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CEO'S COLUMN

REFLECTING ON THE PAST, CHARTING A PATH FORWARD

Felicia K. Taylor, MBA, CAE

Chief Executive Officer

New Jersey Chapter, American Academy of Pediatrics

Strategic Planning

The NJAAP Executive Council has begun conducting an environmental scan to better understand opportunities for expansion, sustainability and advocacy for pediatricians as well as to identify and address child health issues. A new strategic plan is on the horizon, one that will further shape our priorities and support you and the patients you serve. NJAAP is poised to reach new heights through a committed Executive Council and talented staff. Our goal is to remain relevant to practicing pediatricians and improve long-term health outcomes for your patients.

A Strategic Planning workgroup was formed to identify these priorities and make recommendations to the Executive Council in June 2024. The strategic planning process is critical to help us craft a roadmap for growth for the overall wellbeing of pediatricians, child health and the financial stability of the chapter. We need to hear from you first. NJAAP will issue a survey to help us learn how the chapter can further support you. We are committed to learning from your experiences, as a busy clinician, and your interactions with the New Jersey chapter. Please keep a close eye on your email for the 2024 member survey.

Coding and Billing Session Coming Soon

Please watch your email over the next few weeks for information about an upcoming webinar on best practices for coding and billing for pediatric visits. If you are experiencing payment denials, you may want to tune in to learn the latest at our introductory coding and billing webinar for pediatricians on May 13th. We would like to hear from you, the practicing pediatrician, to better understand your challenges. Your feedback will help us design the session to address the most common coding and billing issues in your practice. Feel free to share your feedback during the registration process.

NJAAP is moving to Plainsboro!

In July 2024, NJAAP will be moving its offices to 101 Morgan Lane, Plainsboro, NJ. The office move will further support our hybrid workstyle and will result in significant savings for the chapter. Work is underway to prepare the new office for the staff's arrival. Please watch for additional announcements about the move and information about where to send mail and other communications after July 1, 2024.

14th Annual Children's Ball

Please join us at The Palace in Somerset, NJ on Wednesday, May 8, 2024 to help us celebrate New Jersey's Champions for Child Health. We will honor the Pediatrician of the Year, Jeffrey Boscamp, MD, FAAP. Other honorees will include the Champions for Children: Karen Andrade-Mims, Judy Aschner, MD, FAAP, Susan Tellone, RN, BSN, CSN, MSN and Pamela Tew, LSW. The Youth Achievement Awards will be presented to the Youth NJ Consortium for Immigrant Children, Immigrant Youth Advocates, Avani Verma and Raghav Mahajan. We look forward to seeing you in person! Reserve your tickets today.

2024 Annual Conference & Exhibition

We hope you will join us for our Annual Conference & Exhibition on Tuesday, June 4, 2024 for a full day of learning and earn up to 7 MOC Part 2 points. Nurses can attend and earn CNEs. Attend our annual business meeting where you will receive updates on chapter programs and activities. Our program will include some of the best speakers in pediatrics throughout the state. Plenaries and workshops will include topics such as immunization updates, nutrition, gastrointestinal issues, diversity equity and inclusion, gynecology topics for adolescents, LGTBQ, mental health advocacy and more. Registration opens soon.

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MEDICAL DIRECTOR'S COLUMN

NEW JERSEY'S CONTINUED COMMITMENT TO CHILD MENTAL HEALTH

Steven Kairys, MD, MPH, FAAP

Founding Chair of Pediatrics, Hackensack Meridian School of Medicine

K. Hovnanian Children's Hospital, Jersey Shore, University Medical Center, Hackensack-Meridian Health

New Jersey should be applauded for its long-term commitment to child mental health. The Children's System of Care may be the country's most comprehensive program. Each county offers a variety of care management supports for children with serious mental health needs. Each county has a Family Support Organization that provides education, advocacy, and assistance to families. Mobile Response offers same-day in-home counseling support to families to stabilize and decrease family distress.

New Jersey Pediatric Psychiatry Collaborative

The most recent New Jersey budget includes continued full support for the New Jersey Pediatric Psychiatry Collaborative (NJPPC). This grant funding is a positive affirmation of the value of training pediatric providers in early identification and care management of children with mental health concerns.

The NJPPC continues to expand its services. A child developmentalist has recently been added to the NJPPC team to provide additional expertise in consulting with the NJPPC Hub Child and Adolescent Psychiatrists, on referrals made by pediatricians for mental health concerns which may have a developmental component. Dr. Denise Aloisio has been a child developmental pediatrician in New Jersey for more than twenty years.

Challenges continue. Pediatricians, despite listing mental health as a major crisis in their cohort of children, are still reluctant to use evidence-based screening and do not reach out to the NJPPC as often as would be expected. Having almost same-day access to a child and adolescent psychiatrist for curbside consults or to help care manage a child is a true gift. The child and adolescent psychiatrists who are part of the NJPPC have joined the system because they want to work with pediatricians, and they want to expand the fragile service system that exists.

NJAAP is an active partner in the NJPPC and continues to offer webinars, virtual learning collaborative series (recent offering include an ADHD boot camp and an Autism series), in-person CME dinner events, toolkits and other resources. The NJPPC continues to work on the policy side to increase reimbursements for screening and to provide better funding mechanisms for the time spent on care coordination and management. For more information on the NJPPC or to register, please visit the NJPPC website here or contact the Mental Health Collaborative team at NJAAP at mhc@njaap.org.

New Jersey Statewide Student Support Services

Most recently, NJ Statewide Student Support Services (NJ4S) offers regional hubs to work with school districts and provide educational and direct counseling support to schools requesting such services. Prevention efforts, especially focused on suicide prevention, are spreading throughout the state. Click here for more information on the NJ4S project and click here for a summary and FAQ.

New Jersey Screening, Brief Intervention and Referral to Treatment (SBIRT) Program

There are also new grant funded programs focused on addressing substance use, misuse and dependence. The NJ Department of Children and Families has provided grant dollars to NJAAP to launch a new program that will provide education to pediatric clinicians in primary and specialty care, community-based clinicians, school physicians, school nurses, and other school-based mental health service providers about the early detection and management of adolescents with substance use concerns. The program centers around training providers to implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) model, using a trauma informed approach to screen effectively for substance use/misuse, provide immediate counseling about concerning substance use, and explore motivation for behavioral change when appropriate.

The NJ SBIRT program will be hosting three regional educational dinners to share about the SBIRT model and recruit pediatric clinicians in primary and specialty care and community-based clinicians to join the Project ECHO program scheduled to begin in the fall. Community partners are also invited to encourage connection to resources. For more information about NJ SBIRT please visit the website here or contact Aldina Hovde at ahovde@njaap.org.

#1 CHILDREN'S HOSPITALS IN NEW JERSEY.

THREE YEARS IN A ROW.

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT CANCER 2023-2024

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT NEPHROLOGY 2023-2024

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT NEUROLOGY & NEUROSURGERY 2023-2024

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT UROLOGY 2023-2024

For the third year in a row, we're thrilled to announce that **Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center** and **K. Hovnanian Children's Hospital at Jersey Shore University Medical Center** have been ranked by *U.S. News & World Report* as the #1 children's hospitals in New Jersey. We're also honored to receive national recognition in Pediatric Cancer, Urology, Nephrology, and Neurology & Neurosurgery – the most ranked specialties ever for a New Jersey children's hospital. It's proof that at Hackensack Meridian Children's Health, we're ready with the expert, compassionate care kids need.

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BRIEF

LEVERAGING A VIRTUAL PLATFORM TO IMPROVE ADVOCACY EDUCATION IN NEW JERSEY: THE "NJPRAC MORNING REPORT"

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c. Rutgers - New Jersey Medical School
d. Rutgers - Robert Wood Johnson Medical School

Introduction

The New Jersey Pediatric Residency Advocacy Collaborative (NJPRAC) includes all nine pediatric residency programs in the state, with faculty and resident champions from each program. The nine residency programs vary in size and are in multiple regions across the state (see Figure 1 and Table 1). The regions served represent both suburban and urban environments and contain diverse demographics of patients. By collaborating amongst our programs, we gain access to experience with these diverse patient populations and can leverage the expertise of faculty across programs. Virtual meetings have been found to be an effective platform for residency educational activities during the COVID-19 pandemic [1, 2]; beyond the pandemic, continued use of this method of communication can allow us to connect multiple residency programs and provide educational activities without geographical limitations.

Education focused on advocacy and social determinants of health (SDOH) is a vital part of pediatric residency education. Knowledge of SDOH is particularly important for pediatricians as exposure to these factors in childhood has been found to put patients at higher risk of poorer health outcomes. [3] Many resident continuity clinics screen for common SDOH [4], and residents should be trained to address these factors. Moreover, there is a correlation between having received residency training in advocacy and participation in post-residency advocacy activities [5]; therefore, it is crucial that we engage trainees in education to foster advocacy work at the start of their career.

Recognizing the value of training residents in pediatric advocacy and the effectiveness of virtual educational platforms, we developed the "NJPRAC Morning Report," a virtual advocacy education program for pediatric residents throughout New Jersey. While it is conducted as a traditional "Morning Report" with a case presentation, the focus is on the social drivers affecting the patient's health, as opposed to the clinical aspects. While Boston Medical Center was a pioneer in developing this format entitled the "Health Equity Morning Report," the "NJPRAC Morning Report" is unique in that the audience consists of learners from all pediatric residency programs in New Jersey. Throughout the case presentation, community resources and legislative issues are discussed. Additionally, residents are encouraged to invite

Figure 1: Map of the Nine NJ Pediatric Residency Programs

Table 1: Program Sizes and Region Type

Program	Location	Type of Region	Program Size
Cooper University Hospital	Camden, NJ	Urban	29
Goryeb Children's Hospital/Atlantic Health	Morristown, NJ	Suburban	36
St. Joseph's Medical Center	Paterson, NJ	Urban	36
Newark Beth Israel Medical Center	Newark, NY	Urban	32
Saint Peter's University Hospital	New Brunswick, NJ	Suburban	24
Jersey Shore University Hospital	Neptune, NJ	Suburban	28
Monmouth Medical Center	Long Branch, NJ	Suburban	16
Rutgers Robert Wood Johnson Medical School	New Brunswick, NJ	Suburban	33
Hackensack University Medical Center	Hackensack, NJ	Urban	25

representatives from community-based organizations and allied professionals to lend their expertise from a multi-disciplinary perspective. NJPRAC leadership helps to facilitate invited speakers as well.

The objective of this study is to evaluate the effectiveness of the virtual morning report format as well as the benefit of multidisciplinary participation for educating pediatric trainees and other learners in advocacy, community health, and addressing SDOH.

Methods

The inaugural "NJPRAC Morning Report" was launched in November 2021. Three morning report conferences were conducted as part of the pilot series. NJPRAC residency programs volunteered to present cases over a Zoom platform to allow trainees from throughout New Jersey to attend. The topics of the pilot conferences included: immigrant health, maternal depression, and care of a newborn of a parent with hearing impairment.

Prior to each resident presentation, NJPRAC faculty leads distribute guidelines for presentation and review and discuss the cases and resources with the presenter. To expand knowledge of the topic on a systems-wide level, it is suggested to include a review of both the medical and mainstream literature. After the initial presentation of the case scenario, the resident presenter will facilitate interactive discussion by encouraging conference attendees to:

1. Generate a list or "differential" of the SDOH affecting the patient in the case.
2. Develop a "treatment plan" for the patient's social needs that includes identification of community resources applicable to the patient.
3. Address questions raised by the presenters at the conclusion of their case presentation.

Evaluation data from those in attendance at the pilot morning report conferences was collected using an anonymous survey via Survey Monkey. This survey asked attendees to evaluate the effectiveness of the format for advocacy education, the interactivity of the sessions, the value of inviting representatives from community-based organizations and allied professional experts in the field to lend their expertise to the discussion, and the impact of the conferences on their clinical practice. Respondents were also asked to rate their comfort in addressing SDOH both before and after attending the conference series. These were assessed using a "Likert scale" (from 1 point assigned for "strongly disagree" to 5 points assigned for "strongly agree").

Results

Approximately 50 unique Zoom users attended each of the three pilot programs of the "NJPRAC Morning Report". These attendees included faculty, residents, and students, and multiple attendees from the same residency program joined on one Zoom account in some cases. Data was not obtained on the precise number and role of attendees. Survey data evaluating the pilot morning report series was collected from 40 respondents. The roles of respondents are shown in Table 2.

Table 2: Roles of survey respondents.

Role	Number of Respondents
PGY-1 Pediatric Resident	8
PGY-2 Pediatric Resident	13
PGY-3 Pediatric Resident	11
PGY-4 Pediatric Resident	1
Non-Pediatric Resident	1
Pediatric Subspecialty Faculty	1
General Pediatric Faculty	3
Medical Student	1
Not answered	1

Evaluation data showed a significant overall improvement in the comfort of resident attendees in addressing SDOH (Table 3). The average "Likert score" of respondents before attending the morning report series was 3.38; after attending, it was 3.95. Using a two-tailed t-test, this was found to be statistically significant ($p = 0.0005$).

Table 3: Comfort addressing SDOH before and after morning report attendance.

Response	# Before	# After
Strongly Disagree (1)	1	0
Disagree (2)	4	0
Neutral (3)	16	7
Agree (4)	17	28
Strongly Agree (5)	2	5
Mean Score	3.38	3.95
Standard Deviation	0.84	0.55
Standard Error of the Mean	0.13	0.09

Responses to the overall interactivity, effectiveness of the format, and benefit of having community partners and interdisciplinary experts participate in the morning reports are shown in Figures 2-4 below. Overall, 85% strongly agreed or agreed that morning report format is effective for SDOH education, 78% strongly agreed or agreed that the sessions were interactive, and 90% strongly agreed or agreed that participation of community partners was beneficial to their education. The survey was updated to evaluate whether respondents believed that the morning report series would impact their clinical practice (Figure 5), and 28 responses were collected to this question; of those who responded, 85% strongly agree or agreed that the sessions would impact their clinical practice.

Figures 2-4:

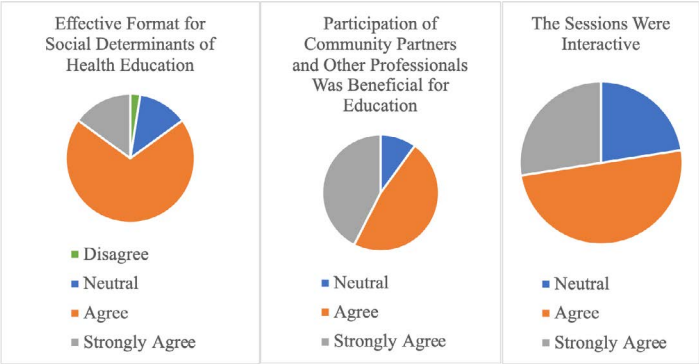

Figure 5:

Discussion

The "NJPRAC Morning Report" leverages the advocacy experiences and expertise of residency programs across the state. This conference is distinct in that it combines multiple pediatric residency programs, community-based organizations, and allied professionals to create an interactive case-based conference focusing on the social aspects of patient care. Based on the results of survey data, the series appeared to have a positive impact on respondents with the vast majority strongly agreeing or agreeing that the format is effective for education on social determinants of health, the sessions are interactive, the participation of community-based organizations is beneficial for education, and the series will impact their clinical practice. There was a statistically significant improvement in respondents' comfort in addressing SDOH after attending the morning report series.

Limitations of the study include the presence of both observer and response bias. We acknowledge that the survey data was analyzed by the same team who developed the "NJPRAC Morning Report" which may result in a more positive interpretation of the results. The outcomes of the study are derived from survey data which has an inherent response bias. A more effective measure of the educational effectiveness would be to look at the outcomes of attendees, such as increased patient referrals to community organizations and engagement in advocacy activities. Furthermore, survey data was not collected from all attendees, which limits the generalizability of the results.

Several hurdles were encountered during the initial pilot series. Residency programs have conflicting didactic schedules which makes having all nine programs in attendance particularly challenging. Initially, the presenting program would choose the timing of the conference; however, this would limit attendance of other programs. As a result, we established a more consistent schedule that allows more programs to attend the "NJPRAC Morning Report". Additionally, it is often difficult for residents to identify and acquire interdisciplinary speakers; therefore, NJPRAC leads employ our network of connections to assist residents in recruitment. We have found the attendance of interdisciplinary speakers lends itself to enriching the discussion.

After the initial three conference pilots, the series has continued into the academic year (2023-2024), giving trainees the opportunity to learn more about the intersection of clinical case presentations, SDOH, and pediatric advocacy. The series has been reorganized to address the five main domains of SDOH: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Presenters are asked to select a SDOH domain most relevant to their medical institution, clinical environment, community partnerships, and faculty expertise. Through this shared platform, NJPRAC trainees can benefit from the collective resources that they may not have access to from their home program. The following topics have since been presented: childhood nutrition, early childhood health, special education, limitations of Medicaid coverage across state lines, and developing projects for CATCH Advocacy Grants.

Conclusion

Leveraging relationships formed through a statewide collaborative along with a virtual platform allows a shared resource model across residency programs, bringing together experts across disciplines and professions. This novel educational approach uses a health equity lens to address an individual patient's needs, while identifying community partners and amplifying statewide advocacy legislative issues. Moving forward, we plan to evaluate more longitudinal changes to participants' clinical practice and participation in advocacy activities after attending the "NJPRAC Morning Report". This will address gaps in the current literature on how providing SDOH education to pediatric physicians can impact clinical practice and healthcare outcomes.

Acknowledgements: We would like to acknowledge all residents and faculty across the state who have participated in the NJPRAC Morning Report since its inception in 2021.

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IMPACT OF THE TWIN EXPERIENCE ON CHILD DEVELOPMENT

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Highlights

- Twins experience unique biological and social conditions that are often overlooked in the classical twin study design and throughout life.
- Twins' shared developmental environment is associated with twin-specific patterns.
- Autonomous language production and the "twinning effect" of early language delay are well documented communicative sequelae of twinning.
- Global neurodevelopmental delays in twins are associated with confounders such as prematurity and low birth weight, rather than the twin experience.
- Psychosocial sequelae of internal and external deindividualization are driven by the "couples effect" of twins identifying and being treated as a unit.
- The unique twin condition should be considered an independent variable which should be factored into the research, treatment, and upbringing of this population.

Keywords: Twins, Multiples, Twin experience, Child development

Introduction

Twin studies are traditionally utilized to determine the relative contributions of heredity and environment by an external variable. However, twins experience a unique set of biological and social conditions that are often overlooked in the classical twin study design, which poses twins as singletons' equal controls, and throughout life, as twins navigate unique dynamics within a world designed for singletons; rarely do such studies shift focus to the twins themselves. Historically, Day first described a "twinning effect" of early language delay, and Zazzo first recognized a "couples effect" of deindividualization that is both internalized and imposed, but modern updates are scarce despite recent increases in the twin population. [1-3] This narrative review synthesizes recent literature on the impact of the twin experience on child development, focusing on communicative, global neurodevelopmental, and psychosocial effects.

Methods

A review of recent and historical literature was conducted through PubMed. With the exception of studies chosen for historical impact, primary studies within the past 10 years were emphasized to prioritize recent findings despite limited studies existing on this topic, as most twin studies use twins to evaluate other variables rather than comparing twins to singletons with twinship as the independent variable. In study analysis, findings were synthesized by subtopic – communicative impact, neurodevelopmental impact, and psychosocial impact – given large variability in appropriate studies.

Results

Recent studies have consistently confirmed the "twinning effect", or pattern of early language delay in twins, but reevaluated its etiology and persistence. Early differences are most frequently attributed to limited parental resources and attention and to the constant presence of an immature linguistic role model. [4-7] To further distinguish the role of environmental factors, a recent cross-sectional study assessed skills in both native language and a foreign language learned in school. [8] Singletons only outperformed twins in native language skills, but not significantly for foreign language, emphasizing the association between language delay and discrepant early childhood experiences, rather than innate deficits. Autonomous language development is also commonly cited more frequently in twins than singletons, but as a reflection of shared immature language rather than a direct cause of language delay. [9] Overall, in contrast to Day's initial study where language discrepancies increased over time, most modern studies focusing on language development found that the twin-singleton difference is reduced or resolved by school age, and twins ultimately achieve language skills in the normal range (Figure 1). [5-7] Recurrence of a discrepancy between age 7 and adolescence was only found in developing countries, attributed to inequitable resources and educational systems exaggerated by the increased demand of twins. [4, 10]

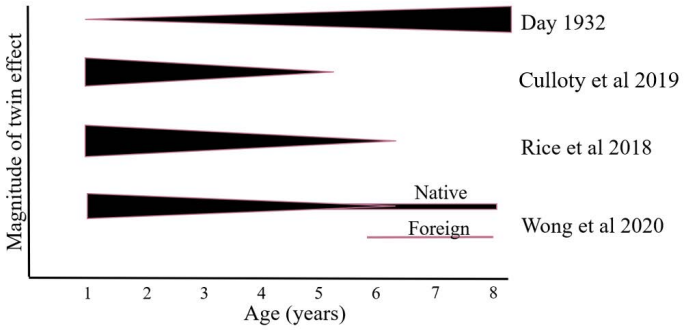

Figure 1. Persistence of the twinning effect in developed countries

Most other studies assessing twins' neurodevelopment emphasize secondary factors rather than the postnatal twin experience; these factors include gestational age, birth weight, maternal age, chorionicity, gender, birth order, discordance, assisted reproductive methods, APGAR scores, prenatal complications, maternal education, and socioeconomic status. [11] Among these, prematurity and very low birth weight are consistently most influential, as highlighted by recent studies comparing twins and singletons' development while controlling for these factors; no global differences were present in this context. [12-14] On sub-analysis, discrepancies existed only in

locomotor skills, personal-social development, externalizing behaviors, and verbal IQ, consistent with twins' decreased individual attention, hyperstimulation, and the "twinning effect". Given trends of increased maternal age and lower Apgar scores in twins, other studies have evaluated these factors, finding developmental progression negatively correlated with maternal age but positively associated with Apgar scores. [15] Another risk unique to twins is discordance, or >20% discrepancy in birthweight between twins, which was associated with higher rates of long term adverse neurodevelopmental outcomes for both twins in a discordant pair relative to concordant twins, with excess risk comparable for both the larger and the smaller of each discordant pair. [16] Overall twins have higher rates of shared risk factors and unique risks relative to singletons, but controlling for such effects reveals that twin-singleton differences in global development are largely attributable to these variables rather than the postnatal twin experience.

Psychosocial effects are best captured by the "couples effect", or twins being treated as a unit. This pattern was first linked with sequelae including delayed construction of the self-image, lower verbal IQ and marriage rates, improved conflict resolution skills, and higher introversion scores. [2] More dangerous consequences were demonstrated in a retrospective cohort study of infants in the NICU, in which multiples experienced higher rates of wrong orders, with the excess risk attributable to intrafamilial wrong orders. [17] Later twins perpetually face deindividualization in school, with the ongoing question of whether to school together or separately. No consistent difference has been found in overall educational outcomes, but twins' performances were more similar when educated together, with this effect magnified in monozygotic relative to dizygotic twins, reinforcing the impact of ongoing coupling. [18, 19]

Discussion

The communicative associations with twinship – language delay and autonomous language production – are logically connected to the incessant presence of a similarly immature counterpart, providing twins with increased stimulation and interaction, but reinforcing an imperfect version of language. [4, 5] Fortunately, although recent evidence still demonstrates an early twinning effect and the specific age by which twins catch up is inconsistent, they ultimately reach comparable outcomes to singletons by school age in developed countries (Figure 1). While global neurodevelopment is largely comparable when controlled for confounders, especially prematurity, smaller effects in language, personal-social, and motor development all relate to twins' decreased individual attention and increased co-twin stimulation. Psychosocial effects are most intuitive but harder to quantify, as always being half of a twin unit is inextricably tied to a twin's identity, personality, and both co-twin and outside relationships.

These findings should be incorporated into screening, anticipatory guidance, and further research for twins. Because the twin population has higher rates of prematurity, increased maternal age, and low birth weight, and unique risks such as discordance, each individual twin should be risk stratified in assessing development. Overall, language screening should be heightened, although with reassurance of good outcomes. Counseling should also emphasize individualization and mature language modeling to balance the inherent closeness between co-twins and the risk of ongoing discrepancies in resource-limited settings. Lastly, it should be recognized that the twin population is quite heterogeneous. Therefore, future research should target subsets of twins, including monozygotic compared to dizygotic twins and same-sex compared to opposite-sex dizygotic twins; other family dynamics, including increased familial stress and shared resources; and changes in the twin population over time, especially its association with reproductive technology. [3, 20]

Conclusions

As hypothesized, the unique shared twin environment bears communicative and psychosocial effects due to frequent exposure to an immature role model and deindividualization. However, global neurodevelopmental discrepancies in twins are largely attributable to secondary factors. Although twins' early delays eventually trend toward normalcy, the unique twin condition should be considered an independent variable incorporated into twin-specific assessment, counseling, and upbringing. Overall, relatively little research focuses on twins themselves, and future investigations may explore subsets within the twin population and other associations and implications with twinning.

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BRIEF

PNEUMOCOCCAL VACCINES: AVAILABLE PRODUCTS AND RESULTING UPDATES TO THE RECOMMENDED IMMUNIZATION SCHEDULE

Sanjna Shah, MD, FAAP
Secretary/Editor
NJAAP

While pediatricians have been administering pneumococcal vaccines since the 1980s, there have been several iterations of available products and resulting updates to the recommended immunization schedule. The Centers for Disease Control and Prevention (CDC) most recently changed vaccination guidance in June 2023, based on the three Food and Drug Administration (FDA)-approved vaccines that are currently available in the United States for use in children.

FDA Approved Vaccines

The FDA approved PCV20 (Prevnar 20, Wyeth/Pfizer) in 2023 for routine immunization in children ages 2-24 months but is approved as young as 6 weeks of age. This vaccine is available in addition to PCV15 (Vaxneuvance, Merck), first FDA-approved in 2021. In 2022, PCV15 was recommended for routine immunization in children ages 2-23 months and children ages 6-18 years with risk conditions who had not yet been immunized with PCV13, PCV15, or PCV20. Pediatricians are likely most familiar with PPSV23 (Pneumovax, Merck), which has been FDA-approved since 1983 and recommended for children ages 24 months and older who are at increased risk of pneumococcal disease.

PCV15 or PCV20 for Routine Administration and Catch Up Vaccination

The CDC recommends routine administration of PCV15 or PCV20 to all children younger than 5 years of age as a 4-dose series at ages 2 months, 4 months, 6 months, and once between 12-15 months. PCV15 and PCV20 can both be used for catch-up vaccinations. Catch-up guidance can be found on the CDC website.

Unvaccinated, Under-Vaccinated, Risk Conditions and Other Considerations

Children between the ages of 2-4 years without risk factors who are unvaccinated or received an incomplete PCV series require just one dose of PCV15 or PCV20 to be considered fully vaccinated. However, children with risk conditions have different needs. If a child is unvaccinated or under-vaccinated (less than 3 doses before age 2 years), then these children need two doses of PCV15 or PCV20 at least 8 weeks apart. If they do not receive PCV20 as one of these vaccines, then they should receive at least 1 dose of either PCV20 or PPSV23 at least 8 weeks after their last PCV dose. As additional nuances are to be considered based on the age of the child and whether they have any risk conditions, the CDC has endorsed the app PneumoRecs VaxAdvisor (also available at https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html). This clinical decision-making tool is based on current pneumococcal vaccinations recommendations and can help clinicians in the office customize vaccine recommendations specific to their patient based on age, pneumococcal vaccination history and medical conditions.

High Risk Conditions for Children 2-5 Years Old

- Cerebrospinal fluid leak
- Chronic heart disease (including cyanotic congenital heart disease and cardiac failure)
- Moderate persistent and severe persistent asthma
- Chronic liver disease
- Chronic kidney disease
- Cochlear Implant
- Diabetes mellitus
- Immunocompromising conditions (such as nephrotic syndrome, renal failure requiring dialysis, asplenia or splenic dysfunction, congenital or acquired immunodeficiencies)
- Diseases or conditions treated with immunosuppressive drugs or radiation therapy (including generalized malignancy, Hodgkin disease, leukemia, lymphoma, multiple myeloma, and solid organ transplant)
- HIV infection
- Hemoglobinopathies (such as sickle cell disease)

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NEW JERSEY VACCINES FOR CHILDREN

NEWS FROM THE NEW JERSEY VACCINES FOR CHILDREN PROGRAM

Taylor Crosby, NJ Department of Health

Every year, the Centers for Disease Control and Prevention (CDC) requires providers participating in the Vaccines for Children (VFC) program to re-enroll in the program. The New Jersey Vaccines for Children program (NJVFC) would like to extend gratitude and thanks to all NJVFC providers for completing provider re-enrollment. NJVFC has new initiatives to help disseminate knowledge of the VFC program, increase access to the program and VFC providers, and expand community collaboration to improve vaccination knowledge and vaccination rates amongst children.

NJVFC providers serve as critical players in the success of increasing immunization coverage rates and reducing the incidence of vaccine-preventable diseases. NJVFC has launched an initiative to better support VFC providers through in-person and virtual training opportunities, updating program guidance materials, and hosting VFC office hours to answer provider questions or address concerns to better meet the needs of providers.

These targeted initiatives aim to improve the programmatic support offered to current providers and encourage new provider sites to enroll in VFC. Below are examples of these initiatives launched by VFC.

- **Program Initiatives: (Matchmaking)**

  With every new VFC provider, a child has increased access to lifesaving vaccines. Our program has also been working with the New Jersey Office of Primary Care and Rural Health to identify gaps in community coverage rates and bridging those gaps by linking VFC providers and community stakeholders through our matchmaking initiative. If you are interested in participating in the matchmaking program, please contact vaxmatch@doh.nj.gov

- **Program Guidance Documents: (NJ VFC Provider Manual, Vaccine Management Plan, TEVA)**

  NJVFC has published a variety of program documents on the New Jersey Immunization Information System (NJIIS) website including the New Jersey VFC/317 Provider manual, the Vaccine Management Plan template, and the Temperature Excursion Viability Assessment Worksheet (TEVA). These documents have been updated to reflect the current CDC requirements and information.

- **New Provider Enrollment**

  NJVFC is also excited to announce the New Provider Enrollment process is now completely online! For additional information on enrolling as a provider in the New Jersey Vaccines for Children program, please email vfc@doh.nj.gov. It is important that all providers who see Medicaid-enrolled children for well-child visits participate in the VFC Program and have access to VFC vaccines for the children in their practice.

- **NJVFC Office Bi-Weekly Hours: New Jersey Department of Health Vaccinator Call**

  Please join us every other Monday for the 1 pm Vaccinator Call. During the call, our team shares updates, reminders and announcements, and answer provider questions in real time. If you would like to receive the Teams call information, please email vax.operations@doh.nj.gov

Our goal as a program is to continue to work towards a provider-focused program to support providers in efforts to improve vaccination rates.

THE CONUNDRUMS OF CREDENTIALING

Naveen Mehrotra, MD, MPH
Board Certified in Pediatrics
My Whole Child Pediatrics

The amount of paperwork and time required to credential new providers or to enroll in new insurance networks can be a daunting task for many of us. The questions to answer, the forms to complete, and the required licenses and documents become difficult to manage. However, it is necessary if we want to ensure that our providers are credentialed with various insurances and if we want to get paid for our work.

There are companies that can do the credentialing work for you, but that can quickly become a financial burden. Many insurances have turned to online credentialing where everything must be uploaded electronically. One central location to use is the online portal CAQH. This portal allows a provider to upload all their key documents and demographic information in one place and requires it to be updated on a regular basis, so the information stays current.

To credential a new provider, take the following steps:

1. Ensure the provider's CAQH profile is up to date.
2. Ensure the key documents for the provider like Drug Enforcement Administration (DEA) and Controlled Dangerous Substances (CDS) certificates, medical license, malpractice, resume, and the insurance company contract are current.
3. Ask the insurance company about their protocol to credential a provider. Some have a paper application while others have an online option either through the insurance company portal or another online portal like Availity, Navinet, etc.
4. Set aside a dedicated time to complete the application in one session, as some online portals may not allow you to save your work; if you leave the portal while your application is incomplete, you may have to start over.
5. Ensure that the application is signed in all the required fields.
6. Submit the application and make sure you receive confirmation of the submission as you will need it to track the application. Make a copy of the application if possible.

Most insurance companies require a minimum of 30 days to 90 days to get the provider credentialed. If you do not have proof of submission, you will not be able to follow through. Keep your eyes open for any communication where the insurance company may need clarification on what you entered on the application or additional documents. If you are not able to get updates, make sure you reach out to the credentialing department or even your provider representative who can guide you on the next steps. As always, if you are not able to get a resolution, do submit an NJAAP Hassle Factor Form!

Please complete this Hassle Factor Form to report insurance administrative and claims processing concerns. The information provided will assist in identifying trends and facilitating public and private sector advocacy.

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LEGAL UPDATE

PAYORS IN NEW JERSEY FOCUSING AUDITS ON HEARING TESTS

Guillermo J. Beades, Esq.
Partner, Frier Levitt LLC
General Counsel to NJAAP

Payors in New Jersey have been initiating pre-payment reviews and post payment audits on pediatric practices that bill Current Procedural Terminology (CPT) code 92587 (distortion product evoked otoacoustic emissions) with increased frequency. Insurance companies are concerned that this code may be overused, leading them to scrutinize its usage more closely.

When auditing a practice, payors want to see detailed documentation supporting the need for this specific test, as it is not supposed to be used as a screening test, but rather a problem-focused one. Many times, auditors at insurance companies will look to see if there are specific concerns over the child's hearing, such as a parent's concern or a school's request for a hearing test. The reasoning for the testing must include the concerns for the testing to not be considered a "routine screening" by insurance company auditors.

To navigate this increased focus and avoid potential claim denials or audits, there are some important steps pediatricians in New Jersey should take:

- **Understanding Documentation Requirements**

  Pursuant to the CPT manual, the procedure involves testing 3 to 11 discrete frequencies (i.e., 3-11 frequencies per ear) in both the right and left ears. The interpretation cannot merely be a "pass/fail" but, instead, must clearly document the ear and frequency-specific test results. If the testing results are only documented in a pass/fail manner, the code will be denied, and a recoupment will be initiated. When a payor asks for proof of an "interpretation and report", pediatricians must include the interpretation of the test results in the patient's medical record. A printout from the equipment used, standing on its own, is not considered a report.

  Many times, payors will provide a credit for providing hearing testing, but will reduce it to CPT 92558 when the documentation suggests that the provider relies only on the equipment determining the pass/fail response, without further clinical assessment and/or interpretation.

- **Proactive Corrective Action**

  A silver lining in the audit clouds is that many payors in New Jersey are using pre-payment reviews rather than the standard post payment audits. For pre-payment reviews, the focus is on current documentation, not what was documented years ago. This means that a practice can become fully compliant today, and if audited later this year, the auditors will assume the current documentation reflects how the practice has documented historically.

  To ensure proper reimbursement and avoid potential headaches with insurance audits, pediatricians should proactively review their hearing testing practices and implement a Corrective Action Plan ("CAP") if necessary. This proactive approach can mitigate risks. A CAP can be established to address any inconsistencies, such as ensuring documentation adequately justifies the medical necessity of hearing testing. This focus on accurate coding and documentation strengthens a pediatrician's position during an audit and minimizes the risk of reimbursement denials or penalties.

By taking these proactive steps, pediatricians in New Jersey can navigate the increased scrutiny around hearing testing, ensuring they can continue providing these essential services to their patients while minimizing the risk of claim denials or audits.

LEGISLATIVE UPDATE

PUBLIC STRATEGIES IMPACT

Tracie DeSarno

As reported in the Winter 2023-2024 issue of NJ Pediatrics, the 221st Legislature was sworn in on January 9, 2024. While Senate committees remained virtually the same with the addition of new members on committees, there was substantial change in the Assembly Committee structure, including the formation of a new committee, Children, Families and Food Security. The new Chair of this Committee is Assemblywoman Shama Haider from Bergen County, the Vice-Chair is Assemblyman William Spearman from Camden County, and the members are Assemblywomen Alixon Collazos-Gill from Essex County, Aura Dunn from Morris County, Verlina Reynolds-Jackson from Mercer County and Assemblyman Paul Kanitra from Ocean County. This Committee, along with the Health Committees in both houses, will consider legislation important to pediatricians and the children they serve.

As is generally the case when a new Legislature is sworn in, the first month or two is spent organizing the new committees and holding introductory meetings. However, even with the slow start, NJ Chapter, the American Academy of Pediatrics (NJAAP) has already indicated support for important legislation that was considered by the Senate Health, Human Services and Senior Citizens Committee. These policies include S2504, which requires the Medicaid reimbursement rates for primary care and mental health services to match the reimbursement rate for those services under Medicare, and S1188/S1970, which lowers the age at which a minor can consent to behavioral health care treatment from 16 years of age or older to 14 years of age or older.

NJAAP's leadership and members of the Government Affairs Committee have been meeting with legislators on other important pieces of legislation:

- We met with Speaker Coughlin to indicate NJAAP's support for A1899, legislation introduced by Health Committee Chairman Conaway, that will permit a pharmacist, pharmacy intern, pharmacy extern, or pharmacy technician to administer only flu and COVID-19 vaccines to patients five years of age or older. At that meeting we stressed to the Speaker that all other childhood vaccines must be given in the medical home.
- We are meeting with new members of the Education Committee to indicate NJAAP's strong support for A3116/S2012, legislation requiring that in order to receive any State aid pursuant to the "School Funding Reform Act of 2008" or any other law, a school district, charter school, renaissance school project, county vocational school district, or county special services school district that includes grades 9 through 12 will be required to begin regular instruction for high school students no earlier than 8:30 AM. We were pleased that Speaker Coughlin and Senate Education Chairman Gopal re-introduced this legislation and are working to secure the support they need to move it forward.
- Finally, we were pleased that Governor Murphy's proposed budget funds the New Jersey Pediatric Psychiatry Collaborative (NJPPC) at its current level of $12.85 million. The NJPPC has long been a top budget priority for NJAAP, and we will work through the budget process to ensure that this funding remains intact.

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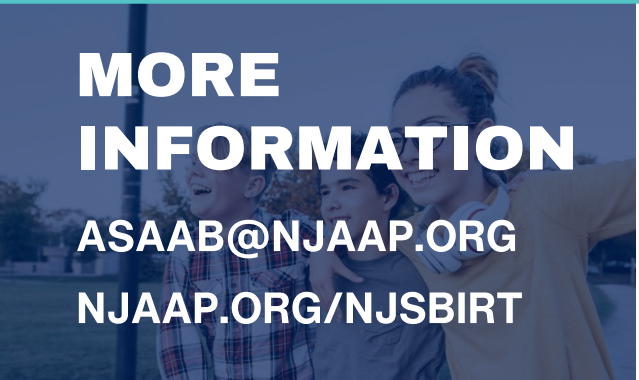

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RESIDENT VOICE

THE IMPORTANCE OF ATTENDING SPECIALTY CONFERENCES

Patricia Hoffman, DO
Pediatric Resident, PGY-3
Rutgers Robert Wood Johnson Medical School

National conferences are wonderful opportunities for residents to learn more about recent specialty advancements, improve their foundational knowledge, present their research, and network with their colleagues. Pediatrics has both an annual national conference and multiple subspecialty conferences.

I am a current third-year pediatric resident, and I will be starting my Pediatric Rheumatology fellowship following graduation in June 2024. I had both a personal (patient) experience and early career exposure that influenced my training and career interest in Pediatric Rheumatology. Given this early decision, I sought out opportunities to become more involved in Pediatric Rheumatology under the guidance of my residency's Pediatric Rheumatology attending mentors. One of the most beneficial opportunities I experienced was attending The American College of Rheumatology (ACR) Convergence for three years, as a resident. This national conference provides information for providers who take care of both adult and pediatric patients with rheumatic diseases, and it gave me different perspectives as I advanced each year in my training.

As a first-year resident attendee, I participated in a program for residents interested in learning more about Pediatric Rheumatology. This was a virtual conference due to the COVID-19 pandemic. I enjoyed being introduced to the field and learned about upcoming research advancements. I saw different career pathways that could be pursued as a pediatric rheumatologist. After attending this conference, I applied the knowledge gained to my first Pediatric Rheumatology rotation.

As a second-year resident attendee, I went to my first in-person conference and planned my second Pediatric Rheumatology rotation around this event. I met with other Pediatric Rheumatology fellows and attendings with whom I collaborated earlier in the year, which emphasized the close-knit community of Pediatric Rheumatology. I continued learning about the upcoming research advancements, and I had a better understanding of the presented information because of my Pediatric Rheumatology rotations. I started to build upon my knowledge since one of the speakers discussed a rare disease called Castleman's Disease, which I did not know previously. This prompted me to purchase the recommended book that discussed the disease in-depth and broadened my differential diagnoses for Pediatric Rheumatology.

As a third-year resident attendee, I presented a poster under the guidance of my Pediatric Rheumatology attending mentor based on research I started as a first-year resident. I had a new experience of receiving questions from other members of the profession during the presentation and having thoughtful discussions and suggestions for future projects. I continued to meet with new Pediatric Rheumatology fellows and attendings and learned about their subspecialty interests.

Across all three years of attending, and later presenting, at the ACR Convergence, I came away with different perspectives that enhanced my training as a pediatric resident and a future pediatric rheumatologist. The first year was exploratory and solidified my anticipated career decision. The second year was foundation-building and reinforced the close-knit community and my interest in the specialty. The third year centered on preparation for my fellowship and allowed me to present my scholarly activity and contribute to Pediatric Rheumatology.

I encourage other pediatric residents to work with their programs and attend conferences in both pediatrics and pediatric subspecialties as it leads to newfound confidence, enthusiasm, and knowledge. I am extremely thankful for my mentors at Rutgers Robert Wood Johnson Medical School who have helped me with both my clinical and research pursuits as a pediatric resident. I am looking forward to starting my Pediatric Rheumatology fellowship in July!

FAMILY VOICE

MORE CHILDREN ARE EXPERIENCING SCHOOL AVOIDANCE: WHAT CAN PEDIATRICIANS DO?

Lauren Agoratus, M.A.

Pediatricians can help their young patients recover from school avoidance, and school-related anxiety.

Please note that the terminology of school avoidance is preferable to school refusal.

> **'This is a crisis,' and COVID made school avoidance worse**
> **- USA Today**

What do the numbers say?

Typically, school avoidance affects 1-15% of children; but now some data shows it is as high as 28%.[1] School avoidance has become such a prevalent issue that there is now a national School Avoidance Alliance (see Resources).

Why is this happening?

The pandemic increased anxiety in children and, subsequently, school avoidance. According to the NJ Department of Education School Performance Report, some contributing factors include a rise in bullying and violence in schools. The report also noted that due to chronic absenteeism, some children are missing 10% or more school days.[2] According to the School Avoidance Alliance, there are 4 key reasons for school avoidance:

- To stay away from certain situations at school
- School-related performance
- Attention seeking
- Rewards of staying home (comfort)

Why is this concerning?

Along with the negative impacts on academic performance and socialization, children with school avoidance may end up with truancy issues or involvement with the juvenile justice system.[3] These consequences can increase anxiety in children, leading to more absenteeism and additional repercussions.

What can help kids get back in school?

School climate is key. The Center for Parent Information and Resources has multiple resources on school climate. This is comprised of fair discipline polices, anti-bullying measures and the use of positive behavioral interventions and supports (PBIS). PBIS is proactive, rather than reactive. Topics include bullying, equity, juvenile justice, and mental health. For the individual child, therapies such as exposure therapy, cognitive behavioral therapy, and dialectical behavioral therapy have proven successful according to the School Avoidance Alliance. The School Avoidance Alliance has a rating scale available to measure the severity and causes of school avoidance in children. There are also tools and courses for families and educators wh ich include school avoidance introduction, Individualized Education Plans, therapies, truancy, and prevention. Finally, there is a family guide "For School Avoidance Families: The Ultimate Guide to Working with Your School".

Pediatricians can help connect families to the tools, therapies, and resources that will help them get their child back in school.

REFERENCES

School Avoidance Alliance

https://schoolavoidance.org/

School Refusal in Youth: A Systematic Review of Ecological Factors

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9686247/

Strategies for Addressing School Avoidance Due to Anxiety

https://www.instride.health/blog/strategies-for-addressing-school-avoidance-due-to-anxiety/

Center for Parent Information and Resources (CPIR)-school climate resources

Parent and Educator Guide to School Climate Resources

https://www.parentcenterhub.org/parent-and-educator-guide-to-school-climate-resources/

Quick Guide on Making School Climate Improvements

https://www.parentcenterhub.org/quick-guide-school-climate-improvements/

School Climate and Discipline

https://www.parentcenterhub.org/school-climate-and-discipline/

Positive Behavioral Interventions and Supports (PBIS)

https://www.pbis.org/

Lauren Agoratus, M.A. Counseling is the State Coordinator of Family Voices NJ housed at the SPAN Parent Advocacy Network at https://spanadvocacy.org/programs/f2f/.

Resources

[1] https://www.usatoday.com/in-depth/news/health/2023/05/15/school-avoidance-becomes-crisis-after-covid/11127563002/

[2] https://www.jerseysbest.com/community/genpsych-helps-adolescents-in-new-jersey-struggling-with-school-avoidance/

[3] https://www.usatoday.com/in-depth/news/health/2023/05/15/school-avoidance-becomes-crisis-after-covid/11127563002/

You'd go to great lengths for your child's health. Good thing you don't have to go far.

We are nationally ranked in pediatric orthopedics at The Bristol-Myers Squibb Children's Hospital at Robert Wood Johnson University Hospital and in pediatric urology at The Bristol-Myers Squibb Children's Hospital, Children's Hospital of New Jersey at Newark Beth Israel Medical Center, McMullen Children's Center at Cooperman Barnabas Medical Center, and Unterberg Children's Hospital at Monmouth Medical Center. And we're also New Jersey's largest provider of children's healthcare.

From primary care to specialized treatments and therapies and in partnership with Rutgers Health, our Children's Health network provides advanced research, teaching, social impact and outstanding care to improve the health and well-being of every child in every community. **Learn more at rwjbh.org/ChildrensHealth.**

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Let's be healthy together.