Joint AAPA-RPA Consensus Statement on Renal Physicians and Physician Assistants: Excellence in Team-Based Medicine

Introduction

Renal physicians and physician assistants (PAs) share the goal of providing high quality, cost-efficient, patient-centered care to improve the health of patients and communities. We are mutually concerned about the predicted shortage of nephrology providers who will be responsible for a growing population of patients with kidney disease.

Ten percent of adults in the United States, more than 20 million people, have chronic kidney disease (CKD).\(^1\) Approximately one in three adults with diabetes and one in five adults with hypertension has CKD; other risk factors include cardiovascular disease, obesity, high cholesterol, family history of CKD, and aging.\(^2\) The incidence of CKD is increasing most rapidly in people ages 65 and older; it more than doubled between 2000 and 2008.\(^3\) The prevalence of recognized CKD in the Medicare population increased more than three-fold between 2000 and 2010, from 2.7 to 9.2 percent, and rose with age within that population.\(^4\) The growing number of Americans with kidney disease and an expanding elderly population indicates an increasing need for a robust nephrology workforce. The anticipated influx of newly insured patients as a result of the Patient Protection and Affordable Care Act is likely to further tax the capacity of the nation’s nephrology practices.

Recent data indicate that the current pace of growth of active nephrologists may not meet present or future patient care needs. Meeting the expected demand for kidney care can be partially solved through effective physician-PA team practice. Acknowledging the critical role that physicians and PAs can play in improving access to care, the American Academy of Physician Assistants (AAPA) and Renal Physicians Association (RPA) offer the following joint statements:

1. **RPA and AAPA believe that nephrologists and PAs working together is a proven model for delivering high quality, cost-efficient, patient-centered care. RPA and AAPA believe that this integrated model is ideally suited to expanding patient access to the comprehensive, complex care needed by patients with kidney disease.**

2. **RPA and AAPA believe it is essential that physician-PA team practice is fully recognized in all new and emerging models of care.**
3. RPA and AAPA encourage inter-professional education of medical students, nephrology residents and PA students throughout their educational programs; encourage ongoing innovations in interdisciplinary education; and support opportunities for nephrologists to precept PA students and participate as faculty at PA programs. In addition, RPA and AAPA encourage increased nephrology rotation opportunities for PA students, medical students and resident.

4. RPA and AAPA believe that national workforce policies should ensure adequate supplies of nephrologists and PAs to improve access to quality care and to avert anticipated shortages of clinicians to care for increasing numbers of patients with kidney disease.

5. RPA and AAPA support federal and state regulation that allows individual institutions or medical practices flexibility to determine appropriate clinical roles within the medical team.

6. RPA and AAPA encourage dialysis corporation policies that maximize patient access to care by allowing individual institutions or medical practices the flexibility to define oversight processes and clinical roles within the medical team. Allowing flexibility at the practice level supports increased patient access, improved continuity and integration of care, and greater patient and provider satisfaction.

**Expanding Access**

1. RPA and AAPA believe that nephrologists and PAs working together is a proven model for delivering high quality, cost-efficient, patient-centered care. RPA and AAPA believe that this integrated model is ideally suited to expanding patient access to the comprehensive, complex care needed by patients with kidney disease.

Team practice built on a foundation of respect and collegiality, clear communication, joint decision-making, understanding of individual roles, and a commitment to positive outcomes can simultaneously improve quality of care and expand access to many more patients.

PAs are licensed to practice medicine with physicians. They practice with nephrologists, providing global care and management of patients with CKD and end stage renal disease (ESRD). A recent survey of PAs practicing with nephrologists found that they serve patients in varied practice sites including hospitals, dialysis units, CKD and transplant clinics, and private offices. Practice laws in all states and federal agencies allow physicians and PAs to work in separate locations. In nephrology, where so much time is spent caring for patients in dialysis centers and hospitals, this ability to consult when necessary using electronic means enables practices and institutions to maximize clinical efficiencies and patient access. PAs who are recent graduates or new to nephrology may work more closely with a nephrologist than seasoned PAs, who typically work autonomously, consulting as needed. In any setting, the specific responsibilities and level of autonomy of a given PA depend on that individual’s experience and expertise.
Outpatient dialysis settings
In outpatient dialysis settings (including in-center hemodialysis, chronic peritoneal dialysis and home hemodialysis) the team provides general medical and nephrology services to patients with ESRD. The PA’s role often includes, though is not limited to, performing weekly dialysis rounds, obtaining annual histories and performing physical exams, ensuring that primary care needs are met, responding to medical and dialysis related emergencies, attending Patient Care Planning and Quality of Care meetings, completing patient-specific forms (such as disability, transfer papers, etc.) and taking call.

Office and outpatient care
In offices and outpatient clinics, PAs are responsible for services such as providing CKD education and ordering arteriovenous access formation; managing anemia, metabolic bone disease, and hypertension; attending to the patient’s primary care needs; providing pre- and post-renal transplant follow-up, and managing and participating in all phases of drug trials.

Hospital inpatient services
PAs work with attending physicians and residents on nephrology services treating patients with acute and chronic conditions. PA duties typically include, though are not limited to, performing line placements for dialysis and other extracorporeal procedures and managing acute and chronic dialysis related problems in the inpatient dialysis setting.

Some nephrology practices utilize PAs as hospitalists. The PAs perform rounds and inpatient consults and manage patients of the practice who are in the ICU. Assigning PAs to the hospital provides continuity for hospitalized patients and gives the physicians more office time, increasing opportunities for patient access, consultations and outpatient diagnostic testing.

2. **RPA and AAPA believe it is essential that physician-PA team practice is fully recognized in all new and emerging models of care.**

As insurance marketplaces and specialty medical homes take hold and other innovations are introduced in the nation’s healthcare system, maximum availability of providers will be essential. Only when language in emerging models calls for full utilization of all clinicians, will patients reap the full benefit of the care that high-functioning, integrated practices can provide.

New and emerging models that do not specifically recognize PAs as medical providers create enormous barriers to effective delivery of care, limiting their potential to expand access and improve health.⁷

**Learning in Teams**

3. **RPA and AAPA encourage inter-professional education of medical students, nephrology residents and PA students throughout their educational programs; encourage ongoing innovations in interdisciplinary education; and support opportunities for nephrologists to precept PA students and participate as faculty at PA programs. In addition, RPA and AAPA encourage increased nephrology rotation opportunities for PA students, medical students and residents.**
To improve inter-professional practice, AAPA and RPA encourage innovative education programs emphasizing the team approach in medical schools, residency programs, and PA education programs. Medical students, medical and surgical residents, and PA students must be adequately prepared to work together in order to provide optimal care and maximum access for patients.

RPA and AAPA encourage renal physicians to serve as faculty and preceptors in educating PAs. This would introduce PA students to the field of nephrology, might lead more graduates into the specialty, and would expose nephrologists to the rich medical education PAs receive. Precepting enables physicians to experience the overlapping and complementary skills PAs bring to an inter-professional team and can facilitate recruitment of new graduates into their practice.

**Building the Workforce**

4. **RPA and AAPA believe that national workforce policies should ensure adequate supplies of nephrologists and PAs to improve access to quality care and to avert anticipated shortages of clinicians to care for the increasing numbers of patients with kidney disease.**

The PA profession is uniquely flexible in adapting and responding to the evolving needs of the U.S. healthcare system. PA educational programs provide a graduate-level, generalist medical education. PAs are trained to think like physicians and to be life-long learners. The intense didactic and clinical instruction produces individuals who know how to practice medicine as part of a team and value their role in the system. Their broad-based training prepares PAs to work with physicians in any specialty, enabling them to move within the overall system to specialties where they are most needed. PA programs average 26 months in length, equivalent to three academic years, after college pre-requisite coursework. This relatively short production pipeline enables a quick response to changes in workforce needs.

**Flexibility at the Practice Level**

5. **RPA and AAPA support federal and state regulation that allows individual institutions or medical practices flexibility to determine appropriate clinical roles within the medical team.**

Making decisions about individual provider roles at the practice level – not the regulatory level – will be essential to meeting increasing demand and the diverse needs among patients with CKD. The most effective teams are able to decide individual scopes of practice, oversight and collaboration plans, and the ratio of PAs to physicians. Flexibility at the practice level enables each clinician to work to the fullest extent of his or her license and expertise to meet the needs of that practice and patient population. Government regulation, when too rigid, creates barriers to innovation, access, and efficiency.

6. **RPA and AAPA encourage dialysis corporation policies that maximize patient access to care by allowing individual institutions or medical practices the flexibility to define oversight processes and clinical roles within the medical team. Allowing flexibility at the practice level supports increased patient access,**
improved continuity and integration of care, and greater patient and provider satisfaction.

Corporate policies that restrict the ability of team members to practice to the extent allowed by state practice laws or federal practice policies can unnecessarily limit their effectiveness. Corporate policies that are more restrictive than licensing laws or federal practice policies create unnecessary barriers to high quality care.

Conclusion

RPA and AAPA believe that the intensity, complexity and continuity of care required by patients with kidney disease make the integrated clinical team an ideal approach to providing care. With the dire predictions of patient need and workforce projections for the coming decade, nephrology providers will have to create new and better ways to deliver patient-centered care. Renal physicians and PAs, working together to provide collaborative, patient-centered care, can simultaneously improve quality and expand patient access, improving the lives and health of the nation.
References


The primary author of this policy paper was Ellen Rathfon, Director, Professional Advocacy, American Academy of Physician Assistants, with input from the Renal Physicians Association. The AAPA Board of Directors approved the document on May 23, 2014, and the RPA Board of Directors approved it on May 30, 2014.

Clinical consultants were Karen Burchell, PA-C, AAPA liaison to RPA, and RPA Clinical Practice Committee members, Jeffrey Perlmutter, MD (Committee Chair); Marilyn Galler, MD; Leland Garrett, MD; and Derrick Latos, MD.