

Discharge of Hospital Patients

Background

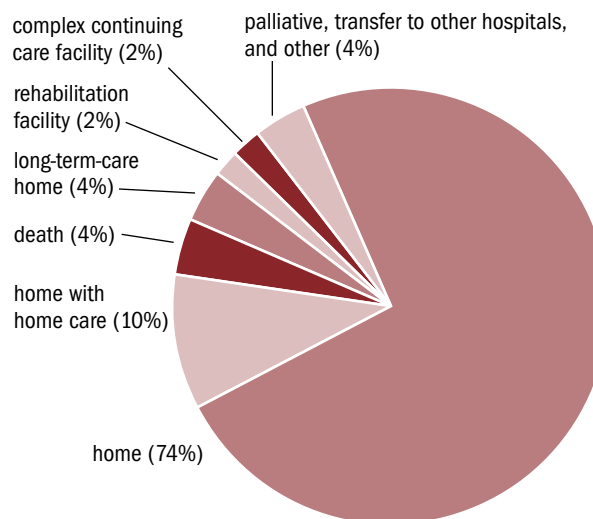
There are over 150 public hospitals with a total of 227 sites operating in Ontario. In the last five years, more than 1 million patients have been discharged annually from these hospitals.

Although most patients go home when they no longer require care in the hospital, over 20% of patients still require various levels of support (see Figure 1). Such support includes home care (for example, nursing and personal-care services such as bathing) provided in the patient's home, as well as specialized services provided by rehabilitation and palliative-care facilities, and ongoing care provided in either long-term-care homes or complex continuing care (CCC) facilities.

It is important that the transition from hospital to home, or to another health-care setting, is done as soon as possible after the decision is made that the patient no longer requires hospital care and can be discharged. Remaining in hospital longer than medically needed can be detrimental to a patient's health for various reasons, including the risk of getting a hospital-acquired infection (for example, *C. difficile*) and, especially for older patients, a decline in physical and mental abilities due to a lack of activity. In addition, when patients remain in hospital longer than necessary, their beds are not

Figure 1: Discharge Destination of Hospitalized Patients in Ontario, 2009 (%)

Source of data: Discharge Abstract Database



available for new patients, which may cause the cancellation of scheduled surgeries, such as elective surgeries, and longer wait times for people being admitted through the hospital's emergency department or for in-patient surgeries.

Although the hospital physician is ultimately responsible for determining when a patient is medically ready to be discharged, the patient's multi-disciplinary team of health-care providers generally determines any post-discharge care needs. Making these arrangements is done in conjunction with the patient and/or the patient's family, and may

be facilitated by hospital staff, for example, who request care at a rehabilitation or CCC facility for the patient, or may be done by the Community Care Access Centre (CCAC), which is responsible for assessing eligibility and arranging for both home care and access to a long-term-care home. Further, cleaning staff at the hospital are responsible for preparing each room for the next patient. Coordination of these parties is essential to having an effective and efficient discharge process.

The Ministry of Health and Long-Term Care (Ministry), primarily through the Local Health Integration Networks (LHINs), provides approximately 89% of total hospital funding. Other hospital funding sources may include accommodation charges for semi-private and private rooms, and donations. In the 2009/10 fiscal year, the total operating cost of Ontario's public hospitals was approximately \$23 billion. In general, the cost of physician services provided to hospital patients is not included in the hospital's operating costs, since the Ministry pays most physicians directly for these services through the Ontario Health Insurance Plan (OHIP).

Audit Objective and Scope

This year, our office audited three areas that can have a significant impact on patient flow in hospitals. This audit focused on the discharge of patients from hospital. The objective of this audit was to assess whether selected hospitals have implemented effective and efficient policies, procedures, and systems for the safe and timely discharge of patients. We also conducted separate audits on hospital emergency-department management and home care provided through the Community Care Access Centres (CCACs), which some patients require to be arranged before they can be discharged from hospital.

We conducted our audit work at three hospitals of different sizes: Credit Valley Hospital in Mississauga (in the Mississauga Halton LHIN),

St. Michael's Hospital in Toronto (in the Toronto Central LHIN), and St. Thomas-Elgin General Hospital in St. Thomas (in the Southwest LHIN). These three hospitals discharged a total of about 56,000 patients in 2009.

In conducting our audit, we reviewed relevant files and administrative policies and procedures; interviewed appropriate hospital, CCAC, and ministry staff; and reviewed relevant research, including attributes of good discharge transition planning identified in Ontario and in other jurisdictions. We also reviewed data received from the Ministry's Wait Time Strategy as well as the in-patient Discharge Abstract Database. As well, we engaged the services of two independent consultants, with expert knowledge in discharge planning, to assist us on an advisory basis.

We did not rely on the Ministry's internal audit service team to reduce the extent of our audit work, because it had not recently conducted any audit work on the discharge of patients from hospital. None of the hospitals we visited had an internal audit function.

Summary

A number of initiatives have been introduced by the Ministry, Ontario's hospitals, and Community Care Access Centres (CCACs) aimed at improving the flow of patients through hospitals, many of which impact on the process of discharging patients. All three of the hospitals we visited were managing their processes for discharging patients well in some areas and were changing certain other processes to improve patient flow. However, all the hospitals had other areas where practices could be improved, such as the early identification and timely revision of patients' estimated discharge dates, and better monitoring of bed availability.

Numerous studies have shown that remaining in hospital longer than medically necessary can be detrimental to patients' health. Further, waiting in

hospital for a bed in a community setting or for other community-based services, including long-term care and home care, to be available is much more expensive than community-based care alternatives. In 2009, over 50,000 patients waited in hospital due to delays in arranging post-discharge care (also known as patients waiting for an alternate level of care, or ALC), accounting for 16% of total patient days in all Ontario hospitals. In addition, the total days ALC patients were hospitalized increased by 75% between 2005/06 and 2009/10, while total hospital patient days increased only 7%. At the time of our audit, no one, such as the Local Health Integration Networks (LHINs), the CCACs, or the hospitals, was ensuring that community-based services, including home care and long-term care, were available when patients were ready to be discharged from hospital.

Although seniors (people aged 65 and over) represent only 13% of Ontario's population, in 2009 they accounted for almost 60% of hospital patient days—and over the next 20 years, the number of seniors is expected to double. Given the aging population, efficient processes for discharging patients from hospitals will become even more critical. The adage “what gets measured gets managed” will need to be kept in mind, because the Ministry, the LHINs, and the CCACs need better information on the timeliness of patient discharge and especially on whether recent initiatives are having an impact on the ALC challenge. Hospital administrators and medical staff would benefit from having more reliable and consistent data on patient flow to benchmark the results of their process improvement efforts.

Some of our other more significant observations included:

- Current best practices recommend a regular quick multidisciplinary team meeting to update discharge planning activities. Although the three hospitals generally held such meetings periodically, physicians attended at only one hospital, and CCAC representatives attended most meetings at only one other hospital.

- Province-wide, 50% of ALC patients who could have been discharged if home-care services were available had to wait in hospital for an average of six days for the services. Determining eligibility and arranging for home care takes time, but about 50% of the time at two hospitals we visited, CCACs were not given sufficient advance notice as set out by established policies. At the third hospital, 90% of the time less than 48 hours' notice was given, because this hospital's CCAC wanted to avoid rescheduling services if the discharge date changed.
- The Ministry's Physician Documentation Expert Panel recommended that hospital physicians prepare a discharge summary, including a medication reconciliation, to communicate patient information (such as follow-up appointments, pending test results, and medications the patient should take) to subsequent health-care providers. Although discharge summaries were generally prepared, one hospital's were completed significantly late. At all three hospitals, medication reconciliations were often not prepared, increasing the risk of medication errors.
- The hospitals we visited indicated that many post-discharge care facilities will not accept patients on the weekend, and therefore less than 10% of their total discharges to long-term-care homes, complex continuing care facilities, and rehabilitation facilities occurred on the weekend.
- The hospitals had some good bed management initiatives. For example, one was developing a system to optimize bed management by providing the status of each bed (occupied, needing cleaning, or available). Another—having found that peak hours for emergency-department admissions were in the morning, whereas peak hours for this hospital's discharges were in the afternoon—had begun to require at least 40% of discharges to occur by 11 a.m., thus reducing the time that

admitted patients waited in the emergency department for a bed.

- Wait times in hospital for ALC patients vary significantly across the province. For example, from November 2009 to February 2010, for hospitals in the North West LHIN, 90% of discharged ALC patients were placed within 27 days of being designated ALC, while in the North East LHIN, the corresponding period was 97 days.
- The time from hospital referral to placement in a long-term-care home can take more than four weeks, yet there were minimal guidelines on or oversight of how long this process should take. At the hospitals we visited, the typical process involved the CCAC conducting a patient eligibility assessment (the goal was to complete this within two or three days); if eligible, the family choosing which long-term-care homes to apply to (which averaged from three days to two weeks); and then the long-term-care homes deciding whether to accept or reject the applicant (which took an average of up to 15 days at one hospital and 22 days at the other hospital that tracked this information). Long-term-care homes rejected between 25% and 33% of applications at the one CCAC that tracked this information, for reasons such as the patient requiring too much care or having behavioural problems. Accepted applicants were often just added to a lengthy wait-list.
- Of ALC patients waiting province-wide for beds in long-term-care homes from November 2009 to February 2010, 90% were placed in long-term-care homes within 128 days, with 50% placed within 30 days. Because hospitals are an inappropriate and expensive place to wait, two hospitals required patients ready for discharge to apply to long-term-care homes with little or no wait, or potentially be charged \$700 to \$1,500 a day to stay in hospital. Patients often did not want these

homes because of their distance from family or because the homes were older facilities.

SUMMARY OF HOSPITALS' OVERALL RESPONSES

Overall, the hospitals generally agreed with our recommendations. One hospital highlighted the importance of recognizing that discharging patients from hospital was just one stage in the continuum of patient care. Further, this hospital noted that to have the maximum impact on the health-care system, the entire continuum of care needed to be considered (including care provided in the emergency room and through Community Care Access Centres).

OVERALL MINISTRY RESPONSE

The Ministry is committed to improving transitions of care for patients so they receive the right care in the right place at the right time. This audit provides constructive recommendations to improve the discharge process for hospital patients. Although the report reviewed the processes and practices in three hospitals, the Ministry takes a province-wide perspective. The Ministry appreciates that the Auditor General identified initiatives that support patient flow and wishes to note the following additional initiatives aimed at further spreading best practices for effective transitions:

- As part of the recently announced Excellent Care for All Strategy (April 2010), the Ministry is working with system partners (for example, the Ontario Health Quality Council) to provide programs that will support health service providers in strengthening their focus on the efficient use of resources and quality improvement based on the best evidence available. This initiative is expected to include the dissemination of best practices and the development of tools (for example, discharge summary and medication

reconciliation templates) to support their implementation.

- Many Local Health Integration Networks are now proceeding with the Alternate Level of Care Resource Matching and Referral Project, which aims to reduce the number of alternate level of care days by improving workflow and communication between organizations (for example, among hospitals and their Community Care Access Centres). This electronic information and referral system matches patients to the earliest available and most appropriate care/support setting at discharge.

Detailed Audit Observations

HOW DISCHARGE WORKS

The process for discharging a patient from hospital begins at different times, depending on whether the patient's hospitalization was planned (for example, to have scheduled surgery, such as elective surgery) or unplanned (for example, as a result of an emergency-department admission). For patients with a planned admission date, establishing an estimated discharge date (because recovery times from planned surgeries are often fairly predictable), as well as planning for the patient's recovery once discharged, can be done in advance of the surgery.

When a patient's admission is unplanned, a nurse, in conjunction with other health-care professionals, conducts an assessment to determine, among other things, if the patient is at high risk for a complicated discharge. A complicated discharge usually occurs when the patient cannot go back to his or her previous living situation—for example, because the patient requires a higher level of care, on either a short-term or an ongoing basis. An estimated discharge date for the patient, which is generally made on the basis of the doctor's diagno-

sis, should usually be established on admission or shortly after admission.

During their hospital stay, patients are assessed on an ongoing basis by members of the multidisciplinary team responsible for their care, which includes their doctors and nurses, and may also include other disciplines such as physiotherapists, dietitians, and social workers. The multidisciplinary team, among other things, assesses the patient's post-discharge needs, and if the patient requires placement in another facility for rehabilitation, complex continuing care, or palliative care, the hospital is responsible for arranging it. If the team determines that the patient requires home-care services or placement in a long-term-care home, the hospital contacts the Community Care Access Centre (CCAC), which is responsible for assessing the patient's eligibility for these services. If the patient is eligible, the CCAC is also responsible for arranging home-care services or processing the patient's application for a long-term-care home. All of these factors, along with any changes or complications in the patient's condition, can have an impact on the estimated discharge date.

When a patient no longer requires hospital care, the physician writes a discharge order, which, under the *Public Hospitals Act*, requires the patient to leave the hospital within 24 hours. Some patients who no longer require hospital care will remain in hospital longer, usually because they are waiting for post-discharge care arrangements, and may be difficult to place (for example, because they have dementia, are significantly overweight, require non-oral feeding, or require frequent medical treatments like dialysis or chemotherapy). Because these patients are waiting for care elsewhere, they are referred to as alternate-level-of-care (ALC) patients.

At the time of discharge, the physician at the hospital prepares a discharge summary detailing specifics about the patient's hospitalization, such as his or her diagnosis, treatment received, discharge medication, and follow-up appointments. The discharge summary is generally sent to the patient's

family physician and may be sent to other physicians to ensure continuity of care.

Patients who do not receive needed support after they are discharged may experience otherwise avoidable health problems, and may require readmission to hospital—a situation that not only negatively affects patient health but also places unnecessary demands on hospital resources.

Figure 2 shows the number of hospital beds, patient discharges, and average length of patient stay in Ontario hospitals from the 2005/06 fiscal year through the 2009/10 fiscal year.

ROLES AND RESPONSIBILITIES AT DISCHARGE

Several parties share responsibility for discharging patients from hospital, under a number of different pieces of legislation. For example:

- The *Public Hospitals Act* provides the framework within which hospitals operate. It sets out the responsibilities of hospital boards (which generally govern the hospital) and their medical committees with respect to the quality of patient care provided by the hospital. It also makes physicians responsible for determining when a patient should be discharged. The Minister of Health and Long-Term Care is responsible for administering and enforcing this legislation.
- Under the *Ministry of Health and Long-Term Care Act*, the Minister of Health and Long-Term Care's duties and functions include governing the care, treatment, and services and facilities that hospitals provide, as well as controlling the charges made to all patients by hospitals.
- Under the *Local Health System Integration Act, 2006*, Local Health Integration Networks (LHINs) are responsible for prioritizing and planning health services and funding certain health-service providers, including hospitals and CCACs. There are 14 LHINs, which are accountable to the Ministry. As of April 1, 2007, each hospital and CCAC is directly

Figure 2: Patient Discharges, Hospital Beds, and Average Length of Patient Stay in Ontario Hospitals, 2005/06–2009/10

Source of data: Ministry of Health and Long-Term Care

Fiscal Year	# of Discharges	# of Beds*	Average Length of Stay (days)
2005/06	1,095,000	18,400	6
2006/07	1,091,000	18,400	6
2007/08	1,091,000	18,700	6
2008/09	1,087,000	18,800	6
2009/10	1,092,000	18,400	6

* excludes bassinets for newborns

accountable to its LHIN, rather than to the Ministry, for most matters. With regard to discharge planning for hospital patients, the LHIN's role includes being accountable to the Minister of Health and Long-Term Care for the performance of local health services, including access to and co-ordination of services.

- There are 14 Community Care Access Centres (CCACs) across the province, one for each LHIN. Under the *Long-Term Care Act, 1994*, as well as under the new *Long-Term Care Homes Act, 2007* (proclaimed July 1, 2010), CCACs are responsible for assessing the eligibility of patients for home-care services and long-term-care homes, as well as arranging for home-care services and processing eligible patients' applications for long-term-care homes. Further, effective September 2009, LHINs may decide to expand the role of their respective CCACs to include placement of patients in complex continuing care and rehabilitation facilities.

INITIATIVES

Ministry

The Ministry has supported a number of initiatives to improve the flow of hospital patients, including the process for discharging patients from hospital:

- The Expert Panel on Alternate Level of Care was established to provide recommendations in response to the problems and challenges of patients waiting in hospital for an alternate level of care. In its 2006 report *Appropriate Level of Care: A Patient Flow, System Integration and Capacity Solution*, the panel proposed 22 recommendations, some of which were adopted, including increasing home-care services and reviewing hospital discharge policies and CCAC placement policies to ensure that patients can be moved into an appropriate long-term-care home in as timely a manner as possible.
- The Flo Collaborative was launched in September 2007 by the Centre for Healthcare Quality Improvement (CHQI), a Ministry-funded initiative. Twenty-nine hospitals participated in the Collaborative, generally in conjunction with their CCACs. The Collaborative's aim was, in part, to improve the effectiveness and timeliness of the processes for transitioning patients from hospital to subsequent care settings, thereby reducing ALC patient days. The Collaborative identified a number of areas for improvement, as well as attributes of good discharge and transition planning. In spring 2009, CHQI launched a strategy to communicate information on the identified areas for improvement to, among others, the hospitals and CCACs that were not able to participate in the Collaborative. We used various Flo Collaborative attributes of good discharge and transition planning as a best practice guideline during our hospital visits.
- The four-year Aging at Home Strategy commenced in 2007/08. The strategy includes increasing community support services such as home care, assistive devices (for example, wheelchairs), and supportive housing, which typically provides personal care (for example, assistance with hygiene and dressing). These additional community services are expected to, among other things, decrease both the

number of patients waiting in hospital for an alternate level of care and the time they wait. The Ministry indicated that it would be assessing the strategy over three years commencing in 2010/11.

- The Emergency Room/Alternate Level of Care Wait Time Strategy was initially introduced as the Emergency Room Wait Time Strategy in 2003 to reduce the time patients spend in the emergency room. It was expanded in May 2008 to include improving hospital bed utilization—for example, through the more timely discharge of patients no longer requiring hospital care. According to the Ministry, this initiative aimed to improve the sharing and implementation of best practices in, among other things, the discharge planning process. This initiative also included increasing home care and community supports for patients when they are discharged from hospital.
- In September 2009, as part of the Ministry's Wait Time Strategy, tracking of wait times using a standardized provincial definition commenced for hospitalized patients who were discharged to an alternate level of care (ALC), such as a long-term-care home. Further, starting in 2011, there are plans to track additional information, such as how long ALC patients still in hospital have been waiting. At the time of our audit, almost all of the 113 hospitals expected to submit ALC wait-time information were doing so.

Community Care Access Centres

The CCACs associated with the hospitals we visited had all implemented initiatives, as part of the Ministry's Aging at Home Strategy, to improve the timing of patient discharges from hospital. These initiatives included:

- *Home at Last*—a program to provide, for patients who do not have family or friends to assist them, a personal support worker or volunteer for a few hours on the day they

are discharged from hospital. Assistance provided is for transportation home and basic necessities, such as picking up the patient's medication and some groceries, and ensuring that the patient has a meal. This program was operating at two of the three hospitals we visited.

- *Wait at Home*—an initiative to provide CCAC-organized homemaking and personal support services in excess of regular home-care hours, to enable patients to wait in their homes for a long-term-care vacancy, rather than waiting in hospital. Under this initiative, patients were eligible for a maximum of almost double the regular number of home-care hours for 60 days in the CCACs associated with two of the hospitals we visited and for up to 90 days in the third CCAC. We noted that most patients participating in this initiative were placed in long-term-care homes within these times. Patients not placed were moved to the top of the wait-list for the long-term-care homes they applied to. One CCAC indicated that it had halted its Wait at Home program in November 2009 due to a lack of funding, but anticipated restarting the program in the 2010/11 fiscal year when next year's funding was received.
- *Stay at Home*—a program to provide CCAC-organized homemaking and personal support services in excess of regular home-care levels for a limited time to enable patients to be discharged home earlier than otherwise. This program was provided by the CCAC at one of the hospitals we visited.

Hospitals

All of the hospitals we visited participated in the Flo Collaborative and were undertaking additional initiatives to improve their discharge practices. For example:

- One hospital had conducted a review of its patient flow processes, including the dis-

charge process and identifying patient flow bottlenecks.

- Another hospital had developed a process, which included the involvement of the medical chiefs of staff, for specifically reviewing and increasing patient discharges where medically possible whenever the emergency department has an unusually high number of patients waiting for a bed.
- The third hospital had updated the process used by its nurses to help identify patients with risk factors that may delay their discharge.

PLANNING FOR IN-PATIENT DISCHARGE

Provisional Discharge Destination and Estimated Discharge Date

According to the Flo Collaborative, an estimated discharge date and a provisional discharge destination (for example, home with home care, a rehabilitation facility, or a long-term-care home) should be established for every patient within 48 hours of admission. The hospitals we visited indicated that the estimated discharge date is generally based on the patient's diagnosis. If the identified discharge destination is different from where the patient came from, the discharge will probably be more complex and time-consuming. For all patients, establishing an estimated discharge date gives health-care providers at the hospital and those in the community, as well as the patient and his or her family, time to prepare for the patient's post-discharge needs.

All the hospitals we visited had a policy requiring the early identification of each patient's estimated date of discharge or expected length of stay, and two of them had policies requiring the identification of post-discharge care needs. However, these policies varied. For example:

- One hospital required that an estimated discharge date be discussed "starting on admission" along with the nature of any post-hospital support that might be required.

- Another hospital required that an estimated discharge date be specified within 24 hours of the patient's admission.
- The third hospital required that the admitting physician state the expected length of stay upon admission for patients admitted with a diagnosis. Other patients were automatically assigned a three-day length of stay.

However, although the provisional discharge destination was usually noted in sampled patients' files, the patient's estimated discharge date was often not documented, either in the patient's file or elsewhere, at the three hospitals visited. For example:

- One hospital implemented a utilization system that it planned to use to record each patient's estimated discharge date. We noted that the hospital had used the system to record the discharge date for some patients in our sample. But on the date of our review, 83% of patients with an estimated discharge date had already passed that date and it had not been updated.
- At another hospital, a single hospital ward indicated that it documented patients' estimated date of discharge on a spreadsheet. But on the date of our review, 53% of patients did not have an estimated discharge date. Further, one-third of patients with an estimated discharge date had already passed that date and the dates had not been updated.
- The third hospital generally did not record an estimated discharge date or an expected length of stay.

Staff at the hospitals visited indicated that estimated discharge dates are not formally established for every patient, either because they have a general idea of the typical length of stay (for example, for elective surgery or childbirth) or because it is too difficult to accurately estimate the length of stay (for example, for unplanned emergency admissions or patients with numerous medical conditions).

Monitoring Patients' Readiness for Discharge

According to the Flo Collaborative, multidisciplinary teams at hospitals should conduct a quick round-table discussion about each patient (referred to as a bullet-round discussion), including his or her medical readiness for discharge and estimated discharge date. The Flo Collaborative also recommended using visual triggers, such as whiteboards, that clearly show each patient's discharge status (that is, his or her readiness for discharge) and required discharge planning activities.

Bullet-round discussions were conducted to varying degrees at the three hospitals we visited. For example, although these discussions were conducted daily in the general medicine wards of all three hospitals, the surgical wards held twice-weekly discussions at one hospital and weekly discussions at the other two. None of the hospitals held bullet-round discussions on discharge plans in their obstetrics wards, nor were discussions held in the pediatric wards at the two hospitals that had such wards. One of the hospitals indicated that these discussions were not held because obstetric and pediatric patients had very predictable lengths of stay in hospital. We attended bullet-round discussions at all three hospitals and noted that most were led by the in-charge nurses, with little input by the other disciplines. We also noted that:

- Physicians, who are responsible for discharging patients, routinely attended bullet-round discussions at only one of the hospitals.
- CCAC representatives, who are responsible for arranging post-discharge home care and admissions to long-term-care homes, routinely attended most bullet-round discussions at only one of the hospitals. The other two hospitals indicated that, due to resource constraints, CCAC representatives could only attend some of the bullet-round discussions.
- Most bullet-round discussions we observed spent minimal time on discharge planning,

other than whether a patient could be discharged today or tomorrow. However, we did note that one hospital ward at each of two different hospitals put a strong emphasis on discharge planning, including identifying actions that needed to occur to get patients ready for discharge, identifying the patients' post-discharge needs, and arranging post-discharge care.

A physician at one of the hospitals indicated that bullet-round discussions were too time-consuming, because they involved discussing other physicians' patients as well as that physician's patients. However, at the hospital where physicians attended bullet-round discussions, the discussions were organized so that each physician attended only that segment during which his or her patients were discussed.

All three hospitals had a patient utilization management system, which helps identify patients who are ready for discharge. However, only two of them were using it regularly for their general medicine and surgical patients. With this system, various indicators (including vital-sign assessments, vomiting, and pain control) are assessed to determine whether a patient is medically stable and ready for discharge. It is not intended to replace clinical evaluation and judgment, but can help focus discharge planning activities. Although one of the purposes of the bullet-round discussions was to assess patient discharge dates, the information provided by the system identifying those patients as ready for discharge was not routinely considered.

Whiteboards in nursing stations were also used to varying extents at the three hospitals we visited. However, many of the whiteboards we observed did not indicate each patient's expected discharge date, expected discharge destination, or outstanding discharge planning actions. In particular, we noted that:

- The whiteboards in the general medicine wards at two hospitals were colour-coded to show when patients were expected to be discharged. For example, green meant the

patient would be discharged within 24 hours, yellow meant the patient would be discharged within two or three days, red meant the patient would be discharged after three days, and blue meant the patient was ALC. However, whiteboards in other wards of these hospitals did not indicate when patients were expected to be discharged.

- At the other hospital, two-thirds of the wards contained a column on their whiteboards to record the estimated discharge date for each patient. However, at the time of our visit we noted that an estimated discharge date did not appear for each patient, and was typically recorded only when patients were likely to be discharged within a day.

One hospital took the initiative of conducting an audit of selected whiteboards, between December 2009 and February 2010, to determine their reliability in predicting patient discharges. This hospital found that 76% of patients who were expected to leave within 24 hours actually did, but that 45% of patients actually discharged had not been identified as a likely discharge the previous day.

Patient Preparation for Discharge

Various methods are used to communicate to patients and their families or caregivers their anticipated discharge dates and the factors influencing that decision. In 2009, about one-third of patients were admitted for planned elective procedures. Before admission, these patients are typically provided with information on their expected length of stay and post-discharge care needs.

While in hospital, all patients (whether their admission was planned or unplanned) typically are informed about their expected discharge date and post-discharge care needs. For example, all three hospitals we visited informed us that they provide patients or their families with pamphlets on how to manage various medical conditions (such as heart disease, stroke, and diabetes) when they return home.

The Flo Collaborative recommended using whiteboards in patient rooms or other visual aids to communicate with patients, among other things, the patient's expected discharge date and the goals (such as stable vital signs and pain under control) that the patient must achieve before discharge. We observed whiteboards in patient rooms at all the hospitals visited. Although some of one hospital's patient whiteboards used colour coding to signify the patient's discharge status (for example, yellow signifying that the patient would be discharged in two or three days), none of the whiteboards we observed indicated the patient's estimated discharge date. Another hospital informed us that it posts a sheet in patient rooms that outlines the goals a patient needs to achieve to be discharged. But this sheet was posted in only one patient room we observed.

RECOMMENDATION 1

To provide sufficient time for a patient's family and other caregivers to prepare for patients' post-discharge needs, hospitals should ensure that:

- key discharge information, such as the patient's estimated discharge date and discharge destination, is established and documented for every patient by the time of admission or shortly thereafter, and revised if the patient's condition warrants a change in the discharge date;
- quick round-table discussions regarding patients' readiness for discharge are attended by key decision-makers from the multidisciplinary team, such as the patient's physician, who is responsible for discharging the patient, and if the patient is going to a long-term-care home or requires home-care services, by a representative of the Community Care Access Centre; and
- the estimated discharge date and discharge plans are communicated to patients and their families by using visual displays, such

as whiteboards in patient rooms, as recommended by the Flo Collaborative.

SUMMARY OF HOSPITALS' RESPONSES

The hospitals generally supported this recommendation, and one hospital reiterated the importance of ensuring that patients with scheduled surgery (for example, elective surgery) had their estimated discharge date established prior to admission. However, two of the hospitals noted that it was not always feasible to establish upon admission an estimated discharge date for patients with multiple complex medical conditions who are admitted through the emergency department because, for example, diagnostic tests need to be completed first.

Although one of the hospitals indicated that physicians generally attended the quick morning round-table meetings to discuss patients' readiness for discharge, another hospital commented that many of its physicians choose to visit patients at different times of the day, and therefore it was often not feasible for these physicians to attend these morning meetings. Both of these hospitals indicated that, although they would like a representative from the Community Care Access Centre (CCAC) to attend all of the quick round-table meetings, resource constraints were currently preventing this. However, one of these hospitals noted that it was holding discussions with its CCAC regarding having a CCAC representative attend twice-daily meetings to discuss bed availability hospital-wide.

One hospital commented on the importance of visual management tools such as centrally located nursing station whiteboards to enhance team communication and patient communication whiteboards to better prepare patients and their caregivers for discharge, and was reviewing the mandatory use of nursing station and patient whiteboards hospital-wide. Another hospital noted that it now has patient

whiteboards for about half of its beds, but that the use of whiteboards would not be beneficial for other patients whose lengths of stay are very predictable.

ARRANGING POST-DISCHARGE CARE

Patients may require care or equipment after being discharged from hospital. In some cases, the hospital provides patients or their families with contact information for various community resources, so that the care or equipment can be arranged. In other cases, when the patient has certain equipment needs or requires home care or placement in a long-term-care home, the hospital contacts the CCAC, which is responsible for assessing the patient's eligibility for these services. If the patient is eligible, the CCAC arranges for the home-care services or processes the patient's application for a long-term-care home. From April through December 2009, Ontario hospitals made over 200,000 requests to CCACs for patient-eligibility assessments for home-care services. This includes requests made for admitted and non-admitted patients, such as emergency patients and out-patients. Information was not available on the total number of hospital patients referred for placement in a long-term-care home. The three hospitals visited had dedicated CCAC representatives on-site to process such referrals.

Some patients require services from a CCAC that is not associated with the hospital they are in (for example, patients who have travelled to another area of the province for specialized medical care). For these patients, the CCAC associated with the hospital conducts the initial assessment and then contacts the other CCAC to make the care arrangements. However, one hospital we visited commented that services vary among the CCACs, with no standardized expectations, so returning patients to their home community was not always easy to do.

Arranging for Home-care Services and Equipment

About 10% of patients require home care after they are discharged from the hospital. Home-care services offered vary among the CCACs, but generally include nursing assistance (for example, changing wound dressings, administering needles with medication, and monitoring vital signs); personal support (for example, helping the patient with activities of daily living such as bathing, dressing, eating, and grooming); physiotherapy (to help the patient regain strength and range of motion after surgery); occupational therapy (to assess the patient's post-discharge environment to ensure safety); and palliative care (to help with end-of-life care).

CCACs require time to determine a patient's eligibility for home care and make arrangements for required services. Therefore, they generally need advance notice in order to have their assessment and arrangements completed by the time the patient is ready for discharge. The hospital's nursing staff or social workers generally contact the CCAC to arrange for post-discharge home care. We noted that one hospital we visited had established, in conjunction with its CCAC, "Notification Guidelines" indicating when staff should contact the CCAC for home-care services, and that these guidelines were posted for easy reference at the nurses' station as well as on this hospital's intranet. Both of the other hospitals had CCAC documents that advised the hospital when to contact the CCAC, which were available to staff on the hospitals' intranet sites.

None of the hospitals visited had information on whether their CCAC referrals were made in accordance with their established time frames. Based on our sample of patients discharged from these hospitals in 2009, we noted that the hospitals often did not refer patients within these time frames (see Figure 3). One hospital indicated that it made many same-day referrals (that is, referrals made on the patient's discharge date) because the

Figure 3: Length of Advance Notice Required for CCAC Home-care Services, and Rate of Compliance Achieved, 2009

Prepared by the Office of the Auditor General of Ontario

Hospital	Required Notification Period before Patient Discharge According to Hospital/ CCAC Policy	Patients Referred in Accordance with the Policy (%)
1	one to seven days in advance, depending on the home care required	50
2	48 hours in advance	10
3	two days in advance for most patients, three days in advance for patients requiring two specific services	54

CCAC requested that referrals not be made until the patient was ready to go home, in order to avoid cancelling services if the patient's discharge date changed. Another hospital noted that the CCAC is aware of patients who may require home-care services, since a CCAC representative attends bullet-round discussions daily.

In order to avoid situations where the CCAC does not have time to arrange for required services, one CCAC had indicated to its referring hospitals that it wanted same-day referrals to be under 15% of total referrals. However, according to a report completed by this CCAC, same-day referrals from the hospitals in its region averaged 31% of total referrals in April 2010. Further, one of its hospitals made 66% of its referrals on the day the patient was scheduled to be discharged.

Two of the hospitals indicated that there are no standardized times for CCACs to respond to hospital referrals for home care. These hospitals noted that, unlike most weekday referrals, new referrals made to the CCAC on Fridays or weekends are not responded to until the next week.

With respect to post-discharge equipment needs (such as a wheelchair), patients having scheduled surgery are generally informed before admission about such needs. For other patients, their equipment needs are identified after admission. In either case, if the patient requires equipment, two hospitals told us they recommend a list of vendors to the patient or direct them to the phone book. One hospital told us that its orthopaedic depart-

ment sometimes sells equipment to the patient at cost and shows him or her how to use it. As well, the CCACs associated with all of the hospitals we visited may provide equipment free of charge for a limited time.

All the CCAC offices we spoke with told us that they rely on the patient to contact them if there are any problems with home-care services or equipment.

RECOMMENDATION 2

To better ensure that any required home-care services are available when eligible patients are ready to be discharged, hospitals, in conjunction with their Community Care Access Centres (CCACs) and Local Health Integration Networks (LHINs), should develop time frames that are standardized within each LHIN that provide adequate advance notice of the date such services will be needed and keep the CCAC apprised of any changes to the required commencement of home-care services.

SUMMARY OF HOSPITALS' RESPONSES

All of the hospitals supported this recommendation, and two of them highlighted that it would also be beneficial for standardized time frames to be developed for Community Care Access Centres to respond to hospital referrals.

Arranging for Long-term Care

Although seniors (people aged 65 and over) currently represent about 13% of Ontario's population, in 2009 they accounted for almost 60% of the total number of hospital patient days. According to Statistics Canada, the number of seniors is expected to double over the next 20 years, which will undoubtedly increase the demand for hospital in-patient services and post-discharge care. The most common destination for patients who cannot return home, the majority of whom are seniors, is a long-term-care home. There are more than 600 long-term-care homes in Ontario, which are either for-profit or not-for-profit nursing homes, charitable homes, or municipal homes. In 2009, about 4% of hospital patients were discharged to a long-term-care home. Therefore, it is important for hospitals to efficiently manage their processes for discharging these patients.

Hospital staff contact the CCAC when they believe a patient will require the higher level of care provided in a long-term-care home upon discharge from hospital. CCACs require time to assess a patient's eligibility for a long-term-care home and process applications for eligible individuals. However, none of the hospitals we visited had policies, nor was there any CCAC guidance, on what advance notice hospital staff should ideally be giving the CCAC when a patient is expected to be discharged to a long-term-care home.

All CCACs use a standardized assessment to determine patient eligibility for a long-term-care home. However, there are no provincial standards regarding how soon the CCAC, after receiving a hospital's referral of a patient believed to require a long-term-care home, must make a decision on the patient's eligibility. The CCAC associated with one hospital we visited had a goal to initiate an assessment within 48 hours of receiving the referral, and the CCAC associated with another hospital had a goal to complete an assessment within 72 hours. The CCAC associated with the third hospital had agreed to make initial contact with the patient

within two working days and indicated that it tries to perform the assessment within two to three days of receiving a referral. Information maintained by one of these CCACs indicated that almost all of the assessments were conducted within three days. Neither of the other two CCACs could provide us with this information.

For patients assessed as eligible for a long-term-care home, applications to several selected homes are typically completed by the patient or the patient's family. Two of the hospitals we visited had policies on the maximum time allowed for families to select the homes they wished to apply to: three days at one hospital and two weeks at the other. Once the applications are completed they are submitted to the applicable long-term-care facilities, which review them and either accept or reject the patient's admission. Information from a CCAC associated with one of the hospitals we visited indicated that about one-quarter to one-third of applicants were rejected by long-term-care homes in the 2009/2010 fiscal year. But none of the CCACs associated with the hospitals we visited had tracked the specific reasons applicants were denied admission during 2009. Anecdotally, CCAC representatives informed us that the main reasons for rejecting applicants are that patients are too heavy, require too much care (for example, require assistance with feeding, dressing, and toileting), or have behavioural problems. In January 2010, one CCAC started tracking information on the reason applications were rejected, and another CCAC indicated that it would be able to track such information using a newly implemented information system.

Legislation requires long-term-care homes to give the CCAC their response to an application within five business days, but there are no penalties levied if homes take longer than five days. At the two hospitals we visited that tracked this information in 2009, the long-term-care homes' average response time varied from a low of three days to a high of 15 days at one hospital, and from a low of eight days to a high of 22 days at the other hospital. However, even if a patient is accepted by the home,

this does not mean the patient can be discharged to that home, because many long-term-care homes do not have any available beds. The patient is therefore put on the home's waiting list for a bed.

Under the *Public Hospitals Act*, patients no longer needing treatment in a hospital generally have to leave on their discharge date. But in practice, given the lengthy time frames involved in arranging for a long-term-care home, these patients often end up staying in hospital longer than necessary while waiting for required post-discharge care. This situation is discussed in more detail later in this report, under "Patients Waiting in Hospital for Post-discharge Care."

RECOMMENDATION 3

To improve the process for admitting hospitalized patients to a long-term-care home, the Ministry, working in conjunction with the Local Health Integration Networks (LHINs), Community Care Access Centres (CCACs), long-term-care homes, and hospitals, should determine the best approach to placing a patient in a long-term-care home and establish benchmark standards for completing each stage in this process, such as determining patient eligibility, completing applications to long-term-care homes, and the long-term-care homes' processing of patient applications. The Ministry should also consider whether LHINs should be made accountable for monitoring adherence to the target time frames.

SUMMARY OF HOSPITALS' RESPONSES

All three hospitals supported this recommendation, and two of the hospitals further highlighted the need for ensuring that long-term-care homes comply with the legislated time frames for either accepting or rejecting a patient's application.

MINISTRY RESPONSE

The Ministry supports the principle of using benchmark standards to drive performance, and agrees with benchmark standards for the timing of each stage in the long-term-care-home placement process. In this regard, the Ministry, in conjunction with the LHINs, CCACs, hospitals, long-term-care homes, and researchers, will undertake a feasibility study of establishing benchmark standards for completing each stage of the process of placing patients into a long-term-care home. A potential mechanism for monitoring could be through the LHIN accountability agreements with health-service providers.

As mentioned in the Auditor General's report, target time frame standards already exist for long-term-care-home response times and are specifically legislated in the *Long-Term Care Homes Act, 2007*. The Ministry expects CCACs to enforce the legislative requirements with the long-term-care homes and notify the Ministry if the homes are non-compliant. Further, through the Ministry's inspections of long-term-care homes, inspectors, when noting that homes are not meeting this requirement, will issue an action/order that takes into consideration the severity and scope of the home's non-compliance and any history of overall non-compliance at that home.

LHINs have service accountability agreements, which include performance measures, with various health-care providers including hospitals, community agencies, and long-term-care homes. The Ministry, in conjunction with the LHINs, will look at ways to strengthen accountability for all stakeholders involved in the placement of patients into a long-term-care home. For example, education sessions are being held with long-term-care homes, CCACs, and the LHINs to ensure their understanding of and adherence to the provisions of the *Long-Term Care Homes Act, 2007*.

COMMUNICATING INFORMATION TO SUBSEQUENT HEALTH-CARE PROVIDERS

A discharge summary is used by the hospital physician to communicate information about the patient's hospital stay and post-discharge care needs to subsequent health-care providers, such as the patient's family physician. Timely discharge summaries are important for the continuity and quality of patient care, and therefore can help patients avoid adverse medication reactions and readmissions to hospital. The Physician Documentation Expert Panel, established by the Ministry, indicated in its 2006 report *A Guide to Better Physician Documentation* that the discharge summary is among the most crucial pieces of documentation in the patient's health record. The panel indicated that hospitals may develop policies for completing discharge summaries, and outlined what discharge summaries should contain, such as follow-up appointments and details of discharge medications (with reasons for giving or altering medications, frequency, dosage, and proposed length of treatment). However, the panel did not recommend any time frame for completing discharge summaries.

Hospital Policies on Discharge Summaries

All hospitals we visited had policies requiring the completion of discharge summaries for their patients. However, we noted that the policies varied among the hospitals. For example:

- Two of the hospitals did not require the completion of discharge summaries for patients with hospital stays of less than two or three days, respectively. The third hospital required discharge summaries for all patients.
- One hospital required all physicians to complete, date, and sign the discharge summary within 10 working days after discharge, with failure to do so resulting in the suspension of admitting privileges for the physician. The other two hospitals informed us that they had not established a time frame within which

physicians must complete the discharge summary.

- Two of the hospitals required that the discharge summary be copied to the patient's family physician. At the third hospital, staff told us that patients are usually given discharge instructions and are asked to provide a copy to their family physician. None of the hospitals required that discharge summaries be provided to long-term-care or other health-care providers.

We reviewed the files of a sample of patients discharged from the three hospitals in 2009, and noted the following:

- Discharge summaries were generally completed at two of the hospitals in accordance with their stated policies and practices. At the third hospital, a discharge summary was prepared for 70% of patients whose files we reviewed. The files for the other patients indicated that they were given discharge instructions, but these instructions did not contain any details of the patients' treatment while in hospital.
- At one hospital, 90% of discharge summaries were signed off by the physician within the 10 days specified by hospital policy. At the second hospital, 72% of discharge summaries were signed off within 10 days, with 90% signed off within 32 days. But at the third hospital, only 7% of discharge summaries were signed off within 10 days, with 90% signed off within 139 days.
- Between 50% and 95% of patients required a follow-up appointment—for example, with their surgeon. Although none of the hospitals had a policy on scheduling follow-up appointments for patients, between 20% and 30% of patients had a follow-up appointment made for them by the hospital before discharge. The pre-scheduling of follow-up appointments may assist patients in obtaining the post-discharge care they need.

One hospital informed us that it was implementing an electronic discharge summary. This was expected to improve the quality and timeliness of discharge summaries because it was easy to use and would result in more complete and consistent presentation of key patient information, such as what procedures were done in the hospital, any follow-up appointments required, pending test results, and discharge medications.

Medication Reconciliations

Medication reconciliations, which are conducted before the patient's discharge, compare the medications a patient will be taking after being discharged from hospital to the medications the patient was taking before admission and during his or her hospital stay. The goal of a medication reconciliation is to help prevent adverse drug events by ensuring that any changes in medications on discharge (such as adding or discontinuing medications, or changing the dosage or frequency of medications) are readily apparent to the subsequent prescribing physician. Accreditation Canada, which examines the quality of health services at hospitals with the aim of helping them improve the quality of services they provide, requires that medication reconciliations be completed. Further, the Physician Documentation Expert Panel indicated that details of discharge medications (including reasons for giving or altering medications, frequency, dosage, and proposed length of treatment) should be part of the discharge summary. All the hospitals we visited informed us that they were in the process of implementing the use of medication reconciliations.

In order to complete a medication reconciliation, hospitals need information on the drugs patients were taking before admission. According to hospital staff, a patient's medication history should be obtained from the patient or patient's family at the time of admission. It is also beneficial to verify the medication history against another source where possible. In fact, both the Institute

for Safe Medication Practices Canada and Safer Healthcare Now! (a campaign to improve patient safety by integrating best practices into the delivery of patient care) recommend that medication histories be verified against at least two sources of information. At the three hospitals we visited, the majority of medication histories were taken at the time of admission. However, most information was not verified against other sources, which could include, for example, the Ontario Drug Benefit system (which lists medications paid for by the system for all seniors and eligible low-income individuals) or a list of medications provided by the patient's pharmacist. Hospitals stated that they usually seek information from an independent source when the patient is uncertain about his or her medications. Further, one hospital noted that some patients bring their medications with them to hospital and that this provides the basis for determining the best possible medication history for the patient. However, we noted many differences (for example, missing medications and differences in medication dosages) between the independent source that had been identified in some patient's files and the list of medications on admission used to complete the medication reconciliations.

Based on our sample of discharge summaries at the three hospitals, we noted that:

- The percentage of discharge summaries that included some type of medication reconciliation ranged from a low of 10% at one hospital we visited to a high of 30% at another. At one of the hospitals the reconciliation was a specific document, whereas at two of the hospitals, the reconciliation was informal, consisting simply of physician comments throughout the summary on whether new medications should be added and whether medications taken before hospital admission should be continued, stopped, or put on hold.
- Between 54% and 70% of the summaries just listed the medications that patients should take post-discharge, without any indication that they had been compared to the patients'

medications on admission and without providing the reasons for any changes or new medications prescribed.

- Between 10% and 27% of the summaries had no information on the patients' discharge medications, although many of these patients were taking medication when they entered hospital.
- The frequency or dosage of at least one new medication was missing for 14% to 20% of the patients.

RECOMMENDATION 4

To ensure that medical information essential for the continuity and quality of patient care is communicated in a timely manner to subsequent health-care providers, hospitals should:

- require discharge summaries to be completed for all patients in accordance with the *Guide to Better Physician Documentation* developed by the Ministry's Physician Documentation Expert Panel;
- establish a target time frame, such as a maximum of 10 days, for completing discharge summaries and forwarding them to the patient's family physician or other subsequent health-care providers; and
- consider the use of a medication reconciliation template to be completed for each patient detailing any changes between the medications the patient was taking on admission and the medications that the patient will be taking post-discharge.

SUMMARY OF HOSPITALS' RESPONSES

The hospitals generally agreed with this recommendation. One hospital already had practices in place requiring physician completion of discharge summaries for all patients within 10 days of discharge and in accordance with the *Guide to Better Physician Documentation*. Another

hospital commented that hospitals should have accountability structures for ensuring that discharge summaries are completed and forwarded to subsequent health-care providers within targeted time frames.

With respect to the use of a medication reconciliation template, one of the hospitals commented that it has found that its use of such a template has promoted and facilitated the completion of accurate medication reconciliations at discharge.

HOSPITAL BED AVAILABILITY

A shortage of in-patient beds can create problems throughout a hospital. For example, emergency patients may have to wait in the emergency department for a bed, post-operative patients may have to remain in the recovery room, and patients with pre-scheduled surgeries, such as elective surgeries, may have their surgeries cancelled.

Timing of Patient Admissions and Discharges

Most hospitals in Ontario have a very high occupancy rate, with virtually all beds being occupied the majority of the time. In fact, two of the hospitals we visited had bed occupancy rates over 85%, with one hospital consistently over 90% occupancy. Research indicates that hospitals will experience regular bed shortages if occupancy is above 90%. One way to create additional bed capacity is to reduce the average length of patients' stay in hospitals. However, according to 2008/09 data from the Canadian Institute for Health Information, Ontario hospitals have an average length of patient stay that is shorter than that of almost all other Canadian provinces. One hospital we visited indicated that to determine whether lengths of stay could be reduced, comparisons between actual and estimated length of stay, based on patient diagnosis, are made.

Given the high hospital occupancy rates, discharges need to occur before new patients can be admitted. Therefore, the timing of patient admissions and discharges is important. Using data provided by the Ministry, we analyzed all hospital admissions and discharges in Ontario for January through November 2009 (see Figure 4). The number of unplanned admissions (for example, admissions through the emergency department) remained relatively consistent throughout the week. However, considerably fewer planned admissions (for example, for scheduled surgeries) occurred on weekends, even though almost 20% of all discharges occurred on Fridays—more than on any other day of the week. Further, hospital admissions exceeded discharges on Sundays through Wednesdays, which can potentially create shortages of in-patient beds. The hospitals we visited indicated that many post-discharge care facilities will

not accept patients on the weekend. For example, province-wide, patients are almost four times as likely to be discharged to long-term-care homes on a weekday than on a Saturday or Sunday. At the hospitals we visited, less than 10% of total discharges to long-term-care homes, complex continuing care facilities, and rehabilitation facilities occurred on the weekend.

We also noted that although roughly 65% of hospital discharges occur between 9 a.m. and 3 p.m., admissions peak between 6 a.m. and 8 a.m. (see Figure 5). This pattern means admitted patients may have to wait (for example, in the emergency department) a number of hours for other patients to leave and the room to be cleaned before they can be moved into a hospital bed.

All three hospitals we visited had processes for reviewing the status of their bed availability daily:

Figure 4: Admissions and Discharges to Ontario Hospitals by Day of the Week, January through November 2009

Source of data: Discharge Abstract Database

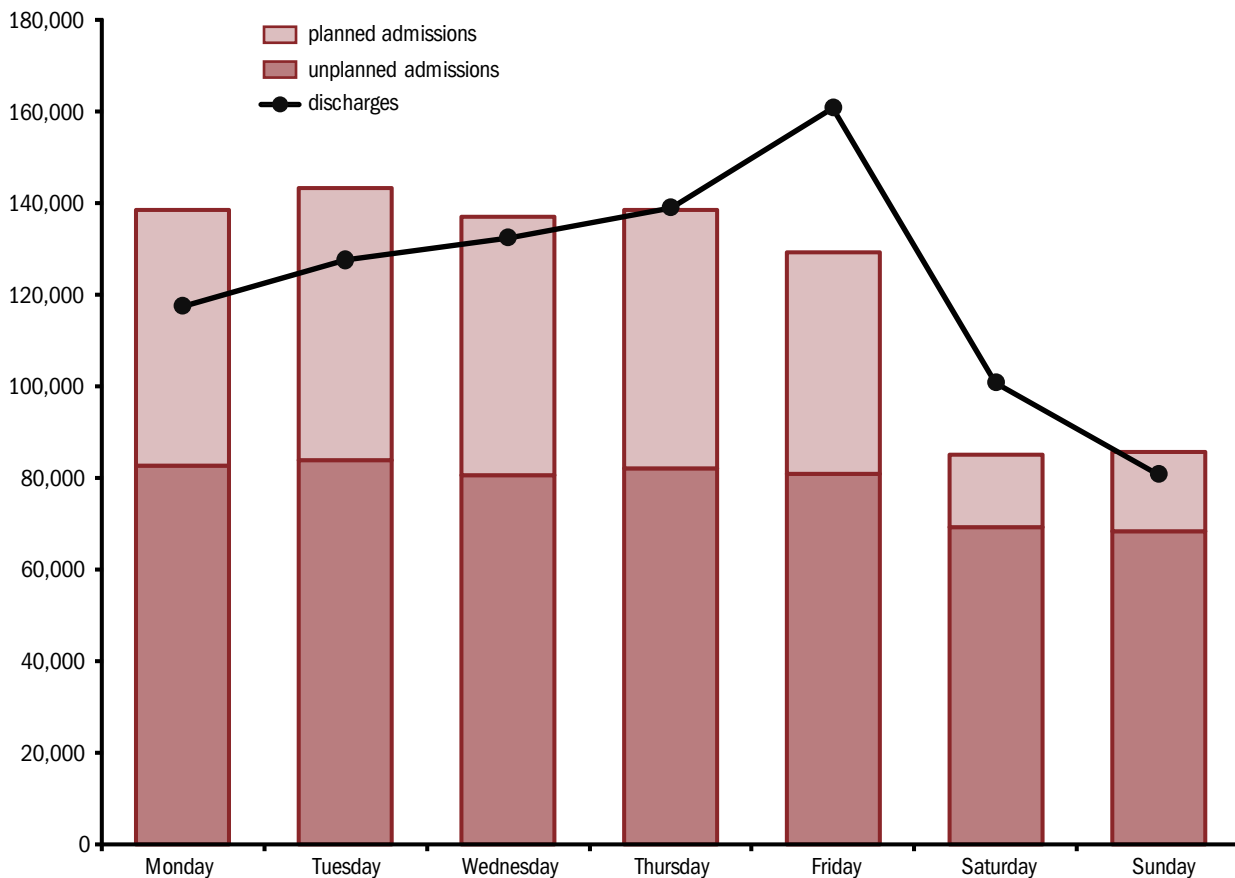
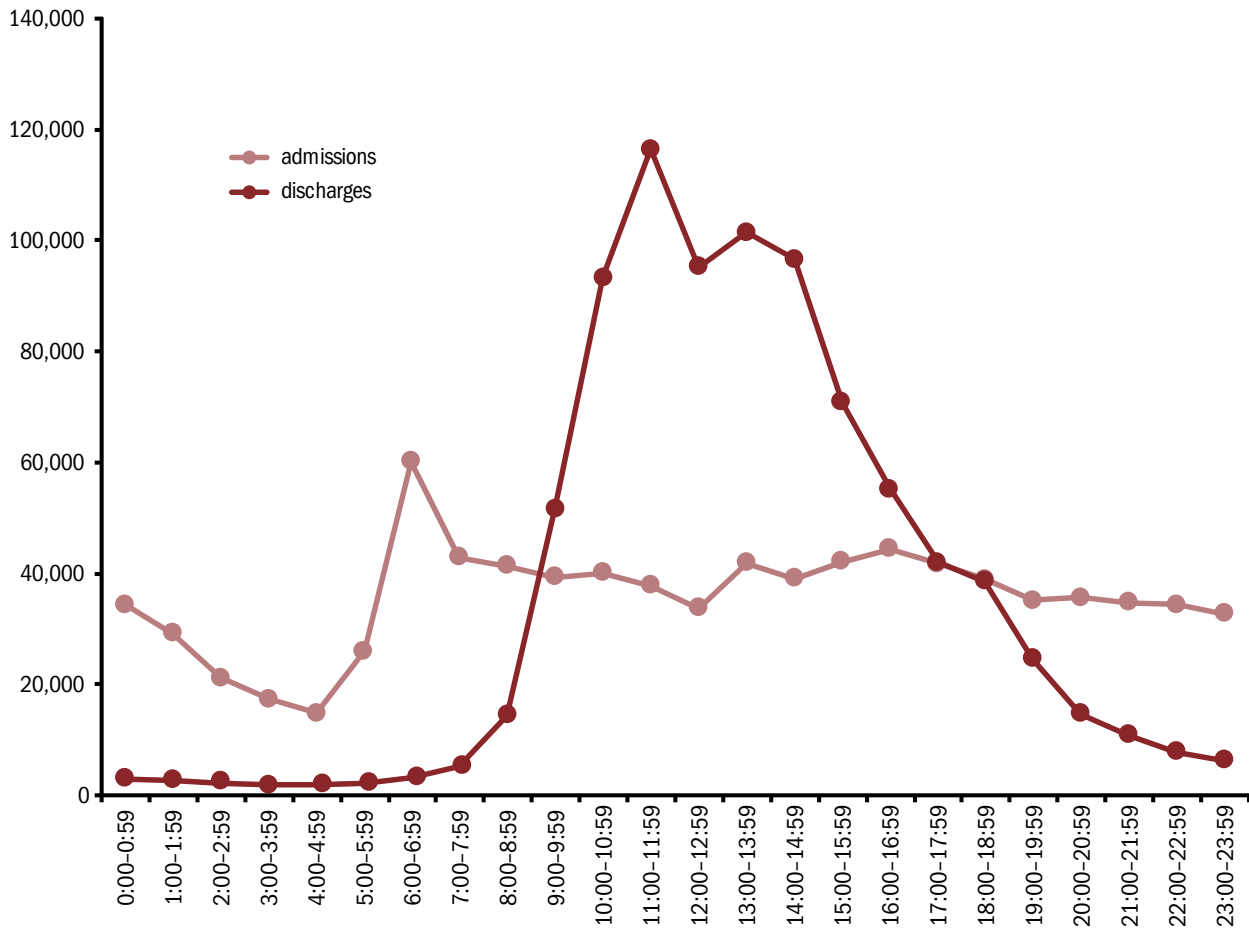


Figure 5: Admissions and Discharges to Ontario Hospitals by Hour of the Day, January through November 2009

Source of data: Discharge Abstract Database



- One hospital had every hospital ward provide a twice-daily update on its intranet of the number of beds available, anticipated admissions (scheduled and through the emergency department), and anticipated discharges.
- All three hospitals held a daily meeting with representatives from all hospital wards to update a list of available beds and anticipated admissions for the day.

We did note a couple of good practices at the hospitals we visited. For example, one hospital was developing a system to optimize bed management, which it expected to implement in summer 2010.

We were informed that this system will provide a “live” status (for example, occupied, empty but requires cleaning, or available) for each bed.

Another had analyzed the timing of patient admissions and discharges. This hospital found that peak hours for its emergency-department admissions were in the morning, whereas peak hours for its discharges were in the afternoon. As a result, this hospital developed a policy to have 40% to 60% of the day’s discharges occur by 11 a.m., which reduced the time that admitted patients waited in the emergency department for a bed.

Length of Time Beds Are Empty between Patients

All of the hospitals visited indicated challenges in ensuring that beds were available when needed. Monitoring the status of hospital beds (for example,

whether they are occupied, empty but require cleaning, or available for a new patient) helps hospitals manage this challenge. All of the hospitals we visited had at least some information on whether their beds were occupied, empty and clean, or empty and in need of cleaning. But none of the hospitals tracked the time to fill an empty in-patient bed—that is, from the time one patient leaves the bed until the time a new patient occupies the bed.

At our request, the three hospitals conducted one or two days of tracking the time beds were empty between patients on selected wards. The results indicated that all three took about one hour to clean the rooms, from the time housekeeping was notified to the time the room was clean. However, the average time a bed stayed empty ranged from three hours to just over six hours. The hospitals indicated that the additional time could be due to the wards' not being able to take new patients because of the current patient workload and/or because of nurses' lunches and breaks. The hospital that averaged six hours advised us that it had no patients waiting for a bed during the time most of the beds were empty.

RECOMMENDATION 5

To help reduce the time admitted hospital patients wait for a bed:

- hospitals should review the times and days of the week patients are admitted and discharged, and arrange patient discharges to allow sufficient time for beds to be prepared in advance for new admissions, especially for patients arriving at known peak admission times; and
- larger hospitals should assess the costs and benefits of implementing a bed management system that provides “live” information on the status of hospital beds, including which beds are occupied, awaiting cleaning, and available for the next patient, as well as the reasons for delays in placing admitted patients in available beds.

SUMMARY OF HOSPITALS' RESPONSES

The hospitals generally supported this recommendation. One of the hospitals noted that, although it is feasible to match patient bed needs to capacity for scheduled patient admissions, it is much more challenging to meet the needs of emergency patients because emergency admissions to surgeries are less predictable and cannot be delayed or cancelled. Another hospital commented that additional bed capacity, which can provide more timely access to an in-patient bed, can be created by better matching peak times of patient admissions and appropriate patient discharges, and by optimizing the length of in-patient stay in hospitals. Further, this hospital indicated that actively planning for discharges enables a smoother workflow for staff and physicians, and provides an improved patient experience.

One hospital indicated that, although it does use various systems to obtain some of the information that an electronic bed management system would provide, it is currently assessing the costs and benefits of implementing such a system to integrate this information. The hospital noted that the successful implementation of this type of system would depend on a number of factors, including how easily staff can enter data. This hospital commented that information from a bed management system could be used in conjunction with its twice-daily meetings to discuss bed availability hospital-wide.

PATIENTS WAITING IN HOSPITAL FOR POST-DISCHARGE CARE

Numerous studies have shown that remaining in hospital longer than medically necessary can be detrimental to patients' health for various reasons, including the potential for a hospital-acquired infection (for example, *C. difficile*) and, especially

for older patients, a decline in physical and mental abilities due to a lack of activity. But patients who are ready to be discharged often need to wait in the hospital for post-discharge care (such as home-care services or placement in a long-term-care home, a complex continuing care facility, or a rehabilitation facility) to be arranged. These patients are referred to as alternate-level-of-care (ALC) patients. In addition to the potentially negative impact that waiting in hospital may have on the patient's health, it is much more costly to keep patients in a hospital as opposed to a community setting. We were informed by the Ontario Hospital Association that it estimated that it costs about \$450 per day to care for an ALC patient in a hospital.

In 2009, over 50,000 ALC patients were discharged from Ontario hospitals; almost 85% of them were seniors (aged 65 and older). Most senior ALC patients arrived at the hospital as an unplanned admission through the emergency department. Although ALC patients accounted for only 5% of all hospital discharges, they represented 16% of the total number of days patients were hospitalized. In addition, although the total days ALC patients were hospitalized has been relatively constant for the past two years, these days had increased by 75% between 2005/06 and 2009/10. However, the total days all patients were hospitalized increased by only 7% during this time period.

The Ontario Hospital Association conducts a monthly survey of the number of ALC patients in almost all acute-care hospitals in Ontario. As of June 2010, results indicated that 16% of all acute-care beds in the province were occupied by a patient waiting for an alternate level of care, although results varied significantly across the province, with the percentage of beds occupied by ALC patients ranging from 3% in the Central West LHIN to 24% in the North East LHIN. At the hospitals we visited, an average of between 11% and 23% of their beds were occupied by ALC patients.

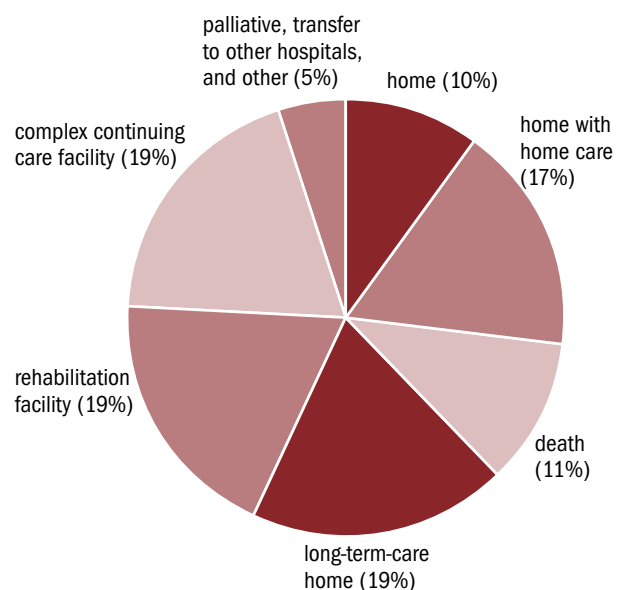
Province-wide, most ALC patients were waiting to be placed in another facility, such as a long-term-care home, although 17% were waiting for home

care, as shown in Figure 6. Further, about 50% of ALC patients in rehabilitation or complex continuing care facilities were waiting in these facilities for placement in a long-term-care home. According to the CCACs we spoke with, one reason patients wait in hospital for a long-term-care home is that applicants prefer the less expensive "basic" accommodation in long-term-care homes (about \$250 less per month than a semi-private room and \$600 less than a private room). Further, only low-income residents in basic accommodations can qualify for a Ministry subsidy; residents in private and semi-private rooms do not qualify. In the 2009/2010 fiscal year, 80% of applicants from one hospital we visited requested basic long-term-care accommodations. However, according to legislation, only 40% of long-term-care homes' beds are required to be basic accommodation.

As an example of how critical the situation can get in hospitals, in January 2010, because a large number of people were waiting in the emergency department for an in-patient bed, the LHIN of one of the hospitals we visited, through its CCAC, moved all of this hospital's ALC patients waiting for

Figure 6: Discharge Destination of ALC Patients in Ontario, 2009 (%)

Source of data: Discharge Abstract Database



placement in a long-term-care home to the top of the wait-list. This caused patients at other hospitals, as well as people in the community, to wait longer for a long-term-care home. The hospital indicated that this was a rarely used measure that it and the LHIN hoped to avoid in the future.

The issue of patients waiting in hospital for alternate accommodation is not unique to Ontario. For example, according to the Canadian Institute for Health Information, Newfoundland and Ontario have about the same rate of ALC patients waiting in hospital, as a percentage of all hospitalizations. B.C. is a bit better, and Alberta has only about half Ontario's rate.

Identifying Patients at Risk of Delayed Discharge

Patients who cannot go back to their previous living situation are sometimes difficult to find post-discharge care for. Examples of patients who may be difficult to place include those who have dementia, are significantly overweight, require non-oral feeding, or require frequent medical treatments like dialysis or chemotherapy. The Flo Collaborative recommends that patients be screened within 48 to 72 hours of admission to hospital for risk factors that may delay their discharge, and that plans be developed for managing any identified risks. It also suggests using standardized risk criteria for the early identification of patients who will need CCAC services, such as for placement in a long-term-care home. The early identification of these patients, regardless of any challenges in estimating their discharge date, is important because it provides additional time for post-discharge care arrangements to be put in place.

Only one hospital we visited had a policy of screening upon admission for risk factors that may delay discharge. This hospital had developed a formal process, which assessed areas such as the patient's cognitive ability, level of confusion, and risk of falls. The other two hospitals indicated that they conducted informal processes. However,

for the sample of patient files we reviewed, there was generally no documentation to indicate that such informal assessments were being completed, although one hospital indicated that it would assess selected risk factors for certain patients during their admission and indicate "yes" on its utilization system if the patient was considered high-risk.

Copayments for Patients Waiting for a Long-term-care Home or Complex Continuing Care Facility

Under the *Health Insurance Act*, hospitals are permitted to charge a copayment to patients who wait in hospital for a place in either a long-term-care home or a complex continuing care (CCC) facility. The purpose of the copayment charge is to eliminate any financial incentive for patients to stay in a hospital, for which they would otherwise pay nothing, as opposed to a long-term-care home, where some payment is normally required. Therefore, the established hospital copayment is the same as the basic rate charged to residents in a long-term-care home or a CCC facility. On July 1, 2010, the copayment was about \$1,600 per month, and could be reduced for low-income individuals. Money collected from copayment charges is retained by the hospitals.

Each of the three hospitals visited had policies in place for charging patients a copayment. Two of the hospitals' policies stated that patients were to be charged once they were designated ALC by their physician. Although the third hospital's policy was to charge patients once they were designated ALC, in practice, this hospital gave patients a five-day grace period, to ensure that patients were informed of the charges.

None of the three hospitals had documentation on whether all patients who could have been charged the copayment were actually charged it. We compared the number of patients whose discharge destination was a long-term-care home or a CCC facility with the number who were actually charged a copayment, and noted that one hospital charged only about 10% of eligible patients a copayment.

This hospital indicated that it serves many low-income people who are exempt. Both of the other hospitals charged over 85% of eligible patients.

Additional Daily Charges

Under the various laws governing long-term-care homes at the time of our audit, eligible patients or their substitute decision-makers may submit an application to a maximum of three long-term-care homes of their choice. The new *Long-Term Care Homes Act*, which came into effect July 1, 2010, permits applicants to select a maximum of five homes. Some hospitals, including two that we visited, have established more specific requirements in order to move patients into long-term-care homes as quickly as possible, so that the hospital beds are available for other patients requiring in-patient care. In particular:

- One hospital we visited required patients needing long-term care to apply to three homes: one home of their choice and two homes from a CCAC-prepared list of homes with either available beds or a short wait-list. The three homes must be selected within 72 hours after the hospital provides the list, and the patient must go to the first home that offers a bed.
- Another hospital we visited required patients to apply to three long-term-care homes. But if those homes do not have an available bed, the patient must consent to going to any home that has an empty bed within the catchment area of either the hospital's CCAC or the neighbouring CCAC.

At these two hospitals, failure to follow hospital policy resulted in more senior hospital personnel (for example, a nurse manager, hospital vice-president, and/or a representative of the legal department) approaching the patient and his or her family to encourage them to comply. If that approach did not work, these hospitals had a policy of charging a per diem rate (\$700 per day at one hospital and \$1,500 per day at the other). This

policy is used to persuade patients to leave hospital and wait for their ideal discharge destination in a more appropriate place. One of these hospitals indicated to us that it informed patients that the per diem would be charged, but had never actually charged it; the other informed us that although it has charged a few patients, it has not successfully collected from them.

Based on our discussions with representatives from seven CCAC offices across the province, there are various reasons patients do not want to live at the long-term-care homes that have frequent vacancies. These reasons include:

- *Location*—Applicants prefer a long-term-care home close to family and friends, so that they can easily visit. A home that is further away makes it especially difficult for an elderly spouse to visit regularly.
- *Value*—Applicants prefer newer facilities to older ones. Basic accommodation in newer facilities is generally one or two people to a room with a bathroom. In contrast, basic accommodation in an older facility generally consists of four people in one room with one shared bathroom. For the three hospitals visited, we reviewed their associated list of long-term-care homes with frequent vacancies and noted that they were almost all older facilities.
- *Performance*—Applicants prefer long-term-care homes that operate in accordance with the standards set by the Ministry. We reviewed the results of the Ministry's inspections at the long-term-care homes with frequent vacancies that accepted patients from the hospitals we visited, for the period July 2007 through June 2008 (the most recent information available at the time of our audit). We found that about 60% of these homes had at least five unmet standards, which was almost double the provincial average of unmet standards.

Alternatives to Long-term Care

CCAC representatives told us that hospitals generally do not suggest alternatives to long-term-care homes to patients. Examples of such alternatives—which often have minimal, if any, waiting lists—include retirement homes or hiring help at home. We compared the cost of these options and noted that both can be more expensive for the patient than the cost of a long-term-care home. In particular, as of July 2010, the amount paid by residents of long-term-care homes ranged from about \$1,600 per month for basic accommodation to \$2,200 per month for private accommodation, with subsidies available for low-income individuals. However, Ministry information indicated that retirement homes, which are not intended for people with heavy care needs, generally cost between \$1,500 and \$5,000 per month. Further, we noted that hiring individuals from private agencies, which generally bill for a minimum visit of four hours, can cost up to \$2,900 per month to provide daily care at home. Both these alternatives may still be more cost-effective than keeping the ALC patient in a hospital bed.

Another alternative to a long-term-care home is supportive housing, which typically includes some personal care, such as assistance with hygiene and dressing. In some buildings, all of the residents receive care, whereas in others, only a small number do. According to the Ministry, accommodation costs paid by residents can range from about \$600 to \$1,200 per month, and can be further subsidized based on a resident's income, with costs for personal care funded by the LHIN. However, there is a waiting list for these units.

Unlike long-term-care homes, these alternative care arrangements are for the most part not regulated or inspected by the Ministry. In June 2010, the *Retirement Homes Act* was proclaimed, and the Ministry indicated that related care and safety standards were being developed and would be included in regulations to be made under the act.

Wait Times for Post-discharge Care

In September 2009, Cancer Care Ontario started collecting data on ALC patients discharged from most hospitals, as well as the number of ALC patients still waiting at each hospital at month-end, as part of the Ministry's Wait Time Strategy. At the time of our audit, this information was not publicly reported. The Ministry indicated that through the Wait Time Strategy, it also plans to collect data on how long ALC patients not yet discharged have been waiting in most hospitals, starting in the 2010/11 fiscal year. Hospitals were to report this information using a standard definition provided by the Ministry.

According to data gathered by Cancer Care Ontario, as of March 31, 2010, about 3,700 patients were waiting in hospital for alternate accommodation, such as home care, a long-term-care home, or a complex continuing care or rehabilitation facility. We analyzed the ALC data for the period November 2009 through February 2010, and noted the following:

- *For all ALC patients*—The median wait times by LHIN ranged from four days to 15 days. For the province as a whole, 50% of all discharged ALC patients went to their discharge destination within eight days of being designated ALC (90% went within 51 days). However, the wait time in hospital for these discharged ALC patients varied considerably across the province. For example, for hospitals in the North West LHIN, 90% of all discharged ALC patients went to their discharge destination within 27 days, whereas in the North East LHIN, the corresponding period was 97 days. Most patients waiting for complex continuing care and rehabilitation facilities were placed within 30 and 20 days, respectively.

Further, within two days of admission to hospital, 15% of ALC patients were designated ALC. This may imply a lack of community supports to care for these patients at home causing these patients to come to the hospital.

In addition, as shown in Figure 7, about half of ALC patients were discharged from hospital within seven days of being designated ALC. This may signify a problem co-ordinating post-discharge services on a timely basis. Hospitals indicated that these problems occur for various reasons, including the CCAC not always being available to complete eligibility assessments on weekends, and facilities, such as long-term-care homes, not always accepting patients on weekends.

- For ALC patients waiting for home care—90% had received services within 28 days, with only 50% receiving them within six days.
- For ALC patients waiting for a long-term-care home—90% were placed within 128 days (50% were placed within 30 days). Further, 5% of these patients waited more than six months for a long-term-care home.

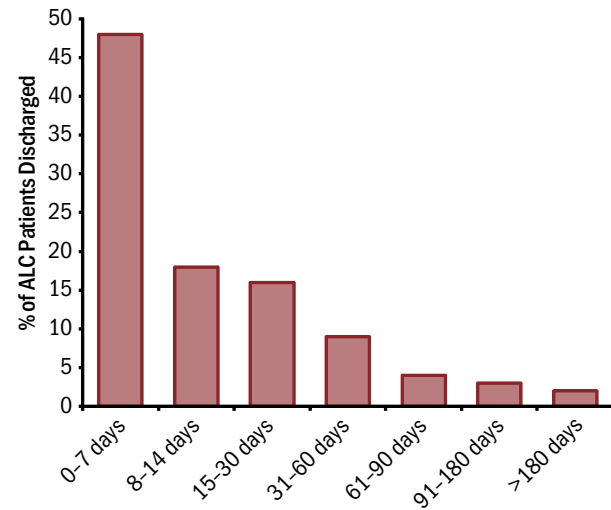
We also noted that the wait times recorded for ALC patients may not be comparable among hospitals. For example, two of the hospitals we visited transferred at least some of the ALC patients to their hospital's complex continuing care (CCC) ward to wait for required post-discharge care. At one of these hospitals, the wait time was calculated from the time the patient was initially designated ALC to the time the patient was discharged from hospital. At the other hospital, patients had two wait times: one for their ALC stay in the ward where they received treatment, and then a separate ALC stay in the CCC ward. If the two wait times were added together, 90% of this hospital's ALC patients would have been placed within 64 days, rather than the 49 days reported.

Ability to Use Beds for Acutely Ill Patients

Within hospitals, ALC patients may be located in hospital wards with acutely ill patients (such as the ward where they received their treatment); hospital wards established for ALC patients; or other hospital wards, such as rehabilitation and CCC. The

Figure 7: Percentage of ALC-designated Patients Discharged from Hospitals, by Number of Days between Designation and Discharge, November 2009 through February 2010

Source of data: Wait Time Information System, Cancer Care Ontario



three hospitals we visited located their ALC patients as follows:

- One hospital placed these patients in acute-care wards throughout the hospital, with 50% located in two wards.
- Another hospital located three-quarters of these patients in wards with acutely ill people located throughout the hospital, with the remainder in its CCC ward.
- The third hospital located most ALC patients in its CCC ward.

Hospital staff informed us that ALC patients typically require fewer nursing resources than acute-care patients. Therefore, if acute-care beds are used for ALC patients on a long-term basis, hospitals may reduce their staff. Additionally, some ALC patients make copayments. To “reopen” these beds for acute-care patients can be costly, because hospitals incur additional costs and no longer collect the copayment from the ALC patients. In fact, one of the hospitals we visited had had a separate ward for some of its ALC patients, but closed the ward after these ALC patients were placed.

RECOMMENDATION 6

To ensure that patients receive the care they need in the location best for the patient:

- hospitals, in conjunction with their Local Health Integration Networks (LHINs), should educate all patients and their families on the fact that, for patients whose condition has stabilized and who no longer need acute care (especially older patients), hospitals are not a safe or appropriate place to wait for post-discharge care (for example, because of the risk of getting a hospital-acquired infection such as *C. difficile*);
- the Ministry, in conjunction with the LHINs, should assess the costs and benefits of increasing the level of post-discharge services that can commence on weekends to better enable hospitals to safely discharge patients on weekends; and
- the Ministry, in conjunction with the LHINs, hospitals, and Community Care Access Centres, should give increased consideration to options such as more appropriate places for patients to safely wait for placement in an alternate-care facility such as a long-term-care home; or increased supportive-housing arrangements to enable patients to continue to live more independently.

Further, to help hospitals better manage their patients who are waiting for post-discharge care, the Ministry should:

- further clarify how alternate-level-of-care (ALC) wait times should be measured so that ALC wait times are being consistently reported to the Ministry's Wait Time Strategy; and
- publicly report the time ALC patients wait in hospital before being discharged into a community-based setting.

SUMMARY OF HOSPITALS' RESPONSES

The hospitals generally supported this recommendation. One of the hospitals highlighted that, although its LHIN was supporting patients through numerous strategies, there continued to be a gap in community services available on weekends and that many of the long-term-care homes associated with the hospital were not willing to accept patients on weekends. Further, this hospital noted that since the new *Long-Term Care Homes Act, 2007*, which came into effect in July 2010, the number of ALC patients waiting for a long-term-care home had doubled. The hospital also noted that many patients and their families are now requesting placement in only one long-term-care home, and expecting to wait in hospital for this home—a wait that could take many months, if not years. As a result, this hospital highlighted the need for an interim place, rather than the hospital, where patients could safely wait for the long-term-care home of their choice.

Another hospital indicated that the transition from an acute-care hospital to a post-discharge destination can be the most vulnerable point of care for patients. Therefore, this hospital noted that additional system capacity may be needed for hard-to-place patients, and further strategies and greater supports should be considered to better facilitate smooth transitions for patients seven days of the week. In this regard, it is leading a pilot project to care for patients at home through a “virtual ward.” Patients participating in this pilot are to have access to an interdisciplinary team of health-care professionals, including a physician, and receive home-based community care. This hospital also commented that it would be reviewing its current practices for managing ALC patients, in terms of both clinical process and information flow, to identify opportunities for improvement. However, this

hospital and another hospital cautioned that ALC indicators need to be linked to health system planning and actionable outcomes.

MINISTRY RESPONSE

The Ministry will work with the LHINs, provincial associations such as the Ontario Hospital Association and the Ontario Association of Community Care Access Centres, and hospitals to identify opportunities to meet this recommendation in order to ensure that patients receive quality care in the most appropriate location. The Ministry agrees with the need to continuously improve patient transitions between sectors, such as between hospitals and long-term-care homes, and is supporting policy initiatives that improve these transitions on a seven-day-a-week basis. Further, the Ministry is continuing to enhance a variety of initiatives, including the Aging at Home Strategy, which encourages the LHINs and CCACs to adopt a “Home First” philosophy. This enables patients to return home, once their acute care at hospital is complete, to determine in their normal environment their required care needs and living arrangements. The Ministry’s investment in the Aging at Home Strategy is allowing the LHINs to increase community capacity, thus expanding the range of appropriate places for patients who do not require a long-term-care home to wait for services and other options. The Ministry is working with the LHINs to resolve any legislative, regulatory, or policy barriers that would prevent the LHINs from implementing initiatives to address this recommendation.

Since the implementation of the ALC definition in July 2009, operational processes and tools have been put in place to answer clinical questions related to patients’ ALC designation, and hospitals have been provided with additional guidance through bulletins, help

desk support, teleconferences, and special documents. This is to ensure that data quality is of a high standard. Further, the Ministry has directed Cancer Care Ontario to monitor hospital adherence to and application of the new ALC definition. As system improvements are deployed in 2011, the Ministry will reinforce the definition of ALC with all hospitals. In addition, the Ministry will explore the recommendation to publicly report wait time data for ALC patients waiting to be discharged to the community.

PERFORMANCE MEASUREMENT

Performance indicators enable hospitals to monitor the progress of any initiatives, track their performance over time, and compare their performance with that of other hospitals using the same indicators. It is important that the indicators be reviewed by individuals with the power to facilitate change when needed, such as senior management and in some cases the board of directors.

All of the hospitals visited had systems in place for monitoring performance, including some indicators of patient flow throughout the hospital. One hospital monitored a number of indicators related to the discharge process, and reported results to senior management and the board of directors. For example, this hospital monitored the number of surgeries cancelled because of a lack of beds, the percentage of patients staying beyond their expected length of stay, the number of patients discharged by 11 a.m. each day, and the number of patients not in the best ward for their illness (for example, a heart patient in an orthopaedic ward). Although one other hospital tracked some similar measures, neither it nor the third hospital monitored all of these indicators or reported these measures to their board of directors. A lack of consistent performance measures used by hospitals limits the ability of the hospitals, as well as the

LHINs and the Ministry, to monitor and benchmark performance to identify and implement better practices in patient flow and the discharge process.

Performance measures can also be used to monitor the safety of patient discharges. Indicators for this purpose include the results of patient satisfaction surveys and readmission rates. All the hospitals visited had access to this information, but only one reported it to the board of directors on a regular basis.

All three hospitals visited used an independent survey firm to conduct patient satisfaction surveys. These surveys, which were mailed monthly to randomly selected discharged patients, included some questions on the discharge process, such as whether the purpose of the post-discharge medications had been explained and whether the patient had been told whom to call with any questions post-discharge. One of the hospitals we visited had over 80% of surveyed patients respond positively to both of these questions; the other two hospitals had positive response rates between 72% and 77% for the questions. However, the survey contained no questions on whether the patient had had sufficient time to make discharge arrangements before his or her discharge.

With respect to readmission rates, the Canadian Institute for Health Information (CIHI) is responsible for managing the Discharge Abstract Database (DAD), which captures data on unplanned readmissions within seven days and from eight to 28 days after discharge. For CIHI's purposes, an unplanned readmission is defined as the unscheduled return of a previously discharged patient to the same hospital for the same or a related condition. Unplanned readmissions to hospital within seven days of discharge may be an indicator that the patient was discharged from hospital prematurely. Unplanned readmissions to hospital within eight to 28 days of discharge are more likely to be an indicator of a systemic failure—that is, insufficient community resources. For the period April through December 2009, the provincial rate for unplanned readmissions within seven days of discharge was less than

2%; the rate from eight to 28 days post-discharge was just over 2%. These rates were consistent with previous fiscal years.

About 10% of Ontario hospitals do not report information on readmissions to CIHI, because reporting is voluntary. However, all three of the hospitals we visited reported such information. Two of these hospitals had fewer readmissions than the provincial average, whereas the third had almost double the average. One of the hospitals with fewer readmissions than the provincial average tracked and reviewed readmissions for specific ailments, in order to see if there were any systemic issues that needed to be addressed.

CIHI indicated that the unplanned readmissions are probably understated, for various reasons, including data not accurately reported by hospitals (that is, hospital staff may not identify every readmission) and no tracking of patients who return to a different hospital (for example, patients may receive specialized treatment at a regional hospital, but return to a local hospital with subsequent problems). Further, based on our analysis of information from the DAD, we noted that 22% of the people discharged from hospital during 2009 were hospitalized more than once that year. Although this group would include people admitted to hospital on different occasions for different illnesses, the percentage also suggests that readmissions are probably higher than currently reported. As well, none of the hospitals we visited tracked people who returned to the emergency department for the same or a related condition post-discharge, but were not readmitted to hospital.

RECOMMENDATION 7

To help evaluate the patient discharge process, hospitals should:

- in conjunction with their Local Health Integration Networks (LHINs) and Community Care Access Centres, develop measures for monitoring and reporting on the effectiveness and safety of hospital processes for

discharging patients, and compare results among hospitals to help identify areas for improvement or best practices that can be shared with other hospitals; and

- regularly report key discharge performance indicators to senior management and the board of directors.

As well, to help monitor, on a province-wide and regional basis, unplanned returns to hospital for the same or related conditions, the Ministry, in conjunction with the LHINs, hospitals, and the Canadian Institute for Health Information, should track post-discharge emergency-department visits as well as readmissions to any hospital that occur within a few days (or otherwise established reasonable time frame) after a patient is discharged from a hospital.

SUMMARY OF HOSPITALS' RESPONSES

The hospitals generally agreed with this recommendation; one of the hospitals indicated it was reporting such information on a regular basis. This hospital also indicated that its LHIN, in collaboration with its hospitals and its CCAC, has created a monthly discussion forum to facilitate collaborative, transparent, and open dialogue about performance across institutions. Further, the hospital commented that such forums support peer-to-peer accountability and yield opportunities for the sharing of best practices and ideas to advance initiatives for improvement. Another hospital commented that much information was already available daily to its senior management and that its board of directors received quarterly updates. Further, this hospital indicated that all hospitals in its LHIN were using the same system to assess each

patient's readiness for discharge, and that the LHIN, CCAC, and hospitals in its LHIN review indicators of hospital safety and effectiveness and share best practices.

With respect to patient readmission rates, one hospital suggested that, in addition to overall rates, readmissions should be tracked by medical condition because certain conditions, such as jaundice in newborns, tend to have a higher rate of medically required readmissions.

MINISTRY RESPONSE

The Ministry recognizes the importance of tracking readmissions and is in agreement with the Auditor General's observations. In this regard, the Ministry continues to work on capturing data on post-discharge visits to any emergency department because almost all unplanned hospital readmissions are admitted via the emergency department. However, capturing such data requires linking hospital inpatient and emergency department data sources (that is, linking the Discharge Abstract Database to the National Ambulatory Care Reporting System), which is resource intensive. Therefore, as a result of an external technical expert panel's evaluation of numerous readmission indicators (part of the development of the Health Care System Scorecard), tracking is initially being conducted on unplanned emergency department visits by mental-health and substance-abuse patients that occur within 30 days of the patient's discharge from any hospital. In addition, the indicator "readmissions to any hospital for certain medical conditions" is included in the proposed renewal of the performance agreement between the Ministry and the LHINs.