



Working Together:
**Addressing
Cardiometabolic Risk**
in Underserved Populations

Steering Committee



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Disclosures

- Eden Miller, DO does research support for Abbott. She serves as a consultant and is on the speakers bureau for Abbott, Bayer, BI, Corcept Therapeutics, Embecta, Eli Lilly, Insulat, and Novo Nordisk.
- Jay Shubrook, DO does non-CE consulting for Abbott, Bayer, Eli Lilly, Madrigal, Novo Nordisk, and Sanofi, and receives royalties from Wolters Kluwers.
- Kevin Miller, DO does research support for Abbott. He serves as a consultant for Biolinq and Novo Nordisk.
- Kenneth Frye, DO has no relevant financial disclosures.
- **All content was reviewed by a non-conflicted content reviewer to ensure that it is not commercially biased, is fair and balanced, and is based on scientific evidence and/or clinical reasoning**

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Accreditation



[CME Information](#)

Accreditation Statement

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Learning Objectives

- Discuss with patients the health risks associated with cardiometabolic risk factors, including the benefits of early intervention
- Commit to utilizing available patient-centered strategies for risk assessment and multidisciplinary care for patients who may be at risk for cardiometabolic disorders such as diabetes, obesity, CVD, and CKD
- Outline to patients the available therapeutic approaches which may positively impact their risk for development of cardiometabolic disease



Agenda

1

Guess What?

Communicating the Importance of Addressing Risk Now

2

So What?

Explaining Cardiometabolic Risk Assessment

3

Now What?

Discussing Treatment Options with Patients

4

Key Takeaways and Wrap Up





Guess What?
Communicating the
Importance of
Addressing Risk Now

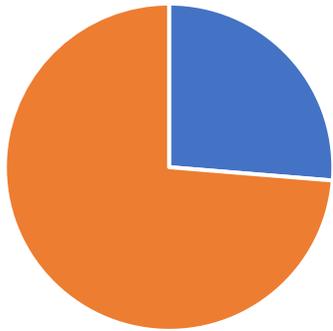


Dr. Martinez is discussing cardio-renal-metabolic risk factors with Mr. Garcia, a 45-year-old Hispanic patient. Mr. Garcia has recently been diagnosed with hypertension (BP: 145/95 mmHg) and prediabetes (HbA1c: 6.3%). His BMI is 32, indicating obesity, and his LDL cholesterol is slightly elevated at 130 mg/dL.

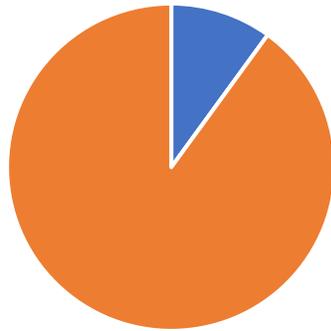
Which of the following statements best communicates to Mr. Garcia the benefits of addressing his cardio-renal-metabolic (CRM) risk factors?

Cardio-Renal-Metabolic Disease Accounts for 1 in 3 Deaths in the US

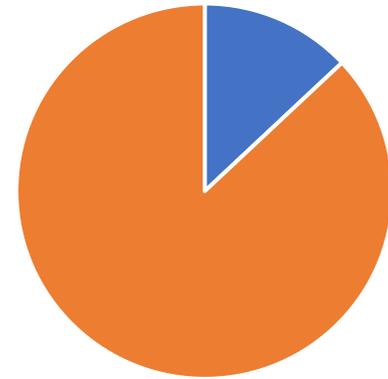
**26% of adults have at
least 1 CRM condition**



**9%-11% have coronary
vascular disease**



13% have diabetes



Serial cross-sectional US data 2015-2020; N = 11,607 non-pregnant adults (≥ 20 years)

Ostrominski JW, et al. *JAMA Cardiol.* 2023;8(11):1050-1060.



What Is Cardio-Renal-Metabolic Disease?

- “A systemic disorder characterized by pathophysiological interactions among metabolic risk factors, chronic kidney disease (CKD), and the cardiovascular system, leading to multiorgan dysfunction and a high rate of adverse cardiovascular outcomes”
- Also known as cardio-kidney-metabolic (CKM)



Who Is at Risk for CRM Disease?



Individuals at risk for cardiovascular disease (CVD) due to the presence of metabolic risk factors, CKD, or both

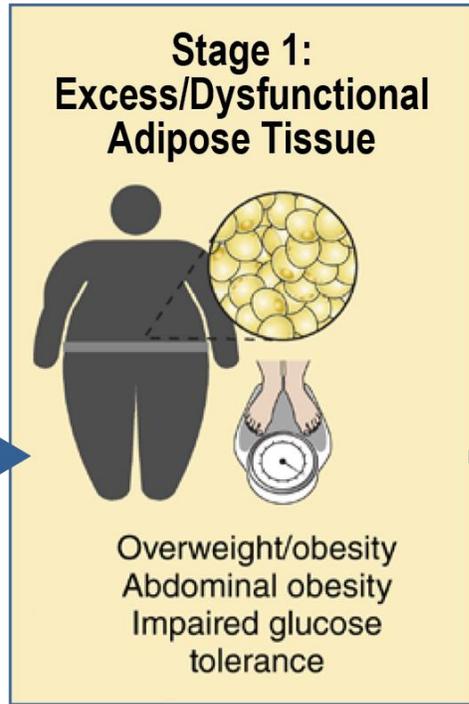


Individuals with existing CVD that is potentially related to or complicates metabolic risk factors or CKD

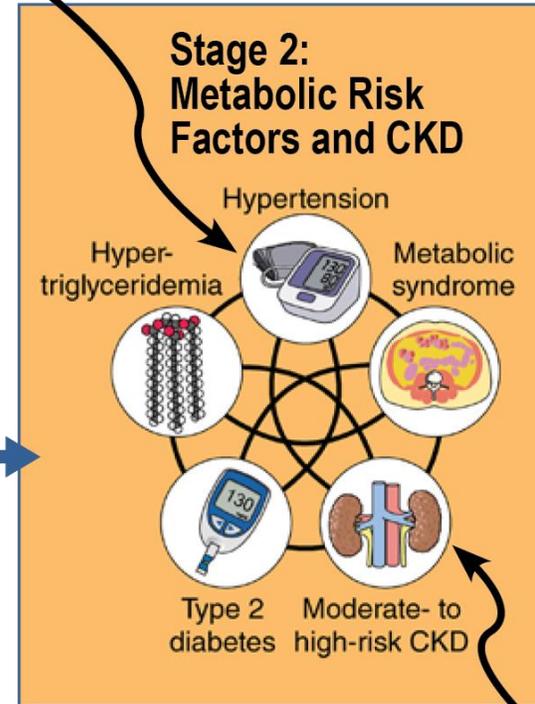


Stages of CRM

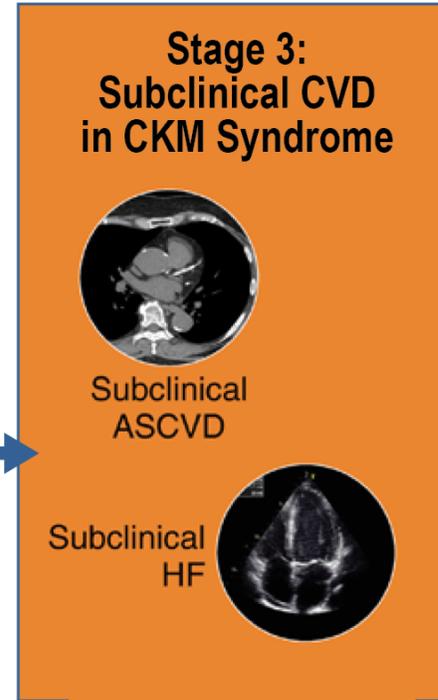
Stage 0: No Risk Factors



Nonmetabolic etiologies of hypertension

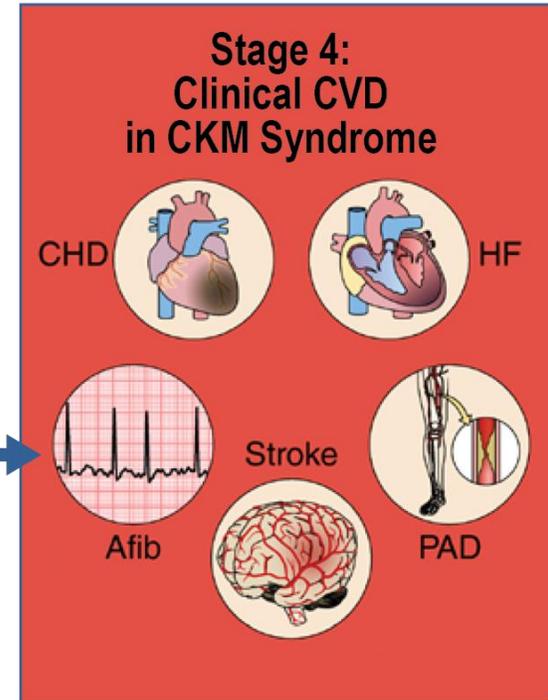


Nonmetabolic etiologies of CKD



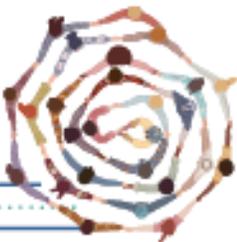
Risk equivalents of subclinical CVD in CKM Stage 3:

- Very high risk CKD (G stage 4 and 5 CKD or by KDIGO heat map)
- High predicted risk for CVD using risk calculator



CKM, cardiovascular-kidney-metabolic

Ndumele CE, et al. *Circulation*. 2023;148(20):1606-1635.





Poll #1: Approximately what percentage of persons with prediabetes are aware of their diagnosis?



Poll #2: Which of the following statements are true? (select all that apply)

Case: Patient Description

- A 52-year-old African American female presents as a new patient to your ED. She shares that she was diagnosed with T2D about 5 years ago and is concerned about elevated blood sugars at home.
- **PMH:** T2D, HTN, hyperlipidemia, obesity
- **Social History:** Non-smoker, No ETOH
 - She is an accountant working 40-45 hours per week; she moved from a big city to a suburb to take a job promotion
 - Married and lives with her husband and has two teenage daughters
 - **Exercise:** walks the dog once or twice a week, about 1 mile
 - **Diet:** eating out more due to her busy schedule



Case: Patient Description

- **Family History:**
 - **Father** is 76, living, MI at 72, no diabetes
 - **Mother** is 75, living, has diabetes (she reports her mother has swelling and burning in her feet and heart failure)
 - **Siblings:** brother has prediabetes, obesity; sisters: T2D, obesity; sister: healthy, slim
- **Medications:** Losartan 50 mg, simvastatin 10 mg, metformin 1,000 mg bid
- **Allergies:** no medication, food, or latex allergies



Case: Physical Exam and Labs

- **Physical Exam**

- **Vitals:** BMI 31.5, BP 138/90, pulse 82
- She is noted to have truncal obesity, acanthosis is noted at her neckline, and she has mild edema at the ankle

- **Laboratory Values**

- HbA1c 7.4% (performed 6 months ago)
- eGFR > 60 ml/min
- Creatinine 1.0 mg/dl
- CMP AST 48, ALT62
- Platelets 210
- Glucose 160 mg/dl
- Other values on the CMP are WNL



Cardio-Renal-Metabolic Risk Factors

Obesity

Hypertension

Insulin
resistance/
hyperglycemia

Dyslipidemia

Chronic kidney
disease

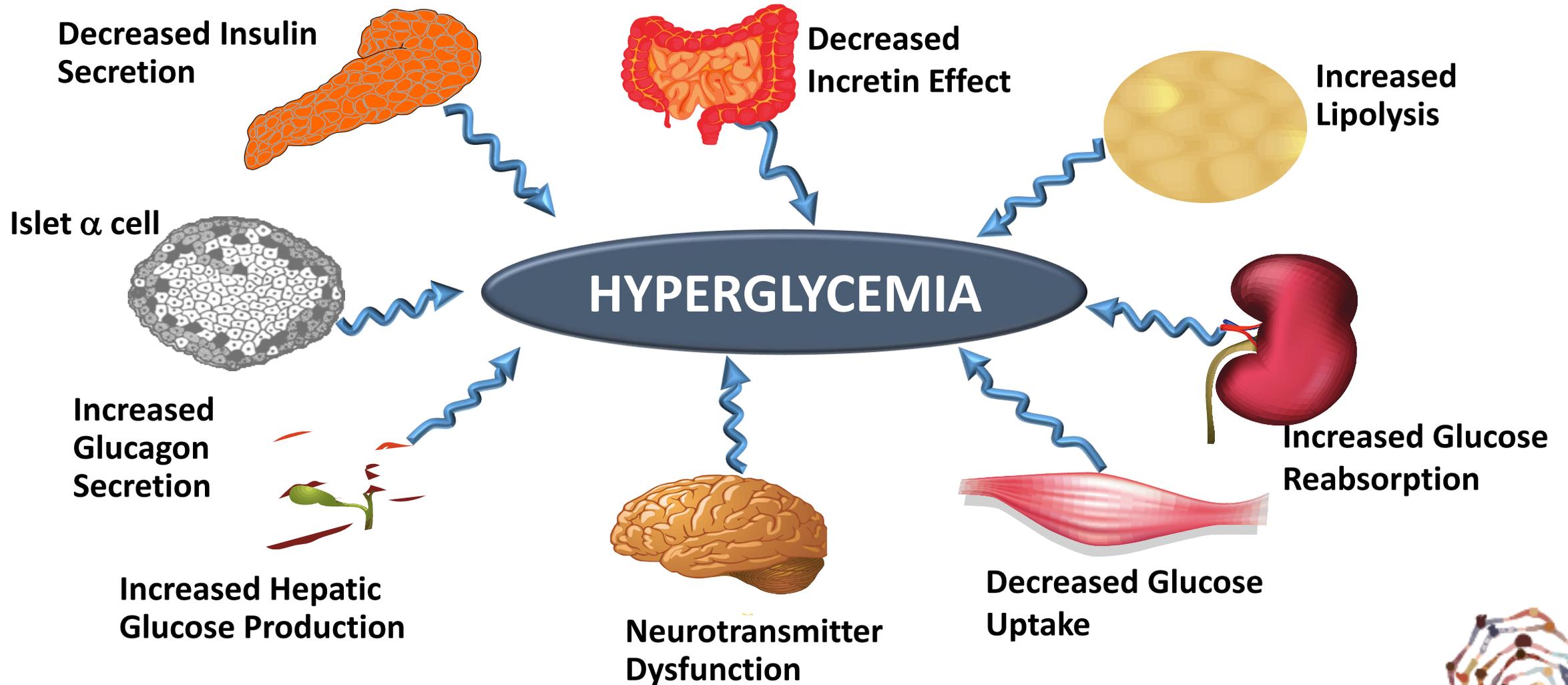
Physical
inactivity

Smoking

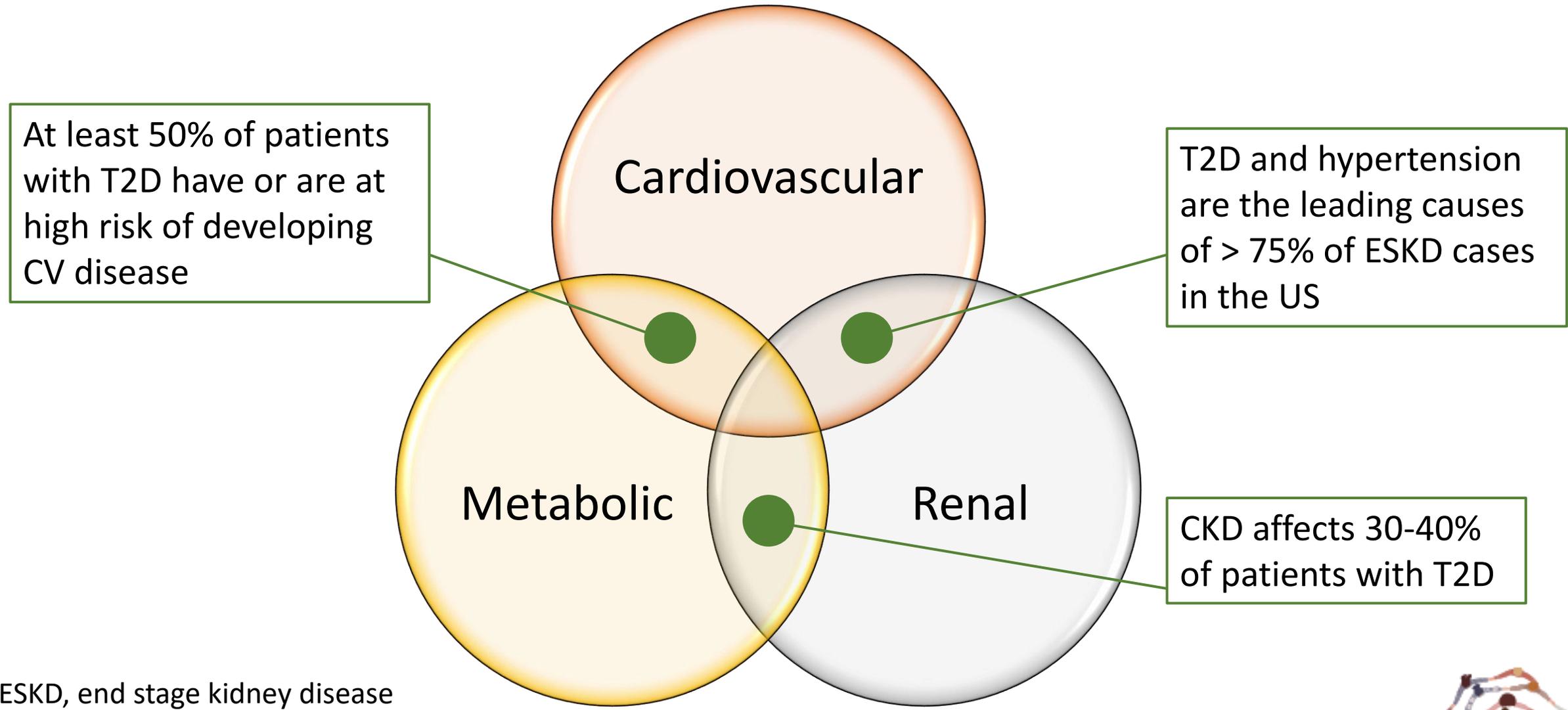
Unhealthy
eating



A Look Inside the Prediabetic Body

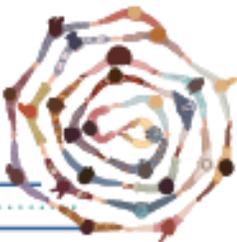


Coexistence of Cardio-Renal-Metabolic Systems

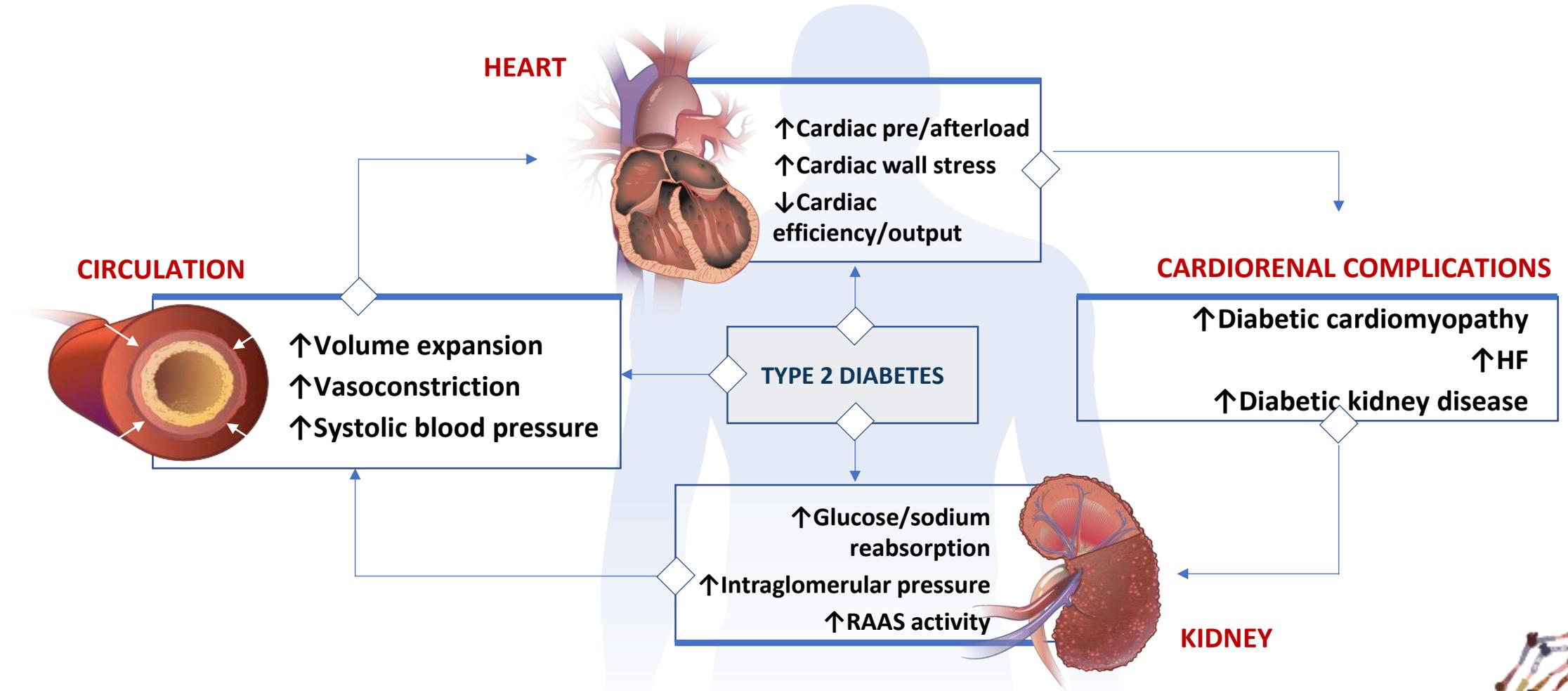


ESKD, end stage kidney disease

Wong K, et al. *J Diabetes Complications*. 2012;26:169-174; Feng X, et al. *Kidney Med*. 2022;4(1):100385; Burrows NR, et al. *MMWR Morb Mortal Wkly Rep*. 2022;71(11):412-415.



Bidirectional Pathophysiological Interaction Between Kidney and Heart in T2D



Mazidi M, et al. *J Am Heart Assoc.* 2017;6(6):e004007; Muralidaran Y, et al. *J Diabetes Metab.* 2015;6:10; Sattar N, et al. *Diabetologia.* 2016;59(7):1333-1339; Sattar N, et al. *Circulation.* 2018;138:7-9; Wanner C, *Am J Cardiol.* 2017;120(1S):S59-S67;



Initiating Conversations With Patients About Risk Factors



Communicating CRM Risk to Patients: Key Points to Convey



Explain

- **Explain the synergistic effect** of combined risk factors (hypertension, prediabetes, obesity, dyslipidemia)

Emphasize

- **Emphasize increased risk** for both cardiovascular and kidney diseases

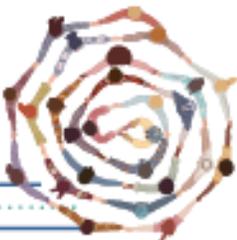
Stress

- **Stress the importance** of addressing all risk factors promptly

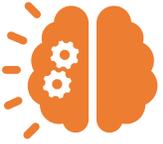
Tailor

- **Tailor the discussion** to the patient's specific risk profile and ethnic background

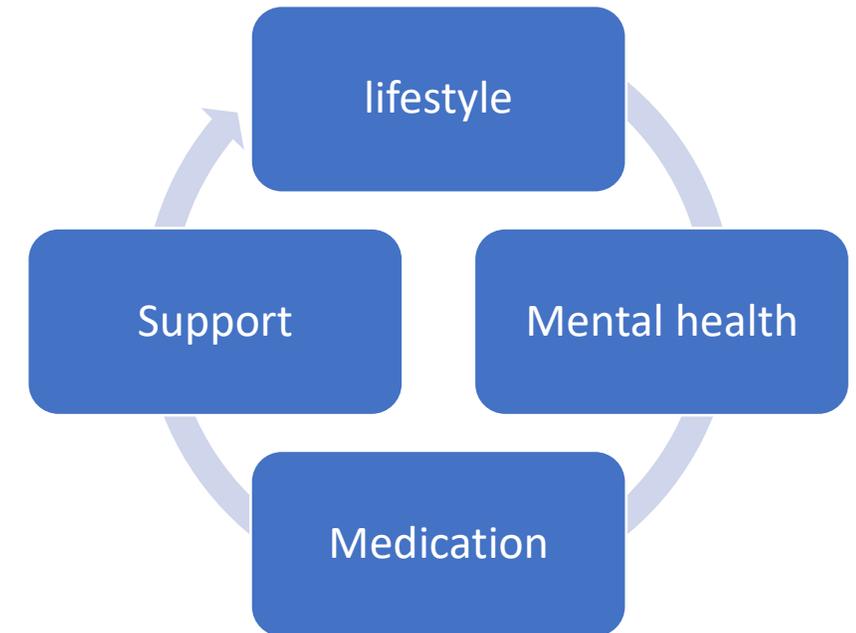
"Your combination of high blood pressure, elevated blood sugar, and obesity significantly increases your risk for both heart and kidney problems. By addressing all these factors now, we can work together to prevent serious complications and improve your overall health."



Information to Communicate to Patients About CRM Risk



- **Clearly** state the increased health risks associated with the patient's condition
- **Help patients understand** how different risk factors are interconnected (use teach back)
- **Focus on the benefits** of early, comprehensive intervention
- **Don't downplay the seriousness** of multiple risk factors, even if individual factors seem mild
- **Invite patients to participate** in developing their treatment plan (shared decision-making)

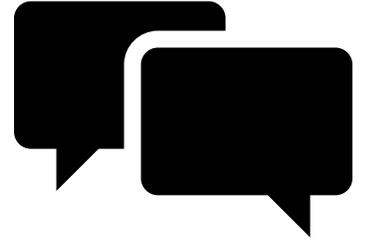




Dr. Martinez is discussing cardio-renal-metabolic risk factors with Mr. Garcia, a 45-year-old Hispanic patient. Mr. Garcia has recently been diagnosed with hypertension (BP: 145/95 mmHg) and prediabetes (HbA1c: 6.3%). His BMI is 32, indicating obesity, and his LDL cholesterol is slightly elevated at 130 mg/dL.

Which of the following statements best communicates to Mr. Garcia the benefits of addressing his cardio-renal-metabolic (CRM) risk factors?

Interaction/Discussion



- How do you begin the CRM conversation with patients?
- What has worked for you?
- Do you have any great strategies?





So What? Explaining Cardiometabolic Risk Assessment



Dr. Patel is treating Mr. Thompson, a 60-year-old male with multiple cardio-renal-metabolic risk factors: obesity (BMI: 34), hypertension (BP: 146/92 mmHg), elevated HbA1c (6.7%), and microalbuminuria (uACR: 45 mg/g). Mr. Thompson has limited health literacy and expresses frustration with his previous experiences in the healthcare system.

In addition to screening for and addressing socioeconomic factors, which of the following would be most effective in managing Mr. Thompson's cardio-renal-metabolic risk?

Case: Risk Factors for CRM

- 52-year-old female with inability to lose weight
 - History of T2D, HTN, mixed dyslipidemia, obesity (BMI 31.5)
 - Physical exam findings of obesity, insulin resistance, and fluid retention
 - A1c 7.4%
 - eGFR > 60 ml/min, UACr > 30 mg/g
 - Fib- 4 index 1.51 (MASH increased risk)





Poll #3: Which of the following do you use to screen for CRM risk in your practice? Select all that apply.

CRM Risk Assessment Strategies

- Tools to screen for CRM risk
 - BMI
 - Waist circumference
 - Blood pressure
 - HbA1c/eAG
 - Urine albumin-creatinine ratio (uACR)
 - High-sensitivity C-reactive protein (hs-CRP)
 - Lipoprotein a (Lp[a])



Patient Education About Assessments

Increase Patient Knowledge and Promote Understanding

- Recognize obesity, diabetes, cardiovascular, kidney, and other cardiorenal and metabolic diseases as chronic conditions
 - Types of diabetes, lipid disorders, etc
 - Vascular complications
 - Risk factor monitoring: BP, glucose, lipids,
 - eGFR + UACR
- Exams and tests to expect for eyes, kidney, heart, liver, feet, hearing
- “Know and understand your numbers”: BMI, A1C, TIR, FPG, BP, LDL-C, ApoB, TG, HDL-C, non-HDL-C, FIB-4, eGFR, UACR
- Treatment options: lifestyle, pharmacologic, surgical/invasive interventions
- Health-related technology (apps, wearables, etc)
- Healthcare systems and reimbursement

A1C = hemoglobin A1C (HbA1c); ApoB = apolipoprotein B; BMI = body mass index; BP = blood pressure; eGFR = estimated glomerular filtration rate; FIB-4, fibrosis 4 calculation; FPG = fasting plasma glucose; HDL-C = high-density lipoprotein cholesterol; LDL-C = low-density lipoprotein cholesterol; TG = triglycerides; TIR = time in range; UACR = urine albumin-creatinine ratio.

Shared Decision Making

- Elicit patient's priorities
- Emphasize early and aggressive treatment
- Ask open-ended questions
- Affirm personal challenges and goals
- Encourage belief patient can control health outcomes

Dos and Don'ts

- Do provide education every clinic visit
- Don't try to cover all topics at once
- Do repeat and reinforce
- Don't be judgmental

Tailor to Individual Patient

- Evaluate and consider health literacy
- Account for socioeconomic factors and other social determinants of health

Improve Adherence



Explaining Assessments to Patients: Examples

- Explain in plain language all the different test and examinations that a patient might undergo
- Ensure that patients “know their numbers,” what they mean for their health, and the target/goal for the patient

Parameter	What It Tells Us	What's Normal	What's Risky	Goal
BMI	Whether your weight puts you at risk for other diseases	18 to 25	≥ 30	Lower
Waist circumference	Measures how much fat is around your stomach area; too much puts you at risk for other diseases	Women ≤ 88 cm (35") Men ≤ 102 cm (40")	More than these	Lower
HbA1c	How well your diabetes is controlled overall	< 5.7	> 6.5 or 7 or 7.5*	Lower
eGFR	How well your kidneys are working	> 90	< 60	Higher (or stay the same)

*HbA1c goal between 6.5 and 7 for most people with T2D. ≥ 7.5 for older adults with comorbidities

Handelsman Y, et al. *Metabolism*. 2024;159:155931.



Explaining Assessments to Patients: Examples

- Using a spot glucose in the Emergency Department, ideally fasting, can be used as a rough surrogate for HbA1c.
- This surrogate comparison could provide an opportunity for emergency physicians to engage early and implement impactful change, significantly influencing the course of patient care throughout a patient's lifetime.

Table 1

HbA1c (%)	eAG (mg/dL)	eAG (mmol/l)
5	97	5.4
6	126	7.0
7	154	8.6
8	183	10.2
9	212	11.8
10	240	13.4
11	269	14.9
12	298	16.5

*Table available at:

<https://ngsp.org/A1ceAG.asp>



Multidisciplinary Care: Why and How?



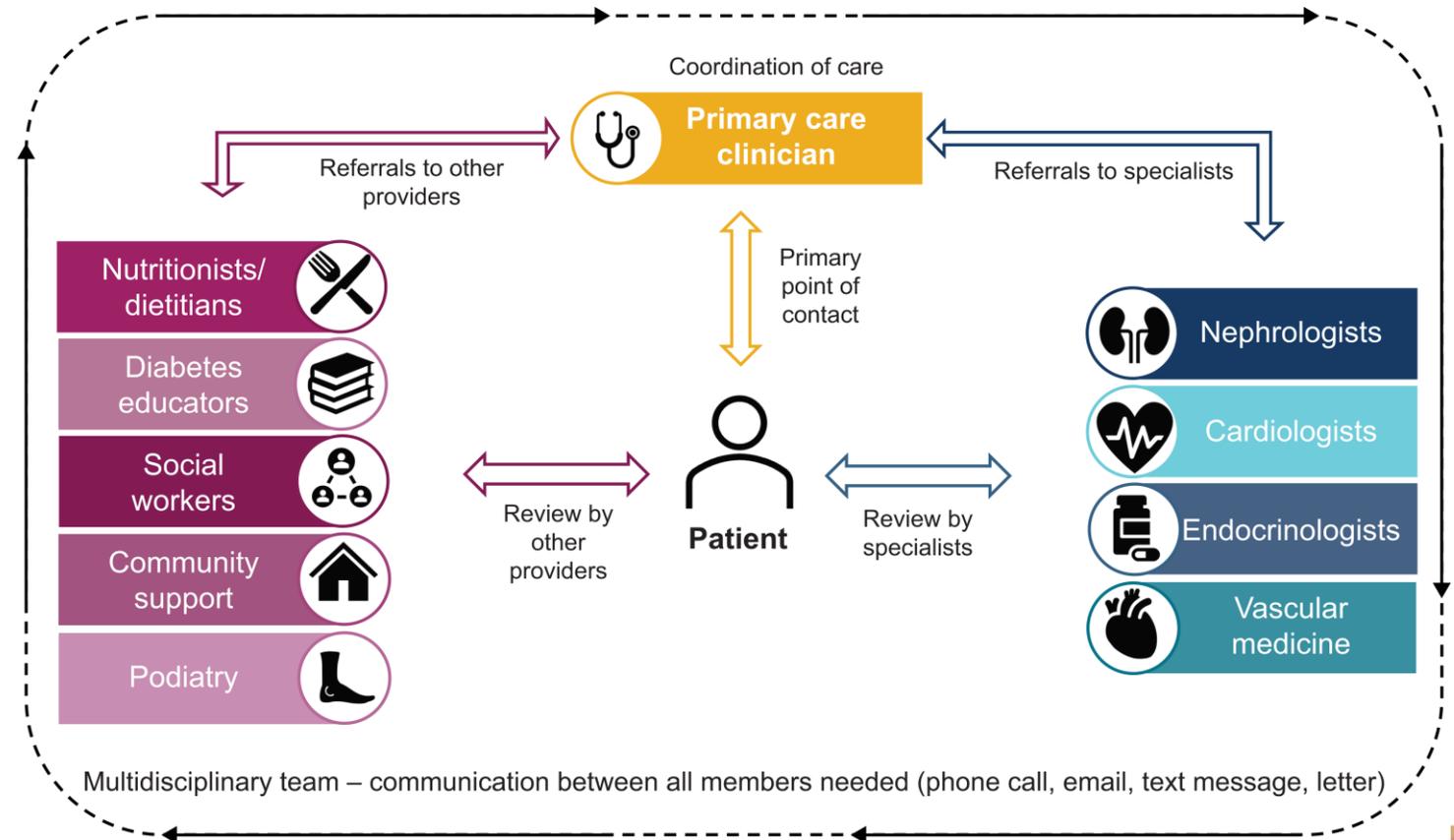
- Most US adults have multiple chronic conditions
- Office visits are often too short to fully address them, leading to overflow into ED care spaces
- **Ways to improve care:**
 - Involve a team and/or the patient's PCP
 - Assist office staff in identifying CRM risks and enhancing documentation of these risks (when applicable)
 - Create a unified message across care teams
 - Identify a CDCES in your area and refer all persons with diabetes (if available)
 - Have frequent touch points
- Create a CRM journal club of colleagues in your area to engage in EBM
- Be aware of and post community events and resources for healthier living



Multidisciplinary Care for Patients With CRM Disease



- Office staff
- Certified diabetes care and education specialist (CDCES)
- Nutritionist/dietitian
- Social worker
- Cardiologist
- Nephrologist
- Obesity specialist
- Diabetologist
- Endocrinologist
- Emergency Physicians





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In addition to screening for and addressing socioeconomic factors, which of the following would be most effective in managing Mr. Thompson's cardio-renal-metabolic risk?



Now What? Discussing Treatment Options With Patients



According to the ADA standards of care, which medications are considered first line for people with T2D and increased cardiovascular disease (CVD) risk?

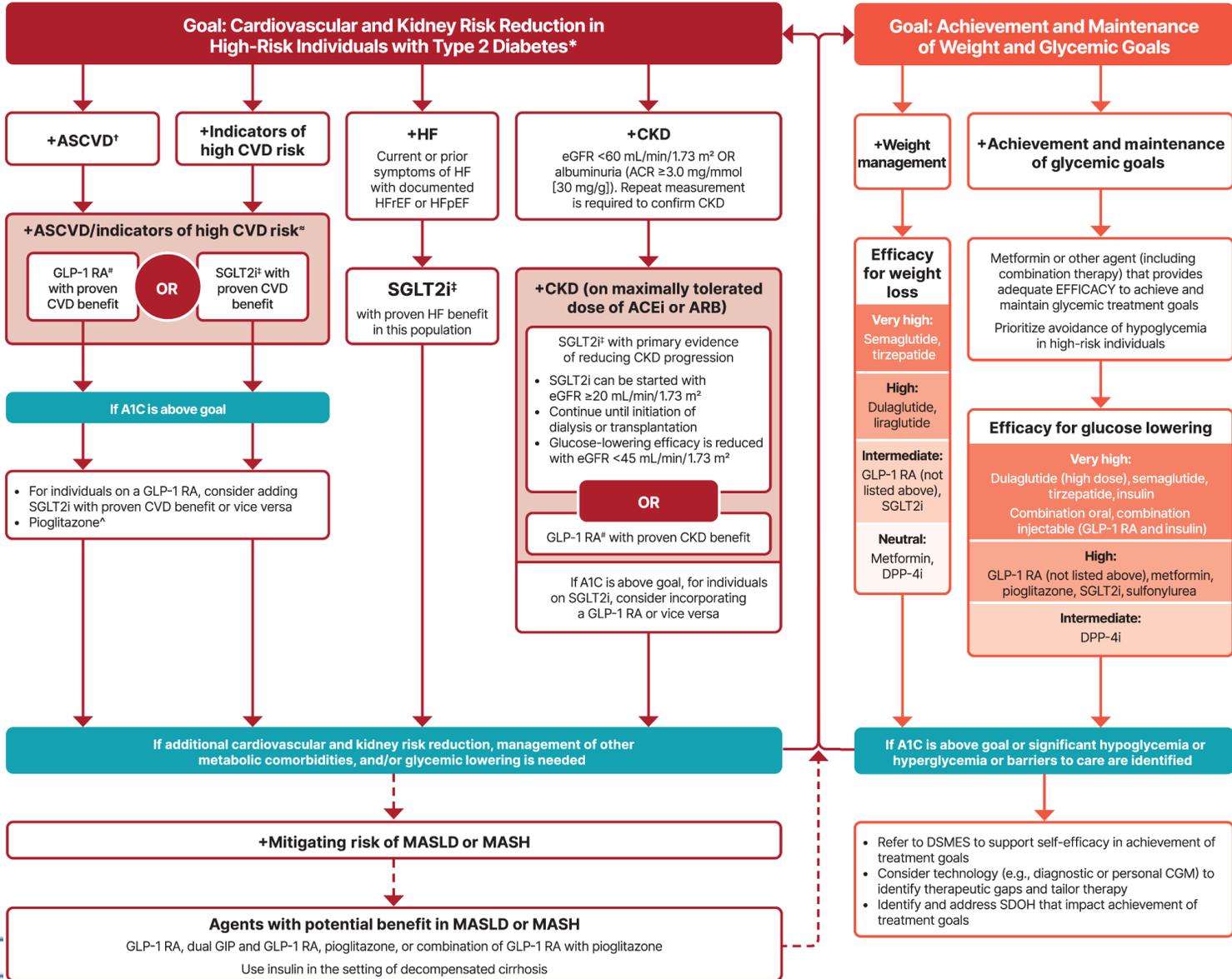
Case: Recap

- A 52-year-old African American female who was diagnosed with T2D about 5 years ago
- **PMH:** T2D, HTN, hyperlipidemia, obesity
- **Medications:** Losartan 50 mg, simvastatin 10 mg, metformin 1,000 mg bid
- T2D under good control but she is concerned about her inability to lose weight

How will you set her up for a successful outcome?



Glucose-Lowering Medications in the Management of T2D

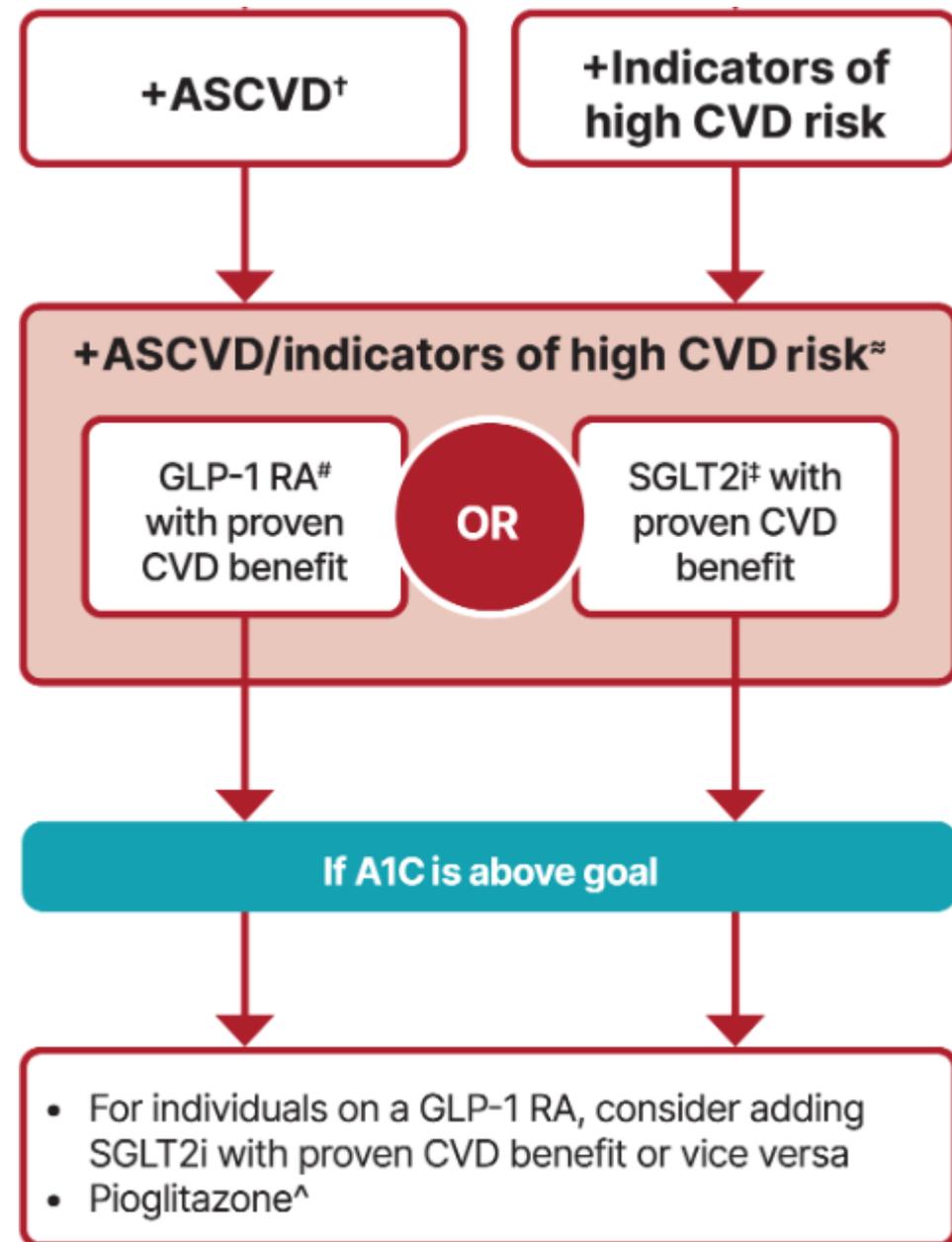


Patients With T2D and ASCVD or High CVD Risk

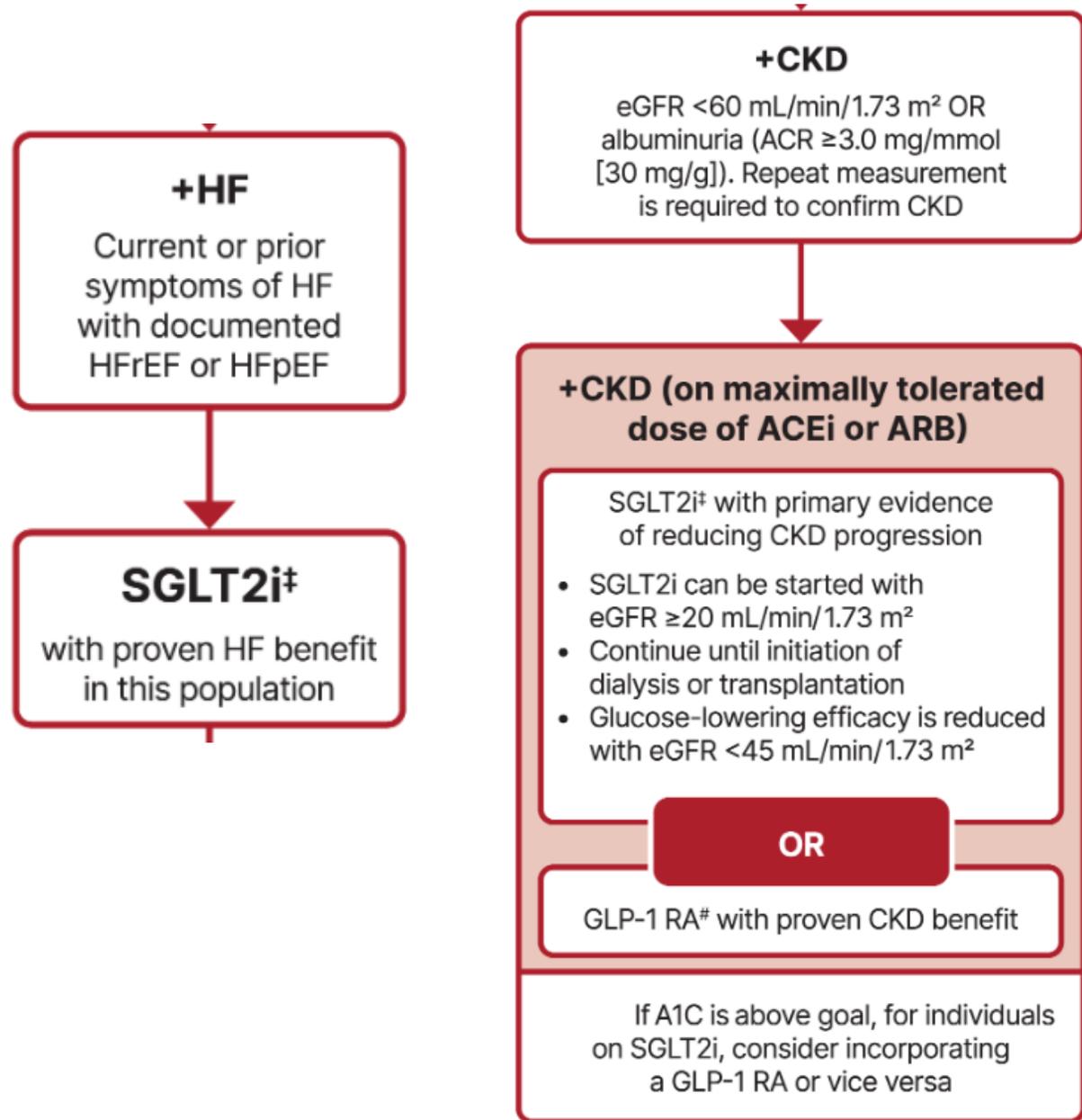
Most common definition of indicators of high risk:

- ≥ 55 years of age with 2 or more additional risk factors
- Risk factors: obesity, hypertension, smoking, dyslipidemia, albuminuria

American Diabetes Association Professional Practice Committee. *Diabetes Care*. 2025;48(Supplement_1):S181-S206.



Patients With Heart Failure or Diabetic Kidney Disease





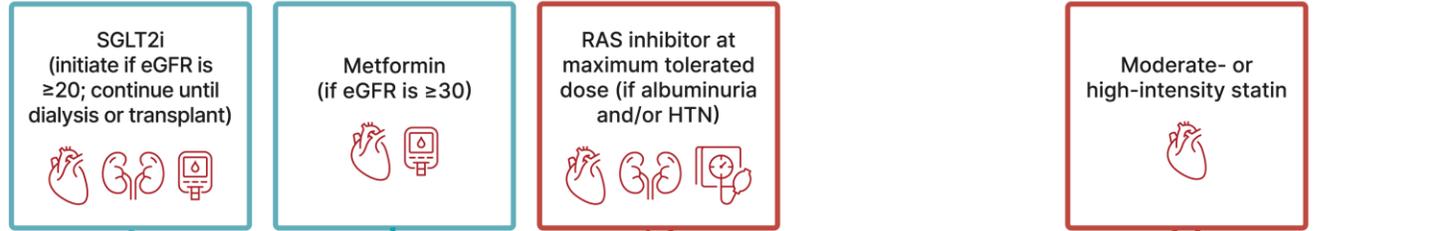
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Lifestyle and Medications for Improving Outcomes in Diabetes and CKD

LIFESTYLE

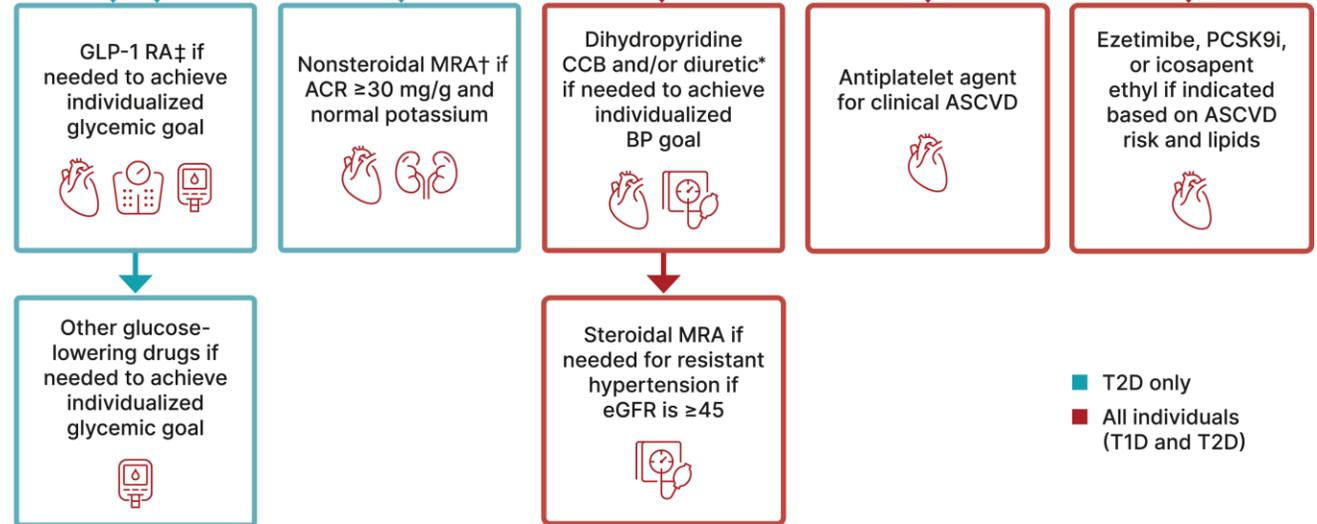


FIRST-LINE DRUG THERAPY

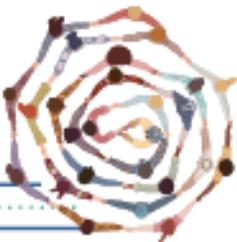


Regular reassessment of glycemia, albuminuria, BP, CVD risk, and lipids

ADDITIONAL RISK-BASED THERAPY



■ T2D only
■ All individuals (T1D and T2D)



Discussion: Practical Tips for Successful Patient Outcomes



- How do you partner with your patients to select the right medication(s) for them?
- How would you explain the options to them?
- What treatment approaches might be best for this patient case and why?
- What questions might this patient have?



Case: CRM Care Options

Current Medications: Losartan 50 mg, simvastatin 10 mg, metformin 1,000 mg bid



Add GLP-1 RA/GIP-GLP-1 RA maximum dose to metformin

- 1.2-2.1% A1c reduction
- 8-20% body weight reduction secondary
- Dual CV and renal benefit with specific GLP-1 RA
- Lipid and BP lowering

Add SGLT2i maximum dose to metformin

- 0.6-0.8% A1c reduction
- All options carry some type of cardiovascular, HF, and renal benefit
- Small blood pressure lowering

Discontinue metformin; add GLP-1 RA and SGLT2i

- 1.6-2% A1c reduction
- Secondary weight reducing effect with both agents
- Dual CV and renal benefit
- Lipid and BP lowering

Jastreboff AM, et al. *N Engl J Med*. Published online November 13, 2024. doi:10.1056/NEJMoa2410819; Sorli C, et al. *Lancet Diabetes Endocrinol*. 2017;5(4):251-260; Zinman B, et al. *Lancet Diabetes Endocrinol*. 2019;7(5):356-367; Zinman B, et al. *N Engl J Med*. 2015;373(22):2117-2128; Anker SD, et al. *N Engl J Med*. 2021;385:1451-1461; Packer M, et al. *N Engl J Med*. 2020;383(15):1413-1424; Heerspink HJL, et al. *N Engl J Med*. 2020;383:1436-1446; Solomon SD, et al. *N Engl J Med*. 2022;387:1089-1098; Wivott SD, et al. *N Engl J Med*. 2019;380:347-357; Anderson JE. *Diabetes Spectr*. 2020;33(2):165-174.



Side Effects and Safety Considerations

Medication	Common Side Effects	Possible Safety Considerations
GLP-1 RA GIP/GLP-1 RA	<ul style="list-style-type: none"> Gastrointestinal side effects—nausea, vomiting, diarrhea, esophageal reflux, constipation, abdominal pain 	<ul style="list-style-type: none"> Hypoglycemia with concomitant use of insulin or sulfonylurea Use caution in people with kidney disease when initiating or increasing dose Pancreatitis reported in clinical trials, discontinue if suspected Black box warning: do not use if personal or family history of medullary thyroid cancer or multiple endocrine neoplasia type 2
SGLT-2i	<ul style="list-style-type: none"> Genital mycotic infection Urinary tract infections Volume depletion 	<ul style="list-style-type: none"> Lower threshold of ketoacidosis Pyelonephritis
nsMRA (finerenone)	<ul style="list-style-type: none"> Hyperkalemia 	<ul style="list-style-type: none"> Monitor serum potassium levels especially in people with CKD and T2D

American Diabetes Association Professional Practice Committee. *Diabetes Care*. 2025;48(Supplement_1):S181-S206; Braunwald E. *N Engl J Med*. 2022;386(21):2024-2034; Karagiannis T, et al. *Diabetologia*. 2022;65(8):1251-1261; Nicholas SB, et al. *J Nephrol*. 2024;37(8):2223-2232.



Managing Medication Side Effects: GLP-1 RA

Managing Side Effects

- Dose titrate according to the label monthly
- Hold a lower dose longer if needed
- Avoid during pregnancy and nursing

Educating Patients

- Avoid overeating—stop the moment you feel full
- Eat small, low-fat meals, and avoid high carbohydrate liquids
- Hold 1 week prior to surgery
- Call HCP if excessive GI loss through nausea, vomiting, or diarrhea
- Remind about good hydration and nutrition when reducing calories

HCP, health care professional



Managing Medication Side Effects: SGLT-2i and nsMRA

Managing Side Effects

SGLT-2 inhibitors

- Genital infections
 - If in doubt culture to check it out
- DKA-relative insulin deficiency given metabolic needs
 - Always work up for T1D

nsMRA

- Monitor potassium at baseline to confirm that it is less than 5 and again 4-6 weeks after initiating treatment
- Avoid strong CYP3A4 inhibitors

DKA, diabetic ketoacidosis

Pozzi A, et al. *Heart Fail Rev.* 2024;29(1):207-217.

Educating Patients

- SGLT-2 inhibitors
 - Practice good peri-care
 - Use barrier creams and bidet
 - If any body part turns purple, contact HCP
 - Reduce carbohydrates
 - Hydrate well and watch for UTIs
- nsMRA
 - Contact HCP if muscle weakness, fatigue, or palpitations occur





Takeaways



Key Points to Remember

- CRM risk is interconnected
 - Obesity drives inflammation
 - CKD increases CV risk
 - MASLD is emerging as a new cardiometabolic condition
- CRM management requires treating the whole person, as well as current and future health
- A multidisciplinary team approach can improve management and outcomes
- Interventions exist that have proven benefits for CRM risk and impact more than one condition
- Implement the standards of care that support CRM intervention





Tips for Your Clinical Practice

Make

- Make a CRM intervention (risk identification, lifestyle support, barrier busting, and therapeutic consideration) at each patient encounter
 - Use the EHR to remind you of screenings

Ensure

- Ensure that patients understand their risks, treatment targets, treatment side-effects, and when to contact you

Choose

- Choose interventions that impact multiple conditions

Celebrate

- Celebrate with your patients as you address and improve T2D and obesity with CRM deliberation



Clinical Companion Toolkit

Please download the toolkit for additional resources



Working Together: Addressing Cardiometabolic Risk in Underserved Populations

Clinical Companion Toolkit

Multidisciplinary Care for Patients With CRM Disease

PATIENT EDUCATION RESOURCES

Strategies for Effective Communication With Patients and Families

Ezeh E, Ilonze O, Perdoncin M, et al. *Life's essential eight as targets for cardiometabolic risk reduction among non-Hispanic black adults: A primary care approach.* *J Natl Med Assoc.* 2024;116(5):468-476.

Sebastian SA. *Cardiovascular disease risk communication: Strategies, impact, and future directions.* *Curr Probl Cardiol.* 2024;49(5):102490.

Working Together: Addressing Cardiometabolic Risk in Underserved Populations

Clinical Companion Toolkit

CLINICAL TOOLS

Guidance Documents

American Diabetes Association Professional Practice Committee. *Standards of care in diabetes-2025.* *Diabetes Care.* 2025;48(Supplement_1).

American Diabetes Association Professional Practice Committee. *3. Prevention or delay of diabetes and associated comorbidities: standards of care in diabetes-2025.* *Diabetes Care.* 2025;48(Supplement_1):S50-S58.

Handelsman Y, Anderson JE, Bakris GL, et al. *DCRM 2.0: Multispecialty practice recommendations for the management of diabetes, cardiorenal, and metabolic diseases.* *Metabolism.* 2024;159:155931.

Samson SL, Vellanki P, Blonde L, et al. *American Association of Clinical Endocrinology consensus statement: comprehensive type 2 diabetes management algorithm - 2023 Update.* *Endocr Pract.* 2023;29(5):305-340.

Writing Committee, Birtcher KK, Allen LA, et al. *2022 ACC expert consensus decision pathway for integrating atherosclerotic cardiovascular disease and multimorbidity treatment: a framework for pragmatic, patient-centered care: a report of the American College of Cardiology solution set oversight committee.* *J Am Coll Cardiol.* 2023;81(3):292-317.

Characteristics of Ideal Therapy

Improved survival
consistently seen in studies across a range of patient populations
(e.g., statin for ASCVD)

Improved health status
where a treatment improves function, symptoms, and quality of life
(e.g., CRT for ischemic heart disease with reduced LVEF and LBBB)

Fewer risks, harms, burdens
where side effects, drug-drug interactions, and dosing frequency are more limited
(e.g., DOAC for AF and PAD)

Lower cost
to the patient and to society
(e.g., generic medications)

Multituse
where a single treatment applies to multiple chronic conditions
(e.g., SGLT2 for ASCVD with T2D, CKD, and HF)

Ideal Therapy

AF, atrial fibrillation; ASCVD, atherosclerotic cardiovascular disease; CKD, chronic kidney disease; CRT, cardiac resynchronization therapy; DOAC, direct-acting oral anticoagulant; HF, heart failure; ICD, implantable cardioverter-defibrillator; LBBB, left bundle branch block; LVEF, left ventricular ejection fraction; PAD, peripheral artery disease; SGLT2, sodium-glucose cotransporter 2 inhibitor; T2D, type 2 diabetes





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