Rural Primary Care Physician Workforce

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There’s a storm ahead
Current Workforce Issues

• Rural Primary Care Physicians
  – Many are close to retirement age
    • Nationally 28%
    • Kansas 30% are over age 55
  – Work more hours (average of 6 hours more)
  – Have higher numbers of patients in their panel (average of 20 more office visits per week)
  – Have less help from Non-Physician Providers
    • Ratio of 28 NPs per 100K rural (36 Urban)
  – Have barriers to seeking transfers to urban centers
Current (Cont.)

• Rural Primary Care Physicians
  – Small rural systems don’t have the resources to adopt best electronic medical records due to cost
  – Have an increased social burden to provide indigent care (lack safety net)
  – Have higher percentages of Medicare and Medicaid in their panels
  – Burnout rates are higher
  – Professional stress and isolation can be significant issues
Rural Hospitals

- 75 rural hospitals have closed since 2010
- 673 are at risk for closure
- 68% of those are critical access hospitals
- ER coverage for these areas is at risk
- Kansas has 31 hospitals at risk for closing
Primary Care – Clinical Care

• The practice of clinical medicine is heavily burdened with regulation.
  – 49% of time spent on activities that are not billable time now spent on “paperwork”
  – Only 33% of time directly with patients
  – Most doctors complete their medical records after leaving the office in the evening
  – Now it takes an average 10-12 office staff to support one physician in clinic

• Used to be 2-3
Primary Care – Clinical Care

• Higher educational debt to earnings potential ratios, and yet are paid up to 5 times less than colleagues with a divergent gap
  – Some medical students have $500,000 in educational debt

• Less Internal Medicine and Pediatrics physicians remain in general practice, instead choosing to further specialize
Payment Gap is Widening

Figure 10. Progress of the Physician Payment Gap

RL Phillips, MS Dodoo, S Petterson, I Xierali, A Bazemore, B Teevan, K Bennett, C Legagneur, J Rudd, and J Phillips; “Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?”; The Robert Graham Center; Michigan State University College of Human Medicine; March 2, 2009
Direct Primary Care

• Physicians leaving insurance driven practice models for a more traditional model of care

• Contract directly with patient
  – Joins practice with monthly fee
    • Usually around $50 per month
  – Patient visits take a variety of forms
    • Some with an extra fee for face-to-face time
Family Medicine Positions Offered and Filled in March 2007-2017

Source: National Resident Matching Program® Advance Data Tables 2017

Positions Offered  Positions Filled  Filled U.S. Seniors

2007  2,621  2,313  1,107
2008  2,654  2,404  1,172
2009  2,555  2,329  1,083
2010  2,630  2,404  1,184
2011  2,730  2,576  1,317
2012  2,764  2,611  1,335
2013  3,062  2,938  1,374
2014  3,132  3,000  1,416
2015  3,216  3,060  1,422
2016  3,260  3,105  1,481
2017  3,378  3,237  1,530

Predicted Shortages by 2025

From 37,000

To 115,900

According to the AAMC and Western Journal of Medicine, 2015
5-10 years

• National data suggests a physician shortage
• Addressing the shortage should be as simple as increasing medical school enrollment and increasing the number of GME slots
• Look at Kansas as an example of the need to examine county level data in rural areas
Age Histogram of Frontier, Rural and DSR PCP in Kansas

Average age of retirement

- Age over 65: 108
- Age over 55: 268
- Average Age: 51
- Max Age: 87
- Min Age: 30
From 2004 to 2014 there are an additional 9 counties at risk due to physician losses.

- There are now 38 rural and frontier counties in Kansas with less than 2 PCP-FTE to cover the entire county. Up from 29 in 2004.
IN 2014 26 counties have 1-2 Physicians and 9 of those (35%) have physicians that are **over** 65
Kansas’ Future

• The Robert Graham Center, in a report about Kansas, states that we need 87 PCP in 2015 and a projection of 247 additional by 2030 for the state (adjusting for aging and population growth).
Practice Instability Due to Low Numbers

• 38 counties in 2014 have 2 or less physicians, 10 years ago that number was 29.

• In general counties with 2 physicians or less have instability in their health care system.

• These counties are susceptible to a single accident or injury leaving the remaining physician to provide solo coverage for an entire county.

• Counties with 2 doctors or less pose an unsustainable situation.
Granularity is Needed

- County level workforce analysis is needed to understand the level of physician need.
- Special attention to small 1-2 physician practices is needed to avoid a health care crisis in frontier and rural areas.
- For the entire state the rural PCP-FTE actually increased slightly by 12.5 FTE over 10 years.
  - Most of these distributed to large rural practices
  - But there were substantially more physicians going to urban areas (58)
National Level Data

- Kansas is at the median for most workforce markers
- Using state level numbers grossly underestimates the frontier and rural needs.
  - Graham Center est. for next 10 years = 190
- Using straight ratios misses the effect of instability and unsustainability in counties with 2 or less physicians
Kansas actually needs 361 Physicians

- Kansas would need 31 additional PCP-FTE to have at least 2 physicians per county.
- Would need 62 PCP-FTE to replace all individual county losses in the last 10 years.
- Kansas is projected to lose another 30% (268) of its rural and frontier PCP workforce due to retirement in the next 10 years.
Bottom-line

- Rural Physician Workforce is an extremely complex issue
- National predictions for Primary Care Workforce are sobering with as many as 43,000 more PCPs needed by 2025.
- More non-physician providers is not the sole answer
- In response to a call for increased numbers of UME positions the US has grown medical school enrollment by 30%.
- We need to fund more targeted rural primary care physician programs in the US
- Institutes of Medicine published a recommendation to create “Graduate Medical Education That Meets the Nation’s Health Needs”
- We need specific funding for programs that train physicians in rural locations
- The rural and frontier PCP workforce is, as predicted, heading for significant strains in the next several years, an issue that is further compounded by maldistribution of the primary care physician workforce and population migration.
- County level data needs to drive workforce analysis and predicted needs.
- Due to projections, we will need to address the shortcomings expected due to the unsustainable nature of rural and frontier practices with less than two physicians.
- We will need to have plans to address further hospital closures.
All bets are off!

AFTER 10 YEARS
SPECIAL THANKS TO THE SUMMER INTERNS AT THE NATIONAL RURAL HEALTH ASSOCIATION!
References

- KDHE Office of Primary Care and Rural Health; Primary Care Health Professional Underserved Areas Report, 2004-2014; http://www.kdheks.gov/olrh/rural.html
- 2015 State Physician Workforce Data Book, Center for Workforce Studies; Nov 2015; https://members.aamc.org; Accessed 4-25-2016
- Further references available on request
THANK YOU!