Letters to the Editor

The AEP in the assessment of appropriate hospital stay

To the Editor: The Appropriateness Evaluation Protocol (AEP) is a useful tool for detecting the overuse of hospitalization resources [1,2]. In his article [3], Dr Panis reported results for inappropriateness of stay in the Department of Internal Medicine that were significantly lower than ours [4] (14.1% compared with 33%) and other studies [2,5,6]. This made us re-read the article in order to find the causes that might explain the difference. We thought we would find the answer to this question in Appendix 2, after reading about the modifications made to the US version of the AEP (US-AEP) to create the Dutch AEP (D-AEP). However, the criteria applied to determine whether a stay is appropriate are even more restrictive in the D-AEP: cardiac catheterization, angiography, biopsy of internal organ(s), tests requiring dietary control and respiratory care are not considered criteria of appropriateness of stay in the US-AEP, whereas we consider these appropriateness criteria. We would like to know what percentage of the patients in that subgroup did not fulfill any other criteria of stay, because many of these techniques usually require nursing care or intravenous medication that could make the stay appropriate. Secondly, another point that might explain the difference is the use of the override criteria, mentioned in the Methods section of Dr Panis’ study, to consider the stay appropriate. It would be useful to know the percentage of patients to whom these criteria were applied in order to discern whether the clinical criteria were the determinants of this result. Thirdly, the low percentage of stays may be an indirect marker of low inappropriateness of admissions, because the inappropriate admissions usually generate more inappropriate stays than those that fulfill the criteria of admission [7,8]. Finally, comorbidity of patients may prolong the stay [9,10], sometimes inappropriately. It would be useful to compare the comorbidity of the patients in our respective Internal Medicine Departments. After making these adjustments, it is possible that the difference between the inappropriate stays in the two hospitals would be lower. On the other hand, we want to mention that we have had similar reasons for inappropriate stays. After an analysis was made in 1999, we carried out an intervention program to decrease inappropriate admissions and stays. A diagnosis review and consultation service called the Diagnostic Orientation Consultation service (DOC) was established. The service consists of two internists at any time who are available by telephone or e-mail 24 hours a day for consultation requests from primary care practitioners. The average time from consultation request to response is 72 hours, with the possibility of immediate advice by telephone when necessary. Other main causes of inappropriate admission and stay in our service were the need for a test or examination that could not be delayed to allow for response from the consultation service, and also the wait for test results as the only cause of stay. With this service, we created an accurate in-hospital consultation service with an average waiting time of 7 days from the time of referral from the Emergency Department and 2 days from the performance of tests. These measures allowed a decrease in inappropriate admissions from 13.4% in 1999 to 9.1% in 2001 [4]. Inappropriate stays remain at 33%, however, probably due to the higher comorbidity of patients hospitalized after selection of patients to be admitted to the hospital.

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References
