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<https://reachmd.com/programs/cme/enhancing-adherence-to-maintain-glycemic-control-in-patients-with-type-2-diabetes/9875/>

Released: 11/28/2017

Valid until: 11/28/2018

Time needed to complete: 15 minutes

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Enhancing Adherence to Maintain Glycemic Control in Patients with Type 2 Diabetes

ANNOUNCER INTRO:

This is CME on ReachMD. The following activity, titled "Enhancing Adherence to Maintain Glycemic Control in Patients with Type 2 Diabetes" is provided by Prova Education. This activity is supported by an educational grant from Merck.

The following is an expert interview recorded live at Prova Education's Guideline to Practice: Managing Challenging Cases in Primary Care.

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Your host is Dr. Matt Rosenberg.

Dr. Rosenberg:

As healthcare professionals, we spend a lot of time and energy communicating the risks of poor glycemic control over extended periods, from diabetes-associated comorbidities to early death, but attaining and maintaining glycemic control continues to be very difficult for patients with type 2 diabetes, and one major reason for this is low adherence to therapy.

I'm Dr. Matt Rosenberg and joining me is Dr. Monica Peek, Associate Professor of Medicine in the Section of General Internal Medicine at the University of Chicago. She is also Associate Director at the Chicago Center for Diabetes Translation Research, and Director of Research at the MacLean Center for Clinical Medical Ethics, also based at the University of Chicago. Today, we will be discussing the problem of adherence to diabetes medications and practice, and explore ways to help our patients to become more treatment compliant. Welcome, Dr. Peek.

Dr. Peek:

Thank you.

Dr. Rosenberg:

So, to start, what's your general experience with patient adherence in your practice and how does this compare with the levels of adherence that are reported though clinical studies and case reports?

Dr. Peek:

So, that's an important question. I am a primary care provider at the University as well as a researcher, and so what I see in my clinical practice, despite my best efforts, is not the same as what we ordinarily see in randomized controlled trials where there is a difference between efficacy and effectiveness, between what we can see under ideal circumstances and what actually happens in real practice. The University of Chicago is primarily a community health center essentially for the surrounding neighborhood as well as a tertiary and quaternary care center. And so, most of my patients are low income, racial and ethnic minorities, with type 2 diabetes as my average patient, with a lot of challenges around health literacy. And so, while I do the very best I can to try and increase adherence, it is still such a challenge for a lot of reasons, in general, we can assume that at least a third of the medications we prescribe are not being taken by our patients.

Dr. Rosenberg:

And what about clinician inertia?

Dr. Peek:

So, there are a lot of reasons why people aren't taking their medications. Some of them are barriers for patients, which I think we are going to get into, but some of it is actually our responsibility as well, and it's not only that patients don't want to listen, it's also that we sometimes have a hard time ingesting all of the guidelines that are there that are always changing. Every year the ADA comes out in January with a new set of clinical guidelines with the whole issue of diabetes care, and so it's hard for us to keep up. A lot of the medications have names that are difficult for us to pronounce, much less patients, and for primary care doctors, which is what I am, it's sometimes easy to say, "Well, your blood pressure's a little high today, I know you're stressed, let's see what it is next time I see you; your A1c is a little high, but we just came through the holidays, I know you want to work on it a little bit better, and let's see what happens next time," and so, there's a phenomenon called clinical inertia, where we as clinicians kind of drag our feet on enacting what we know to be the right thing to do for clinical care for reasons that make a lot of sense of the time, but it ends up being an addition to the growing problem of diabetes under management and subsequent complications.

Dr. Rosenberg:

So, we've been referring to adherence issues as a barrier to treatment, but also we need to recognize the barriers to adherence itself. What are these factors that affect patients' adherence to their treatments?

Dr. Peek:

Things that we all, all of us in this room, have seen in practice. So cost and, particularly, I think in our changing health policy environment, and as insurance companies are really scrambling to try and figure out how to stay afloat and keep up and change the formularies, it is really increasingly difficult for us as providers to know what's on formulary, what's the preferred medication, and how much of that cost is being transferred to our patients? And so, I just never know anymore, and so I just prescribe things that I'm hoping are affordable for my patients. It's embarrassing a lot of times and challenging for patients to admit they can't afford medications, or they are trying to make really tough decisions about keeping their lights on or paying for this new great medicine that you just talked about. And so, there are issues around cost, issues around literacy and health literacy, which are not the same, issues around side effects, and so patients are experts in taking medications. We're experts in prescribing medications, but unless we are a patient ourselves, we don't really know what it's like to have the bloating, the diarrhea, the discomfort, the weight gain, the frustration, the fatigue, things that come with a lot of the medications that we prescribe to sort of keep the ABCs for diabetes care under control, and that's a huge barrier for people who may not be experiencing symptoms from the disease itself on a daily basis, particularly I'm thinking about hypertension, but may be experiencing side effects from the medications they must take to prevent complications. And so, really taking a good hard look at a lot of the people's personal experiences with the treatment plans that we are giving I think will help us and help and help our patients be more adherent.

Dr. Rosenberg:

Sure. You know, you mentioned a point that really affects me personally as a provider. You know, we have, my office manager told me recently, we have over 50 different insurances that we deal with, and every insurance...

Dr. Peek:

Has negotiated something.

Dr. Rosenberg:

...has different formularies, so I may have a habit of writing certain medications, but inevitably, it's destroyed by whatever insurance I'm using, and that in and of itself creates inertia.

Dr. Peek:

Right.

Dr. Rosenberg:

There's enough times if we get beaten enough, then we stop the behavior...

Dr. Peek:

(Inaudible)

Dr. Rosenberg:

...and it becomes an obstacle. What do we, as providers, do about this?

Dr. Peek:

It's a challenge, and some of us are lucky enough to have nurses and office managers who can do that, and I was just online during the

break, because I got an email about a patient whose medication that they had been on is suddenly no long covered, and so what are these options? And so, my nurse had fortunately already called the pharmacist and sort of did some troubleshooting for me, and there are resources for us as providers as far as being able to access formularies online, but it still takes some time away from the hustle of seeing patients, you know, in a tight time frame. And so, I think that, I'm hoping, I spend a lot of my time sort of thinking about health policy and the landscape and what's happening with health policy changes, that the dust will settle in a year or so, and then we have a better sense of some stability around the insurance markets, who knows, and some more continuity about coverage and things that are easier for patients to understand and for us to understand.

Dr. Rosenberg:

Sure. Maybe as we're dealing with healthcare reform, something that they can do, and you know, because the government always tells us what we can do, maybe they can at least make it easier for us to fight for the right medication as opposed to that myriad of things that we have to go through to get a prior auth.

Dr. Peek: Yep.

Dr. Rosenberg:

So streamlining that process...

Dr. Peek: Absolutely.

Dr. Rosenberg:

... in and of itself might help.

Dr. Peek:

Absolutely. The more paperwork that we have to deal with, the harder it is to take care of patients, and I am someone who really promotes the idea of team-based care and really thinking about operationalizing clinical guidelines, but we have to do that in a way that does not come at the cost of increasing the administrative burden for providers and practices.

Dr. Rosenberg:

Right, which we seem to be doing a great deal, a great deal of. So, you know, this is actually a good chance for us to turn now to shared decision making as we are dealing with patient care. So, help us understand, from your standpoint, what you see as shared decision making, and how it fits into this game plan for improving medication adherence?

Dr. Peek:

It's a perfect example or way to sort of discuss or think about shared decision making is diabetes and chronic diseases and these sort of new medications and what to sort of do about that and adherence. So, for me, I spend a lot of my time, you had mentioned that I am the Director of Research at the MacLean Ethics Center, and a lot of my work has to do with shared decision making and thinking about how we can activate patients to be more actively involved in their healthcare, to have more ownership about these kinds of decisions, and bring information to the table that is going to be helpful for us as providers in making treatment recommendations. So, shared decision making really simply is what it sounds like, a shared medical decision, and it recognizes the importance of patient perspectives as well as provider perspectives in two areas; one of which is knowledge and expertise. So, we obviously have gone to school. We have something to contribute to the conversation about medical decisions as medical providers, but patients are experts in living with chronic diseases, and they experience the side effects. They know what it's like to undergo invasive treatments and diagnostic testing. And so, it's worthwhile for us to acknowledge that that's an expertise that patients are bringing to the table. So, one is sort of skills and expertise, and the other is values, and I might think it's more important to value quality of life over quantity of life, but patients may decide that they really don't care how bad their life is, as long as they can make it to see their great grandson born, or their kids make it off to college. And so, these values about what we think is important around quality of life are important not just for the physician, but also for the patients who are experiencing them; and so sharing and sort of recognizing that that information and those health values may be different, but all are important to making decisions that ultimately the patients have to be the ones who operationalize them. They are the ones who have to take the medications. They are the ones who have to go see all of the providers and specialists, and unless they're on board with that, we're back to square zero, and so, we really need to have patient buy-in. And so, for me shared decision making is a way of thinking about and identifying barriers to adherence, lifestyle issues that patients are facing so that we can come up with a plan that seems doable, that they can be excited about, that they can have some ownership of, and feel like it's financially feasible and doable given their resources and circumstances within their communities, and so it's really just, you know, tailoring treatment plans to fit patient's needs.

Dr. Rosenberg:

And a little bit of a tangent there, but it seems to me that there is nobody better suited for that kind of discussion than the primary care

provider.

Dr. Peek:

Absolutely. I mean, it's crucially important when you're in high stakes situations in the hospital and having to decide what to do about a heart attack, but really for me it is a luxury to have ongoing continuity of care relationships and to be able to say, "You know, we can make this decision today, but we can also come back and revisit it, and so, we're going to, you know, let's try this, and see how it works, and if it's not working so well for you, guess what, we have other options, we can think about it again." And so, I think that it really reinforces part of the goodness of the patient-provider relationship and that therapeutic relationship, to be able to feel like you're a team together exploring what's going to ultimately be the best fit for that patient.

Dr. Rosenberg:

Sure. All right. So, let's talk specifically about shared decision making in diabetes. You know, maybe you can share with us some examples that you've had or how we can improve that as providers.

Dr. Peek:

Absolutely. So, sort of just diving a little bit deeper into the nuts and bolts; so I spend a lot of time doing a lot of patient education and talking about the importance of asking questions and all of that, but really as providers what we want to be able to think about is what are patient issues, what are the patient barriers to ideally getting to the goal of managing their ABCs, and is there a way that we can engage patients, that we can identify what is important to them to be able to meet those goals? And so, I always try to socially normalize behavior that people would want to say no to, like, so as opposed to saying, "You've taken all your pills today, haven't you?" You know, it's really challenging for people who have diabetes to do all the things they're supposed to do to manage their disease, and a lot of people have a hard time taking their medications every day or every week. "On average, how many times in a week do you miss your pills?" So then the answer is, "I miss my pills sometimes and this is how often," as opposed to, "Of course, doctor, I filled all of those prescriptions on time and I'm having no side effects at all, and you know, we're all doing great, and why is my A1c still 13?" And so, really trying to provide an open safe space for them talking about a medication non-adherence, "Great, okay, I'm so glad that you told me that you're unable to take your medications this many times a week and let's figure out how we can work to improve those numbers, tell me what are the barriers? Is it side effects, is it time, is it management, cost?" And so, some of the things that we think about to try and reduce those barriers are ones that we always have in our head, but to be able to put those on the table for patients is important. "Did you know that there's a combination pill, there's a blood pressure pill that's got three medications in it? There are diabetes medications that have the short-acting and the long-acting. There are some of the newer medications that are out that are also with the tried and true ones that you are already on right now, so we can add a DPP-4, or we can add something else, but we could also do something in a way that just means that you are taking the same number of pills, just one, but get the new medication in that." And so, really understanding and thinking about the patient's comorbidities, do they have irritable bowel syndrome? Do they have congestive heart failure? Do they already have existing atherosclerotic disease, and would they benefit from some of the medications that can improve that safety profile, reduce the comorbidities, or would they interact with them? And so, having our understanding about those things as well as the patient's experience of those potential side effects and barriers, I think, really provides a ripe opportunity for us to be able to then think about what the best plan is. And so, it's exciting for me to be able to have things to offer patients when they're having problems, and so, I have some agreements with people and they are like, "We can change the plan of care, but the total number of pills stays the same," and so, I'm like, "Okay, we can try something stronger. We can increase the dose. We can add a combination pill." So, that's another tool kit, something that is a tool that is in our tool kit that we can think about for patient medications, but there are a lot of ways for us to be able to basically try and unpack all the difficulties that patients are having in trying to address them in a way that lets patients understand that we really care if they can afford the medications or not. We really care if they're up all night with symptoms, and so how can we deal with that.

Dr. Rosenberg:

This has been fantastic. I appreciate...

Dr. Peek: Our time is up?

Dr. Rosenberg:

Our time is up, but I will give you a chance here in any last minute you would like to mention or takeaways for our audience?

Dr. Peek:

I would, maybe two things. So, one is just acknowledging that patients for the most part really want to share and unburden all of these problems they're having with medication adherence, and the safer space that we can provide for them to be able to talk with us about that helps relieve them. They don't want to have to lie to us and tell us they're doing things that they're not. And so, if we can create a space for them to be able to talk about medication adherence in a way that is positive and promoting, then I think we'll go a long way to

sharing in those decisions and to seeing a reduction, not only in non-adherence, but in the subsequent outcomes as far as complications.

Dr. Rosenberg:

Great. Well, Dr. Peek, thank you so much. We'll have to do this again.

Dr. Peek:

Thank you.

Dr. Rosenberg:

Thank you very much.

Dr. Peek:

What a pleasure being here, thank you for having me.

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