

Health Equity Learning

Learning and Action Network (LAN)

October 24, 2023

Facilitator: 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

CMS OMH

Hear from experts from Networks
1, 2, and 3

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?

CMS Office of Minority Health

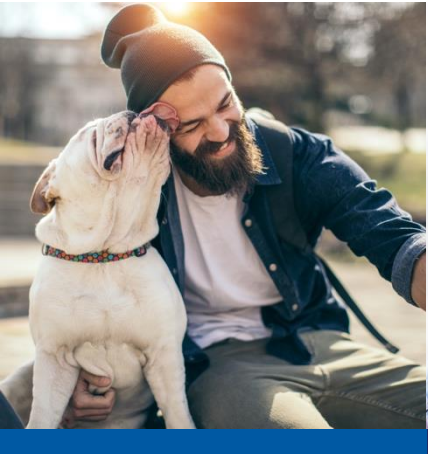
Michelle D. Oswald, MA, BSW

Technical Director

Policy & Program Alignment Group

CMS Office of Minority Health





Health Equity Learning and Action Network (LAN)

Michelle Oswald, MA, BSW
Technical Director
CMS Office of Minority Health

October 24, 2023

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About CMS OMH



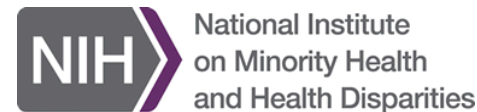
CMS Office of Minority Health

Mission

CMS OMH will lead the advancement and integration of health equity in the development, evaluation, and implementation of CMS's policies, programs, and partnerships.

Vision

All those served by CMS have achieved their highest level of health and well-being, and we have eliminated disparities in health care quality and access.



Executive Order 13985

Advancing Racial Equity and Support for Underserved Communities Through the Federal Government



- **Key Objectives:**

- Eliminate systemic barriers in sectors like healthcare, housing, education, and criminal justice.
- Assess and revise federal policies to prioritize equity and equal opportunity.
- Enhance data collection for tracking progress and ensuring transparency.
- Foster engagement with historically underserved communities for insights and feedback.



- **Focus Areas:**

- Training for federal employees on implicit bias and cultural competence.
- Tribal consultation in policies affecting Native American communities.
- Reviewing previous regulatory actions with potential disparate impacts.

CMS Framework for Health Equity

- Operationalize health equity across all CMS programs: Medicare, Marketplace, Medicaid, and CHIP
- Is evidence-based and informed by decades of research and stakeholder input
- Review the framework: [go.cms.gov/framework](https://www.cms.gov/framework)

CMS Framework for Health Equity 2022–2032

Definition of Health Equity

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

CMS Framework for Health Equity Priorities

-  Priority 1: Expand the Collection, Reporting, and Analysis of Standardized Data
-  Priority 2: Assess Causes of Disparities Within CMS Programs, and Address Inequities in Policies and Operations to Close Gaps
-  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
-  Priority 5: Increase All Forms of Accessibility to Health Care Services and Coverage

To read the CMS Framework for Health Equity 2022-2032, visit [go.cms.gov/framework](https://www.cms.gov/framework).

The CMS Office of Minority Health offers health equity technical assistance resources, aimed to help health care organizations take action against health disparities. If you are looking for assistance, visit [go.cms.gov/omh](https://www.cms.gov/omh) or email HealthEquityTA@cms.hhs.gov.

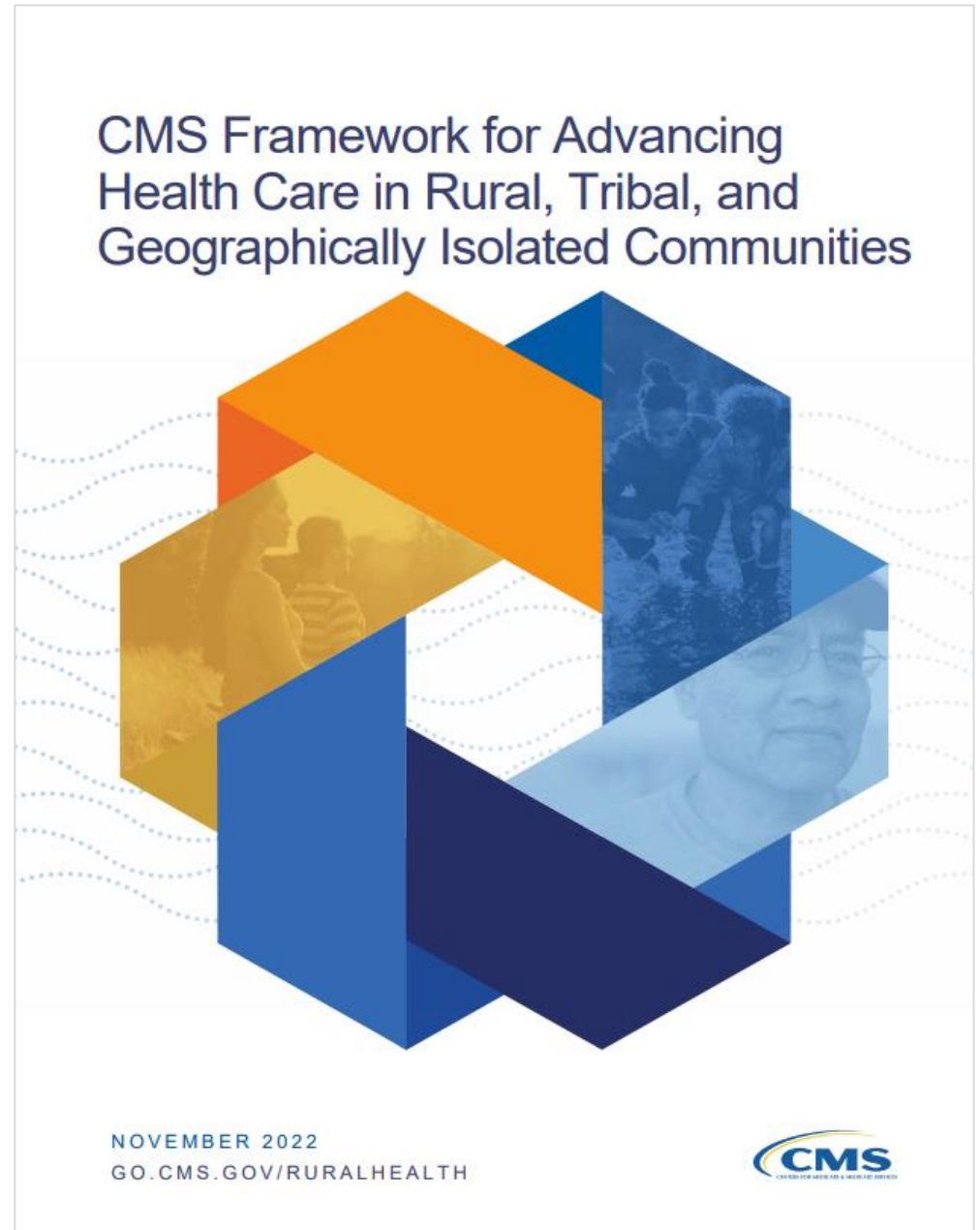


Overview

CMS OMH released the updated *CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities* in November 2022.

To help shape the framework, CMS held listening sessions with government agencies, individuals, and organizations across the country who have experience receiving health care or supporting health care service delivery in rural communities.

The Framework focuses on **six priorities** over the next five years.



Social Determinants of Health (SDOH)



- The U.S. Department of Health and Human Services (HHS) defines SDOH as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- SDOH can be grouped into five categories:
 - Economic Stability
 - Education Access and Quality
 - Health Care Access and Quality
 - Neighborhood and Built Environment
 - Social and Community Context

Resources

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Coverage to Care (C2C)

What is C2C?

C2C aims to help individuals understand their health coverage and connect to primary care and the preventive services that are right for them, so they can live a long and healthy life.



Updated translations available for all C2C consumer materials in at least 8 languages.



- **Personal Health Literacy:** the degree to which individuals are able to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational Health Literacy:** the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Roadmap to Better Care



- Explains what health coverage is and how to use it to receive primary care and preventive services
- Includes consumer tools:
 - Eight Steps to Better Care
 - Insurance card
 - Primary care vs. Emergency care
 - Explanation of Benefits
- Available in nine languages, Tribal version, and a customizable version
- [Roadmap to Better Care PDF](#)

Roadmap to Behavioral Health



ROADMAP TO BEHAVIORAL HEALTH

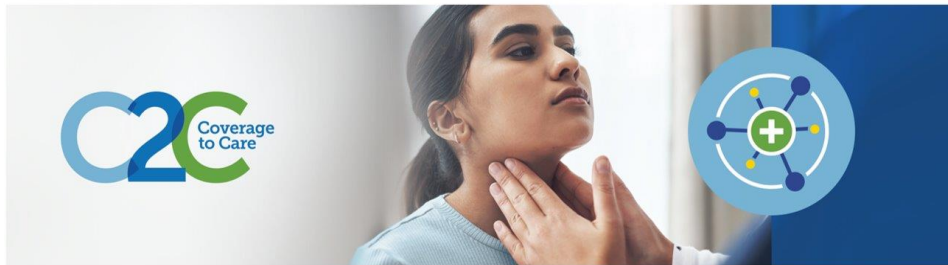
Guide to Mental Health and
Substance Use Disorder Services



- Offers information specific to mental health and substance use disorder services
- Use alongside the *Roadmap to Better Care*
- Eight Steps:
 - Understand your behavioral health
 - Learn about health insurance
 - Where to go for help and treatment
 - Find a behavioral health provider
 - Make an appointment with a behavioral health provider
 - Prepare for your appointment
 - Decide if the behavioral health provider is right for you
 - Stay on the road to recovery
- Available in eight languages
- [Roadmap to Behavioral Health PDF](#)

C2C Prevention Resources

CMS OMH created resources in multiple languages, free of charge organization and consumers, to help health care professionals and national and community organizations support consumers as they navigate their coverage.



[Consumer Resources](#)

[Prevention Resources](#)

[Order Printed Copies](#)

Patient Resources:

- The Prevention Resources page focuses on prevention and healthy living. Materials can be shared with consumers, reposted online, printed, or ordered.
- Resources include:
 - [Adults Preventive Services Flyer](#)
 - [Women Preventive Services Flyer](#)
 - [Men Preventive Services Flyer](#)
 - [Teens Preventive Services Flyer](#)
 - [Children Preventive Services Flyer](#)
 - [Infants Preventive Services Flyer](#)
 - [Put Your Health First Tabloid](#)

Provider Resources

- Whether providers represent an organization or are an individual community advocate, they can be part of the important effort to improve the health of our nation. CMS encourages the sharing of C2C resources in churches, clinics, health systems, and your community settings.

Resources include:

- [New C2C COVID-19 Materials](#)
- [Partnership Toolkit](#)
- [C2C Community Presentation](#)
- [Telehealth for Providers: What You Need to Know](#)
- [Manage Your Health Care Costs](#)
- [Enrollment Toolkit](#)
- [Stay Safe: Getting the Care You Need at Home](#)
- [Fillable Test Results Card](#)
- [Fillable Contact Information Card](#)
- [Fillable Appointment Reminder Card](#)



Chronic Care Management (CCM)

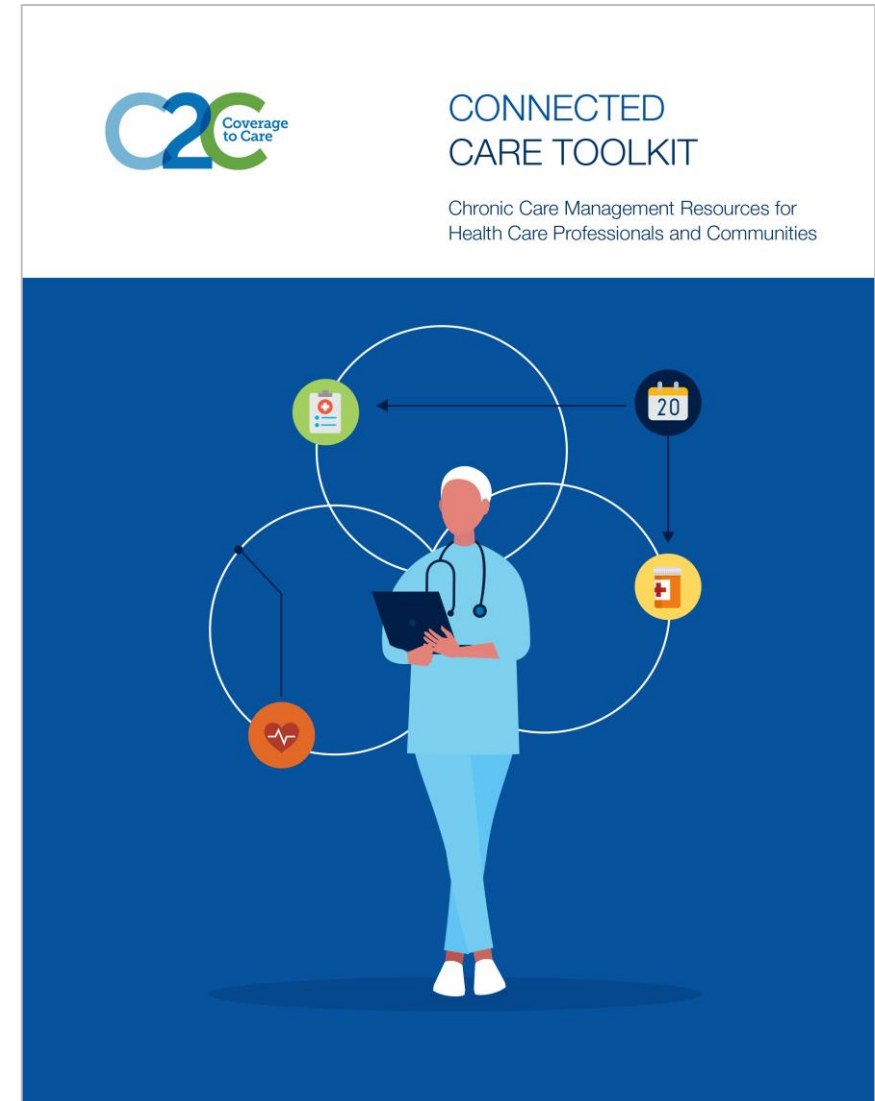
- CCM is care coordination outside of a regular office visit for patients with 2+ chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.
- It provides access to care outside of and in between doctors' visits.
- CCM services can also help reduce geographic and racial or ethnic health care disparities.

To learn more visit: go.cms.gov/ccm



Provider Resources

- The [CMS Care Management page](#) includes CCM resources, including fact sheets, FAQs, and data on chronic conditions in Medicare.
- Resource categories include:
 - Advance Care Planning
 - [Advance Care Planning Services Fact Sheet](#)
 - [Advance Care Planning Services FAQs](#)
 - Behavioral Health Integration
 - [Behavioral Health Integration Services Booklet](#)
 - [Behavioral Health Integration FAQs](#)
 - Chronic Care Management
 - [Chronic Care Management Services Fact Sheet](#)
 - [Chronic Care Management Frequently Asked Questions](#)
 - [Chronic Care Management and Connected Care](#)
 - [Chronic Conditions in Medicare](#)
 - [Chronic Conditions Data Warehouse](#)
 - Transitional Care Management
 - [Transitional Care Management Services Fact Sheet](#)
 - [Billing FAQs for Transitional Care Management 2016](#)



CMS Health Equity Technical Assistance Program



The CMS OMH Health Equity Technical Assistance program supports quality improvement partners, providers, and other CMS stakeholders by offering:

- Personalized coaching and resources
- Guidance on data collection and analysis
- Assistance to develop a language access plan and disparities impact statement
- Resources on culturally and linguistically tailored care and communication

HealthEquityTA@cms.hhs.gov

Medicare Mapping Disparities Tool

The CMS Office of Minority Health has designed an interactive map, the **Mapping Medicare Disparities (MMD) Tool**, to identify areas of disparities between subgroups of Medicare enrollees (e.g., racial and ethnic groups) in health outcomes, utilization, and spending.



Visit the [CMS OMH website](#) for resources on how to use the tool, including an interactive video.

The screenshot shows the CMS.gov website interface. At the top, there's a search bar and navigation links. The main content area features a sidebar on the left with a 'Research & Data' section containing links to 'Health Care Disparities Data', 'Data Highlights', 'Data Snapshots', 'Issue Briefs', 'Research Reports', 'Stratified Reporting', 'Mapping Medicare Disparities (MMD) Tool', and 'Data Tools'. The main content area is titled 'Mapping Medicare Disparities (MMD) Tool' and includes a header image of a man at a laptop, a map of the United States with a blue and white data overlay, and a 'Get Started' button with a 'GO' input field and a 'Share' button with social media icons. A 'Feedback' button is visible on the right side of the map. At the bottom, there's a 'Questions' section with a question mark icon and text: 'If you have any questions, feedback or suggested enhancements from your experience using the MMD Tool, please contact'.

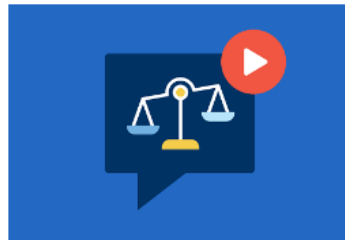
CMS OMH Webinars and Trainings

Health Equity Webinars

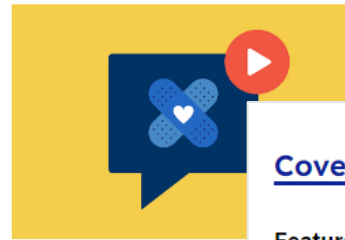
Featured Resources



[Minority Research Grant Program Partner Meeting \(June 2022\)](#)



[Health Equity Symposium \(April 2022\)](#)



[Pediatric Vaccine Partner Webinar \(December 2021\)](#)

[See All Health Equity Webinars](#)

Coverage to Care (C2C) Webinars

Featured Resources



[Coverage to Care \(C2C\) Partner Webinar \(July 2022\)](#)



[Coverage to Care Partner Webinar \(October 2021\)](#)



[Coverage to Care: How to Use Health Coverage Webinar \(February 2021\)](#)



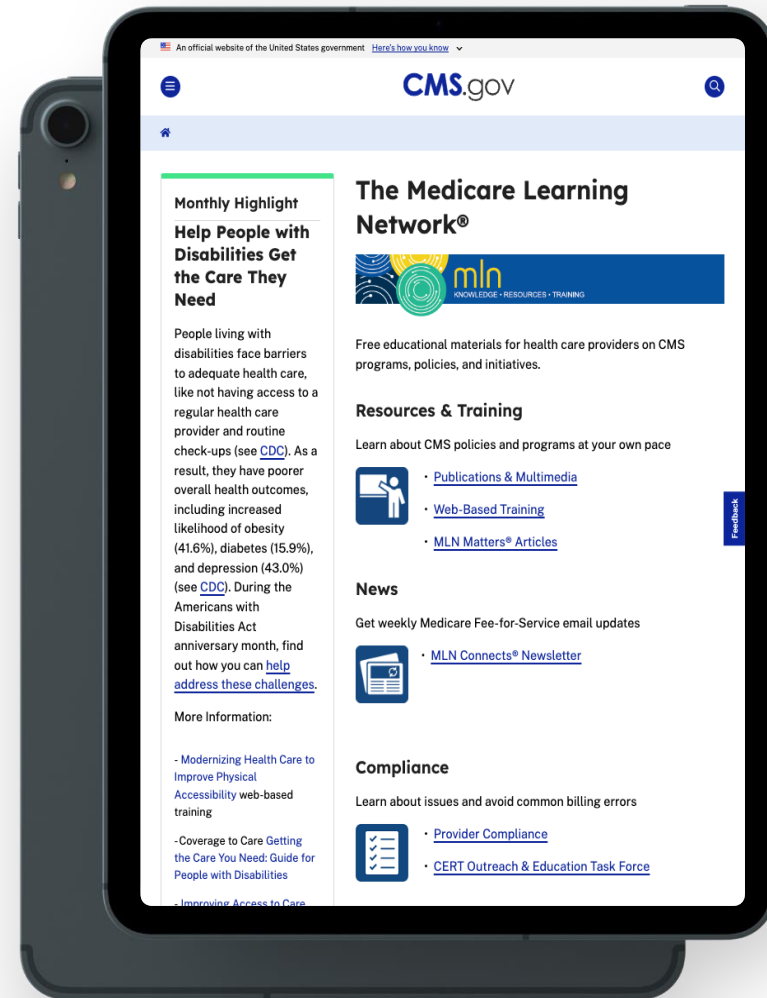
Stay up to date on new webinar opportunities by signing up for our listserv: bit.ly/CMSOMH

The Medicare Learning Network (MLN)

Free education materials for health care providers on CMS programs, policies, and initiatives

Provides guidance on:

- Resources & Training
 - Publications & Multimedia
 - Web-based Training
 - MLN Matters® Articles
- News
 - MLN Connects® Newsletter
- Compliance
 - Provider Compliance
 - CERT Outreach & Education Task Force



Visit productordering.cms.hhs.gov

Product Ordering

Centers for Medicare & Medicaid Services



Username:

Password:

[Login](#)

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[Forgot Username or Password?](#)



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OMH@cms.hhs.gov

Visit Our Website

go.cms.gov/omh

Listserv Signup

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Network 3

Quality Insights

New Jersey, Puerto Rico, and U.S. Virgin Islands

Andrea Moore

Health Equity Specialist





Addressing SDOH as a Health Equity Intervention

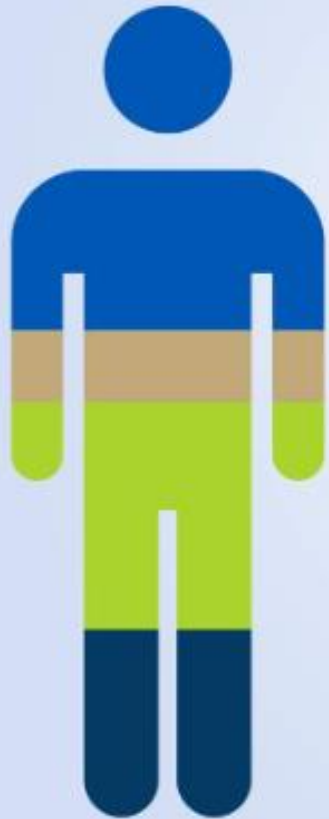
Health Equity Learning and Action Network



Andrea Moore
Health Equity Specialist

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



▶ **40%** **SOCIOECONOMIC FACTORS**
Education, Job Status, Family/Social Support, Income, Community Safety 

▶ **10%** **PHYSICAL ENVIRONMENT**
Land, Air, Water, Plants, Animals, Infrastructure, Natural Resources 

▶ **30%** **HEALTH BEHAVIORS**
Tobacco Use, Diet & Exercise, Alcohol Use, Sexual Activity 

▶ **20%** **HEALTH CARE**
Access to Care, Quality of Care 

20%

of a person's health and well-being is related to access to care and quality of services.

The physical environment, social determinants and behavioral factors drive **80%** of health outcomes.



Community Assets Profile (CAP)

- **Purpose:** Serve as a guide for making linkages aimed at addressing some of the social and structural drivers that contribute to poor health outcomes among patients dialyzing in targeted ZIP Codes/Counties
- **Includes:**
 - Mental Health Provider data in the County – [County Health Rankings & Roadmaps](#)
 - Information on access to transit and the “walkability” of the area in which the clinic is located – [Walk Score](#)
 - Community Health Needs Assessment
 - Snapshot of Homelessness in the County
 - Local resources categorized by the SDOH domains
 - Food/Nutrition
 - Shelter/Housing
 - Health/Mental Health
 - Transportation
 - Training/Education/Literacy
 - Employment/Income



Essex County Community Assets Profile

Below is a list of state and community-based assets within Essex County. While not comprehensive, this list can serve as a guide for making linkages aimed at addressing some of the social and structural determinants that are contributing factors to poor health outcomes among patients dialyzing in Essex County.

This is a “living, breathing” document that can be modified and expounded upon. To help you learn more about local resources in Essex County start by accessing [Find Help](#) and [New Jersey 211](#).

QUICK FACTS:

According to [2022 data](#), there is one mental health provider per 410 people in Essex County. The US average is 340 people per provider, while statewide in New Jersey there is an average of one mental health provider per 370 people.

The [Walk Score](#) is 49 out of 100, meaning Essex County as a whole is very car/vehicle dependent.

Access the 2022 Essex County Community Health Needs Assessment [HERE](#) and [HERE](#).

Review the Essex County Resource Guide [HERE](#).

Car-Dependent ? [Add scores to your site](#)

A location in Essex County

Commute to **Downtown East Orange**

12 min 33 min 60+ min View Routes

Favorite Map Nearby Apartments

Walk Score 49 Car-Dependent
Most errands require a car.

Bike Score 31 Somewhat Bikeable
Minimal bike infrastructure.

[About your score](#)

Essex County Community Assets Profile

Food/Nutrition	Shelter/Housing	Health/Mental Health	Transportation	Training/Education Literacy	Employment/Income
Essex County Food Resources	Housing Rehab Opportunities	New Jersey Directory of Mental Health Services	Nearby Bus Lines: 29 71	La Casa De Don Pedro Community Improvement -Hosted by Newark Public Library -HSE/GED 973.419.3675	Job Connection Vocational Rehabilitation Program 877.922.2377 access@centerffs.org
Interfaith Food Pantry 357 S. Jefferson Street, Orange	NJ Housing Resource Center www.nj.gov/njhrc	Center for Family Services Virtual and in-person outpatient therapeutic services www.centerffs.org 877.922.2377 access@centerffs.org	Catholic Charities Transportation Solutions -Must be a client of Catholic Charities 800.227.7413	All the Way Up Adult Education Center -GED/ESL Classes	NJ Division of Vocational Rehabilitation Services 1480 Tanyard Rd., Suite A Sewell, New Jersey 08080 856.384.3730 https://www.nj.gov/labor/career-services/special-services/individuals-with-disabilities/
Community Food Bank of New Jersey	Utility Assistance Programs	Division of Developmental Disability 153 Halsey St., 2 nd Flr Newark, NJ 973.693.5080	Lyft Healthcare	Literacy Volunteers of America -Bloomfield Public Library 90 Broad Street, Bloomfield 973.566.6200 x 217 or 225	MOVES -Program for Veterans -Job/Career Training -Employment Placement -Transportation Services -Mental Health Services infor@movesnj.com

Community Assets Profile

How is the CAP Developed?

- Find Help
- 211
- County Resource Guide
- Chamber of Commerce
- United Way
- YMCA/YWCA

- Catholic Charities
- Community Services Board
- State Vocational Rehabilitation
- County Libraries
- Mobile Dental Clinics

- County Funded Senior Farmers Market
- Food “Farmacies”
- Local Shelters
- Volunteer Match
- Universities/Colleges



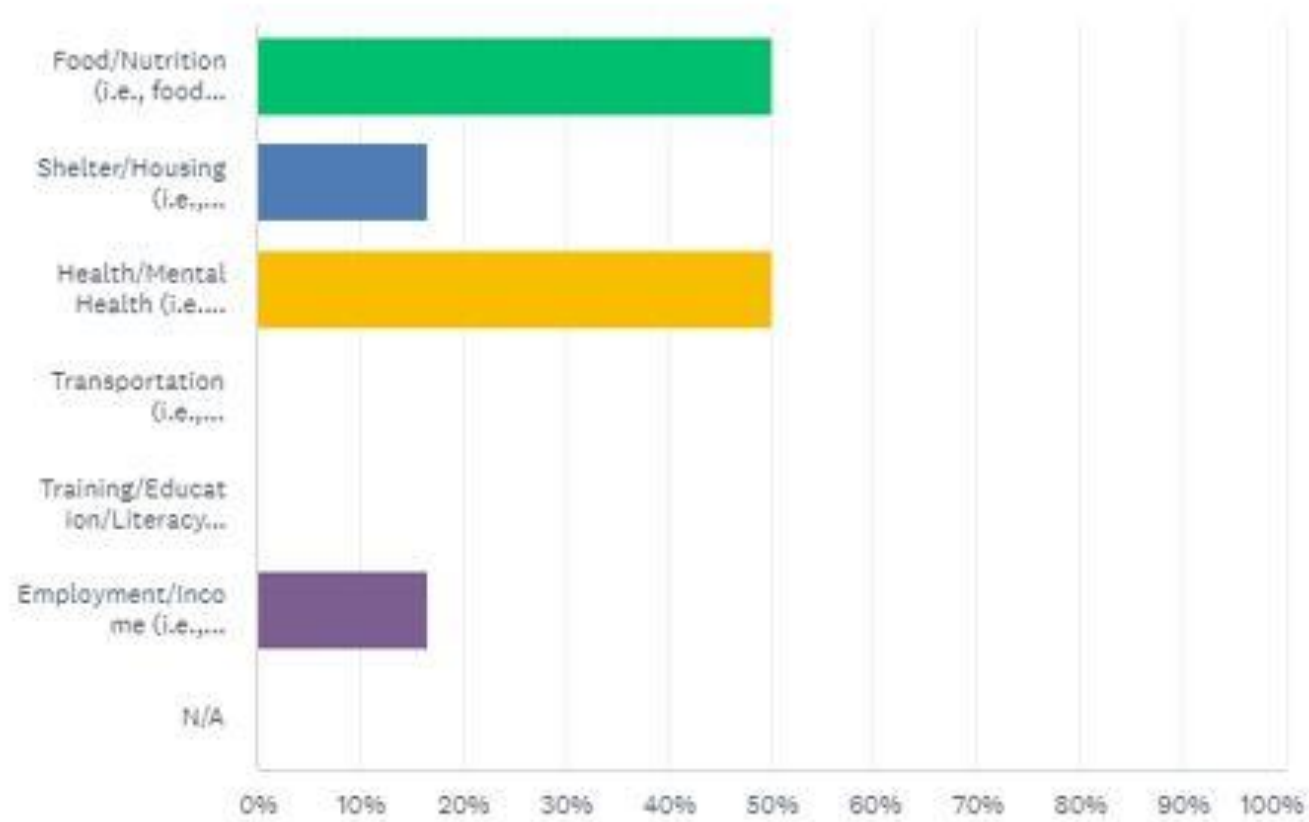
Impact

- 100% of facility respondents report that the CAP is a “valuable resource”
- 67% of facility respondents report learning about resources they weren’t aware of previously
- 67% of facility respondents report using the CAP to make patient referrals/linkages
- 50% of facility respondents report that referred patients have received services/goods from at least 1 resource listed on the CAP



Impact

In which areas listed on the Community Assets Profile have you made referrals/linkages? Select all that apply.





Questions?



Network 1: IPRO

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,
& Vermont

Network 2: IPRO

New York

Stacy Jean Claude

Outreach Program Manager

Massachusetts General Hospital Transplant Center





Massachusetts General Hospital
Founding Member, Mass General Brigham

Equity in Kidney Transplantation

Improving Access to Transplantation for Underserved Communities

Stacy Jean-Claude | Outreach Program Manager

Agenda

Introduction: Equity in Kidney Transplantation (EqKT)

Barriers to Transplantation

EqKT Program Review

EqKT Barriers & Challenges

Contacts



[Scan to email](#)
Stacy Jean-Claude
Outreach Program Manager
Mass General Transplant Center



EqKT Program Introduction



African-American/Black Population in the US

- Make up **13.6% of US population**, in 2020
- Worse health outcomes with respect to:
 - anemia
 - hypertension
 - nephrology referral
 - access placement
 - transplantation access
- Faster progression to and higher incidence of end stage renal disease (ESRD)
- Make up about **35 – 45% of the dialysis population**



Hispanic Population in the USA

- Make up **18.9% of US population**
 - Fastest growing minority group in the US
 - Projected to be 1/3 of US population by 2060
- Heterogenous ethnic group
 - Variety of cultures
 - Variety of racial/genetic backgrounds
 - Socioeconomic levels
 - Country of origin



EqKT Background

Non-Hispanic whites represent more than 70% of the kidney transplant waitlist at MGH



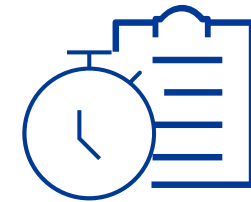
2x – 4x

Incidence of ESRD is two- and four-times higher in Hispanic and Black patients, compared to their white counterparts



~26%

Black and Hispanic patients represent less than 26% on waitlist at MGH



50%

Black and Hispanic representation on MGH waitlist should be 50% based on rates of ESRD



EqKT Model

Vision: 3 Pillars to Address Transplant Disparities



Care in the Community



Care and Resource Navigation



Quality Improvement



scan to learn more

A joint initiative between the Massachusetts General Hospital Equity and Community Health & Transplant Center



EqKT Evaluation Program Scope

Model

Location: Chelsea Community HealthCare Center

Schedule: monthly*

- 4-5 patients per clinic

Scope

Bilingual multidisciplinary evaluation program serving patients in the community/surrounding areas and those who identify as:

- **Black or African-American**
- **Hispanic**
- **Disadvantaged**
- Patients with an **immigrant status** keeping them from getting the standard state insurance product can also be evaluated with a **MassHealth Limited coverage plan**

*subject to change with referral volume



Mass General Kidney Transplant Evaluation Program in Chelsea, MA

The Mass General Transplant Center is committed to addressing health care disparities through our **Equity in Kidney Transplantation (EqKT) Initiative**.

This program boasts:

- a **bilingual health & wellness navigator**
- a **bilingual care team**
- **virtual group visits** available in English and Spanish
- **community outreach** within local dialysis centers
- additional **resources to support** patients throughout the transplant journey



Abraham Cohen Bucay, MD
Transplant Nephrologist



Scan for more information.

mghkidneytransplant@partners.org



Meet the Core EqKT Clinical Team



Abraham Cohen-Bucay, MD
Lead Transplant Nephrologist

Completes medical evaluation

Conducts medical virtual group visits (VGVs)



Rumalda Paniagua, RN, BS
Transplant RN Coordinator

Coordinates patient clinical care

Provides nurse education



Laura Cornacchini, RN
Transplant RN Coordinator



Jacqueline Almestica, LICSW
Transplant Social Worker

Completes psychosocial evaluation

Collaborates with Health & Wellness Navigator



Isabella Baquero
Health & Wellness Navigator

Provides transplant process navigation

Provides supplementary patient education & regular check-ins

Connects patients to resources

Facilitates VGVs

Health & Wellness Coaching



*The Health & Wellness Navigator serves all EqKT patients regardless of place of residence.

Meet the EqKT Leadership Team



Nahel Elias, MD

Surgical Director
Kidney Transplantation,

Chair of Quality Improvement



Jay Fishman, MD

Associate Director
MGH Transplant Center,

Director, Transplant Infectious
Diseases and Compromised
Host Program



Harman Kaur, MHA

Administrative Manager
MGH Transplant Center



Leonardo V. Riella, MD, PhD

Medical Director
Kidney Transplantation,

Harold and Ellen Danser
Endowed Chair in Transplantation



Winfred Williams, MD

Founding Director, MGH
Center for Diversity &
Inclusion

Associate Chief, Division of
Nephrology



Stacy Jean-Claude

Program Manager
Kidney Transplant
Outreach



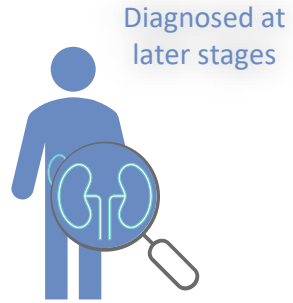
scan to learn more



Barriers to Transplantation



Road to Kidney Transplantation



CKD Diagnosis

- Educational Material
- eGFR – race free calculation

EqKT Program

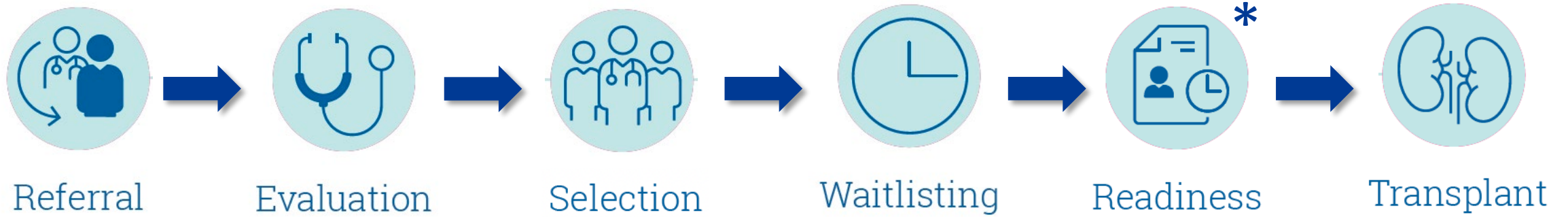
- Navigator
- HRSNs/Resources

Partnering w/ Tufts REACH Lab re: documentation / implicit bias during selection committee

- Virtual Group Visits
- Coaching
- Finding a Living Donor education



MGH Kidney Transplant Expedited Listing Process



Scan to learn
more



Scan for full **MGH
Kidney Transplant
Roadmap**

*The Readiness phase is unique to the MGH Transplant Center transplant process allowing for expedited listing. More intensive testing takes place during this phase, approximately 12- to 18-months before anticipated organ offer.



Social Factors Contributing to Disparities

- **Lower education** and limited **health literacy**
 - Only 17.8% of Hispanics with CKD are aware of their CKD diagnosis
- **Lack of health insurance**
 - ~40% of Hispanics and ~12% of African-Americans are uninsured
- **Language barrier**
- Poverty and **economic instability**
- **Lack of access to:**
 - Transportation
 - Childcare
 - Paid time off
- **Migration status**
 - In some areas, 10% of organs come from undocumented donors, even though they receive <1% of donated organs
- Multiethnic patients w/ CKD are **less likely to have a nephrologist** than non-Hispanic white patients
- **Worse CKD management:**
 - Less use of newer antihypertensive agents (ACEI/ARB)
 - ↓ AVF at start of dialysis



Difficulties Finding a Living Donor

- Lack of knowledge and education regarding living donation
- Cultural concerns
- Myths and misconceptions regarding risks of kidney donation
- Language barrier
- Financial concerns
- Distrust of medical establishment
- Lack of family members in the US

The screenshot shows the website for the Massachusetts General Hospital Transplant Center. The top navigation bar includes the hospital logo, 'The Mass General Difference', and links for 'Conditions & Treatments', 'Patients & Visitors', and 'Research & Innovation'. A search bar is located on the right. Below this is a dark blue navigation bar with 'Transplant Center' and links for 'About Us', 'Transplant Programs', 'Center for Transplantation Sciences', 'Research & Clinical Trials', 'Education & Career Opportunities', and 'Patient Resources'. The main content area has a breadcrumb trail: 'Home - Transplant - Patient Resources'. The title of the page is 'Event Series: How to Find a Living Kidney Donor'. Below the title is a section titled 'About the Series' which states: 'The [Massachusetts General Hospital Transplant Center](#) is committed to providing every patient with quality care and exceptional support throughout their transplant journey. As such, the [living donor](#) team is pleased to present a new virtual education series called "How to Find a Living Kidney Donor" — a monthly series alternating on the fourth Monday or Thursday of every month, which aims to equip kidney recipients and their loved ones with the necessary knowledge, support and tools to find a living donor.' To the right of this text are two buttons: 'Schedule a session (PDF) >' and 'Email us >'. At the bottom right, there is a light blue box with the text 'Living Kidney Donor Program' and 'Donating a kidney is an act of great'.



Myths and Misconceptions

Common concerns:

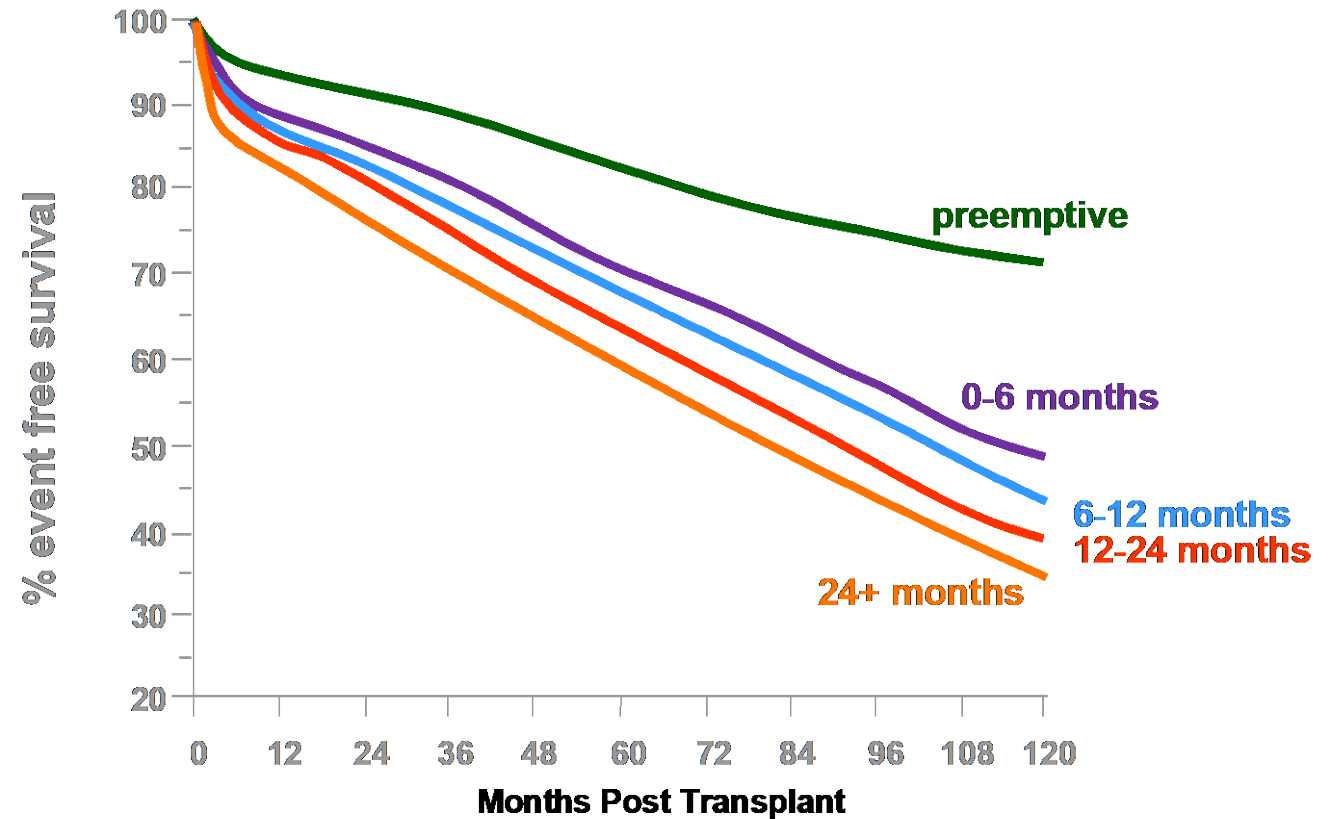
- “no potential donors available”
- “not a match with my potential donor”
- “living donation affects fertility”
- “putting potential donor at risk”
- “fear of government corruption”
- “organ donation is against my religion”
- “medical personnel will not attempt to save the donor’s life in an emergency situation”
- “potential donor is too old / has a medical condition”
- “living donation is too expensive”

<https://lifepassitn.org/african-americans-organ-donation-debunking-myths/>



Advantages of Living Donation

- Pre-emptive transplantation
- Scheduled and planned
- Better outcome and longevity
- Less likelihood of organ rejection



Tackling Health Literacy and CKD Education

1. EqKT Landing Page
2. Appointment Request e-forms
- 3. Virtual Group Visits (VGVs)**
4. Pre-Transplant Education Video
5. Pre-Evaluation Checklists
6. Kidney Transplant Roadmap
7. Living Donation Roadmap
8. Health & Wellness Coaching
- 9. Educational Webinars: How to Find a Living Kidney Donor / Cómo encontrar un donante vivo**

The collage features several educational resources:

- Virtual Group Visits:** A slide titled "Healthy Lifestyles for CKD Virtual Group Visits" listing topics such as Chronic Kidney Disease (CKD), Advanced CKD, Impact of Nutrition, Hypertension & Diabetes, Treatment Modalities, Transplantation, Living Donation, and a list of speakers including Abraham Cohen, Bryan, and others.
- Webinar Agenda:** A vertical list of 10 topics for a webinar, including "Opciones de tratamiento para la enfermedad renal crónica", "Trasplante de riñón de donante", "Cómo se evalúan los candidatos?", "Trasplante de riñón de donante vivo", "Alimentación saludable para los riñones", "Control del azúcar en sangre y salud", "Trabajo social", "Asesoramiento financiero", "Cirugía de trasplante de riñón", and "Medicamentos para el trasplante de riñón".
- Patient Education Brochure:** A document titled "Kidney Transplant" with sections for "Después del Trasplante" (After Transplant) and "Mantenimiento del Órgano" (Organ Maintenance). It includes a QR code and the date "21.08.2022 V2".
- Other Elements:** A doctor's portrait, a laptop displaying a virtual meeting, and the Massachusetts General Hospital logo.

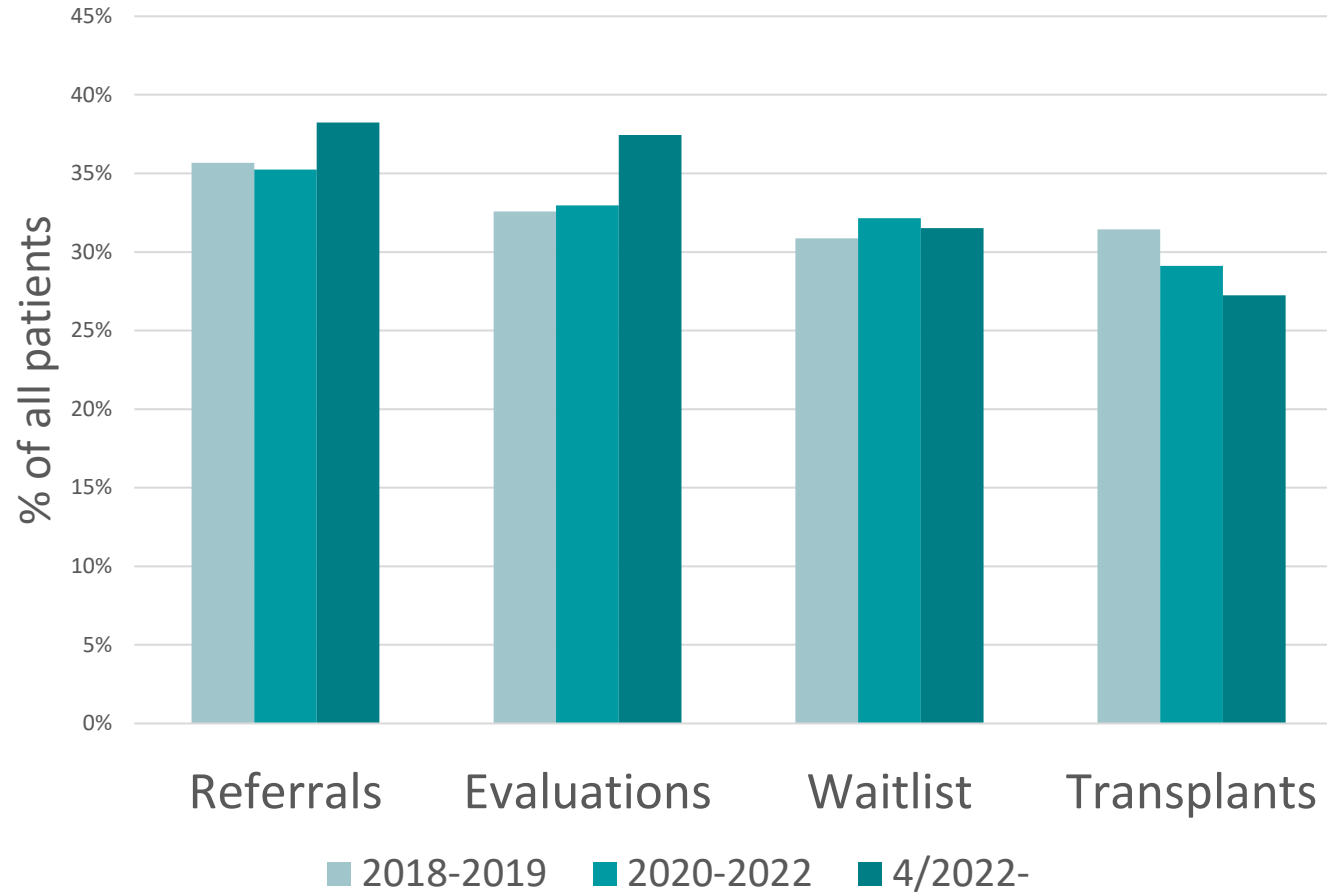


EqKT Program Review



Composition of MGH Kidney Transplant Program

Equity Patient

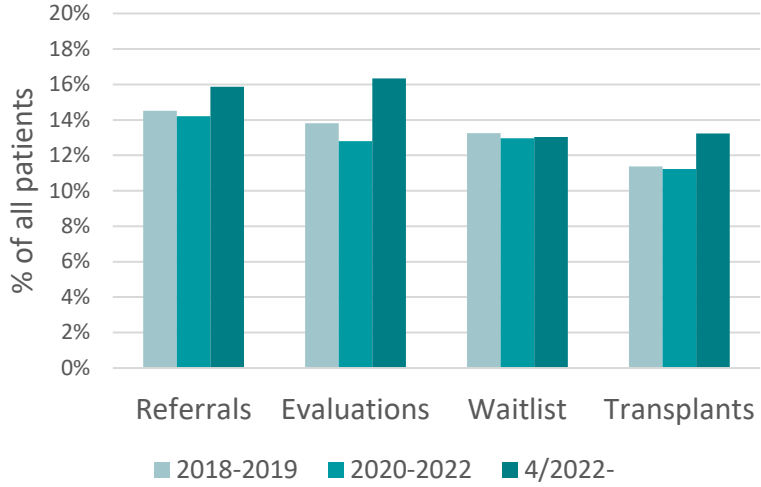


Equity Patients:

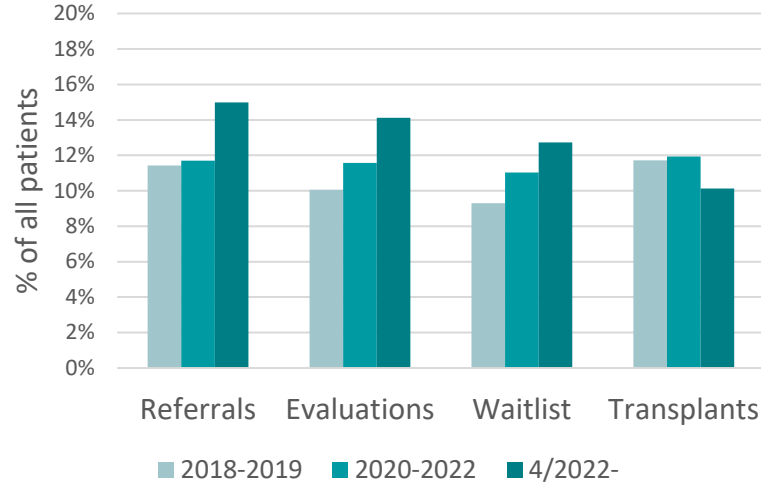
- African American
- Native American
- Hispanic
- Non-English Speaker
- Mass Health Limited



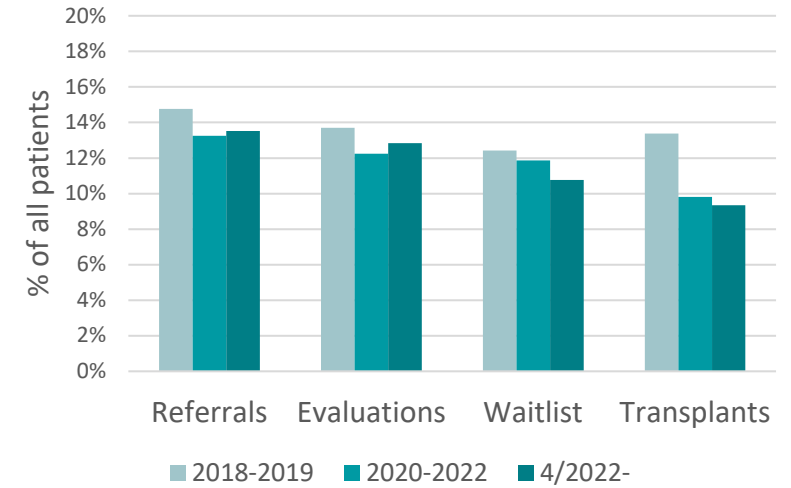
African American



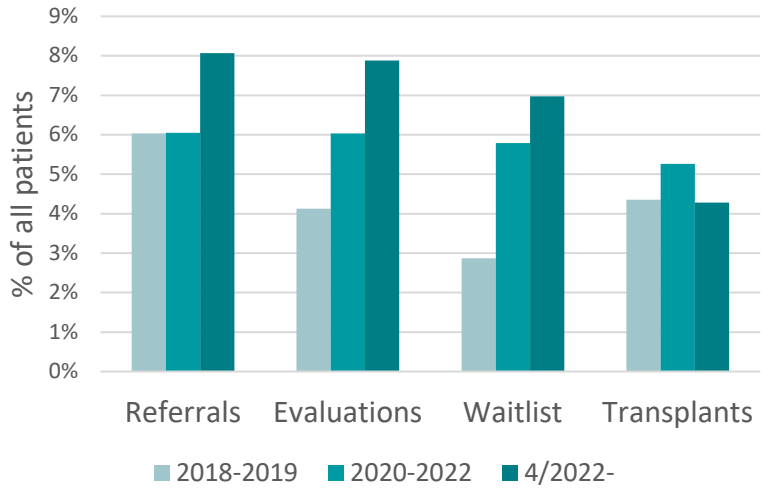
Hispanic



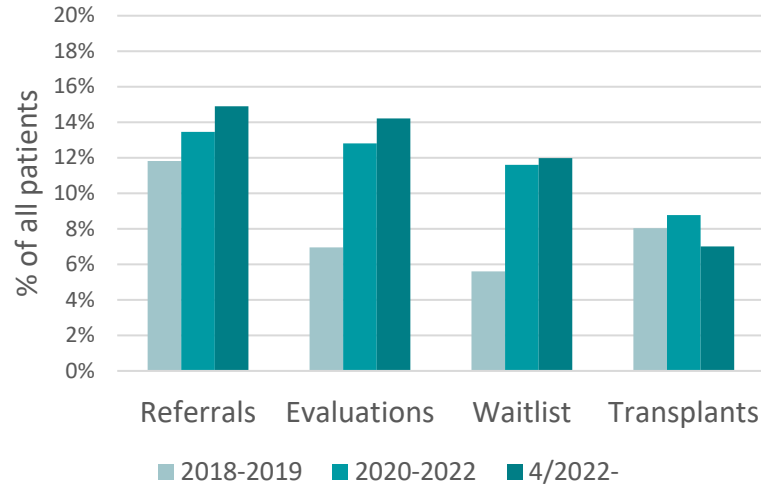
Mass Health Limited



Spanish-Speaking



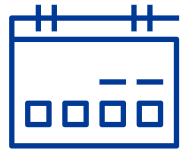
Non-English Speaker



Metrics March 2022 – September 2023

★ = referring practice

● = referred patient



88 Patients Scheduled
in CHCC



69 Patients Evaluated
in CHCC



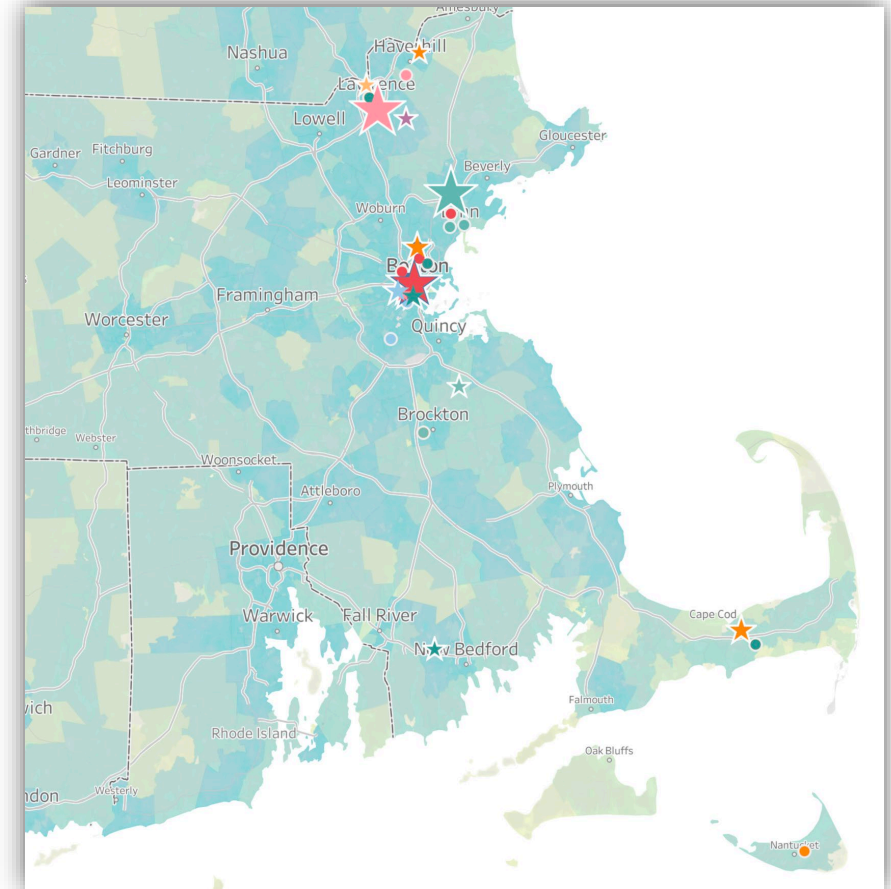
13 Patients in Evaluation
Phase Pending



38 Patients Waitlisted



3 Patients Transplanted



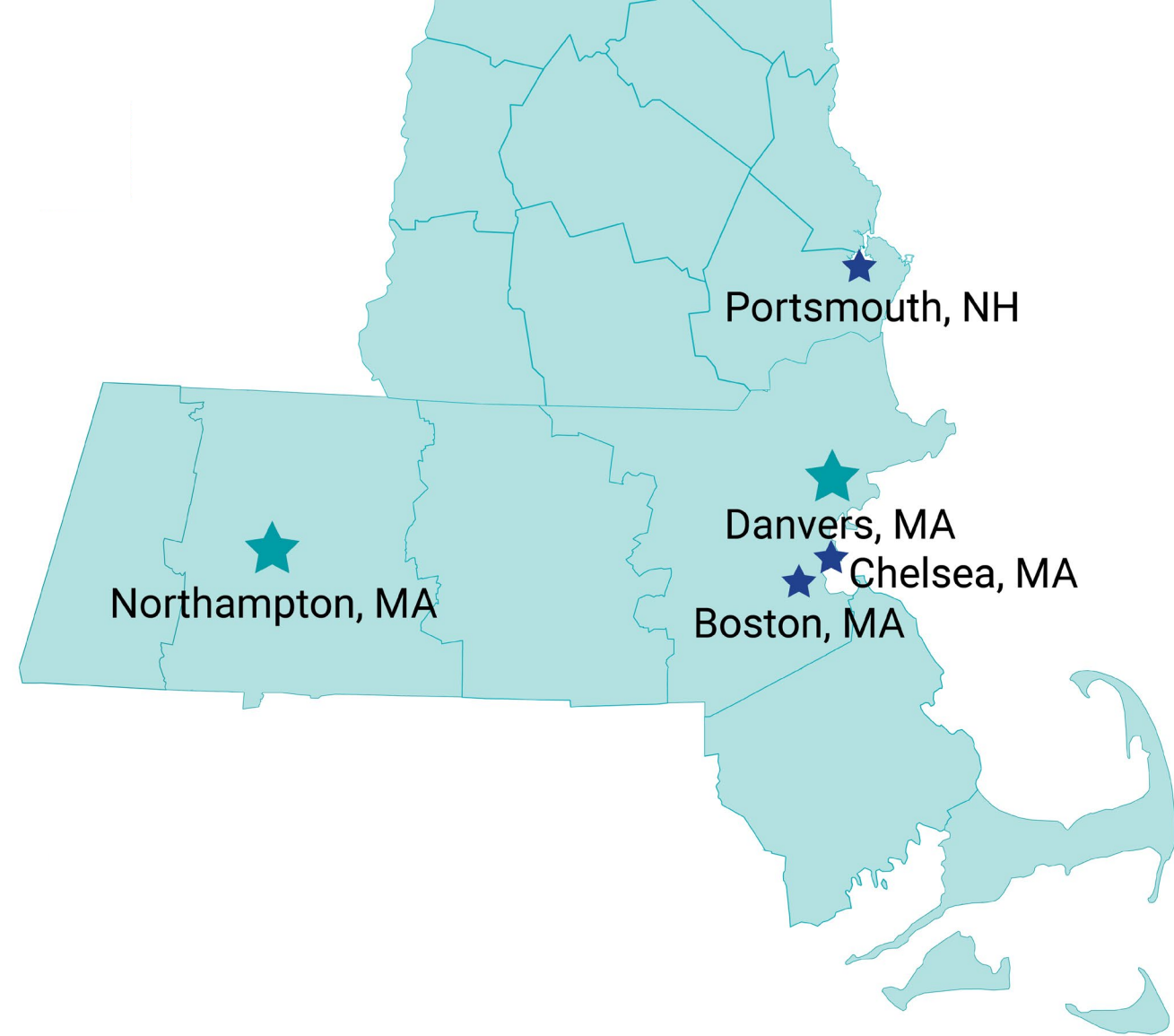
EqKT patients are mostly coming from Lawrence and Chelsea area (*Chelsea, Lynn, Everett, Malden*) with growth from Springfield area



Outreach Locations

Based on referring relationships & demand / need

- **Chelsea** (monthly)
- **Danvers** (bimonthly)
- **Northampton** (quarterly)
- **Portsmouth** (bimonthly)

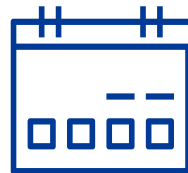


Virtual Group Visits (VGVs)

- Nephrologist + Health & Wellness Navigator
- 5-8 patients
- 4 monthly 1 hr sessions:
 - 30 min topic education/discussion.
 - 30 min of individual check in
 - SMART goals



3 VGV Cohorts



18 Patients Scheduled



20 Loaner iPads Distributed

Attendance Rate

75-100% Attendance

72%

Loaner iPad Return Rate

Within 4 weeks of program end

100%



UNOS eGFR / Wait Time Modification Policies

At MGH (as of September 21, 2023):

- 221 patients identified
- 205 patients have completed the process (confirmation of race, chart review for eGFR, submission forms etc)
 - **110** patients qualified for extra time
 - 79 patients do not qualify for extra time
 - 16 patients in process
- **8 patients have been transplanted**
- Range of time back 0 – 4178 days



EqKT Barriers & Challenges



Barriers

- **Health Literacy:** EqKT patients require more education
- **Staffing:** A small team caring for a complex, multiethnic subset of patients
- **Case Management & Resource Coordination:** EqKT patients are complex and require:
 - more time & resources
 - coordination for health-related social needs (HRSNs)
- **Cross-Team Handoff and Coordination**
- **Social Determinants of Health Data Management & Reporting**
- **Financial Resources**



Logistics

EMR

Equity flag

Social Determinants of Health

Social Vulnerability Index

Reporting / Data Management

Provider templates

Staff

Training and education

Schedule management

Performance

Accessibility & communication

Workflows

Patient HRSNs requests/coordination

Patient selection criteria

Patient scheduling

Financial clearance

Ongoing financial coordination

Readiness*

Inpatient Hand-off

Post-Transplant coordination

Resources

Collaborations

Integrated Care Management Program

Community Health Workers and Resource Specialists

Fund for Mitigating Health Barriers

Online hub

Grant writing and funding

*The Readiness phase is unique to the MGH Transplant Center transplant process allowing for expedited listing. More intensive testing takes place during this phase, approximately 12- to 18-months before anticipated organ offer.



Bottom Line

Historically disadvantaged patients are:



Less likely to be referred for transplantation early



Less likely to be listed before starting dialysis



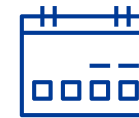
More likely to wait longer for transplantation compared to NHW



Less likely to receive a kidney transplant



Less likely to receive a living donor kidney



Predicted to live longer with a kidney transplant than on dialysis



Bottom Line cont'd

Vision: 3 Pillars to Address Transplant Disparities



Care in the Community



Care and Resource Navigation



Quality Improvement



scan to learn more

A joint initiative between the Massachusetts General Hospital Equity and Community Health & Transplant Center



Contacts



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Mghkidneytransplant@partners.org

Scan to learn more
about EqKT



Scan to email
Stacy Jean-Claude
Outreach Program Manager



Scan to be added to our
e-Newsletter List-Serve





Massachusetts General Hospital

Founding Member, Mass General Brigham



Discussion

Objective Key Result (OKR) Change Packages

A Change Package To Increase Home Dialysis Use

Key Change Ideas for Dialysis
Facilities to Drive Local Action



A Change Package To Improve Patient Experience of Care (Grievances and Access to Care)

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Released 2022



A Change Package To Increase Kidney Transplantation

Key Change Ideas for Dialysis
Facilities to Drive Local Action



A Change Package To Increase Vaccinations

Key Change Ideas for Dialysis
Facilities to Drive Local Action

Released 2022



ESRD NCC's Health Equity Change Package

A Change Package To Improve Health Equity

Key Change Ideas for Dialysis Facilities to Drive Local Action

Released 2023

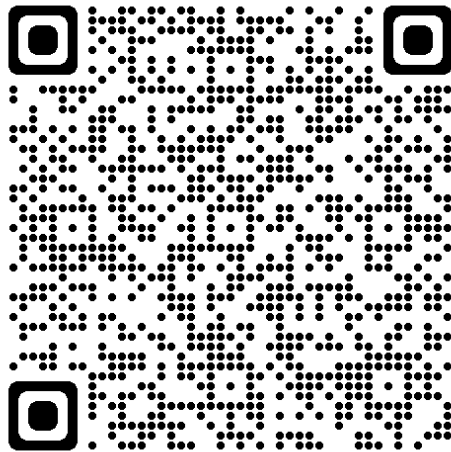


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Moving from Learning to Action...

- 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 \(esrdncc.org\)](https://esrdncc.org)

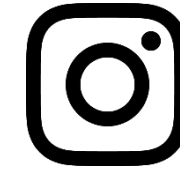


Use your phone's camera to scan QR code to go directly to the change package.

Social Media and Website



ESRD National Coordinating Center



@esrd_ncc



@esrdncc



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National Coordinating Center (NCC)

ESRD National Coordinating Center
ESRDNCC.org

Thank you!

Please take the post-call survey, the page will pop up when you close the meeting window.



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