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Cardiovascular Risk Reduction for Adults With Type 2 Diabetes & ASCVD: A Collaborative Approach

ReachMD Announcer:
Welcome to *Heart Matters* on ReachMD. This episode is sponsored by Novo Nordisk. Here's your host, Dr. Charles Turck.

Dr. Turck:
Patients with type 2 diabetes may have a number of comorbidities that can complicate their treatment plan. These comorbidities could require not only endocrinologists, but also cardiologists, nephrologists, and primary care physicians to address all aspects of the disease. That's why on today's program, we'll explore collaborative care strategies to help improve patient care and to enhance our own approach to managing type 2 diabetes.

Welcome to *Heart Matters* on ReachMD. I'm Dr. Charles Turck, and joining me to share their perspectives are Dr. Matthew Budoff and Dr. Joshua Stolker. Dr. Budoff is Professor of Medicine at the David Geffen School of Medicine at UCLA in Los Angeles and an investigator at The Lundquist Institute in Torrance, California. Dr. Budoff, thanks so much for being on Heart Matters today.

Dr. Budoff:
Thank you for having me.

Dr. Turck:
And Dr. Stolker is an interventional cardiologist at Mercy Heart and Vascular, in Washington and Saint Louis, Missouri. Dr. Stolker, it's great to have you with us as well.

Dr. Stolker:
Thanks - pleasure to be here.

Dr. Turck:
So Dr. Budoff, let's start with you. From your vantage point as a cardiologist, why should clinicians consider a multidisciplinary approach to managing treatment decisions for patients with type 2 diabetes?

Dr. Budoff:
Well it's important to know that patients with type 2 diabetes, especially those with ASCVD, present to cardiologists much more often than to endocrinologists,[1] which is why I think there's an opportunity for this cross-collaborative care.[2,3] And what it really comes down to is the gap between the number of patients with type 2 diabetes versus the number of endocrinologists available, meaning we have a lot more cardiologists than endocrinologists practicing in the United States.[1] And with over 11 percent of the US population having type 2 diabetes,[4] there simply aren't enough diabetes specialists to provide appropriate care for these patients.

Dr. Turck:
And given what Dr. Budoff just discussed, Dr. Stolker, can you tell us a little bit about the implications and barriers this lack of diabetes specialists presents? In your opinion, do you see this impacting treatment for patients with type 2 diabetes and established cardiovascular disease, or CVD?

Dr. Stolker:
Well, yes. I've seen cardiologists reluctant to overstep boundaries into the territory that, traditionally, diabetes specialists like primary care physicians or endocrinologists have managed. You know, we cardiologists have been told for decades—by our mentors in training, by our partners in practice— "diabetes per Primary Care" or "diabetes per Endocrine." And because of this longstanding philosophy, the

overarching mentality for most cardiovascular practitioners is that it's not the cardiologist's responsibility to make recommendations about diabetes therapies.[2,3]

But at the same time, we have treatment options now with proven cardiovascular disease benefit. And nonetheless, you know, a recent study in a large US academic medical center from 2020 showed that 1.4 percent of patients were receiving an SGLT-2 inhibitor and 1.6 percent were receiving a GLP-1 receptor agonist,[2,3] despite the current guidelines from the American Heart Association, American College of Cardiology, and the American Diabetes Association recommending these drugs.[5-7]

So, you know, cardiologists generally lack familiarity about diabetes therapies, and particularly the newer drug classes, so we may be reluctant to prescribe these drugs, or to adjust existing diabetes medications.[2,3] And this, unfortunately, can result in therapeutic inertia, or the lack of timely treatment adjustment if treatment goals aren't met, since the person managing the diabetes, which is usually a primary care physician, is commonly bogged down with many other issues aside from adjusting diabetes medicines. In my opinion, this absolutely underscores the need for multidisciplinary care.[8]

Dr. Turck:
Thanks for walking us through those important considerations, Dr. Stolker. And if we come back to you, Dr. Budoff, how has this lack of collaboration affected your patients with type 2 diabetes?

Dr. Budoff:
My patients, especially those who have established cardiovascular disease and type 2 diabetes, are at a very high risk of experiencing cardiovascular events. And as a result, patient outcomes can suffer because of the therapeutic inertia that Dr. Stolker mentioned.[8] So, in addition to utilizing standards of care for treatment of CVD and diabetes, this is an incredible opportunity for cardiovascular practitioners and diabetologists to recognize and counsel patients with type 2 diabetes and established CVD on their cardiovascular risks and to prescribe guideline-directed therapies that can help both their diabetes and their CV event risks.[5-7]

Dr. Turck:
For those just tuning in, you're listening to *Heart Matters* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Matthew Budoff and Joshua Stolker about how we can take a collaborative approach when caring for patients with type 2 diabetes and ASCVD.

So Dr. Stolker, let's help break down some of those treatment barriers. What strategies or best practices can help us overcome collaborative-care challenges across specialties?

Dr. Stolker:
Ok, so first, cardiovascular clinicians must familiarize themselves and embrace the new guidelines that recommend this multidisciplinary approach to type 2 diabetes care in patients with atherosclerotic cardiovascular disease or those at high risk for cardiovascular disease. And that includes adding to our treatment armamentarium the SGLT-2 inhibitors and the GLP-1 receptor agonists with proven cardiovascular benefit—which, by the way, is defined by the American Diabetes Association as having a label indication for CVD benefit.[2,3]

Second, the cardiology practitioner should figure out how to implement this part of care for their patients with diabetes. Some people, like myself, have become quite comfortable prescribing these drugs, and adjusting other diabetes therapies if needed. Others may prefer to send notes to their, you know, diabetology or primary care colleagues, asking them to start appropriate therapies. And either way, the support of the cardiology community really helps bolster the prescription of appropriate therapies that have been shown to reduce this cardiovascular risk in patients with type 2 diabetes and established cardiovascular disease.[2]

I've also seen some successes within cardiometabolic clinics where cardiologists and diabetes specialists are working together with primary care physicians and sometimes even with nephrologists, pharmacists, and dieticians. It can really be a one-stop shop for patients with type 2 diabetes that's designed to help overcome some of this therapeutic inertia, and to get more of these type 2 diabetes patients with established cardiovascular disease on these medications with proven cardiovascular disease benefit.

Dr. Turck:
Those are some great suggestions, Dr. Stolker, thank you. Turning back to you now, Dr. Budoff, how do you go about balancing your own goals with other team members' priorities?

Dr. Budoff:
Well I think it's important to remember that in a truly collaborative environment, our universal overarching goals should always be to support patient care.[8] And in my experience, when patients and primary care physicians hear similar recommendations from different experts, use of, and adherence to, those therapies goes up dramatically. For example, if the endocrinologist is thinking about an SGLT-2

inhibitor or a GLP-1 receptor agonist with proven CVD benefit in a patient with type 2 diabetes and established CVD, and then I also advocate for one or both to my patient and his or her health care professional, then I think it's much more likely that he or she will embrace these therapies. So when everybody is in agreement, I feel this is a huge opportunity to get patients on the right treatments and to meet everyone's goals.

Dr. Turck:
Thanks, Dr. Budoff. Now we're almost out of time for today, but before we close, I'd like to hear some final thoughts from each of you on how we can optimize our multidisciplinary approach to help reduce cardiovascular risk in patients with type 2 diabetes and established CVD. Dr. Stolker, let's hear from you first.

Dr. Stolker:
Sure. Well, I really think the first step should be to embrace the new guidelines and recommendations. The urgency is real, and cardiovascular specialists need to collaborate with diabetologists and other clinicians to help optimize care by prescribing these glucose-lowering agents with a demonstrated cardiovascular benefit to their appropriate type 2 diabetes patients.[5]

Now I'm not in the business of driving down A1C values, and I'm not nearly as experienced as my diabetology colleagues, but by putting my patients on therapy, and at least getting the ball rolling with the initial prescription of a GLP-1 receptor agonist or an SGLT-2 inhibitor with proven cardiovascular disease benefit, then additional escalation for glycemic control can always be performed in the future when needed.

And as Dr. Budoff mentioned earlier, our number one goal should be to support patient care.[8] And I think implementing a cardiometabolic clinic atmosphere, where each member of the team is focused on improving patient outcomes, this is one way to achieve this important goal.

Dr. Turck:
Thanks, Dr. Stolker. And Dr. Budoff, I'll give you the final word.

Dr. Budoff:
Until we can close the type 2 diabetes patient/endocrinologist gap, a multidisciplinary approach to care is imperative. Now is the time for cardiologists to cross that line into diabetes care for patients with type 2 diabetes and ASCVD,[2,3] and the guidelines are encouraging us to do so.

I think the American College of Cardiology, American Heart Association, and American Diabetes Association have all really put forth straightforward recommendations that show we as cardiologists need to be involved in type 2 diabetes treatment. This gives us the chance to not only help to improve patient adherence, but to also put patients on therapies with proven CVD benefit in patients with type 2 diabetes and ASCVD.[9]

Dr. Turck:
Well with those best practices in mind, I want to thank my guests, Dr. Matthew Budoff and Dr. Joshua Stolker, for joining me to share their unique perspectives on this important topic. Dr. Budoff, Dr. Stolker, it was great having you both on the program.

Dr. Budoff:
It was a pleasure to be here.

Dr. Stolker:
Absolutely. Thank you for having me.

ReachMD Announcer:
This episode of *Heart Matters* was sponsored by Novo Nordisk. To access other episodes in this series, visit ReachMD.com/Heartmatters, where you can Be Part of the Knowledge. Thanks for listening!

References:
1. Romeo GR, Hirsch IB, Lash RW, Gabbay RA. Trends in the endocrinology fellowship recruitment: reasons for concern and possible interventions. *J Clin Endocrinol Metab*. 2020;105(6):1701-1706.

2. Adhikari R, Blaha M. New insights into prescribing of SGLT2 inhibitors and GLP-1 receptor agonists by cardiologists in 2020: major barriers limiting role. American College of Cardiology. Accessed January 5, 2022. https://www.acc.org/Membership/Person?id=bcd607bf-26aa-428d-93ab-af136d07f525.

3. Hamid A, Vaduganathan M, Oshunbade AA, et al. Antihyperglycemic therapies with expansions of US Food and Drug Administration

indications to reduce cardiovascular events: prescribing patterns within an academic medical center. *J Cardiovasc Pharmacol*. 2020;76:313-20.

4. Centers for Disease Control and Prevention. 2022 national diabetes statistics report: estimates of diabetes and its burden in the United States. Updated January 18, 2022. Accessed May 19, 2022. https://www.cdc.gov/diabetes/data/statistics-report/index.html.

5. Harris SB, Cheng AYY, Davies MJ, Gerstein HC, Green JB, Skolnik N. *Person-centered, outcomes-driven treatment: A new paradigm for type 2 diabetes in primary care*. Arlington (VA): American Diabetes Association; May 2020.

6. Das SR, Everett BM, Birtcher KK, et al. 2020 Expert Consensus Decision Pathway on novel therapies for cardiovascular risk reduction in patients with type 2 diabetes: a report of the American College of Cardiology Solution Set Oversight Committee. *J Am Coll Cardiol*. 2020;76(9):1117-1145.

7. American Diabetes Association. Standards of medical care in diabetes—2022. *Diabetes Care*. 2022;45(suppl 1):S1-S270.

8. Kleindorfer DO, Towfighi A, Chaturvedi S, et al. 2021 Guideline for the prevention of stroke in patients with stroke and transient ischemic attack: A guideline from the American Heart Association/American Stroke Association. *Stroke*. 2021;52(7):e364-e467.

9. Low Wang CC, Hess CN, Hiatt WR, Goldfine AB. Clinical update: cardiovascular disease in diabetes mellitus: atherosclerotic cardiovascular disease and heart failure in type 2 diabetes mellitus - mechanisms, management, and clinical considerations. *Circulation*. 2016;133(24):2459-2502.

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