Fellowship Recruitment and the Future of the Nephrology Workforce

By Joseph Mattana

The past several years have seen a decline in the number of applicants for nephrology fellowship positions with about half of all programs having unfilled slots. It is anticipated that a further decline will be found for the current recruiting season. The recent US Nephrology Workforce 2015: Developments and Trends (1) from George Washington University (ASN Nephrology Workforce report) highlights many of the key issues that are likely to affect the future of the nephrology workforce, issues that are intrinsically linked to interest in nephrology and fellowship recruitment.

It is somewhat ironic that decreasing interest in nephrology careers is taking place at a time when great progress is being made in the care of patients with renal disease. For example, end stage renal disease (ESRD) incidence rates have been falling for the past several years, undoubtedly reflecting the efforts of nephrologists to use angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, and other interventions to slow progression of chronic kidney disease (CKD).

Mortality rates for CKD have been falling and are declining at a rate faster than the non-CKD population. ESRD mortality rates are declining as well. There are new therapeutic regimens and remarkable pathophysiologic and genetic insights in glomerular disease, transplantation, hypertension, electrolyte metabolism, and many other areas. Ongoing laboratory and clinical investigations continue to yield valuable results that are having a positive impact and continue to add to the excitement of being a nephrologist.

There are, however, a number of factors that are contributing to declining interest. There is a perceived lack of job opportunities and concern that this will be a continued problem. There is also a perception that the quality of life and compensation of the nephrologist is less compared to those in other specialties. Alternative careers have become more appealing, especially hospitalist medicine, regarded by many as being better compensated and having a better quality of life. The ASN Nephrology Workforce report indicated that about a third of nephrology fellows would not recommend nephrology to others. If practicing nephrologists are negative about their chosen specialty this can understandably be devastating for students and residents who are considering careers in the field.

The composition of the nephrology applicant pool will continue to have important implications for the future workforce as well. Applications from US medical graduates (USMGs) are decreasing. In the past, this has been counterbalanced by nephrology having a substantial pool of international medical graduates (IMGs), but as outlined in the ASN Nephrology Workforce report, IMGs face particular challenges in pursuing nephrology careers. While IMGs have less educational debt to manage compared to their USMG peers, they report having a harder time finding jobs, with 72.5% reporting having a difficult time finding a job with which they were satisfied in 2015. Only 62.7% of IMG fellows said they would recommend nephrology as a career. The percentage for USMGs recommending nephrology was somewhat higher at 74.4%.

While interest in nephrology has been declining in recent years, over the past 15 years there has been a large increase in the number of fellowship slots, with an almost 50% increase since 2000. The impetus for this increase has been based on past predictions of eventual shortages of nephrologists. Finally, there is a mal distribution of the ratio of nephrologists to patients throughout the country, a problem without a simple solution as choice of where to practice is influenced by additional factors aside from patient location.

Fortunately, ASN is making great efforts together with the nephrology community to promote interest and provide a robust nephrology workforce for years to come, with many promising interventions being implemented and published. The variables discussed here and detailed in the ASN Nephrology Workforce report merit close observation.

Joseph Mattana is chief of the Division of Nephrology and Hypertension at Winthrop-University Hospital in Mineola, NY, and is a member of the Kidney News Editorial Board.

Reference

Changing Payment and Care Models for Kidney Patients

By Richard Lafayette

After the signing into law of the Affordable Care Act in 2010, the Centers for Medicare & Medicaid Services developed the idea of accountable care organizations (ACOs) as a way to improve health care outcomes while controlling costs. ACOs are legal entities composed of physicians, other providers, clinics, and hospitals, with shared governance toward providing patient care. The idea is to share risk in the management of a given population toward providing high-quality, cost-effective care. It was expected that this approach would foster multidisciplinary preventive care that would improve health and avoid expenses. If organizations save money for Medicare while achieving quality metrics to assure full engagement of patients, they share in the savings. Ultimately, if they spend more, or do not provide quality care, their payments from typical fee-for-service charges are reduced. Thus, they must get a handle on the entire treatment of a patient from primary care to specialist care, including outpatient and inpatient treatment, to have some impact on the quality of care and associated costs.

For patients with chronic kidney disease (CKD), especially those with ESRD, this model brings up many challenges but also opportunities. CKD care is incredibly expensive, complex, and highly specialized. Patients have multiple comorbidities, are frequently hospitalized, and have wide variability in their care. Those already receiving dialysis are cared for under the present rules (at least the vast majority of patients covered by Medicare), with separate quality initiatives and monthly capitation for most of their dialysis-specific costs. Physicians are paid on the number of face-to-face visits per month. The general format of ACOs is that patients are enrolled by primary care groups, which determine the quality interventions and management. Specialists are not central to patient care.

For patients with CKD, it has been suggested that nephrologists have the experience, interaction, and skills to best coordinate the care of these patients, especially those with progressive or advanced disease. These ideas led to Medicare sponsoring the creation of ESRD seamless care organizations. These organizations are intended to capture the overall burden of care and costs for ESRD patients, with shared savings and risks and measures of quality and outcome. This experiment has rolled out slowly, largely embraced by large dialysis organizations and some large health care systems, but the results have not yet been well reported. The results should prove very interesting and should provide a key to whether or not other specialty-specific care models will go forward. Once evaluated, this may determine whether nephrologists and kidney care teams will become the central players in the care of patients with CKD, or rather a captured employed resource for other management organizations.

It strongly behooves us to become intensely involved in these experiments and other launches of ACOs and, in fact, all discussions of models of care of our patients. We must defend the health of kidney patients to the best of our ability while ensuring that the nephrology care team maintains its value and professionalism. The American Society of Nephrology has been closely involved with Medicare and other payers, and I hope all involved parties stay tuned and active in 2016 and beyond.

Richard Lafayette, MD, FACP, is Associate Professor, Medicine/Nephrology, at Stanford University Medical Center, and is Editor-in-Chief of Kidney News.