Hospital readmissions

Resource for Indicator Standards (RIS)
Health Analytics Branch, Ministry of Health and Long-Term Care

Indicator description

RIS indicator name

Hospital readmissions

Other names for this indicator

- Percentage of home care clients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital

Indicator description

Percentage of home care clients who experienced an unplanned return to hospital within 30 days of hospital discharge.

Accountability agreement(s) or ministry initiative(s) the indicator supports

- Quality Improvement Plan (home care)

Numerator

Data source

Discharge Abstract Database (DAD)

Inclusion/exclusion criteria

Includes:

1. Hospital Discharge Date is within 30 days of Hospital Index case;
2. Urgent Readmission: Hospital Admission Category=U.

Excludes:

1. Planned Readmission: Hospital Readmission Code=1.

Calculation

Steps:

1. Select urgent/unplanned readmissions.

Denominator

Data source

Home Care Database (HCD) and Discharge Abstract Database (DAD)

Inclusion/exclusion criteria

Includes:

1. Client applied for in-home services: request program = 01;
2. Client is Short or Long-Stay: Last SRC=91, 92, 93, 94;
3. Client is active at time of hospital discharge: HC Admission Date <= Hospital Discharge Date + 7 days AND HC Discharge Date is NULL OR > Hospital Discharge Date;
4. Client is discharged from an acute hospital: analytical institution type =1;
5. Client received home care service within 30 days of hospital discharge: HC Service Date between Hospital Discharge Date AND Hospital Discharge Date + 30 days.

Excludes:

1. Invalid Health Card Numbers: HCN_index=D;
2. Palliative Care Clients: Last SRC= 95;
3. Newborn or Stillborn Discharges: Hospital Entry code = N,S;
4. Cadaver Donor Discharges: Hospital Admit Category=R;
5. Case Management Services: Service Type Code=10;
6. Clients less than 18 at time of hospital discharge: Hospital Age <19;
7. Hospital transfer to acute care: Inst_to_type=1 AND Disposition code= 01;
8. Hospital sign-outs and deaths: Disposition code = 06 or 07.

Calculation

Steps:

1. Select short or long-stay in-home home care clients.
2. Link active home care clients to DAD.
3. Identify active home care clients.
4. Link to service table to get home care visits within 30 days of hospital discharge.

Timing and geography

Timing/frequency of release

How often and when data are being released (e.g., be as specific as possible…data are released annually in mid-May)

Data released every quarter

Trending

Years available for trending

Data are available from 2007/08.

Levels of comparability

Levels of geography for comparison

Data are available at the level of the LHIN and province.

Additional information

Limitations

Specific limitations

N/A

Comments

Additional information regarding the calculation, interpretation, data source, etc.

1. Hospital is based on the location of the index visit.
2. Client's SRC is based on the last SRC recorded.
3. Age is calculated at time of discharge.

References

Provide URLs of any key references (e.g., Diabetes in Canada, http:// …)

N/A

Contact information

For more information about this indicator, please contact RIS@ontario.ca.

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