A cardio-kidney-metabolic health discussion guide

FOR PRIMARY CARE VISITS

In primary care, addressing cardio-kidney-metabolic (CKM) health involves more than identifying risk. It also requires understanding your patient's priorities, challenges and readiness to change. You can use this resource to guide the conversation and move toward a practical, individualized care plan. More detailed guidance is available in the American Heart Association/American College of Cardiology guideline on the prevention, detection, evaluation and management of CKM syndrome, developed in collaboration with other medical societies.[1]

Key patient information to document

- Biggest current day-to-day challenges
  (e.g., symptoms, logistics, adherence, cost, access, health literacy)
- What has been tried, what helped and what did not help
  (e.g., lifestyle changes, medications)
- Support system
- Adverse social determinants of health
  (e.g., economic instability, food insecurity, transportation barriers)
- Patient-stated goals for the next one to three months
  (i.e., what "better" looks like)

Assess

Clarify the patient's current clinical status and the main factors driving their CKM risk and disease burden.

Review recent clinical trends.[1,2]
Routine assessment of CKM health should be individualized and may include the following:

- Body mass index
- Waist circumference
- Blood pressure
- Fasting blood glucose/A1C
- Lipid levels
- Kidney function:
  - Estimated glomerular filtration rate (eGFR)
  - Urine albumin-to-creatinine ratio (uACR)

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Identify the patient's main CKM drivers.[1]

- ☐ Overweight/obesity
- ☐ Hypertension
- ☐ Hypertriglyceridemia
- ☐ Type 2 diabetes
- ☐ Chronic kidney disease (CKD)
- ☐ Atherosclerotic cardiovascular disease
- ☐ Heart failure

Set a focus for the visit.

- Determine where the patient falls on the CKM syndrome staging spectrum.[1]
- Explain their top one or two near-term risks in plain language *(e.g., "Your blood pressure is elevated today. If this continues, it can increase your risk of heart disease, stroke and heart failure.").*
- Identify the main focus of today's visit.

Cardio-kidney-metabolic syndrome staging[1]

Stage 0: No CKM risk factors

Stage 1: Excess and/or dysfunctional adiposity

Stage 2: Metabolic risk factors and/or moderate- to high-risk CKD

Stage 3: Subclinical cardiovascular disease (CVD) in CKM syndrome

Stage 4: Clinical CVD in CKM syndrome

Discuss

Use focused conversation prompts to explore the patient's experiences, priorities, challenges and questions. Choose those most relevant to the patient's main CKM drivers and the time available for today's visit.

Core prompts to start the conversation

Daily routine
Walk me through your typical day. When do you get up? What do you do during the day? When do you eat and who do you eat with? *(Try to keep questions as open-ended as possible.)*
How well do you sleep?
Medications
What medications do you take? Do you know what they are for and how they help you?
Are you having any challenges with your medications?
What questions do you have about your medications?
Visit goals
What are your goals for today's visit?
What questions can I answer for you today?

Additional prompts if diabetes is a main CKM driver

Diabetes history
Tell me about your diabetes diagnosis. When and how were you diagnosed? What was your reaction?
What diabetes management approaches have worked for you?
What are your current challenges?
Family context
Does diabetes run in your family?
What has your family's experience with diabetes been like? Have you had any diabetes-related conflicts?
Glucose monitoring
How often do you check your glucose?
What numbers do you typically see?
At what numbers do you feel best?
Are you having any challenges with glucose monitoring?

Additional prompts if CKD is a main CKM driver

CKD history
Tell me about your kidney disease diagnosis. When and how were you diagnosed? What was your reaction?
Have you noticed any symptoms or changes that you think may be related to your kidney disease?
Do you know your stage of kidney disease?
Family context
Has anyone in your family had kidney disease?
What has your family's experience with kidney disease been like?
CKD monitoring
How often do you get eGFR and uACR testing?
CKD management
What are you currently doing to manage your CKD? *(e.g., diet, lifestyle changes or medications)*
Are you having any challenges following your CKD treatment plan?

Clarify the patient's priorities.

- ☐ Preserving daily function and independence
- ☐ Managing symptoms and preserving quality of life
- ☐ Extending longevity
- ☐ Avoiding hospitalization
- ☐ Minimizing medications
- ☐ Managing weight
- ☐ Maintaining ability to work and/or be a caregiver
- ☐ Other: _____

Discuss acceptable trade-offs.

- Lifestyle changes
- Medication burden or side effects
- Testing/monitoring frequency
- Time, cost or access considerations

Decide

Choose one or two practical next steps based on the patient's main CKM drivers, current clinical status, priorities and readiness to change.

Lifestyle options to discuss

Use the American Heart Association's Life's Essential 8 to frame counseling about lifestyle changes that address CKM risk factors.[3,4]

Medication options to consider

Use the following table as a quick reference when considering selected medication options to fit the patient's main CKM drivers, current clinical status, risk profile and goals.

Medication	Primary action	Cardiovascular benefit	Kidney benefit	Metabolic benefit
ACE inhibitor or ARB	Lowers blood pressure	✓	✓	
SGLT2 inhibitor	Lowers glucose	✓	✓	✓
Nonsteroidal MRA	Lowers albumin in urine	✓	✓	
GLP-1 RA or GIP/ GLP-1 RA*	Lowers glucose and weight	✓	✓	✓

ACE = angiotensin-converting enzyme; ARB = angiotensin II receptor blocker; GIP = glucose-dependent insulinotropic polypeptide; GLP-1 RA = glucagon-like peptide-1 receptor agonist; MRA = mineralocorticoid receptor antagonist; SGLT2 = sodium-glucose cotransporter-2.

*American Diabetes Association guidance includes dual GIP/GLP-1 RA therapy as an option for selected adults with type 2 diabetes who have either obesity and symptomatic heart failure with preserved ejection fraction or overweight/ obesity and metabolic dysfunction–associated steatotic liver disease.

Information from references 1, 2 and 5-8.

Plan

Close the visit with a specific, realistic and shared care plan.

Agree on one or two next steps.
Lifestyle change: _____
_____
Medication change: _____
_____

Set one or two SMART* goals and a timeframe.
SMART goal(s): _____
_____
Timeframe: _____
_____

**SMART = specific, measurable, achievable, relevant and time-bound.*

Plan follow-up and monitoring.
Follow-up interval: _____
_____
Planned retesting (labs/vitals):_____
_____

Assign responsibilities.
Patient actions: _____
_____
Labs/other testing ordered:_____
_____
Referrals: _____
_____
Care team outreach:_____
_____

Concluding the visit

Before concluding the visit, answer your patient's questions and use a brief teach-back to confirm their understanding of the plan and any medication changes.

References

1. Writing Committee Members, Ndumele CE, Rodriguez F, et al. 2026 AHA/ACC/ADA/ASN guideline for the prevention, detection, evaluation, and management of cardiovascular-kidney-metabolic syndrome: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines [published online June 9, 2026]. *Circulation.* Accessed June 26, 2026. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001453

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6. American Diabetes Association Professional Practice Committee for Diabetes. 9. Pharmacologic approaches to glycemic treatment: standards of care in diabetes-2026. *Diabetes Care*. 2026;49(Supplement_1):S183-S215.

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