

Pediatrics 2025: The AMSPDC Workforce Initiative

May 14, 2021

1:00pm – 5:00pm ET



Strategy Discussion: Economic Domain

We will begin momentarily.



Pediatrics 2025: The AMSPDC Workforce Initiative



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Welcome to the Pediatrics 2025: The AMSPDC Workforce Initiative

Ann Reed, MD
President, AMSPDC

Housekeeping Notes:

- Turn on video so we can see each other.
- Rename yourself on Zoom so we know your name and organization you're representing.
- Please keep your line muted unless you are speaking to avoid background noise.
- Use the chat box for questions and comments and/or to indicate that you would like to speak.



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Organizational Partners



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NextGenPediatricians



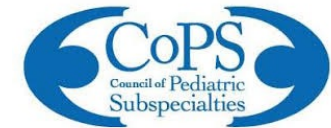
CHILDREN'S
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ACADEMIC
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ASSOCIATION



National Association of
Pediatric Nurse PractitionersSM



AAMC Association of
American Medical Colleges



COMSEP
Better Health for All Patients
Through Pediatric Education



Eunice Kennedy Shriver National Institute
of Child Health and Human Development

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AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

CMS.gov



Association of Administrators in Academic Pediatrics

National Pediatric Physician-Scientist Collaborative Workgroup

Pediatrics 2025: The AMSPDC Workforce Initiative Summit #3 - Attendees

#FuturePedsRes: **Dr.** Nicholas Heitkamp

AAAP: Ms. Desiree Brown

AAAP: Ms. Liz McCarty

AACOM: Dr. Natasha Shah

AAMC: Ms. Amy Adams

AAMC: Mr. Michael Dill

AAP: Mr. James Baumberger

AAP: Mr. Mark Del Monte

AAP: Dr. Anne Edwards

AAP: Dr. Jon Price

ABP: Dr. Laurel Leslie

ABP: Dr. David Nichols

ABP: Mr. Adam Turner

ABP: Dr. Suzanne Woods

AMSPDC: Ms. Laura Degnon

AMSPDC: Dr. Sherin Devaskar

AMSPDC: Dr. Mary Leonard

AMSPDC: Dr. Ann Reed

AMSPDC: Dr. Joe St. Geme, III

AMSPDC: Dr. Bob Vinci

AMSPDC: Dr. Leslie Walker-Harding

APA: Dr. Teri Turner

APA: Dr. Latha Chandran

APPD: Dr. Becky Blankenburg

APPD: Dr. Patricia Poitevien

APS: Dr. Clifford Bogue

CHA: Mr. Mitch Harris

COMSEP: Dr. Joseph Gigante

COMSEP: Dr. Rachel Thompson

COMSEP: Dr. April Buchanan

CoPS: Dr. Jill Fussell

CoPS: Dr. Debra Boyer

CoPS: Dr. Angie Myers

CMS: Dr. Ellen Marie Whelan

Emory: Dr. Hal Simon

Harvard: Dr. James Perrin

NAPNAP: Dr. Kristin Gigli

NAPNAP: Dr. Andrea Kline-Tilford

NAPNAP: Ms. Raji Koppolu

NASEM: Ms. Karen Helsing

NPSCW: Dr. Audrea Burns

NPSCW: Dr. Jordan Orange

NPSCW: Dr. Kate Ackerman

SPR: Dr. Stephanie Davis

U of MI: Dr. Gary Freed

U of WA: Dr. Tumaini Coker

UNC: Dr. Colin Orr

UNC: Dr. Victor Silva Ritter

US House of Reps: Congresswoman Kim Schrier

US House of Reps: Congressional staff

AMSPDC team: Ms. Abigail Blake

AMSPDC team: Ms. Erin Ross

Pediatrics 2025: The AMSPDC Workforce Initiative

May 14, 2021

Strategy Discussion: Economic Domain

Initiative Co-Leads:

Bob Vinci, MD, AMSPDC Board Member
Laura Degnon, CAE, AMSPDC Executive Director



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Pediatrics 2025: The AMSPDC Workforce Initiative

- Created in 2020 with the goal to increase the number of high-quality students who enter training in categorical Pediatrics, Medicine-Pediatrics, and Combined Pediatric Subspecialty training programs, as well as improve recruitment of pediatric residents into pediatric fellowship programs, with an emphasis on those fellowship programs that are not filling their training positions.
- Multi-Organizational involvement to develop strategies based in the four domains of our work
- Governance: Oversight Committee, Domain Leads Committee, Organization Representatives Committee, Forming an Advisory Committee



amspdc.org/workforce
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Overview of Workforce Summits

1. February 27, 2020: Creation of 4 Domains

1. Change the Educational Paradigm (Lead: APPD; R. Blankenburg)
2. Workforce Needs/Data (Lead: ABP, CoPS; L. Leslie; J. Fussell)
3. Economic Strategy (Lead: AMSPDC; M. Leonard)
4. Early Exposure and Integration (Lead: COMSEP; J. Gigante)

2. October 23, 2020: Updates from Domain Leads; Breakouts and action items for next steps

3. May 14, 2021: Focused on Economic Strategy (Domain 3)



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Governance: Oversight Committee

Purpose: The Oversight Committee is designed to ensure close communication within and across each domain. This Committee will deliberate, make decisions, advise, provide strategic oversight, ensure inclusiveness and collaboration in the pediatrics community, review the goals, timelines, reports and serve as advocates for this Initiative.

Commitment: Five years; quarterly Oversight Committee calls; periodic emails; attend the AMSPDC sponsored workforce summits.

Members:

Bob Vinci and Laura Degnon (Initiative Co-Leads)

Sherin Devaskar (AMSPDC Past President); Ann Reed (AMSPDC President)

Leslie Walker-Harding (AMSPDC Board Member) and Joe St. Geme (AMSPDC President-Elect)



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Oversight Committee



Robert J. Vinci, MD, Initiative Co-Lead
Board Member, AMSPDC
Joel and Barbara Alpert Professor,
Pediatrics, Boston University School of
Medicine



Laura Degnon, CAE
Initiative Co-Lead
Executive Director, AMSPDC



Ann Marie Reed, MD
President, AMSPDC
Samuel L. Katz Professor of Pediatrics,
Professor of Pediatrics, Chair of the
Department of Pediatrics, Duke
University



Sherin Devaskar, MD
Past President, AMSPDC
Mattel Executive Endowed Chair,
Department of Pediatrics, David
Geffen School of Medicine at UCLA



Joseph W. St. Geme, MD
President Elect, AMSPDC
Physician-in-Chief and Chairman of the
Department of Pediatrics, Leonard and
Madlyn Abramson Endowed Chair in
Pediatrics, Children's Hospital of Philadelphia



Leslie R. Walker-Harding, MD
Board Member, AMSPDC
Senior Vice President and Chief
Academic Officer, Department of
Pediatrics Chair, Seattle Children's
Hospital



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Governance: Domain Leads Committee

Purpose: The Domain Leads Committee is designed to help ensure the work within each domain moves forward in a thoughtful, collaborative manner. It's essential each domain has close communication with the other domains. This Committee will deliberate, advise, provide strategic suggestions, ensure inclusiveness and collaboration in the pediatrics community, and serve as advocates for this Initiative.

Commitment: Five years; monthly Domain Lead Committee calls; periodic emails; attend the AMSPDC sponsored workforce summits.

Members: Bob Vinci and Laura Degnon (Initiative Co-Leads)
Becky Blankenburg (Domain 1 Lead)
Jill Fussell and Laurel Leslie (Domain 2 Leads)
Mary Leonard (Domain 3 Lead)
Joe Gigante (Domain 4 Lead)



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Domain Leads



Rebecca Blankenburg, MD, MPH

Domain 1 Lead

President, Association of Pediatric Program Directors (APPD); Associate Chair of Education, Lucile Packard Children's Hospital, Stanford School of Medicine



Mary Leonard, MD, MSCE

Domain 3 Lead

Member, AMSPDC

Arline and Pete Harman Professor and Chair of the Department of Pediatrics, Stanford University School of Medicine
Adalyn Jay Physician in Chief, Lucile Packard Children's Hospital Stanford



Laurel K. Leslie, MD, MPH

Domain 2 Lead

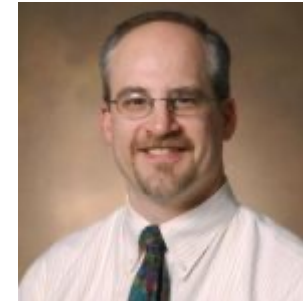
Director of Research, The American Board of Pediatrics (ABP)



Jill Fussell, MD

Domain 2 Lead

Executive Committee, Council of Pediatric Subspecialties (CoPS)
Developmental Pediatrics and Habilitative Medicine Section Chief, University of Arkansas for Medical Sciences College of Medicine



Joseph Gigante, MD

Domain 4 Lead

Past President, Council on Medical Student Education in Pediatrics (COMSEP)
Professor of Pediatrics, General Pediatrics, Vanderbilt University Medical Center



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Governance: Advisory Committee

Purpose: The Advisory Committee is designed to guide the Co-Leads and provide strategic input to the Workforce Initiative. Designed to advance the work of this initiative, the Advisory Committee will serve as a sounding board to the Co-Leads and provide guidance on potential directions of the Workforce Initiative, provide advice on strategic partners and offer expert opinions on the domains of the Workforce Initiative.

Commitment: Four years; periodic calls with Initiative Co-Leads and quarterly Committee calls; periodic emails; attend the AMSPDC sponsored workforce summits when possible.

Members: Bob Vinci and Laura Degnon (Initiative Co-Leads)

TBD

Please share names of potential leaders for our Advisory Committee



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Governance: Organizational Representative Committee

Purpose: The Organizational Representatives Committee is designed to help ensure the work of the Pediatrics 2025: The AMSPDC Workforce Initiative is a community effort! We seek a minimum of 1-2 representatives of each stakeholder organization.



Commitment: Representative(s) to serve five years; periodic emails; attend the AMSPDC sponsored workforce summits, ensure your organization is aware of and involved with components of this Initiative that make most sense. Help us by connecting us to appropriate people doing relevant work to help advance this Workforce



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Organizational Representatives Committee We Need You!



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Domain 1: Change the Educational Paradigm

Domain Lead: APPD; R. Blankenburg

- ***Advocacy:***
 - Engage regulatory agencies (ACGME, COCA, 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



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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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Domain 2: Data Needs/Access

Domain Leads: ABP and CoPS; L Leslie; J Fussell

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 (PAs and NPs)

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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Domain 3: Economic Strategy

Domain Lead: AMSPDC



- Financial Burden
 - Target new strategies to minimize debt burden
- Compensation
 - Develop strategies to achieve greater parity with adult providers and greater parity among procedural and non-procedural pediatric subspecialists
- Reform our payer system
 - Advocate for Medicaid reform with a goal to achieve parity with Medicare reimbursement



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Domain 4: Early Exposure and Integration

Domain Lead: COMSEP; J. Gigante

- **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 (allopathic and osteopathic) students decide to choose Pediatrics and Pediatric Subspecialties



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Domain 4: 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)

- **Longterm Strategy**

- Provide Department Chairs with a toolkit for promoting Pediatrics to our medical students
- Develop a Choose Pediatrics Campaign



Accomplishments Between February - October 2020

1. Domains Refined and Leads Established
2. Governance Structure
3. Partnerships with other organizations
4. Website
5. Approval for a Series of Publications via AMSPDC in *Journal of Pediatrics*
6. Domain specific goals established



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Accomplishments Between October 2020 – May 2021

1. Governance Structure: Advisory Committee
2. Greater Partnerships with other organizations
3. Website: Bibliography Expanded with over 70 references
4. Two Publications (Vinci in *Pediatrics* on Match Data; Vinci, Degnon, Devaskar in *Journal of Pediatrics* Summarizing Our Work)
5. Significant Focus on Economic Strategy



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Agenda

Share ideas, offer advice, ask questions, share contacts/connections

1:00-1:05pm	Welcome, Introductions (A. Reed, AMSPDC)
1:05-1:30pm	Initiative Overview, Update, Today's Goals (B. Vinci; L. Degnon, AMSPDC)
1:30-1:45pm	Domain 3 Update: Economic Strategy (M. Leonard, AMSPDC)
1:45-1:55pm	Keynote Address by Congresswoman Schrier (Introduction by A. Reed)
1:55-2:15pm	Facilitated Q&A with Congresswoman Schrier (Moderated by B. Vinci)
2:15-2:30pm	Domain 2 Update: Data/Needs and Access – Economics (Drs. Laurel Leslie and Colin Orr)
2:30-2:45pm	Discussion (Facilitated by Dr. Leslie Walker-Harding)
2:45-3:00pm	Break



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Agenda

Share ideas, offer advice, ask questions, share contacts/connections

3:00-3:15pm	Impact of Lifetime Earnings on Workforce (H. Simon)
3:15-3:30pm	Discussion (Facilitated by B. Vinci)
3:30-3:45pm	Primary Care NASEM Study (T. Coker)
3:45-4:00pm	Discussion (Facilitated by L. Degnon)
4:00-4:10pm	NASEM Potential Consensus Study on The Pediatric Clinical Workforce and Its Impact on Child Health and Well-Being (J. St. Geme; Introduced by S. Devaskar)
4:10-4:30pm	Break-Outs @ NASEM Potential Study
4:30-4:35pm	Report Outs (Facilitated by L. Degnon)
4:35-5:00pm	Open Discussion, Wrap Up, Next Steps & Save the Dates (B Vinci; L Degnon)
5:00pm	Adjourn



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Goals For Today

1. Keynote Address from Congresswoman Kim Schrier
 1. Kids' Access to Primary Care Act
 2. Q&A to foster collaboration with the pediatric community
2. Discussion of economic drivers
 1. Debt burden
 2. Lifetime earning potential
3. Update on NASEM Consensus on High Quality Primary Care and implications for pediatrics
4. Review a proposed NASEM Study on the Pediatric Workforce
 1. NASEM objectives and core topics
 2. Potential NASEM sponsors
5. Establish next steps



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Domain #3 Update

Mary Leonard, MD



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Pediatrics Workforce 2025 Initiative

Domain #3: Economic Strategy

Mary B. Leonard, MD, MSCE

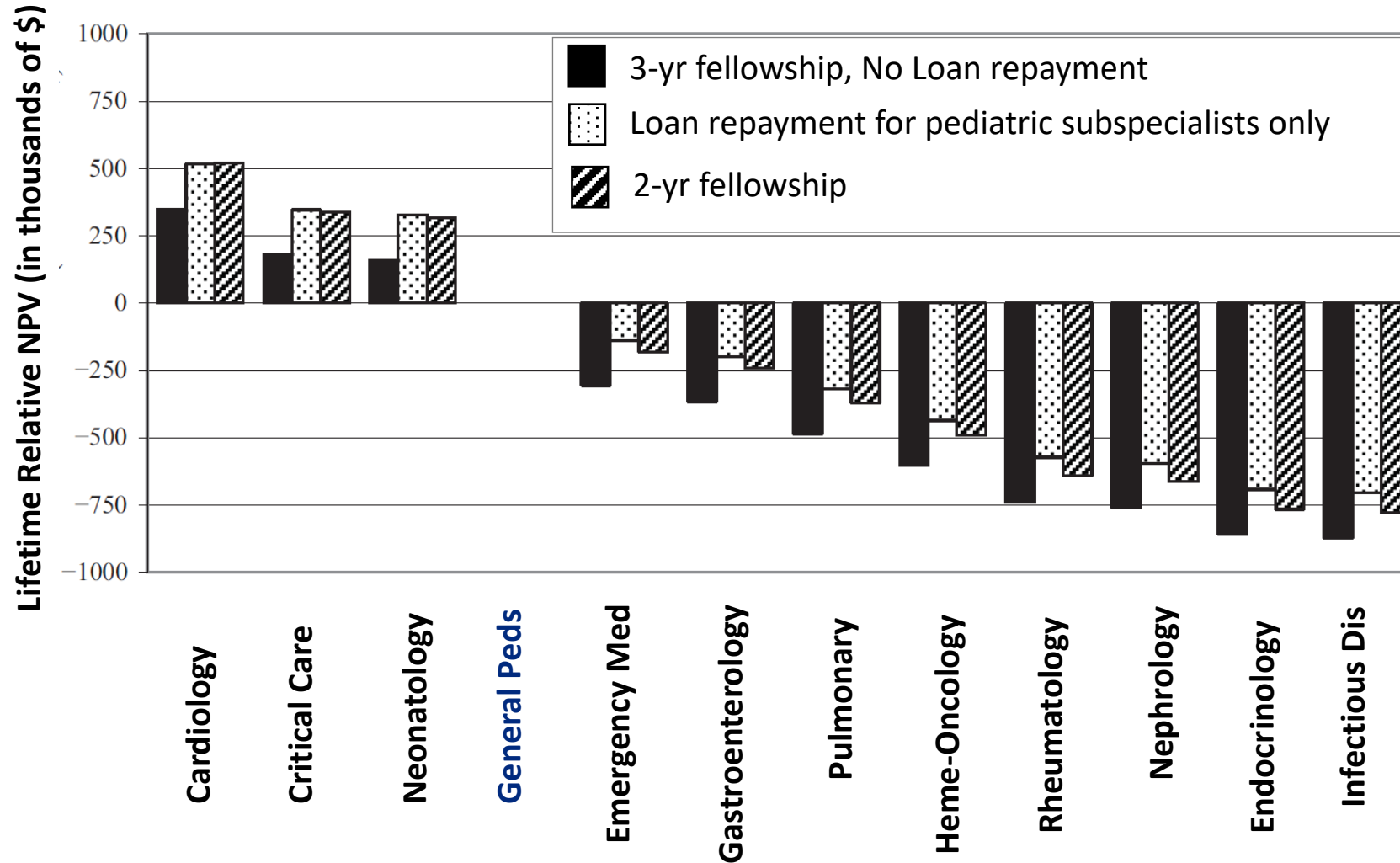
Arline and Pete Harman Professor and Chair, Department of Pediatrics
Stanford School of Medicine

Adalyn Jay Physician in Chief, Lucile Packard Children's Hospital
Director, Stanford Maternal and Child Health Research Institute

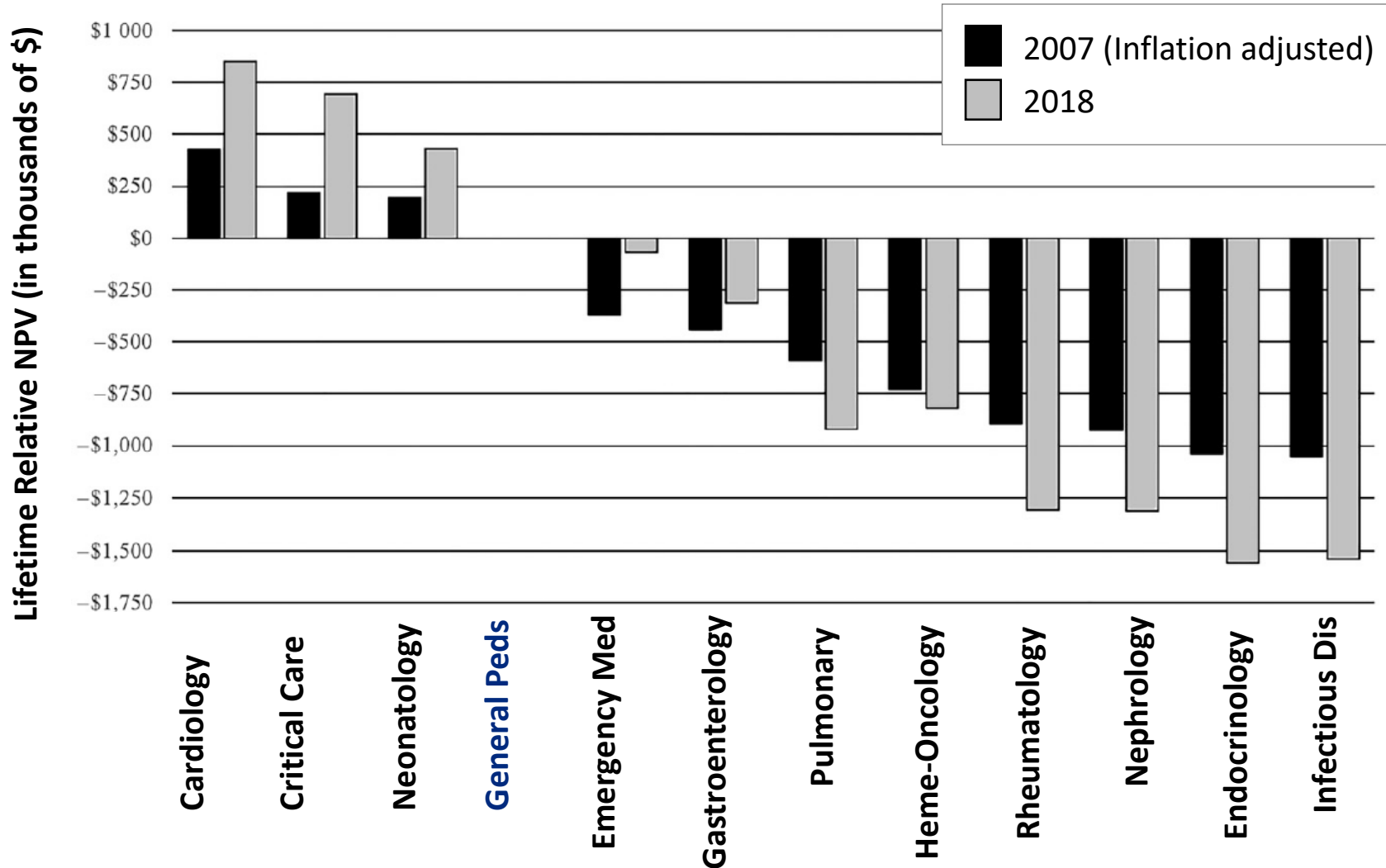
Economic Strategy Topic Areas

- Financial Burden
 - Target new strategies to minimize debt burden
 - Pediatric Subspecialty Loan Repayment Program
- 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



Updated Analyses



Medical Student Debt

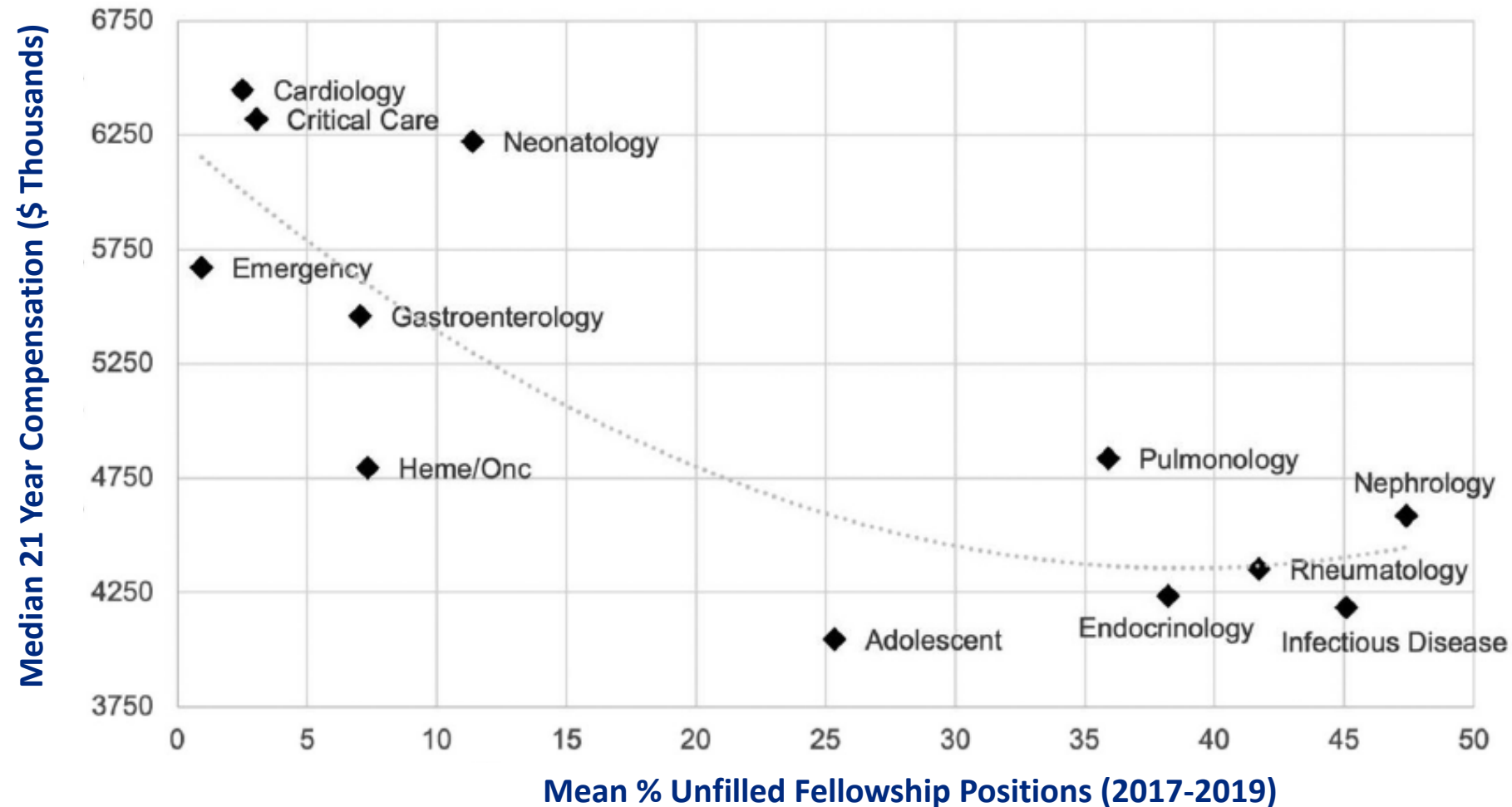
Graduate in 2008:

- 87% had educational debt
- mean debt burden \$158,061

Graduate in 2019:

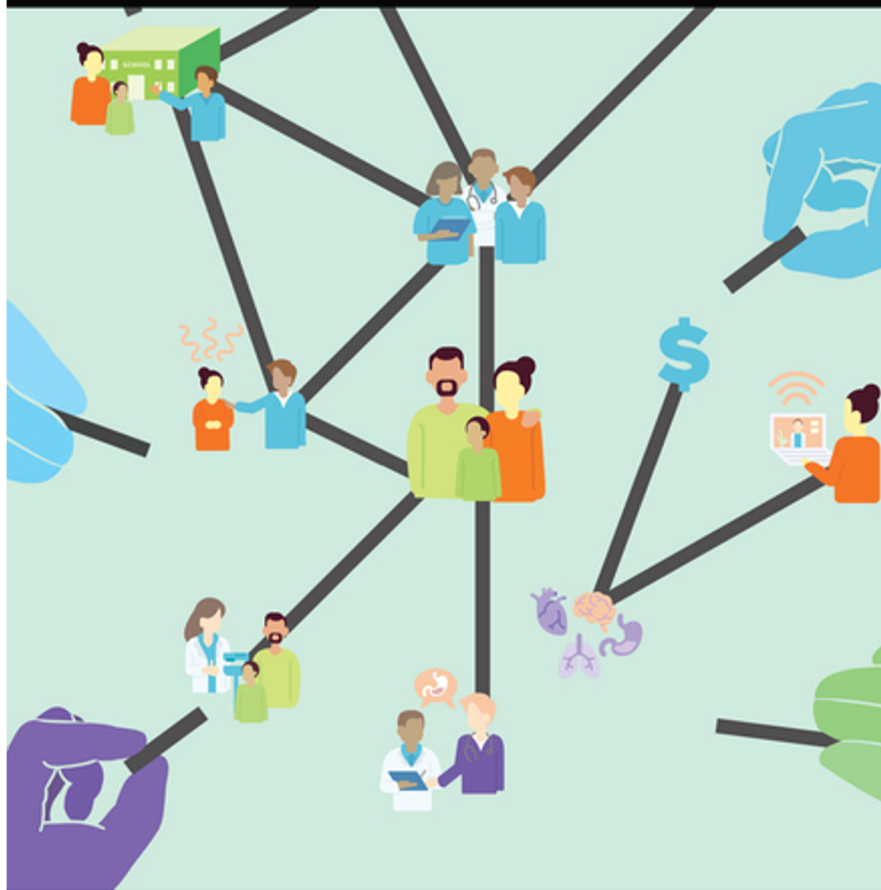
- 73% had educational debt
- mean debt burden \$200,000

Unfilled Pediatrics Subspecialty Fellowship Positions



The National Academies of
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CONSENSUS STUDY REPORT



Implementing High-Quality Primary Care

Rebuilding the Foundation of Health Care

“The foundation is crumbling: visits to primary care clinicians are declining, and the workforce pipeline is shrinking, with clinicians opting to specialize in more lucrative health care fields.”

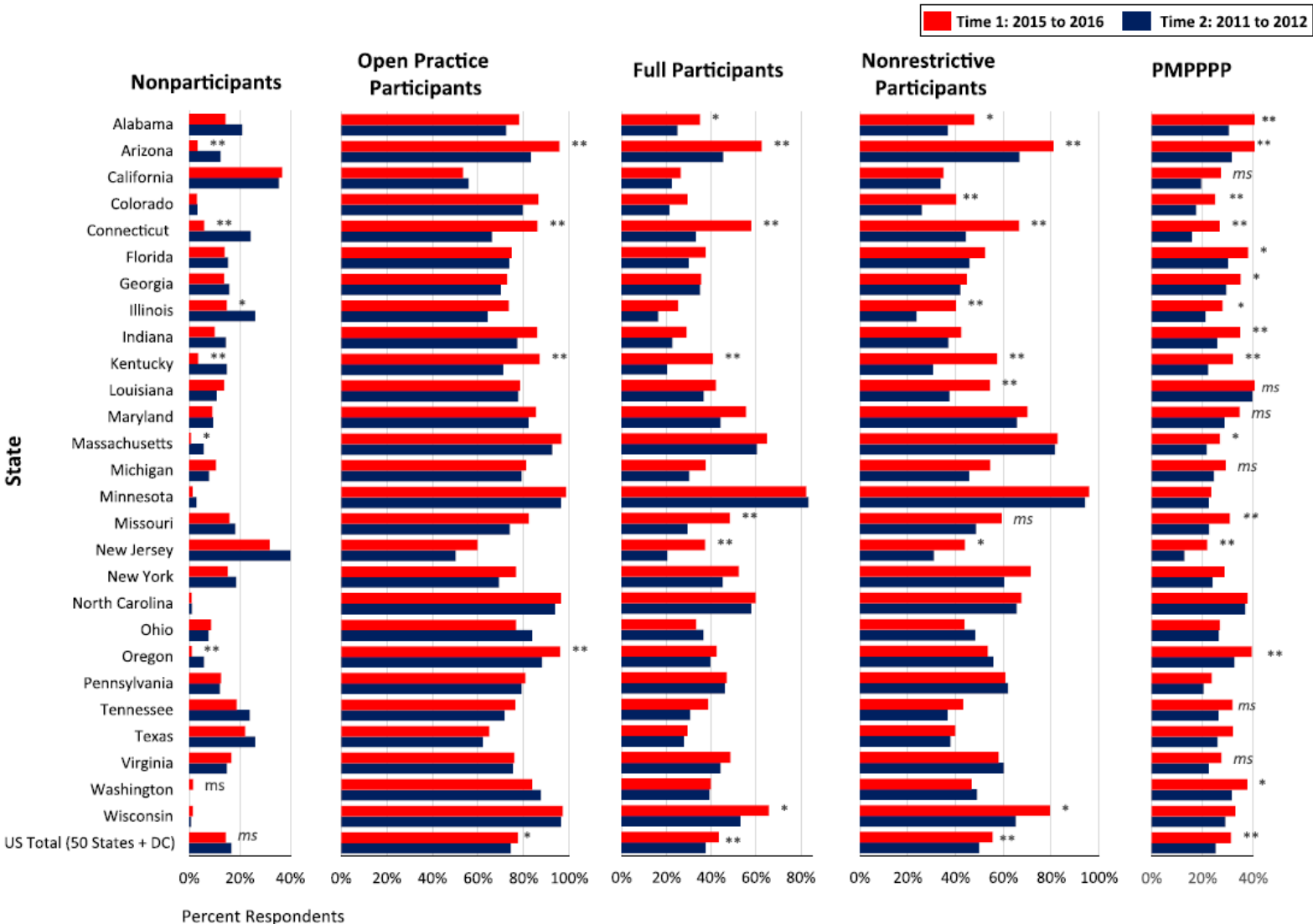
Children's Health Insurance

- 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

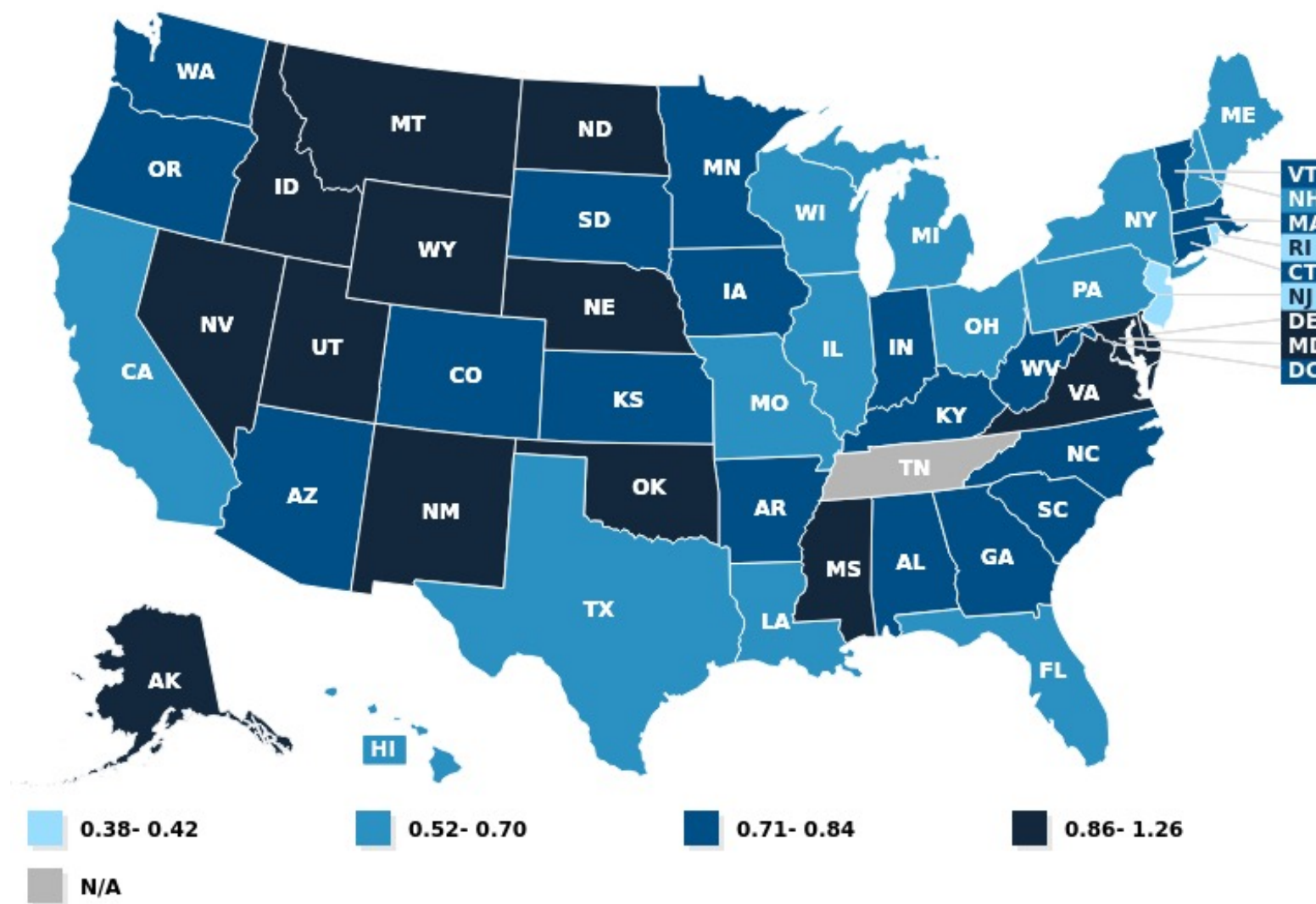
Increasing Medicaid Payment Increases Access to Pediatric Care



American Academy
of Pediatrics



Medicaid-to-Medicare Fee Index (2016)



SOURCE: Kaiser Family Foundation's State Health Facts.



Principles of Child Health Care Financing

Mark L. Hudak, MD, FAAP,* Mark E. Helm, MD, MBA, FAAP,[†] Patience H. White,
MD, MA, FAAP, FACP[‡] 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 51.7% 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.

*Department of Pediatrics, University of Florida College of Medicine—Jacksonville, Jacksonville, Florida; †Childhood Health Associates of Salem, Salem, Oregon; ‡Got Transition, District of Columbia; and Departments of †Medicine and Pediatrics, George Washington University School of Medicine and Health Sciences, Washington, District of Columbia

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.

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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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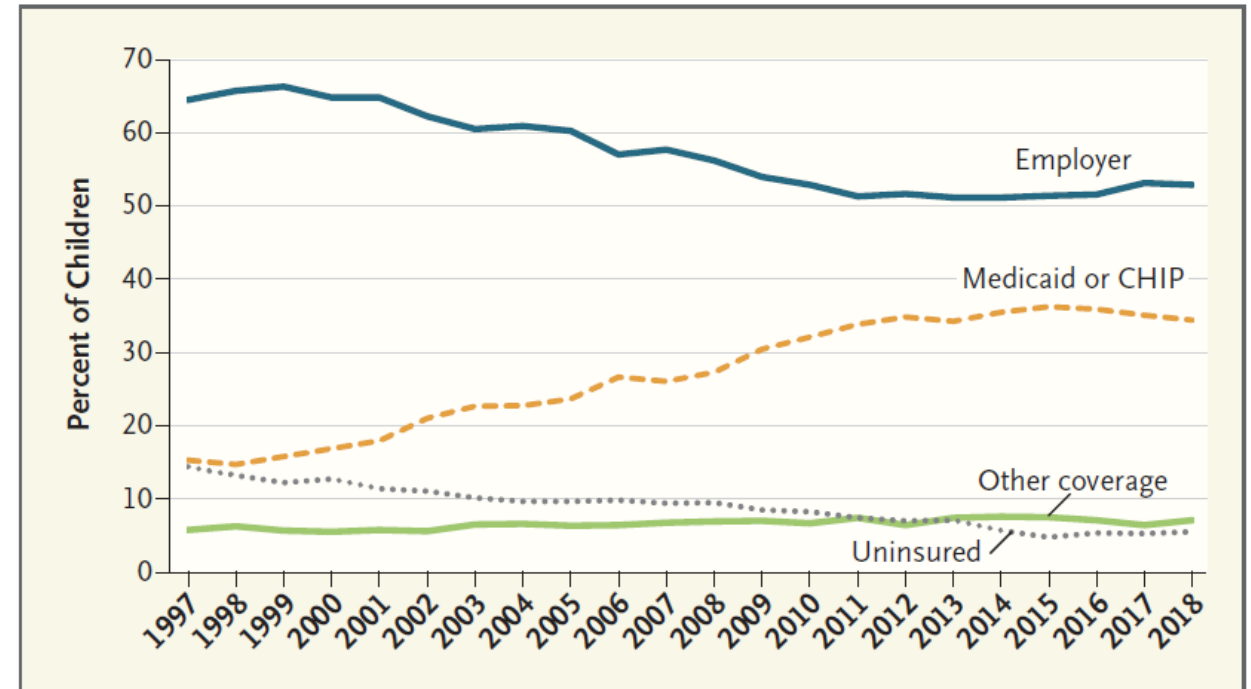
To cite: Hudak ML, Helm ME, White PH, AAP COMMITTEE ON CHILD HEALTH FINANCING. Principles of Child Health Care Financing. *Pediatrics*. 2017;140(5):e20172098

“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.”

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.

CALIFORNIA

Pediatric Subspecialty Shortages: A Threat To Children's Health

CHILDREN WITH SPECIAL HEALTH CARE NEEDS REQUIRE SPECIALLY TRAINED DOCTORS

14.0% of children in California have special health care needs, including conditions such as **cancer, Down syndrome, asthma, and depression.**

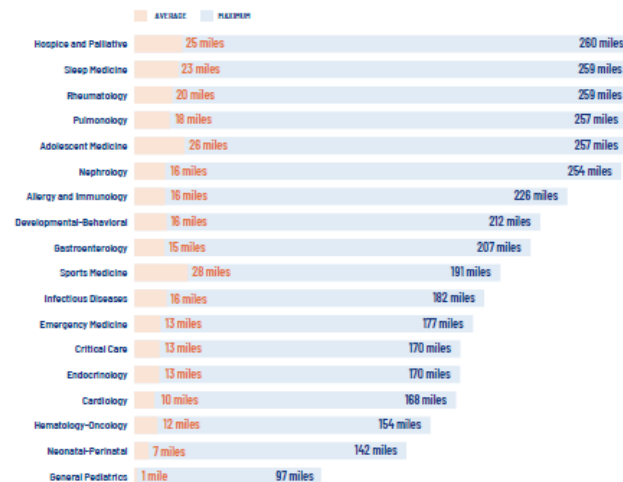
13.5M children nationwide (20% of all U.S. children) have special health care needs.

Many of these children need to get care from physicians who have completed extra training in specific areas of medicine for children: pediatric medical subspecialists or surgical specialists.

For instance, **pediatric endocrinologists** take care of children with **diabetes**. **Developmental-behavioral pediatricians** help children with **autism**. **Pediatric rheumatologists** take care of children with **juvenile arthritis**.



HOW FAR DOES A CHILD IN CALIFORNIA NEED TO DRIVE FOR PEDIATRIC SUBSPECIALTY CARE?



WHAT SUBSPECIALTY SHORTAGES MEAN FOR CHILDREN AND THEIR FAMILIES:

1. Traveling long distances to get care
2. Waiting weeks or months to get an appointment with a subspecialist
3. Going without care or getting care from providers with less specific training

CHILDREN WHO SUFFER FROM
JUVENILE ARTHRITIS IN
CALIFORNIA NEED TO DRIVE AS
FAR AS 259 MILES FOR CARE.

SHORTAGE IMPACT SPOTLIGHT: AUTISM SPECTRUM DISORDER

Imagine a family with a toddler named Julian. After his second birthday, his parents take him to his pediatrician, Dr. Lopez, for his check-up. Dr. Lopez performs a routine screening and she sees signs that indicate Julian might have autism spectrum disorder (ASD).

She explains to Julian's parents that therapy programs can greatly benefit children with ASD, but that insurance won't cover some therapies without Julian getting testing and diagnosis by a provider such as a **developmental-behavioral pediatrician**.

When Julian's parents try to make an appointment for his full evaluation, they discover that there is a shortage of developmental-behavioral pediatricians. This means they will have to wait almost half a year to get their child an evaluation. Meanwhile, Julian misses out on the services he needs and his parents struggle with his challenging behaviors they don't yet have the tools to manage.



TOO FEW DOCTORS

There are approximately **1.5 MILLION** children with ASD, but there are only about **700** practicing board-certified developmental-behavioral pediatricians.



WAIT TIMES

The national average wait time for a pediatric developmental evaluation is **5.4 MONTHS**.



RACIAL DISPARITIES

ASD prevalence among Hispanic children is about **16%** lower than among white and black children, which suggests that more Hispanic children with autism are not being identified.

Black children with ASD are significantly less likely than white children to have a first evaluation by the age of three.

A ROOT CAUSE OF SHORTAGES: MORE TRAINING, LESS NET CAREER EARNINGS

Pediatric subspecialists require an extra three years of fellowship training in addition to the four years of medical school and three years of residency that are needed to become a general pediatrician. That's at least 10 years of training after college.

Pediatricians are already among the lowest-paid physicians nationally. Although they receive more training, many pediatric subspecialists have relatively lower earnings potential over their careers than general pediatricians when you factor in the time and costs required for additional training. **Indeed, a recent study showed that 12 of the 15 pediatric subspecialties analyzed had lower career net earnings than primary care pediatricians, who do not require extra subspecialty training.**

The financial disincentives are one root cause of workforce shortages and disparities in access to care. Children who need specialized care bear the burden of difficulties in accessing pediatric subspecialists.

LOAN REPAYMENT CAN HELP

Loan repayment for pediatric subspecialists would lessen the financial burden of their additional training, meaning more doctors will be able to specialize and treat children with special health needs. Loan repayment can be targeted to underserved areas where children have insufficient access to care.



For data sources used, see: services.aap.org/subspecialtyfactsheet



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H.R. 1025, the Kids' Access to Primary Care Act of 2021

- Align Medicaid reimbursement rates with Medicare payments;
- Expand eligibility for payment rate increases to OB/GYNs, nurse-midwives, nurse practitioners, physician assistants, and pediatric subspecialists;
- Track the results of these efforts by studying changes in Medicaid enrollment and the types and rates of services provided.

“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.”

Acknowledgements



- 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
 - Michael Artman, AMSPDC Representative
- Children's Hospital Association
 - Amy Knight, COO



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Advancing child health through public policy



CHILDREN'S
HOSPITAL
ASSOCIATION



CONGRESSWOMAN
KIM SCHRIER

Representing the 8th District of **WASHINGTON**



Domain 2 Update
Data/Needs and Access – Economics
Laurel Leslie, MD, MPH and Colin Orr, MD

Discussion
Facilitated by Leslie Walker-Harding, MD



Pediatrics 2025: The AMSPDC Workforce Initiative



@AMSPDC
#Peds2025Workforce

PEDIATRIC WORKFORCE NETWORK AMSPDC'S WORKFORCE INITIATIVE: DOMAIN 2

Laurel K. Leslie, MD, MPH

Colin J. Orr, MD, MPH

AMSPDC Workforce 2025 Initiative Summit

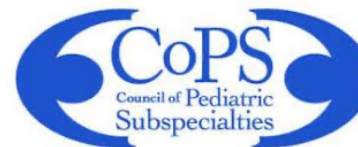
May 14th, 2021



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CHILD HEALTH EVALUATION
AND RESEARCH CENTER



ASSOCIATION
OF PEDIATRIC
PROGRAM
DIRECTORS

DOMAIN 2: DATA/NEEDS AND ACCESS

- *Data*
 - Investigate the **diverse makeup of the pediatric workforce** by analyzing data regarding:
 - Race/ethnicity
 - Debt
 - DOs/MDs/IMGs
 - Work profiles (clinical, teaching, research, other activity)
 - Geography
 - Advanced practitioners (PA's and NP's)
 - Modeling subspecialty workforce
- *Needs and Access*
 - Partner with appropriate organizations to **understand workforce challenges**
 - Access by race/ethnicity, insurance, geography
 - Regionalization of care
 - Care model changes
 - Changes in referral patterns
 - Changes in response to COVID/racism

Educational Debt and the Pediatric Workforce

THE AMERICAN BOARD *of* PEDIATRICS
FOUNDATION



Objectives

- To describe educational debt among pediatric trainees
 - Describe variations by self-reported race/ethnicity (R/E)
- To describe importance of financial considerations (debt and earning potential) on selecting Pediatrics as a career
 - Describe variations by self-reported R/E

Background

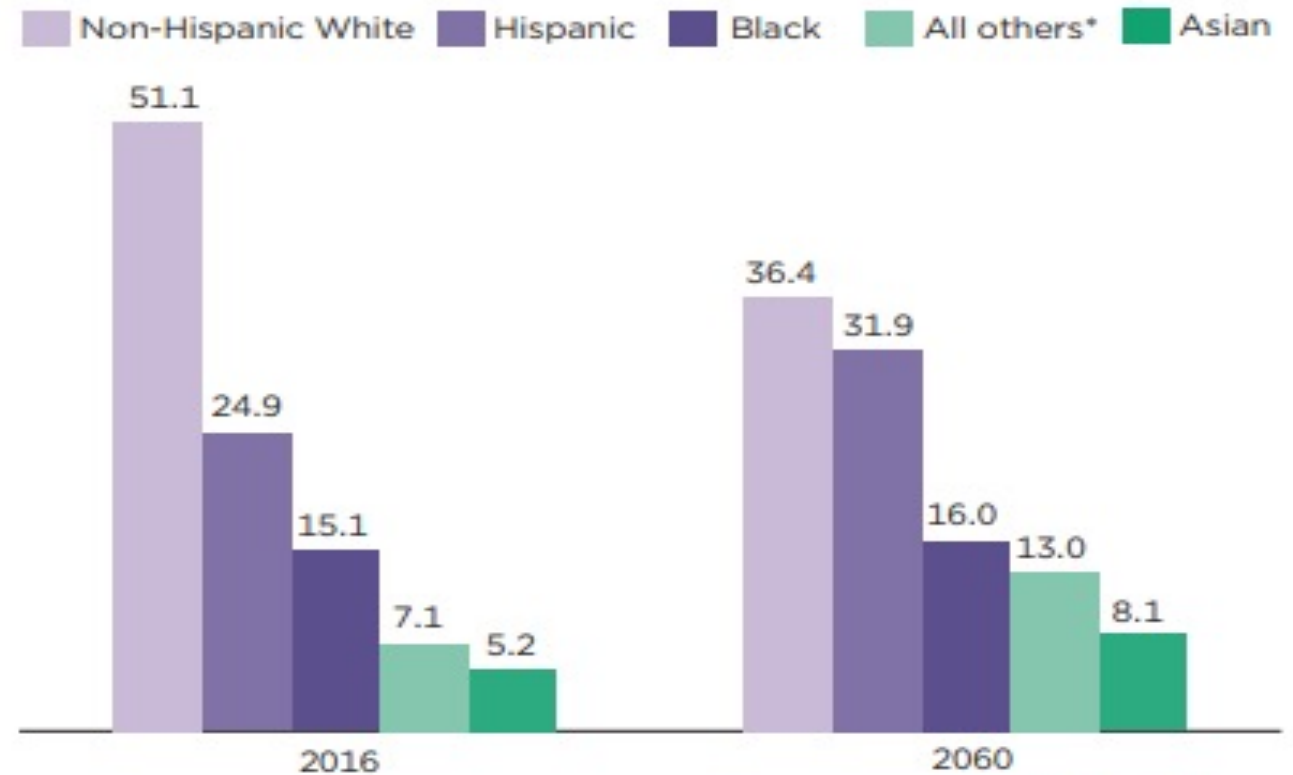
- Educational debt is increasing
 - How debt impacts career trajectory and decision making within Pediatrics is unknown
- No national study has looked at R/E and debt within Pediatrics
 - 2020 AAMC data suggests variations in educational debt by R/E
 - 2020 AAMC report suggests debt does not influence career course
- R/E concordance between provider and patient/family impacts outcomes

Diversity of U.S. children

Figure 3.

Racial and Ethnic Composition of Children Under Age 18

The share of children who are non-Hispanic White is projected to fall from one-half to about one-third by 2060.
(In percent)



* The other race group includes children who are American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, and Two or More Races.

Note: Hispanic is considered an ethnicity, not a race. The percentages do not add to 100 because Hispanics may be any race.

Source: U.S. Census Bureau, 2017 National Population Projections.

Methods

- Data: annual In-training Exam (ITE) Survey
 - Years: 2018-2020
 - N=10,253 first year residents across 3 years of survey
 - Response rate: 88%
- Independent variable:
 - Self-reported R/E based on 2015 US Census recommendations
- Dependent variables:
 - Self-reported educational debt
 - Importance of financial considerations in choosing a career in Pediatrics
- Analysis:
 - Descriptive statistics, chi-square tests, ANOVA F-test

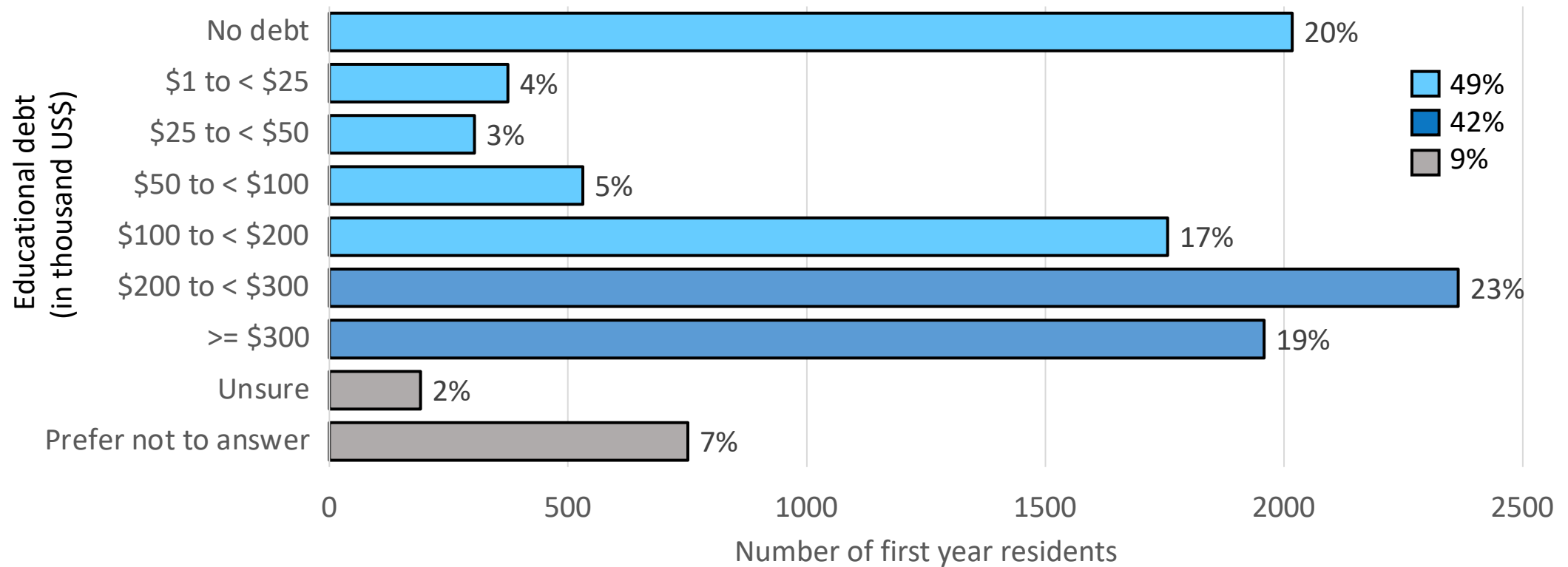
Results

Race/ethnicity of the sample compared to U.S. children

	Overall	White	Hispanic/ Latinx	Black/African American	Asian	Other/ Multiracial	Prefer not to answer
	<i>N=10,253</i>	<i>N=5,555</i>	<i>N=722</i>	<i>N=585</i>	<i>N=2,094</i>	<i>N=797</i>	<i>N=500</i>
Sample Self Reported Race/Ethnicity		54%	7%	5.7%	20%	7.8%	4.9%
US <18yr Race/Ethnicity		50%	26%	13%	5%	6%	

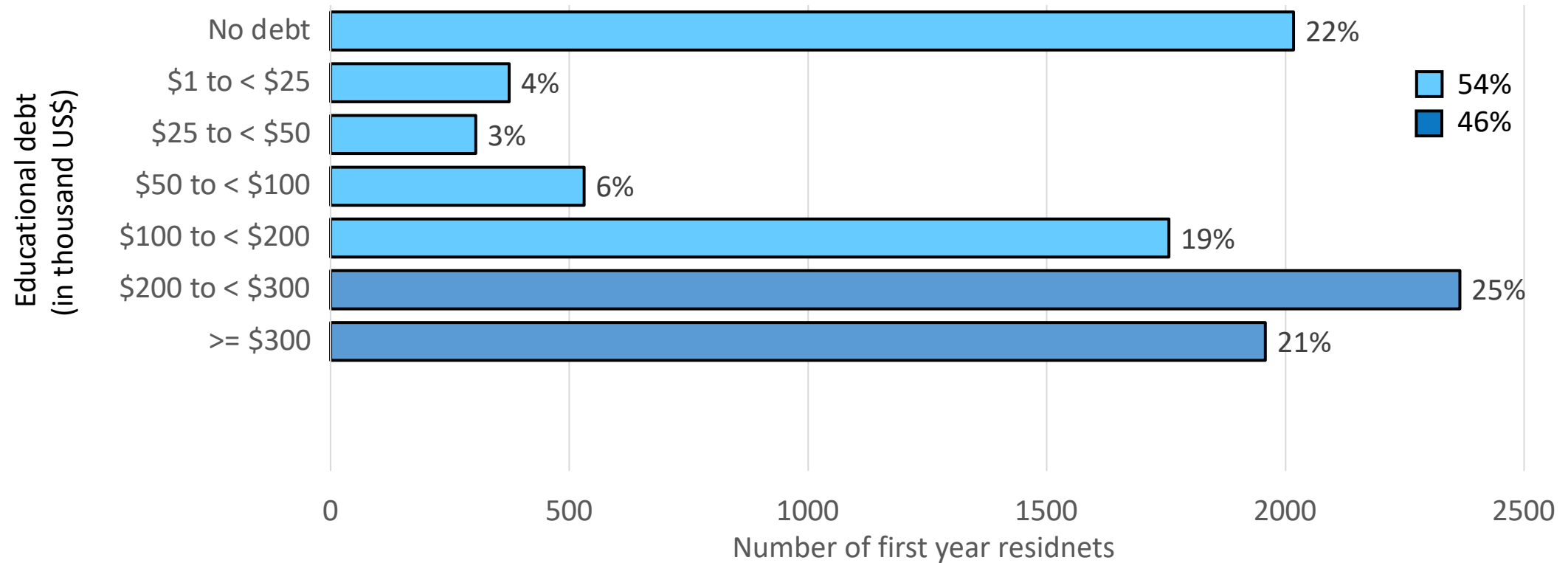
Results N=10,253

Educational debt among pediatric first year residents from 2018-2020



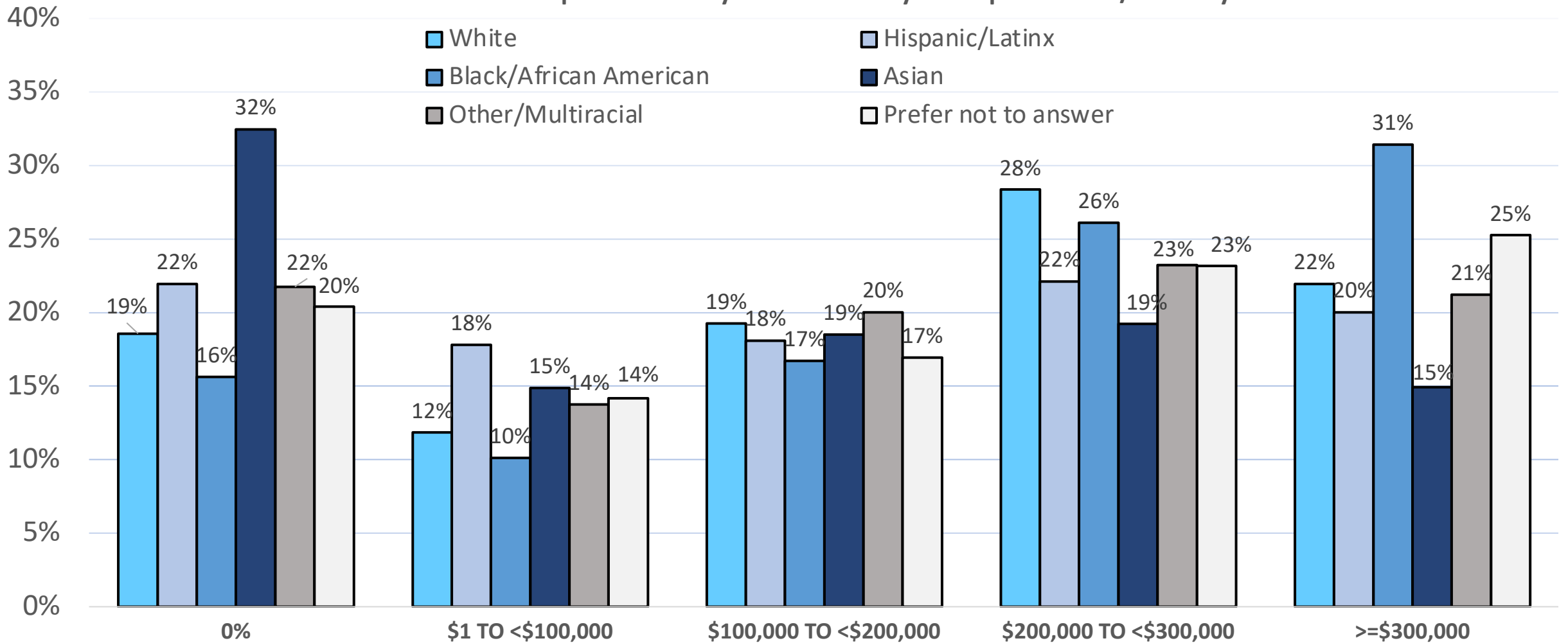
Results N=9,305

Educational debt among pediatric first year residents from 2018-2020



Results

Educational debt of pediatric first year residents by self reported race/ethnicity



Results

Importance of financial factors for choosing a career in pediatrics and variations by self reported race/ethnicity for first year residents (Mean, 95% CI)							
	Overall	White	Hispanic/ Latinx	Black/African American	Asian	Other/ Multiracial	Prefer not to answer
	N=10,253	N=5,555	N=722	N=585	N=2,094	N=797	N=500
Financial considerations- debts	1.92 (1.90, 1.94)	1.84 (1.82, 1.86)	1.99 (1.92, 2.06)	2.08 (2.01, 2.16)	2.03 (1.99, 2.07)	1.84 (1.78, 1.90)	2.18 (2.09, 2.27)
Financial considerations- earnings	1.97 (1.95, 1.98)	1.86 (1.84, 1.88)	2.08 (2.01, 2.15)	2.16 (2.08, 2.24)	2.11 (2.07, 2.15)	1.91 (1.85, 1.97)	2.22 (2.14, 2.31)

Likert scale: 1 (not at all important) to 4 (very important)
F-test for both variables statistically significant at 5% level

Conclusions

- Educational debt is common among first year pediatric residents
 - 42% have more than \$200,000 in educational debt
 - 31% of those identifying as Black/African American have >\$300,000 in debt
- Educational debt may be impacting decisions to pursue pediatrics
 - Financial considerations were most important among those who identified as Black/African American or preferred not to answer

Implications

- These data may help to inform recruitment, pipeline and debt management interventions (e.g., re-payment strategies and policies)
- Educational debt may have implications for the current and future pediatric workforce (e.g., diversity) and match to the current and projected U.S. child population

QUESTIONS

The content is solely the responsibility of the authors and does not necessarily represent the official views of the American Board of Pediatrics, the American Board of Pediatrics Foundation, UNC Children's, or UNC Sheps Center.

Race/ethnicity Question

The ABP's race/ethnicity question version:

Which of the following describes your race/ethnicity? *(Please select all that apply.)*

- a. **White**
For example: German, Irish, English, Italian, Polish, French, etc.
 - b. **Hispanic, Latino, or Spanish origin**
For example: Mexican, or Mexican American, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, etc.
 - c. **Black or African American**
For example: African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, etc.
 - d. **Asian**
For example: Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.
 - e. **American Indian or Alaska Native**
For example: Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.
 - f. **Middle Eastern or North African**
For example: Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian, etc.
 - g. **Native Hawaiian or Other Pacific Islander**
For example: Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
 - h. **Some other race, ethnicity, or origin (please specify):** _____
 - i. **I prefer to not answer**
-

The race/ethnicity question we ask was based on the United States [Census Bureau's 2015 National Content Test Race and Ethnicity Analysis Report](#), which reviews their research examining different variations of race/ethnicity questions and how accurately they perform. While this newer model was proposed for the 2020 US Census by the Census Bureau, it did not move forward under the White House's Administration of Office of Management and Budget at that time. Given the ABP had already started using a variation of the proposed 2020 Census question—and believing it to be the best question version per the Census Bureau's findings—the ABP has continued to ask the question as shown below.

Major changes to this question from common variations seen include:

1. One can select all that apply. This is an important variation in that many people are not 100% of a particular race/ethnicity. The 2010 Census Survey already allowed for this.
2. The options regarding “Hispanic, Latino, and/or Spanish origin” ethnicities were moved into the above question instead of being a separate question. This was empirically proven by the Census Bureau to decrease confusion for those who find themselves in this category and find it difficult to secondarily choose another race. Completion of the two-question option was found to be lower than the single question option.
3. The “Middle Eastern or North African” options were historically included in the “White” category and are broken apart here to reflect unique distinctions among these groups.
4. Unlike the Census Bureau's version, we include an opt-out option in “I prefer to not answer.” This is an exclusive option.

Diversity and Inclusion Training in Pediatric Departments

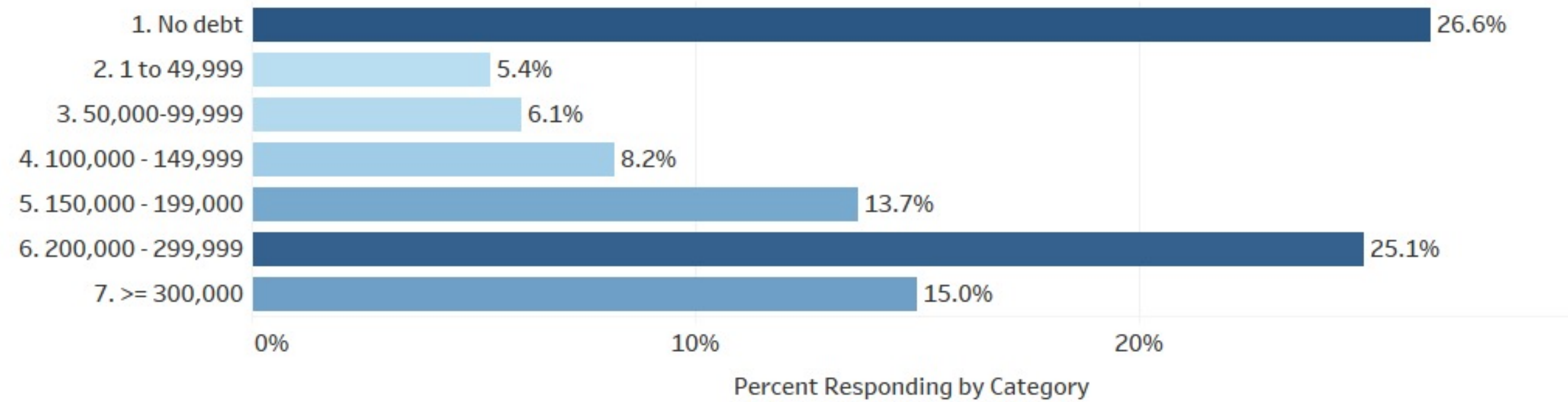
Fernando S. Mendoza, MD, MPH^a, Leslie R. Walker, MD^b, Barbara J. Stoll, MD^c, Elena Fuentes-Afflick, MD, MPH^d, Joseph W. St Geme III, MD^e, Tina L. Cheng, MD, MPH^f, Javier A. Gonzalez del Rey, MD, MEd^g, Christopher E. Harris, MD^h, Mary E. Rimsza, MDⁱ, Jie Li, PhD^a, Theodore C. Sectish, MD^j

Pediatrics 2015

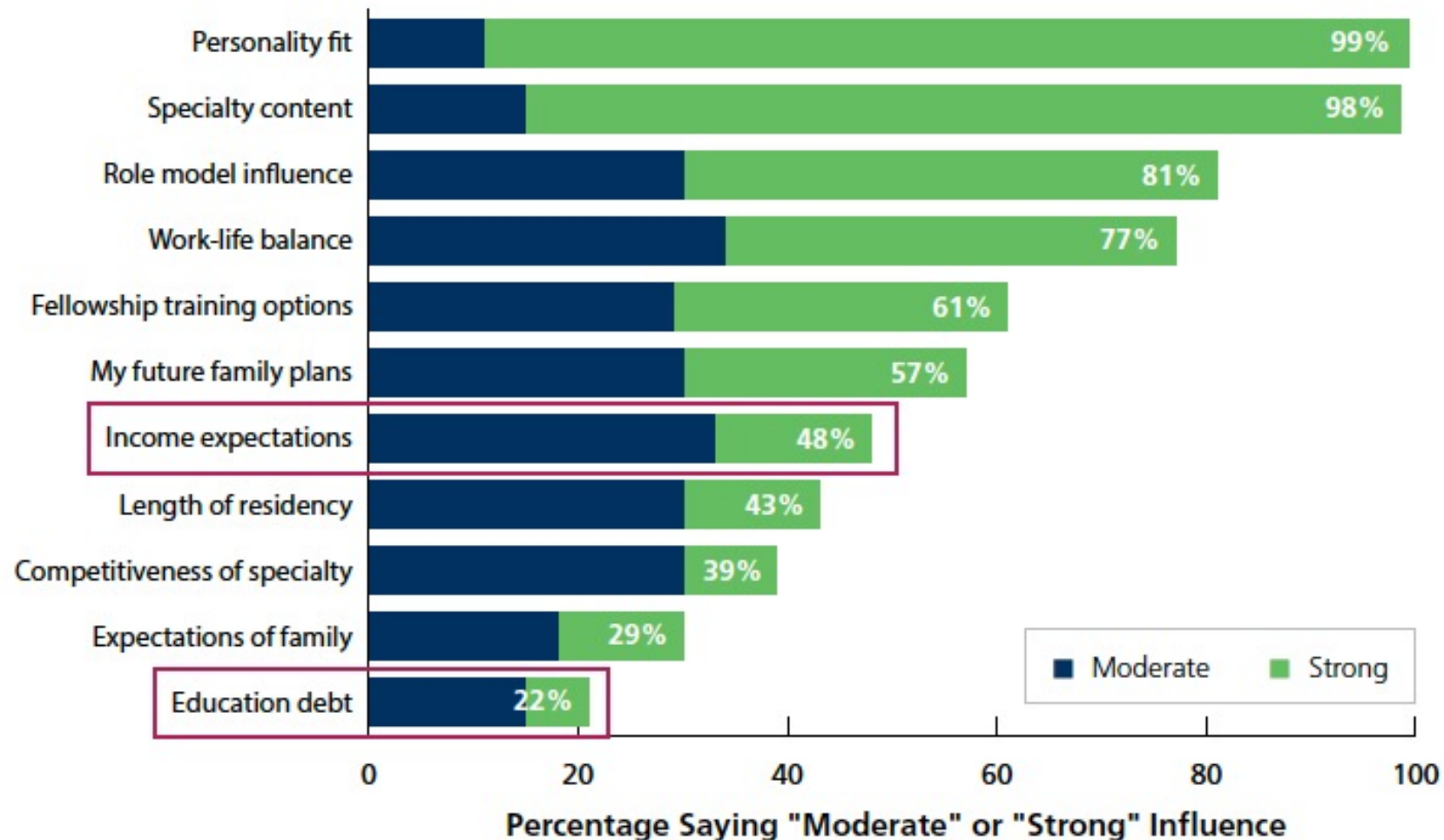
TABLE 3 Representation of Racial and Ethnic Diversity by Level

Group (N)	Residents (3832)	Clinical Fellows (2286)	Research Fellows (945)	Faculty (11 168)	Residency Directors (118)	Division Chiefs (837)	Vice Chairs (197)	Chairs (65)
African American, %	6.6	4.7	2	4.2	2.5	2.3	1.0	4.6
Native American or Alaska Native, %	0.3	0.2	0.1	0.1	0	0.2	0.5	0
Asian American, %	14.9	19.7	32.7	14.4	4.2	7.8	4.6	0
Latino, %	5.1	5.6	3.7	4.4	2.5	3.6	1	9.2
Hawaiian or Pacific Islander, %	0.4	1.4	0.4	0	6	0	0	0
White non-Hispanic, %	70	56.8	42.5	73.2	79.7	80.3	87.8	86.2
LGBT, %	0.8	0.3	0.2	0.4	5.1	1.0	2.0	0
Physically disabled, %	0.4	0	0.1	0.2	0	0.4	1.5	0
Unknown, %	1.5	11.2	18.2	2.7	0	4.4	1.5	0

Total Education Debt Categories from AAMC 2020 Medical School Graduation Questionnaire



Influence of various factors on the specialty choice of 2019 graduating medical students



Influence of various factors on specialty choice

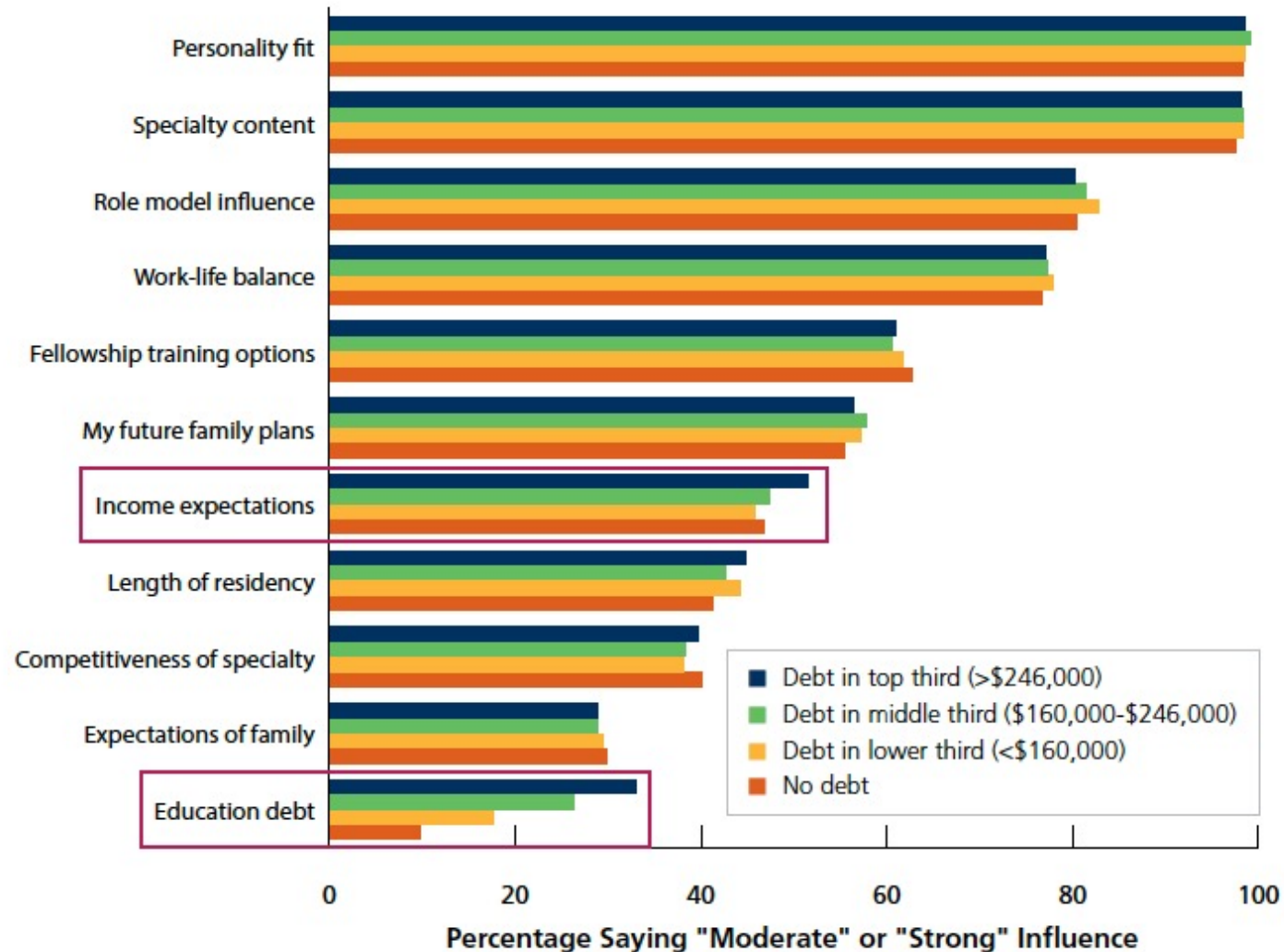
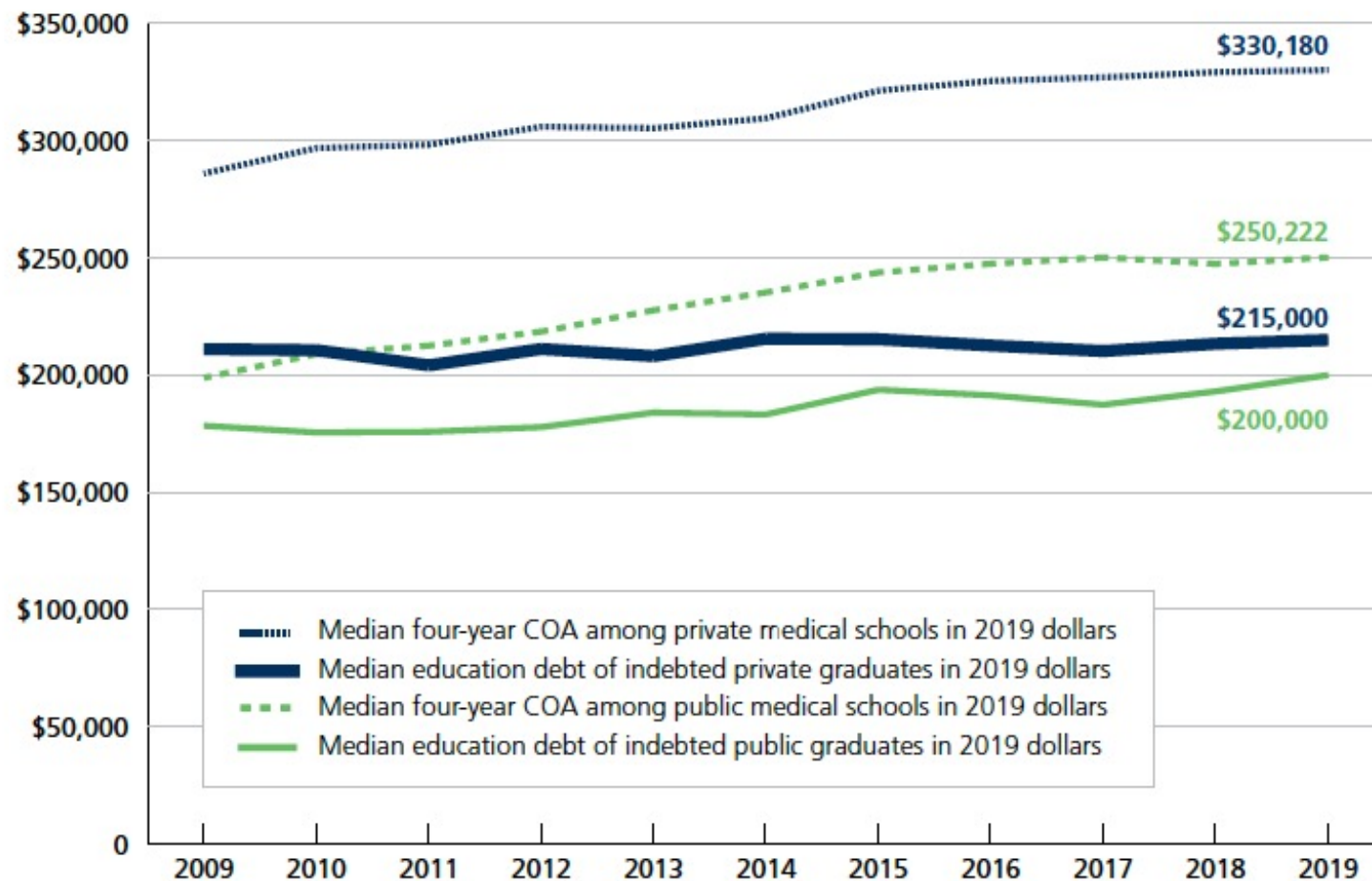


Table 6. Education Debt Data for 2019 Medical School Graduates by Race and Ethnicity

Race or Ethnicity	With education debt	Median education debt of indebted graduates	Public/Private school	Reported scholarship funds	Median self-reported parental income	Average for percentage of medical education to be financed with:		
						"Personal/parents/relatives/spouse/partner" funds	"Scholarship with or without a service commitment/work-study" funds	Loans
All	73%	\$200,000	61%/39%	62%	\$130,000	24%	19%	56%
American Indian and Alaska Native, alone or in combination	80%	\$212,375	71%/29%	84%	\$90,000	14%	33%	52%
Asian, not Hispanic	61%	\$180,000	56%/44%	56%	\$120,000	33%	17%	49%
Black, not Hispanic	91%	\$230,000	50%/50%	83%	\$80,000	8%	34%	57%
Hispanic	84%	\$190,000	57%/43%	65%	\$70,000	13%	25%	61%
White, not Hispanic	75%	\$200,000	65%/35%	61%	\$150,000	24%	17%	58%
All others, mostly those reporting multiple combinations of race and ethnicity or "other"	71%	\$200,000	59%/41%	64%	\$110,000	24%	23%	53%

Source: AAMC Medical School Graduation Questionnaire (GQ), 2019, and the corresponding Matriculating Student Questionnaire (MSQ).



Source: AAMC Medical School Graduation Questionnaire (GQ) and Tuition and Student Fees Questionnaire (TSF).

Figure 2. Median four-year cost of attendance (COA) and education debt of indebted medical school graduates by public or private school, 2009-2019 (in constant 2019 dollars).

Break

We will begin again at 3:00pm ET



Pediatrics 2025: The AMSPDC Workforce Initiative



@AMSPDC
#Peds2025Workforce

Impact of Lifetime Earnings on Workforce

Hal Simon, MD, MBA

Discussion

Facilitated by Bob Vinci, MD



Pediatrics 2025: The AMSPDC Workforce Initiative



@AMSPDC
#Peds2025Workforce

Workforce Issues and Earnings Potential

Harold K. Simon MD, MBA

Marcus Professor & Vice Chair for Faculty, Dept of Pediatrics
Professor of Pediatrics & Emergency Medicine, Emory University,
Children's Healthcare of Atlanta

May 14, 2021

Key Collaborators :

Eva Catenaccio, MD

Department of Neurology/Pediatric Neurology
Johns Hopkins University School of Medicine

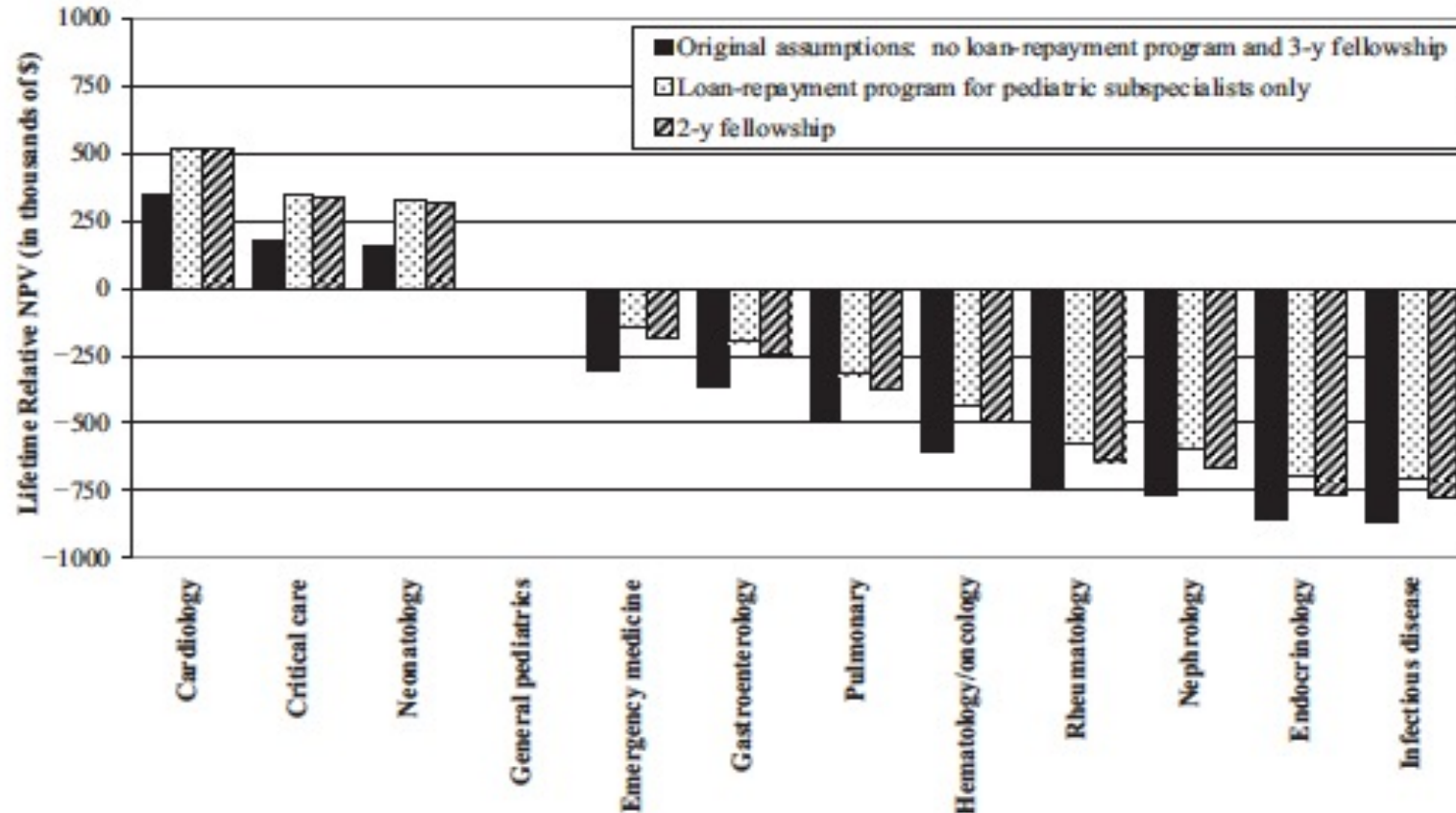
Jonathan Rochlin, MD

Division of Pediatric Emergency Medicine
Maimonides Medical Center

Disclosures:

- No financial conflicts related to these works but I do serve as Vice Chair for Faculty for the Department of Pediatrics at Emory/Children's Healthcare of Atlanta and as Chair of the AAP Committee on Pediatric Workforce.

Does Fellowship Pay: What is the Long-term Financial Impact of Subspecialty Training in Pediatrics?



Rochlin JM, Simon HK Does Fellowship Pay: What Is the Long-term Financial Impact of Subspecialty Training in Pediatrics? Pediatrics Jan 2011. DOI: 10.1542/peds.2010-1285

Are Things Getting Worse? How Do New Subspecialties Compare? Modeling Interventions?

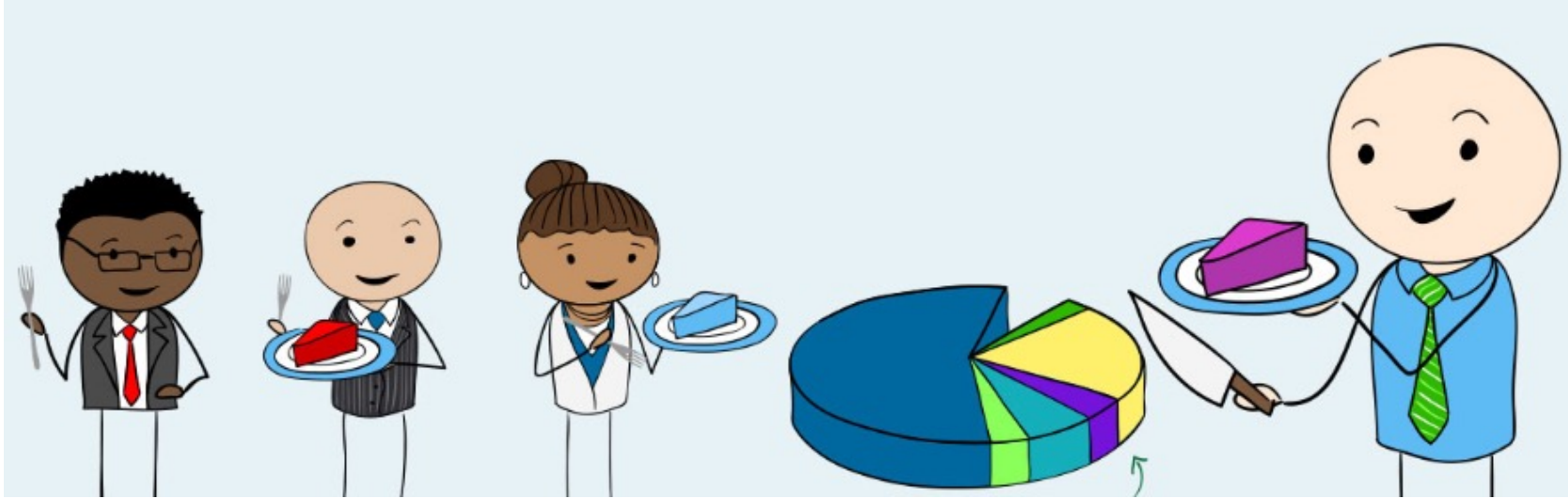
Differences in Lifetime Earning Potential for Pediatric Subspecialists

Eva Catenaccio MD^a, Jonathan M. Rochlin MD^b, Harold K. Simon MD, MBA^c

^aDept of Neurology, Division of Pediatric Neurology, Johns Hopkins University School of Medicine, Baltimore, MD; ^bDept of Emergency Medicine, Division of Pediatric Emergency Medicine, Maimonides Medical Center, Brooklyn, NY; and ^cDepts of Pediatrics and Emergency Medicine, Emory University School of Medicine and Children's Healthcare of Atlanta, Atlanta, GA



Show Me the Money (or Not)*



Lewis First: “...I would venture to bet that for most of us, our career decision to become pediatricians in medical school was not based on the financial earnings we would be making relative to other fields.”*

Many other factors beyond economic concerns affect the decision to subspecialize, such as lifestyle considerations, research opportunities, and interest in specific diseases or organ systems.

* Lewis First Editor and Chief, Pediatrics Journals Blog
<https://www.aappublications.org/news/2021/03/09/lifetime-earning-subspecialists-pediatricians-pediatrics>

Sources and background:

- Mean educational debt:
 - 87% had debt in 2008, Mean >\$158,000
 - 73% had debt in 2019, Mean >\$200,000
- Association of American Medical Colleges (AAMC) Resident/Fellow Survey of Stipends and Benefits
- AAMC Annual Faculty Salary Report (mean annual total compensation with benefits)
- Medical Group Management Association Physician Compensation (MGMA)

Net Present Value (NPV)

$$\sum_{t=1}^n NI_t / (1 + r)^t$$

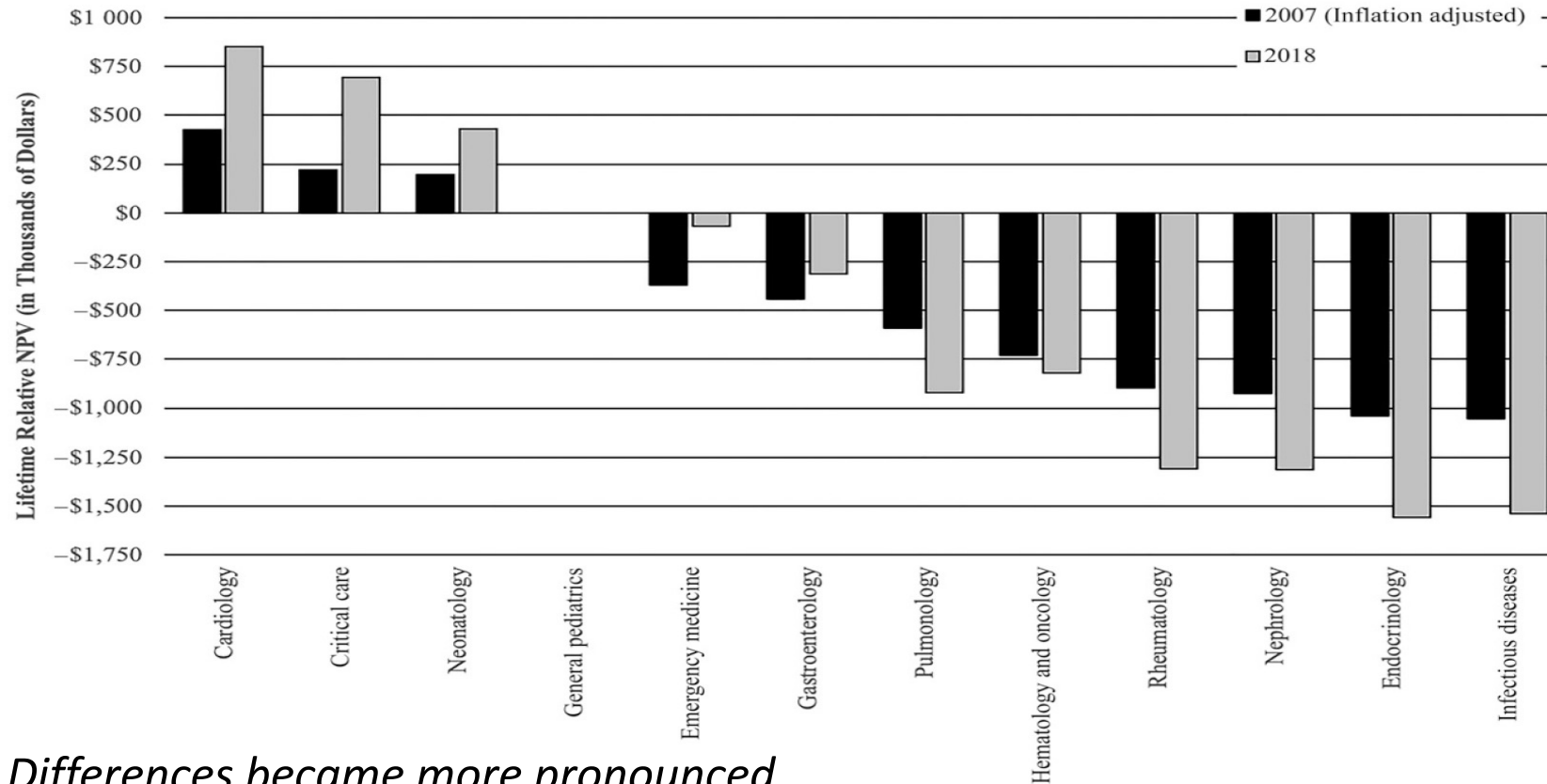
- NI is the annual net income, defined as annual compensation less annual debt repayment costs
- The formula takes the sum of the annual net incomes over time (from t=1 to n years) and discounts them back to the present at a discount rate (r).
- From the calculation, we compared the current value of future net income streams of the pediatric subspecialties relative to general pediatrics to generate a Lifetime Relative NPV.
- Opportunity costs during fellowship included delayed compensation during subspecialty training and prolonged debt repayment.

Modeling & Sensitivity Analyses

In addition to evaluating trends over time we modeled:

- Shortening fellowship length from 3 years to 2 years
- Implementing a pediatric subspecialty specific loan repayment program
- Eliminating medical school tuition and thus educational debt for both pediatric subspecialists and general pediatricians

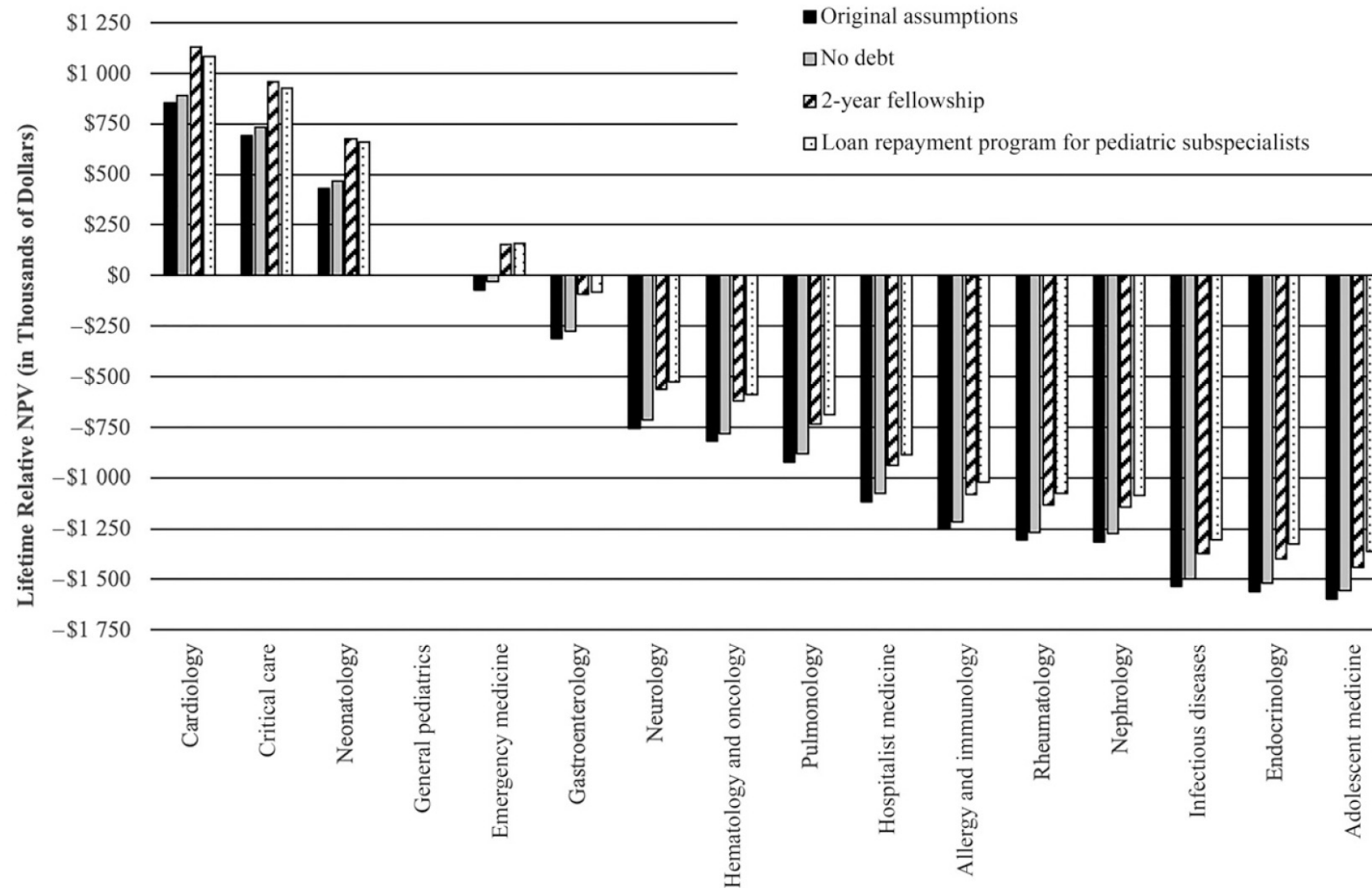
Are the Gaps Widening? Lifetime Earning 2007-2018



- Differences became more pronounced.
- Spread between highest to lowest earning subspecialties:
 - >\$1.4 Million in 2007/2008
 - >\$2.3 million in 2018/2019

Catenaccio E, Rochlin JM, Simon HK. Differences in Lifetime Earning Potential for Pediatric Subspecialists. Pediatrics. 2021;147(4):e2020027771

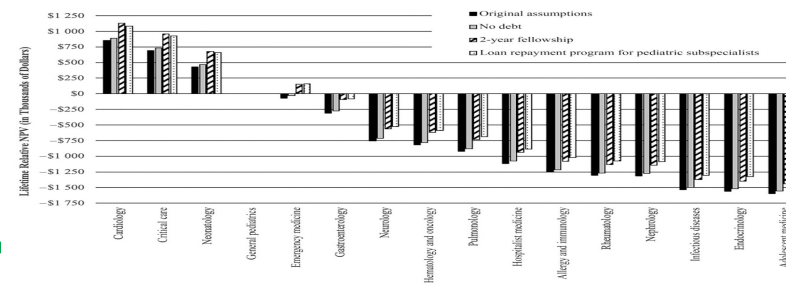
Impact of LRP, Length of Training, Med School Debt



Limitations

- Assumptions made in our referenced data sources as well as the assumptions inherent to our models: continuity of training, timing of academic promotion, proportion of academic practice per subspecialty, and rates of debt repayment.
- Academic practice, not private practice (most pediatric subspecialists practice in academic settings).

Conclusions:



- 12 of 15 subspecialties yielded negative financial returns compared to a career in general pediatrics.
 - Procedure focused subspecialties did better (Cardiology, PICU, NICU, EM)
 - Newest subspecialties (adolescent medicine, hospital medicine) and other less procedure focused did worse
 - (Note data was not available on Developmental Peds)
- Differences became more pronounced.
- Spread between highest to lowest earning subspecialties:
 - >\$1.4 Million in 2007/2008
 - >\$2.3 million in 2018/2019
- Negative financial return could be partially ameliorated by:
 - Shortening length of training
 - Implementing a loan repayment program
- Elimination of medical school debt could make ALL of the subspecialties along with General Peds more attractive.

Do differences in lifetime earning potential between subspecialists play a role in workforce shortages?

YES

Many non-financial considerations drive career choice

Debt loads of trainees are only increasing

Earning gaps are widening within the field of pediatrics

Peds is comparably lower paying than most specialties

Peds is lower paying even than directly comparable adult specialties

Real question is not if trainees chose pediatrics or a peds subspecialty based on \$\$

Do they NOT choose pediatrics or a specific peds subspecialty because of \$\$?

What role could it play in future workforce shortages?

The Impact of Differences in Lifetime Earning Potential on Pediatric Subspecialty Workforce Distribution

Eva Catenaccio MD^a, Jonathan M. Rochlin MD^b,
Harold K. Simon MD, MBA^c

Institutions: ^aDepartment of Neurology, Division of Pediatric Neurology, Johns Hopkins University School of Medicine, Baltimore, MD; ^bDepartment of Emergency Medicine, Division of Pediatric Emergency Medicine, Maimonides Medical Center, Brooklyn, NY; and ^cDepartments of Pediatrics and Emergency Medicine, Emory University School of Medicine and Children's Healthcare of Atlanta, Atlanta, GA

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Children's
Healthcare of Atlanta



EMORY
UNIVERSITY



Maimonides
Medical Center

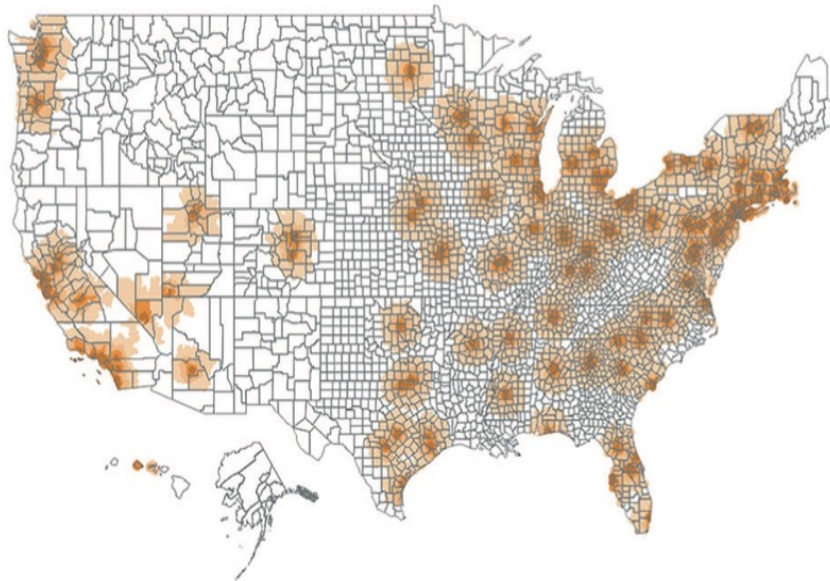


JOHNS HOPKINS
MEDICINE

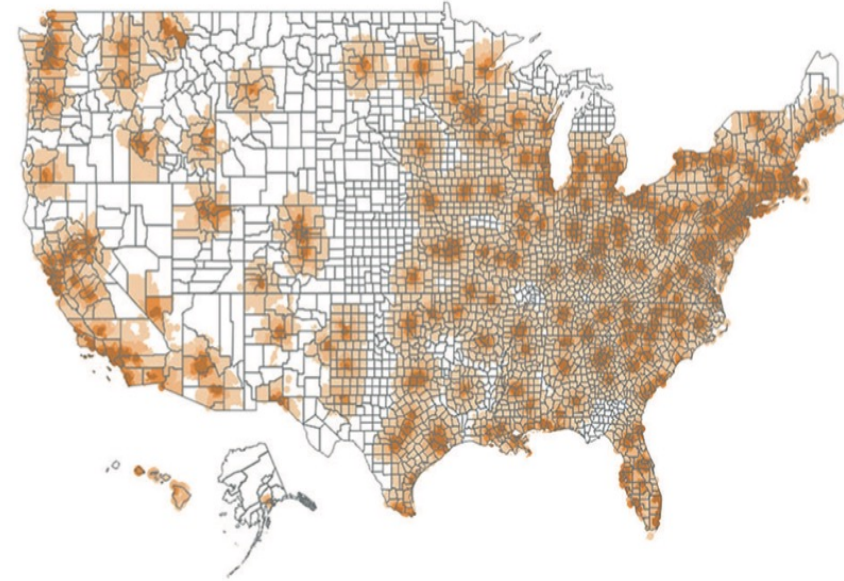
Is Access Equal Across Subspecialties?

What are the Trends?

A Estimated driving distance to pediatric rheumatologist



B Estimated driving distance to pediatric hematologist-oncologist



Turner A, Ricketts T, Leslie LK. Comparison of Number and Geographic Distribution of Pediatric Subspecialists and Patient Proximity to Specialized Care in the US Between 2003-2019. JAMA Pediatr. 2020;174(9):852-860.

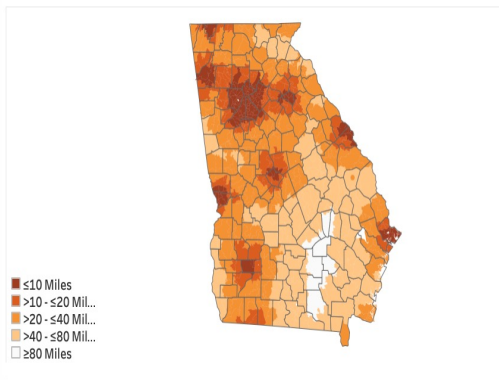
Is Access Equal Across Subspecialties?

What are the Trends?

Estimated Driving Distances to Pediatric Subspecialty Care in Georgia: Pediatric Cardiology

For considerations on interpreting this data, please see the notes below or visit our summary [methodology](#).

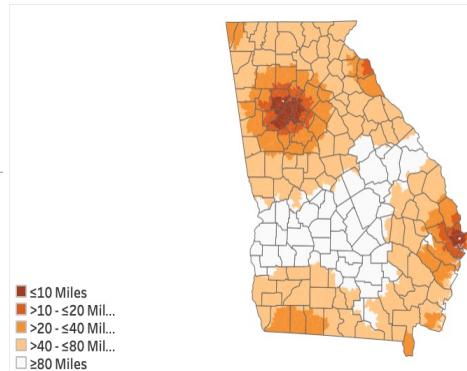
Choose Different State			
Georgia			
Choose Different Subspecialty	United States Average	Georgia Average	Georgia Maximum
Pediatric Cardiology	17.3 miles	17.5 miles	96.5 miles



Estimated Driving Distances to Pediatric Subspecialty Care in Georgia: Adolescent Medicine

For considerations on interpreting this data, please see the notes below or visit our summary [methodology](#).

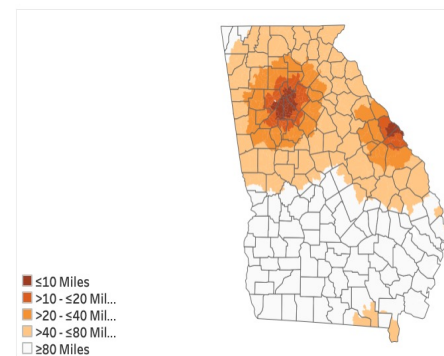
Choose Different State			
Georgia			
Choose Different Subspecialty	United States Average	Georgia Average	Georgia Maximum
Adolescent Medicine	35.8 miles	35.4 miles	121.1 miles



Estimated Driving Distances to Pediatric Subspecialty Care in Georgia: Pediatric Rheumatology

For considerations on interpreting this data, please see the notes below or visit our summary [methodology](#).

Choose Different State			
Georgia			
Choose Different Subspecialty	United States Average	Georgia Average	Georgia Maximum
Pediatric Rheumatology	42.8 miles	43.7 miles	165.8 miles



Wait Times and Workforce:

- Wait times and access to subspecialists
 - 17% of peds cardiologists reported wait times for new, non-emergent appointments of longer than two weeks.
 - 27% of adolescent medicine, 38% of endo, 48% of pulm, 52% of rheum, and 71% of nephrology subspecialists reported wait times of more than two weeks.

These correlate with our lower career-long earning fields

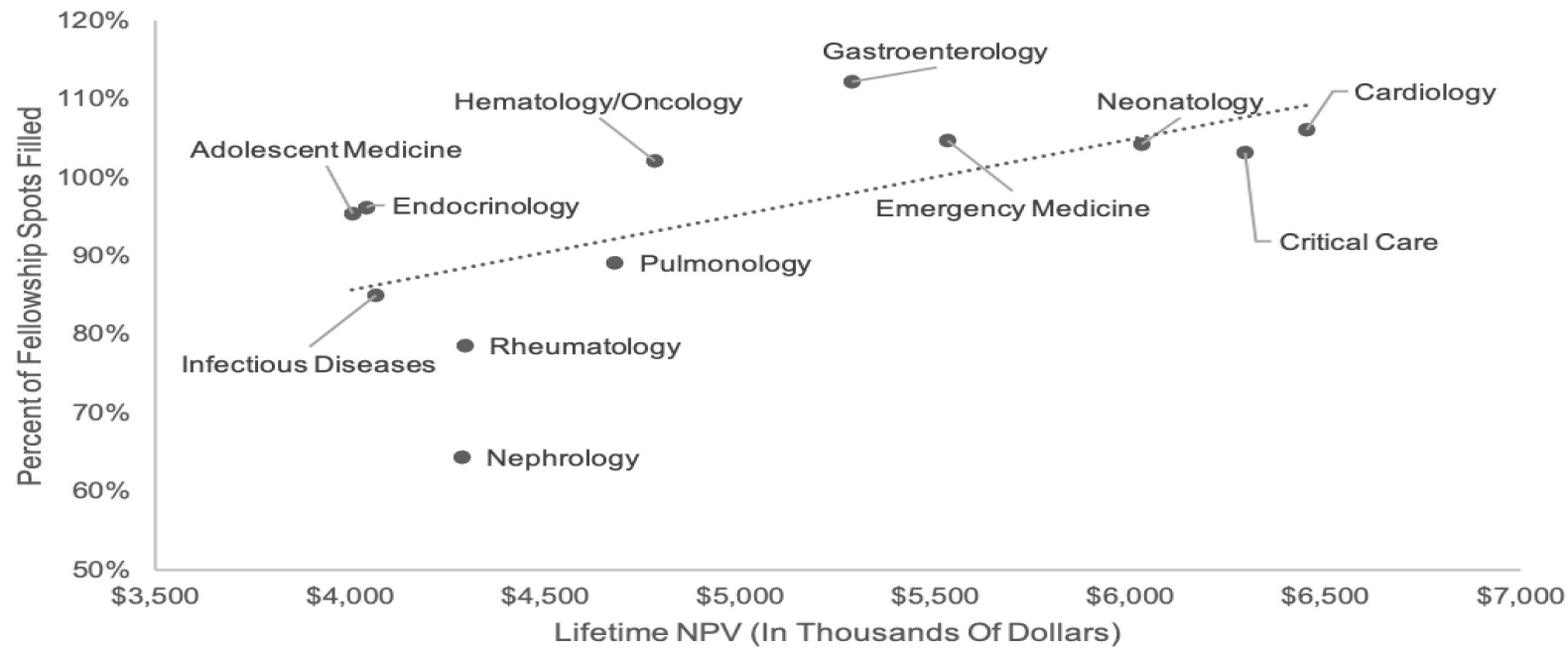
Current Workforce Distribution

- Higher lifetime earning potential was associated with:
 - Higher percentage of hospital referral regions with a specific type of pediatric subspecialist.
 - Shorter straight-line distance to subspecialists.



Future Workforce Distribution

Do trainees NOT choose a specific peds subspecialty because of \$\$?



Implications

- The lifelong financial impact of pediatric subspecialty of choice may contribute to imbalances in both the current and future workforce.
- Disparities in salaries exists across subspecialties
 - Worsening over time
 - Especially true between procedure heavy and procedure limited fields
- Pipelines (Fellowship Fill Rates) correlate with earning potential
- Enhancing lifetime earning potential can address disparities across peds and in choosing pediatrics over other specialties.
 - Loan repayment programs or other financial incentives
 - Length of training considerations
 - Enhancement of salaries across fields

Implications:



Crossroads for Our Pipeline and Future Workforce!



Not the Only Driver But We Need to Advocate for Financial Stability to Enhance the Workforce

Implications

- ADVOCATE for:
 - Increased financial literacy and data sharing across the field and future pipeline
 - Higher reimbursements and payment across the field
 - Leverage uniqueness/clout at the contracting table (Other specialties thrive at this)
 - RVU based system with minimal representation among pediatrics
 - CMS-Relative Value Scale Update Committee (RUC) 25 Specialties (Peds focused?)
 - Legislative change for enhanced and equal Medicare and Medicaid payments
 - Advocate for federal and other loan repayment programs or other financial incentives
 - Pediatric Subspecialty Loan Repayment Program
 - » Previously expired before receiving funding
 - » Reauthorized under the CARES Act
 - » Needs Congressional appropriations to start fiscal 2022
 - » Bipartisan support (Rep Kim Schrier D-Wash, Rep John Joyce R-PA)
 - » \$50 million requested
 - National Health Services Loan Repayment Program
 - » (1^o Care Peds underserved areas)
 - Public Health Service Loan Forgiveness Program

Thank you

??

Primary Care NASEM Study

Tumaini Coker, MD, MBA

Discussion

Facilitated by Laura Degnon, CAE



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Implementing High-Quality Primary Care:

Rebuilding the Foundation of Health Care

May 4, 2021

 [Nationalacademies.org/primarycare](https://nationalacademies.org/primarycare)
primarycare@nas.edu

Committee Members

- **Linda McCauley**, Emory University (Co-Chair)
- **Asaf Bitton**, Ariadne Labs
- **Tumaini Coker**, University of Washington School of Medicine and Seattle Children's
- **Carrie Colla**, Geisel School of Medicine at Dartmouth
- **Molly Cooke**, University of California, San Francisco
- **Jennifer DeVoe**, Oregon Health & Science University
- **Rebecca Etz**, Virginia Commonwealth University
- **Susan Fisher-Owens**, University of California, San Francisco School of Dentistry
- **Jackson Griggs**, Heart of Texas Community Health Center, Inc.
- **Robert Phillips, Jr.**, American Board of Family Medicine (Co-Chair)
- **Shawna Hudson**, Rutgers University
- **Shreya Kangovi**, University of Pennsylvania
- **Christopher Koller**, Milbank Memorial Fund
- **Alex Krist**, Virginia Commonwealth University
- **Luci Leykum**, University of Texas at Austin
- **Mary McClurg**, Eshelman School of Pharmacy at University of North Carolina at Chapel Hill
- **Benjamin Olmedo**, Dignity Health
- **Brenda Reiss-Brennan**, Intermountain Healthcare
- **Hector Rodriguez**, University of California, Berkeley
- **Robert Weyant**, School of Dental Medicine at University of Pittsburgh

Staff: Marc Meisnere, Sharyl Nass, Tracy Lustig, Sarah Robinson, Samira Abbas

NAM Fellows: Kameron Matthews, Lars Peterson, Dima Qato

Committee Expertise

- Clinicians including physicians (family medicine, internal medicine, pediatrics), nurses, dentist, pharmacist, physician assistant
- Community health worker program Executive Director
- Health center CEO
- State and federal health policy experts
- Economist
- Medical and cultural anthropologists
- Sociologist

Study Sponsors

- Agency for Health Research and Quality
- American Academy of Family Physicians
- American Academy of Pediatrics
- American Board of Pediatrics
- American College of Physicians
- American Geriatrics Society
- Academic Pediatric Association
- Alliance for Academic Internal Medicine
- Blue Shield of California
- The Commonwealth Fund
- Department of Veterans Affairs
- FMA Health
- Health Resources and Services Administration
- New York State Health Foundation
- Patient-Centered Outcomes Research Institute
- Samueli Foundation
- Society of General Internal Medicine

Statement of Task

NASEM committee will examine the current state of primary care in the United States and **develop an implementation plan** to build upon the recommendations from the 1996 IOM report, *Primary Care: America's Health in a New Era*, **to strengthen primary care services** in the United States, especially for underserved populations, and **to inform primary care systems** around the world.

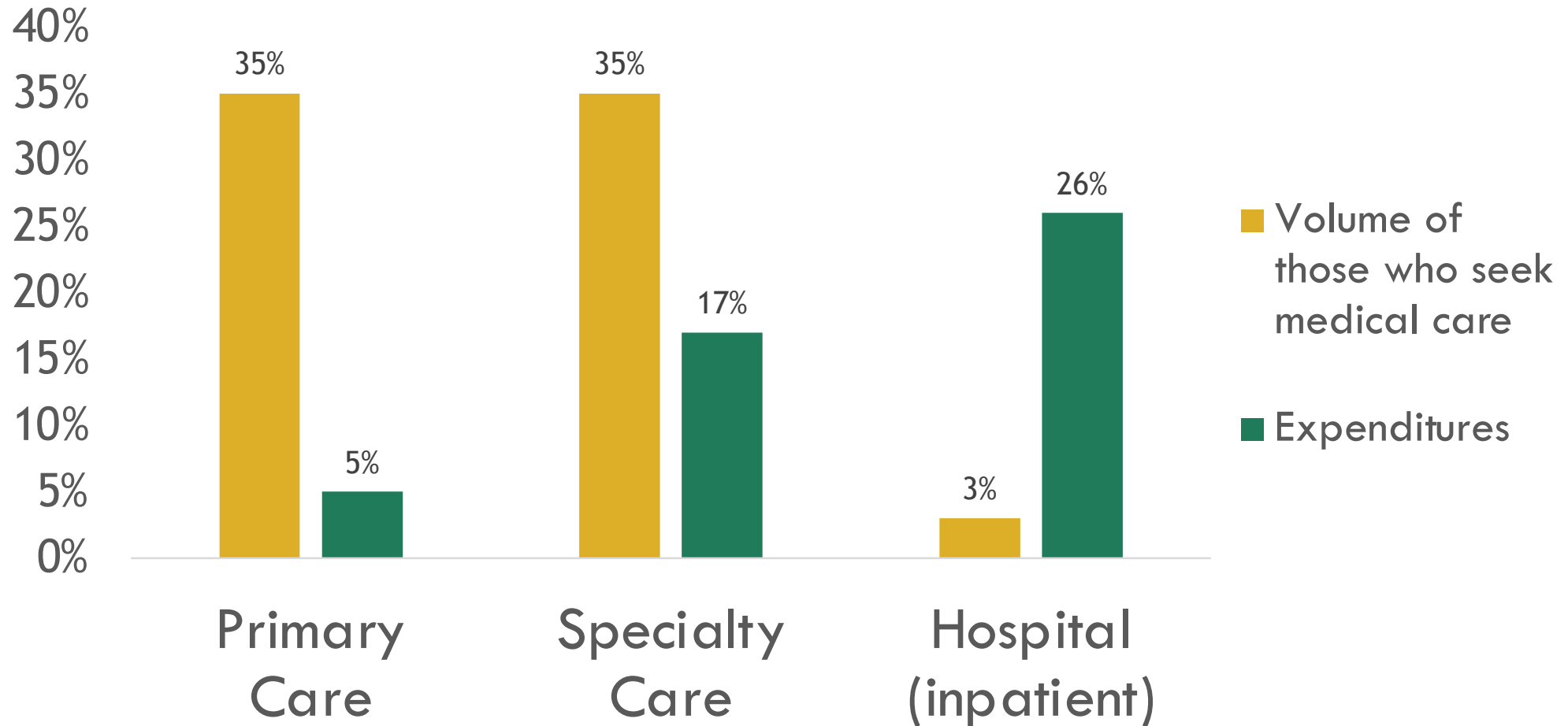
The Committee's Process

- 5 meetings, a webinar, and many conference calls
- 3 public information-gathering sessions
- 3 commissioned papers: the historical evolution of primary care; the effects of the pandemic; and payment reform
- Literature review (~6,000 articles) and synthesis of findings and conclusions
- Recommendations driven by consensus
- External peer-review by 16 experts in variety of disciplines

Study Context

- Primary care is only part of health care system that results in longer lives and more equity.
- It is weakening in the U.S. when it is needed most.
- Systems, localities, and states have had success implementing high-quality primary care.

Visits vs Expenditures in Medical Care



The National Academies of
SCIENCES • ENGINEERING • MEDICINE

SOURCES: Johansen et al., 2016; Martin et al., 2020
All categories are not included in the figure and thus do not add up to 100 percent.

Study Context

- Share of total health care spending on primary care is decreasing in majority of states
- COVID-19 pandemic amplified economic, mental health, and social health inequities
- Exacerbated access to care problems and financial pressures on practices
- Some meaningful policy changes, including relaxation of telehealth rules

An Updated Definition of Primary Care

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.

Primary Care as a Common Good

- Primary care has high societal value among health care services yet is in a precarious status
- Requires public policy for oversight and monitoring
- Needs strong advocacy, organized leadership, and public awareness

The Committee's Implementation Plan

System View

- Target recommended actions to 3 levels of U.S. health care

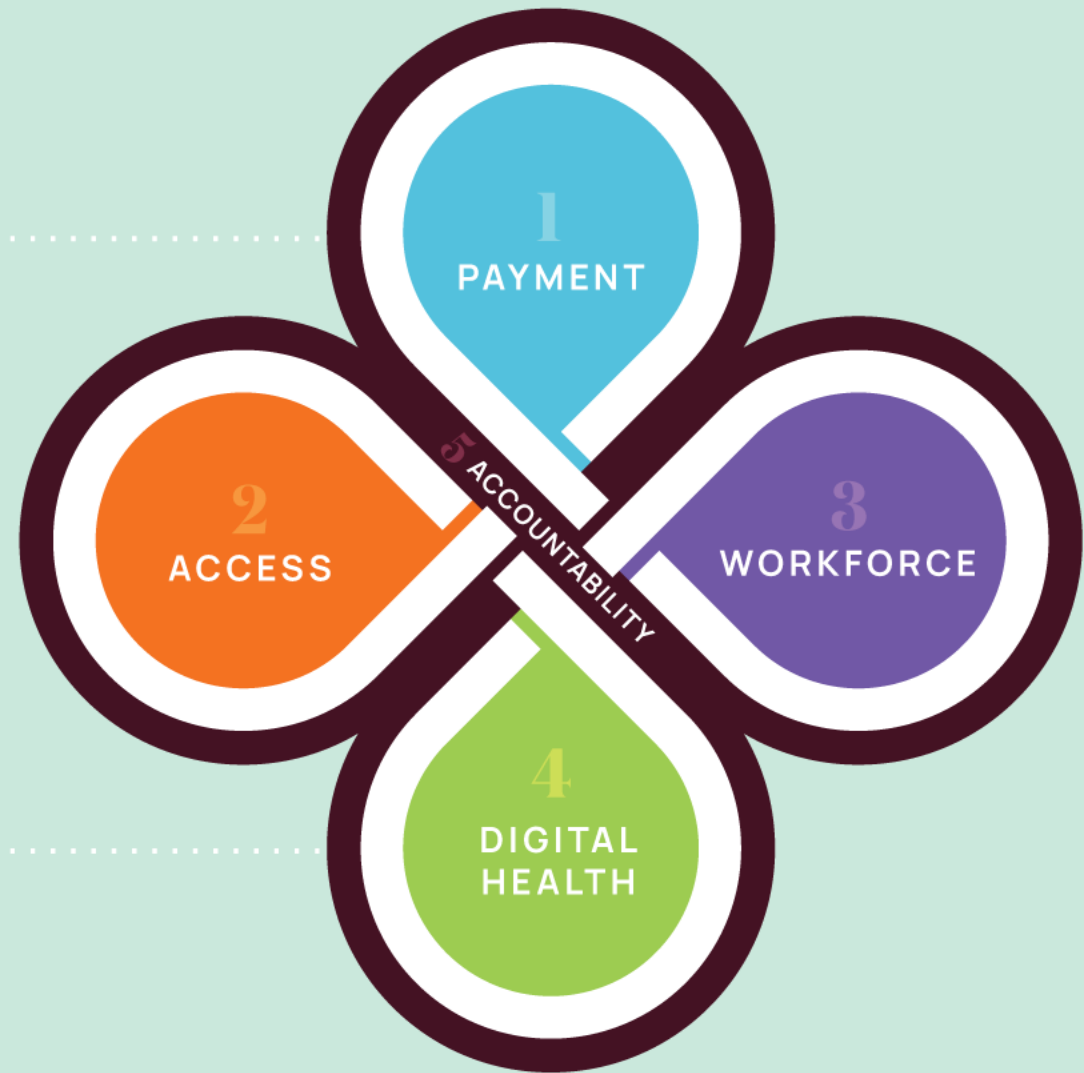
Accountability

- Establish unified body for oversight and assessment
- Create public scorecard to track progress

Policy Window

- Population is concerned with future of U.S. health system
- COVID-19 pandemic revealed weaknesses

5 Objectives for Achieving High-Quality Primary Care



5 Objectives for Achieving High-Quality Primary Care

1

PAYMENT

Pay for primary care teams to care for people, not doctors to deliver services.

2

ACCESS

Ensure that high-quality primary care is available to every individual and family in every community.

3

WORKFORCE

Train primary care teams where people live and work.

4

DIGITAL HEALTH

Design information technology that serves the patient, family, and interprofessional care team.

5

ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.



1

PAYMENT

**Pay for primary care
teams to care for
people, not doctors
to deliver services.**

Action 1.1: Payers should evaluate and disseminate payment models based on their ability to promote the delivery of high-quality primary care, not short-term cost savings.

Action 1.2: Payers using fee-for-service models for primary care should shift toward hybrid reimbursement models, making them the default over time. For risk-bearing contracts, payers should ensure that sufficient resources and incentives flow to primary care.

Action 1.3: CMS should increase overall portion of health care spending for primary care by improving Medicare fee schedule and restoring the RUC to advisory nature.

Action 1.4: States should facilitate multi-payer collaboration and increase the portion of health care spending for primary care.

Paying for Primary Care Teams to Care for People

Full Fee-for-service:

- Phase out



Risk Adjusted Capitation + FFS + patient assignment:

- Default payment for primary care
- Revalued E&M codes
- Resources for transformation



Risk Bearing Contracts with Focus on Population Health:

- Sufficient resources and incentives for primary care



2

ACCESS

**Ensure that
high-quality primary
care is available to
every individual and
family in every
community.**

Action 2.1: Payers should ask all beneficiaries to declare usual source of care. Health centers, hospitals, and primary care practices should assume ongoing relationship for the uninsured they treat.

Action 2.2: HHS should create new health centers, rural health clinics, and Indian Health Service facilities in shortage areas.

Action 2.3: CMS should revise access standards for primary care for Medicaid beneficiaries and provide resources to state Medicaid agencies for these changes.

Action 2.4: CMS should permanently support COVID-era rule revisions.

Action 2.5: Primary care practices should include community members in governance, design, and delivery, and partner with community-based organizations.



3

WORKFORCE

**Train primary
care teams
where people
live and work.**

Action 3.1: Health care organizations should strive to diversify the primary care workforce and customize teams to meet the needs of the populations they serve. Government agencies should expand educational pipeline models and improve economic incentives.

Action 3.2: CMS, the Department of Veterans Affairs, HRSA, and states should redeploy or augment Title VII, Title VIII, and GME funding to support interprofessional training in community-based, primary care practice environments.



4

DIGITAL HEALTH

**Design information
technology that
serves the patient,
family, and
interprofessional
care team.**

Action 4.1: ONC and CMS should develop next phase of digital health certification standards that support relationship-based, continuous and person-centered care; simplify the user experience; ensure equitable access and use; and hold vendors accountable.

Action 4.2: ONC and CMS should adopt a comprehensive aggregate patient data system that is usable by any certified digital health tool for patients, families, clinicians, and care team members.



5

ACCOUNTABILITY

**Ensure that
high-quality primary
care is implemented
in the United States.**

Action 5.1: The HHS Secretary should establish a Secretary's Council on Primary Care to coordinate primary care policy, ensure adequate budgetary resources for such work, report to Congress and the public on progress, and hear guidance and recommendations from a Primary Care Advisory Committee that represents key primary care stakeholders.

Action 5.2: HHS should form an Office of Primary Care Research at NIH and prioritize funding of primary care research at AHRQ.

Action 5.3: Primary care professional societies, consumer groups, and philanthropies should assemble, regularly compile, and disseminate a “High-quality primary care implementation scorecard” to improve accountability and implementation.

Improving Accountability: A U.S. Scorecard

Scorecard measures are:

1. Already in use (not new)
2. Few in number, easily understood, consistent
3. Built on data that is regularly collected and publicly available
4. Appropriate for use at national and state levels

Objective 2: Assure high-quality primary care is available to every family in every community	
Measure 2.1: Percentage of adults without a usual source of health care	
Potential data source: National Health Interview Survey (NHIS) (CDC, 2021)	Sample performance 14.6 percent (2018) (CDC, 2018)
Measure 2.2: Percentage of children without usual source of health care	

5 Objectives for Achieving High-Quality Primary Care

1

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ACCOUNTABILITY

Ensure that high-quality primary care is implemented in the United States.

Download the report and view more resources at:

[Nationalacademies.org/primarycare](https://nationalacademies.org/primarycare)

Questions? E-mail primarycare@nas.edu

NASEM Potential Consensus Study on The Pediatric Clinical Workforce and Its Impact on Child Health and Well-Being

Joe St. Geme, MD

Break-Outs - NASEM Potential Study

Report Outs

Facilitated by Laura Degnon



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National Academies of Sciences, Engineering, & Medicine

A Consensus Study on The Pediatric Clinical Workforce and Its Impact on Child Health and Well-being



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NASEM Contacts

- Victor Dzau, MD – President NAM
- Michael McGinnis, MD, MA, MPP – Executive Officer NAM
- Sharyl Nass, PhD – Sr Board Director NASEM Health & Medicine
- Natacha Blain, JD, PhD – Director NASEM Board on Children, Youth, & Families
- Karen Helsing, MPH – Senior Program Officer/Study Director NAM



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Background

- General pediatricians and pediatric subspecialists play critical role in ensuring state-of-the-art care for pediatric patients
- Steady decline in US medical students at MD granting schools selecting pediatrics
- Critical shortage of pediatric subspecialists in many areas and high likelihood of worsening shortages
- Adverse implications for patients of pediatric subspecialist shortages (wait times, delays in diagnosis and timely treatment, slowing of research progress)



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Background - Pediatric Rheumatology

- American College of Rheumatology Workforce Study Group carried out study of pediatric rheumatology workforce in US in 2015
- Workforce demand (MDs, NPs, PAs) exceeded supply in 2015 by 33% (382 FTEs v. 287 FTEs) and projected to exceed supply in 2030 by 100% if no changes
- Delay in access to pediatric rheumatology assessment is common and often results in inappropriate invasive investigations, prolonged untreated active disease, worsened long-term outcomes



Background - Economics

- Average income for pediatricians is generally lower than for any other medical specialty
- Fellowship fill rates are lowest in subspecialties with lowest income and vice versa, perhaps influenced by education debt among pediatric residents
- Lower salaries in pediatrics v. other specialties and in least popular pediatric subspecialties generally correlate with reimbursement rates
- % of pediatric patients covered by Medicaid often exceeds 50% at academic medical centers
- Medicaid reimbursement rates are ~70% of Medicare reimbursement



Statement of Task

- Examine clinical workforce trends related to healthcare needs of infants, children, and adolescents
- Examine impact of workforce trends on child health and well-being
- Recommend strategies and actions to ensure adequate pediatric workforce to support broad access to high-quality care and robust research portfolio to advance care for all infants, children, and adolescents



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Topics To Be Considered by NASEM Ad Hoc Committee

- 1) How pediatric workforce has evolved over time (general pediatrics, pediatric subspecialties, diversity)
- 2) Trends in selection of pediatric residency and pediatric subspecialty fellowship training (debt, cost of training, earning potential, etc)
- 3) Impact of different payment models in pediatrics on trainee selection of pediatrics and pediatric subspecialties
- 4) Data on other clinicians who provide care for children (family practitioners, NPs, PAs)



Topics To Be Considered by NASEM Ad Hoc Committee

- 5) Impact of workforce shortages on care for pediatric patients and on child health research
- 6) Evidence gaps in what is known about current pediatric workforce and how well it meets estimated needs of pediatric population
- 7) Strategies to better align clinician specialty selection with current and future medical and behavioral health needs of infants, children, and adolescents
- 8) Role of state and federal policies and resources in developing and supporting well-trained workforce to improve child health



Potential Sponsors

- Robert Wood Johnson Foundation
- Annie E. Casey Foundation
- Commonwealth Fund
- Henry J. Kaiser Family Foundation
- W.K. Kellogg Foundation
- David and Lucile Packard Foundation
- J.B. and M.K. Pritzker Family Foundation
- Wellspring Philanthropic Fund
- Alliance for Early Success
- AHRQ
- NICHD
- Pediatric Organizations
- Children's Hospital Association



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Break-Outs

Thank you to our facilitators

Group 1: Are there topics that are missing? Dr. St. Geme

Group 2: Best sources of data to address topics 1-4? Dr. Reed

Group 3: Best sources of data to address topics 5-8? Dr. Devaskar

Group 4: Potential sponsors that are missing? Dr. Walker-Harding



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NASEM Potential Study Report-Outs



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Open Discussion, Wrap Up, Next Steps & Save The Date!



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Discussion

Other Potential Sponsors and/or Contacts for NASEM Study?

Are we headed in the right direction?

How did today's Summit feel focusing on one topic?

Recommendations for future Summits?

What have we missed? Who else should we involve?

Continue to share your notes and thoughts with Bob and Laura.



Wrap Up & Next Steps



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About the Initiative

The Pediatrics 2025: AMSPDC Workforce Initiative was created in 2020 with the goal to increase the number of high-quality students who enter training in categorical Pediatrics, Medicine-Pediatric, and Combined Pediatric Subspecialty training programs, as well as improve recruitment of pediatric residents into pediatric fellowship programs, with an emphasis on those fellowship programs that are not filling their training positions.

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Working Document 5/11/2021

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Literature Review

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Please share Workforce-related work with Bob and Laura.

Summary of today will be distributed soon.



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Friday, November 12, 2021
1 - 5pm ET
Summit #4

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Thank you!



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