CARDIO RENAL
SOCIETY OF AMERICA

INTEGRATIVE, PATIENT-CENTERED HEALTHCARE SOLUTIONS

PATH TO WELLNESS

WHO ARE WE?

MISSION:

- Cardio Renal Society of America (CRSA) is a nonprofit community healthcare organization whose goal is to help prevent heart and kidney disease through public and professional education and research, thereby reducing the impact of the global burden of these diseases.

VISION:

- CRSA aspires to be the foremost leader in identifying and raising awareness of the interconnections between heart and kidney disease, resulting in improved quality of life and survival.

OUR COMMITMENT

The Cardio Renal Society of America (CRSA) is the only organization of its kind in the nation. CRSA is committed to providing

- **integrative, patient-centric healthcare solutions** for those at highest risk for the “triple threat.”
- **professional medical education** for those seeking to address the “triple threat”
- **research and scientific projects** needed by healthcare organizations serving patients impacted by the “triple threat”

THE TRIPLE THREAT

Chronic kidney disease, cardiovascular disease and diabetes are major contributors of health disparities, and primary clinical outcomes associated with obesity and metabolic syndrome.

This "triple threat" is of particular concern in poor, ethnic minority, uninsured and underserved populations with higher incidence rates and prevalence of these chronic conditions.

COMMUNITY EDUCATION

Path to Wellness (PTW)…

- ❑ our first community education program
- ❑ changes the ways in which patients are served
- ❑ integrative, patient-centered, outcome driven
- ❑ empowers patients so that they can avoid complications associated with heart disease, kidney disease, and diabetes
- ❑ increases patient engagement
- ❑ directly connects those at risk to early intervention services and resources

PATH TO WELLNESS: A NEW APPROACH

- **Integrative and holistic** – it addresses multiple, chronic conditions as well as the interconnections between these conditions

- One of the most **comprehensive** of its kind in the country, coupling point-of-care testing with one-on-one clinical consultation, health education, guidance into a medical home, and enrollment in a six-week series of Healthy Living workshops.

- **Patient-centered** – it focuses on improving patient outcomes and patient engagement by empowering a diverse demographic of at-risk patients to make significant, positive changes in their personal well-being and quality of life

IMPROVING PATIENT OUTCOMES

Our overarching goal is to **improve patient outcomes by changing the way in which patients are served**

- this requires that we “shift the paradigm” into an integrative, collaborative service model.
- our model allows local community organizations to serve their clients collectively, rather than through a system of referrals.
- this reduces the burden on both the patient and the service organization, but more importantly, it also **facilitates patients abilities to make connections between overlapping co-morbidities**

IMPROVING PATIENT ENGAGEMENT

New directions in quality measurement suggest that measurement should:

- …focus on the patient, including patient experience and patient outcomes…emphasizing that patients are essential players in their own health outcomes.
- …be longitudinal and capture what happens…at more than one point in time to understand how care is affecting patients' experiences, their capabilities for self-management, and their quality of life, health, and ability to function.

We utilize Hibbard, et al.'s Patient Activation Measure (PAM) - a tool for assessing patient outcomes such as knowledge, skills, and confidence for self-management.

Participants complete this brief set of questions pre- and post-test and at follow-up.

EARLY INTERVENTION

Most patients do not learn about the relationships between these conditions until their most advanced stages.

The goal for community preventive education and screening is to improve early identification of people who are at risk.

Early identification is associated with

- implementation of healthy lifestyle changes
- more timely referral into the health care system for treatment
- a reduction in the burden of disease and health care costs, undiagnosed conditions, and associated complications

WORKING IN PARTNERSHIP

CARDIO RENAL SOCIETY OF AMERICA

National Kidney Foundation® of ARIZONA

Arizona Living Well Institute
Advancing Evidence Based Programs for Arizona Communities

CRSA received a Dignity Health Community of Care grant from *St. Joseph's Hospital and Medical Center* in collaboration with *National Kidney Foundation of Arizona* and *Arizona Living Well Institute* to develop a new integrative approach to community screenings for populations at-risk for heart disease, kidney disease, and diabetes – a screening that is NOT based on the single-disease model.

CURRENT SCOPE: PHOENIX, AZ (YEARS 1 & 2)

- 4 of its 10 municipalities have been ranked by Forbes in the top ten fastest growing cities in the U.S.
- located in Maricopa County, which is comprised of approximately four million residents (well over half of the total population in the state)
- encompasses a land area greater than that of seven states
- ethnically diverse - 30% of the population is of Hispanic origin
- includes 5 Indian reservations, as well as the largest number of urban dwelling Native Americans in the U.S.
- over 13% of its residents live below the federal poverty level
- nearly 1 in 5 of its residents are uninsured; members of ethnic minorities were more likely to be uninsured than non-minorities.
- concentrates resources in communities disproportionately impacted by these diseases, including urban dwelling American Indian, African American and Hispanics.

THEORY-BASED

Participants are guided through a series of "steps of engagement" based on the Stages of Change model, the theoretical foundation for our intervention.

The model includes multiple episodes of engagement (or steps) that encourage participants to take the actions necessary for long-term behavior change and risk reduction:

STEP 1: Participants are invited to engage with the program through referrals and an extensive marketing campaign.

STEP 2: Participants attend the health education and screening event, and as a result, create an action plan that will guide them on their Path to Wellness.

STEP 3: Participants implement their action plan by engaging in the workshops provided through the program and/or by following up with their doctor

STEP 4: Participants maintain change by continuing with their action plan and by developing and following a prevention, care and treatment plan in conjunction with their medical home.

OUTCOME DRIVEN

- pre- and post- testing
- follow-up and data tracking with participants, including longitudinal data on service utilization, treatment compliance and adherence, behavior change, patient engagement, and biometric outcomes
- evidence-based program data to be disseminated through peer-review publications

TARGETED OUTREACH

- FREE integrative healthcare services to the most at-risk and hard-to-reach populations
- poor, uninsured, underserved
- racial/ethnic minorities
- cultural and linguistic barriers to care
- lack of trust or engagement with the healthcare system

EXPANDED EDUCATIONAL COMPONENTS

- printed materials with key educational messages developed using stakeholder data (professional advisory committee, focus groups)
- group discussion of key educational messages
- one-on-one consultation with a clinician to discuss test results, answer questions, and identify next steps

IMMEDIATE RESULTS

- ❑ Point-of-Care testing
- ❑ Immediate test results, including:
  - ✓Weight, Height, BMI, Blood Pressure
  - ✓Hemoglobin A1C, Serum Creatinine (GFR), Lipid Panel
  - ✓Albumin to Creatinine Ratio

FOLLOW UP SERVICES

- Participants are enrolled in an existing evidence-based program on chronic disease self-management
- free, six-week “Healthy Living” workshops to attendees following the event
- workshops utilize the Stanford Patient Education Research Center's chronic disease self-management program (CDSMP),
- trained CDSMP facilitators and materials, fidelity monitoring

IN COMPARISON

OTHER SCREENINGS

- rarely this comprehensive
- lab results may take days, weeks, even months to process – this limits the potential IMPACT of the screening in terms of motivating behavior change
- often provide only limited patient education in the form of brochures or posters
- fee-based services, up to $200
- target those who are already engaged in the healthcare system, and who are less likely to require services for multiple, chronic conditions
- rarely outcome driven, providing little follow-up beyond the initial screening
- pre- and post- test data often not collected or unavailable, providing little insight on the efficacy of the program in terms of biometrics or behavior change
- longer-term outcomes (30 day, 6 month, 12 month) are rarely tracked
- follow-up services are typically not provided

OVERARCHING GOALS

- To develop a replicable, evidence-based model that can be adopted across the nation
- To develop a self-sustaining funding stream for local screenings by providing licensing and training to other organizations