Ontario
Health Quality Ontario

Home Care Patients Readmitted to Hospital within 30 Days

Alternate Name*

The percentage of new patients receiving publicly funded home care who had an unplanned readmission within 30 days of leaving hospital, among those referred to home care from hospital or within 7 days of discharge

INDICATOR DESCRIPTION

Description*

This indicator shows the percentage of new patients receiving publicly funded home care who had an unplanned hospital readmission within 30 days of leaving hospital, among those referred to home care from hospital or within 7 days of discharge.
Timely follow-up after hospital discharge can help prevent readmissions and improve patient outcomes.
A lower percentage is better.

HQO Reporting tool/product

Public reporting

Dimension*

Effective

Type*

Outcome

DEFINITION AND SOURCE INFORMATION

Unit of Measurement*

Percentage

Calculation Methods*

Numerator divided by denominator times 100

Numerator (short description i.e. not inclusions/exclusions)*

The number of unplanned hospitalizations by home care patients newly referred to home care services within 30 days of initial hospital discharge

Denominator (short description i.e. not inclusions/exclusions)*

The number of patients newly referred to home care from hospital or within 7 days of discharge who were discharged from hospital and received their first home care service visit within the time period of interest

Adjustment (risk, age/sex standardization)- generalized

None

Data Source

Home Care Database (HCD)

Registered Persons Database (RPDB)

Discharge Abstract Database (DAD)

Data provided to HQO by

Institute for Clinical Evaluative Sciences (ICES)

Reported Levels of comparability /stratifications (defined)

Province

Region

OTHER RELEVANT INFORMATION

Caveats and Limitations

Readmission may occur before or after the first home care service visit.

Comments Summary

Hospital readmissions are counted as up to 30 days from the discharge of the index hospitalization, not including the day of discharge. This can extend into the next fiscal year. This indicator is reported for new home care patients only (referrals only occur for patients not already receiving home care). This indicator assumes that referrals within a referral date between hospital admission date and seven days after hospital discharge are referrals from hospital. It does not capture the location of the referral. Although unlikely, a patient can be counted in the denominator more than once in the same fiscal year.

TAGS

TAGS*

Home Care

Outcome

Readmission

Integration

Effective

Home Care Database (HCD)

Registered Persons Database (RPDB)

Discharge Abstract Database (DAD)

PUBLISH

PUBLISH DATETIME*

16/04/2024 13:28:00