

PAHO's HEARTS 2.0 Outlines 38-Step Pathway for Cardio-Renal Care

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Managing the intersection of cardiovascular disease (CVD) and chronic kidney disease (CKD) presents a significant challenge in primary care, often leading to fragmented patient management and suboptimal outcomes. The Pan American Health Organization (PAHO) HEARTS 2.0 initiative offers a structured, 38-step pathway designed to integrate cardio-renal care, aiming to streamline diagnosis, treatment, and follow-up for these complex patients.

KEY TAKEAWAYS

- ° The Pivot: PAHO HEARTS 2.0 provides a comprehensive, integrated framework for cardio-renal care, moving beyond siloed disease management.
- ° The Data: The initiative comprises 38 specific steps across six modules, targeting improved identification and management of CVD and CKD risk factors.
- ° The Action: Clinicians should review and consider adopting the HEARTS 2.0 framework to enhance coordinated care for patients with or at risk of cardio-renal conditions.

The global burden of non-communicable diseases (NCDs) includes a substantial proportion of patients experiencing both cardiovascular disease (CVD) and chronic kidney disease (CKD). This comorbidity is associated with increased mortality, higher healthcare costs, and diminished quality of life.¹ Traditional healthcare models often address these conditions separately, leading to gaps in care and missed opportunities for early intervention and risk factor modification.² The need for an integrated approach that considers the bidirectional relationship between the heart and kidneys has become increasingly evident to improve patient outcomes.³

PAHO HEARTS 2.0: A Structured Approach

The Pan American Health Organization (PAHO) developed the HEARTS initiative to improve the prevention and control of cardiovascular diseases in primary healthcare settings. HEARTS 2.0 expands upon this foundation by specifically addressing the integration of cardio-renal care.⁴ This updated framework outlines a 38-step pathway, structured across six core modules, designed to guide healthcare providers in the comprehensive management of patients with or at risk of cardio-renal conditions.⁴

The six modules of HEARTS 2.0 include: Healthy Lifestyles, Evidence-based Guidelines, Access to essential medicines and technology, Risk factor management, Team-based care, and Systems for monitoring.⁴ Within these modules, specific steps detail actions for screening, diagnosis, treatment, and follow-up. For instance, the 'Risk factor management' module includes steps for systematic blood pressure measurement, lipid profile assessment, and glucose monitoring.⁵

The 'Access to essential medicines and technology' module emphasizes the availability of key medications such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), and sodium-glucose cotransporter-2 (SGLT2) inhibitors, which have demonstrated cardio-renal protective effects.⁶

A key aspect of the HEARTS 2.0 pathway is its emphasis on early identification of CKD, particularly in patients with hypertension and diabetes, which are significant risk factors for both CVD and CKD.⁷ The framework recommends routine screening for albuminuria and estimated glomerular filtration rate (eGFR) in these high-risk populations.⁷ Furthermore, the initiative promotes team-based care, involving physicians, nurses, and other allied health professionals, to ensure coordinated patient management and education.⁸ The 'Systems for monitoring' module includes steps for establishing patient registries and utilizing data to track progress and identify areas for improvement in care delivery.⁹ The HEARTS 2.0 pathway is intended for implementation at the primary healthcare level, aiming to empower general practitioners and specialists with a standardized, evidence-based approach to cardio-renal care.⁴ While the framework provides a detailed roadmap, successful implementation requires robust training, adequate resource allocation, and sustained political commitment from health authorities.¹⁰ The initiative does not present new clinical trial data but rather synthesizes existing evidence into an actionable operational framework for healthcare systems in the Americas.⁴

Clinical Context and Epidemiology of Cardio-Renal Syndrome

Cardio-renal syndrome (CRS) describes disorders of the heart and kidneys in which acute or chronic dysfunction in one organ induces acute or chronic dysfunction in the other. This bidirectional interplay is complex, involving hemodynamic, neurohormonal, inflammatory, and metabolic pathways. For example, chronic hypertension can lead to both left ventricular hypertrophy and nephrosclerosis, while chronic kidney disease can exacerbate heart failure through fluid overload, anemia, and electrolyte imbalances.³ The prevalence of CKD is substantial, affecting approximately 10-15% of the adult population globally, with a higher incidence in individuals with pre-existing CVD risk factors.² Similarly, a significant proportion of patients with heart failure also have concomitant CKD, which independently predicts worse outcomes.¹

Expanded Methodology and Patient Populations

The 38 steps within the HEARTS 2.0 framework are designed to be adaptable to various primary care settings across the Americas, considering differences in resource availability and healthcare infrastructure. The 'Healthy Lifestyles' module, for instance, includes steps for counseling on diet, physical activity, and smoking cessation, which are foundational for preventing both CVD and CKD progression.⁷ The 'Evidence-based Guidelines' module ensures that clinical decisions align with current scientific recommendations, promoting the use of validated diagnostic tools and therapeutic strategies.⁴ The target patient population for HEARTS 2.0 includes individuals with established CVD or CKD, as well as those at high risk due to conditions such as hypertension, diabetes, dyslipidemia, and obesity. The framework emphasizes a proactive approach, moving beyond reactive treatment of symptomatic disease to early risk stratification and preventive interventions.⁴

Limitations and Implementation Challenges

Despite its comprehensive nature, the HEARTS 2.0 pathway faces several implementation challenges. Resource limitations, particularly in low- and middle-income countries, can hinder the availability of essential diagnostic equipment (e.g., for eGFR and albuminuria testing) and medications. Training healthcare personnel to effectively

implement all 38 steps requires significant investment in education and ongoing support. Furthermore, patient adherence to lifestyle modifications and long-term medication regimens remains a persistent challenge, necessitating robust patient education and follow-up strategies. The integration of data from patient registries into actionable insights requires sophisticated information systems and trained personnel for data analysis and interpretation. Sustained political will and financial commitment are crucial for the successful and equitable adoption of this integrated cardio-renal care model across diverse healthcare systems.¹⁰

CLINICAL IMPLICATIONS

The PAHO HEARTS 2.0 initiative, with its 38-step pathway, represents a significant move towards standardizing integrated cardio-renal care. For too long, primary care clinicians have navigated the complex interplay of heart and kidney disease with fragmented guidelines, often leading to delayed diagnosis of CKD in high-risk patients or suboptimal management of concurrent conditions. This framework offers a welcome, if ambitious, attempt to provide a unified approach, particularly in resource-constrained settings where specialists may be scarce. The emphasis on early screening for albuminuria and eGFR in patients with hypertension and diabetes is particularly pertinent, as these are often overlooked in routine primary care until advanced stages.

The inclusion of specific medication classes like SGLT2 inhibitors and GLP-1 receptor agonists within the 'Access to essential medicines' module is a direct acknowledgment of their established cardio-renal benefits. This is a critical step, as the mere existence of evidence-based guidelines is insufficient without ensuring the availability and affordability of these transformative therapies. Health systems and policymakers must now focus on procurement and formulary inclusion to translate these recommendations into tangible patient benefits. Without this, the 38 steps risk becoming an academic exercise rather than a practical guide for improving patient outcomes.

Ultimately, the success of HEARTS 2.0 hinges on its practical implementation. While the framework is comprehensive, the sheer number of steps could be daunting for busy clinicians. Training and simplified tools will be essential to facilitate adoption. The initiative's focus on team-based care and monitoring systems is commendable, suggesting a move towards more accountable and collaborative healthcare delivery. However, the true test will be whether this structured pathway can genuinely reduce the incidence of adverse cardio-renal events and improve the quality of life for patients across the Americas, moving beyond theoretical integration to demonstrable clinical impact.

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