Pediatrics 2025
The AMSPDC Workforce Initiative

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AMSPDC Workforce Summit - Goals

1. Increase the number of high-quality students who enter training in our categorical Pediatrics, Medicine-Pediatrics and Combined Pediatric Subspecialty training programs.

2. Improve recruitment of pediatric residents into pediatric fellowship programs, with an emphasis on fellowship programs that are not filling their training positions.

3. Recognize the ongoing national efforts at understanding and addressing current concerns with pediatric workforce, led by AMSPDC.
AMSPDC Workforce Summit
Workforce Summit Domains

1. Change the Educational Paradigm
2. Workforce Needs/Data
3. Early Exposure and Integration
4. Economic Strategy
Change the Educational Paradigm

Domain Lead: APPD

- **Advocacy:**
  - Engage regulatory agencies (ACGME, AACOM and LCME) to drive change

- **Curricula:**
  - Explore opportunities to redesign our UME and GME learning environments
  - Adopt best practices
  - Develop more focused training pathways
  - Re-examine existing residency program components
  - Incorporate novel training experiences
  - Prepare trainees for the future
Change the Educational Paradigm

• **Subspecialty Exposure**
  - Increase subspecialty exposure early in training
  - Promote interactions between residents and subspecialty fellows.

• **Positive Role Modeling**
  - Enhance engagement between faculty and trainees
  - Celebrate unique aspects of careers in pediatrics
Change the Educational Paradigm

• How can Department Chairs Help?
  • What are you doing that is innovative?
  • Do you have a “best practice” model for encouraging pathways into pediatrics?
  • When the new RRC requirements are reviewed, what suggestions do you have for revising the pediatric training requirements?
Data Needs/Access
Domain Leads: ABP and CoPS

**Data**
- Understanding recent trends in pediatric workforce by analyzing data
- Workforce diversity
- Physician scientists
- DOs
- Work profiles (clinical, teaching, research, other activity) of our pediatric subspecialists
- Advanced practitioners (PA’s and NP’s)

**Needs and Access**
- Partner with appropriate organizations to understand workforce challenges
  - Access
  - Regionalization of care
  - Distribution of workforce
  - Care model changes (APPs, Psychologists, Social workers)
- Changes in referral patterns
- Impact of other components of the workforce (DOs)
Data/Needs and Access

1. Osteopathic Medical School Graduates in the Pediatric Workforce
2. Physician Scientist
3. DEI – Diversity in the fellowship pipeline
4. Work profiles/Practice settings
5. Pediatric Subspecialty Supply Workforce Modeling Project
6. Advanced practice providers
   a. Data complex for nurse practitioners
   b. While a smaller portion of the pediatric workforce, data on physician assistants becoming available
7. International Medical School Graduates in the Pediatric Workforce
ABP and AAP Collaboration
Subspecialty shortages and access to care

One-Pager for Use with Congress

Dynamic Dashboard by State/Subspecialty
Early Exposure and Integration

Domain Lead: COMSEP

- **Advocacy**
  - Survey the top 10 allopathic medical schools that have had the highest percentage of medical students entering pediatrics (with the AAMC data received by AMSPDC) to learn what they do

- **Marketing**
  - Identify when, how and why medical and osteopathic students decide to choose Pediatrics and Pediatric Subspecialties
Early Exposure and Integration

• **Early Exposure**
  - Subspecialty awareness survey: survey being finalized to collect information on how subspecialties increase awareness about pediatrics and pediatric subspecialties with the aim of recruiting to fellowship, develop toolkit of programs and initiatives in use for the CoPS website

• **Recruitment/Outreach**
  - Collect data on what programs are currently doing to promote medicine overall and how can we highlight pediatrics better, especially to URiM students (e.g. Tour4Diversity.org)
Early Exposure and Integration

- **Long Term Goals:**
  - Provide department chairs/medical schools/osteoathopic schools/COMSEP members with a tool kit for promoting pediatrics to medical students
  - Develop a national campaign for **Choosing Pediatrics**

- **Chairs can support by:**
  - Increased incorporation of pediatric faculty and pediatric cases into the preclinical curriculum
  - Increased shadowing/research/other experiences for preclinical medical students with pediatric faculty
  - Develop strategies to recruit medical students and pediatric residents to subspecialties
  - Funding to support these efforts?
Economic Strategy
Domain Lead: AMSPDC
Economic Strategy

- **Financial Burden**
  - Target new strategies to minimize debt burden
    - Pediatric Subspecialty Loan Repayment Program
    - Title VII Health Professions Workforce Development Programs

- **Compensation and Revenue Stream**
  - Develop strategies to achieve greater parity with adult providers and greater parity among procedural and non-procedural pediatric subspecialists

- **Children’s Hospital GME**
  - Develop strategies to achieve parity with Medicare GME
Strategies to Minimize Debt Burden

Medicaid is the single largest insurer of children. Medicaid, with CHIP, covers ~40% of all US children. Of all Medicaid enrollees, nearly half are children. Medicaid has historically paid physicians lower fees than Medicare for the same services.
- hovering ~ 70% of Medicare fees, on average, and ~ 64% for pediatric primary care

The Affordable Care Act included a mandatory two year increase in fees for primary care to Medicare levels for Medicaid fee-for-service and managed care in 2013 and 2014. Federal lawmakers did not reauthorize funding for the increased payments to primary care services, ending the fee bump in December 2014.
- Increasing Medicaid payment resulted in increased access to pediatric care (Tang, et al. Pediatrics 2018)
Medicaid-to-Medicare Fee Index (2016)

SOURCE: Kaiser Family Foundation’s State Health Facts.
"Payments for pediatric health care services should be structured to achieve parity with payments for similar services for adults. In particular, Medicaid payments for services to children and young adults should be set at a minimum to Medicare payments made for the care of adults. A service provided to a child is not less complicated or time consuming than a similar service rendered to an adult because the child is younger or smaller; in fact, pediatric services not infrequently require greater effort because of a higher degree of medical complexity or procedural difficulty."
Children’s Health Insurance

“The imperative to achieve racial and socioeconomic health equity in the United States demands structural changes to Medicaid to make access universal for children, ensure stable and adequate funding, and address Medicaid’s historically low payment rates”.

I am particularly excited that this bill also includes the Kids’ Access to Primary Care Act, a bipartisan bill I introduced to expand primary care access for children and families on Medicaid. By matching Medicaid reimbursement rates to higher Medicare rates, Medicaid patients will have access to more physicians, and children will get the care they need from their own primary care physician. That kind of access shouldn’t depend on zip code, income, or skin color.
Economic Strategy Partners

- **AAP Leadership**
  - Mark Del Monte, CEO/Executive Vice-President
  - Ann Edwards, AAP Chief Population Officer

- **AAP Committee on Pediatric Workforce**
  - Lauren Barrone, AAP Senior Manager, Pediatric Practice and Workforce
  - Harold K. Simon, Chair, Committee on Pediatric Workforce

- **Pediatric Policy Council**
  - James Baumberger, AAP Senior Director, Federal Advocacy
  - Matthew Mariani, AAP Policy Associate
  - Shetal Shah, SPR Representative

- **Children’s Hospital Association**
  - Amy Knight, COO
  - Amanda Major, Manager, Federal Affairs
What is the impact?
AMSPDC-AAAP CFTE WORKING GROUP

UPDATE AND NEXT STEPS
BACKGROUND

- One of the key focus topics during the 2019 AMSPDC-AAAP National Meeting was clinical FTE (cFTE).

- AAAP/AMSPDC cFTE Working Group was established to identify key principles and definitions around the components of clinical effort (cFTE) for academic clinical physicians.
WHY IS IT IMPORTANT?

Consistent definition can ensure alignment in reporting of productivity data as well as salary for benchmarking purposes.

Can help ensure better understanding of work culture and physician burnout factors.

No comprehensive benchmarks; many email inquiries and webinars highlighting what some groups are doing.

Defining cFTE is always a topic of interest for everyone:

- Physician practices, hospitals, academic departments/divisions
- Academic and non-academic organizations (AAMC, MGMA, specialty organizations, etc)
- Consultants (Sullivan Cotter, Vizient, Huron, etc)
AMSPDC-AAAP CFTE WORKING GROUP

Frame more of the cFTE discussion to advocate best practices

Understand how to report institutional information to optimally inform benchmarking

Understand components of FTE vs CFTE and what to consider when setting own expectations

Create a survey to capture institutional definitions
Full-time Equivalent (FTE)

Clinical FTE (cFTE)

Billable cFTE (bcFTE)

Clinical Administration

Face-to-Face bcFTE

Non Face-to-Face bcFTE

Academic FTE (aFTE)

Research

Education

Academic Administration
Workgroup deliverables for AMSPDC and AAAP members by end of 2022
- Finalized key principles and framework
- Survey to gather benchmarking data on cFTE expectations for primary care and specialty care pediatrics and protected administrative time for physician leadership roles

Both deliverables should be used to help leadership understand best practices and align with national benchmarks.

Should help leadership teams to understand how to report their institutional information consistently in benchmarking surveys to ensure appropriate best practices and national benchmarks.