

# 4<sup>th</sup> International Conference on **Pediatrics & Pediatric Emergency Medicine**

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## **Primary payer status is significantly associated with postoperative mortality, morbidity, and hospital resource utilization in pediatric surgical patients within the United States**

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The purpose of the study was to examine risk-adjusted associations between primary payer status and postoperative morbidity, mortality and resource utilization in pediatric surgical patients within the United States. A weighed total of 153,333 pediatric surgical patients were evaluated using the national Kid's Inpatient Database (2003, 2006): appendectomy, intussusception, decortication, pyloromyotomy, congenital diaphragmatic hernia repair and colonic resection for Hirschsprung's disease. Patients were stratified according to payer status: Medicare (n=180), Medicaid (n=51,862), uninsured (n=12,539) and private insurance (n=88,753). Multivariable hierarchical regression modeling was utilized to determine multivariable hierarchical regression modeling was utilized to evaluate risk-adjusted associations between payer status and outcomes. Overall median patient age was 12 years and appendectomies accounted for the highest proportion of cases (81.3%). After adjustment for patient, hospital and operation-related factors, payer status was independently associated with increased in-hospital death for uninsured patients ( $p<0.0001$ ). Medicaid payer status was associated with increased risk for postoperative complications ( $p<0.02$ ), adjusted lengths of stay and total hospital charges ( $p<0.001$ ). Importantly, these results were dependent on operation type. Thus, primary payer status is associated with risk-adjusted postoperative mortality, morbidity and resource utilization among pediatric surgical patients. Uninsured patients are at increased risk for postoperative mortality while Medicaid patients accrue greater morbidity, hospital lengths of stay and total charges.

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## **Operationalizing emergency care delivery in sub-Saharan Africa: Consensus-based recommendations for healthcare facilities**

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A major barrier to successful integration of acute care into health systems is the lack of consensus on the essential components of emergency care within resource limited environments. The 2013 African Federation of Emergency Medicine Consensus Conference was convened to address the growing need for practical solutions to further implementation of emergency care in sub-Saharan Africa. Over 40 participants from 15 countries participated in the working group that focused on emergency care delivery at health facilities. Using the well-established approach developed in the WHO's Monitoring Emergency Obstetric Care, the workgroup identified the essential services delivered—signal functions—associated with each emergency care sentinel condition. Levels of emergency care were assigned based on the expected capacity of the facility to perform signal functions and the necessary human, equipment and infrastructure resources identified. These consensus based recommendations provide the foundation for objective facility capacity assessment in developing emergency health systems that can bolster strategic planning as well as facilitate monitoring and evaluation of service delivery.

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