

Sutter Joins Leading Health Institutions in Excluding Race from eGFR Equation

By Stephanie Brown, M.D., MPH

Clinical Lead, Institute for Advancing Health Equity, Sutter Health
Emergency Physician, Alta Bates Summit Medical Center, Sutter Health

One of the benefits of practicing medicine within a large integrated healthcare delivery network is that it enables sharing of best practices and real-time data that can further health equity for our 3 million patients and those across the country. A great example is the work happening to ensure the scientific tools we use for clinical decision-making are free from bias, which can affect how we care for different groups of patients.

A diagnostic calculation to measure kidney function – estimated glomerular filtration rate (GFR) – guides pharmacologic utilization, timing of nephrology referral for management of chronic kidney disease (CKD) and eligibility for kidney transplant waitlisting. Current national practice for estimating GFR includes a race-based adjustment for Black patients compared with other patients, a suboptimal practice based on race, a social construct with no genetic correlate. Using race in this way contributes to systemic racism in healthcare and leads to disparities in outcomes for affected groups of people.



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Sutter Health has joined the ranks of leading national health institutions including Massachusetts General, Mt. Sinai, University of Washington, UCSF, UC Davis, and others in eliminating race-based GFR reporting. A National Kidney Foundation/American Society of Nephrology joint task force released [new recommendations](#) calling for immediate implementation of the creatine equation refit without the race variable, known as the eGFR 2021 EPI Creatine-Based Equation. Sutter's clinical and laboratory leaders are implementing this change, which will minimally impact medical staff and significantly advance equitable care for our patients.

Black Americans are 3-4 times more likely to suffer from CKD and end-stage renal disease than whites ([USRDS, 2010](#)) and are less likely to receive kidney transplant ([Eneanya et al, 2019](#)). A change in the equations we use to estimate kidney function could affect the care of millions of patients, as well as our national estimates of the public health burden of chronic kidney disease. One health center demonstrated the removal of the race-coefficient from the eGFR report improved transplant eligibility for Black patients ([Hoenig et al, 2021](#)).

In anticipation of the national joint task force guidelines, our team at the Sutter Health [Institute for Advancing Health Equity](#) (IAHE) examined the impact of the race coefficient on patients within our system. This work started over a year ago, when Dr. Hussain Gilani, Chief of Nephrology at Alta Bates Summit Medical Center (Summit Campus) approached IAHE about this issue, and the Sutter Medical Group Race, Equity, Diversity and Inclusion (REDI) Taskforce passed a resolution in support of removing race from the calculation. Dr. Gilani and REDI's leaders, [Drs. Andy Brothers](#) and Emma Garforth, joined forces with IAHE to further evaluate and advocate for this change at every affiliate across our network.

As a result of these Sutter physicians' leadership and advocacy efforts, in June 2022, Sutter will convert to the eGFR 2021 CKD EPI Creatinine-Based Equation formula to calculate eGFR in result reporting for all patients seen at our hospitals and acute care centers. A task force of clinical and

laboratory leaders at Sutter have convened to operationalize this change. For more on the interim solution, [please refer to the KDS](#).

While changing the equation is a huge step in the right direction toward narrowing the gaps in disparities for kidney disease, it is only one piece of the puzzle. We must continue to address implicit bias in healthcare, address the social determinants of health, and continue to improve access to high-quality healthcare for all the patients we serve.

At the IAHE, we plan to convene a work group to ensure the ongoing evaluation and assessment of clinical decision-making tools and algorithms to ensure they are free from bias (including race, age, gender, socioeconomic status, and other factors). We are currently examining the impact of bias in pulse oximetry devices, which can be less accurate for patients with darker skin, and plan to release our findings in the coming months.

We must commit to researching these types of biases in medicine, increasing awareness among our fellow clinicians and advocating for better tools. This is good medicine.