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Appreciating the Role of Advanced Practice Providers in Oncology

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The integration of physician assistants (PAs) and nurse practitioners (NPs) into practices caring for patients with cancer is well recognized and decades old. Advanced practice providers (APPs), as they are collectively identified, play an important role in both academic and private practices. In light of well-known projections for increased numbers of cancer diagnoses, increased numbers of cancer survivors, and a shortfall of fellowship-trained hematology and oncology physicians over the next 8 to 10 years, examination of several variables relative to APPs is timely.¹ Areas of consideration include recruitment, training, clinical role, productivity, and retention. To successfully ensure continued growth in APP capacity in oncology, all of these areas, and possibly others, must be addressed by practices considering or using APPs.

Recruitment

APPs are graduates of accredited university-based programs. PAs graduate with a certificate or baccalaureate or Master's degree. Graduation renders them eligible for sitting for national certification boards administered by the National Commission for Certification of PAs. NPs are Master's-prepared registered nurses (RNs) who must pass requisite boards in their specialty. Both PAs and NPs must obtain state licenses and practice within statute-defined scopes of practice. The lucky recruiter may find an applicant with relevant oncology experience. However, recognizing that new graduates will make up a large proportion of the applicant pool makes showcasing attractive career opportunities in oncology important.

Training

A significant number of new graduates are hired into oncology practices, including medical, surgical, and radiation-based practices. Therefore, successful recruitment involves not just salary and benefits but also includes the opportunity within practices to participate in a structured learning or orientation period that assures the new provider of a solid theoretical and applied basis for going forward in clinical practice.

Most training programs do not have a sophisticated approach to cancer, and most graduates come to practices with little clinical or didactic exposure. Practices must be willing to accept the up-front expense required to ensure a thorough grounding in the principles of care relevant to the particular practice, because new providers may require 6 months or longer before their productivity begins to pay back the expense of training. Without this investment, however, provider retention is threatened (and the cost of replacement possibly incurred). Additionally, financial allocations for ongoing medical education, usually required for relicensing, must be included in training expenses.

More importantly, particularly for academic practices, is the larger recognition that oncology training guidelines are not fully agreed on across institutional boundaries. National organizations such as NCCN and ASCO have the opportunity to participate in the creation of training modules, disease-specific or otherwise, that could be incorporated into training programs or used in the employment training of

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newly hired providers. Such a modular package would help to standardize training, incorporate multiple best practices, and provide a training tool for smaller practices that might not have the resources for such all-encompassing training. It would also serve as a further recruitment and retention tool for APPs interested in oncology. Of particular interest recently is the concept of an APP postgraduate residency program in oncology to meet these needs. Although there is no clear answer, a modular approach readily distributed via the Web would potentially meet this training need without the organizational burden and expense of a full-fledged residency program.

Clinical Role

APP practice varies across sites, types of practice, practice size, and specialty, among other variables.^{2,3} Certain common themes regarding use can be identified. First of all, although most APP practice occurs in the clinic, oncology-focused APPs are increasingly working throughout the hospital. This is particularly true in academic practices where increasingly stringent Accreditation Council for Graduate Medical Education regulation of house staff practice has led to the creation of APP-staffed oncology services that function independently of the house staff. In the clinic, use patterns reflect the ability of APPs to see follow-up patients in the course of their therapy either independently or in shared visits with partnering physicians. Each practice defines its own parameters for when patients are seen in a shared visit and when they are seen solely by an APP.

In addition to direct patient care (solo or shared), APPs routinely perform procedures such as bone marrow aspirations and biopsies, lumbar punctures with or without instillation of chemotherapy, and paracenteses. Some practices have unique niches that foster a more independent practice model. Such niches include survivorship or wellness clinics. In an analysis of PA roles in oncology, Ross et al⁴ noted that 77% of PAs responding to their survey wrote some form of chemotherapy orders, and 77.9% of those respondents were required to have physician sign off on these orders. Some PAs were limited in writing chemotherapy orders (as well as Schedule II narcotics) by restrictive state statute.

Although published literature on APP role use in oncology is scarce, nearly all of it mentions APP contributions to clinical research that take many forms. In addition, APP roles generally include some degree of semiclerical responsibility, such as generating insurance clearance or performing patient call backs. Moote et al,⁵ in an analysis of APP use in oncology at the University of Michigan, described a practice model similar to many academic practices and noted that APPs had significant room for increased productivity in the form of direct reimbursable patient care that could be accomplished by rearranging the ratio of independent to shared visits. Increasing the number of independent patient encounters for APPs increases both APP revenue and opens more clinic time for physicians to see new or more complex patients. Maximizing utilization not only ensures maximal productivity but also that APPs are practicing to the fullest extent. The latter is a major factor in APP job satisfaction and retention.

Productivity

With the substantial investment needed to recruit and train an APP, as well as salary and benefit considerations, increased scrutiny is being focused on APP clinical efficiency and productivity. In an analysis of APP utilization in NCCN Member Institutions, Hinkel et al⁶ showed essentially no difference in productivity (or use) between NPs and PAs.



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May 2013



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The admixture of shared visits within practices can make clearly defining APP productivity challenging using professional billing as the sole marker for productivity. To better quantify the contribution of APPs, cancer centers have attempted to estimate the additional contribution of an APP to a practice by designating a number of relative work value work units (wRVUs) per full-time employee. This estimation usually ranges between 1000 and 2000 wRVUs per year and is prorated on the actual percent full-time employee. For half of a full-time employee (50%), the productivity for the integrated practice should be 500 to 1000 wRVUs plus the targeted productivity for the practice or individual physician that is institutionally determined. This metric allows measurement of overall practice productivity and allows the team to apportion independent or shared visits for the APP. However, it does not necessarily account for nonbillable APP responsibilities, such as patient call backs, insurance clearances, prescription call-ins, or scheduling. With that caveat, however, this model does allow for benchmarking and practice comparisons to assess best practices and maximize APP practice integration.

Retention

Without compensation that meets, if not exceeds, community standards, retention will be difficult. However, meeting this standard is necessary but not sufficient to ensure long-term career commitment. Hinkel et al's analysis of APP use in NCCN Member Institutions noted that 54% of APPs had been employed in at least one other institution before their present employment, and 34% had been employed in 3 or more institutions before current employment. This indicates both the mobility of APPs and the fluidity of the market.

APP surveys consistently note that professional recognition, collegial relationships with physicians and other providers, high level use of APPs, opportunity for professional growth, and a continued supportive educational environment are major components of retention. Practices that insure full professional integration, including participation in practice governance, are best positioned for retention. Academic practices that include a faculty position enhance the overall status of the role. APP governance in larger practices, particularly academic ones, allows representation in the broader administrative and clinical structures and helps to ensure that APP concerns and initiatives are heard and understood within the institution as a whole. As part of this, consciously working to develop APP leadership via institutional leadership development programs and tuition support for professional growth should be part of any practice.

Leadership development helps not just in retention and organization but is an important area of leadership replenishment for the institution as a whole. Further, the institution benefits from leadership that grows from the clinical workforce.

Conclusions

In conclusion, this article highlights areas for practices to concentrate on. The growing need for increased use of APPs in all aspects of the provision of care to patients with cancer is not in doubt. The challenges revolve around determining ways to ensure the highest level of care consistent with training and licensure and at the same time create and nurture a working environment conducive to recruitment and retention of this highly skilled group of medical providers.

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JNCCN-N-0180-0513