Qsource ESRD Networks

X4 HEALTH

SUPERIOR HEALTH Quality Alliance

Midwest Kidney Network

esrd.qsource.org

Advancing Health Equity for Kidney Care

October 25, 2022

This program is brought to you by:

Qsource ESRD Networks 10 & 12
Midwest Kidney Network-Network 11
X4 Health

Welcome Attendees!

- This webinar is being recorded and will be available a few days after the live presentation.
- All lines are muted, but we do want to hear your questions during the Q&A portion of the call.
- Staff will be monitoring the Chat box, so feel free to add your questions or comments there during the presentation.
- Please fill out the survey at the end of the presentation to provide valuable feedback to us for future webinars.

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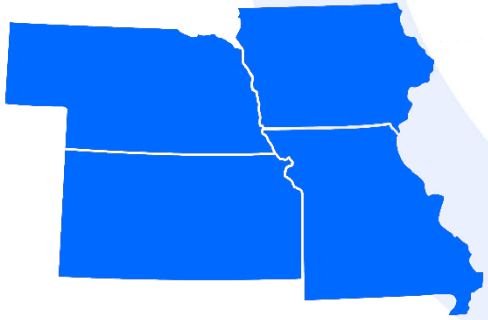
Qsource ESRD Networks 10 & 12

Much of the territory in Networks 10 and 12 are considered rural, but most of the population (including ESRD patients) of the states live in urban cities including Chicago, IL, Kansas City, MO and St. Louis, MO.

ESRD Network 10

Illinois



ESRD Network 12

Iowa, Kansas,
Missouri, Nebraska

59,284 Dialysis and Transplant Patients

685 Dialysis Facilities

21 Transplant Centers

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Midwest Kidney Network 11

African Americans and Native Americans have a disproportionately higher incidence of kidney disease in the five-state region.

- At 83%, Detroit, Michigan has the second highest percentage of African American population in a US city.
- Midwest Kidney Network's five-state area contains more than fifteen Native American reservations with some of the largest populations in the United States.
- Over 10% of the population of South Dakota identifies as American Indian or Alaskan Native making it the state with the 4th highest percentage of Native American population in the US.

ESRD Network 11- North Dakota, South Dakota, Minnesota, Michigan, Wisconsin

51,145 Dialysis and Transplant Patients

542 Dialysis Facilities

20 Transplant Centers

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Today's Speaker

Pooja Kothari RN, MPH, is a nurse by training and is currently working with the Qsource team as a health equity subject matter expert. She has over 10 years of experience working on healthcare issues. Kothari spent 5 years working on quality improvement and measurement in New York, especially around bridging quality and equity. Prior to that, her experience has involved working in public health and consulting.

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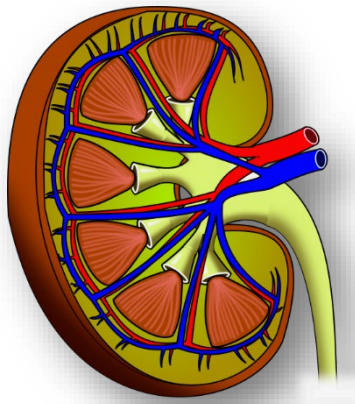
Advancing Health Equity for Kidney Care

Pooja Kothari, RN, MPH

Health Equity SME, QSource

October 25, 2022



Agenda

- Welcome
- Understanding Health Equity and Disparities
- Addressing Social Determinants of Health (SDOH)
- Providing Culturally and Linguistically Appropriate Services (CLAS)

Health Equity and Health Disparities

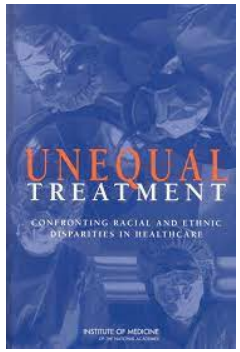
"Health equity means that ***everyone has a fair and just opportunity*** to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

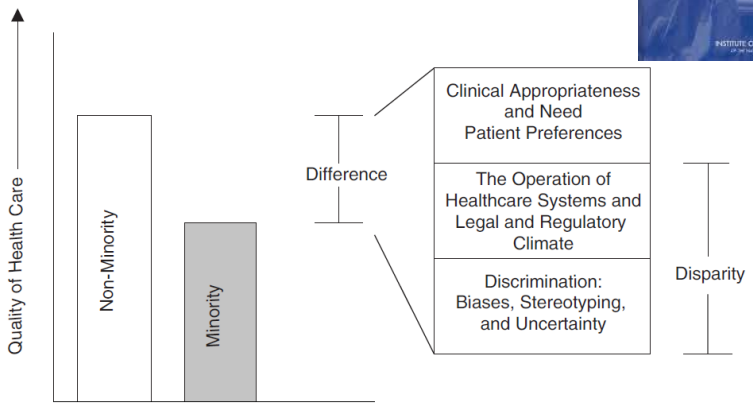
"Health disparities are ***preventable*** differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."

Robert Wood Johnson Foundation, What is Health Equity, https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
CDC, Health Disparities, https://www.cdc.gov/healthyyouth/disparities/index.htm

Disparities in Healthcare

- Racial and ethnic disparities in health care exist and are associated with worse health outcomes.
- Occur in the context of broader historic and contemporary social and economic inequalities.
- Many sources - including health systems, healthcare providers, and utilization managers - may contribute.
- Bias, stereotyping, prejudice, and clinical uncertainty may contribute to racial and ethnic disparities in health care.





Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.
https://hospital.uillinois.edu/Documents/IGX/MSHC/IOM-REPORT-Summary.pdf

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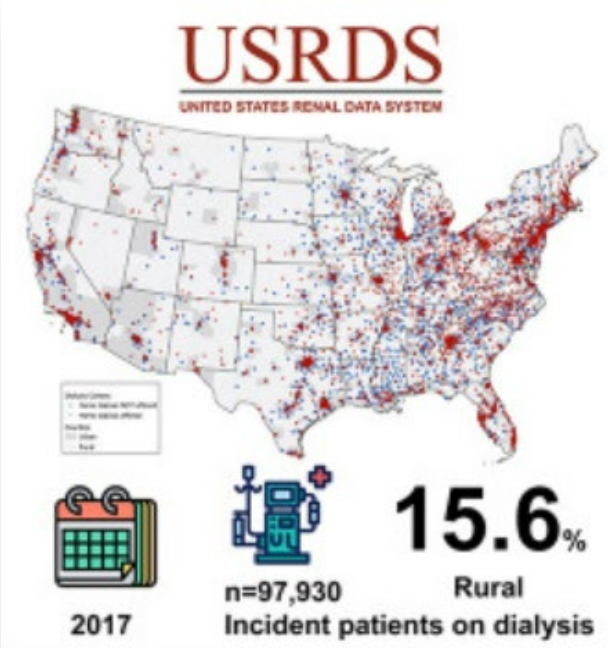
Racial and Ethnic Disparities

- 15% of adults in the U.S. have chronic kidney disease (CKD).
- Most adults (9 in 10) with CKD do not know they have it.
- African Americans are 3.6 times more likely to have kidney failure.
- Hispanic Americans and Native Americans are almost twice as likely to develop kidney failure compared to the general population.
- Racial minorities have a higher risk of progressing from CKD to ESRD more rapidly.

CMS, Chronic Kidney Disease Disparities: Educational Guide for Primary Care, April 2021.
https://www.cms.gov/files/document/chronic-kidney-disease-disparities-educational-guide-primary-care.pdf

Rural vs. Urban Health Disparities

- 240,000 rural patients with ESKD have less access to care and a higher mortality
- Over 15,000 rural patients began dialysis in 2017 which was ~15% of new dialysis nationwide
- Transportation is a need for rural patients with ESKD
- Racial and ethnic disparities are layered on top of rural/urban disparities



RHIhub, Staving Off One's Mortality: Rural Kidney Health and Its Disparities.
https://www.ruralhealthinfo.org/rural-monitor/rural-kidney-health/
Adler JT, Husain SA, Xiang L, Rodrigue JR, Waikar SS. Initial Home Dialysis Is Increased for Rural Patients by Accessing Urban Facilities. Kidney360. 2022 Jan 4;3(3):488-496. doi: 10.34067/KID.0006932021

CMS Health Equity Framework

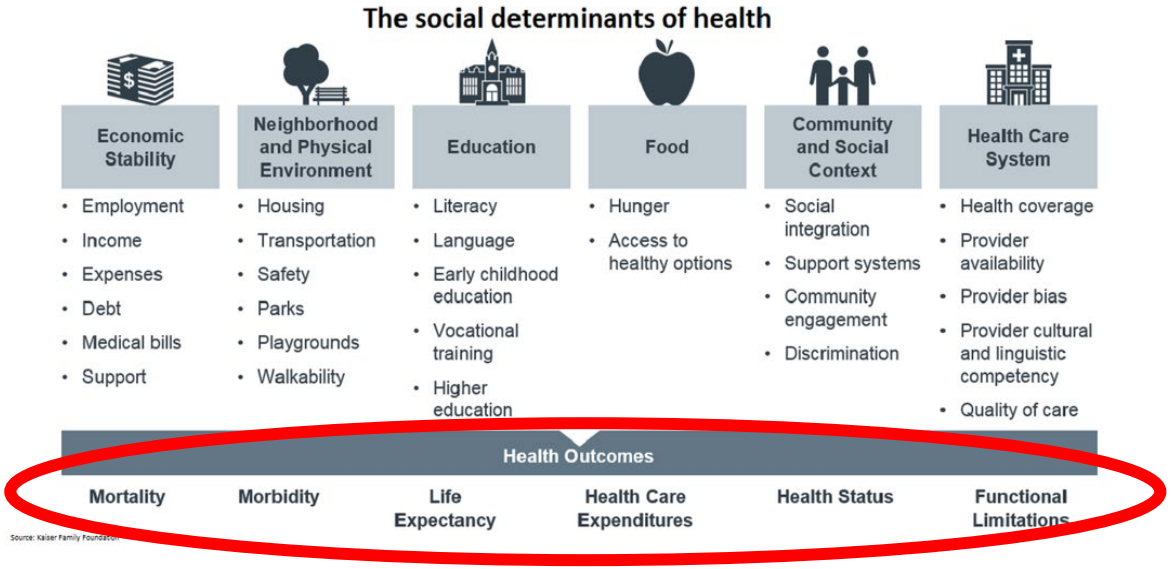
Social Determinants of Health

Culturally and Linguistically Appropriate Services (CLAS)

Centers for Medicare & Medicaid Services, CMS Framework for Health Equity 2022–2032, https://www.cms.gov/files/document/cms-framework-health-equity.pdf.

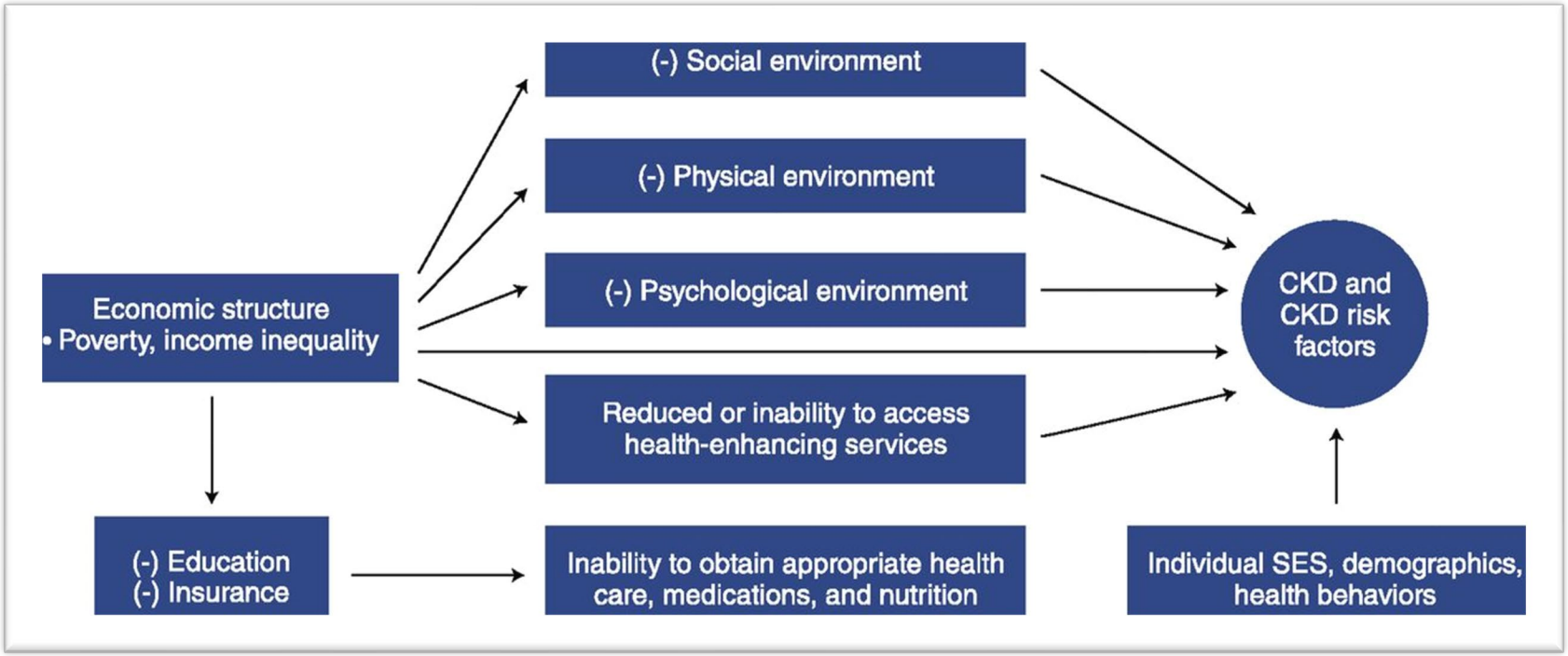
Defining Social Determinants of Health (SDOH)

Social determinants of health (SDOH) are 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."



Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
https://health.gov/healthypeople/objectives-and-data/social-determinants-health
UIC Center. What are the social determinants of health?
https://www.center4healthandsdc.org/the-social-determinants-of-health.html

SDOH and Kidney Disease

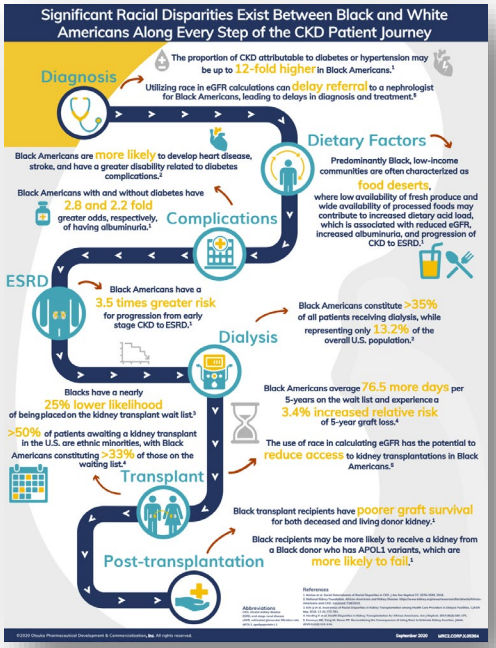


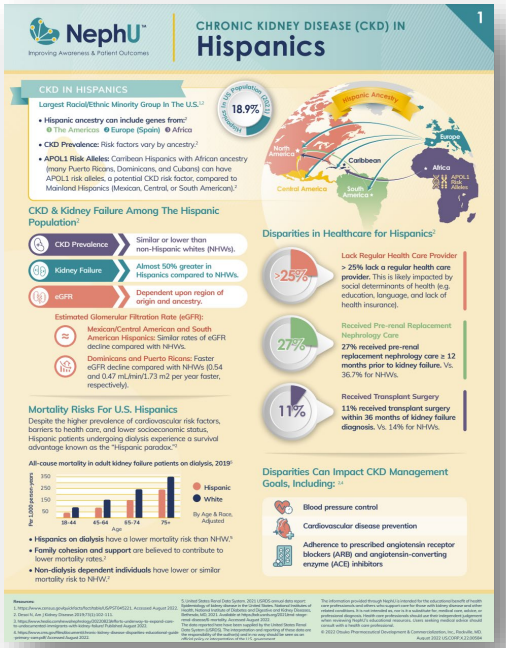
Norris, Keith C., and Bettina M. Beech. "Social determinants of kidney health: focus on poverty." *Clinical Journal of the American Society of Nephrology* 16.5 (2021): 809-811, https://pubmed.ncbi.nlm.nih.gov/33441465/

Best Practices to Address SDOH

1. Train and promote awareness about disparities and SDOH and how they can affect patients with chronic kidney disease
2. Screen for social needs especially during primary care visits and identify risk factors.
3. Partner with community-based organizations to direct referrals for services to patients with chronic kidney disease.
4. Increase access to home dialysis for diverse populations
5. Improve patient education and consider health literacy and cultural competency.

Train Staff on CKD Disparities





NephU, Infographic – Chronic Kidney Disease (CKD) In Hispanics, September 16, 2022. https://nephu.org/infographic-chronic-kidney-disease-in-hispanics

NephU, Significant Racial Disparities Exist Between Black & White Americans Along Every Step Of The CKD Patient Journey, November 4, 2020. https://nephu.org/significant-racial-disparities-exist-between-black-white-americans-along-every-step-of-the-ckd-patient-journey/

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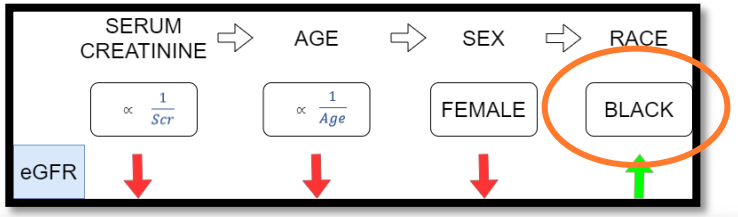
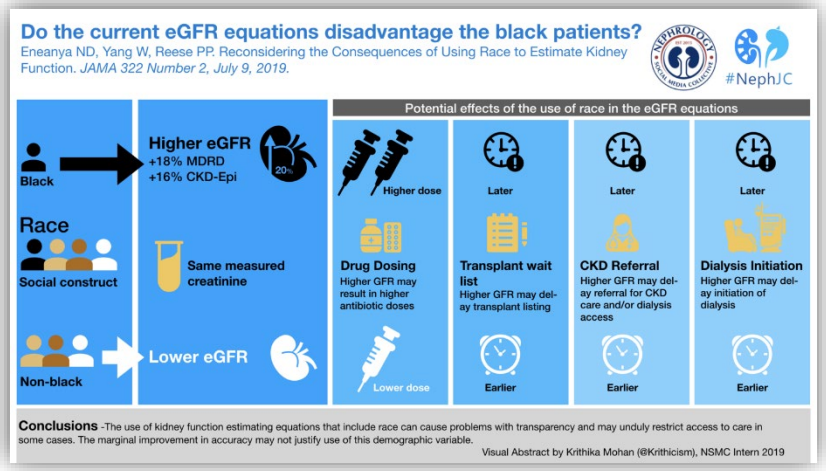
Revising Race Embedded in Clinical Algorithms

Estimated Glomerular Filtration Rate (eGFR) Equation

- Used to diagnose chronic kidney disease
- Higher values = better kidney function
- Race multiplier based on assumption Black patients had more muscle mass

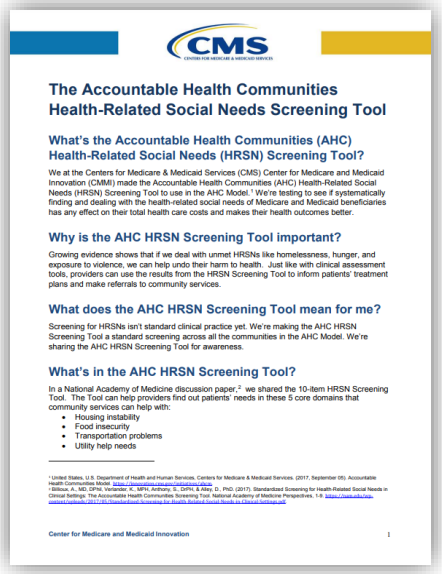




Vyas, Darshali A., Leo G. Eisenstein, and David S. Jones. "Hidden in plain sight—reconsidering the use of race correction in clinical algorithms." New England Journal of Medicine 383.9 (2020): 874-882. https://www.nejm.org/doi/pdf/10.1056/NEJMms2004740

Eneanya ND, Yang W, Reese PP. Reconsidering the Consequences of Using Race to Estimate Kidney Function. JAMA. 2019;322(2):113–114. doi:10.1001/jama.2019.5774

Screening for Social Needs



CMS

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

[1] United States, U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm

[2] Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH, & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

Center for Medicare and Medicaid Innovation 1

What Does PRAPARE Measure?

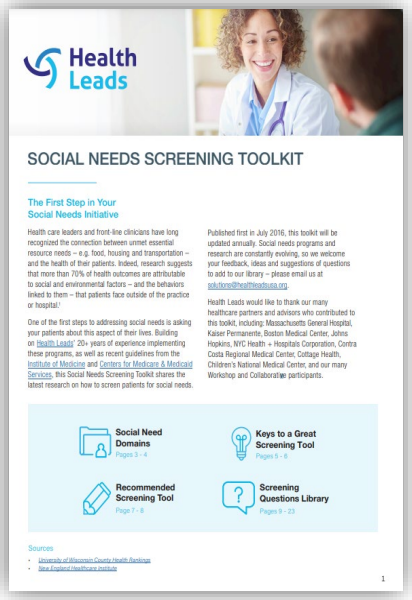
The PRAPARE tool is both evidence-based and stakeholder driven. It was informed by research on social determinant of health domains that predict poor outcomes and high cost, the experience of existing social risk assessments, and the advice and feedback from key stakeholders including patients, providers, clinical leadership, non-clinical staff, and payers. It aligns with national initiatives prioritizing the social determinants of health (e.g., Institute of Medicine's recommendations, Healthy People 2020 goals), measures proposed under the next stage of Meaningful Use, clinical coding under ICD-10 Z codes, and health centers' current federal reporting requirements (i.e., Uniform Data System). PRAPARE emphasizes measures, listed below, that are actionable.

Core Measures in PRAPARE

PERSONAL CHARACTERISTICS	• Race • Ethnicity • Farmworker Status	• Language Preference • Veteran Status
FAMILY AND HOME	• Housing Status and Stability • Neighborhood	
MONEY AND RESOURCES	• Education • Employment • Insurance Status	• Income • Material Security • Transportation Needs
SOCIAL AND EMOTIONAL HEALTH	• Social Integration and Support • Stress	
OTHER MEASURES IN PRAPARE	• Incarceration History • Refugee Status	• Safety • Domestic Violence

PRAPARE measures are mapped to ICD-10 Z codes, LOINC codes, and SNOMED codes in our PRAPARE Data Documentation and Codification file to further standardize data for aggregation and analysis. Many of the PRAPARE EHR templates automatically map to the ICD-10 Z codes so that they can be easily added to the diagnostic/problem list.

CHAPTER 1: Understand the PRAPARE Project 3



Health Leads

SOCIAL NEEDS SCREENING TOOLKIT

The First Step in Your Social Needs Initiative

Health care leaders and front-line clinicians have long recognized the connection between unmet essential resource needs – e.g. food, housing and transportation – and the health of their patients. Indeed, research suggests that more than 70% of health outcomes are attributable to social and environmental factors – and the behaviors linked to them – that patients face outside of the practice or hospital.

One of the first steps to addressing social needs is asking your patients about this aspect of their lives. Building on Health Leads' 20+ years of experience implementing these programs, as well as recent guidelines from the Institute of Medicine and Centers for Medicare & Medicaid Services, this Social Needs Screening Toolkit shares the latest research on how to screen patients for social needs.

Published first in July 2016, this toolkit will be updated annually. Social needs programs and research are constantly evolving, so we welcome your feedback, ideas and suggestions of questions to add to our library – please email us at solutions@healthleadsusa.org.

Health Leads would like to thank our many healthcare partners and advisors who contributed to this toolkit, including: Massachusetts General Hospital, Kaiser Permanente, Boston Medical Center, Johns Hopkins, NYC Health + Hospitals Corporation, Contra Costa Regional Medical Center, Cottage Health, Children's National Medical Center, and our many Workshop and Collaborative participants.

Social Need Domains Pages 3 - 4

Keys to a Great Screening Tool Pages 5 - 6

Recommended Screening Tool Page 7 - 8

Screening Questions Library Pages 9 - 23

Sources

- University of Wisconsin County Health Rankings
- New England Healthcare Institute

1

CMS, The Accountable Health Communities Health-Related Social Needs Screening Tool. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

NACHC. PRAPARE Screening Tool. https://prapare.org/the-prapare-screening-tool/

Health Leads. The Health Leads Screening Toolkit. https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/

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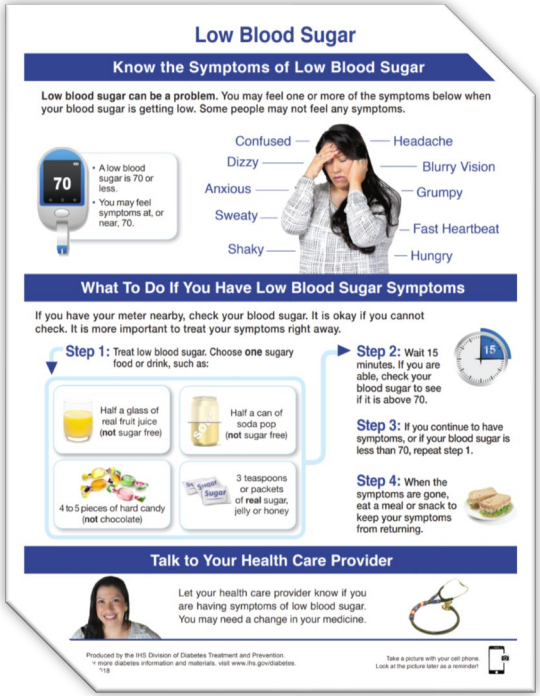
Examples of Addressing SDOH for Kidney Disease

- Dialysis centers and registered dieticians partnered with local food programs to develop renal menus.
- A transport services provider partnered with dialysis centers to improve access to affordable transport for dialysis patients.
- Care navigators contacted patients and worked with them directly to understand their condition, treatment plan, and address barriers to treatment e.g., childcare, transportation.
- Indian Health Service cut the rate of kidney failure by 50% by improving diabetes control, developing routine laboratory monitoring, developing culturally relevant patient education materials and EHR-based population health management tools.



Belmonte, K. Social Care and Medical Care Become Kidney Care, September 21, 2020. https://fmcna.com/insights/amr/2020/ckd-social-healthcare-outcomes/
Healthmap. Health Equity and Kidney Disease Management, August 25, 2022. https://news.healthmapsolutions.com/blog/health-equity-and-kidney-disease-management

Providing Culturally and Linguistically Appropriate Services (CLAS)

- Culturally and linguistically appropriate services ensure that the services you and your organization provide are ***respectful*** and ***responsive*** to each patient's culture and communication needs. They factor in cultural health beliefs, preferred language, health literacy, and communication needs.

- Culture plays an important role in health beliefs, behaviors, and practices as well as communication styles and treatment adherence. Language is central to communication, which is essential to patient care and safety.

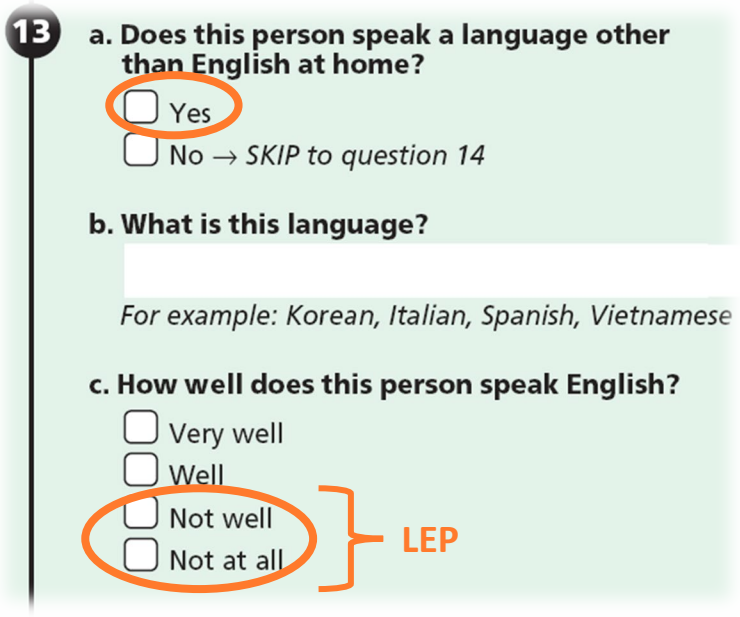
- Cultural competence can lead to improved patient communication, patient safety, fewer healthcare disparities, and decreased costs.

U.S. Department of Health and Human Services Office of Minority Health, National CLAS Standards, https://thinkculturalhealth.hhs.gov/clas

What Is Limited English Proficiency (LEP)?

The U.S. Census Bureau characterizes people with limited English proficiency as the population 5 years or older who self-identify as speaking English less than "very well."

This is similar to HHS's Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language and Disability Status.



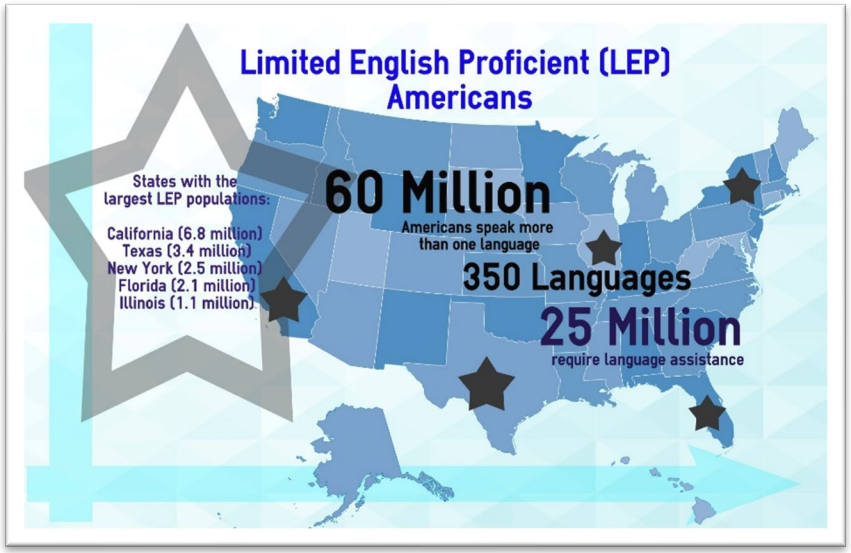
U.S. Census Bureau, Frequently Asked Questions (FAQs) About Language Use, https://www.census.gov/topics/population/language-use/about/faqs.html
HHS Office of the Assistant Secretary for Planning and Evaluation, HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status, https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0#III

Why Focus on LEP Patients?

Approximately 20 percent of the U.S. population, speak a language other than English at home. The number has nearly tripled since 1980, and more than doubled since 1990.

More than 25 million, or 9 percent of the U.S. population, are defined as limited English proficient. This number is expected to increase to 67 million by 2050.

Title VI of the Civil Rights Act of 1964 requires that health care providers receiving federal funds implement guidance on providing ***competent*** interpreter services when needed.



Migration Policy Institute, The Limited English Proficient Population in the United States in 2013, https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states-2013
Center for Immigration Studies, 67.3 Million in the United States Spoke a Foreign Language at Home in 2018, https://cis.org/Report/673-Million-United-States-Spoke-Foreign-Language-Home-2018
AMA Journal of Ethics, Language-Based Inequity in Health Care: Who Is the "Poor Historian"?, https://journalofethics.ama-assn.org/article/language-based-inequity-health-care-who-poor-historian/2017-03
White House, Marking 15 Years of Improving Federal Access to the Limited English Proficient, December 18, 2015 https://obamawhitehouse.archives.gov/blog/2015/12/18/marking-15-years-improving-federal-access-limited-english-proficient

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Some of the Disparities in Care Faced by LEP patients

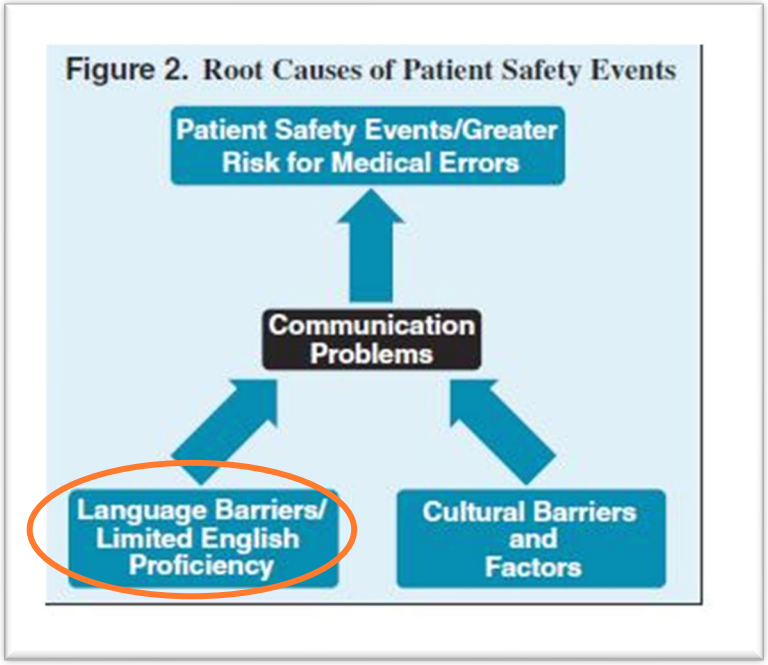
- 30 percent higher readmission rates
- 4.3-day longer hospitalizations
- 30 percent longer emergency department visits
- Greater risk of surgical infections, falls, and pressure ulcers.
- Greater risk of surgical delays due to difficulty understanding instructions, including how to prepare for a procedure.
- Difficulty understanding how to manage their conditions and take their medications, as well as which symptoms should prompt a return to care or when to follow up.

These disparities have been further exacerbated by the COVID-19 pandemic.

The Joint Commission, Quick Safety 13: Overcoming the challenges of providing care to limited English proficient patients, October 2021, https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-13-overcoming-the-challenges-of-providing-care-to-lep-patients/overcoming-the-challenges-of-providing-care-to-lep-patients/#.Y01VDHbMLEY
Agency for Healthcare Quality and Research, Improving Patient Safety Systems for Patients With Limited English Proficiency, https://www.ahrq.gov/health-literacy/professional-training/lepguide/chapter1.html
United Hospital Fund, Language Access Equity: A Roadmap for Improving Care for Language-Minority Patients, January 25, 2022, https://uhfnyc.org/publications/publication/language-access-equity/

Common Causes of Adverse Events for LEP patients

- Use of family members, friends, or nonqualified staff as interpreters.
- Use of basic language skills by providers to “get by”
- Cultural beliefs and traditions that influence patient care e.g., pain reporting



The Joint Commission, Quick Safety 13: Overcoming the challenges of providing care to limited English proficient patients, October 2021, https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety--issue-13-overcoming-the-challenges-of-providing-care-to-lep-patients/overcoming-the-challenges-of-providing-care-to-lep-patients/#.Y01VDHbMLEY
Agency for Healthcare Quality and Research, Improving Patient Safety Systems for Patients With Limited English Proficiency, https://www.ahrq.gov/health-literacy/professional-training/lepguide/chapter1.html

Conducting a Needs Assessment

- Collect Race, Ethnicity, and Language (REaL) data to understand the population with LEP needs.
- Ensure there is linguistically accessible and appropriate services at every point of access for a patient e.g., call center, security, reception, exam room, website, written materials – discharge plan, educational packets
- Obtain feedback from stakeholders and community-based organizations and surveys of individuals with LEP as well as specific cultural considerations to better serve the communities' needs

CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf

Improving Access to Services

- Ensure access to program services and post notices in visible areas. Examples to help individuals with LEP identify their languages include:
  - “I speak” cards
  - Preferred sign language cards
  - Patient notices in a variety of languages
  - Taglines for language assistance

CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf

Providing Appropriate Language Services

- Provide interpretation services – consider qualifications interpreters may need e.g., knowledge of medical terminology
- Provide translated materials – consider what documents are vital e.g., consent forms, patient rights and responsibilities, discharge forms
- Develop policies around translation – consider working with communities to ensure translations are culturally relevant

CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf
Dialysis Patient Citizens Education Center, ESRD Teen Booklets Are Now Available in Spanish, https://www.dpcedcenter.org/news-events/news/esrd-teen-booklets-are-now-available-in-spanish/

Training on Language Assistance and Culture

- Provide training to all staff on language assistance for individuals with LEP, including receptionists, clinicians, security guards
  - Why this is important
  - How to effectively and respectfully communicate
  - Where to find resources e.g., list of translation and interpreter services, bilingual staff
  - How to capture preferred language e.g., upon registration, in EHR
  - What are procedures on working with interpreters
- Provide training to all staff on specific cultural considerations based on the communities and patients being served

CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf

Evaluating Services Being Provided

- Assess and monitor the plan for providing appropriate language and culturally competent services
  - Review complaints or suggestions from the community, employees, patients
  - Understand local demographics by partnering with community-based organizations, local health departments, faith-based communities, schools
  - Review utilization of language access services
  - Survey staff and patients about whether language access services meet their needs
  - Explore use of technology and other tools to improve access for individuals with LEP
  - Ask the communities for feedback on culturally specific considerations

CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan-508.pdf

Summary

- Disparities exist in chronic kidney disease care and treatment
- Focus on social determinants of health is important because of how social needs can impact health outcomes
  - Train staff on disparities and the impact of SDOH
  - Screen for social needs
  - Close the referral loop on social needs
- Provide cultural and linguistic appropriate care because there is a link to patient safety and health outcomes
  - Conduct a needs assessment
  - Improve access to services
  - Provide appropriate language services
  - Train on language assistance and culture
  - Evaluate language services

General Health Equity Related Resources

AMA - Racial and Health Equity: Concrete STEPS for Health Systems

AHRQ - Improving Patient Safety Systems for Patients With Limited English Proficiency

CMS/OMH - Guide to Developing a Language Access Plan

HHS/OASH - Social Determinants of Health

IHI - Achieving Health Equity: A Guide for Health Care Organizations

OMH - Resources on Culturally and Linguistic Services

The Joint Commission - Overcoming Challenges of Providing Care to Limited English Proficient Patients

TRAIN Learning Network - Effective Communication For Healthcare Teams: Addressing Health Literacy, Limited English Proficiency and Cultural Differences (Online training course with CE)

Q&A

Thank you!

Thank You

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