Currently, there is not a systematic approach to population health for patients with CKD. Nephrologists and other providers should work together to develop new, improved approaches for care for patients with CKD.

8 Increasing access to kidney transplant

Most agree that transplant is the optimal therapy for patients with kidney failure. Yet few patients benefit from a transplant: only 2.6% of patients with kidney failure receive a preemptive transplant as a treatment; the remaining 97.4% start dialysis. Nephrologists and other providers should work together to develop new approaches to improve access to kidney transplantation.

9 Improving end-of-life care

Patients >80 years old with multiple co-morbidities have comparable outcomes if they receive comprehensive conservative care instead of dialysis, yet few choose this option. One of the barriers to improving access to non-dialytic care for those who might benefit more from an aggressive medical approach to their uremia, rather than from dialysis, is the lack of training in non-dialytic care. In addition, patients on dialysis at the end of life utilize hospice much less frequently than other patients with similar co-morbidities and cost of care. Nephrologists and other providers should work together to improve end-of-life care, both for patients with CKD and patients on dialysis. ASN could explore curricula elements that inform nephrology trainees about medical strategies that extend the duration and quality of life without dialysis.

10 Improving access to home dialysis

Most nephrologists and clinicians would choose home dialysis for themselves, yet few patients on dialysis are able to benefit from dialysis at home. A patient dialyzing at home has more autonomy, is more likely to continue to work, and has more satisfaction in their kidney care. Many training programs do not have a sufficiently large home dialysis program to adequately train fellows. They therefore have difficulty recognizing appropriate candidates for home modalities and do not feel comfortable prescribing home dialysis when they get into practice. Nephrologists and other providers should work together to identify opportunities to make it more likely that patients on dialysis can benefit from home dialysis, including rethinking curriculum structure and requirements for training and competence in home dialysis.

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ASN President: State of Kidney Care 2016

By Eleanor D. Lederer, MD, FASN, with David White

Medical care in the United States is poised to undergo one of the most comprehensive transformations in the past 50 years, prodded by ever-rising costs and poor population health performance. To address these and other challenges, Congress—with support from President Barack Obama—passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015. MACRA has led to Medicare's creation of a new physician reimbursement system, the Quality Payment Program (QPP). QPP represents the most significant step to date in transitioning from a volume-based reimbursement system to a value-based one. Transitions of this magnitude engender anxiety among patients about legitimate concerns for their medical care and for providers who have equally legitimate concerns about their role in the new order. In my opinion, no group of health care providers is better equipped to comprehend and implement these changes than nephrologists.

For decades, nephrologists have worked within ever increasing regulations, guideline expectations, and cost-conserving measures. And they have succeeded in adjusting their practices accordingly while simultaneously delivering state-of-the-art care to the ever-growing population of patients with kidney diseases. Nephrologists have firsthand experience in the comprehensive care for patients with multiple co-morbidities over extended periods of time, providing care for patients with kidney diseases at all stages, treating and guiding patients who transition between multiple treatment modalities, and supporting patients who need end-of-life care. These transitions for patients with kidney disease can be fraught with uncertainties and risks and require a robust patient-nephrologist relationship. Nephrologists are uniquely positioned to assume leadership roles in the development and implementation of new, thoughtful health care delivery models. Yet, in order to accomplish these goals, nephrologists have to stand up and speak up. As US medical care undergoes transition, so will nephrology as a profession, nephrologists as a group, and the American Society of Nephrology (ASN)—as an advocate for patients and nephrology health professionals.

How positive this transition or transformation is may largely be determined by the role nephrologists play and the leadership nephrologists offer as a collective profession. In his ASN President's Address at ASN Kidney Week 2016 in Chicago, Raymond C. Harris, MD, FASN, eloquently outlined the path forward.

Surveying the crossroads

In the United States, interest in nephrology as a career has decreased among internal medicine residents. There are a host of factors behind that decrease. In my opinion, contributing to a softening of interest in the profession is increasing concern about issues of reimbursement and of career autonomy. The dominant role of dialysis in the practice of nephrology combined with the increasingly prominent role of the dialysis organizations in defining nephrology practice have led some to question whether the relationship between the dialysis organizations and nephrologists has become imbalanced.

Federal policy decisions further complicate the situation, such as the failure to implement laws allowing the provision of antirejection medications for the life of a kidney transplant or to protect the insurability and job security for living kidney donors. These policy decisions appear to be shortsighted and driven by short-term budget considerations rather than consideration of the best long-term results for our patients. The recertification process and the realities of practice feel misaligned to many. Research funding for kidney diseases by federal agencies and foundations has stagnated, diminished, or, in some cases, disappeared, dissuading young investigators from entering the field.

The current system of reimbursement for end stage renal disease (ESRD) care has led to the entrenchment of "silos" of kidney care, fragmenting the delivery of nephrology care to patients with chronic kidney diseases, ESRD patients on dialysis, and transplant patients. How the QPP might create new opportunities to overcome this situation may prove challenging as Medicare moves to a quality system emphasizing care coordination.

Determining the nephrologist's role in the practice of medicine

Despite the decline in nephrology fellowship applications, surveys indicate that the vast majority of nephrologists in practice enjoy their work and feel engaged. The same conclusion is borne out by nephrology trainees in those surveys, which suggest that defining the role of the nephrologist in comprehensive kidney care may provide a more attractive view of the profession and enhance recruitment. Nephrologists have long worked as members of multidisciplinary health care teams and have engaged providers at all levels—clinic managers, APRNs, PAs, nurses, dietitians, social workers, pharmacists—to provide the best care for patients with ESRD. Nephrologists need to actively define their role in the practice of medicine, and to occupy that space as leaders in care throughout their patients' journeys through stages of kidney disease.

Nephrologists should also look for leadership roles across the kidney care delivery spectrum. There will be a variety of settings for professional development where nephrologists can play a leadership role such as LDO chief medical officers (CMOs), SDO CMOs, hospital CMOs, and more.

A large kidney disease population with high rates of co-morbidities demands coordinated care. The nephrologist is an internist first and foremost and should not easily cede oversight care of their patients' non-kidney conditions. Under the incoming quality-based system with a heavy emphasis on clinical outcomes, it is important that nephrologists remain hands-on to ensure optimal outcomes.

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State of Kidney Care

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Working toward Comprehensive Kidney Disease Care

Patients with kidney diseases need comprehensive kidney disease care. Nephrologists should play a significant role in developing that model along with primary care physicians, transplant nephrologists and surgeons, pediatric nephrologists, dialysis organization CMOS, nurses, social workers, and regulatory agencies. A greater focus needs to be placed on guiding patients through transitions such as transitioning to late-stage kidney diseases, dialysis, transplantation, and back to dialysis.

If there is to be a re-imagined comprehensive kidney care approach that follows care across, and breaks down, silos, then there must also be a re-imagined role of the nephrologist who leads the team. There must also be a role for the primary care physician as well as transplant surgeons and nephrologists, medical directors and CMOs of dialysis organizations, nurses, social workers, and others to provide unified, seamless care. Medicare will continue to move toward value and clinical-based outcomes for reimbursement, and such an approach demands coordinated care.

As Dr. Harris said in his President's Address at Kidney Week 2016, now is the time to broaden, not constrict, the vision of what a nephrologist is. The logical conclusion follows that the nephrologist's role in the care continuum would broaden as well. The current training for nephrologists needs to also emphasize interventional techniques, novel imaging modalities, clinical genetics, and immunology. Perhaps all medical training should include medical economics and administration as well as international medicine and global health.

Making the case for aggressive funding for innovation, discovery, and research

Few parts of kidney care are more in need of a transition to a better state than funding for research and discovery. The investment in innovation, discovery, and research in kidney diseases must grow if the burden of kidney diseases is to be reduced. Kidney diseases affect 300 million people around the world, including more than 20 million Americans. More than 650,000 Americans have kidney failure and need dialysis or a transplant to live.

Kidney failure is unique in that it is the only health condition automatically covered by Medicare regardless of age or income, and the costs to the program are staggering. Medicare spends over $32 billion annually on the ESRD Program alone, which is 7% of Medicare's budget for less than 1% of its patient population and more than the entire budget for the National Institutes of Health (NIH).

To reduce the large Medicare commitment to the ESRD program, ASN has advocated that Congress must increase its commitment to curing kidney diseases by boosting funding for research. In addition to fully funding the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at NIH for Fiscal Year 2017 (October 1, 2016, to September 30, 2017), Congress needs to allocate an additional $150 million per year over 10 years for NIDDK-funded kidney research above the current funding level. These are crucial and necessary investments for preventing illness and maintaining fiscal responsibility. Investing in research to slow the progression of kidney diseases and improve therapies for patients would yield significant savings to Medicare in the long run.

A state of transition is here. Nephrologists, other health professionals, and ASN must work together with CMOs and other stakeholders—especially patients and their families—toward a future in kidney care that builds on the amazing advances of the last half century for continued advancements for patients, nephrologists, and the entire state of medicine.

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