HEALTH QUALITY ONTARIO'S
Quality Compass
Navigate from knowledge to action

Ontario
Health Quality Ontario
Qualité des services de santé Ontario

Health Quality Ontario
Home and Community Care
Unplanned ED Visits

Best Practices

Created on October 03, 2017

“Insanity is doing things the way we’ve always done them and expecting different results.”

Albert Einstein

Unplanned emergency department visits [http://indicatorlibrary.hqontario.ca/Indicator/Summary/Unplanned-emergency-department-visits-QIP/EN] is a priority indicator for the QIP. This indicator provides information on the percentage of home care clients with an unplanned, less-urgent emergency department (ED) visit within the first 30 days of discharge from hospital. In Ontario [http://www.hqontario.ca/System-Performance/Home-Care-Performance/Emergency-Department-Visits]the percentage of ED visits by home care patients has remained fairly steady at 26% during the last six years.

Below are best practices and change ideas for decreasing unplanned, less urgent ED visits from the home care sector. Many of these change ideas are also used for “Reducing Hospital Readmissions [http://qualitycompass.hqontario.ca/portal/Home-and-Community-Care/Hospital-Readmission#.Wck0r8iGOUk]”. They are graded according to Type of Evidence [http://qualitycompass.hqontario.ca/Documents/EN/QualityCompassLevelsofEvidence.pdf]. Evidence-informed best practices are based on quality evidence, they can optimize outcomes and should be implemented into practice where possible.

To help you move from best evidence to best practice refer to Health Quality Ontario’s report The Emergency Department Return Visit Quality Program: Results from the First Year [http://www.hqontario.ca/Portals/0/documents/qi/ed/report-ed-return-visit-program-en.pdf]. Or browse the interactive table below for a quick summary of how to improve and decreased unplanned ED visits.

EVIDENCE-INFORMED BEST PRACTICES

Recognition and Assessment

Evidence-Informed Best Practice	Change Ideas	Toolbox

Assess post-discharge risk and activate appropriate follow-up	• Use an evidence based risk assessment tool to assess rehospitalisation risk.
	• Follow up phone call within 48 hours of discharge.
	• Appointment booked with their primary care team 5 days post discharge.
	• Ontario Telemedicine Network or e-notification about discharged patients.
	• Post-transition phone calls and information using teach-back for those assessed as high risk for readmission.
	  • How to recognize worsening symptoms
	  • When and how to seek help, and from whom
	  • When, how and why to take medications,
	  • Scheduled appointments (when, where, why, and with whom)
	• Consider referring complex patients to Health Links
		• LACE Online risk assessment tool [http://hsprn.ca/lace2/lace_app_desktop.html]
		• LACE Tool [https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0ahUKEwj9k_6TktzVAhVI04MKHd-gBiQQFgg0MAI&url=http%3A%2F%2Fmicmrc.org%2Fsystem%2Ffiles%2FLACE_tool%2520word%25204.23.13.pdf&usg=AFQjCNHtTZMnXXCCWA1PkJel45apC2QvRA]
		• RNAO: Care Transitions Clinical Best Practice Guideline [http://rnao.ca/bpg/guidelines/care-transitions]
		• AHRQ Teach-back Method. [https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html]
		• Teach-Back Toolkit [http://www.teachbacktraining.org/]
		• Ontario Telemedicine Network [https://otn.ca/]
		• Health Links [http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx]

Self-Management and Patient Education

Evidence-Informed Best Practice	Change Ideas	Toolbox
Encourage Self-Management / Self-Care to avoid unexpected ED visits. This involves educating people about their condition and care, motivating them to care for themselves better and tracking their progress.	• Patient and caregiver education programmes • Identify key family members/caregivers; consider them, along with the person, as "learners" and consider their level of health literacy. Use Teach-Back methods. • Use Healthlinks for better coordination. • Medication management advice and support. • Create an open environment and lines of communication for questions. Have in person conversations. • Psychological interventions and advice and support about diet and exercise (e.g., coaching) • Empower people/families to share in and manage their own health information and care plans and give them better access to their own records.	• Self-Management Program [http://www.swselfmanagement.ca/] • AHRQ Teach-back Method [https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html] • Teach-Back Toolkit [http://www.teachbacktraining.org/] • IHI "How To" Guide for Transitions [http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionsfromHospitaltoHomeHealthCareReduceAvoidableHospitalizations.aspx] • RNAO: Care Transitions Clinical Best Practice Guideline [http://rnao.ca/bpg/guidelines/care-transitions] • Self-Management Website [https://www.selfmanagementuk.org/] • Health Links [http://www.health.gov.on.ca/en/pro/programs/transformation/community.aspx] • Nesta People Powered Health [http://www.nesta.org.uk/project/people-powered-health] • Trust in the Doctor Patient Relationship [http://bmjopen.bmj.com/content/3/5/e002762.full]

Specialized Outreach and Technology Enablers

Evidence-Informed Best Practice	Change Ideas	Toolbox
Use specialized teams of practitioners and convenient technology enablers to create specific, successful outreach and care in the home.	• Create specialized outreach teams to assess unique needs in the home upon discharge (e.g. Palliative Team) • Create partnerships with Emergency Medical Services to directly refer clients in need of home care. • Use of Technology such as Ontario Telemedicine Network or using e-notifications about patient discharge. • Matching care coordinators to primary care providers	• Connected Care Across Ontario Ontario Telemedicine Network (OTN) [https://otn.ca/] • Ontario Medical Association's (OMA) Canadian EMR Report [https://www.cma.ca/Assets/assets-library/document/en/advocacy/Enhanced-Use-of-EMRs-Discussion-Paper-Final-May-2014.pdf]

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Measurement

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"While all changes do not lead to improvement, all improvement requires change"

Institute for Healthcare Improvement

How do we know if a change is an improvement? Measurement is a critical step in QI to assess the impact of a change. Quality indicators are used in the QIPs to measure how well something is performing. There are three types of quality indicators used to measure QI efforts:

- ***Outcome Indicators***: capture clinical outcomes and or system performance,
- ***Process Indicators***: track the processes that measure whether the system is working as planned, and
- ***Balancing Indicators***: ensure that changing one part of the system does not cause new problems in another.

Indicator	Unplanned emergency department visits [http://indicatorlibrary.hqontario.ca/Indicator/Summary/Unplanned-emergency-department-visits-QIP/EN]
Topic	Readmission
Quality Dimension	Effective
Type of Indicator	Process
Measure	Percentage (%)
Data Source	Discharge Abstract Database (DAD), Home Care Database (HCD), National Ambulatory Care Reporting System (NACRS)
Data Collection Instrument	Collected by Health Shared Services Ontario (formerly the Ontario Association of Community Care Access Centres (OACCAC))
How to Calculate	The percentage is calculated as: (Numerator/Denominator) x 100 **Numerator**: # of adult home care clients who had an ED visit assessed at Canadian Triage and Acuity Scale levels 4 or 5 (but who were not admitted to hospital) in the first 30 days after hospital discharge. **Denominator**: # of total adult CCAC home care clients discharged from a hospital.
Target	Lower is better
Range	0 – 100%
HQO Reporting Tool	Quality Improvement Plans (QIPs)

This data can be presented using Run Charts [http://qualitycompass.hqontario.ca/Documents/EN/Interpreting%20Run%20Charts.pdf] to track improvement over time. To read more about general measurement in QI refer to Measurement for Quality Improvement [http://www.hqontario.ca/Portals/0/Documents/qi/qi-measurement-primer-en.pdf] or the QI Getting Started Section [http://qualitycompass.hqontario.ca/portal/getting-started#.WZMhL1F96Uk].

Tools & Resources

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Health Quality Ontario's Tools and Resources

- Health Quality Ontario's Report **The Emergency Department Return Visit Quality Program [http://www.hqontario.ca/Portals/0/documents/qi/ed/report-ed-return-visit-program-en.pdf]**
- Health Quality Ontario's Report **Under Pressure Emergency Department Performance in Ontario [http://www.hqontario.ca/portals/0/Documents/system-performance/under-pressure-report-en.pdf]**
- **Health Quality Ontario's best PATH Transitions of Care Workbook [http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-transitions-en.pdf]**

Other Tools and Resources

- **AHRQ's Teach Back Method [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool5.pdf]**
- RNAO's Care Transitions: Clinical Best Practice Guidelines [http://rnao.ca/bpg/guidelines/care-transitions]
- **CIHI's All Cause Readmission to Acute Care and Return to the Emergency Department [https://secure.cihi.ca/free_products/Readmission_to_acutecare_en.pdf]**
- **Enhancing the Continuum of Care: Report of the Avoidable Hospitalization Advisory Panel [http://www.health.gov.on.ca/en/common/ministry/publications/reports/baker_2011/baker_2011.pdf]**
- Living a Healthy Life With Chronic Conditions: The South West Self-Management Program [http://www.swselfmanagement.ca/]
- OHTAC Recommendation: Impact of Advanced (Open) Access Scheduling on Patients with Chronic Diseases (Draft) [http://www.hqontario.ca/en/mas/pdfs/2012/tech/AdvAccOHTACRecommendation20120807v08.pdf]
- **Qmentum Quarterly: Quality In Health Care - Transitions in Care [http://qualitycompass.hqontario.ca/Documents/EN/Tools/Accreditation%20Canada%20Care%20Transitions%20Newsletter.pdf]**
- **"Teach Back": A Tool for Improving Provider-Patient Communication [https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool5.html]**

Background

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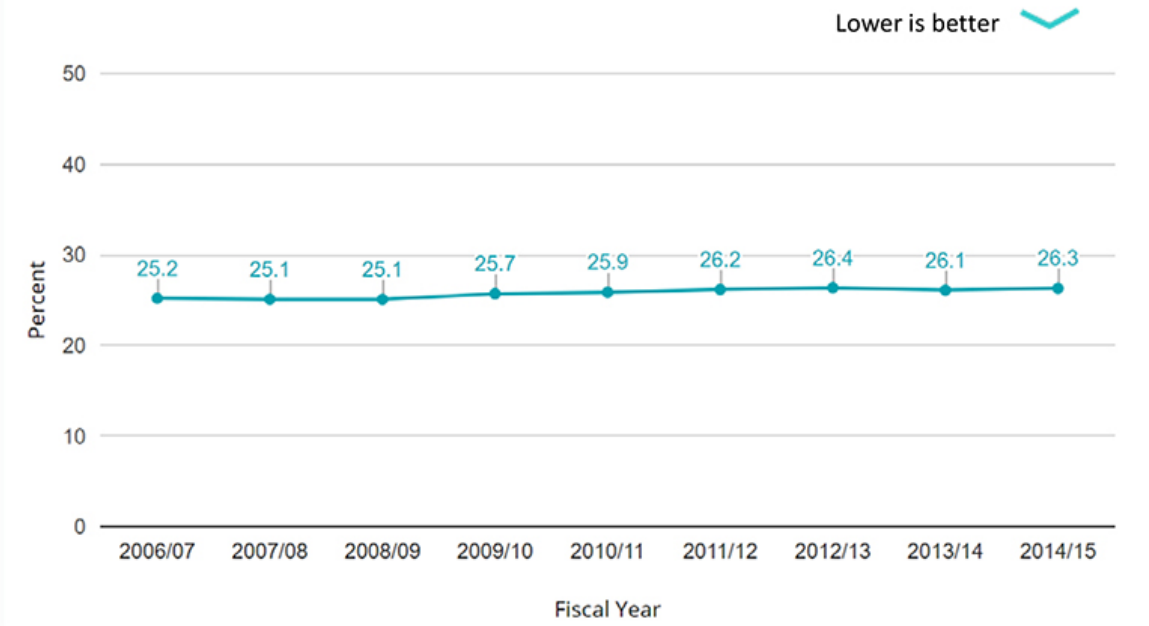
Issue

In 2014/15, people in Ontario made approximately 5.9 million visits as patients to emergency departments (HQO 2016; HQO 2015). The majority of people in Ontario appear satisfied with the emergency care they receive, Ontarians are spending less time in Ontario's emergency departments and seeing emergency doctors more quickly than in previous years (HQO, 2016; HQO 2015). A mix of sociodemographic and clinical characteristics, rather than disease diagnoses are the main drivers for the visits we are seeing (Neufeld et al., 2016). In 2014/2015 26.3% of ED visits were unplanned less urgent visits by home care patients (Figure 1).

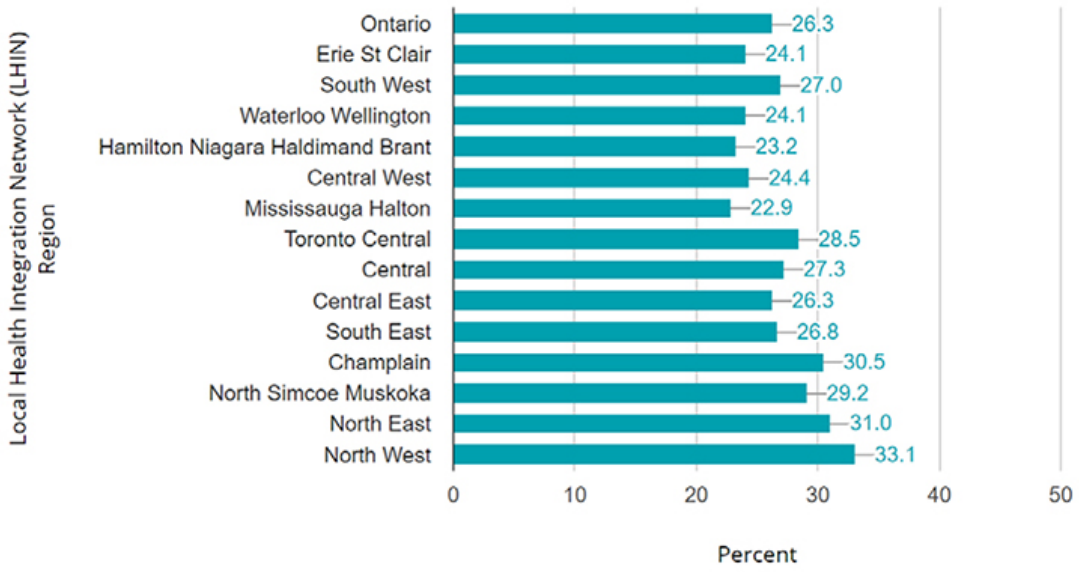
FIGURE 1: Percentage of emergency visits by home care patients in Ontario, 2006/07 to 2014/15 - Overall



Data source: Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Registered Persons Database (RPDB), Home Care Database (HCD), provided by the Institute for Clinical Evaluative Sciences (ICES).

Considering unplanned ED visits based on Local Health Integration Networks (LHINs) we see that most LHINs are within the provincial range or lower. However, there are a few LHINs in the north and central areas that are above the provincial average (Figure 2).

FIGURE 1: Percentage of emergency visits by home care patients in Ontario, by LHIN region, (2014/15) - Overall



Data source: Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS), Registered Persons Database (RPDB), Home Care Database (HCD), provided by the Institute for Clinical Evaluative Sciences (ICES).

Call to Action

Despite the success of keeping unplanned, less urgent ED visits fairly stable, emergency departments are still under a great deal of pressure. Factors such as the ageing population, difficulty in securing same / next day primary care appointments and patients coming in sicker than before puts extra pressure on emergency departments. Thus, reducing or even attempting to eliminate unplanned, less-urgent emergency department (ED) visit within the first 30 days of discharge from hospital would greatly reduce the stress on the ED and help keep patients at home (HQO 2016; Neufeld et al. 2016; Seow et al., 2016).

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