Commentary: Physician Assistant Perspective on the Results of the ASCO Study of Collaborative Practice Arrangements

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In this issue of *Journal of Oncology Practice*, Towle et al[1] present the findings of a study exploring collaborative practice models between oncologists and nonphysician practitioners (NPPs). The study design did not differentiate between physician assistants (PAs) and advanced practice nurses. In this commentary, we offer a brief review of these new data in the context of what we know about NPP practice, summarize salient facts about the role of PAs, and provide recommendations for future consideration from our perspective as PAs.

What Do We Know About NPPs in Oncology Practice?

The ASCO Study of Collaborative Practice Arrangements (SCPA) was undertaken by the ASCO Workforce Advisory Group after completion of the initial ASCO workforce study that recommended inclusion of NPPs in the oncology workforce as one component of meeting anticipated shortfalls in the supply of oncologists.[2] Subsequently, a number of studies have been published in *JOP* describing models of NPP use in various clinical practice settings[3-5] and examining the roles and the productivity of NPPs in oncology practice.[6-8] The SCPA extends our knowledge of NPPs, providing important evidence regarding patient understanding of the clinical provider identity and the level of satisfaction with clinical care given by NPPs in collaborative practice models.

Among the significant findings of the SCPA is evidence that oncology patients are aware of who is providing their care, and that they are very satisfied with the care provided by NPPs in a collaborative practice model. We would speculate that reasons for these findings include the delicate nature of the patient-provider relationship in cancer care, and the higher frequency of encounters between NPPs and patients in active therapy. A second significant finding is the increase in productivity of clinical practices in which NPPs work across the spectrum of patient disorders, and with all of the physicians in the practice, rather than with only one or a few oncologists. It makes sense that an NPP with a broad range of knowledge and skills would increase practice productivity through the ability to provide care regardless of the current patient mix. Finally, this study verifies that the physician and NPP satisfaction levels with their collaborative practice arrangements are very high, indicating support for collaborative practice, although responses to these indicators are not as tightly distributed as others.

The Role of PAs

PAs are trained in the medical model, with the majority of educational programs promoting a generalist education. All PAs must pass the National Commission on the Certification of Physician Assistants (NCCPA) certification examination for entry into practice. The NCCPA is the sole certifying organization for PAs. The NCCPA's board of directors is composed of members of the public, physicians, and PAs, including representatives from organizations such as the American Medical Association, American College of Physicians, American Hospital Association, Association of American Medical Colleges, and the Federation of State Medical Boards. The certification examination includes content on all organ systems; the diseases, disorders, and medical assessments within those systems; and the competencies physician assistants should exhibit when confronted with those diseases, disorders, and assessments. The major neoplasm and malignant disorders, as well as their diagnosis and treatment, are included in each organ system. Specialty certification in oncology is not required for practice. There is one postgraduate residency program in oncology currently offered. Ross et al[7] have demonstrated that the majority of PAs receive oncology-specific training through mentorship with employing physicians. For more information regarding PA education, roles, scope of practice, and use in oncology, go to http://www.aapa.org/uploadedFiles/content/Common/Files/SP_Oncology_v3.pdf.

The physician assistant practice model is collaborative by definition. All PAs practice in collaborative practice arrangements with supervising physicians. PAs do not practice medicine independent of the supervisory relationship with the physician. Scope of practice is regulated at the level of the individual state medical licensing authority. PAs in all 50 states have prescriptive privileges. PAs may be found in all oncology disciplines, in the inpatient and outpatient settings, as well as in clinical research and teaching.

An excellent summary of the clinical partnership between PAs and physicians has been written by Heather Hylton, MS, PA-C, and published in the ASCO Daily News during the 2011 ASCO Annual Meeting.[9]

Where Do We Go From Here?

Through the American Academy of Physician Assistants (AAPA), and its specialty organization the Association of Physician Assistants in Oncology (APAO), PAs have enjoyed a growing relationship with ASCO. The initial focus of this relationship has been on improving opportunities for oncology education for PAs. In 2006, a joint educational preprogram symposium at ASCO–Atlanta was held. This effort has led to shared educational programming such as Best of ASCO sessions at the APAO Annual Meeting. ASCO and AAPA formalized a relationship several years ago; the creation of a Medical Liaison

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from AAPA to ASCO has led to PA participation on ASCO membership, education, and integrated technology committees. Strengthening our organizational relationships through new avenues of collaboration will enhance the ability of PAs to provide quality patient care in collaborative practice settings.

The SCPA study makes note of an incidental finding regarding practices that do not use NPPs. The most prevalent responses for why NPPs were not used include lack of patient volume, which the looming workforce shortage suggests may not be an issue in the future; physician disinterest; and failure of a previous collaborative practice with an NPP. These last two items bear further consideration, as there may always be physicians who prefer not to work with NPPs, despite the favorable data regarding collaborative practice arrangements. Understanding how or why collaborative practices do not succeed is important for developing education and training programs that might prevent subsequent problems with collaborative practices. In addition, the growing body of data demonstrating increased productivity for practices utilizing NPPs suggests that we need to understand how to maximize use of those successful practice models. This will be valuable to efforts to minimize practice inefficiency, reduce conflict between NPPs and physicians, and address other practice concerns.

Although, data from the SCPA are supportive of NPP utilization in oncology, we believe additional study of the differences in provider satisfaction with collaborative practice would further enhance efforts to improve clinical practice. Reasons for physician dissatisfaction with collaborative practice arrangements are likely to be different from reasons an NPP might be dissatisfied. These differences in provider satisfaction may be related to role differentiation, workload, different management styles, and/or issues regarding level of NPP supervision.

One caution is in order. As in many endeavors, it is not just what we say, but how we say it that is important. Terminology matters in the discussion of the NPP workforce. One SCPA collaborative model is described using the phrase "independent practice model." Although the text makes fairly clear that this means a practice in which the NPP sees patients according to his or her own practice schedule, it does not specify whether or not a physician-NPP supervisory relationship exists. This is a critical distinction; the notion that NPPs may wish to have "independent" (ie, nonsupervised) practices may represent an impediment to physicians employing NPPs in clinical practice. Likewise, the use of a descriptor such as "incident-to practice" based on language used in Medicare reimbursement may lead the casual reader to a misunderstanding of appropriate supervision and billing procedures. For an excellent overview of the "incident-to" billing issues, please refer to a recent article by Michael Powe of the AAPA.[10]

The prediction of a workforce shortage for oncologists is an important factor that will influence the need for strengthened collaborative practice between NPPs and physicians. However, many other forces in health care will drive this need, including health care reform policy, changing reimbursement models, changing conditions in the economy, a focus on primary and preventative care in the patient-centered medical home, and general societal and professional expectations regarding our roles as clinical providers. All of these complex issues will shape how we meet the needs of our patients for decades to come. The findings from the SCPA suggest that patients are satisfied with the concept of collaborative care from NPPs and physicians. Our challenge remains to improve recruitment, retention and education of qualified NPPs. Expanding educational efforts and professional collaboration between ASCO, APAO, and AAPA will be crucial to success in these endeavors.

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