By Dinushika Mohottige and Mitchell R. Lunn

LGBTQ+ Kidney Health Equity

Although there have been advances in civil rights legislation, including same-sex marriage equality aimed to equalize some socio-political opportunities, there are innumerable persistent social, economic, legal, 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 examine important opportunities for kidney health 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 SGM 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.

References

Advancing LGBTQ+ Kidney Health Equity

Continued from page 19

7. Bonvicini KA. LGBT healthcare disparities: What is the evidence-based interventions and later established the Indian Health Service (IHS) as a part of primary care delivery to indigenous communities, which became a part of primary care delivery to indigenous communities served by the IHS (2). As a result, the Indian Health Service (IHS) implemented a system 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 2015—a triumph for kidney health equity. Among adults with diabetes, ESRD-D incidence was the same in AIs/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 Al 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 Al 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 stigma.

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.

Stephanie Mahooty, DNP is with Renal Medicine Associates in Albuquerque, NM.

Dr. Mahooty reports no conflicts of interest.

References

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 AIs/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 system 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 2015—a triumph for kidney health equity. Among adults with diabetes, ESRD-D incidence was the same in AIs/ANs as in White Americans.