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Addressing Academic vs. Community Cardiology Perspectives on the 2020 ACC Expert Consensus Decision Pathway

Announcer:
You're listening to ReachMD, and this episode of Heart Matters is sponsored by Novo Nordisk. Here's your host, Dr. Matthew Sorrentino.

Dr. Sorrentino:
Welcome to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino, and here with me today to talk about the application of the 2020 ACC Expert Consensus Decision Pathways on Novel Therapies for Cardiovascular Risk Reduction in Patients with Type 2 Diabetes, specifically in academic and community settings, is Dr. Sandeep R. Das. Dr. Das is a Professor of Medicine in the Cardiology Division at the University of Texas Southwestern Medical Center in Dallas, and Director of Acute Coronary Care at Parkland Health and Hospital system. He serves as a health system quality officer for UT Southwestern and is a founding member of the Center for Innovation and Value at Parkland. Dr. Das represents the American College of Cardiology on the American Diabetes Association standards of care. And he co-authored the 2018 and 2020 ACC Expert Consensus Decision Pathways on Novel Therapies for Cardiovascular Risk Reduction in Patients with Type 2 Diabetes. Dr. Das welcome to the program.

Dr. Das:
Thank you very much, Dr. Sorrentino. I appreciate the invitation.

Dr. Sorrentino:
I think the cardiovascular world, but also the endocrine world, internal medicine world, have all been excited about some of these new therapeutics that are available to treat diabetes and the fact that they have an impact on cardiovascular risk reduction. But I wonder how well some of these new therapeutics are being introduced into practice, and specifically the difference in practice in academic centers like you and I are in versus community centers in adopting some of these strategies.

Dr. Das:
So thanks. That's a great question. So first, let me just start as my background. The two new classes of drugs that we're talking about first are sodium glucose cotransporter-2, or SGLT-2, inhibitors. And the second is glucagon-like peptide-1 receptor agonists, also called GLP1-RA. So, when we're talking today, that's kind of what I have as a mental frame.

Let me start off by answering my question by saying, I think there's a bit of a false dichotomy between academic and community practice. I mean, really, all of us are working hard to ensure the best possible outcome among the patient we care for. And that really means providing compassionate, patient-centered care consistent with current practice guidelines. That's, universal, and it's really more important than any differences between the academic and community settings. That said, there are differences, right? So in academics, we have a lot of time dedicated to formal didactics which is a luxury a busy community may not have. We also tend to have more of an external stimulus. I'm surrounded by colleagues and fellows, who sort of expect everybody to be talking about the latest published literature, and not wanting to look bad in front of my peers, that sort of as an external incentive for me to stay current as well. And then in terms of teaching trainees, etcetera, and research contexts.

In a community setting, dealing with high clinical volumes tends to be more of an issue. And there's a lot of focus on pragmatic delivery of high-quality care at scale and efficiently. So, I think there's a little bit of a sort of conceptual focus, but in the end, we're all trying to do the same thing.

Dr. Sorrentino:

If we look specifically at your 2020 Expert Consensus Decision Pathway, and even in guidelines in general, there's so many of them that come out in cardiology in what ways do these updates and these guidelines inform the way you practice cardiology? Are you somebody who adopts them as soon as they come out? Or how do you use them in your own practice?

Dr. Das:
That's another great question. What I would say is if the guidelines have an Achilles heel, it's that they are too comprehensive and too literal. And what I mean by that is you have to account for every possible nuance of every possible situation, rather than saying, 'Oh, well, you know, if you want to get to this place, you drive north on the highway, and then you take this exit.' Instead, you have to say and micro-detail every little bit. And sometimes that you lose the forest for the trees. So, I think that the role of something like the Expert Consensus Pathway, is that we can say, you know what, looking at all the evidence out there, this is kind of what we think a good clinician should be doing or thinking and in a much more sort of approachable manageable way. So, it's shorter, and just doesn't have all the sort of extraneous side detail knowledge, where we don't feel like it really impacts how you would provide care.

So, I think that that's really the sweet spot of these kinds of documents is that they allow you to be a little bit more big picture than the guidelines while at the same time being succinct and practical.

Dr. Sorrentino:
How would you see standard cardiologists in academic centers best using these pathways? Is this something that we should integrate electronically? Or is it something that should be, a card in our pocket?

Dr. Das:
Yeah, so I'm definitely of the age where card in the pocket kind of resonates. But I feel like that's been left behind., I think that in 2021, the goal here would be to integrate it into electronic systems of care delivery. There are a lot of options ranging from sort of the ubiquitous best practice advisories to protocoled clinic notes, etcetera. So we have a couple of different approaches for various conditions. We have dedicated order sets or order panels that then sort of prompt the right drugs to consider. And they don't force you to do anything, but they at least put the language up there for you to think about it and decide whether to do it. And then we also have just simple things that go in progress notes, like smart phrases, etcetera, that allow you to clarify your thinking. I mean, one of the things that I like to focus on with the fellows is to explain your thinking about why you did something, or why you didn't do something rather than just not doing it. I think that if you intentionally choose not to do something for a reason, that's fine. But you should put that into your thinking, put that in your notes, etcetera. So, I think the EHR is kind of the way forward for us to be able to systematize care delivery.

Dr. Sorrentino:
On the flip side, how might a cardiologist in a community setting who doesn't have the full electronic record systems that we have implemented some of these updates?

Dr. Das:
Yeah, so that's also a good question. So the issue, I think, is that there's a lot less sort of horizontal integration between EHRs in the community setting. I work for UT Southwestern, so if someone goes to see a primary care doc or goes to see a diabetes specialist, or sees a cardiologist, we're putting all of our information into the same EHR that then allows it to generate these alerts, etcetera, and communicate it in ways that are facile. Now, in practice, if you go see one doctor, and they have their own EHR. And then you go see a specialist, and that specialist may have an entirely unrelated system, they may even have a completely different software package that runs it becomes a lot harder to have this sort of seamless communication. And I will say, again, in 2021, I'm kind of embarrassed that medicine is the last bastion of the fax machine that people are saying, why are we running around with pagers and fax machines like it's 1991?

The real issue here, I think, is developing systems of communication. So, I do think that in practice community docs have figured out how to communicate with their referral referring docs or their docs that they get referrals from. I think that people have figured out what works well for them. And I wouldn't reinvent the wheel. I would say, leverage your existing communications strategies to make sure that you're clearly communicating.

And then also, I think, there's an opportunity here to empower every individual physician to make a change that's in the patient's best interest. So, if I'm seeing someone in cardiology, and I say, 'Hey, here's a person with diabetes, CKD, proteinuria. I'm going to start them on a SGLT-2 inhibitor,' even though I'm not the nephrologist, and I'm not the primary care doc, and I'm going to shoot the primary care doc a note that says, 'Hey, I saw this patient, we talked about it, we talked about the indications, and I started this drug.' You know that to me is the right thing to do for patients, because really, the war here is against therapeutic inertia. And the real challenge here is to do everything we can to expedite that. So one of those things I think is not requiring someone to come to their 14th office visit before we get them on the right therapies.

Dr. Sorrentino:
For those just tuning in, you're listening to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino, and today I'm speaking with Dr. Sandeep Das about the application of the 2020 ACC Expert Consensus Decision Pathway, specifically talking about academic and community settings.

So, we've looked at academic centers, we looked at community centers somewhat individually. Let's try to bring them together. I'm thinking specifically in what ways can our academic centers work with our community practicing cardiologists? How can we collaborate with them to help better manage cardiovascular risk, in our type 2diabetes patients, and even just in our high-risk cardiovascular patients?

Dr. Das:
Thanks. I think one of the key things is that everybody should play to their strengths. So, the academic centers have a lot of people that spend a lot of time thinking about these trials, thinking about the research questions figuring out how to properly nuance the findings. And then these are the folks—and I'll include myself here—who then get together and collaborate with people across the country or across the world to develop care pathways expert recommendations, guidelines, etcetera. And I think that's really the contribution of the academic cardiologist here is really to spend a lot of time looking at some of the underlying data to help figure out how people are supposed to use this in practice. Now the issue on the practicing clinician community doc side really is the opposite, where they may not have dedicated time for didactics really at all built into their schedules. However, their clinical volumes are high, they see a ton of patients, they learn a lot more about sort of the pragmatic issues associated with these drugs. So, what's the best way to communicate between cardiologists and primary care doc? What's the best way to educate patients about how to useGLP1-RAs subcutaneously? Those are things that the community docs are going to have well in hand, because they're going to be good at it, and they're going to be doing a ton of it. And so I think that there's a bi-directional conversation here. I think a purely academic answer, that doesn't reflect real-world frontline perspective as much is gonna fall short. And then simultaneously a pragmatic, 'well this is all we're able to do because we're just really bandwidth-constrained,' is gonna miss some opportunities. So I think that there's a real natural synergy here. Everybody's trying to do the right thing for the patient. So, I think it's a real opportunity.

Dr. Sorrentino:
Well, just like your final thoughts on the pathway, it seems to me that you and the group that put this pathway together tried to think of a way to make it as simple as possible, which I think is probably what we all need with all these new agents coming out. And just looking at the summary graphic in the pathway the summary graphic says you identify a patient who's at risk, you optimize guideline-directed medical therapy, and then you start one of these agents. So, it looks like we're moving these agents much higher up in the armamentarium. Starting them really at the outset, in patients who are at higher risk. Is there a way that we can communicate that to not only our colleagues but to the community about how simple this algorithm really needs to be to just get these patients on these different medications?

Dr. Das:
Well, thanks for the kind words about the pathway. It was a lot of work over a lot of time, so I appreciate that it came across the way it was intended. And that was exactly what we were shooting for. So, we were shooting for simple and usable. The idea was not to come up with something to say, 'Well, in this study of 18 left-handed people from New Zealand, it showed X.' You know that's not very helpful. Instead to say, 'Well, we really have fantastic outcomes benefits in terms of preventing recurrent heart attacks, so these are drugs that should be at the top of your list.' And I think that your comment that you made was exactly right, which is these drugs really should bump their way to the top. We've been thinking very long about metformin, and other drugs in terms of glucose-lowering, but I would not think of these as glucose-lowering drugs at all, I would think of these as outcomes improving drugs, that, oh, by the way, happened to have an effect on glucose. So I think, the conceptual shift. And what it takes to get people in practice to start doing it, I think is, frankly, to just start doing it. I think that the concern or the hesitation that, 'Well, I don't want to do this, and I don't want to offend so and so or I don't want to cause a problem,' I think that the people that suffer from that are the patients. Because they're not going to get the therapies they need. And I've done that before. When I first started out, I would write a note in my cardiology recommendation saying, 'Hey, consider starting an SGLT-2 inhibitor, consider starting a GLP1-RA,' and I would find a lot of times that it just wouldn't happen because people look to the cardiologist as the expert on cardiovascular prevention. And so, if we're not prescribing it, then we're sort of sending a message whether we want to or not, that maybe there's a reason not to prescribe it.

So I think that really the way to do it is to sort of metaphorically rip off the Band-Aid and just start writing for the things and just communicate clearly. Number one, make sure the patient understands. And then number two communicate clearly with your collaborating docs that are all trying to help the patient. And what I found in practice is that general internist, etcetera, they love it. They have 15 things they have to cover at an office visit. They love the fact that I spent some time talking about this. So that saves them time that they can focus on other issues that are equally important.

Dr. Sorrentino:
Well, this has been a great discussion, Dr. Das. Thanks for providing these important insights into the 2020 ACC Expert Consensus Decision Pathway on these Novel Therapies for Cardiovascular Risk Reduction. It was great having you on the program today.

Dr. Das:
Well, thanks so much. I appreciate the invitation. I appreciate the opportunity to chat.

Announcer:
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