



End-Stage Renal Disease
Network Program

Depression and Health Equity Best Practice Webinar

March 2023



Today's Agenda

- Review meeting reminders
- Depression interventions and best practices
- Patient and family engagement interventions and best practices
- Health Equity
- Health Equity Guest Speaker: Decreasing Health Barriers to Transplant
- Closing remarks

Meeting Reminders

- Please mute your line when not speaking to avoid background noise
- Be present and engaged
- Participants are encouraged to utilize chat to ask questions and make comments using “all participants”
- All meeting materials are available via IPRO Learn or the Network Program Website



Depression CMS Goals and Network Interventions

Michelle Prager, MSW, LSW

Depression Report Cards



- This report is sent to:

Facility Data EQRS Contact

Facility Medical Director

Regional/Divisional Vice President

Regional Quality Manager

Regional Director of Operations

Facility Social Worker

Reporting Depression Screenings in EQRS Report

**Brand
New
Report!**



CCN # Facility

Name	Email	Facility Data EQRS Contact
		Facility Medical Director
		Regional/Divisional Vice President
		Regional Quality Manager
		Regional Director of Operations
		Facility Social Worker
		Regional/Divisional Vice President

CMS requires dialysis facilities to have a Patient Depression Screening Rate of 80% or higher. This performance scorecard outlines where your facility currently stands. The patient UPIs listed below have not yet received a depression screening according to EQRS.

Review the list for accuracy and complete any missing Depression Screening to stay in compliance with the CMS standard.

You may reference the Entering Patient Clinical Depression Assessment in EQRS tool on our knowledge portal to assist with

[Entering Patient Clinical Depression Assessment in EQRS](#)

Additional education tools are available on our website:

www.esrd.ipro.org



- CMS requirement for Depression screening is 80% or higher

Report As Of Date	# of Pts Screening Reported	# of Pts Screening Eligible	% Screening Reported Rate
12/5/2022	54	72	75.00%
0	Option 1	Number of depressions screenings with Screening for clinical depression is documented as being positive, and a follow-up plan is documented selected	
0	Option 2	Number of depressions screenings with Screening for clinical depression is documented as being positive, and a follow-up plan is not documented, and the facility possess documentation stating the patient is not eligible selected	
1	Option 3	Number of depressions screenings with Screening for clinical depression is documented as being positive, the facility possesses no documentation of a follow-up plan, and no reason is given selected	
53	Option 4	Number of depressions screenings with Screening for clinical depression is documented as being negative, and a follow-up plan is not required selected	
0	Option 5	Number of depressions screenings with Screening for clinical depression is not documented, but the facility possesses documentation stating the patient is not eligible selected	
0	Option 6	Number of depressions screenings with Clinical depression screening not documented, and no reason is given selected	

See UPIs on Next Page of this Report!



Resources Listed on the Report Card

- Reference “Entering Patient Clinical Depression Assessment in EQRS Tool”
- Additional tools on the website

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Six Conditions in EQRS

- Number of patients screened reported
- Number of patients screening eligible
- Percentage of Screening Reported
- Six Conditions in EQRS with number of patients for each category

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The Six Conditions in EQRS

1. Screening for clinical depression is documented as being “**positive**,” and a **follow-up plan** is documented
2. Screening for clinical depression documented as “**positive**,” and a **follow-up plan not documented**, and the facility possess documentation stating the patient is **not eligible**
3. Screening for clinical depression documented as “**positive**,” the facility possesses no documentation of a **follow-up** plan, and no reason is given
4. Screening for clinical depression is documented as “**negative**,” and a **follow-up plan is not required**
5. Screening for clinical depression **not documented**, but the facility possesses documentation stating the patient is **not eligible**
6. Clinical depression screening **not documented**, and no reason is given



Definitions to Know

Positive and Negative

Positive screening -

- Based on the scoring and interpretation of the specific standardized tool used, and through discussion during the patient visit, the provider should determine if the patient is deemed positive for signs of depression

Negative screening -

- Based on the scoring and interpretation of the specific standardized tool used, and through discussion during the patient visit, the provider should determine if the patient is deemed negative for signs of depression

Definitions to Know



Follow-Up Plans

~ A documented outline of care for a positive depression screening

A follow-up plan has at least one of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Definitions to Know

Patients Who are Not Eligible



Not eligible for follow-up –

- A patient may not be eligible for follow-up plan, or it may not be appropriate for a patient to undergo treatment or therapy for depression because such treatments are medically contraindicated

Not eligible for screening – A patient is not eligible for depression screening if one or more of the following reasons are documented in the patient's medical record:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g., certain court-appointed cases; cases of delirium)
- Patient has an active diagnosis of depression
- Patient has a diagnosed bipolar disorder



Barriers Related to Treatment

- Lack of knowledge
- Fear
- Accessibility
- Stigma





How Can Your PFR Help?

- Ask your PFR to assist you in distributing patient education materials
- Ask your PFR to help develop a bulletin board to educate patients
- Invite your PFR to participate in a lobby days
- Invite your PFR to QAPI meetings to report on progress of their work

Increasing Patient and Family Engagement at the Facility Level



Sherrie Shivley
Patient at US Renal Care North Haven

Patient Newsletter

THIS IS USRC A PATIENT NEWSLETTER

Volume 1 / Issue 1

PATIENT REPRESENTATIVE

Hi, my name is Sherrie, I am a 62 year old widow I live in Hamden, CT. I am a college student pursuing an Associate's Degree in Paralegal Studies.

I began dialysis in January of 2020. I was asked to be your Patient Facility Representative. That means that I am here to help you on your journey in any way that I can. Please feel free to reach out to me.

I can be reached by phone at 475-219-0778 or by email at gsservant@gmail.com.



Sherrie Shively, Patient Representative

REDUCING HOSPITALIZATIONS

IPRO End Stage Renal Disease Network has the Facts: On average, a dialysis patient dialyzes three times a week for 4 hours each treatment. This treatment replaces the work that your kidneys perform 24 hours per day, seven days a week. Missing minutes of dialysis decreases the improved health benefits (outcomes) seen with dialysis and increases the likelihood of complications and hospitalizations.

WHAT WILL HAPPEN TO MY BODY IF I MISS TREATMENT?

- Feeling weak, tired, and getting short of breath
- Losing your appetite and feeling nauseated
- Swelling in your ankles, stomach or other areas
- Taste of ammonia in your mouth
- Prolonged bleeding after dialysis

WHAT HAPPENS TO PATIENTS WHO SHORTEN OR MISS THREE OR MORE TREATMENTS A MONTH

- Higher risk of hospitalization
- May develop serious life threatening complications
- Could be delayed getting wait-listed or removed from transplant list
- A greater chance of infection
- Fluid may accumulate around the heart, causing the heart to swell

Missing 1 treatment per month=12 treatments per year=missing an entire month of treatment per year.

Shortening each treatment 1 hour=144 hours of dialysis a year=36 missed treatments per year.

The effects on your health with less dialysis may not show up right away. You may not notice the extra fluid building up in your body but it will make your heart pump harder which can cause it to swell and wear out your heart.

For more information visit esrd.ipro.org



HOW CAN I MAKE DIALYSIS MORE ENJOYABLE AND COMPLETE MY REQUIRED TREATMENT?

- Cards
- Hobbies such as adult coloring books, crochet, word puzzles, reading
- Play games on your phone, talk to family/friends, watch television
- Journaling

We're Not Being Nosy. We Care!

In order to provide the best care, we may ask you certain questions. Alert your care team if:

- You have been in the hospital
- You have been in the E.R. or any Urgent Care Center
- You started a new medication
- You stopped a medication
- You experienced and bleeding for any longer than 10 minutes (anywhere)
- You have any new access pain, changes, or problems.

Preventing Falls

- Wear comfortable, well-fitted, flat-soled shoes that have gripping soles and are secured to your feet.
- Use handrails in restrooms and stairways.
- Stand up and sit down slowly when your blood pressure is being checked before and after your dialysis treatment.
- If you drop something, ask for assistance to pick it up,
- Let your nurse and/or family know if you are feeling dizzy, weak or lightheaded.
- Use a walker, cane or wheelchair as needed.
- Make sure you have enough light when walking. Your balance is affected in the dark.
- Have your vision tested. Wear glasses if prescribed. Keep them clean and keep your prescription updated.

This is USRC Care. We care about you!



Patient Newsletter



THIS IS USRC A PATIENT NEWSLETTER

Treating Depression When You're on Dialysis

PATIENT REPRESENTATIVE

Hi, my name is Ralph, I am the Patient Facility Representative for the Orange clinic. I was in the police force for 30 years and trained by the FBI. I ran the suicide hot line. I have experienced depression first hand within my own personal life when my father died. When I started dialysis my life changed, but I didn't let it change me. I thought of dialysis as a part time job that was keeping me alive. My deep spirituality also helps me to cope with whatever is thrown at me in life. I am also grateful for my family. Find whatever helps you to cope, and if you are struggling help is available.

My advice to anyone on dialysis is to recognize some of the signs of depression which may include sadness, loss of interest/pleasure in activities, issues with sleep, hopelessness, weight gain/loss, crying, and thoughts of self-harm. If you experience these signs/symptoms a social worker is available at the dialysis center to help. I am an advocate for therapy and I believe help is available you just need to ask for it.



COPING, LIVING, AND THRIVING WITH KIDNEY DISEASE:

Being diagnosed with kidney disease can leave you feeling overwhelmed and with more questions than answers. There are a lot of emotions and actions to think through.

IPRO NETWORK WANTS TO ASSIST PATIENTS WITH THE FOLLOWING PHASES:

ACKNOWLEDGE: Identify who is a part of your social support team. Recognize any negative feelings you may be having, so you and your team can overcome these negative feelings and build a more positive response.

ADDRESS: Identify short-term and long-term goals to begin problem solving.

RE-ASSESS: Determine what role each member of your team can have in helping you take charge of your health.

RE-PROGRAM: Revise your thinking and approach to your kidney disease

CONCLUSION

Remember, you are not alone. One in seven U.S. adults has some form of chronic kidney disease, so chances are, you may already know one or more people in a very similar situation.

For more information visit esrd.ipro.org

Facility Bulletin Boards



DEPRESSION

WHEN YOU'RE ON DIALYSIS

Depression is common in people who are on dialysis. Depression worsens your quality of life, makes you feel tired, and can affect your kidney health as well as your overall well-being.

NAVIGATING a mental health CRISIS

WARNING SIGNS of a Mental Health Crisis

- Thoughts come daily, rather than infrequently
- Thoughts are persistent
- Thoughts are **changed in kind**
- Thoughts are **intrusive** and not wanted
- Thoughts are **distressing** and not helpful
- Thoughts are **harmful**
- Thoughts are **persistent** and not helpful
- Thoughts are **harmful**

Symptoms

- Loss of interest and activities
- Sleep Disturbance
- Loss of Energy

Treatments

- Resting and Relaxing
- Social Interactions
- Balanced Diet

WHAT TO DO in a Mental Health Crisis

- If you are having thoughts of suicide or self-harm, call 911 or go to the nearest emergency room.
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Affirmation Cards



Stickers





Questions? Comments?



Health Equity CMS Goals and Network Interventions



Danielle Andrews, LMSW, MPH





What is Health Equity?

According to the World Health Organization (WHO) health inequalities are systematic differences in healthcare outcomes.

- Equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. **Health equity is achieved when everyone can attain their full potential for health and well-being.**
- **Health Inequities:** are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age.
 - Neighborhood and Physical Environments
 - Health and Healthcare
 - Income and Wealth Distribution
 - Education



Health Equity Barriers

- Unstable Housing
- Racism and Discriminatory Practices
- Lack of medical access
- Health Literacy
- Insufficient Insurance Policies
- Language Barriers
- Consistent Transportation
- Access to renal friendly foods
- Income Inequality



Initial Health Equity Interventions



Transportation:

- **Uber Health:** Uber Health is a HIPAA-compliant technology solution for healthcare organizations that leverages the ride hailing power of the Uber platform. The web-based dashboard allows hospitals and other healthcare professionals to request, manage, and pay for rides for others, at scale.

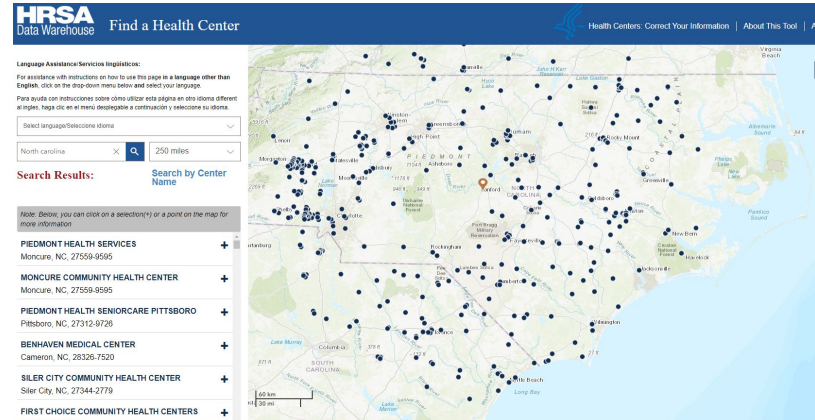
Telehealth:

- **Assurance Wireless Phone:** Assurance Wireless is a federal Lifeline Assistance program. Lifeline is a government assistance program. The Assurance Wireless offer provides eligible low-income customers free monthly data, unlimited texting, and free monthly minutes. Plus a free phone.
- **Affordable Connectivity Program:** The Affordable Connectivity Program is an FCC benefit program that helps ensure that households can afford the broadband they need for work, school, healthcare and more. The benefit provides a discount of up to \$30 per month toward internet service for eligible households and up to \$75 per month for households on qualifying Tribal lands. (Specific to Each Network)

Initial Health Equity Interventions

Healthcare Accessibility:

- **HRSA: Health Center Program** Health centers are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and veterans.
 - **[Find a Health Center Tool](#)**: locates All federally funded integrated health centers within a 250 miles radius (can be selected based on the patient's language preferences)



HRSA Data Warehouse Find a Health Center

Health Centers: Connect Your Information | About This Tool | A

Language Assistance/Services Implicaciones:
 For assistance with instructions on how to use this page in a language other than English, click on the drop-down menu below and select your language.
 Para ayuda con instrucciones sobre cómo utilizar esta página en otro idioma different al inglés, haga clic en el menú desplegable a continuación y seleccione su idioma.

Select language/Selecciona idioma

North Carolina 250 miles

Search Results: Search by Center Name

Note: Below, you can click on a selection(s) or a point on the map for more information

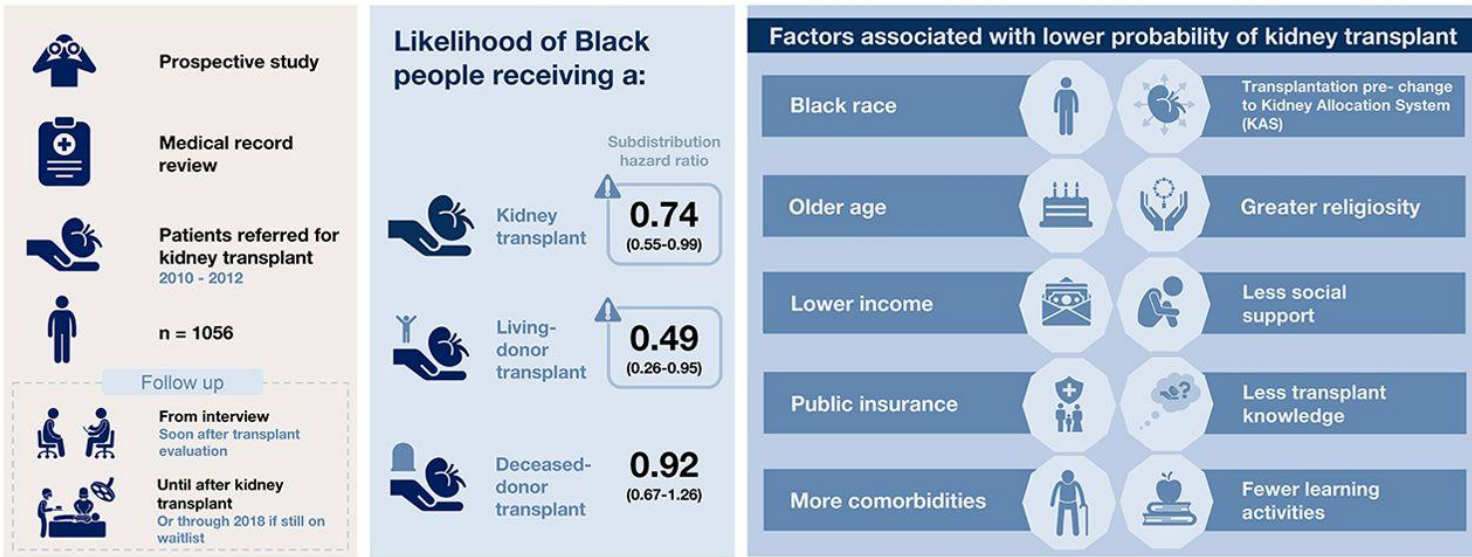
PIEDMONT HEALTH SERVICES Moncure, NC, 27559-9595	+
MONCLURE COMMUNITY HEALTH CENTER Moncure, NC, 27559-9595	+
PIEDMONT HEALTH SENIORCARE PITTSBORO Pittsboro, NC, 27312-9726	+
BENHAVEN MEDICAL CENTER Cameron, NC, 28520-7520	+
SILER CITY COMMUNITY HEALTH CENTER Siler City, NC, 27344-2779	+
FIRST CHOICE COMMUNITY HEALTH CENTERS	+



Health Equity and Transplant

Which demographic and social factors predict the likelihood of receiving a kidney transplant?

CJASN
Clinical Journal of the American Society of Nephrology



Conclusions Race and social determinants of health are associated with the likelihood of undergoing kidney transplant.

Hannah Wesselman, C. Graham Ford, Yuridia Leyva, et al. *Social Determinants of Health and Race Disparities in Kidney Transplant*. CJASN doi: 10.2215/CJN.04860420. Visual Abstract by Michelle Lim, MBChB, MRCP

Decreasing Health Barriers to Transplant



Tara Fulgham, LMSW, NSW-C
Fresenius Medical Care Kenmore



The Referral Stage

- This is the information-gathering stage.
- Initially, we complete the transplant referral form:
 - The Transition Report (requires previous and current medical and vaccination history within the past 12 months)
 - 2728
 - Medical Insurance Coverage

REFERRALS





Education Stage

- Education occurs simultaneously with the referral process after the patient discloses their interest in a transplant
- If a client is undecided we do a readiness assessment to determine the patient's level of change
 - **Precontemplation or Contemplation**
- If a patient has no prior knowledge of transplant we provide them with:
 - A transplant checklist: explaining all the necessary appointments and clearances needed to complete the transplant process
 - Mammogram, Chest X-Ray, Colonoscopy, Pap Smear, etc.
 - Cardiac Clearance
 - Dermatology and Dental Clearance
- **Additional resources:**
 - Pathways to Transplant
 - Getting A Kidney Transplant: What to Expect



The “Follow-Up” Stage

- Consistent follow-up with patients
 - Appointment Compliance
 - If non-compliant, we assess the barriers to compliance
 - Follow-up happens during every dialysis visit
- Assessing Barriers determined by the Transplant Center
 - Unstable Housing
 - Insurance
 - Lack of Social Support
 - Caregiver Agreements
 - Treatment and Judgement from the Transplant Center
 - “Patients feel like the center does not want them on the list”
 - “The transplant center talk me out of it”



Best Practice

- Advocating directly with the transplant surgeon
 - Discussing barriers that were put in place at the transplant facility
 - Advocating for patients based on their current situation rather than their past history
 - Previous Substance Abuse
 - Previous mental health non-compliance
 - Coordinating with other medical providers and providing clarity on the transplant process
 - Insurance Referrals (Out of Network)

BEST
PRACTiCE





Questions? Comments?



Thank You!



Better healthcare,
realized.

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<http://ipro.org>