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Pediatric Workforce Issues: Tools and Resources for Advocacy in Pediatrics

AAP National Committee on Pediatric Workforce

2013

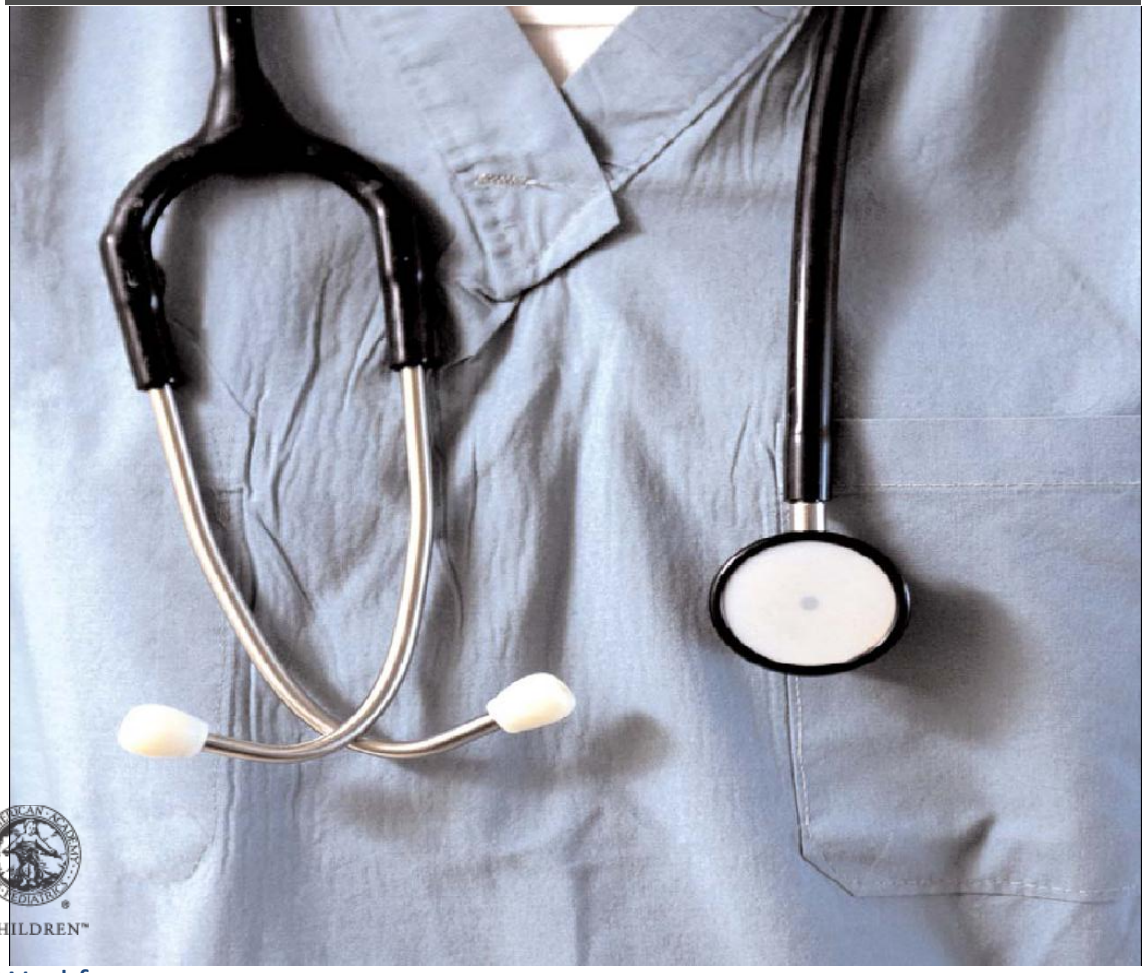
"It's not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."
--Charles Darwin

Objectives

- **A. Overview of Pediatrician Workforce, by the numbers**
- **B. Sub-topics**
  - Topic 1. Changes in Pediatrician Workforce
  - Topic 2. Changes in Pediatric Patients
  - Topic 3. Changes in Pediatric Practice
  - Topic 4. Changes in Health Care Policy
- **C. Inspiring Conclusion !**

Help Wanted: More U.S. Doctors

Projections Indicate America Will Face Shortage of M.D.s by 2020



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Let's begin with a question …

How well is

the pediatrician workforce

meeting the needs of

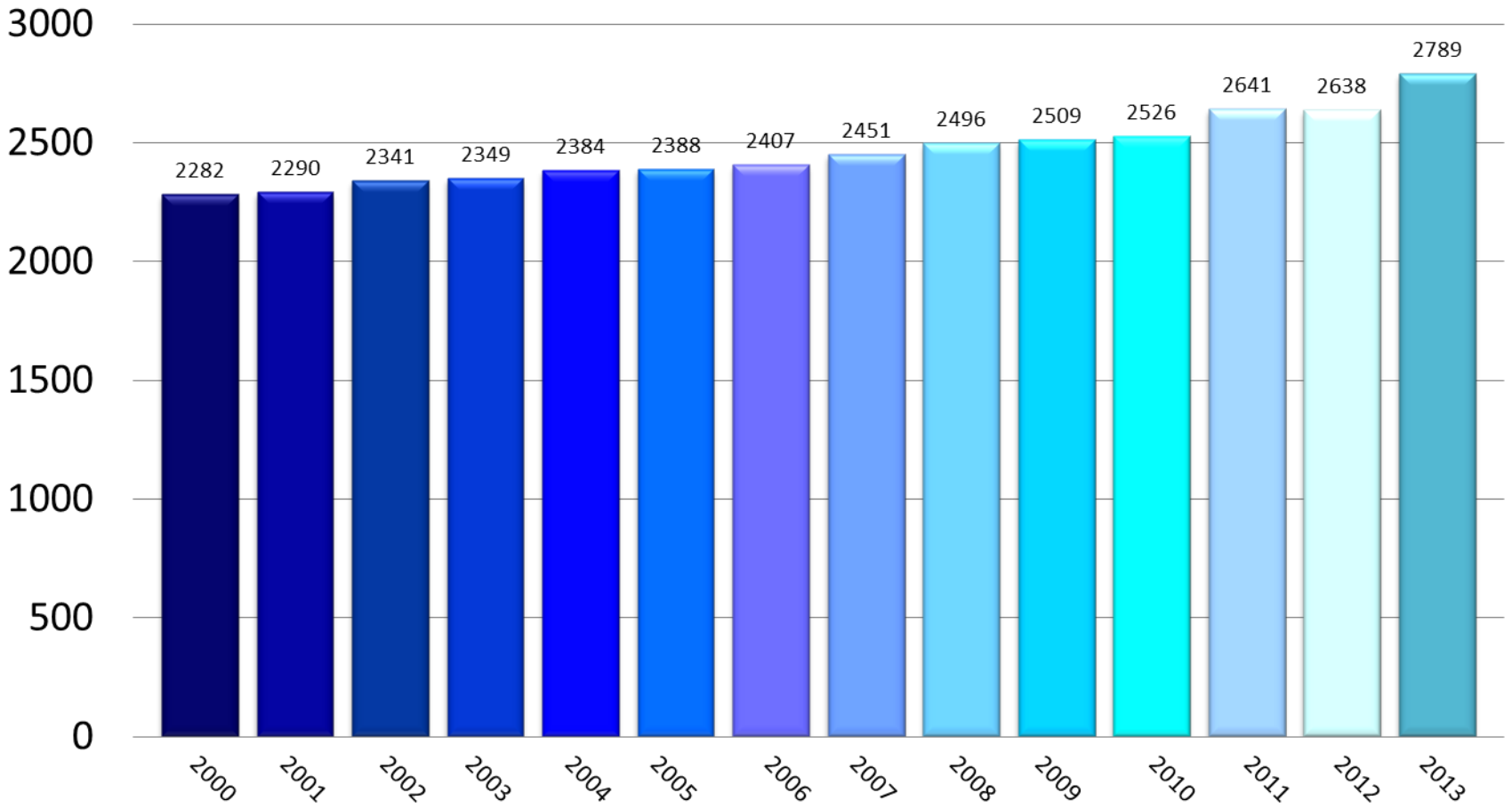
children?

Answering the question

"The current pediatric workforce is not meeting the primary care, subspecialty, or surgical needs to provide quality health care for our country's children. Key reasons include the geographic maldistribution of physicians, an increase in the number of chronically ill children, and an increasingly diverse patient population."

from AAP Advisory Committee to the Board on Education, November 2008

PGY-1 positions offered in pediatrics



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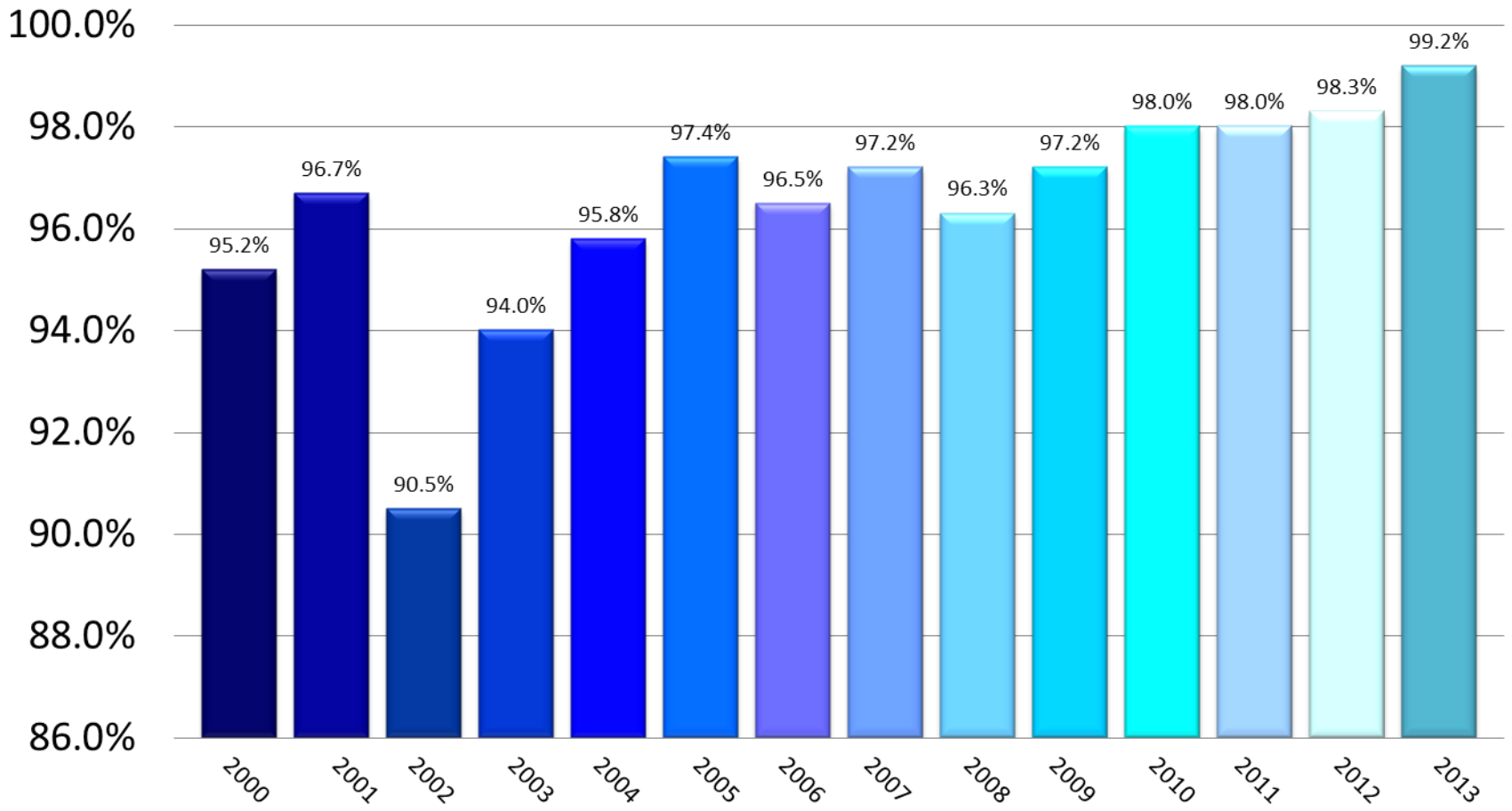
Data compiled from the National Resident Matching Program by the AAP Division of Workforce and Medical Education Policy

% of PGY-1 positions filled in pediatrics



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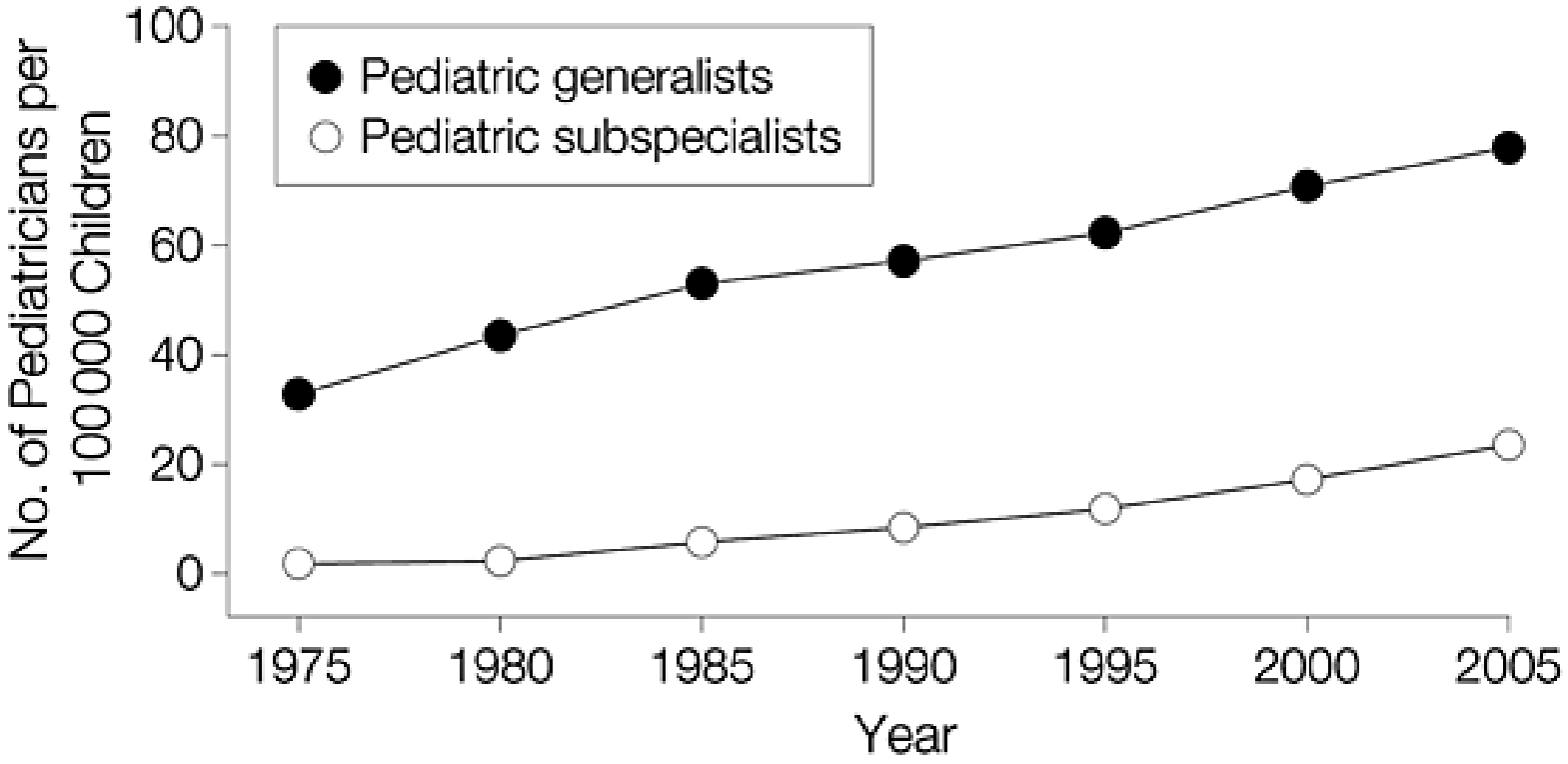
Data compiled from the National Resident Matching Program by the AAP Division of Workforce and Medical Education Policy

Pediatricians per 100k children, 0 ≤ 17 years, 1975-2005



Source: Freed and Stockman. JAMA 2009;301:1920-1922.

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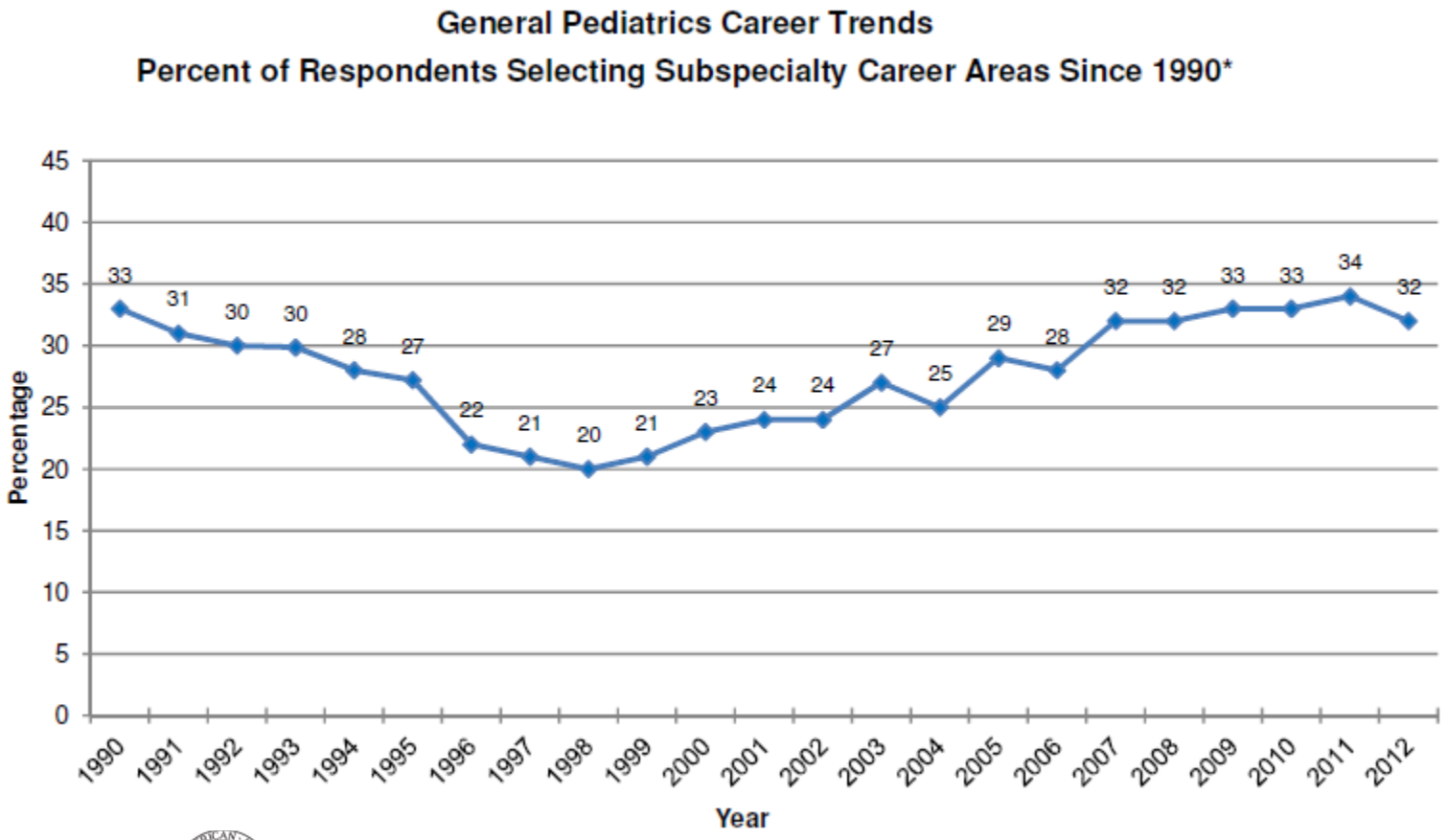
Subspecialization rates



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Source: American Board of Pediatrics, Workforce Data Book, 2012

Geographic maldistribution is the 1st problem

- Despite dramatic growth since 1981, rural areas with population < 25,000 saw little to no gain in pediatricians.
- The proportion of pediatric residency graduates seeking jobs in areas with lower supply of pediatricians (esp. rural) is in decline

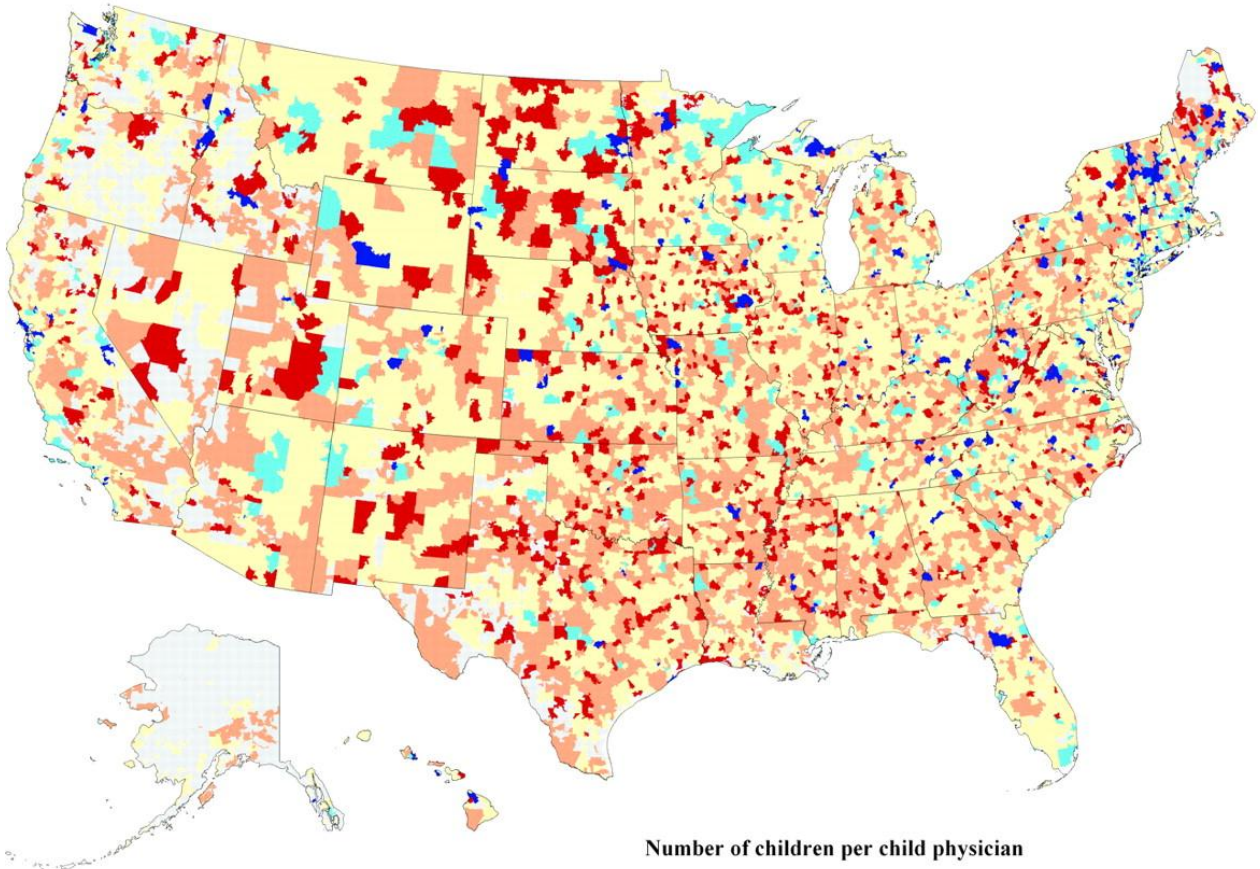
Sources: Randolph & Pathman *Pediatrics*. 2001;107(2).;
Cull et al, *Ambul Peds*, 2005;5:228-34.

Distribution of children/child physician

Percentage of US Child Population	Children/Provider Ratio
17.6%	< 1000 children/child physician
47.5%	1000-2000 children/child physician
18.3%	2000-3000 children/child physician
15.4%	> 3000 children/child physician
1.3% (1 million children)	No child physician

Source: Shipman, S. A. et al. *Pediatrics.* 2011;127:19-27.

Extremes of child physician (MD) supply in 2006 (in PCSAs, N = 6542)



Source: Shipman, S. A. et al. *Pediatrics* 2011;127:19-27

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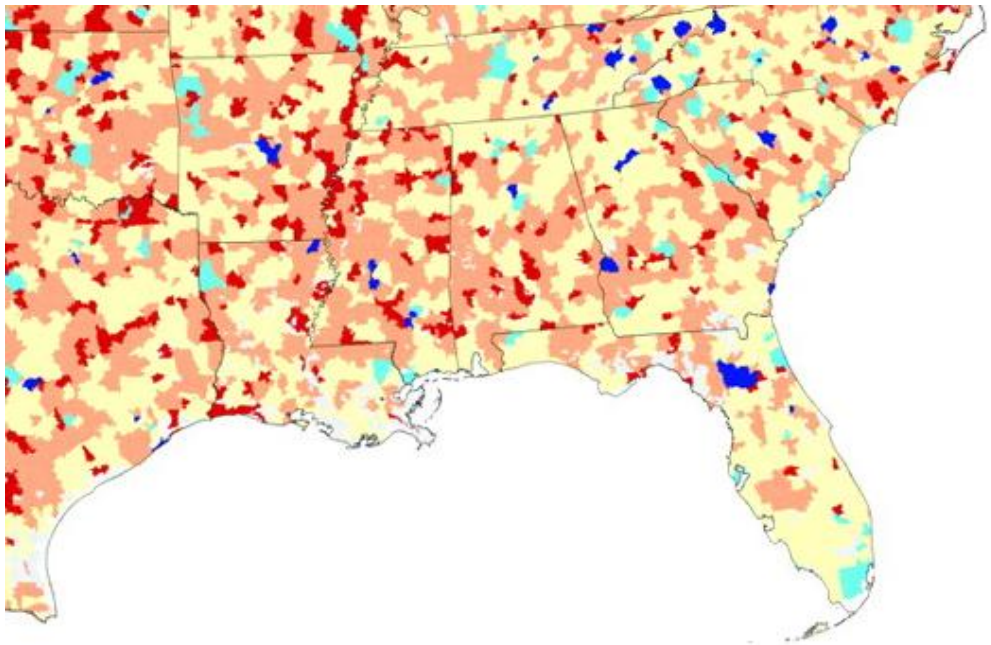
PEDIATRICS®

Extremes of child physician (MD) supply in 2006 (in PCSAs, N = 6542)



Number of children per child physician

- No Child MD (984 PCSAs)
- 3,001 or More Children per MD (2,059)
- 1,001 to 3,000 Children per MD (2,803)
- 750 to 1,000 Children per MD (372)
- Less than 750 Children per MD (324)
- Census unpopulated areas

Source: Shipman, S. A. et al. *Pediatrics.* 2011;127:19-27

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Workforce Summary "By the Numbers"

- Pediatrics as a specialty is faring well among medical students.
- General pediatrics is faring well among pediatric residents.
- General pediatrics supply appears to be adequate *by the numbers.*
- Production of general pediatrics needs to be maintained so that increased movement into subspecialties doesn't "cannibalize" primary care pediatrics (different from recommendations for adult primary care).
- 5. General pediatricians are maldistributed.

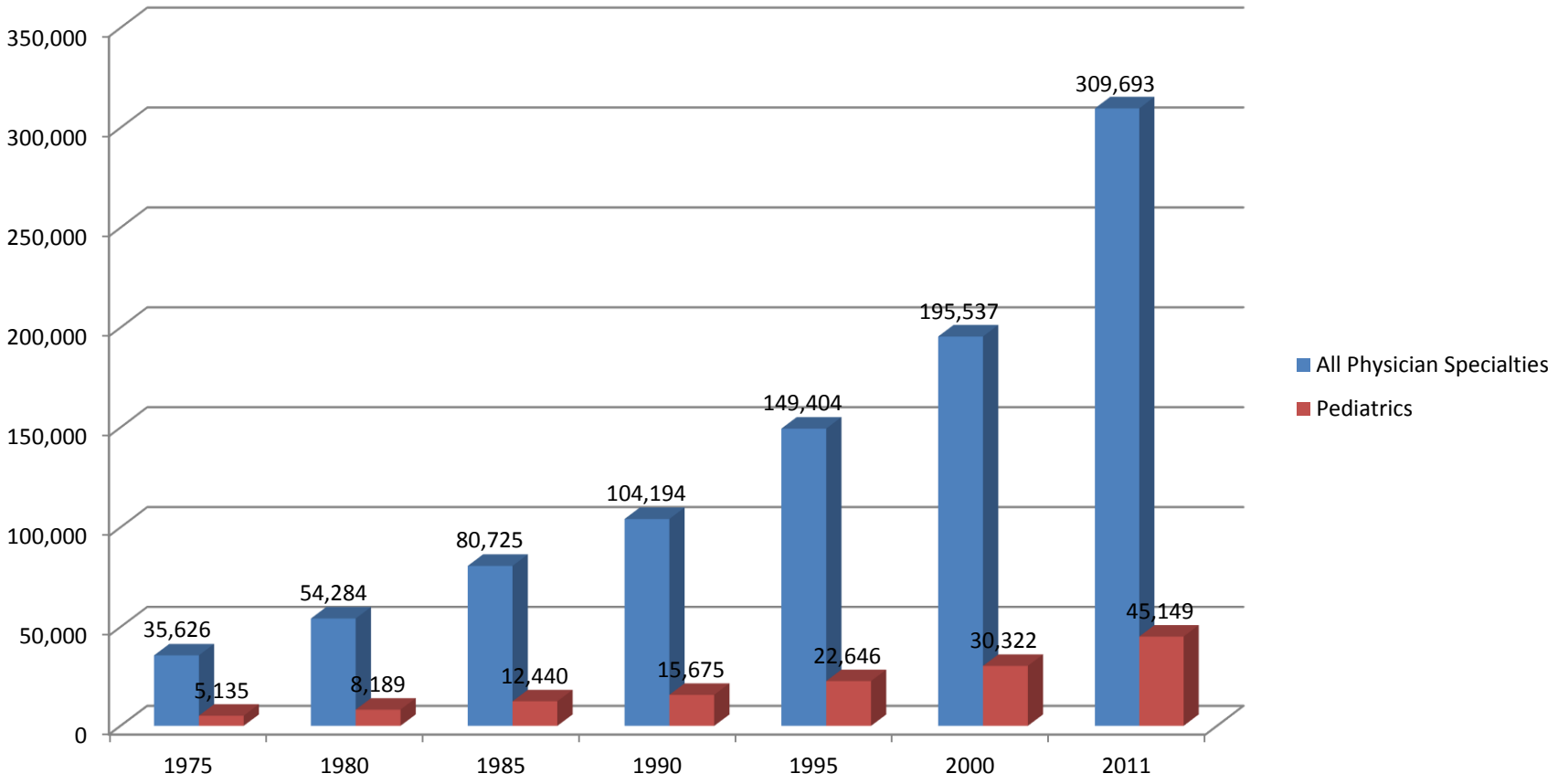
Topic #1: Current and Anticipated Changes in Pediatrician Workforce

- What is the impact of increased number and proportion of women in the pediatrician workforce?
- What will be the impact of increased part-time practice?
- Percentage of FP visits that are for children is declining.
- Is the supply of pediatric medical subspecialists and pediatric surgical specialists adequate?
- How do we handle the issues around physician reentry into the workforce?

Topic #1: Current and Anticipated Changes in Pediatrician Workforce

- What is the impact of increased number and proportion of women in pediatric workforce? Will this alter:
  - a. Subspecialty entry rates?
  - b. Geographic disparities?
  - c. Assumptions regarding workload (part-time)
  - d. Number of academic pediatricians?

Female physician percentages, 1975-2011



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Source: Physician characteristics and distribution in the U.S., 2013 edition. American Medical Association.

What % of pediatric residency graduates take part-time jobs?

- A. 10%
- B. 14%
- C. 21%
- D. 38%
- E. 45%

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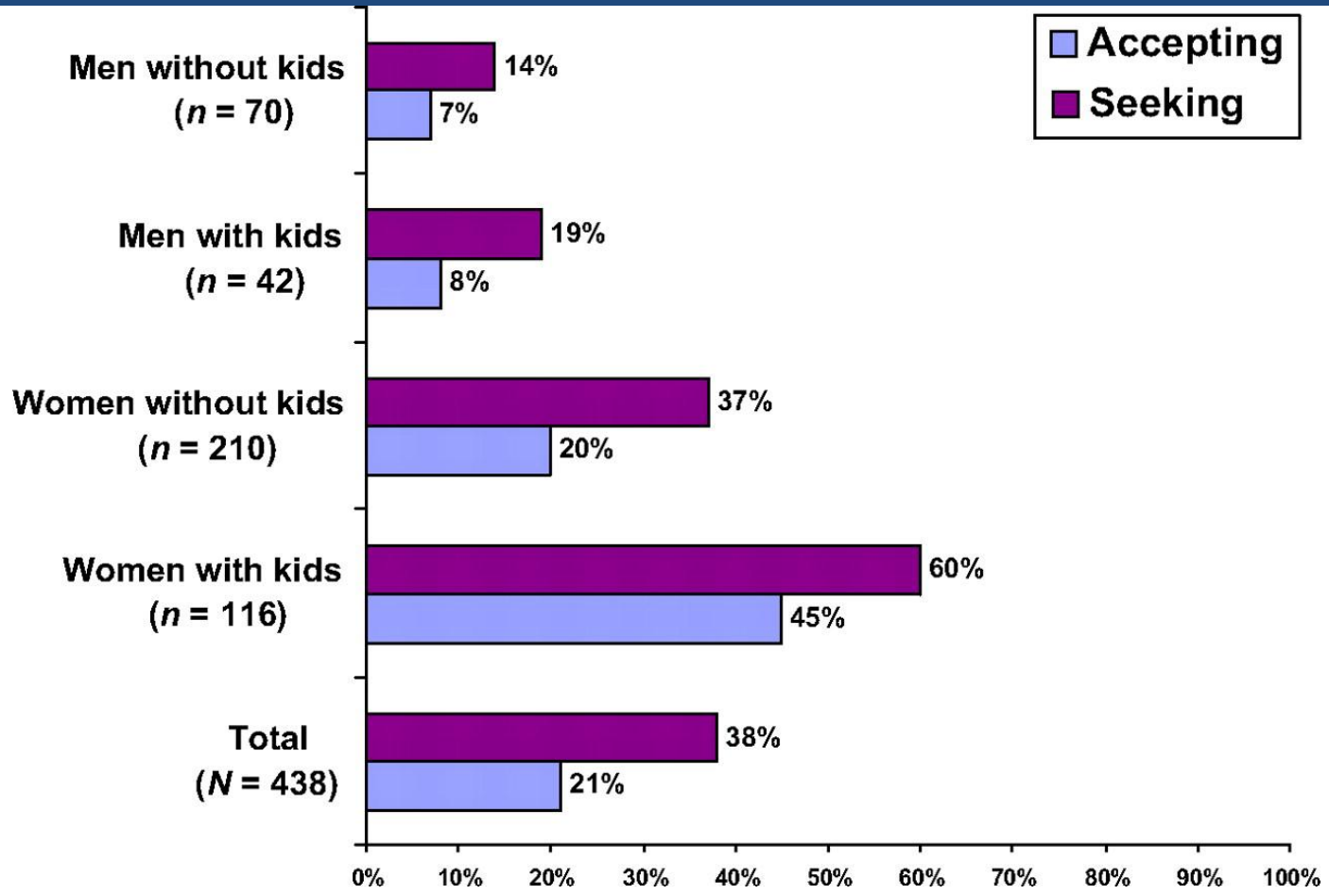
Success in obtaining part-time positions, according to gender and having children



Source: Cull, W. L. et al. *Pediatrics*. 2008;121:276-281

Adequacy of **Pediatric Medical Subspecialist** and **Pediatric Surgical Specialist** Availability

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Which Pediatric Specialties are Considered in Need by > 50% of Practicing Pediatricians?

- A. Child Psychiatry
- B. Pediatric Nephrology
- C. Pediatric Rheumatology
- D. Pediatric Cardiology
- E. A and C only

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Pediatric medical subspecialty shortages, greatest need

Specialty	Shortage?
Child Psychiatry	96%
Developmental/Behavioral	87%
Pediatric Rheumatology	68%
Pediatric Nephrology	48%
Pediatric Cardiology	17%
Neonatology	5%

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Source: Pletcher et al. *J Pediatr,* 2010;156*:* 1011-5.

Other ways to measure need: Wait times for appointments

- 2010, the National Association of Children's Hospitals and Related Institutions (NACHRI) reported weeks patients had to wait to obtain subspecialty appointments.
- For 10 subspecialties, patients had to wait longer than 5 weeks.
- For 3 subspecialties, patients had to wait longer than 10 weeks.

Reproduced from NACHRI, Pediatric Subspecialty Shortages Affect Access to Care

Specialty	% of hospitals over 2-week benchmark	Wait times (business days)	Wait times (weeks)
Endocrinology	68%	51.4	10.3
Neurology	61%	47.6	9.5
Gastroenterology	59%	26.5	5.3
Nephrology	52%	33.6	6.7
Developmental Pediatrics	50%	65.7	13.1
Pulmonology	50%	40.7	8.1
Rheumatology	36%	31.9	6.4
Orthopedics	34%	38.2	7.6
Dermatology	32%	66.0	13.2
Urology	30%	35.2	7.0

Disparities in referrals

"The percent of pediatric outpatient visits resulting in referral increased from 3.5% in 1999 to 6.1% in 2007" (Merline et al., 2010).

"68% of rural PCPs and 49% of nonrural PCPs were dissatisfied with waiting times for [subspecialist] appointments … more than 65% of rural and only 19% of non-rural PCPs rated the number of subspecialists in their area as poor or fair" (Pletcher et al., June 2010).

A recent GAO report found that 84% of physicians treating children insured by Medicaid or CHIP had great or some difficulty making specialty referrals; 26% of physicians treating privately insured children had great or some difficulty making specialty referrals.

> "For all children, **physicians had the most difficulty making referrals for mental health, dermatology, and neurology**."

Short-term solutions to shortage of pediatric medical subspecialists and surgical specialists

- PCPs manage more chronic patients themselves
  - Increase our own training in chronic conditions and their management
  - Will they increase "triage" of who they send to subspecialists?
- Subspecialists educate PCPs
  - CME meetings in your local area
  - Disseminating your pathways so that PCPs try them first

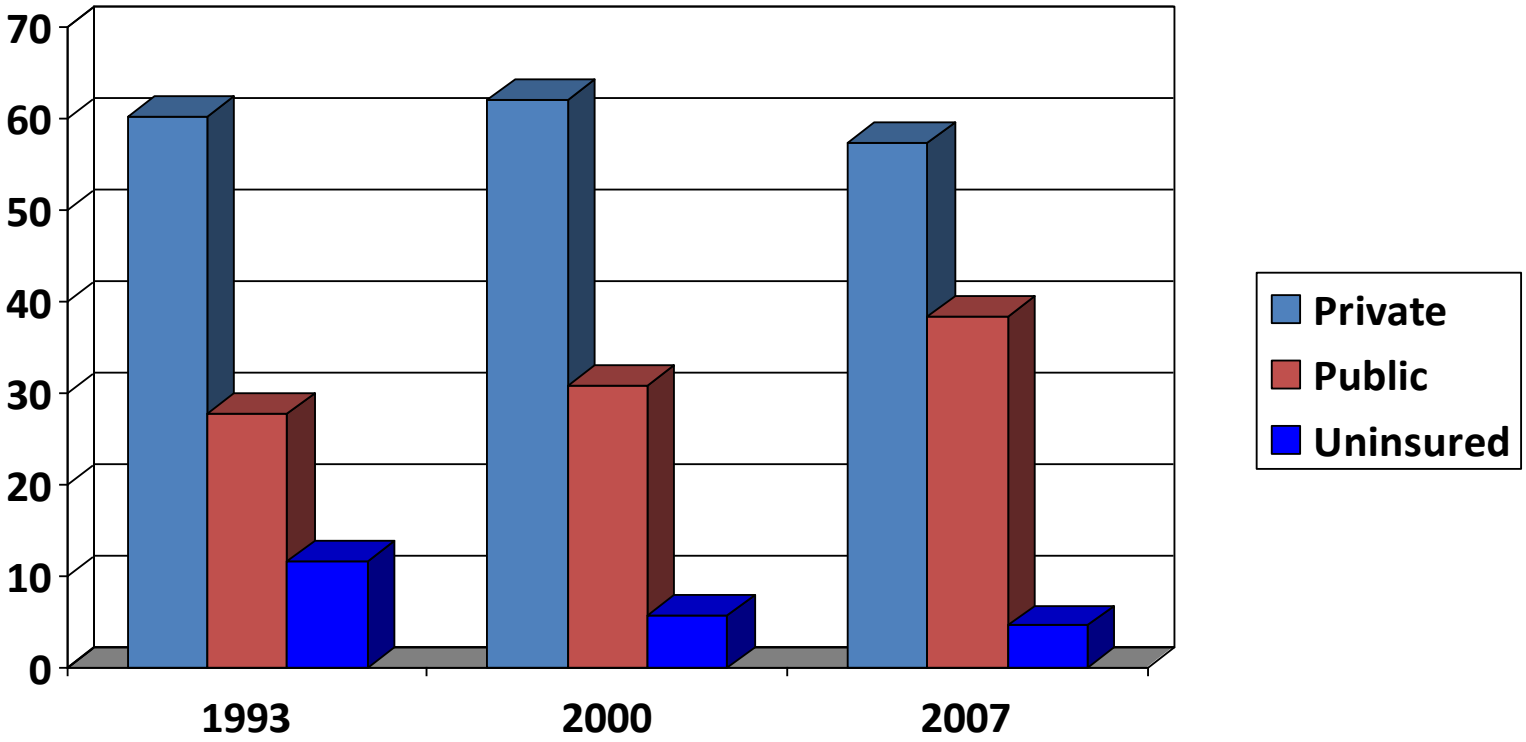
Topic #2: Current and anticipated changes in pediatric patients

- Changing patient demographics require increased cultural competency.
  - AAP Culturally effective care toolkit:
    - http://practice.aap.org/content.aspx?aid=2999
  - AAP Policy Statement:
    - Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy, *Pediatrics* December 2004
- Advent of **millennial morbidities**
  - (e.g., mental health, obesity, hypertension, complex patients)
- Increased proportion of children with special healthcare needs (Technology dependence)
- No longer practicing **PRIMARY PREVENTION** for a lot of children

Topic #3: Current and anticipated changes in pediatric practice

- How will health care reform with increased number of insured children affect the demand for healthcare services?
- Patient-centered medical home concept and its impact on pediatric workforce?
- Non-physician clinicians, scope of practice, and their impact, if any, on adequacy of pediatric workforce

Insurance status of your patients



Source: AAP Periodic Surveys #21,42, 67, American Academy of Pediatrics
Basco et al. *Pediatrics* 2010; 125: 460-467

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PERIODIC SURVEY OF FELLOWS

Joint Principles of the Patient-Centered Medical Home (AAFP, AAP, ACP, AOA, March, 2007)

" The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. "

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care is coordinated and integrated
- Quality and safety are hallmarks
- Enhanced access

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"The Medical Home for Children: Financing Principles" (Dec. 2008, AAP)

- AAP The medical home payment method should have 3 fee structures

- 1. A contact- or visit-based fee component
- 2. A care management fee
- 3. A performance or pay-for-performance fee

Today's Care → Medical Home Care

Today's Care	Medical Home Care
My patients are those who make appointments to see me	Our patients are those who are registered in our medical home
Patients' chief complaints or reasons for visit determines care	We systematically assess all our patients' health needs to plan care
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet patient needs without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
Patients are responsible for coordinating their own care	A prepared team of professionals coordinates all patients' care
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Acute care is delivered in the next available appointment and walk-ins	Acute care is delivered by open access and non-visit contacts
It's up to the patient to tell us what happened to them	We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs	A multidisciplinary team works at the top of our licenses to serve patients

Source: Slide from Daniel Duffy MD. School of Community Medicine Tulsa Oklahoma

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Source: Slide from Daniel Duffy MD. School of Community Medicine Tulsa Oklahoma

Non-physician clinicians and scope of practice

Which of these clinicians call themselves “Doctor?”

- A. Advance practice registered nurses
- B. Chiropractors
- C. Pharmacists
- D. Physicians
- E. All of the above

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Changes in degrees

- NP ⇨ Advanced Practice Nurse ⇨ Doctor of Nursing Practice (by 2015)
- Pharmacist ⇨ Doctor of Pharmacy (began 1990, transition complete)
- AAP "Scope of Practice" Policy Statement reviews all of this in detail:

AAP Committee on Pediatric Workforce. "Scope of practice issues in the delivery of pediatric health care." *Pediatrics.* 2013;131(6):1211-1216.

Why titles matter …

- The Patient Protection and Affordable Care Act (ACA) uses the terms “health care provider,” “primary care provider,” or “medical home” > 400 times.
- A chiropractor is now classified as a “Primary Care Provider.”
- Retail-Based Clinics now qualify as a “Medical Home.”
- Such legislative action erodes the role of the physician as the leader of the health care team and could potentially compromise patient safety and quality of care.

Example: Advanced Practice Nurses

- Nurse practitioners/advanced practice nurses continue to seek scope of practice expansions in nearly every state.
- 2015 deadline - "Doctor of Nursing Practice" degrees
- Nationally – proposed as “solution” to the primary care crisis.
  - **The Future of Nursing: Leading Change, Advancing Health**
  - Consensus Report of the Institute of Medicine
  - Released: October 5, 2010

Source: James G. Pawelski, Director
Division of State Government Affairs | American Academy of Pediatrics

What APN groups propose

- APN Practice Associations, IOM report, etc:
  - Pay should be equal to Physicians for same services
  - APNs should be allowed to ***LEAD*** care teams
  - Restrictive state laws prevent APNs from practicing to their full potential
  - APNs will can help fill the voids not filled by physicians, including primary care and rural areas

APNs: Just the facts

- Primary Care Physicians receive ***24 TIMES*** the clinical hours of training of APNs.
- In states without restrictions on APN supervision, only 11% practice independently. Freed. *J Pediatr* 2010;157: 589-93.
- APNs workforce is more concentrated than physician workforce in urban+suburban areas. Lin, Burns, & Nochajski, 1997 and American Nurses Credentialing Center, 2008 Role delineation study: Pediatric nurse practitioner—national results, ANCC, Silver Spring, MD (2009)
- A minority provide inpatient or ED care. Freed Pediatrics 2010;126: 846-850
- The number of *Pediatric* APN programs is in decline. Freed. *J Pediatr* 2010;157: 589-93.

Scope of practice summary

- Nearly all non-physician clinician groups are ***continually*** seeking expansions in scope of practice.
- The action for these changes is at the level of the STATE LEGISLATURES.
- These issues are important to YOU!

Topic #4: Changes in health care policy, including GME funding and reimbursement

- How should GME change to ensure adequate supply of pediatricians of all types?
- How should healthcare financing be structured to ensure an adequate supply of pediatric primary care physicians?
- Using policy to address geographic maldistribution, including technology and incentives.
- Research needs.

GME structure and funding are broken

- AAP Policy Statement: "Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce" *Pediatrics* 2008; 121: 855 - 861.
- Macy Report 2009
  - " The **graduate medical education system needs to be better aligned to meet the physician workforce needs of the country**."
  - "At present, most hospitals base decisions about the specialty residency programs they will support and the number of residents they plan to train on the specialty needs of hospitalized patients rather than on the needs of patients from their communities who may lack the care they need."

GME solutions

- Increase number of GME spots to match the increase in US medical school output – partial solution
- Stop "zeroing" out CH GME – stop with annual appropriations and make permanent
- Will need to find a way to increase how workforce needs play into GME funding decisions
  - Option: Increase Federal funding, then Federal funders need to be more proscriptive of type of providers it needs.
  - Option: Create all-payer system, but then less clear who directs it.
  - Option: Cap GME specialties felt to be in excess, and increase spots for those we need (PC?)
  - Option: Un-link GME spots from hospitals, so that PC training in communities can increase

Policy changes in healthcare financing to improve interest in primary care pediatrics

- "House of Pediatrics"
  - Actively advocate on Federal and State levels for pediatric workforce issues
  - Collect quality workforce data to inform agencies
- Federal and State:
  - Can't just pay pediatricians more, but it would help!
  - Reformulate HOW we are paid – PCMH might help do this.
  - Increase PC training funding
  - Improving training structure = Investment in children

Policy changes to improve access to pediatric medical subspecialists and surgical specialists

- "House" of Pediatrics:
  - Should we consider unlinking pediatric subspecialty practice from academic medical centers?
  - Should we consider fast-tracking future pediatric subspecialists?
- Federal:
  - Work toward appropriation of Section 5203 of the ACA (pediatric subspecialty loan repayment program) and state loan repayment programs.
  - Need to address the "longer training in order to make less money" reality for
    - Selected pediatric medical subspecialists
    - ALL pediatric surgical specialists.

What % of Medicaid dollars are spent on children?

- A. 10%
- B. 20%
- C. 30%
- D. 40%
- E. 50%

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- A. 10%
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Take-home points: what can I do?

1. Join your state AAP Chapter
2. PARTICIPATE in your state AAP Chapter
3. Join national AAP Committees
4. Be willing to help recruit, train, and mentor future pediatricians
5. Help train students, residents, practitioners in community settings

"Americans can be relied upon to do the right thing, when they have exhausted the alternatives."

--Sir Winston Churchill

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Acknowledgment

Deepest thanks to William Basco, MD, FAAP, who developed this presentation as an advocacy tool while serving as a member of the AAP Committee on Pediatric Workforce.

ATTRIBUTION

Physician workforce is a multi-faceted topic with far-reaching implications for healthcare delivery in the US. In health policy and almost every venue, there are significant differences between adult-medicine and the provision of care to the pediatric population.

The Committee on Pediatric Workforce has developed and is disseminating these slides to foster a broader understanding of some of the key issues and considerations germane to the pediatrician workforce.

If this PowerPoint Presentation (or some of the slides therein) are used, then attribution must be given to the AAP Committee on Pediatric Workforce.

Thank You.

Mary Ellen Rimsza, MD, FAAP
Chairperson
AAP Committee on Pediatric Workforce
mrimsza@aap.net