Expert Teams – Health Equity

Case-Based Learning & Mentorship

Tuesday, August 22, 2023

Facilitator: Sara Eve Schaffer, ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Participants can unmute themselves
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Meeting Guidelines

INTRODUCE YOURSELF BEFORE SPEAKING

KEEP PATIENT-SPECIFIC INFORMATION CONFIDENTIAL

BE WILLING TO SHARE SUCCESSES AND DIFFICULTIES

BE OPEN TO FEEDBACK

ASK THE DIFFICULT QUESTIONS

RESPECT OTHERS

USE "…AND" STATEMENTS

KEEP TO TIME LIMITS

Who Is On The Call?

- Clinician and Practitioner Subject Matter Experts
- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Kidney Care Trade Association Members
- Centers for Medicare & Medicaid Services (CMS) Leadership

What are Expert Teams?

Participants from varying levels of organizational performance, each with lived experience and knowledge, come together to support continual learning and improvement

Help others learn faster by sharing what worked and what didn't work around a particular case, situation, or circumstance

Bring the best possible solutions to the table

Expert Team Call Objectives

- Prepare for improvement using shared clinical cases
- Test processes through the application of knowledge from the cases
- Use inquiry-based learning to problem solve
- Examine clinical reasoning, problem solving, and decision making through lived experience
- Act as a consultancy for behavior change and improvement

Questions to Run On

How Might We …

- Assist patients who have health-related social needs, so they can receive the care that that they need?
- Adapt educational materials for patients with limited health literacy or limited English proficiency?
- Improve patient-provider communication with patients from diverse cultural backgrounds, as well as vulnerable patients faced with barriers caused by health status, psychosocial, or disabilities?

Opportunities to Advance Health Equity
Food Insecurity

August 22, 2023

Teri Williams, RN
Freeman Health System
Administrative Director of Dialysis Services

Meghan VanSlyke
Qsource ESRD Network 12
Quality Improvement Advisor

Facility Demographics

- Freeman Health System is a not-for-profit hospital-based dialysis center in Southwest Missouri
- Payor mix includes self-pay/no pay patients
- Mostly rural and the population average income would be in a low-income bracket bordering on poverty levels

In-Center Census-60

38 patients reside in Joplin city limits
22 patients reside outside of Joplin
12 in Missouri
7 in Kansas
2 in Oklahoma
1 in Arkansas

PD Census-26

8 patients reside within Joplin city limits
18 reside outside of city limits including some in Kansas and Oklahoma

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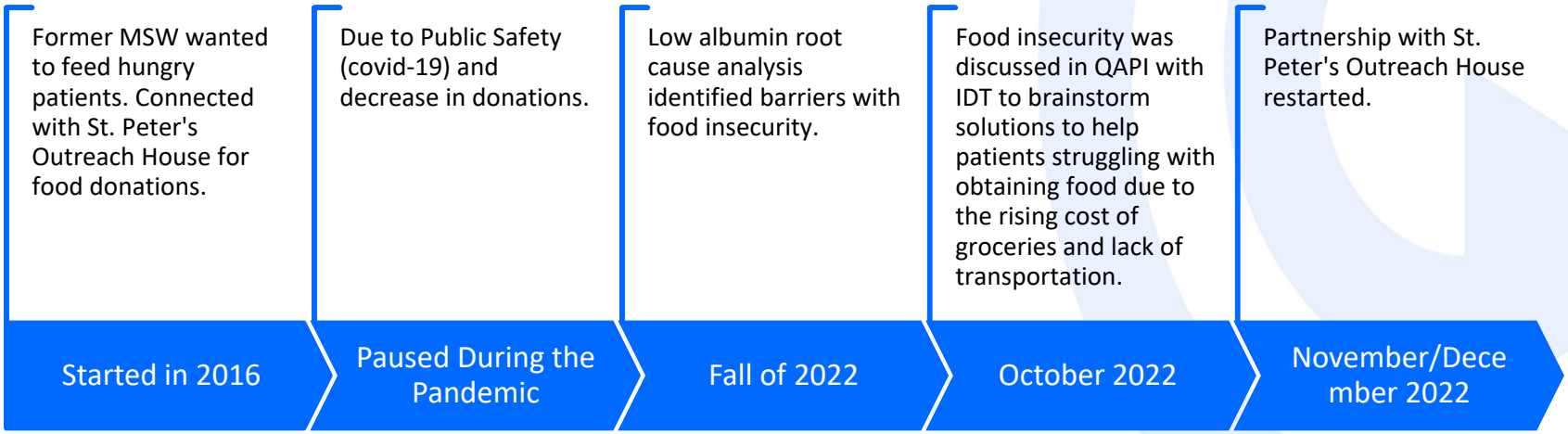
ESRD Networks

Case Background



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Food Donation Logistics

How many patients benefit?

~20 dialysis patients to help supplement meals once a month

How are patients identified?

Self Pay Patients
Patients that voice need for nutrition assistance
RD & SW Assessment
Staff/MD Observation

What food items are included?

2 cans tuna	1 can apple sauce	1 lb ground beef
1 can chicken	Cereal	1 lb chicken
1 can corn	Pasta	Apples
1 can green beans	Rice	
1 can mixed fruit	Bread	

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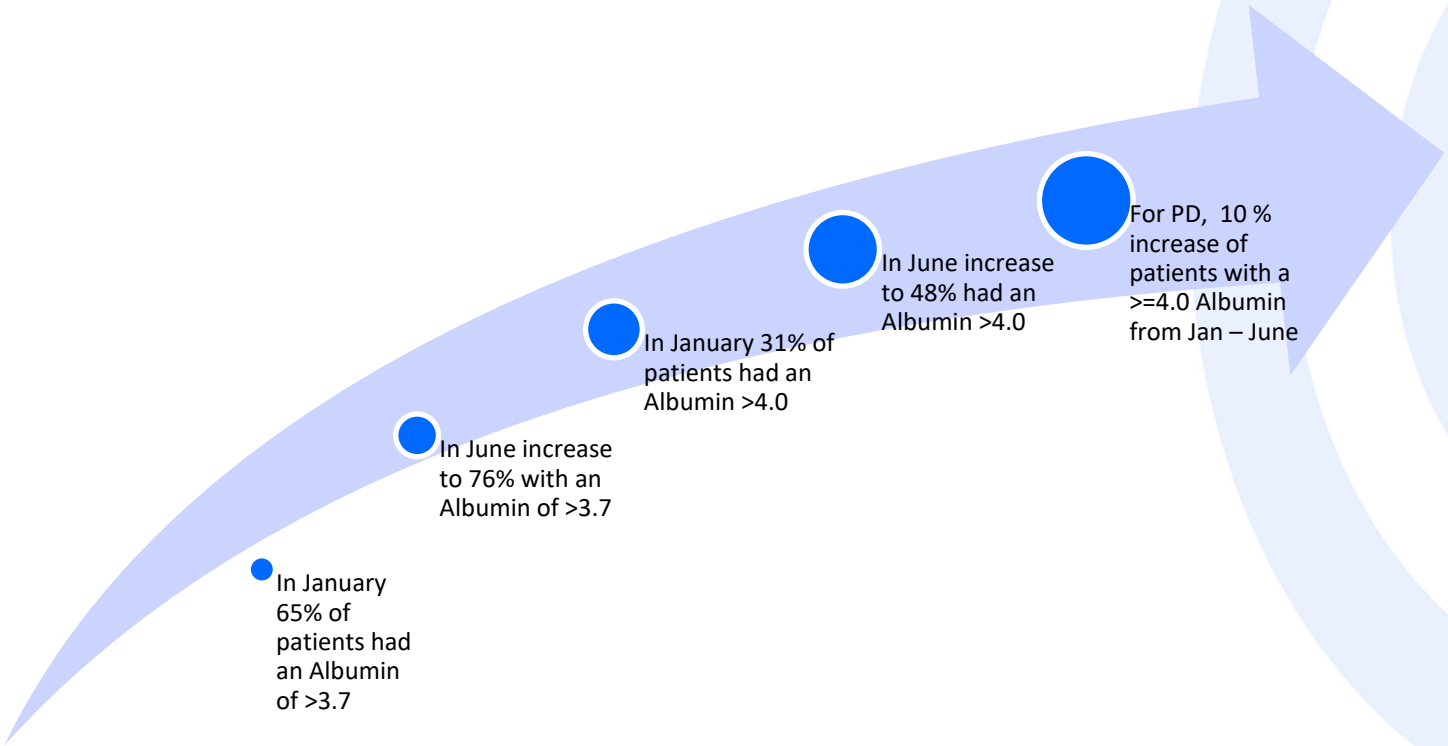
ESRD Networks

Facility Efforts Realized



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Network 12 Follow-Up Action Steps

Focus on SDOH and Food Insecurities

- Working to help dialysis facilities screen for food insecurities.
- Assist in identifying patients that may have benefits that provide medically tailored home delivered meals.
- Building relationships with organizations/companies that provide MTMs.

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ESRD Networks

esrd.qsource.org

Thank You

Questions?

This material was prepared by Qsource, an End-Stage Renal Disease (ESRD) Network under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 23.ESRD.07.107

Presentations

Dr. Praise Matemavi
Associate Professor of Surgery at University of Mississippi Medical Center

Enhancing Equity in Kidney Transplantation

Praise Matemavi, DO, FACS
Associate Professor of Surgery
University of Mississippi Medical Center

- I have no financial disclosures

Disparities Across the Kidney Transplant Trajectory

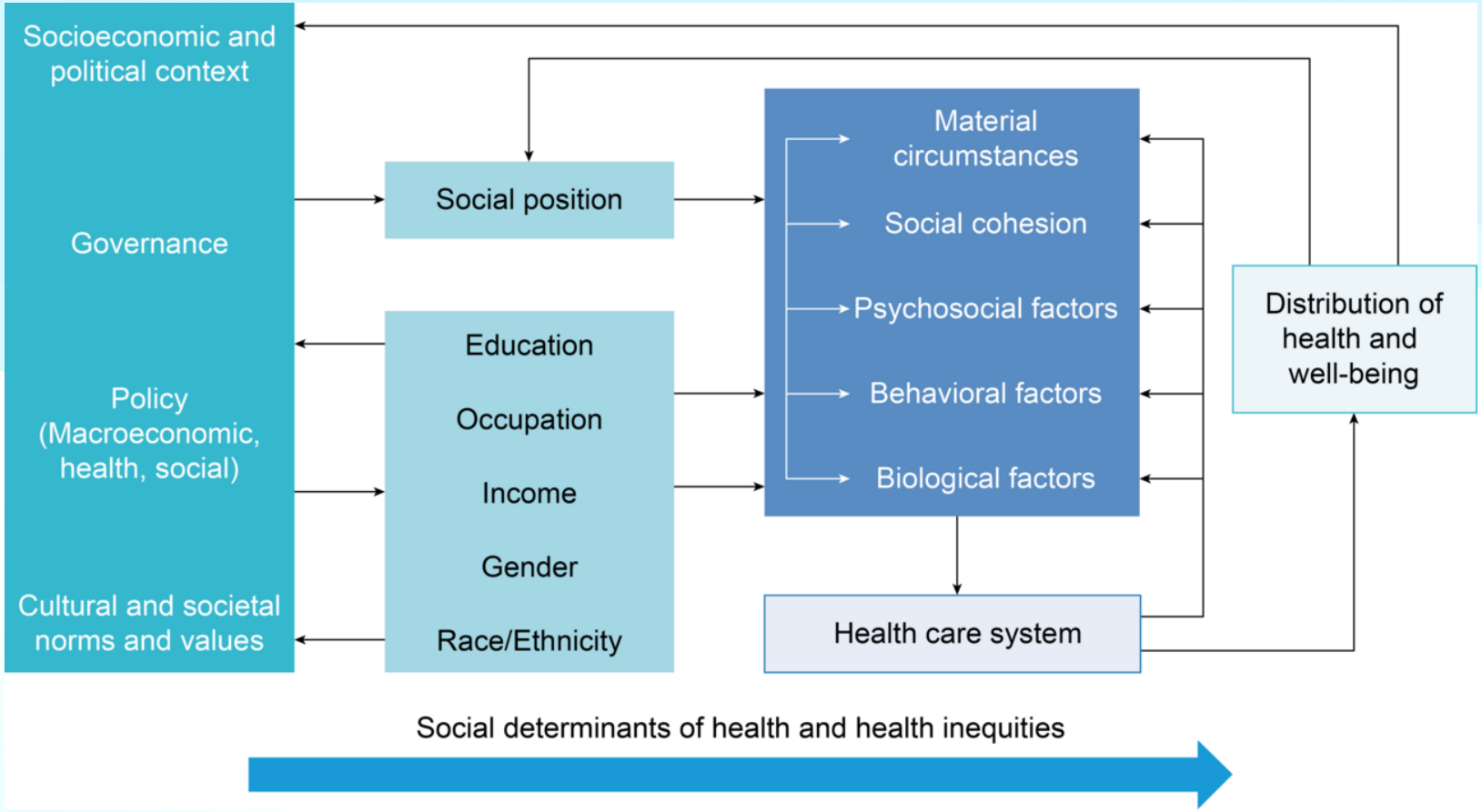
- Rates of kidney failure
- Referral for kidney transplant
- Kidney transplant evaluation
- Time on waitlist
- DDKT and LDKT
- Post KT Outcomes and adherence

Multifactorial Problem

- Lack of psychosocial support
- Misconceptions about the risks to recipients and donors
- Mistrust about equity in the organ-allocation process
- Inadequate insurance or low SES
- Medical unsuitability
- Severity of illness, incidence of diabetes, obesity, and comorbidities are higher among blacks and hispanics compared with whites.

*****Late and lower referral rates

Social Determinants of Health



Predictors of Waitlisting

Dr. Larissa Myaskovsky's group

- White Race
- Younger age
- Higher income
- Private insurance
- Lower comorbidities
- No dialysis
- Social support
- Transplant knowledge

Predictors of time to transplant

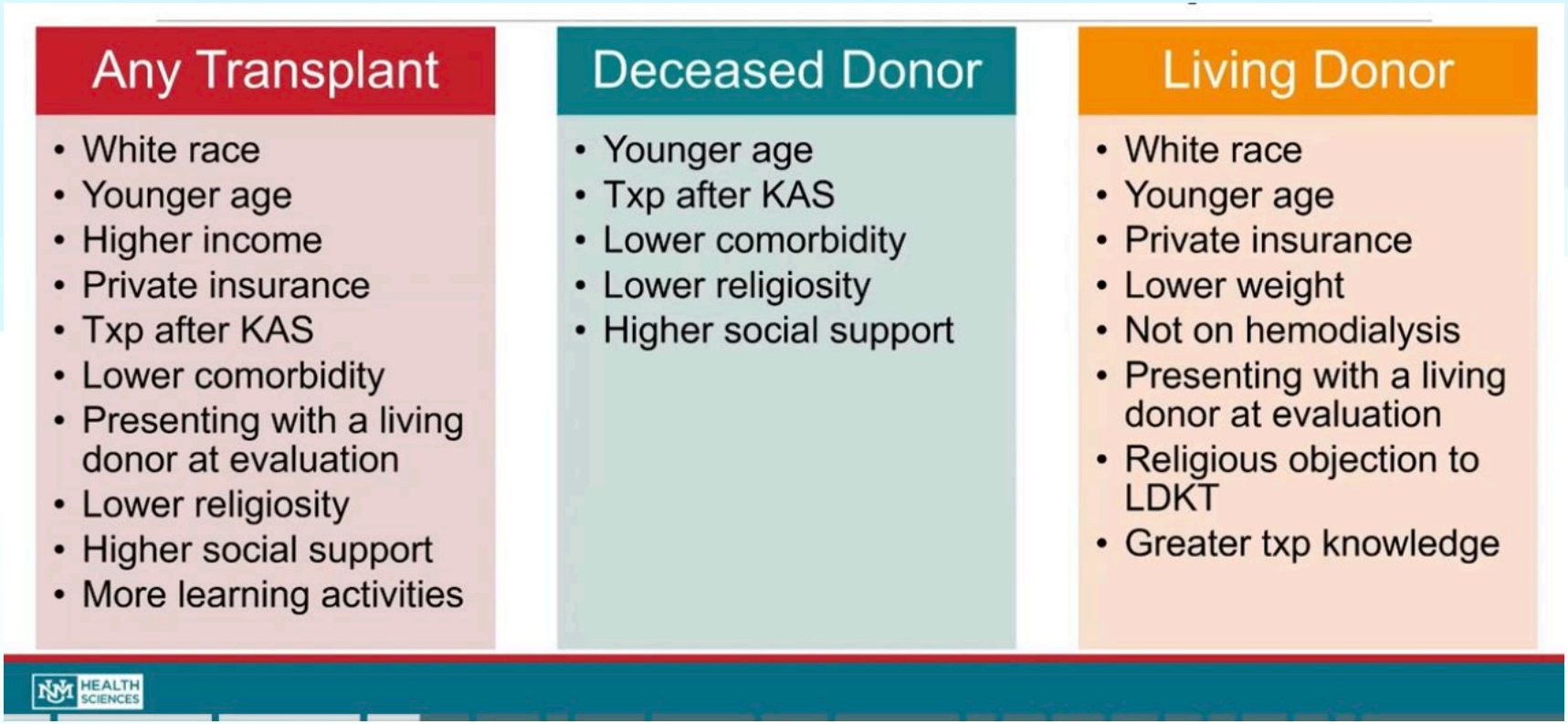
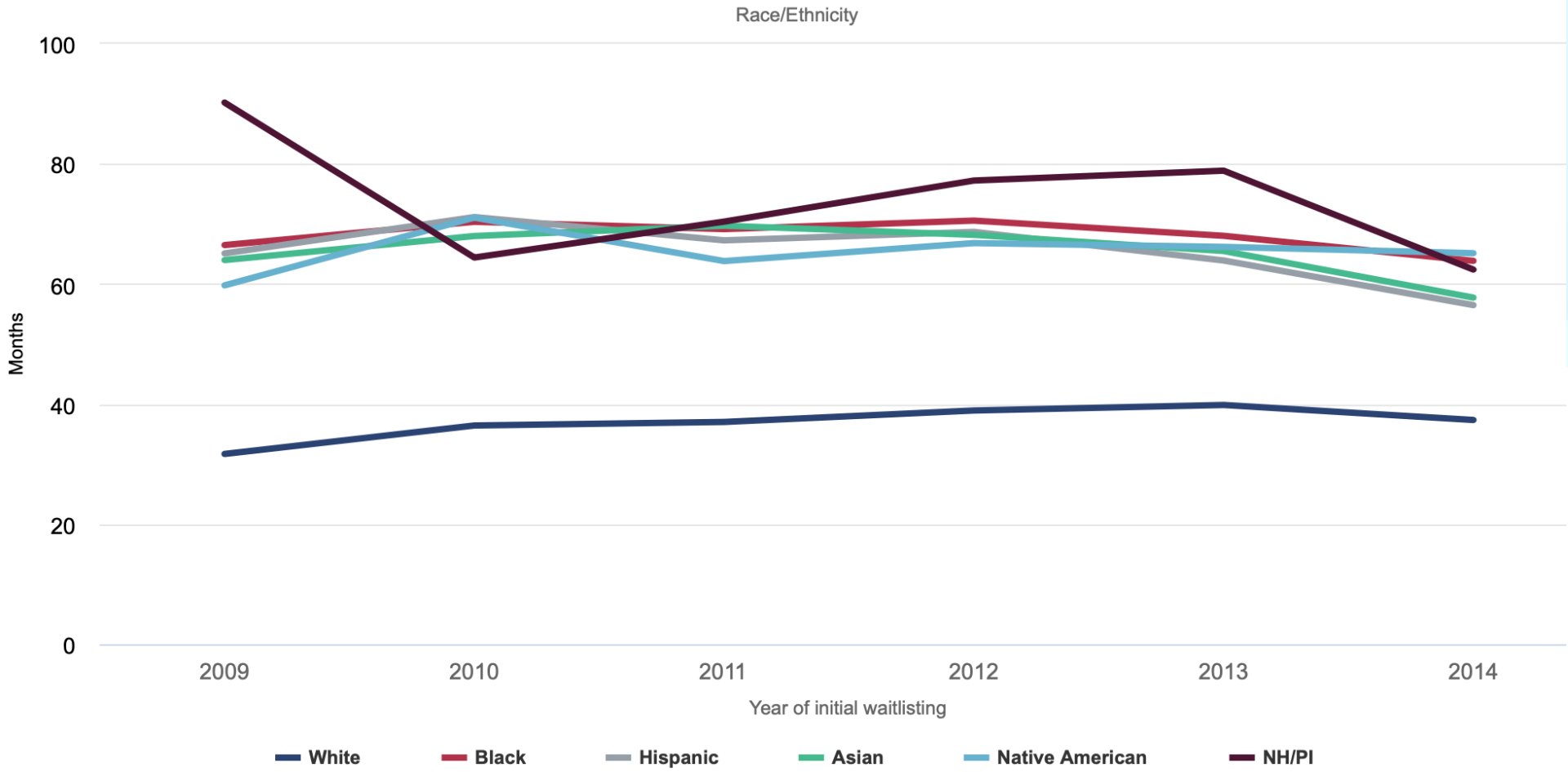


Figure 7.10 Median waittime for a kidney transplant among ESRD patients



Data Source: 2021 United States Renal Data System Annual Data Report

What can we do?

- Working together as multidisciplinary teams in the pre-transplant phase
  - Nephrologists
  - Primary care providers
  - Dialysis access providers
  - Dialysis centers
  - Transplant centers
  - Patients and families

Where can we start as organizations?

- Must explicitly acknowledge that race and racism factor into health care.
- Implicit bias training for healthcare workers
- More racial diversity in the medical professions
- Prioritizing the measurement of health disparities within institutions and among providers.
- Building partnerships to enable patients to play a meaningful role in developing solutions.
- Making racial equity a strategic priority.
- Racism is a large and multifaceted problem, there are concrete steps health care providers can and should take to combat racial inequlity.

"Because we are talking about structural racism — something that is such a broad and deep force in our society — it is tempting to say we are a small organization, what are we going to do about this? We don't have the power to control national policy or address all these big forces," says Tom Kieffer, executive director of Southern Jamaica Plain Health Clinic. "For us, it was important just to recognize that we can start small and be explicit about what we are trying to address."

THANK YOU

Case Study Presentation

Community Health Workers: Engaging a New Workforce to Help Facilitate Change

Elizabeth Lively, Eastern Region Advocacy Director

Dialysis Patients Citizens

DPC

DIALYSIS PATIENT CITIZENS

Community Health Workers:

Engaging a New Workforce to Help Facilitate Change

Compelling Data Requires New Strategies

- The prevalence of CKD in adults 30 years or older is projected to increase from 13.2% currently to 14.4% in 2020 and 16.7% in 2030.
  - Hoerger, et. al. AJKD Vol. 65, Issue 3, March 2015, Pages 403-411
- Black people are half as likely to be put on a kidney transplant wait list than are White people
  - *Source: Realizing the Promise of Equity in the Organ Transplantation System, National Academies of Sciences, Engineering, and Medicine Committee, 2022*
- Home Dialysis in the United States: To increase utilization, address disparities
  - Daniel E. Weiner and Klemens B. Meyer, Kidney Med. Vol. 2, Issue 2, March-April 2020
- Estimated 60% of new dialysis patients “crash” into dialysis
  - Molar, et.al Syst Rec, 2016, 5:117.

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DIALYSIS PATIENT CITIZENS

Why Engage CHWs in Kidney Failure Work?

- Low kidney disease awareness in the general population
- CHWs uniquely positioned to engage with community residents as they understand the social structure of their community
  - As members of the community, they are trusted health workers
  - Present in all types of communities: rural, urban, communities of color
  - CHWs focus on education and empowerment
- 2021 Illinois law (PA 102-0004) promotes CHWs as a new health care profession
- CHW reimbursement included in the 2024 Medicare Physician Fee Schedule Proposed Rule, published 8/7/2023

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IKCA Task Force Deliverables

PHASE ONE COMPLETED:

- General CKD Kidney Failure Patient Navigator career pathway
- Deliverables: Job Description, training curriculum objectives
- Scope:
  - Focus on identifying patients at risk for kidney disease
  - Navigate patients through screening tests, referrals to physicians and other resources as needed to improve social determinates of health
  - Patient/community education and awareness
  - Capture data and metrics to assist public health planning and outreach

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IKCA Task Force Deliverables

PHASE TWO Initiated June 2023:

- Develop a specialty CHW Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) career pathway
- Deliverables: Job description, training curriculum objectives
- Scope:
  - Focus on individuals diagnosed with CKD who are pre-dialysis
  - Upstream patient and community education to help prevent emergent diagnosis of ESRD and emergency dialysis
  - Dialysis modality and kidney transplant education for pre-dialysis
  - Home dialysis and mental health support (non-clinical)
  - Referrals to resources to improve social determinates of health

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DIALYSIS PATIENT CITIZENS

Questions?

Elizabeth Lively, Eastern Region Advocacy Director

Dialysis Patient Citizens

1415 West 22nd Street, Tower Floor

Oak Brook, Illinois 60523

elively@dialysispatients.org

312-890-1428

dialysispatients.org

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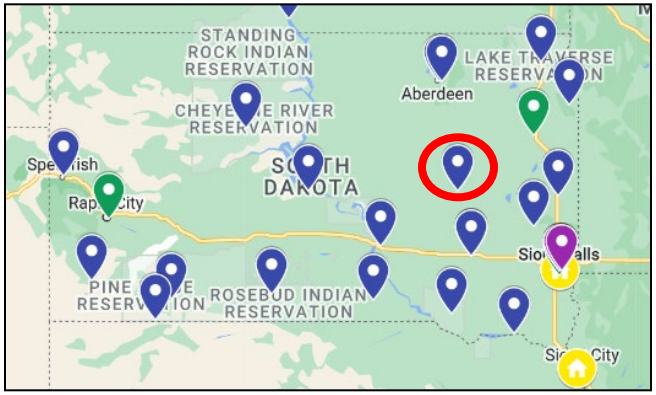
Presentations – ESRD Networks

Health Equity Expert Team

Claire Taylor-Schiller
Quality Improvement Coordinator Midwest Kidney Network/NW 11
August 22, 2023

CLAS in Action

- Collaboration with Great Plains QIN (North and South Dakota)
- Attended “Continuing the Conversation” Health Equity Webinar Series https://greatplainsqin.org/initiatives/health-equity/
- Case example identified in Network service area of a regional healthcare system truly living out the CLAS standards at the organizational level



- Transplant Centers
- In-center dialysis units
- Home dialysis units
- In-center/home dialysis units

Huron Regional Medical Center

Brooke Sydow, EdD
Program Manager

- HRMC: 25 bed independent critical access hospital, 12 chair dialysis unit
- As our community's only hospital, it's vital that we emphasize our mission and goals in delivering knowledgeable, helpful, and easily accessible services to the greater Huron community and surrounding service area
- A key to a healthcare facility's success is WORKFORCE!

HRMC
Huron Regional Medical Center

Midwest Kidney Network

SUPERIOR HEALTH
Quality Alliance

Aim: Create a Workforce that Reflects the Community

Bringing Healthcare Education to the Huron Area

- Partnership with Southeast Technical College
  - Nursing (LPN/RN)
  - Medical Assistant
  - CNA
- Partnership with Department of Labor and Regulation
  - Apprenticeships
    - Nursing (LPN/RN – STC)
    - Surgical Technician (STC)
    - Youth CNA (dual credit program with high school and STC)
    - Informational Technology (OJT)
    - Respiratory Therapy (partnership with SDSU)

HRMC Huron Regional Medical Center

Midwest Kidney Network | SUPERIOR HEALTH Quality Alliance

Making Pathways for English Language Learners

- Community Partnerships for ELL Training
  - CCLC (ESL Courses-Nights/Weekends/Intro to healthcare)
  - MTC (Accelerated TEAS Prep Course)
  - SDSU and Voxy
  - STC – Intense Language Training for Healthcare

HRMC Huron Regional Medical Center

Midwest Kidney Network

SUPERIOR HEALTH Quality Alliance

Community Health Workers (CHW)

- Intent of program is to bridge the gap for community members who need assistance navigating the healthcare system and accessing community resources
- Connecting with cultural community members
  - Hispanic population
  - Karen population

Karen Success Story

- Horizon Healthcare referral
- 76-year-old female diabetic patient
- Set up appointment with dietician and pharmacy
- Arranged transportation and attended with patient
- Met at the grocery store – translated food labels and helped with purchasing new foods
- Helped provide basic living needs – bed, furniture
- Built relationship and continued to help with additional needs and healthcare screenings

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Karen Success Story – continued

- CHW helped patient understand colonoscopy procedure and importance
- Set up colonoscopy and worked through financial concerns
- CHW facilitated monthly payment plans
- Colonoscopy detected cancer
- CHW has assisted with treatment, informed decisions, and empowerment

The CHW improved the patient's living conditions, enabled her to prioritize her health, and overall well-being by improving her knowledge and access to healthcare services.

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Questions and Answer Discussion

Knowledge Into Action

Top Take-Aways

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community through coalition meetings
  - Using Case Study examples to identify new ways of doing something and missed opportunities

- Next meeting – Tuesday, November 28, 2023 @ 12 pm ET

Visit the ESRD NCC website to find materials and share

https://esrdncc.org/en/professionals/expert-teams/

Social Media

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Thank You

Julie Moss
jmoss@hsag.com
813-300-6145

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