The Workforce We Have and the Workforce We Need: How Do Pediatricians Fit into Evolving Systems of Care?

AAP Committee on Pediatric Workforce
www.aap.org/copw
“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. The Pediatrician Workforce
  – Topic 2. Pediatric Practice
  – Topic 3. Adequacy of Pediatric Medical Subspecialist & Pediatric Surgical Specialist Availability
  – Topic 4. Telemedicine and Workforce Shortages
  – Topic 5. Physician Reentry
  – Topic 6. Scope of Practice
  – Topic 7. Changes in Health Care Policy
"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

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

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Data compiled from the National Resident Matching Program by the AAP Division of Workforce and Medical Education Policy
PERCENTAGE OF TOTAL FILLED POSITIONS IN PEDIATRICS FILLED BY USMGs (2002-2015)

Data compiled from the National Resident Matching Program by the AAP Division of Workforce and Medical Education Policy
GENDER AND GRADUATING PEDIATRIC RESIDENTS YEARS, 1997-2014

Trends in the Proportion of Graduating Pediatric Residents Who are Women (1997-2014)

Source: AAP Graduating Resident Surveys, 1997-2014
Percentage of Fellows in ABP Subspecialty Training - Gender

Future Clinical Practice Goals for Graduating Pediatric Residents Not Entering Primary Care Practice

Source: AAP Graduating Resident Surveys, 1997-2014
## Age and Gender

### Table 9. Age and Gender Distribution of AAP U.S. Members

(Excluding Retired & Excluding Residents)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 71 yrs</td>
<td>1.5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>61 - 70 yrs</td>
<td>8.7%</td>
<td>6.2%</td>
</tr>
<tr>
<td>51 - 60 yrs</td>
<td>10.8%</td>
<td>14.8%</td>
</tr>
<tr>
<td>41 - 50 yrs</td>
<td>10.2%</td>
<td>18.3%</td>
</tr>
<tr>
<td>≤ 40 yrs</td>
<td>6.4%</td>
<td>22.7%</td>
</tr>
</tbody>
</table>

Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #85, 86, and 87; 2014
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.

<table>
<thead>
<tr>
<th>Percentage of US Child Population</th>
<th>Children/Provider Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.6%</td>
<td>&lt; 1000 children/child physician</td>
</tr>
<tr>
<td>47.5%</td>
<td>1000-2000 children/child physician</td>
</tr>
<tr>
<td>18.3%</td>
<td>2000-3000 children/child physician</td>
</tr>
<tr>
<td>15.4%</td>
<td>&gt; 3000 children/child physician</td>
</tr>
<tr>
<td>1.3% (1 million children)</td>
<td>No child physician</td>
</tr>
</tbody>
</table>

EXTREMES OF CHILD PHYSICIAN (MD) SUPPLY IN 2010 (IN PCSAs, N = 7144)

- Maldistribution of general pediatricians
- States with large rural areas and fewer training programs have biggest shortages
- Physician/population ratios do not adequately reflect clinical workload

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Pediatric Practice
Table 4. Percent of Pediatricians by Practice Location
(Excluding Residents)

<table>
<thead>
<tr>
<th>Practice Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban, Inner City</td>
<td>23.7%</td>
</tr>
<tr>
<td>Urban, not Inner City</td>
<td>26.3%</td>
</tr>
<tr>
<td>Suburban</td>
<td>40.2%</td>
</tr>
<tr>
<td>Rural</td>
<td>9.7%</td>
</tr>
</tbody>
</table>

Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #85, 86, and 87; 2014

Table 3a. Generalists’ Primary Practice Type
(Excluding Residents & those in Fellowship Training)

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo/2-physician Practice</td>
<td>14.2%</td>
</tr>
<tr>
<td>Group Practice/HMO</td>
<td>63.2%</td>
</tr>
<tr>
<td>Med School/Hospital/Clinic/CHC</td>
<td>20.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #85, 86, 87, and 89; 2014
**EMPLOYMENT SETTING**

**Table 3. Percent of Pediatricians by Primary Employment Setting**

(Excluding Residents)

<table>
<thead>
<tr>
<th>Employment Setting</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo/2-phys Practice</td>
<td>10.7%</td>
</tr>
<tr>
<td>Pediatric Group 3-10 Peds</td>
<td>25.4%</td>
</tr>
<tr>
<td>Pediatric Group &gt; 10 Peds</td>
<td>5.0%</td>
</tr>
<tr>
<td>Multi-specialty Group</td>
<td>15.0%</td>
</tr>
<tr>
<td>HMO</td>
<td>2.3%</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>15.7%</td>
</tr>
<tr>
<td>Medical School</td>
<td>15.7%</td>
</tr>
<tr>
<td>Cmt'y Hlth Center</td>
<td>3.8%</td>
</tr>
<tr>
<td>Other</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #85, 86, and 87; 2014
**WHAT % OF PEDIATRIC RESIDENCY GRADUATES TAKE PART-TIME JOBS?**

- A. 10%
- B. 14%
- C. 21%
- D. 38%
- E. 45%
WHAT % OF PEDIATRIC RESIDENCY GRADUATES TAKE PART-TIME JOBS?

• A. 10%
• B. 13%
• C. 21%
• D. 38%
• E. 45%
PART-TIME PRACTICE

Table 11. Percent of Pediatricians Reporting They Are Practicing Part-Time

(Excluding Residents & those in Fellowship Training)

<table>
<thead>
<tr>
<th>Year</th>
<th>% Working Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>10.9%</td>
</tr>
<tr>
<td>2000</td>
<td>14.9%</td>
</tr>
<tr>
<td>2003</td>
<td>14.9%</td>
</tr>
<tr>
<td>2004</td>
<td>20.4%</td>
</tr>
<tr>
<td>2006</td>
<td>20.3%</td>
</tr>
<tr>
<td>2007</td>
<td>23.2%</td>
</tr>
<tr>
<td>2008</td>
<td>23.3%</td>
</tr>
<tr>
<td>2009</td>
<td>24.1%</td>
</tr>
<tr>
<td>2010</td>
<td>22.8%</td>
</tr>
<tr>
<td>2012</td>
<td>24.6%</td>
</tr>
<tr>
<td>2013</td>
<td>24.6%</td>
</tr>
<tr>
<td>2014</td>
<td>23.3%</td>
</tr>
</tbody>
</table>

Note: Average number of hours per week in direct patient care (for those who work part-time) by survey year: 22.9 (1993); 24.5 (2000); 25.0 (2003); 26.2 (2004); 24.8 (2006); 24.5 (2007); 24.8 (2008); 25.1 (2009); 24.5 (2010); 24.7 (2012); 24.4 (2013); 24.2 (2014).

Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #21 (1993); 43 (2000); 54 (2003); 60 (2004); 65 (2006); 67.59 (2007); 70.72.73 (2008); 74.75 (2009); 78.77 (2010); 79.80 (2012); 82.83 (2013); 86.87 (2014).
SUCCESS IN OBTAINING PART-TIME POSITIONS, ACCORDING TO GENDER AND HAVING CHILDREN

Part-time positions were more likely to be in the same city/area as the residency, with 6 of 10 residents who accepted part-time positions staying in the same city/area as their residency, compared with 47% of residents with full-time positions (P = .028).

Adequacy of Pediatric Medical Subspecialist & Pediatric Surgical Specialist Availability
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
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
WHAT FACTORS CONTRIBUTE TO SUBSPECIALTY (MEDICAL AND SURGICAL) SHORTAGES?

Many issues, including (but not limited to):

- Lower payment to debt ration
- Difficulty recruiting and referring
- Medicaid payments
An investment in a pediatric fellowship generated variable returns. Pursuing a fellowship in cardiology, critical care, or neonatology yielded greater financial returns than pursuing no fellowship at all or practicing as a general pediatrician. However, pursuing a fellowship in the other 8 pediatric subspecialties was a negative financial decision when compared with pursuing no fellowship at all or practicing as a general pediatrician.

*Pediatrics* 2011;127:254-260
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.

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

Reproduced from NACHRI (CHA), Pediatric Subspecialty Shortages Affect Access to Care
DIFFICULTY REFERRING

• “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.
**Percentage of children who must travel > 80 miles to care**

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>Percentage of U.S. Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent medicine</td>
<td>19</td>
</tr>
<tr>
<td>Critical care medicine</td>
<td>7</td>
</tr>
<tr>
<td>Developmental pediatrics</td>
<td>20</td>
</tr>
<tr>
<td>Neonatal medicine</td>
<td>4</td>
</tr>
<tr>
<td>Neurodevelopment</td>
<td>26</td>
</tr>
<tr>
<td>Pediatric cardiology</td>
<td>7</td>
</tr>
<tr>
<td>Pediatric heme/onc</td>
<td>8</td>
</tr>
<tr>
<td>Pediatric endocrinology</td>
<td>11</td>
</tr>
<tr>
<td>Pediatric rheumatology</td>
<td>24</td>
</tr>
<tr>
<td>Pediatric sports medicine</td>
<td>30</td>
</tr>
<tr>
<td>Pediatric gastroenterology</td>
<td>12</td>
</tr>
<tr>
<td>Pediatric nephrology</td>
<td>16</td>
</tr>
</tbody>
</table>

Myer ML. Are We There Yet? Distance to care and relative supply among Pediatric medical subspecialties. Pediatrics. 2006;118:2313-2321.
## Difficulty Recruiting

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>Percentage of Organizations Recruiting</th>
<th>Percentage of Organizations Reporting Medium to High Difficulty in Recruiting</th>
<th>Percentage of Positions Being Recruited for 6 Months or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>33%</td>
<td>83%</td>
<td>67%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>33%</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>33%</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>General Pediatrics</td>
<td>42%</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>33%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Nephrology</td>
<td>33%</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Neurology</td>
<td>33%</td>
<td>100%</td>
<td>75%</td>
</tr>
</tbody>
</table>


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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
WHAT % OF MEDICAID DOLLARS ARE SPENT ON CHILDREN?

• A. 10%
• B. 20%
• C. 30%
• D. 40%
• E. 50%
WHAT % OF MEDICAID DOLLARS ARE SPENT ON CHILDREN?

• A. 10%
• B. 20%
• C. 30%
• D. 40%
• E. 50%
SHORT-TERM SOLUTIONS TO SHORTAGE OF PEDIATRIC MEDICAL SUBSPECIALISTS AND SURGICAL SPECIALISTS

• Primary care pediatricians (PCP) manage more chronic patients

• Subspecialists educate PCPs

• Telemedicine
Telemedicine and Workforce Shortages
TELEMEDICINE

• The best uses can improve access to care, provide more patient- and family-centered care, increase efficiencies in practice, enhance the quality of care, and address shortages in the clinical workforce.

• Can serve as a platform for providing more continuous care, linking primary and specialty care to support management of the needs of complex patients in their community, reducing the burdens of travel on patients and families, while supporting the medical home, and reducing costs.

• But..., when used for episodic care by nonmedical home providers fragmented care may result creating redundancy and imprudent use of health care resources.

*Pediatrics* 2015;136:202-209
TELEMEDICINE -- AAP RECOMMENDS:

• Use of telemedicine services for episodic care should be done within the context of the medical home, because such care offers continuity, efficiency, and the prudent use of health care resources. Fragmented care delivered outside the medical home model must be avoided.

• Ongoing and future research, including demonstration projects, to study the effectiveness of telemedicine to address workforce needs, expand patient access to care, improve quality of care, reduce health care costs, and ensure patient/family and pediatric physician satisfaction, should be increased and financially supported.

• Regulatory and licensing authorities should partner with medical organizations and other health care stakeholders to overcome administrative, financial, and legislative barriers to implement telemedicine and expand patient access to health care.

• *For additional recommendations:* “The Use of Telemedicine to Address Access and Physician Workforce Shortages”  PEDIATRICS Volume 136, number 1, July 2015
Physician Reentry into the Workforce
PHYSICIAN REENTRY

Definition

The returning to professional activity/clinical practice for which one has been trained, certified or licensed after an extended period of absence. Excludes those physicians reentering after remediation due to disciplinary intervention, breach of medical ethics, substance abuse, involuntary loss of one’s medical license, or similar events.

Organizations they worked with are the AAP, AMA, FSMB, CMSS, AAFP, and others too numerous to name. Established in 2005.
A national survey of ‘inactive’ physicians in the United States of America: enticements to reentry

Ethran A. Jewett1, Sarah E. Brotherston2, Holly Rubch-Ross3

Abstract

Background: Physicians leaving and reentering clinical practice can have significant medical workforce implications. We surveyed inactive physicians younger than typical retirement age to determine their reasons for clinical inactivity and what barriers, real or perceived, there were to reentry into the medical workforce.

Methods: A random sample of 4,975 inactive physicians aged under 65 years was drawn from the Physician Masterfile of the American Medical Association in 2008. Physicians were mailed a survey about activity in medicine and perceived barriers to reentry. Chi-square statistics were used for significance tests of the association between categorical variables and t-tests were used to test differences between means.

Results: Our adjusted response rate was 36.1%. Respondents were fully retired (37.5%), not currently active in medicine (43.9%) or now active (reentered, 19%). Nearly half (49.5%) were in or had practiced primary care. Personal health was the top reason for leaving for fully retired physicians (37.8%) or those not currently active in medicine (37.8%) and the second highest reason for physicians who had reentered (29.9%). For reentered (47.9%) and inactive (51.5%) physicians, the primary reason for reentering or considering reentering to practice was the availability of part-time work or flexible scheduling. Retired and currently inactive physicians used similar strategies to explore reentry; and 85% of both groups thought it would be difficult to reenter, among those who had reentered practice, 35.9% reported it was difficult to reenter. Retaining was uncommon for this group (37.5%).

Conclusions: Availability of part-time work and flexible scheduling have a strong influence on decisions to leave or reenter clinical practice. Lack of retraining before reentry raises questions about patient safety and the clinical competence of reentered physicians.

National survey of inactive physicians, using data from the 2008 AMA Masterfile. Inactive Physicians < 65 years old were mailed a survey about activity in medicine and perceived barriers to reentry.

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This study from data from 2006 was conducted by the AAP in conjunction with the AAMC and eight medical associations.

This survey asked questions regarding work status, work history, and education.
PHYSICIAN REENTRY

Key Findings from Reentry Studies:

• Health issues were one of the key reasons for leaving
• Leaving to care for family members also common, especially for women
• Availability of part-time work or flexible scheduling was cited by both men and women as the primary reason they would return to practice
• From the AMA Masterfile study: the average length of time away was 5-10 years
• Other reasons to reenter:
  • Miss caring for patients
  • Financial needs
  • Change in personal circumstances
Characteristics of Arizona Physicians Reentering Clinical Practice (N= 604)

- 75% were men
- Mean age was 50 years
- 83% attended U.S. medical schools
- No difference in age, specialty, or practice location between reentering physicians and other AZ physicians
- Approximately 5% of the AZ licensed physician workforce were reentering physicians over 4-year period
- Few physicians who leave and reenter practice have done so due to board action; only 10% reentered in a different specialty

There is a large “shadow workforce” of physicians who leave and reenter practice who could substantially reduce physician workforce shortages.

Mary Rimza, MD Past Chair AAP COPW
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
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
WHY TITLES MATTER ...

- A chiropractor is now classified as a “Primary Care Provider.”
- Retail-Based Clinics now qualify as a “Medical Home.”
- Nurse practitioners/advanced practice nurses (APN) continue to seek scope of practice expansions in nearly every state.
- 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.
APNs: Just the Facts

- Primary Care Physicians receive 24 TIMES the clinical hours of training of APNs.
- 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.
Changes in Health Care Policy
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 for authorization and funding of a pediatric subspecialty loan repayment program and state loan repayment programs.
  – Need to address the “longer training in order to make less money”
THE PEDIATRIC WORKFORCE: WHAT TO EXPECT SUMMARY

• The high percentage of women entering pediatrics and more practitioners looking for part-time positions will potentially impact the pediatric workforce landscape and render the absolute numbers of trainees less reliable in workforce calculations.

• Physicians coming out of training are far more likely to enter practice in a high supply versus low-supply region, resulting in continued access problems for pediatric patients across the United States.

• Shortages in pediatric primary care, certain medical subspecialties and surgical specialties will persist and the academic pediatric workforce may be challenged without disruptive innovations to the current production (including funding), distribution (incentives) and academic work environment (promotion issues).

• Telemedicine technologies will impact health care access, quality and education and costs of care and help address projected shortages in clinical workforce.

AAP Committee on Pediatric Workforce
WORKFORCE POLICY STATEMENTS FROM THE COMMITTEE ON PEDIATRIC WORKFORCE

AVAILABLE AT: www.aap.org/copw

- Definition of a Pediatrician
- Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making
- Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce
- Nondiscrimination in Pediatric Health Care
- Pediatric Primary Health Care
- Pediatrician Workforce Policy Statement
- Prevention of Sexual Harassment in the Workplace and in Educational Settings
- Scope of Practice Issues in the Delivery of Pediatric Health Care
- The Use of Telemedicine to Address Access and Physician Workforce Shortages
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.

William Moskowitz, MD, FAAP, Chairperson
AAP Committee on Pediatric Workforce