

A Change Package to Improve Health Equity

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Updated 2024





Table of Contents

I. Introduction	1
How to Get Started.....	1
Contacting ESRD Networks.....	2
II. Change Package Methodology	2
III. Health Equity Drivers.....	3
IV. Key Change Ideas.....	4
Primary Driver #1: Create An Environment of Trust With Patients	4
Secondary Driver #1a: Develop relationships with patients.....	4
Secondary Driver #1b: Connect through the culture of the patient.....	6
Primary Driver #2: Determine Patients' Health-Related Social Needs	7
Secondary Driver #2a: Conduct psychosocial needs assessments	7
Secondary Driver #2b: Gather information through interactions with patients	9
Secondary Driver #2c: Observe for signs that could indicate health-related social needs.....	10
Primary Driver #3: Use a Team Approach to Identify and Resolve Health-Related Social Needs.....	12
Secondary Driver #3a: Engage the whole team	12
Secondary Driver #3b: Communicate and collaborate on issues, solutions, and progress	13
Primary Driver #4: Maximize All Available Resources	15
Secondary Driver #4a: Identify resources.....	15
Secondary Driver #4b: Link patients to resources and provide support.....	17
Primary Driver #5: Educate Patients and Staff	22
Secondary Driver #5a: Design patient education around health-related social needs.....	22
Secondary Driver #5b: Train staff on diversity and health-related social needs assessment and resolution	25
V. Conclusion and Next Steps	26
VI. References	27



I. Introduction

This change package is intended to support dialysis facilities and End Stage Renal Disease (ESRD) Networks in improving health equity for patients receiving dialysis. The document includes actionable change ideas, collected from dialysis facilities that performed above the national average for patients in a home program and/or on a transplant waitlist, despite their patients' residing in the most disinvested neighborhoods and having complex health-related social needs. The change ideas are intended as a menu of interventions from which leaders can choose to implement within their facilities.

The purpose of the change package aligns with the *Centers for Medicare & Medicaid Services (CMS) Framework for Health Equity 2022–2032*,¹ which “brings focus to CMS’s work supporting health care organizations, health care professionals and partners ... in activities to achieve health equity.” Specifically, the ideas presented in this document support Priority 3 (Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities), Priority 4 (Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services), and Priority 5 (Increase All Forms of Accessibility to Health Care Services and Coverage).

How to Get Started

Change happens at the local level. Dialysis facility Quality Assessment and Performance Improvement (QAPI) meetings are the perfect place to start. Giving interdisciplinary team (IDT) members this change package for review will allow them to identify and prioritize change ideas that they could implement to improve health equity for patients receiving dialysis.

The change ideas presented in this change package represent the practices used by high-performing dialysis facilities. They are not meant to serve as the entire universe of approaches to meet the health-related social needs of patients and improve health equity. They can, however, serve as “tests of change” that drive performance improvement and quality improvement programs.

About QAPI: QAPI merges quality assessment (QA) and performance improvement (PI) into a comprehensive approach to quality management. QA is the process of meeting standards and ensuring care reaches an acceptable level. PI is the proactive, continuous study of processes with the intent to identify opportunities and test new approaches to fix the underlying causes of persistent, systemic problems. Data-driven QAPI programs may be customized to facility needs. Key steps include:

- Identifying the problem and defining the goal.
- Deciding on a measurement to monitor improvement.
- Brainstorming solutions based on barriers and root causes.
- Planning an intervention.
- Using plan-do-study-act (PDSA) to implement the improvement project.

Learn more about QAPI: <https://esrdnetworks.org/toolkits/professional-toolkits/qapi-toolkit/>.



Contacting ESRD Networks

Dialysis facilities can contact their local ESRD Networks for assistance with Plan-Do-Study-Act (PDSA) principles and practices, questions about change strategies, and health equity resources. A complete listing of ESRD Networks is at <https://esrdncc.org/en/ESRD-network-map/>.

II. Change Package Methodology

The ideas presented in this change package were assembled after extensive interviews with dialysis facilities that performed above the national average for patients dialyzing from home and/or patients on a transplant waitlist. They achieved this despite their patients' residing in the most disinvested neighborhoods^a and having complex health-related social needs. The selection of home and transplant metrics aligns with the Advancing American Kidney Health initiative² as well as the current goals for ESRD Networks. The facilities were identified by linking national ESRD Quality Reporting System (EQRS) data with the Area Deprivation Index (ADI),³ a multidimensional evaluation of a region's socioeconomic conditions based on 17 census variables, including income, education, and housing.

Systemic themes that emerged during the interviews were organized into driver diagrams—visual displays of what drives and contributes to achieving an overall aim.⁴ The drivers and associated change ideas were reviewed by four nephrology experts who are members of the ESRD National Coordinating Center (NCC) Health Equity Advisory Board, as well as three professionals from the ESRD Network Program, to ensure relevance to a broad range of dialysis facilities. The input of these experts was incorporated into the document.

2024 update: Ten additional interviews with high-performing facilities (based on EQRS data) were conducted in late 2023/early 2024. Change ideas indicated by asterisks were derived from information gathered from those dialysis facilities' staffs.

^a“Neighborhood” is defined as a census block group.



III. Health Equity Drivers

Interviews with high-performing dialysis facilities revealed primary and secondary drivers being used to improve health equity (Table 1). Primary drivers are the most important influencers that contribute directly to achieving the aim. Secondary drivers are the actions and interventions that impact the primary drivers.⁴

The primary and secondary drivers (Tables 1–12), as well as the associated change ideas in the driver diagrams (Tables 2–12), are numbered for easy reference, not in ranked order.

Table 1. Primary and Secondary Drivers to Improve Health Equity

AIM: IMPROVE HEALTH EQUITY	
PRIMARY DRIVERS	SECONDARY DRIVERS
1. Create an environment of trust with patients.	1a: Develop relationships with patients. 1b: Connect through the culture of the patient.
2. Determine patients' health-related social needs.	2a: Conduct psychosocial needs assessments. 2b: Gather information through interactions with patients. 2c: Observe for signs that could indicate health-related social needs.
3. Use a team approach to identify and resolve health-related social needs.	3a: Engage the whole team. 3b: Communicate and collaborate on issues, solutions, and progress.
4. Maximize all available resources.	4a: Identify resources. 4b: Link patients to resources and provide support.
5. Educate patients and staff.	5a: Design patient education around health-related social needs. 5b: Train staff on diversity and health-related social needs assessment and resolution.



IV. Key Change Ideas

The following driver diagrams (Tables 2–12) expand on the health equity drivers (Table 1) and include specific change ideas for all the secondary drivers identified by high-performing dialysis facilities. The visualizations show the relationships between the primary and secondary drivers and the associated change ideas.

Table 2. Develop Relationships With Patients

PRIMARY DRIVER #1: CREATE AN ENVIRONMENT OF TRUST WITH PATIENTS
Secondary Driver #1a: Develop relationships with patients
<p>Developing relationships with patients builds trust, which helps patients feel comfortable to share the details of their lives. This better enables staff to identify health-related social needs that could impact dialysis care and to address them in ways that consider the whole patient.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Greet patients by name. 2. Ask patients how they want to be addressed by staff: he, she, or they. 3. Treat patients as individuals; remember that everyone is different. <ol style="list-style-type: none"> a. Practice person-first language. Remember individuals are persons first and patients second. They are not their diagnoses.* b. Use the word client instead of patient, if appropriate.* 4. Build rapport with patients on an ongoing basis. <ol style="list-style-type: none"> a. Get to know patients through multiple conversations and by spending time with them. b. Learn about what matters to each patient. c. Ask general questions, (e.g., “How are things going?” “How is dialysis going?” “How is life going?”)* d. Use humor after rapport is established to make patients feel comfortable. e. Show an interest in what patients are doing during dialysis, (e.g., talk about books they are reading or music to which they are listening). f. Discuss non-medical topics of shared interest to staff and patients, such as hobbies or sports. g. Chat with patients casually as they come or go to treatment or are in the lobby. h. Let patients know staff are paying attention by casually commenting on noticed differences, (e.g., “I see your nails are painted.”). i. When helping patients to fill out an application form or make a call, be with the patient at chairside to build trust.* j. Follow through with patients on items you have discussed together.* k. Pick up on verbal and nonverbal cues and “read the patient,” (e.g., through making eye contact). Learn about your patient population. For instance, it may not be appropriate to use a sharp pitch or phrases like "honey, sweetie, dear" with patients.* l. Use the words and phrases such as "always" and "it's my pleasure to help" or “I am so happy to help” to make patients feel comfortable and not like they are a burden.*



PRIMARY DRIVER #1: CREATE AN ENVIRONMENT OF TRUST WITH PATIENTS

Secondary Driver #1a: Develop relationships with patients

- m. Validate the feelings of patients and care partners. Ask patients, “Is there anything you think we can do for you?” Tell them, “We are here to support you.” Explain that “this is what you may be experiencing on dialysis. Don’t be afraid to ask for help.” *
5. Encourage family involvement in care planning, according to the patient’s wishes.
 - a. When communicating with care partners or family members, try to speak in person or via phone. Refrain from email-only communication.*
6. Sit down with patients for discussions, so that staff are at eye level with patients and do not appear to be in a position of power.
7. Ask patients about their personal short- and long-term goals, not just health-related goals, (e.g., “How can we help you be successful in the needs/goals you have? How can we help you reach your short- and long- term goals?”).
8. Describe staff roles. For example, explain how the social worker can assist the patient.
9. Let patients know that staff are available to them. Emphasize that the staff is there to listen to and support them, have heart-to-heart conversations, (e.g., “I am here for you.”).
10. Approach patients without judgment.
11. If patients do not want to share, wait until trust is established to ask personal questions about unmet needs for which patients could use support. At first, patients may be guarded with you because they do not know you. Keep building trust; this is not going to happen overnight. If patients do not warm up to one person, they may warm up to another staff member.*
12. Form a connection with families on first contact by mentioning staff members’ names who they already know.
13. Support patients as whole persons in all ways possible, (e.g., socially, economically, spiritually).
14. Be transparent about restrictions on resources, such as waiting lists or limited funding, so patients have realistic expectations.

*Added 2024.



Table 3. Connect Through the Culture of the Patient

PRIMARY DRIVER #1: CREATE AN ENVIRONMENT OF TRUST WITH PATIENTS
Secondary Driver #1b: Connect through the culture of the patient
<p>When staff members honor patients’ cultures, patients see that staff view them as individuals, yet consider the whole person. This adds another layer of trust to the staff-patient relationship and opens the door to information exchange during patient education and assessment of needs.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Ask patients what their preferred language is and communicate in that language, (e.g., Spanish). 2. Never indicate to patients that their language is a problem. 3. Use translation services, as appropriate. <ol style="list-style-type: none"> a. If a dialect is not offered via a language line, consider bringing an in-person interpreter to the facility.* 4. Say hello in the patient’s language, if not fluent in the language. 5. Offer American Sign Language translation services for a person who is hard of hearing. 6. Gain an understanding of the patient’s culture related to seeking and receiving help. <ol style="list-style-type: none"> a. Explore whether transplant is something they want to discuss. Understand patients’ beliefs before providing transplant information.* 7. Employ diverse staff to whom patients can relate. 8. When possible, aim for patient-provider racial and cultural concordance with staff being mostly from the same community, so that staff members understand the patients and know and have good relationships with patients’ families. “We see them as people. That they’re our neighbors. They are our friends.” 9. Recognize that patients may be a part of more than one culture, (e.g., deaf and Nepali communities). <ol style="list-style-type: none"> a. Use multiple translators. b. Meet with patients as many times as needed to learn each patient’s perspectives and beliefs. 10. Train staff on different cultures, cultural bias, and cultural beliefs of patients at their facility, so staff can interact with sensitivity. 11. Be aware that patients’ cultural beliefs may make them reluctant to ask for help. Let them know that people need help sometimes. Encourage help-seeking behaviors and reinforce that it is OK to use available resources.

*Added 2024.



Table 4. Conduct Psychosocial Needs Assessments

PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS
Secondary Driver #2a: Conduct psychosocial needs assessments
<p>The use of tools and formal assessments at scheduled intervals allows staff to collect information on urgent and chronic health-related social needs of patients. This is a critical step in improving health equity on a patient-by-patient basis.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Begin the initial screening of social needs before patients arrive at the clinic, (e.g., have the administrative assistant obtain information from the coordinator at the hospital, transferring dialysis center, nephrology practice, or primary care provider [PCP]). Find out about insurance, demographics, marital status, family support, living situation, and whether patients have limited English proficiency. 2. Have the social worker meet with the patient on the first day or check with the nurse doing intake to determine any immediate health-related social needs, including housing instability, food insecurity, and lack of transportation. 3. Explain the purpose of assessment questions at every point in the engagement. Reassure patients that information is not shared with other patients. 4. Use tools in the patient's language, (e.g., pull up an assessment in the patient's language on a tablet or laptop). 5. Administer the Kidney Disease Quality of Life (KDQOL) initially, at 90 days, and annually. <ol style="list-style-type: none"> a. Use it as a gateway to start conversations and encourage patients to talk about something they have not mentioned. b. Document identified patient issues. 6. Fill out the Method to Assess Treatment Choices for Home Dialysis (MATCH-D) tool⁵ for every patient on admission and annually to assess suitability for home dialysis. <ol style="list-style-type: none"> a. Identify challenges that can be addressed, such as visual impairment or less than ideal living situations. b. Discuss the results weekly among in-center teammates, including the facility administrator, dietitian, nurse, social worker, and physician, if available. 7. During home visits, perform a psychosocial assessment that includes storage space, cleanliness, care partners, employment, and equipment. <ol style="list-style-type: none"> a. Ask questions that help identify needs that the home dialysis facility could address, (e.g., asking, "Where do you perform your dialysis?" may lead a patient to respond, "I dialyze in the bed, but I would rather use a chair."). b. Conduct follow-up assessments to ensure issues have been resolved. Ask patients about their other doctors' appointments. Ask whether they went and what they found out. If you notice a patient is not following through with referrals, a social worker can sit with the patient and suggest they can go through the referral process together.* c. Check in with patients after they share something personal, (e.g., "Is there anything else you'd like to talk about?").* 8. Identify simple, easy-to-complete tools that contain visual cues, such as a distress thermometer or tangible charts or pictures that rate patients' perspectives on what is impacting them.*



PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS

Secondary Driver #2a: Conduct psychosocial needs assessments

- a. Assess patients initially, at six months, and as often as is necessary or feasible, (e.g., if they come in once a month for a home program, complete the assessment each time they come in). Every month ask whether there are new questions or concerns.*
 - b. Ask patients to rate their distress using a scale, (e.g., 0 to 10, with 10 being extreme distress).
 - c. Inquire about the cause of the stress, (e.g., transportation, housing and food insecurity, insurance, family or emotional or physical issues).
 - d. Incorporate the results into the care plan, (e.g., if a patient has no air conditioning, discuss during the monthly meeting to identify cooling centers in the area).
9. Expand psychosocial assessments to include multiple sources of information, (e.g., review the family history in the medical record).
 10. Contact the family with the permission of the patient to help complete assessments.
 11. Be sensitive to how patients want to communicate verbally—“I don’t want people to know my business.” Speak softly and directly and move close to patients, as culturally appropriate, or use a conference room.
 12. Use discharge notes provided by a hospital case manager or social worker, if available, to understand and prepare for potential issues, (e.g., transportation, lack of support, physical therapy assessment), before the patient first arrives at the dialysis facility. Look at the notes to see when patients’ start date is and start to figure out transportation. Do preadmission intake collaboratively with nurses and social workers.*

*Added 2024.



Table 5. Gather Information Through Interactions With Patients

PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS
Secondary Driver #2b: Gather information through interactions with patients
<p>Patients may feel uncomfortable or pressured or may overthink responses to formal assessment questions, which can lead to an incomplete picture of their health-related social needs. In addition to formal assessments, having relaxed conversations with patients puts them at ease and encourages them to share concerns.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Identify needs such as a change in the household through conversations with patients. <ol style="list-style-type: none"> a. Make the conversation casual but with a purpose. Start where patients are. Let them feel that the staff member's attention is on them. Do not make them feel rushed. b. Speak with patients about their day to elicit information, (e.g., asking, "What did you have for dinner last night?") might uncover that the oven is not working). c. Keep the conversation general to encourage patients to share information that they might not realize could impact their care, (e.g., asking, "How was your weekend?" could prompt a patient to talk about a fall that occurred). d. Maintain trust by letting patients know the issue is going to be shared with other team members or asking permission to share the information. e. Each person is different, so meet patients where they are. For some patients, you may ask a question gently and directly, while for others you may need to be indirect. Always be nonjudgmental and read between the lines.* 2. Listen carefully to patient responses/conversation points to determine additional questions to ask. Give patients the space to talk and share. 3. Ask patients what questions they have. Reassure them that all questions are welcome. 4. Persist in talking with patients who are not ready to open up. Build trust by suggesting a solution to an observed need, (e.g., the dietitian can refer a patient to an organization that delivers meals). Follow up to see whether the proposed solution is working. <ol style="list-style-type: none"> a. Understand that patients may be in denial of their diagnosis. Work slowly; know when to back up and when to confront patients and push a little further.* 5. With permission, speak with patients' significant others or families to capture information on health-related social issues. 6. Collect information during routine care, (e.g., monthly social worker, dietitian, and physician rounds). 7. Determine how important the concerns are to patients, so the issues can be prioritized. 8. Use open-ended statements or questions to elicit information, <ol style="list-style-type: none"> a. For instance, say, "Tell me how you take your medications or how are things at home?" and "How hard is it for you to follow medical instructions?"* b. Use direct questions such as, "What kind of transportation to dialysis do you have?" and "What barriers are there?"*

*Added 2024.



Table 6. Observe for Signs That Could Indicate Health-Related Social Needs

PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS
Secondary Driver #2c: Observe for signs that could indicate health-related social needs
<p>Staying alert to changes in patients' affect, appearance, behavior, and physical well-being enables staff to identify and investigate health-related social needs that patients may not verbalize.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Be attentive to signs and clues. <ol style="list-style-type: none"> a. Watch for changes in the patient's demeanor or behavior, (e.g., the patient is teary-eyed). Follow up with questions to discern the cause and offer support. b. Pay attention to details that could indicate a problem, (e.g., a patient's shoes are on the wrong feet, a blanket is dirty, or he or she is coming in with dirty clothes when he or she normally presents good hygiene practices).* c. Look at the overall appearance of the patient and care partner to identify when respite care might help. Query the patient and care partner to see whether the care partner needs a break.* d. Look for nonverbal cues. Notice when a patient is upset and say, "You look like something is really bothering you. What's going on?""* e. Review the absence report. Missing treatments, (e.g., two appointments in a row), may indicate emerging issues, (e.g., changes with familial support, or transportation challenges). Hold patients accountable for missing appointments. Ask what happened and figure out how to avoid an issue next time.* f. Look for patients' issues with mobility, including barriers, such as stairs, to ensure that needed referrals can be made.* 2. Recognize changes in the patient's clinical status that could be related to health-related social needs. <ol style="list-style-type: none"> a. Monitor labs, (e.g., albumin or phosphorus, for trends). Start a conversation to find out whether something new in the patient's life could be causing a change. b. Notice trends that might indicate the patient does not have enough food, (e.g., losing weight).* c. Explore further, (e.g., ask patients: "Do you have access to food at home?" "Where do you get your food?" "Is your family able to bring you food?" "Is there a certain time of the month when you do not have money to buy food?" "Who does grocery shopping?" "What do you have in your kitchen that helps you cook?"). Note whether the person has any family emergency or personal challenges that may require more frequent care planning follow-up.* 3. Conduct patient rounds with the interdisciplinary team (IDT) to identify and track issues. 4. Get to the root cause. <ol style="list-style-type: none"> a. Pull up a chair and sit with the patient to dive deeper into concerns. b. Allow the staff member with the best relationship with the patient to meet with the patient for difficult conversations. c. Focus on specific observations that may be barriers to care, such as missed appointments.



PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS

Secondary Driver #2c: Observe for signs that could indicate health-related social needs

- d. Use clarifying questions to identify the underlying issue, (e.g., if a patient says she did not take her medicine because she did not eat anything, ask questions to ascertain the reason, such as “Did you have food in the house?”).
 - e. Take cues from team members on the patient’s receptiveness to follow-up, (e.g., a patient care technician (PCT) indicates the patient is not in a frame of mind to work on a problem that day).
5. Spot signs of low literacy, low health literacy, or limited English proficiency.*
- a. Be aware of the patient using verbal clues that may signal a need for reading assistance, such as the patient saying “I don’t know the words” or “I don’t know what to say” when completing an application.
 - b. Investigate reasons for the patient asking staff to fill out forms.
 - c. Ask the patient to read something and then follow up to see what the patient thinks about it. Recognize that vague answers like “I’m not sure” may indicate a lack of understanding or an inability to read.
 - d. Look for clues about not understanding information, (e.g., head tilting, furrowed brows, squinting, shoulders hunched), and work to rephrase information until the patient shows signs of understanding, (e.g., nodding).*
6. Check insurance coverage monthly; a change could indicate a new employment status.

*Added 2024.



Table 7. Engage the Whole Team

PRIMARY DRIVER #3: USE A TEAM APPROACH TO IDENTIFY AND RESOLVE HEALTH-RELATED SOCIAL NEEDS
Secondary Driver #3a: Engage the whole team
<p>Facilities that perform well on quality metrics despite their patients’ residing in disadvantaged neighborhoods and having complex health-related social needs, find that a team effort is most beneficial to identify and resolve health-related social needs. Staff members contribute individual expertise and perspectives, while the team as a whole employs a consolidated approach. “Every staff member has a role in the patient’s outcome.”*</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Delineate each staff member’s role in identifying and addressing health-related social needs. <ol style="list-style-type: none"> a. Ensure each staff member is aware of their team members' roles, so they know the appropriate staff member to go to about patient needs. b. Have one-on-one meetings during staff onboarding to make sure staff know everyone’s role.* 2. Give staff the freedom to explore issues with patients, (e.g., a patient may feel more comfortable discussing a utility bill with the PCT rather than with the nurse). 3. Fully staff the unit, so each team member has time to sit with patients and get to know them. 4. Involve the whole team in drawing out patients’ concerns, (e.g., the dietitian may ask, “How are you preparing your food?” The social worker may ask, “Are you living in a safe place?”). 5. Empower all staff to share concerns with the appropriate team member, (e.g., the PCT may know that the patient came to treatment hungry, or the administrative assistant may learn that the patient wants information on subsidized housing and can involve the social worker). When training technicians, manager can share that, “you are my extra hands, my eyes, and my ears.”* <ol style="list-style-type: none"> a. Share scripted dialogues and prompts with staff.* 6. Work together to address patients’ health-related social needs. For instance, the dietitian assesses that a patient does not have enough to eat and follows up with the social worker for a list of resources. Determine what is happening with patients and how to meet their needs. 7. Call on the administrative assistant to free up social worker time, (e.g., have the administrative assistant set up rides for patients, call for appointments, or follow up on vascular appointments). 8. Allow any team member to call a huddle to share information. 9. Consider including team members from outside of the facility, (e.g., hospital staff, community organizations), to solve social needs. 10. Engage physicians, who are well aware of the socioeconomic situations of patients before dialysis, to share concerns and to prompt information from patients.

*Added 2024.



Table 8. Communicate and Collaborate on Issues, Solutions, and Progress

PRIMARY DRIVER #3: USE A TEAM APPROACH TO IDENTIFY AND RESOLVE HEALTH-RELATED SOCIAL NEEDS
Secondary Driver #3b: Communicate and collaborate on issues, solutions, and progress
<p>Teamwork and communication, both within the facility and with outside stakeholders, are key elements in a facility’s strategy to support patients as they work through health-related social needs.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Maintain open communication among team members. Establish formal and informal methods of communication, including the electronic health record (EHR), meetings, email, telephone calls, and quick chats throughout the day. 2. Use methods that expedite communication for staff disciplines that cover multiple units, (e.g., the nurse may use secure email to tell the dietitian or social worker that a patient is out of food). <ol style="list-style-type: none"> a. Use daily report sheets that charge nurses can fill out to note any concerns or issues related to personnel, social issues, infection control, etc., to help create a plan to resolve them.* 3. Hold brief meetings or huddles away from the patient unit every morning and after shift change to share information on patients’ health-related social needs as they arise and as interventions are implemented. <ol style="list-style-type: none"> a. Vary the frequency of meetings to address barriers (weekly, biweekly). b. Brainstorm how teams can better handle situations and share lessons learned. 4. Talk about patients’ health-related social needs, including progress in resolving them, at weekly team meetings. <ol style="list-style-type: none"> a. Expand the meetings to include all team members, (e.g., administrative assistant). b. Focus on patients with identified health-related social needs. c. Take IDT ideas back to patients: Hold 1-on-1 patient conferences and brainstorm with patients. 5. Pull electronic reports of MATCH-D results for a list of patients in green, yellow, or red categories to plan interventions. Set a goal for the green category (strong candidates for home consideration). Review progress weekly. 6. Partner with other facilities from the same dialysis organization, so social workers, dietitians, and facility administrators can collaborate on solutions to specific difficulties identified during individual QAPI meetings. 7. Include social issues on QAPI meeting agendas. Invite patient representatives to speak, rotating in different patients each month to get varying views. 8. Discuss best practices and “think outside the box” during home program monthly conference calls to assist patients who are not thriving on the home modality and could return to in-center treatment. 9. Hold regional corporate nurse meetings quarterly to review case studies and discuss barriers from different angles. 10. Report psychosocial assessments every month in the EHR. <ol style="list-style-type: none"> a. Set triggers for care activities with due dates and reminders for actions.



PRIMARY DRIVER #3: USE A TEAM APPROACH TO IDENTIFY AND RESOLVE HEALTH-RELATED SOCIAL NEEDS

Secondary Driver #3b: Communicate and collaborate on issues, solutions, and progress

- b. Grant access to all staff to see what other team members are doing and what needs to be done.
- 11. Work with patients to solve challenges, (e.g., look at storage options in the home and offer delivery of supplies twice a month instead of once a month).
- 12. Collaborate on case management.
 - a. Work with case managers through the patient’s insurance or at a hospital to provide care coordination support, (e.g., refer patients to specialists, coordinate medical appointments, provide equipment such as shower chairs or walkers, and monitor patients’ status).
 - b. Integrate efforts with programs such as the CMS Program of All-Inclusive Care for the Elderly (PACE)⁶ or organizations that provide a comprehensive team approach to care, as well as services from senior centers or local distribution centers, (e.g., delivery of medications, provision of meals or medical equipment [wheelchair, ramp, stretcher, or walker]).
- 13. Address issues in a timely manner as they are discovered, if possible.

*Added 2024.



Table 9. Identify Resources

PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES
Secondary Driver #4a: Identify resources
<p>Casting a wide net to find reliable resources produces a robust catalog that staff can access to support patients.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Build on resource information from previous social workers and dietitians at the facility. 2. Network with social workers and dietitians at other dialysis facilities (e.g., conferences, local Council on Aging events). Let them know their knowledge and expertise are valued. Networking sources include: <ol style="list-style-type: none"> a. Renal dietitian Facebook groups to help identify educational materials. b. University alumni groups for social workers and dietitians to find patient resources. 3. Contact hospitals and physician offices to identify patient resources. 4. With the patient, call resource lines such as 2-1-1 available in the state or county. <ol style="list-style-type: none"> a. Ask whether patients feel comfortable calling these places. If not, help them with a sample script or tell them what to expect on the call.* 5. Use Internet search engines to locate local resources that provide free or reduced-cost services, (e.g., food banks, clinics associated with dental schools, violence prevention organizations, or centers for elder law to help with housing evictions, utility terminations, and issues with insurance, disability benefits, or Medicaid). 6. Go to findhelp.org to search for financial assistance, food pantries (especially sites that distribute fresh food), and other free or reduced-cost aid. 7. Pick up handouts of resources at community fairs. 8. Gather information about community resources from patients. 9. Ask patient ambassadors/representatives/advocates to share awareness of community resources during QAPI meetings and at informal gatherings. 10. Explore programs that pay family members as care partners. 11. Look into state programs such as the In-Home Supportive Services (IHHS) Program in California, which pays for services, such as housecleaning, grocery shopping, and meal preparation. <ol style="list-style-type: none"> a. Refer individuals with limited mobility to home health agencies for aid if they have insurance that will cover it. 12. Research local and national organizations, (e.g., American Kidney Fund, Mississippi Kidney Fund, faith-based organizations, and local Councils on Aging), to find out what they provide, such as help with transportation, medical equipment, utility or medical bills, or clothing. 13. Follow up with community service providers regularly to stay abreast of services. 14. Access corporate intranets, if available, to see what resources are offered, (e.g., educational materials in different languages).



PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

Secondary Driver #4a: Identify resources

15. Find out whether the local electric utility company offers discounts or a payment program for patients dialyzing at home.
16. Collect resources in a central repository, such as a binder or an electronic database, to provide access to the team.
 - a. Include resource details as well as other information, such as how to get a birth certificate or a Social Security number.
 - b. Document resources by city, county, state, or national.

*Added 2024.



Table 10. Link Patients to Resources and Provide Support

PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES
Secondary Driver #4b: Link patients to resources and provide support
<p>Staff support for patients encompasses a wide array of resources and actions, individualized for the patient. While the social worker may lead, an integrated team effort is ideal to provide resources to meet patient needs.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Prioritize and act first on what is most important to the patient. 2. Empower patients by coaching them to be proactive; teaching them what they can do and how to do it, and reinforcing that they are partners in their healthcare; <ol style="list-style-type: none"> a. Encourage people to self-advocate: “You are the expert on your life and your health.”* b. Hold people accountable and help them find solutions, (e.g., obtaining medication when it runs out).* c. Be honest and be real with patients.* 3. Set up email on patients’ cell phones. 4. Help patients to understand the content of letters that may impact their health-related social needs, (e.g., from Social Security). 5. Assist patients with applications for Medicare or other services, (e.g., provide lists of dentists, PCPs, and other doctors who take Medicare or Medicaid).* 6. Provide Internet access and support in the dialysis facility for patients who may not have a computer at home or the skillset to use the Internet for applications. 7. Extend resources to other patients in the facility, (e.g., if calling a transportation company for one patient, see whether other patients qualify). 8. Involve families and care partners, (e.g., have the family train on home dialysis for a patient who cannot see or ask the care partners to join in problem-solving with a patient). 9. Share information on community resources via monthly patient newsletters that meet National Standards for Culturally and Linguistically Appropriate Services (CLAS)⁷. Offer the newsletters in multiple languages. 10. Offer respite care for patients on home dialysis to give care partners a chance to regroup and to support patients, (e.g., bring a home hemodialysis patient back to the home department for hemodialysis treatments for a week). 11. Meet people where they are. Keep checking in with them; do not push them to resources before they are ready.* <p><u>Low Health Literacy</u></p> <ol style="list-style-type: none"> 1. Use a laptop at chairside to help patients complete online applications.* <p><u>Limited English Proficiency</u></p> <ol style="list-style-type: none"> 1. Obtain information from the hospital via email on what language patients speak, so interpreter services can be available for intake. 2. Use interpreter services when English is not a patient’s first language and phone or video/ virtual translation lines, in-person translators, and sign language interpreters for patients who are hard of hearing. When using an interpreter, practice correct body language, (e.g., make eye



PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

Secondary Driver #4b: Link patients to resources and provide support

contact with the person, not the interpreter), speak normally, and avoid background noise or discussions.

3. Establish and maintain relationships with translation companies.
4. Use a translation app for short questions. Type the question on the tablet and show the translation to the patient. Then ask the patient to use a tablet or phone with a translation app to answer the question.
5. Arrange for multiple translators, if needed, (e.g., for patients who are hard of hearing and do not speak English).
6. Ask staff members who speak the patient's language to assist with translation and communication.
7. Refer patients based on language, as applicable, (e.g., if a transplant center does not work out for a Spanish-speaking patient, refer the patient to a transplant center that provides excellent service to Spanish-speaking patients).

Housing Insecurity

1. Maintain a list of local resources for patients who are homeless, (e.g., Salvation Army).
 - a. If appropriate, make calls and referrals to sober living homes or halfway houses.*
2. Share housing resources with patients; follow up after a couple of days.
3. Assist patients with low income to apply for the U.S. Department of Housing and Urban Development Section 8 Housing Choice Voucher Program.
4. Work with patients dialyzing at home to find solutions to housing challenges. Provide suggestions. Be open to compromise. Include families.
5. Involve the social worker to remove barriers to home dialysis, such as the need for a cleaner house or a lack of storage space for supplies.
 - a. Look for local organizations, (e.g., furniture banks, charities), that offer free furniture to those in need.*
 - b. Locate resources to address bedbugs.*
 - c. Give people time and be transparent about expectations for home dialysis, (e.g., work with individuals with hoarding tendencies).*
6. Modify/adapt what works best for patients, (e.g., for a patient living in a camper without running water, provide supplies of water and educate the patient about using hand sanitizer and wipes).
 - a. Contact the local water service based on patients' needs, (e.g., a pump for a patient whose well broke down).*
7. Call the electric utility company or help the patient fill out an application for a discount or payment program. Faith-based organizations may assist patients unable to pay rent.*

Food Insecurity

1. Involve the dietitian to see whether patients with low albumin levels are eligible for oral supplements.
2. Based on Medicaid criteria, check to see whether patients qualify for Supplemental Nutrition Assistance Program (SNAP) benefits.
3. Refer patients to Meals on Wheels, community food banks, and faith-based food pantries.



PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

Secondary Driver #4b: Link patients to resources and provide support

- a. Recognize that people may find it more challenging to get food at the end of the month.*
4. Help patients apply for state food assistance programs, (e.g., a state chronic renal disease program could help with copays, nutritional supplements, and a variety of other needs).
5. Patients who qualify for a total home program (depending on their insurance) may be able to have medically tailored meals or supplements shipped to their homes.*
 - a. Provide resources where patients can purchase supplements directly from companies at lower cost (Oral Nutrition Supplement Program).*
6. Realize that grocery bills are expensive. Work with patients with low income to offer solutions to dietary dilemmas, (e.g., suggest affordable vegetarian protein sources instead of meat).
7. Prepare handouts of kidney-friendly recipes for foods commonly found in food pantries and educate patients to recognize high-sodium items. Brainstorm meal plans and snacks with patients. Make the materials available in multiple languages at appropriate reading levels.
8. Ask an affiliated hospital to deliver nutritional boosters to the unit, if available.

Lack of Transportation

1. Ask patients on the first day of treatment whether they are interested in and eligible for Medicaid transportation.
 - a. Walk patients through the Medicaid application process.
 - b. Set up a standing order for transportation six months at a time.
 - c. Explore whether a transportation liaison in your region can assist with Medicaid transportation issues.*
2. Explore available transportation assistance programs:*
 - a. See if people on medical assistance may receive reimbursement for travel costs from the county.*
 - b. Look for grants that allow buses to pick up outside of the city limits or if the county has disability or elder funding to provide transportation services free of charge.*
 - c. Connect people with paratransit through local metro/busing system and help them apply for the services.*
 - d. Identify whether towns or cities have a senior van.*
 - e. If applicable, look for tribal resources that may offer services, such as ambulatory transportation and gas vouchers.*
 - f. People may need help with setting up transportation services initially. Have hands-on conversations (e.g., calling transportation companies, being on the phone with them).*
3. Work with patients to engage families, neighbors, and church members to give rides.
4. Share information about local bus services that are available for trips to dialysis, the grocery store, or other appointments.
5. Connect patients to hospitals or organizations that provide transportation or financial aid for transportation, (e.g., look up charities that might provide car repairs).*
6. Collaborate with patients' insurance companies on transportation benefits; assist patients with filling out applications.



PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

Secondary Driver #4b: Link patients to resources and provide support

7. Hold regular meetings with transportation companies at the dialysis facility, including the facility manager, to maintain good relationships and open discussions about observed issues or conflicts.
 - a. Educate transportation providers and drivers about the demographics, geographic areas, and the importance of dialysis and that missed or late sessions can result in life-threatening outcomes. “This is my patients’ lifeline.” Document how many times a patient is late for treatment and share that information when communicating with the transit service provider.*
 - b. Identify the disconnect: Find out more if a person missed a ride; was it the patient or the driver who did not show up?
 - c. Schedule weekly follow-up with the transportation company for a couple months until issues are resolved. If the issues arise due to new drivers or new schedulers, work with the schedulers to group patients who reside in close proximities on the same ride to save time. Adjust patients’ chair time when possible so that the drivers aren’t running back and forth.*
 - d. Understand that a person who is partially blind may need the driver or a staff to help guide the rider to the vehicle.*
 - e. Speak to transportation companies about emergency preparedness and explain the gravity to patients of reaching a dialysis facility, (e.g., during a snowstorm, many transportation companies may close).*
8. Call transportation companies to coordinate pickup and drop-off, so patients do not wait. Help patients as needed to report issues to the transportation company.
9. Allow flexibility in scheduling dialysis sessions in the middle of the day for people who have unreliable transportation.*
10. Have patients contact transportation companies directly; their requests for temporary assistance may be effective even if they do not ordinarily qualify.

Mental Health Needs and Social Isolation

1. Hold early discussions about anger, anxiety, and depression. Refer patients to mental health services, (e.g., counseling through home health agencies or substance abuse programs). Follow up to see whether patients are getting counseling.
2. Provide counseling by the social worker, (e.g., meet with the patient weekly for six months).
3. Give patients contact information for virtual support groups where they can talk to other patients about concerns such as starting dialysis or anger.
4. Share the national suicide hotline number.
5. Acknowledge how patients are feeling and that it is normal to go through an adjustment.
6. Recognize that patients may be grieving the loss of kidney function and the loss of freedom and that for some, dialysis is a destination therapy.
7. Encourage patients to get social support from others besides family, (e.g., church members or neighbors). Senior centers sometimes have resources or groups for emotional support.*
8. Identify crisis grants for people who may be struggling with mental health conditions.*

Other Communication Needs*



PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

Secondary Driver #4b: Link patients to resources and provide support

1. Provide a translator during dialysis sessions, if needed, to sit next to a person who is deaf and unable to speak.*
2. Do not scream at a person who is deaf or hard of hearing and lacks an effective hearing aid.*
 - a. Use drawing as a tool to communicate when appropriate.*
 - b. Find tools, such as a machine with a headphone and a speaker, to help communicate with the person.*
3. Use a special interpreter for a person who is blind and deaf.*

*Added 2024.



Table 11. Design Patient Education Around Health-Related Social Needs

PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF
Secondary Driver #5a: Design patient education around health-related social needs
<p>Successful facilities personalize their educational programs to help patients overcome barriers to learning. This gives all patients an equal opportunity to understand and participate in their care and to make informed decisions about treatment modalities, including home dialysis or transplant.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Pause while patients come to terms with what is happening to them. Let them settle in, (e.g., start introducing material after two or three weeks, once patient has had some time to adjust).* 2. Assess the learning style of each patient and find out what approach works best, (e.g., visual, hands-on, website, handout, virtual or in person). Ask, “How do you learn best?” 3. Try not to overwhelm patients with too much information. Offer a bit of education every time for the first three months.* 4. Recognize that everyone is different. Tailor the education and discussions to each patient. <ol style="list-style-type: none"> a. Use labels or training checklists for people who experience forgetfulness or may benefit from visual cues.* b. Help people decipher complex information, (e.g., have the nurse sit down with the patient and explain).* 5. Clear up preconceptions. During education in a conference room, listen to patients as they talk about their beliefs and list them on a white board. Discuss each one, (e.g., “Transplants are not for people like me.”). Talk about what is valid and what is not. 6. Establish goals and monitor progress. Adjust the pace in response to patients’ needs. <ol style="list-style-type: none"> a. Use questions like “Has anyone talked to you about the access in your arm?” “Is transplant a goal of yours?” Explain the steps to reach the patient’s goals.* 7. Employ creative methods with a variety of virtual and in-person materials. <ol style="list-style-type: none"> a. Use online courses via phone or tablet, written materials (handouts, books, newsletters), fun activities (coloring pages, crossword puzzles), videos, and equipment (practice mannequins, peritoneal dialysis [PD] cyclers). b. Supply tablets and/or show patients how to use them to view educational videos or participate in telehealth calls. c. Work with patients one on one, (e.g., allow patients to practice in front of the PD nurse and voice feedback and concerns). Tailor the length of hands-on training to the patient’s learning needs. d. Use laminated educational resources with pictures or bulletin boards in lobby areas to highlight different topics or seasonally relevant information.* e. Use color, underline, or bold in monthly report cards; consider summarizing important information for patients in a one-page report.* f. Be creative in your approaches, (e.g., use pieces of candy to relay information on sugar consumption); use bags with different fluid capacities as visual cues.* g. Deliver quarterly patient newsletters and include topics from different team members, (e.g., disaster preparedness, impacts of the weather).*



PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF

Secondary Driver #5a: Design patient education around health-related social needs

- h. Help patients learn about home dialysis or transplant options by connecting with kidney care advocates, patient advocates, or patient learning groups in the area, Work with the local Kidney Foundation chapter for outreach and lobby days.*
8. Build in repetition for all patients. Use push notifications through services like Twistle to educate patients or provide reminders. Reinforce the same message from all team members.
9. Help patients feel comfortable. Be conscious of body language and tone of voice. “I don’t want to ever make my patients feel like they’re not smart enough to learn PD.”
 - a. Emphasize eye contact if appropriate. (Some people like it; others do not.)*
 - b. When introducing terms, let people know that it’s “dialysis lingo.” If you say, “You need a bath,” tell them you’re not talking about them, but the machine. Help people relax and not be afraid to ask questions.*
10. Gauge how much patients understand throughout training to determine how much more time and education patients need. “We don’t just tell them that this is what they need to do. We try to see how much they understand about these processes because they are very complicated processes.”
 - a. Use the teach-back method, (e.g., “Tell me what you understood from this conversation?”).*
 - b. Ask simple questions such as “How do you feel about connecting yourself if you are completely alone?” Avoid asking, “Does this make sense to you?”*
 - c. Ask people on what topics they would like extra information or wish to learn more.*
 - d. Use the ask-tell-ask method: Ask questions to figure out what people already know.*
11. Extend and adapt the training for patients who are not reaching educational goals, (e.g., change from a visual to hands-on method or switch staff members to see whether a patient learns better from someone else). “You just keep trying until something sticks.”
 - a. Be open to changing tone of voice or pace in interactions with the patient.*
 - b. Patients may change viewpoints monthly, so gauge interest levels to see whether they are open to learning more.*
12. Reeducate patients during monthly visits.
13. Address low literacy or low health literacy.
 - a. Talk with patients instead of giving them written materials.
 - b. Use words that patients understand.
 - c. Give patients information at grade levels 3 to 5. Include materials with pictures.
 - d. Incorporate information that patients can hear or watch, (e.g., videos, recordings by staff, or the Amia cyler for home dialysis, which has auditory steps).
 - e. Partner with families. If patients agree, share educational resources with families members or care partners.*
 - f. Use online health literacy checkers to ensure materials are easy to understand.*
14. Adapt training for patients with limited English proficiency.
 - a. Translate information. Call the translator line, ask translators to come to the facility, have staff translate, or set up an iPad and wheel it to chairside for translation.
 - b. Provide materials and videos in the patient’s language.



PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF

Secondary Driver #5a: Design patient education around health-related social needs

15. Use large print materials for patients with low vision.
16. Teach patients on home dialysis what to do if they have limited dexterity, (e.g., hold the transfer set with their fists instead of their fingertips, use gripper pads that open jars, and practice on the PD apron [training tummy] instead of themselves to gain proficiency and prevent self-contamination). Train partners to help connect and disconnect.
17. Provide culturally sensitive materials tailored to the patient, (e.g., a video by Native Americans talking about transplant).*
18. When communicating with people whose cognitive abilities have declined or who do not have the capacity to answer questions, include family members or the staff in a nursing facility.*
19. Tailor information for patients with different communication needs, (e.g., consider alternatives to written information to a person with low vision or a phone call to someone who is suddenly hard of hearing).*
20. Identify positive things and celebrate the small wins with patients to get them to see what they did right, (e.g., “This was so perfect! How did you do it?”).*

*Added 2024.



Table 12. Train Staff on Diversity and Health-Related Social Needs Assessment and Resolution

PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF
Secondary Driver #5b: Train staff on diversity and health-related social needs assessment and resolution
<p>Effective staff education related to patient health-related social needs integrates ongoing training with mentoring by experienced staff, and is built on a culture of inclusion.</p> <p>Change Ideas</p> <ol style="list-style-type: none"> 1. Educate staff to identify personal or internalized biases that may inhibit their ability to help a patient effectively. 2. Focus on a patient-centered culture with support from the leadership team. Reinforce the concept with staff as needed. 3. Provide health equity–related trainings for all staff initially and annually utilizing different communication techniques.* <ol style="list-style-type: none"> a. Include any additional health equity–related trainings, (e.g., for prevention of human trafficking and domestic or intimate partner violence).* b. Use existing ESRD Network training resources and identify trainings related to what the facility needs.* c. Create monthly training, lunch and learns, or team huddles on topics based on needs. Reframe roadblocks as “wobbles.”* d. Provide training on emergency preparedness and issues related to people’s health-related social needs during natural disasters.* 4. Remember that patients had a life and a culture before they started dialysis. 5. Have the social worker train staff how to identify patients’ unspoken health-related social needs and how to understand their situations by asking the right questions. 6. Incorporate staff training on making patients feel comfortable, use of body language, and tone of voice. 7. Assign mentors in each discipline for new employees to learn from more experienced staff. 8. Model good conversations with patients. Show staff what conversations can produce related to patient health-related social needs. Use strong preceptors to sit with staff until they master the art of purposeful conversation. 9. Educate social workers and dietitians on motivational interviewing twice a year, supplemented with multiple small learning sessions throughout the year. 10. Train newly hired staff on the translation line for patients with limited English proficiency. 11. Discuss challenges during huddles to facilitate knowledge transfer among team members. 12. During monthly team meetings, review scenarios to identify barriers faced by patients that may indicate their psychosocial needs. 13. Share best practices, case studies, and new ways to address barriers at regional nursing meetings. 14. Retrain staff after incidents related to cultural diversity or grievances filed by patients or staff.

*Added 2024.



V. Conclusion and Next Steps

The ideas presented in this change package are being implemented in high-performing dialysis facilities across the United States. These ideas can be tailored and adapted to fit the needs of dialysis facilities and the patients with ESRD whom they serve across the country.

A best practice is to start small and build improvement toward any systemic change. Facilities can start with one test of change and do it well. This will relieve the burden on staff and encourage buy-in when change begins. Measuring and monitoring performance improvement will ensure the facility stays on track with goals. Celebrating every success with staff, patients, families, and community partners will be contagious. Above all, the best time to start performance improvement is now. With this change package in hand, program leaders, administrators, and staff should ask themselves, “What can I do by next Tuesday to get this started?”



VI. References

1. CMS. CMS Framework for Health Equity 2022–2023. Available at: <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>. Accessed on: April 12, 2024.
2. U.S. Department of Health and Human Services. Advancing American Kidney Health. Available at: <https://aspe.hhs.gov/system/files/pdf/262046/AdvancingAmericanKidneyHealth.pdf>. Accessed on: April 12, 2024.
3. Kind AJ, Buckingham WR. Making neighborhood-disadvantage metrics accessible—the neighborhood atlas. *The New England Journal of Medicine*. 2018; 378(26): 2456. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6051533/>. Accessed on: April 16, 2024.
4. Institute for Healthcare Improvement. QI Essential Toolkit [ebook]. 2017; 7–8. Available at: http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihl. Accessed on: April 12, 2024.
5. Home Dialysis Central. Medical Education Institute, Inc. Method to Assess Treatment Choices for Home Dialysis (MATCH-D). Available at: <https://homedialysis.org/match-d>. Accessed on: April 12, 2024.
6. CMS. Program of All-Inclusive Care for the Elderly (PACE). Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE>. Accessed on: April 12, 2024.
7. U.S. Department of Health and Human Services, Office of Minority Health. National culturally and linguistically appropriate services standards. Available at: <https://thinkculturalhealth.hhs.gov/clas/standards>. Accessed on: April 12, 2024.

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