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

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 kid-
ney failure receive a preemptive transplant as a treat-
ment; the remaining 97.4% start dialysis. Nephrolo-
gists and other providers should work together to
develop new approaches to improve access to kidney
transplantation.

Improving end-of-life care
Patients >80 years old with multiple co-morbidities
have comparable outcomes if they receive compre-
prehensive conservative care instead of dialysis, yet few
choose this option. One of the barriers to improv-
ing 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 mor-
bidities 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 strat-
gies that extend the duration and quality of life
without dialysis.

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 dia-
lyzing at home has more autonomy, is more likely to
choose this option. Of the barriers to impro-
ing access to non-dialytic care for those who might
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The current system of reimbursement for end-stage
renal disease (ESRD) care has led to the entrench-
ment of “silos” of kidney care, fragmenting the deliver-
y of nephrology care to patients with chronic kidney
diseases, ESRD patients on dialysis, and transplant
patients. How should nephrology organize to adapt new opportuni-
ties 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 appli-
cations, surveys indicate that the vast majority of
nephrologists in practice enjoy their work and feel
engaged. The same conclusion is borne out by neph-
rology 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—clinicians, 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
cos-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 qual-
ity-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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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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State of Kidney Care

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