ASN President's Update

Bootstraps, Basic Needs, and Kidney Health

By Deidra C. Crews

Dr. Martin Luther King, Jr., said during an interview in 1967, less than 1 year prior to his assassination, that "It's a cruel jest to say to a bootless man that he ought to lift himself by his own bootstraps" (1). I often think of this statement when I ask a patient to be more engaged in their kidney care. Many people at risk for or living with kidney diseases have unmet basic needs like housing, food, transportation, and utilities (such as electricity). Surely these needs would rank higher on their list of concerns than the medications I wish they would take more regularly (if they *can* even access them) or the dietary changes I think they should make. Yet, for most of us in nephrology, our training did not include, nor do our clinical practice structures facilitate, full consideration of these nonmedical basic needs.

Pervasive burden

Unmet basic needs are quite pervasive among the more than 37 million Americans living with kidney diseases. One study found that 30% of a nondialysis-dependent population of people with kidney diseases experienced at least one unmet basic need during the COVID-19 pandemic (2). The burden of unmet basic needs is particularly stark for people with kidney failure treated with dialysis. A pilot study of children receiving dialysis treatment in Indianapolis, IN, and Seattle, WA, identified that 62% lived in food-insecure households, and the majority of them (72%) had experienced worsening of their food insecurity during the pandemic (3). Among a group of adults treated with dialysis in Baltimore, MD, and Washington, DC, 36% reported food insecurity, and 18% reported housing instability (4). Most US studies of this topic have been conducted in urban settings, but the expected burden of unmet basic needs would be even greater for people living with kidney diseases in rural and remote communities throughout the world.

We also know that having unmet basic needs increases the likelihood of experiencing several adverse outcomes related to kidney health (5–7) (Table). Yet, our policies and practices are based in many ways on the false assumption that most patients can meet these basic needs. Take housing, for example. The 2019 executive order on Advancing American Kidney Health included, among three priorities, a focus on increasing patient choice in kidney failure treatment, boldly setting a target that by 2025, 80% of the Medicare beneficiaries who initiate kidney failure treatment do so with a home modality or kidney transplant (8). At present, however, we fail to systematically ask and document whether patients have a stable place to live or the ability to make modifications to their home that would support their being able to dialyze there.

I am reminded of one of my patients who, despite having intermittent transportation needs, has excellent adherence to in-center hemodialysis treatments. She was interested in home hemodialysis because it would allow her to work more regularly and afford to buy the car that she needs, as the engine in her old car died. Unfortunately, her apartment landlord would not approve of the plumbing and wiring changes that would make home hemodialysis feasible for her—and so she has remained a patient of in-center hemodialysis who relies on public transportation.

Now, far upstream from patients being treated for kidney failure are those millions of people worldwide who could benefit from the primary prevention of kidney diseases. Multiple campaigns invite a focus on addressing unmet basic needs in the general population toward preventing morbidity and mortality with messages like "Housing Is Healthcare" and "Food Is Medicine." It sometimes seems—at least to me—a bit outrageous that we need campaigns to call attention to the importance of meeting basic needs to achieve optimal health. Former ASN Secretary-Treasurer Donald E. Wesson MD, MBA, FASN, somewhat rejects the Food Is Medicine mantra, asserting, "Food Is Food." It really should be that simple.

Of course, some would argue that this is not "our lane." According to this perspective, nephrologists and other clinicians should focus on medical treatments and not devote time to understanding and addressing the unmet basic needs of their patients, especially given our expanding medical armamentarium in kidney care. However, these needs may actually be bigger drivers of overall health and kidney health than is medical care itself. Analyses of various health indices in Organisation for Economic Co-operation and Development (OECD) countries and among US states have been more closely, and positively, related to rates of social service spending (on provisions such as housing and food) than with health care spending (9, 10).

Addressing unmet needs

The significance of the problem of unmet basic needs and their impact on kidney health cannot be overstated. Fortunately, there are actions that we can each take to address them. First, clinicians can ask our patients about these needs. Several very brief tools are available, such as the following question about financial resource strain, recommended by the National Academy of Medicine (formerly Institute of Medicine): "How hard is it for you to pay for the very basics like food, housing, medical care, and heat? Very hard? Somewhat hard? or Not hard at all?" (11). These tools have been incorporated into many electronic health records to support documentation, follow-up, and linkage to available services.

Second, once we identify a patient as having unmet basic needs, we can leverage community resources to support patients registering for public and privately funded services that can address their needs. Several health systems have employed community health workers, drawn primarily from the communities they serve, often in partnership with social workers, to help patients navigate community resources. This approach is gaining traction in kidney care (12) and has great promise if barriers to patient enrollment and funding of community health workers can be addressed.

Third, investigators can pursue research into how these unmet basic needs lead to biologic consequences. For example, how does the psychologic stress of financial strain surrounding housing, food, and other needs impact markers of kidney health? What are the underlying mechanisms? And a great need exists for intervention studies examining best practices for identifying, addressing, and monitoring the outcomes of efforts to address unmet basic needs impacting kidney health. Studies on whether approaches should vary depending on the type of kidney disease with which a person lives are also warranted. For example, does an individual with a rare kidney disease, who may need to see multiple specialists, undergo a kidney biopsy, and receive other diagnostic procedures require more intensive support if they have unmet basic needs compared with someone with a more common form of kidney disease requiring a less arduous diagnostic and treatment journey?

Fourth, we can all advocate for "little p" (health system/clinic setting) and "big P" (health and public) policies that could support the basic needs of people with or at risk for kidney diseases. By making use of the "natural experiment" of numerous public policies established during the COVID-19 pandemic to mitigate its economic impact, we can examine whether they had impacts on kidney health. For instance, in March 2020, the US Congress passed the Coronavirus Aid, Relief, and Economic Security Act, which included a moratorium on the evictions of tenants in rental properties that receive federal funding or have federal government-backed mortgages. Many states initially extended this moratorium, but those extensions have since ended. An examination of the impacts on kidney health during this moratorium could reveal data that compel present-day policy changes.

I agree with Dr. King's statement from nearly 60 years ago and believe it would be cruel to ask people who are "bootless" to address their own unmet basic needs that impact their kidney health. Supporting them is *our* responsibility, *our* duty,

Table. Adverse kidney health outcomes associated with unmet basic needs

Unmet basic need	Population(s) studied	Example of adverse outcomes
Housing and/or food insecurity	• Adults	↓ • Kidney disease risk factor control
Housing insecurity	• Adults • Adults with CKD • Older adults on dialysis	↑ • Risk of developing albuminuria • Delays in seeking medical care • Mortality
Food insecurity	• Adults with CKD • Children on dialysis	↑ • Progression to kidney failure • Acute care utilization
Transportation needs	• Adults on dialysis • Transplant candidates	↓ • Hemodialysis treatment adherence • Waitlisting for kidney transplant

and the right thing to do, especially if we are serious about achieving a world without kidney diseases. ■

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To comment on Dr. Crews' editorial, please contact email@asn-online.org.

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