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

@FuturePedsRes

NextGenPediatricians

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**

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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)

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Data/Needs and Access

Manuscripts in development

1. Osteopathic Medical School Graduates in the Pediatric Workforce
2. Physician Scientist
3. DEI – Diversity in the fellowship pipeline

Dashboard

Active progress

4. Work profiles/Practice settings
5. Pediatric Subspecialty Supply Workforce Modeling Project

Initial discussions

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

Recruiting partners

7. International Medical School Graduates in the Pediatric Workforce

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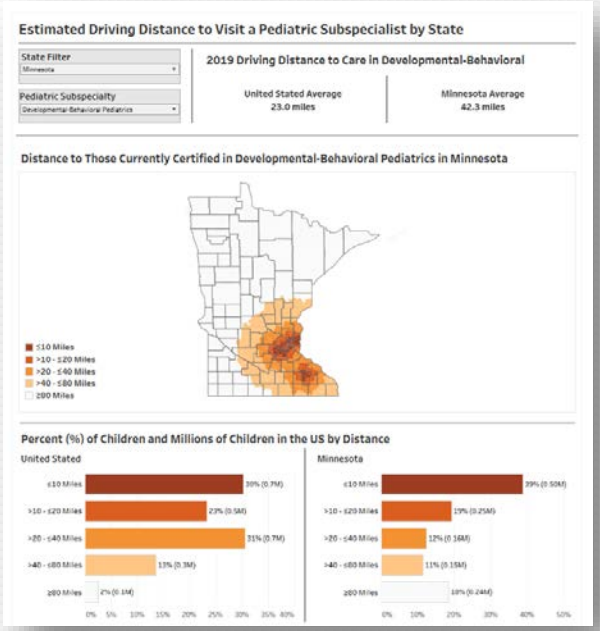
ABP and AAP Collaboration

Subspecialty shortages and access to care

One-Pager for Use with Congress

Dynamic Dashboard by State/Subspecialty



https://www.aap.org/en-us/state-county-distributions-general-pediatricians-subspecialt

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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/osteopathic 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 pre-clinical medical students with pediatric faculty
  - Develop strategies to recruit medical students and pediatric residents to subspecialties
  - Funding to support these efforts?

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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

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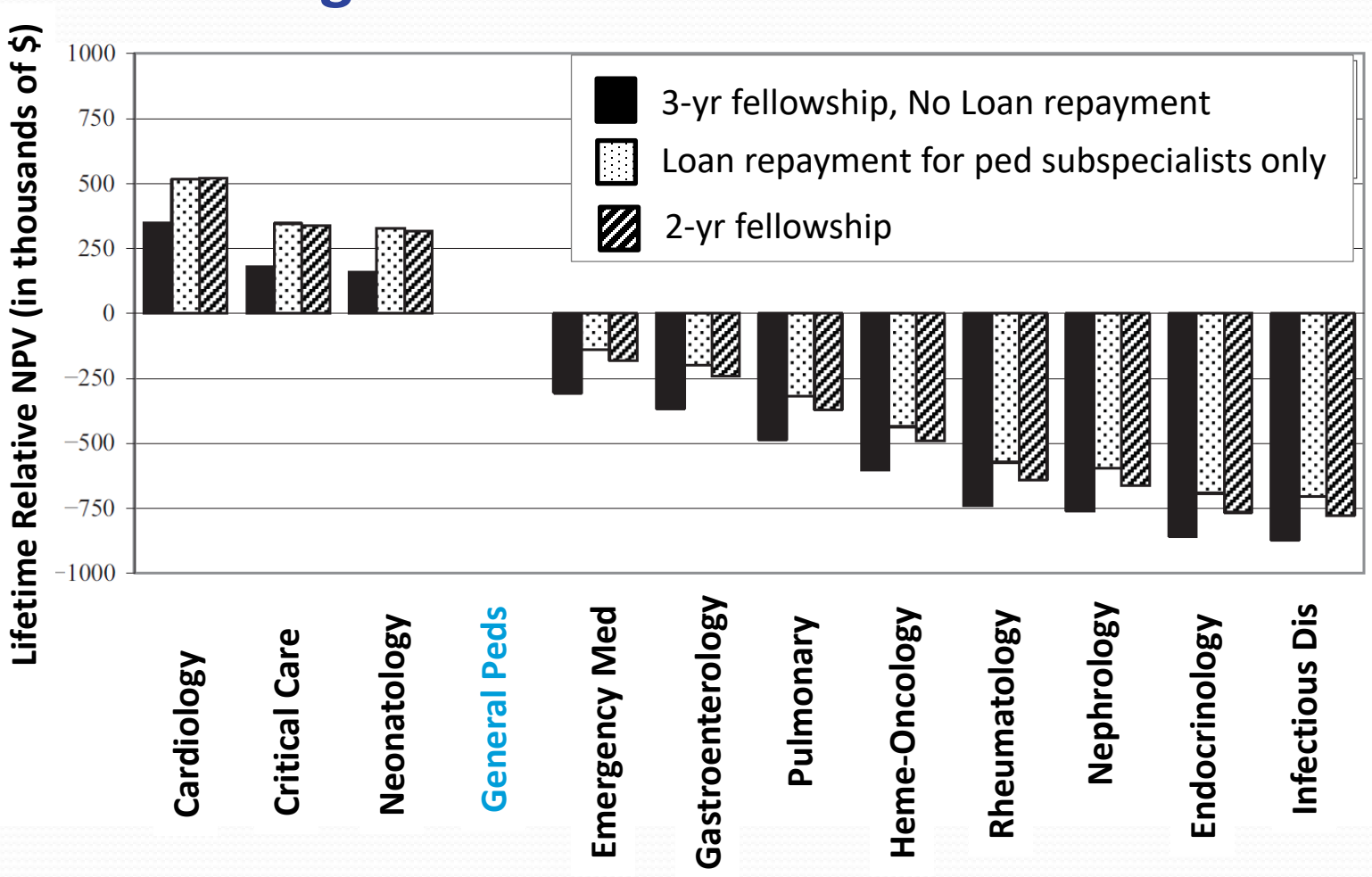
Strategies to Minimize Debt Burden



Rochlin & Simon. Does Fellowship Pay: What is the Long-term Financial Impact of Subspecialty Training in Pediatrics? Pediatrics 2011.

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Children's Health Insurance

- 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)

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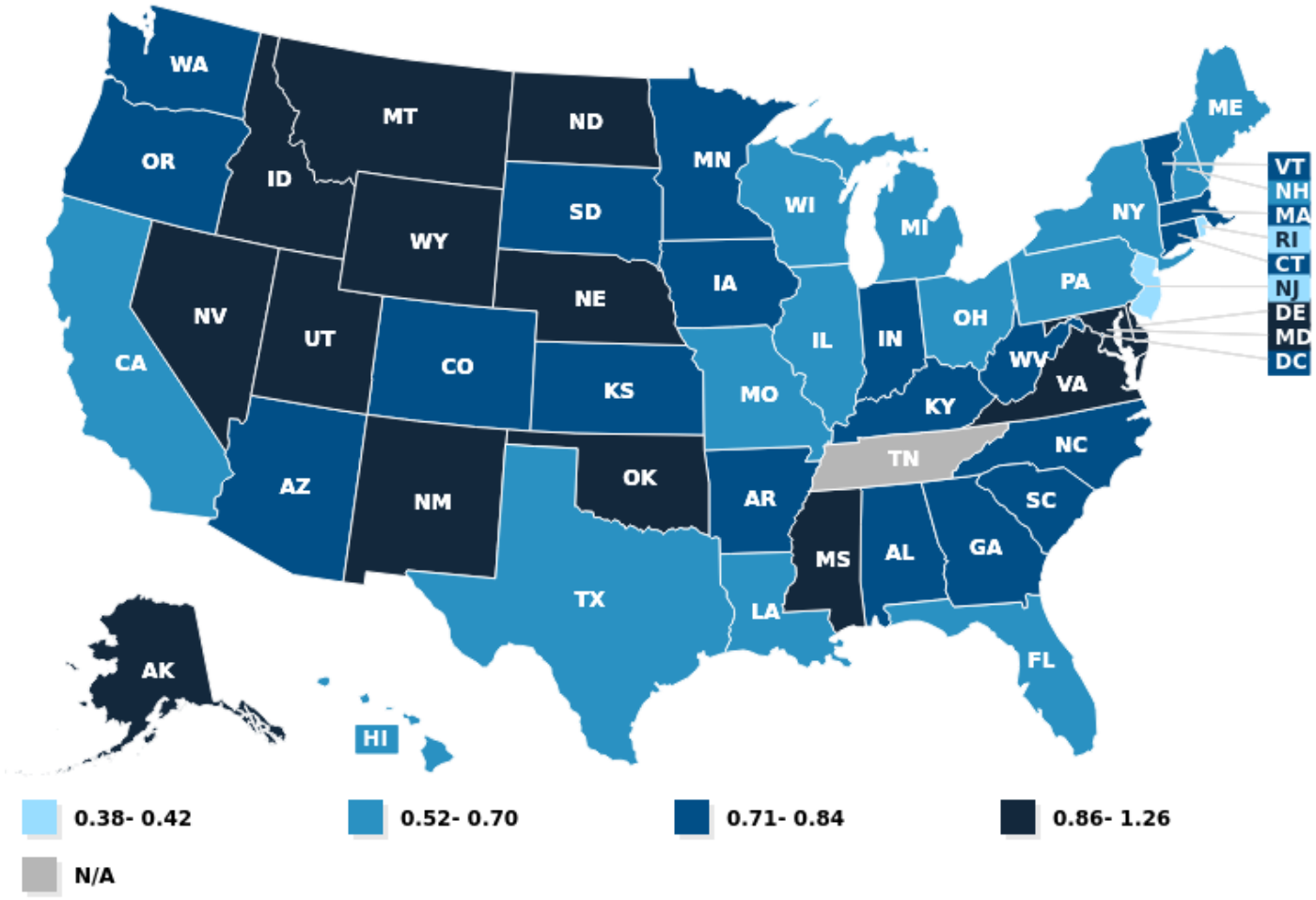
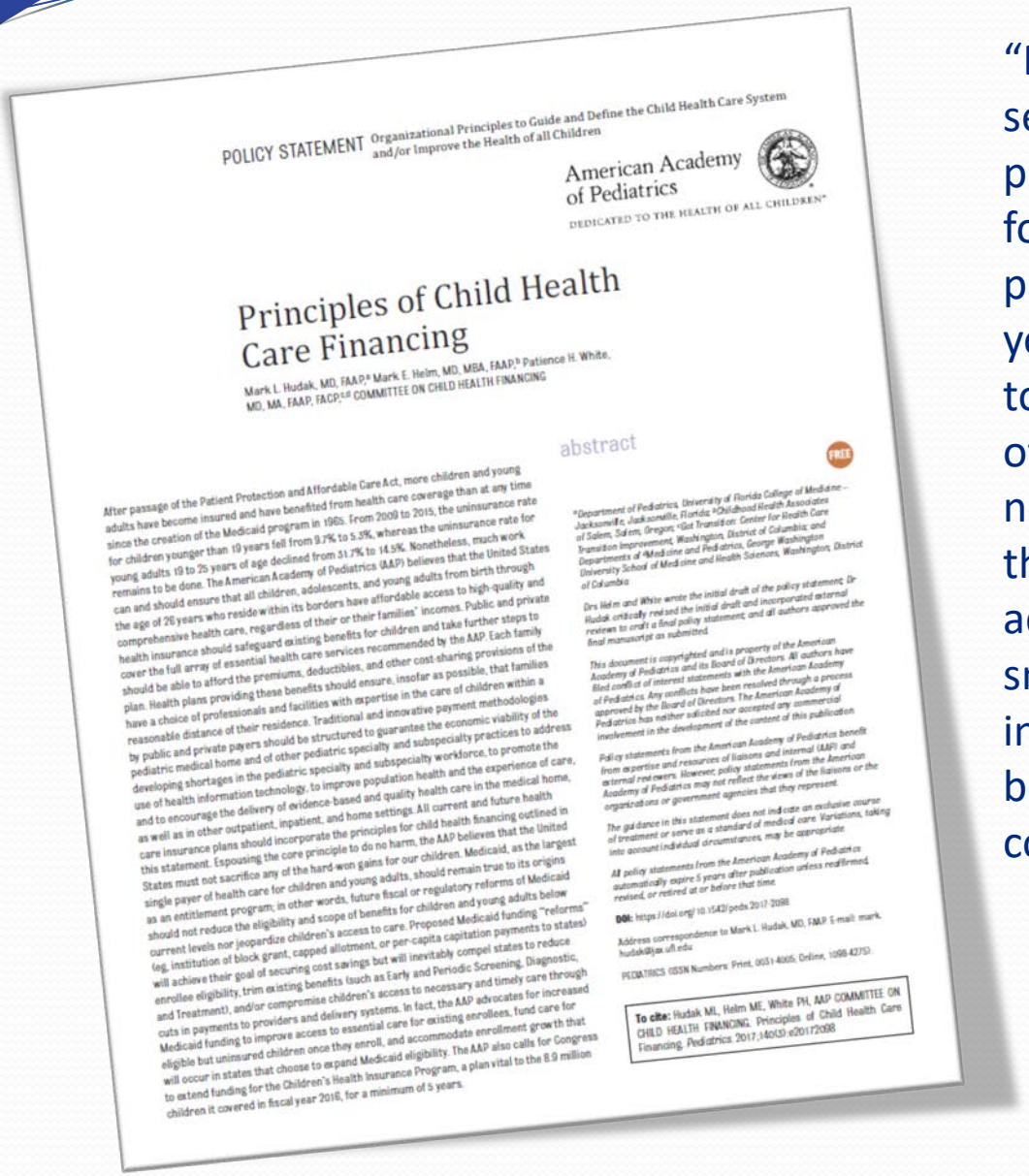
Medicaid-to-Medicare Fee Index (2016)



SOURCE: Kaiser Family Foundation's State Health Facts.



POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Principles of Child Health Care Financing

Mark L. Hudak, MD, FAAP,[a] Mark E. Helm, MD, MBA, FAAP,[b] Patience H. White, MD, MA, FAAP, FACP,[c,d] COMMITTEE ON CHILD HEALTH FINANCING

abstract

FREE

After passage of the Patient Protection and Affordable Care Act, more children and young adults have become insured and have benefited from health care coverage than at any time since the creation of the Medicaid program in 1965. From 2009 to 2015, the uninsurance rate for children younger than 19 years fell from 9.7% to 5.3%, whereas the uninsurance rate for young adults 19 to 25 years of age declined from 31.7% to 14.5%. Nonetheless, much work remains to be done. The American Academy of Pediatrics (AAP) believes that the United States can and should ensure that all children, adolescents, and young adults from birth through the age of 26 years who reside within its borders have affordable access to high-quality and comprehensive health care, regardless of their or their families' incomes. Public and private health insurance should safeguard existing benefits for children and take further steps to cover the full array of essential health care services recommended by the AAP. Each family should be able to afford the premiums, deductibles, and other cost-sharing provisions of the plan. Health plans providing these benefits should ensure, insofar as possible, that families have a choice of professionals and facilities with expertise in the care of children within a reasonable distance of their residence. Traditional and innovative payment methodologies by public and private payers should be structured to guarantee the economic viability of the pediatric medical home and of other pediatric specialty and subspecialty practices to address developing shortages in the pediatric specialty and subspecialty workforce, to promote the use of health information technology, to improve population health and the experience of care, and to encourage the delivery of evidence-based and quality health care in the medical home, as well as in other outpatient, inpatient, and home settings. All current and future health care insurance plans should incorporate the principles for child health financing outlined in this statement. Espousing the core principle to do no harm, the AAP believes that the United States must not sacrifice any of the hard-won gains for our children. Medicaid, as the largest single payer of health care for children and young adults, should remain true to its origins as an entitlement program; in other words, future fiscal or regulatory reforms of Medicaid should not reduce the eligibility and scope of benefits for children and young adults below current levels nor jeopardize children's access to care. Proposed Medicaid funding "reforms" (eg, institution of block grant, capped allotment, or per-capita capitation payments to states) will achieve their goal of securing cost savings but will inevitably compel states to reduce enrollee eligibility, trim existing benefits (such as Early and Periodic Screening, Diagnostic, and Treatment), and/or compromise children's access to necessary and timely care through cuts in payments to providers and delivery systems. In fact, the AAP advocates for increased Medicaid funding to improve access to essential care for existing enrollees, fund care for eligible but uninsured children once they enroll, and accommodate enrollment growth that will occur in states that choose to expand Medicaid eligibility. The AAP also calls for Congress to extend funding for the Children's Health Insurance Program, a plan vital to the 8.9 million children it covered in fiscal year 2016, for a minimum of 5 years.

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Drs Helm and White wrote the initial draft of the policy statement; Dr Hudak critically revised the initial draft and incorporated external reviews to craft a final policy statement; and all authors approved the final manuscript as submitted.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

DOI: https://doi.org/10.1542/peds.2017-2098

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

To cite: Hudak ML, Helm ME, White PH, AAP COMMITTEE ON CHILD HEALTH FINANCING. Principles of Child Health Care Financing. Pediatrics. 2017;140(3):e20172098

"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."

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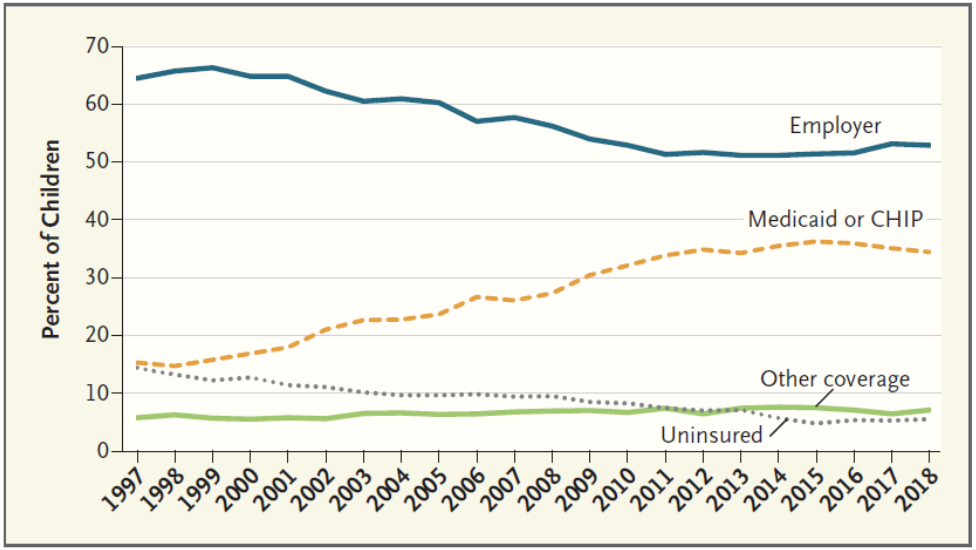
Children's Health Insurance

"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".



Health Insurance Coverage for Children, 1997–2018.

Perrin, et al. Medicaid and Child Health Equity. New Engl J Med 2020.

REP. SCHRIER STATEMENT ON HOUSE PASSAGE OF BILL TO INCREASE HEALTH CARE ACCESS AND REDUCE COSTS

June 29, 2020 | Press Release

WASHINGTON, DC – *Congresswoman **Kim Schrier**, M.D. (WA-08) released the following statement after voting for the "Patient Protection and Affordable Care Enhancement Act" which included her bill, the "Kids' Access to Care Act":*

"The *Affordable Care Act* was a phenomenal first step that provided protection for 26 million Americans with pre-existing conditions who otherwise would not have access to health insurance. However, I have heard from many constituents that the cost of premiums and other expenses are putting health care out of reach. The *Patient Protection and Affordable Care Enhancement Act* addresses this by capping premiums to 8.5% of a family's income, which will cut premiums in half for the average family in my district. That is a tangible difference and will make healthcare truly affordable and accessible.

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 to care shouldn't depend on zip code, income, or skin color.

This bill also addresses the exorbitant price of prescription drugs by giving Medicare the power to negotiate those prices, and extending the same price to everyone.

I have held 49 town halls and spoken to thousands of 8th district residents, and the most consistent concern I hear is the cost of health care and prescription medications. This bill addresses those very issues. No family should ever face bankruptcy because of medical expenses. As one of the few doctors in Congress, I will always work to ensure that everyone can afford the care they need."

###

Rep. Schrier's floor speech on HR 1425, the *Patient Protection and Affordable Care Enhancement Act.*

Issues: Health

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?

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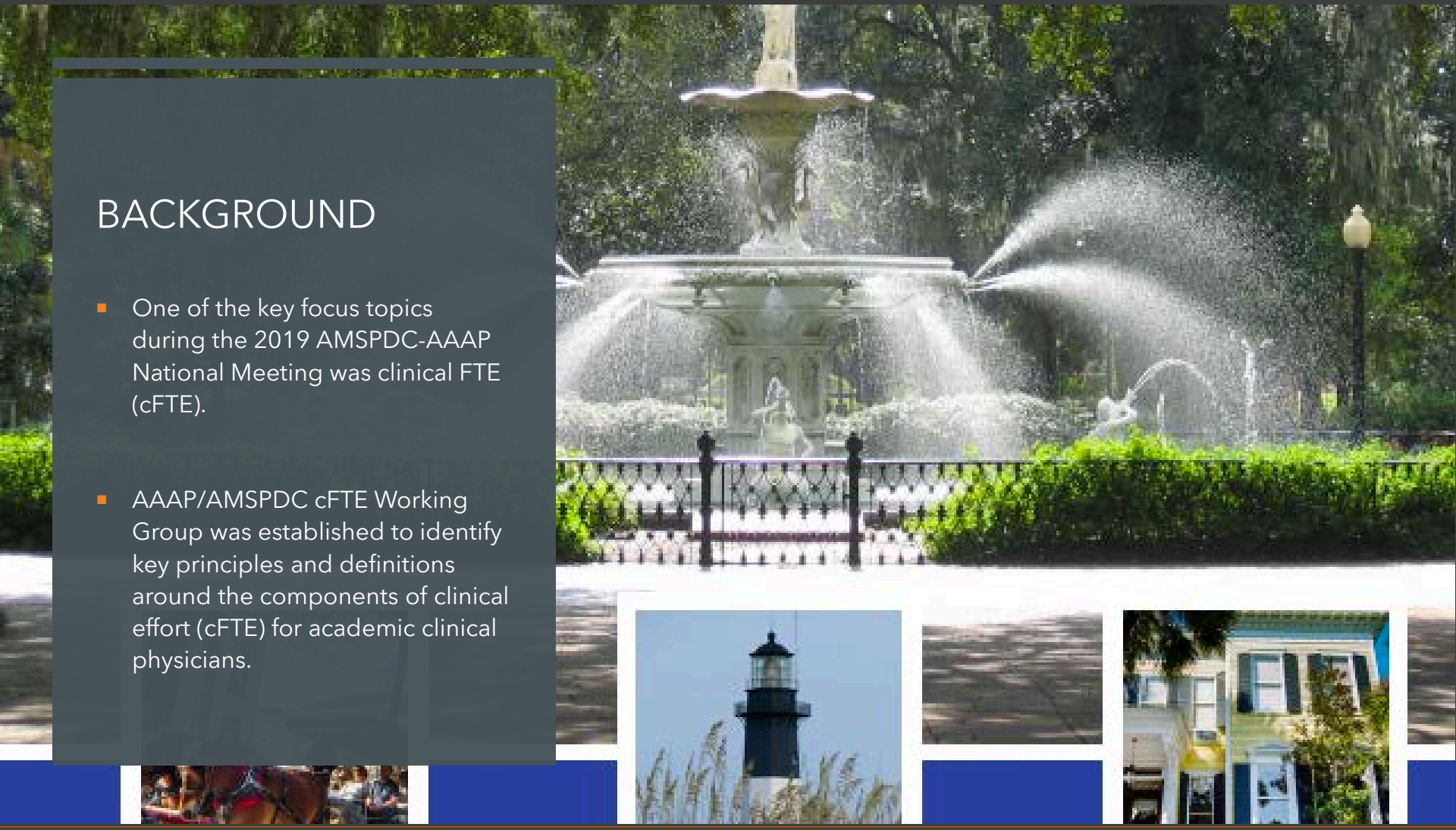
AMSPDC-AAAP CFTE WORKING GROUP

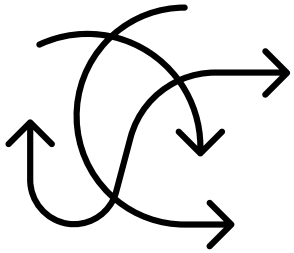
UPDATE AND NEXT STEPS

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.

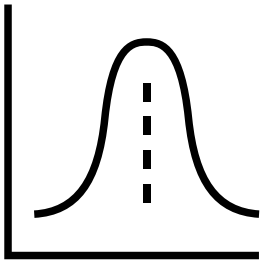


WHY IS IT IMPORTANT?

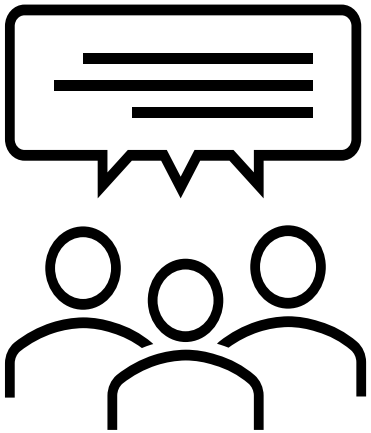


No comprehensive benchmarks; many email inquiries and webinars highlighting what some groups are doing

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



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

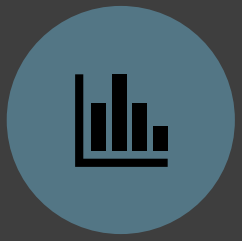


Defining cFTE is always a topic of interest for everyone:

- 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

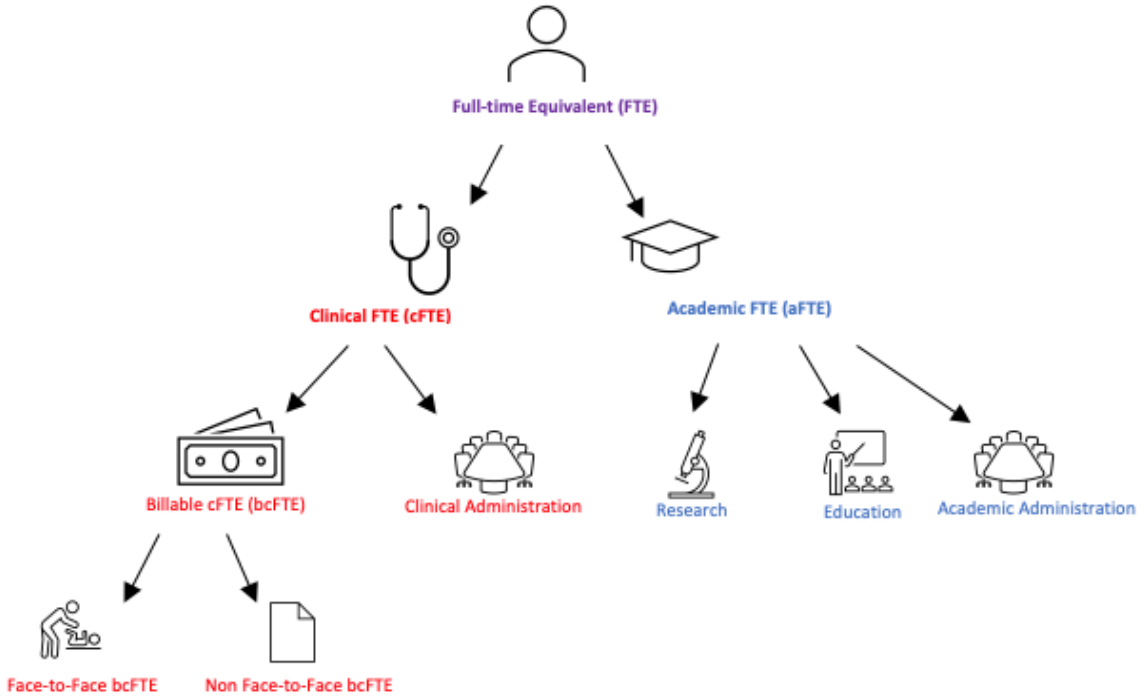


Understand how to report institutional information to optimally inform benchmarking

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

Create a survey to capture institutional definitions

FTE LOGIC TREE



NEXT STEPS

- 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.