

May 28, 2010

James I. Golden, Ph.D.
Director, Division of Health Policy
Minnesota Department of Health
625 Robert St. N.
PO Box 64975
St. Paul, MN 55164-0975

Re: Quality reporting measures by pediatric facilities

Dear Dr. Golden:

Children's Hospitals and Clinics of Minnesota appreciates the opportunity to provide comments and recommendations on the Statewide Quality Reporting System. As the state's largest pediatric health care provider, we embrace and support the uniform collection and transparent display of quality measures that allow consumers and purchasers to make informed decisions about their care delivery choices.

As you know, under the Administrative Rule published in the Minnesota State Register on December 28, 2009, MDH will "consider recommendations for addition, removal, or modification of standardized quality measures that are submitted by June 1 of each year." Please consider this letter Children's recommendations. Our recommendations fall into two categories: Reporting Population and Suggested Measure Modifications and Additions.

Reporting Population

As noted above, Children's strongly supports the collection and transparent dissemination of quality information. In particular, we agree with the intent of the 2008 health reform law that information relevant to a consumer or group purchaser's health care provider choice should be available to them during their care choice decision process. For example, information related to the quality of care provided to children should be available to parents and other decision makers as they choose among providers of care for their children. We have placed many of our outcomes on our website (<http://www.childrensmn.org/AboutUs/Outcomes/>)

At Children's, we strive to deliver the best care possible to the specific population we serve. This population is overwhelmingly children under the age of 18. In both 2008 and 2009, 97.8% of our inpatient admissions were for children under age 18. Therefore, we recommend that measures and reporting for hospitals and clinics that overwhelmingly serve pediatric patients reflect that population, and that those hospitals and clinics be required to report on this under age 18 population and not on an adult population. For example, we had only 238 admissions with an age ≥ 18 years in 2009, thereby meeting the exclusion criterion for exemption from reporting HCAHPS, Hospital Consumer Assessment of Healthcare Providers & Systems. We want to be clear that we are not seeking an exemption from reporting. Rather, we are seeking to report on the most meaningful and relevant population for purposes of consumer and purchaser decision making. We suggest that a threshold of 95% of total admissions be established and those providers who have a patient population exceeding this threshold be required to report only on children and not on the much less relevant adult population.

We respectfully make specific recommendations for pediatric quality of care indicators based on our experience. We believe that many existing measures would serve the public well, provided that results were segmented into those from patients <18 years of age and those ≥ 18 years of age. We would be happy to provide additional information regarding these recommendations and work with any committees to refine the measures.

Recommended Quality Measures

General Pediatrics

Background/Importance: Childhood asthma and obesity represent major problems in our community. We are already reporting on a home management plan for asthma patients and support the Minnesota Hospital Association (MHA) recommendation that this currently reported outcome be segmented into pediatric patients and adult patients. Obesity has also become a pediatric problem of almost epidemic proportions. We propose that pediatric caregivers document and address these two important problems:

1. *Document a home management plan given to asthma patients*
2. *Measure and document the BMI in all pediatric patients aged ≥ 2 years.*

Feasibility: For us and for most pediatric providers, we believe the marginal cost of data acquisition and reporting to be minimal. BMI is already recorded in most clinics and with most hospitalizations and this information is readily available from the electronic record. Over the next few years we believe that documenting a plan to address a high body mass index (BMI) should also be required of general pediatric providers.

Neonatal Care

Background/Importance: Neonatal patients are a small subset of all pediatric patients, but their costs of care are high. Neonatal treatment can affect a child for the subsequent 80 or more years. These babies, although only a fraction (usually about 25%) of NICU patients, have a wide range of outcomes allowing discrimination of performance. We would recommend that the Minnesota Department of Health ask each Level III NICU to submit their patient-level data

as submitted to the VON, which would permit a state-wide characterization of the very-low-birth-weight patients treated within Minnesota. These analyses, coupled with birth certificate data could uniquely inform public health efforts to reduce prematurity and improve its treatment. Benchmark data are readily available (over 700 NICUs participate in the VON) and are part of the public domain, making the VON data even more informative to the public. The particular measures we recommend are very much within the control of caregivers. Antenatal steroids increase survival and reduce almost all morbidities associated with very-low-birth-weight babies. Its use varies within the Twin Cities and probably throughout the State. Failure to administer antenatal steroids increases mortality and morbidity. Nosocomial infections in very-low-birth-weight infants are clearly influenced by provider practices, and sufficiently common to give this measure discriminatory power among facilities. The same could not be said for nosocomial infections in all neonates. This is a much less useful measure because the infections occur rarely, and would require additional expense to track, for at least some facilities. Reporting of hepatitis B vaccine and immunoglobulin administration where appropriate is an important measure of attentive newborn care and could be used at all facilities treating newborns. We propose using:

1. *Antenatal steroids given to mothers of infants delivering at 24-33 weeks gestation*
2. *Nosocomial bacteremia or meningitis in very-low-birth-weight infants (those with birth weights < 1500 grams).*
3. *Hepatitis B vaccine and immune globulin for newborns of mothers with chronic hepatitis B.*

Feasibility: Antenatal steroid administration and nosocomial infection data are available and would require no increase in data acquisition costs. Each NICU in Minnesota submits data to the Vermont Oxford Network (VON) Collaborative Database and annually receives both patient level and aggregated outcomes reports on very low birth weight babies with birth weight 501-1500 grams. Data on hepatitis B vaccine and immunoglobulin administration are not routinely tracked, but since it involves relatively few cases could be tracked without great expense. The Minnesota Department of Health (MDH) tracks most of the known hepatitis B positive mothers already, which would provide verification of the accuracy of the data submitted.

Surgical Care:

Background: Surgical care is a common reason for hospitalization of pediatric patients. We performed over 19,000 cases in 2009. Monitoring the quality of surgical care has been unexpectedly difficult for us due the usually short hospitalization and discharge before a surgical complication might become apparent. Efforts to call parents after hospital discharge have required parents' lay opinion about wound problems and contacting each surgeon about complications has been likewise problematic. Therefore, we have had difficulty obtaining numerator data. We recommend that the requirement to report hair removal by shaving be lifted as this is not the standard of care and is never done in our operating rooms (to our knowledge). We endorse the MHA recommendations that the following quality measures be used:

1. *Foreign body left during procedure*

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2. *Administration of prophylactic antibiotics within one hour of “cut” time –*
 3. *Pediatric heart surgery mortality*
 4. *Pediatric heart surgery volume*

Feasibility: The first two items are already tracked and reported and we join the MHA in recommending that the results be segmented into pediatric and adult populations. Pediatric heart surgery mortality and volume would be meaningfully reported at only three institutions, but are good measures of technical expertise. We recommend that the Society for Thoracic Surgery database be incorporated in future measurements as that would allow for acuity adjustment.

Infection Prevention

★ Background: Nosocomial bacteremias increase mortality and morbidity. They can be prevented and are a reasonable measure of quality. We endorse the MHA recommendation to segment existing data into pediatric and adult reports.

1. *Central venous catheter-associated bacteremias*

Feasibility: Benchmark data is readily available.

We appreciate the opportunity to submit these recommendations and to work with you on developing additional pediatric measures for inclusion in the statewide quality data set. We support these efforts to make available to the public relevant quality measures.

Sincerely,



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