the Coronavirus Outbreak issued on June 22, 2020, ASN collaborated with the Council of Medical Specialty Societies and 20 other specialty societies to express grave concerns to the administration over its suspension of certain immigration visas (including H-1B and some J-1 visas) for the remainder of 2020.

In a letter to the heads of the Department of Labor, Department of Homeland Security, Department of State, and the Department of Health and Human Services, the group stressed that it was not in the nation's best interest to further close its borders to skilled health and science professionals. The Executive Order will limit the nation's ability to attract the world's most talented clinicians, researchers, and educators, impacting the healthcare workforce and harming public health. The letter further urged the administration to "clarify that all healthcare professionals and researchers—not only those who are involved in COVID-19 research and practice—are critical to our nation's interest, and therefore exempt from the executive order" (2).

To provide optimal healthcare for all Americans, ASN will continue to advocate for federal policies that maintain the nation's robust healthcare workforce, advance patient care, and protect our research enterprise. Future articles in *Kidney News* and *Kidney News Online* will include continued coverage of ASN's advocacy efforts on this and other policy priorities. For the most up to date information, follow @ASNAdvocacy on Twitter.

References

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Persistent Kidney Health Disparities Require New Approaches

By Bridget M. Kuehn

Patients receiving dialysis in predominantly black neighborhoods have higher rates of hospitalization, and Black and Hispanic women have higher rates of hypertension after preeclampsia, according to a pair of studies.

The studies are the latest in a growing body of evidence to suggest that substantial disparities in kidney care exist among patients who are Black and Hispanic, and they highlight the need for improved care to reduce preventable complications.

While the studies identify disparities, they fail to explicitly address the role that both structural racism and implicit biases in care may play in causing them, said Vanessa Grubbs, MD, associate professor in the Division of Nephrology at the University of California–San Francisco and author of "Hundreds of Interlaced Fingers: A Kidney Doctor's Search for the Perfect Match."

"We keep trying to find the reason within the group rather than looking at the common denominator of who takes care of these groups," Grubbs said. "There's a consistent push, it seems, to call race a risk factor rather than racism. Until we are willing to really acknowledge that there is no biologic meaning to race and rather how we attribute meaning to it, that affects our clinical judgment and therefore patient outcomes and we're always going to see these disparities."

Hospitalizations and hypertension

Research by Ladan Golestaneh, MD, a professor of medicine in the Department of Nephrology at Montefiore Medical Center in the Bronx, New York, assessed hospitalization rates among 4567 patients on hemodialysis in 154 facilities in 127 zip codes to assess what causes extreme variability in dialysis patient outcomes from community to community. The analysis found that patients in majority Black neighborhoods had high hospitalization rates.

This trend occurred even though patients receiving care in majority Black communities were younger and healthier. Patients receiving care in these communities also received dialysis care that was of comparable quality to care in other areas in terms of the medications and duration of dialysis they received and the urea reduction ratio. But they were more likely to receive dialysis in for-profit facilities with higher patient ratios.

Golestaneh could not pinpoint the exact cause of these higher hospitalization rates among those living in majority Black communities but she did rule out race itself as the explanation. She said she would like to see fine grained data on the health systems that serve these patients or whether other services fall short in their communities. Examples might include a lack of culturally sensitive education materials or poor access to healthy foods.

"Hospitalization may or may not reflect a need for acute care," Golestaneh said. "A lot of times, hospitalization really reflects failures of outpatient care coordination, or outpatient care provision, such that a lot of unnecessary hospitalizations occur."

Golestaneh acknowledged her analysis could not definitively provide an answer about what is driving higher hospitalization rates but suggested "that maybe hospitalizations in this case are really just a surrogate for not getting the outpatient care coordination and outpatient care intensity that that you need in communities."

A second analysis by Jessica Sheehan Tangren, MD, a nephrologist and instructor in medicine at Massachusetts General Hospital in Boston, looked at a cohort of 20,864 women with a pregnancy between 1998 and 2014, including 524 who developed preeclampsia: 23% were Hispanic and 6% were Black. The risk of hypertension after pregnancy was elevated in women of all races and ethnicities, but it was particularly high among Hispanic women, who had an adjusted hazard ratio of 2.8, and Black women, who had an adjusted hazard ratio of 2.7. Non-Hispanic white women had an adjusted hazard ratio of 1.8.

Root causes

Golestaneh suggested it would be important to consider how socioeconomic and other factors contribute to these disparities.

"It's something significant that needs to be explored if we want those disparities to go away, or if we want to have health equity in our society," she said.

She acknowledged that physicians don't do a good job of understanding their patients' experiences with the health system. For example, are patients able to get in touch with primary care physicians or get prescriptions filled?

"We need to do a better job of looking at the patient more holistically, and really going after those details in their lives," she said.

But Grubbs, whose book details her husband's kidney failure, her decision to donate a kidney to him, and their experiences with the health system, would like physicians to pay more attention to both structural racism and racism in medicine as potential contributors to persistent disparities.

"Most of us believe that we are coming from a really positive place, and that we're trying to do the best for our patients," she said. "But I don't think, in general, we're willing to consider the role that unconscious bias has, that we're not willing to question the assumptions that we make about the person in front of us."

She noted that unconscious bias can contribute to a lack of trust or cause stress among patients. For example, if a woman experiences a complicated pregnancy and feels she's not being heard or listened to, that could increase her level of stress, which could contribute to higher blood pressure later on.

"The structure of our entire society for centuries has led to where we are now, so that certain groups have always been treated inequitably," she said. "If no one is going to address those structural systemwide issues, or even acknowledge them, then you don't have to do anything outright to be blatantly racist."