Letters

In Reply We read with interest the comments submitted by Kohler et al in response to our analysis exploring the influence of sociodemographic factors on timing of asymptomatic umbilical hernia repair in children.1 In their commentary, they propose that the disparities in care characterized in the analysis may be owing to practice variation arising from a lack of well-established consensus guidelines. While we agree that marked practice variation exists in the timing of umbilical hernia repair across children's hospital's,2 we would disagree with the notion that a lack of (or compliance with) recommendations is inherently responsible for the observed disparities. Hierarchical regression was used in our analysis to control for hospital-level differences in timing of umbilical hernia repair when assessing potential risk factors. Following adjustment, marked disparities in the risk of early umbilical hernia repair remained for children with public insurance and lower income, and these trends were observed across most children's hospitals examined. These findings would suggest that disparities associated with disadvantaged sociodemographic backgrounds are not only pervasive but also independent from the broader practice variation that exists across children's hospitals.

From a public health and intervention perspective, the increased risk of early umbilical hernia repair associated with sociodemographic factors should be considered a separate issue from that pertaining to broader practice variation. Strategies to address disparities should begin with outreach programs and multidisciplinary educational efforts targeting both high-risk families and the clinicians who predominantly serve these communities. Policy changes surrounding insurance coverage may also play an important role because differential reimbursement policy may inadvertently enable surgeons to perform earlier repairs on publicly insured children. Future efforts to reduce disparities, as well as the variation surrounding potentially unnecessary early repairs for all children, are needed to ensure that surgeons are providing equitable and optimal care to all children with this common condition. In this regard, we could not agree more with Kohler et al that establishing more formalized consensus guidelines are an important next step in addressing practice variation on a broader scale.

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CORRECTION

Error in Figure: The study titled ‘‘Trends in Foster Care Entry Among Children Removed From Their Homes Because of Parental Drug Use, 2000 to 2017,’’ published online July 15, 2019, had 2 labels switched in the Figure. The label ‘‘Entries owing to parental drug use’’ was positioned over the line that indicated the proportion of foster care entries owing to parental drug use, and the label ‘‘Proportion of entries owing to parental drug use’’ was positioned over the line indicating the total number of foster care entries owing to parental drug use. The labels have been moved to the correct positions.


Errors in Table and Figures: In the Original Investigation titled ‘‘Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels,’’ there were errors in Table 2 and in Figures 1 and 2. In the third column of Table 2, the row of ‘‘2-3 ACEs reported’’ should read ‘‘29.2%.’’ Additionally, in Figures 1 and 2, the first sentence of the legends should read ‘‘See eTable 5 in the Supplement for percentages of depression and/or poor mental health and adult-reported social and emotional support across PCEs items and scores.’’ Finally, in Figure 2B, the label should read ‘‘Cumulative Scorea,b.’’ This article was corrected online.


Error in Table 2: In the Original Investigation titled ‘‘Association of a School-Based, Asthma-Focused Telehealth Program With Emergency Department Visits Among Children Enrolled in South Carolina Medicaid,’’ published online September 9, 2019, there was an error in Table 2. In row 14, columns 8 and 15 should read ‘‘NA.’’ This article was corrected online.