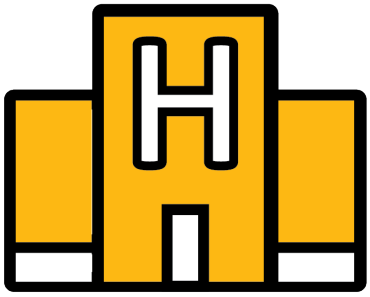


EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM

Information for Hospital Sites

Guidance Document

NOVEMBER 2024

Ontario Health

Table of Contents

Purpose of This Document

This document replaces:
The Emergency Department Return Visit Quality Program Guidance (Updated January 2024)

This guide is for hospital team members who are involved in coordinating the analysis of return visit data or auditing and submitting findings for their hospital's participation in the Emergency Department Return Visit Quality program (EDRVQP). This document first provides an overview of the program and its purpose, then details requirements, data definitions, and recommended procedures for hospital sites.

Throughout this document, important information – changes to the program that are new for 2024, links to resources for additional information, and contact information – has been placed in textboxes with a shaded background and highlighted with prominent icons.

This document is accompanied by the following documents:

- The EDRVQP document *How to Screen and Audit Return Visit Cases*, which provides step-by-step instructions for completing the audit and using the audit template
- The Quality Improvement Plan (QIP) program document *2025/26 QIP Narrative Questions*, which contains all narrative questions for the 2025/26 QIP program cycle, including EDRVQP narrative questions
- The document *EDRVQP and QIP Integration*, which provides step-by-step instructions for submitting audit and narrative files through the QIP Navigator platform

The most up-to-date versions of these documents are available from the Emergency Department Return Visit Quality Program website.

The Emergency Department Return Visit Quality Program

Overview

The Emergency Department Return Visit Quality program (EDRVQP) is focussed on building a culture of quality in emergency departments in Ontario.

As part of the program, hospital sites review data on emergency department visits, conduct audits on return visit cases where hospital admission was required, investigate causes that could signal quality issues, explore opportunities for improvement, and submit annual findings to their CEO and Quality Committee of the Board and to Ontario Health.

Ontario Health publishes a summary report on quality issues and themes, as well as improvement strategies identified and implemented across the province, to share lessons learned with all hospitals in Ontario.

Rationale

Return Visits

When a patient returns to the emergency department and requires hospital admission after an initial visit for the same or a related concern, it may represent a gap in quality care.[1] Although some return visits are unavoidable – they happen for reasons that cannot be prevented, such as natural disease progression, or are scheduled[2,3] – some return visits are preventable[2,4-6] and occur due to gaps in the quality of care provided in the index visit.

Preventable Harm

Preventable return visits to the emergency department can be due to adverse events or other quality issues. They can add to the burden on the health system of existing issues (i.e., long wait times and unnecessary health care spending) and, most importantly, may indicate preventable harm.

By identifying and investigating factors associated with emergency department return visits, hospitals can then take steps to address preventable causes in order to improve clinical outcomes, increase patient satisfaction, and provide high-value care.[7,8]

Sentinel Diagnoses – Subarachnoid Hemorrhage, Acute Myocardial Infarction, and Pediatric Sepsis

The program focusses on 3 conditions – subarachnoid hemorrhage, acute myocardial infarction, and pediatric sepsis. These 3 conditions represent areas in emergency medicine where there may be diagnostic challenges; they are also conditions for which a delayed diagnosis means a risk of a poorer outcome for the patient.[9-11]

Better Care Is the Goal

Although participation in EDRVQP is mandatory for hospitals in the Pay for Results (P4R) program, it is important to note that the overall number of return visits is not used as a determinant of P4R funding. In fact, the goal of auditing return visits is not to decrease the overall number of return visits, which could lead to unintentional consequences, such as increased admission or unnecessary testing, but to identify instances of potentially preventable harm and improve care by addressing quality issues that led to their occurrence. Thus, the goal of this program is to encourage continuous and ongoing quality improvement that is the foundation of high-quality emergency care.

New for EDRVQP 2024/25

Alignment with the Quality Improvement Plan Program

Ontario Health has made several changes to synchronize EDRVQP with the Quality Improvement Plan (QIP) program:

- EDRVQP submissions are now to be submitted through the QIP Navigator platform as part of hospital QIP submissions
- Hence, submissions are due April 1 yearly

These changes go beyond aligning schedules and consolidating efforts for convenience or efficiency – they are designed to create more opportunity for quality improvement in emergency medicine, because some quality improvement issues identified through audits may be best addressed by enacting changes at organization or system level.

Alignment of EDRVQP with the QIP program strategically enables quality improvement initiatives in emergency medicine to be discussed at the executive and board level at the opportune moment – annual hospital-wide resource allocation planning.

Site-Level Process Summary

Steps

1. ESTABLISH TEAM AND IDENTIFY REQUIREMENTS

- Establish a quality team for the hospital site and inform Ontario Health (i.e., please email EDQuality@ontariohealth.ca)
- Confirm that the appropriate personnel have access to necessary data, tools, and resources early on (e.g., *iPort Access* data portal and EDRVQP guidance materials and templates)
- Determine audit submission requirements (i.e., number of cases required, which is based on site emergency department patient volumes; see *Requirements* section)

2. ACCESS DATA

Hospital sites do not have to collect their own return visit data.

- Access quarterly return visit data reports via *iPort Access* data portal (January 1, April 1, July 1, and October 1; see Item 1 and *Data* section)

3. SCREEN VISITS

- Using the EDRVQP audit template, screen site-level return visit data by visit characteristics, diagnoses, and other criteria detailed in the technical specifications (see *Screening and Selection* section)

4. AUDIT CASES

- Using the EDRVQP audit template, investigate circumstances and underlying causes (see *Auditing* section) for:
  - All cases with sentinel diagnoses
  - Additional cases with other diagnoses to meet audit submission requirements

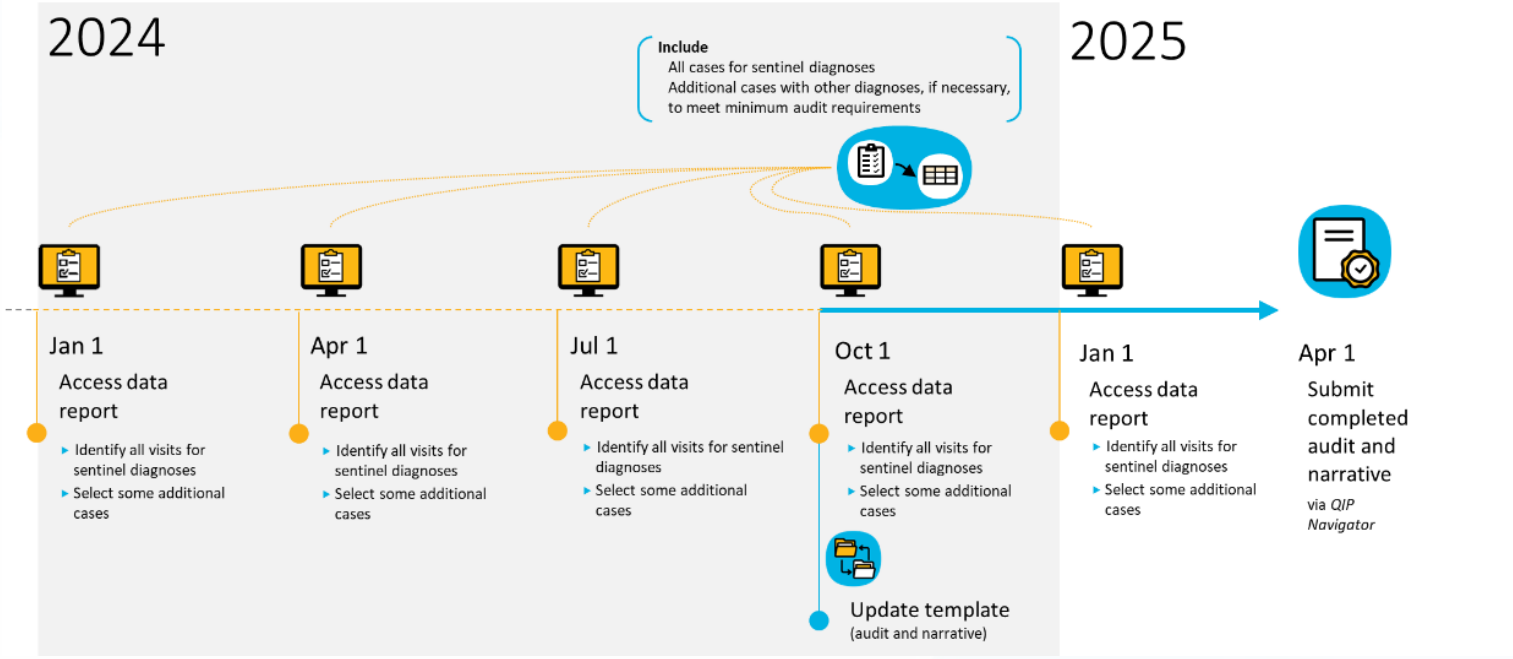
The document *How to Screen and Audit Return Visit Cases* describes screening and auditing processes (e.g., using the template, identifying quality issues, and developing improvement initiatives) in detail.

5. REFLECT, SUBMIT, AND IMPROVE

- Using the EDRVQP narrative template, summarize audit findings and resulting quality improvement actions
- Include the completed audit and narrative files for each site in the hospital's yearly QIP submission by April 1 so that the CEO and Quality Committee of the Board of the hospital can review the findings and integrate actions constructively and strategically into operational planning (see *Audit Findings* section)

Timeline

Item 1. Important Dates.



Hospital sites should have the required audits and draft narrative completed by the end of January to ensure that EDRVQP findings are also presented to their hospital's board when the hospital's draft QIP submission is presented.

Note: Five quarters of data are to be included in the April 2025 submission (see Appendix B: Data Report Schedules for future program cycle dates).

.

Requirements

Submission requirements, namely, the minimum number of cases that must be audited (i.e., investigated and analyzed) as part of the hospital site's annual submission, are determined by the site's P4R tier (i.e., by annual emergency department visit volume; see Item 2).

Item 2. Summary of Requirements.

Hospital participation?	Mandatory, if the hospital is part of the Pay for Results program			
For each hospital site				
Site volume:	**Large volume**	**Small volume**		
	> 30,000 annual ED visits	17,500 to 29,999 annual ED visits	7,000 to 17,499 annual ED visits	< 7,000 annual ED visits
Requirements:				
Getting data	• Request access for 2 users (1 primary and 1 back-up) for *iPort Access* data portal			
Screening data	• Exclude ○ Return visits clearly unrelated to the index visit ○ Patient transfers or repatriation ○ Scheduled visits ○ Cases for which the patient's chart cannot be located • Apply detailed criteria listed in the technical specifications			
Auditing	• Download updated audit and narrative templates • Complete analysis for the following minimum number of cases:			
	50	40	20	10
	○ All cases related to **A visit to the ED within 7 days of discharge from the initial ED nonadmit visit, to the same or a different hospital, resulting in an admission to an inpatient unit in the second visit with a sentinel diagnosis** – Subarachnoid hemorrhage – Acute myocardial infarction – Pediatric sepsis ○ A selection of cases for any diagnosis for **A visit to the ED within 72 hours of discharge from the initial ED nonadmit visit, to the same or a different hospital, resulting in an admission to an inpatient unit on the second visit**			
Submission	• Identify and work with hospital QIP lead to prepare submission for CEO and board of directors • Upload completed audit and narrative to QIP Navigator; submit by April 1			

Abbreviations: ED, emergency department; QIP, quality improvement plan.

Data

Data Reports

All hospital sites participating in EDRVQP will have access to quarterly reports containing return visit data through Ontario Health's *iPort Access* data portal.

Accessing Return Visit Data (*iPort Access* Portal)

Access for 2 users (a primary user and a back-up user) per site must be requested by the *iPort Access* local registration authority for the hospital site using the email template (see Item 3). Please email ATC@ontariohealth.ca.

Item 3. Email Template for *iPort Access* User Registration.

Email: ATC@ontariohealth.ca

Subject: Return Visit Rate Report Access Request (Patient Level)

Email Body:

- Local registration authority details:
  - Site name
  - Name
- Authorized users:
  - Site name
  - Name

Report Types

Two types of reports will be made available: an aggregated site-level report and a patient-level report.

AGGREGATED SITE-LEVEL DATA REPORT

The aggregated site-level report contains return visit numbers and rates from all sites in Ontario (although data points describing small numbers of patients may be suppressed to ensure that patient privacy is protected).

PATIENT-LEVEL DATA REPORT

The patient-level report shows:

- Month of index visit
- Medical record number
- Diagnosis at the initial visit
- Diagnosis upon admission at the second visit
- Whether a subsequent visit occurred within 72 hours
- Whether a subsequent visit occurred within 7 days and resulted in a sentinel diagnosis
- Whether the subsequent visit was to the same hospital

Source and Contents

Data related to the index visit are obtained from Level 3 National Ambulatory Care Reporting System (NACRS) data. Data related to a subsequent visit associated with admission are obtained from the Discharge Abstract Database (DAD).

In data reports, cases for which the subsequent visit was marked as a transfer or as a scheduled visit in the NACRS database have generally already been excluded (i.e., do not appear in the report). Cases for which the subsequent visit occurred to a different hospital will only be identified as a return visit in the data report of the hospital to which the initial visit occurred. (It will be clearly marked that the subsequent visit was to a different hospital, but this hospital will not be identified in the data reports in order to comply with privacy legislation.)

Data quality may be imperfect, and some transfers or scheduled visits may still appear in the report. These cases should be excluded during screening.

The reports are based on data from approximately 3 to 6 months prior to the report release date. For logistical reasons, DAD data incurs a delay; for example, if a patient stays in hospital for several months, data are not available until the patient is discharged.

Screening and Selection

The screening process is to exclude cases that do not need to be examined further. All nonsentinel cases should be screened for eligibility. When selecting nonsentinel cases for inclusion in the audit, they should also be screened.

General Exclusion Criteria

- Cases for which
  - The patient's chart cannot be located
  - The subsequent visit is clearly unrelated to the index visit
  - The subsequent visit was a repatriation
  - The subsequent visit was a transfer between emergency sites
  - The subsequent emergency department visit was scheduled (NACRS *ED Visit Indicator* = 0); a scheduled visit is one for which the visit date and time are fixed, and the appointment is recorded in a manual or electronic scheduling system

Detailed Criteria and Diagnosis-Specific Considerations

Cases With Sentinel Diagnoses

DEFINITION

Visits included in the data report for sentinel diagnoses are defined as

> A visit to the emergency department within 7 days of discharge from the initial emergency department nonadmit visit, to the same or a different hospital, resulting in an admission to an inpatient unit in the second visit with a sentinel diagnosis

CASE SPECIFICATIONS

Cases with sentinel diagnoses should meet the criteria listed in Item 4. Relevant conditions and associated ICD-10-CA (*International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*, Canada) codes are listed for sentinel diagnoses and potential misdiagnoses (i.e., conditions such as angina [for acute myocardial infarction], headache [for subarachnoid hemorrhage], and fever [for pediatric sepsis], which may be diagnosed in the index visit[9-11]).

Item 4. Technical Specifications.

Return visit (DAD data element[a,b] and criteria [condition with ICD-10-CA diagnosis codes or variable values])	Index visit (NACRS data element[b] and criteria [condition with ICD-10-CA diagnosis codes or variable values])
Acute myocardial infarction	
Most responsible *Diagnosis Code* • Acute myocardial infarction (I21.0–I21.9) *Age* • 20–95 years **Excludes patients with most responsible *Diagnosis Code* = I21.0–I21.9 [acute myocardial infarction] in previous year.**	*Main Problem* diagnosis • Chest pain (R07.1–R07.4) • Angina (I20) • Shortness of breath or congestive heart failure (R06.0, R06.8, I50, or J81) • Abdominal pain (R10.1, R10.3, or R10.4) • Heartburn, esophagitis, or gastritis (R12, R13, K20, K21, K22.9, K23.8, K29, or K30) • Syncope/malaise (R42, R53, or R55)
Subarachnoid hemorrhage	
Most responsible *Diagnosis Code* • Nontraumatic subarachnoid hemorrhage (I60.0–I60.9) *Age* • ≥ 18 years **Excludes patients with most responsible *Diagnosis Code* = I60.0–I60.9 [nontraumatic subarachnoid hemorrhage] or I67.1 [cerebral aneurysm] in previous year.**	*Main Problem* diagnosis • Migraine/headache (F454, G430–G439, G440–G442, G448, R51) • Neck pain (M436, M4642, M4782, M4792, M4802, M501–M509, M530, M531, M542, S1340–S1342, S1348, S136, S168) • Hypertension (I100 or I101) • Sinusitis (J010–J019, J320–J329) • Stroke/transient ischemic attack (G450, G459, I64, I674) • Meningitis (A870–A879, G000–G009, G01, G020–G028, G030–G039, G042) • Syncope and collapse (R55) • Giant cell arteritis (M315 or M316)
Pediatric sepsis	

Total Length of Stay
• ≥ 4 days
 	
or *Discharge Disposition*
• Died (07, 72, 73, or 74) with main *Diagnosis Code*:
  ○ Meningitis (A390, G000, G001, G002, G003, G008, G009, G01, G030, G039, A870, A871, A878, A879, B003, B010,B021, B051, B261, B375, G020)
  ○ Septicemia/sepsis (A021, A327, A392, A394, A400, A401, A402, A403, A408, A409, A410, A411, A412, A413, A414, A4150, A4151, A4152, A4158, A4159, A4180, A4188, A419, A483, R572)
or *SCU Unit Number* (special care unit code)
• Not 90, 93, 95, or 99
• With direct admission to ICU (within 30 minutes of admission)
Age
• 30 days to 5 years
 	
Excludes patients with prior acute inpatient discharge (regardless of diagnosis) in previous 14 days.
	Main Problem diagnosis
	• Fever of unknown origin (R50)
	• Cough (R05)
	• Other general symptoms and signs (R68)
	• Nausea and vomiting (R11)
	• Convulsions, not elsewhere classified (R56)
	• Abnormalities of breathing (R06)
	• Rash and other nonspecific skin eruption (R21)
	• Malaise and fatigue (R53)
	• Abdominal and pelvic pain (R10)
	• Headache (R51)
	• Other disorders of eye and adnexa (H57)
	• Other noninfective gastroenteritis and colitis (K52)
	• Symptoms and signs concerning food and fluid intake (R63)
	• Diarrhea and gastroenteritis of presumed infectious origin (A09)
	• Acute obstructive laryngitis [croup] and epiglottitis (J05)
	• Other functional intestinal disorders (K59)
	• Back pain (M54)
	• Viral infection, unspecified (B34.9)

Abbreviations: DAD, Discharge Abstract Database; ICD-10-CA, *International Statistical Classification of Diseases and Related Health Problems Tenth Revision* Canada; ICU, intensive care unit; NACRS, National Ambulatory Clinical Reporting System.

[a] Acute Inpatient abstracts.

[b] Discharge Abstract Database and National Ambulatory Clinical Reporting System data elements are *italicized*.

Additional Cases

DEFINITION

Visits included in the data report for nonsentinel diagnoses are defined as

> A visit to the emergency department within 72 hours of discharge from the initial emergency department nonadmit visit, to the same or a different hospital, resulting in an admission to an inpatient unit on the second visit.

CASE SELECTION APPROACHES

If including additional cases, either to meet audit requirements or to conduct an audit that is as comprehensive as possible, there are many selection strategies that can be considered. Randomly selecting cases to audit will provide a good overview of the common causes of return visits to your hospital's emergency department.

To increase the likelihood that selected cases will reveal learning opportunities, look for cases that align with hospital-wide or regional quality priorities. For example, if access to diagnostic imaging after hours is a challenge in your facility, and it is possible that appendicitis diagnoses are possibly being missed because of this, your team may wish to select cases with a return diagnosis of appendicitis and investigate whether access to imaging was a factor.

When using a targeted selection approach, be mindful not to exclude cases that may involve quality issues or adverse events.

We encourage hospitals to go beyond the minimum number of audits to learn from the valuable information presented in the data reports.

Auditing

Templates

Templates may be updated annually. In alignment with the QIP program, the updated templates are released in the fall to allow hospitals time to prepare EDRVQP submissions for inclusion in draft QIPs.

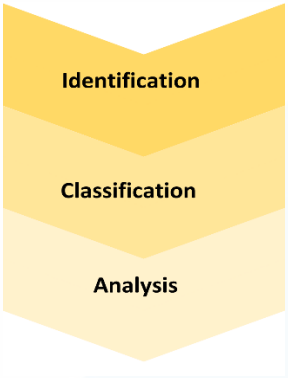
Refer to the audit template and accompanying document, *How to Screen and Audit Return Visit Cases*, for detailed instructions on capturing the outputs of the auditing process.

Audit Process

Auditing is conducted after determining which cases require further assessment in the screening and selection process. The auditing process consists mainly of 3 steps:

- **Identification:** Identify any adverse events or quality issues.
- **Classification:** Classify adverse events and quality issues according to type, preventability, and impact
- **Analysis:** Assess underlying causes of adverse events and quality issues and identify areas for improvement.

Item 4. Diagram of Main Steps in the Audit Process.



The audit process used in EDRVQP was adapted from that described by Calder et al.[13]

Because initial investigation of a case will be based on medical record review and will likely be performed by a different physician than the treating physician, the time elapsed since the case will not matter in most instances. 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 time the case is audited.

It is highly recommended that teams conduct audits, at a minimum, quarterly (when data reports are released) to maximize case recall and efficiently manage the auditing process.

The emergency department is dependent on multiple different services – consultants, radiologists, laboratories, etc. – and return visits will often reveal issues beyond those of the emergency department. Highlight these findings in the audit and narrative reports to Ontario Health. The strength of this program will

lie in the collaborative process of the audit to identify opportunities for quality improvement across health disciplines and sectors.

If broad system issues are identified, we would like to hear about them in the narrative. We hope that your team begins to develop quality improvement initiatives that also involve reaching out to other organizations in the community to improve broader issues that could be contributing to returns visits to the emergency department that could otherwise have been prevented.

Your team may discover cases that can be classified as critical incidents but were not captured by a critical incident reporting system. Follow your hospital's existing critical incident reporting process for these cases.

Roles and Responsibilities

The hospital's EDRVQP team should be led by an emergency department physician. Ideally, this physician should engage the treating team. Many sites have established interprofessional teams or committees to conduct the audits and drive actions for improvement as a group.

A qualitative study of the program[14] showed when sites employed a centralized approach to conducting audits (e.g., when the audit is conducted solely by the emergency department chief, manager, or director), it often led to a poorer understanding of program goals, whereas when sites that employed a multidisciplinary and more distributed approach, it led to a better understanding of program goals, performance, and results. Hospitals can appoint a program lead to guide work related to EDRVQP according to their own judgment.

However, participation in this program will ideally be collaborative, with processes and integrated into organizations based on the procedures that they currently have in place for managing and overseeing quality. Hospitals may deem it appropriate for the Quality Committee of the Board to have broad oversight or may wish to leverage the Medical Advisory Committee. 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 and overseen by the CEO.

Audit Findings

Submission

In alignment with the QIP program cycle, participating hospitals will submit EDRVQP results for all sites via QIP Navigator by April 1 of each year.

The QIP lead will input EDRVQP results into QIP Navigator. The guide, EDRVQP and QIP Integration, provides detailed information about how to include EDRVQP results in hospital QIP submissions.

Identify and work with the QIP lead at your hospital. Partner with them to ensure that EDRVQP results will be incorporated into the QIP discussion with the CEO and board of directors. The CEO, board chair, and emergency medicine lead (e.g., physician, executive) must also sign off on the EDRVQP components within the hospital's QIP.

A hospital's annual submission will include the following for every site:

1) A completed audit (with all personal health information removed)

2) A completed narrative

Submission Review

Once received, Ontario Health reviews submission content to ensure that:

- All components (audits and narratives for each site) are complete
- No personal health information has been included
- Audit requirements have been met
- Sufficient and detailed information has been provided for audited cases
- The narrative reflects that careful thought and consideration has been put into the analysis, in line with the purpose and spirit of the program

Hospital site leads will be contacted if revisions to an EDRVQP submission are deemed necessary.

Sharing Findings

Based on submitted information , Ontario Health will annually share high-level report with:

- Aggregated findings on types of quality issues found, their impact, and common underlying causes;
- Approaches to quality improvement; and
- Updates on quality improvement initiatives (as appropriate)

As part of this work, Ontario Health may reach out to participating hospitals for permission to share stories or examples included in their narrative submissions. Ontario Health will not identify individual hospitals unless the hospital provides permission.

Apart from the stories or examples shared with permission, year-end submissions to Ontario Health will not be made public. Hospitals are required to post their annual QIP publicly (typically on the hospital's website). Due to the sensitive nature of return visit audits, EDRVQP audits will not be available publicly via posted QIPs or QIP Query.

Your team may also consider sharing findings from the audits and potential actions for quality improvement with clinical teams in the emergency department, and possibly, Patient and Family Advisory Committee or other quality committees.

Next Steps

Accountability for proposed quality improvement actions is to be determined by each hospital's administration. While it is required that CEO and the Quality Committee of the Board are aware of audit findings and incorporate results into the organizational QIP, specific accountability mechanisms are at the discretion of each hospital's administration.

Resources

- Ontario Health provides resources (e.g., general program guidance, instructions for auditing, and tips for learning from identified quality issues), which are available on the ED Return Visit Quality Program website. Regional clinical leads for emergency medicine can also provide coaching and guidance

Questions regarding *iPort Access*, data reports, and data collection methodology can be directed to ATC@ontariohealth.ca.

Please contact us at EDQuality@ontariohealth.ca with questions regarding program guidance, requirements, or about how results will be reported or shared.

- Ontario Health also hosts webinars and provides other opportunities to connect with emergency medicine clinicians and interprofessional teams via the Provincial Emergency Services community of practice on Quorum. Upcoming opportunities will be announced via email and the community of practice.

1. Visit Quorum and create an account if you do not already have one.
2. Go to the Provincial Emergency Services community of practice page and click on the “JOIN GROUP” button.
3. Don't forget to "subscribe to updates" by clicking the button once your request to join has been processed.

References

1. Resar RK, Rozich JD, Classen D. Methodology and rationale for the measurement of harm with trigger tools. Qual Saf Health Care. 2003;12(Suppl 2):ii39–ii45.
2. Pierce JM, Kellerman AL, Oster C. "Bounces": an analysis of short-term return visits to a public hospital emergency department. Ann Emerg Med. 1990;19:752–7.
3. Wu CL, Wang FT, Chiang YC, et al. (2010). Unplanned emergency department revisits within 72 hours to a secondary teaching referral hospital in Taiwan. J Emerg Med. 2010;38:512–17.
4. Friedman SM, Provan D, Moore S, Hanneman K. Errors, near misses and adverse events in the emergency department: what can patients tell us? Can J Emerg Med. 2008;10:421–7.
5. Kuan WS, Mahadevan M. Emergency unscheduled returns: can we do better? Singapore Med J. 2009;50:1068–71.
6. Nunez S, Hexdal, A, Aguirre-Jaime A. Unscheduled returns to the emergency department: an outcome of medical errors? Qual Saf Health Care. 2006;15:102–8.
7. Chern CH, How CK, Wang LM, Lee CH, Graff L. Decreasing clinically significant adverse events using feedback to emergency physicians of telephone follow-up outcomes. Ann Emerg Med. 2005;45:15–23.
8. Jones J, Clark W, Bradford J, Dougherty J. Efficacy of a telephone follow-up system in the emergency department. J Emerg Med. 1988;6:249–54.
9. Vermeulen MJ, Schull MJ. Missed diagnosis of subarachnoid hemorrhage in the emergency department. Stroke. 2007;38:1216–21.
10. 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):647–55.
11. 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):625–32.
12. Griffin FA, Resar RK. IHI Global Trigger Tool for Measuring Adverse Events (Second Edition). IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2009 [cited 2016 Mar]. Retrieved from: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHIGlobalTriggerToolWhitePaper.aspx
13. Calder L, Pozgay A, Riff S, Rothwell D, Youngson E, Mojaverian N, Cwinn A, Forster A. Adverse events in patients with return emergency department visits. BMJ Qual Saf. 2015;24:142–8.
14. Chartier LB, Jalali H, Seaton MB, Ovens H, Borgundvaag B, McLeod SL, Dainty KN, Ostrow O. Qualitative evaluation of a mandatory provincial programme auditing emergency department return visits. BMJ Open. 2021 Apr 7;11(4):e044218.

Appendices

Appendix A: Audit Submission Requirement Examples

Example 1

The main site of a regional hospital has approximately 33,000 emergency department (ED) visits and approximately 800 ED return visits annually. After screening, there are 16 cases related to sentinel diagnoses and 784 cases related to other diagnoses.

This hospital site is classified as large volume**,** because it has more than 30,000 annual ED visits; therefore, the site is required to audit and submit a minimum of 50 cases. All 16 cases related to sentinel diagnoses and at least 34 additional cases must be audited.

Example 2

Data for a hospital site show that there were 7,941 total visits to the emergency department and 83 ED return visits. After screening, there appear to be 7 return visits related to sentinel diagnoses.

This site is classified as small volume with between 7,000 and 17,499 annual ED visits and is required to submit a minimum of 20 audits. All 7 cases related to sentinel diagnoses must be audited and at least an additional 13 cases must also be selected and audited. (There is no upper limit, so all 83 cases can be audited, if desired.)

Example 3

Hospital A is a community hospital with 6,902 annual ED visits and 58 annual ED return visits. There are 5 recorded return visits related to sentinel diagnoses and 42 return visits related to other diagnoses that meet the specified screening criteria.

This site is classified as small volume with < 7,000 annual ED visits. All 5 return visits related to sentinel diagnoses and at least an additional 5 cases must be audited. (There is no upper limit so all 42 cases can be audited, if desired.)

Example 4

Hospital Z is a community hospital with 6,759 annual ED visits and 71 annual ED return visits. There are 12 recorded return visits related to sentinel diagnoses and 27 return visits related to other diagnoses that meet the specified screening criteria.

This site is classified as small volume with < 7,000 annual ED visits. All 12 return visits related to sentinel diagnoses. (There is no upper limit so all 39 cases can be audited, if desired.)

Appendix B: Data Report Schedules

Table B1. Corresponding Audit Submission Date for Data Reports for 2024/25.

Data report release date[a]	QIP and EDRVQP audit submission date
January 1, 2024	April 1, 2025
April 1, 2024	
July 1, 2024	
October 1, 2024	
January 1, 2025	

Abbreviations: QIP, quality improvement plan; EDRVQP, Emergency Department Return Visit Quality program.

[a] Five quarters of data are to be included in the April 2025 submission.

Table B2. Corresponding Audit Submission Date for Data Reports for 2025/26.

Data report release date	QIP and EDRVQP audit submission date
April 1, 2025	April 1, 2026
July 1, 2025	
October 1, 2025	
January 1, 2026	

Abbreviations: QIP, quality improvement plan; EDRVQP, Emergency Department Return Visit Quality program.

Appendix C: Frequently Asked Questions

Should the audits be conducted under the *Quality of Care Information Protection Act, 2016* (QCIPA)? Can the results of the audit be requested under the *Freedom of Information and Protection of Privacy Act (FIPPA)*?

Each hospital has a process for determining whether quality of care reviews are conducted under QCIPA. Please note that 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 a patient's chart are generally not protected by QCIPA.

FIPPA currently provides some exemptions for certain types of quality of care information.

Teams are advised to speak with hospital legal counsel and consult the numerous resources created by the Ontario Hospital Association (at www.OHA.com) regarding QCIPA, FIPPA, and quality of care information.

Should a hospital committee have oversight over audits?

Many sites have established teams or committees to routinely conduct audits and drive actions for improvement as a group. This approach is valuable as it encourages discussion and allows for an interprofessional view of the case.

It would also be appropriate for an internal hospital committee such as the Quality Committee of the Board (to which the audit results are to be reported) to have broad oversight over the work related to the program and review the audit findings in a consistent and comprehensive manner. Hospitals may also wish to leverage the Medical Advisory Committee or another existing committee to oversee the audit process.

Are funds tied to performance on the rates of ED return visits?

Participation in EDRVQP is a condition of the Pay for Results program; however, funds are not tied to ED return visit rates, for two reasons: first, there may be variability in ED return visit rates among hospitals due to factors outside of their control; and second, this will serve to avoid inadvertently encouraging hospitals to increase admissions on index visits to reduce their rate of return visits.

Would coroner cases constitute a "return visit"? For example, if a patient discharged from the ED who subsequently suffers a fatal acute myocardial infarction, but never returned 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 have been reported to NACRS and included in the data report. If the coroner has concerns about a death involving a patient treated in your hospital's ED, they will be in touch with your organization, and you will learn about the case in this way. These cases do not need to be included in the audit for this program.

Will other sentinel diagnoses be considered for inclusion in EDRVQP?

We will continue to revise the program and learn from experience as the program progresses. We are open to considering any changes that could make the program more effective in future years.

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca
Document disponible en français en contactant info@ontariohealth.ca

ISBN 978-1-4868-8551-0 (PDF)