Monday, March 19, 2018

A New Breed of Nephrologists: Can We Change the Practice Paradigm?

I want you to put yourself in the shoes of your average nephrologist, it seems frenetic when looked at from a birds eye view. A typical day begins with rounding on first shift dialysis patients, then on to seeing hospital patients at a different location. After tucking in patients who need urgent care, the next stop is clinic, yet again at a different location. Clinic time is peppered with phone calls with follow-up questions after morning rounds diverting attention from the clinic patients there to seek advice in front of you. We're not factoring in the possibility of urgent consults (i.e.emergent dialysis or severe hyponatremia) or coverage at Long Term Acute Care Facilities (LTAC's) yet. Add to this the additional time needed to round on the evening dialysis patients or going to see that late urgent consult, it all seems draining. Underestimated in this picture is that of lag time, the distance between the dialysis unit, the hospital or the clinic; depending on where one works this can be upwards of one to two hours of pure driving/lag time. Those two hours could have been spent seeing patients or focusing on the ones already on the roster! The icing on the cake is night coverage - the uncertainty of a restful sleep after a hectic day with the potential to be called into the hospital in the middle of the night. Could this be a reason why residents are not considering nephrology? They see the clinical nephrologist stretched thin and starting to show signs of burnout?.

It's no secret that interest in nephrology has waned and much interest has been paid to hone in on the exact reasons for this observed trend. On the one hand, it's sad to see a field I love need some resuscitation yet on the other, there's a bold charge from angles such as academia and physician engagement which is comforting and refreshing to see. These visionaries are making nephrology cool again;nerdy is the new cool. The topic I'm going to talk about is based on my experiences thus far and reflective of a personal journey. I've recently had the privilege of joining the Nephrology Social Media Collective as well as joining a private practice nephrology group, Dallas Renal Group (DRG). These new opportunities have allowed me to rub elbows with some of the smartest clinicians and innovators in the field who have found a knack for weaving nephrology with fun ways of learning and teaching others how to run a successful practice. One aspect that may be a contributing factor to the current trends is that of the structure of what a real life nephrology practice looks like. En route to becoming a nephrologist, a pit stop was as a hospitalist, what can I say, the siren song of the nephrons was too strong.

Having that experience coupled with seeing a pioneering prototype of a novel practice structure at DRG has given me perspective that can be applied broadly and hopefully attract future nephrologists.

What's being done? Locally at the fellowship level, faculty and training program directors have increased efforts to innovate and increase interest among residents via innovative teaching techniques and creative nephrology electives for medicine residents. At the national level, ASN started the Kidney Treks program to enhance interest in medical students and residents. In addition, outside the confines of institutions, there is a blossoming charge being led by visionaries in the academic arena embracing use of social media platforms such as Twitter to conduct journal clubs with the hashtag #NephJC, and the Nephrology Social Media Collective #NSMC which aims to connect, mentor, and inspire future nephrologists from around the world. In the coming month we'll be looking forward to NephMadness, a play on March Madness using a game format and competitive enthusiasts to get the community engaged with current topics in nephrology moderated by world renowned experts and KIDNEYcon, a conference with a focus on hands on workshops. In the business/leadership realm there is Nephrology Business Leadership University (NBLU), an initiative created by physician leaders at DRG and UCSD that's now expanded to include other practices as well. This course is teaching graduating fellows the economics and business of a nephrology practice, some of the intangibles acquired often after years of private practice. Topics covered at NBLU include transitioning from fellowship to private practice, leadership tracks, billing and coding, understanding insurance and reimbursement and marketing strategies topics that are not often addressed during fellowship.

There's already been success in spurring interest in the game, what about switching up how the game looks like in practice? It's interesting and ironic to note that most fellowship programs have a focused rotation format with months devoted solely to inpatient, transplant, research and dialysis with clinic incorporated throughout begging the question as to why as attendings are we juggling our time. A field where cues can be taken from is hospitalist medicine. The lure of hospitalist medicine is shift work, work life balance and a decent compensation. Hospitalist medicine has impressively boomed since its advent in 1995 tallying a total of 50,000 physicians in 2016, roughly half of internists. Why can't nephrology follow a similar pattern? Nephrologists need to entertain morphing their current practice structures to decrease "windshield time" which will translate to increased efficiency, better patient outcomes, and decreased physician burnout. Finding a new system that works will definitely take some time but also innovation.

There are novel options such as nephro-hospitalist and nephro-nocturnist. These two positions are reminiscent of internal medicine training and current hospitalist structures where there are focused rotations for 4-6 weeks at a time, including night float, divvied up amongst all the residents. In a group practice with as many attendings as a traditional residency program, these ideas potentially are feasible. Having worked as a hospitalist in the past, one of the most attractive aspects was the schedule allowing me the ability to travel for medical relief work abroad primarily with the Syrian American Medical Society and the Islamic Medical Association of North America while not sacrificing compensation.

As fate would have it, the unique role of the **nephro-hospitalist** has been piloted with success at my current job at DRG. From a logistical perspective, there have to be enough inpatients requiring nephrology consultation to justify the existence of a nephro-hospitalist. DRG happens to be a large and growing nephrology group in the Dallas, Texas area with a robust patient population and thus was ideally suited for this new structure. However, there are pros and cons to consider. Pros being a flexible schedule, since you're aware of the census and it's acuity, you can tailor when you're going to round. You're delivering efficient care knowing that there is no second or third site to rush to throughout the day, minimizing lag/windshield time. You know that your responsibility is limited to the confines of the hospital. The position of a nephro-hospitalist is mutually beneficial for the hospital and a powerful asset given the assurance of knowing that a sick patient will be seen quickly when a nephrologist is onsite. To complement the nephro-hospitalist, there would be a nephrologist focusing solely on the outpatient realm (clinic and dialysis). This would allow for focused attention to patients in the clinic and the dialysis unit with less distraction from hospital phone calls. For a nephrologist, efficiency and decreased lag time is the name of the game.

The caveat of focusing on hospital patients is that invariably there is a higher level of acuity which may predispose the physician in this role to burnout. Going forward the development of hard patient caps, established backup systems for when the census becomes overwhelming or perhaps more time off may need to be considered. Some potential downsides of this model is that both the nephro-hospitalist and outpatient nephrologist could lose their respective skills of the other setting. This notion can be countered with the fact that in this layout every group member is taking calls on the weekends hence staying in touch with inpatient nephrology. A blended rotation approach has also been implemented at DRG maintaining the best of both worlds. Similar to a rotation schedule but on a smaller scale. Each physician, out of a group of four, rotates through the

hospital for a week at a time, coinciding with and preceding their weekend on call. Benefits of this layout are the ability to stay in touch with outpatient nephrology, focused care, plus the added perk of knowing all the patients for the weekend call making rounding much more fluid.

Another idea is the **nephrology nocturnist**. This is aimed aimed at handling urgent consults and phone calls at night. The sole task would be to address emergent issues and see consults overnight. Theoretically this would certainly lead to a better quality of life for the daytime physicians who at present are conducting full days of work despite being summoned in the middle of the night for emergent consults. Sleep is known to be an important contributor to well-being. In fact, poor hygiene is associated with cognitive decline. Having a nephrologist on standby could lead to better physician wellness and potentially higher satisfaction from patients and referral sources. In the hospitalist world finding and retaining nocturnists is difficult, which is not surprising. Despite this challenge, nocturnists contribute to the success of several hospitalist programs. There may be some feasibility in piloting a nocturnist rotation in fellowship programs or private practice. As an example, nocturnal nephrology coverage is currently in place at Icahn Mount Sinai Nephrology fellowship program as well as SUNY Downstate. Thus, this is not a completely foreign concept in nephrology.

The two potential alternative staffing models listed above are assuming that the amount of patients needed to generate revenue for the practice remain constant. Physicians find themselves guided through structured paths in the process of obtaining an undergraduate degree to graduating from a residency and/or fellowship. These are predetermined paths and frankly little attention is paid to the economics of medicine throughout. Once doctors reach the workforce however, that lack of exposure to business and finance is apparent once decisions are made regarding how best to optimize valuable time. At NBLU there is a heavy emphasis on the concept of shifting focus away from factors not immediately in our control, like reimbursements and regulations. Instead, more focus should be placed on leadership roles as well as exploring passive revenue models. Leadership roles endow a sense of empowerment among those in them and ensure our voice and point of view as physicians are heard. Passive revenue models can help us work "smarter" instead of "harder." Some options include investing in dialysis units, research, access centers and real estate.

These new models and ideas can help increase job satisfaction and decrease the burnout among nephrologists. In addition, fellows in programs with such models might have better coverage systems and experience more "learner" centered fellowships rather than "service" centered ones. It is refreshing to see these new trends emerging from academics and private practices who are leading the way in taking on the challenges presented and joining other nephrologists in reinvigorating the field. Time will only tell how successful these models are, judging from the success of the hospitalist mold and pilot structural changes at DRG, hopefully these will be as well.

Nimra Sarfaraz
@DrNimraS
Nephrologist
Dallas Renal Group
Dallas Texas
NSMC Intern, Class of 2018