# Expert Teams – Health Equity

*Case-Based Learning & Mentorship*

Tuesday, February 27, 2024

Moderator: Chiao Wen Lan, PhD, MPH, CPH

ESRD National Coordinating Center

# What are Expert Teams?

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

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

Bring the best possible solutions to the table

# Who Is On The Call?

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

# Questions to Run On

# How Might We …

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

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Regenstrief Institute

# Improving access to kidney transplantation

Rachel Patzer, PhD, MPH
Regenstrief Institute
President & CEO

Professor, Department of Surgery
Regenstrief Foundation Leonard Betley Chair, Indiana University School of Medicine
Department of Surgery, Division of Transplantation

Fairbanks School of Public Health
Department of Epidemiology

@RachelPatzerPhD

rapatzer@iu.edu

# Disclosures

- Research funding by NIH:
  - R01DK122701
  - R01MD010290
  - R01DK 114891
  - U01MD010611
- No other relevant financial disclosures

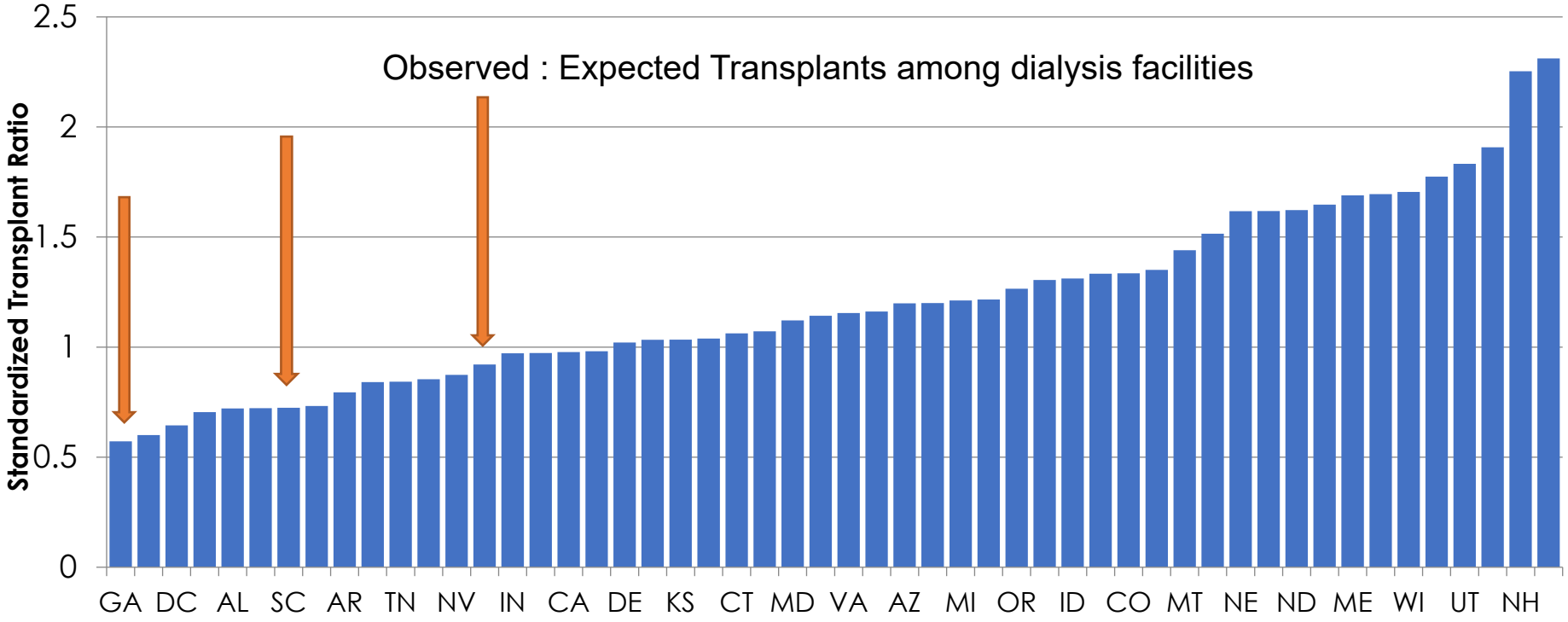
Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

# Objectives

- Introduce the Early Steps to Transplant Access Registry (E-STAR)
- Describe the variation and disparities in access to kidney transplant at different steps in the kidney transplant process
- Describe the RaDIANT intervention to improve access to transplant

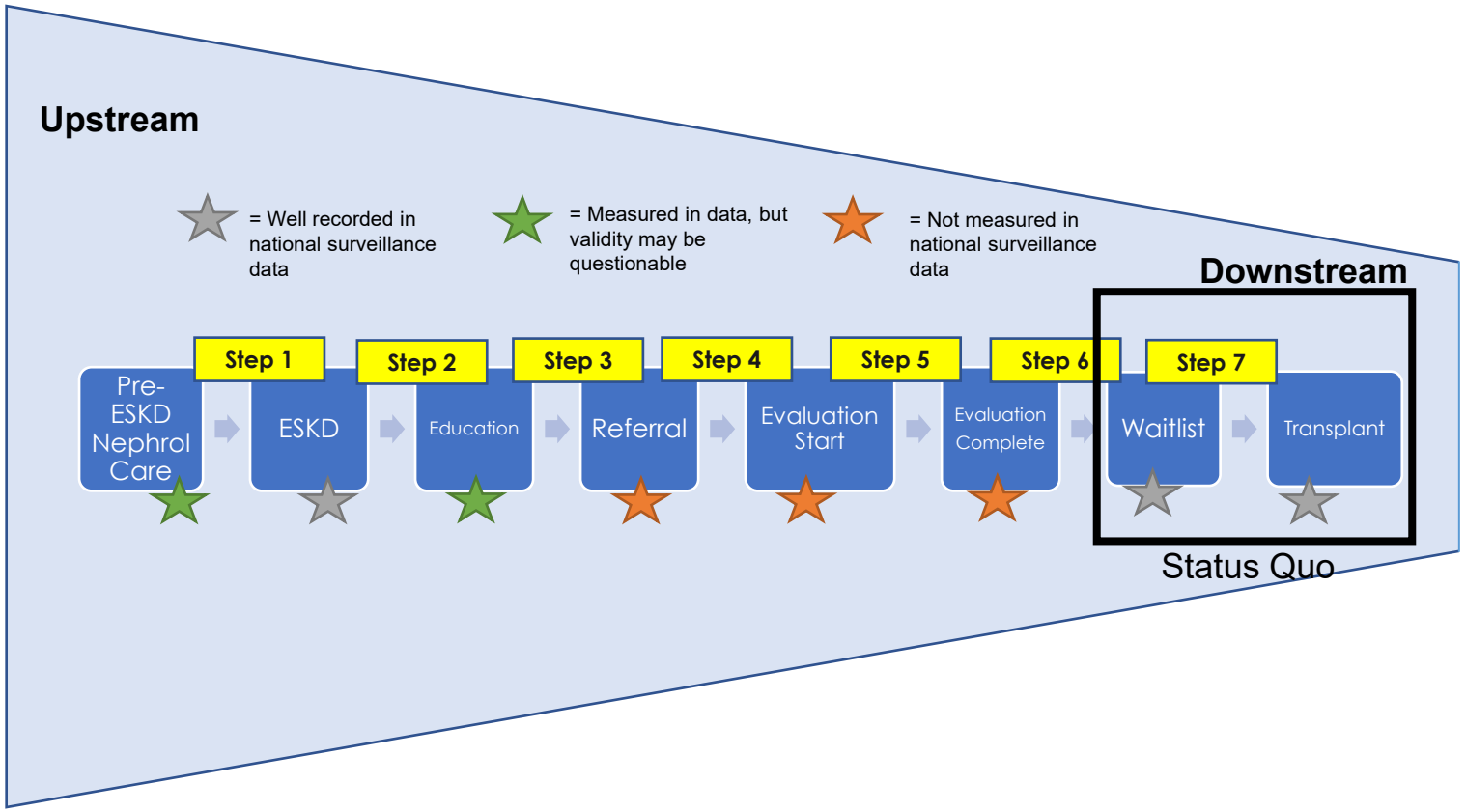
# Problem: Lowest Rates of Kidney Transplant in the Nation




Patzer RE, Plantinga L, Krisher J, Pastan SO, *American Journal of Transplantation.* 2014, 14(7)
Patzer RE and Pastan SO. "View from the Bottom" *Atlanta Journal-Constitution, 2014*

$$\text{STR} = \frac{\text{Actual \# of first transplants}}{\text{Expected \# of first transplants}}$$

# A Population Health Approach in Transplant: which Denominator?




Patzer RE, Adler J, et al. A Population Health Approach to Transplant Access: Challenging the Status Quo. Am J Kidney Dis. 2022 Feb 25:S0272-6386(22)00519-4.

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

# Solutions to the Problem

Regenstrief Institute

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

# Transplant Referral and Evaluation Data Collection: the Early Steps to Transplant Access Registry (E-STAR)

A collaborative project among transplant centers to **collect data on early steps in the transplant process**, including referral to a transplant center and start of the transplant evaluation process

These are important steps in the transplant process that <u>are not currently captured in national surveillance data</u> such as the United States Renal Data System and the United Network for Organ Sharing

E-STAR
EARLY STEPS TO TRANSPLANT ACCESS REGISTRY

# Early Transplant Access Data Surveillance Data Registry Data Collection Methods

**Stephen Pastan, MD**

**Emory University**

**Laura Mulloy, MD**

**Augusta University**

**Eric Gibney, MD**

**Piedmont Transplant Institute**


**Transplant centers submit patient-level via a Secured Filed Transfer Protocol**

REDCap
Research Electronic Data Capture

**US Renal Data System Surveillance Data**

**ESRD Network 6**
***Coordinating Center***

Early Transplant Access Registry Data

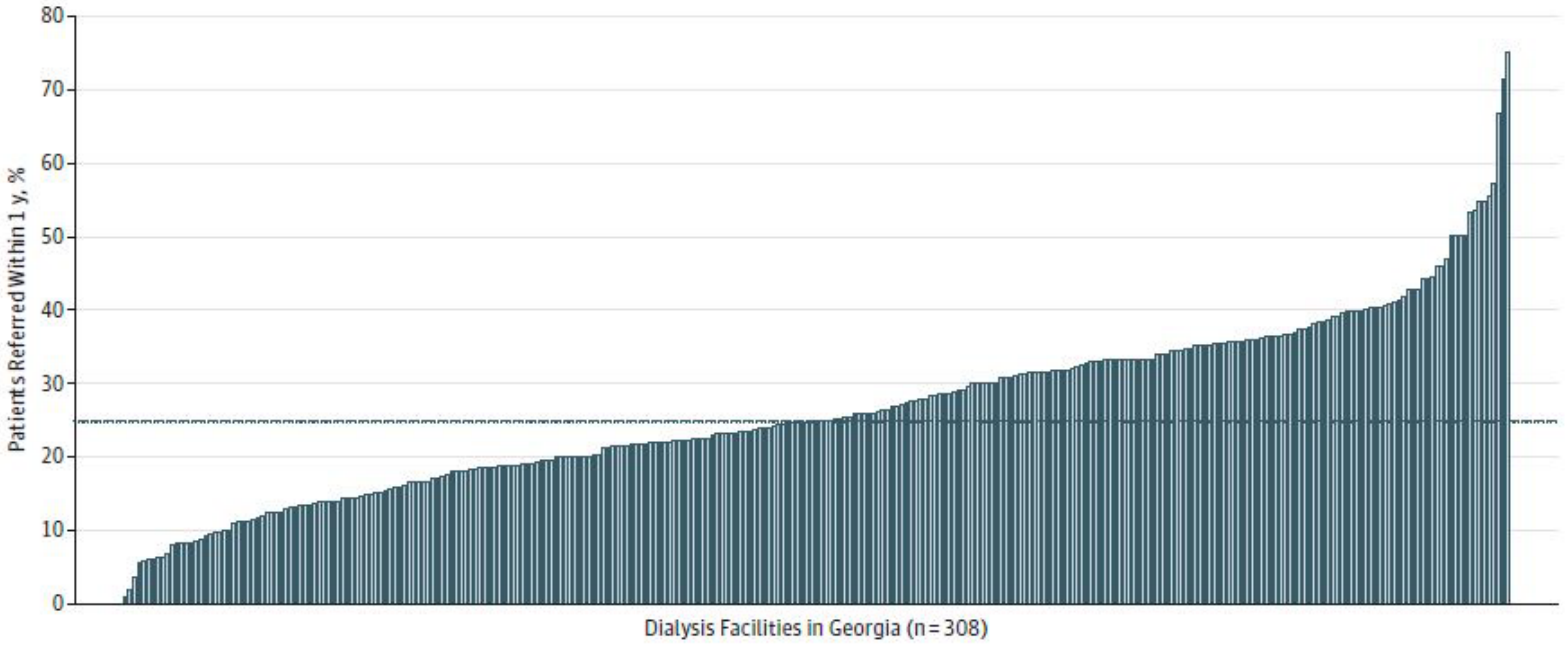
**Patient-Level Pre-Transplant Data Registry – Collected Fields**

| | | |
|---|---|---|
| **Patient Name** | **Referred Transplant Center** | **Referral Date** |
| **Patient DOB** | Preemptive Referral | **Eval Start Date** |
| **Patient SSN** | Dialysis Start Date | Eval Completion Date |
| **Patient Race** | Dialysis Facility Name | Waitlisting Date |
| **Patient Sex** | Dialysis Facility Address | Referring Physician |
| Patient Address | **Dialysis Facility CCN** | Referring Staff |
| Patient Insurance | | |

*** BOLD indicates required field**

# Variation in Referral for Transplant

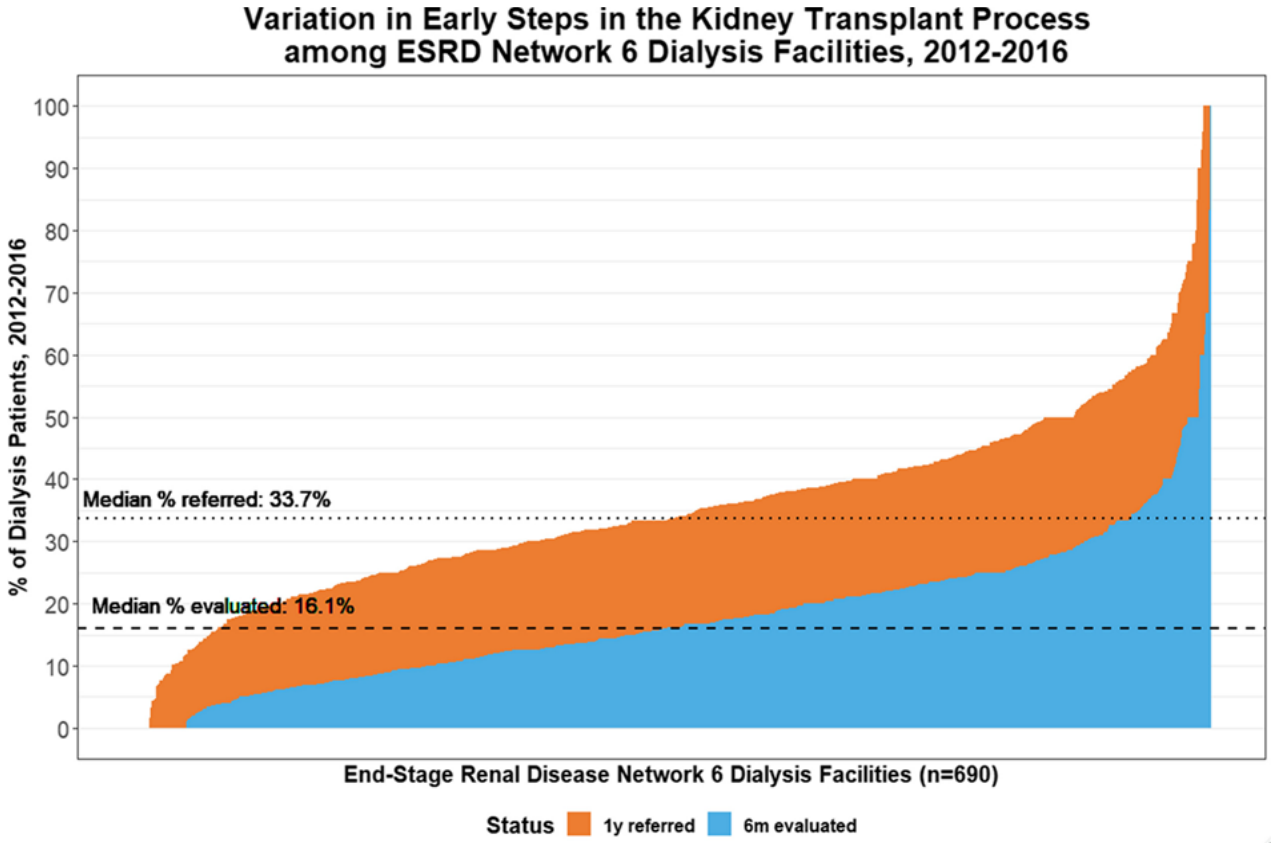
**Figure 2. Percentages of Patients With End-Stage Renal Disease Referred for Kidney Transplantation Within 1 Year of Starting Dialysis Among Georgia Dialysis Facilities: 2005-2011**




Dotted line indicates median (24.4%).

Patzer RE et al "Variation in Dialysis Facility Referral for Kidney Transplantation Among Patients With End-Stage Renal Disease in Georgia." *JAMA 2015.*

# Expansion in the Southeast: Variation in Access to Kidney Transplant Referral and Start of Evaluation



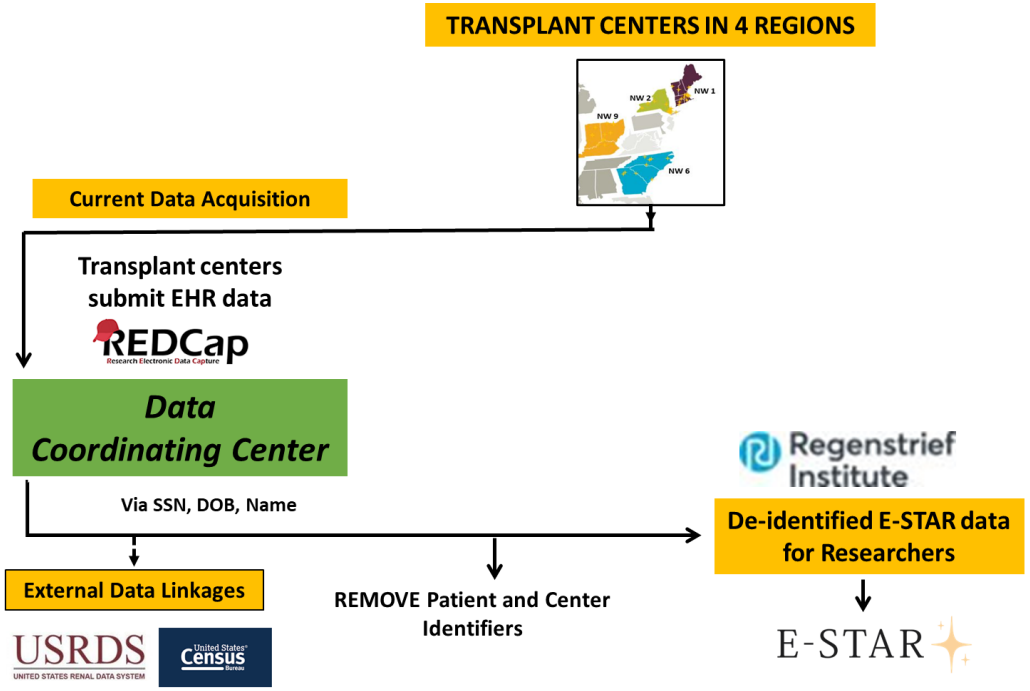

Patzer, R. E., McPherson, L., Wang, Z. et al. Dialysis facility referral and start of evaluation for kidney transplantation among patients treated with dialysis in the Southeastern United States. *American journal of transplantation* (2020).

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

## Transplant Referral and Evaluation Data Collection Process Across Transplant Centers in IPRO ESRD Networks

- In 2019 – expanded to include 4 additional Networks (NW) in the Northeast and Midwest regions of the US
- Data are linked with national USRDS data to estimate rates of referral/evaluation among all ESKD patients
- **~242,754** patient referrals within E-STAR after the most recent data collection



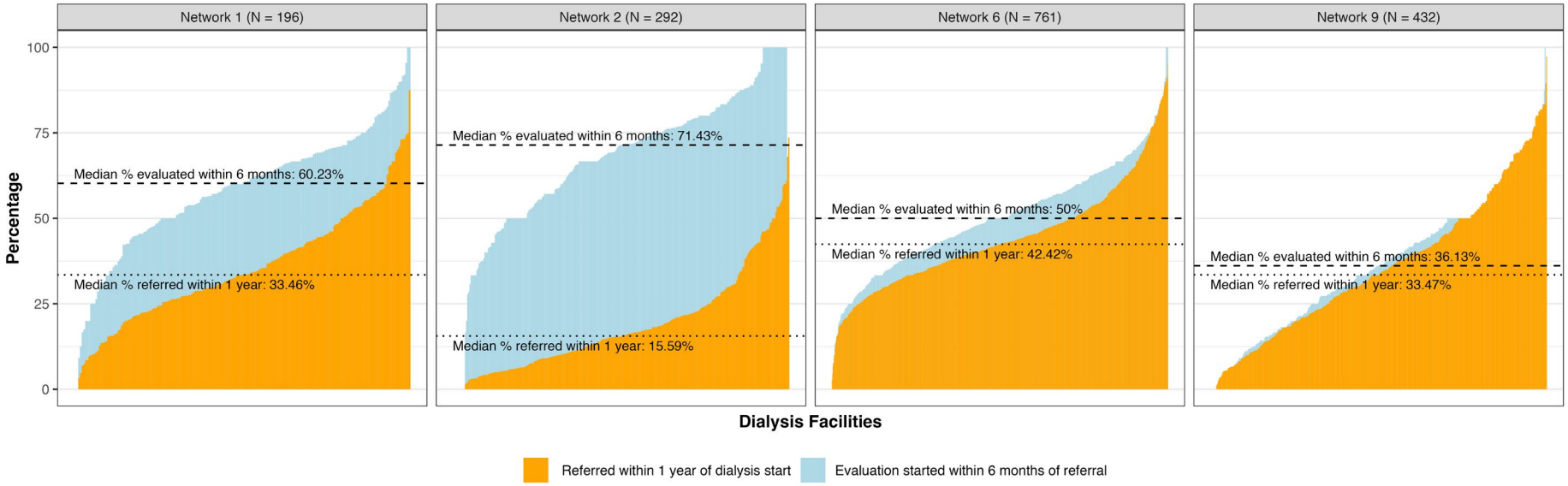

| Early Steps to Transplant Access Registry – Collected Fields* | | | | |
|---|---|---|---|---|
| Patient Name<br>Patient DOB<br>Patient SSN<br>Patient Race | Patient Sex<br>Patient Address<br>Referred Transplant Center<br>Preemptive Referral | Dialysis Start Date<br>Dialysis Facility Name<br>Dialysis Facility Address | Dialysis Facility CCN<br>Referral Date<br>Evaluation Start Date | Evaluation Completion Date<br>Waitlisting Date<br>Referring Physician Info |

Funding: R01DK114891

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

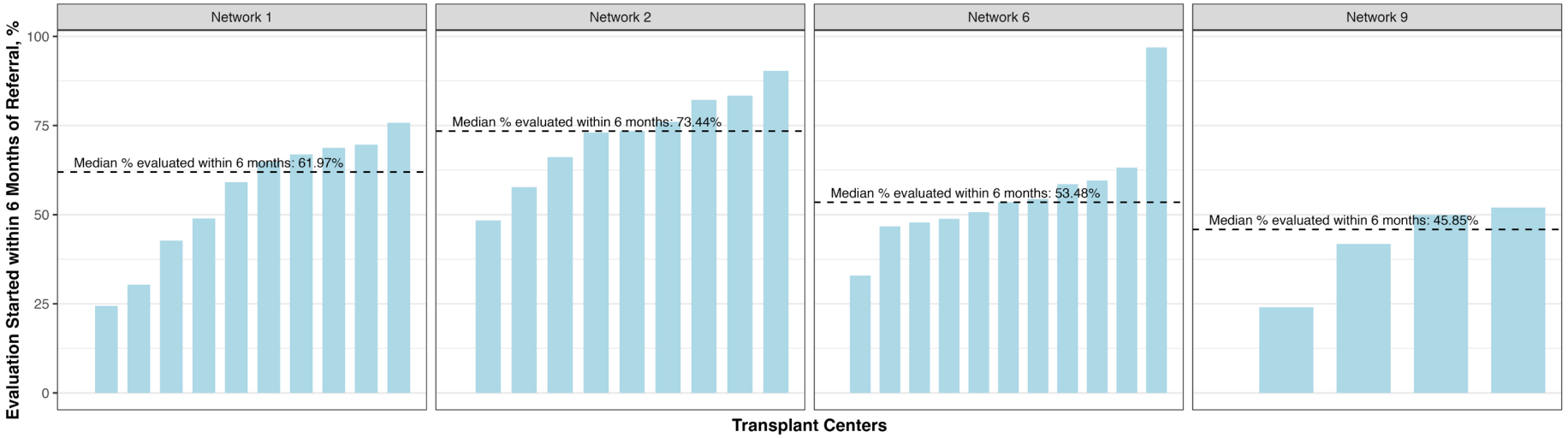
# Percentages of Incident ESRD Patients Referred for Kidney Transplantation Within 1 Year of Dialysis Start and Starting Evaluation Within 6 Months of Referral Among Dialysis Facilities: 2015-2022




*Patients started dialysis between 01/01/2015 and 12/31/2020, followed up through 6/30/2022 for referral and through 12/31/2022 for evaluation

E-STAR
Early Steps to Transplant Access Registry

# Proportion of Patients Starting Transplant Evaluation among Patients Referred to Transplant Centers in ESRD Networks 1, 2, 6, 9, 2015-2022

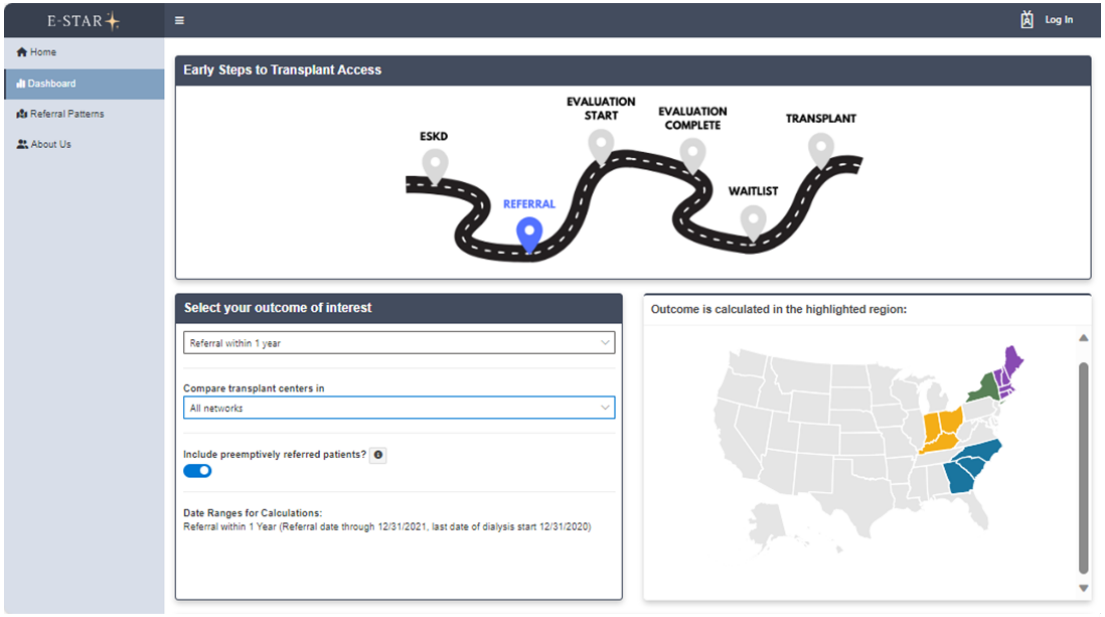


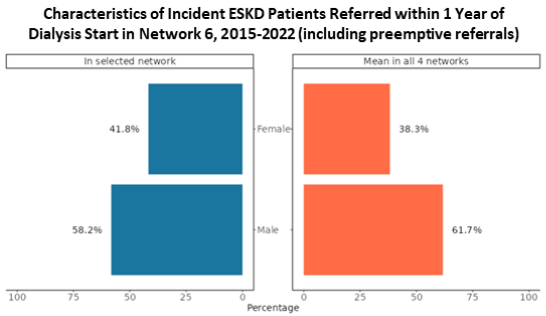

*Patients referred between 01/01/2015 and 6/30/2022, followed up through 12/31/2022 for evaluation.

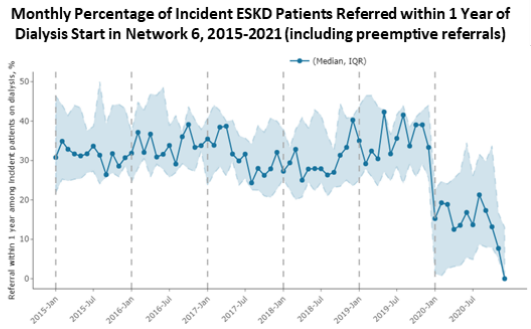
E-STAR
Early Steps to Transplant Access Registry

## Dissemination to Community: Early Steps to Transplant Access Data Dashboard

- An interactive dashboard providing health equity information for transplant centers on two measures: evaluation start, and waitlisting
- Information is displayed at the center- and network level to allow for comparisons across centers
- Password-protected center-specific dashboards for quality improvement within centers




https://estardashboard.shinyapps.io/public/

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

## Interventions in kidney transplant: what has worked? What hasn't?

- Multiple educational interventions (mostly at the patient or patient + provider levels) have shown promise in early steps of accessing transplant,[1] such as knowledge about transplantation.[2,3,4,5]
  - Many have targeted minorities and/or low-income groups with interventions.[2,3,5,6,7,8]
  - Few have specifically examined racial disparity reduction as an endpoint.[6]
- Overarching themes across successful interventions: authentic community engagement, multi-component/multi-level, targeting social networks and environment beyond the individual patient, interactive, and culturally competent education at multiple levels
  - As seen in: RaDIANT Community Study[6], "House Calls" Trial[7], Explore Transplant @ Home Study[2], Hispanic Kidney Transplant Program at Northwestern[8], ASCENT[9]
- Health system barriers and other **structural factors** have not been targeted as often[1]


1. Park et al *Int J Equity Health*, 2022
2. Waterman et al *AJKD*, 2019
3. Basu M et al CJASN, 2018
4. Patzer RE et al AJT, 2018
5. Arriola KJ et al *Prog Transplant* 2014
7. Rodrigue J et al, 2014, *Nephrol Transplantation*
8. Gordon EJ, 2021, Am J Transplant
9. Patzer RE et al, CJASN, 2023


Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

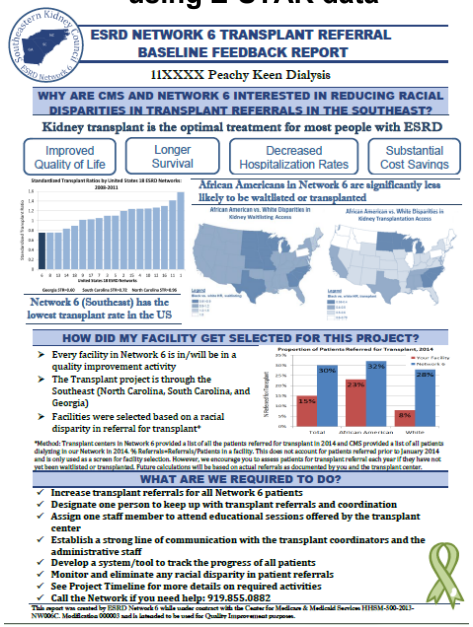
# RaDIANT Community Study

**R**educing **D**isparities **I**n **A**ccess to kid**N**ey **T**ransplantation

## Multilevel, Multicomponent Intervention


- Health System Leaders
- Clinical Staff
- Patients

**Audit-and-Feedback Report using E-STAR data**


ESRD NETWORK 6 TRANSPLANT REFERRAL BASELINE FEEDBACK REPORT

1IXXXX Peachy Keen Dialysis

WHY ARE CMS AND NETWORK 6 INTERESTED IN REDUCING RACIAL DISPARITIES IN TRANSPLANT REFERRALS IN THE SOUTHEAST?

Kidney transplant is the optimal treatment for most people with ESRD

Improved Quality of Life | Longer Survival | Decreased Hospitalization Rates | Substantial Cost Savings

African Americans in Network 6 are significantly less likely to be waitlisted or transplanted

Network 6 (Southeast) has the lowest transplant rate in the US

HOW DID MY FACILITY GET SELECTED FOR THIS PROJECT?

- Every facility in Network 6 is in/will be in a quality improvement activity
- The Transplant project is through the Southeast (North Carolina, South Carolina, and Georgia)
- Facilities were selected based on a racial disparity in referral for transplant*

WHAT ARE WE REQUIRED TO DO?

- ✓ Increase transplant referrals for all Network 6 patients
- ✓ Designate one person to keep up with transplant referrals and coordination
- ✓ Assign one staff member to attend educational sessions offered by the transplant center
- ✓ Establish a strong line of communication with the transplant coordinators and the administrative staff
- ✓ Develop a system/tool to track the progress of all patients
- ✓ Monitor and eliminate any racial disparity in patient referrals
- ✓ See Project Timeline for more details on required activities
- ✓ Call the Network if you need help: 919.855.0882

**Combination of interventions with established efficacy + Quality improvement approaches**

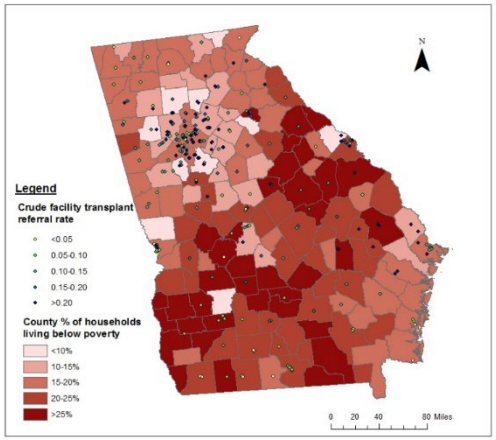

Patzer RE, Gander J, Plantinga L, …Pastan SO. *BMC Nephrology* 2014

Patzer RE, Paul S, Plantinga L, Gander J, McClellan WM, Arriola KJ, Pastan SO, *JASN* 2017


Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

# Randomize High Racial Disparity & Low Referring Facilities for Intervention




Georgia
(Facility n=283)

Population less than age 70; >12 patients per facility
(Facility n=274)

**Two Tier Selection Criteria**
1. Facilities with a within-facility racial disparity in kidney transplant referrals (n=75)
2. Among remaining facilities, facilities with a crude referral in the lowest 50th percentile (n=59)

Final Pool of Facilities for Randomization
(Facility n=134)

Intervention Group
(n=67)

Control Group
(n=67)

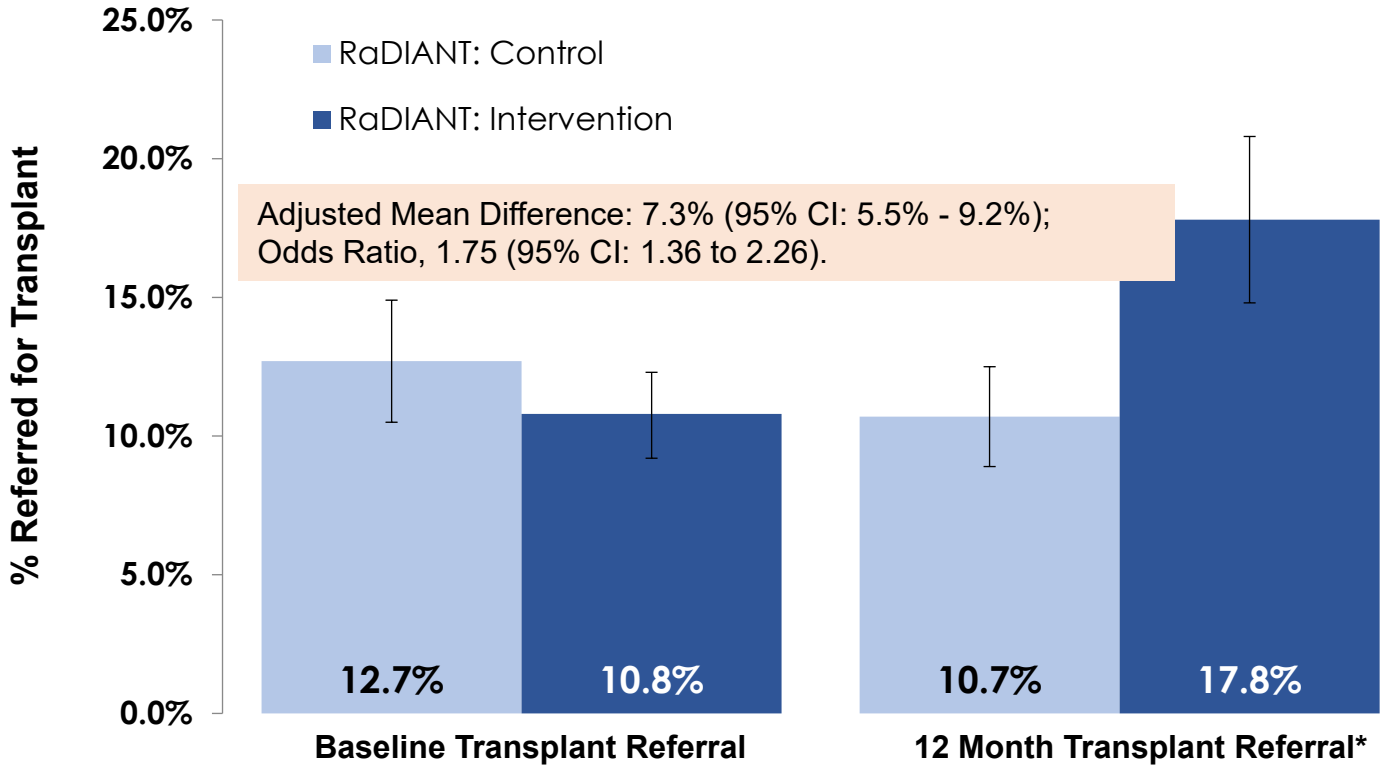
RaDIANT
Reducing Disparities In Access to kidNey Transplantation

Patzer RE, Gander J, Plantinga L, …Pastan SO. *BMC Nephrology* 2014
Patzer RE, Paul S, Plantinga L, Gander J, McClellan WM, Arriola KJ, Pastan SO, *JASN* 2017

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

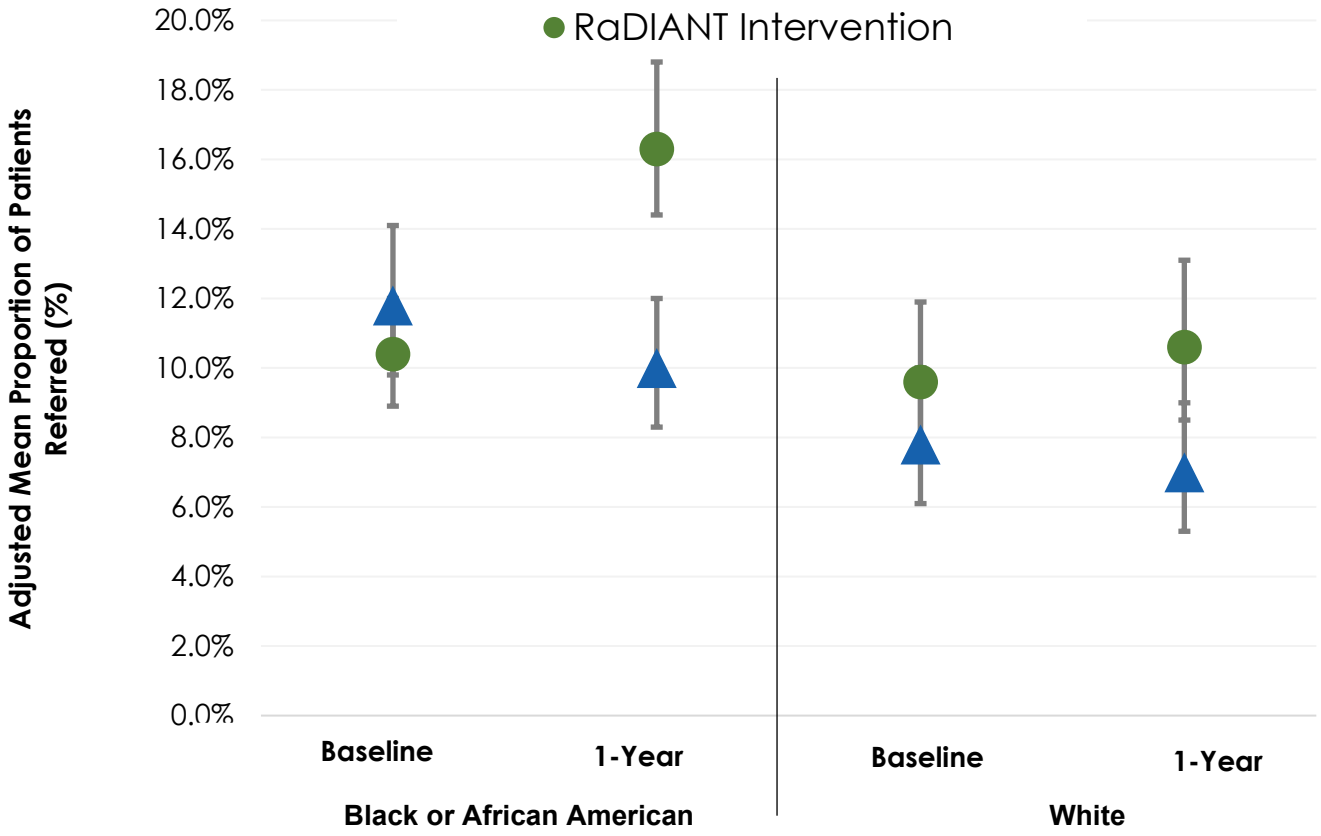
# Change in Proportion of Patients Referred for Transplant by Study Group




Patzer RE, Paul S, Plantinga L, Gander J, McClellan WM, Arriola KJ, Pastan SO, *JASN* 2017

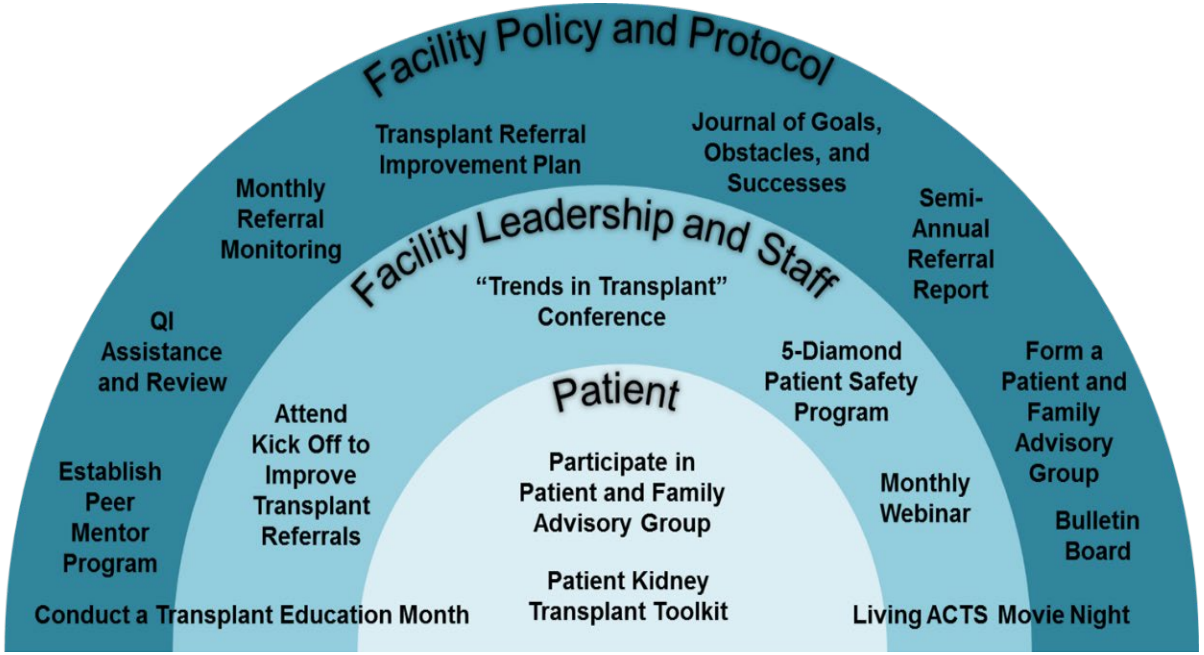
RaDIANT

# Reduction in Racial Disparities in Transplant Referral




Patzer et al, *JASN* 2017

# Mixed Methods Approach to Identifying Barriers to Implementation & Sustainability

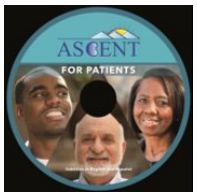



Facilities were asked to participate in 9 "required" activities and 2 out of 5 "optional activities"

Hamoda et al, *BMC Nephrology* 2017

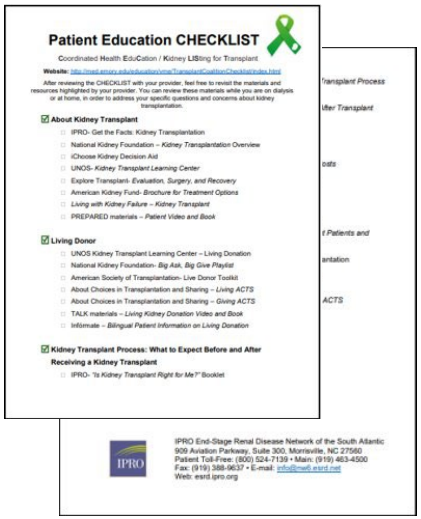
# RaDIANT Regional Study: Multilevel, Multicomponent Intervention

## Quality Improvement Activity Collaboration with ESRD Network 6





**Tailored Patient Transplant Education**



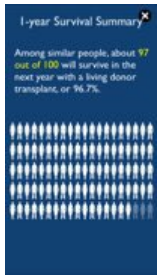

LIVING ACTS

**Monthly Webinars to Encourage Communication between Dialysis Facilities and Transplant Centers**


Health System Leaders

Clinical Staff

Patients


**Combination of interventions with established efficacy + Quality improvement approaches**

Regenstrief Institute

INDIANA UNIVERSITY SCHOOL OF MEDICINE

# Questions?

Regenstrief Institute

INDIANA UNIVERSITY
SCHOOL OF MEDICINE

# Acknowledgements & Thank you


**Emory Research Team**

- Franchesca Amor Aguilar
- Emma Blythe
- Margo Bowers
- Jade Buford, MPH
- Sara Useche DeAbreu
- Mengyu Di, MPH
- Kelsey Drewry, PhD
- Annika Gompers, MPhil
- Jonathan Gunasti, MPH
- Jessica Harding, PhD
- Alexandra Kauffman
- Zihao Liu, MPH
- Laura McPherson, MPH
- Melisa Meza
- Ariana Mora
- Tracy Obertone, PhD
- Sofia Oviedo
- Samantha Retzloff, MPH
- Katie Ross-Driscoll, PhD, MPH
- Larissa Teunis, MPA
- Megan Urbanski, PhD, MSW
- Adam Wilk, PhD
- Rebecca Zhang, MS


**Research Team**

**Southeastern Kidney Transplant Coalition**


**Co-I's and Collaborators**

- Kimberly Jacob Arriola, PhD (RSPH)
- Cam Escoffery, PhD (RSPH)
- Stephen Pastan, MD (SOM)
- Sudeshna Paul, PhD (SON)
- Laura Plantinga, PhD (SOM)

**National Collaborators**

- IPRO (ESRD Network 1, 2, 6, 9)
- Bhavna Chopra, MD (BIDMC)
- Teri Browne, PhD (USC)
- Anne Huml, MD (Cleveland Clinic)
- Sumit Mohan, MD (Columbia)
- Ana Rossi, MD (Piedmont)

**Funding Support:**

R01DK122701
R01MD010290
R01DK 114891
U01MD010611

# Case Study Presentation

**Sauntia Griffin, MSW**
**Network 16**

# Case Study Presentation

**Mae Billanes, MSN, BSN, RN**
**Leonardo Llamas, MSW**
**Susan Copper, MSW, LCSW**

**Network 18**

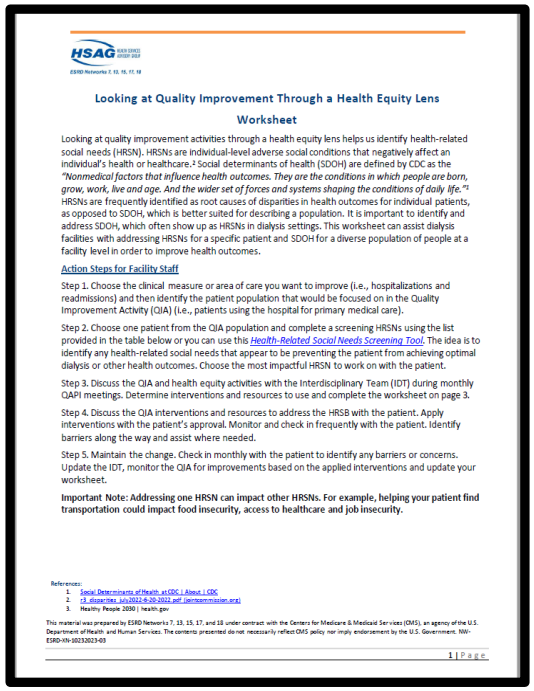
HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

# *Looking at Quality Improvement Through a Health Equity Lens Worksheet*

A Dialysis Facility Case Study

# The Worksheet



HSAG

ESRD Networks 7, 13, 15, 17, 18

## Looking at Quality Improvement Through a Health Equity Lens

### Worksheet

Looking at quality improvement activities through a health equity lens helps us identify health-related social needs (HRSN). HRSNs are individual-level adverse social conditions that negatively affect an individual's health or healthcare.[2] Social determinants of health (SDOH) are defined by CDC as the *"Nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live and age. And the wider set of forces and systems shaping the conditions of daily life."*[1] HRSNs are frequently identified as root causes of disparities in health outcomes for individual patients, as opposed to SDOH, which is better suited for describing a population. It is important to identify and address SDOH, which often show up as HRSNs in dialysis settings. This worksheet can assist dialysis facilities with addressing HRSNs for a specific patient and SDOH for a diverse population of people at a facility level in order to improve health outcomes.

**Action Steps for Facility Staff**

Step 1. Choose the clinical measure or area of care you want to improve (i.e., hospitalizations and readmissions) and then identify the patient population that would be focused on in the Quality Improvement Activity (QIA) (i.e., patients using the hospital for primary medical care).

Step 2. Choose one patient from the QIA population and complete a screening HRSNs using the list provided in the table below or you can use this *Health-Related Social Needs Screening Tool*. The idea is to identify any health-related social needs that appear to be preventing the patient from achieving optimal dialysis or other health outcomes. Choose the most impactful HRSN to work on with the patient.

Step 3. Discuss the QIA and health equity activities with the Interdisciplinary Team (IDT) during monthly QAPI meetings. Determine interventions and resources to use and complete the worksheet on page 3.

Step 4. Discuss the QIA interventions and resources to address the HRSB with the patient. Apply interventions with the patient's approval. Monitor and check in frequently with the patient. Identify barriers along the way and assist where needed.

Step 5. Maintain the change. Check in monthly with the patient to identify any barriers or concerns. Update the IDT, monitor the QIA for improvements based on the applied interventions and update your worksheet.

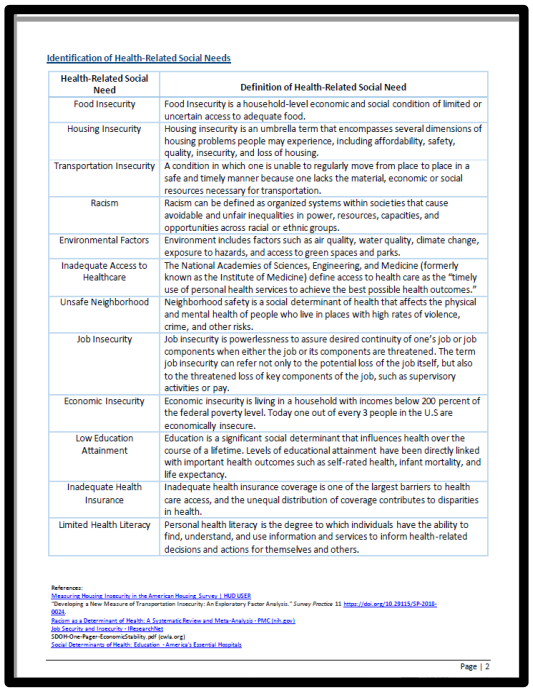
**Important Note: Addressing one HRSN can impact other HRSNs. For example, helping your patient find transportation could impact food insecurity, access to healthcare and job insecurity.**

References:

1. Social Determinants of Health at CDC | About | CDC
2. r3_disparities_July2022-6-20-2022.pdf (aenonprovision.org)
3. Healthy People 2030 | health.gov

This material was prepared by ESRD Networks 7, 13, 15, 17, and 18 under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government. NW-ESRD-YN-10232023-03





**Identification of Health-Related Social Needs**

| Health-Related Social Need | Definition of Health-Related Social Need |
|---|---|
| Food Insecurity | Food Insecurity is a household-level economic and social condition of limited or uncertain access to adequate food. |
| Housing Insecurity | Housing insecurity is an umbrella term that encompasses several dimensions of housing problems people may experience, including affordability, safety, quality, insecurity, and loss of housing. |
| Transportation Insecurity | A condition in which one is unable to regularly move from place to place in a safe and timely manner because one lacks the material, economic or social resources necessary for transportation. |
| Racism | Racism can be defined as organized systems within societies that cause avoidable and unfair inequalities in power, resources, capacities, and opportunities across racial or ethnic groups. |
| Environmental Factors | Environment includes factors such as air quality, water quality, climate change, exposure to hazards, and access to green spaces and parks. |
| Inadequate Access to Healthcare | The National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) define access to health care as the "timely use of personal health services to achieve the best possible health outcomes." |
| Unsafe Neighborhood | Neighborhood safety is a social determinant of health that affects the physical and mental health of people who live in places with high rates of violence, crime, and other risks. |
| Job Insecurity | Job insecurity is powerlessness to assure desired continuity of one's job or job components when either the job or its components are threatened. The term job insecurity can refer not only to the potential loss of the job itself, but also to the threatened loss of key components of the job, such as supervisory activities or pay. |
| Economic Insecurity | Economic insecurity is living in a household with incomes below 200 percent of the federal poverty level. Today one out of every 3 people in the U.S are economically insecure. |
| Low Education Attainment | Education is a significant social determinant that influences health over the course of a lifetime. Levels of educational attainment have been directly linked with important health outcomes such as self-rated health, infant mortality, and life expectancy. |
| Inadequate Health Insurance | Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. |
| Limited Health Literacy | Personal health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. |

References:

Measuring Housing Insecurity in the American Housing Survey | HUD USER

"Developing a New Measure of Transportation Insecurity: An Exploratory Factor Analysis." *Survey Practice* 11 https://doi.org/10.29115/SP-2018-0026

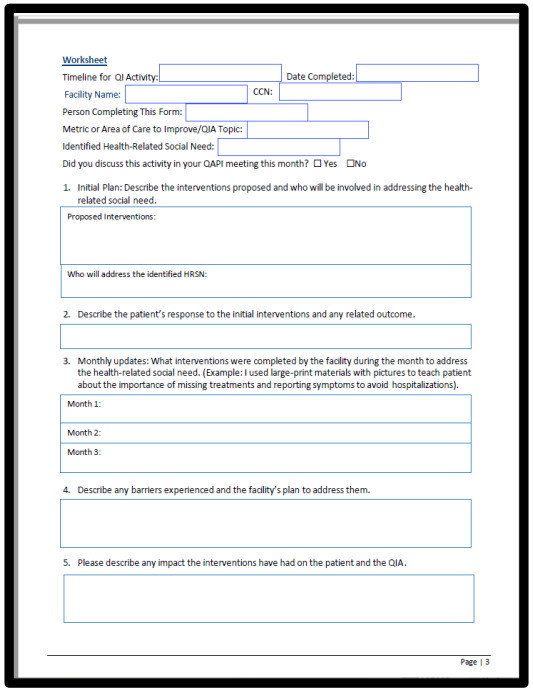
Racism as a Determinant of Health: A Systematic Review and Meta-Analysis - PMC (nih.gov)

Job Security and Insecurity - (Researchfile)

SDOH-One-Pager-EconomicStability.pdf (uwla.org)

Social Determinants of Health: Education - America's Essential Hospitals





**Worksheet**

Timeline for QI Activity: Date Completed:

Facility Name: CCN:

Person Completing This Form:

Metric or Area of Care to Improve/QIA Topic:

Identified Health-Related Social Need:

Did you discuss this activity in your QAPI meeting this month? ☐ Yes ☐ No

1. Initial Plan: Describe the interventions proposed and who will be involved in addressing the health-related social need.

Proposed Interventions:

Who will address the identified HRSN:

2. Describe the patient's response to the initial interventions and any related outcome.

3. Monthly updates: What interventions were completed by the facility during the month to address the health-related social need. (Example: I used large-print materials with pictures to teach patient about the importance of missing treatments and reporting symptoms to avoid hospitalizations).

Month 1:

Month 2:

Month 3:

4. Describe any barriers experienced and the facility's plan to address them.

5. Please describe any impact the interventions have had on the patient and the QIA.



HSAG HEALTH SERVICES ADVISORY GROUP

# Initial Assessment

Did you use the list of health-related social needs (HRSNs) to assess your patient?

Once you identified the patient's HRSN, what were your next steps? Were there other staff or outside agencies involved?

What resources were utilized? Did you create your own resources?

Can you describe your patient's initial response?

# Second and Third Month Follow-up

The time between your initial assessment with your patient, and the next meeting, were there other developments that you would like to share?

Can you describe what you did with your patient at the second visit? Is there anything you are doing to prepare for your third month meeting with patient?

How has this QI Activity impacted the facility staff and other patients?

# Sustainment

Can you describe how you plan to sustain the intervention with your patient?

What are your take aways? Is there anything you would like to share with others about addressing HRSNs with dialysis  patients?

HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

# Thank you!

Mae Billanes, MSN, BSN, RN
Leonardo Llamas, MSW
Susan Cooper, MSW, LCSW
(480) 578-9306 scooper@hsag.com

# Questions and Answer Discussion

# Knowledge Into Action

# Top Take-Aways

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

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

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

# Recap & Next Steps

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

Visit the ESRD NCC website to find materials and share

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

# Social Media

ESRD National Coordinating Center

@esrd_ncc

@esrdncc

ESRD NCC | End Stage Renal Disease
National Coordinating Center (NCC)

# Thank You

Chiao Wen Lan
clan@hsag.com

This material was prepared the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government. FL-ESRD NCC-NC3HEQ-02222024-01