients, on either oral anti-diabetes medications (OADs) or insulin therapy whose A1C persisted above 7.0%, significantly increased the risk of myocardial infarction, heart failure, stroke, and a composite of cardiovascular events

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2. Explore barriers of patient support within the medical team-

- Reports from surveys demonstrate a disconnect between HCP-and patient-perceived barriers.
- HCPs identified fear of hypoglycemia and absence of symptoms as barriers to basal insulin initiation and dose titration, whereas patients reported the length of time taken to reach target as a greater barrier than hypoglycemia.
- Patients often get frustrated when they do not achieve glycemic targets, a feeling that increases in parallel with treatment duration and may lead patients to stop medication without discussion with their physician.
- Physicians often overestimate patient resistance to insulin initiation because of fear of injection-induced pain
- While there have been numerous studies on the best approach for educating patients with T2D, there is less information available on how to educate and support HCPs

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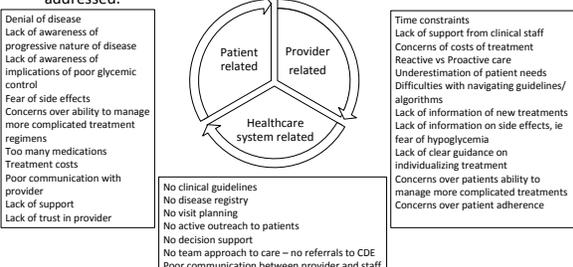
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• Clinical inertia results from a complex interaction between patient, health-care providers, and healthcare system barriers that need to be addressed.




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<https://youtu.be/JhJGOYJo9mM>

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What does this mean for CDE's?

- We are in the best place ever to decrease patient and provider barriers
- We have our own clinical inertia that we must admit and address
- We have work to do!

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Why should we care?

***You are either part of the solution or part of the problem. – Eldridge Cleaver***

Rapidly changing medical market –aka the 'Uber-ization of health care'  
Consumer market

Project Vision – AADE

BE THE AGENT OF CHANGE for patients/providers

Career security now and for the future

Career satisfaction – love what you do and be appreciated for it

Stay relevant!

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The hard part.....

We have to admit that we may be part of the problem

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What does CDE clinical inertia look like?

You know you are stuck in neutral if you find yourself doing the following things:  
You recommend the 45g carbs for every woman and 60g for every man as and RD or as a non-RD w/ o referral to dietician  
Your patient has an elevated A1C and is maxed out on current meds and you do not educate them on next line therapy options  
You know your patient needs insulin but you don't recommend it to the provider  
If asked, "what is your favorite CGM or pump", you have a specific product answer  
You answer Yes or No to nutrition questions, such as "is Diet Coke bad for me"  
You do not reach out to colleagues for assistance for topics out of your comfort zone or scope of practice  
You don't recommend a medication or medication class because you think it might cost too much.  
You do not think you can or are allowed to initiate or manage technology – pumps/cgm  
Answers on behalf of patient based on assumptions  
Negative barrier language: 'Can't, Not my job, Won't, We've always done it this way,'  
What are others you can think of? Asking for a friend.....

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Lets take a step back

- CDE scope of practice
  
- CDE competencies

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3. Review the role of the CDE and scopes of practice to help initiate therapy changes

• Overview:  
All diabetes educators, no matter their discipline, provide all aspects of DSME/T. It is recognized that members of the various healthcare disciplines who practice diabetes education bring their particular focus to the educational process. This widens or narrows the scope of practice for individual educators as is appropriate within the boundaries of each health profession, which may be regulated by national or state agencies or accrediting bodies. Regardless of discipline, the diabetes educator must be prepared to provide clients with the knowledge and skills to effectively manage their diabetes. Diabetes educators must possess a body of knowledge that spans across disciplines to provide comprehensive DSME/T-  
**AADE The Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators**

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### Competencies

AADE 2016 Competencies for diabetes educators and diabetes paraprofessionals

The purpose of the practice levels is to increase access to DSMES and achieve better patient care by:

- 1. Delineating the roles and responsibilities of the multiple levels of diabetes educators and diabetes paraprofessionals.
- 2. Suggesting a career path for diabetes educators and diabetes paraprofessionals. Levels of practice are designed to help individuals determine his or her appropriate entry point in to the practice of diabetes education and to clarify the competencies required for the advancement to the next level.
- 3. Clarifying the contribution that can be made by individuals who have the knowledge, capability, diversity, and language skills needed to address diabetes self-management education and support in a variety of settings.

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### Competencies – where are you and what should you know?

Initially based on number of Years in **Direct** Diabetes Education and/or Management

- LEVEL 1: 0 – 2 years of direct care experience in diabetes (percentage of time devoted to diabetes specialty practice).
- LEVEL 2: 3 – 5 years post achievement of CDE®/or more experienced in diabetes clinical/ educational care.
- LEVEL 3: More than 5 years of direct engagement in the diabetes as a specialty practice.

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### 5 Competency domains – as we know them today

Domain 1: Pathophysiology, Epidemiology, and Clinical Practice of Prediabetes and Diabetes Competency Statement: Demonstrates familiarity with pathophysiology, epidemiology, and clinical practice consistent with practice level.

Domain 2: Cultural Competency Across the Lifespan Competency Statement: Provides diabetes support and care in a culturally-competent manner across the lifespan.

Domain 3: Teaching and Learning Skills Competency Statement: Applies current principles of teaching and learning and/or behavior change to facilitate self-management skills. Pursues ongoing professional development

Domain 4: Self-Management Education Competency Statement: Works with an interdisciplinary diabetes care team to tailor interventions to individual self-management education needs.

Domain 5: Program and Business Management Competency Statement: Applies principles of program and/or business management to create a climate that supports successful self-management of diabetes.

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Example of domain breakdown

Domain 1 example: PATHOPHYSIOLOGY

Diabetes Educator, Level 1 Describes normal glucose metabolism. Explains the pathophysiologic mechanisms responsible for the development of prediabetes, type 1 diabetes, type 2 diabetes, and gestational diabetes. Explains the signs and symptoms of acute hyperglycemia, hyperosmolar hyperglycemic state (HHS), and diabetic ketoacidosis (DKA). Identifies causes of hypoglycemia. Identifies common risk factors for the development of the acute and chronic complications of diabetes.

Diabetes Educator, Level 2 Outlines the pathophysiology of gestational diabetes and its relationship to the development of type 2 diabetes. Describes the pathophysiologic basis of hypoglycemia, HHS, and DKA. Identifies risk factors for hypoglycemia, HHS, and DKA.

Diabetes Educator, Level 3 Applies knowledge of diabetes pathophysiology to direct diabetes education and/or diabetes care.

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Domain breakdown example 2

DOMAIN 4: Self management education TAKING MEDICATIONS

- **Diabetes Educator, Level 1** Identifies and explains the differences between prescribed oral and injectable medications for diabetes and co-morbid conditions. Discusses safe use and common side effects of prescribed diabetes medications. Teaches staff and patients on safe preparation, storage, administration of injectable medications and disposal of syringes and lancets. Discusses use of over the counter (OTC) medications, supplements, and complementary alternative medicine (CAM) and possible effects on glucose levels.
- **Diabetes Educator, Level 2** Works with person and healthcare team to individualize the diabetes medication regimen. Supports person as they consider, initiate, and learn how to use an insulin pump. Coordinates the plan of care between the prescriber, insulin pump manufacturer, and insulin pump trainer during pump initiation and ongoing management. Obtains certification to provide training in the use of each specific brand and model of insulin pump with which they work.
- **Diabetes Educator, Level 3** Works with person and diabetes care team to simplify medication regimens and find lower medication cost opportunities, when need is identified. Assesses for potential drug/drug or food/drug interactions and refers to pharmacist or registered dietitian/registered dietitian nutritionist as appropriate. Periodically assesses for changes in person's clinical condition, motivation, abilities, and life circumstances that may necessitate the need to reconsider appropriateness of insulin pump therapy. Makes medication changes or follows medication adjustment protocols, or makes necessary recommendation to primary care provider.

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Press pause:

Where are you? Where are you going?  
Where do you need to be? Where do you want to be? How do you get there?

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Identify your personal areas of clinical inertia  
Create a plan to reduce them  
Expand your voice and improve diabetes care

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4. List techniques/approaches used to help reduce personal clinical inertia and help patients reach *their* goals

- Use The Language of Diabetes
- Find resources for you, your patients, your referring providers
- Patient center models
- MI approaches, CBT referrals
- Checklists are guides; not road maps
- RELATIONSHIPS!
- RECOMMENDATIONS! Stick your neck out

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The value of the CDE to the team

- You know the patient
- You know the disease
- You know the meds
- You know the technology
- You know your scope of practice
- MAKE THE RECOMMENDATIONS

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5. Create change: make a therapeutic recommendation

- Who are you communicating with?
  - The prescriber
- What should you know?
  - Etiquette: When and how to approach
- What do you know?
  - The BRIEF synopsis of the story and the answers to the anticipated questions
- What do you not know?
  - Verbalize uncertainty with a solution
- What are you trying to accomplish?
  - Change in therapy to reduce clinical inertia of provider/patient
- How do you say it?
  - With practice. On paper. Verbal. In front of a mirror. With your colleagues. To your dog, or hedgehog

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How NOT to say it?

- "Dr. X – Patient Y needs to be on insulin right away"
- "Dr. X – Patient Y has take a higher dose of med Z"
- "Dr. X – Patient Y needs a different medication"
- "Dr. X – Patient Y has to go on a pump"

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<https://youtu.be/nSIUoUuVktw>

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A good example/approach

• Dr. X – Patient Y has been experiencing consistent hyperglycemia >200 after breakfast, throughout the day. He/She has been taking medications as prescribed and sticking to the meal plan. I have educated him/her on the next line therapies. He/She is not opposed to injection therapy. I checked with his/her insurance plan and the following are covered. We also have co-pay cards to assist out of pocket costs. Please advise if this sounds like the direction you would like to go.

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George McFly needs a little help

<https://youtu.be/cZ7XXrRhXgl>

<https://youtu.be/JcBWGIYRhrC>

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• The power of the CDE – what parts of clinical inertia do we have an impact on?

PATIENT RELATED:	PROVIDER RELATED:	HEALTH SYSTEMS:
<ul style="list-style-type: none"> <li>✓ Denial of disease</li> <li>✓ Lack of awareness of progressive nature of disease</li> <li>✓ Lack of awareness of implications of poor glycemic control</li> <li>✓ Fear of side effects</li> <li>✓ Concerns over ability to manage more complicated treatment regimens</li> <li>✓ Too many medications</li> <li>✓ Treatment costs</li> <li>✓ Poor communication with provider</li> <li>✓ Lack of support</li> <li>✓ Lack of trust in provider</li> </ul>	<ul style="list-style-type: none"> <li>✓ Time constraints</li> <li>✓ Lack of support from clinical staff</li> <li>✓ Concerns of costs of treatment</li> <li>✓ Reactive vs Proactive care</li> <li>✓ Underestimation of patient needs</li> <li>✓ Difficulties with navigating guidelines/algorithms</li> <li>✓ Lack of information of new treatments</li> <li>✓ Lack of information on side effects, ie fear of hypoglycemia</li> <li>✓ Lack of clear guidance on individualizing treatment</li> <li>✓ Concerns over patients ability to manage more complicated treatments</li> <li>✓ Concerns over patient adherence</li> </ul>	<ul style="list-style-type: none"> <li>? No clinical guidelines</li> <li>No disease registry</li> <li>? No visit planning</li> <li>No active outreach to patients</li> <li>No decision support</li> <li>✓ No team approach to care – no referrals to CDE</li> <li>Poor communication between provider and staff</li> </ul>

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### Summary and challenge

- Identify your individual points of inertia
- Create a learning plan to build knowledge and confidence
- Be the expert within your scope
- Be the advocate
- Speak up
- Reduction of our clinical inertia has the power to reduce systemic inertia

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### References

J Okemah, J Peng, M Quinones: Addressing Clinical Inertia in Type 2 Diabetes Advancements in Therapy, October 2018  
 K Khunti, D Millar-Jones Clinical inertia to insulin initiation and intensification in the UK: a focused literature review Prim Care Diabetes, 2017  
 SK Paul, K Klein, BL Thorsted, MJ Wolden, K Khunti Delay in treatment intensification increases the risks of cardiovascular events in patients with type 2 diabetes Cardiovasc Diabetol, 2015  
 SA Ross Breaking down patient and physician barriers to optimize glycemic control in type 2 diabetes Am J Med, 2013  
 SA Ross, HD Tildesley, J Ashkenas Barriers to effective insulin treatment: the persistence of poor glycemic control in type 2 diabetes Curr Med Res Opin, 2011  
 M Povrot, RH Rubin, T Lauritzen Resistance to insulin therapy among patients and providers: results of the cross-national diabetes attitudes, wishes, and needs (DAWN) study Diabetes Care, 2005  
 S Nakar, G Yitzhaki, R Rosenberg, S Vinker Transition to insulin in type 2 diabetes: family physicians' misconception of patients' fears contributes to existing barriers J Diabetes Complications, 2007  
 Yoshioka N, Ishii H, Tajima Y, Iwamoto Y, DAWN Japan group. Differences in physician and patient perceptions about insulin therapy for management of type 2 diabetes: the DAWN Japan study. Curr Med Res Opin. 2014;30(2):177-83  
 WD Strain, M Blaher, P Psodrius Clinical inertia in individualising care for diabetes: is there time to do more in type 2 diabetes? Diabetes Ther, 2014  
 CA Chvala, D Sherr, RD Lipman Diabetes self-management education for adults with type 2 diabetes mellitus: a systematic review of the effect on glycemic control Patient Educ Couns, 2016  
 A Zafar, MA Stone, M Davies, K Khunti Acknowledging and allocating responsibility for clinical inertia in the management of type 2 diabetes in primary care: a qualitative study Diabet Med, 2015  
 DH Laursen, KB Christensen, U Christensen, A Frølich Assessment of short and long-term outcomes of diabetes patient education using the health education impact questionnaire (HeIQ) BMC Res Notes, 2017

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