Health Equity Learning

Learning and Action Network (LAN)

January 23, 2024

Facilitator: Chiao Wen Lan and Emma Okamoto
ESRD National Coordinating Center

Meeting Logistics

Call is being recorded

All participants are muted upon joining the call

We want to hear from you.

Type questions and comments in the “Chat” section, located in the bottom-right hand corner of your screen.

Meeting materials will be posted to the ESRD NCC website

Who Is on the Call?

- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Centers for Medicare & Medicaid Services (CMS) Leadership
- Patients and Families

Key Objectives for Today

- NPFE-LAN Updates
- Hear from experts from Networks 4, 5, 6 and 14
- Discuss and share

Ways to Spread Best Practices from Today's LAN

- Listen and share your approaches/experiences via Chat
- Identify how shared information could be used at your facility
- Apply at least one idea from today's LAN at your facility
- Commit to sharing your learnings with other colleagues

Learning and Action Networks (LANs) bring people together around a shared idea, opportunity, or challenge to offer and request information and experiences to improve the identified topic of discussion.

Questions To Run On

What “ah ha” concept will I hear today that I can introduce to my organizations’ leadership team?

How might organization use the change package to improve outcomes?

In what way can my organization adapt this approach to increase and sustain improved outcomes?

National Patient and Family Engagement Learning and Action Network (NPFE-LAN) Committee

Who We Are

Committee made up of ESRD NCC SMEs (subject matter experts)

Meet monthly in collaboration with OMH

Develop resources and spread health equity awareness

What Is Person-First Language?

Person-first language emphasizes the ***person*** and views the condition a person has as **only one part of the whole person**.

For example, ***a person with diabetes*** not a diabetic.

DRAFT

Contact Us

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This material was prepared by the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy not imply endorsement by the U.S. Government.
FL-ESRD NCC-??????-????????-??

The words we use can make a big difference in how someone feels. Being mindful of the words we use is the first step in changing the culture. Use this list to start a conversation around destigmatizing language with your friends, family, and care team.

Examples

Instead of failed treatment...

Use ***the treatment was not effective in the patient*** or ***the patient did not respond to treatment***.

Instead of homeless people...

Use ***persons who are unhoused,*** or ***persons without an address***.

Instead of addicts/ drug abusers...

Use ***persons with substance use disorder, persons who use drugs,*** or ***persons who returned to use***.

Examples

Instead of caretaker...

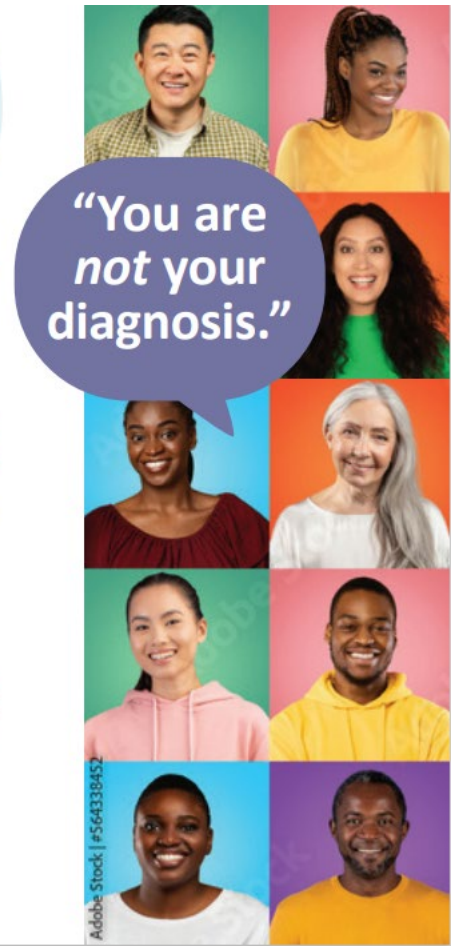
Use ***caregiver*** or ***care partner***.

Instead of crazy, insane, mental defect...

Use ***persons with a mental illness,*** or ***persons with a diagnosis of mental health disorder***.

Instead of rural people...

Use ***residents of rural areas*** or ***persons who live in sparsely populated areas***.



Network 14: Alliant Health Solutions

Texas

Rosa Abraha, MPH

ALLIANT
ESRD NETWORK 14

The Essential Steps to Facility Health Equity Action Planning

Rosa Abraha, MPH

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Health Equity Lead
Alliant Health Solutions
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Rosa leads Alliant Health Solution's first health equity strategic portfolio and embeds health equity in the core of Alliant's work.

Rosa has 10 years of experience in public health advisory for premier agencies, including the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA).

She holds a Master of Public Health in Health Policy and Management from Emory University.

Six Step Model for Health Equity Action Planning

Today's presentation will focus strictly on steps #1, #2 and #6!

Step #1: Facility IDT Engagement and Health Equity Team

CMS HCHE	**MUC 2021-106	Domain 5A** Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.

Building Your Baseline Health Equity Team in a Dialysis Facility

You may not have a large facility or a large team so at minimum your facility health equity team could include the following key personnel:

- MSWs
- Administrative Assistant
- Nurses
- PCTs
- RDs
- Leadership/Management

- **Hospital Staff Pertaining to the 5 CMS SDOH Domains:**
  - **Food Insecurity**: RD, RN, MSW, PCT
  - **Transportation:** AA, MSW, RN, PCT
  - **Homelessness:** MSW, RD, RN, PCT, AA
  - **Utility Difficulties:** MSW, RD, RN
  - **Interpersonal Violence:** MSW, PCT, RN, RD
  - **All Domains:** Language line interpretation services/personnel

Step #2: Data Collection - REaL and SDOH Patient Demographic Data

● CMS HCHE

MUC 2021-106

Domain 2A

Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients.

Domain 2B

Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.

Domain 2C

Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.

Data Collection: 5 Domains of SDOH Screening

1. **Food Insecurity**
   Food insecurity is defined as limited or uncertain access to adequate quality and quantity of food at the household level.

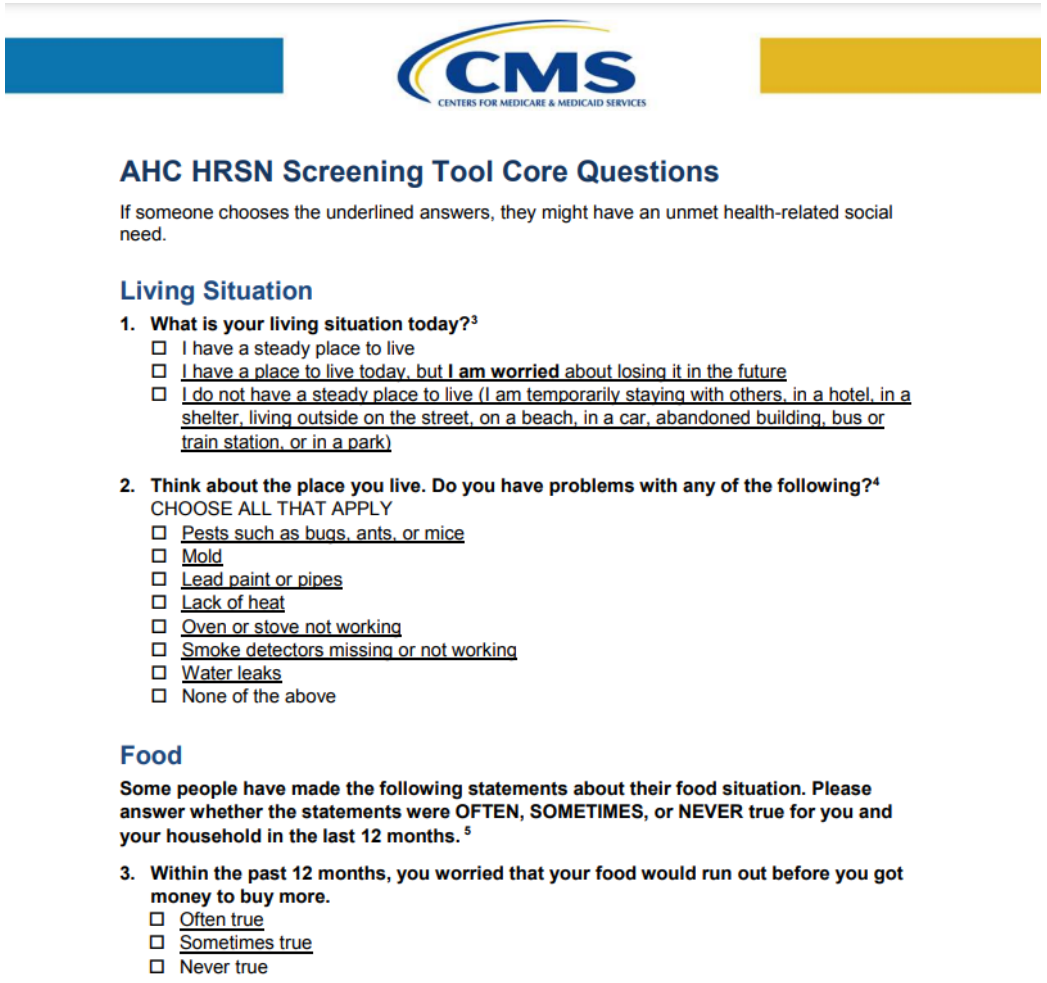
2. **Housing Instability**
   Housing instability encompasses multiple conditions ranging from the inability to pay rent or mortgage, frequent changes in residence including temporary stays with friends and relatives, living in crowded conditions, and actual lack of sheltered housing in which an individual does not have a personal residence.

3. **Transportation Needs**
   Unmet transportation needs include limitations that impede transportation to destinations required for all aspects of daily living.

4. **Utility Difficulties**
   Inconsistent availability of electricity, water, oil, and gas services is directly associated with housing instability and food insecurity.

5. **Interpersonal Safety**
   Assessment for this domain includes screening for exposure to intimate partner violence, child abuse, and elder abuse.

CMS AHC HRSN - SDOH Screening Tool



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

AHC HRSN Screening Tool Core Questions

If someone chooses the underlined answers, they might have an unmet health-related social need.

Living Situation

1. **What is your living situation today?**[3]
   - ☐ I have a steady place to live
   - ☐ I have a place to live today, but **I am worried** about losing it in the future
   - ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following?**[4]
   CHOOSE ALL THAT APPLY
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ None of the above

Food

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months. [5]

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

- CMS and CMMI developed the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool.
- It is recommended to use this form and integrate the questions into your EHR as it contains 2 questions in each of the 5 core domains that CMS will be evaluating for both structural measures (SDOH-1 and SDOH-2) .
- This is a great tool to embed into your record keeping systems and asking these on the front end of the patient experience will help you to address social barriers that impede a patient's consistent and sustainable dialysis care.

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

Evaluate Health Equity Data Collection in Your Dialysis Facility

What data do you already collect and how is it collected?

- Example: Race, Ethnicity and Language (REaL) Data is self-reported at registration
  - *Suggested registrar training: (https://ifdhe.aha.org/hretdisparities/collecting-data-nuts-bolts)*

What data do need to start collecting to meet CMS standards and how do you plan to do that?

- Solidify a process for SDOH data collection and trigger consult to address issues that arise
  - Example: Interdisciplinary treatment facility staff (i.e., RD, RN, social worker etc.) would ask these questions and the system would immediately trigger a social worker consult if a patient screens positive for a SDOH to develop a plan of care to address that SDOH

Information Systems:

- Does your EMR have a custom report built into it for collecting this data into a report? If not, please consider discussing this with leadership to built your health disparities reporting to show to CMS.

RESOURCES: Additional SDOH Screening Tools

HealthBegins

Upstream Risks Screening Tool & Guide

"Everyone deserves the opportunity to have a safe, healthy place to live, work, eat, sleep, learn and play. Problems or stress in these areas can affect health. We ask our patients about these issues because we may be able to help."

Domain*	Minimum Frequency**	Question	Response	Suggested Scoring	Referral Plan Complete?
Education	First visit	1a. What is the highest level of school you have completed? Check one.	Elementary School High School College Graduate / Professional School	+1 for "Elementary School "	
		1b. What is the highest degree you earned? Check one.	High school diploma GED Vocational certificate (post high school or GED) Associate's degree (junior college) Bachelor's degree Master's degree Doctorate	+1 for "High School Diploma, GED, or Vocational Certificate)	
Education	First visit & annually	1c. Are you concerned about your child's learning, performance, or behavior in school?	YES NO Not applicable	+1 for YES	
Employment	First visit & biannually	2. Choose one of the following. Which best describes your current occupation?	Homemaker, not working outside the home Employed (or self-employed) full time Employed (or self-employed) part time Employed, but on leave	+1 for: "Employed, but on leave for health reasons"; "Unemployed"; OR	

PRAPARE

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street: _____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

NOTE: Facilities may use any self-reported screening tool, but it's recommended (not required) to use as many questions as possible from the CMS AHC health-related social needs screening tool. When you click on the image of each tool, you will see the link to take you to view it in full.

RESOURCES: Sample Scripting to Ask REAL and SOGI Questions in a Culturally Sensitive Manner

REAL Data Collection Script and Definition

This document can be provided to staff during orientation or training on the collection of REAL data to ensure consistent screening and documentation are being collected across all points of registration. These are recommended script and suggested responses when screening patients.

Recommended Script for Patient's Ethnicity, Race, and Language Screening

"I would like you to tell me your race and ethnic background. We use this information to review the treatment patients received and make sure everyone gets the highest quality of care."

- *First, do you consider yourself Hispanic or Latino? (See ethnicity definition at end of document)*
  - ☐ Yes
  - ☐ No
  - ☐ Declined
  - ☐ Unknown/ Unavailable
- *Which category or categories best describe your race? (See race definitions at end of document)*
  - ☐ American Indian or Alaska Native
  - ☐ Asian
  - ☐ Black or African American
  - ☐ Native Hawaiian or Other Pacific Islander
  - ☐ White
  - ☐ Declined
  - ☐ Unknown
  - ☐ Other Race
- *What language do you feel most comfortable speaking with your doctor or nurse (patient's primary language)?*
  - ☐ Provide a list of options. Consider the community you serve, for example if your community is mostly Asian, provide a list of Asian languages (i.e., Mandarin, Hindi, Japanese, etc.) along with your commonly spoken language such as English and Spanish.

Sample script for collecting patient race and ethnicity

Using OMB Race and Ethnicity Categories

"We want to make sure that all of our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care."

Ethnicity Question	Race Question
Do you consider yourself Hispanic/Latino/Spanish?	*Which category best describes your race?*
☐ Yes ☐ No ☐ Declined ☐ Unavailable/Unknown	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Some other race ☐ Declined ☐ Unavailable/Unknown

Using Open-ended or Granular Categories

"We want to make sure that all of our patients get the best care possible. We would like you to tell us your racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. I would like you to describe your race or ethnic background. You can use specific terms such as Korean, Mexican, Haitian, Somali, etc..."

If people express concern about confidentiality or who will see this information, state the following:

"The only people who see this information are registration staff, administrators for the hospital, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law."

Race, Ethnicity, and Language (REaL) Sexual Orientation and Gender Identity (SOGI) Data Collection Conversation

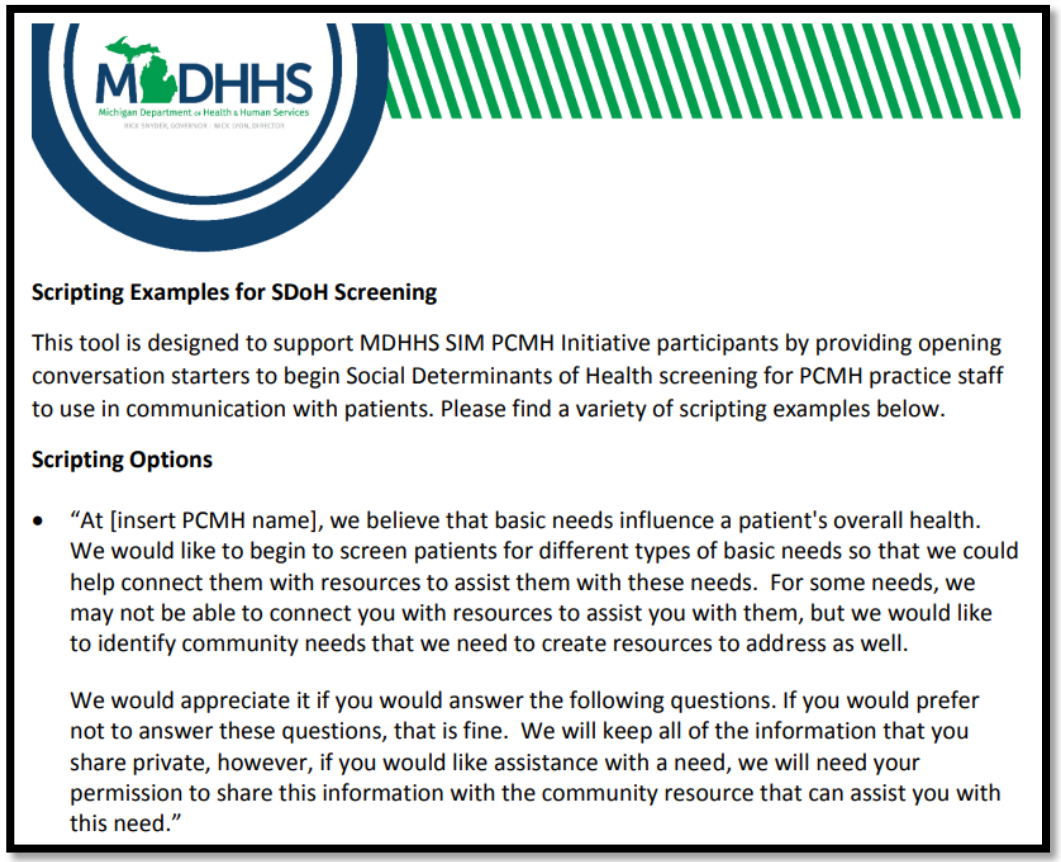
PURPOSE:

Collecting verbal self-reported REaL SOGI data from patients ensures your hospital has accurate information that can be used to improve care for all patients.

REMINDERS:

1. Everyone comes to interactions with a set of ideas based on their own experiences over time, this is called implicit bias. Understanding your own bias helps you to connect more authentically with the person in front of you. Consider identifying any implicit bias that you may have by taking the Harvard Implicit Association Tests.
2. It is recommended that you ask the SOGI questions first. This will ensure you are referring to the person by the correct pronoun.
3. It is recommended that you ask for ethnicity before race.
4. Language changes constantly. Consider reviewing and revising your script annually.
5. Use the patient's name until their pronouns are discovered. Consider asking pronouns at the beginning of the conversation.
6. Your hospital may consider adding "other" or "unknown" as an option. This may run the risk of unclear data
7. If someone expresses discomfort, share the patient education document.

RESOURCES: Sample Scripting to Ask SDOH Questions in a Culturally Sensitive Manner



MDHHS
Michigan Department of Health & Human Services

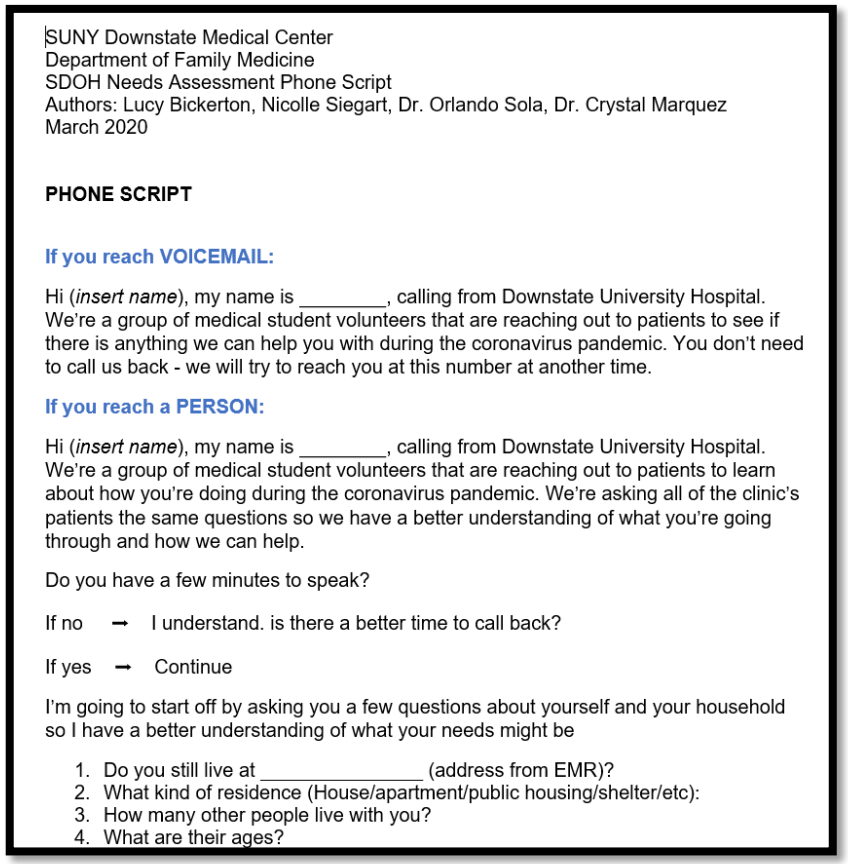
Scripting Examples for SDoH Screening

This tool is designed to support MDHHS SIM PCMH Initiative participants by providing opening conversation starters to begin Social Determinants of Health screening for PCMH practice staff to use in communication with patients. Please find a variety of scripting examples below.

Scripting Options

- "At [insert PCMH name], we believe that basic needs influence a patient's overall health. We would like to begin to screen patients for different types of basic needs so that we could help connect them with resources to assist them with these needs. For some needs, we may not be able to connect you with resources to assist you with them, but we would like to identify community needs that we need to create resources to address as well.

  We would appreciate it if you would answer the following questions. If you would prefer not to answer these questions, that is fine. We will keep all of the information that you share private, however, if you would like assistance with a need, we will need your permission to share this information with the community resource that can assist you with this need."



SUNY Downstate Medical Center
Department of Family Medicine
SDOH Needs Assessment Phone Script
Authors: Lucy Bickerton, Nicolle Siegart, Dr. Orlando Sola, Dr. Crystal Marquez
March 2020

PHONE SCRIPT

If you reach VOICEMAIL:

Hi (*insert name*), my name is _____, calling from Downstate University Hospital. We're a group of medical student volunteers that are reaching out to patients to see if there is anything we can help you with during the coronavirus pandemic. You don't need to call us back - we will try to reach you at this number at another time.

If you reach a PERSON:

Hi (*insert name*), my name is _____, calling from Downstate University Hospital. We're a group of medical student volunteers that are reaching out to patients to learn about how you're doing during the coronavirus pandemic. We're asking all of the clinic's patients the same questions so we have a better understanding of what you're going through and how we can help.

Do you have a few minutes to speak?

If no ➞ I understand. is there a better time to call back?

If yes ➞ Continue

I'm going to start off by asking you a few questions about yourself and your household so I have a better understanding of what your needs might be

1. Do you still live at _____ (address from EMR)?
2. What kind of residence (House/apartment/public housing/shelter/etc):
3. How many other people live with you?
4. What are their ages?

Note: These scripts are downloadable by clicking on the picture.

Step #6: Health Equity Community Partnerships

CMS HCHE	**MUC 2021-106** **Domain 4A** Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
CMS HCHE	**MUC 2021-106 Domain 1D** Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
TJC	**Standard LD.04.03.08** Reducing healthcare disparities for the [organization's] [patients] is a quality and safety priority. **EP 2** The [organization] assesses the [patient's] health-related social needs and provides information about community resources and support services.

A Culture of Health Equity: Key Clinical-Community Partnerships

Example Clinical Partners

- Nephrologists
- Nephrology Social Workers
- Registered Nurses
- Registered Dietitians
- Technicians
- Registration Staff

Example Community Partners

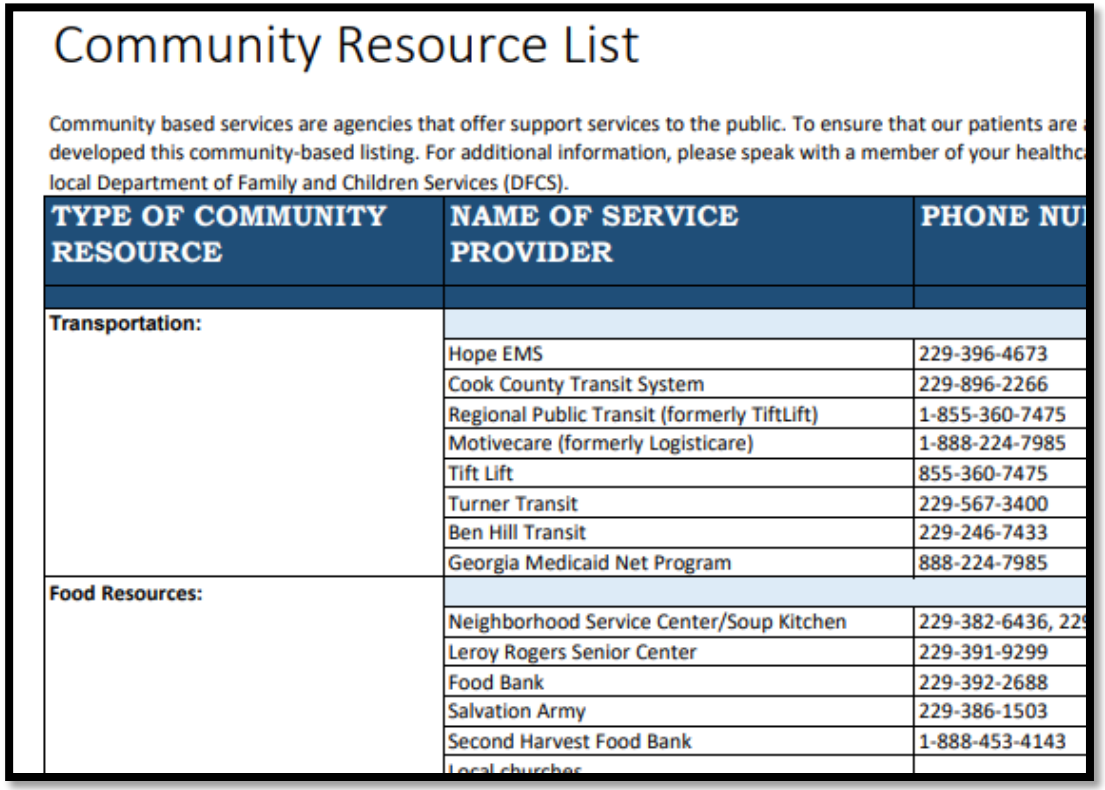
- United Way
- Area Agency On Aging
- Area Medicaid Reps
- Faith-Based Organizations
- Local Business (i.e., Barbershops, Grocery Stores)
- Local Employee Retiree Organizations
- Local Senior Centers
- Local Political Organizations
- Local Power Company
- Community Health Workers
- Local Transportation Agencies
- Housing Agencies
- Food Pantries/Shelters
- Literacy Volunteers
- Police and Fire Depts.
- Veterans Association
- Universities/Research Centers

Developing Your Health Equity Community Partnerships List

- Best practice is to develop a community resource list and embed this tool intentionally into care planning when your patient screen positive for a SDOH.
  - Example to the right from Tift Regional Hospital in GA and you can see that their resource list clearly differentiates the type of resource labeled in categories by the 5 CMS SDOH Domains

- Ensure this tool is clearly labeled and consistently available at your nurses' station, as well as making sure your providers are trained on this tool.

- When developing your community resources lists clearly identify who are your trusted local, state and national partners. Does your EHR vendor already have a list you can pull from?

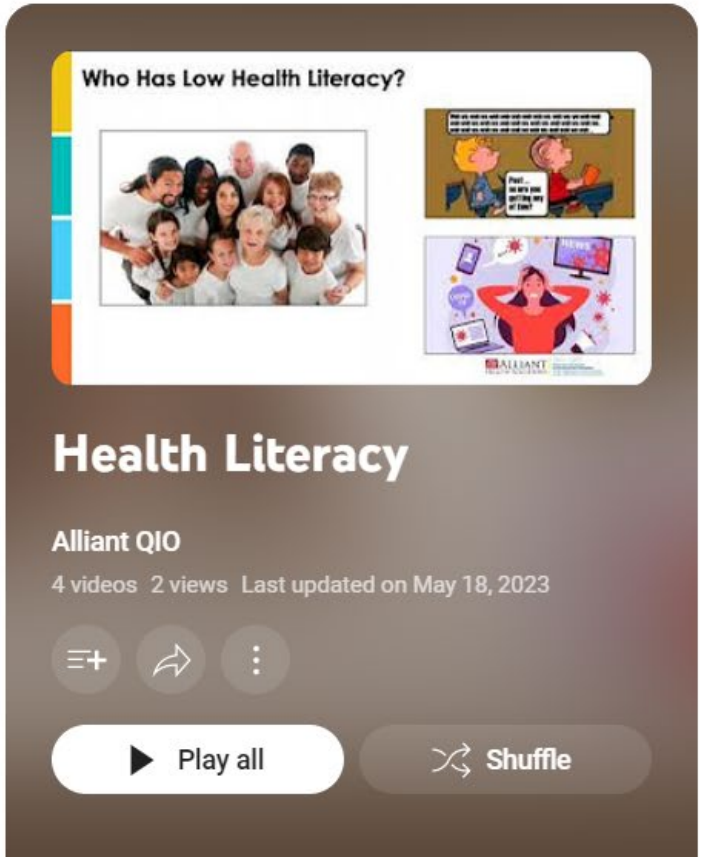


Community Resource List

Community based services are agencies that offer support services to the public. To ensure that our patients are
developed this community-based listing. For additional information, please speak with a member of your healthc
local Department of Family and Children Services (DFCS).

TYPE OF COMMUNITY RESOURCE	NAME OF SERVICE PROVIDER	PHONE NU
Transportation:		
	Hope EMS	229-396-4673
	Cook County Transit System	229-896-2266
	Regional Public Transit (formerly TiftLift)	1-855-360-7475
	Motivecare (formerly Logisticare)	1-888-224-7985
	Tift Lift	855-360-7475
	Turner Transit	229-567-3400
	Ben Hill Transit	229-246-7433
	Georgia Medicaid Net Program	888-224-7985
Food Resources:		
	Neighborhood Service Center/Soup Kitchen	229-382-6436, 229
	Leroy Rogers Senior Center	229-391-9299
	Food Bank	229-392-2688
	Salvation Army	229-386-1503
	Second Harvest Food Bank	1-888-453-4143
	Local churches	

Cultural and Linguistically Appropriate Services (Alliant Health Solutions CLAS Video Toolkit)



1 

Health Literacy with Dr. Iris Feinberg, PhD, CHES

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Website: https://quality.allianthealth.org/nqiic/esrd/esrd-network-14/

ALLIANT
ESRD NETWORK 14

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ESRD Network of Texas

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ESRD Networks 8 and 14

Produced under CMS Contract number 75FCMC19D005-75FCMC21F0002.

Network 6: IPRO

Georgia, North Carolina, and South Carolina

Andrea Collins, MSW

End-Stage Renal Disease Network Program

Network 6
Learning and Action Network Call

Andrea Collins, MSW

January 23, 2024

Agenda

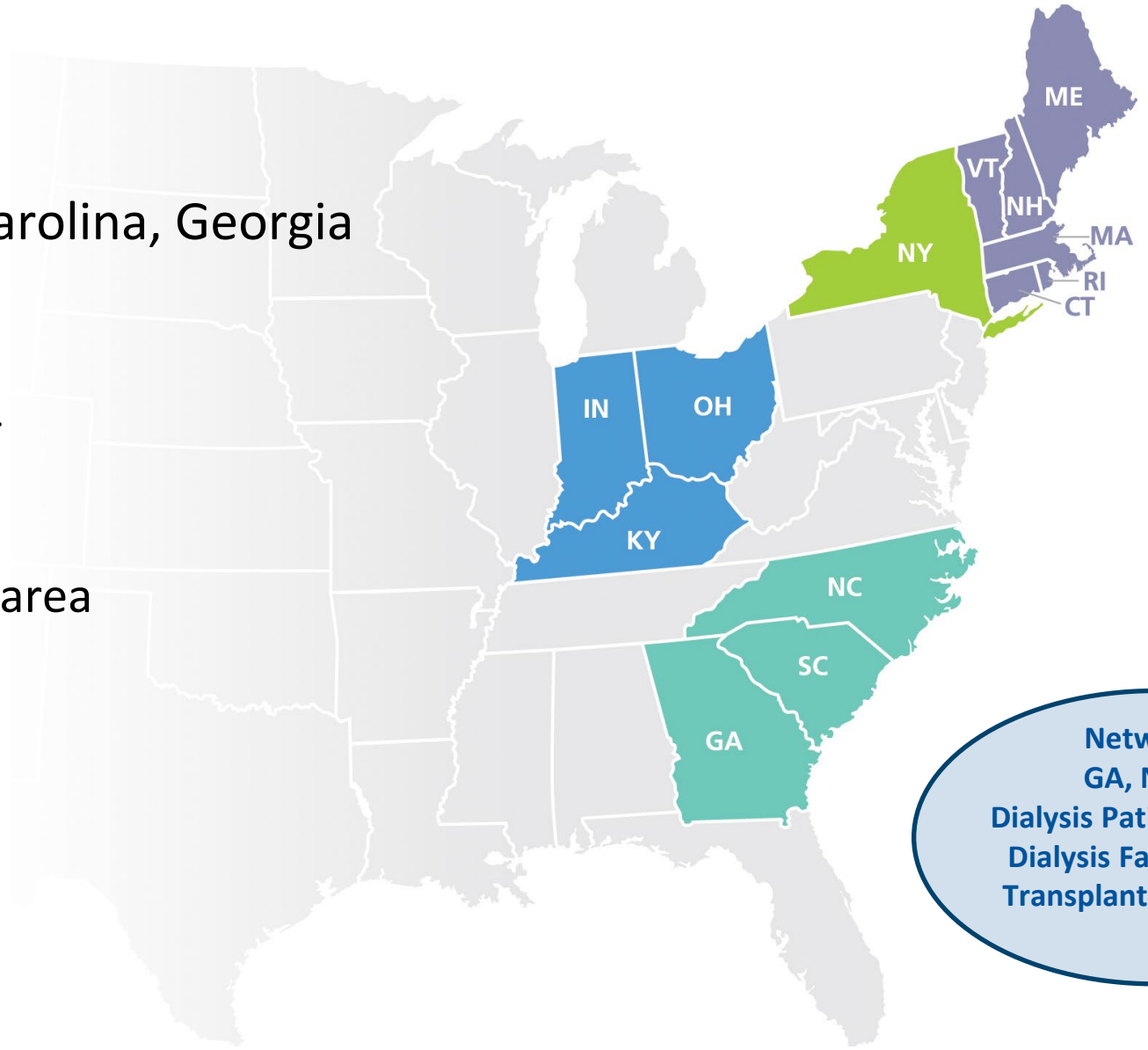
- Demographics
  - Network 6
  - Davita Mint Hill
- Intake and screening
- Identified barriers
- Intervention process and results

Demographics

Network 6

- North Carolina, South Carolina, Georgia
  - Patients: 50,065
  - Dialysis facilities: 767
  - Transplant centers: 12

- Davita Mint Hill
  - Charlotte, NC - Urban area
  - Patients: 48



Network 6
GA, NC, SC
Dialysis Patients: 50,065
Dialysis Facilities: 767
Transplant Centers: 12

Intake/Screening Process

- Interdisciplinary team approach (AA, SW, RN, RD, etc.)
- Initial assessment
  - Individual barriers identified
  - Collaboration with current supports for the patient (caregivers).
  - Education on available resources provided- connecting patient to patient's chosen resources

Identified Barriers

- Transportation

- Food Insecurity
  - Options greatly depend on their natural resources- how can they access these resources? (Car, friend, family to prepare food).

- Housing
  - Setting realistic and honest expectations from the start about limitations in our community

Intervention Process and Positive Results

Transportation

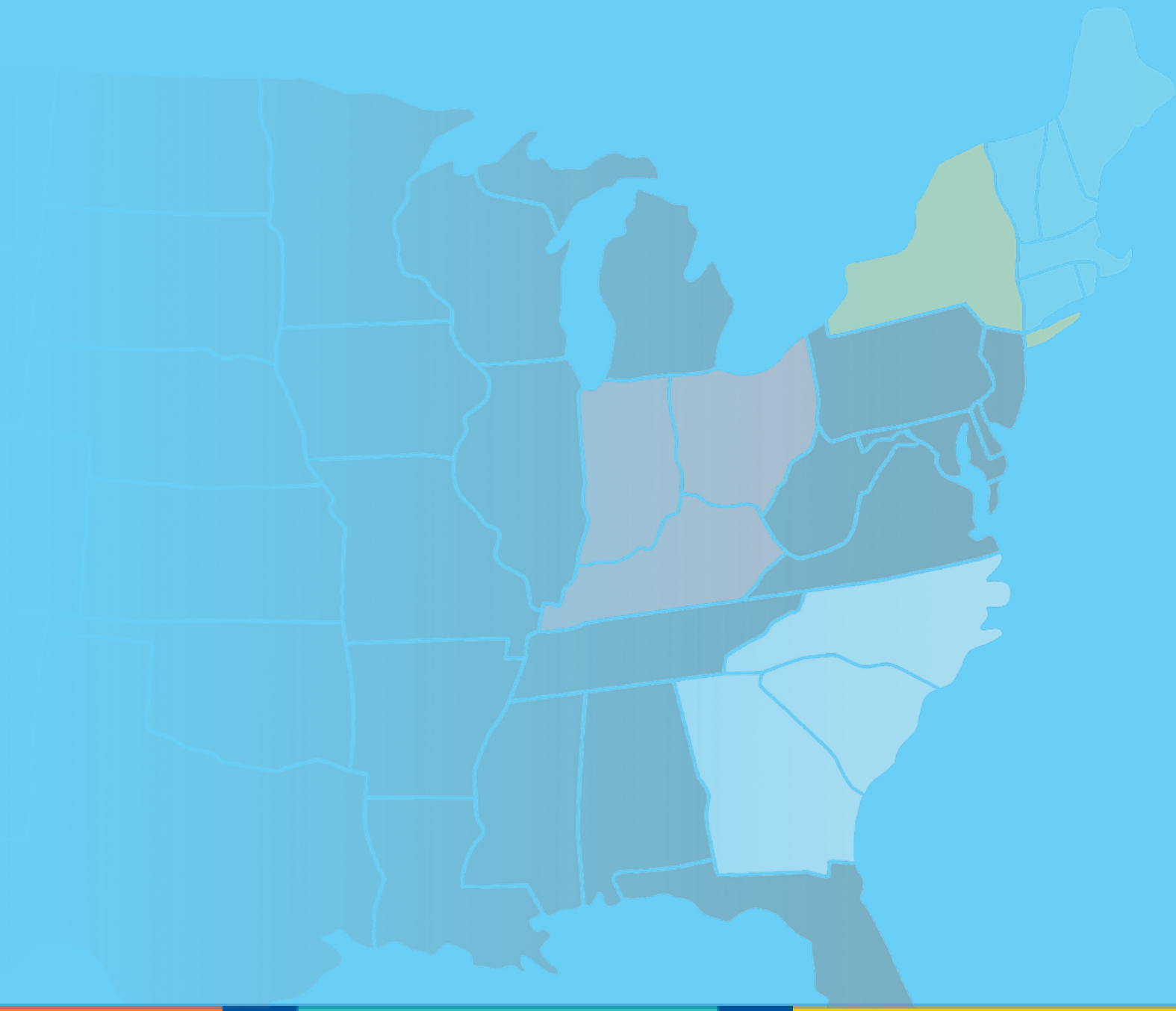
- Community partner collaborations- Local Social Services, Special Transportation services through city buses, Insurance provided rides

- Team approach - Empowering dialysis teammates to know how to reach transportation resources

- Education opportunity- Ensuring patients know their options and how to work with the limitations of their resources

- Patient empowerment
  - Improved compliance to dialysis treatment
  - Become invested in their own health
  - Gained new skills and independence

Questions?



Andrea Collins, MSW

Thank you!

End-Stage Renal Disease Network Program

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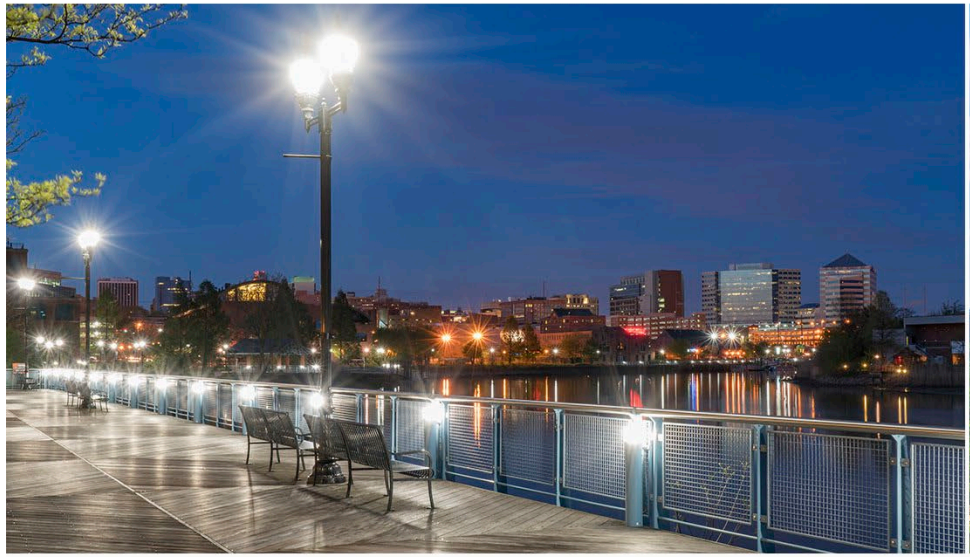
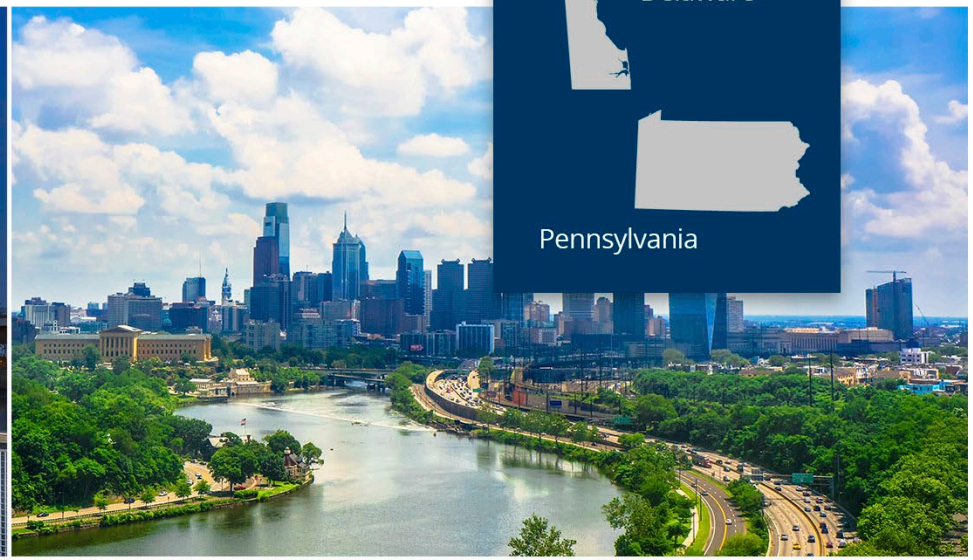
Network 4: Quality Insights
Delaware and Pennsylvania





Language Equity at DaVita Warren

Health Equity Learning and Action Network

Quality Insights
Renal Network 4

Language Equity

Inclusivity

Communication that **centers the patient's point of view** and **helps them understand and be understood.**

Belonging

Language can make people feel like they **belong,** or be used to discriminate and **advance inequities and disparities.**

Patient Safety

Language concordance between patients and providers helps to **prevent medical errors. hospitalizations, bias, and low treatment adherence**.

Accessibility

Language equity is supported by the **level of access** provided through translation and interpretation services.

Quality Insights
Renal Network 4

DaVita Warren

Language Equity Champion

- Identified and scaled a method of communication to effectively communicate with a patient who is deaf and blind
- Patient is fluent in American Sign Language (ASL); 2 DaVita Warren staff able to communicate in sign language
- Facility Social Worker used the ASL alphabet to train all staff on basic words in ASL
- Patient engages in her care by verbally asking questions and informing staff of her concerns
- Responses are spelled on the patients arm and the “teach back” method is applied to confirm understanding
- Visiting teammates also taught this method of communication to ensure the patient is involved in her care and language equity is in place

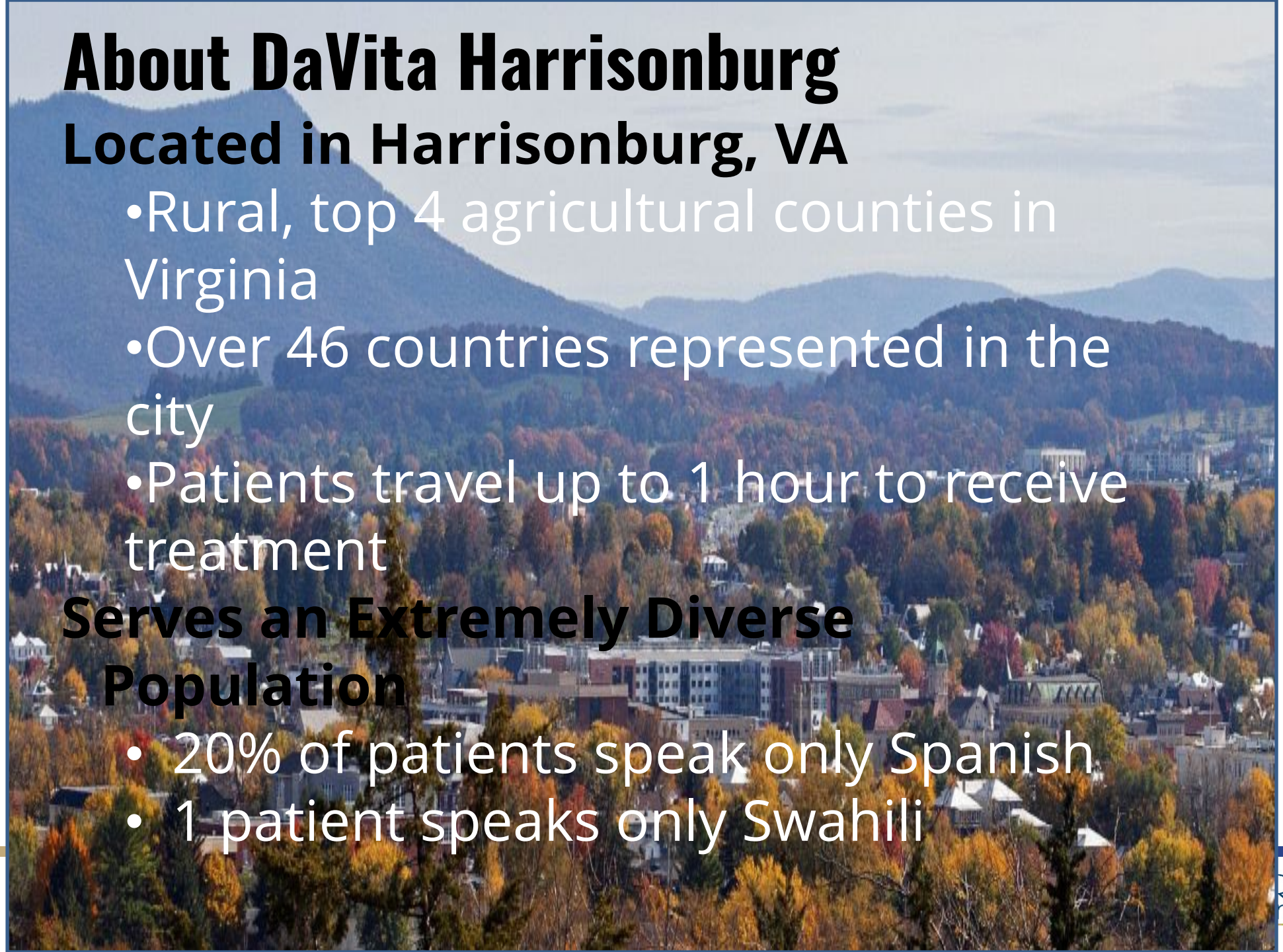

Questions?

Network 5: Quality Insights
Maryland, Virginia, District of Columbia, and West Virginia

Breaking Down Language Barriers at DaVita Harrisonburg Dialysis Center

Health Equity LAN

Quality Insights



About DaVita Harrisonburg

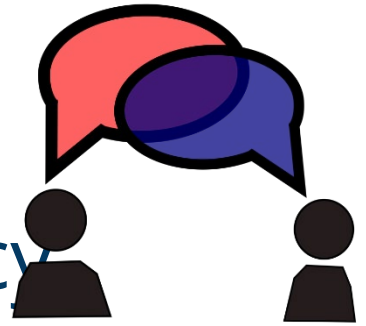
Located in Harrisonburg, VA

- Rural, top 4 agricultural counties in Virginia
- Over 46 countries represented in the city
- Patients travel up to 1 hour to receive treatment

Serves an Extremely Diverse Population

- 20% of patients speak only Spanish
- 1 patient speaks only Swahili

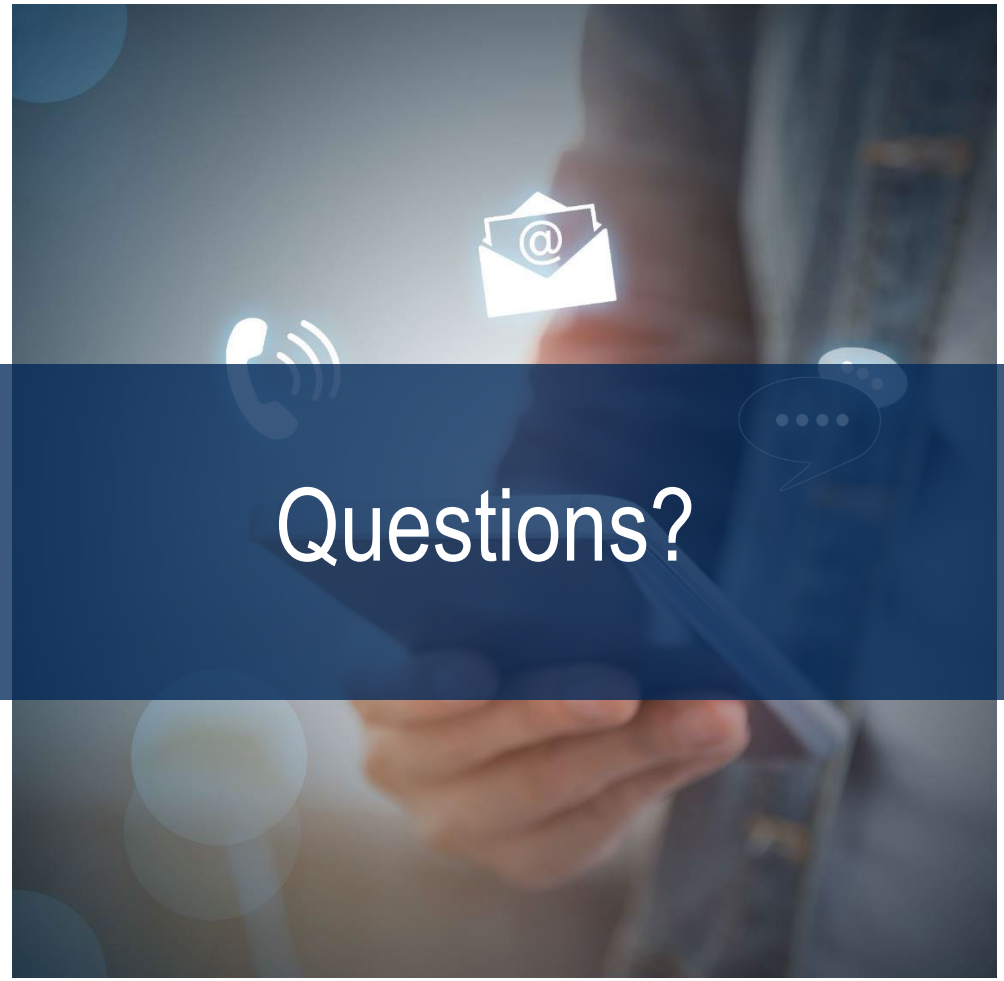
Language Barriers



- Limited general and health literacy
  - Many of the Spanish-speaking patients also struggle with reading Spanish
- Family members are not reliable translators
- Missed information leads to increased hospitalizations and decreased quality of care

Interventions

- Utilize Community Health Interpreter Services
  - Provide an in-person interpreter for Spanish and Swahili
  - Rounds with Physician Assistant every Monday and Tuesday
  - Also provide home trainings with the nursing team
- Videos in Spanish accessible to patients who struggle with reading
- Bilingual staff member who can assist with translation
- In the absence of Community Health Interpreter Services, Cryacom Language Solutions is utilized

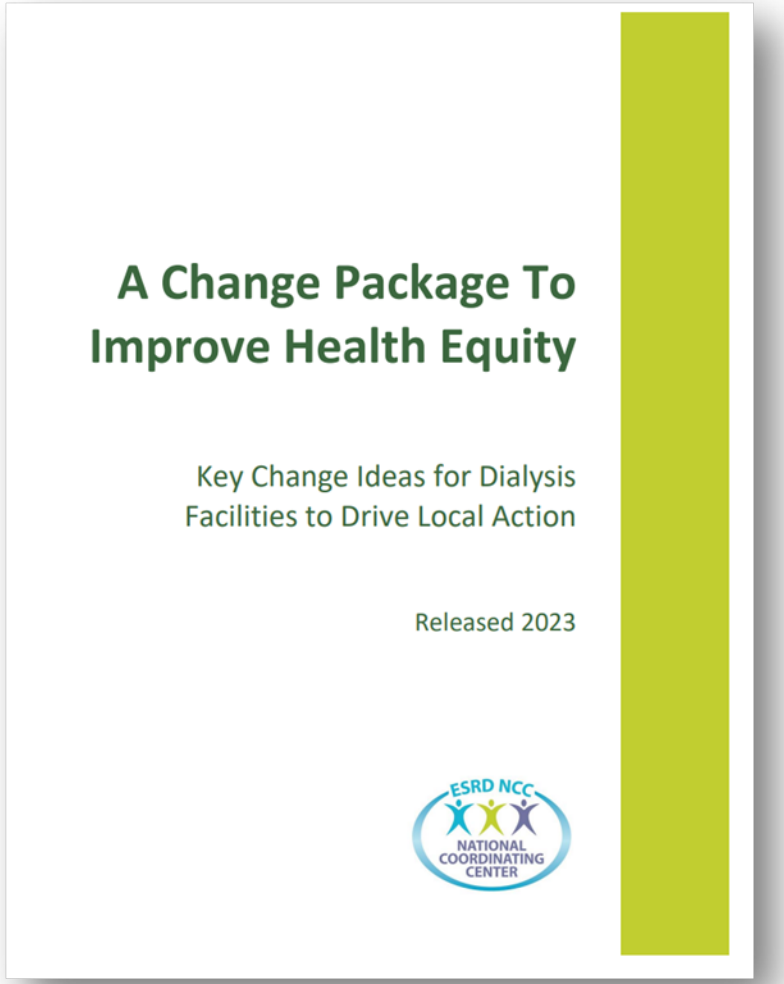


Questions?

Quality Insights

Discussion

ESRD NCC's Health Equity Change Package



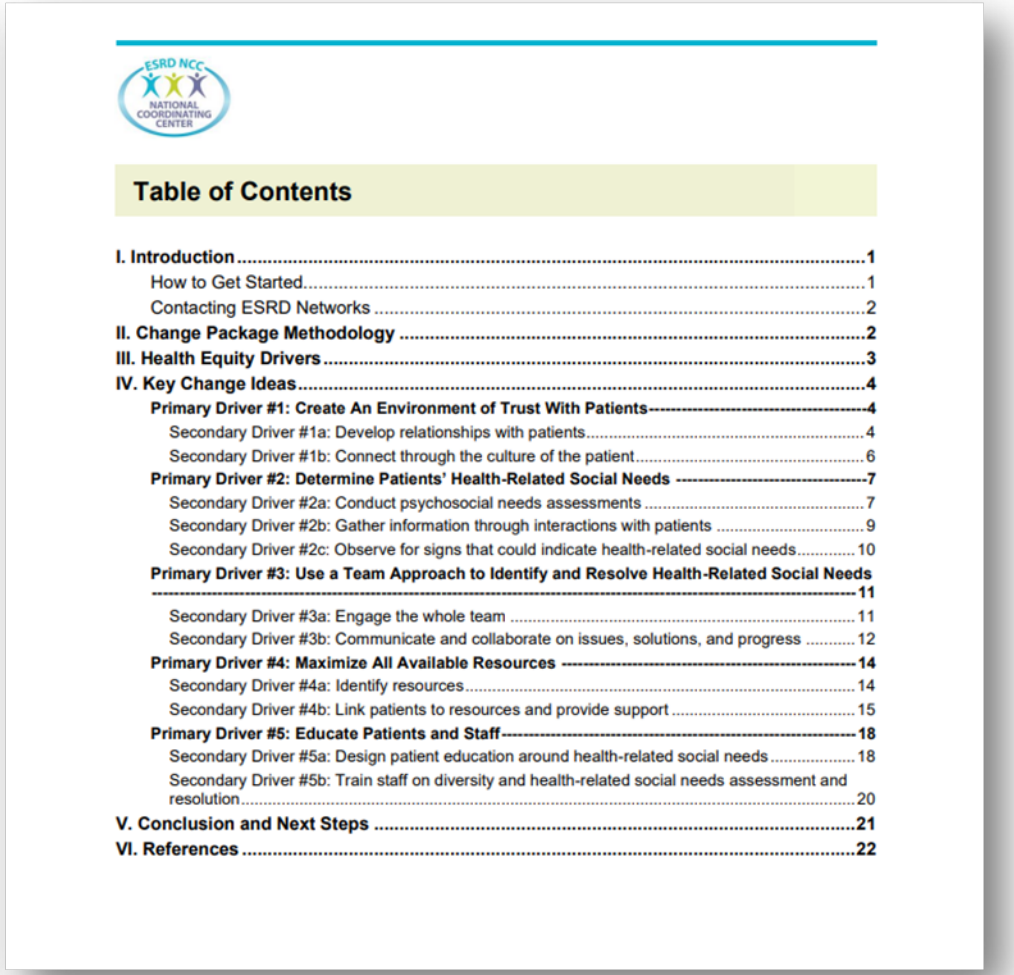
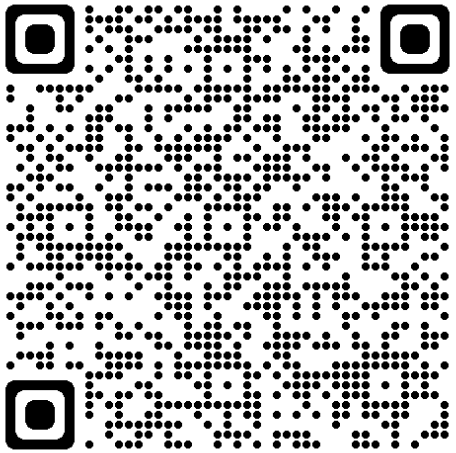


Table of Contents

Moving from Learning to Action…

- Share best practices from this presentation with your colleagues.
- Use the ESRD NCC Changes Packages (i.e., Transplant, Home, Hospital, Vaccination, and Patient Experience of Care change package) as a supplementary resource to improve your patient outcomes and overall patient experience of care.
- A Change Package To Improve Health Equity (esrdncc.org)



Use your phone's camera to scan QR code to go directly to the change package.

Social Media and Website

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ESRDNCC.org

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