Inpatient Care for Uncomplicated Bronchiolitis

Comparison With Milliman and Robertson Guidelines

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Context: Bronchiolitis is the most common lower respiratory tract infection in infancy. A recent Centers for Disease Control and Prevention report confirmed that hospitalization rates for bronchiolitis have increased 2.4-fold from 1980 to 1996. Controversies exist about optimal treatment plans. Milliman and Robertson recommend ambulatory care management; in case of hospitalization, the recommended length of stay is 1 day.

Objectives: To relate actual practice variation for infants admitted with uncomplicated bronchiolitis to Milliman and Robertson’s recommendations.

Design: Prospective observational study.


Patients: First-time admissions for uncomplicated bronchiolitis in patients not previously diagnosed as having asthma and who were younger than 1 year.

Main Outcome Measures: Respiratory rate, monitored interventions, attainment of discharge criteria goals, and length of stay.

Results: Eight hundred forty-six patients were included in the final analysis: 85.7% were younger than 6 months, 48.5% were nonwhite, and 64.1% were Medicaid recipients or self-pay. On admission to the hospital, 18.3% of the infants had respiratory rates higher than higher than 80 breaths per minute, 53.8% received supplemental oxygen therapy, and 52.6% received intravenous fluids. These proportions decreased to 1.9%, 33.8%, and 20.3%, respectively, 1 day after admission, and to 0.7%, 20.1%, and 8.6%, respectively, 2 days after admission. The average length of stay was 2.8 days (SD, 2.3 days).

Conclusions: Milliman and Robertson’s recommendations do not correspond to practice patterns observed at the hospitals participating in this study; no hospital met the Milliman and Robertson recommended 1-day goal length of stay. Administration of monitored intervention persisted past the second day of hospitalization.

PATIENTS AND METHODS

The Child Health Accountability Initiative is a 13-hospital collaborative established to enhance the quality of child health services with evidence- and consensus-derived outcome measures. In December 1998, member hospitals of Child Health Accountability Initiative implemented a previously published, evidence-based guideline for inpatient bronchiolitis. Results are reported for the 8 member hospitals completing all data collection and evaluations for this study.

PATIENT POPULATION AND DATA COLLECTION

All patients admitted between January 1, 1999, and March 31, 1999, younger than 1 year at the time of admission and with a principal report of bronchiolitis were considered for enrollment in the study. Prospective exclusion criteria included the following: previous hospital admissions for bronchiolitis; patients with a history of lung disease (eg, asthma or bronchopulmonary dysplasia), congenital cardiovascular disorders, or immunodeficiency disorders. Patients with bronchiolitis admitted directly to a critical care service or patients requiring ventilator care were also excluded. To ensure that all patients included in the final analysis were truly patients with uncomplicated bronchiolitis, patients with discharge International Classification of Diseases, Ninth Revision diagnostic codes other than bronchiolitis or indicative of a more complicated course of illness were excluded retrospectively from the data set. The practice guideline, supporting documents, and medical record packets including preprinted orders were made available on all wards caring for study-eligible patients. Patient enrollment on the guideline was voluntary. Medical record data were collected prospectively for each patient and then retrospectively matched with discharge diagnoses from the electronic administrative record from the admitting institution for that patient.

STUDY VARIABLES

Variables collected prospectively included the following: medical history including history of wheezing, bronchodilator (eg, albuterol) use, and reactive airway disease; laboratory and diagnostic tests performed; therapeutic interventions including oximetry; nasopharyngeal suctioning; administration of intravenous fluids; pharmacological treatments including antibiotics and inhalation therapies; attainment of discharge criteria; discharge details including discharge medications; readmissions or emergency department visits for bronchiolitis within 7 days of discharge; and enrollment on the guideline. Information obtained during post-discharge telephone interviews with caregivers is reported elsewhere. Guideline-established clinical discharge criteria were as follows: patient breathing room air or stable breathing oxygen at less than 0.5 L/min for longer than 1 day; documented teaching of bulb suctioning to parents or caregivers; oral feedings at a level sufficient to prevent dehydration; and respiratory rate usually 80 breaths per minute. Comparatively, M-R criteria for hospital discharge are listed in the P-HSIM as absence of fever, ability to tolerate regular diet and activity, oral and inhaled medication, and breathing comfortably with adequate oximetry.

GLOS AND LOS: DEFINITIONS AND CALCULATION

Milliman and Robertson define GLOS as:

The expected length of inpatient hospitalization required to manage each condition. . . . This length of stay assumes that treatment and healing occur without significant complications. Should treatment and healing not occur in the time frames outlined, the guidelines become appropriate when the patient's stage of recovery reaches a level of acute care similar to those listed. For bronchiolitis (International Classification of Diseases, Ninth Revision codes 466.1), the M-R P-HSIM define the GLOS as 1 day.

For this study, LOS was calculated in accord with health care industry standards. That is, the date of admission was subtracted from the date of discharge resulting in an integer representing the number of “midnights” for which the patient was in the hospital. The same method of calculating LOS is used by the M-R P-HSIM: “The M-R GLOS is counted the day the health care industry counts hospital days; that is, overnight stays in the hospital.”

DATA ANALYSIS

Data were entered into a relational database and data from all 8 hospitals were analyzed at a central location. All mean values are reported as the aggregate (data pooled from all 8 hospitals) mean (N = 846) ± SD. All proportional values are reported as the aggregate study proportion (data pooled for all 8 hospitals) with the lowest and highest proportion from individual participating sites reported in parentheses. Direct statistical comparisons with M-R GLOS are not possible because the M-R recommendations are not published with any measures of variance.

Attempts to predict hospital length of stay (LOS) using clinical or laboratory findings at the time of admission have met with little success. In a study of 102 patients, McMillan et al9 reported that in a subset of 56 patients who otherwise had no complications, the following variables were not correlated with the likelihood of longer hospital stay: respiratory rate; fever; white blood cell count; percentage of band forms; polymorphonuclear leukocyte count; hypoxia; or chest x-ray film findings.9 While management of bronchiolitis infection is primarily supportive, controversies exist about the optimal treatment strategies, particularly as related to the use of β-agonist inhalation treatment6-8; there is well-documented variation in practice both within and across sites.911 With such wide variations in practice and the consequent effects on quality and cost of care, standardization of inpatient management would be desirable. Perlstein et al10 developed an evidence-based guideline for bronchiolitis and, in a 1-year evaluation, the guideline has been reported to be effective in modifying care in 1 academic pediatric setting. Available through the National Guideline Clearinghouse, this guideline meets the standard for publication by the National Guideline Clearinghouse and the American Medical Association12 with
documented evidence from the medical literature to support each recommendation. Similar evaluation of commercially produced guidelines may be difficult because of their proprietary nature.

A well-known, commercially available series of guidelines are those from Milliman and Robertson (M-R). Milliman and Robertson is an actuarial consulting firm based in Seattle, Wash, whose health care guidelines are widely used by managed care organizations across the country. Milliman and Robertson has recently released the Pediatric Health Status Improvement and Management (P-HSIM) manual and, despite assertions of evidence-based development, the P-HSIM has been criticized in the medical literature for failing to meet American Medical Association standards for guideline development. Furthermore, the most controversial aspects of the M-R recommendations, goal lengths of stay (GLOS), have been questioned in recent reports.

While these studies have been valuable in raising questions about the M-R recommendations, their use of administrative data inherently limits the conclusions that can be drawn, as these data sets can neither account for daily patient clinical status nor ensure homogeneous patient populations. The objective for this study was to use a prospective design that tightly controlled patient inclusion criteria to examine not only the LOS but also the daily patient clinical parameters, thereby allowing comparisons with and assessment of the M-R recommendations. The hypothesis for this study was that observed LOS for uncomplicated bronchiolitis is longer than the M-R recommended GLOS.

RESULTS

Eight hundred forty-six patients were enrolled in the study between January 1, 1999, and March 31, 1999. Demographic characteristics of the 846 patients were as follows: 51.5% were white (3.9%-82.6%), 27.0% African American (0.0%-61.0%), and 16.7% Hispanic (0.0%-78.6%); 3.59 months old (0.34 months) with 50.6% of the patients aged between 2 and 6 months (36.9%-69.6%) and 35.1% younger than 1 month (17.4%-46.7%); 45.3% of the patients had publicly funded health insurance (Medicaid) (15.9%-85.5%) while 35.9% had commercially funded insurance (11.6%-55.8%); and 42.1% (10.1%-62.0%) of all patients, with either commercially or publicly funded insurance, were members of a managed care organization. Additionally, 18.7% of the patients were born at fewer than 38 weeks gestation (4.3%-28.3%), and almost one fifth of the patients had a history of prior wheezing, albuterol use, or parents with asthma 14.4% (3.3%-52.2%), 11.5% (2.9%-39.1%), and 18.3% (7.3%-25.0%), respectively. A total of 80.1% of the 846 study patients were enrolled on the treatment guideline (52.2%-97.1%).

Figure 1 shows the trajectory of patient treatment for the first 5 days of the hospital stay. On admission, more than half of all patients (53.8% [34.8%-84.0%]) received supplemental oxygen support or intravenous fluids to maintain hydration (52.6% [27.3%-96.0%]). Therapeutic support persisted: one fifth of all patients (20.1% [8.7%-56.7%]) continued to receive supplemental oxygen therapy 2 days after admission.

Patient attainment of the 3 guideline-determined clinical discharge criteria (patient breathing room air or stable breathing oxygen at <0.5 L/min for >1 day; oral feedings at a level sufficient to prevent dehydration; and respiratory rate usually <80/min) is shown in Figure 2. One quarter (26.7% [2.9%-47.8%]) of all patients attained all 3 clinical discharge criteria on the same day as admission. After 1 day of hospitalization, one half of all patients (53.3% ± [21.4%-87.0%]) met all 3 clinical discharge criteria on the same day as admission. After 1 day of hospitalization, one half of all patients (53.3% ± [21.4%-87.0%]) met all 3 clinical discharge criteria on the same day as admission.
This study reports substantial differences in hospital LOS from the M-R GLOS for bronchiolitis at each of the 8 pediatric study hospitals. In this study, implementation of a practice guideline—of which the implicit intent was to decrease administration of unproven therapies and resource use—and to account for residual differences in practice patterns both within and across sites—did not result in any site achieving either an average or median LOS less than the M-R 1-day GLOS. In fact, no site achieved a median or mean LOS of fewer than 2 days. Furthermore, this longer LOS was in a patient population that was, by definition, uncomplicated. In all, 43.2% of all patients were hospitalized longer than the M-R 1-day GLOS; 10.4% were hospitalized for longer than 5 days.

The observed LOS longer than the M-R GLOS is consistent with other recent reports. Sills et al illustrated that, in 1995 in New York State, pediatric LOS differed markedly from the M-R recommendations, with as many as 80% of all patients exceeding M-R GLOS for many diagnoses. For example, the observed LOS for uncomplicated appendectomy was 4.3 days vs the M-R 2-day GLOS, and the observed LOS for bacterial meningitis was 13.0 days vs the M-R GLOS of 4 days. While this study has been criticized for using data from 1995, and because of the use of a secondary data set, the likely inclusion of patients with medical complications, this study does share these deficits. In the current study, patients were enrolled and data were collected prospectively, and enrollment was strictly limited to only those patients with uncomplicated bronchiolitis.

In the patient population reported herein, the perceived need for continued monitored intervention and therapy, as measured by the attainment of clinical discharge criteria, persisted past the second day of hospitalization in one quarter (28.7%) of all patients. The role of supportive therapy by trained caregivers is important to avoid unnecessary morbidity. Additionally, the role of parent learning in a controlled environment cannot be overemphasized, as it has been reported that symptoms persist for 5 days or longer after discharge for 20% of the infants.

Milliman and Robertson state, “... the purpose of the inpatient guidelines is to define care for patients who recover from their illness as well as can be expected and without complications.” However, it is unclear if the M-R GLOS guidelines are intended for all patients with bronchiolitis or for only uncomplicated patients, as the P-HSIM guidelines for bronchiolitis describe, in the same section of the guidelines, reasons for admission to the intensive care unit or to routine floor care. In the tightly controlled, uncomplicated population reported herein, almost half (43.2%) of all patients exceeded the M-R 1-day GLOS. It is likely that the proportion of patients exceeding this 1-day GLOS would be much higher when patients requiring intensive care are considered as this patient population is very medically and clinically dissimilar to the patient population included in this study.

The important and positive contribution of commercial groups in the development of practice guidelines should not be understated; valid medical management recommendations can greatly improve the quality and efficiencies of care. However, the methods used for the development of the guideline must be made available for evaluation. The credibility of guidelines, including a full understanding of their possible effects on patient safety, hinges on their development in robust evidence- and outcomes-based methods. Guideline or treatment recommendations advocating GLOS based on “ideal” patient and clinical situations, as is the assumption with the M-R GLOS, have the potential to be arbitrarily applied to all patients, with possible adverse health outcomes for some patients. In summary, rather than attempting to discharge patients within a predefined or recommended period, the focus of care should be expedi-
Commercially available guidelines are in widespread use for clinical and reimbursement purposes. The basis for their development, applicable patient cohorts, and whether they apply to the population at large is unclear. Our work demonstrates that there is tremendous variation across the country for care of a common respiratory condition but more importantly, none of the centers met the GLOS of a commercially available guideline. This highlights the need for clinicians and other users to be able to have full access to the basis for development of such guidelines to determine their applicability with the same rigor given to scientific literature.

References