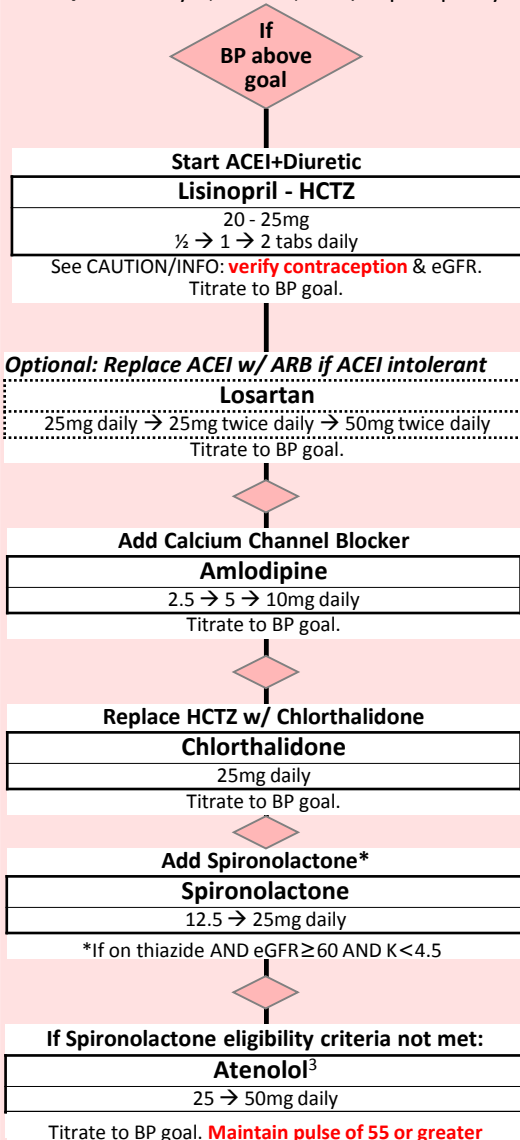


## BP Goals<sup>1</sup>

≤ 139/89: < 60 yrs and/or DM, and/or CKD<sup>2</sup>:  
≤ 149/89: ≥ 60 yrs, no DM, CKD/nephropathy



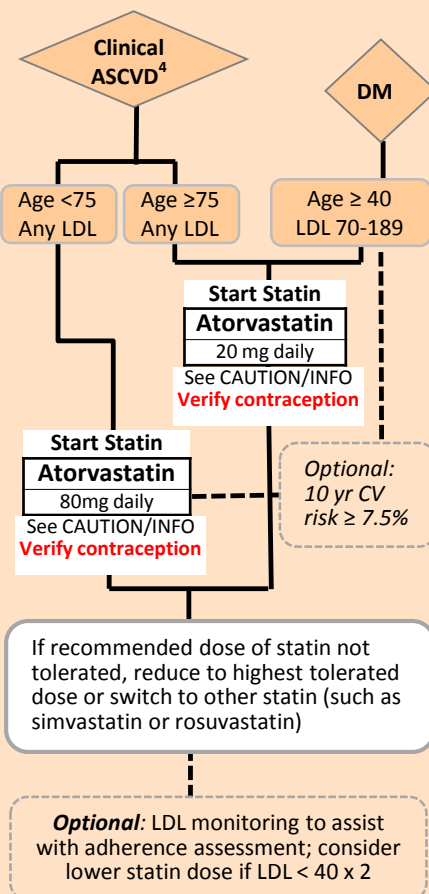
## Statin Goals

**Atorvastatin 40-80 mg:**

- Clinical ASCVD<sup>4</sup> Age < 75 + any LDL

**Atorvastatin 10-20 mg:**

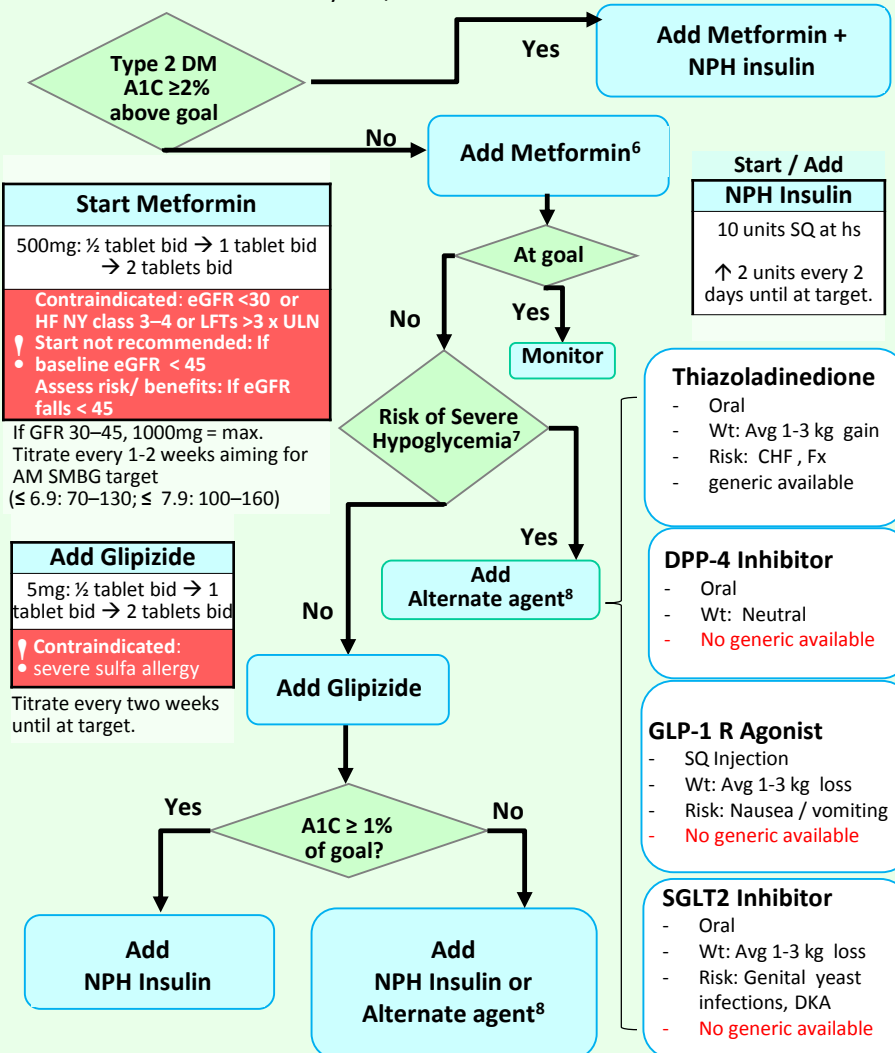
- Clinical ASCVD Age ≥ 75 + any LDL
- DM: Age ≥ 40 + LDL 70-189



<sup>4</sup> Clinical Atherosclerotic Cardiovascular Disease (ASCVD), defined as: CAD, TIA/CVA, Symptomatic PAD.

Adapted from Kaiser Permanente Northern California Clinical Practice Guidelines for Coronary Artery Disease, Diabetes, Cholesterol, and Hypertension.

**A1c Goals** ≤ 7.9%: ≥ 65 yrs or clinical factors<sup>5</sup>  
≤ 6.9%: < 65 yrs w/o clinical factors



<sup>5</sup> Individualize A1c goal based on risk of hypoglycemia, duration of DM, life expectancy, co-morbidities, vascular complications, member resources and support system.

<sup>6</sup> If intolerant to immediate release metformin, **strongly** consider sustained release metformin.

<sup>7</sup> **Severe Hypoglycemia** = Hypoglycemia resulting or likely to result in seizures, loss of consciousness, or needing help from others. **Mild to moderate hypoglycemia** = recognized signs and symptoms of neuro-glycopenia such as hunger or sweating that the patient can effectively self-treat.

<sup>8</sup> A1c above goal after 3 months despite non-insulin agents, **strongly** consider discontinuing ineffective medications and initiating insulin + metformin.

**Disclaimer:** This treatment algorithm is informational only. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners, considering each patient's needs on an individual basis. Treatment algorithm recommendations apply to populations of patients. Clinical judgment is necessary to design treatment plans for individual patients.

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<sup>1</sup> BP algorithm applies if eGFR ≥ 30 and if LVEF ≥ 40%.

<sup>2</sup> CKD: Microalbuminuria or [(age/2) + eGFR] < 85

<sup>3</sup> Beta Blockers, independent of their mild anti-hypertensive effect, are sometimes indicated for secondary cardio-protection