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BMJ 2004;329:315-; originally published online 8 Jul 2004;
doi:10.1136/bmj.38159.650347.55

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Hospital at home for patients with acute exacerbations of chronic obstructive pulmonary disease: systematic review of evidence

Felix S F Ram, Jadwiga A Wedzicha, John Wright, Michael Greenstone

Abstract

Objectives To evaluate the efficacy of hospital at home schemes compared with inpatient care in patients with acute exacerbations of chronic obstructive pulmonary disease (COPD).

Design A systematic review of randomised controlled trials.

Main outcome measure Mortality and readmission to hospital.

Results Seven trials with 754 patients were included in the review. Hospital readmission and mortality were not significantly different when hospital at home schemes were compared with inpatient care (relative risk 0.89, 95% confidence interval 0.72 to 1.12, and 0.61, 0.36 to 1.05, respectively). However, compared with inpatient care, hospital at home schemes were associated with substantial cost savings as well as freeing up hospital inpatient beds.

Conclusions Hospital at home schemes can be safely used to care for patients with acute exacerbations of COPD who would otherwise be admitted to hospital. Clinicians should consider this form of management, especially as there is increasing pressure for inpatient beds in the United Kingdom.

Introduction

In the United Kingdom, chronic obstructive pulmonary disease (COPD) continues to be responsible for over 90 000 admissions to hospital every year. It is estimated that the mean duration of hospital stay for typical acute exacerbations of chronic obstructive pulmonary disease is 11 days, which means that about a million hospital bed days a year are taken up in the United Kingdom alone as a result of admissions for COPD.¹ Acute exacerbations of COPD are the most common cause of admission to hospital for respiratory illness,² and they account for about 10% of all acute medical admissions in the United Kingdom.³ This causes an increased demand on hospital beds especially during winter months. The annual cost of COPD to the NHS at 1996-7 prices is around £817.5m (\$1505m, €1222m).⁴ Admission to hospital accounted for about 35% of this annual expenditure, despite the fact that less than 2% of patients with COPD were admitted in the year examined. The cost of a typical hospital admission was estimated as £3000.

The Royal College of Physicians of London has recommended the provision of respiratory care helpers to improve the management of patients with COPD at home.⁵ Selected patients currently admitted with acute exacerbations of COPD could safely be cared for at home with sufficient support. Mortality from these episodes is closely related to the degree of hypercapnia and acidosis at admission and to the presence of non-respiratory comorbidities.⁶⁻⁸ Many

patients admitted to hospital do not have these features, and it may be possible to manage them equally well outside the hospital environment.

Hospital at home services are a recent innovation in the management of such acute exacerbations.⁹ The rationale is that such services increase patients' satisfaction and reduce costs without adverse effects on clinical outcome. Evidence in support of such a service is contradictory and has been extrapolated mainly from generic hospital at home schemes.¹⁰⁻¹³ Despite the paucity of objective evidence of efficacy, interest in hospital at home services for acute exacerbations has been considerable, with many respiratory departments establishing their own schemes in the United Kingdom,¹⁴ Spain,¹⁵ and Australia.¹⁶ We conducted a systematic review comparing hospital at home schemes with inpatient care to observe the effects of each type of care on mortality and readmissions to hospital.

Methods

Types of trials and participants—To be considered for inclusion trials had to study patients presenting to the emergency department with an acute exacerbation who were randomised to either hospital at home or inpatient care. All patients had to be randomised into trials within 72 hours of presenting to the department and after an initial assessment by the hospital medical team. Patients were not included in the trials if they were deemed obligatory admissions.¹⁷ These include patients with impaired level of consciousness, acute confusion, acute changes on radiography or electrocardiography, arterial pH <7.35, or concomitant medical conditions. Patients randomised to hospital at home would be under the care of a specialist respiratory nurse.

Identification and selection of trials—We used a pre-defined search strategy and searched various relevant databases, including Cochrane controlled trials register, Science Citation Index, Embase, Medline, UK National Research Register, Web of Science, individual respiratory journal websites, and proceedings of the European Respiratory Society, American Thoracic Society, British Thoracic Society, and Thoracic Society of Australia and New Zealand. All searches were completed from database conception up to and including May 2003. Trialists and known experts were contacted to obtain any unpublished trials.

Data analysis—For continuous variables, we pooled trial data using fixed effect weighted mean differences and 95% confidence intervals. For dichotomous

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BMJ 2004;329:315-8



This is the abridged version of an article that was posted on bmj.com on 8 July 2004: <http://bmj.com/cgi/doi/10.1136/bmj.38159.650347.55>

Characteristics of trials included in review

Study reference	Participants' characteristics at baseline		Intervention
	Inpatient group	Hospital at home group	
Cotton et al ¹⁸	Mean age 68 years, M/F 16/24, PaO ₂ (kPa)=9.2, PaCO ₂ (kPa)= 5.5, FEV ₁ (L)=0.94	Mean age 65.7 years, M/F 19/22, PaO ₂ =8.5, PaCO ₂ =6.0, FEV ₁ =0.95	36 patients underwent early discharge; 34 were discharged with nebulised bronchodilators and 16 with oxygen. Median duration of nurse follow up=24 days, median No of nurse visits=11
Davies et al ¹⁹	Mean age 70, M/F 30/20, FEV ₁ =0.65, respiratory rate 23, pH 7.39, PaO ₂ =9.0, PaCO ₂ =5.2	Mean age 70 years, M/F 45/55, FEV ₁ =0.71, respiratory rate 24, pH 7.4, PaO ₂ =9.7, PaCO ₂ =5.2	Patients usually supervised by primary care physician who was not aware of study protocol. Median duration of nurse follow up=8 weeks, maximum No of nurse visits=5
Hernandez et al ¹⁵	Mean age 70.5 years, M/F 98/3, respiratory rate 26.8, PaO ₂ =8.63, PaCO ₂ =5.84, pH 7.4	Mean age 71.0 years, M/F 118/4, respiratory rate 26.9, PaO ₂ =8.67, PaCO ₂ =5.69, pH 7.4	Patients escorted home by nurses. Nurses visited patients mornings and evenings for 3 days and thereafter at discretion of nurses. Evening and night cover provided by district nurses. If progress was unsatisfactory, nurse or patient could trigger admission
Nicholson et al ¹⁶	Patient included in trial if aged > 45 years, diagnosis of COPD, current or former smoker, FEV ₁ < 60% predicted, admission required by primary care physician or by hospital staff		Patients had nursing visits on days 1, 2, 3, and 7 (days 4, 5, and 6 were optional) Allied health interventions included dietitians, occupational therapy, pharmacy, physiotherapy, and psychology
Ojoo et al ²⁰	Mean age 70.1 years, M/F 15/15, FEV ₁ (L)=0.85, FVC=1.83, SGRQ total score=67.6	Mean age 69.7 years, M/F 16/14, FEV ₁ =1.0, FVC=1.99, SGRQ=67.9	Patients were monitored daily by nurses. Nurses filled in daily progress and symptom score charts for patients in both study arms. Evening and night cover was provided by a direct line to medical chest unit
Shepperd et al ²²	—	Mean age 71 years, M/F 5/10, no data provided on lung function	Care included nursing, physiotherapy, occupational therapy, and pathology. Patients given mobile phone
Skwarska et al ²¹	Mean age 69.9 years, M/F 24/38, respiratory rate 23.2, FEV ₁ =0.66, oxygen saturation=91.9%, PaO ₂ =10.0	Mean age 68.5 years, M/F 63/59, respiratory rate 22.8, FEV ₁ =0.77, oxygen saturation=92%, PaO ₂ =8.4	122 patients underwent early discharge. Patients visited by nurse next morning and thereafter at 2 to 3 days to monitor need for treatment

SGRQ=St George's hospital respiratory questionnaire.

variables, we calculated fixed effect relative risk and 95% confidence intervals. Heterogeneity among pooled estimates was tested with the DerSimonian and Laird method; P < 0.05 was considered significant.

Results

We included seven randomised controlled trials in the review.^{12 15 16 18-21}

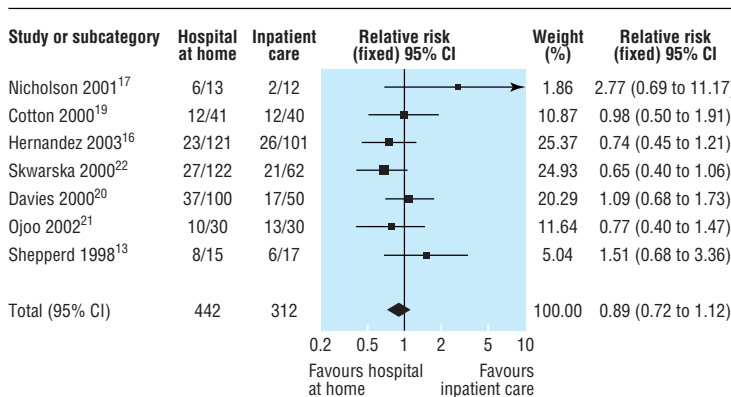
Methodological quality of included trials—All included trials stated that the allocation of treatment was randomised. All except one trial¹⁶ adequately described the allocation concealment method used. We graded six trials as A and one as B. Double blind trial design was not possible because of the nature of the interven-

tion. All except three trials^{12 15 16} adequately reported withdrawals and dropouts. The table shows further details of included trials.

Efficacy variables—Included trials reported study outcome measures two to three months after the initial exacerbation. All seven trials with 754 participants provided data on the rate of readmission to hospital (fig 1). The rate of admission to hospital was not significantly different in the hospital at home group compared with the inpatient group (relative risk 0.89, 95% confidence interval 0.72 to 1.12). Six trials with 729 participants reported mortality data (fig 2). Mortality was not significantly different in the two trial groups (0.61, 0.36 to 1.05).

Six trials provided data on the number of patients presenting with acute exacerbations of COPD who met the strict trial inclusion criteria. These six trials screened a total of 2786 patients presenting with acute exacerbations, 744 (26.7%) of whom met the strict study entry criteria. Most of patients who were not eligible for inclusion in the trials required immediate admission, had concomitant medical conditions (including underlying malignancy, pneumothorax, pneumonia, uncontrolled left ventricular failure, acute changes on electrocardiography), or were attending hospital for non-medical reasons.

Four trials reported cost analysis data, which showed substantial savings with hospital at home schemes. Hernandez et al¹⁵ and Nicholson et al¹⁶ both reported cost savings with hospital at home schemes compared with inpatient care (£533 (\$975, €807) and £649 (\$1188, €967) per patient, respectively). Skwarska et al showed that the mean health service cost for hospital at home care was roughly half that of inpatient care (£877 and £1753, respectively), and the authors went on to conclude that there could also be a notional saving of 433 bed days a year.²¹ Cotton et al reported a



Total events: 123 (hospital at home), 97 (inpatient care)

Test for heterogeneity: $\chi^2=7.35$, df=6, P=0.29

Test for overall effect: z=0.98, P=0.33

Fig 1 Relative risk for readmission to hospital, calculated with fixed effect model with 95% confidence intervals. Square box indicates relative risk for each trial with line representing 95% confidence interval

saving of 201 bed days a year with hospital at home schemes.¹⁸

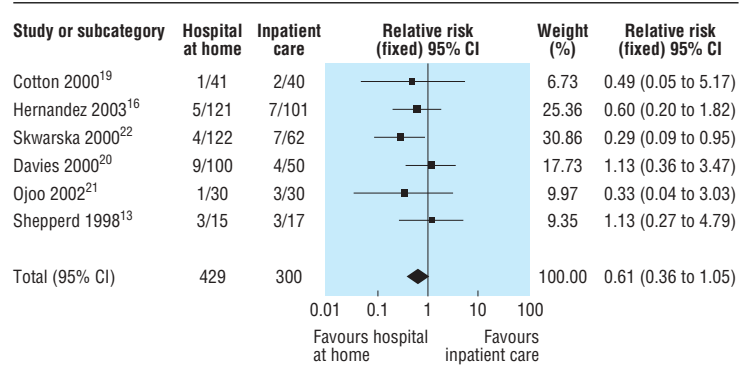
Discussion

The results of this systematic review suggest that selected patients presenting to emergency departments with acute exacerbations of COPD can be safely and successfully treated at home if they are discharged to home care with support from visiting respiratory nurses and a multidisciplinary team.

One of the disadvantages of comparing hospital at home schemes is the difference in the interventions and how the patients were recruited in each of the trials. The interventions varied from avoiding admission by using respiratory nurses based in an emergency department, through to admission and next day discharge, and early discharge with support at home with or without care from a general practitioner with variable intensity of home support. Due to the paucity of data on costs of these different interventions, we can draw no conclusions about their cost effectiveness. Further research is required to define the optimal level of home support, which should incorporate the “real” and full cost of running such services so that comparisons with inpatient care can be justified.

Our review indicates that hospital at home schemes are currently not a suitable option for most patients with acute exacerbations of COPD because only one in four of all such patients presenting to hospital could be managed at home with respiratory nurse support. This figure may be an underestimate because of the limited generalisability of the intervention used in the included trials and the strict inclusion criteria in clinical trials—some patients who did not meet the entry criteria may have been suitable for hospital at home schemes. Additional explanations may be that patients were anxious and refused to take part and the difficulty in recruiting acutely ill patients into clinical trials.

Nevertheless, the small percentage of patients discharged early with respiratory nursing support brings with it substantial cost savings both in terms of



Total events: 23 (hospital at home), 26 (inpatient care)

Test for heterogeneity: $\chi^2=3.66$, $df=5$, $P=0.60$

Test for overall effect: $z=1.77$, $P=0.08$

Fig 2 Relative risk for mortality

direct financial cost and the number of hospital bed days freed, and, importantly, it offers patients' choice. Many admissions for COPD do not occur because of severe exacerbations but because of comorbidities and social circumstances; these patients could safely be managed at home.

As experience and confidence grows with hospital at home schemes and as multidisciplinary organisational arrangements providing such services become harmonised, we will feel more able to discharge patients earlier with nursing and other relevant health-care support. However, if a patient is to be discharged directly from the emergency department extra safeguards should be considered as the patient should have adequate support to be able to cope at home, the patient should understand the treatment prescribed, and sufficient medication should be supplied to last until the next consultation with their general practitioner or specialist.¹⁷

We thank Jo Picot (research fellow, Wessex Institute for Health Research and Development, University of Southampton) for her assistance with the review; Nicholson and coauthors¹⁶ for providing further data; and Sheree Wellington for copyediting/proof reading the manuscript.

Contributors: See bmj.com

Funding: FSFR received a fellowship from the Netherlands Asthma Foundation for the conduct of this review.

Competing interests: None declared.

Ethical approval: Not required.

What is already known on this topic

Acute exacerbations of COPD are an increasingly common cause of admission to hospital, leading to about 90 000 admissions and requiring a million bed days a year

Most patients start to improve within a day or two of initiating standard treatment

Early discharge schemes for patients with less severe exacerbations of COPD are now being widely introduced

What this study adds

In a systematic review with the primary end points of readmission and death, “hospital at home” care was found to be as safe as inpatient care

Cost analysis data suggests considerable financial savings with this form of care

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(Accepted 12 May 2004)

doi 10.1136/bmj.38159.650347.55

Does access to cardiac investigation and treatment contribute to social and ethnic differences in coronary heart disease? Whitehall II prospective cohort study

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BMJ 2004;329:318-21

Abstract

Objective To determine whether access to cardiac procedures and drugs contributes to social and ethnic differences in coronary heart disease in a population setting.

Design Prospective study with follow up over 15 years. Civil service employment grade was used as a measure of individual socioeconomic position. Need for cardiac care was determined by the presence of angina, myocardial infarction, and coronary risk factors.

Setting 20 civil service departments originally located in London.

Participants 10 308 civil servants (3414 women; 560 South Asian) aged 35-55 years at baseline in 1985-8.

Main outcome measures Use of exercise electrocardiography, coronary angiography, and coronary revascularisation procedures and secondary prevention drugs.

Results Inverse social gradients existed in incident coronary morbidity and mortality. South Asian participants also had higher rates than white participants. After adjustment for clinical need, social position showed no association with the use of cardiac procedures or secondary prevention drugs. For example, men in the low versus high employment grade had an age adjusted odds ratio for angiography of 1.87 (95% confidence interval 1.32 to 2.64), which decreased to 1.27 (0.83 to 1.94) on adjustment for clinical need. South Asians tended to be more likely to have cardiac procedures and to be taking more secondary prevention drugs than white participants, even after adjustment for clinical need.

Conclusion This population based study, which shows the widely observed social and ethnic patterning of

coronary heart disease, found no evidence that low social position or South Asian ethnicity was associated with lower use of cardiac procedures or drugs, independently of clinical need. Differences in medical care are unlikely to contribute to social or ethnic differences in coronary heart disease in this cohort.

Introduction

Low social position and South Asian ethnicity are both associated with increased risk of dying from coronary heart disease.^{1 2} Most studies, but not all, find that low social position is associated with lower rates of coronary angiography and revascularisation. Several studies, mainly small and retrospective, report less aggressive treatment of South Asian people with coronary disease compared with white patients. Such potential disparities have stimulated calls for remedial action.^{3 4}

Three inter-related questions remain unanswered. Firstly, in a general population that exhibits social and ethnic differences in rates of coronary heart disease, do differences exist in access to care? Secondly, how does the social deprivation of an individual patient, as opposed to an area, influence access to cardiac investigation and treatment? Thirdly, among South Asians, is the use of cardiac investigation and treatment independent of or explained by their social position?⁵

The Whitehall II prospective cohort study of civil servants offers the opportunity to consider these questions. Our objective was to determine whether access to cardiac procedures and secondary prevention drugs



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