AFRICAN-AMERICAN RENAL PD HEALTH DISPARITIES OPPORTUNITY ASSESSMENT SUMMARY

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Peritoneal dialysis is the second most under-represented therapy of the three therapies, even though it has been clinically linked to improved RRF and improved preparation for kidney transplantation – which is essentially the end goal of dialysis.

Only 9.4% of U.S. patients currently on dialysis treatments (about 33,000 people nationwide) are on peritoneal dialysis.

Relative to this percentage, African-American patient growth lags the rest of the market, at only 6.6% penetration.

Baxter’s goal is to increase penetration to the national average and, henceforth, realize a considerable upswing in African-American patient adoption.

This all begins with developing a deep understanding of the African-American ESRD market.
Research Objectives

1. To develop a deep understanding of the African-American renal patients’ journey including pre-diagnosis, diagnosis, initial treatment, and current therapy.

2. To explore the unique experiences, drivers, and barriers that African-American renal patients confront throughout their journey.

3. To ascertain who are the key influencers along the African-American patient journey, and the ways in which they interface with these influencers.

4. To establish initial hypotheses about an African-American ESRD patient segmentation.

5. To identify key opportunities to create a Go-to-Market (GTM) strategy that will enable Baxter to drive greater adoption of PD therapy with the African-American ESRD patient population.
The research participant pool was diverse and captured the voices of almost 60 respondents.

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2.5 hr. In-home Interviews
75 min. In-Depth Interviews
90 min. Focus Groups
90 min. Support Groups
PATIENT JOURNEY
IDEAL PATIENT JOURNEY

Definition:
Ideal/Glide/Office patients are concerned about the symptoms of CKD/ESRD, pay attention to these symptoms, and actively seek medical attention in response to these symptoms.

Ideal Patients:
• Represent the types of patients nephrologists and nurses describe as “easiest to treat”
• Comply with medical advice and work in partnership with health care providers
• Educate themselves in order to make better choices about treatment options
• Proactively make decision on initial treatment months (or even years) in advance

KEY FINDING:
At any point, an ideal patient can exit this journey and move into the crash patient journey. Many patients began as ideal patients.
Definition:
Crash patients are those patients who are either unaware or in denial about their symptoms that lead to CKD, avoid medical treatment and do not take action until they are forced to by their disease.

Crash Patients:
• Have several co-morbidities that have been ignored for years
• Typically have little discipline and no accountability for their health
• Are not prepared to make decisions around treatment therapy options when treatment is needed
• May have been told about their kidney disease, but remain in denial until it is too late

KEY FINDING:
The context of the "crash" makes adopting PD difficult, if not impossible, for many patients that end up in the ER for diagnosis and initial treatment.
DETAILED FINDINGS
**AA INSIGHTS - NEPHROLOGISTS**

**AA #1** Nephrologists use socioeconomic status (SES) to determine which patients are “right” for PD. Indicators of SES are as follows:

- **INSURANCE**
  - "Insurance plays a major factor. People who come through the ER cannot go on PD because of the limits to hospital stays.” — Neph., L.A.

- **RACE**
  - "The majority of African-Americans that would have been a good candidate for PD are not in the right living conditions.” — Neph., Atlanta

- **QUALITY OF QUESTIONS**
  - "The more questions they ask, the more “educated” they are, the more “motivated” they are for PD.” — Neph., Washington, D.C.

- **LIVING SITUATION**
  - "The person may be a single parent or have many kids and so the home is too chaotic to be a place to do dialysis.” — Neph., Chicago

- **APTITUDE**
  - "PD requires a lot of physical faculties and [a patient] to be more knowledgeable with what they are doing.” — Neph., L.A.

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Because physicians **do not perceive any clinical differentiation** between ICHD and PD, they view PD as a QOL therapy option.

Physicians **defer to socioeconomic factors** to determine the right patients for PD.

Many of these socioeconomic factors have **no impact** on a patient's ability to perform PD.

Instead, they only **increase the physician's confidence** in the patient's ability to perform PD.

**IMPLICATION**

AA get disproportionately pushed to ICHD based on where they disproportionately fall in SES.
Patients fear that lifestyle benefits of PD could make them ineligible for disability

- PD is sold as a QOL treatment that allows a person to continue working
- Some believe if they adopt PD, they will be expected to return to work, despite their health status, and will lose all disability benefits
- They are too afraid / embarrassed to ask this question, so the myth prevails

AAs would rather not risk the loss of the disability check that PD presents and choose, instead, to stay with ICHD.
Patients are reluctant to share their full medical history with HCPs. Some feel the HCP does not have their best interest at hand. Others just believe that they know their body best.

“I don’t think doctors need to know all of your personal business. If my doctor were to ask me, I just wouldn’t tell him..”

–Sharon, Chicago

Patients often refer to websites, online research, blogs, patient chat rooms, and personal experiences or experiences of those closest to them to build their knowledge about CKD and ESRD. Often times, this information is inaccurate or incomplete.
Patients are made aware of PD through their nephrologists or nurse, but stay in-center due to non-medical recommendations at the clinic.

“When I go to the center, I am watching everyone. As soon as I see something, I ask the techs what I need to do to make sure that doesn’t happen to me”

--Jennifer, Washington, D.C.

The patient / technician testimonial has the power to enable or impede PD adoption.
AA INSIGHTS – PATIENTS

The longer patients are in-center, the less receptive they are to other treatment options

• Patients get **comfortable** in the dialysis center, **create a routine**, and build a **social network** where they can be “normal”

• This creates a **sense of security and confidence** that may have been lost once their kidneys failed

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**IMPLICATION**

The longer a patient performs ICHD, the less likely the patient will be to adopt PD unless they experience access issues and are forced to adopt PD

“I love going to the dialysis center. It gives me something to do. I like the people and I feel like I have a purpose there.”

—Robert, L.A.
AA INSIGHTS - PATIENTS

Stigma about discussing health makes it difficult for many patients to discuss their CKD/ESRD with friends or family.

Fear of loved ones pulling away
“I see lots of people at the clinic whose spouses left them because of this disease.” – John, L.A.

Being thought of as “weak” or dependent
“When people hear you have this, they start to think of you as weak.” – Dana, Chicago

Inconveniencing their loved ones
“I just felt bad about inconveniencing my family.”
– Georgia, Atlanta

Restrictions make patient less “fun”
“People try to get you to eat certain things. When you can’t, they look at you crazy” – Chris, Atlanta

It creates a “stone wall” in the home related to conversation. They avoid engaging those close to them in the ESRD portion of their life journey.
AFRICAN-AMERICAN BARRIERS TO PD ADOPTION
BARRIERS TO PD ADOPTION – PD #1

**PD #1**

Patients have heard many “horror stories” about PD in the clinic, where rumors are heightened and left unaddressed

PD patients with **failed experiences** are transferred to the ICHD unit where they **share their experience** with other patients.

ICHD patients **typically encounter failed PD patients** and this becomes their **only constant exposure** to PD.

**Lack of knowledge/support by ICHD nurses and nephrologists** amplify the issue because many of the **myths are never addressed appropriately**.

> “I was going to do PD because it would be the easiest for me to work. But, then I heard about all of the boxes that had to be delivered, not to mention, there is the risk of infection”

- John, Los Angeles

**IMPLICATION**

The **longer a patient is in center**, the more often they will hear these rumors and the **harder it becomes to dispel these rumors**.
BARRIERS TO PD ADOPTION – PD #2

PD #2
Nephrologists are typically not supportive of PD for many crash patients and majority of AAs enter the system as crash patients

When possible, nephrologists will try to steer crash patients to ICHD.

“I might go ahead and share PD as an option to a person I know is not a fit because, statistically, I know that PD is not going to be adopted by the majority of these people.” --Neph., Atlanta

“African Americans survive longer on ICHD than they do on any other modality (including transplant). So, in-center really is the best option for African-Americans.” --Neph., L.A.

“African Americans, as a rule, are less educated and should fit more with in-center.” --Neph., Chicago

IMPLICATION
Crash patients send unspoken signals to physicians that label them as poor PD candidates. AAs are more likely to be assigned to ICHD and less likely to receive treatment information at a critical point in their disease.
BARRIERS TO PD ADOPTION – PD #3

Caregivers believe patients do not have the discipline for PD and worry that it will result in more work for them and more infections for patients

ICHD is viewed as a partner in the care of the patient

- Caregivers perceive PD to be a more difficult therapy when compared to ICHD and worry about the additional skills and expertise PD requires
- At-home dialysis is an added responsibility that they do not feel they have the capacity to do
- At-home means even less time for themselves because they can no longer depend on the dialysis center for their needed “me time”

“I already have to cook, clean, grocery shop, make daily visits by the house. Now, I have to add PD on top of it. It is just too much for me. I would rather just have in-center do all the work.” —D.C. Caregiver

IMPLICATION

Unlike ICHD, PD is not viewed as a partner in their care of the patient and the perceived risks (infection, less expertise/resources) impedes adoption
BARRIERS TO PD ADOPTION – PD #4

Nephrologists and nurses believe “Body Image” is a greater barrier for AAs than for other ethnicities

“I see more of my African-American men talk about body image with PD. I think they associate being ill with being embarrassed. The bags and catheter are a tell/tale sign that they are ill.” – Neph., L.A.

“Having kidney disease already puts a damper on the love life. The last thing I need is some tube coming out of my stomach.”

--Chris, Atlanta

IMPLICATION

The catheter is major barrier – particularly for AA men - that visually shuts down candidates before they can ever fully engage with the treatment opportunity.
**BARRIERS TO PD ADOPTION – PD #5**

**PD #5**

Nurses are not supportive of PD due to concerns of patient’s ability to do PD

Nurses perceive PD to be a **difficult therapy** for patients to perform in the absence of clinically trained professionals.

They have **little confidence in many of their ICHD patients** to accurately and consistently perform dialysis alone or in the home.

ICHD nurses are **misinformed** and **exaggerate risk levels** associated with PD.

**IMPLICATION**

They will not recommend PD to patients; PD adoption rates will be impeded.
OPPORTUNITY PLATFORMS
THEMES THAT RISE TO THE TOP
While all platforms are deemed important to the AA Renal Go-To-Market Plans, a few overarching themes rose to the top.

**Education**

1. Help **neps and nurses embrace the clinical benefits** of PD, not just lifestyle benefits.
2. Teach **caregivers, patients and technicians** about the clinical benefits of PD. Eradicate false perceptions related to infections, disability support and lessen the burden stemming from home care as opposed to center care.

**Eradicate the Stigma**

1. Create a movement to change **public and patient perceptions of PD**. Relieve patient of guilt, blame and shame. **Offer CKD patients hope for a “normal” life.**
2. Optimize the delivery and home set-up of PD such that it is more acceptable to the patient.

**System Change**

1. **Evaluate PD-First Option.** Partner with government affairs, law-makers and insurance carriers to explore the economic and clinical benefits of a “PD-First” Option.
2. **Encourage Neph cultural sensitivity** such that they understand that PD can be appropriate for a broader pool of patients, especially AA.
3. **Increase credible PD messaging.** Earlier in the care plan, utilize AA Ambassadors to encourage ICHD patients to make the transition to PD sooner.
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THANK YOU!

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