Transcript Details

This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/heart-matters/evolving-interprofessional-care-models-assessing-the-management-of-t2d-patients-with-cvd-risk/12483/

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Evolving Interprofessional Care Models: Assessing the Management of T2D Patients with CVD Risk

Announcer Introduction
Welcome to Heart Matters on ReachMD. On this episode, sponsored by Novo Nordisk, we're joined by Dr. Erin Michos. Not only is Dr. Michos an Associate Professor of Medicine, but she's also the Director of Women's Cardiovascular Health and the Associate Director of Preventive Cardiology at Johns Hopkins Medicine in Odenton, Maryland. Dr. Michos joins us to discuss the evolving interprofessional care models in the management of type 2 diabetes patients who are at risk of cardiovascular disease. Here's Dr. Michos now.

Dr. Michos:
Great. So we're seeing an emergence, which I think is a really good thing. The development of these dedicated cardiometabolic clinics. So these are driven by preventive cardiology in collaboration with endocrinology, primary care, nephrology, that includes not only the physicians but includes advanced practice providers, uh, such as nurse navigators we have nutritionists, exercise physiologists, pharmacists, individuals who have experience with forms to help out with some of the paperwork. Really a comprehensive focus not only to get patients on these important diabetes medicines, these GLP1 receptor agonists and SGL2 inhibitor SGL2 inhibitors which have meaningful cardiovascular outcome reduction but also for comprehensive cardiovascular risk reduction, including management of lipids, blood pressure, smoking cessation, diet physical activity, other lifestyle counseling.

So the reason why this is so important, as data suggests that a handful of patients with diabetes are really getting guideline-directed medical therapy. A study by Dr. Arnold in 2019, using the GOLD registry suggested that less than 10% of patients with diabetes are getting guideline-directed SGL2 inhibitors and GLP1 receptor agonists. So it's really this gap in treatment implementation. And cardiologists like myself, it's estimated that we're prescribing you know, less than 2% of SGL2 inhibitors and GLP1 receptor agonists. Endocrinologists are more likely to prescribe these but when we consider that in the United States, there's over 34 million individuals with diabetes and only 7,500endocrinologists, that's approximately 4,500 patients with diabetes per a single endocrinologist. So clearly, we need other specialties to get on board and collaborate with endocrinologists. You know, the number of cardiologists outnumber endocrinologist by threefold. And patients with diabetes are three times more likely to see a cardiologist than an endocrinologist, and patients with diabetes and cardiovascular disease are five times more likely to encounter cardiology. So we really need to have cardiologists on board and feel comfortable with prescribing these SGL2 inhibitors and GLP1 receptor agonists that can have meaningful you know, outcome reduction in our patients and reducing major adverse cardiovascular events and heart failure hospitalizations, as well as decreased progression of diabetic kidney disease, particularly with the SGL2 inhibitors.

So I think that there's a lot of benefits of having a cardiometabolic clinic. I think it's good for patients, it's good for clinicians, and it's good for the healthcare system and reducing costs. That with adequately trained staff, they can teach patients how to give themselves injections and how to deal with side effects. Pharmacists can help guide, adjusting doses of both these drugs and other medications, and having our trained dieticians and an exercise physiologist help give lifestyle advice. And again, as I mentioned before, we can focus on comprehensive cardiovascular risk reduction. So we're really trying to harmonize and unify cardiometabolic management in one overarching clinic. And so I think this will help overcome clinical inertia, get more patients on these proven treatments, improve treatment consistency, and further reduce healthcare costs by avoiding these major adverse cardiovascular events.

Announcer Close
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