



American Heart Association

Target: Type 2 DiabetesSM

Target: Type 2 Diabetes Pillar Resources & Examples

A Toolkit for Understanding & Attesting to All Pillar Questions

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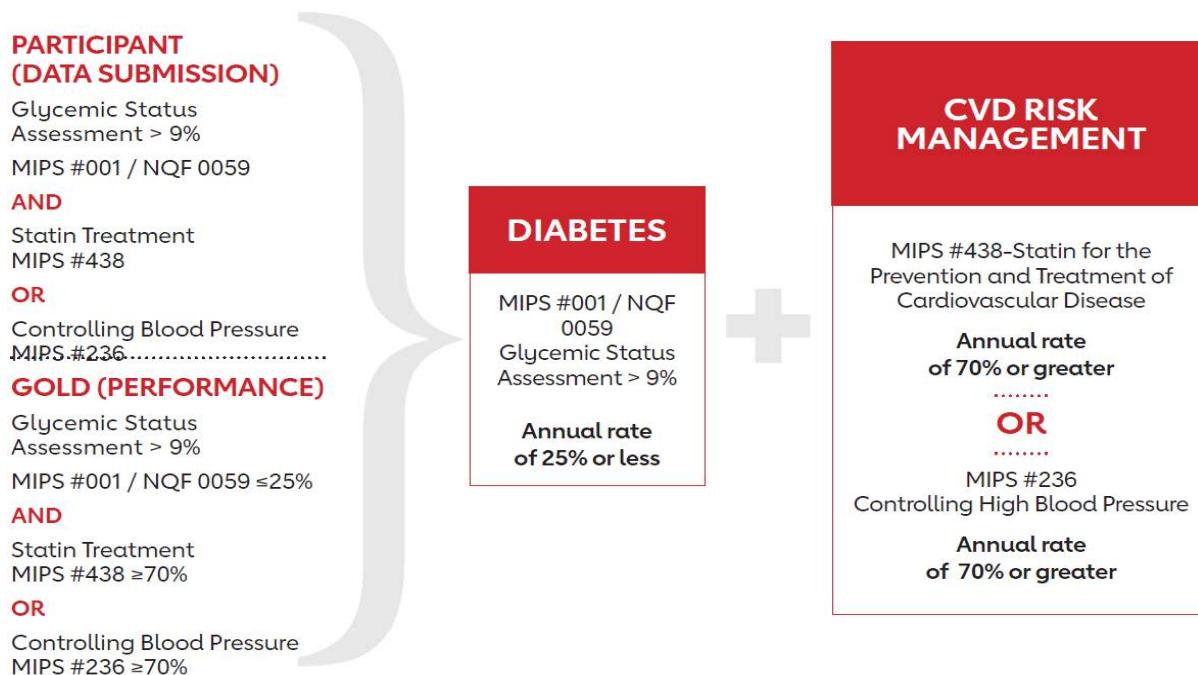
Background

In 2020, the American Heart Association (AHA), in collaboration with Know Diabetes by Heart™, launched Target: Type 2 Diabetes—a quality improvement and recognition program designed for outpatient organizations committed to reducing cardiovascular disease (CVD) risk in patients with type 2 diabetes.

As part of the program, participating organizations are invited to submit annual aggregate data for MIPS #001: Diabetes: Glycemic Status Assessment Greater Than 9%. In addition, they must report on at least one CVD risk management measure by selecting either MIPS #438: Statin Therapy for the Prevention and Treatment of CVD or MIPS #236: Controlling High Blood Pressure.

To recognize organizations for their dedication and achievements, the program requires both the submission of yearly data and the completion of a self-attestation section. These attestations include clinical practice questions aimed at identifying current practices, barriers to evidence-based care, and opportunities to align with the latest standards of care.

To qualify for recognition, organizations must demonstrate a commitment to continuously improving strategies for managing CVD risk in patients with type 2 diabetes, supported by their performance on the submitted measures.



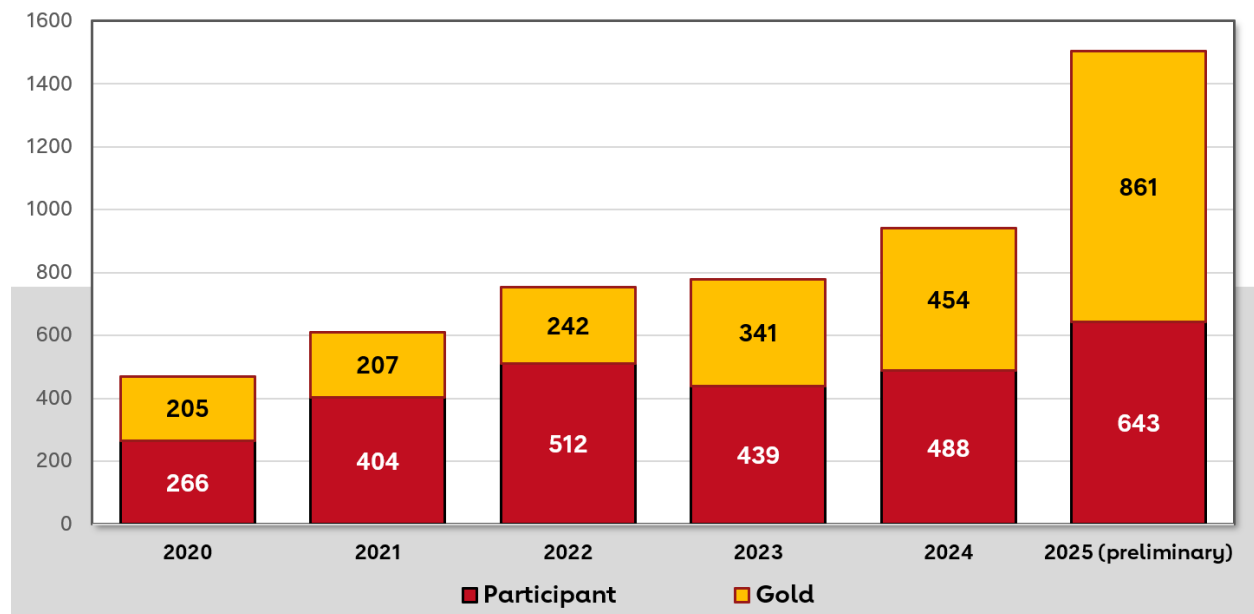
13. My organization is committed to continuously improving strategies for addressing CVD risk in patients with type 2 diabetes.

Yes No

A yes response is required for award eligibility.

Rationale for Evolving Programmatic Structure

Since its launch in 2020, the Target: Type 2 Diabetes program has experienced consistent growth, with a notable surge in participation and preliminary award achievement in early 2025. This upward trend reflects not only increased engagement but also measurable improvements in clinical practices and outcomes, particularly in glycemic control. This indicates the program can be an effective strategy for driving quality improvement in outpatient care.



A significant number of participating organizations are also engaged in multiple outpatient award achievement programs, with Target: BP™ being the most common. This overlap highlights the value of aligning program structures to streamline participation and maximize impact.

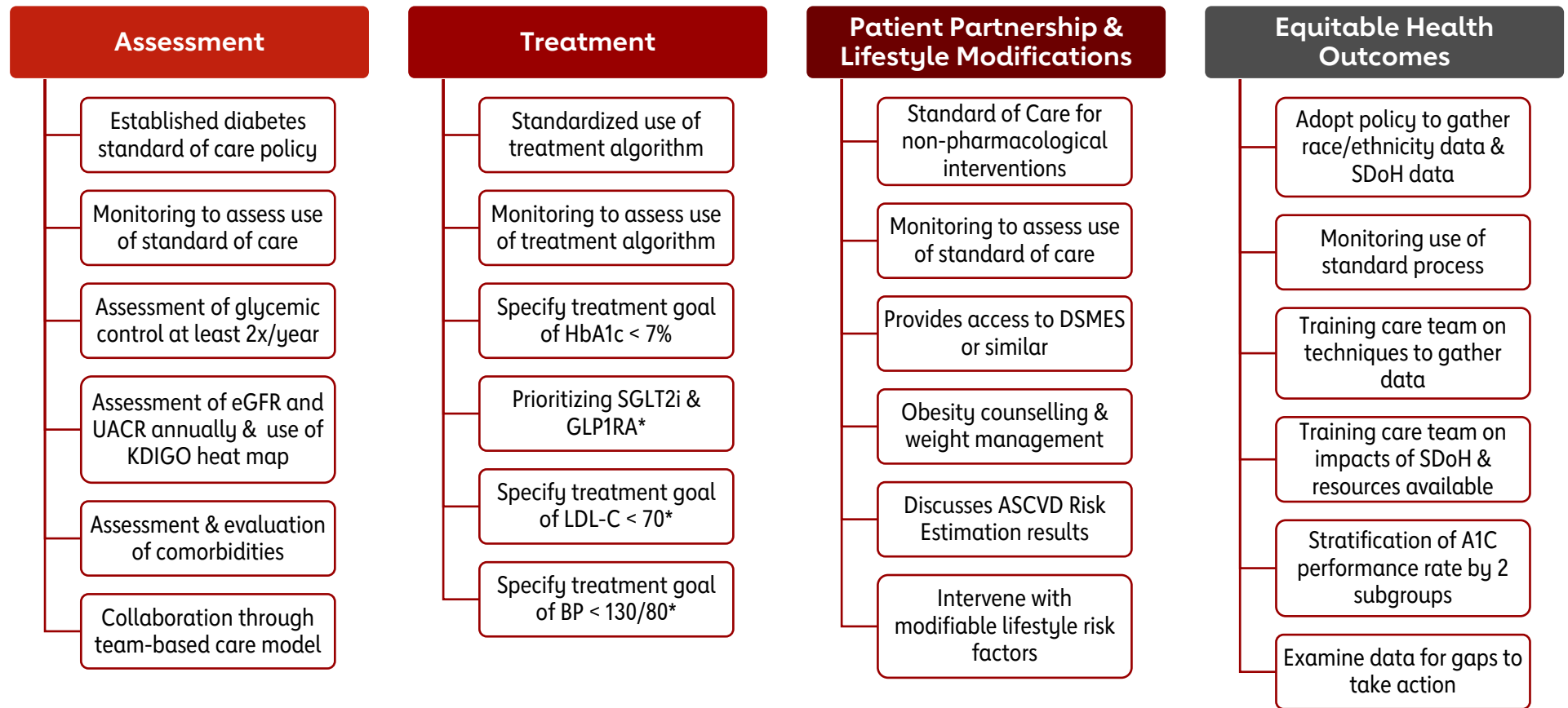
In response, the AHA is evolving the program's structure by expanding attestation criteria and introducing a new "pillar" framework. This format enables organizations to align their quality improvement strategies with evidence-based activities outlined in Target: Type 2 Diabetes, while also supporting a more structured and scalable approach to recognition. The updated framework includes the opportunity for additional award levels, designed to foster continued growth and appropriately recognize organizations for their commitment to improving care.

The proposed enhancements were developed by AHA's Outpatient Quality Programs team in collaboration with a volunteer workgroup of subject matter experts, three internal workgroups, and two external focus groups. Final approval was granted by the commissioned Outpatient Quality Improvement Advisory Committee.

This document outlines the updated structure, expanded content, rationale for each component, and practical examples to help organizations assess whether their current practices align with the updated recommendations.

Overview of the Evidence-Based Activities Pillars

Note: This outline is intended to display a condensed version of the evidence-based activities in a succinct format. The full questions should be utilized whenever possible and/or made available when displaying this abbreviated version to provide complete context for the content.



**When clinically indicated*

Frequently Asked Questions

What counts as a “standard of care”?

Standard of care is inclusive of any policy, protocol, or formally adopted process that is routinely and systematically used across the entire organization as part of standard practice.

How do organizations determine what is “clinically indicated”?

The term “when clinically indicated” leaves room for physicians and other health care professionals to liberalize or change goals and treatment plans when clinical factors and evidence/ guidelines indicate.

How will my attestations affect my award status?

For the 2026 award year the attestation questions will not affect award status. However, answering the questions is required to receive an award.

The pillars recommend using a standard of care or having a policy to address the items outlined. Can one policy or standard of care be used to cover all the pillars or is a separate standard of care/ policy required for each pillar?

The questions on standard of care and policies can be achieved through one organizational document or the elements can be included in separate documents as long as all the elements are present.

My organization is prioritizing addressing cardiovascular disease risk in all patients, not just those with diabetes. How can we get involved with other outpatient quality improvement programs?

The American Heart Association’s Outpace CVD™ suite offers technology solutions and quality improvement support for health care organizations participating in our programs and partnered initiatives as they target cardiovascular disease.

Our goal is to connect guideline adoption, evidence-based programming and systematic approaches to addressing and reducing chronic cardiovascular diseases treated in the outpatient space.

Learn more at www.heart.org/OutpaceCVD.

Assessment Pillar ("A" Pillar)

"A" Questions

I attest that my organization uses a medical standard of care focused on diabetes management and CVD risk that includes (at a minimum):

- An established diabetes standards of care policy¹ that is documented and available across the continuum of care
- Monitoring² to assess the use of the standard of care in practice
- Assessment of glycemic control as measured by HbA1c at least 2 times/year or every 3 months for patients not at goal
- Assessment of eGFR annually, assessment of uACR annually and use of the KDIGO heat map for kidney health classification based on the results of both eGFR and uACR measurements
- Assessment and evaluation of comorbidities (inclusive of Chronic Kidney Disease, Hypertension, Dyslipidemia, Atherosclerotic Cardiovascular Disease and Obesity) into the standard of care
- Collaboration through a team-based care model³ that provides comprehensive continuity of care for patients with diabetes

NOTE: For each evidence-based pillar, HCOs must attest "Yes/No/Unsure" to each.

¹ "Standard of care" is inclusive of any policy, protocol, or formally adopted process that is routinely and systematically used across the entire organization as part of standard practice.



² "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review, peer review, sampling, or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.

³ "Team-based care model" is inclusive but not limited to internal or external collaboration for the purposes of promoting continuity of care such as partnership with community pharmacies, diabetes educators, specialist referrals, community health workers, etc.

"A" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"A" Attestation Criteria	 Example(s) that meets the intent of the criteria	 Example(s) that does not meet the intent of the criteria
An established diabetes standards of care policy that is documented and available across the continuum of care	<p>✓ The administrative and/or clinical leadership that oversees the entity for which the data is submitted has approved and endorsed the use of a specific standard of care for the treatment of diabetes (i.e., protocol, algorithm, order set).</p> <p style="text-align: center;">- AND -</p> <p>This standard is made systematically available through electronic or paper distribution channels to all clinicians who treat patients with diabetes.</p>	<p>✗ The standard of care has not been approved through the process in which other clinical standards are defined and implemented in your HCO.</p> <p style="text-align: center;">- OR -</p> <p>✗ The standard is not implemented in all locations where clinicians are diagnosing and treating patients with diabetes in the entity for which the data are submitted (i.e., a few primary care sites, but not all).</p>
Monitoring to assess the use of the standard of care in practice	<p>✓ Using electronic health record or population health tools to examine if the standard is being followed using 1 or more of the other attestation criteria in this pillar (i.e. assessment of glycemic control at least 2 times per year, assessment of eGFR and uACR annually, assessment and evaluation of comorbidities, etc.).</p> <p style="text-align: center;">- OR -</p> <p>✓ Performing manual chart review or conducting a peer review process on a sample of records that includes all clinicians who treat patients with diabetes for the entity submitting data and</p>	<p>✗ Implementing a standard of care but not examining if the standard is being followed.</p> <p style="text-align: center;">- OR -</p> <p>✗ Monitoring adherence to a standard of care without the intent to improve performance.</p> <p style="text-align: center;">- OR -</p> <p>✗ Sampling charts of only some of the clinicians who care for patients with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ Having no way to measure if the standard of care is being performed.</p>

	<p>examining 1 or more of the attestation criteria in this pillar.</p> <p>NOTE: This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.</p>	
<p>Assessment of glycemic control as measured by HbA1c at least 2 times/year or every 3 months for patients not at goal</p>	<p>✓ Patients with diabetes follow up with their care provider at least 2 times per year and complete HbA1c testing.</p> <p style="text-align: center;">- AND -</p> <p>✓ Patients with diabetes who are not meeting their HbA1c goal have follow up care every three months and complete HbA1c testing.</p> <p style="text-align: center;">- AND -</p> <p>✓ The results of HbA1c testing are entered into the electronic health record.</p>	<p>✗ The HCO does not collect HbA1c measurements.</p> <p style="text-align: center;">- OR -</p> <p>✗ The HCO utilizes the Glucose Management Index (GMI) exclusively for glycemic control evaluation.</p> <p style="text-align: center;">- OR -</p> <p>✗ Patients with diabetes have an HbA1c evaluation less than 2 times per year.</p> <p style="text-align: center;">- OR -</p> <p>✗ Patients with diabetes that are not meeting their HbA1c goal have follow up care less than four times a year with complete HbA1c testing.</p>
<p>Assessment of eGFR annually, assessment of uACR annually and use of the KDIGO heat map for kidney health classification based on the results of both eGFR and uACR measurements</p>	<p>✓ All clinicians in the HCO order laboratory testing of eGFR annually for patients with diabetes.</p> <p style="text-align: center;">- AND -</p> <p>✓ All clinicians in the HCO order laboratory testing of uACR annually for patients with diabetes.</p> <p style="text-align: center;">- AND -</p> <p>✓ Clinicians use the results of uACR and eGFR to classify the patient’s kidney health per metrics outlined in the KDIGO heat map.</p> <p style="text-align: center;">- OR -</p>	<p>✗ Clinicians routinely assess eGFR annually for patients with diabetes but do not routinely assess uACR or vice versa.</p> <p style="text-align: center;">- OR -</p> <p>✗ Clinicians in the data submitting organization do not routinely assess kidney health or assess these metrics less than annually.</p> <p style="text-align: center;">- OR -</p> <p>✗ Kidney health is assessed by some metric other than uACR or eGFR.</p> <p style="text-align: center;">- OR -</p>

	<p>✓ For patients co-managed by other health care professionals who may have lab testing ordered outside of the data submitting organization, records are obtained and evaluated up to, and including, all three components listed above.</p>	<p>✗ Clinicians do not utilize the KDIGO heat map for kidney health classification.</p>
<p>Assessment and evaluation of comorbidities (inclusive of Chronic Kidney Disease, Hypertension, Dyslipidemia, Atherosclerotic Cardiovascular Disease and Obesity) into the standard of care</p>	<p>✓ Clinicians routinely assess all listed comorbidities for all patients diagnosed with diabetes through a combination of anthropometric measurements, laboratory tests, and other metrics as clinically indicated and within recommended timeframes (all comorbid conditions should be assessed at the time of diagnosis of diabetes, annually thereafter for CKD and ASCVD, and at all follow up visits for obesity and hypertension.)</p>	<p>✗ The data submitting organization does not assess comorbidities.</p> <p style="text-align: center;">- OR -</p> <p>✗ Clinicians routinely assess one or more of the listed comorbidities but not all.</p> <p style="text-align: center;">- OR -</p> <p>✗ Clinicians routinely assess one or more of the listed comorbidities but at a cadence outside of evidence-based timeframe recommendations.</p>
<p>Collaboration through a team-based care model that provides comprehensive continuity of care for patients with diabetes</p>	<p>✓ Clinicians collaborate with others health care professionals such as endocrinologists, nephrologists, dietitians, pharmacists, diabetes educators, or others to ensure care is coordinated across the continuum of care.</p> <p style="text-align: center;">- OR -</p> <p>✓ Clinicians ensure review of patient health records from other health care professionals to stay informed about the full picture of the patient’s care.</p>	<p>✗ Clinicians do not collaborate or communicate with others involved in the care of patients with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ The HCO does not have access to other health care professionals through in-house or outside referrals and cannot provide access to comprehensive care.</p>

“A” Frequently Asked Questions

What if my patient has an HbA1c ordered by another health care professional or organization?

If a patient has completed an HbA1c at another organization and is not yet eligible for additional testing, the data submitting organization should obtain the patient records and document the value in their EMR for accurate tracking.

Do the patients HbA1c measurements need to all occur in the same calendar year?

The standard for HbA1c measurement should be determined based on the following schedule: every 6 months for all patients with diabetes and every 3 months for patients with diabetes with a HbA1c not at goal.

My organization provides HbA1c testing for evaluation purposes but only provides referrals for treatment. Can my organization still submit data to achieve an award?

No, only organizations who treat diabetes, including prescription of medications, are eligible for award achievement.

MIPS #001 now allows for HbA1c measurements and glucose management index (GMI) to meet the measure criteria. Does my organization need to provide HbA1c testing to meet the glycemic management attestation criteria?

Yes, although submitting organizations may utilize GMI metrics for the purpose of HbA1c poor control measure submission, they will still need to provide regular HbA1c testing for patients with diabetes at a cadence that is indicated (either 2 or 4 times per year).

“A” Rationale & Guideline Recommendations

American Diabetes Association Standards of Care in Diabetes- 2025

LOE	Recommendation
E	Assess glycemic status at least two times a year, and more frequently (e.g., every 3 months) for individuals not meeting glycemic goals or with recent treatment changes, frequent or severe hypoglycemia or hyperglycemia, or changes in health status, or during periods of rapid growth and development in youth.
B	Assess kidney function (i.e., spot urine albumin-to-creatinine ratio [UACR]) and estimated glomerular filtration rate [eGFR] in all people with type 2 diabetes regardless of treatment.
C	People with diabetes can benefit from a coordinated interprofessional team that may include but is not limited to diabetes care and education specialists, primary care and subspecialty clinicians, nurses, registered dietitian nutritionists, exercise specialists, pharmacists, dentists, podiatrists, and behavioral health professionals.

"A" Resources

- [Kidney Health in Type 2 Diabetes](#)
- [Webinar: Team-Based Care Strategies to Improve Patient Outcomes](#)
- [Ready, Set, Go Standardizing Type 2 Diabetes Management for the Reduction of Cardiovascular Disease: Implementation Guide](#)
- [KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease](#)
 - See [table 4.1](#) for components of comprehensive medical evaluation at initial, follow-up, and annual visits.
- [Figure 11.1 Risk of CKD progression... | American Diabetes Association](#)

Treatment Pillar ("T" Pillar)

"T" Questions

I attest that my organization uses a guideline-directed standard of care¹ to treat patients with diabetes that includes:

- Standardized use¹ of a treatment algorithm or protocol
- Monitoring² to assess the use of the treatment algorithm or protocol
- Setting a treatment goal of HbA1c <7%³ when clinically indicated
- Prioritizing SGLT2i and GLP1RA's in the treatment algorithm or protocol when clinically indicated
- Setting a cholesterol treatment goal of LDL-C <70 mg/dL for patients with ASCVD risk factors
- Setting a blood pressure treatment goal of <130/80 mmHg for patients with hypertension⁴

NOTE: For each evidence-based activity, HCOs must attest "Yes/No/Unsure" to each.

¹ "Standardized use" refers to any protocol that is documented or organizationally accepted and is systematically available.

² "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review, peer review, sampling, or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.



³ Less stringent glycemic goals may be appropriate for individuals with limited life expectancy or where the harms of treatment are greater than the benefits.

⁴ For all adults with additional considerations for those who are pregnant, require institutional/hospital care, or have limited life expectancy.

"T" Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

"T" Attestation Criteria	 Example(s) that meets the intent of the criteria	 Example(s) that does not meet the intent of the criteria
Standardized use of a treatment algorithm or protocol	<p>✓ The administrative and/or clinical leadership that oversees the entity for which the data is submitted has approved and endorsed the use of an evidence-based treatment algorithm or protocol for the pharmacologic treatment of diabetes.</p> <p style="text-align: center;">- AND -</p> <p>This standard is made systematically available through electronic or paper distribution channels to all clinicians who diagnose and treat patients with diabetes.</p>	<p>✗ The treatment algorithm or protocol has not been approved through the process in which other clinical standards are defined and implemented in your HCO.</p> <p style="text-align: center;">- OR -</p> <p>✗ The treatment algorithm or protocol is not implemented in all locations where clinicians are diagnosing and treating patients with diabetes in the entity for which the data are submitted (i.e., a few primary care sites, but not all).</p>
Monitoring to assess the use of the treatment algorithm or protocol	<p>✓ Using electronic health record or population health tools to examine if the treatment algorithm is being followed when clinically indicated using 1 or more of the other attestation criteria in this pillar (i.e. setting a treatment goal of <7% when clinically indicated, prioritizing SGLT2i or GLP1-RA in the treatment algorithm, setting a cholesterol treatment goal of LDL <70 mg/dL, or setting a blood pressure treatment goal of <130/80 mmHg).</p> <p style="text-align: center;">- OR -</p> <p>✓ Performing manual chart review or conducting a peer review</p>	<p>✗ Implementing a treatment algorithm but not examining if it is being followed.</p> <p style="text-align: center;">- OR -</p> <p>✗ Monitoring adherence to the treatment algorithm without the intent to improve performance.</p> <p style="text-align: center;">- OR -</p> <p>✗ Sampling charts of only some of the clinicians who care for patients with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ Having no way to measure if the treatment algorithm is being</p>

	<p>process on a sample of records that includes all clinicians who treat patients with diabetes for the entity submitting data and examining 1 or more of the attestation criteria in this pillar.</p> <p>NOTE: This does NOT require a specific level of adherence to the standard. The intent is that HCOs are examining adherence to the treatment algorithm with the goal of minimizing variation in practice.</p>	<p>followed when clinically indicated.</p>
<p>Setting a treatment goal of HbA1c <7% when clinically indicated</p>	<p>✓ An HbA1c goal of <7% is set for most patients.</p> <p style="text-align: center;">- AND -</p> <p>✓ If a more liberalized HbA1c goal is used, current guidelines are utilized to inform that decision.</p> <p style="text-align: center;">- AND -</p> <p>✓ Clinicians discuss HbA1c goals with patients and discuss treatment options available to obtain this goal.</p> <p style="text-align: center;">- AND -</p> <p>✓ Clinicians tailor treatment options (pharmacologic and non-pharmacologic) in order to make progress toward achieving the HbA1c goal.</p>	<p>✗ Clinicians do not discuss HbA1c treatment goals with patients diagnosed with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ Clinicians do not utilize standardized HbA1c treatment goals or target their treatment plans for the purpose of achieving these goals.</p>
<p>Prioritizing SGLT2i and GLP1RA's in the treatment algorithm or protocol when clinically indicated</p>	<p>✓ Across the organizations clinicians utilize a standardize pharmacologic treatment algorithm or protocol that prioritizes prescription of SGLT2i and GLP1RA's as indicated to reduce the risk of CVD and CKD and assist in weight management.</p>	<p>✗ SGLT2i and GLP1RA's are not included in the pharmacologic treatment protocol used by clinicians in the organization.</p> <p style="text-align: center;">- OR -</p> <p>✗ Clinicians in the data submitting organizations do not prescribe SGLT2i or GLP1RA's as a part of their standard practice.</p>
<p>Setting a cholesterol treatment goal of LDL-C <70 mg/dL for patients with ASCVD risk factors</p>	<p>✓ Clinicians set a goal of LDL-C <70 mg/dL for all patients with diabetes and ASCVD risk factors.</p>	<p>✗ Clinicians do not set a cholesterol treatment goal for</p>

	<p align="center">- AND -</p> <p>✓ Clinicians regularly monitor LCL-C levels for these patients through laboratory testing to assess progress to the goal.</p>	<p>patients with diabetes and ASCVD risk factors.</p> <p align="center">- OR -</p> <p>✗ Clinicians do not routinely order laboratory testing to evaluate LCL-C levels for patients with diabetes.</p>
<p>Setting a blood pressure treatment goal of <130/80 mmHg for patients with hypertension</p>	<p>✓ Stating thresholds for the diagnosis and treatment of hypertension that align with the 2025 AHA/ACC High Blood Pressure Guideline.</p> <p>NOTE: This patient treatment goal (<130/80 mmHg) is NOT the same threshold that is used in the current performance measure (CMS 236 / NQF 18) for reporting population control rates (<140/90mmHG).</p>	<p>✗ The clinicians in my organization utilize a blood pressure treatment goal of 140/90 mmHg.</p>

“T” Frequently Asked Questions

The prescribers in my organization would like to prescribe SGLT2i and GLP-1 RA’s per the guidelines but often encounter barriers such as cost. Does this disqualify me from attesting yes to this question?

No, this question asks about prioritization of these medications in the treatment algorithm that is being used by health care professionals organization wide.

Inability to prescribe these medications per the treatment algorithm due to cost or other factors does not disqualify an organization from attesting yes.

Why is the HbA1c treatment goal set at <7% but the MIPS measure sets poor control at >9%?

The MIPS measure sets a HbA1c level of >9% to denote poor diabetes control as a way to evaluate quality and facilitate quality improvement. To achieve an award in Target: Type 2 Diabetes, organizations must achieve a level of 25% or less for this measure.

However, per the American Diabetes Association’s Standards of Care in Diabetes 2025, <7% is an appropriate treatment goal for most patients with diabetes. Clinicians are encouraged to discuss this goal with patients.

My organization is opposed to broadly utilizing treatment algorithms. How should I attest for this question?

If your organization is opposed to broadly utilizing a standard treatment algorithm for prescription of medications for people with diabetes, you should attest “no” to this question. Standardizing approaches to care management for people with diabetes facilitates quality improvement and can improve patient outcomes across the organization.

Why is the blood pressure treatment goal set at <130/80 mmHg and not <140/90 mmHg?

The 2025 AHA/ ACC high blood pressure guideline recommends a blood pressure treatment goal of <130/80 mmHg.

Are there treatment algorithms that currently exist that my organization can easily adopt into our standard of care?

Yes, the most commonly used guideline for pharmacologic management of diabetes can be found [here](#) in the American Diabetes Association’s Standard of Care in Diabetes 2025.

NOTE: the Standards of Care in Diabetes is updated annually and organizations should align their treatment algorithms in accordance with the newest Standard of Care.

“T” Rationale & Guideline Recommendations

American Diabetes Association Standards of Care in Diabetes- 2025

LOE	Recommendation
A	An A1C goal of <7% (<53 mmol/mol) is appropriate for many nonpregnant adults without severe hypoglycemia or frequent hypoglycemia affecting health or quality of life.
A	In adults with type 2 diabetes and established or high risk of atherosclerotic cardiovascular disease, the treatment plan should include medications with demonstrated benefits to reduce cardiovascular events (e.g., glucagon-like peptide 1 receptor agonist [GLP-1 RA] and/or sodium–glucose cotransporter 2 [SGLT2] inhibitor) for glycemic management and comprehensive cardiovascular risk reduction (irrespective of A1C).
A	In adults with type 2 diabetes who have CKD (with confirmed estimated glomerular filtration rate [eGFR] 20–60 mL/min/1.73 m ² and/or albuminuria), an SGLT2 inhibitor or GLP-1 RA with demonstrated benefit in this population should be used for both glycemic management (irrespective of A1C) and for slowing progression of CKD and reduction in cardiovascular events. The glycemic benefits of SGLT2 inhibitors are reduced at eGFR <45 mL/min/1.73 m ² . While the glucose-lowering effects of SGLT2 inhibitors are blunted with eGFR <45 mL/min/1.73 m ² , the renal and cardiovascular benefits were still seen at eGFR levels as low as 20 mL/min/1.73 m ² .
A	For people with diabetes aged 40–75 years at higher cardiovascular risk, including those with one or more additional ASCVD risk factors, high-intensity statin therapy is recommended to reduce LDL cholesterol by ≥50% of baseline and to obtain an LDL cholesterol goal of <70 mg/dL (<1.8 mmol/L).
A	The on-treatment blood pressure goal is <130/80 mmHg, if it can be safely attained.

“T” Resources

- [Figure 9.3 Use of glucose-lowering... | American Diabetes Association](#)
- [Ready, Set, Go: Standardizing Type 2 Diabetes Management for the Reduction of Cardiovascular Disease Implementation Guide](#)
- [2025 AHA/ACC Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guideline](#)

Patient Partnership & Lifestyle Modification Pillar ("P" Pillar)

"P" Questions

I attest that my organization provides risk-factor assessment and non-pharmacological interventions for patients with diabetes to support positive lifestyle changes that include:

- A standard of care¹ for the assessment of risk-factors and use of non-pharmacological interventions
- Monitoring² to assess the use of the standard of care in practice
- Provides access to Diabetes Self-Management Education and Support (DSMES) or equivalent services³
- Provides access to obesity counselling and weight management
- A discussion of ASCVD Risk Estimation results derived from CVD risk assessment models including but not limited to the Pooled Cohort Equation (PCE) or Predicting Risk of cardiovascular disease EVENTS (PREVENT)
- Engaging patients in interventions to address tobacco/vaping cessation, alcohol moderation/cessation, and depression as indicated by validated screening tools

NOTE: For each evidence-based pillar, HCOs must attest "Yes/No/Unsure" to each.

¹ "Standard of care" is inclusive of any policy, protocol, or formally adopted process that is routinely and systematically used across the entire organization as part of standard practice.



² "Monitored/Monitoring" can be achieved through means such as but not limited to manual chart review, peer review, sampling, or analysis of EMR or population health data, at least annually to assess if the policy/protocol is being followed. This requirement does not specify a level of adherence to the policy/protocol.

³ Minimum requirements of DSMES or equivalent services include delivery of content addressing: 1. Pathophysiology of diabetes and treatment options, 2. Healthy coping, 3. Healthy eating, 4. Being active, 5. Taking medication, 6. Monitoring of blood sugars, 7. Reducing risk (treating acute and chronic complications), 8. Problem solving & behavior change strategies

“P” Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

“P” Attestation Criteria	 Example(s) that meets the intent of the criteria	 Example(s) that does not meet the intent of the criteria
A standard of care for the assessment of risk-factors and use of non-pharmacological interventions	<p>✓ A standard of care that defines assessment protocols for modifiable lifestyle risk factors for every patient with diabetes at least annually.</p> <p style="text-align: center;">- AND -</p> <p>✓ A standardized assessment tool (i.e., a history form, structured electronic health record fields, or validated questionnaire) to assess modifiable risk factors.</p> <p style="text-align: center;">- AND -</p> <p>✓ A standard to intervene in response to the identified risk factors (i.e., motivational interviewing techniques, patient education materials, referrals for DSMES, nutrition counseling, physical activity, or substance use counseling).</p>	<p>✗ No defined standard of care to systematically assess risk-factors and use of nonpharmacologic interventions.</p> <p style="text-align: center;">- OR -</p> <p>✗ No structured approach to gather assessment data.</p> <p style="text-align: center;">- OR -</p> <p>✗ No defined standard of care for intervening based on assessment results.</p>
Monitoring to assess the use of the standard of care in practice	<p>✓ Using electronic health record or population health tools to examine if the standard of care is being followed such as documentation of risk factor assessments and documentation of interventions when risk factors are identified.</p> <p style="text-align: center;">- OR -</p> <p>✓ Performing manual chart review or conducting a peer review process on a sample of records</p>	<p>✗ Implementing a standard of care but not examining if the standard is being followed.</p> <p style="text-align: center;">- OR -</p> <p>✗ Monitoring adherence to a standard of care without the intent to improve performance.</p> <p style="text-align: center;">- OR -</p> <p>✗ Sampling charts of only some of the care team members who are responsible for risk factor</p>

	<p>that includes all care team members who are responsible for risk factor assessments and non-pharmacologic interventions.</p> <p>NOTE: This does NOT require a specific level of adherence to the standard of care. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.</p>	<p>assessment and non-pharmacologic intervention.</p> <p align="center">- OR -</p> <p>✗ Having no way to measure if the standard of care is being performed.</p>
<p>Provides access to Diabetes Self-Management Education and Support (DSMES) or equivalent services</p>	<p>✓ All patients with diabetes are offered DSMES or equivalent services at the following times: diagnosis, annually, when new complicating factors arise, and at transitions of care.</p> <p align="center">- AND -</p> <p>✓ DSMES services address all of the following: pathophysiology of diabetes and treatment options, healthy coping, healthy eating, being active, taking medication, monitoring of blood sugars, reducing risk (treating acute and chronic complications), and problem solving & behavior change strategies.</p>	<p>✗ The HCO does not provide access to DSMES or equivalent services.</p> <p align="center">- OR -</p> <p>✗ The HCO provides services to educate patients with diabetes about healthy eating but does not provide services addressing the other required components of DSMES.</p>
<p>Provides access to obesity counselling and weight management</p>	<p>✓ Clinicians assess weight status in all patients with diabetes.</p> <p align="center">- AND -</p> <p>✓ Discussions about weight are initiated in individuals with obesity and diabetes.</p> <p align="center">- AND -</p> <p>✓ For patients who are interested in treatment for obesity, clinicians facilitate access to guideline directed options.</p>	<p>✗ The HCO does not have a standard process to address and treat obesity in patients with diabetes.</p>
<p>A discussion of ASCVD Risk Estimation results</p>	<p>✓ ASCVD risk estimation is completed for all patients with</p>	<p>✗ ASCVD risk estimation is completed but the results are not</p>

<p>derived from CVD risk assessment models including but not limited to the Pooled Cohort Equation (PCE) or Predicting Risk of cardiovascular disease EVENTS (PREVENT)</p>	<p>diabetes using a validated equation of the clinicians choosing.</p> <p style="text-align: center;">- AND -</p> <p>✓ The results of the risk estimation are discussed with the patient and used to engage the patient in treatment decisions and prevention efforts.</p>	<p>discussed with the patient and are not utilized to inform treatment decisions.</p> <p style="text-align: center;">- OR -</p> <p>✗ ASCVD risk estimation equations are not used at all or are sometimes used but not by all clinicians or are not used for all patients with diabetes.</p>
<p>Engaging patients in interventions to address tobacco/vaping cessation, alcohol moderation/cessation, and depression as indicated by validated screening tools</p>	<p>✓ Validated screening tools are used to assess tobacco and vaping use, alcohol use, and depression for all patients with diabetes at an established cadence.</p> <p style="text-align: center;">- AND -</p> <p>✓ Clinicians engage patients in discussions when indicated by screening results.</p>	<p>✗ Screening tools to assess alcohol use, vaping and tobacco use, and depression are not used at all or are not provided to every patient with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ Depression screenings are conducted for every patient with diabetes, but alcohol and tobacco screenings are not given to every patient with diabetes.</p> <p style="text-align: center;">- OR -</p> <p>✗ Screenings are completed but the HCO does not have a standard process to provide interventions to address the results when indicated.</p>

“P” Frequently Asked Questions

My organization does not provide DSMES or obesity counseling services at our facility, but we do refer patients to outside organizations for these services. How should my organization attest to these questions?

This question allows for in-house referrals as well as referrals to other organizations to provide these services.

Why are conversations around ASCVD Risk Estimation prioritized for patients with diabetes?

The PREVENT calculation and publication that was released in 2023 encourages clinicians to utilize the tool as a discussion point with the patient to ensure they understand their future risk of a cardiac event.

Healthy eating is extremely important to managing diabetes. Why is weight management prioritized in the attestation questions over healthy eating in general?

Healthy eating is a core component of DSMES for all patients with diabetes regardless of weight or BMI. This component of diabetes care is addressed in the question about DSMES.

When providing access to DSMES and/or obesity counseling via a referral, do the referrals need to be trackable within the EMR to count?

No, the data submitting organization can independently decide on their referral and tracking processes for these services.

My organization offers obesity counseling to all eligible individuals, but some patients decline this service. Would all patients need to complete obesity counseling in order for my organization to attest yes to this question?

No, if the data submitting organization is offering these services to all individuals who qualify that would count for this question.

In my organization physicians calculate ASCVD Risk Estimation scores but another health care professional such as the nurse or clinical pharmacist engages the patient in discussion about the results. Does this count?

Yes, team-based care can be deployed to meet this criteria as long as the care team is routinely following the standard process for all patients.

Our organization is in a rural area and patients have limited access to programs like DSMES, however we work with an organization that provides these services via telehealth. Does this count?

Yes, in person, virtual, and group visits for these types of services would count.

“P” Rationale & Guideline Recommendations

American Diabetes Association Standards of Care in Diabetes- 2025

LOE	Recommendations
A	All people with diabetes should be advised to participate in developmentally and culturally appropriate diabetes self-management education and support (DSMES) to facilitate informed decision-making, self-care behaviors, problem-solving, and active collaboration with the health care team.
A	In people with type 2 diabetes and overweight or obesity, weight management should represent a primary goal of treatment along with glycemic management.
A	Ask people with diabetes routinely about the use of cigarettes or other tobacco products. After identification of use, recommend and refer for combination treatment consisting of both tobacco/smoking cessation counseling and pharmacologic therapy.

“P” Resources

- [Initiating DSMES Referrals at Four Critical Times](#)
- [DSMES Referral Form](#)
- [Development and Validation of the American Heart Association's PREVENT Equations | Circulation](#)
- [2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk](#)
- [Implementation of Obesity Science Into Clinical Practice: A Scientific Statement From the American Heart Association](#)
- [Depression Screening: Patient Health Questionnaire-9 \(PHQ-9\)](#)
- [Alcohol Use Disorder Screening: Alcohol Use Disorders Identification Test \(AUDIT\)](#)
- [CDC Smoking and Tobacco Use Tools](#)
- [American Heart Association Quit Smoking, Vaping, and Tobacco Use](#)

Equitable Health Outcomes Pillar ("EHO" Pillar)

"EHO" Questions

I attest that my organization collects and uses patient population data to assess for equitable health care improvements and outcomes in diabetes control that includes:

- Adoption of a standard process¹ to systematically gather race and ethnicity data
- Adoption of a standard process¹ to assess patient level Social Drivers of Health (SDoH)
- Monitoring of care team adherence to the standard process(es)
- Training the care team on techniques to gather data per the standard process(es)
- Training the care team on impacts of SDoH and the resources available to address identified SDoH when appropriate
- Stratification of HbA1c performance rate by at least two subgroups at-risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by other SDoH metrics annually
- Examining stratified data and taking action to address gaps and outcomes across groups

NOTE: For each evidence-based pillar, HCOs must attest "Yes/No/Unsure" to each.

¹ "Standard process" refers to any protocol or practice that is documented or organizationally accepted and is systematically available.

“EHO” Examples

Examples of what actions would satisfy the intent of the attestation criteria.

These examples are not the only ways that the criteria can be met or not met but help illustrate the intent of the criteria and provide ideas for achieving these evidence-based practices.

“EHO” Attestation Criteria	✓ Example(s) that meets the intent of the criteria	✗ Example(s) that does not meet the intent of the criteria
Adoption of a standard process to systematically gather race and ethnicity data	<p>✓ A standard process that defines how a patient’s race and ethnicity data will be gathered that includes explaining why this information is important and asking a patient to self-identify their race and ethnicity.</p> <p style="text-align: center;">- AND -</p> <p>✓ Defining the personnel who are responsible for gathering the information and the training they should receive to perform the task.</p>	<p>✗ No defined process for systematically gathering race and ethnicity data.</p> <p style="text-align: center;">- OR -</p> <p>✗ Not defining responsible personnel.</p> <p style="text-align: center;">- OR -</p> <p>✗ Not defining required training.</p>
Adoption of a standard process to assess patient level Social Drivers of Health (SDoH)	<p>✓ A standard process is in place to assess SDoH including a standardized assessment tool.</p> <p style="text-align: center;">- AND -</p> <p>✓ Defining the personnel who are responsible for gathering the information and the training they should receive to perform the task.</p>	<p>✗ No defined process for systematically gathering SDoH data.</p> <p style="text-align: center;">- OR -</p> <p>✗ Not defining responsible personnel.</p> <p style="text-align: center;">- OR -</p> <p>✗ Not defining required training.</p>
Monitoring of care team adherence to the standard process(es)	<p>✓ Using electronic health record or population health tools to examine if the standard process is being followed such as documentation of race/ethnicity or SDoH.</p> <p style="text-align: center;">- OR -</p> <p>✓ Observe all staff who are responsible for gathering race/ethnicity data or SDoH</p>	<p>✗ Implementing a standard process, but not examining if the standard is being followed.</p> <p style="text-align: center;">- OR -</p> <p>✗ Monitoring adherence to a standard process without the intent to improve performance.</p> <p style="text-align: center;">- OR -</p>

	<p>for adherence to the policy.</p> <p>NOTE: This does NOT require a specific level of adherence to the standard process. The intent is that HCOs are examining adherence to the standard with the goal of minimizing variation in practice.</p>	<p>✗ Sampling charts of only some of the care team members who are responsible for data gathering.</p> <p style="text-align: center;">- OR -</p> <p>✗ Having no way to measure if the standard of care is being performed.</p>
<p>Training the care team on techniques to gather data per the standard process(es)</p>	<p>✓ As part of orientation, training front office reception staff on the standard approach for gathering race/ethnicity data from patients including practice of scripts for explaining why the information is important for their care and asking patients to self-identify.</p> <p style="text-align: center;">- AND -</p> <p>✓ As part of annual competency training, provide clinical staff with training to administer a standardized SDoH assessment tool.</p>	<p>✗ Do not provide training for the responsible staff to gather race/ethnicity data in accordance with the standard process.</p> <p style="text-align: center;">- OR -</p> <p>✗ Do not provide training for the responsible staff to gather data around SDoH in accordance with policy.</p>
<p>Training the care team on impacts of SDoH and the resources available to address identified SDoH when appropriate</p>	<p>✓ As part of orientation, training front office reception staff on the impacts of SDoH and the resources available to address identified SDoH.</p> <p style="text-align: center;">- AND -</p> <p>✓ As part of annual competency training, provide clinical staff with training on SDoH and the resources to address needs when they are identified.</p>	<p>✗ Do not provide training for the responsible staff on the impacts of SDoH in accordance with the standard process.</p> <p style="text-align: center;">- OR -</p> <p>✗ Do not provide training for the responsible staff on the resources to address SDoH in accordance with the standard process.</p>
<p>Stratification of HbA1c performance rate by at least two subgroups at-risk for inequitable health outcomes such as patients from racial or ethnic groups, without insurance, by zip code and/or by other</p>	<p>✓ Stratifying your HbA1c performance rate by race so you can compare your overall control rates across demographic groups (Example: compare your American Indian / Alaskan Native population control rate to overall control rate).</p> <p style="text-align: center;">- AND -</p>	<p>✗ Not stratifying your performance rate data.</p> <p style="text-align: center;">- OR -</p> <p>✗ Only stratifying your performance rate data by 1 group at risk for inequitable health outcomes.</p>

SDoH metrics annually	✓ Stratifying your HbA1c performance rates by a second subgroup (Example: insurance status so you can compare your overall control rate to your uninsured patients' control rate).	
Examining stratified data and taking action to address gaps and outcomes across groups	✓ Examining your stratified control rate data, finding a disparity between groups, and taking a CLAS-standard informed action to address the gap such as using patient education material in a patient's primary language or recruiting bi-lingual staff to support patient engagement and education for the population experiencing disparate outcomes.	✗ Not examining the data. – OR – ✗ Not taking any actions to address gaps.

“EHO” Frequently Asked Questions

My organization wants to attest yes to the equitable health outcomes pillar questions but are worried about losing some of our funding based on our answers. Will my answers be identifiable or reported?

The American Heart Association only publishes organization names for the purpose of recognizing award achievement. No identifiable information about organization attestation answers is shared publicly.

What can “stratification” include?

It can include, but is not limited to, examining control rates by characteristics such as age, sex and/or gender identity, race and/or ethnicity or primary language, insurance status, and/or geography/zip code.

“EHO” Rationale & Guideline Recommendations

American Diabetes Association Standards of Care in Diabetes- 2025

LOE	Recommendations
C	Health systems should assess and address disparities in diabetes care and health outcomes (e.g., by stratifying clinical quality data by factors such as insurance status, race, ethnicity, preferred language for health care discussions, disability, and other social drivers of health (SDoH)).
A,B	During clinical encounters, assess for social drivers of health, including food insecurity, housing insecurity, financial barriers, health insurance and health care access, environmental and neighborhood factors, and social capital/social community support, to inform treatment decisions, with referral to appropriate local community resources.

“EHO” Resources

- [American Heart Associations’ Health Equity Learning](#)
- [American Diabetes Association Health Care Access](#)

Additional Resources & References

- [KDIGO 2022 Clinical Practice Guideline for Diabetes Management in Chronic Kidney Disease](#)
- [Implementation of Obesity Science Into Clinical Practice: A Scientific Statement From the American Heart Association](#)
- [Novel Prediction Equations for Absolute Risk Assessment of Total Cardiovascular Disease Incorporating Cardiovascular-Kidney-Metabolic Health: A Scientific Statement From the American Heart Association](#)
- [Development and Validation of the American Heart Association's PREVENT Equations | Circulation](#)
- [2025 AHA/ACC Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guideline](#)
- [2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines](#)
- [2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk](#)
- [Social Determinants of Risk and Outcomes for Cardiovascular Disease | Circulation](#)

Questions?

Please reach out to the American Heart Association at bit.ly/AQContactUs.

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