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KI Reports Commentary:**Why Policy Changes May be Necessary but Not Sufficient in Overcoming Disparities**

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In the last seven years, important policy changes have been advanced with the intention of improving access to transplant and End Stage Renal Kidney (ESKD) outcomes. Many of these changes have been targeted towards 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 wait-listing time, advancing patients whose referral for transplant 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 ESRD 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 (CMS) implemented new changes under the ESRD Quality Incentive Program (QIP) 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 financially penalize those centers with insufficient Total Performance Scores (TPS).³

While 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, Sword, and Krueger, "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 System 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 transplant 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 sub-study 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 five correct answers indicating full comprehension.

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4 Interestingly, despite comprehensive education about KAS system changes, only a modest change in
5 knowledge was seen. At follow-up, the intervention group had a higher average knowledge score (mean
6 (SD): 3.14 (1.28)) compared to the control group (mean (SD): 3.07 (1.24)). The intervention was less
7 impactful in facilities with high numbers of diabetic patients (>50%), smaller staffs, and at for-profit
8 facilities. Overall, staff (nurse managers, facility administrators, social workers, etc.) were less
9 knowledgeable than medical directors.
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11

12 Simon Sinek's Book, "Start with Why"⁸ recommends an approach for greatest system change where
13 leadership orients first around discussions of why new policies should be implemented, then discusses
14 generally how to adopt the changes, and ends with practical specifics of what has to be done at an
15 individual center level. While dialysis center leadership may feel the pressure to increase waitlisting—so
16 as to avoid loss of federal funding in 2022—these findings reveal gaps in knowledge and, potentially
17 motivation to educate, for frontline staff. Without a strong connection to the importance of these changes
18 for patients, dialysis providers might treat this learning as any other type of routine CE or mandatory
19 training, something to tolerate, but not to implement.
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22 As evidenced by this study, clear, short, targeted video interventions and webinars may not be sufficient
23 to increase provider knowledge, no matter how well-made. We do not know whether providers who
24 received the intervention were attentive to it or whether they had sufficient time to engage in learning
25 more about dialysis policies. Additionally, while the materials were presented in both webinar and short
26 video formats, it is also possible that additional repetition would have improved knowledge retention
27 further.
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30 We must wait for the complete findings from the ASCENT study to be published before it is known whether
31 the multilevel intervention as a whole—including system-, provider- and patient-level interventions
32 reduce disparities in wait-listing for racial and ethnic minority groups. However, with less than one fifth
33 (16%) of dialysis patients on the transplant waitlist in 2017,⁹ opportunities to improve waitlisting are
34 certainly needed.
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36

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