



American Heart Association®
Cardiovascular-Kidney-Metabolic
Health Initiative™

CARDIOVASCULAR - KIDNEY - METABOLIC (CKM) CARE

CLINICAL QUICKSTART GUIDE

For Healthcare Professionals



CKM Health
Screening



CKM
Syndrome
Staging



Check Risk-
Enhancers



Management
Highlights
& Follow-up

Welcome – What’s Inside

- The patients you're already treating for cardiovascular, kidney, or metabolic conditions are at the center of an interconnected system.
- Managing that system as a whole improves outcomes across the board.
- This guide shows you how to quickly align your practice with the evolving science.

Step 1: Screen CKM Risk Factors

Step 2: Stratify risks of CKD

STEP 1 – Screen for CKM Risk Factors
New to CKM Screening? Start here. These three steps apply to every patient and will reveal where additional screening is needed.

1. Complete routine assessments for all patients

Annually:
• Blood Pressure
• BMI
• Waist circumference

Every 1–5 years*:
• Lipids
• Glucose
• eGFR

At Intake + routinely:
• SDOH
• Screening

Support for Weight-Related Decisions:
• Standard | Standard | Standard

*At least every 5 yrs for all patients.
*At least every 2–3 years for overweight/obese or prediabetes.
*At least every 1–2 years for those with stage 2 CKD or higher, or at least every 1–2 years for those with stage 3 CKD or higher or advanced CKD.

2. Perform additional screening when indicated

Additional testing is advised if the following criteria are met:

Add UACR if any:
• TG ≥ 150 mg/dL or
• BP $\geq 130/80$ mmHg or
• CVD or
• Diabetes or

Then:
• MetS or
• CVD or
• Subclinical/clinical CVD

If obese:
• Screen annually
• Obstructive sleep apnea

If prediabetes:
• Screen every 2–3 yrs
• FBG-4 Index

If T2D or ≥ 2 risk factors:
• Screen every 1–2 yrs
• FBG-4 Index

Once you have these results, you're ready to stage your patient and determine next clinical steps.

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STEP 2 – Stratify CKD Risk
Stratify UACR and eGFR results for classification of chronic kidney disease risk.

CKD is CLASSIFIED BASED ON:
Cause of CKD
Albuminuria (UACR)

ALBUMINURIA CATEGORIES
Description and range

A1	A2	A3
Normal to mildly decreased	Moderately increased	Severely increased
<30 mg/g or <3.0 mg/mmol	30 – 299 mg/g or 3 – 29.9 mg/mmol	≥ 300 mg/g or ≥ 30 mg/mmol

CKD is CLASSIFIED BASED ON:
Cause of CKD
Albuminuria (UACR)

Stage	Normal or high	eGFR	Screen	Test	Test and refer
G1	Normal or high	≥ 90	Screen	1	Test and refer
G2	Mildly decreased	60 – 89	Screen	1	Test and refer
G3a	Mildly to moderately decreased	45 – 59	Screen	1	Test and refer
G3b	Moderately to severely decreased	30 – 44	Screen	1	Test and refer
G4	Severely decreased	15 – 29	Test and refer	1	Test and refer
G5	Kidney failure	<15	Test and refer	1	Test and refer

LOW RISK if NO OTHER WARNERS OF ADVANCED CKD, NO CVD
MODERATELY INCREASED RISK
HIGH RISK
VERY HIGH RISK

*Cause when the issue of CKD is determined by the clinician. Most patients who fit into the cardiovascular staging model also fit into the CKD staging framework and have CKD associated with diabetes, hypertension, and other metabolic risk factors. However, phenocopies such as an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker and non-diabetic glomerulonephritis have accelerated kidney and cardiovascular results in CKD staging. The CKM staging framework is aimed at almost all patients with CKD. CKM staging may not be relevant for those with non-metabolic causes. Depending on local practice policies on screening for CKD, CKD staging may be relevant for those with non-metabolic causes and CKD, glomerular disease.

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Step 3: Calculate risk estimates to aid clinical decisions and patient dialogues

Step 4: Consider and evaluate risk enhancers

STEP 3 – Calculate Risk Estimates
Quantitative Risk Assessment for Total CVD, ASCVD & HF

CV: Cardiovascular Disease | ASCVD: Atherosclerotic Cardiovascular Disease | HF: Heart Failure

Click or Scan to Calculate
Using the American Heart Association
PREVENT™ Online Calculator

Check for high predicted 10 yr total CVD risk
This indicates a risk equivalent to CKM syndrome stage 3.

Available via Web Tool

For more about interpreting risk estimates, visit this 2-page resource

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STEP 4 – Consider Risk-Enhancers
Prioritize monitoring and risk-reduction strategies for patients with:

CHRONIC INFLAMMATORY CONDITIONS
• Examples: rheumatoid arthritis, Lupus, HIV/AIDS

SEX-SPECIFIC RISK ENHANCERS
(Beyond gestational diabetes consideration in stage 1)
• History of premature menopause (age <40 years)
• History of adverse pregnancy outcomes (Hypertensive or Preterm Birth)
• Polycystic ovarian syndrome
• Erectile dysfunction

MENTAL HEALTH DISORDERS
• Depression and anxiety

ELEVATED HIGH-SENSITIVITY C-REACTIVE PROTEIN
• >2.0 mg/L

FAMILY HISTORY
• Kidney failure
• Diabetes

HIGH-RISK DEMOGRAPHIC GROUPS
• South Asian ancestry
• Lower socioeconomic status

HIGH BURDEN OF ADVERSE SDOH
Examples include:
• Food access instability
• Chronic economic instability
• Low community support or low social support

SLEEP DISORDERS
Examples include:
• Obstructive sleep apnea
• Insomnia
• Chronic short sleep duration

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Step 5: Stage CKM Syndrome

Step 6: Refer to Treatment Algorithm by Stage to determine therapies

STEP 5 – Stage CKM Syndrome
Patients are assigned the highest stage where criterion is met.

Stage 4 – Clinical CVD with CKM Risk Factors
• Diagnosis of: Heart Failure, Stroke, CHD, PAD, or AF (Stage 4B if + kidney failure)

Stage 3 – Subclinical CVD with CKM Risk Factors or Risk Equivalents
• Subclinical ASCVD (with CKM Risk Factors)
• Pre-HF with CKM Risk Factors
• High Predicted 10-year Total CVD risk Using PREVENT CVD Equations
• Very High-Risk CKD Per KDIGO Heat Map

Stage 2 – Metabolic Risk Factors and/or CKD
• Type 2 Diabetes If HbA1c $\geq 6.5\%$ or FPG ≥ 126 mg/dL
• Hypertension If BP $\geq 130/80$ mmHg
• Hypertriglyceridemia If fasting triglyceride levels ≥ 150 mg/dL
• Moderate- to High-Risk CKD Per KDIGO Heat Map
• Metabolic Syndrome: (If only 3 or more of the following criteria apply)
• Abdominal Obesity See Stage 1 Criteria
• High Fasting Triglycerides ≥ 150 mg/dL
• Low HDL Cholesterol <40 mg/dL women / <40 mg/dL men
• Increased fasting blood glucose ≥ 100 mg/dL or $\geq 130/80$ mmHg
• High Blood Pressure

Stage 1 – Excess/Dysfunctional Adipose Tissue
• Overweight / Obesity BMI ≥ 25 kg/m²
• Asian ancestry BMI ≥ 23 kg/m²
• Abdominal Obesity waist circ. women: ≥ 88 cm / men: ≥ 102 cm
• Asian ancestry waist circ. women: ≥ 80 cm / men: ≥ 90 cm
• Prediabetes Fasting plasma glucose ≥ 100 – 125 mg/dL or HbA1c between 5.7%–6.4%

CKD: Chronic kidney disease | FPG: Fasting plasma glucose | HbA1c: Hemoglobin A1c | HDL: High-density lipoprotein | LDL: Low-density lipoprotein | BP: Blood pressure

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STEP 6 – Refer to Treatment Algorithm
Stages 1–3 Management Highlights

Prevention of cardiovascular health and outcomes on CKM identified in framework for prevention

Staging model for CKM staging framework with emphasis on Life Essential 8 Framework for prevention

Systematic screening for SDOH using validated tools, incorporation of community health workers and care navigators into care team, leveraging existing community resources and community engagement

Implementing stage 1–3 CKM risk stratification and management plan

Refer also to additional American Heart Association guidelines for prevention and management of CHD, AF, PAD and Stroke

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STEP 6 – Refer to Treatment Algorithm
Stage 4 Management Highlights

Prevention of cardiovascular health and outcomes on CKM identified in framework for prevention

Staging model for CKM staging framework with emphasis on Life Essential 8 Framework for prevention

Systematic screening for SDOH using validated tools, incorporation of community health workers and care navigators into care team, leveraging existing community resources and community engagement

Implementing stage 1–3 CKM risk stratification and management plan

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Step 7: Monitor patient’s progress by therapeutic recommendations

Resources Review additional patient resources

STEP 7 – Monitor by Therapeutic Need
Use criteria to determine screening frequency and re-check.

Therapy	Assess & Monitor Accordingly
GLP-1-based therapy initiation	Assess weight loss within 3–6 months
HTZD and SGLT2/GLP-1-based therapy initiation	Assess glycemic status every 3 to 6 months (more frequently if not meeting glycemic goals)
If UACR ≥ 30 mg/g and SGLT2/GLP-1-based therapy initiation	Assess albuminuria after 3 to 6 months
If RASi or MRA initiation	Assess eGFR and potassium after 2 to 4 weeks

For more resources on CKM care, refer to **CKM Health for Professionals**

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(Resource) – Patient Discussion Tool
A staging model for shared decision-making

CKM Staging Model

Talking points to consider:

- Heart, kidney, and metabolic health often get stressed together.
- We test the whole body to prevent CKM symptoms.
- The vast majority of people see significant health improvements with lifestyle modifications. (Promote Life's Essential 8)

Motivational Interviewing Quick Start:

- On a scale of 1 to 10, with 1 being not ready and 10 being ready to start now, how ready are you to make change?
- Why did you choose that number instead of a lower one? (allows patients to articulate their own reasons for change)

Cardiovascular • Kidney • Metabolic (CKM) Health Initiative **CLINICAL QUICKSTART GUIDE**

STEP 1 – Screen for CKM Risk Factors

New to CKM Screening? Start here. These three steps apply to every patient and will reveal where additional screening is needed.

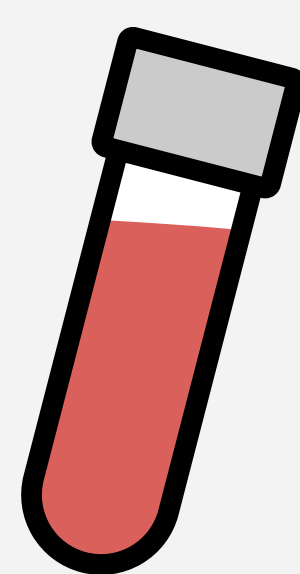
1 Complete routine assessments for all patients

Annually



- Blood Pressure
- BMI
- Waist circumference

Every 1 - 5 years*



- Lipids
- Glycemia
- eGFR

At Intake + routinely



- SDOH Screening

[Popular tools](#)

Support for Weight-Related Discussions:

[1-Page PDF](#)

[3-Page PDF](#)

[2-Minute Video](#)

* At least every 5 yrs for all patients;

At least every 2 - 3 years for overweight/obese or prediabetes

At least annually for those in stages 2-4

(TG $\geq$ 150 mg/dL; or BP $\geq$ 130/80 mmHg or T2D or MetS or CKD or subclinical/clinical CVD)

2 Perform additional screening when indicated

Additional testing is advised if the following criteria are met:

Add UACR if any:



- ☐ TG $\geq$ 150 mg/dL or
- ☐ BP $\geq$ 130/80 mmHg or
- ☐ Diabetes or

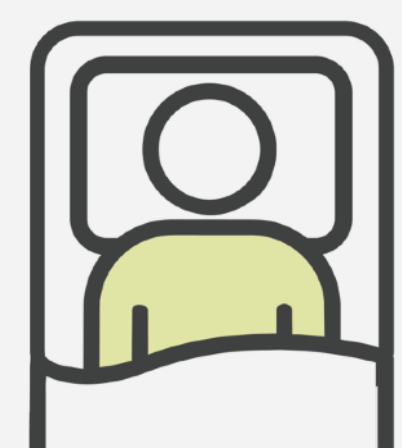
- ☐ MetS or
- ☐ CKD or
- ☐ Subclinical/clinical CVD

Then:

→ [Stratify CKD risk with KDIGO Heat Map](#)

If obese

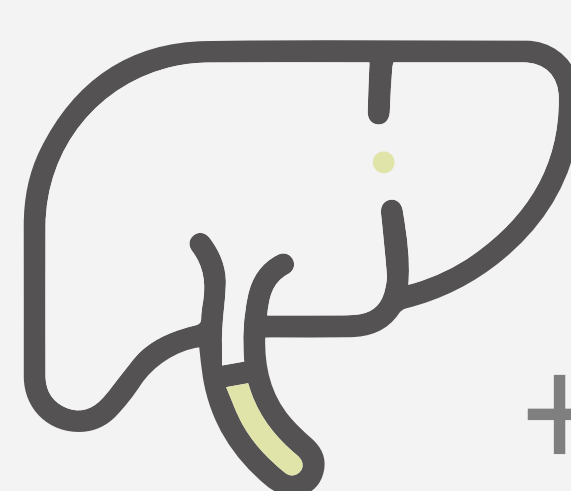
- Screen annually



+ Obstructive sleep apnea

If prediabetes

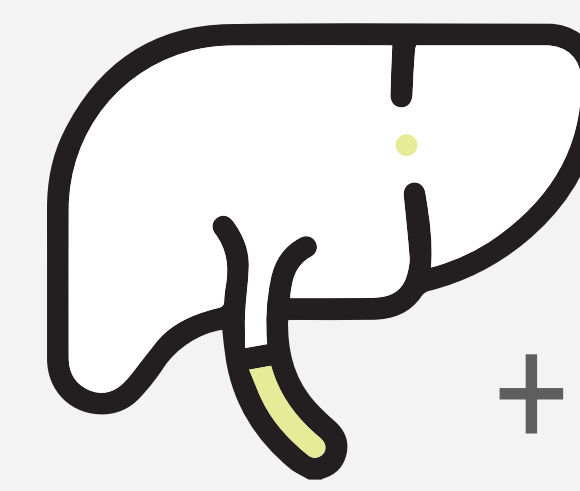
- Screen every 2-3 yrs



+ FIB-4 Index

If T2D or $\geq$ 2 risk factors

- Screen every 1-2 yrs



+ FIB-4 Index

Once you have these results, you're ready to stage your patient and determine next clinical steps.

Abbreviations:

BMI - Body Mass Index

CKD - Chronic Kidney Disease

CKM - Cardiovascular Kidney Metabolic

CVD - Cardiovascular Disease

eGFR - Estimated Glomerular Filtration Rate

FIB-4 - Fibrosis 4 liver scan

MetS - Metabolic Syndrome

OSA - Obstructive Sleep Apnea

SDOH - Social Determinants of Health

TG - Triglycerides

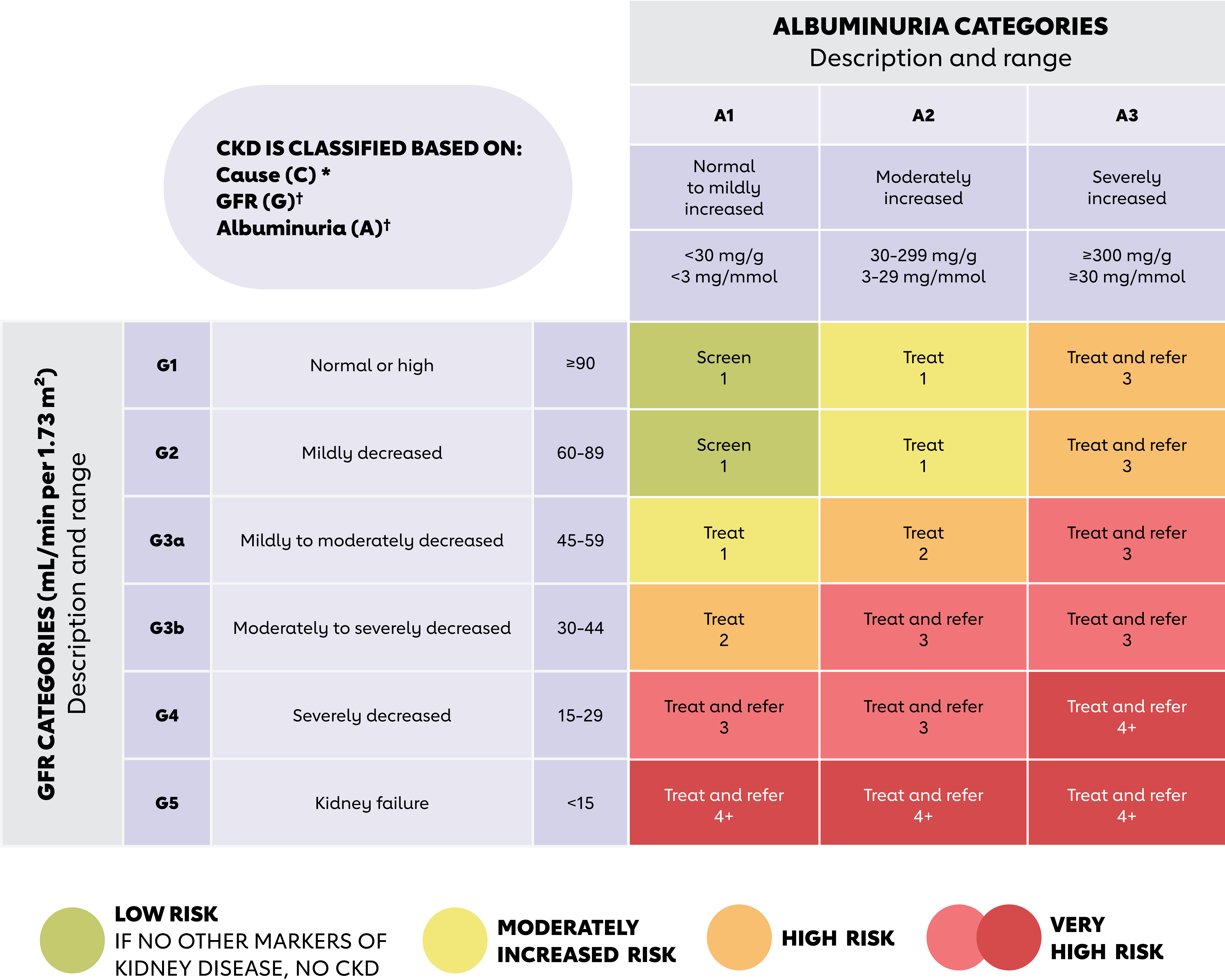
T2D - Type 2 Diabetes

UACR - Urine Albumin-to-Creatinine Ratio

STEP 2 – Stratify CKD Risk

Stratify **UACR** and **eGFR** results for classification of chronic kidney disease risk.

KDIGO Heat Map FOR CKD CLASSIFICATION



*Cause refers to the cause of CKD as ascertained by the clinician. Most patients who fit into the cardiovascular-kidney-metabolic (CKM) staging framework will have CKD attributable to diabetes, hypertension, and other metabolic risk factors. However, pharmacotherapies such as angiotensin-converting enzyme inhibitors/angiotensin receptor blockers and sodium-glucose cotransporter-2 inhibitors have demonstrated kidney and cardiovascular benefits in trials for patients with CKD resulting from either metabolic risk factors or other causes (eg, some glomerulopathies). Therefore, the CKM staging framework is relevant for almost all patients with CKD.

†Clinicians may wish to discuss with their nephrology service, depending on local practice patterns on monitoring or referring. CKD indicates chronic kidney disease; and GFR, glomerular filtration rate.

STEP 3 – Calculate Risk Estimates

Quantitative Risk Assessment for Total CVD, ASCVD & HF

[Click or Scan to Calculate](#)

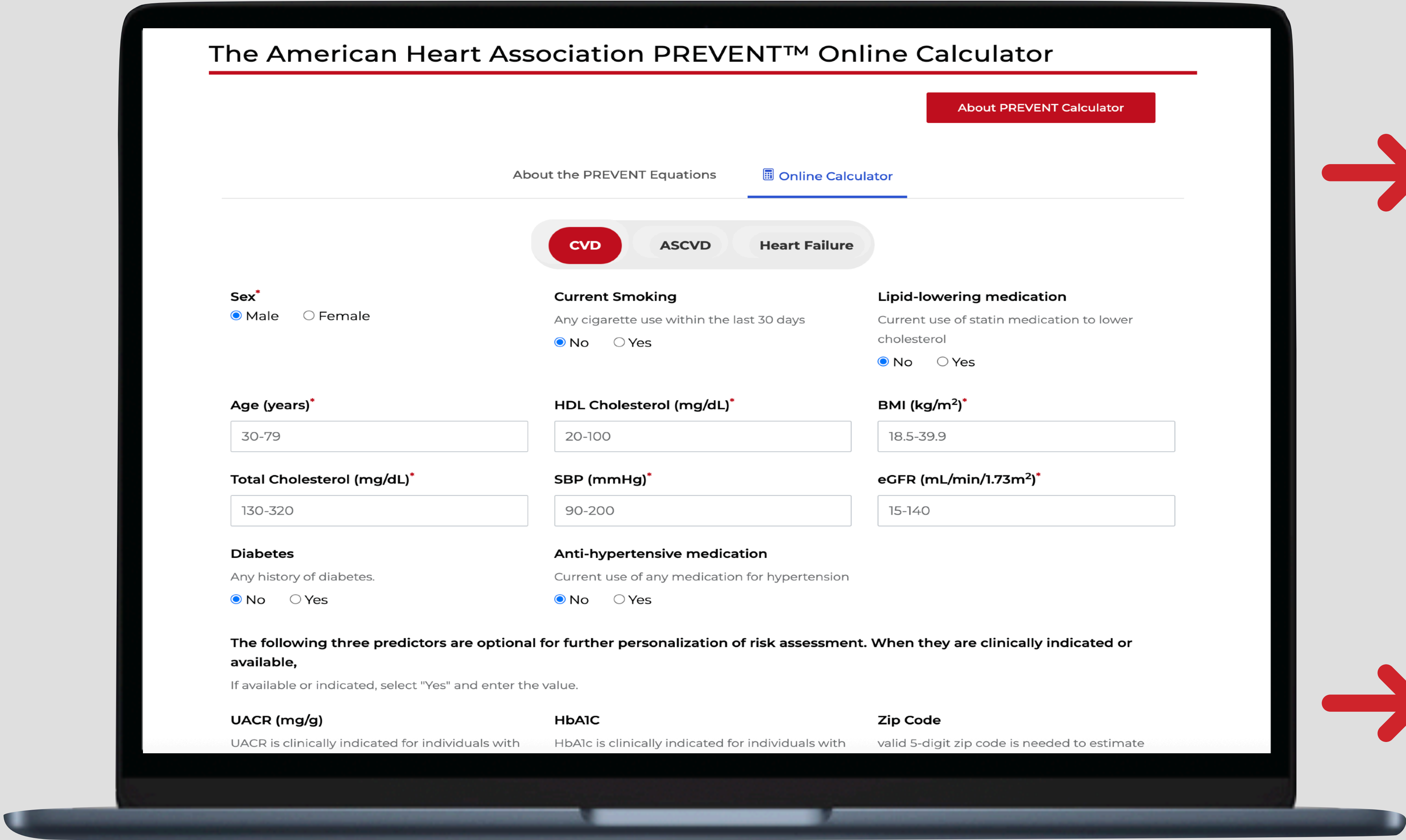
Using the American Heart Association
PREVENT™ Online Calculator



Check for **high predicted 10 yr total CVD risk**

This indicates a risk equivalent in
CKM syndrome stage 3.

Available via Web Tool



Quickly assess risks and staging
info for clinical decision-making

Estimated **10-year**
risk of CVD
5.2%

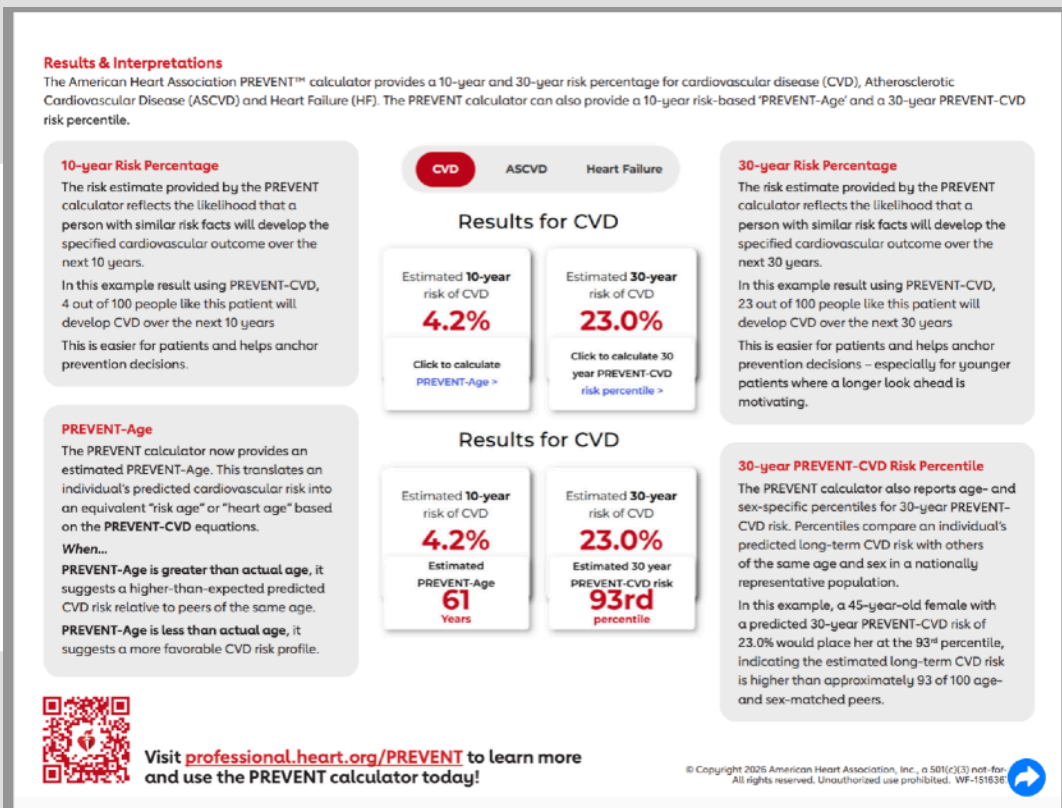
Estimated **30-year**
risk of CVD
26.9%

Estimated
PREVENT-Age
61
Years

Estimated 30 year
PREVENT-CVD Percentiles
51st
percentile

Strengthen dialogue with patients
using context of relative risk

For more about interpreting risk
estimates, visit this 2-page resource



Consider diagnostic testing for subclinical CVD based on risk estimates.

Abbreviations:
CVD – Cardiovascular Disease; ASCVD – Atherosclerotic Cardiovascular Disease; HF – Heart Failure

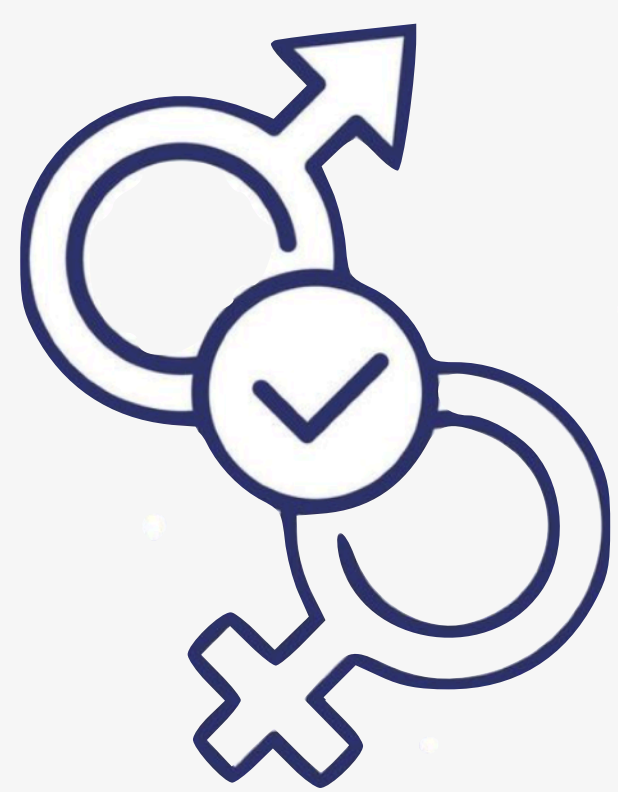
STEP 4 – Consider Risk-Enhancers

Prioritize monitoring and risk-reduction strategies for patients with:



CHRONIC INFLAMMATORY CONDITIONS

- Examples: rheumatoid arthritis, Lupus, HIV/AIDS



SEX-SPECIFIC RISK ENHANCERS

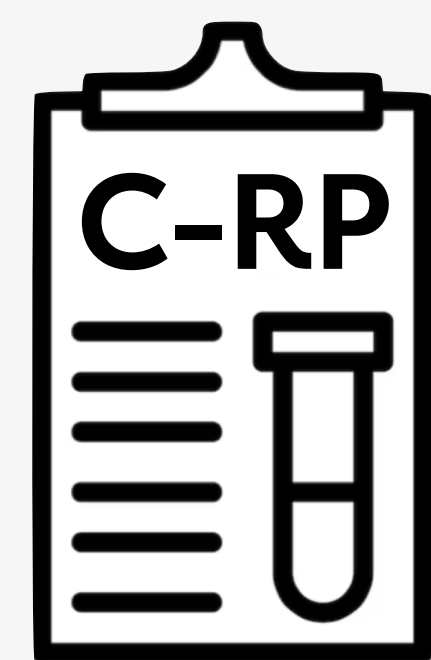
(Beyond gestational diabetes consideration in stage 1)

- History of **premature menopause** (age <40 years)
- History of **adverse pregnancy outcomes** (Hypertensive or Preterm Birth)
- Polycystic ovarian syndrome
- Erectile dysfunction



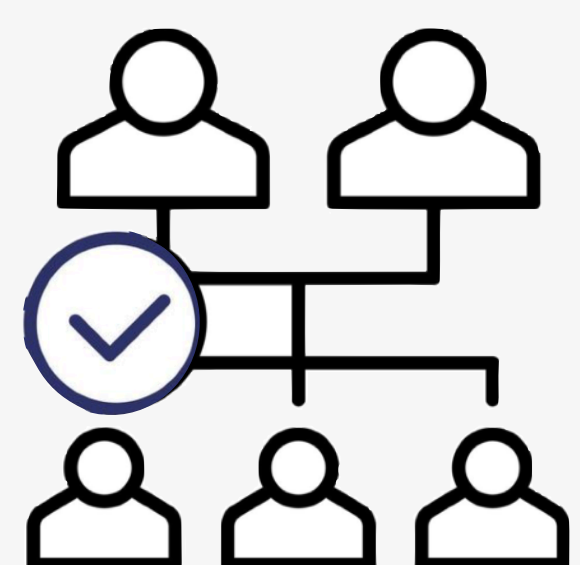
MENTAL HEALTH DISORDERS

- Depression and anxiety



ELEVATED HIGH-SENSITIVITY C-REACTIVE PROTEIN

- ≥ 2.0 mg/L



FAMILY HISTORY

- Kidney failure
- Diabetes



HIGH-RISK DEMOGRAPHIC GROUPS

- South Asian ancestry
- Lower socioeconomic status



HIGH BURDEN OF ADVERSE SDOH

Examples include:

- Food access instability
- Chronic economic instability
- Low community support or low social support



SLEEP DISORDERS

Examples include:

- Obstructive sleep apnea
- Insomnia
- Chronic short sleep duration

STEP 5 – Stage CKM Syndrome

Patients are assigned the highest stage where criterion is met.

Stage 4 - Clinical CVD with CKM Risk Factors

- Diagnosis of: **Heart Failure, Stroke, CHD, PAD, or AF** (Stage 4b if + kidney failure)

Stage 3 - Subclinical CVD with CKM Risk Factors or Risk Equivalents†

- | | |
|--|----------------------------------|
| ○ Subclinical ASCVD (with CKM Risk Factors) | CAC $\geq$ 100 or low ABI |
| ○ Pre-HF (with CKM Risk Factors) | Abnormal biomarkers or imaging |
| ○ †High Predicted 10-year Total CVD risk | PREVENT-CVD $\geq$ 20% |
| ○ †Very High-Risk CKD | Per <u>KDIGO Heat Map</u> |

Stage 2 - Metabolic Risk Factors and/or CKD

- | | |
|--|---|
| ○ Type 2 Diabetes | If HbA1c $\geq$ 6.5% or FPG $\geq$ 126 mg/dL |
| ○ Hypertension | If BP $\geq$ 130/80 mmHg |
| ○ Hypertriglyceridemia | If fasting triglyceride levels $\geq$ 150 mg/dL |
| ○ Moderate- to High-Risk CKD | Per <u>KDIGO Heat Map</u> |
| ○ Metabolic Syndrome:
(If any 3 or more of the following criteria apply) | |
| ☐ Abdominal Obesity | See Stage 1 Criteria |
| ☐ High Fasting Triglycerides | $\geq$ 150 mg/dL |
| ☐ Low HDL Cholesterol | <50 mg/dL women / <40 mg/dL men |
| ☐ Increased fasting blood glucose | $\geq$ 100 mg/dL |
| ☐ High Blood Pressure | $\geq$ 130/80 mmHg |

Stage 1 - Excess/Dysfunctional Adipose Tissue

- | | |
|--|---|
| ○ Overweight / Obesity
if Asian ancestry | BMI $\geq$ 25 kg/m ²
BMI $\geq$ 23 kg/m ² |
| ○ Abdominal Obesity
if Asian ancestry | waist circ. women: $\geq$ 88 cm / men: $\geq$ 102 cm
waist circ. women: $\geq$ 80 cm / men: $\geq$ 90 cm |
| ○ Prediabetes | Fasting plasma glucose $\geq$ 100-125 mg/dL
or HbA1c between 5.7%- 6.4% |

CHD: Coronary Heart Disease **FPG:** Fasting Plasma Glucose **PAD:** Peripheral Artery Disease **AF:** Atrial Fibrillation

STEP 6 – Refer to Treatment Algorithm

Stages 1-3 Management Highlights

Promotion of cardiovascular health with an emphasis on Life's Essential 8 Framework for prevention
— See resources for [Patients](#) and [Professionals](#)

Systematic screening for SDOH using validated tools, incorporation of community health workers and care navigators into the care team, leveraging existing community resources and community programs
— See [popular SDOH tools](#)

Begin care with Stage 0– Emphasize primordial prevention through Life's Essential 8



Interdisciplinary care - use of CKM coordinator and interdisciplinary team; targeted referrals of high-risk CKM patients to sub-specialists

STAGE 1 EXCESS OR DYSFUNCTIONAL ADIPOSYTY

- **Weight loss counseling using nonjudgmental approach** (STOP Obesity Alliance [toolkit](#))
- **Lifestyle modification** to achieve 5–10% loss of baseline weight
- Support from integrated interdisciplinary team
- **If BMI ≥ 27 kg/m²** (without comorbidities) or insufficient weight loss despite lifestyle modification
→ Adding GLP-1-based therapy is reasonable
- **If BMI ≥ 35 kg/m²** (without comorbidities) or ≥ 30 kg/m² (with comorbidities) or insufficient weight loss despite lifestyle modification
→ Metabolic and bariatric surgery (MBS) is reasonable
- **If OSA**
→ Treat with CPAP if indicated

STAGE 2 ESTABLISHED CKM RISK FACTORS

Presence of CKM risk factors trigger intensive lifestyle intervention targeting multifactorial risk control

Pharmacotherapy for comprehensive control of residually uncontrolled CKM risk factors.

Hypertension

- Follow established hypertension guidelines to achieve BP $<130/80$ mmHg
- **If T2D and CKD with UACR ≥ 30 mg/g**
→ RASi (ACEi/ARB)

Hypertriglyceridemia

- Follow established dyslipidemia guidelines to achieve individualized lipid goals
- **If borderline-intermediate or higher ASCVD risk**
→ statin therapy
- **If persistent TG ≥ 150 –499 mg/dL + additional CV risk factors:** can consider adding icosapent ethyl
- **If TG ≥ 500**
→ add fibrate

Moderate-High Risk CKD

- **If UACR ≥ 30 and eGFR ≥ 30 mL/min/1.73m²**
→ RASi (ACEi/ARB)
- **If UACR ≥ 30 –199 mg/g**
→ Adding SGLT2i is reasonable
- **If UACR ≥ 200 mg/g**
→ Add SGLT2i
- **If T2D**
→ RASi + SGLT2i
- **If T2D & UACR ≥ 30 mg/g with eGFR ≥ 25 mL/min 1.73m² (despite RASi + SGLT2i)**
→ Add nsMRA
- **If T2D & UACR ≥ 100 mg/g (despite RASi + SGLT2i)**
→ Add GLP-1-based therapy

Type 2 Diabetes

- Moderate-high intensity statin
- **If higher ASCVD risk**
→ consider adding ezetimibe
- Continue metformin (if already using)
- **If CKD**
→ SGLT2i
- **GLP-1-based therapy if any:**
 - If BMI ≥ 35 kg/m²
 - If HbA1c $\geq 9\%$
 - If MASLD
- **If increased risk* for CVD or multiple CKM risk factors**
→ SGLT2i or GLP-1-based therapy (may consider combination therapy)
- **If HbA1c levels 0.5–1% above goal (despite SGLT2i/GLP-1-based therapy)**
→ Adding metformin is reasonable

* **Increased risk** is defined as a 10-year PREVENT-CVD of $\geq 7.5\%$ or age ≥ 50 years with T2D and additional CKM risk factors.

STAGE 3 SUBCLINICAL CVD WITH CKM RISK FACTORS or RISK EQUIVALENTS

Subclinical ASCVD

- First-line GDMT:
 - Aspirin + antiplatelet and/or anticoagulation when indicated
- Statin therapy and/or ezetimibe, bempedoic acid, PCSK9i when indicated

Pre-HF

- **If T2D or CKD**
→ SGLT2i
- **If T2D and CKD with UACR ≥ 30 mg/g**
→ Adding nsMRA is reasonable
- **If T2D and CKD with UACR ≥ 100**
→ Adding GLP-1-based therapy is reasonable

Risk Equivalents

- Very high-risk CKD
→ use same algorithm as moderate-high risk CKD
- High predicted 10-year CVD risk (PREVENT-CVD $\geq 20\%$)
→ Escalate therapies based on risk

Abbreviations:

ACEi: Angiotensin-Converting Enzyme inhibitor
ARB: Angiotensin II Receptor Blocker
ASCVD: Atherosclerotic Cardiovascular Disease
BMI: Body Mass Index
BP: Blood Pressure
CKD: Chronic Kidney Disease
CKM: Cardiovascular-Kidney-Metabolic
CPAP: Continuous Positive Airway Pressure

CV: Cardiovascular
eGFR: Estimated Glomerular Filtration Rate
GDMT: Guideline-Directed Medical Therapy
GLP-1 (or GLP): Glucagon-Like Peptide-1
HbA1c: Hemoglobin A1c
MASLD: Metabolic Dysfunction-Associated Steatotic Liver Disease
MBS: Metabolic Bariatric Surgery
nsMRA: Non-steroidal Mineralocorticoid Receptor Antagonist

OSA: Obstructive Sleep Apnea
PCSK9i: Proprotein Convertase Subtilisin/Kexin type 9 inhibitor
RASi: Renin-Angiotensin System inhibitor
SGLT2i: Sodium-Glucose Cotransporter-2 inhibitor
T2D: Type 2 Diabetes
TG: Triglycerides
UACR: Urine Albumin-to-Creatinine Ratio

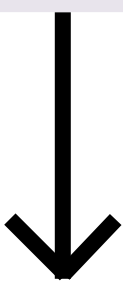
STEP 6 – Refer to Treatment Algorithm

Stage 4 Management Highlights

Promotion of cardiovascular health with an emphasis on Life’s Essential 8 Framework for prevention
— See resources for [Patients](#) and [Professionals](#)

Systematic screening for SDOH using validated tools, incorporation of community health workers and care navigators into the care team, leveraging existing community resources and community programs
— See [popular SDOH tools](#)

Interdisciplinary care → Use of CKM coordinator and interdisciplinary team; targeted referrals of high-risk CKM patients to subspecialists



STAGE 4 CLINICAL CVD WITH CKM RISK FACTORS

See treatment algorithm below to supplement management of individual conditions as previously outlined with additional treatment by comorbidity below.

ASCVD

- First-line GDMT:
 - Aspirin + antiplatelet and/or anticoagulation when indicated
- Maximal statin therapy and/or ezetimibe, bempedoic acid, PCSK9i when indicated

HEART FAILURE

- HFpEF/HFmrEF:
 - SGLT2i + diuretics if indicated
- HFrEF:
 - First-line GDMT:
 - BB + RASi (ARNI/ACEi/ARB) + SGLT2i + MRA

EXCESS OR DYSFUNCTIONAL ADIPOSITY

ASCVD:

- If BMI ≥ 27 kg/m² → GLP-1-based therapy
- If BMI ≥ 30 kg/m² and insufficient weight loss (despite intervention) → MBS is reasonable

HFpEF:

- If BMI ≥ 30 kg/m² → SGLT2i + GLP-1-based therapy

HFrEF:

- If BMI ≥ 30 kg/m² → GDMT (BB, RASi, SGLT2i, MRA)

TYPE 2 DIABETES

Treat per Stage 2 algorithm +

ASCVD:

- SGLT2i and/or GLP-1-based therapy
- If coexisting pre-HF/HF → Adding GLP-1-based therapy + SGLT2i is reasonable

HF:

- If HFpEF/HFmrEF → SGLT2i
- If HFrEF → BB, RASi, SGLT2i, MRA
- If CKD with UACR ≥ 30 mg/g → add GLP-1-based therapy
- If coexisting ASCVD → add GLP-1-based therapy

CHRONIC KIDNEY DISEASE

Treat per Stage 2 algorithm +

ASCVD:

- If T2D or UACR ≥ 30 mg/g → RASi + SGLT2i
- If T2D with UACR ≥ 30 mg/g (despite RASi + SGLT2i) → add GLP-1-based therapy

HF:

- If eGFR ≥ 30 mL/min/1.73m² → RASi
- If eGFR ≥ 20 mL/min/1.73m² → SGLT2i
- If HFpEF/HFmrEF and T2D with UACR ≥ 30 mg/g and eGFR ≥ 25 mL/min/1.73m² → nsMRA is reasonable
- If HFrEF with eGFR ≥ 30 mL/min/1.73m² → May consider oral potassium-binding agent

Refer also to additional American Heart Association guidelines for prevention and management of CHD, AF, PAD and Stroke.

Abbreviations:

ACEi: Angiotensin-Converting Enzyme inhibitor
ARB: Angiotensin II Receptor Blocker
ARNI: Angiotensin Receptor-Neprilysin Inhibitor
ASCVD: Atherosclerotic Cardiovascular Disease
BB: Beta-Blocker
BMI: Body Mass Index
CKD: Chronic Kidney Disease
CKM: Cardiovascular-Kidney-Metabolic
CVD - Cardiovascular Disease

eGFR: Estimated Glomerular Filtration Rate
GDMT: Guideline-Directed Medical Therapy
GLP-1: Glucagon-Like Peptide-1
HF: Heart Failure
HFmrEF: Heart Failure with Mildly Reduced Ejection Fraction
HFpEF: Heart Failure with Preserved Ejection Fraction
HFrEF: Heart Failure with Reduced Ejection Fraction
MBS: Metabolic Bariatric Surgery
MRA: Mineralocorticoid Receptor Antagonist

nsMRA: Non-steroidal Mineralocorticoid Receptor Antagonist
PCSK9i: Proprotein Convertase Subtilisin/Kexin type 9 inhibitor
RASi: Renin-Angiotensin System inhibitor
SDOH: Social Determinants of Health
SGLT2i: Sodium-Glucose Cotransporter-2 inhibitor
T2D: Type 2 Diabetes
UACR: Urine Albumin-to-Creatinine Ratio

STEP 7 – Monitor by Therapeutic Need

Use criteria to determine screening frequency and re-check.

Therapy	Assess & Monitor Accordingly
GLP-1-based therapy initiation	Assess weight loss within 3-6 months
If T2D and SGLT2i/GLP-1-based therapy initiation	Assess glycemic status every 3 to 6 months <i>(more frequently if not meeting glycemic goals)</i>
If UACR ≥ 30 mg/g and SGLT2i/GLP-1-based therapy initiation	Assess albuminuria after 3 to 6 months
If RASi or MRA initiation	Assess eGFR and potassium after 2 to 4 weeks

For more resources on CKM care, refer to [CKM Health for Professionals](#)

CKM Health for Professionals

[eModule](#) | [Toolkits](#) | [Micro-Learnings](#) | [Podcasts](#) | [Videos on Demand](#) | [CKM Quiz](#) | [Apps & Tools](#) | [Educational Resources](#)

Cardiovascular-kidney-metabolic (CKM) syndrome is a health disorder made up of heart disease, kidney disease, diabetes and obesity, leading to poor health outcomes.

Groundbreaking new therapies exist, but many patients experience fragmented care. By recognizing CKM as a connected syndrome, we can shift from reactive care to earlier detection, coordinated treatment, and better outcomes.

Live Events

Register for upcoming live events related to improving CKM care

FREE VIRTUAL SUMMIT



CKM Syndrome Guideline Unpacked: A Unified Approach for Interdisciplinary Prevention & Care

JUNE 30, 2026 | 10:00 A.M. - 12:30 P.M. CDT

Join us live for a dynamic, interdisciplinary virtual summit where leading experts translate science into action. Discover enhanced screening tools, evidence-based therapies, and coordinated care models that can reshape outcomes for millions of patients.

Register Today! CKM Guideline Unpacked

Cardiovascular • Kidney • Metabolic (CKM) Health Initiative

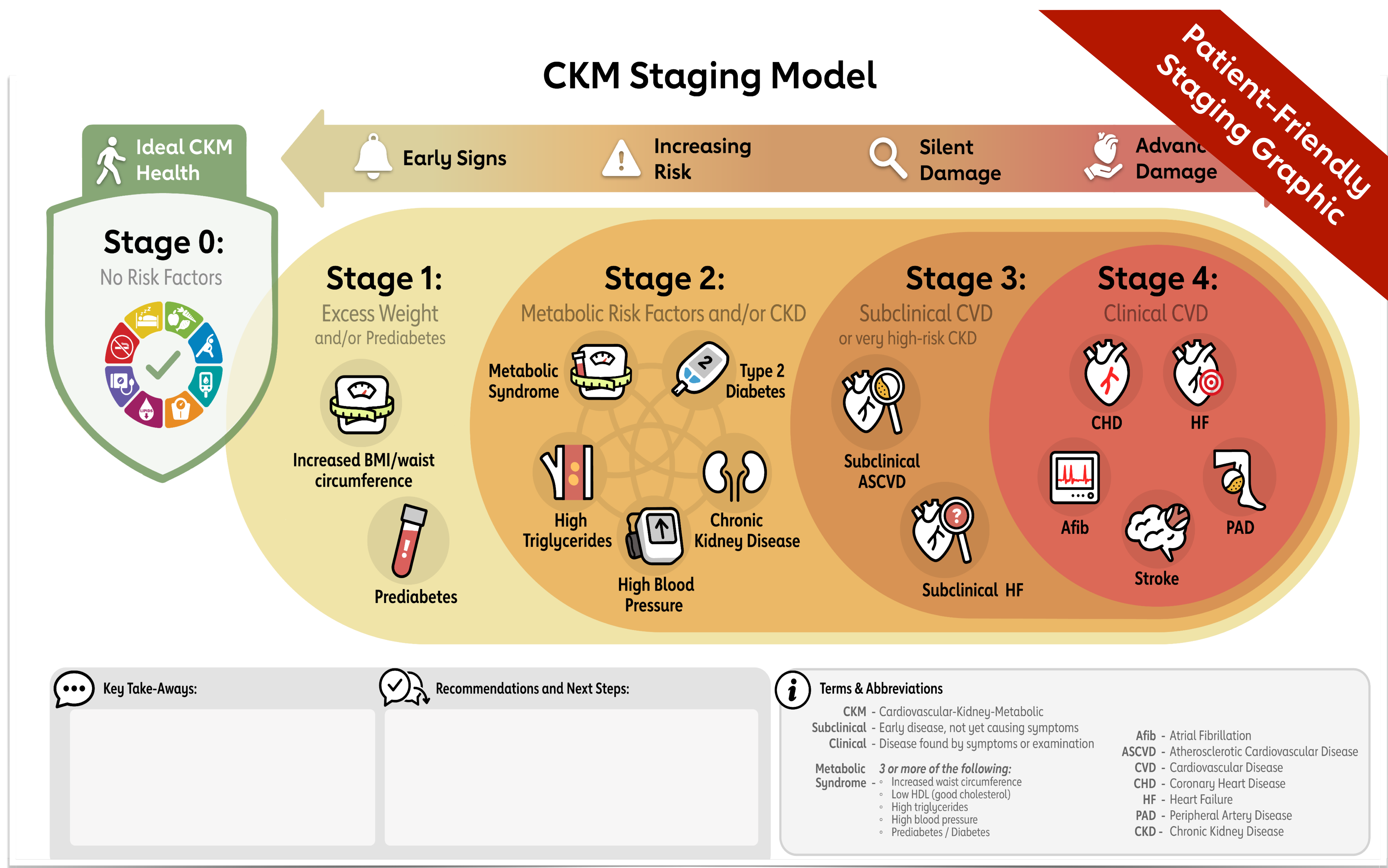
CLINICAL QUICKSTART GUIDE

10

(Resource) – Patient Discussion Tool



A staging model for shared decision-making



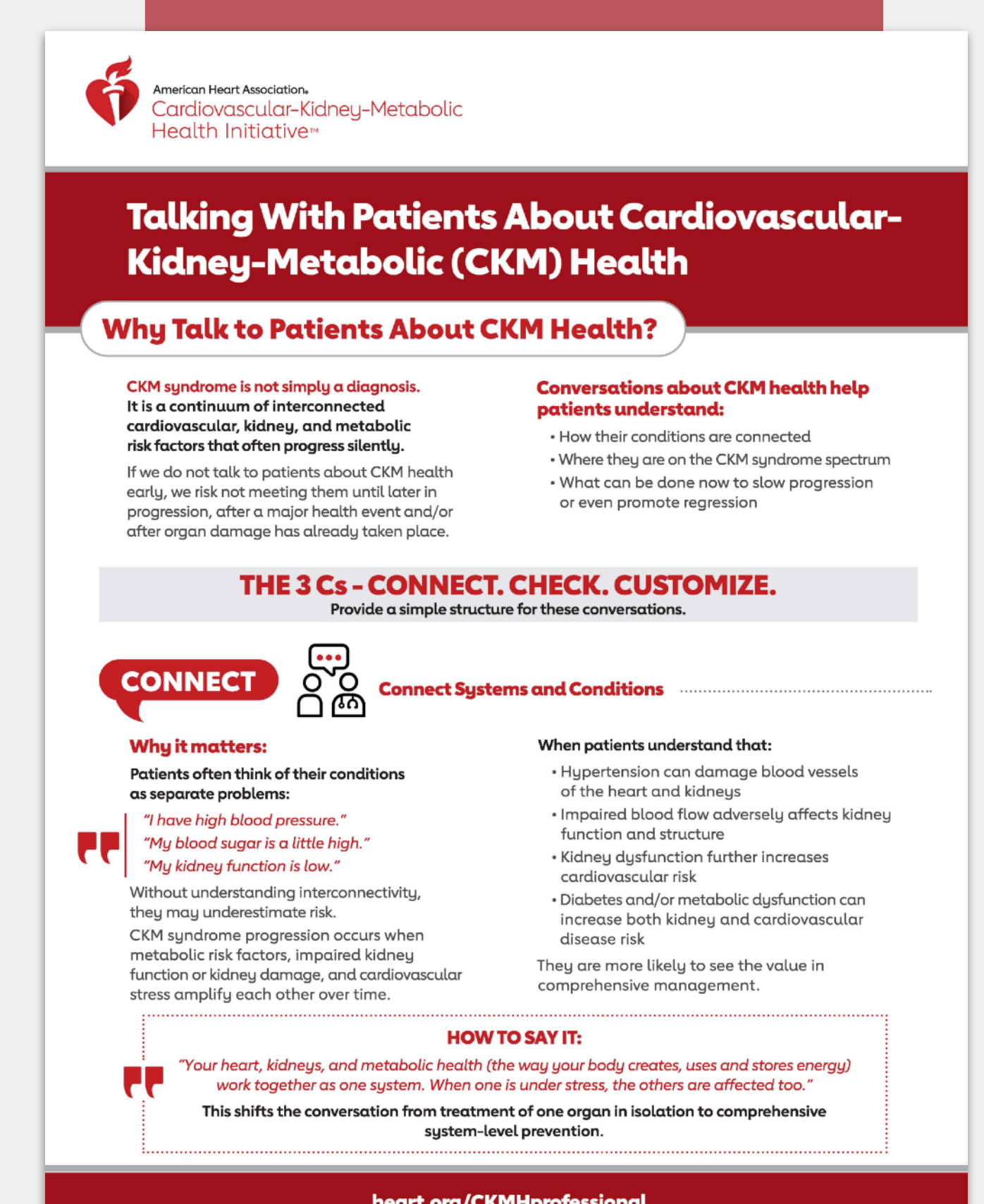
Talking points to consider:

- Heart, kidneys, and metabolic health often get stressed together.
- We treat the whole body to prevent CKM syndrome.
- The vast majority of people see significant health improvements with lifestyle modifications. ([Promote Life's Essential 8](#))

Motivational Interviewing Quick Start:

- On a scale of 1 to 10, with 1 being *not ready* and 10 being *ready to start now*, how ready are you to make change?
- Why did you choose that number instead of a lower one?
(allows patients to articulate their own reasons for change)

Additional Resource





American Heart Association®

Cardiovascular-Kidney-Metabolic
Health Initiative™

CLINICAL QUICKSTART GUIDE

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