
Identifying and Engaging Patients Experiencing Therapeutic Inertia in Diabetes Care

Practice Action Checklist

- 1. Use your EHR's tools, like a patient registry, to regularly identify patients who may be experiencing therapeutic inertia—** and reach out to them. Run reports on a monthly or quarterly basis. For example, obtain a list of all patients with no office visit in the past 4 months whose last A1C was > 9%. This resource can help you use the population health tools in your specific EHR to identify those who have not reached their target and those who may have uncontrolled diabetes: <https://www.novomedlink.com/practice-resources/EHR.html>.
- 2. Work with your technical team to flag high A1Cs in an EMR record without making it overly obtrusive to the workflow.** If done with input from all on the care team, this can support addressing therapeutic inertia at the point of care. It can be part of pre-visit planning or an alert that fires at a convenient step in the clinical workflow (but think carefully about how to make them useful without creating “alert fatigue”).
- 3. Agree on a diabetes treatment algorithm that everybody in your practice uses consistently.** We recommend ADA's treatment algorithm, of course. Consider making print copies, laminating them, and placing copies in each exam room. Many clinicians have also found **ADA's Standards of Care App** to be a great tool to support better point-of-care decision making.
- 4. Disseminate unblinded quality metrics reports to all staff—Identify positive outliers.** By identifying practices and approaches that are achieving the best results and sharing this information, you support a learning culture that drives continuous quality improvement. Transparency, mutual support, and open communication are essential for overcoming therapeutic inertia.
- 5. Complete the ADA Practice Self-Assessment tool** to understand more about where therapeutic inertia may be showing up in your practice.
- 6. Consider scheduling diabetes-only visits at least annually, especially for patients with multiple chronic conditions.** Focus on diabetes-related issues such as A1C goal attainment, medication compliance, diabetes distress, and diabetes-related health maintenance.
- 7. Arrange more frequent office visits based on A1C and recent treatment change.** For example, every six to eight weeks for those at 9% or higher, every two to three months for those between 7 and 8.9%, and every 3–6 months for those <7% or at their personal target. Leverage telehealth to make it easier.
- 8. Use a team-based approach to increase frequency and quality of engagement.** Leverage each member of the care team at the top of their license. Tap medical assistants and care managers to provide active follow up. Engage qualified nurses, CDEs, and pharmacists to ensure that people with diabetes have their treatment evaluated and goals reinforced at every possible opportunity.
- 9. Adopt technology to increase touchpoints and improvement engagement.** When it comes to engagement, both quantity and quality matter. Frequent touchpoints are important for optimizing disease management. This could include the arrangement of more frequent office visits/telehealth visits, use of texting, CGM monitoring, and leveraging a patient portal.