





### Susan Kressly, MD, FAAP

Making the Case for Investing in Child Health





# Making the Case for Investing in Child Health

**Susan Kressly, MD, FAAP AAP President -Elect** 



# Disclosure

Dr. Kressly discloses that she and her husband have ownership shares in Connexin Software.

I do not intend to discuss an unapproved/investigative use of a commercial product/device in our presentation.



# Learning Objectives

- Identify key trends in the pediatric population
- Identify important statistics about pediatricians
- Articulate new strategies for investing in child health
- Embrace equity in practice and innovation





# What's My Frame?

- General Pediatrician
- Entrepreneur
- Problem Solver
- Innovative Thinker
- Accidental Informaticist
- Fierce Child Health and Pediatrician Advocate



## Who are US Children?



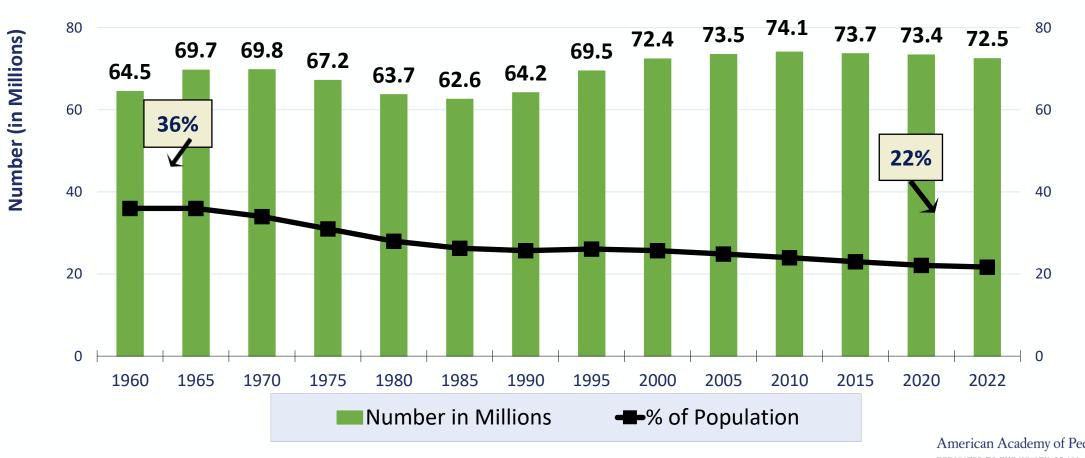
- Highly diverse
- Declining portion of population
- Large geographic variability
  - Substantial child population shift

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- Notable growth in South, shrinkage in Northeast
- Interconnections: income, race and ethnicity, immigration, geography

### **US Child (under 18) Population: Number** and % of Overall Population, 1960-2022

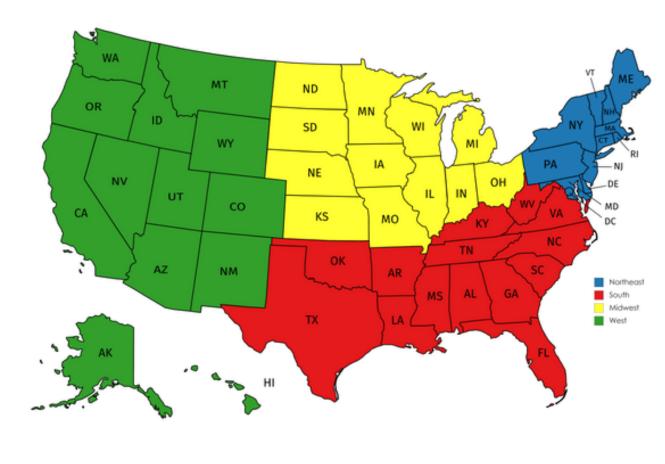
100 100



% of Population

### Where Do US Children Live?

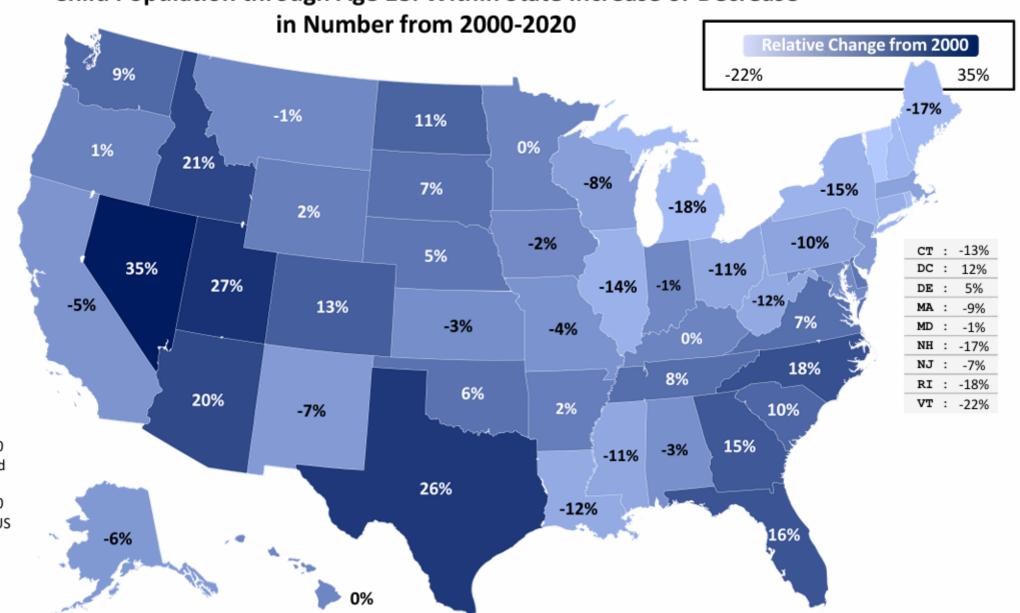
	% of All US Children
Northeast	16%
Midwest	21%
South	39%
West	24%



Created with mapchart.net 0



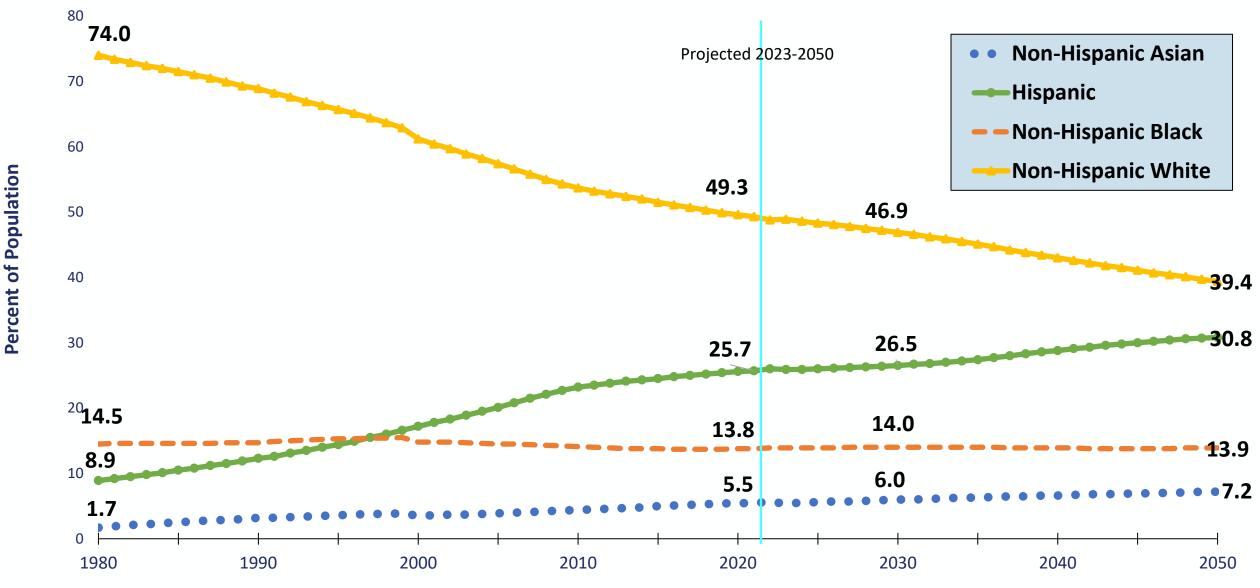
Child Population through Age 18: Within State Increase or Decrease



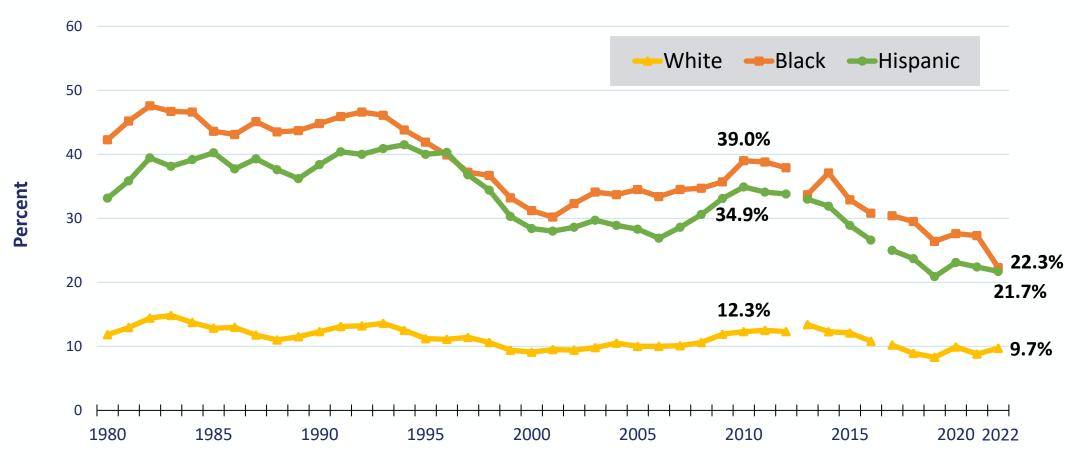
Source: AAP analysis of (i) State Population by Characteristics: 2010-2020 (published June 2021), and (ii) State Demographic Characteristics: 2000-2010 (published March 2012); US

Bureau of Census.

# Race and Ethnicity of US Children Recorded (1980-2022) and Projected (2023-2050)



# Percent of US Children (under 18) Living Below Poverty Level by Race/Ethnicity, 1980-2022\*

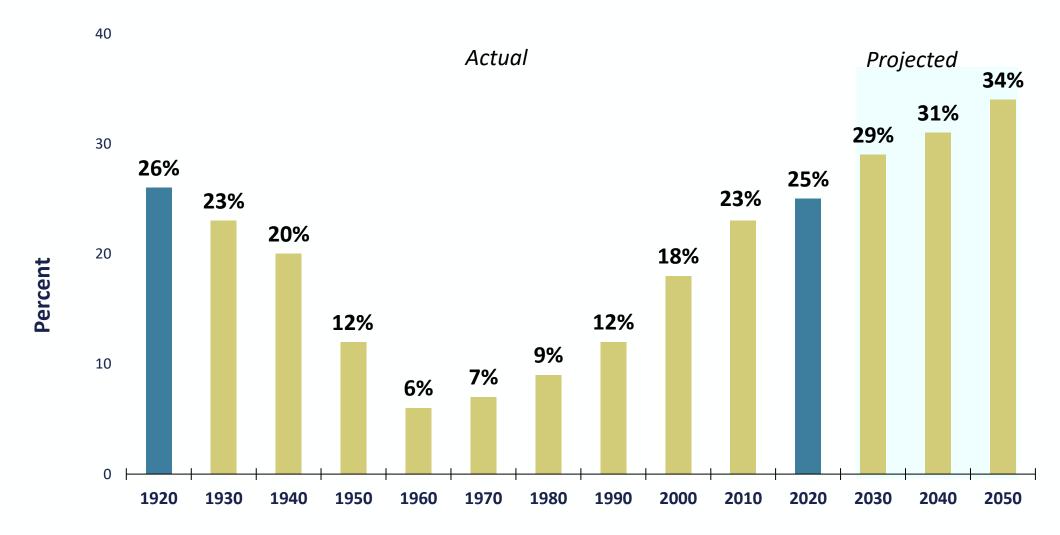


<sup>\*</sup>Estimates for 2013 and beyond are not directly comparable to previous years due to a re-design of the income questions. Estimates for 2017 and beyond are not directly comparable to previous years due to the implementation of an updated CPS ASEC processing system.

Poverty Level in 2022: \$29,678 (Family of 4 with 2 children)



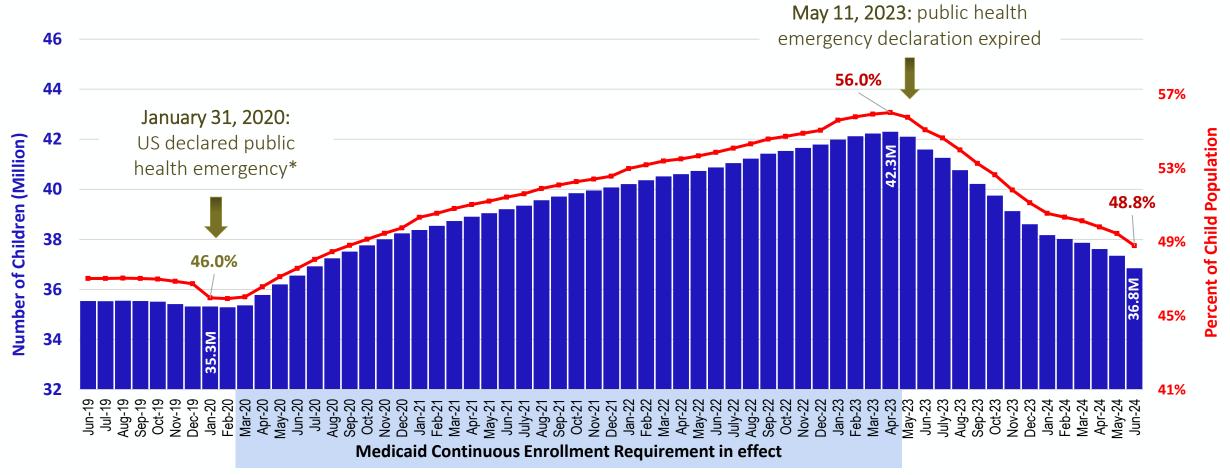
### Immigrant Children as Share of All US Children, 1920–2050\*



<sup>\*&</sup>quot;Immigrant children" defined as children under age eighteen who are either foreign-born or U.S.-born to immigrant parents; gray shaded region (2030-2050) refers to population projections.



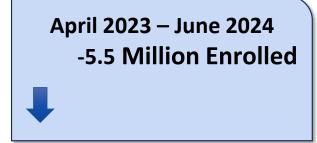
# Number & Percent of US Children Enrolled in Medicaid/CHIP Before & Since the COVID-19 Pandemic, June 2019 - June 2024



\*The Families First Coronavirus Response Act (FFCRA) enacted in March 2020 required continuous enrollment and made available a temporary 6.2 percentage point increase to each state or territory's federal medical assistance percentage (FMAP) during the national Public Health Emergency. **Notes:** Arizona did not submit any child data throughout the reporting period and is not included in this report. ^ June 2024 data, for all sates, are preliminary. Numbers may not sum up precisely due to rounding. **Source:** AAP analysis of data submitted by states to CMS released through the Medicaid and the Children's Health Insurance Program (CHIP) Performance Indicator Projects.

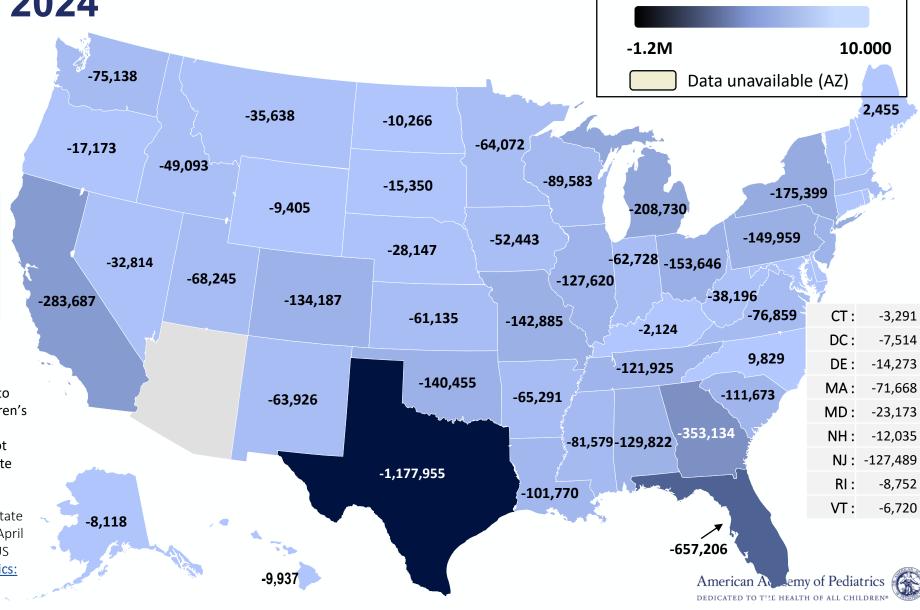


Change in Number of State Children Enrolled in Medicaid/CHIP, April 2023 - June 2024

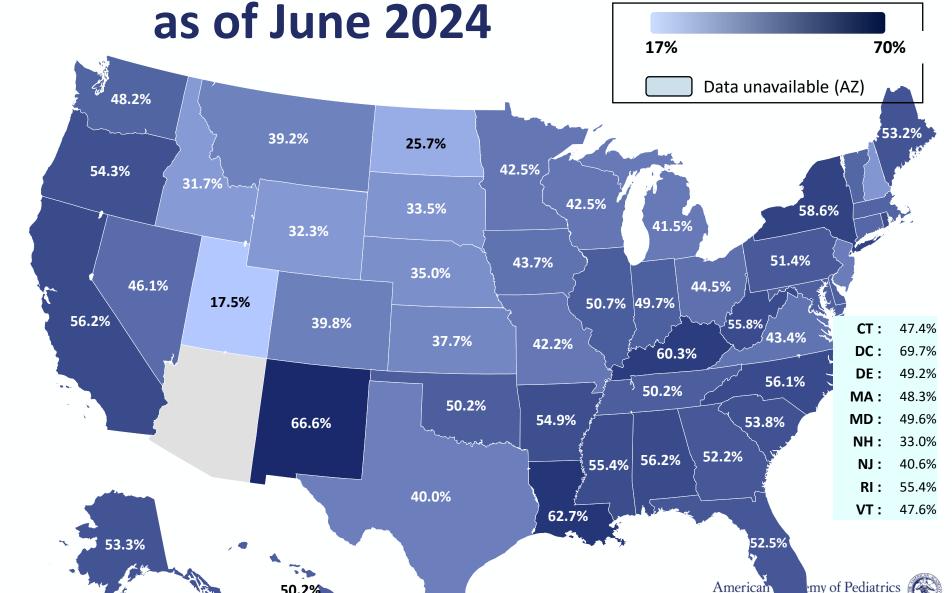


**Source:** AAP analysis of data submitted by states to CMS released through the Medicaid and the Children's Health Insurance Program (CHIP) Performance Indicator Projects. The available CMS data does not provide information from US Territories or the State of Arizona.

Child population estimates are based on "Annual State Resident Population Estimates for 6 Race Groups: April 1, 2020 to July 1, 2023 (SC-EST2023-ALLDATA6). US Census Bureau." [State Population by Characteristics: 2020-2023 (census.gov)]



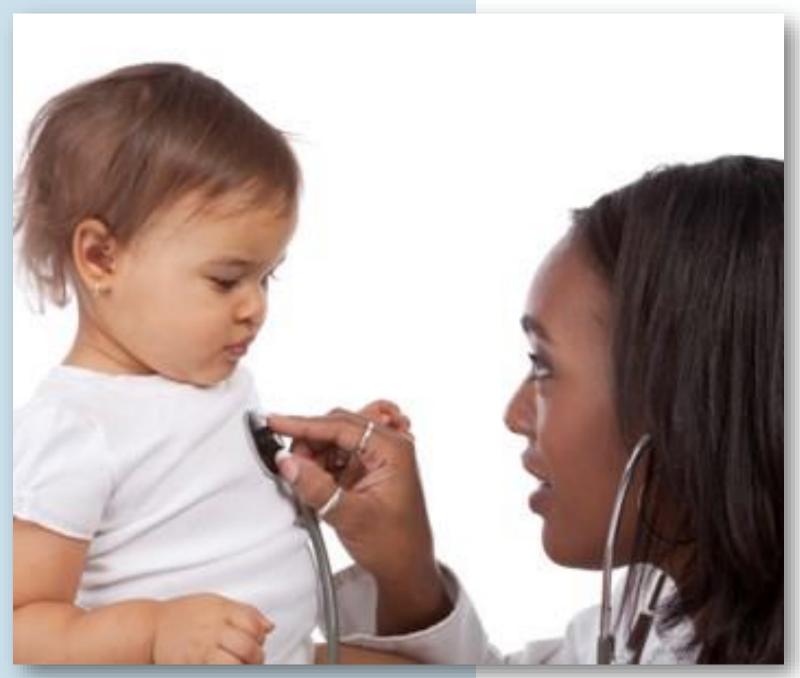
Percentage of State Children Enrolled in Medicaid/CHIP



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Source: AAP analysis of data submitted by states to CMS released through the Medicaid and the Children's Health Insurance Program (CHIP) Performance Indicator Projects

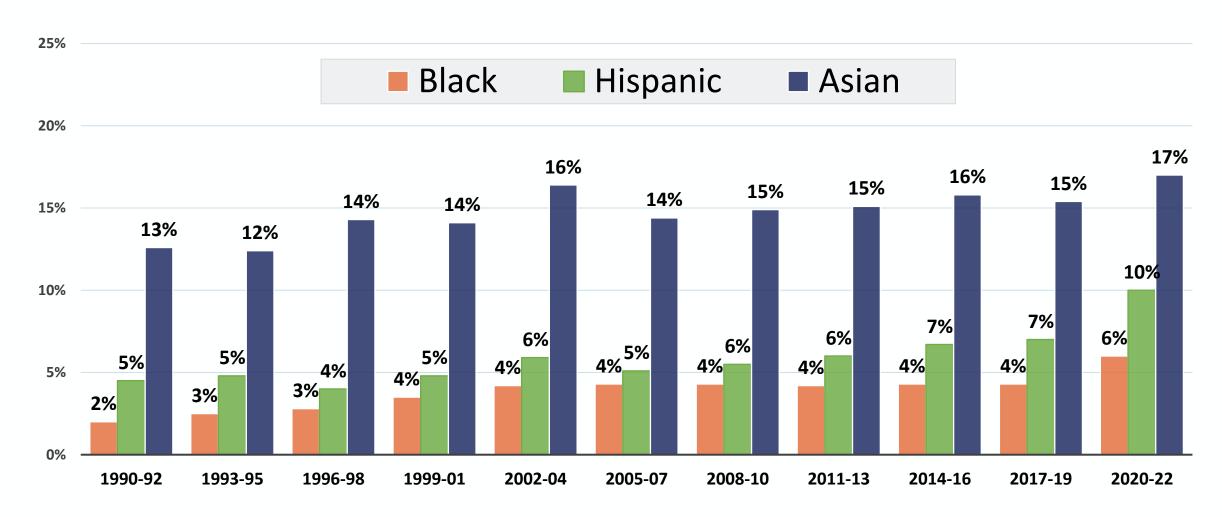
Notes: CMS reports of Medicaid/CHIP enrollment based on state administrative data has been generally higher than estimated by national surveys.



# Who Are Pediatricians?



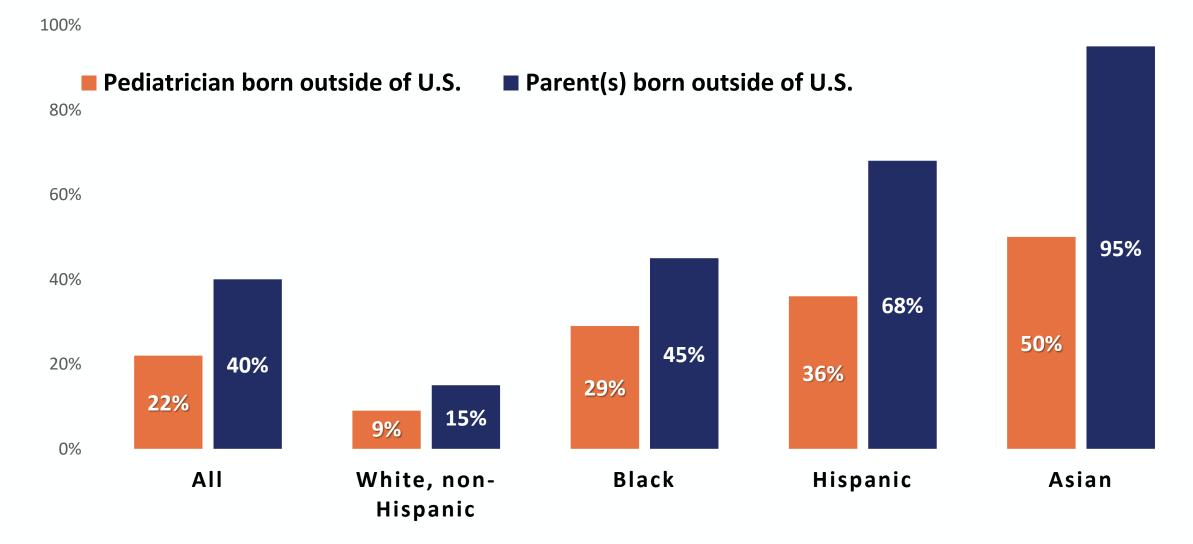
### Race and Ethnicity of US <u>AAP Members</u>, 1990-2022



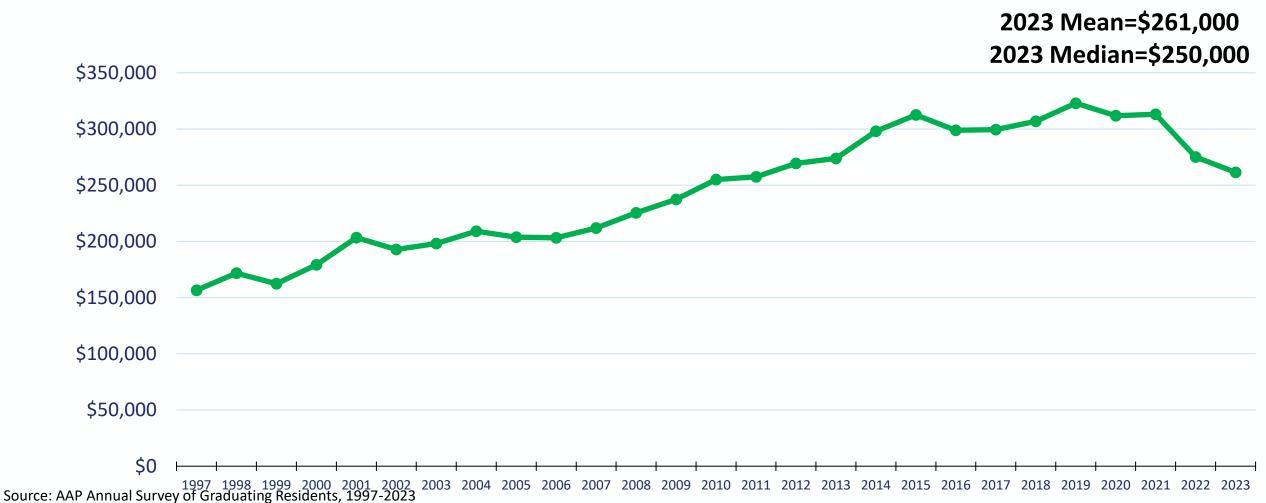
Source: AAP Periodic Survey 1990-2022 (including residents; no survey fielded in 2020 due to COVID-19 pandemic)



# % of PLACES Pediatricians Reporting They or a Parent Was Born Outside the US, by Race and Ethnicity

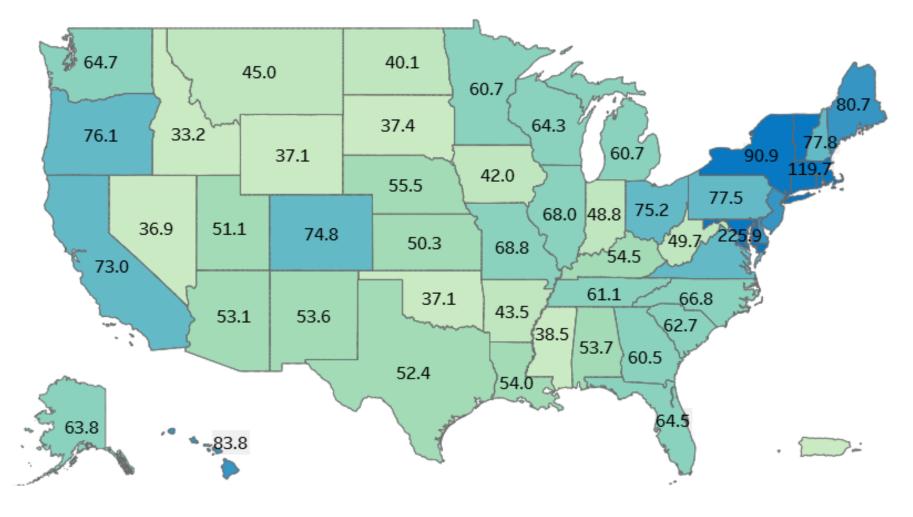


# Average Educational Debt\* Among Graduating Pediatric Residents Reporting Any Debt (adjusted for inflation, in 2023 dollars)



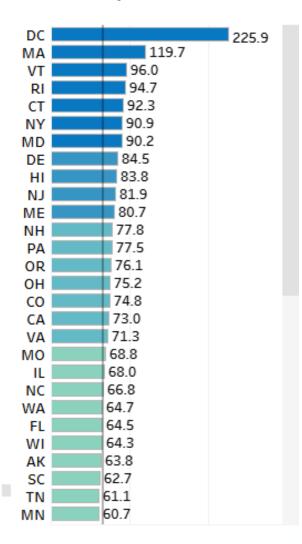
\*Includes spouse's/partner's educational debt for married/partnered residents

#### Distribution of those certified in General Pediatrics (alone) by pediatricians per 100,000 Children (0-17)

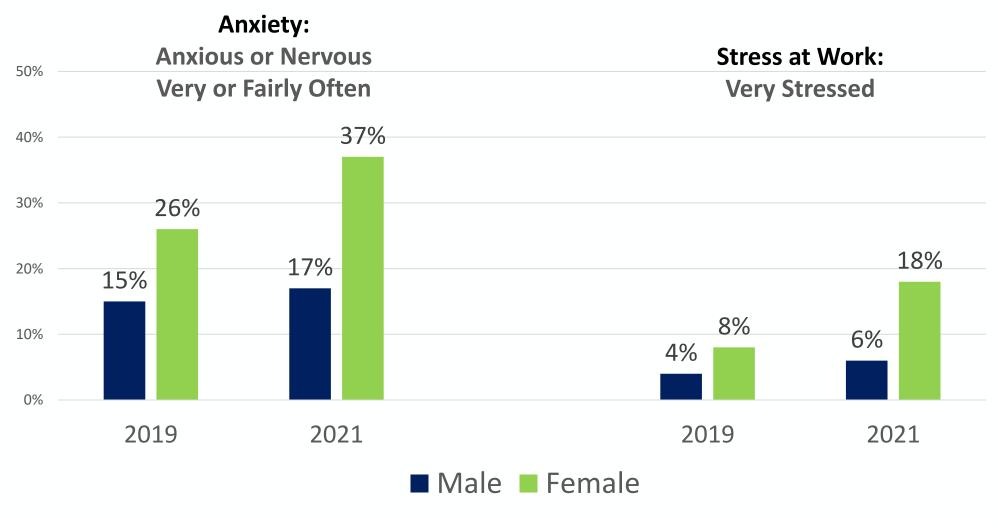


Source: <u>General Pediatricians U.S. State and County Maps | The American Board of Pediatrics (abp.org)</u> data for 2024

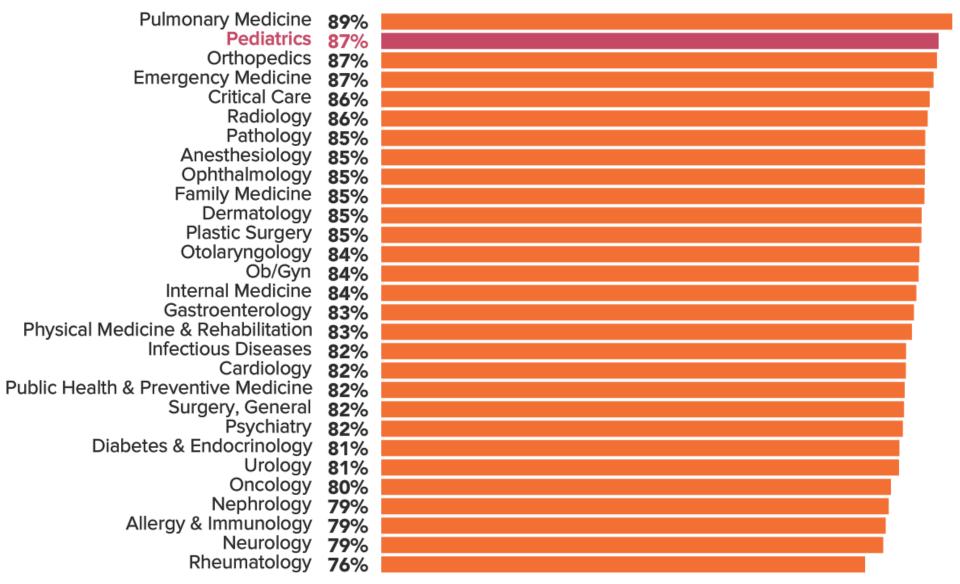
#### State rank, per 100,000 children



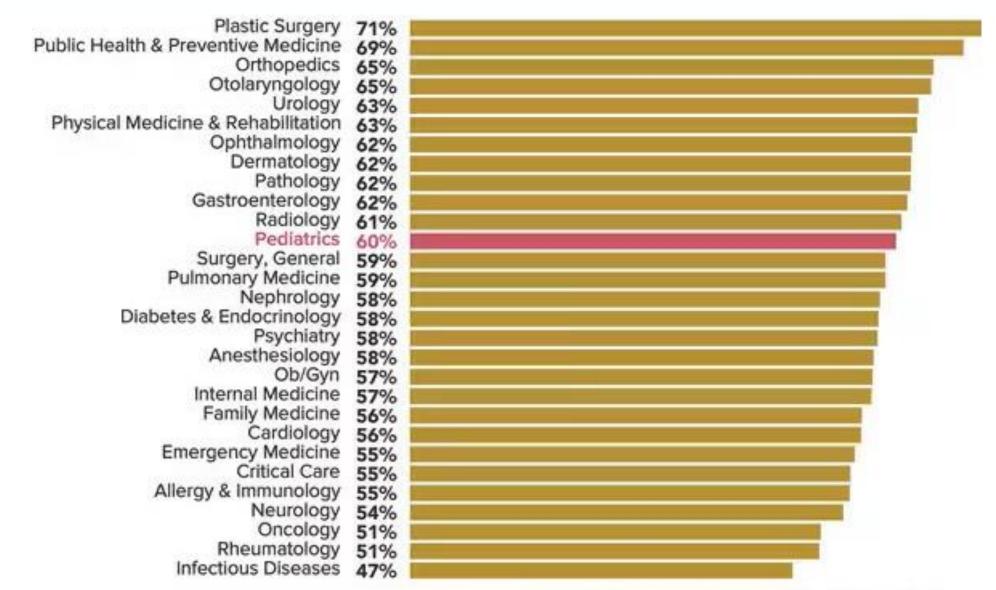
# PLACES Pediatricians' Reported Anxiety and Stress at Work: 2019 vs 2021



### Happiest Specialties Outside of Work Pre-Pandemic



## **Happiest Specialties Outside of Work Now**

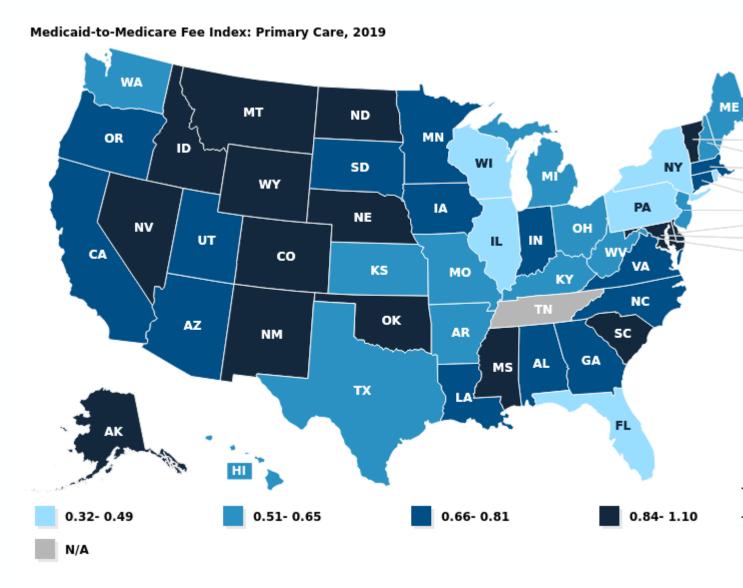




# **Current State of Pediatric Payment**



### Medicaid to Medicare Fee Index



MD 0.90

(primary care: 0.94)

D.C. 0.80

(primary care: 0.80)

VA: 0.78

СТ

NJ DE MD DC

(primary care: 0.78)

RI: 0.32 -Alaska: 1.10

**USA: 0.67** 

<a href="https://www.kff.org/medicaid/state-">https://www.kff.org/medicaid/state-</a>
indicator/medicaid-to-medicare-fee-index





https://www.nationalacademies.org/ourwork/improving-the-health-and-wellbeing-ofchildren-and-youth-through-health-caresystem-transformation

# Child Health Financing and Payment

- ALL pediatric clinical team members are underpaid compared to adult medicine
  - ->50% of children in this country are covered by Medicaid/CHIP
  - Current CPT/RVU structure rewards procedures, not thinking
  - AMA E/M changes increased pay to primary care for adults, but not children
- Health insurance is designed to amortize risk of catastrophic events over populations

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# The Current Child Health Landscape

U.S. faces a crisis with poor and worsening child health and wellbeing with impacts on the workforce of the future

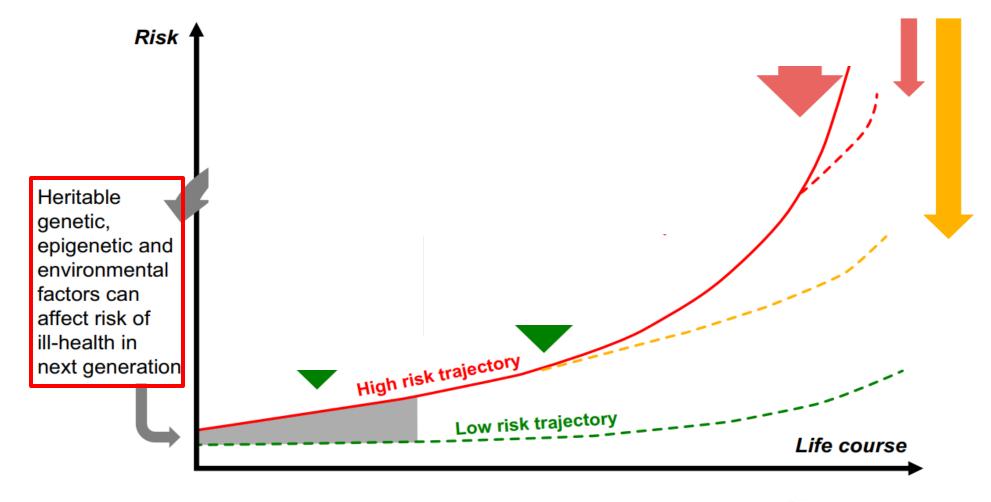
U.S. ranks at the bottom among wealthy nations on mental wellbeing, physical health, and academic and social skills

Children living in poverty and from marginalized groups all face poorer health and higher rates of mental health conditions

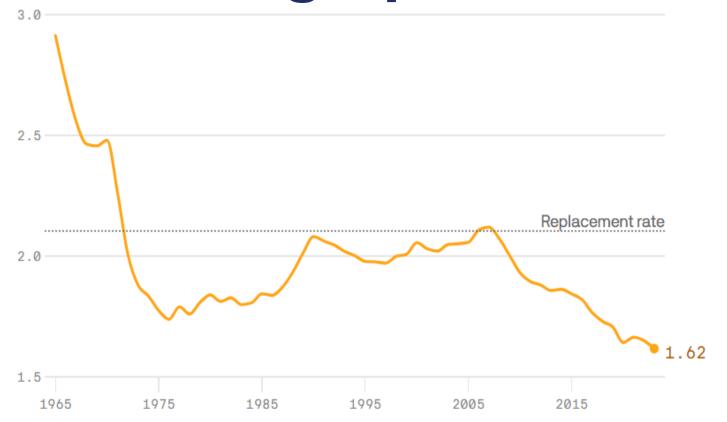
Increased incidence of chronic diseases, though many conditions are preventable Increases in mortality and morbidity, mental health conditions, obesity and cardiovascular and pulmonary disease, substance use among working-age adults with roots in childhood

### Life course View of Health Risk

Fig 2-4, Launching Lifelong Health: Hanson & Gluckman, Physiol Rev 2014; 94(4): 1027-1076

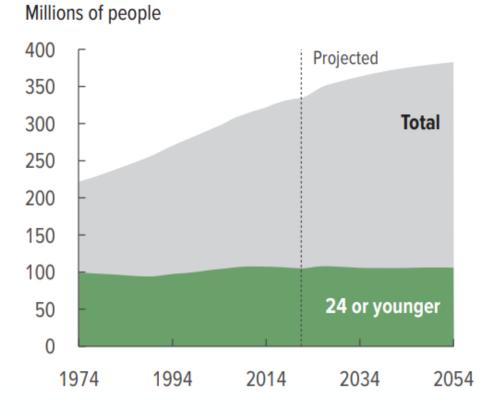


# **US Demographic Trends**



"US fertility rates drop to another historic low." CDC, April 2024. DOI: https://dx.doi.org/10.15620/cdc/151797, Axios graph





A smaller number of children will need to support a growing older population.

CBO, Jan 2024, https://www.cbo.gov/system/files/ 2024-01/59697-Demographic-Outlook.pdf



**FACTSHEET** 

# 77 Percent of American Youth Can't Qualify for Military Service

Better nutrition and physical activity can yield healthier outcomes for youth and bolster national security

https://www.strongnation.org/articles/2006-77-percent-of-american-youth-can-t-qualify-for-military-

service January 24, 2023

https://www.strongnation.org/articles/2288-we-need-all-that-they-can-be December 11, 2023





#### 2020 Qualified Military Available (QMA) Study

	7	7% - DISQUA (w/o waive							23% - QUALIFIED (w/o waiver)							
Youth 17 to 24 years old	More than one reason or condition	Overweight Only	*Drug Abuse Only	Medical/Physical Only	Mental Health Only	Aptitude Only	Conduct Only	Dependents Only	Qualified - enrolled in college	Qualified - available for Military Service (QMA)						
Total You	44%	11%	8%	7%	4%	1%	1%	1%	11%	12%						

content/uploads/2023/07/ DOD-QMA-2020-Brief-PUBLIC.pdf

https://amarkfoundation.o

rg/wp-

#### 2020 QMA STUDY KEY FINDINGS

- The proportion of youth eligible for military service without a waiver is 23%. This is a decrease from previous estimates (29%).
- Most ineligible youth are disqualified for multiple reasons (44%).
- The largest increases in disqualification estimates observed between 2013 and 2020 were for mental health and overweight conditions.
- When considering youth disqualified for one reason alone, the most prevalent disqualification rates are overweight (11%), \*drug abuse (8%), and medical/physical health (7%).
- The proportion of youth who are Qualified Military Available (QMA), defined as both eligible and not currently enrolled in college, is 12%.



# **Child-First Design**

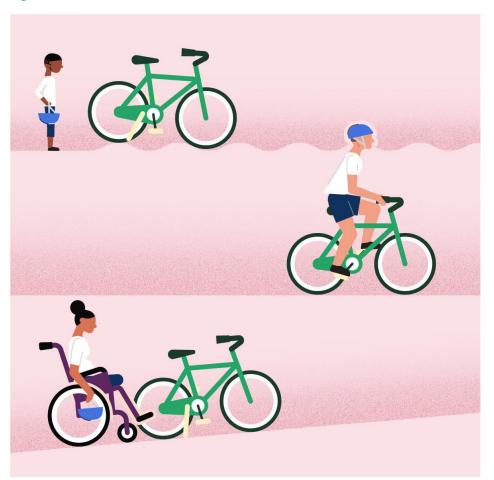
- Developmental trajectory model
- Context of caregivers/family
- Context of community



# **Equity-Centered**

#### **EQUALITY**:

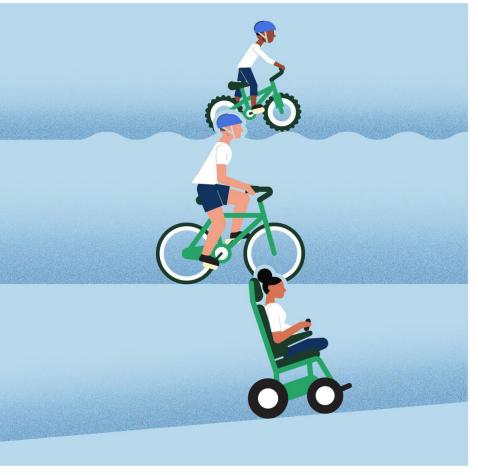
Everyone gets the same-regardless if it's needed or right for them.



#### **EQUITY:**

Everyone gets what they need–understanding the barriers, circumstances, and conditions.





### Health information technology and equity: Applying history's lessons to tomorrow's innovations

Sansanee Craig MD ス 🖾 , Katie E. McPeak MD, Chinonyerem Madu MPH, George Dalembert MD, MSHP

https://doi.org/10.1016/j.cppeds.2021.101110









### The Unsustainable Ask

- Do more work
- Do it in multiple formats
- Do it faster
- Do it safely
- Make everyone happy



# 1974

#### RECOMMENDATIONS FOR PREVENTIVE HEALTH CARE<sup>1</sup>

The "Recommendations for Preventive Health Care of Children and Youth" represents a guide for the care of well children who receive competent parenting, who have not manifested any important health problems and who are growing and developing satisfactorily Circumstances which may indicate the need for additional visits are outlined in the accordance panying text.

parry ring text.			_				_							_
AGE <sup>2</sup>	2-4 Wks	2-3 Mos,	4-5 Mos.	6-7 Mos.	9-10 Mos	12-15 Mos.	16-19 Mos. 1	23-25 Mos.	35-37 Mos.	5-6 Yrs.			13-15 Yrs.	16-21 Yrs,
HISTORY														
Initial						· At								
Interval						. At	each	visi	t.					
MEASUREMENTS														
Height & Weight			• .			- At	each	visi	t ·					
Head Circumference	111	111		111		111								
Blood Pressure	L.								111		111	111	11	11
SENSORY SCREENING														
Sight <sup>3</sup>	111	111		111					//0	R.	111	111		
Hearing <sup>4</sup>				111					//0	R\		1		
DEVELOPMENTAL APPRAISAL <sup>5</sup>			, -			· At	each	visi	t ·					
PHYSICAL EXAM						· At	each	visi	t ·					
PROCEDURES <sup>6</sup>		-		!										
Immunization		111	111	111		111	22	_		111			111	'
Tuberculin Test <sup>7</sup>		_			111		_					1		
Hematocrit or Hgb.				!	111				/ (d	R\\		111		
Urinalysis <sup>8</sup>							_	11					111	
Urine Culture (girls only)9									111		111	. ]	_	
DISCUSSION & COUNSELING <sup>10</sup>					,	· At	each	visit	t ·	, ,				
DENTAL SCREENING <sup>11</sup>			-			· At	each	visit	t ·		-			
NIT. DENTIST'S EXAM <sup>12</sup>									173					



#### Recommendations for Preventive Pediatric Health Care



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal.

Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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					_	_	_		-	_					_					UUU	_			_	_	_	_					_
Age	Prenatal*	Newborn	3-5 d	By 1 mo	2 mo	4 mo	6 ma	9 mo	12 m	15 ma	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY																																
Initial/interval	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																											$\Box$					
Length/height and weight		•		•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•					•	•	•	•	•
Head circumference		•	•	•	•	•	•	•	•	•	•	•												-								
Weight for length		•	•	•	•	•	•	•	•	•	•																					
Body mass index												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Blood pressure		*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	•	•	•	•	•	•	•					•	•	•	•	•
SENSORY SCREENING																								$\Box$	Т	$\Box$	$\Box$					
Vision		*	*	*	*	*	*	*	*	*	*	*	*	•			•	*		*		*		*	*		*	*	•	*	*	*
Hearing		••	*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	*	•	*	•	*	*	*	*	*	*	*	*	*	*	*
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT																									-	$\overline{}$	-					
Developmental screening*													•																			
Autism screening											•	•													_		_					
Developmental surveillance		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•					•	•	•	•	•
Psychosocial/behavioral assessment		•	•	•	•			•			•	•	•	•	•	•	•	•	•	•	•	•	•					•	•	•	•	•
Alcohol and drug use assessment																						*	*	*	*	*	*	*	*	*	*	*
PHYSICAL EXAMINATION		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES*																								$\overline{}$			$\overline{}$					
Newborn metabolic/hemoglobin screening		-			-																											
Immunization*		•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•
Hematocrit or hemoglobin						*					*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Lead screening*							*	*	o <sub>cr</sub> †°		*	Our At		*	*	*	*															
Tuberculin test*				*			*		*		*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Dyslipidemia screening'												*			*		*		*		*	*	*	*	*	*	*	*	-		-•-	-
STI screening																						*	*	*	*	*	*	*	*	*	*	*
Cervical dysplasia screening																						*	*	*	*	*	*	*	*	*	*	*
ORAL HEALTH							*	*	●or*		●or★*	●or★*	●or★"	è			•*															
ANTICIPATORY GUIDANCE"	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

- \* If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of besattleeding and planned method of feeding per AAP statement "The Prenatal Visit" (2001)
- [URL: http://asppolicy.asppublications.org/cgi/content/ful/pediatrics;107/6/1456]. Every infant should have a newborn evaluation after birth, breastfeeding encouraged, and instruction and support offered.
- 4 Every infant should have an evaluation within 3 to 5 days of birth and within 46 to 72 hours after discharge from the hospital. to include evaluation for feeding and jaundice. Breastfeeding intents should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement "Breastfeeding and the Use of Human Milk" (2005) [URL: http://sappolicy.aappublications.org/cgi/content/full/pediatrics;115/2/496]. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 46 hours of discharge per AAP statement "Hospital Stay for Healthy Term Newborns" (2004) [URL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/5/1434].
- Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3.
- years.

  If the patient is uncooperative, rescreen within 6 months per AAP statement "Eye Examination and Vision Screening in
- Infants, Children, and Young Adults" (1996) [LPL: http://aappolicy.aappublications.org/cg/heprint/pediatrics;98/1/153.pdf], is All newborns should be screened per AAP statement "Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs \* 60000 (URL: http://asppolicy.asppublications.org/cg/content/ful/

- pediatrics;106/4/798), Joint Committee on Infant Hearing. Year 2007 position statement: principles and guidelines for early tearing detection and intervention programs. Pediatrics. 2007;120:896-921.
- AAP Council on Children With Dissbillies, AAP Section on Developmental Behavioral Partiatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying Infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006;118:405-420 JURL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405].
- Gupta VB, Hyman SL, Johnson CR, et al. Identifying children with autiem early? Pediatrics. 2007;119:152-153 [URL: http://pediatrics.aappublications.org/cgi/content/full/119/1/152].
- At each visit, age-appropriate physical examination is essential, with infant totally unclothed, cider child undressed and sulfably draped.
- \* These may be modified, depending on entry point into schedule and individual need.

ing should be done in accordance with state law where applicable.

- Newborn metabolic and hemoglobinopathy acreening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
- Schedules per the Committee on Infectious Diseases, published annually in the January issue of Pediatrics, Every visit
- should be an opportunity to update and complete a child's immunizations. \* See AAP Padiatric Nutrition Handbook 5th Edition (2000) for a discussion of universal and selective acception options. See
- to Recommendations to prevent and control iron deficiency in the United States. MMWR Recomm Rep. 1990;47/RR-3;1-36. \* For children at risk of lead exposure, consult the AAP statement "Lead Exposure in Children Prevention, Detection, and Management" (2005) JURL: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/4/1036). Additionally. screen-

- Perform risk assessments or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas. \* Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of Red
- Book: Report of the Committee on Infectious Diseases. Testing should be done on recognition of high-risk factors. "Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report" (2002) (URL: http://circ.shajournals.org/cgi/ content/full/105/05/01433 and "The Expert Committee Recommendations on the Assessment, Devention, and Teatment of Child and Adolescent Overweight and Obesity." Supplement to Redistrics. In press.
- All sexually active patients should be acreened for sexually transmitted infections (STIs).
- All sexually active oirs should have screening for cervical deplace as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first). · Referral to dental home, if available. Otherwise, administer oral health risk assessment, if the primary water source is defi-
- cient in fluoride, consider oral fluoride supplementation. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient
- does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
- Refer to the specific guidance by age as listed in Bright Futures Guidelines. (Hagan JF, Shaw JS, Duncan PM, eds. Bright Future: Guidelines for Health Supervision of Intents Children, and Adolescents: Set ed. Els Grove Wilson B.: American Academy of Pediatrics; 2008.)

Bright Futures/American Academy of Pediatrics



Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Hagan JF, Shaw JS, Duncan PM, eds. for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. American Academy

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

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

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				INFANCY							EARLY	CHILDHOOD	)				A	MIDDLE CI	HILDHOOD	)						AD	OLESCENCE					
AGE*	Prenatal <sup>2</sup>	Newborn <sup>1</sup>	3-5 d*	By 1 mo	2mo	4mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	By	9 y	10 y	11 y	12 y	13 y	14y	15 y	16 y	17 y	18y	19 y	20 y	21)
HISTORY Initial/Interval	•	•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																																
Length/Height and Weight		•	•	•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Head Circumference		•	•	•		•	•	•	•	•	•	•																				
Weight for Length		•		•		•	•	•	•	•	•																					
Body Mass Index <sup>6</sup>												•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	
Blood Pressure <sup>4</sup>		*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
SENSORY SCREENING																																
Vision <sup>2</sup>		*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	•	*	•	*	•	*	•	*	*	•	*	*	*	*	*	*
Hearing		•1	•**-		-	*	*	*	*	*	*	*	*	*	•	•	•	*	•	*	•	-		<b>●</b> 10	→	-		-	-			-
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening <sup>11</sup>				•	•	•	•																									
Developmental Screening <sup>10</sup>								•			•		•																			
Autism Spectrum Disorder Screening <sup>11</sup>											•	•																				
Developmental Surveillance		•	•	•	•	•	•		•	•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Behavioral/Social/Emotional Screening <sup>14</sup>		•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol, or Drug Use Assessment <sup>15</sup>																						*	*	*	*	*	*	*	*	*	*	*
Depression and Suicide Risk Screening's																							•	•	•	•	•	•	•	•	•	
PHYSICAL EXAMINATION®		•		•		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	
PROCEDURES**																																
Newborn Blood		•11	●20,	_	-																											
Newborn Bilirubin <sup>31</sup>		•																														
Critical Congenital Heart Defect <sup>20</sup>		•																														
Immunization <sup>20</sup>		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	
Anemia <sup>24</sup>						*			•	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Lead <sup>is</sup>							*	*	or ★ <sup>26</sup>		*	⊕ or ★ <sup>36</sup>		*	*	*	*															
Tuberculosis <sup>20</sup>				*			*		*			*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Dyslipidemia <sup>38</sup>												*			*		*		*	-	-•-	-	*	*	*	*	*	-				-
Sexually Transmitted Infections <sup>26</sup>																						*	*	*	*	*	*	*	*	*	*	*
HIV**																						*	*	*	*	•-						-
Hepatitis B Virus Infection <sup>11</sup>		*																														-
Hepatitis CVIrus Infection <sup>10</sup>																													•-			-
Sudden Cardiac Arrest/Death <sup>10</sup>																						*-										-
Cervical Dysplasia™																																•
ORAL HEALTH**							<b>●</b> 16	•10	*		*	*	*	*	*	*	*															
Fluoride Varnish <sup>10</sup>							+									<b>—</b>																
					-		*	*	*		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*					
Fluoride Supplementation <sup>ia</sup>					_	_																										

- 1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
- 2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding 6. and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
- 3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support
- 4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and laundice. Breatifeeding newborns should receive formal breatifeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Policy Statement: Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2022-057988). Newborns discharged less than 48 hours after delivery must be examined within
- 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0593.

  5. Screen, per "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity"
- (https://doi.org/10.1542/peds.2022-060640).
  Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
- 7. A visual aculty screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System
  Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2019-3449).

  13. Screening should occur per "Identification, Evaluation, and Management of Children With Autiem Spectrum Disorder" for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
  - Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened. per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs"
- 9. Verify results as soon as possible, and follow up, as appropriate.
- 10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies\* (https://www.sciencedirect.com/science/article/abs/pii/51054139X16000483)
- 11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
- 12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental
- (https://doi.org/10.1542/peds.2019-3447).



### Overworked and Under-Resourced Pediatric Teams

Don't ask them to do one more thing that...

- Increases implementation burden
- Isn't paid
- Isn't integrated into their workflow and technology
- Makes them feel inadequate





# Building Equity into Your Pediatric Team

- What does each team member need to be successful?
- What connects each team member to the organizational mission?
- What connects each team member to the meaning in their work?





# The Power of Collaboration

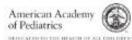








POLICY STATEMENT Organizational Principles to Golde and Define the Child Health Care System and/or fegurate the Bealth of all Children



The American Academy care system that provid comprehensive care that child and family achieve infants children adoles system. Medicaid and th provide critical support programs currently sermembers of racial and e medical conditions. Med and well-being of US This statement review program reforms and e comprehensive, familyaccess to services, reduadulthood. This stateme and CHIP that can impr

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#### The Unique Value Proposition of Pediatric Health Care

James M. Perrin, MD, FAMP Petroia Flanagon, MD, FAMP Jude Kerkin, MD, FAMP Greg Bondsell, MB, FAMP Jonathan Price, MD, DAAP' and the Committee on Child South Financing

This document provides a framework for the value proposition of pediatric health care. It is intended to provide a succinct set of principles for establishing this proposition that demonstrates the shortand long-term value to the child and family, the health care system, and society as a whole

#### VALUE IN PEDIATRIC CARE

The health and well-being of children and youth strongly influence their health and well-heing as adults. Health early in life has vital importance to many interests across society, where the basic aim of society is the well-being of families and individuals. Value (in health care) is defined as outcomes relative to costs.1 Outcomes for children include resolution of disease and current health status, but these connections between health and long-term well-heing clarify the need to address long-term outcomes as well. The value of healthy children becoming healthy adults provides a focus for the value of high-quality pediatric care.

Health is more than the absence of disease.2 Our vision as pediatricians is that all children, including those with chronic conditions and disabilities, grow and develop in safe, loving families and supportive communities that help them achieve their greatest potential. Families are critical to these goals, and children's health and well-being partly reflect parental mental and

Pediatrics, at its core, is about prevention of illness, early recognition of problems, and provision of care based on individual needs delivered in the context of a patient- and family-contered, coordinated, culturally appropriate delivery system. Its aim is to promote children's physical, developmental, social-emotional, and mutritional health and to detect and treat challenges. early enough to mitigate lifelong effects. High rates of mental and behavioral health issues call for addressing these conditions directly in pediatric care, including apstream prevention. Adversity in childhood, including the effects of

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Brs Perre, Panagan, Kelkin, Baratell, and Price were all directly tracked in planning, resourching and writing of this report. approved the first managerist as submitted, and are appointable

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#### FROM THE AMERICAN ACADEMY OF PEDIATRICS

## **AAP: Grounded in Policy**

- Driven by subject matter experts
- Evidence-based
- Scientific rigor
- Broad stakeholder feedback



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Senate overwhelmingly passes package of bills aimed at protecting kids and teens online

The bill heads to the House where it will face further consideration.



# Kids' online safety measure easily clears key Senate hurdle in 86-1 vote

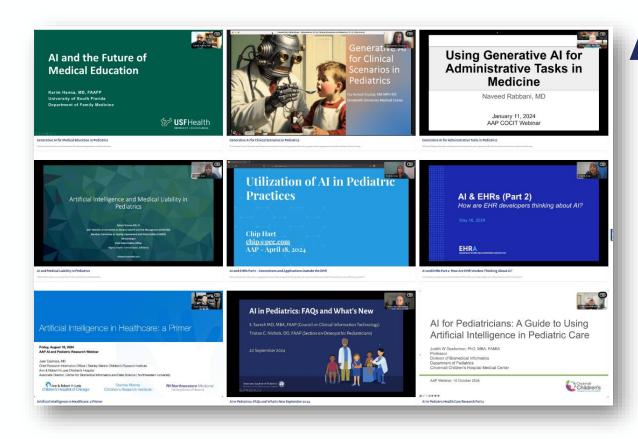
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# AAP: The Power of Advocacy

- Respected voice for children and pediatricians
- Relationships/collaborations
  - Community partners
  - Industry
  - -Other professional societies





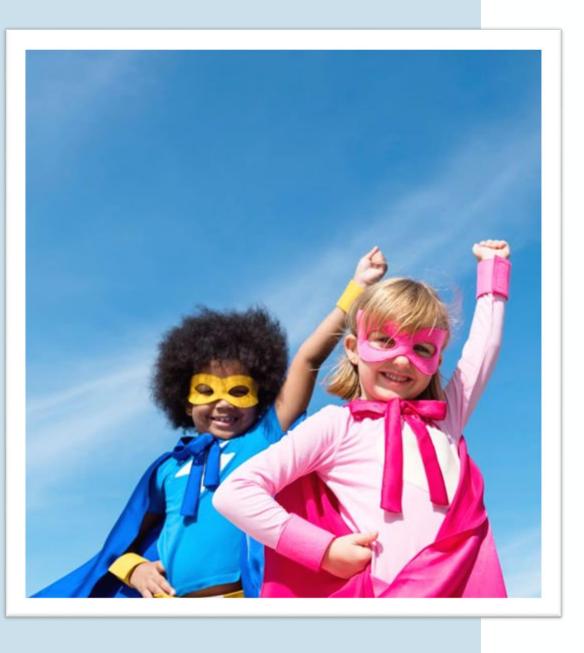
# AAP: The Strength of Education

- National and International networks to disseminate information
- Education models that reach all levels of learner

# And What Would Our Vision Mean for Children, Families and Pediatricians?

- Every child would have their best shot at a Bright Future
- Every family would feel seen, heard and valued
- Communities would be healthier
- The workforce would be healthier and better prepared for the future
- Pediatric care teams would be excited to come to work, connect with families and make the world a better place
- Every child would want to grow up and work in pediatric healthcare delivery because it's such a joy!

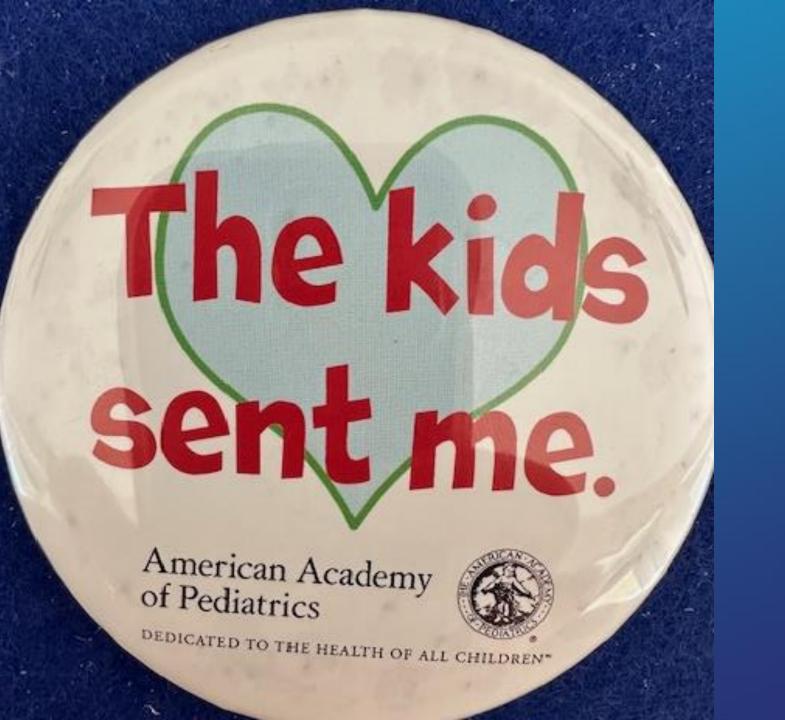
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# What's Next?

# Be BRAVE & BOLD for Children & Pediatricians!





# Thank You!

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®