

Advanced Practitioners in Oncology: Meeting the Challenges

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In the year 2020, it is estimated that office waiting rooms will overflow by 9.5 to 15 million oncology patient visits, and there may be no practitioner available to see them (Erikson, Salsberg, Forte, Bruinooge, & Goldstein, 2007). While this may feel like job security for current health care providers, this shortage of oncology practitioners could potentially affect patient outcome. A study commissioned by the American Society of Clinical Oncology (ASCO) projects that the demand for oncologist visits will increase 48% by the year 2020, but the visit capacity is expected to increase by only 14% (Association of American Colleges, 2007). Many reasons are cited for this shortage, including aging of the population, increasing number of cancer survivors, and expanding treatment options that require an increased frequency of visits. One of the proposed solutions to meet this challenge is the increased use of nurse practitioners (NPs) and physician assistants (PAs; Erikson, Salsberg, Forte, Bruinooge, & Goldstein, 2007). hereafter, this group of NPs and PAs will be referred to as advanced practitioners, or APs.

Advanced practitioners are poised to be a vital part of this current and impending health care crisis. APs provide quality, safe, and cost-effective care

(Loftus & Weston, 2001). To meet the projected demand for oncology services in 2020, it will be essential to utilize APs to their fullest scope of practice, to expand the AP workforce, to accurately define the AP role, and to form creative collaborative practice models. The current challenges facing oncology and health care seem vast, but these challenges may be viewed as an opportunity for the maturation of the AP role.

Nonphysician Shortages

While medicine is anticipating physician shortages across health care fields, nursing is experiencing shortages of its own (American Association of Colleges of Nursing, 2009c). It is estimated that by 2025, there will be a shortage of 260,000 registered nurses (Buerhaus, Auerbach, & Staiger, 2009). In addition, there are current and projected nursing faculty shortages (American Association of Colleges of Nursing, 2009b). Nursing schools in the United States turned away almost 50,000 qualified applicants from baccalaureate and graduate nursing programs in 2008 because of faculty shortages and budget restraints (American Association of Colleges of Nursing, 2009a). Almost 7,000 of those denied admission were candidates for masters or doctoral degree programs.

PA educational programs are also experiencing a shortage of clinical training sites and preceptors (American Academy of Physician Assistants, 2009a). Shortages of faculty and budget issues also plague these programs, and eligible PA students are turned away because of these difficulties. One factor cited for PA faculty shortages is the recent transition to predominantly masters-degree curricula resulting in the need for doctorally prepared faculty (Jones, 2007). As with advanced practice nursing, debate exists over the need for a clinical doctorate for PAs.

Oncology APs are relatively few in number. An estimated 72,433 individuals are eligible to practice as PAs in the U.S. However, less than 1.5% work in oncology (American Academy of Physician Assistants, 2010). According to the 2010 Pearson Report (Pearson, 2010), there are almost 158,000 NPs in the U.S. Approximately 2,200 of these NPs work in oncology (Oncology Nursing Society, 2010). There are over 72,000 clinical nurse specialists (CNSs) in the U.S. (Health Resources and Services Administration, 2004). There are about 1,300 CNSs working in oncology (Oncology Nursing Society, 2010). According to the Oncology Nursing Certification Corporation, there are around 2,100 (1.3%) advanced practice nurses with advanced board certification in oncology: 1,139 as advanced oncology certified nurses, 687 as advanced oncology certified nurse practitioners, and 305 as advanced oncology CNSs (Oncology Nursing Certification Corporation, 2010).

AP Challenges

Oncology PAs, CNSs, and NPs share many professional roles and challenges. Umbrella terms such as midlevel providers or physician extenders are often used to collectively identify these advanced practitioners. Such terms tend to trivialize the significant and unique contributions of APs to the health care team. Multiple studies show that APs provide excellent, cost-effective, and safe care complementing the care given by other members of the health care team (Loftus & Weston, 2001; Nevidjon et al., 2010).

APs have prescriptive privileges in every state. In fact, in 15 states and the District of Columbia, advanced practice nurses have no requirement for any physician involvement. The rest of the states require written documentation of physi-

cian involvement, which may entail collaboration, supervision, authorization, delegation, and/or direction (Pearson, 2010). PAs are authorized to prescribe in every state as per physician delegation. PAs, CNSs, and NPs have other common and distinctive professional elements as well. Table 1 denotes commonalities and variances between the three types of APs.

ONCOLOGY-SPECIFIC EDUCATION

One of the common challenges of APs in oncology is the lack of an oncology-specific educational background. Most advanced practice nurses are educated in a primary care setting such as adult, family, pediatrics, women's health, gerontology, or acute care populations. Very few advanced practice nurses complete an oncology-specific graduate program. However, advanced practice nurses may receive advanced board certification in oncology, indicating additional education and clinical practice expertise in an advanced oncology role (Oncology Nursing Certification Corporation, 2010). PAs are trained in internal medicine and required to pass a national certifying examination administered by the National Commission on Certification of Physician Assistants before they can practice. PAs do not have set standards for specialty practice, and specialty credentialing and certification are controversial in the field (Jones, 2007).

The lack of available graduate and postgraduate oncology educational programs creates an educational gap for the many new APs in oncology. This educational gap, in turn, increases the amount of time required for the AP to become a fully competent and independent oncology practitioner. Both PAs and advanced practice nurses report that their current oncology clinical skills and knowledge were obtained most often via mentoring by a collaborating physician or through self-study (Rosenzweig, Giblin, Mickle, Morse, Sheehy, & Sommer, 2009; Ross, Polansky, Parker, & Palmer, 2010).

SCOPE OF PRACTICE

The oncology AP also faces challenges regarding scope of practice. The PA's scope of practice is defined by the education and experience of the individual as well as by state law, federal policy, and physician delegation (American Academy of Physician Assistants, 2009b). Physician dele-

Table 1. Advanced practitioners in the United States

| | Clinical Nurse Specialist | Nurse Practitioner | Physician Assistant |
|---|--|---|---|
| Approximate # in U. S. | 72,000 | 158,000 | 72,433 |
| Approximate # in oncology | 1,306 | 2,264 | 1,800 |
| Autonomous practice eligibility | Yes ^a | Yes ^a | No |
| Entry level degree | Masters/post-masters/ doctorate | Masters/post-masters/ doctorate | Certificate/BA/BS/Masters |
| Prescriptive privileges eligibility | Yes ^a | Yes ^a | Yes ^b |
| Primary job functions | Diagnose/manage acute and chronic illnesses, health promotion, disease prevention, education/ counseling. Nursing staff development. Systems change agent. | Diagnose/manage acute and chronic illnesses, health promotion, disease prevention, education/ counseling. | Diagnose/manage acute and chronic illnesses, health promotion, disease prevention, education/ counseling. |
| Oncology-specific certification available | Yes | Yes | No |

Note: ^aExtent of autonomy and prescriptive privileges varies between states ^bPrivilege/extent of privilege dependent upon physician delegation, although all 50 states authorize prescriptive privileges. Data from American Academy of Physician Assistants, 2009b; American Academy of Physician Assistants, 2010; Health Resources and Services Administration, 2004; Oncology Nursing Society, 2010; Pearson, 2010.

gation may vary widely between practices, but it is the largest determinate of PA scope of practice. The advanced practice nurse scope of practice is determined by each state’s nurse practice act. Currently, 23 states allow independent practice (no requirement for any physician involvement; Pearson, 2010). Other states require a range of physician involvement, such as collaboration, supervision, authorization, delegation, and/or direction. This variation in advanced practice nursing scope of practice limits the mobility of the practitioner (Nevidjon et al., 2010) and can create confusion among health care providers (Hudspeth, 2009).

Advanced practice nurses face additional challenges to their scope of practice. The American Medical Association (AMA) has established the Scope of Practice Partnership, a coalition of national medical specialty organizations and state medical societies, created to counter legislation that might expand the scope of practice of nonphysician health professionals (Sorrel, 2010). The AMA recently published ten resource compendiums created by this coalition for state medical associations, national medical specialty societies, and policy makers. One of the most recent publications concerns nurse practitioners;

however, concerns over inaccurate statements in this report exist (American Medical Association, 2009).

UNCLEAR ROLE

Another challenge to oncology APs is the lack of a clearly defined role. Oncology APs are delivering safe, quality care in numerous oncology settings, spanning the cancer trajectory from high-risk cancer clinics to hospice and palliative care (Vogel, 2003; Volker & Limerick, 2007). Responsibilities may vary from traditional (such as patient education and symptom management) to advanced (new consults, ordering chemotherapy, or performing invasive procedures; Association of American Colleges, 2007). The range of tasks performed by the oncology AP is immeasurable, but some unique settings in which oncology APs are working include interventional oncology practices (Hong et al., 2006), cancer genetics (Lynch, Snyder, & Lynch, 2009; Snyder, Lynch, & Lynch, 2009), prostate cancer clinics (Madsen, Craig, & Kuban, 2009), and radiation oncology (Kelvin & Moore-Higgs, 1999).

Workforce studies may underestimate the role of the oncology AP (Polansky, 2010). Work performed by the AP may be attributed to a su-

pervising physician if data is not collected properly. Practices often do not track AP productivity accurately, particularly when billing “incident-to” physician services. Prescriptions written by the AP are often deemed that of the physician and reported accordingly. More extensive research is needed to delineate the responsibilities, workload, productivity, and efficiency of the oncology AP. Defining the role of the oncology AP can increase efficiency of practice models and improve health-care delivery (Ross et al., 2010).

The oncology team of physicians and APs work together in differing practice models (Buswell, Ponte, & Shulman, 2009). New, innovative model development is needed to increase productivity and improve patient outcomes by delivering higher levels of care. New models should require each team member to function at their highest scope of practice and expertise and to relinquish tasks that a lesser trained team member could perform. Effective utilization of support staff, administration, and electronic tools can improve efficiency and effectiveness. This will require effective collaboration among all team members. There are few published articles on AP/physician collaborative models, and those that are available are primarily found in nursing journals.

Solutions

Solutions to the challenges facing health care in general and oncology specifically will come from within the multidisciplinary health care team. The AP can and should have an integral part in both the elucidation of the issues and formulation of the remedies.

WORKFORCE STUDIES

Data is needed to better define the current questions and then to find the right answers; therefore, participation in studies such as the ASCO Workforce Study is essential. The ASCO-commissioned workforce study is an ongoing study funded by Susan G. Komen for the Cure that will examine the role of nonphysician practitioners in treating cancer patients (Emple, 2009). It is intended to be a comprehensive analysis of how current oncology practices provide patient care through collaborative care teams. The study will examine up to 40 private and hospital-based oncology practices. Results are expected in early 2011. Additional studies like this are needed, par-

ticularly in the community setting, where at least 80% of cancer care is provided (Levit, Smith, Benz, & Ferrell, 2010).

RECRUITMENT STRATEGIES

Recruitment of APs, registered nurses, and physicians to oncology and oncology education is fundamental to addressing the health care shortages. Successful recruitment strategies can be examined, and similar strategies can be designed for oncology. Recruitment can begin as early as junior high school or high school by introducing students to the oncology field through lectures, field trips to cancer centers, internships, professional job shadowing, and partnering with student organizations at charitable cancer events. APs can contribute to oncology education by serving as adjunct faculty for undergraduate and graduate students. Mentoring and precepting students will yield long-term rewards to the oncology field.

RETENTION OF CLINICIANS

Retention of oncology health care professionals is an integral component of solving the health care shortage crisis. Improving the work environment by mutual respect between team members is often more effective than increased salary. However, salary remains a factor that affects retention as well (Levit et al., 2010). Adequate orientation for new employees, ongoing education, coaching and mentoring programs, and flexible work schedules are other factors that contribute to employee retention. Additional innovative ideas are needed.

EDUCATION AND TRAINING

Education and training for the AP who does not have an oncology background is essential. Oncology providers (including physicians, APs, and facilities) can work with medical, nursing, and pharmacy schools to ensure that oncology is a greater part of the general curricula (Levit et al., 2010). Development of in-house educational and preceptorship programs is cost-effective and ensures that trainees are oriented to the institution or facility culture. Oncologists who allow time for adequate mentoring of APs will find that the AP will be prepared more quickly for autonomous practice. Creative mentorship initiatives are needed. Experienced APs can fill the mentor roles in place of physicians and serve

as a resource for the novice AP. Studies show that oncology APs frequently use self-study as a method of becoming comfortable in their role. Novel self-study models, utilizing electronic resources, may be designed and distributed to the new oncology AP. Contributions from both medicine and nursing are essential to a comprehensive educational program.

Mentorship also comes in the form of networking. Oncology APs should be encouraged and supported in participation with professional societies including, but not limited to, ASCO, the Oncology Nursing Society (ONS), ONS special interest groups, national PA and advanced practice nursing organizations, as well as local professional societies. Financial support and time allowances will be necessary.

Oncology APs must be allowed to function at their highest scope of practice. Recognition of and respect for the training and skills of each team member will enable the most effective delegation, the highest level of care, and the best patient outcomes. Efforts to limit a discipline's scope of practice should not be supported by any health care team member, as these efforts are divisive and impede collaboration to develop solutions to the health care crisis. Data from the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank illustrate that states in which advanced practice nurse practice autonomously do not have higher rates of malpractice reports (Pearson, 2010). It is necessary to recognize that pioneering effective new models of care delivery are, in essence, a culture change (Levit et al., 2010). Flexibility, tolerance, and open-mindedness of all team members will allow the smoothest, most efficient changes to occur.

LEGISLATIVE MEASURES

Oncology APs must be legislatively savvy and active. Potential legislation must be carefully examined for language that is inclusive for all health care providers. The biggest obstacle to the most effective utilization of APs is the lack of full practice and prescriptive authority. Currently, the scope of practice, licensing, prescribing authority, and supervision requirements of APs vary based on state law. For advanced practice nurses, implementation of the Consensus Model will standardize education, certification, accreditation, and regulation across the U.S. (APRN Consensus

Work Group: APRN Joint Dialogue Group, 2008). Legislative advocacy is an important function of national AP associations. Through membership in these organizations, APs can support legislative activities and obtain information about legislation affecting clinical practice.

Conclusion

It has been said that "if you are not at the table, then you are probably on the menu." Oncology APs are an essential component of the solution for the U.S. health care crisis. Advanced practitioners cannot just settle for being "at the table," but must set the table and plan the menu! At this crucial moment in time, current APs can position future generations to reflect that their success and the resolution of a crisis in health care was created by what APs did today! Advanced practitioners must engage in arenas outside of their current comfort zones. Now is the time, not tomorrow or next week. Proactivity, not reactivity, is the key. So, forego the status quo...and show up, stand up, and speak up.

Start the dialogue...

Do you have some thoughts you would like to share on this Commentary? We'd love to hear from you! Please send any Letters to the Editor via e-mail:
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