

# A Change Package To Improve Health Equity

Key Change Ideas for Dialysis  
Facilities to Drive Local Action

Released 2023





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## I. Introduction

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

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

### How to Get Started

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

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

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

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

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



## Contacting ESRD Networks

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

## II. Change Package Methodology

The ideas presented in this change package were assembled after extensive interviews with dialysis facilities that performed above the national average for patients dialyzing from home and/or patients being on a transplant waitlist, despite their patients' residing in the most disadvantaged neighborhoods<sup>a</sup> and having complex health-related social needs. The selection of home and transplant metrics is in alignment with the Advancing American Kidney Health initiative<sup>2</sup> as well as the current goals for ESRD Networks. The facilities were identified by linking national ESRD Quality Reporting System (EQRS) data with the Area Deprivation Index (ADI),<sup>3</sup> a multidimensional evaluation of a region's socioeconomic conditions based on 17 census variables, including income, education, and housing.

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

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<sup>a</sup>"Neighborhood" is defined as a Census Block Group.



### III. Health Equity Drivers

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

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

**Table 1. Primary and Secondary Drivers to Improve Health Equity**

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



## IV. Key Change Ideas

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

**Table 2. Develop Relationships With Patients**

PRIMARY DRIVER #1: CREATE AN ENVIRONMENT OF TRUST WITH PATIENTS
<b>Secondary Driver #1a: Develop relationships with patients</b>
<p>Developing relationships with patients builds trust, which helps patients feel comfortable to share the details of their lives. This better enables staff to identify health-related social needs that could impact dialysis care and to address them in ways that consider the whole patient.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Greet patients by name.</li> <li>2. Ask patients how they want to be addressed by staff: he, she, they.</li> <li>3. Treat patients as individuals; remember that everyone is different.</li> <li>4. Build rapport with patients on an ongoing basis.             <ol style="list-style-type: none"> <li>a. Get to know patients through multiple conversations and by spending time with them.</li> <li>b. Learn about what matters to each patient.</li> <li>c. Ask general questions, e.g., how are things going?</li> <li>d. Use humor after rapport is established to make patients feel comfortable.</li> <li>e. Show an interest in what patients are doing during dialysis, e.g., talk about books they are reading or music to which they are listening.</li> <li>f. Discuss non-medical topics of shared interest between staff and patients, such as hobbies or sports.</li> <li>g. Chat with patients casually as they come or go to treatment or are in the lobby.</li> <li>h. Let patients know staff are paying attention by casually commenting on noticed differences, e.g., “I see your nails are painted.”</li> </ol> </li> <li>5. Encourage family involvement in care planning, according to the patient’s wishes.</li> <li>6. Sit down with patients for discussions, so that staff are at eye-level with patients and do not appear to be in a position of power.</li> <li>7. Ask patients about their personal short- and long-term goals, not just health-related goals.</li> <li>8. Describe staff roles.</li> <li>9. Let patients know that staff are available to them.</li> <li>10. Approach patients without judgment.</li> <li>11. If patients do not want to share, wait until trust is established to ask personal questions about unmet needs for which patients could use support.</li> <li>12. Form a connection on first contact with families by mentioning staff members’ names that they already know.</li> </ol>



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

**Secondary Driver #1a: Develop relationships with patients**

13. Support patients as whole persons in all ways possible, e.g., socially, economically, spiritually.
14. Be transparent about restrictions on resources, such as waiting lists or limited funding, so patients have realistic expectations.



**Table 3. Connect Through the Culture of the Patient**

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





**Table 4. Conduct Psychosocial Needs Assessments**

PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS
<b>Secondary Driver #2a: Conduct psychosocial needs assessments</b>
<p>The use of tools and formal assessments at scheduled intervals allows staff to collect information on urgent and chronic health-related social needs of patients. This is a critical step in improving health equity on a patient-by-patient basis.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Begin the initial screening of social needs before patients arrive at the clinic, e.g. have the administrative assistant obtain information from the coordinator at the hospital, transferring dialysis center, nephrology practice, or primary care provider (PCP), including insurance, demographics, marital status, family support, living situation, and if patients have limited English proficiency.</li> <li>2. Have the social worker meet with patients on the first day or check with the nurse doing intake to determine any immediate health-related social needs, including housing instability, food insecurity, and lack of transportation.</li> <li>3. Explain the purpose of assessment questions at every point in the engagement. Reassure patients that information is not shared with other patients.</li> <li>4. Use tools in the patient's language, e.g., pull up an assessment in the patient's language on a tablet or laptop.</li> <li>5. Administer the Kidney Disease Quality of Life (KDQOL) initially, at 90-days, and annually.             <ol style="list-style-type: none"> <li>a. Use it as a gateway to start conversations and encourage patients to talk about something they have not mentioned.</li> <li>b. Document identified patient issues.</li> </ol> </li> <li>6. Fill out the Method to Assess Treatment Choices for Home Dialysis (MATCH-D) tool<sup>5</sup> for every patient on admission and annually to assess suitability for home dialysis.             <ol style="list-style-type: none"> <li>a. Identify challenges that can be addressed, such as visual impairment or less than ideal living situations.</li> <li>b. Discuss the results weekly among in-center teammates, including the facility administrator, dietitian, nurse, social worker, and physician, if available.</li> </ol> </li> <li>7. Perform a psychosocial assessment during home visits to include storage space, cleanliness, care partners, employment, and equipment.             <ol style="list-style-type: none"> <li>a. Ask questions that help identify needs that could be addressed by the home dialysis facility, e.g., asking, "Where do you perform your dialysis?" may lead a patient to respond, "I dialyze in the bed, but I would rather use a chair."</li> <li>b. Conduct follow-up assessments to ensure issues have been resolved.</li> </ol> </li> <li>8. Identify simple, easy-to-complete tools that contain visual cues, such as a distress thermometer, that rate patients' perspectives on what is impacting them.             <ol style="list-style-type: none"> <li>a. Assess patients initially, at six months, and as often as necessary or is feasible, e.g., if they come in once a month for a home program, complete the assessment each time they come in.</li> <li>b. Ask patients to rate their distress using a scale, e.g., 0 to 10 with 10 being extreme distress.</li> </ol> </li> </ol>



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

### **Secondary Driver #2a: Conduct psychosocial needs assessments**

- c. Inquire about the cause of the stress, e.g., transportation, housing and food insecurity, insurance, family or emotional or physical issues.
  - d. Incorporate the results into the care plan, e.g., if a patient has no air conditioning, discuss during the monthly meeting to identify cooling centers in the area.
9. Expand psychosocial assessments to include multiple sources of information, e.g., review the family history in the medical record.
10. Contact the family with the permission of the patient to help complete assessments.
11. Be sensitive to how patients want to communicate verbally – “I don’t want people to know my business.” Speak softly and directly to patients and move close to patients, as culturally appropriate, or use a conference room.



**Table 5. Gather Information Through Interactions with Patients**

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



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

<b>PRIMARY DRIVER #2: DETERMINE PATIENTS' HEALTH-RELATED SOCIAL NEEDS</b>
<b>Secondary Driver #2c: Observe for signs that could indicate health-related social needs</b>
<p>Staying alert to changes in patients' affect, appearance, behavior, and physical well-being enables staff to identify and investigate health-related social needs that patients may not verbalize.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"><li>1. Be attentive to signs and clues.<ol style="list-style-type: none"><li>a. Watch for changes in the patient's demeanor or behavior, e.g., the patient is teary eyed. Follow up with questions to discern the cause and offer support.</li><li>b. Pay attention to details that could indicate a problem, e.g., shoes are on the wrong feet or a blanket is dirty.</li><li>c. Look at the overall appearance of the patient and caregiver to identify when respite care might help. Query the patient and caregiver to see if the caregiver needs a break.</li></ol></li><li>2. Recognize changes in the patient's clinical status that could be related to health-related social needs.<ol style="list-style-type: none"><li>a. Monitor labs, e.g., albumin or phosphorus, for trends. Start a conversation to find out if something new is going on in the patient's life that would cause a change.</li><li>b. Notice weight trends, which might indicate the patient does not have enough food. Explore further.</li></ol></li><li>3. Conduct patient rounds with the IDT to identify and track issues.</li><li>4. Get to the root cause.<ol style="list-style-type: none"><li>a. Pull up a chair and sit with the patient to dive deeper into concerns.</li><li>b. Allow the staff member with the best relationship with the patient to meet with the patient for difficult conversations.</li><li>c. Focus on specific observations that may be barriers to care, such as missed appointments.</li><li>d. Use clarifying questions to identify the underlying issue, e.g., if a patient says she did not take her medicine because she did not eat anything, ask questions to ascertain the reason, such as, "Did you have food in the house?"</li><li>e. Take cues from team members on the patient's receptiveness to follow-up, e.g., a patient care technician (PCT) indicates the patient is not in a frame of mind to work on a problem that day.</li></ol></li><li>5. Spot signs of low literacy or low health literacy.<ol style="list-style-type: none"><li>a. Be aware of the patient using verbal clues that may signal a need for reading assistance, such as the patient saying "I don't know the words" or "I don't know what to say" when completing an application.</li><li>b. Investigate reasons for the patient asking staff to fill out forms.</li><li>c. Ask the patient to read something and then follow up to see what the patient thinks about it. Recognize vague answers like "I'm not sure" may indicate a lack of understanding or an inability to read.</li></ol></li><li>6. Check insurance coverage monthly, which could indicate a change in employment status.</li></ol>



**Table 7. Engage the Whole Team**

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



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

<b>PRIMARY DRIVER #3: USE A TEAM APPROACH TO IDENTIFY AND RESOLVE HEALTH-RELATED SOCIAL NEEDS</b>
<b>Secondary Driver #3b: Communicate and collaborate on issues, solutions, and progress</b>
<p>Teamwork and communication, both within the facility and with outside stakeholders, are key elements in a facility’s strategy to support patients as they work through health-related social needs.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Maintain open communication among team members. Establish formal and informal methods of communication, including the electronic health record (EHR), meetings, email, telephone calls, and quick chats throughout the day.</li> <li>2. Use methods that expedite communication for staff disciplines that cover multiple units, e.g., the nurse may use secure email to tell the dietitian or social worker that a patient is out of food.</li> <li>3. Hold brief meetings or huddles away from the patient unit every morning and after shift change to share information on patients’ health-related social needs as they arise and as interventions are implemented.</li> <li>4. Talk about patients’ health-related social needs, including progress in resolving them, at weekly team meetings.       <ol style="list-style-type: none"> <li>a. Expand the meetings to include all team members, e.g., administrative assistant.</li> <li>b. Focus on patients with identified health-related social needs.</li> <li>c. Take IDT ideas back to patients: hold 1-1 patient conferences and brainstorm with patients.</li> </ol> </li> <li>5. Pull electronic reports of MATCH-D results for a list of patients in green, yellow, or red categories to plan interventions. Set a goal for the green category (strong candidate for home consideration). Review progress weekly.</li> <li>6. Partner with other facilities from the same dialysis organization, so social workers, dietitians, and facility administrators can collaborate on solutions to specific difficulties identified during individual QAPI meetings.</li> <li>7. Include social issues on QAPI meeting agendas. Invite patient representatives to speak, rotating in different patients each month to get varying views.</li> <li>8. Discuss best practices and “think outside the box” during home program monthly conference calls to assist patients who are not thriving on the home modality and could return to in-center treatment.</li> <li>9. Hold regional corporate nurse meetings quarterly to review case studies to discuss barriers from different angles.</li> <li>10. Report psychosocial assessments every month in the EHR.       <ol style="list-style-type: none"> <li>a. Set triggers for care activities with due dates and reminders for actions.</li> <li>b. Grant access to all staff to see what other team members are doing and what needs to be done.</li> </ol> </li> <li>11. Work with patients to solve challenges, e.g., look at storage options in the home and offer delivery of supplies twice a month instead of once a month.</li> </ol>



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

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

12. Collaborate on case management.
  - a. Work with case managers through the patient's insurance or at a hospital to provide care coordination support, e.g., refer patients to specialists, coordinate medical appointments, provide equipment such as shower chairs or walkers, and monitor patients' status.
  - b. Integrate efforts with organizations or programs, such as the CMS Program of All-Inclusive Care for the Elderly (PACE),<sup>6</sup> that provide a comprehensive team approach to care as well as services, e.g., medical equipment (wheelchair, ramp), delivery of medications, provision of meals.
13. Address issues in a timely manner as they are discovered, if possible.



**Table 9. Identify Resources**

PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES
<b>Secondary Driver #4a: Identify resources</b>
<p>Casting a wide net to find reliable resources produces a robust catalog that staff can access to support patients.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Build on resource information from previous social workers and dietitians at the facility.</li> <li>2. Network with social workers and dietitians at other dialysis facilities and at conferences. Let them know their knowledge and expertise are valued.</li> <li>3. Contact hospitals and physician offices to identify patient resources.</li> <li>4. With the patient, call resource lines available in the state or county, such as 2-1-1 lines.</li> <li>5. Use Internet search engines, such as Google, to locate resources such as food banks.</li> <li>6. Go to findhelp.org to search for financial assistance, food pantries, and other free or reduced-cost aid.</li> <li>7. Pick up handouts of resources at community fairs.</li> <li>8. Gather information from patients, who may be aware of community resources.</li> <li>9. Ask patient ambassadors/representatives to share awareness of community resources during QAPI meetings and at informal gatherings.</li> <li>10. Explore programs that pay family members as caregivers.</li> <li>11. Look into state programs, such as the In-Home Supportive Services (IHSS) Program in California, which pays for services such as housecleaning, grocery shopping, and meal preparation.</li> <li>12. Research local and national organizations, e.g., the American Kidney Fund, the Mississippi Kidney Fund, Catholic Charities, and local councils on aging, to find out what they provide, such as help with transportation or paying utilities.</li> <li>13. Follow up with community service providers on a regular basis to stay abreast of services.</li> <li>14. Access corporate intranets, if available, to see what resources are offered, e.g., educational materials in different languages.</li> <li>15. Find out if the local electric company offers discounts for patients dialyzing at home or a payment program.</li> <li>16. Collect resources in a central repository, such as a binder or an electronic database, to provide access to the team.             <ol style="list-style-type: none"> <li>a. Include resource details as well as other information, such as how to get a birth certificate or a Social Security Number.</li> <li>b. Document resources by city, county, state, or national.</li> </ol> </li> </ol>





**Table 10. Link Patients to Resources and Provide Support**

<b>PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES</b>
<b>Secondary Driver #4b: Link patients to resources and provide support</b>
<p>Staff support for patients encompasses a wide array of resources and actions, individualized for the patient. While the social worker may act as the lead, an integrated team effort is ideal to provide resources to meet patient needs.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"><li>1. Prioritize and act first on what is most important to the patient.</li><li>2. Empower patients by coaching them to be proactive, teaching them what they can do and how to do it, and reinforcing that they are partners in their healthcare.</li><li>3. Set up email on patients' cell phones.</li><li>4. Help patients to understand the content of letters that may impact their health-related social needs, e.g., from Social Security.</li><li>5. Assist patients with applications for Medicare or other services.</li><li>6. Provide Internet access and support in the dialysis facility for patients that may not have a computer or Internet access at home or the skillset to use the Internet for applications.</li><li>7. Extend resources to other patients in the facility, e.g., if calling a transportation company for one patient, see if other patients qualify.</li><li>8. Involve families and caregivers, e.g., having the family train on home dialysis for a patient who cannot see or asking the caregiver to join in problem-solving with a patient.</li><li>9. Share information on community resources via monthly patient newsletters with Culturally and Linguistically Appropriate Services (CLAS) standards. Offer the newsletters in multiple languages.</li><li>10. Offer respite care for patients on home dialysis to give caregivers a chance to regroup and to support patients, e.g., bring a home hemodialysis patient back to the home department for hemodialysis treatments for a week.</li></ol> <p><u>Limited English Proficiency</u></p> <ol style="list-style-type: none"><li>1. Obtain information from the hospital via email on what language patients speak, so interpreter services can be available for intake.</li><li>2. Use interpreter services for patients for whom English is not their first language: phone or video translation lines, in-person translators, and sign language interpreters for patients who are hearing impaired.</li><li>3. Establish and maintain relationships with translation companies.</li><li>4. Utilize Google Translate for short questions. Type in the question on the tablet and show it to the patient. Then, ask the patient to use a tablet or phone with Google Translate to answer the question.</li><li>5. Arrange for multiple translators, if needed, e.g., patients who are hearing impaired and do not speak English.</li><li>6. Ask staff members who speak the patient's language to assist with translation and communication.</li></ol>



## PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

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

7. Refer patients based on language, as applicable, e.g., refer a Spanish-speaking patient to a transplant center that provides excellent service to Spanish-speaking patients if another transplant center does not work out for the patient.

#### Housing Insecurity

1. Maintain a list of resources in the county for patients who are homeless, e.g., Salvation Army.
2. Share housing resources with patients; follow up after a couple of days.
3. Assist patients with low income to apply for the U.S. Department of Housing and Urban Development Section 8 Housing Choice Voucher Program.
4. Work with patients dialyzing at home to come up with solutions to home/housing challenges. Provide suggestions. Be open to compromise. Include families.
5. Involve the social worker to remove barriers to home dialysis, such as the need for a cleaner house or a lack of storage space for supplies.
6. Modify/adapt what works best for patients, e.g., for a patient living in a camper without running water, get the patient supplies of water and educate about using hand sanitizer and wipes.
7. Call the electric company with the patient or facilitate filling out an application for discounts or payment programs.

#### Food Insecurity

1. Involve the dietitian to see if patients with low albumin levels are eligible for oral supplements.
2. Based on Medicaid criteria, check to see if patients qualify for Supplemental Nutrition Assistance Program (SNAP) benefits.
3. Refer patients to Meals on Wheels, community food banks, and church food pantries.
4. Help patients apply for state food assistance programs.
5. Realize that grocery bills are expensive. Work with patients with low-income to offer solutions to dietary dilemmas, e.g., suggest affordable vegetarian protein sources instead of meat.
6. Prepare handouts of kidney-friendly recipes for foods commonly found in food pantries. Brainstorm meal plans and snacks with patients. Make the materials available in multiple languages using appropriate reading levels.
7. Ask an affiliated hospital to deliver nutritional boosters to the unit, if available.

#### Lack of Transportation

1. Ask patients on the first day of treatment if they are interested in using Medicaid transportation.
  - a. Walk patients through the Medicaid application process.
  - b. Set up a standing order for transportation for six months at a time.
2. Work with patients to engage families, neighbors, and church members to give rides.
3. Share information about local bus services that are available for trips to dialysis, the grocery store, or other appointments.
4. Connect patients to hospitals or organizations that provide transportation or financial aid with



## PRIMARY DRIVER #4: MAXIMIZE ALL AVAILABLE RESOURCES

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

transportation.

5. Collaborate with patients' insurance companies on transportation benefits; assist patients with filling out applications.
6. Hold regular meetings with transportation companies to maintain good relationships and open discussions about issues.
7. Call transportation companies to coordinate pick up and drop off, so patients do not wait. Help patients to report transportation issues to the transportation company, as needed.
8. Have patients contact transportation companies directly, which may be effective in obtaining temporary assistance, even if they do not ordinarily qualify.

#### Mental Health Needs & Social Isolation

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



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

<b>PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF</b>
<b>Secondary Driver #5a: Design patient education around health-related social needs</b>
<p>Successful facilities personalize their educational programs to help patients overcome barriers to learning. This gives all patients an equal opportunity to understand and participate in their care and to make informed decisions about treatment modalities, including home dialysis or transplant.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Pause while patients come to terms with what is happening to them. Let them settle in.</li> <li>2. Assess the learning style of each patient. Ask which way the patient learns best or prefers to learn, e.g., visual, hands-on training, virtual, in-person.</li> <li>3. Try not to overwhelm patients with too much information.</li> <li>4. Recognize that everyone is different. Tailor the education and discussions to each patient.</li> <li>5. Clear up preconceptions. During education in a conference room, listen to patients as they talk about their beliefs and list them on a white board. Discuss each one, e.g., “Transplants are not for people like me.” Talk about what is valid and what is not.</li> <li>6. Establish goals and monitor progress. Adjust the pace in response to patients’ needs.</li> <li>7. Employ a variety of virtual and in-person materials and methods.             <ol style="list-style-type: none"> <li>a. Use online courses via phone or tablet, written materials (handouts, books, newsletters), fun activities (coloring pages, crossword puzzles), videos, and equipment (peritoneal dialysis [PD] cyclers, practice mannequins).</li> <li>b. Supply tablets and/or show patients how to use them to view educational videos or participate in telehealth calls.</li> <li>c. Work with patients one-on-one, e.g., the PD nurse provides hands-on training, allowing patients to practice in front of the nurse and to voice feedback and concerns and tailoring the length of training to the patient learning needs.</li> </ol> </li> <li>8. Build in repetition for all patients. Reinforce the same message from all team members.</li> <li>9. Help patients feel comfortable. Be conscious of body language and tone of voice. “I don’t want to ever make my patients feel like they’re not smart enough to learn PD.”</li> <li>10. Gauge how much patients understand throughout training to determine how much more time and education patients need. “We don’t just tell them that this is what they need to do. We try to see how much they understand about these processes because they are very complicated processes.”             <ol style="list-style-type: none"> <li>a. Use the teach-back method.</li> <li>b. Ask patients simple questions, such as “How do you feel about connecting yourself if you are completely alone?”</li> </ol> </li> <li>11. Extend and adapt the training for patients who are not reaching educational goals, e.g., change the method from visual to hands-on or switch staff members to see if a patient learns better from someone else. “You just keep trying until something sticks.”</li> <li>12. Reeducate patients during monthly visits.</li> </ol>



## **PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF**

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

13. Address low literacy or low health literacy.
  - a. Talk with patients instead of giving them written materials.
  - b. Use words that patients understand.
  - c. Give patients information at grade levels 3 to 5. Include materials with pictures.
  - d. Incorporate information that patients can hear or watch, e.g., videos, recordings by staff, or the Amia cycler for home dialysis that has auditory steps.
  - e. Partner with families.
14. Adapt training for patients with limited English proficiency.
  - a. Translate information. Call the translator line, ask translators to come to the facility, have staff translate, or set up an iPad that can be wheeled to chairside for translation.
  - b. Provide materials and videos in the patient's language.
15. Use large print materials for patients who are visually impaired.
16. Teach patients on home dialysis what to do if they have limited dexterity, e.g., holding the transfer set with their fists instead of their fingertips, using gripper pads that open jars, and practicing on the PD apron (training tummy) instead of themselves to gain proficiency and to prevent self-contamination. Train partners to help to connect and disconnect.



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

<b>PRIMARY DRIVER #5: EDUCATE PATIENTS AND STAFF</b>
<b>Secondary Driver #5b: Train staff on diversity and health-related social needs assessment and resolution</b>
<p>Effective staff education related to patient health-related social needs integrates ongoing training with mentoring by experienced staff, built on a culture of inclusion.</p> <p><b>Change Ideas</b></p> <ol style="list-style-type: none"> <li>1. Educate staff to identify personal or internalized biases that may inhibit their ability to help a patient effectively.</li> <li>2. Focus on a patient-centered culture with support from the leadership team. Reinforce the concept with staff, as needed.</li> <li>3. Provide cultural diversity training for all staff initially and annually.</li> <li>4. Remember that patients had a life and a culture before they started dialysis.</li> <li>5. Have the social worker train staff on how to identify unspoken health-related social needs of patients and how to understand their situations by asking the right questions.</li> <li>6. Incorporate training on making patients feel comfortable, body language, and voice tone into staff education.</li> <li>7. Assign mentors in each discipline for new employees to learn from more experienced staff.</li> <li>8. Model good conversations with patients. Show staff what conversations can produce related to patient health-related social needs. Use strong preceptors to sit with staff until they master the art of purposeful conversation.</li> <li>9. Educate social workers and dietitians on motivational interviewing twice a year with multiple small learning sessions throughout the year.</li> <li>10. Train newly hired staff on the translation line for patients with limited English proficiency.</li> <li>11. Discuss challenges during huddles to facilitate knowledge transfer among team members.</li> <li>12. Review scenarios to identify barriers faced by patients that may indicate psychosocial needs during monthly team meetings.</li> <li>13. Share best practices, case studies, and new ways to address barriers at quarterly nursing meetings regionally.</li> <li>14. Re-train staff after incidents or grievances filed by patients or staff related to cultural diversity.</li> </ol>



## V. Conclusion and Next Steps

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

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



## VI. References

1. Centers for Medicare & Medicaid Services (CMS). *CMS Framework for Health Equity 2022–2023*. Available at: <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>. Accessed November 15, 2022.
2. U.S. Department of Health and Human Services. *Advancing American Kidney Health*. Available at: <https://aspe.hhs.gov/system/files/pdf/262046/AdvancingAmericanKidneyHealth.pdf>. Accessed November 16, 2022.
3. Kind AJ & Buckingham WR. (2018). Making neighborhood-disadvantage metrics accessible—the neighborhood atlas. *The New England Journal of Medicine*. 2018;378(26);2456. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6051533/>
4. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: [http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm\\_campaign=QI-Toolkit-Promotion&utm\\_medium=Whiteboard-Video&utm\\_source=ihl](http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihl). Accessed February 5, 2020.
5. Home Dialysis Central. Medical Education Institute, Inc. *Method to Assess Treatment Choices for Home Dialysis (MATCH-D)*. Available at: <https://homedialysis.org/match-d>. Accessed March 31, 2023.
6. Centers for Medicare & Medicaid Services (CMS). *Program of All-Inclusive Care for the Elderly (PACE)*. Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE>. Accessed March 31, 2023.

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