



# Association of Florida Children's Hospitals, Inc.

A Council of the Florida Hospital Association

October 11, 2006

Lisa Rawlins, Bureau Chief  
Florida Health Policy  
Agency for Health Care Administration  
2727 Mahan Drive  
Tallahassee, Florida

Subject: Recommendation from the Statewide Workgroup on Pediatric Data Provided on AHCA's Consumer Website

Dear Ms. Rawlins:

On behalf of the children of Florida, we appreciate your support and willingness to consider our recommendations for displaying pediatric data on AHCA's consumer website, FloridaCompareCare. The workgroup feels that it is extremely important for parents to have good, reliable information for making treatment decisions for their children. We commend the Agency for all of its work to promote transparency in Florida and thank you for involving us in the process.

As noted recently by the Agency for Healthcare Research and Quality (AHRQ), providing data on pediatric conditions presents several challenges. Among these challenges is that children are a relatively healthy population and are rarely hospitalized. Another challenge is that children are dependent on parents and other adults for financing, accessing, receiving and evaluating their care. The diversity among children populations, i.e. neonates to adolescents is another challenge for providing information on pediatric care. Because children are in a constant state of development, measures for one age group may be inappropriate for another. Given these factors, adult measures cannot be applied to the pediatric population. (*Measures of Pediatric Health Care Quality Based on Hospital Administrative Data: The Pediatric Quality Indicators*, AHRQ September 2006).

In response to your suggestion, we convened a statewide workgroup on pediatric data to discuss issues impacting data specific to pediatric conditions, how that information could be used by parents and recommendations for possible changes to the website to improve the usefulness of the information for parents. Below are our recommendations for enhancing the usefulness of data about children on the FloridaCompareCare website.

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## **Recommendations for AHCA's Consumer Website**

### **1. Clearly delineate pediatric information from information on adults**

Children's conditions and procedures are very different from adult conditions and procedures. We recommend that AHCA provide Web site users the option to select information for children or adults as a first step in using the FloridaCompareCare website in order to clearly segregate the information from the two distinct populations. Doing this would narrow the search for parents looking for information on pediatric conditions and also allow the children's section of FloridaCompareCare to be expanded to provide additional types of information to help parents manage their child's health care. For example, additional information could be provided on childhood vaccinations, preventing obesity in children, or other topics of interest that educate parents about their children's health.

### **2. Revise the definition of normal newborn**

Currently, "normal newborn" as reported on the AHCA website is defined as APR-DRG code 640 (limited to Severity Level 1), which includes babies that might have complications, such as jaundice. The workgroup recommends that "normal newborn" include only those newborns discharged home within three days of birth. Those remaining, who may have a longer than 3-day stay due to a variety of complications should not be included in this category, nor should babies transferred in to a facility or readmitted to the birth hospital due to complications.

### **3. The risk adjustment for pediatric conditions should be based only on the pediatric population and be indicator specific**

Currently, the risk adjustment methodology applied to pediatric conditions is based on the entire patient population, i.e. adults and children combined. This skews the expected rates for the pediatric patients.

The population from which to determine the risk adjustment should be indicator specific, applying all appropriate filters. For example, in the case of pediatric pneumonia (APR-DRG 139), the state normative value used in risk adjustment calculations should be based on:

- All patients in the state with APR-DRG 139
- Ages 2- 17 ONLY
- Exclude transfers from other institutions
- Exclude patients with cystic fibrosis
- Exclude patients with anomalies of respiratory system

Currently, the normative values include all patients in APR-DRG 139 *of all ages with no exclusions*.

#### **4. Outliers should be excluded from the data**

Given the possibility that one unique pediatric case could skew the data on a hospital, we would recommend that AHCA remove outliers, i.e. those with extremely high or low costs and/or extremely high or low lengths of stay, from the analysis. We recommend that AHCA adopt the outlier trimming methodology used by AHCA on the hospital report cards published in 1996 and 1999. Although this concern also applies to adult populations, in many reporting categories, the sample sizes for pediatrics are much smaller, and thus there is an appreciable risk that the averages will be skewed due to the presence of a small number of outliers.

#### **5. Use selected AHRQ Pediatric Quality Indicators for outcomes reporting**

Since the outcome measures specific to pediatrics are currently not available on the website, the group reviewed the Pediatric Quality Indicators (PDIs) available from the Agency for Healthcare Research and Quality (AHRQ). The PDIs were released earlier this year and there is not a lot of experience with the indicators due to their newness. However, the workgroup members reviewed their PDI data to evaluate the measures for possible inclusion on the FloridaCompareCare website. AHRQ is still in the process of reviewing and validating these measures. Until this validation is completed, the workgroup feels posting these measures is premature. However, recognizing the legislative mandate to provide consumer data the pediatric measures listed below have the fewest concerns:

- Foreign body left in after procedure                      PDI 3
- Pediatric heart surgery volume                              PDI 7
- Postoperative wound dehiscence                              PDI 11
- Transfusion reaction    PDI 13

The workgroup had concerns with the following two measures because they include cardiothoracic procedures where pneumothorax is a planned component of normal patient care.

For these reasons these two measures are under scrutiny by the AHRQ pediatric panel:

- Iatrogenic pneumothorax in neonates at risk              PDI 4
- Iatrogenic pneumothorax in non-neonates                PDI 5

We agree with the AHRQ recommendation to exclude cardiothoracic procedures from these measures if these indicators are utilized in the FloridaCompareCare website.

Based on the workgroup's review of the indicators, we feel that AHCA should delay using the following measures until the present on admission coding for the primary and secondary diagnosis codes are collected and incorporated into the AHRQ methodology:

- Decubitus ulcer (PDI 2) – It is difficult to exclude those patients coming from a long-term care setting because the “source of admission” doesn’t identify those patients as transfers that were first seen in the emergency department. Once hospitals begin reporting present on admission, then patients coming from a long-term care facility with a decubitus ulcer can be excluded from the analysis, improving the validity of the measure.
- Postoperative sepsis (PDI 10) – AHRQ has noted the need for a more comprehensive definition of infection because the term “sepsis” may be used to describe a variety of clinical scenarios, depending upon the physician. The AHRQ pediatric review panel does not recommend this indicator for comparative reporting.
- Selected infections due to medical care (PDI 12) – The AHRQ pediatric review panel noted that not all infections are preventable, and the coding for these will be charted variably. Thus, they do not recommend this indicator for comparative purposes.

We do not recommend using the following PDIs for the outlined reasons:

- Accidental puncture and laceration (PDI 1) – Many of the codes reflect acceptable lacerations that occur commonly in procedures. Thus, the inability of the ICD9 codes to clearly delineate lacerations that are expected from those that are preventable makes this indicator problematic. The AHRQ pediatric indicator panel review group found indeterminate agreement with this indicator for internal quality improvement review but did not recommend this indicator for comparative purposes.
- Pediatric heart surgery mortality (PDI 6) – The AHRQ pediatric panel noted that the validity of this indicator is impacted by the ability to risk adjust the measure. The panel recommended that the relative performance of the risk adjustment with the administrative data be evaluated.
- Postoperative hemorrhage and hematoma (PDI 8) – Any documentation of bleeding is assigned these codes. Thus the ICD9 codes are not definitive enough to discriminate between postoperative hemorrhage or hematoma that was expected in association with a given procedure from a quality of care issue.
- Postoperative respiratory failure (PDI 9) – The indicator captures some patients that will remain on ventilators because of their condition. Thus, the ICD9 codes are not definitive enough to identify a planned component of care from a quality of care issue. In addition, the code does not exclude patients whose respiratory failure is unrelated to the surgical episode. The AHRQ pediatric review panel was not in agreement that this indicator should be used for comparative reporting.

## **6. Provide information on ambulatory surgery conditions for children**

The workgroup also reviewed potential ambulatory surgery procedures that are relevant to children and could be used to show information on number of cases and average charges. Instead of the procedure categories presently used on the website, the workgroup recommends replacing them with the following ambulatory procedures (defined by ICD9 procedure codes) most appropriate for children:

- Tonsil and adenoid removal
- Ear tubes placement
- Diagnostic upper GI endoscopy
- Circumcision
- Hernia and/or hydrocele repair
- Cleft palate repair
- Arthroscopy
- Strabismus (repair of crossed-eyes)
- Treatment of fractures
- Lower gastrointestinal endoscopy
- Diagnostic cardiac catheterization
- Bronchoscopy

## **7. Adopt the 3M methodology for readmission rate reporting with special considerations for pediatric conditions**

We applaud AHCA for working with 3M on a better methodology to examine readmission rates. While we would like to see the specific logic used for calculating readmission rates for certain pediatric conditions, we recommend the following based on our initial discussions with Dr. Norbert Goldfield of 3M:

- Report readmissions based on those occurring within 15 days of the initial admission
- Readmission rates should be segregated for infants (up to one year of age) and non-infants (1 through 17 years)
- Readmission rates should be limited to readmissions for the same condition and only for those conditions in which a readmission is not expected, such as asthma, gastroenteritis, and pneumonia. Those conditions requiring planned follow up procedures or treatment would not be considered a “preventable readmission” and would be excluded from readmission reporting.

## **8. Conduct focus groups to evaluate needs of parents for pediatric data**

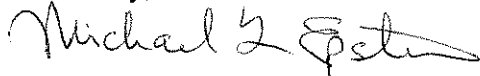
We strongly recommend that AHCA host focus group sessions specifically targeting the parent population to determine their information needs for data on pediatric conditions. The Florida Association of Children’s Hospitals would be willing to assist in those focus groups.

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We look forward to working with the Agency on implementing these recommendations and on expanding the data and information on pediatric health issues on the FloridaCompareCare website. Please let us know if you have any questions or require further explanation of our recommendations.

Sincerely,

A handwritten signature in cursive script that reads "Michael Epstein". The signature is written in black ink and is positioned above the printed name.

Michael Epstein, M.D.

Chair, Workgroup on Pediatric Data for AHCA's Website