

Health Equity Community of Practice (CoP) Call

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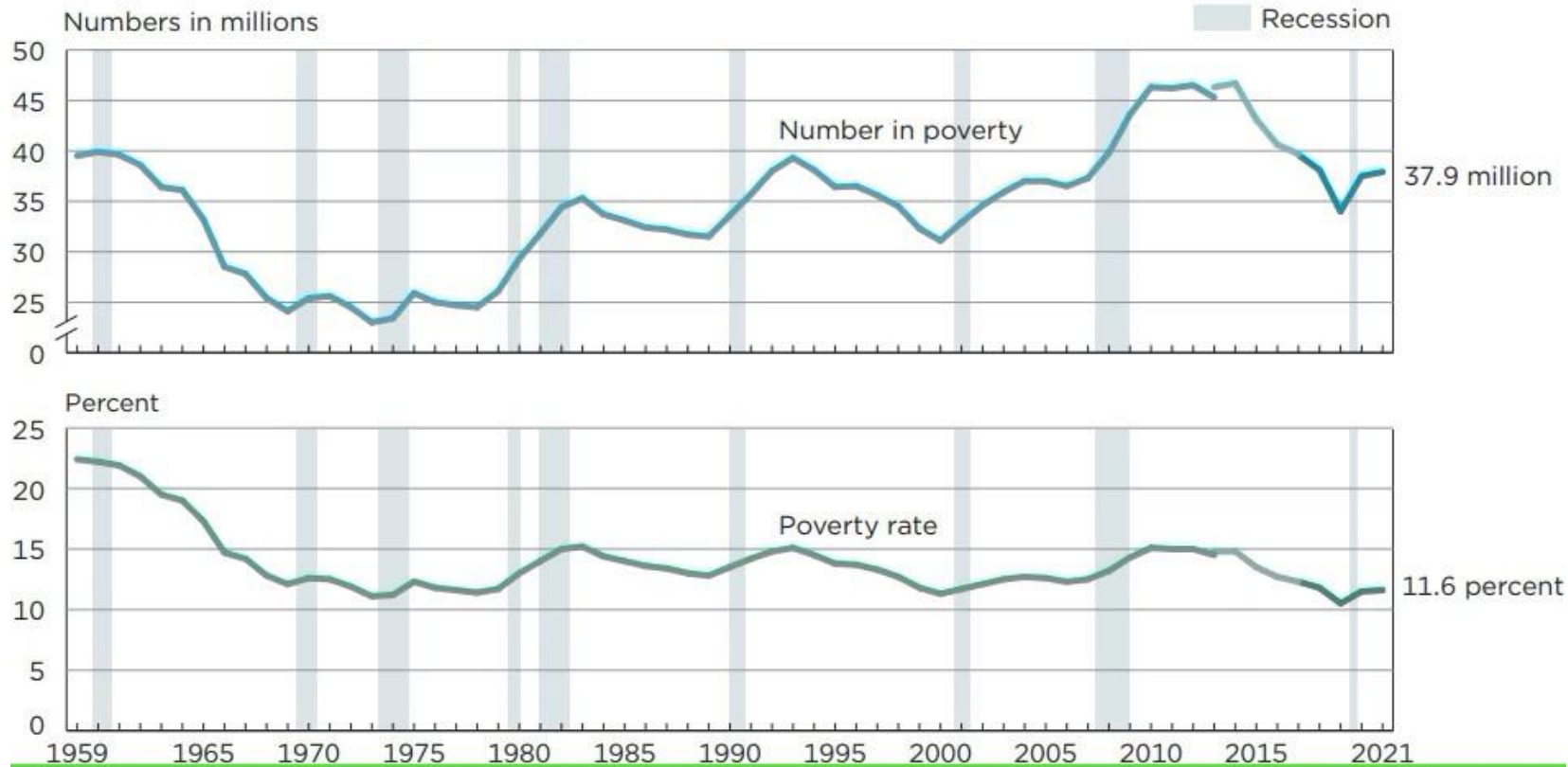


CoP Call Goals

- Engage Networks in ESRD Network program sharing and learning
- Ensure a data-driven approach to improvement (qualitative and quantitative)
- Identify intervention(s) and best practice(s) implemented in the Network service area
- Explain how the intervention was identified and implemented
- Discuss what tracking/monitoring is taking place
- Demonstrate PDSA cycles for continuous improvement
- Report outcomes
- Include coalition engagement, feedback, and outcomes

January was the National Poverty Awareness Month

Figure 1.
Number in Poverty and Poverty Rate Using the Official Poverty Measure: 1959 to 2021

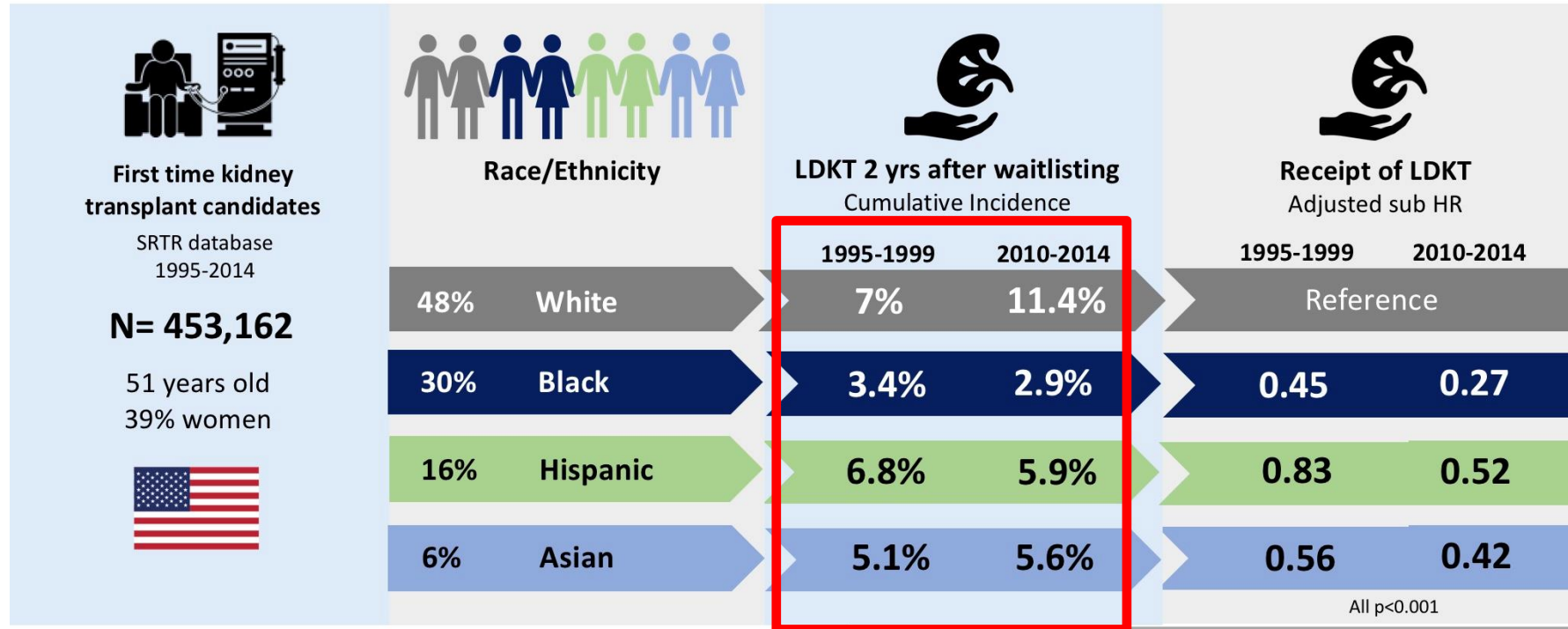


- The official poverty rate in 2021 was 11.6 percent, with 37.9 million people in poverty.
- Neither the rate nor the number in poverty was significantly different from 2020.

Source: US Census Bureau

National Donor Day is on February 14

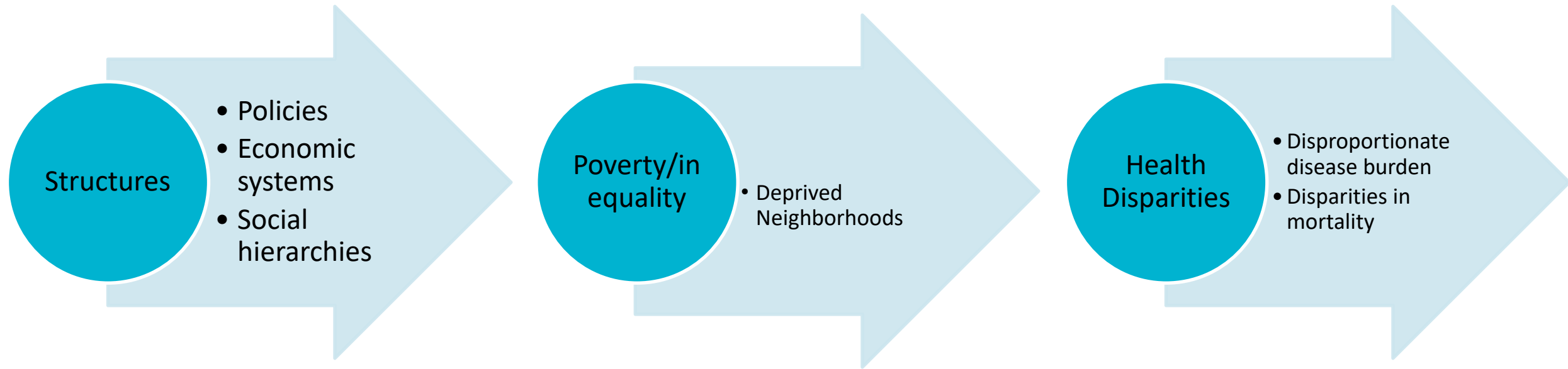
Have Racial and Ethnic Disparities With Live Donor Kidney Transplantation (LDKT) Changed From 1995 to 2014?



Purnell TS, Luo X, Cooper LA, Massie AB, Kucirka LM, Henderson ML, Gordon EJ, Crews DC, Boulware E, Segev DL. JAMA 2018; 319 (1) 49-61 doi:10.1001/jama.2017.19152

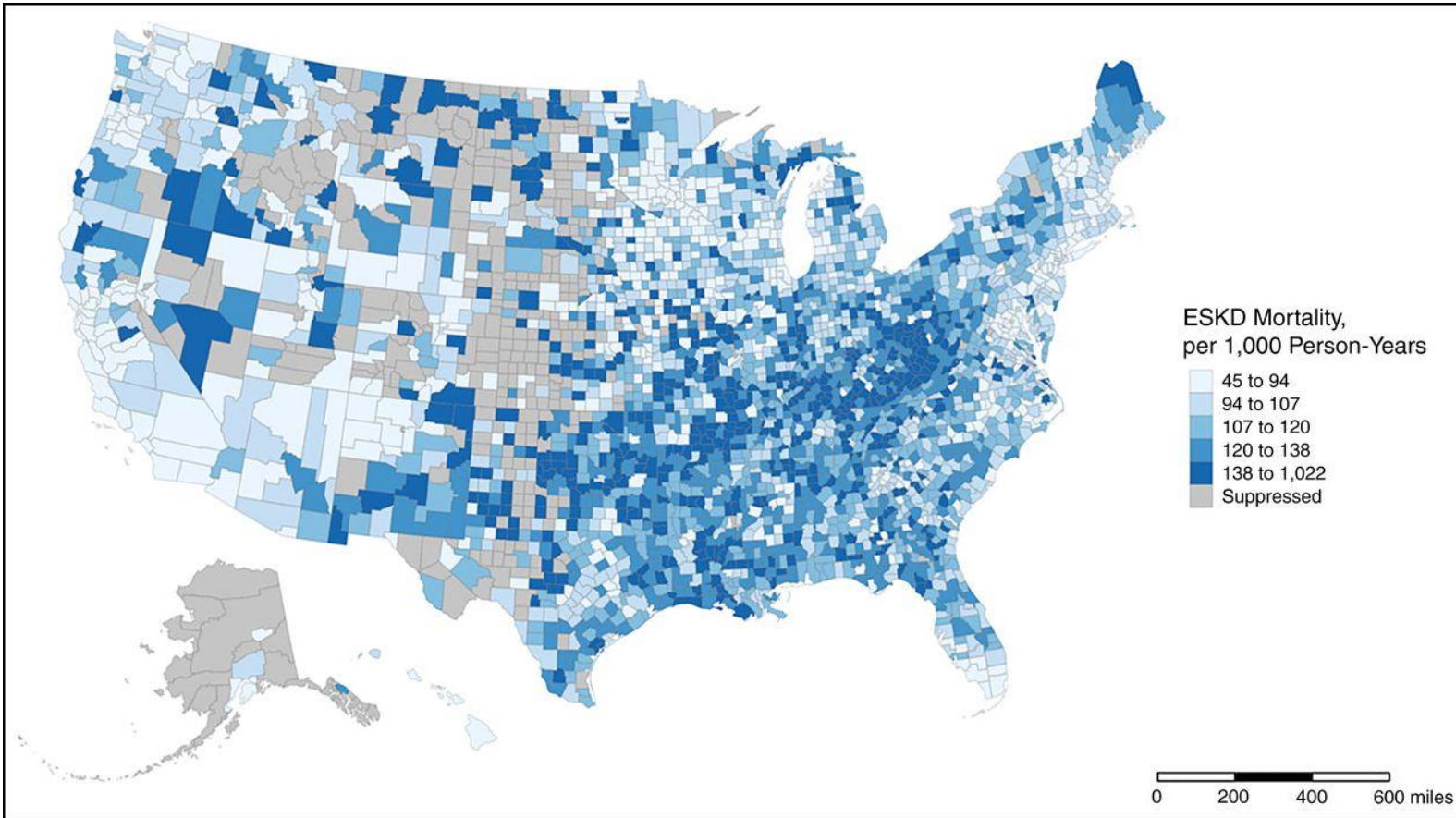
CONCLUSION: Racial and ethnic disparities in the receipt of a live donor kidney transplant have increased from 1995-1999 to 2010-2014 in the United States.

Structural Vulnerabilities and Health Disparities



Structural vulnerability is not caused by, nor can it be repaired solely by individual agency or behaviors.

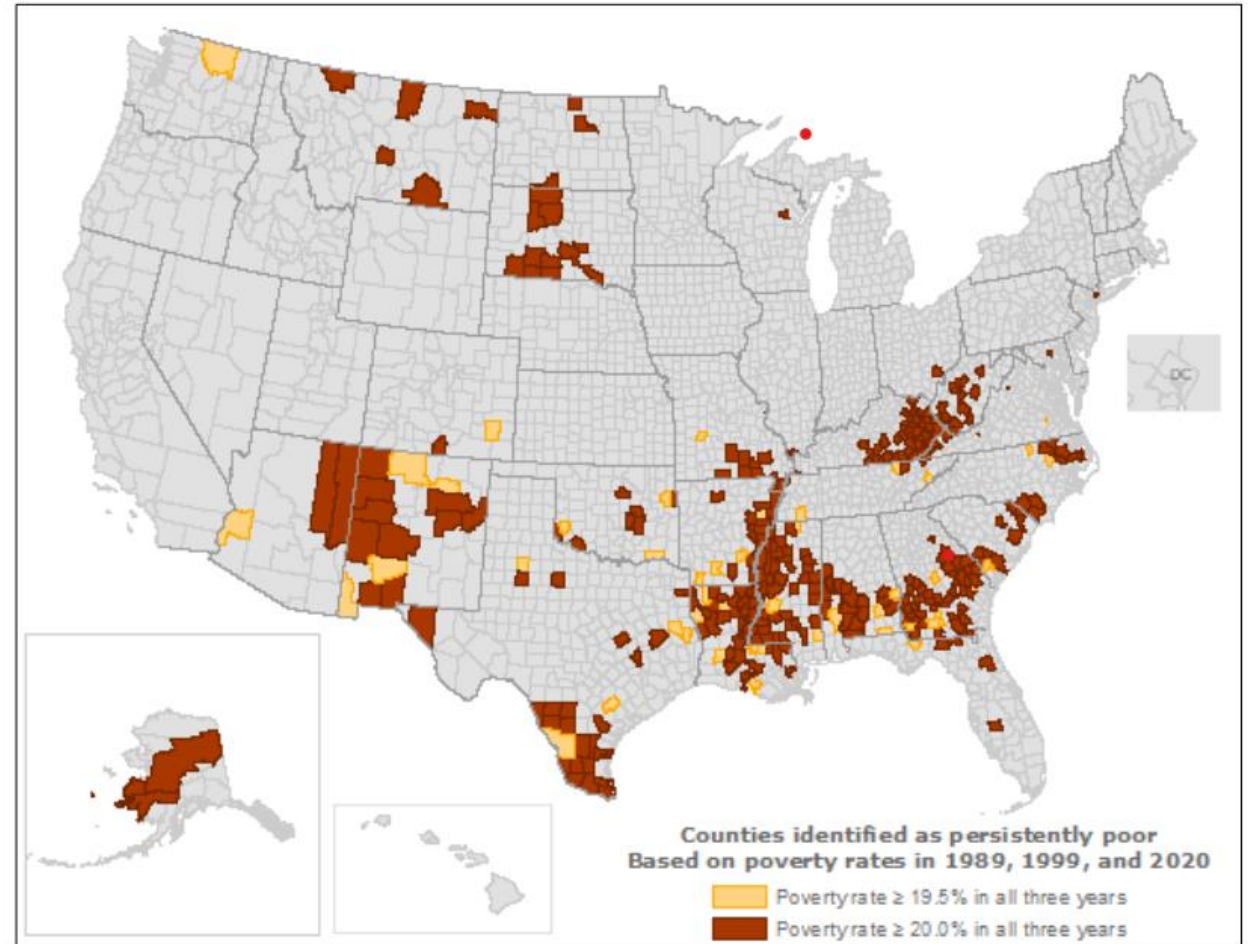
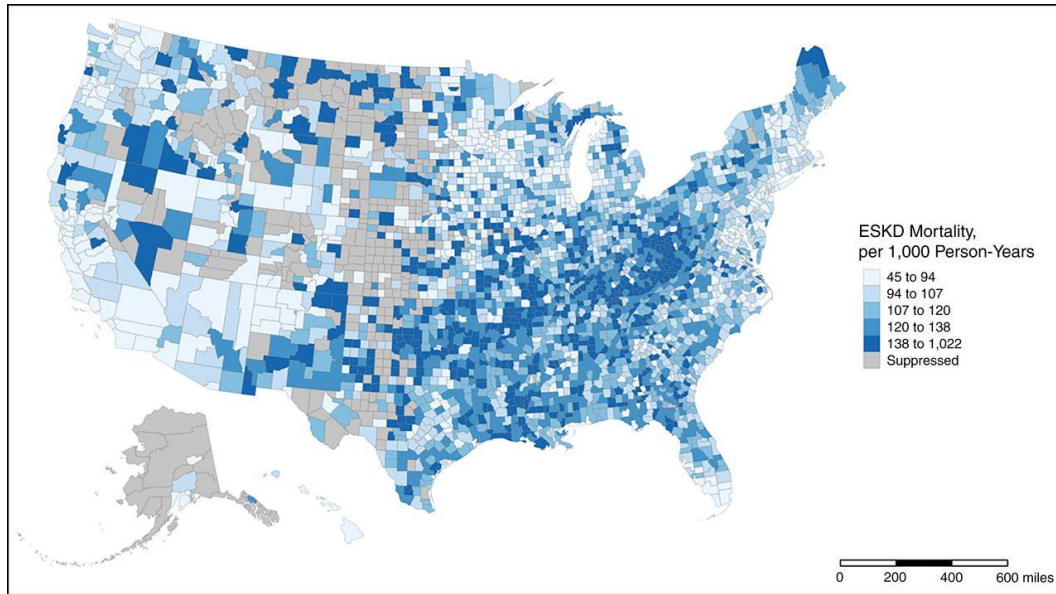
Age-standardized ESRD mortality rates across 2781 counties in the United States, 2010–2018



- 18.9% variations in ESRD mortality rate attributed to county-level characteristics
- Counties with the highest adjusted mortality: Tennessee valley and Appalachia regions

Kylie K. Snow et al. Kidney360 2022;3:891-899

ESRD county mortality vs. persistent poverty counties



Persistent Poverty Counties Based on US Census Bureau 1990, 2000, 2020

The impact of social disadvantages in ESRD community

- Neighborhood deprivation was associated with ...
 - higher rates of CKD
 - Lower rates of kidney transplant
 - Patients of color have lower rates of transplant at every level of poverty (Hall et al.)
 - Higher mortality rates and increased time to transplant (Rodriguez et al.)

Census Variables in the Area Deprivation Index



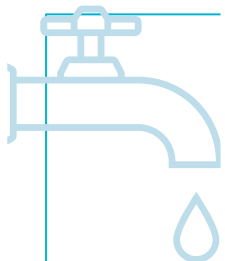
Education

- % pop aged ≥ 25 with < 9 years education



Income/employment

- Income disparity
- % families $<$ federal poverty level
- % pop aged ≥ 16 unemployed



Housing

- % occupied housing without complete plumbing

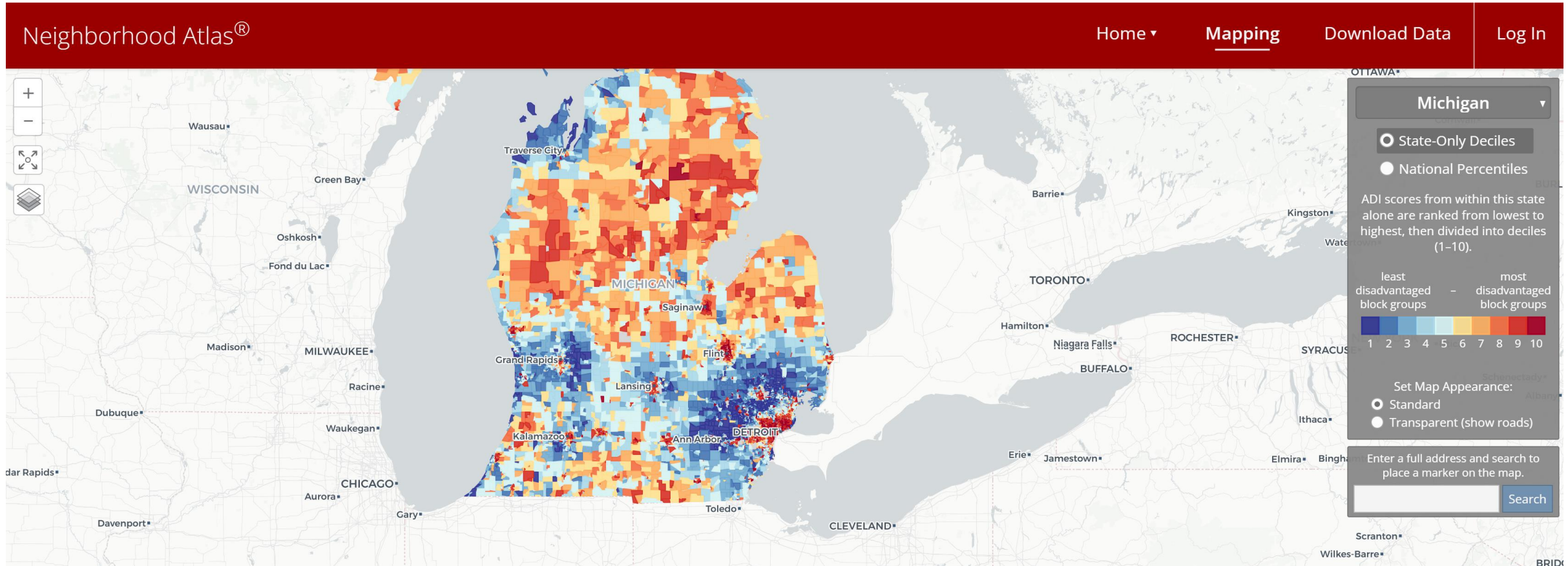


Housing characteristics

- % Household without a motor vehicle
- % Household without a phone

Area deprivation index (ADI) is a composite measure of neighborhood socioeconomic disadvantage that uses 17 census measures capturing education, employment, income, poverty, and housing characteristics

State Decile Rank Area Deprivation Index



A state score of 10 indicates that the census block group is in the top 10% of all block groups in the state in terms of disadvantage.

Meeting Patients' Social Needs to Reduce Health Disparities

Sharonda Riggs, Julia Namou, Caitlin Cunningham

DaVita Grosse Pointe Dialysis

Detroit, MI

Practices to Meet the Needs of Patients

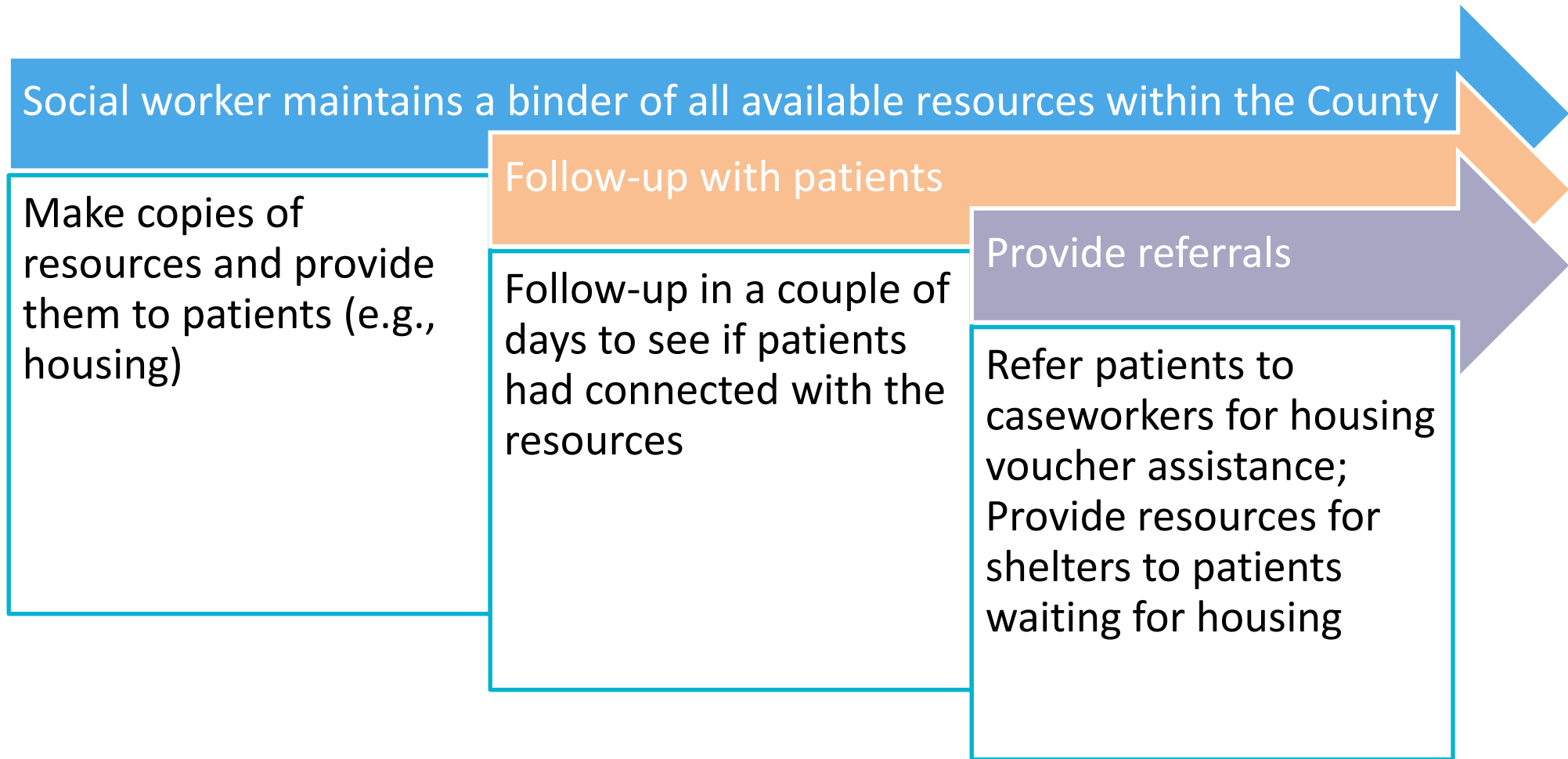
Addressing housing instability

Resolving transportation issues

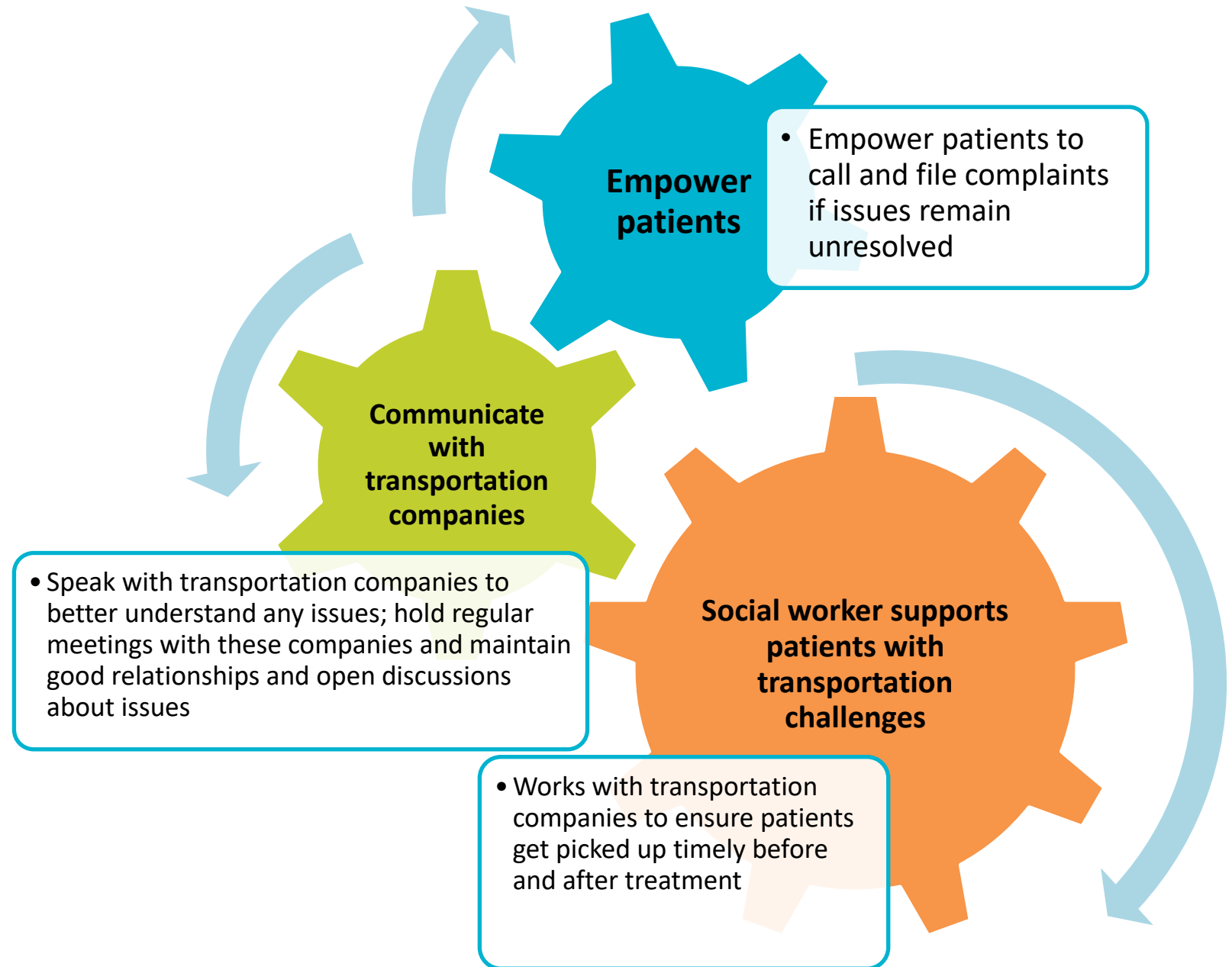
Utilizing other community-based resources

Communicating with patients

Housing Instability – Connecting Patients with Community-Based Resources



Addressing Transportation Challenges



Community-based Resources

- PACE organizations – Program of All-Inclusive Care for the Elderly
 - Nationwide healthcare program that combines medical and social support for those 55 years and older
 - [List of state websites for additional state information on PACE](#)



Best Practices for Communicating with Patients

Build rapport

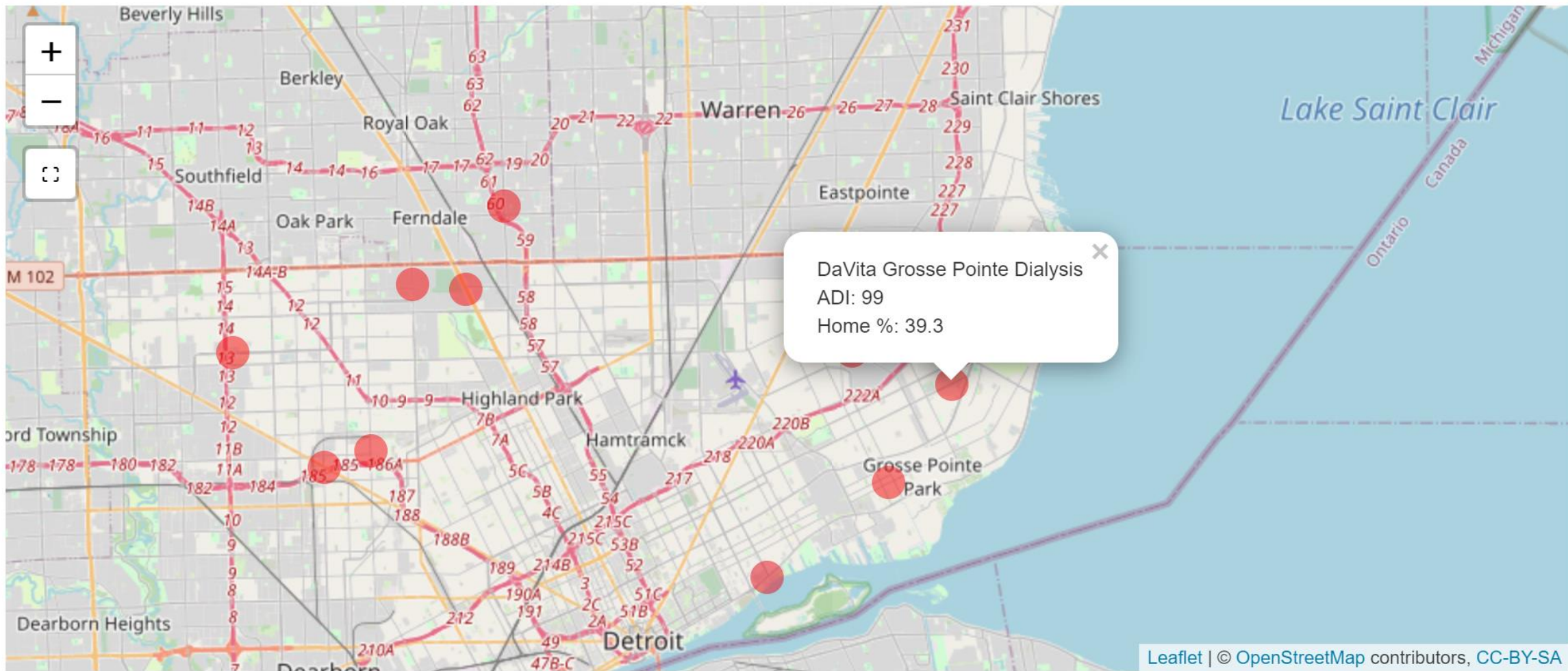
- Pull up a chair and sit with patients.
- Sit down with the patient and dive deeper with them 1:1, really get to know what is going on. It might take a little bit of time and rapport-building before you get to that.

Don't overwhelm

- Let patients settle in and not just overwhelm them with too much information.
- Pace the education.

Gauge reaction

- Be conscious of how the patient is reacting to the education
- Do they seem overwhelmed? Does it seem like a good time to introduce new information into the conversation?



Question and Answer Discussion

What are some community-based resources, state-based, or national programs that offer social services that you have referred patients to?

What are some strategies to improve referrals for social services?

What tools/tips have been helpful to support patients experiencing food insecurity, or housing instability?

Thank You