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Patient Voices and Provider Partnerships to Advance Cardio-Kidney-Metabolic Outcomes

Announcer:
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Dr. Wish:
Here we have what we are calling our Smart Patient CKM online group. This was 92 respondents that participated in a focus group. Some of the information that I will be presenting in the next 2 slides was the result of the patient input into this focus group. At this time, I would like to introduce my cofaculty member today, who is a patient advocate. She is Gail Balch. She lives in Tacoma, Washington. She is, of course, very familiar with some of these issues because she actually cares for her husband, who has cardio kidney metabolic syndrome, and is familiar with a lot of these medical issues, as well as some of the logistical challenges in getting her patient the best possible care. Welcome, Gail.

Gail Balch:
Hi. Thanks for having me.

Smart Patients Speak: Communicating Rationale and Benefit in Complex Regimens

Dr. Wish:
What did the Patient Focus Group come up with? You can see some of the issues that were raised by the group. There are a lot of bullet points here, and we do not have time to go through every one of them, but we can talk top line in terms of categories. There was communication about safety monitoring and adverse events. There was respect and rationale in the dialogue. Quality of life and shared decision making gaps. Communication about the rationale for new or complex treatment. The 1 issue that seemed to be the most concern, as you can see, for 42% of the patients, was that they are just not getting the information that they wanted regarding why a new medicine was needed. What was the rationale? What were the expectations? How was the new medicine going to change their course vs doing what they were doing already. I would like to call on Gail to comment on that perspective.

Gail Balch:
We have just had not as good of luck with physicians and specialty people that tell us what the medication is for. They say, "You need to start this. It will do this," but they do not give us the whys and wherefores behind it. They also have not been giving any, “if you are on this, it would not be a good idea” type of thing. It has been difficult getting information.

Dr. Wish:
Do you find that the provider does not answer the question? Do you think that it is an uncomfortable environment to bring the question up even in the first place? Or do you think when they answer the question, it is not in the English terms that you can understand? Is it maybe too technical, too medical jargon?

Gail Balch:
I think they do not know how to dumb it down. That might be a crass statement, but there are a lot of people out there who do not understand the medical lingo to the point that say, I do. I'm very fortunate that I have got a little bit of a medical background, so I find that they seem to have difficulty in being able to not talk medical lingo.

Dr. Wish:
Okay. Thank you. That is a very important perspective, and I am glad you can share that with us.

Aligning Clinical Guidelines With Patient Centered Approached in CKM Care

Let us talk about aligning clinical guidelines with a patient centered approach to care and cardio kidney metabolic syndrome. This is the definition of cardio kidney metabolic syndrome. You can see it is an interlinked disorder of obesity, diabetes, chronic kidney disease, and cardiovascular disease across at risk and established cases. It is extremely prevalent. You can see the global prevalence 700 million people, about 40% overlap with type 2 diabetes and cardiovascular disease. Heart failure prevalence being about 64 million, 50% of whom also have CKD. Of course, obesity is an important driver for this syndrome. The end organ dysfunction that occurs in terms of cardiac disease, kidney disease, and diabetes, and the residual risk in heart failure despite goal-directed medical therapy, the events remain high.

CKM Syndrome Definition

You can see the stages of cardio kidney metabolic syndrome. For those of you who take care of heart failure, there is heart failure stages. For those of you who take care of patients with kidney disease, there is kidney disease stages. Here we have a staging mechanism for cardio kidney metabolic. Given the constraints of time, I am not going to go through all those individual points.

Interdependent Pathophysiology of DM, CKM, and HF

The interdependent pathophysiology you can see in this diagram, the various organs and how they talk to each other. Perhaps some of that talk becomes dysfunctional because of the overall adverse metabolic environment. If you want to start with any particular organ here, and it is a complicated slide, you can see over on the left hand side, you have the heart, you have sympathetic nervous system and RAS system, over activation, chronic inflammation, cardiovascular dysfunction leading to low cardiac output, decreased renal perfusion, sodium and water retention, and overstimulation of the RAS system.

Uremic toxins again, inflammation rearing its ugly head, and then metabolic dysfunction in terms of the effects of the obesity, the diabetes, hyperglycemia, beta cell dysfunction, etc. It becomes a vicious cycle where all of these organs become dysfunctional. If you can see, there is a common denominator of the inflammatory aspect of this environment that also accelerates the organ dysfunction and ultimately leads to symptoms.

Stages of CKM Syndrome

The stages we talked about very briefly in a previous slide. Stage zero would be no risk factors. Stage 1 is where you start to see the obesity excess adipose tissue. Stage 2 is where you have the metabolic risk factors in terms of the hypertension, hypertriglyceridemia, type 2 diabetes, and chronic kidney disease. Stage 3 you have the subclinical cardiovascular disease, especially subclinical heart failure. Then stage 4 you have the full blown end organ changes of each of these systems with heart failure, chronic kidney disease, atrial fibrillation, stroke, etc. There are a number of subclinical cardiovascular disease risk equivalents that can also act as surrogates for demonstrating the end organ changes of this adverse metabolic environment. Now, these are very, very busy slides. We again, do not have the time to do a deep dive into them. I am going to do a top line here.

Stage 1-3 CKM Syndrome: Management Algorithm

As you can see again stage 1 excess adipose tissue. Stage 2 is where you have the established risk factors. Stage 3, the subclinical, and again you can scan each of these boxes to show all of the possible manifestations in metabolic adverse events that occur.

Stage 4 CKM Syndrome: Management Algorithm

Then moving to stage 4. Here's a management algorithm that has been proposed in terms of addressing each of these subcomponents the dysfunctional adiposity, the CKM risk factors, etc, as atherosclerotic cardiovascular disease, hypertriglyceridemia, hypertension, CKD. It is important, again, when we talk about these things with our patients, to get them on board by understanding that early intervention is going to have the greatest effect in changing that risk trajectory. That this is a progressive disease. It is a multiorgan system disease, and the earlier we can get in and do some intervention, the more likely it is that we are going to change the trajectory and ultimately delay outcomes, if not decrease the outcomes altogether.

KDIGO Health Map for CKD

This is what is called a heat map. Many of you who take care of patients with chronic kidney disease are familiar with it. On the vertical axis is the stage of the glomerular dysfunction stage G1, G2, G3, etc, and then on the horizontal axis is the level of proteinuria. The first column is microalbuminuria, or I should say the first column is no albuminuria. The second column is microalbuminuria between 330 and 300, and then the third column is severe or macroalbuminuria. What you can see here is that you move from left to right to greater levels of proteinuria at any stage of GFR. It becomes higher risk for progression of chronic kidney disease, but also again, because the chronic kidney disease, the cardiovascular disease, and the metabolic disease is all linked, then you are moving to a higher risk state for basically all of these end organ changes. We like to push the patients into that upper left hand corner where they are at the lowest risk, minimal albuminuria, lowest level of GFR dysfunction, and hopefully keep them there for as long as possible with the interventions that we have at our disposal.

CKM Burden and Care Fragmentation

Let us talk a little bit about care fragmentation, because again, the patient groups have let us know that this is 1 of the main barriers to what they feel is the most effective care, that their providers are not talking to each other. They are not communicating. They go to a clinic visit with the nephrologist, and the nephrologist is totally unaware of what happened with the cardiologist or with the endocrinologist, etc. This fragmentation cannot only lead to missed opportunities for care, but can now also pose the risk for a duplication of care; that 1 provider is prescribing a drug that may have an adverse interaction with a drug that is being prescribed by another provider. CKM multimorbidity significantly increases the risk of heart failure, hospitalizations, cardiovascular death. 40% of patients with type 2 diabetes and 50% of patients with cardiovascular disease have comorbid chronic kidney disease. This is a very, very common phenomenon where these patients are seeing multiple providers. Overweight increases twice and obesity increases 4 times for developing cardio kidney multimorbidity. We talked about the fragmented care, the patients often face polypharmacy, conflicting care priorities. Unfortunately, because of this poor communication environment, few patients receive all of their indicated therapies. Because, in many cases, each provider is depending upon another provider to institute that particular aspect of their care and then ultimately no provider does it, or there is duplication.

Guideline-Concordant Therapy Pathways

This is guideline-concordant therapy pathways. We know now that SGLT2 inhibitors are pretty much good for everything. This is obviously an evolution in our understanding of the benefits of this class of drugs. First, they were just for diabetes, and then we realized that they decreased proteinuria. Then we realized that they are good for patients with chronic kidney disease, even in the absence of proteinuria. Then we realized that they are also good for patients with heart failure. As far as I am concerned, SGLT2 inhibitors should probably be in the drinking water, but they are not. They have to be prescribed. Many of them are very expensive, and there are a lot of prescription drug plans, that pose very high copay barriers to SGLT2 inhibitors. It is often a challenge to the medical practice to navigate those barriers and figuring out which SGLT2 inhibitor is favored by that prescription drug plan. Sometimes, we have to be somewhat creative in terms of prior-authorization as well as patient support options.

GLP-1 receptor agonists are recommended for reducing atherosclerotic cardiovascular disease management as well as weight management. As you know, we are now seeing more of these coming into the weight management space, where they again, were initially primarily for diabetes control. Finerenone, which is a nonsteroidal mineralocorticoid receptor antagonist, like spironolactone, only nonsteroidal, has multiple benefits. It has been actually shown to have incremental value in terms of improving outcomes in patients already receiving SGLT2 inhibitors, ACE inhibitors, angiotensin receptor blockers and GLP-1 RAs. RAAS inhibitor therapies, of course, are standards of care for heart failure, for diabetes, and for proteinuria and for hypertension. The statins, of course, make up the baseline therapy for atherosclerotic cardiovascular disease and chronic kidney disease. They are now considered standard of care for patients with CKD, even in the absence of high cholesterol levels because of the benefits in terms of inflammation. Again, the lower your LDL, probably the better.

Underuse of Evidence-Based Therapies

What are we dealing with in terms of opportunities for improvement? We know that these evidence-based therapies are underused. Of those with a class 1A recommendation, those are the recommendations that have the strongest evidence base, only 11.9% of patients with type 2 diabetes, and 3.1% of patients without type 2 diabetes were prescribed an SGLT2 inhibitor. Again, many reasons for this. Again, high copays, perhaps unawareness of the benefits and all of these aspects of care, as I said, probably should be in the drinking water. Again, each provider thinking that it is going to be the other provider that is going to actually do the prescribing. Less than 10% of patients with atherosclerotic cardiovascular disease are treated with GLP-1s. Less than 36% of heart failure patients receive an MRA, either a steroidal or nonsteroidal. Again, the reasons for this underuse are cost, the silos of communication, and then clinical inertia. "Oh,

you are doing fine." Even though we know there is things that we can do that may make your outcome better. You have not had an event yet, so we will just see how things go. That is probably not the way we want to work here.

Patient Case 1: Patient With Obesity, T2D, ASCVD

Let us go back to patient 1. The patient recently relocated and presents at their primary care office. Past medical history: diabetes, obesity, atherosclerotic cardiovascular disease with a prior MI. Recent labs that are A1C is way poorly controlled at 8.1%. eGFR 49 puts them in stage 3B, and you can see albumin-creatinine ratio in the microalbuminuria range. Lots of opportunities here for improvement, better glycemic control, perhaps improvement in GFR and perhaps reduction in proteinuria. Their current medications: metformin, linagliptin, lisinopril, atorvastatin, and ASA.

Poll 3

Next question is what therapy would you prioritize for initiating today in your office?

A. Adding GLP-1 RAs, example semaglutide;

B. Adding an SGLT2 inhibitor, example empagliflozin;

C. Adding a nonsteroidal MRA, example, while actually finerenone being the only one that is approved at this point; or

D. Just continuing their current regimen monitor for now, and perhaps waiting until they end up in the hospital with some complication to decide to change course.

Go ahead and enter your response.

Speaker 3:
Polling is open. Please vote. I will give a few more seconds for incoming replies. All right I will go ahead and close that poll.

Dr. Wish:
I see GLP-1 RA has the highest number of votes, 40%. SGLT2 30%. Nonsteroidal MRA 30%, or continue current regimen zero. That is reassuring that everybody realizes this patient is not doing well with the status quo, and that something needs to be added. Again, I think this is probably a matter of opinion, whether you would go with a GLP-1 RA or an SGLT2 inhibitor. I think many patients or I think many providers, would probably make that decision based on perhaps how overweight the patient is, getting the additional benefit of the GLP-1 RA weight reduction, or if the patient is not severely overweight, perhaps going with SGLT2. The SGLT2 has the advantage of being oral. The GLP-1 at least for glycemic control is an injection. Again, this may require some discussion with the patient in terms of what they are going to buy into. Let me ask Gail, in terms of this particular scenario. Choosing a GLP-1 RA vs an SGLT2 injection vs oral, do you think there is going to be patient pushback for favoring the oral vs the injection?

Gail Balch:
Definitely. People are scared to death of needles. Even from just talking with other individuals in different scenarios, they even cannot give themselves injections. They will have a spouse or a child do it.

Dr. Wish:
That would be a good reason to favor going with the SGLT2 first and then the GLP RA second. Again, I think unless they were morbidly obese or severely overweight, and we felt that was the major barrier in terms of glycemic control, blood pressure control, etc, and then we might favor the weight reduction feature of the GLP-1 over the SGLT2. They all have beneficial effects on glycemic control. They all have beneficial effects on heart failure. They all have beneficial effects on proteinuria, so that is really not a major distinguishing characteristic. The major choice here would be the injectable vs the non-injectable, and the obese vs the non-obese patient. Do you agree with that, Gail?

Gail Balch:
Yes.

Poll 4

Dr. Wish:
Poll 4. When would you initiate additional therapy for this patient?

A. Immediately during today's visit;

B. After confirming repeat labs;

C. After referral to your colleagues in nephrology, cardiology or endocrinology; or

D. Only if symptoms progress;

Go ahead and enter your response.

Speaker 3:
Polling is open. Please vote. I will give a few more seconds for incoming replies. We will go ahead and close that poll and share.

Dr. Wish:
Immediately and after confirming today's labs are neck and neck at about half of the responses. My recommendation would be no time like the present. We had relatively recent labs. There is no reason to think, without any change in the patient's therapy since the last labs were drawn, that their A1C is going to be any different, that their GFR or albuminuria level is going to be much different, because there was no change following the last set of labs. My inclination would be to go ahead and start at today's visit, explaining what you are doing, basically telling the patient, "We are going to do this. We are going to maybe confirm your labs today or maybe not even confirm the labs today and wait till your next visit to see what the effect of this intervention is, and then decide whether or not we are on the right track."

Poll 5

What most often delays therapy initiation for patients like this in your practice? Is it

A. Cost/insurance;

B. Concern about polypharmacy and side effects;

C. Not sure who owns the prescribing; or

D. Patient hesitancy or adherence issues;

I do not think there is any real single best answer here. I think all of these play a role and some play more of a role in some practices than others, and some play more of a role in some patients than in others. What we are asking for here is in your particular practice, in your particular patient population, which perhaps is the greatest barrier. Go ahead and enter your answer.

Speaker 3:
Polling is open. Please vote. We will give a few more seconds for incoming replies. We will go ahead and close that poll.

Dr. Wish:
I see by far and away, cost and insurance access is the number 1 answer, 82%. I agree, this is probably the biggest issue in my own practice. I practice in an inner city. Most of my patients have very, very poor insurance. Even those patients who have a prescription drug plan, the co-pays on things like SGLT2 inhibitors or GLP-1 agonists are prohibitively high. As soon as the patient finds out the sticker shock, they basically say, "No thanks. Cannot afford it. I'm not going to starve my family to take this medicine, even if I agree that it is probably the best thing for me at this particular time."

Key Teaching Points for Patient Case 1

Key teaching points for patient 1. Again, I do not think we need to go through each of these individually, but on the right hand side of the slide, I think it is important to see some of the large scale, very well-designed clinical trials that were done that show the benefits of these classes of drugs. The EMPA-KIDNEY improvement in risk progressions with empagliflozin. With the FLOW study, semaglutide again, kidney disease events, advanced cardiovascular death. The FIDELIO and FIGARO DKD finerenone decreased CKD progression and cardiovascular effects. The DAPA-HF deliver SGLT2 inhibitor benefit across the heart failure spectrum, and the STRONG-HF rapid initiation of disease modifying therapy and include heart failure, improves quality of life, and reduces the risk of 180 day heart failure readmission, as well as all cause death. These are strong evidence bases for the recommendations for the use of these drugs in the patients that we are talking about today.

Get Ready to Interact!

Get ready to interact. Our patient will have an opportunity to do a real talk, sharing their real life experience. Please submit questions, comments, and your own examples in the chat and we will review what the learners, you guys in the audience, submit during this mini-Q&A.

Quick Connect Q&A

All right. Questions for our patients or our patient advocate today. You have this slide. You can tell us in terms of your care of your husband, because you are not the patient you are the patient advocate. Which of these issues drives perhaps a lot of what you do for your husband in terms of improving, their care?

Gail Balch:
The CKD drives us every single day because our life revolves around dialysis. Now, I will admit that my husband is 18 years older than I am, and he has a different perspective on living and how he wants to live the rest of his life. As a younger person, I would tend to take more steps to keep going. He is at the point he wants to enjoy his life. When it comes to a new medication, insurance definitely matters a lot with what they are going to pay. Giving a medication is not so much a problem with us, because I can handle needles with absolutely no problem. He does well also. The polypharmacy is an issue because A, he hates taking medications. If he can get away with it and survive just fine, that is his attitude. Yes, our HCP has started multiple medications, but they tended to be normal everyday type of things. It would be a statin along with something else that would be normal for controlling LDLs, HDLs, that kind of thing. As a patient advocate, no, I do not think the HCP's have shared decision making with him, other than to say, "This is a drug that we would recommend. Do you want to take it? How do you feel about that?" It has been pretty much the care providers, making the decisions for him, even as the disease has progressed over 30 years.

Dr. Wish:
Let me ask, is being on dialysis is a special case because the silo of dialysis is somewhat more compartmentalized than being in, say, a hospital system where you are going to a clinician's office, and they are using the same EMR as all the other clinicians that are taking care of the patient. A dialysis corporation like a DaVita or Fresenius, they have their own EMR. That EMR is not necessarily shared with the local hospital system, where the patient gets their other specialty care. Do you find that is a barrier in terms of communication?

Gail Balch:
Absolutely, without a shadow of a doubt. We constantly cannot get them to send, even though there has been a doctor's order, we cannot get them to send any of the blood works to the care providers. I have to take it every single time I get it. The medications. There are certain medications that the dialysis center will provide my husband, that for a while I did not even know he was getting. Then one day Steve came home and said, "Hey, by the way, I'm getting this pill." I went, "What pill?" He goes, "I do not know," because he cannot remember. They never contacted me.

Dr. Wish:
That is a very good example of the barriers that you and your husband are dealing with. I think this is representative of what is going on in a lot of patient situations. It is unfortunate that these silos continue to exist because the fact that your husband is on dialysis does not protect him from the other complications of CKM. The number 1 cause of death and hospitalization among dialysis patients is not their kidney failure, it is cardiovascular disease complications, heart failure, MI, stroke, etc. It is very, very important that these issues be addressed more effectively. Thank you for sharing.

Dr. Wish:
Let us move on. We are going to move to the second portion of our presentation with patient case 2. This is a 62-year-old woman who was referred from cardiology for worsening glycemic control and weight gain. She is hesitant to start injectable therapy—there you go, reflects what you said—due to concerns about side effects, costs, and using injections. Past medical history, the stuff we have been talking about; type 2 diabetes, obesity, stage 3A CKD. It is eGFR between 45 and 60. Hypertension. Dyslipidemia. Her current medications, the usual gang here, metformin. She is on an SGLT2 empagliflozin. She is on an ACE inhibitor, lisinopril. She is on a statin, rosuvastatin, and she is on aspirin. On recent labs, you can see the A1C is still a little on the high side at 7.9, eGFR in that stage 3A range, and urinary albumin creatinine ratio of 220, which puts her in the microalbuminuria range. If you recall from that heat map, patients with stage 3 CKD and with microalbuminuria, fall into that high risk category in terms of CKD progression.

Poll 6

Next question. When your patients express hesitancy about GLP-1 RAs, what is the most common concern that you hear? Is it

A. The side effects, the GI symptoms, nausea vomiting;

B. The cost and insurance coverage;

C. That injection route of administration;

D. Polypharmacy that they are on too many medications already:

E. Skepticism about the benefits of this class of drugs.

Go ahead and enter your response.

Speaker 3:
Polling is open. Please vote. We will give a few more seconds for incoming replies. We will go ahead and close that poll.

Dr. Wish:
This is another question for which I think there is no best answer. Every patient is different in terms of their perception of this class of drugs. It is interesting that side effects was not a big player here. Only 10% were concerned about the GI symptoms. The cost and the insurance coverage, obviously rear their ugly heads again with 40%. Then again, the polypharmacy of 30%, too many medications already. The problem that we deal with patients with cardio kidney metabolic syndrome is that all of these aspects are on a step therapy. There is a step therapy for the hypertension. There is a step therapy for their diabetes. There may be a step therapy for their hyperlipidemia because they are on a statin and they are on Zetia. There is so many things where you have to incrementally treat their underlying diseases in order to get a satisfactory response. Sooner or later, the patients are often going to say, "Enough is enough." Even if you make a compelling case that they need a particular drug at a particular time. Again, no single best answer. Again, cost and insurance coverage very, very important barrier with GLP-1s as with SGLT2s, because of the very high copay with some insurance plans.

Poll 7

All right. In your practice, how do you typically manage the GI side effects from the GLP-1 RAs? You can select all that apply.

A. Start low titrate slowly;

B. Provide dietary counseling with small meals avoiding high fat foods;

C. Use antiemetic or adjunctive medications;

D. Reassure and continue in less severe because in many cases, the GI side effects do abate after several weeks of therapy; or

E. You often are required to just discontinue it early because the patient just does not tolerate the side effects.

Go ahead and answer your answer.

Speaker 3:
Polling is open. I will give a few more seconds for incoming replies. We will go ahead and close that poll and share.

Dr. Wish:
I see about 90% of you said start low, titrate early. That is what is recommended in the product information for these drugs, and that certainly is a very important way to go to minimize these side effects. Again, these responses are not mutually exclusive. I think it probably behooves us to use as many of these tactics as possible in order to minimize the risk that the patient will abandon a therapy that can be extremely important in terms of decreasing what can be a potentially life threatening events.

Poll 8

Next question how do you most often monitor adherence to the GLP-1 RA therapy?

A. Ask at follow up visits;

B. Review their refill and pharmacy data;

C. Digital health and patient reported tools, where they can actually, enter interactively on the patient portal, perhaps, what is going on in terms of their medication adherence;

D. Nurse or pharmacist follow up, a lot of programs have pharmacists follow up with Coumadin and anticoagulation, so that patients have an ongoing conversation and ongoing monitoring; or

E. It is rarely assessed.

Go ahead and answer. Enter your response.

Speaker 3:
Polling is open. Please vote. We will give it a few more seconds for incoming replies. Excellent. We will go ahead and close that poll.

Dr. Wish:
Okay, so about half of you, 44% said “ask”. This is certainly a reliable tool if you feel that the patient is being honest and they are not

just telling you what you want to hear. Refill or pharmacy data can be very important with all medications in terms of monitoring adherence, how often the patients are getting refills, and if the refills are going twice as long or 3 times as long as they should, you suspect poor adherence. Digital health tools are becoming more and more commonly used and can be very effective. Then of course, nurse and pharmacy follow-up, like we often do with anticoagulation can be very, very effective. I am glad nobody answered rarely assess because, again these agents, which can be extremely important in terms of the care of our CKM patients, you have got to take them for them to work.

Key Teaching Points for Patient Case 2

All right, so our key teaching points for this patient. Again, we went through most of these things. I am not going to belabor them, but the evidence highlights again, the flow study with semaglutide and decreasing kidney disease events and cardiovascular death. The REWIND study dulaglutide decreased MACE in patients with type 2 diabetes. The SUSTAIN also examined semaglutide, decreased MACE and decreasing new or worsening nephropathy in patients with type 2. And Then the SURPASS-CVOT used tirzepatide and demonstrate decreased MACE, and included greater weight and glycemic benefit vs dulaglutide.

Real Talk: Patient & Provider Perspectives Addressing Barriers and Shared Decision-making

All right. Again, engaging our patient. What do you have to add, and we can use these bullet points as an outline for what we want to discuss. Have you ever had trouble getting prescriptions covered or affording the medications? Do you feel your care team includes you in making the treatment decisions? Would you prefer only 1 provider to coordinate your care? Do you like hearing from each specialist and getting their perspective? I should say, who else helps you manage your health? Is there a pharmacist, nurse, or family member that also provides additional information and answers your question in between provider visits? Go ahead and share.

Gail Balch:
We have not yet had any problems getting prescription covered. We have been very fortunate, we have got excellent healthcare coverage. If we did have issues, it would definitely not be a drug that we would be able to take. Our team typically will say, "This is what you need to do," and then they prescribe it. They do not really say, "How do you feel about that? Do you have anything else you want to add to this or anything like that?" They do say, "Do you have questions?" Of course, at the moment you are blank. At least I do. I go blank and my husband does too. When it comes to providing and coordinating care, I like that we have a PCP, but I also, and my husband does too, like having the specialists. Because they are the ones who know theoretically more about what needs to be done.

I would like coordination between them to be better. For instance, our nephrologist is not on my [inaudible 00:48:00]. Trying to get information from him, you have to make a phone call or my husband's provider has to make a phone call or email, that kind of thing. When it comes to managing health, our pharmacy is great. They are absolutely fantastic. They are a small mom and pop place. We love them. As going for family member, that is me. If we get involved into any medications or whatever, the first thing I do, if the doctor cannot give me information, I Google it and I go to reputable sources. I go to Cleveland Clinic, I go to Mayo Clinic. That thing to see what can be contraindications. I actually brought that up to a doctor recently. He prescribed a medication and I looked at it and I went, "I do not think this is a good one because it can cause kidney damage. My husband does not need any more kidney damage." He goes, "Oh my gosh, thank you for bringing that up."

Dr. Wish:
That is great. You are a sophisticated advocate for your patient. You have access to the internet. You know what you are looking for and you have the chutzpah, shall I say, to actually challenge your providers in terms of whether they are doing what needs to be done. The problem is that in many cases, and you probably recognize this, and I am just throwing this out as a common barrier, the infrastructure just is not there for patients to ask questions. As you said, you get prescribed a new medication. You are caught like a deer in the headlights. It takes you a little while to process it, maybe go and Google it and figure out whether or not this is something you are comfortable with. Then when you circle back to the provider, you get a lot of barriers. You get voicemail. They say, "Oh, we will get back to you in 72 hours." You want an answer now, and you are afraid that the 72 hours that you are either giving or not giving your husband this new medication could be a problem. If they get it and it is not good for them, or if they do not get it and they need it. Again, we need a more responsive system. Now, fortunately patient portals and those things where you can interact with the provider have I think changed the environment a little bit so that the communication is not quite as cumbersome and delayed and you are not waiting 72 hours for voicemail to get up through the process. Again, we still have many challenges in terms of addressing patient concerns that we are not very good at.

Gail Balch:
The other thing that also that I am seeing in the geriatric world, the patients still tend to believe that the doctor is 'it'. The doctor knows everything, they are supposed to be responsible for everything. They do not ask questions and they do not advocate.

Dr. Wish:
You are very, very correct. What is it? The greatest generation, the World War II generation. They tend to be very trusting. You shift now to the baby boomers and the Gen X, and they are much more skeptical and they are much more likely to challenge the provider. You are right. The older people that are in their 80s and 90s, you know, they tend to be very trusting because that is the way they were brought up.

From Hesitation to Trust: What Smart Patients Teach Us About Communicating Side Effects and Safety

Dr. Wish:
Let us move to the next slide. Hesitation to trust. Talking about trust. What these patients that have been in that group articulate in terms of understanding treatment hesitation, the side effect communication gaps, the trust and transparency in the dialogue, and the follow-up and shared monitoring. Again, I picked 1 that Gail might want to discuss. That is a dismissive tone. How often do you encounter this and how often is it a barrier in terms of your trusting the provider and actually following what they are recommending?

Gail Balch:
I will give you an experience that just happened to us 9 months ago. My husband was referred to a cardiologist. I will make it quick. We saw the first 1, did not communicate well with him. Went to another person in his practice. He told me that my husband told us, but he was talking at me, not my husband, the patient. He said my husband had heart failure. I said, "Excuse me, what happened with that? How did that happen?" He goes, "Tests." We fired him, at the very next. Because I will not tolerate that kind of behavior from anybody anymore.

Dr. Wish:
Yeah, I agree, and I am seeing more and more providers becoming, shall we say, more responsive, less dismissive, more willing to engage. I think that generation that you mentioned, not only were the patients more trusting, but the providers were more arrogant, shall we say. That is passing on to a more shared communication type of situation.

Unifying Teams and Systems for Coordinated Care

Let us move along. Unifying teams and system coordinated care. These are the players: primary care, cardiologists, nephrologists, dieticians, pharmacists, endocrinologists, diabetes education specialists, and nurses. Obviously, what we are trying to get our arms around today is how to get all these people to play together and to communicate, and to basically do what is best for the patient in a coordinated fashion.

Strategies for Patient Engagement

Some of these strategies for patient engagement and improving communication, not only with the patient, but among the providers. Again, many of these are obvious. Using culturally sensitive plain language, emphasizing benefits beyond glycemic control, especially for the GLP-1As and SGLT2s, which we now know are extremely important in decreasing the rate of progression of heart disease and of kidney disease, and applying motivational interviewing, which can improve adherence, creating visual aids that show risk reduction and avoidable hospitalizations, and understanding that patients want a partnership and not directives. Again, in terms of making sure the patient's understanding, what we are talking about, often that teach back, it is not mentioned here on this slide. You tell the patient or the patient advocate something you want them to know. Then you ask them to teach you that same concept back in their own words to make sure that they processed it and they understand it. That is also going to improve their ability to adhere to what you have discussed.

Shared Decision-making

Shared decision making. Collateral processes between the provider and the patient, engaging and empowering in decision making, providing patients with information about alternative and all treatments, not just the one you picked as your first choice, and incorporating patient preferences and values into the plan. Because every patient is different, every patient's family is different. Some family members may have different ideas and there at the visit or they hear what happened. It transpired at the visit and they say, "Oh, no, you cannot do it that way." Again, you have got to get everybody on the same page. Friction is bad.

Employing Motivational Interviewing

All right. Let us talk about a little bit about motivational interviewing. Again, engaging the patient, building rapport, asking permission not being directive. Focusing on what the patient wants to discuss. Evidence of risk and benefit. Advantages and disadvantages. Evoking patient ideas and solution. Waiting and listening. Asking open ended questions, not just yes or no, and then planning collaboratively towards the next step. Because each decision is not the end of the line. Each decision is a process towards perhaps additional

therapies. I think the patients and their advocates need to understand that when I prescribe an SGLT2 inhibitor in this particular situation, that is not the end of the line. We may want to add a GLP-1 RA. We may want to add a non-steroidal mineralocorticoid antagonist. This is just 1 step in the chain of treatment.

Interprofessional Workflow Challenges

Interprofessional workflow challenges. Again, who owns the initiation? This was something that came up in our initial question series. Cardiology vs PCP vs nephrology. Ideally, nobody owns it. Ideally, everybody has collaborated. Cardio kidney metabolic is a syndrome that involves all 3 specialties. Nobody owns it any more or any less. Everybody has a stakeholder position in this, and there is no reason why for instance, any 1 of those 3, for example, providers could not prescribe an SGLT2 or GLP-1 or an MRA, etc, in professional education to stimulate the communication and the comfort level that each provider has with all of these therapies.

Multidisciplinary care meetings, if logistically possible, can obviously improve communication. The EHR prompts can also help identify eligible patients, and this is something that you are going to see more and more built into the large scale EHRs, like Cerner and Epic. Epic has many of these already. Then integrated care with clinics that improves efficiency. You have a single area in your clinic building that has CKM care, and there are cardiologists there, and there are endocrinologists there, and there is nephrologists there. The patient may actually see all 3 providers or their nurse practitioners in a single visit, 1 after another. That improves the patient's time spent having to go back 1 time, as opposed to 3 times to the clinic, and also all the providers in 1 place at 1 time. They can go in the back room and they can discuss the patient and come up with a single approach to the patient's treatment at that encounter.

Role of Multidisciplinary Teams

Addressing the complexity of CKD as a multimorbid condition, improving adherence to guidelines through palliative care and then empowering patients and self-management, as we mentioned.

CKM Syndrome Prevention and Management: Interdisciplinary Care Models

All right. This slide distinguishes a value-focused approach vs a volume focused approach. I really feel that this distinction is somewhat artificial, it is contrived. All of the points in both of these columns apply. I do not think making 1 side pink and the other side blue really makes much sense to me in terms of their importance, in terms of their prioritization. Obviously, patient-centered care is the overriding priority. Engaging the care team, engaging the patient, guiding by evidence based guidelines or recommendations, and then referring the patients as needed, and having a coordinator, if possible, either a human or an EMR that allows for this communication. Again, telemedicine can also expand the reach and flexing between what I think are these artificial columns is important.

Real Talk: Patient & Provider Perspectives Supporting Adherence and Ongoing Care

All right. Again, getting back to Gail in terms of her input on some of these bullet points, how do you keep track? Would it help if your HCP checked in after you start the medication? Have you ever had some of these side effects, and how would you feel comfortable reaching out sooner vs later? How can your HCP improve communication? Go ahead, lay it on us, Gail.

Gail Balch:
Wow. Up until 7 years ago, I pretty much stayed out of my husband's medical regime. It was whatever he dealt with, he dealt with. It was just something that we agreed between us. Pharmacy alerts would be great. They have that now, whether you are on autofill. Sometimes it works. Sometimes it does not. Keeping track of medications. For him, we have his medications broken into AM, AM and PM, and PM. They are put on separate shelves. I separate the AM and PM into duplicate bottles with the information on it. When he does his AM meds, they are done. When he fills his PM meds, they are done. The PRN stuff, they are AM or PM, so that stays on that shelf. I would love if HCPs could improve communication with each other. It would be fantastic. The problem is there is only so much time in a day, and physicians are being pushed more and more and more. See more patients do this, do that, do this, and they do not have time for the patients. Time constraint is huge, and where in 24 hours, are you going to get more time?

Dr. Wish:
Absolutely correct. We are all being squeezed in many directions. More documentation requirements. The whole issue of prior authorizations, and who does that? Delays in fulfilling these prescriptions that the patients need. It is extremely frustrating to many of us. That is why we face burnout among our fellow providers.

Real Talk: Patient & Provider Perspectives Supporting Adherence and Ongoing Care

When teams do not talk, here are some of the insights that have come up. Again, not going through all these bullet points individually because we are kind of short on time. Coordination within the system, patients as their own coordinators, as Gail has mentioned to us, conflicting recommendations, and the role of clarity and communication quality shapes confidence and trust. One particular point that we

highlighted here. Many feel like message couriers between medical specialties. This is not what the patient should be. The patient should not be the one who tells the cardiologist what the nephrologist recommended or what the nephrologist did. Cardiologist should have that information in an EMR or in a letter from the nephrologist or some way. The cardiologist is prepared to consider that particular change in the patient's treatment in their overall plan. Again, everybody is on the same page, if not by actually sitting together and discussing each patient, because that, as you say, is unrealistic with the pressure that we have on just cycling more patients through our clinics, at least in terms of getting everybody on the same page.

Quick Connect Q&A

Q&A. We are going to have to move through it because we are running short of time.

Faculty & Patient Wrap-Up: From Evidence to Experience in CKM Care

This is the wrap up here. Faculty summary points that is from me. Initiating early with SGLT2s and GLP-1 RAs, as well as finerenone the nonsteroidal MRA. Owning the decision every HCP can act, avoiding the silos and clinical inertia, managing and assessing GI related effects are all manageable with counseling and follow up and working as a team with pharmacists, nurses, and other ways to coordinate workflow. Then the patient message, and I do not want to put words in your mouth, Gail, but include me, tell me why we are doing what we are doing, hear my concerns and support me with communication, and do not make it very, very hard for me to actually get back to you and ask my questions and tell you about what is going on. Make it easy.

Gail Balch:
Exactly.

Posttest Assessment

Dr. Wish:
Let us go to our posttest assessment. Actually, what we will do before we do that, I see there is a couple Q&As. Hopefully, we can get through those quickly. How do you prompt treatment escalation in CKM patients who appear stable but are still at high risk? That is a complicated question but the answer is so, for instance, I'm a nephrologist. I have got a patient who continues to have a high level of proteinuria, even though there seem to be doing okay in other aspects. Their A1C is now less than 7. Their blood pressure is under pretty decent control. They are on their statin in their other medication. Would I want to escalate their doses of their ARB or their SGLT2 or their MRA to get their proteinuria down to as low as possible? The answer is yes. I am not going to wait for an event. That high level proteinuria puts them at high risk. It is a ticking time bomb, and anything I have at my disposal to try to decrease that risk, whether it is adding a new drug or escalating the dose of existing drugs, I think ultimately will benefit the patient. How do you help patients understand the interplay between diabetes, kidney disease, and cardiovascular health? The answer is it just takes time to go through that interaction. We actually have a number of posters in our patient exam rooms that have similar flow diagrams, as you saw in 1 of those slides that has all the organs and all those arrows that show the interrelationship between these particular illnesses. Because again, as nephrologist, yes, we want to keep people off dialysis, but we understand that the number 1 cause of death in patients with CKD is not their kidney disease. It is cardiovascular events, heart failure, MIs and strokes. And we want to make sure that patients understand that. This is not a silo. It is an integrated healthcare challenge. Then for Gail, have you dealt with treatment fatigue, and how do you manage that?

Gail Balch:
Yes. The simple answer is absolutely. I am exhausted and my husband, bless his heart, is tired of doctors. How do we manage it? We sleep. We pretty much go to sleep and pretend the world does not exist, and we complain to family members. There is not a way for us to be able to take care of it and make it go away.

Dr. Wish:
I have 1 other point that was made in the chat. That is how about referring patients to registered dietitian nutritionist? The answer is absolutely yes. We do that all the time, especially in patients with more advanced CKD. There is lots of things that we want to do in these patients in terms of restricting their potassium, their phosphorus, their sodium, their protein. It is almost impossible in the nephrology space to achieve all the dietary considerations that we know are strongly recommended in the CKD guidelines without the assistance of a dietician. I understand that cardiologists and endocrinologists do the same thing, although their goals in dietary management may be somewhat different. With endocrinologists, obviously it is the sources of sugar and why their A1C is high. With cardiologists, it is mostly related to salt and volume.

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