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?

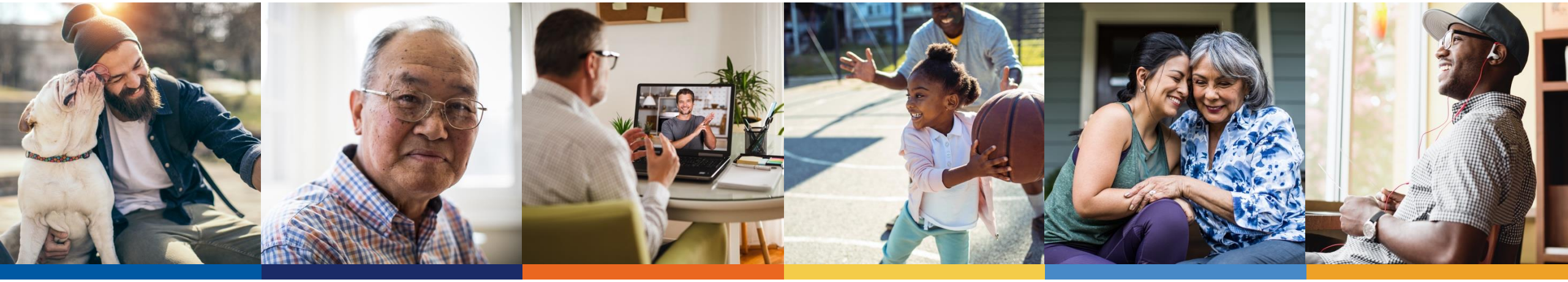
How might organization use the change package to improve outcomes?

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

W O R K I N G T O A C H I E V E H E A L T H E Q U I T Y



Health Equity Learning and Action Network (LAN)

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

October 24, 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF MINORITY HEALTH

About CMS OMH

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF MINORITY HEALTH

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

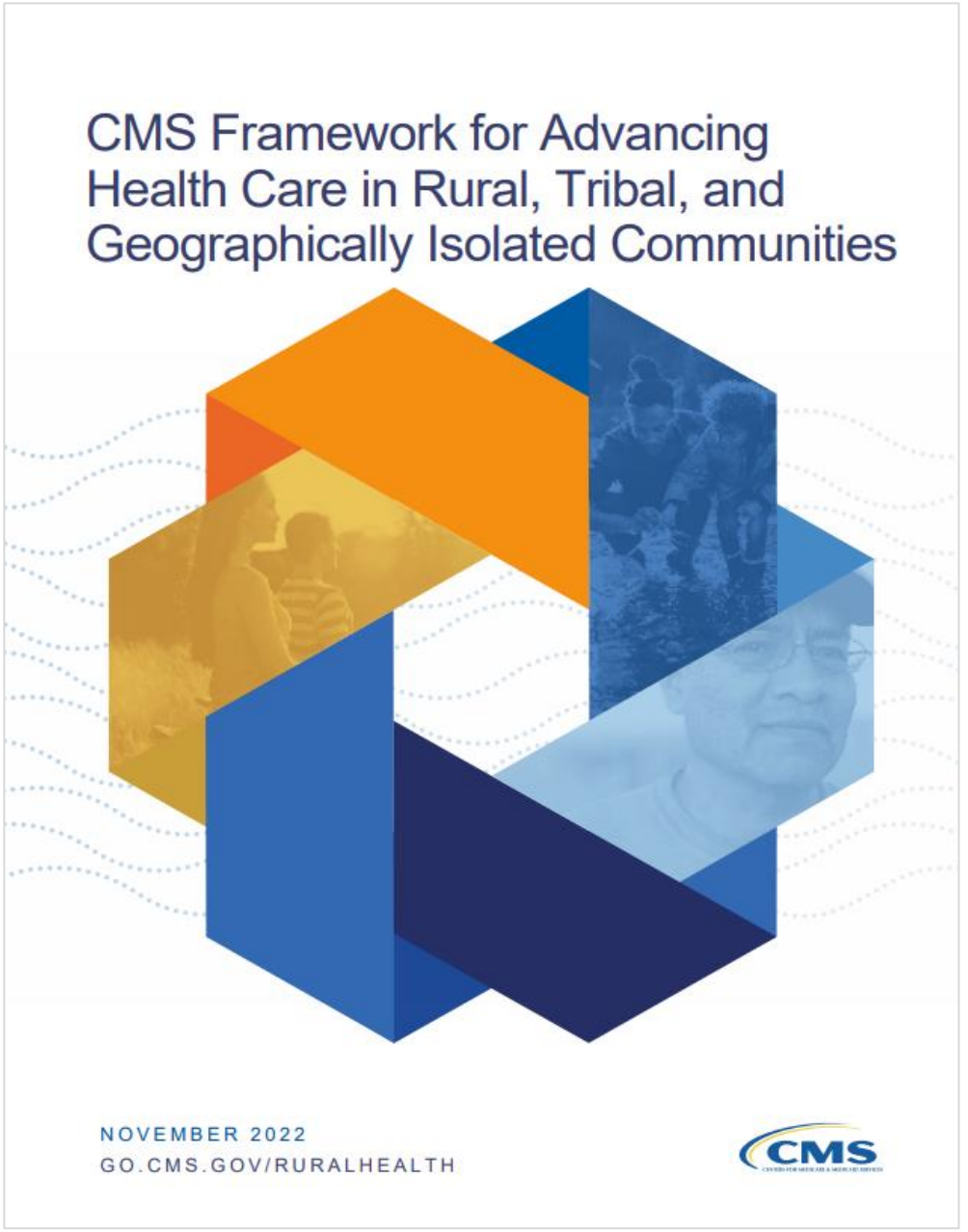
- Operationalize health equity across all CMS programs: Medicare, Marketplace, Medicaid, and CHIP
- Is evidence-based and informed by decades of research and stakeholder input
- Review the framework: go.cms.gov/framework

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF MINORITY HEALTH

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.

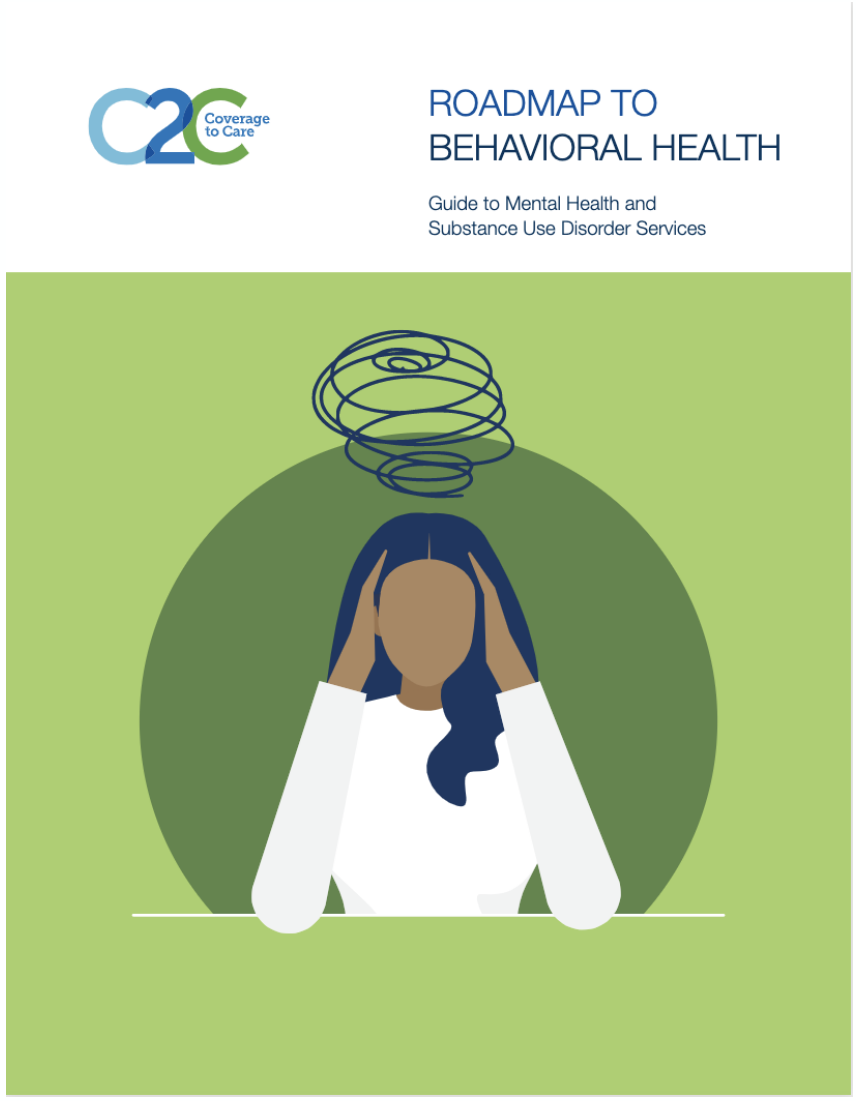
Updated translations available for all C2C consumer materials in at least 8 languages.

- **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

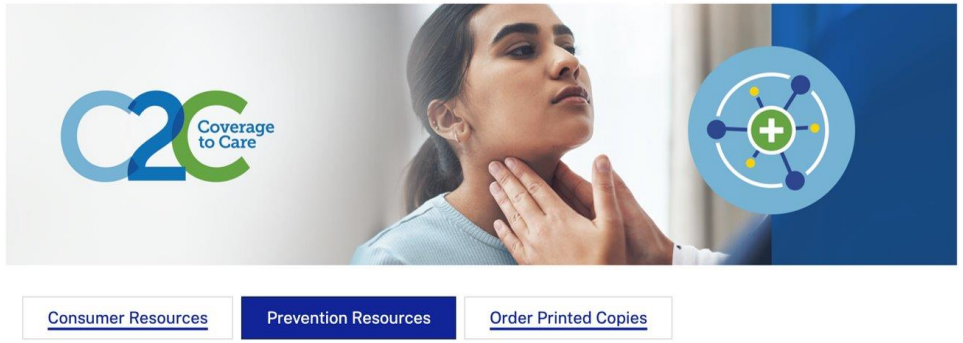
Roadmap to Behavioral Health



- 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.



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

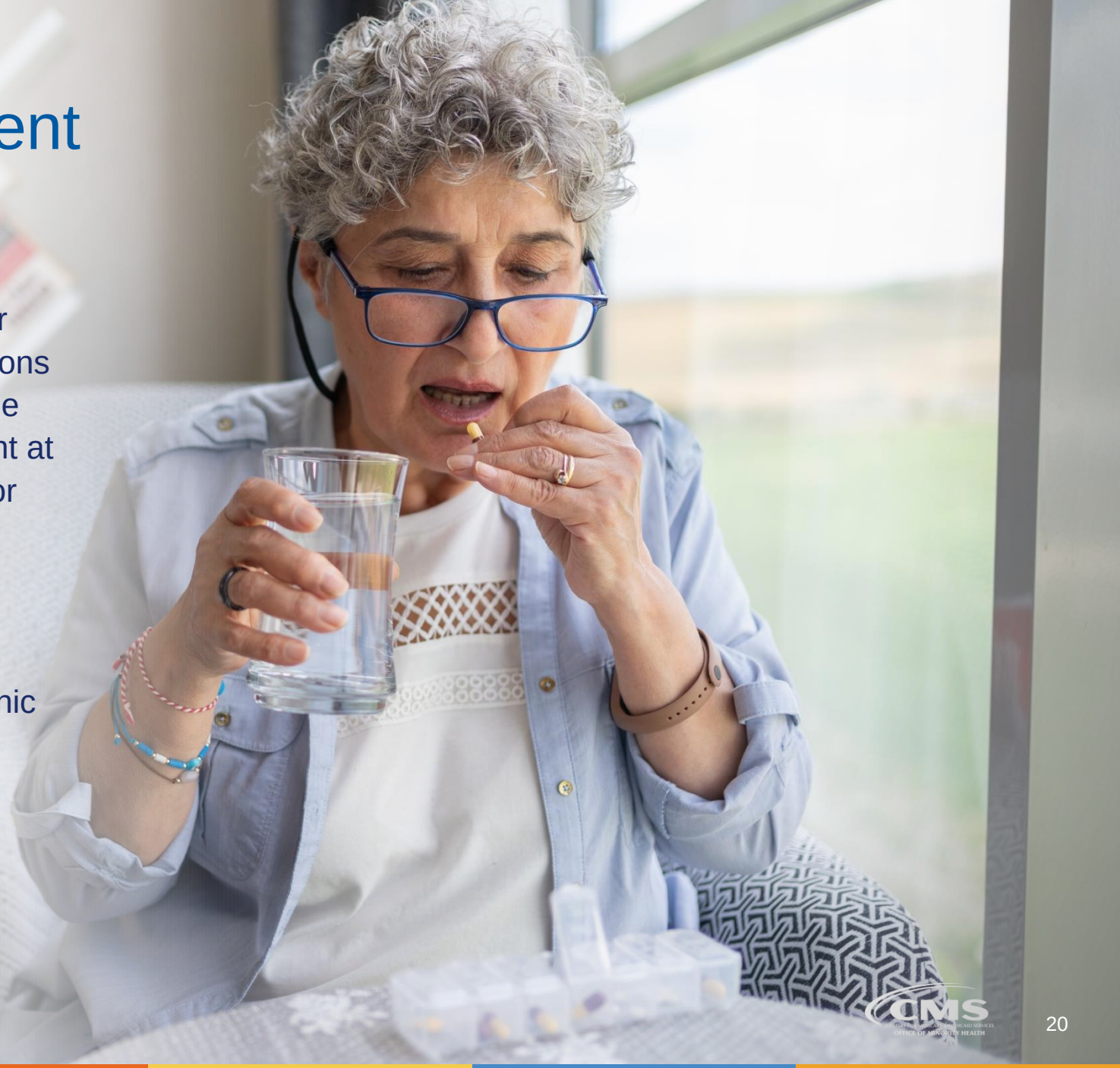
- Whether providers represent an organization or are an individual community advocate, they can be part of the important effort to improve the health of our nation. CMS encourages the sharing of C2C resources in churches, clinics, health systems, and your community settings.

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)

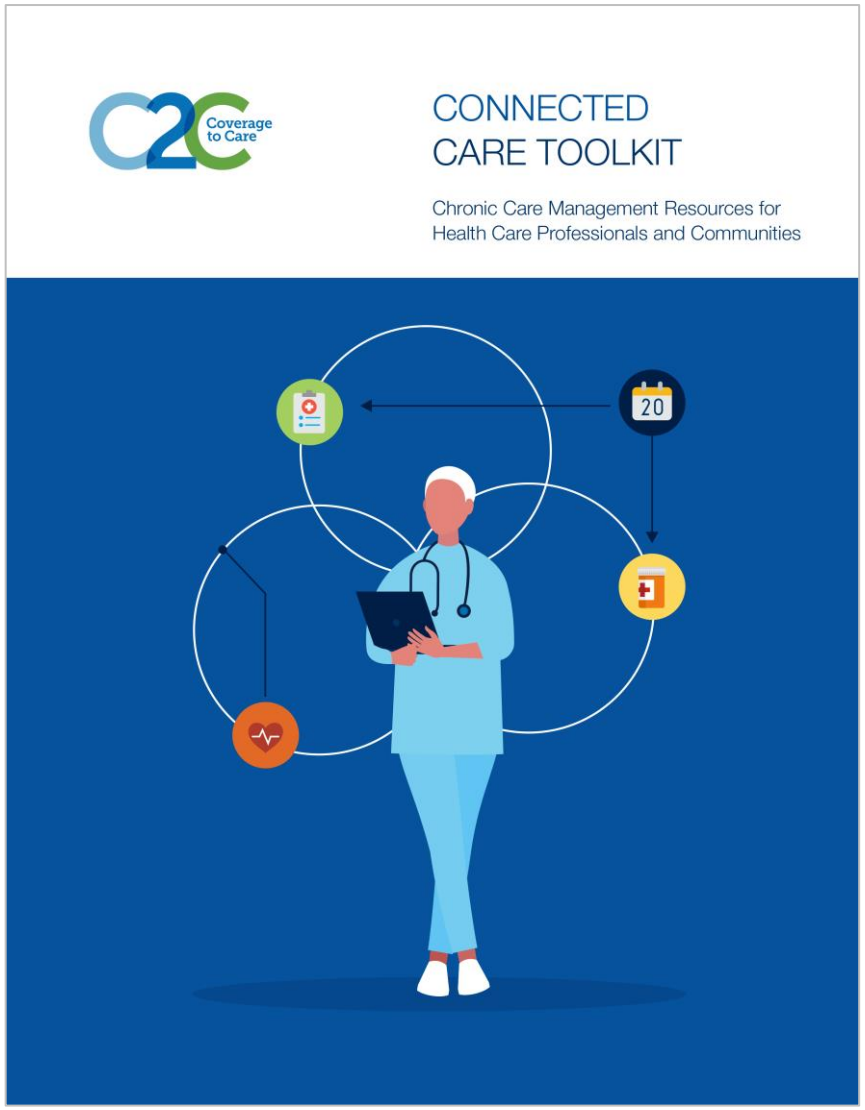
- CCM is care coordination outside of a regular office visit for patients with 2+ chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.
- It provides 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

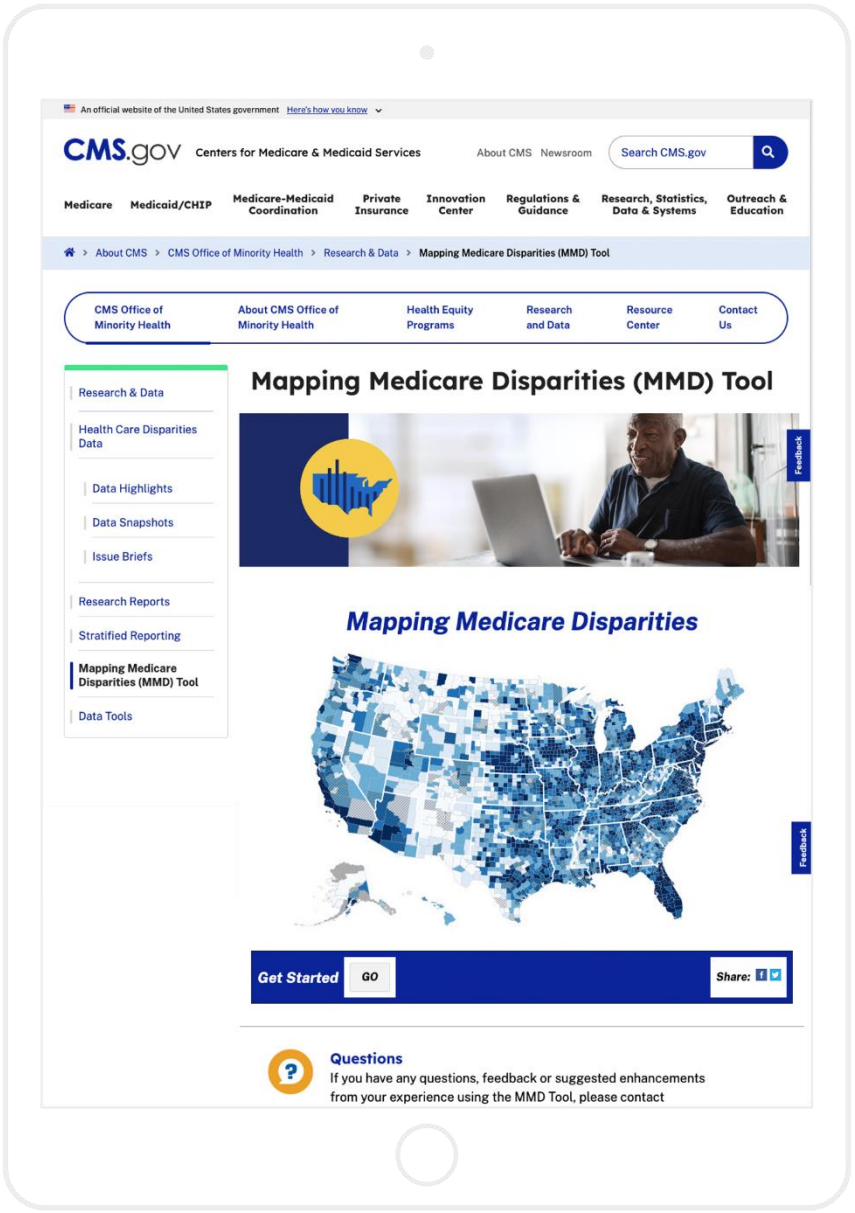


CMS Health Equity Technical Assistance Program

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

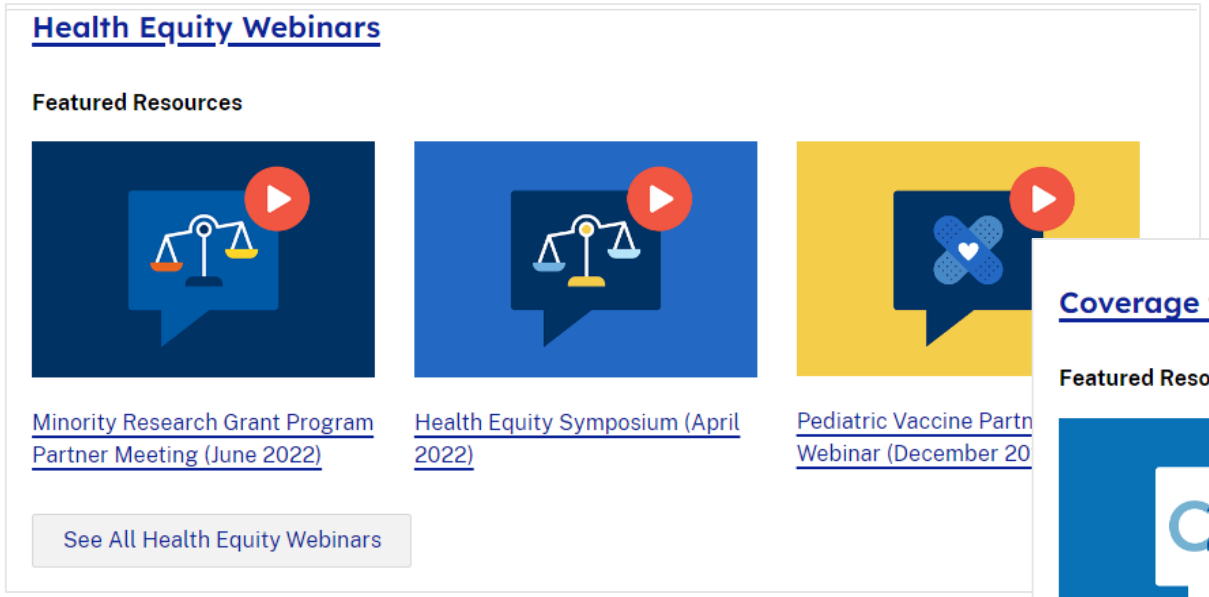


Medicare Mapping Disparities Tool

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.

CMS OMH Webinars and Trainings



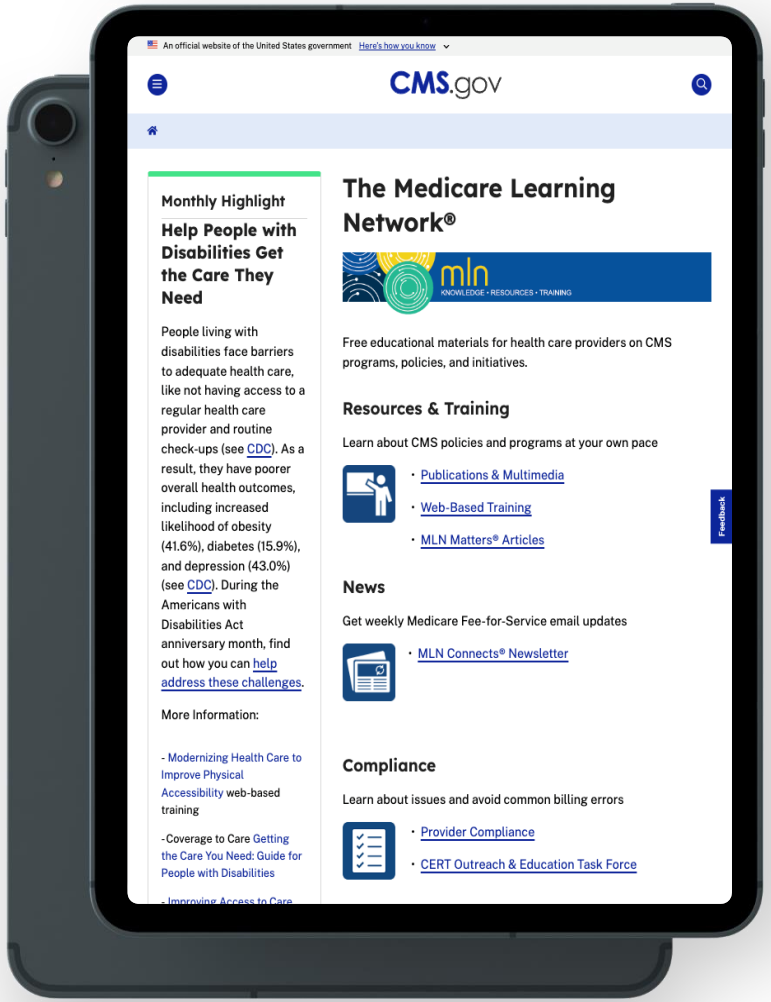
Stay up to date on new webinar opportunities by signing up for our listserv: **bit.ly/CMSOMH**

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

Request an Account

Forgot Username or Password?

Product Ordering

A federal government website managed by the Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Connect with CMS OMH

Contact Us

OMH@cms.hhs.gov

Visit Our Website

go.cms.gov/omh

Listserv Signup

bit.ly/CMSOMH

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

Quality Insights
Renal Network 3

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.

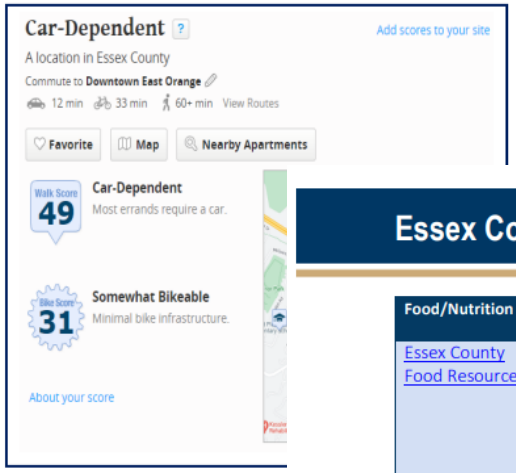
QUICK FACTS:

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.



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., 2nd 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

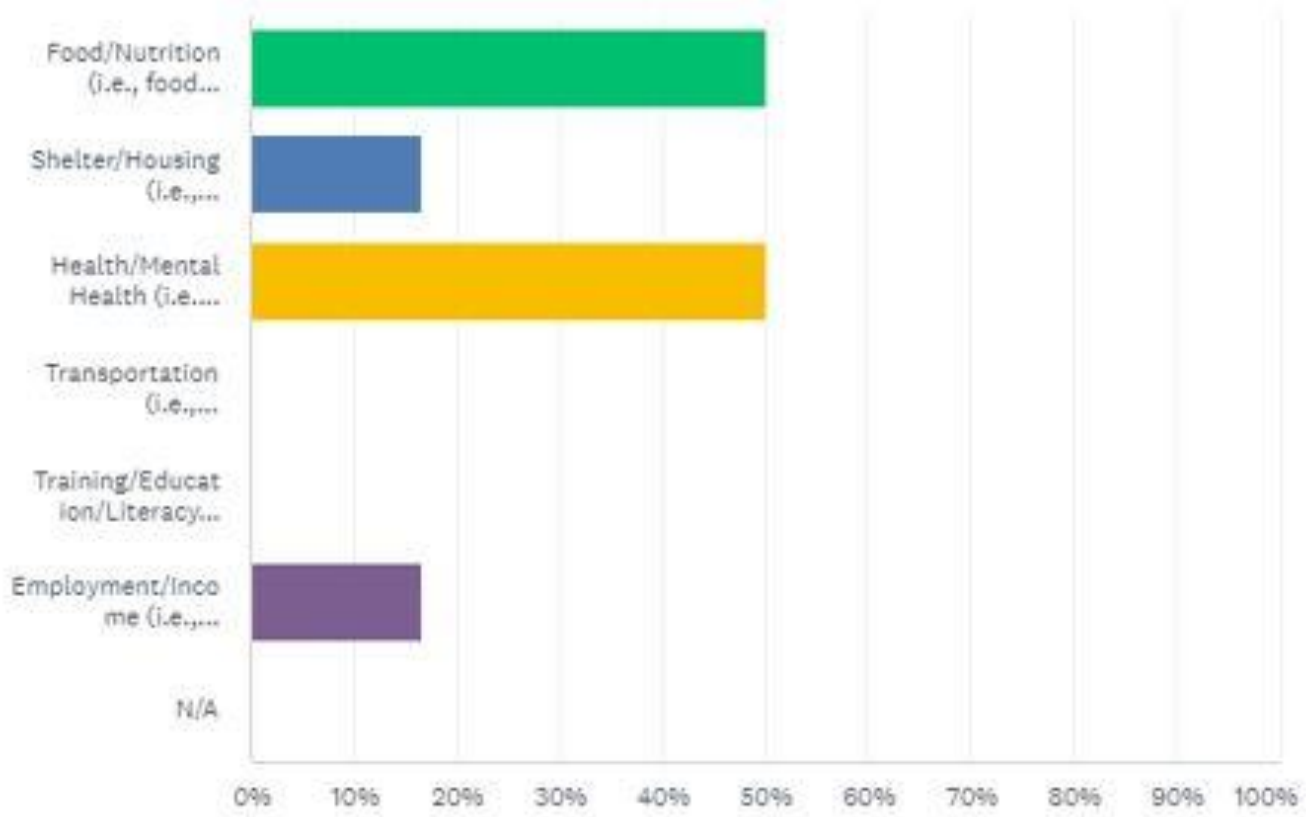
- County Funded Senior Farmers Market
- Food “Farmacies”
- Local Shelters
- Volunteer Match
- Universities/Colleges

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**

Levey, Ann Intern Med 1999; Levey, Ann Intern Med 2009

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

Ana C. Ricardo et al. CJASN 2015;10:1757-1766

EqKT Background

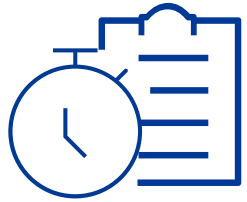
Non-Hispanic whites represent more than 70% of the kidney transplant waitlist at MGH

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

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

scan to learn more

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 EvaluationProgram
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

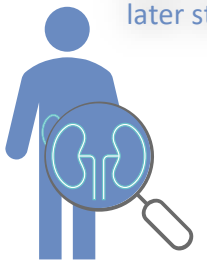
scan to learn more

Barriers to Transplantation

Road to Kidney Transplantation

- **Educational Material**
- **eGFR – race free calculation**

Diagnosed at later stages



CKD Diagnosis

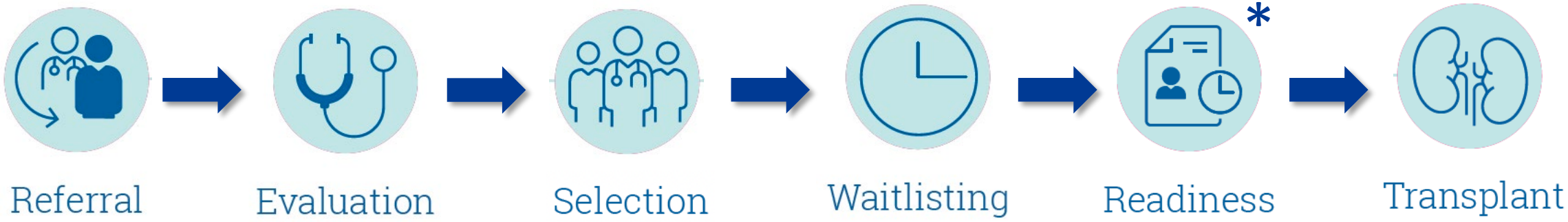
EqKT Program

- **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.

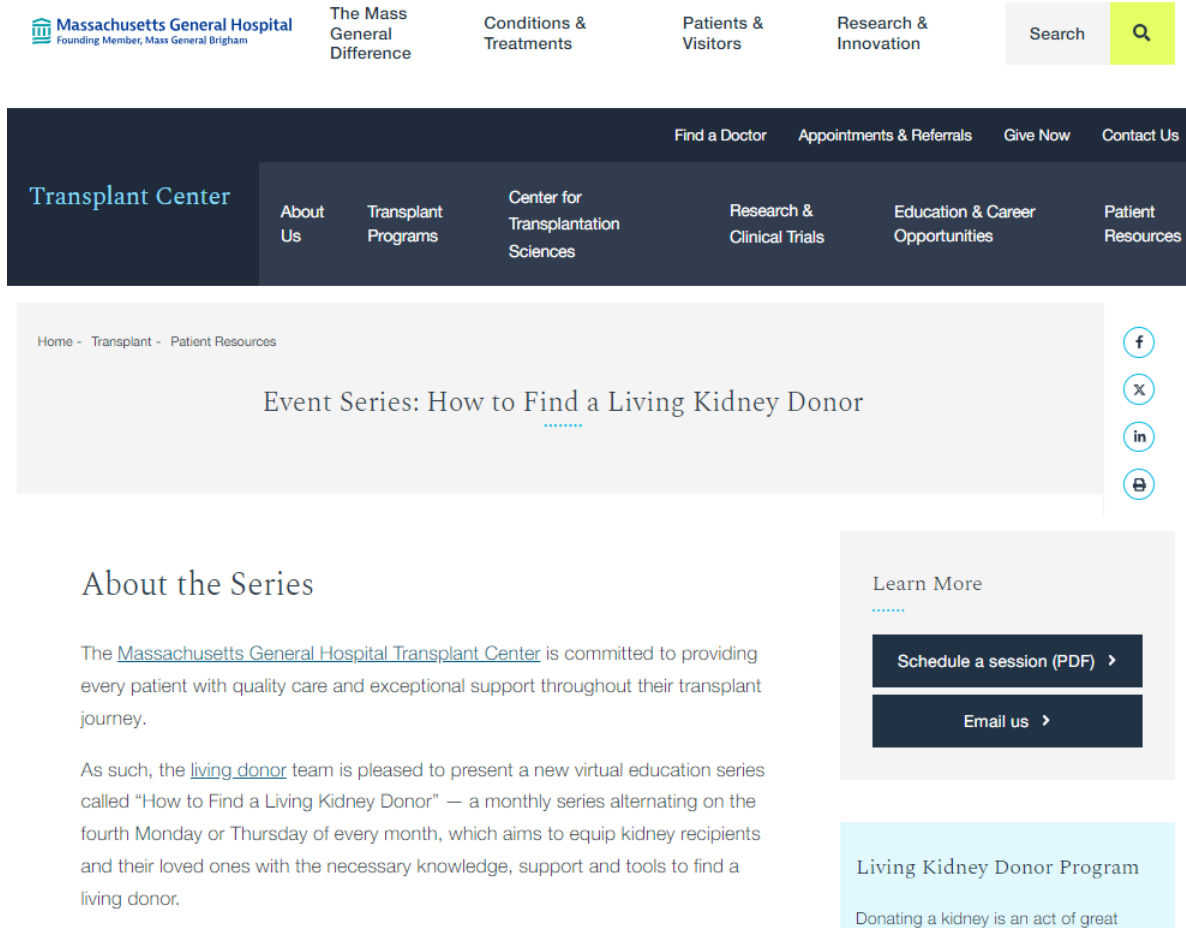
Social Factors Contributing to Disparities

- **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

Desai N, AJKD 2018; Hispanic CRIC study. Fischer MJ, JASN 2016; Ana C. Ricardo et al. CJASN 2015;10:1757-1766

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



Myths and Misconceptions

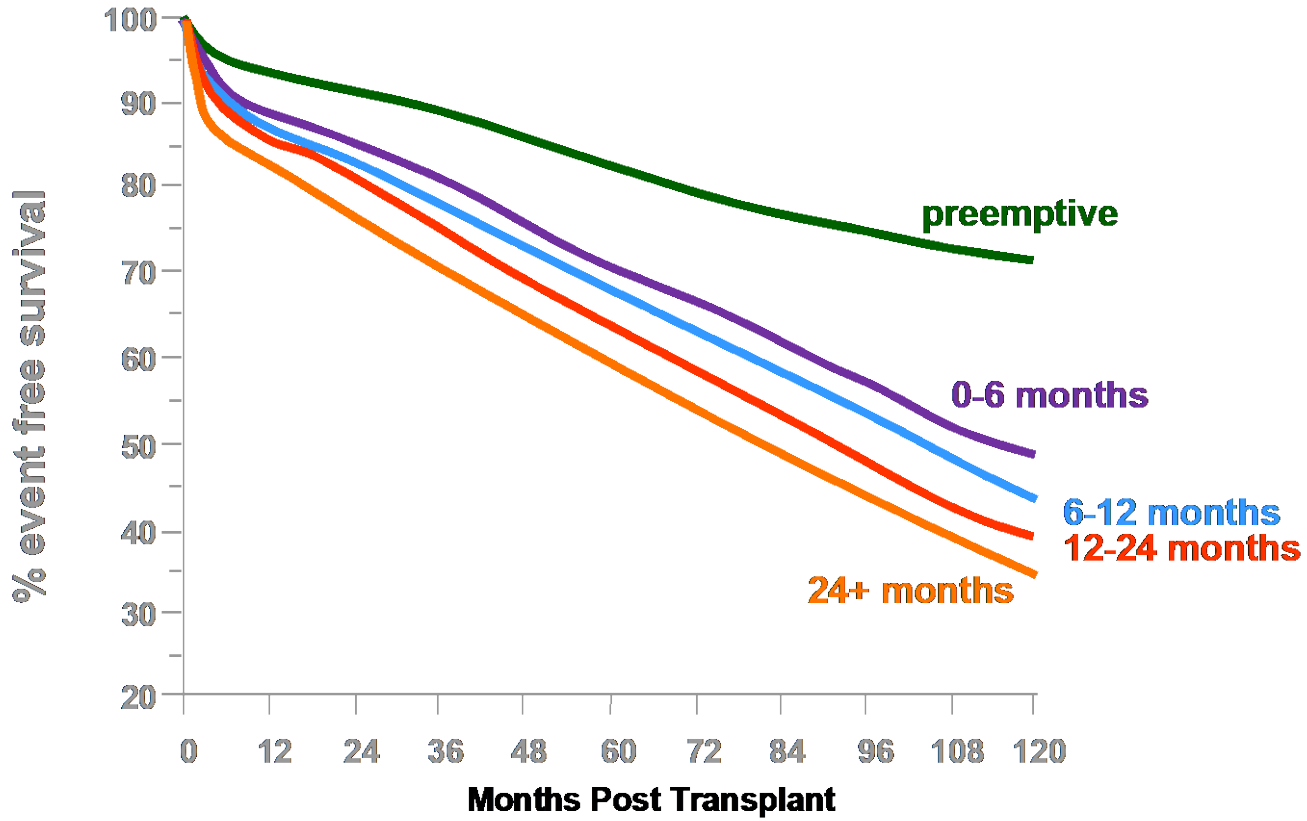
Common concerns:

- “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://lifepassiton.org/african-americans-organ-donation-debunking-myths/

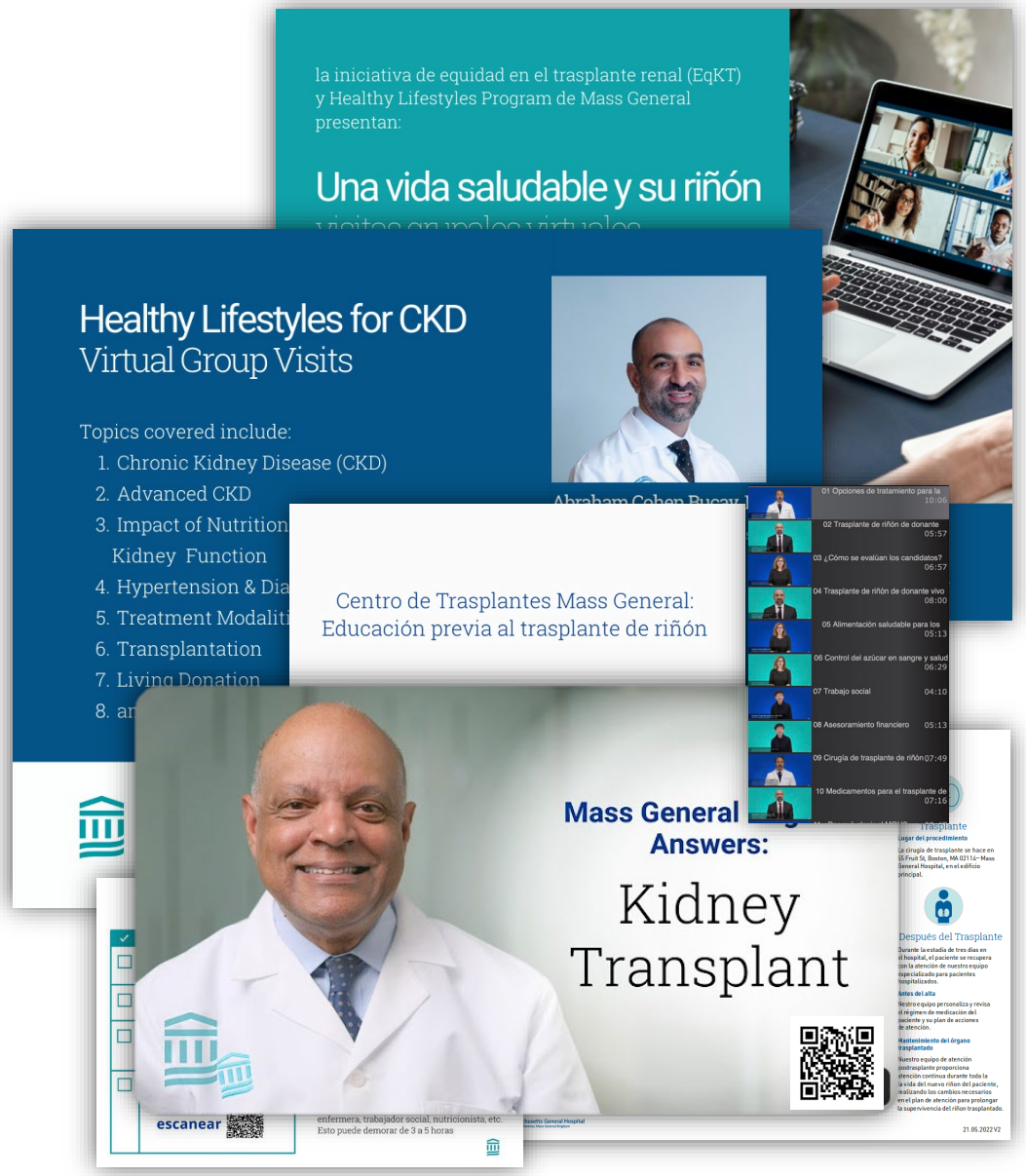
Advantages of Living Donation

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



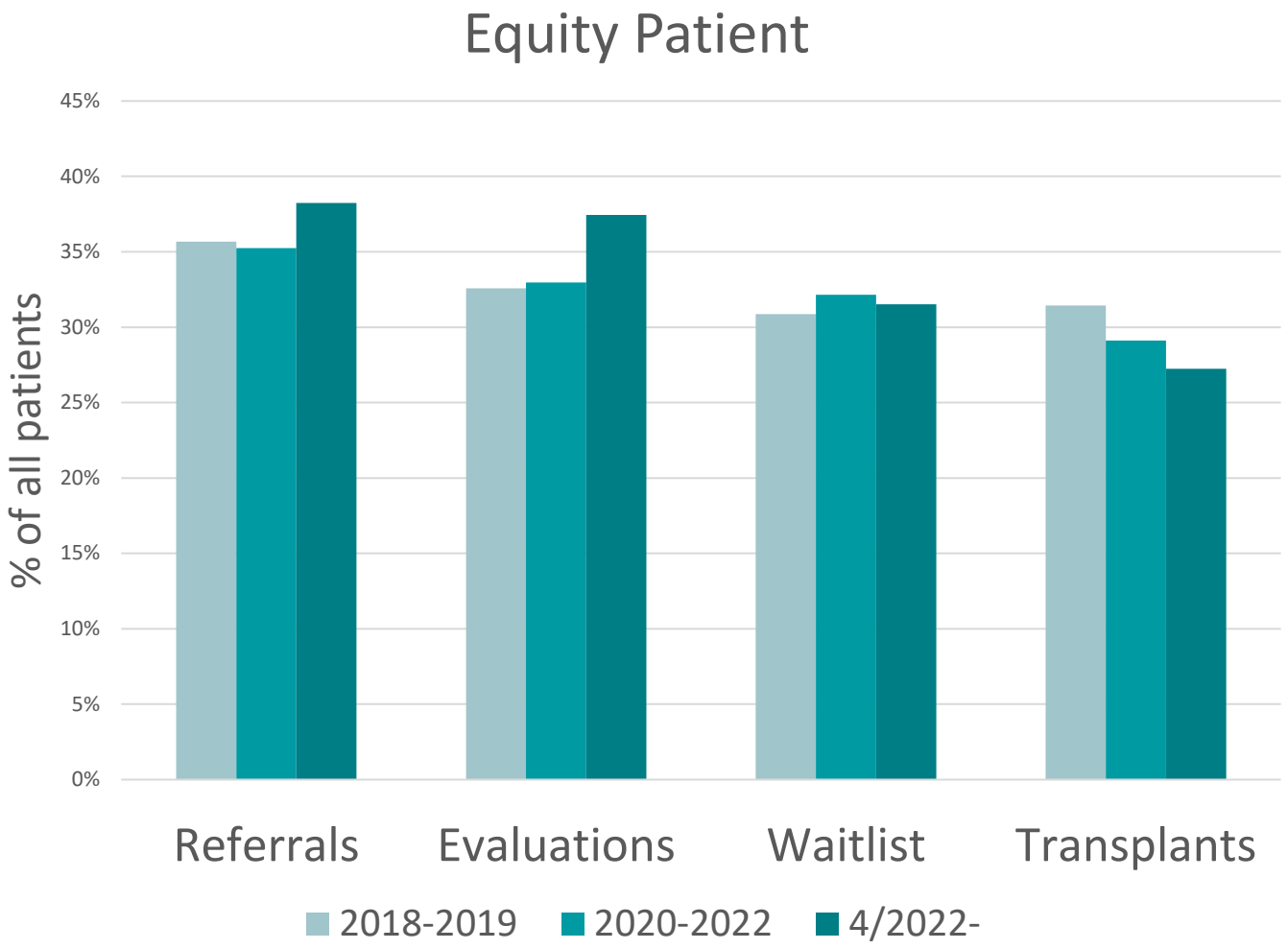
Tackling Health Literacy and CKD Education

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**



EqKT Program Review

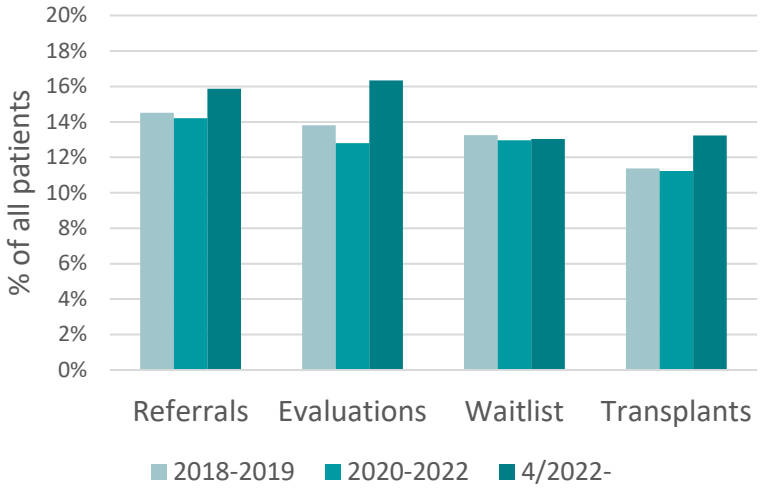
Composition of MGH Kidney Transplant Program



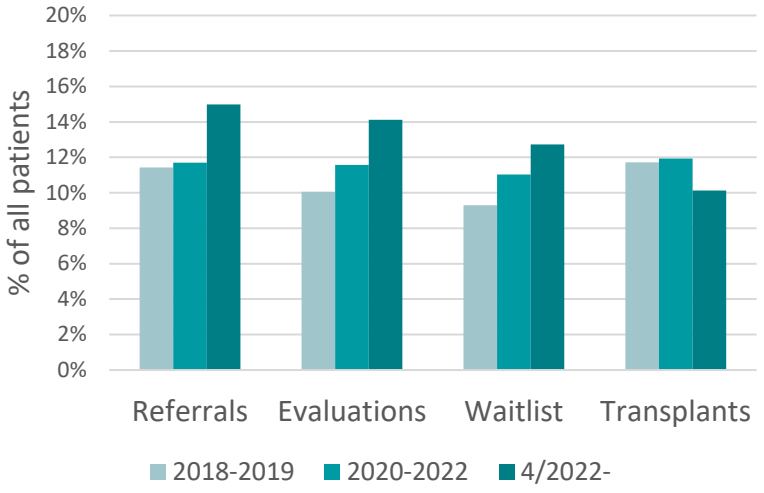
Equity Patients:

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

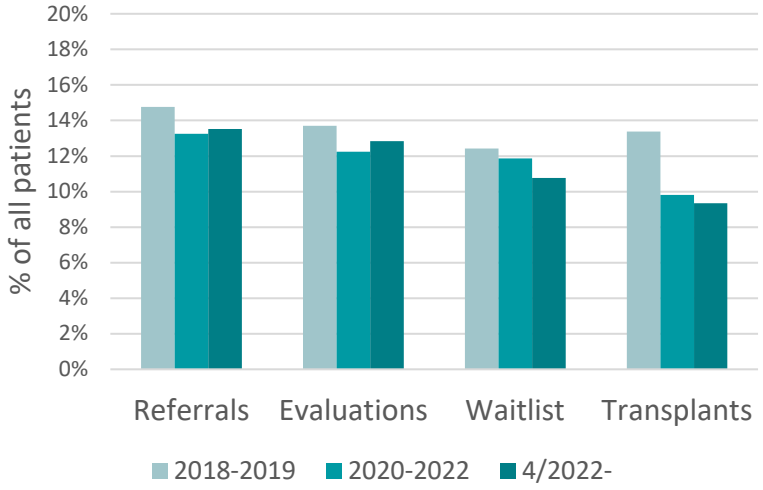
African American



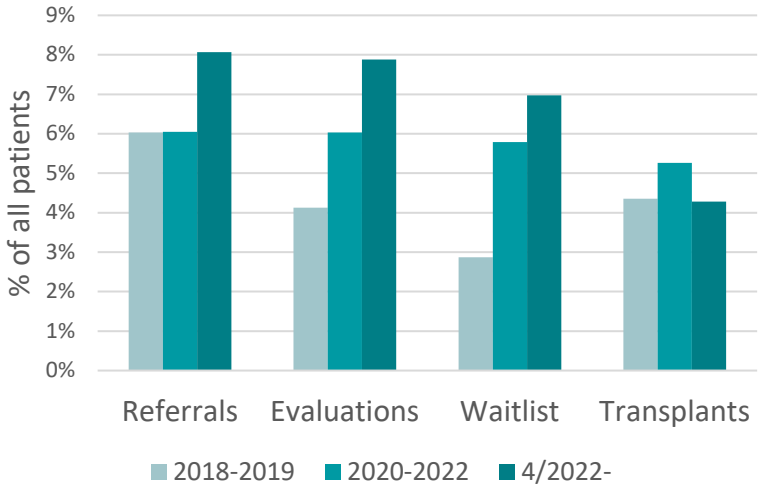
Hispanic



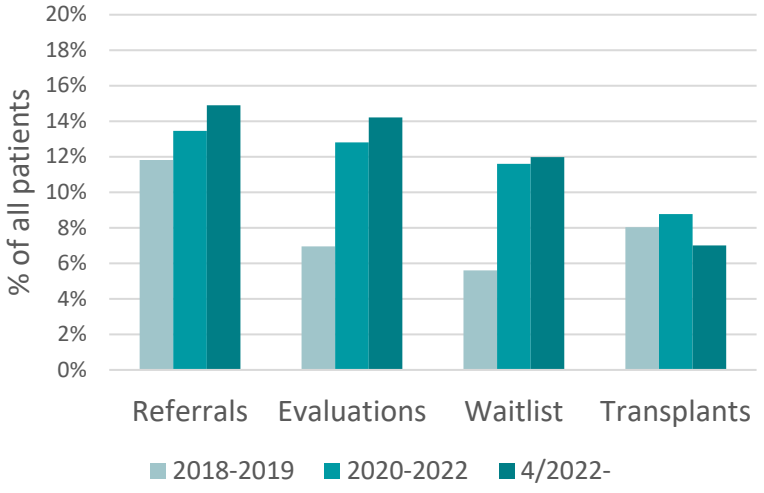
Mass Health Limited



Spanish-Speaking



Non-English Speaker



Metrics March 2022 – September 2023

88 **Patients Scheduled in CHCC**

69 **Patients Evaluated in CHCC**

13 **Patients in Evaluation Phase Pending**

38 **Patients Waitlisted**

3 **Patients Transplanted**

★ = referring practice

● = referred patient

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)

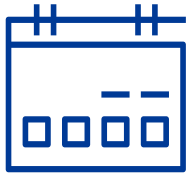
Virtual Group Visits (VGVs)

- 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

Attendance Rate	
75-100% Attendance	72%

Loaner iPad Return Rate	
Within 4 weeks of program end	100%

3 **VGV Cohorts**



18 **Patients Scheduled**

20 **Loaner iPads Distributed**

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:

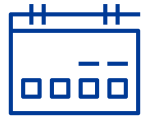
Less likely to be referred for transplantation early

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

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

scan to learn more

Contacts

Contact Us

Via Email:

sjean-claude@mgh.harvard.edu

Mghkidneytransplant@partners.org

Scan to learn more about EqKT

Scan to email
Stacy Jean-Claude
Outreach Program Manager

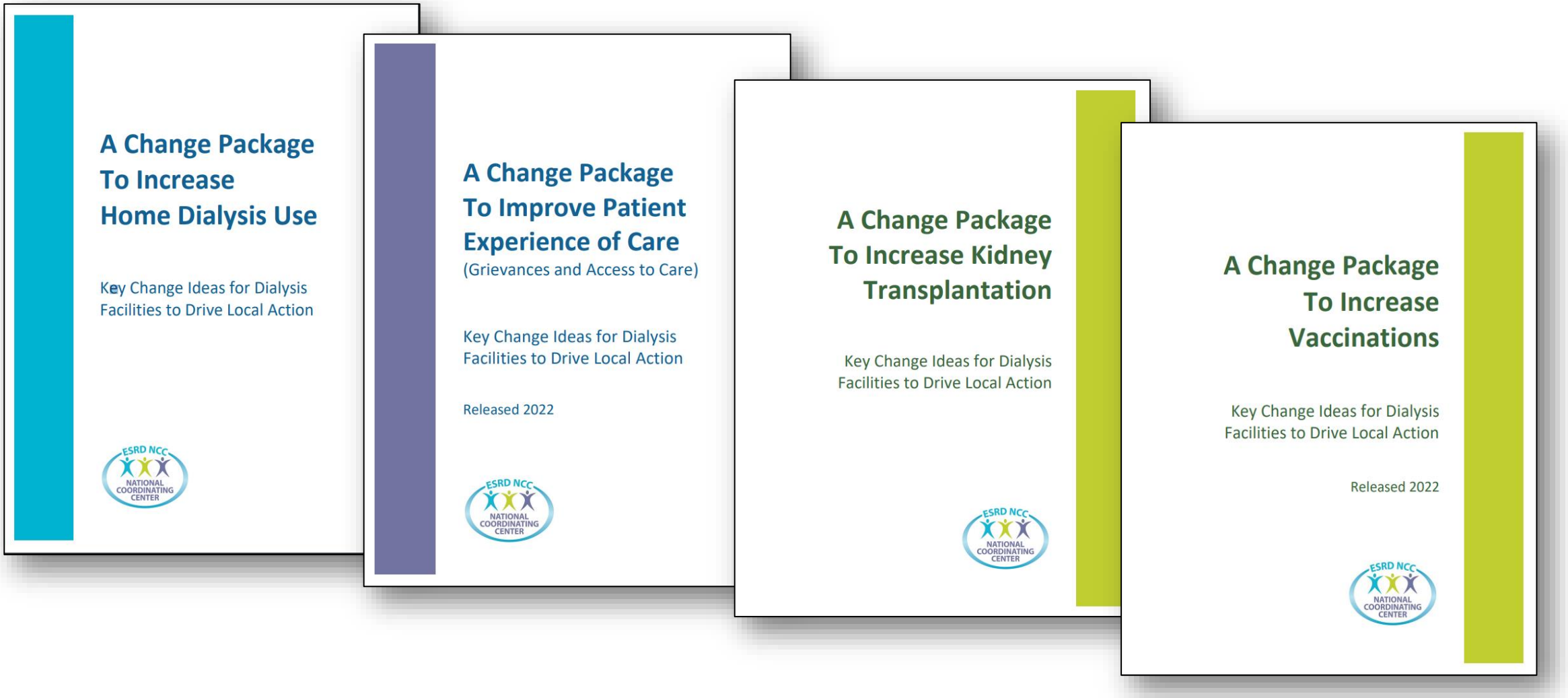
Scan to be added to our e-Newsletter List-Serve

Massachusetts General Hospital

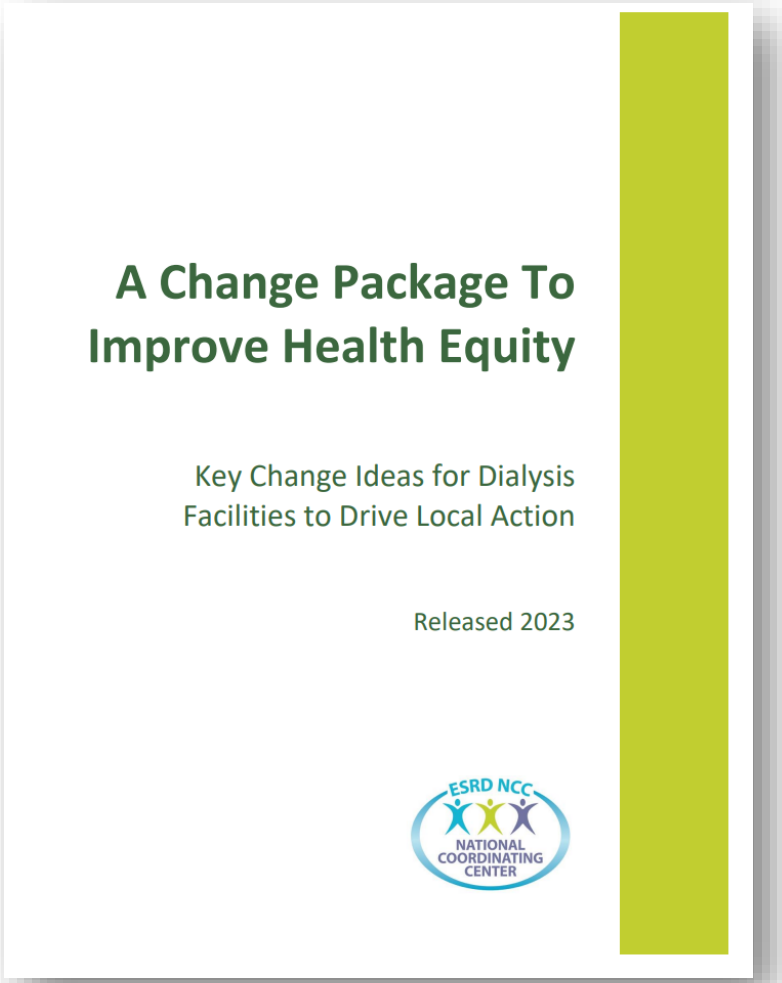
Founding Member, Mass General Brigham

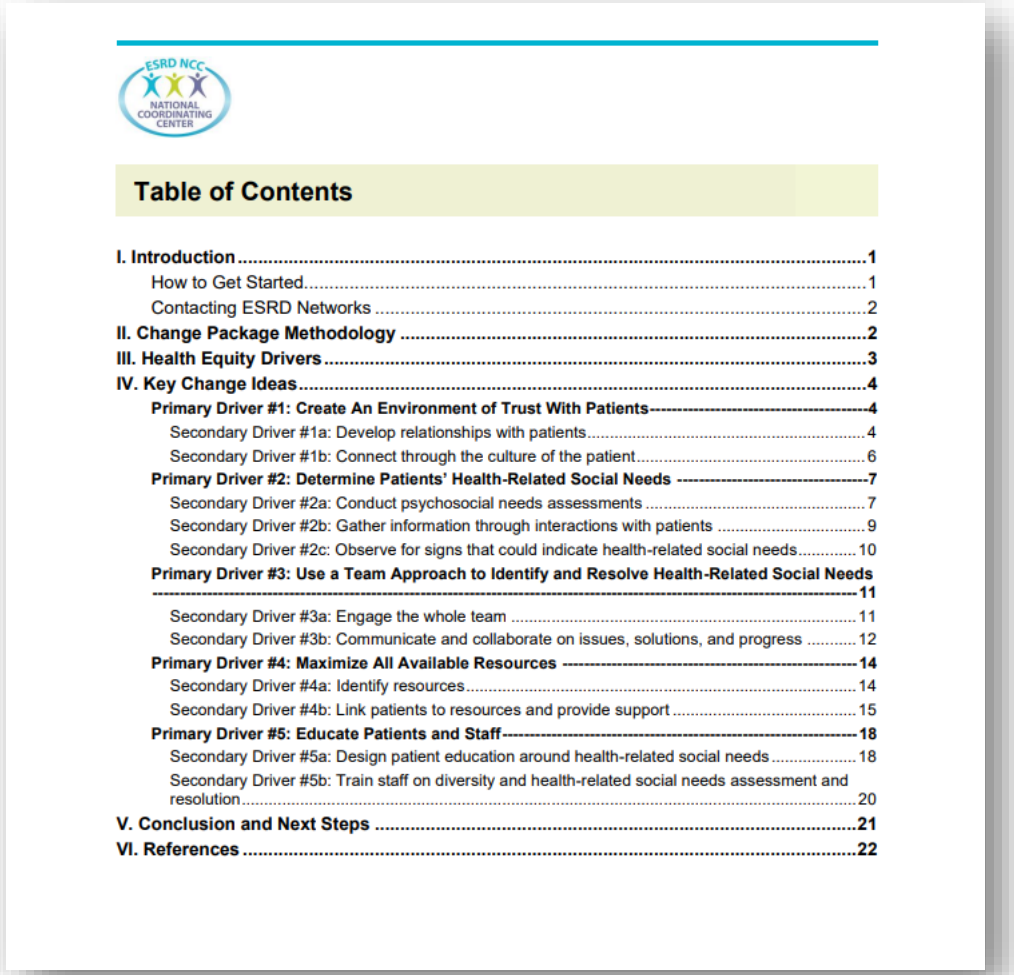
Discussion

Objective Key Result (OKR) Change Packages



ESRD NCC's Health Equity Change Package



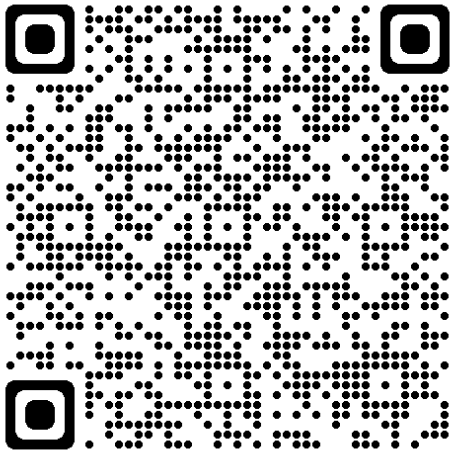


ESRD NCC NATIONAL COORDINATING CENTER

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

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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