The American Academy for Cerebral Palsy and Developmental Medicine (AACPDM) is a professional, multi-disciplinary Academy of over 1,100 health professionals dedicated to advancing the health and well-being of all individuals with cerebral palsy and other childhood-onset disabilities. We are grateful to have the opportunity to comment on the proposed ACGME Program Requirements for General Pediatrics. The following feedback on the proposed changes to pediatric residency training requirements is endorsed by the 2022-2023 AACPDM Board of Directors.

We firmly believe that the care of children with cerebral palsy (CP) and other child-onset disabilities is critical to the practice of general pediatrics, a role that is even more crucial now due to the shortage of subspecialists such as developmental pediatricians, neurodevelopmental pediatricians and physiatrists. Almost 1 in 5 (19.4%) of children in the United Sates have a special health care need according to the most report on the National Survey of Children's Health,[1] adding further clarity to the mandate for pediatricians to be trained to competently provide care for this large cohort of children. In a recent Clinical Report published in Pediatrics,[2] a collaborative effort between AACPDM and the Council on Children with Disabilities Executive Committee of the American Academy of Pediatrics, the important role of the general pediatrician related to screening and identification of CP, coordination with subspecialists, provision of guidance related to education and general primary care, monitoring of child development, and pain management is clearly outlined. ***We stand firmly behind the recommendations in this report and advocate for the critical importance of the inclusion of developmental disabilities training for pediatric residents.***

As competition from urgent care and telehealth providers for low-complexity acute pediatric care grows, it is ever more important for pediatricians to be experts in the management of children with disabilities and medical complexities. We are concerned that the change to no longer require training programs to have Developmental-Behavioral Pediatric board-certified faculty will markedly diminish exposure to developmental and behavioral pediatrics, and ultimately, the capacity for general pediatricians to fulfill the important role of providing a medical home for children with developmental and behavioral disabilities. We have had a long-standing concern that one month of developmental and behavioral pediatrics in residency is inadequate to prepare residents to provide care to children with a broad range of developmental and motor disabilities. The removal of requirements to have developmental pediatricians on faculty in addition to the lack of exposure residents already have in neurodevelopmental pediatrics and pediatric rehabilitation, will further widen this gap. We recognize the challenge with workforce issues related to subspecialty faculty, in particular, but we encourage the ACGME to explore options to ensure faculty support related to children with disabilities is maintained in pediatric residency programs.

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Proposed changes to require management of children with complex and chronic conditions in IV.B.1.b).(1).(a).(iii) are positive, but it is unclear how this is will be accomplished, especially when resident continuity clinic panels may prefer less complex and chronic patients, language in IV.C.6.g).(7) on the medical home for children with special health care needs has been removed, and the new requirements for inpatient and outpatient blocks in IV.C.6 – IV.C.6.f).(2) do not specifically mention complex care, rehabilitation, and other outpatient and inpatient experiences that would give residents experience managing children with disabilities across the continuum of care. Programs should be required to include children with a broad array of child-onset disabilities and complex and chronic conditions in resident panels in both the inpatient and outpatient settings and/or have residents rotate through dedicated clinics. Reductions in PICU time could reduce resident comfort with complex patients, and so programs that reduce PICU time should find other ways for residents to get comfort with this patient population.

As an interprofessional organization, we strongly agree with IV.B.1.f).(3) and (4) –to require collaboration with interprofessional colleagues and community organizations. We believe that such collaboration should include the many professionals who care for children with child-onset disabilities. Collaboration with community organizations is important but we also believe that residents should also learn about and collaborate with key state and federal programs that serve children with child-onset disabilities, including but not limited to, Early Intervention, Title V programs, systems of special education, Supplemental Security Income, and Home and Community Based Services.

The health equity additions in IV.B.1.c).(5).(m) are positive, but should explicitly include anti-ableism, given the discrimination faced by children with disabilities and their families. We hope that an anti-ableist lens will be applied to the overall revision of the pediatric ACGME requirements and that ACGME will commit to ensuring that the pediatricians of the future are trained on the needs of children with child-onset disabilities in a manner that is proportionate to the needs of this population and their health systems impact.

Thank you for this opportunity to provide input. Children with childhood onset disabilities are amongst our most vulnerable citizens and they already face inequitable access to medical care.[3,4] The ability of pediatricians to be advocates for *all* children requires broad training and exposure, including training related to Developmental-Behavioral Pediatrics. We hope that the ACGME explores all options to ensure faculty support in the area of Developmental-Behavioral Pediatrics is maintained, particularly as the global agenda is increasingly focussed on equitable access to quality early childhood development care and education (UN 2030 Sustainable Development Goal 4.2).[5]

Please do not hesitate to contact us if you would like to collaborate further on these issues.

Sincerely,

Lesley Pritchard PT, PhD

2022-23 AACPDM President

On behalf of the AACPDM Board of Directors

References

1. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). 2019- 2020 National Survey of Children's Health (NSCH) data query.

2. Noritz G, Davidson L, Steingass K, et al; AAP Council on Children with Disabilities, the American Academy for Cerebral Palsy and Developmental Medicine. Providing a Primary Care Medical Home for Children and Youth with Cerebral Palsy. Pediatrics. 2022;150(6):e2022060055

   https://publications.aap.org/pediatrics/article/150/6/e2022060055/190094/Providing-a-Primary-Care-Medical-Home-for-Children

3. Jawed, A., Peck, C Navigating the broken road: A call to strengthen access, equity, and inclusivity in the care of children with developmental disabilities and neurobehavioral disorders. Health Promotion Perspectives. 2022;12(4): 345-349.

4. Prokup, JA, Andridge, R, Havercamp, SM, Yang, EA. Health Care Disparities of Ohioans With Developmental Disabilities Across the Lifespan. Annals of Family Medicine. 15(5):471-474.

5. UN General Assembly, Transforming our World: the 2030 Agenda for Sustainable Development, 21 October 2015, A/RES/70/1, available at: https://www.refworld.org/docid/57b6e3e44.html [accessed 5 April 2023]