90th percentile emergency department length of stay by acuity level

Alternate Name*

Maximum amount of time 9 of 10 patients spent in the emergency department by acuity level

INDICATOR DESCRIPTION

Description*

This indicator measures the maximum amount of time (in hours) in which 9 of 10 patients have completed their emergency department visits to go home or be admitted to hospital as an inpatient (by acuity level).
High acuity patients are all admitted patients plus non_admitted patients with CTAS Level in ('1','2','3')
Low acuity patients are all non_admitted patients with CTAS Level in ('4','5')
A lower number of hours is better.

HQO Reporting tool/product

Public reporting

Dimension*

Timely

Type*

Process

DEFINITION AND SOURCE INFORMATION

Unit of Measurement*

Hours

Calculation Methods*

The maximum length of time 90% of patients spend from registration or triage (whichever occurs first and valid) until the time patients leave the emergency department, less any time spent in a Clinical Decision Unit (CDU).
Exclusions:

From April 2013 onwards:

1. Cases where Registration Date/Time and Triage Date/Time are both blank/unknown (9999)
2. Cases where the MIS functional centre under Emergency Trauma, Observation and Emergency Mental Health Services (as of January 2015 data)
3. Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number
4. Cases where the ED visit Indicator is = '0'
5. Cases where Patient Left ED Date/Time are blank/unknown (9999)
6. Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 & 03)
7. ED LOS is greater than or equal to 100000 minutes (1666 hours)

From FY 2011-2012 to FY 2012-2013

1. Cases where Patient Left ED Date/Time are blank/unknown (9999)
2. Cases where Registration Date/Time and Triage Date/Time are both blank/unknown (9999)
3. Cases where patients over the age of 125 on the earlier of triage or registration date
4. Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number
5. Cases where the ED visit Indicator is = '0'
6. Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 & 03)
7. ED LOS is greater than or equal to 100000 minutes (1666 hours)

FY 2010-2011

1. Cases where Patient Left ED Date/Time and Disposition Date/Time are both blank/unknown (9999)
2. Cases where Registration Date/Time and Triage Date/Time are both blank/unknown (9999)
3. Cases where patients over the age of 125 on the earlier of triage or registration date
4. Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number
5. Cases where Patient left ED date/time is unknown or blank and the Disposition Code is 06-09, 12, 14 (admitted and transferred patients)
6. Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 & 03)
7. ED LOS is greater than or equal to 100000 minutes (1666 hours)

FY 2009-2010

1. Cases where Patient Left ED Date/Time and Disposition Date/Time are both blank/unknown (9999)
2. Cases where Registration Date/Time and Triage Date/Time are both blank/unknown (9999)
3. Cases where patients over the age of 125 on the earlier of triage or registration date
4. Duplicate cases within the same functional center where all ER data elements have the same values except for Abstract ID number
5. Cases pertaining to Psychiatric assessment units reported in functional centre 7131076 - evaluated and approved by CCO's ED Information Program
6. Cases where the Scheduled visit Indicator flag is = 'Y'
7. Cases where ED LOS are negative • Cases where Date/Time patient left ED missing and the Disposition Code is 06-09 (admitted patients and transferred patients)
8. Cases where patient has left without being seen by a physician during his/her visit (Disposition Code 02 & 03)

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

NA

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

NA

Adjustment (risk, age/sex standardization)- generalized

None

Data Source

National Ambulatory Care Reporting System (NACRS)

Data provided to HQO by

Cancer Care Ontario (CCO)

Reported Levels of comparability /stratifications (defined)

Time

Region

Acuity Level

OTHER RELEVANT INFORMATION

Caveats and Limitations

This definition is not aligned with other reporting at HQO such as online reporting and specialized report.

Comments Summary

For QIPs, the current reporting period is the calendar year.

TAGS

TAGS*

Acute Care/Hospital

Process

Wait Times

Access

Timely

National Ambulatory Care Reporting System (NACRS)

PUBLISH

PUBLISH DATETIME*

14/10/2016 08:46:00