Health Quality Ontario

The provincial advisor on the quality of health care in Ontario

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The ED Return Visit Quality Program: Frequently Asked Questions

Ontario
Health Quality Ontario

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Overview

1. What is the ED Return Visit Quality Program?

The ED Return Visit Quality Program is an initiative that aims to bring focus on the quality of ED care to supplement the performance indicators that are part of the Pay-for-Results (P4R) program. This program was recommended by a task force with expertise in quality improvement that included ED physicians as well as representatives from a number of stakeholder organizations, including the Ministry of Health and Long-Term Care, Access to Care (Cancer Care Ontario), and Health Quality Ontario (HQO).

In the ED Return Visit Quality Program, hospitals are provided with quarterly data reports summarizing their performance on two types of ED return visits, and conduct routine and random audits of return visits to identify and understand their underlying causes. Hospitals will present the results of these audits to their CEO and Quality Committee of the Board and submit results to HQO annually. HQO will then summarize and report on key quality issues and themes discovered, as well as the improvement strategies identified, so that these key lessons can be shared among hospitals to support ongoing quality improvement.

2. Why was the ED Return Visit Quality Program created? What is the goal of the program?

Returning to the ED after an initial visit is a life event that is important to patients and may represent a gap in quality care.[1] These return visits may occur for a variety of non-preventable reasons such as natural disease progression or a scheduled return.[2,3] However, there are some return visits that are preventable, because they are related to the quality of care provided in the index visit.[2,4-6] These preventable return visits may be due to adverse events (AEs) or other quality issues.

From a health system perspective, preventable return visits to the ED are significant because they may lead to increased wait times and unnecessary health care spending and, most importantly, may indicate preventable harm. Identifying and addressing the factors associated with return visits will help to improve clinical outcomes, increase patient satisfaction, and promote high-value care.[7,8] It is also a unique opportunity for clinicians to receive feedback about their clinical care, and identify quality and/or educational improvements. Thus, the goal of this program is to promote high-quality ED care by helping clinicians and hospitals identify, audit, and investigate underlying causes of return visits to their ED and take steps to address these causes, preventing future return visits and harm.

It is important to note that funding will *not* be tied to the overall number of return visits for P4R hospitals. The emphasis is not on decreasing return visits, as this may lead to unintended consequences such as increased admission or unnecessary testing. The emphasis is on the process of auditing return visits to identify opportunities for quality improvement.

3. How are ED return visits defined in this program?

Two types of return visits are defined in this program. The two types of return visits are:

1. Number and percentage of ED return visits within 72 hours of discharge from the initial ED non-admit visit, to the same or a different hospital, and resulting in an admission to

an inpatient unit on the second visit.

2. Number and percentage of ED return visits within 7 days of discharge from the initial ED non-admit 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 [SAH], acute myocardial infarction [AMI], or paediatric sepsis) and with a relevant diagnosis* documented in the initial ED non-admit visit.

*The relevant diagnoses in the index visit are potential misdiagnoses for each sentinel diagnosis (for example, angina for AMI, headache for SAH, and fever for paediatric sepsis). A full list of relevant diagnoses and associated *International Classification of Diseases – 10th revision* (ICD-10) codes is presented in the technical specifications on page 9.[9-11]

Please note that ED return visits within 72 hours related to sentinel diagnoses will be captured in both types of return visits.

Hospitals are encouraged to pay particular attention to the numbers rather than rates for each type of return visit, because each number represents a patient who potentially suffered preventable harm.

Hospitals do not have to collect the data on these return visits; Access to Care (ATC) will provide data reports on a quarterly basis. More information on the technical specifications and methodology used by Access to Care is presented on page 9.

4. Is every hospital required to participate?

All ERNI* hospitals will be provided with the quarterly data reports on the two types of return visits and are encouraged to participate in the ED Return Visit Quality Program; however, participation is mandatory only for P4R hospitals.

Non-ERNI hospitals will not be provided with the quarterly data reports, and are not required to participate in the program. However, it is possible for non-ERNI hospitals to participate in the program if they are able to collect data internally.

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

Participation in the ED Return Visit Quality Program is a condition of the P4R program. However, funds are *not* tied to performance on the rates of ED return visits, 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.

*The ER NACRS Initiative (ERNI) includes the 126 participating hospital sites that submit level 1 data to NACRS on a monthly basis.

6. What resources or support will be provided as part of the program?

The following supports are available for this program:

- HQO provides guidance materials outlining the program, how to conduct an audit, and how to use the audit template and learn from any identified quality issues.
- ATC provides training and education related to the use of iPort Access™ to run reports and extract data, as well as their methodology for collecting the data.

Local coaching to review and learn from return visits is also available through LHIN Leads for Emergency Medicine.

Data & Reports

7. How and why were these types of return visits chosen for investigation?

ED return visits were chosen as the focus for this program because of literature evidence suggesting that they are a useful "trigger" to flag cases in which adverse events and quality issues are more likely to be identified.[12,13] The specific definitions of the two types of return visits used in this program were selected based on literature review and consideration of factors such as data availability and application across a broad spectrum of cases and EDs.[9-11,13]

The sentinel diagnoses were chosen for two reasons. First, these diagnoses have a potential to highlight the presence of quality issues – i.e., if a patient presented with one of the diagnoses related to a sentinel diagnosis, was not admitted after the index visit, and returned within a week to be admitted and diagnosed with a sentinel diagnosis, it is possible that a quality issue is at play. This increases the usefulness of these cases as a flag for such issues, and fewer cases will need to be screened before opportunities for quality improvement are identified. Second, SAH, AMI, and paediatric sepsis represent diagnoses for which there is a high likelihood of disability or death resulting from a missed diagnosis; thus, organizations should focus quality improvement initiatives toward preventing issues that have resulted in missed sentinel diagnoses if these are observed.

8. How can I access the data reports?

Two reports will be made available* by ATC on a quarterly basis:

1. An aggregated site-level report, which contains return visit numbers and rates from all sites in Ontario. This report is sent on a quarterly basis to each P4R hospital's ED Administrative Director, ED Manager, ERNI Clinical Lead, ERNI Coordinator(s), and identified point person for the ED Return Visit Quality Program. The report will also be sent to ED LHIN Leads and LHIN ER Performance Leads.
2. A patient-level report, which shows patient-level data including month of index visit, medical record number, diagnosis at the initial visit, admitting diagnosis at the second visit, whether the return visit was within 72 hours, whether the return visit occurred within 7 days and resulted in a sentinel diagnosis, and whether the return visit was to the same hospital. These reports can be accessed through iPort Access™ by authorized users.

*Non-P4R hospitals will only receive the aggregated site-level report if they submit contact information for their identified point person for the ED Return Visit Quality Program to HQO at EDQuality@hqontario.ca.

It should be noted that data points describing small numbers of patients may be suppressed in the aggregated site-level report to ensure that patient privacy is protected. These data will *not* be suppressed in the patient-level reports.

For privacy and security purposes, hospital sites are also required to identify a **maximum of two people** (a primary user and a back-up user) who are currently iPort Access™ registered users to gain access to the patient-level reports. The iPort AccessTM Local Registration Authority (LRA) at each site should submit the details of the identified users using the email outline below:

Email to: iPortAccess@cancercare.on.ca
Subject: Return Visit Rate Report Access Request (Patient Level)
Email Body:

- Local Registration Authority (LRA) details:
  - Site Name
  - iPort™ Access LRA User
- Authorized Users:
  - Site Name
  - iPort™ Access User

If you have any questions about iPort Access™, please email iPortAccess@cancercare.on.ca.

9. What are the benefits of conducting audits even if the rates are low?

Rates will be presented in your data reports, and they may be low at your site. However, it is important to remember that the focus of this program is on the number of patients captured under each type of return visit, which represents patients who potentially suffered preventable harm.

The provincial average rates of the two types of return visits defined in the ED Return Visit Quality Program have been calculated using ATC data for 2014/15, and are as follows:

- The percentage of return ED visits within 72 hours of the initial ED non-admit visit, to the same or a different hospital, and resulting in an admission to an inpatient unit on the second visit was 1.05%.
- The percentage of return ED visits within 7 days of the initial ED non-admit visit, to the same or a different hospital, and resulting in an admission to an inpatient unit in the second visit with a sentinel diagnosis (SAH, AMI or paediatric sepsis) was 0.05%.

10. Will the data reports be based on actuals, rates, age-standardized rates or risk-adjusted rates?

The reports will contain actual numerator and denominator values as well as associated rates. This will allow for direct comparison with the patient-level report. The rates will not include age or risk adjustments.

11. How timely are the data? What data will be included in the results submitted to HQO each year?

The data reports will include data from the previous quarter (i.e. three to six months prior). Final results are due to HQO **in January of each year**, and the data summarized in each final audit report will extend to **the end of Q1 of the previous year.** Thus, the final results to be submitted to HQO will include data from July 1 through June 30 (Q2, Q3, Q4 and Q1) each year. See Table 1 for data release and submission dates through 2019.

Table 1. Timing of release of data reports and final report submission.

Fiscal quarter	Data release date	Final report in which data will be included
Q2 2016/17 (Jul 1 – Sep 30, 2016)	Jan 1, 2017	January 2018
Q3 2016/17 (Oct 1 – Dec 31, 2016)	Apr 1, 2017	
Q4 2016/17 (Jan 1 – Mar 31, 2017)	Jul 1, 2017	
Q1 2017/18 (Apr 1 – Jun 30, 2017)	Oct 1, 2017	
Q2 2017/18 (Jul 1 – Sep 30, 2017)	Jan 1, 2018	January 2019
Q3 2017/18 (Oct 1 – Dec 31, 2017)	Apr 1, 2018	
Q4 2017/18 (Jan 1 – Mar 31, 2018)	Jul 1, 2018	
Q1 2018/19 (Apr 1 – Jun 30, 2018)	Oct 1, 2018	

There are circumstances in which new information will be provided up to six months later – for example, when a patient stays in hospital for several months. For this reason, data are continually refreshed throughout the calendar year; however, only small fluctuations are anticipated with each refresh.

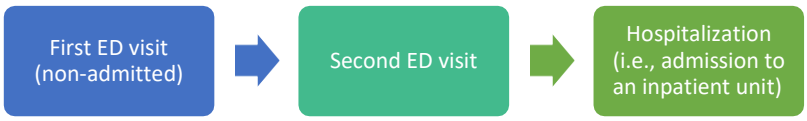
12. Are there any concerns about the delay in the availability of the data reports? It will be difficult for physicians to remember the case if it is reviewed potentially six months after the return visit.

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

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

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

13. Are there additional technical specifications for the return visits? If so, what are they?



1. Overall return visit rate within 72 hours

Numerator: Number of patients returning to ED resulting in admission to an inpatient unit (from the Discharge Abstract Database [DAD]) within 72 hours (based on registration date/time) following discharge from initial visit

Denominator: Total number of non-admitted ED patients (i.e., discharged patients)

2. Sentinel return visit rate within 7 days

Numerator: Number of patients with a return visit to the ED resulting in admission to an inpatient unit with a most responsible diagnosis matching a sentinel diagnosis* within 7 days of discharge from the initial visit (based on registration date/time) and whose diagnosis in the initial visit was relevant to their admitting sentinel diagnosis*. For the paediatric sepsis group, direct admissions to ICU (regardless of diagnosis) on the return visit are also included.

*See Table 2 for technical specifications for sentinel diagnoses in the admitting visit and relevant diagnoses in the index visit.

Denominator: Total number of non-admitted ED patients (i.e. discharged patients) with main problem matching a relevant diagnosis

Table 2. Technical specifications

Sentinel diagnosis	Technical specifications for sentinel diagnoses (in the return/admitting visit)	Technical specifications for relevant diagnoses (in the index visit)
Acute myocardial infarction	Discharged inpatient cases (DAD) that have any of the following ICD-10 codes as the most responsible diagnosis: acute myocardial infarction, I21.0 to I21.9 Patient age: 20 to 95 years	First ED visit (NACRS) that has any of the following ICD-10 codes as the main problem diagnosis: • Chest pain (R07.1 to 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 (ICD-10-CA R42, R53, or R55)

Subarachnoid hemorrhage	Discharged inpatient cases (DAD) that have any of the following ICD-10 codes as the most responsible diagnosis: nontraumatic subarachnoid hemorrhage, I60.0 to I60.9 Patient age: ≥ 18 years	First ED visit (NACRS) that has any of the following ICD-10 codes as the main problem diagnosis: • Migraine/headache (F454, G430-9, G440-2, G448, R51) • Neck pain (M436, M4642, M4782, M4792, M4802, M501-9, M530, M531, M542, S1340-2, S1348, S136, S168) • Hypertension (I100-1) • Sinusitis (J010-9, J320-9) • Stroke/transient ischemic attack (G450, G459, I64, I674) • Meningitis (A870-9, G000-9, G01, G020-8, G030-9, G042) • Syncope and collapse (R55) • Giant cell arteritis (M315-6)
Paediatric sepsis	Discharged inpatient cases (DAD) with minimum Total Length of Stay of 4 days or Discharge Disposition of Died ('07'), and with any of the following ICD-10 codes as the main diagnosis: • **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, A 327, A392, A394, A400, A401, A402, A403, A408, A409, A410, A411, A412, A413, A414, A4150, A4151, A4152, A4158, A4159, A4180, A4188, A419, A483, R572 Patient age: 30 days to 5 years	• 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)

Exclusion Criteria:

- Invalid/non-Ontario Health Care Numbers with values ‘0’, ‘1’, ‘9’, Province Issuing Code not ‘ON’
- Non-Ontario residents (postal code does not start with K, L, M, N, O or P)
- Scheduled ED visits

Data sources:

Data related to the index visit are obtained from the Level 3 National Ambulatory Clinical Reporting System (NACRS). Data related to return visits associated with admissions are obtained from the DAD.

For further details regarding methodology, please contact Access to Care at ATC@cancercare.on.ca.

14. Will there be consideration to include other sentinel diagnoses?

We selected the three sentinel diagnoses based on published research.[9-11] We chose to use the same sentinel diagnoses as described in these publications because the reporting procedures as well as the quality of data that results are already validated. In addition, we confirmed that selection of these diagnoses will identify a manageable number of cases that are very likely to be worth reviewing. Apart from this justification based on methodology and scope, the chosen sentinel diagnoses represent areas where there may be diagnostic challenges in emergency medicine, and where a delayed diagnosis presents a risk of a poorer outcome for the patient.

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

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

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

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

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

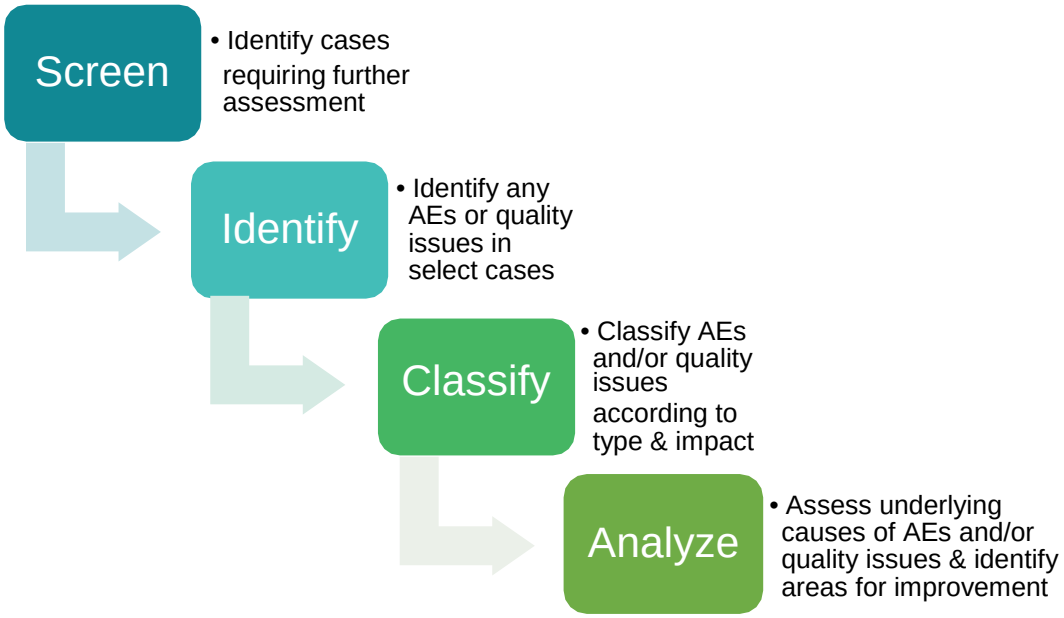
17. Are patients who return for scheduled interventions following an ED visit and subsequently require admission based on findings included in total return visit volume?

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

Conducting Audits

18. What will an audit require?

The audit process used in this program was adapted from that described by Calder et al.[13] The following is an overview of the process:



The screening process will identify cases for which the return visits were clearly unrelated to the index visit or were scheduled. These cases do not need to be examined further.

The cases selected for further assessment are those in which quality issues are more likely to be found. More detailed assessment of these cases will be conducted to identify any quality issues or AEs that occurred in the index visit, classify them according to type and impact, and analyze the underlying causes and potential areas for quality improvement.

Refer to the audit template and accompanying guidance document, How to Conduct an Audit, for more detailed instructions on the audit process. These documents are available from the ED Return Visit Quality Program website: http://www.hqontario.ca/ED-Return-Visit.

19. How many audits need to be completed?

Each year, participating sites will need to audit a minimum of 50 cases. However, **all cases relating to sentinel diagnoses *must* be audited.**

These requirements are applied on a per-site basis; thus, multi-site organizations will be expected to conduct a minimum of 50 audits for each ED site.

Cases will be broken down as follows:

20. Excluding the sentinel event cases, should hospitals randomly choose the cases to review?

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

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

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

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

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

22. Who should perform these audits?

The audits will consist of an initial screening process followed by a more extensive analysis of select cases identified during the screening process. The more extensive analysis of these cases should be conducted by an ED physician. Ideally, this physician should engage the treating team in the analysis of underlying causes. If it is helpful, another qualified health care

professional (e.g., nurse, physician assistant, etc.) can complete the screening process of the audit. This person should be familiar with the purpose of the program and be assigned and dedicated to completing this portion of the audit.

23. Will my department be held accountable for any actions for quality improvement proposed in the analysis section of the audits?

Accountability for proposed change ideas or next steps for quality improvement is to be determined by each hospital. While every hospital is required to share findings from their audit with their CEO and Quality Committee of the Board, specific accountability mechanisms are at the discretion of each hospital's administration.

24. What actions do I need to take if a critical incident is identified?

During the course of your audits, you 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. Hospitals are advised to consult with their internal legal counsel, risk management, and patient relations to determine what needs to be disclosed to patients for cases in which issues regarding the quality of care are identified.

25. Should a hospital committee have oversight over the audits?

The intention is for the practice of auditing these charts to become part of a routine and reflective practice. It would 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 to drive the process, and review the findings in a consistent and comprehensive manner. Alternatively, hospitals may wish to leverage the Medical Advisory Committee or another appropriate committee to fulfill this role.

26. Can the results of the audit be requested under the *Freedom of Information and Protection of Privacy Act* (FIPPA)?

FIPPA currently provides some exemptions for certain types of quality of care information. Hospitals are advised to speak with their legal counsel and/or consult the numerous resources created by the OHA regarding FIPPA and quality of care information at www.OHA.com.

27. Should the audits be conducted under the *Quality of Care Information Protection Act* (QCIPA)?

Each hospital has its own process for determining whether quality of care reviews are conducted under QCIPA. 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 the patient's chart are generally not protected by QCIPA. Hospitals are advised to speak with their legal counsel and/or consult the numerous resources created by the OHA regarding QCIPA and quality of care information at www.OHA.com.

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

Return visits for which the second visit occurred to a different hospital will only be flagged in the data report of the hospital to which the initial visit occurred. The fact that the return visit occurred at a different hospital will be clearly marked in the data report, but the hospital will not be identified in the data reports in order to comply with privacy legislation.

Cases involving sentinel diagnoses must still be audited if the second visit occurred to a different hospital. Because the focus is on the care provided in the initial visit, these cases can still be audited based on the record of the first visit as well as the discharge diagnosis on the second visit as listed in the data report. To obtain more information or access the medical records of the return visit, you would have to contact the patient or their representative and get the information from them directly or obtain their consent to contact the other hospital.

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

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

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

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

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

30. How will other physicians be involved in reviews of patients who are referred to an internal service such as Medicine or Surgery but are then discharged home by that service? The ED Physician won't be able to comment on the reasons why the person was sent home.

The ED is dependent on multiple different services – consultants, radiologists, laboratories, etc., and return visits will often reveal issues beyond the ED. If these issues arise, we expect that you will describe them in your audit and your report to HQO, and expect you to use your judgment to

pursue them wherever they will lead you. The strength of this program will lie in the collaborative process of the audit to identify opportunities for quality improvement.

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

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

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

Presentation & Submission Requirements

32. What needs to be submitted to HQO?

Participating hospitals will be asked to submit results at the end of January each year.

The annual submission will include:

1. A completed audit template with any personal health information removed
2. A completed narrative template, signed by the CEO

Each of these templates is available on the ED Return Visit Quality Program website.

HQO may also ask participating hospitals to complete an interim check-in survey midway through the year. This check-in survey will only include the number of audits conducted thus far, and whether you anticipate your hospital will meet its audit requirements for the year.

33. What needs to be presented to the CEO and Quality Committee of the Board?

You must present the results of your participation in this program to the CEO and Board at least once every year. This should include a summary of the results of the audits you have conducted to date as well as any quality improvement initiatives you have planned and progress on these as required. The CEO must also sign off on the completed narrative template before submission.

You may also consider sharing (in confidence) the results of the audits and potential actions for quality improvement with your hospital's Patient and Family Advisory Committee and clinical teams in the ED.

34. How will my results be reported or shared?

Based on the information in the annual submission each hospital provides to HQO, HQO will report back to hospitals at a high level on the types of quality issues found, their impact, common underlying causes, approaches to QI, and updates on QI initiatives as appropriate.

Reports will *not* identify individual hospitals unless the hospital provides permission, and year-end submissions to HQO will *not* be made public.

More Information

35. Where can I find more information about the program and submission process?

All guidance materials and templates are available on the ED Return Visit Quality Program website. If you have any questions about this program, feel free to contact EDQuality@hqontario.ca.

Access to clinical leadership to support review of return visits is also available through the LHIN Leads for Emergency Medicine.

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