

Why Policy Changes May Be Necessary but Not Sufficient in Overcoming Disparities



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Kidney Int Rep (2020) 5, 1385–1386; <https://doi.org/10.1016/j.ekir.2020.07.037>

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In the last 7 years, important policy changes have been advanced with the intention of improving access to transplant and end-stage kidney disease outcomes. Many of these changes have been targeted toward changing dialysis center practices and policies. First, in December 2014, the kidney allocation system (KAS) was changed to enable patients' entire time spent on dialysis to be credited to their waitlisting time, advancing patients whose referral for transplantation was delayed for years higher up the waiting list to correct care inequities.¹ Second, in 2019, the Advancing American Kidney Health initiative, as part of an executive order, recommended shifting end-stage renal disease payment models to incentivize increased use of home dialysis and kidney transplants to reduce costs by 2025.² Third, the Centers for Medicare and Medicaid Services implemented new changes

under the end-stage renal disease Quality Incentive Program requiring improved reporting of the percentage of waitlisted patients within individual dialysis centers to incentivize facilities to increase the number of patients being listed for transplant and to financially penalize those centers with insufficient total performance scores.³

Although policy changes can translate to improvements in care delivery, simply enacting policies is not sufficient to ensure that they can be fully integrated. As stated by Watt *et al.*, "Policy enactment is sometimes inadequate to stimulate practice changes in health care. Policy as a tool for practice change must thoughtfully address the organizational, professional, and social contexts within which the policy is to be implemented."⁴ Thus, it is critical that dialysis center leadership and staff understand and become motivated to implement the required policy changes. In their paper "Effect of the ASCENT Intervention to Increase Knowledge of Kidney Allocation Policy Changes Among Dialysis Providers," Patzer *et al.* reported the findings of a

cluster-randomized, pragmatic, effectiveness-implementation study in improving provider knowledge about the first KAS change.

Multilevel, multicomponent interventions such as this have been shown to be effective at improving patient knowledge and outcomes.^{5,6} The present study is among the first multilevel, multicomponent interventions geared specifically to improving provider knowledge of a major policy change.⁷ Through this study, 334 dialysis facilities in the intervention arm received a webinar for medical directors and staff to learn about the changes in the new KAS, a 10-minute video explaining to dialysis staff how they can help patients navigate the kidney transplantation process, and facility-specific reports outlining center performance on total waitlisting and facility-specific disparities in waitlisting compared to the national and state average. As part of a larger, multicomponent, randomized, effectiveness-implementation study, this substudy examined change in provider knowledge of the KAS policy specifically. Provider knowledge of the new waitlisting policies, historical disparities in waitlisting time for dialysis patients by racial group, matching based on life expectancy, and contraindications for transplant referral were assessed. Knowledge about these dimensions were summed into a cumulative knowledge score, with 5 correct answers indicating full comprehension.

Interestingly, despite comprehensive education about KAS changes, only a modest change in knowledge was seen. At follow-up, the intervention group had a higher average knowledge score (mean: 3.14 [1.28 SD]) compared to the control group (mean: 3.07 [1.24 SD]). The intervention was less

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impactful in facilities with high numbers of diabetic patients (>50%), smaller staffs, and at for-profit facilities. Overall, staff (nurse managers, facility administrators, social workers, etc.) were less knowledgeable than medical directors.

Simon Sinek's Book, *Start With Why* recommends an approach for greatest system change in which leadership orients first around discussions of *why* new policies should be implemented, then discusses generally *how* to adopt the changes, and ends with practical specifics of *what* has to be done at an individual center level.⁸ Although dialysis center leadership may feel the pressure to increase waitlisting—so as to avoid loss of federal funding in 2022—these findings reveal gaps in knowledge and, potentially motivation to educate, for front-line staff. Without a strong connection to the importance of these changes for patients, dialysis providers might treat this learning as any other type of routine continuing education or mandatory training, something to tolerate but not to implement.

As evidenced by this study, clear, short, targeted video interventions and webinars may not be sufficient to increase provider knowledge, no matter how well made. We do not know whether providers who received the intervention were attentive to it, or whether they had sufficient time to engage in learning more about dialysis policies. In addition, although the materials were presented in both webinar and short video formats, it is also possible that additional repetition would have improved knowledge retention further.

We must wait for the complete findings from the Allocation System Changes for Equity in Kidney Transplantation (ASCENT) study to be published before it is known whether the multilevel intervention as a whole—including system-, provider-, and patient-level interventions—will reduce disparities in waitlisting for racial and ethnic minority groups. However, with less than one-fifth (16%) of dialysis patients on the transplant waitlist in 2017,⁹ opportunities to improve waitlisting are certainly needed.

With increasing calls for additional reforms to KAS, and with the new Quality Incentive Program requirements already in place, dialysis center leadership should take note of these findings and involve frontline staff in planning care delivery changes relevant to new policies. More intensive educational practices also may be needed to help garner provider buy-in. This study found that policy changes are necessary, but not sufficient to improve knowledge and to engage providers.

DISCLOSURE

All the authors declared no competing interests.

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