

Advancing LGBTQ+ Kidney Health Equity

By Dinushika Mohottige and Mitchell R. Lunn

Lesbian, gay, bisexual, transgender, queer or questioning, and/or other sexual and gender minority (SGM) individuals (LGBTQ+) represent a diverse range of people who experience disparities in health outcomes and other health-promoting resources and opportunities and are served by kidney care professionals (1–3).

Although there have been advances in civil rights legislation, including same-sex marriage equality aimed to equalize some sociopolitical opportunities, there are innumerable persistent social, economic, legal, health, and health care-related disparities facing SGM individuals (2, 4). These challenges are exemplified by a patchwork of non-discrimination policies across the United States that do not universally prohibit discrimination based on sexual orientation and gender identity (SOGI) in public accommodations, including in health care centers, such as dialysis facilities (5).

SGM people face a disproportionate burden of suboptimal and discriminatory health care due to implicit and explicit bias, as well as inadequate education regarding inclusive care (6–9). Furthermore, the national dialogue regarding the problematic use of race in clinical algorithms, including in kidney function estimation (i.e., estimated glomerular filtration rate [eGFR]), has galvanized discussions about the most precise method for estimating kidney function among individuals who are transgender and particularly among those receiving gender-affirming hormone therapy (10–12). Each issue presents opportunities for kidney care professionals to advance health justice and equitable health outcomes for all.

The National Kidney Foundation and American Society of Nephrology led a joint task force to address the use of the Black race coefficient in kidney function estimation (13, 14). Race is a sociopolitical variable without biologic meaning and exemplifies the problematic nature of race essentialism, which is a flawed belief that race captures biological distinctions and defines characteristics that are unique to an individual (15–17). The comprehensive re-evaluation of eGFR calculation provides an important opportunity for kidney care professionals to examine the role of the “female” sex coefficient as it pertains to transgender individuals/gender-expansive individuals who may have a higher prevalence of acute kidney injury (AKI) and chronic kidney disease (CKD) (18). Inaccurate eGFR calculations may contribute to kidney care disparities because of bias and/or systemic eGFR overestimation, and further investigation is needed to clarify the role of gender-affirming hormone

therapies (e.g., estrogen and testosterone) on AKI and CKD (18). Overestimation of eGFR results in delays in referring patients to nephrology care and kidney transplant, as well as, for example, inadequate medication dosing (10, 19–21).

There is a lack of comprehensive data regarding the bias introduced by using the sex coefficient in eGFR calculation among individuals using gender-affirming hormone therapies, which impact muscle mass and creatinine production, versus cisgender people who are not utilizing these therapies.

First, affirming standard practices for obtaining SOGI data is essential to ensure a comprehensive understanding of a patient’s sexual and gender identity. These details influence the patient’s health care needs and our evaluation of laboratory tests (e.g., hemoglobin and eGFR) (10–12, 17, 18, 21, 22). SOGI data collection is needed to determine long-term kidney outcomes associated with sex hormones and other gender-affirming therapies (10, 22).

Second, as kidney care professionals seek greater precision to estimate kidney function and predict kidney failure, we must include populations with a range of sexual and gender identities (including individuals on gender-affirming hormone therapies) to ensure measurement optimization and validation (including the use of cystatin C in lieu of creatinine).

Furthermore, in situations in which there is clinical ambiguity regarding the use of a female sex coefficient for eGFR, we encourage providers to estimate GFR more precisely using additional tools (e.g., 24-hour urine creatinine and urea measurements and measured iothalamate/iohexol clearance) and to assess eGFR at baseline before initiation of gender-affirming therapy. Finally, we recommend that nephrology providers engage multidisciplinary teams (e.g., endocrinology, psychology, social work, and other SGM-affirming care experts) whenever complex decisions regarding gender-affirming hormone therapy occur (e.g., the discontinuation of estrogen therapies when considering kidney transplant and spironolactone use in advanced CKD). These discussions must account for the vital nature of these medications to the improved quality of life and psychological outcomes among many transgender/gender-expansive individuals (10, 23, 24).

SGM people, and especially transgender and gender-expansive individuals, are more likely to lack a usual source of care, health insurance, and a routine checkup in the prior year, as well as to have unmet medical care needs due to

cost (among other barriers to care), compared with their cisgender and heterosexual counterparts (5, 25). To address these persistent inequities, kidney care professionals can advocate for and implement non-discrimination policies that explicitly prohibit bias due to sex, gender identity, gender expression, sexual orientation, and gender, while educating ourselves regarding the evolving, inclusive language and culturally humble best practices (e.g., recording and using a patient’s pronouns and demonstrating signage and informational materials for CKD/transplant education that are inclusive at dialysis facilities and transplant centers). These practices should be embedded into continuing medical education (CME)/graduate medical education (GME) and are essential for earning trust by ensuring barriers to optimal care are addressed (e.g., access to appropriate preventive screenings) and by enhancing the quality of care we provide. Thus, by focusing on inclusive approaches that ensure affirming care and thoughtful attention to SOGI data collection, protecting all patients through comprehensive and inclusive policies, and enhancing CME, which highlights novel advances to improve care provision, we can achieve the equity we seek in kidney care. ■

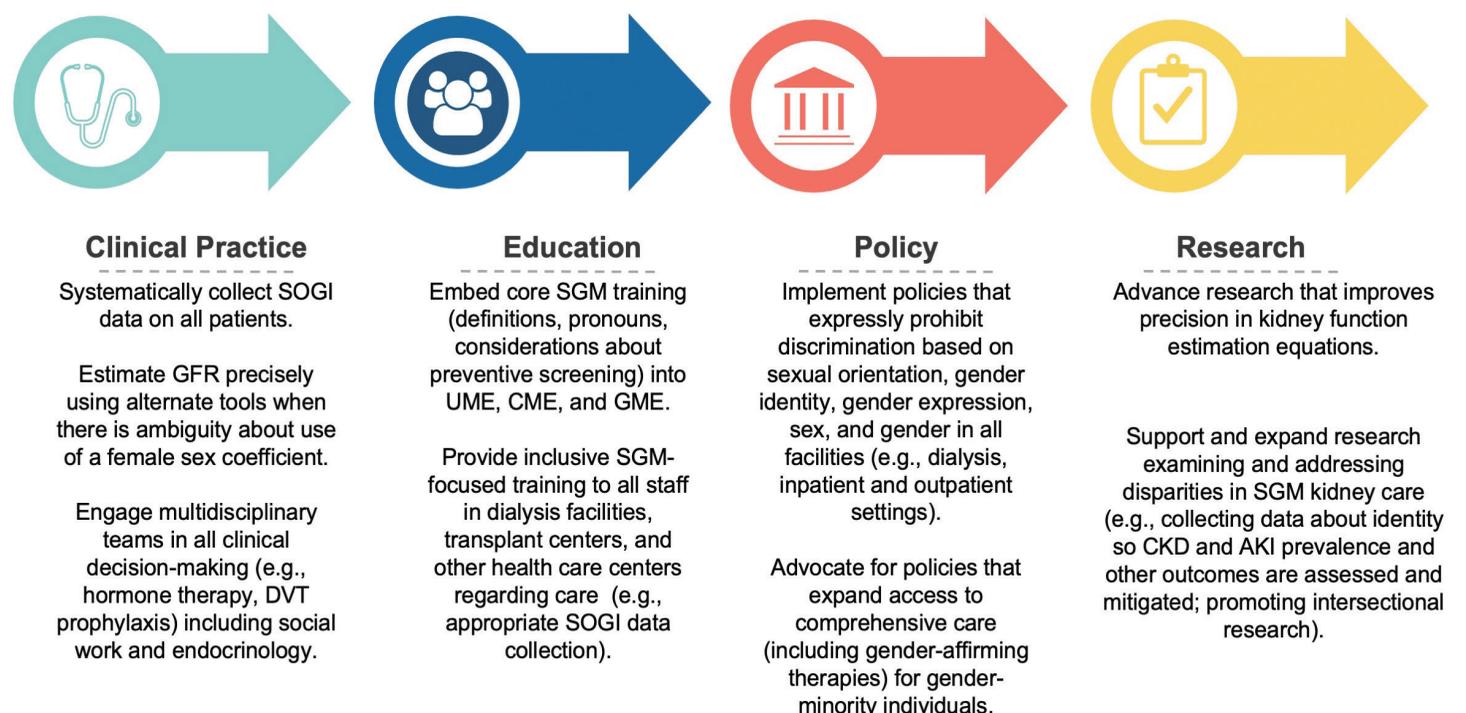
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SGM, sexual and gender minority; DVT, deep vein thrombosis; UME, undergraduate medical education.

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Promoting Kidney Health among American Indians and Alaskan Natives

By Stephanie Mahooty

In the United States, diabetes is the leading cause of kidney failure, and the prevalence of diabetes among American Indians and Alaskan Natives (AI/ANs) is one of the highest among any racial and ethnic group. In the United States, diabetes accounts for 69% of new cases of end stage renal disease (ESRD; diabetes-associated ESRD [ESRD-D]) among the AI/AN population (1).

The roots of this disparity began in the 1950s and 1960s, when the epidemic of diabetes among the AI/AN population was soon followed by a dramatic increase in diabetic kidney disease and subsequent kidney failure, first described in the 1980s (2). From 1982 to 1996, ESRD-D among AI/ANs increased substantially and disproportionately compared with other racial and ethnic groups (1). In 1996, the incidence rate of diabetes among the AI/AN population was approximately 4 times the rate of Americans of European ancestry (2). As a result, the Indian Health Service (IHS) implemented a systemic approach to diabetes care using evidence-based interventions and later established the IHS Kidney Disease Program. These diabetes standards of care were revised in the early 1990s to include screening, identification, and treatment of chronic kidney disease (CKD), which became a part of primary care delivery to indigenous communities served by the IHS (2). The systematic implementation of diabetes and CKD standards of care has contributed to the decreased incidence of ESRD-D among AI/AN adults by 54% from 1996 to 2013—a triumph for kidney health equity. Among adults with diabetes, ESRD-D incidence was the same in AI/ANs as in White Americans

by 2013 (1).

Despite the decrease in incidence in ESRD-D, the prevention of diabetic kidney failure continues to be a challenge. Personally, I come from a small AI community with a huge burden of diabetic kidney disease and ESRD-D. I have experienced my own father and paternal grandmother affected by diabetes and ESRD-D. Thus, this issue is very close to my heart and a primary reason for my decision to pursue a career as a kidney health professional.

There are several important considerations for health care professionals who provide care to this population. First, as a nurse and provider, I have learned that it is important to approach an AI/AN patient who has been newly diagnosed with CKD or ESRD-D with sensitivity, even if the provider is unaware of a particular culture. Many AI patients from the Southwest tribes, for whom I have provided care, associate the terms “kidney disease” or “dialysis” with a negative connotation, such as shameful or a death sentence. Patiently educating these individuals is an important first step to building trust and diminishing stigmas.

Second, it may help to start a conversation with a new patient by simply asking, “How much do you know about kidney disease?” This question can help clear up misconceptions, fears, or myths about kidney disease. It is not uncommon for AI/AN patients from a small community to know of a family member, relative, friend, or neighbor who is or has been on dialysis, but that experience may interfere with the patient’s proper understanding of his or her own kidney disease.

Many AI/AN individuals live in multigenerational households, where family members collectively provide encouragement and support for their loved ones with kidney disease. Educating the patient and family together about kidney disease and care is crucial. I feel this gives the patient empowerment and hope and helps him or her to be more receptive to interventions offered to slow the progression of CKD and prevent ESRD-D.

Through patient education and adherence to evidence-based practice, all kidney health professionals can work together to narrow the disparities faced by AI/AN patients and their families. ■

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Dr. Mahooty reports no conflicts of interest.

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