Credentialing Resource Center Journal

AOA wants more physicians to share their voice

Credentialing Resource Center Journal *recently sat down with David J. Pugach, JD, vice president of public policy for the American Osteopathic Association (AOA) to ask how ongoing initiatives, such as the single graduate medical education accreditation system, are proceeding and what initiatives the AOA will be focusing on in 2019.*

Q: What are some other initiatives and focuses for the AOA in 2019?

Pugach: The AOA will be looking for opportunities to expand loan forgiveness programs and programs that will incentivize and support physicians to work in public service or healthcare workforce shortage areas. There is data that shows loan forgiveness programs are effective in bringing physicians in to areas of need. Physicians tend to stay and practice in close proximity to where they train. So, when we can increase the training opportunities in underserved areas, it also helps bring physicians into those communities.

Workforce is going to be a significant focus for us, both in terms of GME and loan forgiveness/repayment programs, but also continuing to make sure at the state and federal level that we are seeing regulation and legislation that promotes patient access to physician-led care.

The other big thing is really trying to engage physicians in advocacy and the public policy process. When I look at what we have done as an organization in the past year, the total number of individual actions taken, we have had in excess of 50,000 grassroot action takers. As an organization, we think it is imperative that physicians' voices are heard; the people who are experts in medicine and healthcare delivery are able to share their opinions and expertise with lawmakers whether in local government at the state level or with federal government. We are trying to facilitate more opportunities for physician engagement for ways physicians can make their voices heard, whether in the regulatory process or legislative process both through online advocacy and through face to face engagement.

For someone who is concerned about GME funding or physician burnout we need to make sure physicians are engaged in the legislation process and public policy because they obviously know a lot about making sure physicians can comply with their practice and patients can access care and we want to make sure we are increasing the opportunities for them. So that is one of the things we are going to be prioritizing in the upcoming year.

Q: What is the AOA doing to help physicians and trainees with wellness initiatives?

Pugach: The AOA has a task force that focuses on physician wellness, which is run out of our research department. We have a number of initiatives to support students, residents, young physicians, and more established physicians to address issues of burnout, mental health, and general overall work-life balance.

Beyond that, within public policy at the state level, there is legislation we have been engaged in to make sure licensing boards have safe harbor provisions to reduce barriers for physicians who are seeking help when they are experiencing a challenge in life. I think fundamentally physicians need to have a high level of confidence that if they look for help that it is not going to hurt their license or practice. That is something that needs clarification in a few states, and some states have done it already in a proactive and positive way.

At the federal level, one thing we have been actively working on is trying to reduce administrative burnout on physicians. We know that one element that physicians have complained about is the challenge with a lot of the administrative reporting requirements and documentation requirements that have grown significantly over the last handful of years.

Q: Are EHRs the cause of administrative burnout? Are there other administrative tasks I am not thinking of?

Pugach: It's not just the fact that there has been a transition to electronic records; it is also the documentation requirements in terms of billing and justifying why one evaluation and management level is being used as opposed to another. That is something that CMS addresses in the 2019 Medicare Physician Fee Schedule. I think the agency tried to address this in a meaningful way and to be responsive to the concerns of physicians to try to simplify and reduce physician documentation. I've heard some estimates that physicians have been spending comparable amounts of time on paperwork and patients. And at night, they are still doing the write-ups from the

patients they saw that day. Hopefully the changes implemented through the Medicare Physician Fee Schedule will reduce that documentation that has been needed to justify E/M coding decisions that physicians have to make.

Q: An issue we hear a lot about from our audience is not only meeting the regulatory requirements of peer review/OPPE/FPPE, but also getting physicians to engage in this process.

Pugach: When I think about what the prevailing focus for us is in public policy, it is really how do we promote and support the physician workforce. What are the policies we need to protect patient access to physician-led care? On those two overarching themes, there is no shortage of activity. It is premature to say what it is going to look like this year, but I think I could lump the bulk of issues and legislation/regulation into supporting the physician workforce and patient access to physician-led care. It all ties together. Even the priorities within the massive opioid legislative package that Congress in September, much of what we were focusing on in it was tied to supporting the physician workforce and providing incentive to have physicians work in areas hardest hit by the opioid crisis. There are a lot of other issues out there that bleed into these, like the peer review piece and how to make it easier to participate in those processes. That is an important piece of supporting a well-trained workforce.

Q: As nurse practitioners and physician assistants are expanding their scopes of practice, what is the balancing act between this and physician-led care?

Pugach: It is an evolving challenge within healthcare. In a hospital setting, when you can have an advanced practice nurse or physician assistant who is working in tandem with a physician or as part of a physician-led team where the physician has a hand in decision-making and diagnosis and treatment of patients, you have quality care and positive outcomes. I think that is a great example of a model that is effective. But when you have instances of nonphysician providers being able to practice independently and without any physician engagement, sometimes that happens to the detriment of patients where you have a misdiagnosis or unnecessary testing or mistakes in treatment decisions. I think the challenge is, how do you find the right balance to leverage the skills that advanced practice nurses and physician assistants have and really extend the capacity of the physicians in a practice setting or hospital so more patients have access to quality care?

That is something we are very focused on because we do think there is a balance and there is a difference in the level of training and skill that physicians have versus nonphysician providers. There is an important role the nonphysician providers can play, but when they are treating patients in independent practice, sometimes that leads to worse outcomes for the patients. I think our expectation is we are going to see legislative activity in many states this year, and that is something we will be actively engaged in.

Q: We are about 1.5 years away from completing the transition into a single accreditation system between the AOA and Accreditation Council for Graduate Medical Education (ACGME). How do you think the transition is going, and what is the AOA doing to support this initiative?

Pugach: The process has been going relatively well and at this point, if you look at the number of residency slots, training positions in programs accredited by the AOA when this process started, a significant number of the residency slots have already moved over. So, it is going smoothly. It is an ongoing, iterative process.

From a public policy perspective, our focus is on making sure we are supporting postgraduate training broadly in terms of funding; that we are supporting programs and legislation that incentivize increasing training opportunities in areas where there is a workforce shortage or specific need; and ultimately that all U.S.-educated physicians, whether they are DOs or MDs, have access, opportunity, and funding for residency training. We do whatever we can to facilitate those opportunities and support policies that fund residency training. That is a huge priority for us. We have several workforce issues that we focus on in states and at the federal level. But funding for GME is definitely top of that list. When I think about 2019 and what we are working on with the new Congress, GME funding is going to be a high priority for us.

One of the things we were most pleased by in 2018, which I think is a win for the whole medical education community, was the reauthorization of funding for the Teaching Health Center Graduate Medical Education Program. The program is funded through HRSA, and it had a two-year authorization. It was caught up with other public health programs that had their funding lapse at the end of FY17. The program was reauthorized for two years, but the coalition that advocates for that program was able to work with congressional champions and get funding to have the resident allotment nearly doubled, essentially making sure Teaching Health Centers would receive a more accurate reflection of the actual cost of having the residents in their programs. That is a really big deal. I think it will help ensure we have a presence of primary care training in rural and underserved areas, which is what the program is all about

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