



Letter to the Editor

A simple audit of the quality of care during internal medicine admissions



To the Editor

Performance measurement in the health care system and especially in hospitals has expanded dramatically in recent years, but remains complex and inconsistent [1].

There is a growing need to simplify its evaluation [2] and use indices that emphasize patient-centered care and patient safety that are often suboptimal and fragmental despite their unequivocal importance [3].

We suggest a unified, simple and cost-effective approach to evaluate the quality of care during internal medicine admissions that is not disease-specific and is based on grading of ten different issues of primacy, based on chart review (CHART), primary care physician contact by phone (PCP), clinical pharmacist's evaluation (PHARM) and patient's recall (or primary caregiver, as appropriate) by phone contact (Pt.).

Ten themes are to be evaluated at a time point ≥ 30 days post-discharge, selected by a review of the literature on measuring quality in hospitals and incorporated into a single, 10-item questionnaire:

- I. Secondary problems attended to (not just the chief complaint) [CHART]
- II. Patient was treated with respect, and as a person [Pt.]
- III. Medication reconciliation reveals no errors (of dose, duration, duplication, drug interactions) or omissions [PHAR, CHART]
- IV. Lifestyle and non-pharmacologic interventions recommended and recorded [CHART]
- V. Primary prevention advice (vaccinations, colonoscopy, bone mineral density, etc.) administered [CHART]
- VI. Health literacy promoted [Pt.]
- VII. Contextual issues considered [CHART, Pt.]
- VIII. Adequate handoff and follow up arranged [CHART, PCP]
- IX. No unplanned readmission [4] or unexpected mortality within 30 days post-discharge [CHART, PCP]

- X. No preventable adverse events (falls, infections, adverse drug reactions...) reported during admission and after discharge [CHART, Pt., PCP]

A positive answer on each item is awarded 10 points (or 5 points for a partially positive answer) to a top mark of 100 points. The evaluation highlights elements of patient-centered care (items II, VI, VII), patient safety (III, VIII, X) and providers' attention to future comprehensive health maintenance (I, IV, V, VI). The patient's own experience of receiving humanistic care is also being considered (II). These data can be collected with relative ease by an independent audit performed by a 2-person team (hospitalist, pharmacist), and can be used to compare different departments in single or multiple institutions, as well as the same department over time. The proposed audit requires validation, which is currently under way.

At the same time, wide awareness of the points being tested, may well serve to increase providers' level of performance during their care of medical inpatients.

References

- [1] MacLean CH, Kerr EA, Qaseem A. Time out - charting a path for improving performance measurement. *N Engl J Med* 2018;378:1757–61.
- [2] Wilensky G. The need to simplify measuring quality in health care. *JAMA* 2018;319:2369–70.
- [3] Berwick DM. A user's manual for the IOM's 'quality chasm' report. *Health Aff (Millwood)* 2002;21:80–90.
- [4] Krumholz HM, Wang K, Lin Z, et al. Hospital-readmission risk - isolating hospital effects from patient effects. *N Engl J Med* 2017;377:1055–64.

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