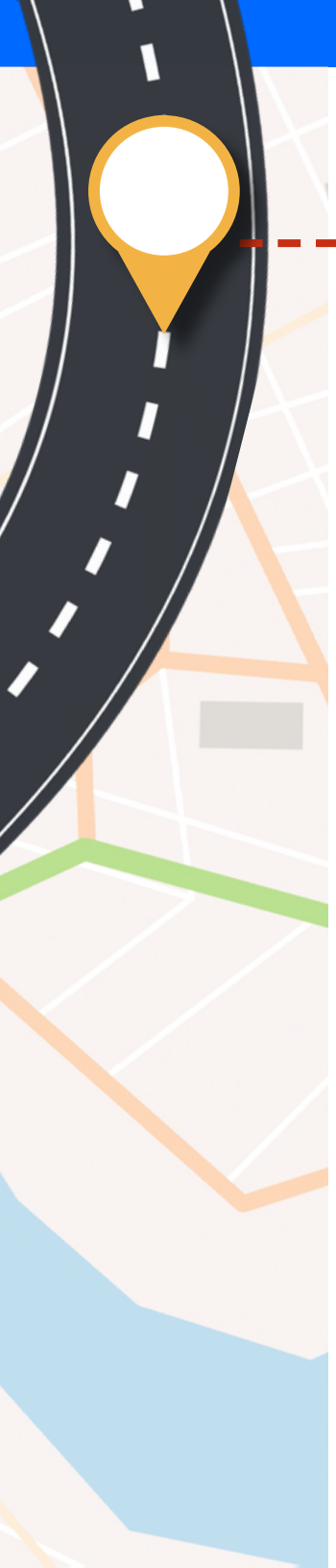
Roadmap to Health Equity Self-Assessment



Purpose

The purpose of this roadmap is to support dialysis facilities and End-Stage 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 disinvested 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.

Instructions:
Step 1: Read through each section and rate yourself based on how well you feel you are currently doing in each of these areas.

Step 2: Once all sections are ranked, choose the area(s) (rated with a 1 or 2) where you feel you can make the most improvement in a short amount of time.

Step 3: Send the Network the area that you have chosen to focus on for this project. The Network will then send you specific action steps from the change package to implement in your clinic during this project.

NOTE: This is meant to assist if you are having difficultly deciding on and coming up with specific action steps. If you are already implementing something different at your clinic, please let the Network know what your action steps are.

Create an Environment of Trust With Patients

Circle your rating for each statement.

1= Don't currently do this **2**= Needs work, could be doing more in this area **3**= Confident, already doing this

1 2 3 **1a:** Develop relationships with patients.

1 2 3 **1b:** Connect through the culture of the patient.

Determine Patients' Health-Related Social Needs

1 2 3 **2a:** Conduct psychosocial needs assessments.

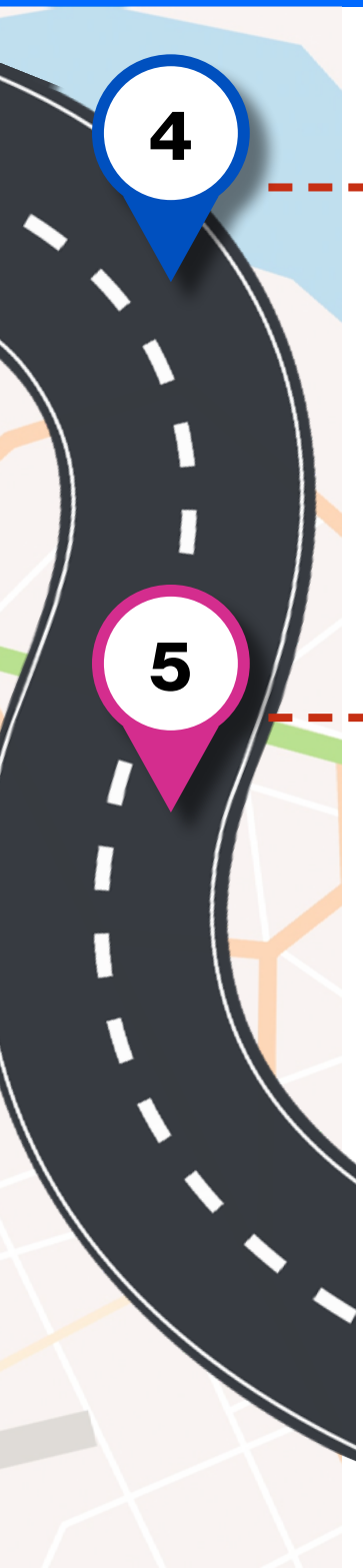
1 2 3 **2b:** Gather information through interactions with patients.

1 2 3 **2c:** Observe for signs that could indicate health-related social needs.

Use a Team Approach to Identify and Resolve Health-Related Social Needs

1 2 3 **3a:** Engage the whole team.

1 2 3 **3b:** Communicate and collaborate on issues, solutions, and progress.



Maximize All Available Resources

Circle your rating for each statement.

1= Don't currently do this **2**= Needs work, could be doing more in this area **3**= Confident, already doing this

1 2 3 **4a:** Identify resources.

1 2 3 **4b:** Link patients to resources and provide support.

Educate Patients and Staff

1 2 3 **5a:** Design patient education around health-related social needs.

1 2 3 **5b:** Train staff on diversity and health-related social needs assessment and resolution.

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Additional Resources

ESRD NCC A Change Package to Improve Health Equity

1. CMS Framework for Health Equity 2022–2023
2. U.S. Department of Health and Human Services. Advancing American Kidney Health
3. Kind AJ, Buckingham WR. Making Neighborhood-Disadvantage Metrics Accessible—The Neighborhood Atlas. The New England Journal of Medicine. 2018; 378(26): 2456.
4. Institute for Healthcare Improvement. QI Essential Toolkit [ebook]. 2017; 7–8.
5. Home Dialysis Central. Medical Education Institute, Inc. Method to Assess Treatment Choices for Home Dialysis (MATCH-D).
6. CMS Program of All-Inclusive Care for the Elderly (PACE).
7. U.S. Department of Health and Human Services, Office of Minority Health. National Culturally and Linguistically Appropriate Services Standards.

This material was prepared by Qsource, an End-Stage Renal Disease (ESRD) Network under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 24.ESRD.11.199

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