ON THE LEARNING CURVE

Workforce Trends

BY LEE SAVIO BEERS, M.D.

Amidst the heated debate regarding health care reform, many young pediatricians are left wondering, "What will pediatrics look like in 10, 20, or even 30 years?" While this may not be what everyone is talking about on the news, it is a big question in many of our minds. In fact, the pediatric workforce has been carefully studied and analyzed for many years. Putting aside the controversies of the national discussion, understanding what the pediatric workforce looks like now and what it is predicted to look like in the future can help all of us as we move through our careers.

With more than 83,000 pediatric physicians in the workforce, issues such as numbers of general and subspecialty pediatricians compared with the pediatric population, geographic trends, percent of part-time pediatricians, and breakdown by sex are very relevant. This is not an area I know much about, although there are a lot of very interesting resources available, many of which come from the American Academy of Pediatrics (which, understandably, is very interested in the topic of the pediatric workforce). According to the AAP's Committee on Pediatric Workforce (www.aap.org/copw), they are currently revising their 2005 policy statement ("Pediatrician Workforce Statement"), so I anticipate we can look forward to even more information in the near future.

It is generally thought that there currently is, and will continue to be, an adequate supply of general pediatricians for the pediatric population in the United States. However, shortages still occur in particular—often rural—geographic areas; additionally there are certainly shortages of some pediatric medical and surgical subspecialists across the country. Somewhat more than half of pediatricians now are women (and almost three-quarters of pediatric residents are women), a number that has increased significantly over the past 40 years. Only about a quarter of physicians overall are women, so the pediatric workforce is very different in that respect. Almost one-quarter of pediatricians report working part time, also up from about 10% in 1993 (a fact that may be related to the increased percentage of women pediatricians).

The racial and ethnic diversity of pediatricians does not closely mirror that of our patients—this is an area considered to be a priority for workforce development.

Most pediatricians practice in suburban areas, followed closely by urban and inner city areas, with fewer than 10% of pediatricians practicing in rural areas.

There are many questions and issues that arise from these trends, such as how to manage increasing numbers of part-time pediatricians, concerns related to reentering the workforce after an extended absence, the availability of subspecialists, workplace diversity, graduate medical education, and matters specific to women pediatricians.

During the next months, I will discuss many of these topics, and what changes we may expect to see in the years ahead. By better understanding the pediatric workforce, we can better manage our own careers and practices. We can be proactive rather than reactive, working with the changes ahead.

Even looking at my own relatively short career—I've transitioned over the past 10 years from working as a full-time general pediatrician with fully clinical responsibilities to a part-time general academic pediatrician with responsibilities divided between clinical, administration, and research duties—I can see that there are many different ways to be a pediatrician.

If we have a better idea of where the workforce is heading, we may be able to better plan our own careers and choose the way that is right for us each step along the way. ■

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Ten Rules for Developing a Health Information Exchange

BY JOYCE FRIEDEN

WASHINGTON — If you're trying to develop a health information exchange to share electronic health record data with other providers in your area, Dr. Larry Garber has some advice for you.

Dr. Garber, an internist who is medical director for informatics at Fallon Clinic, in Worcester, Mass., outlined his 10 rules for developing a health information exchange (HIE) at the eHealth Initiative Conference:

10. Remember that patients are lousy historians. "It's up to our information technology infrastructures that we build to deliver the vast majority of health information to providers at the point of care," rather than relying on patients to deliver the data, said Dr. Garber, who is also vice-chair of the Massachusetts eHealth Collaborative.

9. Don't let physicians and patients become a bottleneck to HIE. "It's hard enough to get emergency room physicians to look at something right under their noses, let alone to start thinking about a consent process," he said. "And patients cannot be expected to use their personal health record as a way of controlling the flow of data."

8. Create a statewide enterprise master person index (EMPI). Each state should have statewide universal consent forms that a patient can sign once and that apply throughout the system, Dr. Garber said. But to ensure that the consent form that John Smith signed applies to him whether he is in his primary care physician's office, a specialist's office, or the hospital, an EMPI is needed to make sure all the John Smiths are the same person. The EMPI also helps with reconciling continuity of care documents. "What do I do when I get 20 medication lists and 20 allergy lists?" he said. "You can only [solve that problem] if you have an EMPI recognizing that these are all the same person."

7. Don't promise to segregate specially protected information such as HIV status or mental health issues. "In order to make that work … the systems will have to err on the side of not sending information, and as a result we will have a true Swiss cheese of data being exchanged," Dr. Garber said. In Massachusetts, health care organizations tried an HIE in which emergency departments filtered out potentially protected data. "It turned out that the resulting medication lists were useless and the project had to be stopped," he said. "You're either all in or all out. It's dangerous [to withhold information], and patients don't understand the implications of not letting certain data flow."

6. Keep the overhead low. The local HIE that Dr. Garber helped start had its software written internally in order to avoid paying licensing fees. The HIE also hosts its servers in its own data center, and the exchange members did not create a legal entity—such as a regional health information organization—in order to avoid paying attorneys' fees. As a result, the exchange's operating expenses are $7,000 annually, he said. "This may take a little more [money] in other communities, but the bottom line is that you have to lower operating fees if you want the HIE to be sustainable."

'Data collection should be a byproduct of the care that we give. Remember everything we build is affecting real workloads of real people.'

5. Store the data based on the content, not on the source. "When the data is stored, you need to file it properly," Dr. Garber said. "If you have outside electronic documents coming in, don't put them in an 'Outside Records' folder; they need to be integrated with the rest of the data. If I want to find the last MRI of the brain, I want to look in the imaging section and find the last MRI regardless of where it was done. File labs with labs and radiology with radiology."

4. Make the electronic health record (EHR) "one-stop shopping." "I only want to go look in one place for information; I don't want to have to go outside the EHR to a different portal to look for things," he said. "I want one place with one common user interface."

3. Re-use data. The beauty of an EHR is that you can take the data and repurpose it, according to Dr. Garber. For example, the clinic uses claims data to populate medication lists, past medical history, and past surgical history.

2. Don't require people to think. "If you want some process done consistently correctly, you have to kind of take the brain out of [it]," he said. For example, if a hospital needs to have patients sign consent forms for HIV testing, "when patients are checking in and being registered, don't ask the registration clerk to check if they have consented or need to consent; let that process happen automatically—the consent form appears when it's appropriate, it doesn't appear when it's not appropriate." The same should be true for ordering health maintenance and disease management tests.

1. Remember that this is the real world. "Don't forget that we're dealing with the real world and real people," Dr. Garber said. "Our patients are our friends and ourselves. Everything we do affects real people and their health and their happiness. That also includes the physicians and nurses and staff that work in these organizations; everything we do affects [them] as well."

No one should expect physicians and staff to be filling out forms "just for the sake of collecting data so someone can do some analysis on the back end. Data collection should be a byproduct of the care that we give.

So remember everything we build is affecting real workloads of real people." ■

Disclosures: *The conference was sponsored by Ingenix, the American Medical Association, and several other industry groups and trade associations. Dr. Garber did not disclose any conflicts of interest related to his presentation.*