

QUALITY STANDARDS

# Transitions Between Hospital and Home

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Care for People of All Ages

Measurement Guide

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**Ontario Health**  
Quality

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# 1 How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support the adoption of the Transitions Between Hospital and Home quality standard. Care for people transitioning between hospital and home is a critical issue, and there are significant gaps and variations in the quality of care that people transitioning between hospital and home receive in Ontario. Recognizing this, the Quality business unit at Ontario Health (formerly Health Quality Ontario) released this quality standard to identify opportunities that have a high potential for quality improvement.

This guide is intended for use by those looking to adopt the Transitions Between Hospital and Home quality standard, including health care professionals working in regional or local roles.

This guide has dedicated sections for each of the two types of measurement within the quality standard:

- **Local measurement:** what you can do to assess the quality of care that you provide locally
- **Provincial measurement:** how we can measure the success of the quality standard on a provincial level using existing provincial data sources

## Important Resources for Quality Standard Adoption

Ontario Health (Quality) has created resources to assist with the adoption of quality standards:

- A *Getting Started Guide* that outlines a process for using quality standards as a resource to deliver high-quality care. It includes links to templates, tools, and stories and advice from health care professionals, patients, and caregivers. You can use this guide to learn about evidence-based approaches to implementing changes to practice
- A *Quality Improvement Guide* to give health care teams and organizations in Ontario easy access to well-established quality improvement tools. The guide provides examples of how to adapt and apply these tools to our Ontario health care environments
- An online community called *Quorum* that is dedicated to working together to improve the quality of health care across Ontario. Quorum can support your quality improvement efforts

## 2 Quality Indicators in Quality Standards

Quality standards inform providers and patients about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are intended to guide quality improvement, monitoring, and evaluation.

Measurability is a key element in developing and describing the quality statements; each statement is accompanied by one or more indicators. This section describes the measurement principles behind the quality indicators, the process for developing these indicators, and the technical definitions of the indicators.

An effective quality statement must be measurable. Measurement is necessary to demonstrate if a quality statement has been properly implemented, and if it is improving care for patients. This is a key part of the [Plan-Do-Study-Act](#) improvement cycle. If measurement shows there has been no improvement, you need to consider a change or try something different.

### 2.1 Measurement Principles

Ontario Health (Quality) uses the process, structure, and outcome indicator framework developed by [Donabedian](#) in 1966 to develop indicators for quality standards. The three indicator types play essential and interrelated roles in measuring the quality of health care and the impact of introducing and using quality standards.

The indicators provided are merely suggestions. It is not expected that every provider, team, or organization will be able measure all of them (or even want to measure all of them), but they can identify which indicators best capture areas of improvement for their care and what can be measured given existing local data sources.

### 2.2 Process Indicators

Process indicators assess the activities involved in providing care. They measure the percentage of individuals, episodes, or encounters for which an activity (process) is performed. In most cases, the numerator should specify a timeframe in which the action is to be performed, established through evidence or expert consensus. When a quality statement applies to a subset of individuals rather than the total population, the denominator should reflect the population of the appropriate subgroup, rather than the entire Ontario population. If exclusions are required or stratifications are suggested, they are reflected in the indicator specifications.

Process indicators are central to assessing whether or not the quality statement has been achieved; nearly all quality statements are associated with one or more process indicators. In most cases, the numerator and denominator for process indicators can be derived from the language of the quality statement itself; additional parameters (such as a timeframe) can also appear in the background and definitions sections. In some cases, a proxy indicator is provided that indirectly measures the process. Proxy indicators are used only when the actual indicator cannot be measured with currently available data.

While most quality statements focus on a single concept and are linked with a single process indicator, some statements include two or more closely related concepts. In these cases, multiple process

indicators can be considered to capture all aspects of the quality statement. For example, a quality statement might suggest the need for a comprehensive assessment with several components, and each of those components might have a process indicator.

Examples of process indicators include the percentage of patients with hip fracture who receive surgery within 48 hours, or the percentage of patients with chronic obstructive pulmonary disease who are offered clozapine after first- and second-line antipsychotics have been ineffective. Please refer to the published [quality standards](#) for more examples.

### **2.3 Structural Indicators**

Structural indicators assess the structures and resources that influence and enable delivery of care. These can include equipment; systems of care; availability of resources; and teams, programs, policies, protocols, licences, or certifications. Structural indicators assess whether factors that are in place are known to help in achieving the quality statement.

Some quality statements have structural indicators associated with them. Structural indicators are binary or categorical and do not require the definition of a numerator and denominator. However, in some cases it could be useful to specify a denominator defining an organizational unit, such as a hospital, a primary care practice, or a local region. In many cases data to measure structural indicators are not readily available using existing administrative data, so local data collection might be required. This local data collection might require regional or provincial level data collection systems to be developed.

Structural indicators should be defined for a quality statement or for the quality standard as a whole when there is strong evidence that a particular resource, capacity, or characteristic is important for enabling the effective delivery of a process of care. It should be theoretically feasible for these structural elements to be implemented across Ontario, even if adoption is aspirational in some cases. In rare instances, a quality statement might have two or more associated structural indicators, if the quality standard advisory committee decides that multiple factors are crucial to the delivery of the quality statement. Structural indicators should align with the Recommendations for Adoption, which outline gaps in resources in the province.

Examples of structural indicators include the availability of a stroke unit, the existence of discharge planning protocols, or access to a specialized behavioural support team. Please refer to the published [quality standards](#) for more examples.

### **2.4 Outcome Indicators**

Outcome indicators assess the end results of the care provided. They are crucial and are arguably the most meaningful measures to collect, but many health outcomes—such as mortality or unplanned hospital readmissions—are often the product of a variety of related factors and cannot be reliably attributed to a single process of care. For this reason, although relatively few quality statements are directly linked to an outcome indicator, a set of overall measures—including key outcome indicators—is defined for the quality standard as a whole, reflecting the combined effect of all of the quality statements in the standard. Similar to process indicators, outcome indicators should be specified using a defined denominator and a numerator that, in most cases, should include a clear timeframe.

Examples of outcome indicators include mortality rates, improvement (or decline) in function, and patients' experience of care. Please refer to the published [quality standards](#) for more examples.

## 2.5 Balancing Measures

Balancing measures indicate if there are important unintended adverse consequences in other parts of the system. Examples include staff satisfaction and workload. Although they are not the focus of the standard and generally not included in the standard, the intention of these types of measures is to monitor the unintended consequences.

# 3 Local Measurement

As part of the Transitions Between Hospital and Home quality standard, *specific* indicators were identified for each of the statements to support measurement for quality improvement.

As an early step in your project, we suggest that your team complete an *initial assessment* of the relevant indicators in the standard and come up with a draft measurement plan.

Here are some concrete next steps:

- Review the list of identified indicators (See Appendix 2 in the quality standard), and determine which ones you will use as part of your adoption planning, given your knowledge of current gaps in care
- Determine the availability of data related to the indicators you have chosen
- Identify a way to collect local data related to your chosen indicators. This may be through clinical chart extraction or administration of local surveys for example.
- Develop a draft measurement plan

The earlier you complete the above steps, the more successful your quality improvement project is likely to be.

## 3.1 Local Data Collection

Local data collection refers to data collection at the health provider or team level for indicators that cannot be assessed using provincial administrative or survey databases (such as databases held by the Institute for Clinical Evaluative Sciences or the Canadian Institute for Health Information). Examples of local data include data from electronic medical records, clinical patient records, regional data collection systems, and locally administered patient surveys. Indicators that require local data collection can signal an opportunity for local measurement, data advocacy, or data quality improvement.

Local data collection has many strengths: it is timely, can be tailored to quality improvement initiatives, and is modifiable on the basis of currently available data. However, caution is required when comparing indicators using local data collection between providers and over time to ensure consistency in definitions, consistency in calculation, and validity across patient groups.

## 3.2 Measurement Principles for Local Data Collection

Three types of data can be used to construct measures in quality improvement: continuous, classification, and count data. For all three types of data, it is important to consider clinical relevance when analyzing results (i.e. not every change is a clinically relevant change).

### 3.2.1 Continuous Data

Continuous data can take any numerical value in a range of possible values. These values can refer to a dimension, a physical attribute, or a calculated number. Examples include patient weight, number of calendar days, and temperature.

### **3.2.2 Classification Data**

Classification (or categorical) data are recorded in two or more categories or classes. Examples include sex, race or ethnicity, and number of patients with depression versus number of patients without depression. In some cases, you might choose to convert continuous data into categories. For example, you could classify patient weight as underweight, normal weight, overweight, or obese.

Classification data are often presented as percentages. To calculate a percentage from classification data, you need a numerator and a denominator (a percentage is calculated by dividing the numerator by the denominator and multiplying by 100). The numerator includes the number of observations meeting the criteria (e.g., number of patients with depression), and the denominator includes the total number of observations measured (e.g., total number of patients in clinic). Note that the observations in the numerator must also be included in the denominator (source population).

Examples of measures that use classification data include percentage of patients with a family physician and percentage of patients who receive therapy.

### **3.2.3 Count Data**

Count data often focus on attributes that are unusual or undesirable. Examples include number of falls in a long-term care home and number of medication errors.

Count data are often presented as a rate, such as the number of events per 100 patient-days or per 1,000 doses. The numerator of a rate counts the number of events/nonconformities, and the denominator counts the number of opportunities for an event. It is possible for the event to occur more than once per opportunity (e.g., a long-term care resident could fall more than once).

$$\text{Rate of 30-day hospital readmission} =$$

$$\frac{\text{Number of hospital readmissions within 30 days of discharge [numerator]}}{\text{Number of discharges from hospital [denominator]}}$$

### **3.2.4 Benefits of Continuous Data**

It is common practice in health care to measure toward a target instead of reporting continuous measures in their original form. An example would be measuring the number of patients who saw their primary care physician within 7 days of hospital discharge instead of measuring the number of days between hospital discharge and an appointment with a primary care physician. Targets should be evidence-based or based on a high degree of consensus across clinicians.

When a choice exists, continuous data sometimes are more useful than count or classification data for learning about the impact of changes tested. Measures based on continuous data are more responsive and can capture smaller changes than measures based on count data; therefore, it is easier and faster to see improvement with measures based on continuous data. This is especially true when the average value for the continuous measure is far from the target. Continuous data are also more sensitive to change. For example, while you might not increase the number of people who are seen within 7 days, you might reduce how long people wait.

### **3.3 Benchmarks and Targets**

Benchmarks are markers of excellence to which organizations can aspire. Benchmarks should be evidence-based or based on a high degree of consensus across clinicians. At this time, Ontario Health (Quality) does not develop benchmarks for the indicators. Users of these standards have variable practices, resources, and patient populations, so one benchmark might not be practical for the entire province.

Targets are goals for care that are often developed in the context of the local care environment. Providers, teams, and organizations are encouraged to develop their own targets appropriate to their patient populations, their current performance and their quality improvement work. Organizations that include a quality standard indicator in their quality improvement plans are asked to use a target that reflects improvement. Timeframe targets, like the number of people seen within 7 days, are typically provided with process indicators intended to guide quality improvement.

In many cases, achieving 100% on an indicator is not possible. For example, someone might not receive care in a wait time benchmark due to patient unavailability. This is why it is important to track these indicators over time, to compare results against those of colleagues, to track progress, and to aim for the successful implementation of the standard.

For guidance on setting benchmarks and targets at a local level, refer to:

- [Approaches to Setting Targets for Quality Improvement Plans](#)
- [Long-Term Care Benchmarking Resource Guide](#)

## 4 Provincial Measurement

In its quality standards, Ontario Health (Quality) strives to incorporate measurement that is standardized, reliable, and comparable across providers to assess the impact of the standards provincially. Where possible, indicators should be measurable using province-wide data sources. However, in many instances data are unavailable for indicator measurement. In these cases, the source is described as local data collection.

For more information on the data sources referenced in this standard, please see the [appendix](#).

### 4.1 Accessing Provincially Measurable Data

Provincial platforms are available to users to create custom analyses to help you calculate results for identified measures of success. Examples of these platforms include IntelliHealth and eReports. Please refer to the links below to determine if you have access to the platforms listed.

#### 4.1.1 [\*IntelliHealth—Ministry of Health\*](#)

IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. IntelliHealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data.

#### 4.1.2 [\*eReports—Canadian Institute for Health Information\*](#)

Quick Reports offer at-a-glance comparisons for the organizations you choose. The tool also provides some ways to manipulate the pre-formatted look and feel of the reports. Flexible or Organization Reports offer you many choices to compare your organization's data with those of other organizations. With these customizable reports, you can view data by different attributes and for multiple organizations.

#### 4.1.3 [\*Applied Health Research Questions \(AHRQ\) — Institute for Clinical Evaluative Sciences\*](#)

ICES receives funds from the Ministry of Health to provide research evidence to organizations from across the Ontario health care system (Knowledge Users). This knowledge is used to inform planning, policy and program development. Knowledge Users can submit an Applied Health Research Question (AHRQ) to ICES. As a health services research institute that holds Ontario's administrative data, ICES is well positioned to respond to AHRQs that directly involve the use of ICES data holdings.

## 5 How Success Can Be Measured for This Quality Standard

This measurement guide accompanies Ontario Health (Quality)'s Transitions Between Hospital and Home quality standard. During the development of each quality standard, a few performance indicators are chosen by the Quality Standards Advisory Committee to measure the success of the entire standard. These indicators guide the development of the quality standard so that every statement within the standard aids in achieving the standard's overall goals.

This measurement guide includes information on the definitions and technical details of the indicators listed below which were selected as the overall measures of success for this standard:

- Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their care and treatment as much as they wanted to be
- Percentage of people discharged from hospital to home who report that the doctors or staff at the place where they usually get medical care seem informed and up to date about the care they received in the hospital
- Percentage of people discharged from hospital to home who received home care who report that their home care started when they needed it to
- Median and mean wait time from hospital discharge to first home care service date for people newly approved for home care services
- Percentage of people discharged from hospital whose primary informal caregiver reports feeling prepared for the role of caregiving
- Percentage of people discharged from hospital to home who visit the emergency department within 7 days and 30 after discharge
- Percentage of people discharged from hospital to home who were readmitted to hospital within 7 days and 30 after discharge
- Percentage of people discharged from hospital for whom discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital

Indicators are categorized as:

- Provincially measurable (the indicator is well defined and validated) *or*
- Locally measurable (the indicator is not well defined, and data sources do not currently exist to measure it consistently across providers and at the system level)

For more information on statement-specific indicators, please refer to the quality standard.

### 5.1 Quality Standard Scope

This quality standard addresses care for people of all ages transitioning (moving) from hospital to home, commonly referred to as a "hospital discharge." This includes people who have been admitted as inpatients (planned and unplanned) to any type of hospital, including complex continuing care facilities and rehabilitation hospitals. "Home" is broadly defined as a person's usual place of residence and may include personal residences, retirement residences, assisted-living facilities, long-term care facilities,

hospices and shelters. The scope of this quality standard includes all clinical populations, including groups that often face challenges with transitions (e.g., people with complex care needs, mental health, addictions, palliative, or end-of-life care needs), and applies to all health care providers.

This quality standard does not address the specifics of or focus on the following transitions, although many of the statements may apply to them:

- Transitions from inpatient mental health settings to home
- Transitions from emergency department visits to home
- Postnatal care for healthy/stable mothers and infants returning home

This quality standard does not address the following transitions:

- Transitions from children's to adult's services for young people
- Inter- and intra-hospital transitions

The Quality Standard will not address details of managing Alternate Level of Care (ALC).

## 5.2 Cohort Identification

People transitioning between hospital and home can be identified in a variety of ways, including surveys or administrative data.

### 5.2.1 Cohort Identification Using Surveys

Several surveys used in Ontario ask respondents if they have recently been discharged from hospital. Examples of these surveys include the following (this list is not exhaustive):

- [Commonwealth Fund International Health Policy Survey of Adults, Commonwealth Fund](#)
- [Commonwealth Fund International Health Policy Survey of Older Adults, Commonwealth Fund](#)
- [Ministry of Health and Ministry of Long-Term Care Health Care Experience Survey \(HCES\), Statistics Canada](#)
- Home Care Client Experience Survey (In Publication), Local Health Integration Networks
- Home Care Caregiver Experience Survey (In Publication), Local Health Integration Networks
- [Canadian Patient Experience Survey \(Inpatient Care\), Canadian Institute for Health Information, Ontario Hospital Organization](#)
- [Ontario Pediatric Patient Experience of Care Survey, Ontario Hospital Organization](#)
- [NHCAHPS Long-Term Care Resident Experience Survey, Consumer Assessment of Healthcare Providers and System](#)
- [Integrated Funding Model](#) (Patient), Ministry of Health
- [Integrated Funding Model](#) (Caregiver), Ministry of Health

For local data collection purposes, questions from these surveys can be included in local surveys or could be used in provincial measures to identify respondents who have recently been discharged from hospital to home.

### **5.2.2 Cohort Identification Using Administrative Data**

The Discharge Abstract Database (DAD) captures administrative, clinical and demographic information on hospital discharges in Ontario and Canada (excluding Quebec). Data is submitted to the Canadian Institute for Health Information from acute care facilities in the province. For more information on this data set, please refer to <https://www.cihi.ca/en/discharge-abstract-database-metadata>.

To identify people who have transitioned from hospital to home, the following parameters can be used:

#### **Inclusions:**

- Discharges for all reasons (medical, surgical, obstetric)
- Admissions that were not transfers from another institution
- Discharge disposition (based on DAD disposition codes prior to 2018):
  - 02 = Transferred to a long-term or continuing care facility
  - 04 = discharged to a home setting with support services
  - 05 = Discharged to home (no support service from an external agency required)
- Discharge Facility Type:
  - 01 = Acute Care

Other administrative databases may also be used to identify people who transition out of acute care, including (this list is not exhaustive):

- [Continuing Care Reporting System](#), Canadian Institute for Health Information
- For patients discharged from Complex Continuing Care facilities
- [National Rehabilitation Reporting System](#), Canadian Institute for Health Information
- For patients discharged from Inpatient Rehabilitation facilities
- [Home Care Reporting System](#), Canadian Institute for Health Information
- For patients discharged home with publicly-funded home care services
- [Ontario Mental Health Reporting System](#), Canadian Institute for Health Information
- For patients discharged from Mental Health Inpatient Care

### **5.3 How Success Can Be Measured Provincially**

The following indicators are currently provincially measurable in Ontario's health care system:

- Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their care and treatment as much as they wanted to be
- Percentage of people discharged from hospital to home who report that the doctors or staff at the place where they usually get medical care seem informed and up to date about the care they received in the hospital
- Percentage of people discharged from hospital to home who received home care who report that their home care started when they needed it to
- Median, mean and range (maximum and minimum) wait time from hospital discharge to first home care service date for people approved for home care services
- Percentage of people discharged from hospital whose primary informal caregiver reports feeling prepared for the role of caregiving
- Percentage of people discharged from hospital to home who visit the emergency department within 7 days and 30 after discharge
- Percentage of people discharged from hospital to home who were readmitted to hospital within 7 days and 30 after discharge

Methodologic details for the provincially measurable indicators are described in the tables below.

**Table 1: Percentage of people discharged from hospital to home who report feeling that they were involved in decisions about their transition planning as much as they wanted to be**

|                     |                             |   |
|---------------------|-----------------------------|---|
| GENERAL DESCRIPTION | Indicator description       | This indicator measures the percentage of people who report feeling that they were usually or always involved in decisions about their transition planning as much as they wanted to be<br><br>Directionality: A higher percentage is better.   |
|                     | <b>Measurability</b>        | <b>Measurable at the provincial level</b>   |
|                     | Dimension of quality        | Patient-centered  |
|                     | Quality statement alignment | <p><b>Quality Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning</b><br/>           People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.</p> <p><b>Quality Statement 4: Patient, Family, and Caregiver Education, Training, and Support</b><br/>           People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on medications and medical equipment.</p> <p><b>Quality Statement 6: Coordinated Transitions</b><br/>           People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.</p> <p><b>Quality Statement 10: Out-of-Pocket Costs and Limits of Funded Services</b><br/>           People transitioning from hospital to home have their ability to pay for any out-of-pocket health care costs assessed by the health care team, and alternatives for unaffordable costs are considered in transition plans. The health care team explains to people what publicly funded services are available to them and what services they will need to pay for.</p> |
|                     |                             |   |

|  |  |
|--|--|
| <b>DEFINITION &amp; SOURCE INFORMATION</b> | <p>Calculation:<br/>General</p> <p><b>Denominator</b><br/>Total number of survey respondents discharged from hospital in the past 8 weeks</p> <p><b>Numerator</b><br/>Weighted number of respondents who answered "always" or "usually" to the following question:</p> <p>Were you involved as much as you wanted to be in decisions about your care and treatment?</p> <ul style="list-style-type: none"> <li>• Never</li> <li>• Sometimes</li> <li>• Usually</li> <li>• Always</li> </ul> <p><b>Data source:</b> Canadian Patient Experiences Reporting System, Canadian Institute for Health Information</p> <p><b>General Exclusions (Apply to the numerator and denominator)</b></p> <ul style="list-style-type: none"> <li>• Patients receiving care primarily for a psychiatric condition or mental health disorder (e.g., bipolar disorder, depression, behavioural disorders, delusional disorders, chromosomal abnormalities)</li> <li>• Patients discharged from a rehabilitation unit</li> <li>• Patients with a primary diagnosis of alternate level of care (ALC) at time of admission</li> <li>• Patients with a primary diagnosis of alcohol/drug abuse or dependence (e.g., the patient was admitted for an overdose or other alcohol-/drug-related urgent admission)</li> <li>• Day surgery patients</li> <li>• Patients requesting not to be contacted or recorded as "do not announce"</li> <li>• Patients residing in prison (e.g., prisoners)</li> <li>• Patients discharged to nursing homes or long-term care facilities</li> <li>• Any patient selected for surveying in the last 12 months within the same hospital</li> <li>• Patients excluded on sensitive or compassionate grounds (e.g., discharged to hospice care, abortion or miscarriage, women with loss of baby, assault, domestic violence, suicide attempt, elder abuse)</li> </ul> <p><b>Method</b><br/>Numerator divided by the denominator times 100</p> |
|--|--|

|                        |                       |  |
|------------------------|-----------------------|--|
| ADDITIONAL INFORMATION | Indicator Limitations | <p>This question only asks about involvement in decisions during a patient's hospital stay. It would also be important to gather this information after discharge to get a full view of the transition from hospital to home.</p> <p>Results of this indicator may need to be interpreted with caution for populations with impairments who are unable to be involved in decisions about their care. In these cases, caregivers or other providers should be surveyed.</p> <p>This indicator does not capture the importance of involving family members or other informal caregivers in the care decisions. For more information on involving informal caregivers in care planning, please refer to Quality Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning in the Quality Standard.</p> |
|                        | Survey Limitations    | <p>In fiscal years 2015–2016 to 2017–2018, the Canadian Patient Experiences Reporting System did not cover all hospitals in the province. Additionally, the response rate was <u>only 38.3%</u>, so there may be some response bias in the indicator results. Commonly respondents with a particularly strong (positive or negative) experience will be more likely to respond to the survey, limiting the generalizability of the results to all patients.</p> <p>The survey population is adults aged 18 and older, so this does not capture the experiences of children or adolescents.</p> <p>Given that this survey excludes patients discharged to nursing homes or long-term care facilities, these patients should be surveyed separately as they are within the scope of the Quality Standard.</p>              |
|                        | Comments              | <p>Results are weighted. Jurisdictions and hospitals have adopted varying sampling approaches based on their number of discharges, patient characteristics and quality improvement goals. As part of standardization, a non-response adjustment was applied. For more information refer to <a href="#">Patient Experience in Canadian Hospitals Methodology Notes</a>, Canadian Institute for Health Information.</p> <p>For more information on Survey methodology, please refer to <a href="#">Canadian Patient Experiences Survey — Inpatient Care Procedure Manual, January 2019</a></p>   |

**Table 2: Percentage of people discharged from hospital to home who report that the doctors or staff at the place where they usually get medical care seem informed and up to date about the care they received in the hospital**

|                     |                             |  |
|---------------------|-----------------------------|--|
| GENERAL DESCRIPTION | Indicator description       | This indicator measures the percentage of people who report that the doctors or staff at the place where they usually get medical care seem informed and up to date about the care they received in the hospital<br>Directionality: A higher percentage is better.   |
|                     | <b>Measurability</b>        | <b>Measurable at the provincial level</b>  |
|                     | Dimension of quality        | Patient-centered   |
|                     | Quality statement alignment | <p><b>Quality Statement 1: Information-Sharing on Admission</b><br/> When people are admitted to hospital, the hospital notifies their primary care and home and community care providers soon after admission via real-time electronic notification. The community-based providers then share all relevant information with the admitting team in a timely manner.</p> <p><b>Quality Statement 5: Transition Plans</b><br/> People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care providers within 48 hours of discharge.</p> <p><b>Quality Statement 6: Coordinated Transitions</b><br/> People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.</p> <p><b>Quality Statement 7: Medication Review and Support</b><br/> People transitioning from hospital to home have medication reviews on admission, before returning home, and once they are home. These reviews include information regarding medication reconciliation, adherence, and optimization, as well as how to use their medications and how to access their medications in the community. People's ability to afford out-of-pocket medication costs are considered, and options are provided for those unable to afford these costs.</p> |

|                                 |  |
|---------------------------------|--|
|                                 | <p><b>Quality Statement 8: Coordinated Follow-Up Medical Care</b><br/> People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.</p> <p><b>Quality Statement 9: Appropriate and Timely Support for Home and Community Care</b><br/> People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.</p>   |
| DEFINITION & SOURCE INFORMATION | <p><b>Calculation:</b><br/> General</p> <p><b>Denominator</b><br/> Total number of survey respondent who had a primary care provider and were admitted to hospital in the previous 12 months.</p> <p><b>Inclusion:</b><br/> Those who responded "yes" to the question: "In the last 12 months, have you been hospitalized overnight?" (response options: "1 yes"; "5 no"; "8 don't know"; "9 refused")</p> <p>Includes ages 16 and older</p> <p><b>Denominator Exclusion:</b><br/> Those who selected "have not seen provider since discharged from hospital"; "did not receive care for medical problem/no tests in last 12 months/not applicable"; "don't know" or "refused"</p> <p><b>General Exclusions (apply to both the numerator and denominator)</b></p> <ul style="list-style-type: none"> <li>a) Patients without a valid health insurance number</li> <li>b) Patients without an Ontario residence</li> <li>c) Gender not recorded as male or female</li> <li>d) Age &lt; 16</li> <li>e) Invalid date of birth</li> </ul> <p><b>Data source:</b> Health Care Experience Survey (HCES)</p> <p><b>Numerator</b><br/> Weighted number of people who answered "yes" to the question "After you were discharged from hospital, did your provider seem informed and up-to-date about the care you received in the hospital?" Response options:</p> |

|                        |                       |  |
|------------------------|-----------------------|--|
|                        |                       | <ul style="list-style-type: none"> <li>• yes</li> <li>• no</li> <li>• have not seen provider since discharged from hospital</li> <li>• did not receive care for medical problem/no tests in last 12 months/not applicable</li> <li>• don't know</li> <li>• refused</li> </ul> <p><b>Data source:</b> Health Care Experience Survey (HCES)</p> <p><b>Method</b></p> <p>Numerator divided by the denominator times 100</p>   |
| ADDITIONAL INFORMATION | Indicator Limitations | <p>A survey respondent might be receiving care from several providers in the community (e.g. primary care, home care, community support services) and this question would not demonstrate if all of these providers were aware of the recent hospitalization.</p> <p>This survey does not produce results that can be broken down by provider, so local data collection would be required to get results at the provider-level.</p> <ol style="list-style-type: none"> <li>1. This indicator captures two concepts, both from the patient perspective: If information about the hospitalization was shared with the provider in the community and</li> <li>2. It was communicated to the patient that the community provider was using this information to inform the care they provided</li> </ol> <p>An additional indicator that asks the provider's perspective if they were informed and up to date about the care the patient received in the hospital would provide additional context to interpret the results of this indicator to determine where the gaps in communication are occurring.</p> |
|                        | Survey Limitations    | <p>Only people aged 16 years and older can complete the Health Care Experience Survey (HCES) survey. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. Respondents who were unable to speak English or French or were not healthy enough (physically or mentally) to complete the interview were not surveyed.</p>   |

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|  | Comments | <p>The Health Care Experience Survey (HCES) is weighted to account for the design characteristics of the survey and post-stratified by age and sex to reflect the Ontario population. In addition, the LHIN and community weighting is applied. The survey population is adults aged 18 and older.</p> <p>For more information, please refer to HQO's indicator library:<br/><a href="http://indicatorlibrary.hqontario.ca/Indicator/Detailed/up-to-date-hospitalization/EN">http://indicatorlibrary.hqontario.ca/Indicator/Detailed/up-to-date-hospitalization/EN</a></p> |
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**Table 3: Percentage of people discharged from hospital to home who received home care who report that their home care started when they needed it to**

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| <b>GENERAL DESCRIPTION</b>                 | Indicator description       | This indicator measures the percentage of people discharged from hospital to home who received home care who report that their home care started when they needed it to<br><br>Directionality: A higher percentage is better.  |
|  | <b>Measurability</b>        | <b>Measurable at the provincial level (in the future)</b>  |
|  | Dimension of quality        | Timely, Patient-centered   |
|  | Quality statement alignment | <p><b>Quality Statement 8: Coordinated Follow-Up Medical Care</b><br/>           People transitioning from hospital to home have follow-up medical care with their primary care provider and/or a medical specialist coordinated and booked before leaving hospital. People with no primary care provider are provided with assistance to find one.</p> <p><b>Quality Statement 9: Appropriate and Timely Support for Home and Community Care</b><br/>           People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.</p> |
| <b>DEFINITION &amp; SOURCE INFORMATION</b> | Calculation:<br>General     | <p><b>Denominator</b><br/>           Total number of survey respondents that were discharged from hospital in the past 6 months who received home care services after discharge.</p> <p>Exclusions: Those who responded “Do not know / Do not remember” to the question below.</p> <p><b>Numerator</b><br/>           Number of individuals in the denominator who answered “Yes” to the following question:</p> <p>6. Did your home care start when you needed it?</p> <ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Do not know / Do not remember</li> </ul>   |

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|                        |                       | <p><b>General Inclusion criteria (Apply to numerator and denominator):</b><br/>All unique active or discharged patients receiving in-home services and discharged patients to placement during the specified time period.</p> <p><b>General exclusion criteria (Apply to numerator and denominator):</b></p> <ul style="list-style-type: none"> <li>• Excludes patients who received in-school service only</li> <li>• Nursing clinic services</li> <li>• Respite services</li> <li>• Medical supplies and equipment</li> <li>• End-of-life patients (SRC 95)</li> <li>• Clients not yet categorized (SRC 99)</li> <li>• In-home patients classified as out of region</li> <li>• Convalescent care patients</li> </ul> <p>Other exclusions: Home care patients with hospital or death discharges; patients on hold in hospital; patients with a claim against the LHIN or before the Ontario Health Services Appeal and Review Board.</p> <p><b>Data source:</b> Home and Community Care Client Experience Survey, Local Health Integration Networks (Survey in development)</p> <p><b>Method</b><br/>Numerator divided by the denominator times 100</p> |
| ADDITIONAL INFORMATION | Indicator Limitations | <p>This indicator asks for the client's perception of when home care should have started, this may or may not align with what was clinically determined to be appropriate. It is recommended that this indicator be taken together with the indicator "Median, mean and range (maximum and minimum) wait time from hospital discharge to first home care service date for people approved for home care services", detailed in Table 4.</p> <p>This indicator does not include people waiting for other post-acute services like community support services or mental health services. It is also recommended that these waits be considered when evaluating the success of the standard.</p> <p>This measure does not evaluate the quality of the home care service or the satisfaction of the home care client with the service. Select measures of home care client satisfaction and quality can be found here:<br/> <a href="https://www.hqontario.ca/System-Performance/Home-Care-Performance">https://www.hqontario.ca/System-Performance/Home-Care-Performance</a></p>  |

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|  | <b>Survey Limitations</b> | <p>Several types of home care clients and services are excluded (e.g. end-of-life clients, respite services, nursing clinic services), suggesting these results cannot be widely applied to all home care clients and all home care services.</p> <p>Caregivers were surveyed in place of clients in the event any of the following criteria were met: 1) Client is &lt;19 years of age at time of sample selection 2) Client is identified as cognitively incapable</p> <p>Surveying may be done while a person is still a home care client. They may feel like they cannot respond honestly because of risk to their services. This is mitigated by the survey not being conducted by the provider.</p> |
|  | <b>Comments</b>           | Results are weighted to reflect the population of home care patients eligible to be surveyed within each region (i.e., sampled home care patients are standardized to the region-specific population).  |

**Table 4: Median and mean wait time from hospital discharge to first home care service date for people approved for home care services**

|                                 |                             |   |
|---------------------------------|-----------------------------|---|
| GENERAL DESCRIPTION             | Indicator description       | This indicator measures the median, mean and range (maximum and minimum) wait time from hospital discharge to first home care service date for people approved for home care services<br><br>Directionality: A lower wait time is generally better.   |
|                                 | <b>Measurability</b>        | <b>Measurable at the provincial level</b>   |
|                                 | Dimension of quality        | Timely, Patient-centered  |
|                                 | Quality statement alignment | <p><b>Quality Statement 9: Appropriate and Timely Support for Home and Community Care</b></p> <p>People transitioning from hospital to home are assessed for the type, amount, and appropriate timing of home care and community services they and their caregivers need. These services are arranged before people leave hospital and are in place when they return home.</p>  |
| DEFINITION & SOURCE INFORMATION | Calculation: General        | <p><b>Calculation Methods</b></p> <p>The wait time is calculated as the number of days between two time points, the discharge date and the date of first (non case-management) service:</p> <p><b>Calculation:</b></p> <ol style="list-style-type: none"> <li>1. Select service date for the time period of interest</li> <li>2. Identify client eligibility for home care</li> <li>3. Determine if the application was from the hospital using the Intake Referral Source</li> <li>4. Calculate the number of days between discharge date and first non-case management service date</li> <li>5. Calculate the median number of days between the discharge date and the first non-case management service date</li> <li>6. Numerator including inclusion/exclusion</li> <li>7. Wait time, in days, between application/discharge and first service</li> </ol> <p><b>Inclusions:</b></p> <ul style="list-style-type: none"> <li>• In-Home Program includes requested programs being In-home (01); in Adult Day Care (05); or in Supportive Housing (06)</li> <li>• Eligible clients: Assessment Outcome EQUAL TO (12) Eligible client admitted to in-home services; (15) Eligible for long-term care (LTC); or (16) Eligible in-home plus other services</li> </ul> |

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|                        | <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Community referrals (School, LTC placement and other programs)</li> <li>• Home care episodes with calculated wait time less than 0 days or more than 365 days</li> <li>• Community clients (based on Step 3 of the Calculation above)</li> <li>• Episodes with only a case management service.</li> </ul> <p><b>Data source:</b> Client Health and Related Information System (CHRIS), Home Care Database (HCD)</p> <p><b>Method</b></p> <p>Median, mean and range (maximum and minimum) wait time</p>  |
| ADDITIONAL INFORMATION | <p><b>Limitations</b></p> <p>Currently this indicator looks at only a subset of the home care population: those receiving nursing care or those receiving personal support work care with complex needs. Ideally, this measure would examine all home care clients. Additionally, the indicator only applies to new home care clients, not clients receiving additional home care services.</p> <p>It is recommended that this indicator be taken together with the previous indicator that measures the experiencing waiting for home care.</p> <p>This indicator does not include people waiting for other post-acute services like community support services or mental health services. It is also recommended that these waits be considered when evaluating the success of the standard.</p> <p>There could be wait lists in place in some regions which would affect the performance in a specific period since the clients will not be counted until the service is delivered. Each case is reported under the fiscal year and quarter in which the client received their first home care service. Approximately 3% of records per fiscal year are dropped due to invalid (less than 0 days) or implausible (more than 365 days) wait times.</p> <p>This measure does not evaluate the quality of the home care service or the satisfaction of the home care client with the service. Select measures of home care client satisfaction and quality can be found here:<br/> <a href="https://www.hqontario.ca/System-Performance/Home-Care-Performance">https://www.hqontario.ca/System-Performance/Home-Care-Performance</a></p> |

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|  | Comments | <p>Median and mean statistics are suggested to get a full picture of the variation in wait times. Other metrics that could be useful include the 25<sup>th</sup> percentile, 75<sup>th</sup> percentile and Interquartile range.</p> <p>For more information, please refer to HQO's Indicator Library (note that this page only described the median calculation, and includes home care wait times for those applying from the community):</p> <p><a href="http://indicatorlibrary.hqontario.ca/Indicator/Detailed/wait-time-home-care-services/EN">http://indicatorlibrary.hqontario.ca/Indicator/Detailed/wait-time-home-care-services/EN</a></p> |
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**Table 5: Percentage of people discharged from hospital to home whose primary informal caregiver reports feeling prepared for the role of caregiving**

|                                 |                             |  |
|---------------------------------|-----------------------------|--|
| GENERAL DESCRIPTION             | Indicator description       | This indicator measures the percentage of people discharged from hospital to home whose primary informal caregiver reports feeling fully prepared for the role of caregiving<br>Directionality: A higher percentage is better.   |
|                                 | Indicator status            | <b>Measurable at the provincial level (in the future)</b>  |
|                                 | Dimension of quality        | Patient-Centred  |
|                                 | Quality statement alignment | <p><b>Quality Statement 3: Patient, Family, and Caregiver Involvement in Transition Planning</b><br/>People transitioning from hospital to home are involved in transition planning and developing a written transition plan. If people consent to include them in their circle of care, family members and caregivers are also involved.</p> <p><b>Quality Statement 4: Patient, Family, and Caregiver Education, Training, and Support</b><br/>People transitioning from hospital to home, and their families and caregivers, have the information and support they need to manage their health after the hospital stay. Before transitioning from hospital to home, they are offered education and training to manage their health care needs at home, including guidance on medications and medical equipment.</p> |
| DEFINITION & SOURCE INFORMATION | Calculation:<br>General     | <p><b>Denominator</b><br/>Total number of survey respondents who are a caregiver for someone that was discharged from hospital in the past 6 months and received home care services after discharge</p> <p>Exclusions: Those who responded “Not applicable / &lt;Client name&gt; was not hospitalized at the start of their recent home care, or in the past six (6) months” to the question below.</p> <p><b>Numerator</b><br/>Number of individuals in the denominator who answered “Fully” or “Mostly” to the following question:</p> <p>If &lt;client name&gt; was hospitalized at the start of their recent home care, or in the past six (6) months...</p>   |

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|  | <p>When &lt;client name&gt; left hospital, how well prepared did you feel for your caregiving role?</p> <ul style="list-style-type: none"> <li>● Not applicable / &lt;Client name&gt; was not hospitalized at the start of their recent home care, or in the past six (6) months.</li> <li>● Not at all</li> <li>● Somewhat</li> <li>● Mostly</li> <li>● Fully</li> </ul> <p><b>General inclusion criteria (Apply to numerator and denominator):</b></p> <p>Caregivers to all unique active or discharged patients receiving in-home services and discharged patients to placement during the specified time period.</p> <p><b>General exclusion criteria (Apply to numerator and denominator):</b></p> <ul style="list-style-type: none"> <li>● Excludes caregivers of patients who meet the following criteria:</li> <li>● Patients who received in-school service only</li> <li>● Nursing clinic services</li> <li>● Respite services</li> <li>● Medical supplies and equipment</li> <li>● End-of-life patients (SRC 95)</li> <li>● Clients not yet categorized (SRC 99)</li> <li>● In-home patients classified as out of region</li> <li>● Convalescent care patients</li> </ul> <p>Other exclusions: Caregivers of home care patients with hospital or death discharges; patients on hold in hospital; patients with a claim against the LHIN or before the Ontario Health Services Appeal and Review Board.</p> <p><b>Data source:</b> Home and Community Care Caregiver Experience Survey, Local Health Integration Network (Survey in development)</p> <p><b>Method</b><br/>Numerator divided by the denominator times 100</p> |
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| ADDITIONAL INFORMATION | Indicator Limitations | <p>Caregiver preparedness is a multifactorial concept that may depend on factors beyond what is in the control of the health care provider. For example, an unexpected diagnosis in the hospital may result in less caregiver preparedness. In addition, living arrangements can also contribute to feelings of not being prepared for the role of caregiving. Despite this, health care providers still have <a href="#">an important role</a> in providing caregivers with the information needed to complete their caregiving role. Research indicates that this information transfer does not always happen (<a href="#">Committee on Family Caregiving for Older Adults;2016</a>).</p> <p>This indicator only includes caregivers for people who are discharged from hospital and receive publicly funded home care services post-discharge. All caregivers should feel prepared for their role of caregiving. A better measure would include informal caregivers for every patient discharged from hospital.</p> <p>Only the primary informal caregiver is included in this indicator. In many cases, people have more than one informal caregiver. It is also important to capture the experience of these providers of care.</p> |
|                        | Survey Limitations    | <p>Several types of home care clients and services are excluded (e.g. end-of-life clients, respite services, nursing clinic services), suggesting these results cannot be widely applied to all home care clients and all home care services.</p> <p>Surveying may be done while a person is still a home care client. A caregiver may feel like they cannot respond honestly because of risk to the client's services. This is mitigated by the survey not being conducted by the provider.</p>   |
|                        | Comments              | <p>There is <a href="#">evidence</a> demonstrating that caregivers who report having a high level of preparedness for caregiving have reduced distress and improved health outcomes.</p> <p>This indicator relies on one survey question. An even better measure would use multiple questions to generate a scale of preparedness. The <a href="#">Preparedness for Caregiving Scale</a> is an example of such a tool.</p> <p>Poor results on this indicator would necessitate a deeper dive into why caregivers felt unprepared. Several other questions in the Home and Community Care Caregiver Experience Survey could help inform this investigation.</p> <p>Results are weighted to reflect the population of home care patients eligible to be surveyed within each region (i.e., sampled home care patients are standardized to the region-specific population).</p>   |

**Table 6: Percentage of people discharged from hospital to home who visit the emergency department within 7 days after discharge and 30 days after discharge**

|                                 |                             |   |
|---------------------------------|-----------------------------|---|
| GENERAL DESCRIPTION             | Indicator description       | <p>This indicator measures the percentage of people discharged from hospital to home who visit the emergency department within:</p> <ul style="list-style-type: none"> <li>• 7 days after discharge</li> <li>• 30 days after discharge</li> </ul> <p>Directionality: Directionality on this indicator is unclear</p>  |
|                                 | Measurability               | <b>Measurable at the provincial level</b>   |
|                                 | Dimension of quality        | Patient-centered  |
|                                 | Quality statement alignment | <b>All statements align with this indicator</b>   |
| DEFINITION & SOURCE INFORMATION | Calculation: General        | <p><b>Denominator</b><br/>Total number of incident hospital discharges</p> <p>Inclusions:</p> <ul style="list-style-type: none"> <li>• Discharge disposition, dischdisp = 02, 04, 05 (prior to 2018)</li> <li>• Discharges at a facility with An_Inst_Type= 1 (Acute Care);</li> <li>• Discharges for all reasons (medical, surgical, obstetric)</li> <li>• Hospital Admissions in facilities in Ontario</li> </ul> <p>Incident = 1st event in a calendar period without any look-back for past events (If multiple hospitalizations in CY, use first).</p> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Invalid health card number</li> <li>• Non-Ontario resident</li> <li>• Age &gt; 105</li> <li>• Transfers from another acute care institution</li> </ul> <p><b>Numerator</b><br/>Number of individuals in the denominator with an unscheduled ED visit for any reason following the incident hospital visit within:</p> <ul style="list-style-type: none"> <li>• 7 days after discharge</li> <li>• 30 days after discharge</li> </ul> |

|                        |             |   |
|------------------------|-------------|---|
|                        |             | <p><b>Exclude:</b></p> <ul style="list-style-type: none"> <li>• Scheduled ED visits</li> <li>• ED visits outside in facilities outside of Ontario</li> <li>• ED visits that result in hospital admission</li> <li>• ED visits that represent transfers from other EDs</li> <li>• ED visits where the patient left without being seen</li> </ul> <p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>• Count only the first visit per health card number during the 30 day follow-up period (but categorize as within 7 days and also within 30 days)</li> <li>• Incident hospital discharges are restricted to calendar years but 7 or 30 day follow-up for numerator can cross over into the next calendar year.</li> <li>• For episodes of care that involve transfers, readmissions should be attributed to the last hospital from which the patient was discharged before readmission.</li> </ul> <p><b>Data source:</b> Discharge Abstract Database, National Ambulatory Care Reporting System</p> <p><b>Method</b><br/>Numerator divided by the denominator times 100</p> |
| ADDITIONAL INFORMATION | Limitations | <p>This indicator should be taken in conjunction with the other measures of success (including measures of patient experience) to provide a full view of the patient trajectory post-discharge.</p> <p>There are survey questions available in the province (for example, in the Health Care Experiences Survey, MOHLTC), that ask patients if their emergency department visit was for a reason that could have been treated by their regular care provider. This information would be useful context to add to this indicator to demonstrate how many of these emergency department visits could have been prevented. In 2017, over 40% of surveyed Ontarians stated that their emergency department visit could have been managed by their primary care provider (<a href="#">Measuring Up 2018</a>, HQO).</p>   |

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|  | Comments | <p>Emergency department rates can be influenced by many factors (which may or may not be related to the recent hospitalization), including the quality of hospital and community care, the individual's health status, the quality of the transition, and disease prevention in the community and the delivery of care within communities. Some areas, for example, may use the emergency department as a source of primary care.</p> <p>While not all unplanned emergency department visits are avoidable, interventions during and after a hospitalization can be effective in reducing emergency department visits following the discharge.</p> |
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**Table 7: Percentage of people discharged from hospital to home who were readmitted to hospital within 7 days after discharge and 30 days after discharge**

|                     |                             |  |
|---------------------|-----------------------------|--|
| GENERAL DESCRIPTION | Indicator description       | <p>This indicator measures the percentage of people discharged from hospital to home who were readmitted to hospital within:</p> <ul style="list-style-type: none"> <li>• 7 days after discharge</li> <li>• 30 days after discharge</li> </ul> <p>Directionality: Directionality on this indicator is unclear</p>  |
|                     | Measurability               | <b>Measurable at the provincial level</b>  |
|                     | Dimension of quality        | Patient-centered   |
|                     | Quality statement alignment | <b>All statements align with this indicator</b>  |
|                     | Calculation: General        | <p><b>Denominator</b><br/>Total number of incident hospital discharges</p> <p>Inclusions:</p> <ul style="list-style-type: none"> <li>• Discharge disposition, dischdisp = 02, 04, 05 (prior to 2018)</li> <li>• Discharges at a facility with An_Inst_Type= 1 (Acute Care);</li> <li>• Discharges for all reasons (medical, surgical, obstetric)</li> <li>• Hospital Admissions in facilities in Ontario</li> </ul> <p>Incident = 1st event in a calendar period without any look-back for past events (If multiple hospitalizations in CY, use first).</p> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Invalid health care number</li> <li>• Non-Ontario resident (1st two characters of PRCDDABLK ne '35')</li> <li>• Age &gt; 105</li> <li>• Discharge disposition: 01, 03, 06, 07, 08, 09, 12, ZZ</li> <li>• Transfers from another acute care institution</li> </ul> <p><b>Data source:</b> Discharge Abstract Database</p> |

|                        |  |
|------------------------|--|
|                        | <p><b>Numerator</b></p> <p>Number of individuals in the denominator with a non-elective hospital admission for any reason following the incident hospital visit within:</p> <ul style="list-style-type: none"> <li>• 7 days of discharge</li> <li>• 30 days of discharge</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• Elective hospital visits</li> <li>• hospital visits to facilities outside of Ontario</li> <li>• An acute care hospitalization that occurs less than seven hours after discharge from the previous acute care hospitalization or same-day surgery visit, regardless of whether the transfer is coded</li> <li>• An acute care hospitalization or same-day surgery visit that occurs between 7 and 12 hours after discharge from the previous acute care hospitalization or same-day surgery visit, and at least one of the hospitalizations or visits has coded the transfer</li> <li>• Notes:</li> <li>• Count only the first visit per health card number during the 30 day follow-up period (but categorize as within 7 days and also within 30 days)</li> <li>• Incident hospital discharges are restricted to calendar years but 7 or 30 day follow-up for numerator can cross over into the next calendar year.</li> <li>• For episodes of care that involve transfers, readmissions should be attributed to the last hospital from which the patient was discharged before readmission</li> </ul> <p><b>Data source:</b> Discharge Abstract Database</p> <p><b>Method</b></p> <p>Numerator divided by the denominator times 100</p> |
| ADDITIONAL INFORMATION | <p>Limitations</p> <p>This indicator should be taken in conjunction with the other measures of success (including measures of patient experience) to provide a full view of the patient trajectory post-discharge.</p> <p>There is a wide range of evidence investigating what proportion of acute care readmissions are preventable, with one review showing ranges from 5% to 79% (<a href="#">van Walraven, 2011</a>). Although we do not know the exact proportion, this indicator can still be interpreted as a proxy measure for the preventable readmissions.</p>   |

|  |          |   |
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|  | Comments | <p>Readmission rates can be influenced by <a href="#">many factors</a>, (which may or may not be related to the recent hospitalization) including the quality of hospital and community care, the individual's health status, the quality of the transition, and disease prevention in the community. While not all unplanned readmissions are avoidable, interventions during and after a hospitalization can be effective in reducing readmission rates.</p> <p>Despite the fact that some readmissions are undoubtably unavoidable, they do contribute costs and burden to the system and to patients. While patients should receive hospital care when needed, when these can be prevented through well planned transitions and coordinated health care in the community – this is better for patients and the system. Additionally, readmissions contribute to the issue of hospital overcrowding.</p> |
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## **5.4 How Success Can Be Measured Locally**

You might want to assess the quality of care you provide to your patients transitioning between hospital and home. You might also want to monitor your own quality improvement efforts. It can be possible to do this using your own clinical records, or you might need to collect additional data. In addition to the provincially measurable indicators, we recommend the following list of indicators, which cannot be measured provincially using currently available data:

- Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital

Methodologic details are described in the table below.

**Table 8: Percentage of people discharged from hospital to home whose discharge summaries are delivered to primary care providers within 48 hours after discharge from hospital**

|                                 |                             |   |
|---------------------------------|-----------------------------|---|
| GENERAL DESCRIPTION             | Indicator description       | This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to the primary care provider within 48 hours of patient's discharge from hospital.<br><br>Directionality: A higher percentage is better.  |
|                                 | Indicator status            | <b>Developed (currently used for 2019/20 Hospital Quality Improvement Plans), dependent on local QI data collection</b>   |
|                                 | Dimension of quality        | Timely, Effective   |
|                                 | Quality statement alignment | <p><b>Quality Statement 5: Transition Plans</b><br/>           People transitioning from hospital to home are given a written transition plan (which can reside fully within the discharge summary), developed by and agreed upon in partnership with the patient, any involved caregivers, the hospital team, and the home and community care team, before leaving hospital. Transition plans are shared with primary care and home and community care providers within 48 hours of discharge.</p> <p><b>Quality Statement 6: Coordinated Transitions</b><br/>           People admitted to hospital have a named health care professional who is responsible for timely transition planning, coordination, and communication. Before people leave hospital, this person ensures an effective transfer of transition plans and information related to people's care.</p> |
| DEFINITION & SOURCE INFORMATION | Calculation:<br>General     | <p><b>Denominator</b><br/>           Number of inpatients discharged for the time period.</p> <p>Inclusions:</p> <ul style="list-style-type: none"> <li>• Acute and post-acute hospital inpatient discharge.</li> </ul> <p>Exclusions:</p> <ul style="list-style-type: none"> <li>• Discharges of inpatients whose primary care provider is not identified.</li> <li>• Emergency department patients.</li> <li>• Newborns, deaths, and delivery summaries</li> </ul>  |

|                        |   |   |
|------------------------|---|---|
|                        | <p><b>Numerator</b></p> <p>Number of patients discharged from hospitals for whom a discharge summary is sent to primary care provider within 48 hours of discharge (electronically or by fax) for the time period.</p> <p><b>Inclusions:</b></p> <ul style="list-style-type: none"> <li>Acute and post-acute hospital inpatient discharge summaries sent electronically to primary care provider with access to Hospital Report Manager, Clinical Connect or similar, or by fax to those without electronic access.</li> </ul> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>Discharges of inpatients who do not have a documented primary care provider.</li> <li>Emergency department patients.</li> <li>Newborns, deaths, and delivery summaries.</li> </ul> <p><b>Method</b></p> <p>Numerator/denominator × 100</p> <p><b>Data source:</b> Local data collection</p> |   |
| ADDITIONAL INFORMATION | <p>Limitations</p>  | <p>While electronic transmission may be preferred, there are many practices who may be unable to receive electronic transmissions at this time. Consequently, fax transmissions are also included in this indicator.</p> <p>There will be situations when 48 hours is not enough time to complete this knowledge transfer, however this timeline should still be strived for. Alternatively, there will also be cases when 48 hours is too long, and a patient should be sent home with this information immediately after discharge. Clinical discretion is required to decide on timelines in these cases.</p> <p>The quality standard focuses on transition plans, which can reside fully within the discharge summary. This indicator was chosen to align with Quality Improvement Plans. Alternatively, an indicator could be used that measures the transfer of the transition plan to the appropriate primary care provider.</p> |

|          |   |
|----------|---|
| Comments | <p>This indicator is a priority hospital indicator for 2019/20 Hospital Quality Improvement Plans. For more information on this indicator, please consult the <a href="#">Indicator Technical Specifications for 2019/20 Quality Improvement Plans</a>.</p> <p>Hospital supports and protocols need to be in place to support the preparation and transmission of the discharge summary.</p> <ul style="list-style-type: none"> <li>• Timely distribution of discharge summaries is predicated on the following core elements:</li> <li>• Physicians (or delegate) dictate discharge summary as close to patient's discharge time (preferably before) as possible</li> <li>• Transcription to occur by the hospital within a timely manner following dictation</li> <li>• Activate 'auto-authentication' to ensure one-step distribution of the discharge summary upon signature (note: will be e-HR specific and may require Medical Advisory (or similar) approval)</li> <li>• Improvement efforts may focus on (1) getting discharge summaries prepared and signed in a timely manner, and (2) signed discharge summaries distributed in a timely manner.</li> </ul> |
|----------|---|

# 6 Resources and Questions

## 6.1 Resources

Several resources are available for more information:

- The **quality standard** provides information on the background, definitions of terminology, numerators and denominators for all statement-specific indicators
- The **Getting Started Guide** includes quality improvement tools and resources for health care professionals, including an action plan template
- The **case for improvement deck** provides data on why a particular quality standard has been created and the data behind it
- The **data tables** provide data that can be used to examine variations in indicator results across the province

## 6.2 Questions?

Please contact [qualitystandards@hqontario.ca](mailto:qualitystandards@hqontario.ca). We would be happy to provide advice on measuring quality standard indicators, or put you in touch with other providers who have implemented the standards and might have faced similar questions.

Ontario Health (Quality) offers an online community dedicated to improving the quality of health care across Ontario together called [Quorum](#). Quorum can support your quality improvement work by allowing you to:

- Find and connect with others working to improve health care quality
- Identify opportunities to collaborate
- Stay informed with the latest quality improvement news
- Give and receive support from the community
- Share what works and what doesn't
- See details of completed quality improvement projects
- Learn about training opportunities
- Join a community of practice

## 7 Appendix: Data Sources Referenced in This Quality Standard

Within this quality standard, there are several data sources used for provincial measurement. The data source(s) for each indicator are listed within the individual indicator specifications. More details on the specific data sources that Ontario Health (Quality) used to produce the indicators are noted below.

### **Canadian Patient Experiences Reporting System (CPERS)**

The Canadian Patient Experiences Reporting System (CPERS) collects standardized patient experience information from participating hospitals across Canada, starting with acute inpatient care. Information from CPERS provides insight into patients' perspectives on the health services they received. This information is used to inform and improve patient-centred care and patient outcomes. CPERS receives data about patient experiences from hospitals or jurisdictions that administer the Canadian Patient Experiences Survey on Inpatient Care (CPES-IC).

### **Discharge Abstract Database (DAD)**

The DAD is a database of information abstracted from hospital records that captures administrative, clinical and patient demographic information on all hospital inpatient separations, including discharges, deaths, signouts and transfers. CIHI receives Ontario data directly from participating facilities or from their respective regional health authorities or the MOHLTC. The DAD includes patient-level data for acute care facilities in Ontario. Data are collected, maintained and validated by CIHI. The main data elements of the DAD are patient identifiers (e.g. name, health care number), administrative information, clinical information (e.g. diagnoses and procedures) and patient demographics (e.g. age, sex, geographic location).

### **Health Care Experience Survey (HCES)**

The HCES is a voluntary telephone survey aimed at Ontarians aged 16 and older and is conducted on a quarterly basis. The HCES asks randomly selected Ontarians for their views about their health care system, how healthy they are, if they have chronic conditions, if they have a primary care provider (family doctor, nurse practitioner or other health care provider), how long it takes to see their provider, their experience using the health care system, if they have been to an emergency room or a walk-in clinic, and their household and demographic characteristics. People living in institutions, in households without telephones, and those with invalid/missing household addresses in the Registered Persons Database (RPDB) are excluded. The Ministry of Health and Ministry of Long-Term Care use the information from the survey to understand the experience of Ontarians with respect to primary care.

### **Home Care Database**

The HCD is a clinical, patient-centred database that captures all home care services provided or coordinated by Ontario's health regions, including government-funded home and community services. The HCD is managed by Health Shared Services Ontario (HSSO). It includes patient, intake, assessment, and admission/discharge information as well as information on home care wait times. This information is used to determine the eligibility of patients and the intensity of care coordination, care planning, and services that align with their care needs. Clinical data are collected using standardized interRAI tools, including the Resident Assessment Instrument for Home Care (RAI-HC).

### **Home and Community Care Client/Caregiver Experience Surveys**

Local Health Integration Networks (LHINs), in collaboration with Health Shared Services Ontario and Ontario Health (Quality), have initiated work to improve measurement of client and caregiver experience for home and community-based care. Two new surveys are being designed to better reflect the perspectives of clients and caregivers. Surveys are key tools for supporting quality improvement and performance management. They should measure what is important to home and community care clients and caregivers and can help identify what clients and caregivers think is working well or needs improvement. As service delivery and planning organizations for home care, the LHINs use survey data for identifying quality improvement opportunities that result in better outcomes for clients and families. The project is being guided by an expert panel, consisting of home care clients, caregivers, service provider, planning and subject-matter experts.

### **National Ambulatory Care Reporting System (NACRS)**

The NACRS contains data for all hospital-based and community-based emergency and ambulatory care, including day surgeries, outpatient clinics and emergency departments. Data are collected, maintained and validated by CIHI. CIHI receives Ontario data directly from participating facilities or from their respective regional health authorities or the MOHLTC. Data are collected, maintained and validated by CIHI. Data elements of the NACRS include patient identifiers (e.g. name, health care number), patient demographics (e.g. age, sex, geographic location), clinical information (e.g. diagnoses and procedures), and administrative information.

### **Ontario Health Insurance Plan (OHIP) Claims Database**

The OHIP claims database covers all reimbursement claims to the MOHLTC made by fee-for-service physicians, community-based laboratories and radiology facilities. The OHIP database at ICES contains encrypted patient and physician identifiers, codes for services provided, date of service, the associated diagnosis and fee paid. Services which are missing from the OHIP data include: some lab services; services received in provincial psychiatric hospitals; services provided by health service organizations and other alternate providers; diagnostic procedures performed on an inpatient basis and lab services performed at hospitals (both inpatient and same day). Also excluded is remuneration to physicians through alternate funding plans (AFPs), which could distort analyses because of their concentration in certain specialties or geographic areas.

### **Registered Persons Data Base (RPDB)**

The RPDB provides basic demographic information about anyone who has ever received an Ontario health card number. The RPDB is a historical listing of the unique health numbers issued to each person eligible for Ontario health services. This listing includes corresponding demographic information such as date of birth, sex, address, date of death (where applicable) and changes in eligibility status. At the Institute for Clinical Evaluative Sciences (ICES), data from the RPDB are enhanced with available information through other administrative data sources; however, even the enhanced dataset overestimates the number of people living in Ontario for several reasons, including the source of death information and record linkage issues. Although improvements have been made in recent years, the RPDB still contains a substantial number of individuals who are deceased or no longer living in Ontario. As such, the RPDB will underestimate mortality. To ensure that rates and estimates are correct, a methodology has been developed to adjust the RPDB so that regional population counts by age and sex match estimates from Statistics Canada.

## QUALITY STANDARDS

# Looking for more information?

Visit **hqontario.ca** or contact us at **qualitystandards@hqontario.ca** if you have any questions or feedback about this guide.

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