The American Heart Association and American Diabetes Association have partnered to summarize key clinical recommendations for cardiometabolic health management for people with type 2 diabetes.

**COMPREHENSIVE CARDIOMETABOLIC HEALTH MANAGEMENT MODEL FOR PERSONS WITH TYPE 2 DIABETES: LIFE’S SIMPLE 8**

The American Heart Association (AHA) has identified eight simple measures ("Life’s Essential 8") to prevent cardiovascular disease.²

1. **Measure lipid levels**

2. **Measure height, weight, waist circumference**

3. **Measure blood pressure**

4. **Assess tobacco use**

5. **Assess physical activity level**

6. **Assess dietary pattern**

7. **Assess sleep pattern**

8. **Assess medication use or medication adherence**

**LIPID LOWERING THERAPY RECOMMENDATIONS FOR PERSONS WITH TYPE 2 DIABETES**

In adults 40 to 75 years of age with diabetes mellitus, regardless of estimated 10-year ASCVD risk, moderate-intensity statin therapy is indicated (S4.3-1—S4.3-9).²

In adults 40 to 75 years of age with diabetes mellitus and an LDL-C level of 70 to 189 mg/dL (1.7 to 4.8 mmol/L), it is reasonable to assess the 10-year risk of a first ASCVD event by using the race and sex-specific Pooled Cohort Equations to help stratify actual ASCVD risk (S4.3-10, S4.3-11).²

In adults with diabetes mellitus who have multiple ASCVD risk factors, it is reasonable to prescribe high-intensity statin therapy with the aim to reduce LDL-C levels by 50% or more (S4.3-12, S4.3-13).²

In adults older than 75 years of age with diabetes mellitus and who are already on statin therapy, it is reasonable to continue statin therapy (S4.3-5, S4.3-8, S4.3-13).²

In adults with diabetes mellitus and 10-year ASCVD risk of 20% or higher, it may be reasonable to add ezetimibe to maximally tolerated statin therapy to reduce LDL-C levels by 50% or more (S4.3-14, S4.3-15).²

In adults older than 75 years with diabetes mellitus, it may be reasonable to initiate statin therapy after a clinician-patient discussion of potential benefits and risks (S4.3-5, S4.3-6, S4.3-13).²

In adults 20 to 39 years of age with diabetes mellitus that is either of long duration (10 years of type 2 diabetes mellitus, 30 years of type 1 diabetes mellitus), albuminuria (230 mcg of albumin/mg creatinine), estimated glomerular filtration rate (eGFR) less than 60 mL/min/1.73 m², retinopathy, neuropathy, or ABI <0.9, it may be reasonable to initiate statin therapy (S4.3-5, S4.3-6, S4.3-8, S4.3-16–S4.3-25).²

In adults with ASCVD, where LDL-C remains > 70 mg/dL while on maximally tolerated statin therapy, ezetimibe can be added and for those at very high risk a PCSK9i.

**ASCVD RISK CALCULATOR**

The assessment of ASCVD risk remains the foundation of primary prevention. The purpose of the ASCVD Risk Calculator is to estimate a patient’s 10-year ASCVD risk at the time of the initial reference point. ACC/AHA guidelines recommend the use of the PCE as an important starting point, not as the final arbiter, for decision-making in primary prevention of ASCVD.²

Adults who are 40 to 75 years of age and are being evaluated for cardiovascular disease prevention should undergo a 10-year atherosclerotic cardiovascular disease (ASCVD) risk estimation and have a clinician–patient risk discussion before starting on pharmacological therapy, such as antihypertensive therapy, a statin, or aspirin.

ACC/AHA 2018 Cholesterol Guidelines and 2017 Hypertension Guidelines recommend the use of quantitative 10-year risk assessment, based on measurement of traditional ASCVD risk factors and with use of a validated risk prediction tool, as the first step in considering treatment options for primary prevention.

**ASCVD Risk Calculator:** [KnowDiabetesbyHeart.org/RiskCalc](http://KnowDiabetesbyHeart.org/RiskCalc)

DECEMBER 2022
STANDARDS OF MEDICAL CARE IN DIABETES
Diabetes Care 1 January 2022; 45 (Supplement_1): S1–S184.

ASSIST KEY PATIENT CHARACTERISTICS
- General health
- Comorbidities, e.g., ASCVD, CKD, HF
- Clinical characteristics, i.e., age, BMI, weight
- Issues such as motivation and depression
- Cultural and socioeconomic context

ASSESS HIGH RISK

IF A1C ABOVE TARGET

MINIMIZE HYPOGLYCEMIA

IF A1C ABOVE TARGET

IF A1C REMAINS ABOVE TARGET

MINIMIZE WEIGHT GAIN/PROMOTE WEIGHT LOSS

IF A1C ABOVE TARGET

IF A1C ABOVE TARGET

ASD/C/O INDICATORS OF HIGH RISK, HF, CKD†

RECOMMEND INDEPENDENTLY OF BASELINE A1C, INDIVIDUALIZED A1C TARGET, OR METFORMIN USES

FIRST-LINE THERAPY depends on comorbidities, patient-centered treatment factors, including cost and access considerations, and management needs and generally includes metformin and comprehensive lifestyle modifications.

CHRONIC KIDNEY DISEASE SCREENING

- At least annually, urinary albumin (e.g., spot urinary albumin-to-creatinine ratio) and estimated glomerular filtration rate should be assessed in patients with type 1 diabetes with duration of ≥ 5 years and in all patients with type 2 diabetes regardless of treatment.
- Patients with diabetes and urinary albumin ≥ 300 mg/g creatinine and/or an estimated glomerular filtration rate 30–60 mL/min/1.73 m² should be monitored twice annually to guide therapy.

Please visit KnowDiabetesByHeart.org_Professional/Guidelines/ for more information.

5. Standards of Medical Care in Diabetes—2022. Diabetes Care 1 January 2022; 45 (Supplement_1): S72–S74. https://doi.org/10.2337/dc21-S009
© 2022 American Heart Association, Inc. and American Diabetes Association, 501(c)(3) not-for-profits. All rights reserved. Know Diabetes by Heart is a trademark of the AHA and ADA. Unauthorized use prohibited. Citations available upon request.