Ontario
Health Quality Ontario

30-day readmission rate after leaving hospital for selected conditions

Alternate Name*

Hospital Readmission rate within 30 days of leaving hospital for selected conditions

INDICATOR DESCRIPTION

Description*

Rate of un-planned hospital readmissions within 30 days of discharge after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions).

HQO Reporting tool/product

Public reporting

Dimension*

Effective

Type*

Outcome

DEFINITION AND SOURCE INFORMATION

Unit of Measurement*

Rate per 100 discharges

Calculation Methods*

Numerator divided by the denominator times100

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

Number of subsequent non-elective (all-cause) readmissions to an acute care hospital within 30 days of discharge after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions).

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

Total number of hospital discharges after hospitalization for any of the following conditions: pneumonia, diabetes, stroke, gastrointestinal disease, congestive heart failure, chronic obstructive pulmonary disease, heart attack and other cardiac conditions (selected HBAM Inpatient Grouper (HIG) conditions).

Adjustment (risk, age/sex standardization)- generalized

Risk adjusted

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Data Source

Discharge Abstract Database (DAD)

Data provided to HQO by

Ministry of Health and Long-Term Care (MOHLTC)

Reported Levels of comparability /stratifications (defined)

Time

Income

Rurality

Region

Sex

OTHER RELEVANT INFORMATION

Caveats and Limitations

Not all readmissions are avoidable and this indicator does not capture which readmissions were avoidable and the underlying reasons (e.g. condition aggravation, poor transition, lack of community support/care). Due to age restrictions for some conditions the results are not reported by age groups. The indicator captures hospital readmission only and does not capture return visits to the emergency department. Results for calendar year 2020 should be interpreted with caution as the COVID-19 pandemic may have impacted the number of hospital admissions and readmissions. We noted reductions in numbers for both numerators and denominators in the 2020 data (readmissions and index admissions, respectively). However, the rate (the published data) was not impacted.

Comments Summary

A similar indicator is calculated for enrolled patients and reported at the primary care practice level for the Primary Care Quality Improvement Plan. Patients are included in the numerator and denominator if CAPE (Client Agency Program Enrollment) records show they are enrolled at the time of discharge for the index case.

TAGS

TAGS*

Primary Care

Outcome

Readmission

Integration

Effective

Discharge Abstract Database (DAD)

PUBLISH

PUBLISH DATETIME*

16/03/2022 16:00:00