Pediatric Hospital Admission and Role of Clinical Practice Guidelines

To the Editor I read with great interest the article by Kaiser et al1 describing pediatric hospitalization patterns in different hospital setups. In the data presented from 3768 US hospitals (Figure 1), an estimate of 34,704 of 1,777,023 nonbirth pediatric hospitalizations (1.95%) occurred because of neonatal hyperbilirubinemia (NHB). The prevalence rankings of NHB differed among hospitals (ranking 5 in urban nonteaching hospitals and rural hospitals, 7 in urban teaching hospitals, and 20 in freestanding children’s hospitals). On further analysis, NHB constituted 2.42 admissions (3,447/1,424) per rural hospital, 6.18 (714/8/115) per urban nonteaching hospital, 16.90 (18,844/1,115) per urban teaching hospital, and 72.15 (526/7/3) per freestanding children’s hospital. It was interesting to note that NHB was ranked 20th in freestanding hospitals but the rate of admissions per hospital was high compared with other hospital types.

These findings suggested a potential practice variation among these hospitals with regard to the management of NHB. Although published guidelines are available for the management of NHB,2,3 high variability has been reported.4 Zhang et al4 reviewed 12 clinical practice guidelines for the diagnosis and management of NHB and reported differences in clarity of presentation and rigor of development.

A possible solution to decrease variability in admission rates for NHB among hospitals is to follow a centralized clinical practice guideline. Rea et al2 suggested centralization of clinical practice guideline prioritization and development through a government-driven system. This could eliminate discrepancies between overlapping guidelines and enforce the validity of clinical practice guidelines, potentially resulting in less variation in admission rates for NHB and decreasing the health care cost.

Shabih Manzar, MD

Author Affiliation: Section of Neonatology, Department of Pediatrics, Louisiana State University Health Sciences Center, Shreveport.

Corresponding Author: Shabih Manzar, MD, Section of Neonatology, Department of Pediatrics, Louisiana State University Health Sciences Center, 1501 Kings Hwy, Shreveport, LA 71103 (shabih.manzar@lsuh.edu).

Published Online: April 25, 2022. doi:10.1001/jamapediatrics.2022.0684

Conflict of Interest Disclosures: None reported.

Editorial Note: This letter was shown to the corresponding author of the original article, who declined to reply on behalf of the authors.


CORRECTION

Errors in the Introduction and Results: In the Research Letter titled “Association of Tax Preparation Service in a Pediatric Clinic With Increased Receipt of The Child Tax Credit,” which published online March 21, 2022,1 there were errors in the Introduction and Results sections. The third sentence of the Introduction incorrectly stated the percentage of eligible recipients who may be prevented from receiving the Child Tax Credit. The sentence should be “However, tax filing barriers (eg, parents who are not US citizens and lack internet access or technological devices) may prevent 2.3 to 5 million children from receiving the CTC.” The last sentence of the Results section incorrectly stated that the analysis was adjusted for race and ethnicity. The analysis was adjusted for race, sex, and age, not ethnicity. This article was corrected online.