As someone living with CKD, you’ve likely faced and overcome challenges. There are many people like you who are also looking for ways to manage their treatment. Would you consider becoming a Patient Peer to share your experience with PD?

Strength in Numbers
Help Other Patients With Chronic Kidney Disease (CKD) by Sharing Your Journey With Peritoneal Dialysis (PD)
Inspiring Others as They Consider Dialysis
Baxter Patient Peer Programs

Nephrologists will always provide the necessary guidance on the best course of treatment for each individual patient. But you have the power to provide comfort and knowledge in a unique way—your story can give strength to those facing similar decisions.

We hope that by speaking with someone like you who has truly walked in their shoes, patients will feel understood and empowered as they look to the next phase of their treatment plan.

Baxter Healthcare Corporation is partnering with nephrologists’ offices to bring together Patient Peers, patients with CKD who are approaching dialysis, and Baxter Clinical Educators.

Becoming a Patient Peer
What Does This Mean?

Your Baxter Patient Peer Program will be held in a nephrologist’s office in a low-key, comfortable space. The program will be facilitated by the Baxter Clinical Educator who will introduce you. You’ll then share your story and talk with the attending patients and families.

The program is approximately 1 hour and will cover the following topics:

- Welcome and Introduction (5 minutes)—nephrologist/nurse/office manager
- Brief PD Presentation (10 minutes)—Baxter Clinical Educator
- Patient Peer: My Life With PD (15 minutes)—this will be your opportunity to share your real-life experiences
  - What were you most concerned about as you started on PD?
  - What did you expect and where are you now with your expectations?
  - Briefly describe your daily routine—what changes did you have to make when you started PD?
  - What challenges did you face as you began PD? What challenges do you continue to face?
- Q&A (30 minutes)—open discussion

Prior to attending the live, in-office event, you’ll participate in a brief training call. We’ll discuss the flow of the meeting, your role, and any other questions you may have. We value your time and input, and you will be compensated by Baxter for both the training and the live event.

If you’re interested in becoming a Patient Peer, please reach out to Avant Healthcare, the agency partnering with us for the Baxter Patient Peer Programs. You may contact them via e-mail at BaxterPatientPrograms@avanthc.com or directly at 317.569.6744.

We look forward to partnering with you!

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Amia Automated PD System with Sharesource Connectivity Platform

Rx Only. For safe and proper use of the devices referenced herein, refer to the Instruction for Use or Operator's Manual.
The Innovative Amia Cycler with the Sharesource Connectivity Platform

Let the first and only talking cycler provide a user friendly step-by-step experience of home peritoneal dialysis!

Experience the WOW of the Sharesource Connectivity Platform: A two-way, web-based connection between the Amia cycler and the clinic.
Meet the Innovative **Amia** Cycler

Let the first and only talking cycler provide a user friendly step-by-step voice-guided experience of home peritoneal dialysis!

- **Ease of use** is enabled with voice guidance, touch-screen navigation, and dynamic animations to help new patients start and conduct PD therapy with confidence.

- **Recommended techniques** are reinforced with voice-guided directions and animations, which may help reduce touch contamination.

- **A personalized experience** is made possible by SMART programming that enables multiple therapy customizations.

- **Patients can resolve** their therapy issues with step-by-step, on-screen troubleshooting.

**40% smaller** and **30% lighter** than the HOMECHOICE PRO Automated PD System.
The Amia cycler provides a SMART Therapy approach for effective care.

SMART features support the delivery of a patient’s treatment regimen.

**Smart Therapy**
- SMART Therapy turns any time-based CCPD regimen into a tidal therapy through a simple option enabled during programming.
- Patients receive the benefits of Tidal Fills and Drains while still receiving all of the prescribed Total Night Therapy Volume.

**Smart Dwell**
- The Amia system adjusts the Dwell Time to accommodate changes in the Fill and Drain Time so that the therapy ends on time.
- SMART Dwell enables patients to tailor therapy when they need to finish by a certain time.

**Smart Drain**
- SMART Drain logic allows the patient to continue treatment when experiencing drain problems during the night portion of therapy.
- SMART Drain reduces the remaining Fill volumes to a safe level and uses all of the remaining therapy solution volume.
The innovative Sharesource Connectivity Platform

The WOW! of the Sharesource Clinical Portal

A two-way, web-based connection between patients and their clinic

- The treatment dashboard gives a quick and easy snapshot of daily treatment data for patients on the Amia cycler
- Cycler settings and programs can be adjusted remotely using the Sharesource portal

On-demand access to timely, accurate historical treatment data

- Customizable “flag alerts” help track issues that may arise during home dialysis treatment
- Standard reports enable clinicians to quickly review historical treatment data

Customizable device programs can be adjusted remotely

- The Amia cycler will hold up to four different device programs that can be adjusted remotely
The Sharesource Connectivity Platform maintains security and privacy. Baxter employs industry standard approaches to data privacy and uses best-in-class partners to ensure security.

**Data Security**
- IBM hosts Sharesource portal data
- Data sent between Amia cycler and Sharesource portal is encrypted
- Accenture provides platform maintenance
- Data security complies with HIPAA HITECH and FDA 21 CFR Part 11 requirements

**Data Privacy**
- Protected Health Information is controlled within Sharesource portal based on role and need
- All Baxter team members receive HIPAA training
Baxter continues to provide excellent service and support for the Amia system and Sharesource portal. Providers and patients receive service and support with the Amia Automated PD System with Sharesource Connectivity Platform.

**Baxter service for providers:**
- Hands-on device training for providers
- Therapy and related product education where subject matter experts interact with health practitioners on a peer-to-peer basis
- Clinical Educator support to help identify improvement areas, share best practices and provide education related to the safe and effective use of the Amia cycler with Sharesource Connectivity Platform

**Baxter service for patients:**
- Delivery and inventory services that include product management, product rotation and personalized delivery schedules
- On-call services to support patient product needs or concerns
- Travel programs to assist patients traveling in over 180 countries
References


HOUSTON: THE TIME IS NOW TO TACKLE URBAN DIABETES

Today, 1 in 10 Houstonians are diagnosed with diabetes.¹

3 in 10 Houstonians have prediabetes.

By 2030, it is estimated that the number of Houstonians with diabetes could double to over 1 million. That’s enough to fill Houston Texans’ football stadium over 13 times.

Identifying Solutions for Houston Using the Findings of CITIES CHANGING DIABETES

Looking at diabetes through a new lens, using social and cultural factors

Pursuing funding from local and national funders

Leverage existing resources among stakeholder organizations

Using data to brainstorm “out of the box” initiatives and solutions

Cities Changing Diabetes is a global program of Novo Nordisk in which 7 cities around the world are learning how to improve diabetes prevention, detection, and care in their communities. The program aims to map the problem, share solutions, and drive concrete action to fight the diabetes challenge.¹²

Houston is the only US city participating. The program invested more than a year researching the diabetes epidemic in Houston. A community-wide assessment identified the populations most at risk for developing the disease.

Participating Cities:
- Shanghai
- Tianjin
- Copenhagen
- Johannesburg
- Vancouver
- Mexico City
- Houston
- Shanghai
THE FACE OF DIABETES IN HOUSTON

Four distinct risk profiles are most vulnerable to develop diabetes in Houston:

- **Isolated Skeptics**
  - Disconnect from community, lack trust in health care system
  - High biomedical risk
  - Economically disadvantaged
- **Financially Pressured Caregivers**
  - Caregiver responsibilities, long commutes
  - Low biomedical risk
  - Economically disadvantaged
- **Concerned Seniors**
  - Low health literacy, dealing with change and transition in neighborhood
  - High biomedical risk
  - Economically secure
- **Time-Pressed Young Adults**
  - Facing time pressure, peer influence on appearance and health decisions
  - Low biomedical risk
  - Economically secure

Five major vulnerabilities were linked to the risk profiles:

- **Perception of change and transition**
  - 78%
- **Feeling of being financially constrained**
  - 45%
- **Adherence to nourishing traditions**
  - 42%
- **Use of cars for long commutes**
  - 42%
- **Experience of time poverty**
  - 40%

Sources:

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Community-Based Care Management
Empowering Patients and Bridging the Gap to Reduce High Cost Utilization

Through our Community-Based Care Management (CBCM) program, Maxim Healthcare Services, Inc. helps reduce avoidable healthcare utilization by addressing both psychosocial factors and medical complexities. We empower patients at high risk for avoidable utilization by engaging them in their own care and providing comprehensive community-based care services in the home using Community Health Workers (CHWs).

Finding the Right Patients
A small percentage of patients drive the majority of healthcare costs. Patients with numerous psychological factors and social determinants have reduced engagement, adherence, and access to care. Many patients are also complex as a result of medical comorbidities and poor functional status, which drives increased utilization. In order to target the right barriers to adherence, Maxim has built a proprietary assessment tool, integrated into our electronic health record (EHR) system, which focuses on four domains of health: psychological factors, social determinants, medical comorbidities, and functional status.

Utilization is Often a Symptom of Other Underlying Problems
Through our experience as both a nationwide homecare and medical staffing company, Maxim brings a unique perspective to this problem. Every day through the more than 250 branch offices we operate across 41 states, we recruit, train, and manage the full spectrum of caregivers and care for some of the most complex and medically fragile patients in the country. Through this perspective, we have realized that avoidable healthcare utilization is not always the real problem. For some complex patients, avoidable utilization may actually be a symptom of underlying socioeconomic, functional, and behavioral challenges. Based on this, we developed an approach to help reduce avoidable healthcare utilization that is anchored to three core beliefs:

1) We cannot succeed if we focus on disease state alone. Non-adherence is often caused by social, behavioral, or functional challenges as well.

2) High-risk patients need high-touch care; telephonic outreach and technology alone are not enough to drive effective engagement for this population.

3) The current system of caregivers is not working for high-risk patients. These patients require a new type of caregiver to help them navigate a complex network of providers.

Partnering Nurses with “Nurse Extenders”
Our program’s strength comes from a partnership between nurses and efficient workforce of Community Health Workers (CHWs) to extend the reach of the nurses and drive more frequent patient engagement. CHWs are front line professionals who are trusted members of their communities. They work to drive better adherence and remove barriers to care by focusing on patient engagement, education, and connection to the appropriate clinical and community services. Our CHW teams complement rather than replace existing home health and other post-acute care services. We create a partnership with hospitals, primary care, and specialty care teams to drive patient engagement and ensure continuity of care.

\[\text{National Governors Association, “Using Data to Better Serve the Most Complex Patients” (Sept. 2015).}\]
Understanding Research Results From Cities Changing Diabetes Houston

Research for Cities Changing Diabetes (CCD) in Houston focused on identifying and characterizing vulnerability among individuals who have not been diagnosed with prediabetes or diabetes. Special attention was paid to the unique cultural and social factors within Houston that might contribute to diabetes.

How was the research conducted?

- Existing public health data shows three biological risk factors in the Houston population living with diabetes: hypertension, a body mass index (BMI) >26.9, and being over the age of 45.
- Characteristics of those living with diabetes were assessed to determine vulnerability indicators. The density of indicators was mapped and identified three Houston neighborhoods for vulnerability assessment interviews: Atascocita – Lake Houston, East Houston – Settegast, and Greater Heights – Washington.
- A total of 125 Adult participants from the three neighborhoods took part in face-to-face interviews.
- Participants were selected based on the following criteria: 18 years or older, English speaking, currently not diagnosed with diabetes, and satisfying at least one of several vulnerability indicators including: age, race, ethnicity, employment status, health insurance status, support from public programs, income adjusted for household size, difficulty buying food, number of poor health days, and poverty level.

What were the key research findings?

Fourteen social and cultural factors linked to vulnerability and 4 distinct groups were identified. The groups were:

- **Isolated Skeptics**: high biomedical risk, economically disadvantaged, disconnect from community, lack trust in health care system;
- **Financially Pressured Caregivers**: low biomedical risk, economically disadvantaged, caregiver responsibilities, long commutes;
- **Concerned Seniors**: high biomedical risk, economically secure, low health literacy, dealing with change and transition in neighborhood; and
- **Time-pressured Young Adults**: low biomedical risk, economically secure, facing time pressure and peer influence on appearance and health decisions.

The factors with the highest overall percentage across the 4 groups were: the perception of change and transition (77.6%), the feeling of being financially constrained (44.8%), the adherence to nourishing traditions (42.4%), the use of cars for long commutes (41.6%), and the experience of time poverty (40%).

What were the conclusions from the research?

Vulnerability to diabetes is impacted by a combination of social and cultural risk factors that extend beyond traditional notions of biological risk and economic disadvantage. The findings should be taken into consideration when designing public health interventions since they mediate both opportunities for and barriers to health-related practices.

How will Cities Changing Diabetes use this research?

The CCD program fosters research collaborations among the global academic team at the University College of London, Novo Nordisk, Denmark, and local academic teams in the participating cities of Copenhagen, Mexico City, Houston, Shanghai, and Tianjin. Research findings from CCD Houston will add to the growing body of knowledge on diabetes from a global perspective, as well as provide direct insight to address the diabetes crisis in Houston today. Over 75 stakeholders in Houston have been collaborating on translating the data into action as part of 5 Action Work Groups. They are incorporating components of the Vulnerability Assessment into the design of solutions that meet Houston area needs. In addition to leveraging existing resources among the stakeholder organizations, the Action Work Group leaders are also pursuing funding from local and national funders.