The inescapable reality is the American health care system is rooted in a US society steeped in systemic racism. In recent years, there has been an increased acknowledgment of how systemic racism in health care has affected kidney disease and kidney care for our patients.1-3 Many of these discussions seek to advance justice in health care and society by focusing on the interwoven systems that perpetuate inequitable care (e.g., individual risks, societal factors, health care access and outcome differences, and beliefs of kidney health care professionals). Mohottige and colleagues provide a compelling review of how these embedded systems perpetuate race (i.e., structural, institutional, and individual) and must be confronted to promote equitable kidney care.2 The impact of racism on healthcare is diffuse and dynamic; therefore, solutions must be integrated within the systems affecting our patients across the lifespan.

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Children are a uniquely vulnerable population, highly susceptible to the effects of systemic racism. In social science, Bronfenbrenner’s socioecological model4 helps to explain the complexities of child development. This model depicts concentric circles, wherein children are born into larger cultural, social, and economic systems, influenced by specific structures (e.g., neighborhood, local politics, social services) and factors in their immediate environment (e.g., school, family, church), all acting on the child’s individual factors (e.g., genetics, age, sex). Such developmental frameworks must be considered when caring for children living with CKD, where a child’s laboratory values must be understood by how they corroborate the social influences and events leading to their diagnosis. In addition to pathophysiologic characteristics, the provider must consider the child’s immediate environment (e.g., family health literacy), social structure (e.g., social drivers of health), and the interaction of these factors, which collectively help to explain each child’s disease progression. We urge that a reconceptualization of the biologic factors that influence pediatric kidney disease, clearing the stress hormone, which may be particularly salient for minority communities who experience recurrent and systemic stressors and may help to explain differential CKD progression and rates of hypertension in minoritized communities.5 Altering our conceptualizations and implementing proactive or preventative interventions to promote health equity in childhood can help equip our patients who are pediatric in transitioning to adult health care with greater confidence, agency, and trust in their care and with their providers, and potentially buffer the effects of external stressors on kidney outcomes.

To understand pediatric kidney disease and its associated risk factors, it is imperative to consider child development in the context of structures and systems influenced by racism, acknowledging the complexities of how these factors intersect (see Figure 1). Given the multifaceted systems at play, our approach to addressing systemic racial disparities in kidney health must be multifaceted, too. At the Nationwide Children’s Hospital, Columbus, Ohio.
Children’s Hospital, intentional strategic planning has allowed for a focus on health equity at the institutional and divisional levels, actualized through our Kidney Health Advocacy and Community Engagement (KHACE) initiative. KHACE was launched to promote lay-ordered changes to our system of kidney care in four areas: research, education, engagement, and policy (Figure 1 highlights a few of these efforts that align with the socioecological model). KHACE leadership, which is multidisciplinary, meets monthly to ensure we are actively pursuing at least one intervention within each focus area. Although in its infancy, KHACE hopes to demonstrate its efficacy through measurable outcomes.

At the most direct individual-patient care level, KHACE encourages our providers to consider their perspective by “centering at the margin.” That is, providers first seek to understand the effect of kidney disease and care from the perspective of the patient, especially within the context of their social status (inclusive of power differentials), health literacy, health beliefs, medical trust, community membership, family values, pertinent physical environment, socioeconomic stressors, and health behaviors. We encourage this perspective by discussing clinical cases openly to gently challenge our colleagues to consider differing perspectives. We also consider how to modify our treatment plans by identifying the unique social determinants of health (including housing, food, financial, and transportation difficulties) that threaten patient and family well-being and challenge medical adherence. By such centering, we hope to offer equitable care, rejecting a one-size-fits-all approach to medicine. At the level of the microsystem, we consider how our care strategies have both direct and indirect influences on our patients’ health outcomes. For example, KHACE highlights efforts at Riley Children’s Hospital, where the pediatric nephrology team addresses food insecurity in their patients through their hospital- and dialysis-based food pantries. Although project initiation is relatively new, we suspect outcomes will demonstrate an improvement in phosphate levels, health-related quality of life (e.g., alleviating the barrier of accessing renal-friendly foods), and food insecurity broadly. By offering renal-friendly food options at no cost to patients, nutritional goals can also be targeted without taxing families’ health literacy skills necessary to interpret food labels. In KHACE, we also work to improve our patient’s educational outcomes by promoting kindergarten readiness and high school graduation rates using targeted evidence-based assessments and interventions within our multidisciplinary teams (e.g., providing additional therapeutic recreation opportunities as a reward for increased school engagement assessments). Relevant to the exosystem, we consider how historical practices have influenced our patients’ relationships with, and trust in, the health care system, inclusive of the pediatric nephrology
workforce, with its disproportionately few Black providers.9 With this consideration, our nephrologists have worked through quality improvement initiatives to increase diversity in our training programs.10 Focusing on the macrosystem, KHACE works to advance kidney health equity through research by convening journal clubs to discuss methodology modifications that consider health equity (e.g., using chapters from The Science of Health Disparities from the National Institutes of Health). We also prioritize community engagement and advocacy locally by training our faculty, staff, and patients in legislative advocacy, then engaging with local and national organizations to promote equitable kidney care through policy.1

Addressing the systemic racial disparities in children with kidney disease is an ambitious task. Social factors are associated with kidney health, and factors such as race consciousness, perceived discrimination, and medical mistrust may be particularly effective for our patients from minoritized communities.6 It takes concerted effort, dedicated time and resources, and purposeful administrative support to meet the diverse needs of our patients; we owe it to them to reconsider the status quo from every level of operation and do better as representatives of the larger US health care system.

DISCLOSURES

A. Dawson reports having an ownership interest via minimal shares in various stocks through Robinhood. O.N.R. Bignall II and J.E. LaMotte have nothing to disclose.

FUNDING

None.

AUTHOR CONTRIBUTIONS

A. Dawson conceptualized the study; O.N.R. Bignall II, provided supervision; A. Dawson, and J. LaMotte wrote the original draft, O.N.R. Bignall II, A. Dawson, and J. LaMotte reviewed and edited the manuscript.

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