Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

June 2016

The ED Return Visit Quality Program: Webcast Follow-Up

Ontario
Health Quality Ontario

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Introduction

On April 28, 2016, a webcast event was held by Health Quality Ontario (HQO) and the Ontario Hospital Association (OHA) to introduce the Emergency Department (ED) Return Visit Quality Program. A recording of the webcast can be viewed here.

This document includes answers to the questions that were submitted by participants in this webcast. If you have any questions that are not answered here, please refer to our Frequently Asked Questions guidance document or consult the other resources related to this program on the ED Return Visit Quality Program website.

Please contact EDQuality@hqontario.ca if you have additional questions about this program.

Data & Reports

1. How do I access the data reports?

You can obtain your data reports through iPort Access™. The iPort Access™ Local Registration Authority (LRA) at each site should submit the details of the identified users using the email outline below:

Email to: iPortAccess@cancercare.on.ca
Subject: Return Visit Rate Report Access Request (Patient Level)
Email Body:
- Local Registration Authority (LRA) details
    - Site Name
    - iPort™ Access LRA User
- Authorized Users:
    - Site Name
    - iPort™ Access User

Please refer to Question 9 in this Frequently Asked Questions guidance document for more information, including who to contact if you have further questions on accessing the reports.

2. How timely are the data reports? Are reports posted to iPort Access™ month by month?

Data reports are released quarterly (i.e., April 1, July 1, October 1 and January 1). The data within the reports will relate to cases in which discharge from an inpatient unit occurred three to six months before the release of the report. For example, the report released on April 1, 2016 contains data for cases involving patients who were discharged between October 1, 2015 and December 31, 2015.

Please refer to Question 12 in this Frequently Asked Questions guidance document for more information on the timelines for data report release.

3. Does 2016/17 reporting align only with 2016/17 cases, or can we start audits now on the Q4 2015/16 cases included in the April 1, 2016 data report and count these towards our 25 2016/17 cases?

Yes, you can start audits now on the Q4 2016/17 cases included in the April 1, 2016 data report and count these towards your 2016/17 cases.

The ED Return Visit Quality Program operates on a calendar year based on when the data reports are released. Thus, the first submission to HQO in January 2017 will include audits of cases identified from the data reports released during 2016 (on April 1, July 1 and October 1). These reports will include data from October 1, 2015 through June 30, 2016.

Please refer to Question 12 in this Frequently Asked Questions guidance document for more information on the timelines for data report release and submission to HQO.

4. Are there any concerns about the delay in the availability of the data reports? It will be difficult for physicians to remember the case if it is reviewed potentially six months after the return visit.

The benefit of using records from the Discharge Abstract Database (DAD) to identify return visits is that the data provided are accurate. Unfortunately, use of the DAD also leads to a delay in data provision. Each data report will list cases for which the patient was discharged between three and six months before the release of the report.

Because the initial investigation of the case will be based on medical record review and will be performed by a physician other than the treating physician, the time elapsed since the case presented will not matter for most cases that are audited. Valuable information can certainly be drawn from these reviews. However, if an incident is uncovered that requires returning to the clinical team for investigation, it is understood that recall may not be high by the point that case is audited.

We encourage you to keep conducting the audits throughout the year to minimize any additional lag induced by waiting to conduct audits. In addition, if you have a way of flagging return visits available in your organization that will provide more recent data or could be generated more quickly, you are welcome to use this to identify cases to audit on a more timely basis.

Case Selection & Technical Specifications

5. How are the return visits included in the data reports identified?

The technical specifications used to identify cases included in the data reports are described in Question 13 in this Frequently Asked Questions guidance document. You can contact Access to Care (ATC@cancercare.on.ca) if you have additional questions about how cases are identified.

6. Will there be consideration to include other sentinel diagnoses – for example, adult sepsis? Is there a reason adult sepsis was excluded in this round?

We selected the three sentinel diagnoses based on published research conducted by ICES.[1,2,3] We chose to use the same sentinel diagnoses as described in these publications because the reporting procedures as well as the quality of data that results are already validated. In addition, we confirmed that selection of these diagnoses will identify a manageable number of cases that are very likely to be worth reviewing. Apart from this justification based on methodology and scope, the chosen sentinel diagnoses represent areas where there may be diagnostic challenges in emergency medicine, and where a delayed diagnosis presents a risk of a poorer outcome for the patient.

We will continue to revise the program and learn from experience as the program progresses. We are certainly open to considering any changes we can make in future years that could make the program more effective. This may include considering more or different sentinel diagnoses in future years, depending on the results of the first year of the program.

7. Besides the mandatory reviews of sentinel admissions, are you looking for the rest of the reviews to be only geared to admissions or could it be repeat ED visits that do not necessarily result in admission?

The data reports will *only* include cases involving return visits that resulted in admission. This applies to both return visits within 72 hours for any diagnosis as well as return visits within 7 days for a sentinel diagnosis. Thus, all audits will be conducted on cases involving return ED visits that resulted in admission.

8. Are we only looking at the 3 sentinel diagnoses?

No – in addition to auditing all cases involving sentinel diagnoses, you will need to audit a random selection of return visits within 72 hours resulting in admission for any diagnosis until the required number of audits is met. The breakdown of cases to be audited is presented in the graphic below.

Audits for 2016 (Year 1)

Audits for 2017 and future years (Year 2 and beyond)

To give an idea of the typical case numbers presented in these data reports, an ED with ~50,000 visits annually would typically have 0, 1 or 2 cases involving sentinel diagnoses per quarter, and 100 to 200 return visits within 72 hours with any diagnosis.

9. Our hospital is participating with NSQIP and the American College of Surgeons - Surgical Quality Improvement Program. Is there a specific audit for return visits to the ED after surgical procedures within 30 days after an operation?

Audits of return visits to the ED within 30 days post-operation will not be included in this program. The data reports provided for this program include return visits within 72 hours for any diagnosis and return visits within 7 days for the three sentinel diagnoses. Your audit requirements can only be fulfilled by auditing cases from these data reports.

Although audits of return visits to the ED after surgical procedures may be valuable, the aim of the ED Return Visit Quality Program is to focus on the quality of care provided *within* the ED. Investigating post-surgical visits to the ED would be expected to reveal information about the quality of care provided *outside* the ED (e.g., to surgical outpatients or inpatients), as well as information about transitions of care. We encourage you to investigate post-surgical return visits to the ED if you feel that this would be valuable; however, this would be out of the scope of the ED Return Visit Quality Program.

10. If a patient is transferred to another site with a sentinel diagnosis, will this trigger a review, or will these cases be exempt?

The data reports provided by Access to Care exclude cases in which the second visit is marked as a transfer in the National Ambulatory Care Reporting System (NACRS) database. Thus, cases involving transfers rather than return visits are exempt and should not appear in the data report. However, as data quality on transfers may be imperfect, some cases involving transfers may appear in the report. You will be able to determine this during the screening portion of the audit based on review of the record of the initial visit. Since these cases are unlikely to involve quality issues, you will not need to complete a full analysis of the cases following the screening portion of the audit.

11. How are you locating the sentinel diagnoses in the electronic medical records?

Cases flagged as Sentinel Diagnosis in the data reports meet the following criteria:

- **Visit 1:** A main problem diagnosis that is deemed to be relevant to their sentinel diagnosis in visit 2 (e.g., angina for acute myocardial infarction, headache for subarachnoid hemorrhage and fever for paediatric sepsis), as recorded in the NACRS database.
- **Visit 2:** A most responsible diagnosis on discharge from an inpatient unit corresponding to one of the three sentinel diagnoses, as recorded in the Discharge Abstract Database (DAD).

For more information, including the *International Classification of Diseases – 10th revision* (ICD-10) codes used to flag cases in each of these visits, refer to the technical specifications presented in Question 13 in this Frequently Asked Questions guidance document.

12. Would coroner cases constitute a 'return visit'? For example, a patient discharged from the ED who subsequently suffers a fatal AMI, but never returns to the ED.

Coroner cases will only be included in your data report if the death was preceded by a return visit to the ED, in which case the return visit will be reported to NACRS and included in the data report. If the coroner has concerns about a death involving a patient you have treated in your ED, they will be in touch with your organization and you will learn about the case in this way. You do not need to include these cases in your audits for this program.

13. What constitutes a return visit: time between visit and/or is it disease specific?

There are two separate classifications of return visits flagged in the data reports. The first includes return visits resulting in admission for *any* diagnosis. The timeline is 72 hours from time of discharge on the index visit to time of return on the visit that leads to admission. The second includes return visits resulting in admission with a sentinel diagnosis, with a main problem diagnosis on the first visit that is deemed to be relevant to the sentinel diagnosis. The timeline is 7 days from the time of discharge from the ED to the time of return on the next visit that leads to admission.

14. Given the sentinel diagnoses mentioned, it does beg the question of compliance with ECFAA and the Public Hospitals Act definition. There will likely be confusion when the word sentinel is used. This triggers a significant response from organizations, i.e., meeting with families and sharing recommendations. We should be clear that this is a separate and distinct process.

A sentinel diagnosis as described in this program refers to a diagnosis on the return admitting visit that will signal a need for a mandatory audit of the case during the audit process. There is an increased likelihood of finding a quality issue while investigating cases involving sentinel diagnoses. The Public Hospitals Act refers to “critical incidents”. Not all cases where there is a sentinel diagnosis will meet the criteria of a critical incident, as defined in the Public Hospitals Act.

15. If a patient leaves without being seen in one facility and presents to another within 72 hours and is admitted, is this included in total return visit volume?

Yes. Patients whose visit disposition is recorded as left without being seen (LWBS) and who have a return visit resulting in admission within 72 hours will be included in the total return visit volume (regardless of whether the return visit is to the same or a different hospital).

16. Are patients who return for scheduled interventions following an ED visit and subsequently require admission based on findings included in total return visit volume?

Scheduled visits are not included in the return visit volumes. Scheduled visits are identified using the ED Visit Indicator in the NACRS database. As per the NACRS guidelines, a value of 0 (Not an ED visit) should be assigned if the patient had a scheduled visit to the ED where the visit date and time are fixed and the appointment is recorded in a scheduling system (electronic or manual).

Who Is Involved in this Program

17. Are small, rural hospitals or hospitals that do not receive data from Access to Care exempt? We do not receive data from Access to Care so are we still obligated to report, audit, etc.? How and when will we have access to the data reports if this is an obligation?

This program is mandatory **only** for hospitals participating in the Pay for Results (P4R) program, although we will support others that wish to participate.

If your hospital reports data through the ER NACRS Initiative (ERNI), Access to Care will be able to provide data to you, and HQO, the OHA and the LHIN leads will provide the same level of attention and support for your efforts as everyone else. Be sure to contact Access to Care to identify the iPort Access users who will receive the data reports for your site. Please refer to Question 9 in this Frequently Asked Questions guidance document for more information, including who to contact if you have further questions on accessing the reports.

If your hospital does not report data through ERNI, you will not receive the data reports. However, you may be able to use your own internal data sets to flag return visits occurring to your ED. We encourage you to use the audit template, guidance material and supports available to conduct audits on return visits.

18. Who would be considered responsible for owning the audit process? Would it be the quality program director, medical director or manager of the ED, or does each hospital make that decision?

Ideally, participation in this program will be a collaborative process. Rather than ownership, participating hospitals should think about how to integrate this program into their organization in the most constructive and efficient way based on the procedures that they currently have in place for managing and overseeing quality.

Hospitals will need to summarize the results of the audits and potential actions for quality improvement for their CEO and Quality Committee of the Board. Thus, some hospitals may deem it appropriate for the Quality Committee of the Board to have broad oversight to drive the process and review the findings in a consistent and comprehensive manner. Alternatively, hospitals may wish to leverage the Medical Advisory Committee or another appropriate committee to fulfill this role.

Ultimately, it is the CEO who will be responsible to ensure that the obligations are met. This is consistent with other components of the P4R program, which are administered/overseen by the CEO.

Conducting Audits

19. Are there definitions for cause type and subtype in the audit template?

The cause types and subtypes presented in the audit template were originally described in the World Health Organization's Conceptual Framework for the International Classification for Patient Safety. Pages 91-92 of this document provide more detailed breakdowns of staff and patient factors that may aid in understanding the meaning of these classifications.

20. Is the number of audits corrected for patient volumes?

No. We are setting minimum standards with the required number of audits. Fifty audits per year represents one audit per week, and our advisors indicated that this would not be onerous, even in smaller EDs.

21. We are a multi-site organization. Are we to audit 25 cases per site or from all sites combined?

Multi-site organizations will need to audit 25 cases per site. This is consistent with the way multi-site EDs are treated with regard to public reporting of performance and funding through the P4R program with each ED site being handled independently and data being provided at the site level.

22. Excluding the sentinel event cases, should hospitals randomly choose the cases to review? Can we utilize those groups of patients that we suspect may have work we need to do at our site and include in this learning opportunity (e.g., chronic obstructive pulmonary disease or surgical cases)?

It is important not to choose cases to audit in a way that would systematically exclude cases that may involve quality issues or adverse events. Random selection is a logical way to do this. Randomly selecting cases to audit will also provide you with a good overview of the common causes of return visits to your ED.

However, there may be ways in which you feel that you could increase the likelihood that the cases you audit reveal learning opportunities – for example, you may screen more than the required number of cases to audit but only include those that you feel may have quality issues in your audit template. In this case, we trust that you will use your best judgement to determine your approach.

We also encourage you to go beyond the minimum number of audits to learn from the valuable information presented in these data reports. For example, if you find that access to imaging after hours is a challenge in your facility and suspect that you may be missing cases of appendicitis that you would otherwise identify because of this, you may wish to scan the report for patients with a return diagnosis of appendicitis to

investigate whether access to imaging was a factor. We encourage you to include the results of these additional audits in your report to HQO.

23. Does screening count as an audit? In other words, if a return visit is screened out, does that count towards the minimum requirement?

Yes. The audit process consists of an initial screening procedure, followed by an in-depth analysis of potential adverse events or quality issues. If you conduct the first part of this screening and find that an in-depth analysis is not necessary (e.g., if the two visits were clearly unrelated), this still counts as an audit.

Reaching Out Beyond Your ED

24. I'm interested to know how you involve other physicians in reviews of patients who are referred to an internal service such as Medicine or Surgery but are then discharged home by that service. The ED Physician won't be able to comment on the reasons why the person was sent home.

The ED is dependent on multiple different services – consultants, radiologists, laboratories, etc., and return visits will often reveal issues beyond the ED. If these issues arise, we expect that you will describe them in your audit and your report to HQO, and expect you to use your judgment to pursue them wherever they will lead you. The strength of this program will lie in the collaborative process of the audit to identify opportunities for quality improvement.

25. How are community and primary care providers engaged in the process to identify failures in the community?

During the audit process, you may identify system issues that extend outside your ED as contributing to return visits. Examples include when patients are unable to access or fill their prescriptions or are unable to attend an appointment to their primary care provider or a clinic as advised on discharge. There may be limits as to what your hospital alone can do to prevent these return visits from occurring.

If you identify broader system issues such as these, we would like to hear about them in your reports to HQO. If trends emerge, we will report on them publicly in our review of the annual reports. We hope that you begin to develop quality improvement initiatives that involve reaching out to other organizations in the community to improve broader issues that can contribute to return visits to the ED.

26. Are hospitals required to screen and/or audit cases where the patient was seen in an ED that is not part of their hospital corporation? Is there transparency between hospitals to facilitate follow-up?

Hospitals are only required to audit cases for which the *initial* visit was to their hospital. Return visits involving a second visit to a different hospital will only be flagged in the data report of the hospital to which the initial visit occurred. The fact that the return visit occurred at a different hospital will be clearly marked in the data report, but the hospital will not be identified to ensure that the privacy of the patient is protected.

Because the focus is on the care provided in the initial visit, you can still conduct the audit based on the record of the first visit as well as the discharge diagnosis on the second visit as listed in the data report. To obtain more information or access the medical records of the return visit, you would have to contact the patient or their representative and get the information from them directly or obtain their consent to contact the other hospital.

Preliminary assessment shows that approximately 80% of return visits with a sentinel diagnosis flagged in the data reports involve the same hospital site; therefore, we anticipate you will be able to access information on the second visit for the majority of cases in your data report.

Funding

27. Is there funding available for the additional workload this initiative will place on lead physicians and ED teams?

Although the program is a requirement for hospitals participating in the P4R program, funding will **not** be tied to the results of the ED Return Visit Quality Program, and no additional funding is available for hospitals that participate in this program. This program was designed to be as user-friendly as possible to ensure that the program is useful, yet it is not onerous to meet the minimum requirements for the number of audits to be conducted. Informal feedback from the field (mainly directors of EDs) as to whether they believed they would require funding, knowing that it would need to come from other sources, was that most did not feel that this would be necessary.

Requirements for Submission to HQO

28. Do we need to submit the audit template to HQO?

We will ask you to **not** send the full template back as part of your submission to HQO because the completed template could constitute personal health information. The audit template is provided as a tool for you to use internally while conducting your audits. HQO will be releasing guidance regarding what information you should include in your submission to HQO in the coming months.

Privacy

29. Will these ED Quality reviews be conducted under the *Quality of Care Information Protection Act* (QCIPA)?

Each hospital has its own process for determining whether quality of care reviews are conducted under QCIPA. QCIPA protects information prepared by or for a committee that has been designated as a quality of care committee under QCIPA. Facts and issues documented in the patient's chart are generally *not* protected by QCIPA. Hospitals are advised to speak with their legal counsel and/or consult the numerous resources created by the OHA regarding QCIPA and quality of care information at www.OHA.com.

QCIPA will not apply to the reports to be submitted to HQO because the reports will not include individual case summaries. We will be releasing guidance regarding what information you will need to submit to HQO in the coming months.

References

1. Vermeulen MJ, Schull MJ. Missed diagnosis of subarachnoid hemorrhage in the emergency department. Stroke 207;38:1216–1221.

2. Schull MJ, Vermeulen MJ, Stukel TA. The risk of missed diagnosis of acute myocardial infarction associated with emergency department volume. Ann Emerg Med 2006;48(6):647–655.

3. Vaillancourt S, Guttmann A, Li Q, Chan IYM, Vermeulen MJ, Schull MJ. Repeated emergency department visits among children admitted with meningitis or septicemia: A population-based study. Ann Emerg Med 2014;65(6):625–632.