JAMD
THE JOURNAL OF AMD

INTERNATIONAL SYMPOSIUM
FACING THE CHALLENGE OF CLINICAL INERTIA IN 2021

How can we overcome clinical inertia? The EASD vision

Stefano Del Prato[1]
[1]University of Pisa, Italy; President of the European Society for the Study of Diabetes.

Corresponding author: **stefano.delprato@unipi.it**

OPEN ACCESS
PEER-REVIEWED

Citation Del Prato S. How can we overcome clinical inertia? The EASD vision How can we overcome clinical inertia? The EASD vision. JAMD 25:34-36, 2022.
DOI 10.36171/jamd22.25.1.6
Editor Luca Monge, Associazione Medici Diabetologi, Italy
Received February, 2022
Accepted April, 2022
Published May, 2022

Data Availability Statement All relevant data are within the paper and its supporting Information files.
Funding The Author received no specific funding for this work.
Competing interest The Author declares no competing interests.

The EASD aims at supporting a better outcomes for people with diabetes across Europe. EASD has had the opportunity to collaborate with ADA since 2006, when the first consensus on the treatment of hyperglycemia in people with type 2 diabetes was released. It has been a long and important journey as unifying the voices of the two major world diabetes organizations has been instrumental in communicating common therapeutic targets, common information, common recommendations. This collaboration has been active for more than 15 years and we look forward to continuing working closely to homogenize treatment of type 2 diabetes across the world.

The Consensus states that a reasonable HbA1c target, for most non-pregnant adults with sufficient life expectancy, to yield microvascular benefits (which is generally in the range of about 10 years) is around 53 mmol/mol, or 7%, or less. Nonetheless, glycemic treatment targets should be individualized based on patient preferences and goals, risks of adverse effects of therapy, risk of hypoglycemia and weight gain, as well as patient characteristics, including frailty and comorbid conditions. The complexity of the task is fully apparent because if it is true that targeting HbA1c is important, a major effort has to be paid to address individual needs of the person with diabetes including his/her cardiovascular risks, or the need of minimizing the risk of hypoglycemia (which - by the way - also is associated with cardiovascular risk) or to prevent, if not reducing, body weight gain being obesity another factor associated with cardiovascular risk. Finally, the societal and economic environment needs to be considered.

Given the availability of new glucose lowering agents with demonstrated cardiorenal protection, a trend in emphasizing organ damage prevention on top and beyond glycemic control may become more apparent. Yet, the cardiorenal protection needs to be integrated within the need of glycemic control given that it remains an effective tool for reducing the risk of microvascular complications[1] and because of a still limited proportion of people with diabetes achieving their glucose targets[2]. Such a relative failure is not limited to glucose control since when lipids or blood pressure are considered, it appears that only 22% of the population with diabetes, according to the most recent HNHANES survey, reach the target for glucose, lipids, and blood pressure control[2].

Multiple factors hamper our ability to ensure adequate control in a larger proportion of the diabetic population, including clinical inertia. The latter per se recognizes the complex interaction of several aspects pertaining to the person with diabetes, the physician as well as the healthcare system. As far as the person with diabetes is concerned denial, lack of trust, poor communication with the physician, costs of treatments, fear of adverse events, number of medications and much more can undermine treatment adherence. For physicians we should consider, among the many, time constraint, lack of adequate support, financial limitations, inadequate update on guidelines and novel treatments or even the concerns over patient's adherence. Lack of disease registries, poor visit planning, difficulties in outreaching patients, poor decision support and poor communication may be factors related to the healthcare system that also can contribute to impair overall effectiveness of medical implementation. It is therefore apparent that to reduce clinical inertia and reconcile clinical practice with guideline targets, we need implementing consistent follow-up procedures, data collection and analysis, facilitated access to resources, continues education for healthcare providers and feedback from people with diabetes[3].

To support these actions, EASD has launched the European Diabetes Forum (EUDF). Together with the EASD and the EFSD, the EUDF includes the Foundation of European Nurses in Diabetes (FEND), the Juvenile Diabetes Research Foundation (JDRF), the International Society for Pediatric and Adolescent Diabetes (ISPAD), The International Diabetes Federation (IDF) and many other organizations. The EUDF is actively implementing actions to improve outcomes for people with diabetes in Europe through three different forums. The first is to support data and registries; the second is to expand self-care technology and digitalization; the third is to support integrated care. A European Diabetes Registry has been deemed necessary to standardize indicators for continuous benchmarking, to improve and harmonize diabetes care throughout Europe, and to monitor and support European policies for diabetes. Such an initiative, by the way, is fully in line with the 2012 European Parliament resolution recommending use of carefully collected data across Europe. Such a registry can be key in tackling clinical inertia, as suggested by the model implemented in Hong Kong showing how the registry can funnel down different information by engaging physicians in collecting data. Moreover, analysis of the data is instrumental to define benchmark performance, identify care gaps, evaluate effectiveness and track secular trends[4]. The Registry, of course, is just a tool but it may become an essential component of the integrated care model. However, for the registry to generate proper feedback and reaction, stakeholder buy-in is critical as well as the role of a steering committee with the mandate required to implement data-driven changes. Once actions for improvement have been identified then a stronger 'Diabetes Voice' is needed to step up the perceived priorities, especially now at the time of the Covid-19, which has consumed and continues consuming a great deal of resources.

The EASD is actively involved in building up a targeted education for healthcare providers through the EASD E-learning. This activity is continuously expanding as witnessed by >2500 site visitors per month, almost 6000 signed up users from over 160 different countries and a growing social media recognition. The course content is represented by 75 modules with 5 new modules launched at the 2021 Virtual Annual Meeting of the EASD, and more courses to be implemented in 2022 covering from diabetes education to research development and clinical management of diabetes. More care will be paid on practical clinical scenarios by incorporating more case studies to the modules[5]. However, it is important to appreciate that the response and interest to educational modules may differ from subject to subject. Therefore, effective education should be able to reach out individuals with different characteristics. Therefore, the EASD E-learning offers different modules with different formats. An example is provided by the "Horizons" hub where news from conferences and journals are provided along with a growing roster of different movies on insulin across the world, and interviews with experienced diabetologists recounting how they approach diabetes or short discussions among experts. The goal is capturing as much as possible the attention of healthcare providers and to certify the participation in these educational activities.

To this purpose the EASD E-learning has been accredited in the UK with more accreditations to be provided in other countries in the near future. In summary, overcoming clinical inertia will be essential to fill the gap between guidelines and clinical practice, and between guidelines and clinical outcomes. Moreover, we must assess the need for a new and ambitious 'declaration' of clinical goals, as it was done many years ago with the St. Vincent Declaration with the ambition to be more successful than we have been in the past in attaining goals that are key for improvement of the quality of life of people with diabetes. This will require the introduction of consistent follow-up procedures, improved access to resources, targeted education of health care providers and proper feedback from the people with diabetes as said. Last, but possibly even more important, is the need to increase and strength the voice of diabetes through a concerted action of all the stakeholders.

References

1. Davies MJ, D'Alessio DA, Fradkin J et al. Management of hyperglycaemia in type 2 diabetes. A consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). Diabetologia 61:2461-2498. https://doi.org/10.1007/s00125-018-4729-5, 2018.

2. Fang M, Wang D, Coresh J, Selvin E. Trends in Diabetes Treatment and Control in U.S. Adults, 1999-2018. N Engl J Med 384:2219-2228. doi: 10.1056/NEJMsa2032271, 2021.

3. Okemah J, Peng J, Quiñones M. Addressing Clinical Inertia in Type 2 Diabetes Mellitus: A Review. Adv Ther 35:1735-1745. doi: 10.1007/s12325-018-0819-5, 2018.

4. Chan JCN, Lim LL, Luk AOY, Ozaki R, Kong APS, Ma RCW, So WY, Lo SV. From Hong Kong Diabetes Register to JADE Program to RAMP-DM for Data-Driven Actions. Diabetes Care 42:2022-2031. doi: 10.2337/dci19-0003, 2019.

5. https://easd-elearning.org/