American Heart Association Cardiovascular-Kidney-Metabolic Center Certification Requirements v1.0

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The American Heart Association invites public feedback on the draft standards for Cardiovascular Kidney Metabolic (CKM) Center Certification. These standards aim to recognize healthcare centers that provide comprehensive, evidence-based care for individuals with CKM syndrome.

We welcome input from clinicians, researchers, administrators, patients, caregivers, and community organizations to ensure the standards are inclusive, practical, and impactful.

1.0 Program Management

The Center defines its mission, goals, scope, and organizational structure. It designates a program champion or champions and establishes a framework for developing and sustaining the program.

1.1 The Center has a designated "champion(s)" who drives and oversees program development, coordination, patient advocacy, and quality management. These individuals oversee the implementation and success of the program and works closely with site/health system leadership.
1.2 A Program Charter is developed and is reviewed annually by the Program leadership/Champions and identified stakeholders.
1.3 The program has defined its mission, goals, organizational structure, scope and patient population it will serve.
1.4 The program has established an Interprofessional Committee/Advisory Committee to ensure that all disciplines involved in the team-based care of the CKM patient are represented.
1.5 The program has a method to identify and ensure current clinical practice guidelines/recommendations are incorporated into the delivery of care.
1.6 The Center reviews/reports goals and outcomes annually to all Center care team members, leadership team/advisory committee(s)/stakeholders.

2.0 Professional Education

Staff are required to possess the appropriate education, experience, and training necessary for the care and management of patients with CKM Syndrome. An ongoing, comprehensive

education plan is implemented as part of the onboarding process and continued at regular intervals thereafter. This program should be tailored to meet the specific needs of all levels of healthcare providers, ensuring that staff have the knowledge and skills necessary to deliver high-quality, effective care to individuals with CKM Syndrome.

2.1 Staff have education, experience and training for the monitoring and management of CKM patients. The educational program should be provided at time of hire, annually, and tailored to all levels of healthcare providers. Educational content and learning objectives are tailored to individual clinical roles and should include:

- CKM Stages/Classification
  - Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart Association
- CKM Risk prevention principles
  - AHA Life's Essential 8
  - Novel Prediction Equations for Absolute Risk Assessment of Total Cardiovascular Disease Incorporating Cardiovascular-Kidney-Metabolic Health: A Scientific Statement From the American Heart Association
  - The American Heart Association PREVENTTM Online Calculator
- GDMT for CKM patient management based on current professional guidelines
- Management/recognition of CKM related comorbidities: (to include) hypertension, ASCVD,HF, CKD, DM, MASH/MASLD, hyperlipemia, obesity
- Accurate attainment of CKM related biometrics and laboratory values (to include but not limited to): blood pressure, BMI, waist circumference, POC testing for A1c, UACR & Lipids (if applicable)
- Understanding of site identified patient education materials
- Understanding of site specific social drivers of health (SDOH) screening needs and tool utilization and follow up

2.2 The Center has a process in place to verify staff compliance with educational requirements.

3.0 Patient Education

The Center has established a comprehensive patient education process designed to address each patient's unique needs and goals. This program anticipates individualized requirements and fosters patient-centered objectives, enhances health outcomes and supports ongoing self-management. The program also facilitates patients understanding of their disease process and fosters the confidence needed to implement self-management skills in their daily lives.

3.1 A learning assessment should be conducted with individual receiving care and their caregiver(s) prior to providing education for the following:

- Education/learning gaps (patient/caregiver)
- Preferred language and method of receiving education (patient/caregiver) True Translated materials need to have "proof " of proper translation (certificate of translation) Placeholder to insert reference(s)
- SDOH that may impact learning (inclusive of cultural competency) Placeholder to insert reference(s)

3.2 Center must provide patient education. Centers that do not provide education can provide proof that the patient was referred to center for education and care coordination. CKM education should be provided on the following:

- Individualized risk factors and prevention
- Warning signs & symptoms
- Self-Management of Health Factors: Weight management, lipid management, blood glucose management, blood pressure management
- Self-Management of Health Behaviors: Physical activity, tobacco cessation, sleep health, diet, mental health/stress management, medication awareness
- Plan of care
- Follow-up plan
- Communication Plan (who to contact, where to go, etc.)
- Appointments/ Referrals (PCP, outpatient therapy)
- Community resources specific to individual needs
- Additional individualized stated needs/desires for education

3.3 The program defines educational touchpoints and frequency which should include:

- At the time of initial visit and with every touchpoint as per individual needs
- Upon change in status/care plan
- If hospitalized, post-discharge follow-up
- Annually after review of individualized needs and identified knowledge gaps

3.4 The Center participates in at least one community education event annually.

4.0 Care Coordination

The Center demonstrates care coordination across the system of care.

4.1 The Center has identified Care Coordinator(s)/Team(s) with a defined scope of duties aimed at prioritizing communication of all relevant information regarding the patient's care plan with the patient and across their care continuum

4.2 The Center has a process in place to assess patient needs, goals and SDOH that may impact the patient's care

4.3 A Comprehensive Care Plan outlining care treatment plan, goals, SDOH items impacting care and care team members is developed for each individual patient and is reviewed/updated as treatment, condition/outcomes change.

4.4 Center has process(s) in place to ensure patients are provided education regarding their care plan and to support self management of CKM health

4.5 The Center has a care coordination protocol (s) in place that facilitates communication of patient care plan to assist in coordination of collaborative services across care continuum (at time of change in patient's condition, handoff at admission, discharge, change in care team etc.)

5.0 Clinical Management

The Center has the ability to provide guideline-based care to CKM patients.

5.1 The Center has a method to ensure that current evidence-based guidelines specific to CKM patients are reflected in individualized patient comprehensive care plan & clinical processes.

5.2 The Center has documentation to reflect initial and ongoing standardized assessments are completed including but not limited to:

- Provider assessment including patient demographics, SDOH, medical history, CKM risk factors, screening for related comorbidities, medication use & adherence, and laboratory studies.
- Standardized laboratory assessments at clinically indicated intervals including (but not limited to): Comprehensive metabolic panel (with eGFR and liver markers), platelet count (to calculate FIB-4), HbA1C, Lipid panel, Urine albumin-creatinine ratio (UACR)
- Ancillary data may include but is not limited to: Continuous glucose monitoring (CGM), Coronary calcium scoring, ECG or echocardiography, BNP or NT-proBNP, hs-cardiac troponin, elastography/Fibro scan
- Standardized vital sign measurement at each visit including (but not limited to): weight, height, body mass index, waist circumference, blood pressure

5.3 The Center has partner providers/programs to provide ancillary support and education to patients. (if not provided within the Center) related to:

- Health Education Promotion (Self Management Behaviors)
- Partner or create alliance(s) with community health care or community-based organizations to address SDOH identified needs
- Specialty care as indicated: endocrinology, nephrology, hepatology, vascular medicine, bariatric surgery, behavioral health, medical nutrition therapy (e.g.,

dietitian), diabetes self-management training (e.g., DCES), lifestyle management (e.g., health coach), medication management (e.g., clinical pharmacist

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6.0 Performance Improvement

The Center performs ongoing quality improvement activities measuring adherence to national evidence-based guidelines aimed at improving care and outcomes for patients with CKM syndrome.

6.1 The Center performs continuous quality/performance improvement, evaluating adherence to evidence-based guidelines using a strategy/methodology (e.g., PDSA) to address performance, clinic outcomes, data review, and process improvements.

6.2 The Center has a method in place to identify outcome goals and select, collect and analyze measures to evaluate performance on a quarterly basis.

6.3 The Center develops and updates performance improvement plans (PIPs) for the identified measures. PIPs incorporate staff communication and education initiatives.

6.4 The Center conducts an annual review to measure effectiveness of the performance improvement plan.