

Hospital Report



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MENTAL HEALTH

HOSPITAL REPORT
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EXECUTIVE SUMMARY

This report is the third in a series focusing on the performance of inpatient mental health care. Hospital-specific results are reported for 53 Schedule 1 hospitals including 43 acute and 10 specialty facilities.

Twenty-three indicators are reported covering the four Balanced Scorecard (BSC) quadrants of System Integration and Change, Clinical Utilization and Outcomes, Patient Perception of Care, and Financial Performance and Condition. The indicators and BSC quadrants are also mapped onto four provincial strategic directions, relevant to inpatient care, which arise out of Mental Health Reform policy documents – appropriate use of inpatient services, integration and continuity of care, care based on best practices, and consumer-centered care.

This is the first time that mental health and addictions (MH/A) indicators are reported at the hospital-corporation level. Other developments include reporting results for the 14 provincial Local Health Integration Networks (LHINs), by hospital peer group, and by hospital functional centre.

Five indicators proposed for the patient satisfaction quadrant are now reported based on data from the new patient perception of care survey. In addition, the financial quadrant indicators have been streamlined. More nuance has been added to two clinical indicators: Emergency department visit within 30 days post-discharge (by incorporating triage level) and regular client input in hospital/functional centre (FC) governance (by expanding the list of inclusion methods that hospitals can report).

Finally, average length of stay (LOS) has been replaced with a new indicator – % of Discharges with Length of Stay of 3 Days or Less.

The indicators as a whole show a complex picture of both progress and continuing challenges. Many values have remained stable since the last report showing a continuation of both hospital strengths and weaknesses vis-à-vis Mental Health Reform objectives. Changes in other results suggest improvement, particularly in hospital awareness of specific quality-improvement processes. New data from the patient perception of care survey highlight strengths as well as discrepancies between the hospital staff and client perspectives.

- **System Integration and Change (SIC) quadrant**

SIC indicator values have significantly increased from those reported previously. Because of concerns about data quality (many hospitals reported ‘guesstimates’ as the relevant client level data were not readily available), this improved performance is best interpreted as a sign of greater awareness among hospitals of the importance of networking, use of staff and client feedback for quality improvement, involving patients in discharge planning, and delivery of care based on best practices. As these are important elements for quality in-hospital care and post-discharge follow-up, continued improvement with particular attention to standardized measurement of implementation of these processes is strongly encouraged.

- **Clinical Utilization and Outcomes (CUO) quadrant**

The CUO indicators have remained stable since the last report. The major implication is that discharge planning and access to follow-up care, previously flagged as needing more attention, continue to need improvement. One out of five discharges is followed by either a psychiatric readmission or an urgent, emergent, or resuscitation triage-level Emergency Department (ED) visit within 30 days. Mental health follow-up within 30 days with an Ontario Health Insurance Plan (OHIP) physician remains at slightly over 50 percent, and individuals with two or more MH/A discharges continue to comprise 25 percent of those receiving such care within a 12-month period.

- **Patient Perception of Care (POC) quadrant**

This is the first time that patient perception data are available for indicator calculation. Two variations of the POC survey were created – a survey for patients on discharge and a survey for current patients in longer-stay programs. Results are summarized across 1,607 surveys from 22 hospitals and presented at the provincial level. Findings show that clients of longer-stay programs give lower ratings than patients discharged after shorter stays across all POC indicators.

Ratings of staff responsiveness are relatively high. However, clients were less positive about their involvement in treatment decisions and discharge planning, and about the information they received – for example, patient rights and medication side effects. The discrepancy between these results and the responses to the SIC survey suggest that increased hospital awareness of including clients in their discharge planning is not (yet) reflected in how patients view the discharge process.

Client ratings of the outcomes of care are lower than their ratings for the other areas of care assessed in the survey. This may reflect the role of acute mental health inpatient services, which is to stabilize individuals and then link them to services and supports in the community for follow-up care after discharge.

- **Financial Performance and Condition (FPC) quadrant**

The FPC indicators have been streamlined from seven to four reported indicators. Three have been retained from the set of indicators used within the 2004 Mental Health Hospital Report (% nursing worked hours, % Registered Nurses (RN) hours, % management and operational staff hours), and a new one (% sick time) has been added.

- **LHIN findings**

LHIN results are reported for CUO and FPC quadrants only, and variation in performance is evident. There are wide differences on rates of post-discharge return to hospital within 30 days – for ED visits (five to 10 percent) and readmission (nine to 17 percent). Similarly, 30-day OHIP follow-up rates range between 23 and 63 percent. While an explanation for this last finding might be the varying supply of physicians across LHINs, the relationship between the two is not straightforward. Other factors to be considered besides provider/service supply include local system and client characteristics as well as hospital practice patterns such as discharge planning.

Contextual data demonstrate varying patterns of inpatient care use across LHINs. The North East and North West LHINs have the highest rates of MH/A hospitalization per 100,000 adult population. They also have high percentages of MH/A discharges from non-Schedule 1 facilities and low percentages of residents who are hospitalized outside of the LHIN.

Rates of use of inpatient services by non-LHIN residents are quite high for some LHINs. Between 27 and 34 percent of the MH/A discharges for residents of Central West, Mississauga Halton, and Central occur in non-LHIN hospitals. On the other hand, 40 percent of the MH/A discharges from Waterloo Wellington hospitals are for non-LHIN residents. This degree of inflow and outflow has significant implications for the allocation of LHIN resources vis-à-vis inpatient MH/A care.

- **Hospital findings**

Results are reported for the hospital corporations within four peer groups. High-performers across the CUO and FPC quadrants are identified, and the performance allocation tables identify the facilities that have exceptionally low or high scores on an indicator. This information should facilitate hospital comparisons, identifying potential problem areas and organizations that may provide possible solutions.

- **Mental Health Reform Objectives**

The indicator results suggest some changes that are consistent with the goals of integration and consumer-centered care. Hospital networking scores show structured linkages with a number of provider groups. However, results also suggest that linking with long-term care, crisis, and other community-based mental health care providers needs attention.

Results also suggest an increased awareness of the importance of including clients in treatment planning and program governance. However, the discrepancy between hospital-reported information and patient perceptions of consumer-inclusion suggests that the systematic processes hospitals are putting in place must be sensitive to what these processes mean for the consumer.

The percentage of discharges followed by a readmission or an Emergency Department (ED) visit remains virtually unchanged. Similarly, the percentage of discharges followed by a mental health and addictions (MH/A) visit to an OHIP provider continues to be slightly above 50 percent. Given that hospitalization is intended for those with the most serious conditions, some form of medical follow-up is an expected part of post-discharge care. While this rate may be an underestimate due to incomplete data for measuring follow-up care (e.g., by community agencies, salaried physicians), information from other Canadian jurisdictions suggests that adding these data might not substantially increase the result.³⁸ Availability of physicians varies across the province, but analyses in this report suggest that supply is only a partial explanation for lower follow-up rates (e.g., OHIP physician supply is not consistently related to the percent of discharges followed by an OHIP mental health visit). How patients are connected with and followed through new services is another critical ingredient.

ABOUT THIS REPORT

The high prevalence of mental health and addictions illnesses¹⁻⁵ and the prominent role they play in the global burden of disease⁶ have been referenced in nearly every major North American or Commonwealth report or publication on the subject for the past decade.⁷⁻¹⁷ In Canada, the recent establishment of the Mental Health Commission following the release of the Kirby and Romanow reports demonstrates our own national concern with addressing the needs of individuals suffering from such illnesses.^{18,19}

Like all chronic illnesses, mental health and addictions disorders range between mild or remitted forms to extremely severe, disabling conditions. Ontario, like most other jurisdictions,²⁰⁻²⁴ has produced a series of Mental Health Reform policy documents²⁵⁻²⁸ outlining a continuum of services that should be linked and coordinated with each other to meet community need for care.

This report is the third in a series designed to measure the performance of services intended for the severe end of the mental health spectrum – namely, inpatient care. Previous reports provided results at the provincial and regional levels. On April 1, 2007, the Ministry's nine Regional Offices were decommissioned and Ontario's 14 Local Health Integration Networks (LHINs) assumed responsibility for prioritizing, planning and funding of most inpatient services. While the LHINs do not provide direct health care services, they are mandated to plan, integrate, and fund many health care services across the province. Consequently, new information is provided in this report in the form of hospital- and LHIN-specific results. Findings are reported for 23 indicators and, where possible, comparisons are made to the 2004 report results.

Consistent with the Hospital Reports series, the results are presented using the balanced scorecard (BSC) approach. In addition, the data are organized to address four provincial priorities under Mental Health Reform – appropriate use of inpatient services, practices to support integration and continuity of care, care based on best practices, and consumer-centered care. Audiences include providers and managers, as well as hospital boards of directors, LHINs, and the Ministry of Health and Long Term Care.

The data can inform understanding of current practices and results, and identify strength and weakness. The results can provide a baseline for monitoring responses to specific quality improvement initiatives. Hospitals can also use the report to identify other hospitals from which they might seek opportunities to learn and areas where changes may be needed. By aligning indicators with objectives of Mental Health Reform, the data also provide some measure of system progress in achieving these objectives pertinent for both LHIN and provincial governance.

This report lays the groundwork for ongoing improvement of mental health care performance monitoring in Ontario. As community mental health service data improves, the potential to measure broader system performance will increase. The availability of the inpatient Resident Assessment Instrument – Mental Health (RAI-MH) may improve precision of internal program quality measures. Expansion of the patient satisfaction survey will broaden the scope of representation of inpatient perspectives. Increased provincial awareness of current practices/programs can support improved system response to persons dealing with mental illness in Ontario.

A BALANCED SCORECARD



WHAT IS A BALANCED SCORECARD?

Providing inpatient care is a complex activity involving diverse skills and practices. No single element causes poor or excellent hospital performance. For this reason, performance monitoring must measure multiple dimensions of a hospital's performance. The balanced scorecard approach describes performance across four dimensions or quadrants critical to the strategic success of any organization. These include System Integration and Change, Patient Satisfaction, Clinical Utilization and Outcomes, and Financial Performance and Condition.

Performance measures for each of the four quadrants are provided at the hospital-specific level, along with average scores for the LHINs, hospital type/peer group and the province as a whole. While the reported LHIN, hospital type, and province results are based on all hospital values, hospital-specific results are reported only for facilities that had sufficient data and agreed to have their results published. This year, data for 56 Schedule 1 hospitals are included (either individually or in aggregate) in at least one quadrant, and 22 facilities participated in all four quadrants.

Using the balanced scorecard format, this report provides a summary of performance scores for 23 indicators across four areas of performance.

System Integration and Change

Indicators in this quadrant pertain to program policies and practices that influence the quality of care and support continuous quality improvement. Information to generate these indicators was drawn primarily from the System Integration and Change Survey (see SIC quadrant results and the Technical Manual for more detail on survey methods). Assessed practices pertained to delivery of evidence-based care, integration of care between inpatient and other facilities and providers, and consumer participation. Responses reflected practices in place at the time of survey completion, as reported and signed off by senior hospital staff.

Clinical Utilization and Outcomes

The indicators in this quadrant generally have an external rather than an internal quality of care focus, reflecting the role that inpatient care is expected to play in the broader continuum of care. Consistent with the aim of maximizing community tenure for persons with mental health and addictions problems, the CUO indicators focus on outcomes related to serving individuals in the least restrictive setting (e.g., admissions for psychotic disorders, short-term length of stay, Alternative Levels of Care rates), and minimizing rates of return to hospital after an initial hospitalization (early readmission, repeated admission, and access to follow-up OHIP care).

Perception of Care

This quadrant captures patient views about the quality of care, using data collected by NRC+Picker Group Canada. One additional indicator (POC2) is based on routinely collected administrative data from the Discharge Abstract Database (DAD) – “discharged against medical advice” (see Technical Manual for a survey description and data collection methods). This quadrant examines patients' perceptions of their hospital experience with a focus on staff responsiveness, participation in treatment, appropriateness of care and treatment outcomes.

Financial Performance and Condition

This quadrant describes how hospitals manage their financial and human resources through examination of four measures of hospital management and human resource use.



REPORT INDICATORS

The 23 MH/A indicators currently reported are shown in Table 1. These are arranged by Balanced Score Card quadrant and Ontario Mental Health Reform objective. (For a comparison of BSC quadrants and common mental health domains,^{30, 31} see Appendix A).

Table 1. MH/A Hospital Report Indicators

BSC Quadrant				
Mental Health Reform Objective	System Integration and Change (SIC)	Clinical Utilization and Outcomes (CUO)	Perception of Care (POC)	Financial Performance and Condition (FPC)
Appropriate use of inpatient services		CU01 ^a Hospitalization for Psychotic Diagnoses CU02 % Discharges with LOS of 3 days or less CU03 ^a ALC Days		FPC1 % Nursing Worked Hours FPC2 % Sick Time FPC3 % RN Hours FPC4 % Management and Operational Staff Hours
Integration & post discharge continuity of care	SIC1 Inter-organizational Networking SIC2 Notification of Hospitalization	CU04 OHIP Care within 30 Days Post-discharge CU05 Emergency Dept Visit within 30 Days Post-discharge (but not admitted) CU06 30-Day Readmission Rate CU07 Repeat Inpatients		
Care based on best practices	SIC3 Use of Guideline Care for Tracer Conditions SIC4 ^b Use of clinical data (staff provided) SIC5 ^b Use of clinical data (client-provided)			
Consumer-centered care	SIC6 Discharge Plans Completed with Client/Family/Provider Involvement SIC7 Regular Client Input into Hospital/FC Governance		POC1 Perception of Staff Responsiveness POC2 Discharged Against Medical Advice POC3 Perception of Appropriateness of Care POC4 Perception of Treatment Outcomes POC5 Perception of Participation in Treatment and Discharge Planning	

a Originally a SIC indicator in 2001 and 2004 *Mental Health Hospital Reports*

b Originally a CUO indicator in 2001 and 2004 *Mental Health Hospital Reports*

HIGH-PERFORMING HOSPITALS WITHIN QUADRANTS



For this Report, high performance is evaluated only for the Clinical Utilization and Outcomes (CUO) and Financial Performance and Condition (FPC) indicators. These are the quadrants where the data were the most complete (available for over 98 percent of Schedule 1^c hospitals) and reliable. The comparisons used to make these judgments are only among participating Ontario hospitals.

Hospital feedback has suggested that the SIC indicators are most accurately interpreted as evidence of increased awareness of important objectives rather than of the quality or completeness of implementation. A number of hospitals indicate that their SIC responses are estimates since they still do not have the level of decision support needed to supply these numbers. The POC indicators are reported in aggregate because only a subset of hospitals participated in data collection for this year. As there are data precision and small sample size issues, indicators within these two quadrants were not included in the assessment of high-performing hospitals.

The value of identifying better performing hospitals is to facilitate hospital exchange of useful ideas and best practices. Within the CUO and FPC quadrants, high performers are listed by hospital type to allow organizations to draw on the knowledge of similar institutions.

^c Schedule 1 facilities are defined in the Methods section.

Clinical Utilization and Outcomes

Criteria

Non-specialty Schedule 1 hospitals: At least one exceptionally high performance score (with no exceptionally low ones) on the following:

- CUO1: Hospitalization for Psychotic Diagnoses
- CUO2: % discharges with LOS of 3 days or less
- CUO3: ALC days
- CUO4: OHIP care within 30 days post-discharge
- CUO5B: ED visit within 30 days – Urgent, emergent, resuscitation
- CUO6: 30-day readmission rate

Specialty Schedule 1 hospitals: The same criteria were applied except that CUO2 and CUO3 were not included. These hospitals typically have longer stay programs and also are not required to track ALC days.

Note that for CUO2, 3, 5B, and 6, lower scores are considered 'better'. The method for calculating 'exceptionally high performance' is described in the Methods section of this report.

High-Performing Hospitals

Community (29 or fewer MH beds):

Alexandra Marine and General Hospital
Windsor Regional Hospital

Community (30 or more MH beds): Hôtel-Dieu Grace Hospital

Specialty hospital: Providence Continuing Care Centre

Financial Performance and Condition

Criteria

At least one exceptionally high score (with all other scores above the provincial average) on FPC1 (% Nursing worked hours), FPC2 (% sick time), and FPC3 (% RN hours).

FPC4 (% management and operational staff hours) was not included in these calculations because the desired value for this indicator could not be defined. For % sick time, lower rates are considered 'better'. The method for calculating 'exceptionally high performance' is described in the Methods section).

High-Performing Hospitals

Community (29 or fewer MH beds):

Huron Perth Healthcare Alliance
Ross Memorial Hospital*
The Credit Valley Hospital
Windsor Regional Hospital

Specialty hospital: Baycrest Centre for Geriatric Care

* Ross Memorial became a Schedule 1 facility shortly before the end of the fiscal year. Please see Methods section for details.

A SNAPSHOT OF MH/A INPATIENT ACTIVITY

In Ontario, a large portion of mental health care is delivered in hospitals designated under the Mental Health Act as Schedule 1 facilities. Hospitals with this designation are required to deliver specific mental health services (i.e., inpatient, outpatient, day care, emergency, consultative and educational²⁹). Table 2a shows the supply of Schedule 1 hospitals (and the acute and specialty beds within these hospitals) across the 14 LHINs. MH/A discharges comprise about eight percent of all Schedule 1 hospital discharges. Rates range between six and 20 percent across LHINs, likely reflecting differing portions of MH/A beds relative to all inpatient beds within LHINs.

Table 2a. Overview – Schedule 1 Hospital Inpatient Mental Health and Addictions (MH/A) Care 2005-06

LHIN	Adult Population* (100K)	# Schedule 1 Hospitals	Acute beds/ 100K population	Specialty beds/ 100K population	MH/A discharges total**	MH/A discharges per 100K adult pop	MH/A discharges as % all discharges
ONTARIO	10,265	57	17	21	59,072	407	8.3
1 Erie St. Clair	528	4	17	3	3,761	454	7.8
2 South West	761	6	25	50	5,704	507	10.4
3 Waterloo Wellington	565	2	26	19	2,849	383	13.1
4 Hamilton Niagara Haldimand Brant	1,124	5	14	14	7,684	483	7.9
5 Central West	596	1	11	0	2,658	314	6.6
6 Mississauga Halton	853	3	9	0	3,318	288	6.0
7 Toronto Central	957	8	22	44	6,528	469	9.4
8 Central	1,286	4	10	1	4,863	275	6.2
9 Central East	1,202	6	14	20	6,311	386	7.0
10 South East	403	3	13	44	2,432	444	19.9
11 Champlain	972	5	28	19	5,153	397	8.6
12 North Simcoe Muskoka	347	3	11	53	1,815	404	6.9
13 North East	474	4	28	47	4,272	550	10.5
14 North West	196	3	21	40	1,724	632	9.2

Notes: Beds – specialty: are based on functional centre as reported to the Ministry, not on setting, and include longer-term, crisis, addiction, child and forensic beds.

* Adult population includes 15 year olds and older.

** Unadjusted numbers and rates

Sources: Daily Census Summary, MOHLTC, 2005-06; Discharge Abstract Database, CIHI, 2005-06

Not all MH/A inpatient care occurs in Schedule 1 hospitals. Overall, 14 percent of discharges are from non-Schedule 1 hospitals (Table 2b) with the LHIN variation ranging between one percent for Toronto Central to 33 percent for the North East LHIN. The wide range is due, in part, to the differing numbers of non-Schedule 1 facility beds within the LHINs.

Tables 2a and 2b highlight the mix of inpatient services available within a region, which can influence service use patterns. One impact is demonstrated in Table 3. For some LHINs, a considerable portion of the inpatient MH/A care used by their residents is provided by hospitals outside of their LHIN boundaries. For example, 34 percent of MH/A discharges for Central West residents occur in hospitals outside of the LHIN. In other LHINs, a considerable amount of inpatient care is provided to residents from outside of their geographical boundaries. In Waterloo Wellington, for example, 40 percent of hospital MH/A discharges are for Ontario residents who do not live in Waterloo Wellington. This reflects, in part, the presence of specialty and addictions facilities (such as Homewood Health Centre) that often have a regional rather than a LHIN area service mandate.

Table 2b. Overview – Non-Schedule 1 Hospital Inpatient Mental Health and Addictions Care 2005-06

LHIN	% LHIN area MH/A discharges from non-Schedule 1 hospitals*
ONTARIO	13.7
1 Erie St. Clair	5.3
2 South West	13.9
3 Waterloo Wellington	29.6
4 Hamilton Niagara Haldimand Brant	5.6
5 Central West	6.2
6 Mississauga Halton	3.4
7 Toronto Central	0.9
8 Central	8.9
9 Central East	4.9
10 South East	20.6
11 Champlain	21.4
12 North Simcoe Muskoka	27.7
13 North East	32.9
14 North West	24.5

* Unadjusted numbers and rates

Source: Discharge Abstract Database, CIHI, 2005-06

Table 3. Inter-LHIN Delivery of Inpatient Mental Health and Addictions Care 2005-06

LHIN	% MH/A discharges from non-LHIN hospitals for LHIN residents (outflow)**	% MH/A discharges from LHIN hospitals for non-LHIN residents (inflow)**
1 Erie St. Clair	11.6	1.9
2 South West*	8.1	9.9
3 Waterloo Wellington*	14.9	40.1
4 Hamilton Niagara Haldimand Brant*	10.5	3.8
5 Central West	33.9	26.8
6 Mississauga Halton	27.2	20.8
7 Toronto Central*	17.7	35.6
8 Central	38.8	29.4
9 Central East*	20.3	14.2
10 South East*	11.4	9.1
11 Champlain*	5.5	3.5
12 North Simcoe Muskoka*	19.5	9.2
13 North East*	6.2	1.9
14 North West*	3.9	1.4

* LHIN has one or more specialty hospitals

** Unadjusted numbers and rates

Source: Discharge Abstract Database, CIHI, 2005-06

As hospitalization is only one service in the envisioned continuum of services, it follows that the availability of other types of services will affect the use of inpatient care. As shown in Table 4a, these can vary considerably across LHINs. General practitioner and family physician supply ranges from a low of 64 per 100,000 population for Erie St. Clair LHIN to more than double that rate (153 per 100,000 population) for the Toronto Central LHIN. Only six psychiatrists are available per 100,000 population in Central West compared to 65 psychiatrists in Toronto Central. MOHLTC funding for community mental health services also varies widely from a low of \$12 (Mississauga Halton) to a high of \$104 (North West) per capita.

Table 4a. Supply of Mental Health Service Resources by LHIN: Physicians and Community Mental Health Services Funding

LHIN	Physician supply/100K population		Community MH service funding per capita
	GP/FPs* (#)	Psychiatrists (#)	
ONTARIO	95.8	17.3	\$39
1 Erie St. Clair	63.8	6.4	\$35
2 South West	91.3	16.3	\$45
3 Waterloo Wellington	85.4	8.9	\$29
4 Hamilton Niagara Haldimand Brant	82.2	13.5	\$28
5 Central West	71.0	5.5	\$23
6 Mississauga Halton	79.8	8.2	\$12
7 Toronto Central	153.1	65.4	\$93
8 Central	92.0	11.2	\$27
9 Central East	79.4	8.0	\$22
10 South East	111.4	20.4	\$56
11 Champlain	122.5	28.6	\$39
12 North Simcoe Muskoka	95.6	8.4	\$37
13 North East	100.6	9.1	\$72
14 North West	123.7	9.7	\$104

* General practitioners and family physicians.

Source: Physician Database, ICES, 2004
Community Mental Health Budgets and Programs Inventory, MOHLTC, 2005/06 (MOHLTC funding only).
These data are now reported in the Ontario Healthcare Financial and Statistical database.

Availability of some specialized mental health services within hospitals varies as well (Table 4b). While mental health crisis teams and day hospital services are provided by at least one facility in nearly all LHINs, holding beds and specialized inpatient programs for concurrent (substance use plus psychiatric) or dual (developmental plus psychiatric) diagnoses are not. Hospitals in Waterloo Wellington and Central West, for example, report that they are not funded to provide any of these services, while the Central and Champlain hospitals report only funding one or two services.

Table 4b. Availability of Mental Health Service Resources by LHIN: Hospital-based Mental Health Services

LHIN	Availability of selected hospital-based mental health services in area hospitals							
	Holding beds		Day hospital	Consult Liaison	Concurrent Dx (IP)	Dual Dx (IP)	Crisis Team	Geriatric Psychiatry
	in ED	in IP ward						
ONTARIO								
1 Erie St. Clair			•	•	•	•	•	•
2 South West			•	•	•	•	•	•
3 Waterloo Wellington				•			•	•
4 Hamilton Niagara Haldimand Brant		•	•	•		•	•	•
5 Central West			•	•			•	
6 Mississauga Halton			•	•	•	•	•	•
7 Toronto Central	•	•	•	•	•	•	•	•
8 Central	•		•	•			•	•
9 Central East			•	•	•	•	•	•
10 South East			•	•	•	•	•	•
11 Champlain		•	•	•			•	•
12 North Simcoe Muskoka			•	•	•	•	•	•
13 North East				•	•	•	•	•
14 North West			•	•	•	•		•

Source: System Integration and Change Survey, 2007



INTERPRETING RESULTS

A central feature of inpatient mental health care, recognized by other mental health performance monitoring initiatives,³⁰⁻³² is that it is embedded in a larger system of services and supports. This leads to a point that is critical in interpreting the findings reported here: measures of inpatient performance **CANNOT** be evaluated in isolation of the broader system context. For example, a high readmission rate is a measure of poor functioning in that: a) it is inconsistent with the Mental Health Reform goal of providing the least restrictive form of care necessary and b) there is considerable literature demonstrating reduced frequency of hospitalization if community services such as Assertive Community Treatment³³ teams are in place. If a hospital shows 'poor' performance on this indicator, it may be that it needs to improve its discharge planning and follow-up linkages³⁴ or that it is releasing individuals before they are ready for discharge. It may also indicate fewer resources to support individuals in the community after discharge.

The mental health *Hospital Reports* have addressed this issue by viewing hospital performance indicators as one level in a multi-level system of care (Figure 1). In the readmission example, the 'poorly' performing hospital would be encouraged to examine its own processes and structures to see if improvements could be made. At the same time, the hospital and the LHIN in which it operates could determine whether there were regional system factors that might be contributing to this result. If a majority of LHINs have low performing hospitals on this indicator, there may be province-wide system issues that need to be addressed.

The distinction in Figure 1 between core and level-specific indicators is based on the definition of Balanced Score Card measures as reflecting the organization's strategic objectives.^{35, 36} This report provides results for core indicators, those based on the strategic objectives outlined in Mental Health Reform policy,²⁵⁻²⁸ which should impact on every level from the province down. Individual LHINs or hospitals will have additional objectives relative to their specific situation. While these are out of scope for the *Hospital Reports*, they are important drivers for hospital and LHIN action and thus are reflected in Figure 1 as level-specific indicators.

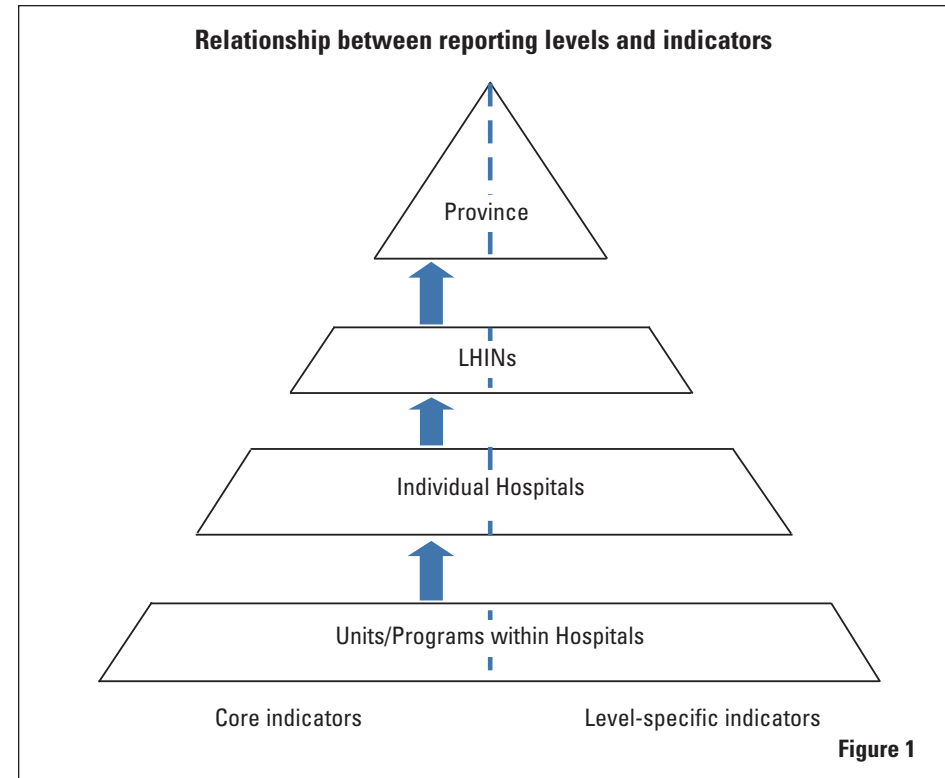


Figure 1

The core indicators reflect four strategic objectives, drawn from the province's Mental Health Reform policy documents, which are particularly relevant to inpatient care. The four objectives are listed below, along with the quadrants where related indicators are reported:

- Appropriate use of inpatient services – CUO and FPC quadrants
- Integration and continuity of care – SIC and CUO quadrants
- Care based on best practices – SIC quadrant
- Consumer-centered care – SIC and POC quadrants.

As a consequence, the Balanced Scorecard could be viewed as pertinent only at the provincial level. To assess whether the core indicators pertain to care delivery at the hospital level, hospitals participating in the *2004 Mental Health Hospital Report* were asked to rate each indicator's relevance to their own strategic plan via a survey conducted in April 2005. The results indicate good correspondence between provincial and hospital-level objectives. Three-quarters of the

surveyed hospitals gave a 'very relevant' rating (the highest category possible) to nine out of the 18 indicators (see Table 5) and another seven indicators were highly rated by at least half of the hospitals. The indicators in this latter group often pertained to areas where hospitals perceived control over performance to be shared with other system providers (e.g., receipt of OHIP follow-up within 30 days). The least relevant from the hospitals' strategic perspectives was 'Use of Guideline Care for tracer conditions', an indicator where they also felt they had little control.

Table 5. Relevance of Mental Health *Hospital Report* Indicators to Hospital Strategic Goals as of 2004

INDICATORS ^d	% VERY relevant
SIC1 Inter-organizational networking	84
SIC2 Notification of hospitalization	72
SIC3 Use of guideline care for tracer conditions	39
SIC4 Use of clinical data (staff provided)	70
SIC5 Use of clinical data (client provided)	81
SIC6 Discharge plans completed with client and/or family involvement	84
SIC7 Regular client input into hospital/functional centre governance	87
CU01 Hospitalization for psychotic diagnoses	63
CU03 Alternative level of care days	91
CU04 OHIP care within 30 days post-discharge	57
CU05 Emergency department visit within 30 days post-discharge (but not admitted)	76
CU06 30-day readmission rate	87
CU07 Repeat inpatients	73
POC2 Discharged against medical advice	71
FPC1 Nursing worked hours as a % of nursing total hours	79
FPC3 Registered nurse hours as % of nursing total hours	73
FPC4 % Management and operational support hours as % of total hours	78

^d Table provided with the permission of Healthcare Policy. These results are for those indicators calculated for the 2004 Mental Health Hospital Report that have been carried forward. These 17 plus six newly-calculated indicators comprise the 23 indicators in this Report.

Notes: Results are reported using indicator numbers and names as defined in the present Report.

Source: Indicator Evaluation Survey, 2005

METHODS^e

PARTICIPATION AND DATA SOURCES

Hospital Participation: Results are reported for Schedule 1 hospitals, i.e., designated mental health facilities. Schedule 1 facilities include some acute care hospitals and all specialty mental health facilities. Fifty-seven Ontario Schedule 1 hospitals were invited to participate.^f Table 6a reports the total number of eligible facilities, and the number of hospitals that participated in each reporting level by quadrant and data source. Indicator values are calculated and presented for provincial and LHIN levels based on data for 22-56 Schedule 1 hospitals (depending on the quadrant). Individual hospital values are reported for 19 to 53 hospitals (depending on the quadrant) that gave consent for that level of reporting.

Table 6a. Numbers of Participating Hospitals by Reporting Level and Quadrant

Reporting Level	Eligible Hospitals	Participating Hospitals				
		SIC Quadrant	CUO Quadrant	POC Quadrant		FPC Quadrant
		Survey based indicators	Admin data based indicators	Survey based indicators	Admin data based indicators	Admin data based indicators
Individual Hospital*	57	53	51	19	51	52
Peer Group**	57	54	55	22	55	56
Acute	46	44	46	16	46	46
<i>Community (29 or fewer MH beds)</i>	21	20	21	3	21	21
<i>Community (30 or more MH beds)</i>	15	15	15	8	15	15
<i>Teaching</i>	10	9	10	5	10	10
Specialty	11	10	9	6	9	10
LHIN**	57	NR	55	NR	55	NR
Province**	57	54	55	22	55	56

NR = not reported

* Data are reported in the Performance Allocation tables.

** Data are included in the peer group, LHIN and provincial results.

e For more detail about methods, please see the Technical Report available on www.hospitalreport.ca.

f Three Schedule 1 children's hospitals and two Schedule 1 treatment programs in provincial correctional facilities were not approached.

Table 6b. Data Sources

Data Source	Level of Information	Reporting Period
SURVEYS		
POC (Perception of Care Survey)	Client	Fall 2006
SIC (System Integration and Change Survey)	Functional Centre/Hospital	FY 2005/06
ADMINISTRATIVE DATABASES		
DAD (Discharge Abstract Database, CIHI)	Hospital Discharge	FY 2005/06
NACRS (National Ambulatory Care Reporting System, CIHI)	Hospital ED visit	FY 2005/06
OHIP database (Ontario Health Insurance Plan)	Physician visit	FY 2005/06
Physician Database (IPDB)	Physician	2004
Canadian MIS Trial Balance	Hospital	FY 2005/06
OTHER DATA SOURCES		
Canadian Census	Population	2001
Community Mental Health Budgets and Programs Inventory	Organization	FY 2005/06

Table 6b lists the data sources for the Report, including level of information and period of reporting. These included survey and administrative data sources.

Survey data sources: The SIC survey was administered to hospital program chiefs and senior managers to obtain information about the characteristics and procedures of their designated units and functional centres. The patient POC survey was completed by clients that were discharged or residents during a specified census period in longer-stay units. Data from these two surveys were used for calculating most of the SIC and POC quadrant indicators.

Administrative data sources: Administrative data sources included Discharge Abstract Database (DAD), combined with information from OHIP claims and the National Ambulatory Care Reporting System (NACRS) data to calculate indicators of post-discharge care. The financial quadrant indicators were based on data from the Management Information System (MIS).

In October 2005, the Ministry of Health and Long-Term Care mandated inpatient mental health data collection through the use of the RAI-MH. This information, incorporated into the Ontario Mental Health Reporting System (OMHRS), was not available for this report but expands opportunities for future inpatient performance monitoring in Ontario.

The RAI-MH and OMHRS

The RAI-MH is the tool used to collect inpatient mental health data for incorporation into the OMHRS. Mandated in October 2005, data collection began in the second half of fiscal 2005/06.

The RAI-MH assessments are completed on all inpatients in designated adult mental health beds in Ontario at admission and discharge, as well as at quarterly intervals for patients in longer stay programs. This mandate covers approximately 70 facilities in Ontario, including general hospitals with designated adult inpatient mental health beds, as well as specialty psychiatric hospitals and Provincial Psychiatric Hospitals. Participation is mandatory and quality monitoring is underway.

In considering the scorecard and Mental Health Reform objectives addressed in this report, RAI-MH data has the potential to improve our understanding of:

- who is admitted to service and why;
- clinical and social barriers to discharge and follow-up linkage;
- factors that increase risk of readmission; and,
- service response to patient need.

Other information valuable for planning purposes includes:

- the percentage of involuntary or forensic admissions; and
- the percentage of MH discharges from designated versus non-designated beds within Schedule 1 facilities.

Future work can explore these and other possible uses of the RAI-MH data.

DEFINITIONS

Mental health/addictions case: The Discharge Abstract Database (DAD) records were used to define mental health and addiction hospital discharges based on the 'most responsible' diagnosis (that is the condition determined by the treating physician as most responsible for the length of hospital stay). This strategy identifies admissions/discharges where the primary focus is on a mental or substance-related illness rather than on either a medical condition or a secondary mental health condition. The Technical Report lists the ICD-10-CA codes used to define mental health and addictions inpatient stays. Given the adult focus of the Report, only admissions/discharges for individuals 15 years of age or older are counted, consistent with the age most commonly used by Ontario hospitals to define transitional youth (i.e., teenagers transitioning to adulthood) and adults. At times, this report uses the word 'case' to refer to the DAD record instead of 'admission,' 'discharge,' or 'admission/discharge.'

Functional centres (FCs): These subdivisions are used in functional accounting to assign revenue and expense statistics to specific areas of hospital activity (Ontario Case Costing Initiative. Ontario Case Costing Project (OCCP)) glossary of terms. [Online]. 2005 Sept [cited 2005 Aug]; Available from: <http://www.occp.com/costing/glossary.htm#FunctionalCentre>. For this Report, the mental health FCs are acute (7127625), addictions (7127645), forensic (7127655), crisis (7127690) and longer term (7127695). While there is an alignment between the FC category and the type of program delivered, it is not exact. Thus, a program may deliver crisis intervention services but be expensed under an acute FC number.

High and low performance: The cut-off points for defining high- and low-performance for each indicator are based on the distance from the mean in standard deviation units. Indicator results more than 1.5 standard deviations above or below the mean are identified as exceptional. In a normal distribution, these boundaries will lead to the classification of approximately the bottom 7% of results as low- and the top 7% as high-performers.

Interpretative aids: The Report includes comments and suggestions for interpreting or analyzing the indicator results further. In addition, a briefing page for each indicator outlines its rationale, reporting level and supporting evidence from selected published, grey, and web-based sources as well as hospital feedback gathered in face-to-face information sessions. Briefing pages are available on www.hospitalreport.ca. An example is provided in Appendix C.

LHIN assignment: Most of the LHIN findings in this Report are based on hospital geographic location. There are, however, some contextual variables (e.g., the inflow and outflow measures reported in Table 2) that are based on the client's residence location.

Client? Consumer? Patient?

For a number of years now, there has been debate on the correct name to refer to persons who receive mental health services. The three most commonly used terms are (in alphabetical order) client, consumer, and patient. Each has a history and represents a different perception of the nature of the relationship between the provider and recipient of care. In this report, rather than using one term and thus, by default, supporting one perception, the three terms are used interchangeably to refer to the person who is experiencing the hospital stay.

Functional Centres

As recommended by hospitals and our Advisory Committee (see Appendix B), several SIC indicators are calculated by functional centre (FC) (see definition of FC next to this box). This has both current and anticipated advantages. While two units with the same FC do not necessarily deliver the same kind of services to the same types of patients, they are more likely to be similar across the province than units with different FCs. Reporting SIC indicators by FC thus increases the chances that similar units are being compared. A future benefit is that, unlike the DAD, the RAI-MH allows indicator calculation and analysis by FC as do the MIS data. Being able to link SIC, CUO, and FPC indicators within the same FC has the potential to provide fine-grained information about the relationships among processes, outcomes, and resource use.

Peer groups: Schedule 1 hospitals for 2005/06 are grouped into specialty and acute hospital peer groups for this Report based on information available at the time of writing from MOHLTC's websites.²⁹ Treatment in acute care hospitals tends to focus on stabilization and discharge, within relatively short lengths of stay. Specialty hospitals serve individuals with more complex treatment and behavioural management needs, who typically require a longer length of stay. Specialty hospitals include both dedicated mental health hospitals and mixed service hospitals (that also provide acute care for mental health and other conditions).⁹ Many specialty facilities are former Provincial Psychiatric Hospitals. For this report, acute hospitals are further grouped as teaching, community with less than 30 designated beds and community with 30 beds or more. Appendix D lists hospital corporations by peer group type.

Risk adjustment: Some indicators were calculated using data sources that also included clients' sex and age. These have been risk adjusted for these characteristics using direct standardization. The population used for standardization was the total group of adult individuals with a MH/A discharge during FY 2005/06.

Schedule 1 hospital: Under the *Mental Health Act*, hospitals with this designation are required to deliver specific mental health services (e.g., inpatient, outpatient, day care, emergency, consultative and educational²⁹). For this report, hospital eligibility was based on their designation as of March 31, 2006, the last day of fiscal 2005/06. Two hospitals, Orillia Soldiers' Memorial and Ross Memorial, became Schedule 1 facilities only shortly before the end of the fiscal year.^h

g Baycrest Centre for Geriatric Care was grouped with specialty facilities due to its focus on the elderly who often have complex needs that require a longer hospitalization. Also, while St. Joseph's Health Care Hamilton delivers both acute and specialty services, it is classified as a specialty facility in this report

h While these hospitals were not officially Schedule 1 facilities during the entire reporting period, most of their performance scores fall well within the range of the total group. The number of discharges they represent is less than one percent provincially and less than four percent in their peer group (community hospitals with 29 or fewer MH beds). Thus, their impact on the provincial and peer group scores is minimal. At the LHIN level, their discharges account for six percent (Central East LHIN) and 17 percent (North Simcoe Muskoka), respectively, hence may have a larger impact on LHIN values.

SIC quadrant indicators measure practices that are expected to improve and maintain the quality of care. They pertain to three Mental Health Reform objectives – care based on best practices, integration and continuity of care, and consumer centered care. Data for these indicators were gathered via a survey, conducted in early 2007, for practices occurring during fiscal year 2005-06. Respondents were chiefs of psychiatry and senior managers working in different service areas (i.e., functional centers) within the program. The results discussed here and reported in the SIC Performance Allocation Table (Table 10) are for acute FCs (7127625) only. Results for the other mental health and addictions FC categories are reported in Appendix E.

As noted earlier, a number of hospitals indicated that responses to some survey questions were estimates since they do not have the decision support systems necessary to supply the needed numbers. Hence, these indicators are best interpreted as reflecting hospital awareness of the importance of system integration and change processes, with measures of the actual implementation awaiting more precise data. This combined with uneven distribution of hospitals across LHINs (several have only one or two hospitals), is the basis for a decision to not report results at the LHIN level.

Indicator Definitions

SIC1: Inter-Organizational Networking

This indicator measures the extent to which hospitals have written protocols in place for working with other service providers (e.g., community services, other hospitals and long-term care facilities) to share knowledge and integrate services. The assumption is that improved inter-organizational networking will enhance continuity of care.

SIC2: Notification of Hospitalization

This indicator measures use of practices to support patient continuity of care. Programs indicate whether they have standardized protocols in place to notify external service providers (given appropriate patient/substitute consent where required) about a patient's admission to the hospital, care while in hospital, and discharge.

SIC3: Use of Guideline Care for Tracer Conditions

This indicator measures whether programs are basing treatment decisions on standardized written guidelines for three patient groups – those with schizophrenia, major depressive disorder or bipolar disorder. A **'core'** version of the indicator (**SIC3A**) reports use of treatment guidelines published by official Canadian and U.S. professional organizations.ⁱ An **'expanded'** version (**SIC3B**) reports use of guidelines developed by other professional organizations such as the National Institute for Clinical Excellence in England. Use of guideline care for treatment of at least one of these patient groups was sufficient to produce a positive rating for the hospital. The provincial result is the percentage of hospitals with a positive rating. Higher is more desirable.

ⁱ For depression and bipolar disorder, these are the Canadian Network for Mood and Anxiety Treatments and the American Psychiatric Association guidelines. For schizophrenia, these are the guidelines recommended by the Canadian and American Psychiatric Associations.

SIC4: Use of Clinical Data – Staff Provided

SIC5: Use of Clinical Data – Client Provided

These two indicators monitor whether data on patient symptom and functional status are collected and used for hospital quality improvement. Assessment data based on two perspectives are included – the staff, and following the provincial objective of consumer-centered care, the client.

SIC6: Discharge Plans Completed with Client(A)/Family(B)/Provider Involvement(C)

This indicator reports the percentage of discharge plans that have “formal, documented consumer/family/provider involvement”, based on program feedback, not chart review. It is intended to be a measure of involvement of different stakeholders in client care.

SIC7: Regular Client Input in Hospital/FC Governance

This indicator measures frequency of implementation of processes for obtaining patient input into program governance, planning and service delivery. These processes include advisory groups, focus groups, retreats and consultation.

PROVINCIAL RESULTS (SIC)

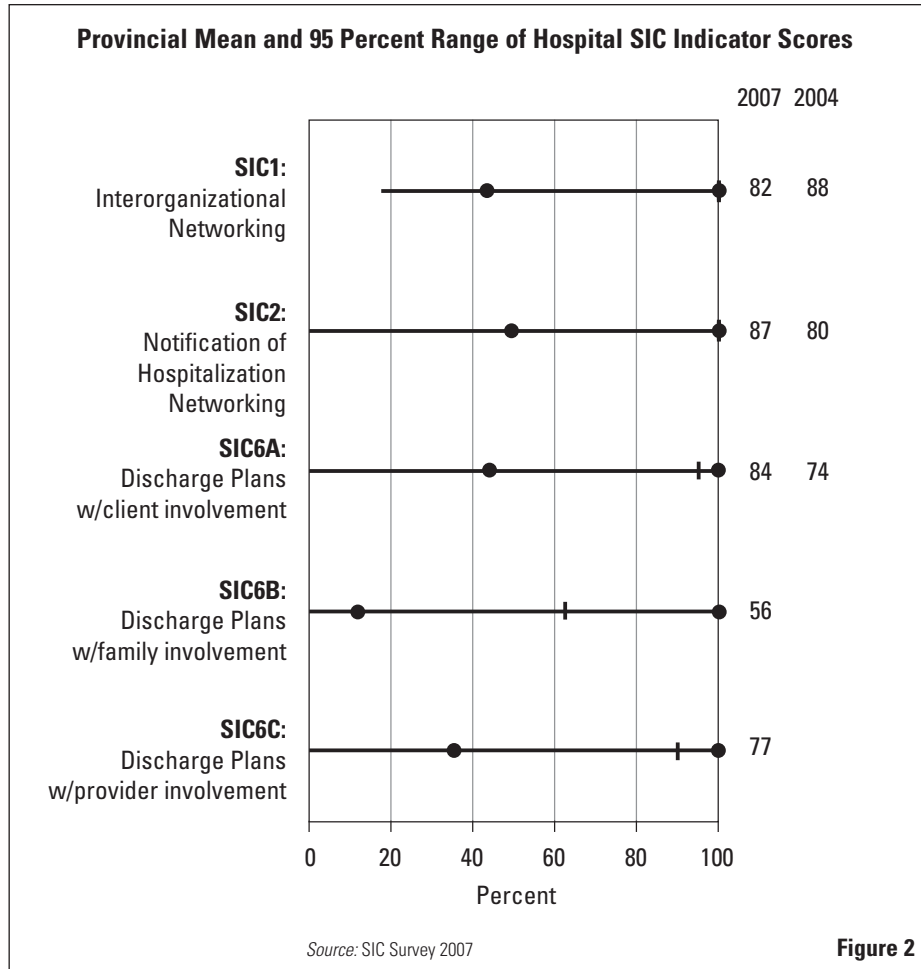


Figure 2

How to read this chart

The *ends* of the horizontal lines represent the maximum and minimum values reported for each indicator.

The *vertical bar* on the line is the median (the value which represents the middle in the distribution of results).

The *shaded circles* are the cut points used to identify exceptionally high or low scores. These are based on the distance from the mean in standard deviation units, as described in the Methods section.

For some indicators, the cut points are the same as the maximum or minimum observed values.

Scores between the cut point and end of the line correspond to the light and very dark shaded cells in the Performance Allocation tables.

Figure 2 depicts the distribution of scores and the provincial average (mean) for five SIC indicators. Hospitals can use this figure to see where their individual score (found in the performance allocation tables) for each indicator falls relative to other hospital scores in the province. This figure is not meant to facilitate comparison between indicators. Four indicators are excluded where the individual hospital results are reported on a yes/no scale. Provincial results from the 2004 report are provided as available for comparison.

The following sections discuss the SIC quadrant results in the context of the three Mental Health Reform objectives noted earlier.

Practices to support service integration

Two program indicators pertain to this Mental Health Reform objective. The inter-organizational networking indicator assesses whether inpatient programs have established protocols with other organizations for delivering care, locating inpatient staff in another organization and sitting on Boards of other organizations. The notification of hospitalization indicator measures whether hospitals have standardized protocols in place to notify external service providers (given appropriate patient/substitute consent where required) about a patient's admission to the hospital, care while in hospital, and discharge. Each hospital received a score from zero to 100 on each indicator, based on the activities reported.

The provincial mean scores for all hospitals are **82 percent** and **87 percent** respectively, indicating that most hospitals have some strategies in place for working with external organizations. There has been minimal change since 2004 at the provincial level when results were **88 percent** and **80 percent** respectively. Tables 7 and 8 describe the targets of these relationships in more detail.

Table 7. Service integration practices used by inpatient programs

Sectors	Strategy in Use (% hospitals)		
	Service agreements	Board Membership	Staff in vivo*
Community MH Program	86	77	51
Assertive Community Treatment (ACT)	61	53	16
Other Hospital	63	53	31
Primary Care	37	39	20
Long Term Care	24	16	16
Other	37	39	18
None	6	2	29

* Inpatient staff spend more than 1/2 day per week providing service in an external program/organization.

Note: Results are reported for the Acute Functional Centre.

Source: SIC Survey 2007

Table 8. Use of protocols for notifying other providers about a patient hospitalization.

Sectors	Protocol in Place (% hospitals)		
	Upon Admission	While in hospital	Upon discharge
Community MH Program	73	69	75
Assertive Community Treatment teams	65	63	73
GP/nurse with hosp. privileges	61	51	65
GP/nurse without hosp. privileges	37	18	51
Home Care	35	29	45
Notify other	25	22	31
No protocols in place	14	22	10

Note: Results are reported for the Acute Functional Centre.

Source: SIC Survey 2007

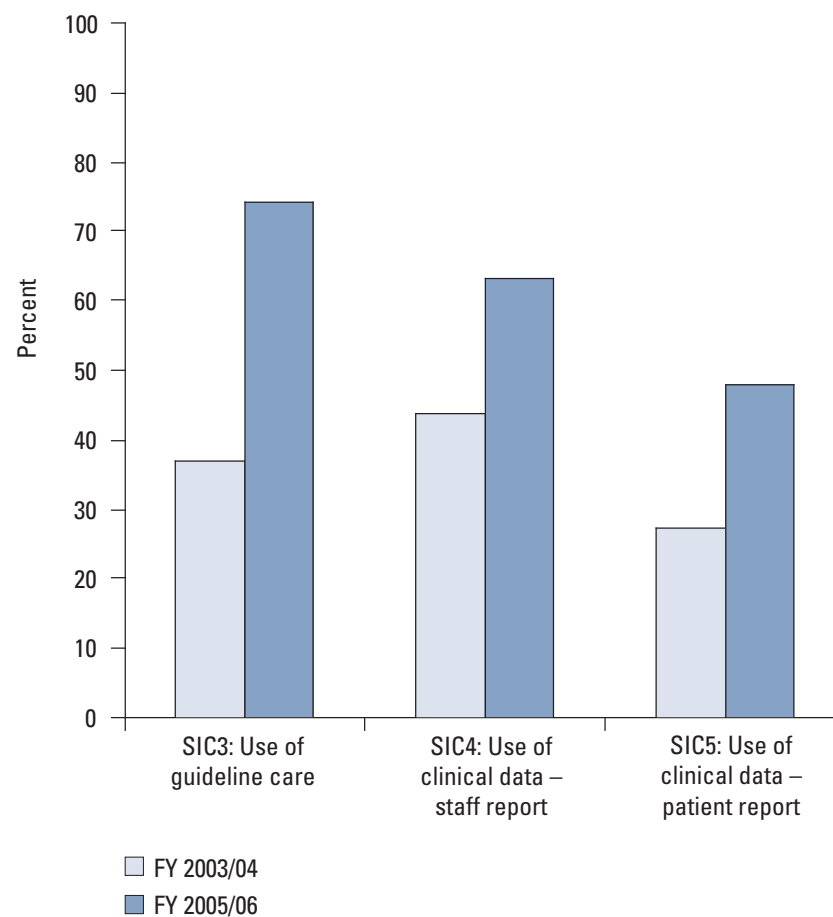
Integration practices are most frequently established with community mental health programs (including Assertive Community Treatment teams). Similarly, community mental health programs are most frequently notified when patients are admitted to hospital. Fluid transition of patients from hospital to community mental health is an important element of Mental Health Reform that hospitals appear to be addressing. Formal relationships with long-term care organizations are less frequently developed. Given that ALC days constitute about 10 percent of mental health/addictions days, it would be important to learn more about whether these relationships are related to more timely discharge for some patients, resulting in fewer ALC days.

Some hospitals report linking with other sectors such as corrections (probation and parole), shelter services and developmental services. There are also selected examples of hospitals developing relationships with local service networks (e.g., crisis networks), which is an important direction for implementing more system-based, integrated management of mental health clients.

Care based on best practices

Figure 3 reports provincial results for three indicators that are related to this provincial Mental Health Reform objective. Compared to the 2004 Mental Health Hospital Report, the rates have increased for all three indicators, suggesting more focus by hospitals on best practices and evidence-based delivery of care.

Best Practices: Provincial results for FY 2003/04 (2004 Report) versus FY 2005/06 (2007 Report)



*Note: Results are reported for Acute Functional Centres.
Source: SIC Survey 2007*

Figure 3

The percentage of hospitals reporting that they base treatment decisions for patients with schizophrenia, depression or bipolar disorder on evidence-based guidelines has doubled from 37 to 74 percent of hospitals. Feedback obtained from hospitals on the 2004 Mental Health Hospital Report (see Table 5, Interpreting Results) indicated that only about 40 percent of hospitals viewed this indicator as ‘very relevant’ to their strategic goals, and a number of staff noted the difficulty of implementation. It is encouraging that the present data show increasing use, and it would be valuable to know specifically how programs are addressing this challenge.

Almost all hospitals reported collecting clinical data based on staff assessment (most often using the RAI-MH) but fewer (63%) are using these data for continuous quality improvement (CQI; see Table 9). The collection and use of patient self-report data in improvement activities is lower at 48 percent. Routine collection and use of patient data can be very challenging to implement, presenting another area where more detail about successful practices could be beneficial to the sector.

As indicated in Figure 4, peer group comparisons on implementation of best practices indicate some variation. Teaching hospitals are the most active and community hospitals with larger psychiatric units the least, in terms of using guideline care and staff-provided clinical data. The use of client-provided clinical data showed lower levels and far less variation than the other two indicators with specialty facilities averaging somewhat higher score on this indicator.

Table 9. Collection and use of clinical data for CQI

	STAFF Provided (%)	PATIENT provided (%)
Data collected	92	69
Data collected & used at least annually	63	48

Note: Results are reported for the Acute Functional Centre.

Source: SIC Survey 2007

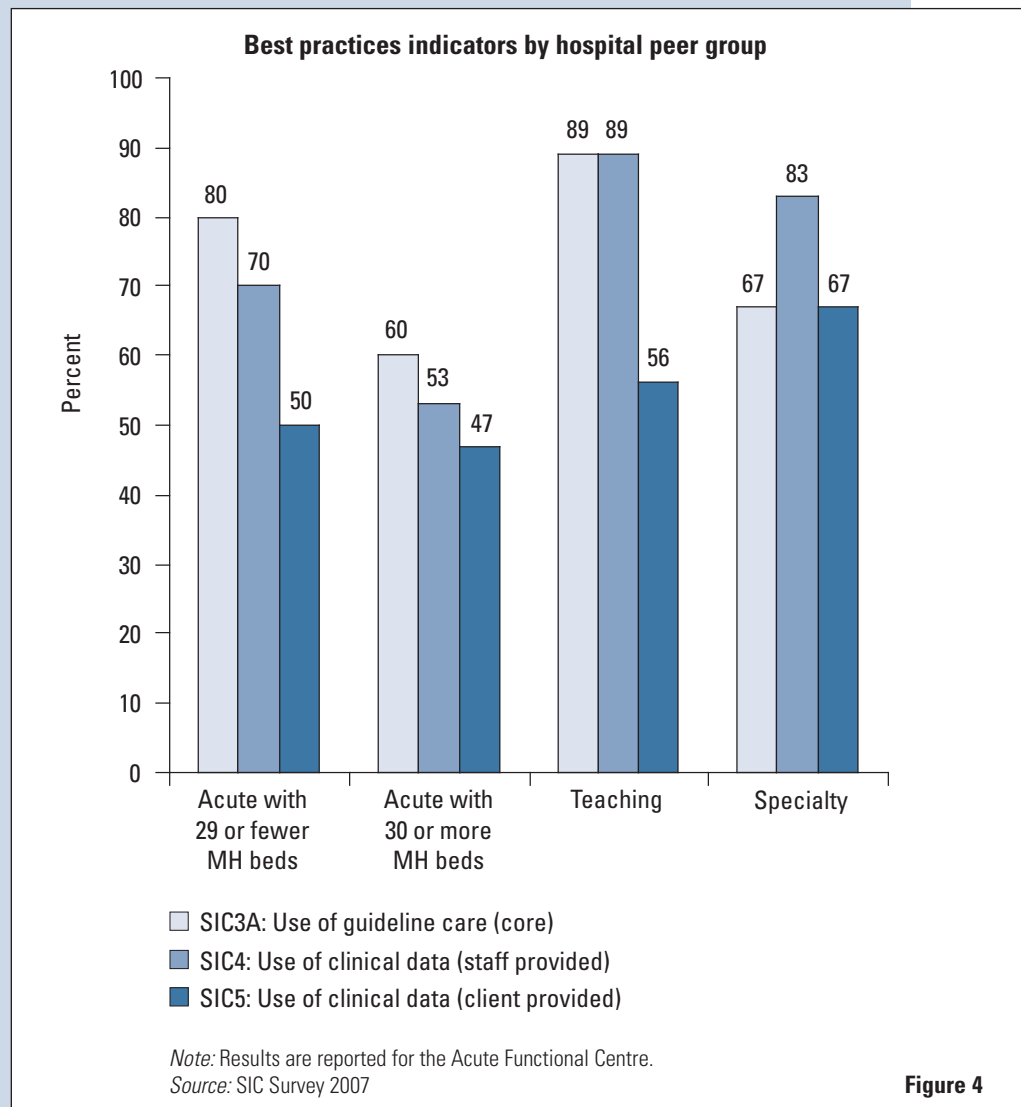


Figure 4

Consumer-centered care

Two program indicators pertain to this provincial Mental Health Reform objective – patient involvement in discharge planning and regular involvement of patients in program governance.

The first indicator reports the percentage of discharge plans that have “formal, documented consumer involvement”, and is based on hospital staff report, not on chart review. The mean hospital result was **84 percent** up from **74 percent** in 2004. This result indicates hospital awareness of the importance of this practice but the majority of programs were only able to provide a ‘guesstimate’ of this rate, lacking ready access to the information needed to answer this question.

This question does not address the meaningfulness of participation for either the staff or the patient. However, in the patient perception of care (POC) survey, about one third of respondents indicated that they were not involved as much as they wished in their discharge planning; about one third reported receiving little information about services available in the community after discharge; and 25 percent were not told who to contact if a problem or crisis arose after discharge. Since evidence suggests that successful transition to community is helped by good discharge planning, this is an area that requires more attention, both to improve practice and to improve documentation for quality monitoring.

The second indicator measures strategies for obtaining consumer input into program (i.e., acute care functional centre) governance, planning and delivery of service (Figure 5). Most hospitals have consumer advisory committees that meet monthly or quarterly. Focus groups and retreats are also used – typically on an annual or occasional basis. These practices again signal hospital efforts to involve consumers. Our next challenge is to understand whether and how input through these channels influences program delivery.



Figure 5

			SIC1	SIC2	SIC3A	SIC3B	SIC4	SIC5	SIC6A	SIC6B	SIC6C	SIC7**
			Interorgani- zational Networking	Notification of Hospitalization	Use of Guideline Care Core	Use of Guideline Care Exp	Use of Clinical Data (staff provided)	Use of Clinical Data (client provided)	Discharge Plans w/client involvement	Discharge Plans w/family involvement	Discharge Plans w/provider involvement	Consumer input into Hospital Governance
ACUTE FUNCTIONAL CENTRE (7127625)	Community Served	LHIN										
Provincial Average (%)			82	87	74	82	63	48	84	56	77	w 24; m 44 q 25; a 2

TEACHING HOSPITALS

Hôpital régional de Sudbury Regional Hospital	Sudbury	13	100	100	yes	yes	yes	yes	99	99	99	weekly
Hotel Dieu Hospital, Kingston	Kingston	10	100	100	yes	yes	yes	yes	100	50	50	monthly
London Health Sciences Centre	London	2	100	100	no	no	yes	no	100	100	100	quarterly
Mount Sinai Hospital	Toronto	7	50	100	yes	yes	yes	no	95	95	95	weekly
St. Michael's Hospital	Toronto	7	100	33	yes	yes	yes	no	100	50	80	monthly
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	100	100	yes	yes	yes	yes	95	75	50	weekly
The Ottawa Hospital	Ottawa	11	100	100	yes	yes	yes	yes	100	75	85	quarterly
Thunder Bay Regional Health Sciences Centre	Thunder Bay	14	50	100	yes	yes	no	no	DK	DK	95	monthly
University Health Network	Toronto	7	100	67	yes	yes	yes	yes	100	DK	DK	quarterly

SMALL COMMUNITY HOSPITALS

Alexandra Marine and General Hospital	Goderich	2	100	100	yes	yes	no	no	85	50	75	monthly
Bluewater Health	Sarnia	1	50	100	no	no	no	no	DK	0	0	monthly
Chatham-Kent Health Alliance	Chatham	1	83	100	yes	yes	yes	yes	100	40	100	monthly
Cornwall Community Hospital	Cornwall	11	50	100	no	no	yes	no	25	45	80	no
Halton Healthcare	Halton	6	100	100	yes	yes	yes	no	100	75	100	monthly
Huron Perth Healthcare Alliance	Stratford	2	100	100	yes	yes	yes	yes	90	25	75	monthly
Joseph Brant Memorial Hospital	Burlington	4	50	100	yes	yes	no	no	75	45	70	quarterly
Markham Stouffville Hospital	Markham	8	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Orillia Soldiers' Memorial Hospital†	Orillia	12	100	100	yes	yes	yes	yes	DK	DK	DK	monthly
Peterborough Regional Health Centre	Peterborough	9	100	100	yes	yes	yes	no	75	65	75	monthly
Queensway Carleton Hospital	Nepean	11	67	0	yes	yes	yes	no	0	0	0	monthly
Quinte Health Care	Belleville	10	100	100	yes	yes	yes	yes	95	100	100	weekly

† Hospital became a Schedule 1 facility towards the end of FY 2005-06.

* DK "Do not know". Note: "DK" was an option for hospitals to report for the SIC A, B, and C indicators (see SIC quadrant section of the Technical Report).

** SIC7 Frequency of consumer input into hospital governance: "w" weekly; "m" monthly; "q" quarterly; "a" annually.

Note: Results are reported for the Acute Functional Centre.

Source: SIC Survey 2007

			SIC1	SIC2	SIC3A	SIC3B	SIC4	SIC5	SIC6A	SIC6B	SIC6C	SIC7**
	Community Served	LHIN	Interorganizational Networking	Notification of Hospitalization	Use of Guideline Care Core	Use of Guideline Care Exp	Use of Clinical Data (staff provided)	Use of Clinical Data (client provided)	Discharge Plans w/client involvement	Discharge Plans w/family involvement	Discharge Plans w/provider involvement	Consumer input into Hospital Governance
ACUTE FUNCTIONAL CENTRE (7127625)												
SMALL COMMUNITY HOSPITALS continued												
Ross Memorial Hospital†	Lindsay	9	100	100	yes	yes	yes	yes	100	100	100	weekly
Royal Victoria Hospital	Barrie	12	50	100	yes	yes	yes	yes	100	0	DK	quarterly
Southlake Regional Health Centre	Newmarket	8	50	33	yes	yes	no	no	DK	0	0	weekly
The Brantford General Hospital	Brantford	4	50	100	no	no	yes	yes	DK	DK	DK	quarterly
The Credit Valley Hospital	Mississauga	6	100	100	yes	yes	yes	yes	100	100	100	monthly
Timmins and District Hospital	Timmins	13	50	100	yes	yes	yes	yes	100	80	75	quarterly
Windsor Regional Hospital	Windsor	1	50	100	no	yes	no	no	DK	DK	60	quarterly
Woodstock General Hospital	Woodstock	2	100	100	yes	yes	yes	yes	95	75	DK	monthly
LARGE COMMUNITY HOSPITALS												
Grand River Hospital	Kitchener	3	17	100	yes	yes	no	no	DK	DK	DK	monthly
Grey Bruce Health Services	Owen Sound	2	100	100	no	yes	yes	yes	90	30	100	monthly
Hôpital Montfort Hospital	Ottawa	11	50	67	no	no	no	no	DK	DK	DK	quarterly
Hôtel-Dieu Grace Hospital	Windsor	1	100	67	yes	yes	no	no	DK	DK	100	annually
Humber River Regional Hospital	Toronto	8	100	67	yes	yes	yes	no	95	80	70	weekly
Lakeridge Health	Oshawa	9	83	67	no	no	no	no	100	60	100	quarterly
Niagara Health System	St Catharines	4	50	100	yes	yes	yes	yes	20	10	50	monthly
North York General Hospital	Toronto	8	100	100	yes	yes	yes	yes	95	90	90	weekly
Rouge Valley Health System	Toronto	9	50	67	no	no	no	no	DK	DK	DK	monthly
Sault Area Hospital	Sault Sainte Marie	13	100	100	yes	yes	yes	yes	100	15	100	monthly
St. Joseph's Health Centre	Toronto	7	100	67	yes	yes	yes	yes	40	30	80	monthly
The Scarborough Hospital	Toronto	9	100	100	yes	yes	yes	yes	25	DK	DK	monthly
Toronto East General Hospital	Toronto	7	50	100	no	yes	yes	yes	75	80	100	weekly
Trillium Health Centre	Mississauga	6	100	100	yes	yes	no	no	85	30	30	weekly
William Osler Health Centre	Brampton	5	100	100	no	yes	no	no	50	50	40	quarterly

† Hospital became a Schedule 1 facility towards the end of FY 2005-06.

* DK "Do not know". Note: "DK" was an option for hospitals to report for the SIC A, B, and C indicators (see SIC quadrant section of the Technical Report).

** SIC7 Frequency of consumer input into hospital governance: "w" weekly; "m" monthly; "q" quarterly; "a" annually.

Note: Results are reported for the Acute Functional Centre.

Source: SIC Survey 2007

■ Average (non-'outlier') score
 ■ Below average "outlier" score
 ■ Yes/No and other responses
 NR Not reported
 DK Do not know*

			SIC1	SIC2	SIC3A	SIC3B	SIC4	SIC5	SIC6A	SIC6B	SIC6C	SIC7**
ACUTE FUNCTIONAL CENTRE (7127625)	Community Served	LHIN	Interorganizational Networking	Notification of Hospitalization	Use of Guideline Care Core	Use of Guideline Care Exp	Use of Clinical Data (staff provided)	Use of Clinical Data (client provided)	Discharge Plans w/client involvement	Discharge Plans w/family involvement	Discharge Plans w/provider involvement	Consumer input into Hospital Governance
SPECIALTY HOSPITALS												
Centre for Addiction and Mental Health	Toronto	7	100	33	yes	yes	yes	yes	DK	DK	DK	quarterly
Mental Health Centre Penetanguishene	Penetanguishene	12	67	100	no	no	yes	yes	90	50	90	weekly
Northeast Mental Health Centre	Sudbury	13	100	100	yes	yes	yes	no	90	70	90	no
Royal Ottawa Health Care Group [†]	Ottawa	11	100	100	yes	yes	yes	yes	100	95	100	monthly
St. Joseph's Health Care Hamilton	Hamilton	4	100	100	yes	yes	yes	yes	98	93	93	monthly
Whitby Mental Health Centre	Whitby	9	100	67	no	no	yes	no	100	70	95	weekly

* DK "Do not know". Note: "DK" was an option for hospitals to report for the SIC A, B, and C indicators (see SIC quadrant section of the Technical Report).

** SIC7 Frequency of consumer input into hospital governance: "w" weekly; "m" monthly; "q" quarterly; "a" annually.

Note: Results are reported for the Acute Functional Centre.

† The Royal Ottawa Health Care Group assigned their Brockville site to be their delegate for answering the SIC survey.

Source: SIC Survey 2007

The CUO quadrant indicators measure client and system level outcomes that are expected to result from better performing systems of care, including the processes monitored by the SIC quadrant indicators. Indicators pertain to two Mental Health Reform objectives – appropriate use of inpatient services, and integration and continuity of care.

Indicator Definitions

CUO1: Hospitalization for Psychotic Diagnoses

This indicator serves as a flag for whether hospitals are reserving inpatient care for those most in need of intensive services, with psychotic disorders used as a proxy for severity. Higher rates suggest better targeting of service.

CUO2: % of Discharges with Length of Stay (LOS) of 3 Days or Less

This indicator replaces the original LOS indicator. It measures the percentage of discharges with a length of stay of three days or less, regardless of whether the discharge is to the community or to another inpatient service. Higher rates may signal a large percentage of admissions for involuntary assessments or the need for more alternative treatment options within the hospital (e.g., holding beds, partial hospitalization) or more efforts to link patients with community care.

CUO3: Alternative Level of Care Days (ALC)

This indicator measures percentage of MH/A inpatient days designated as ALC. A person is designated as ALC “when the physician or designated other indicates that the patient no longer requires acute care”.³⁹ A higher rate could reflect lower availability of appropriate community support options or a need to revise hospital discharge procedures. Note that the indicator values for specialty hospitals should be interpreted with caution since they are not currently required to report ALC days.

CUO4: OHIP Care Within 30 Days Post-Discharge

This indicator measures receipt of one type of post-discharge care. It is the proportion of psychiatric discharges that receive, within 30 days, core mental health services from an OHIP provider – that is assessment, diagnosis, or treatment of an emotional, mental health or addiction problem. While data are not yet available for some sources of medical care (such as salaried physicians in hospitals, community health centres, or community mental health programs), these services likely provide follow-up care to a much smaller percent of individuals currently compared with OHIP providers. Higher rates on this indicator suggest better performance.

CUO5: Emergency Department (ED) Visit Within 30 days Post-Discharge (but not admitted)

This indicator addresses a second type of post-discharge care. It measures the percentage of psychiatric discharges followed within 30 days by a visit to an ED in any Ontario facility for mental health reasons that does not lead to a readmission. (For readmissions, see CUO6 – 30-day readmission rate.) This indicator is reported in two forms: A) any visit; B) only visits associated with an urgent, emergent, or resuscitation triage level. Higher rates suggest a need for more community-based supports or a better transition from hospital to community care.

CUO6: 30-Day Readmission Rate^j

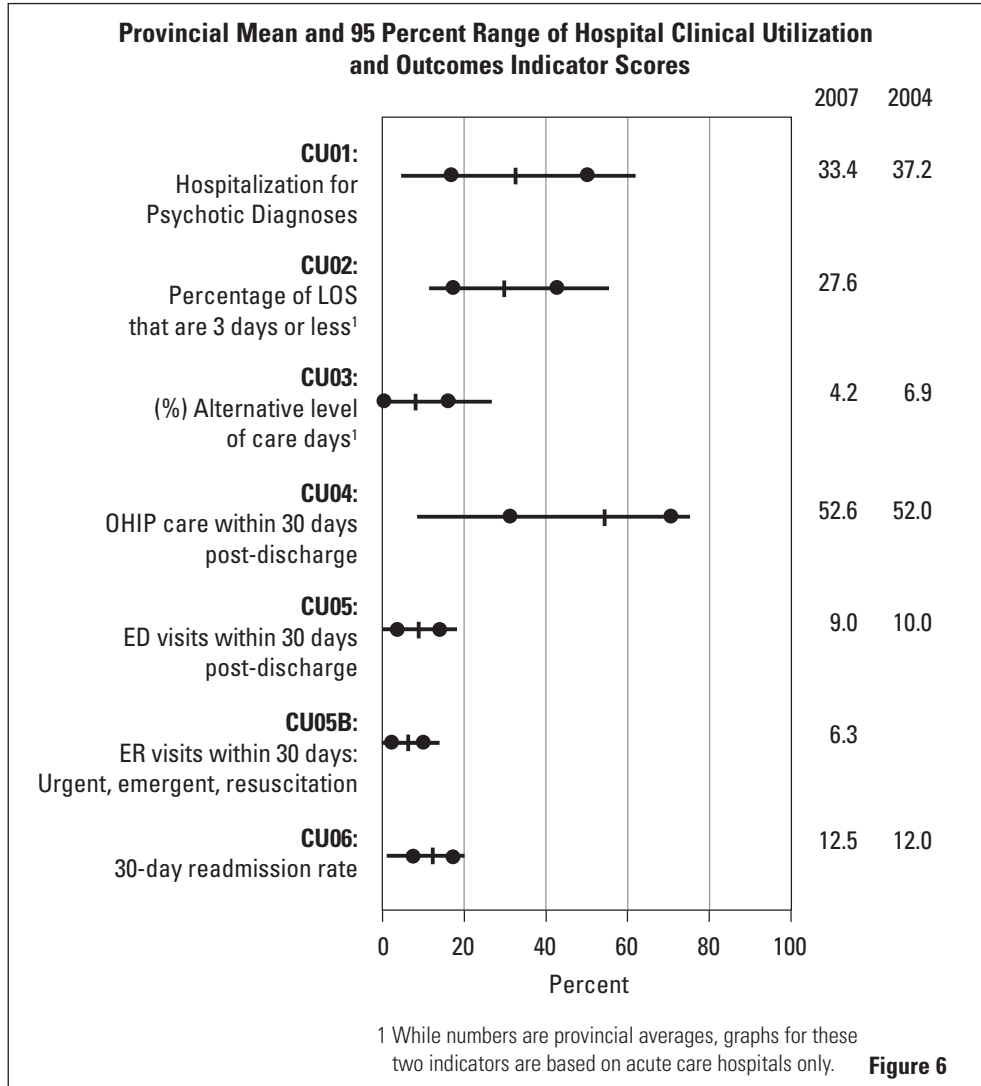
This indicator addresses a third type of post-discharge care. It measures the percentage of psychiatric discharges that are followed within 30 days by another psychiatric admission, whether to the same or a different hospital. Transfers are not considered readmissions. The desired value for this indicator is as low as possible. Higher rates may flag poor preparation for discharge and/or poor community follow-up resulting in inefficient/inappropriate use of inpatient resources. This indicator is mutually exclusive of the CUO5 indicator (ED visit within 30 days post-discharge but not admitted).

CUO7: Repeat Inpatients

This indicator is based on the number of patients seen by a hospital who have had two or more inpatient discharges for mental health or addictions reasons during the fiscal year. It flags a potential failure of the health care system to help individuals maintain their tenure in the community over a longer period of time. Because readmissions over a 12-month timeframe are not necessarily a reflection of the quality of care of any one facility, this indicator is relevant only at the provincial and LHIN levels. (It is, however, reported here as a contextual variable for hospitals at their request). Lower numbers reflect better performance.

^j Note that this indicator, while identical in intent to the 28-day readmission indicators used in the Provincial Health System Scorecard, will yield a marginally higher rate because of the different time period.

PROVINCIAL RESULTS (CUO)



How to read this chart

The *ends* of the horizontal lines represent the maximum and minimum values reported for each indicator.

The *vertical bar* on the line is the median (the value which represents the middle in the distribution of results).

The *shaded circles* are the cut points used to identify exceptionally high or low scores. These are based on the distance from the mean in standard deviation units, as described in the Methods section.

For some indicators, the cut points are the same as the maximum or minimum observed values.

Scores between the cut point and end of the line correspond to the light and very dark shaded cells in the Performance Allocation tables.

Figure 6 depicts the distribution of scores and the provincial average (mean) for the CUO indicators. Hospitals can use this figure to see where their individual score (found in the CUO performance allocation tables) for each indicator falls relative to other hospital scores in the province. This figure is not meant to facilitate comparison between indicators since they differ in whether higher or lower values are desired and in the degree to which they can feasibly be changed.

The following sections discuss the CUO indicator results related to the two Mental Health Reform objectives that they address.

Appropriate use of inpatient services

Three indicators pertain to this objective – hospitalization for psychotic conditions, percentage of alternate level of care days, and discharges with length of stay of 3 days or less. Overall, results are similar to those reported in 2004. The percentage of discharges associated with a psychotic disorder is **33 percent** compared to **37 percent** in 2004. The percent of patient days designated as ALC dropped from **seven to four percent**. While this is a move in the desired direction, the decrease in the number of ALC days may have resulted from how the data are reported rather than real change. Many specialty and recently divested Provincial Psychiatric Hospitals (not all of whom were included in the *2004 Report*) do not record ALC days because the definition only includes acute care. The actual percent of days where the client is awaiting discharge because he/she needs a more intensive or less intensive level of care than is offered by the service is higher, but there is currently no way to know the actual magnitude. Finally, a new indicator related to this objective is the percent of discharges that have a LOS of 3 days or less. The provincial rate is **28 percent**. These indicators taken as a whole continue to suggest room for improvement on this objective.

Figure 7 reports results by hospital peer group. There is consistency across large, teaching and specialty hospitals in percentage of admissions with psychotic disorders, at about 35 percent. One might expect higher rates in specialty facilities, as they are mandated to serve a more complex patient group. However, specialty facilities have targeted programs such as forensic and geriatric services where psychotic disorders may not be an appropriate indicator of severity or reason for admission.

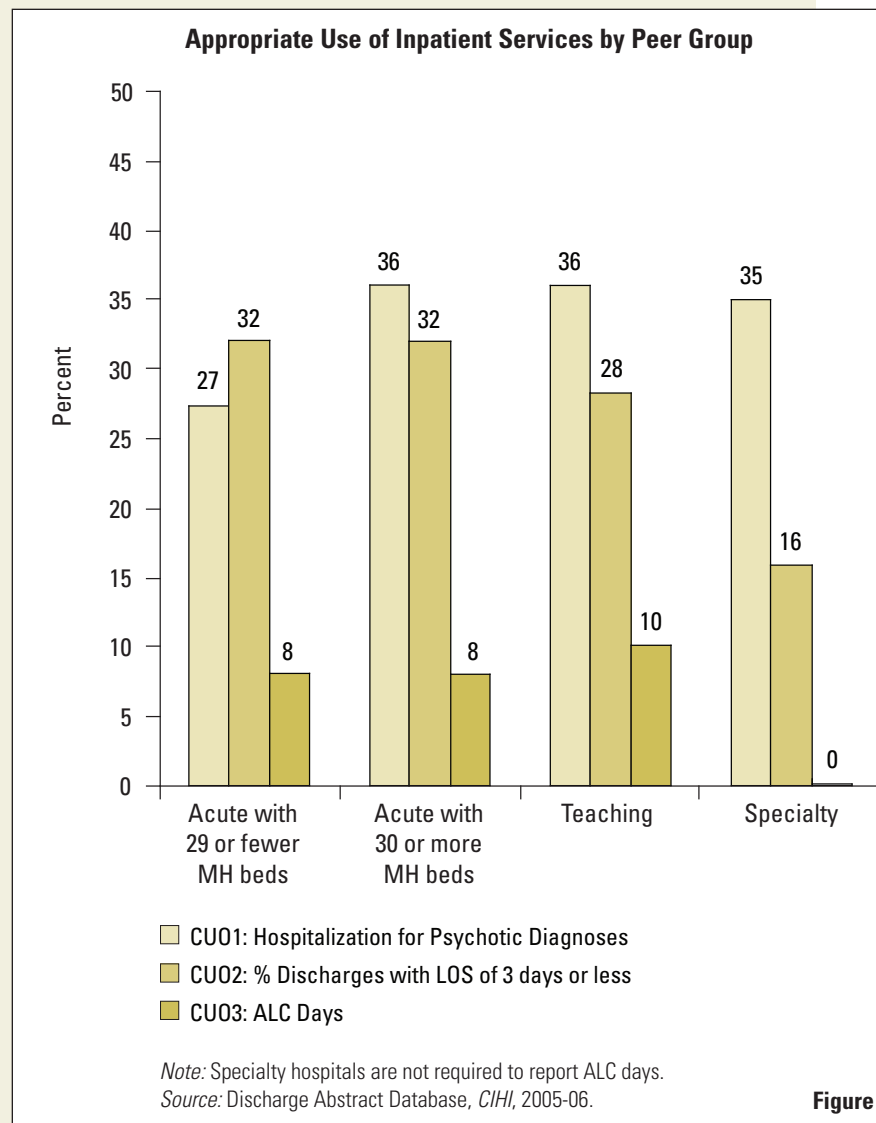


Figure 7

Community hospitals with smaller units are least likely to serve individuals with psychotic disorders. It is possible that some of these hospitals are assuming different roles in their systems of care and serving a less severely ill patient group.

The very low rate of ALC days for specialty hospitals, as noted, reflects reporting practice, and the real values are not known. For the three acute care hospital peer groups, ALC patients account for eight to 10 percent of mental health days, suggesting that bed blocking continues to be a concern affecting access and resource use, and reflecting difficulty in finding an appropriate care setting for some patients.

At a LHIN level (see CUO Indicators by LHIN, Table 12), these indicators show a large, often two-fold, difference between the lowest and highest ranking LHINs. For 'Hospitalization for psychotic disorders', LHIN area values range from a high of 48 percent (Toronto Central) to lows of 20-22 percent (North Simcoe Muskoka and North West). For ALC days, results range between nine percent (Champlain) to less than two percent (Waterloo Wellington, South East). Finally, the LHIN range for rate of discharges with a three-day or less stay was a high of 31-32 percent (North East, North West) to a low of 18 percent (Erie St. Clair).

Interpretation of these indicator results and any consequent action requires a careful look at local practice patterns including admission practices (e.g., proportion of involuntary inpatient stays), available mix of alternative services (e.g., day hospital, intensive management in the community), and how readily clients are connected with and supported in non-inpatient care.

Integration and post-discharge care

Use of community and inpatient/emergency services in the immediate post discharge period has changed little between the current and previous *Reports*. The percentage of discharges followed within 30 days by an OHIP core mental health visit was **51.5 percent** in 2004 versus the current rate of **52.6 percent**. Given the assumption that hospitalized individuals are those experiencing quite severe or destabilized conditions and therefore in need of medical services as part of their care, these figures indicate continued room for improvement on this objective.

The LHIN range for this indicator is considerable. The North West LHIN has the lowest percent of OHIP follow-up (23%) while the rates for the two highest LHINs, Champlain and Toronto Central, are more than double (62-63%). While an obvious explanation would be that the variation is due to the availability of physicians, Figure 8 shows that the explanation is more complex. Some LHINs with similar physician supplies have similar follow-up rates (e.g., Central East and Mississauga Halton) while others (e.g., Erie St. Clair and Champlain) with differing physician supplies show the same proportion of OHIP follow-up. Other factors such as travel distance and local practice patterns must clearly be taken into account.

The 30-day OHIP follow up indicator likely misses medical services delivered in other forms of post-discharge care. However, linkages to data capturing these other forms (e.g., salaried physicians, community mental health programs, client-based initiatives) are either not completely reliable or not currently possible. Non-OHIP providers still account for a small proportion medical care delivered in Ontario, and findings from other Canadian jurisdictions³⁸ suggest that the same is true when community data on medical care are available. Whether new, linkable data sources would noticeably increase the percentage of discharges receiving ambulatory or community-based follow-up is still to be determined.

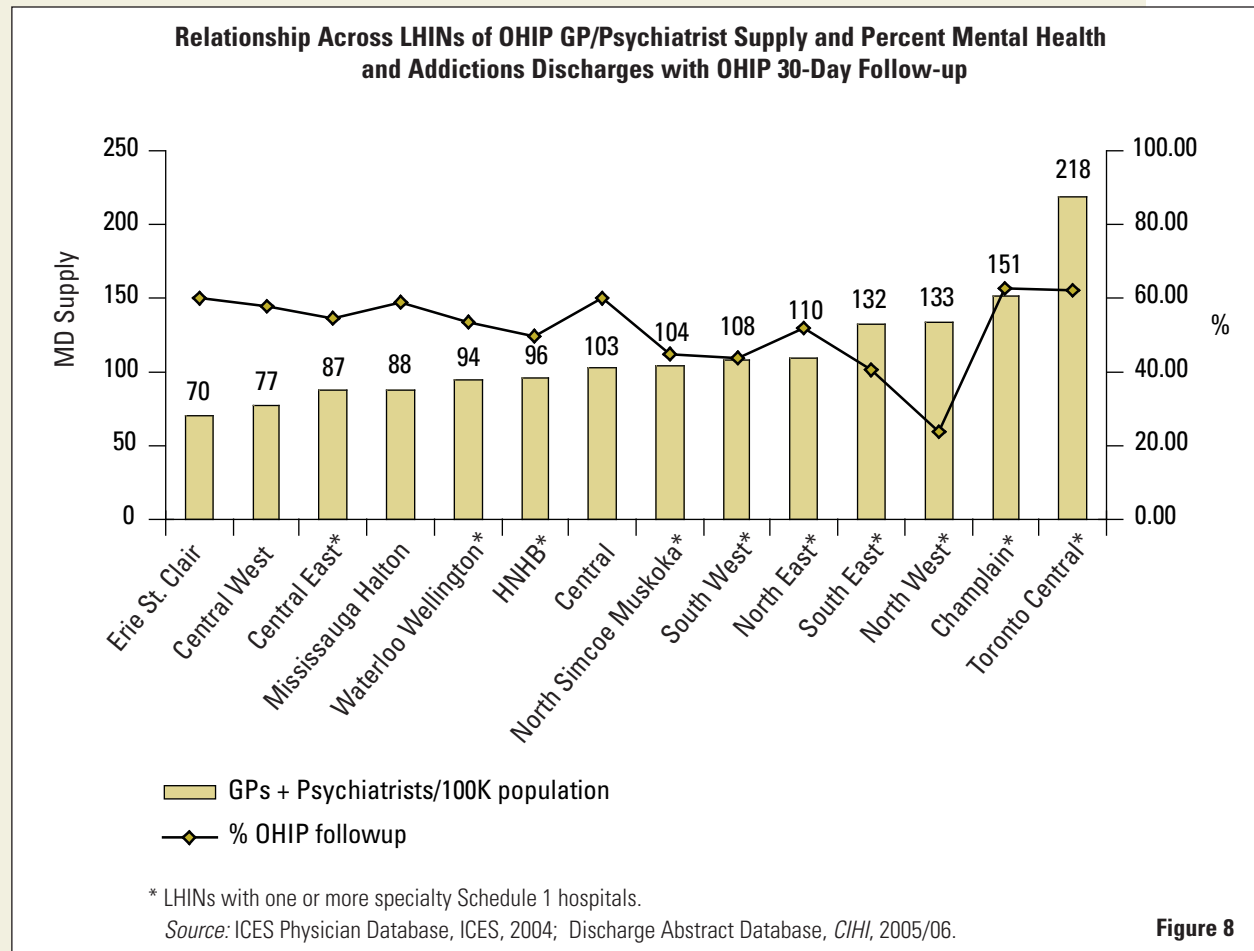


Figure 8

For inpatient and emergency post-discharge care, the combined percentage of ED visits post-discharge or readmissions was **21.7 percent** in 2004 vs. **21.5 percent** in this *Report*. Nearly 70 percent of ED visits had a triage level of urgent, emergent, or needs resuscitation. Similarly, the proportion of repeat inpatients has not changed (26.2% in the *2004 Report* vs. 26.4%). The finding that one out of four individuals receiving MH/A inpatient care within a year is a repeat user demonstrates the persistence of the ‘revolving door’ pattern and underscores the need for continued effort to break this cycle.

For both indicators, there were approximately two-fold differences between the lowest and highest LHIN rates. Over nine percent of ED discharges for the Toronto Central LHIN were assigned urgent, emergent, or resuscitation triage level visits compared to 4.5 percent for the North East. Similarly, the 30-day readmission rates for the North East and Toronto Central LHINs were 16 and 15 percent, respectively, compared to nine percent for Erie St. Clair.

Substantial increases in funding for community mental health care in Ontario are occurring during 2005-08.^k Figure 9 reports the per capita funding for community mental health programs in 2005-06 and the rate of discharges followed by either a MH/A ED visit or readmission. As the availability of community supports including crisis intervention increases, the expectation is that these rates of emergency room visits and early return to hospital post discharge will decline.

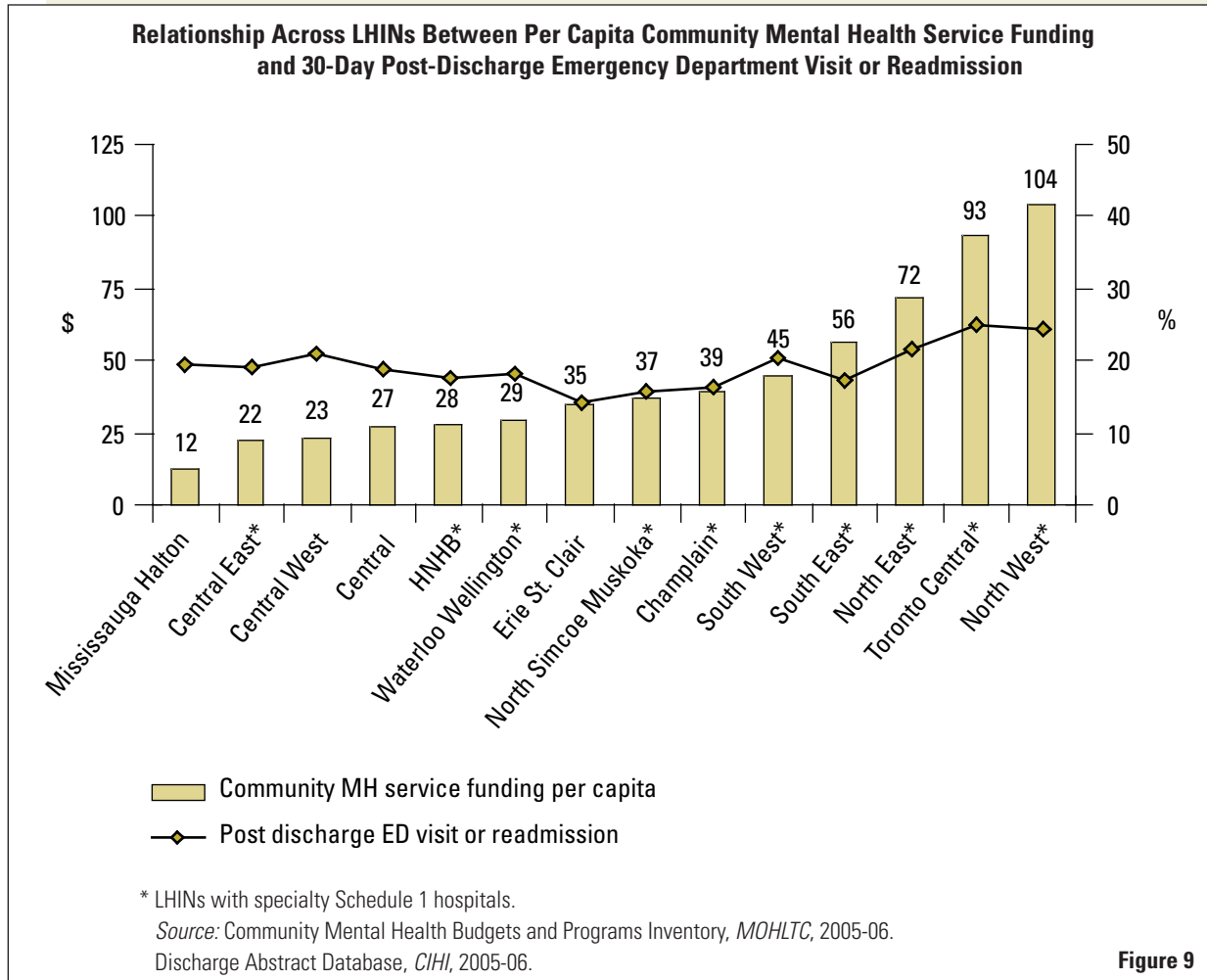


Figure 9

^k January 12, 2005 Ministry of Health and Long-Term Care News Release: http://ogov.newswire.ca/ontario/GPOE/2005/01/12/c2146.html?lmatch=&lang=_e.html

■ Above average "outlier" score ■ Average (non-'outlier') score ■ Below average "outlier" score NR Not reported

										CONTEXTUAL VARIABLE
			CU01	CU02	CU03	CU04	CU05A	CU05B	CU06	CU07
Hospital Corporation (all sites)	Community Served	LHIN	Hospitalization for Psychotic Diagnoses	Percentage of LOS that are 3 days or less	(%) ALC Days	OHIP care within 30 days post-discharge	ED visits within 30 days post-discharge (but not admitted)	ED visits within 30 days: Urgent, emergent, resuscitation	30-day readmission rate	Repeat Inpatients
Provincial Average (%)			33.4	27.6	4.2	52.6	9.0	6.3	12.5	26.4
TEACHING HOSPITALS										
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	28.4	55.3	12.9	59.3	6.7	4.0	13.6	44.8
Hotel Dieu Hospital, Kingston	Kingston	10	38.2	20.4	3.3	46.2	12.5	7.8	13.2	31.0
London Health Sciences Centre	London	2	26.5	27.1	3.7	49.0	9.2	6.8	12.7	28.8
Mount Sinai Hospital	Toronto	7	33.5	18.1	4.5	60.9	9.1	6.7	7.8	25.4
St. Michael's Hospital	Toronto	7	51.9	20.2	12.1	61.5	18.1	13.8	17.7	27.7
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	43.7	17.8	9.6	65.5	8.1	5.7	10.9	23.9
The Ottawa Hospital	Ottawa	11	48.0	21.9	13.7	63.8	8.9	6.6	10.0	26.5
Thunder Bay Regional Health Sciences Centre	Thunder Bay	14	19.0	30.3	9.6	21.4	11.3	9.0	14.8	23.7
University Health Network	Toronto	7	44.3	20.9	3.0	59.8	11.9	8.8	12.6	21.6
SMALL COMMUNITY HOSPITALS										
Alexandra Marine and General Hospital	Goderich	2	26.8	23.5	6.9	45.2	5.7	2.0	13.8	37.1
Bluewater Health	Sarnia	1	28.8	30.0	26.1	54.2	6.8	3.4	10.0	22.3
Chatham-Kent Health Alliance	Chatham	1	31.9	25.0	7.9	40.8	9.5	7.3	9.3	19.1
Cornwall Community Hospital	Cornwall	11	32.7	32.8	7.6	59.5	11.4	8.7	11.0	25.3
Halton Healthcare	Halton	6	24.5	38.3	2.6	62.2	6.5	5.6	12.3	23.7
Huron Perth Healthcare Alliance	Stratford	2	22.6	37.8	8.7	55.2	7.5	4.8	17.3	36.3
Joseph Brant Memorial Hospital	Burlington	4	25.2	26.0	5.0	54.3	5.4	3.5	10.5	23.0
Markham Stouffville Hospital	Markham	8	NR	NR	NR	NR	NR	NR	NR	N/A
Orillia Soldiers' Memorial Hospital*	Orillia	12	14.9	41.8	3.9	33.5	10.7	7.2	10.7	22.4
Peterborough Regional Health Centre	Peterborough	9	27.4	34.4	7.1	47.2	10.5	7.7	11.4	24.4
Queensway Carleton Hospital	Nepean	11	27.1	27.3	14.8	60.9	8.9	6.9	10.9	25.2
Quinte Health Care	Belleville	10	24.3	38.8	12.7	39.1	7.3	5.2	8.8	22.5

* Hospital became a Schedule 1 facility towards the end of FY 2005-06.

Source: Discharge Abstract Database, CIHI, 2005-06

■ Above average "outlier" score ■ Average (non-'outlier') score ■ Below average "outlier" score NR Not reported

										CONTEXTUAL VARIABLE
			CU01	CU02	CU03	CU04	CU05A	CU05B	CU06	CU07
Hospital Corporation (all sites)	Community Served	LHIN	Hospitalization for Psychotic Diagnoses	Percentage of LOS that are 3 days or less	(%) ALC Days	OHIP care within 30 days post-discharge	ED visits within 30 days post-discharge (but not admitted)	ED visits within 30 days: Urgent, emergent, resuscitation	30-day readmission rate	Repeat Inpatients
SMALL COMMUNITY HOSPITALS continued										
Ross Memorial Hospital*	Lindsay	9	17.8	36.2	4.4	54.2	11.6	7.0	10.3	14.1
Royal Victoria Hospital	Barrie	12	23.6	41.4	7.0	48.2	6.1	3.7	8.7	19.9
Southlake Regional Health Centre	Newmarket	8	35.0	29.9	3.8	53.0	10.2	8.3	9.4	20.0
The Brantford General Hospital	Brantford	4	24.9	35.8	8.4	59.5	8.5	5.8	9.6	21.6
The Credit Valley Hospital	Mississauga	6	34.2	28.9	3.5	58.2	9.0	7.8	13.0	22.3
Timmins and District Hospital	Timmins	13	25.4	38.7	8.3	40.3	8.5	4.1	16.2	31.8
Windsor Regional Hospital	Windsor	1	34.3	11.1	2.6	59.8	6.0	4.6	8.8	21.7
Woodstock General Hospital	Woodstock	2	21.4	23.2	1.0	41.1	10.5	5.4	13.5	29.2
LARGE COMMUNITY HOSPITALS										
Grand River Hospital	Kitchener	3	28.2	30.5	4.0	51.4	7.0	5.9	12.7	25.3
Grey Bruce Health Services	Owen Sound	2	29.7	29.6	20.5	38.4	15.1	10.1	12.2	30.6
Hôpital Montfort Hospital	Ottawa	11	32.3	30.4	11.5	49.3	9.8	8.0	12.0	23.4
Hôtel-Dieu Grace Hospital	Windsor	1	31.1	18.4	5.5	75.1	6.0	4.2	7.9	55.3
Humber River Regional Hospital	Toronto	8	45.0	25.8	5.1	59.4	9.3	5.3	12.2	26.4
Lakeridge Health	Oshawa	9	33.6	26.2	11.4	55.8	8.9	7.8	11.9	20.3
Niagara Health System	St Catharines	4	21.0	44.7	9.3	46.3	10.1	6.4	14.3	25.8
North York General Hospital	Toronto	8	39.6	24.4	8.4	64.9	9.0	7.1	12.3	21.2
Rouge Valley Health System	Toronto	9	30.5	28.6	4.6	60.3	7.1	5.2	12.8	24.2
Sault Area Hospital	Sault Sainte Marie	13	27.8	34.6	4.5	40.9	8.9	6.1	20.2	28.0
St. Joseph's Health Centre	Toronto	7	59.3	28.8	12.4	59.7	15.7	11.9	17.9	30.7
The Scarborough Hospital	Toronto	9	45.0	37.8	7.9	53.8	7.9	6.2	14.1	25.5
Toronto East General Hospital	Toronto	7	37.6	38.3	8.0	58.0	14.6	10.8	19.3	28.6
Trillium Health Centre	Mississauga	6	42.6	24.6	7.8	53.8	8.3	7.1	14.7	23.9
William Osler Health Centre	Brampton	5	36.2	34.5	4.2	54.7	8.3	6.6	12.6	24.5

* Hospital became a Schedule 1 facility towards the end of FY 2005-06.

Source: Discharge Abstract Database, CIHI, 2005-06

■ Above average "outlier" score ■ Average (non-'outlier') score ■ Below average "outlier" score NR Not reported

CONTEXTUAL VARIABLE

	Community Served	LHIN	CU01	CU02	CU03	CU04	CU05A	CU05B	CU06	CU07
			Hospitalization for Psychotic Diagnoses	Percentage of LOS that are 3 days or less	(%) ALC Days	OHIP care within 30 days post-discharge	ED visits within 30 days post-discharge (but not admitted)	ED visits within 30 days: Urgent, emergent, resuscitation	30-day readmission rate	Repeat Inpatients

SPECIALTY HOSPITALS

Baycrest Centre for Geriatric Care	Toronto	7	4.7	0.7	0.0	16.8	0.0	0.0	0.6	4.2
Centre for Addiction and Mental Health	Toronto	7	42.0	21.6	0.0	61.5	14.5	9.0	14.3	29.3
Mental Health Centre Penetanguishene**	Penetanguishene	12								
Northeast Mental Health Centre	Sudbury	13	35.5	17.7	0.0	54.6	7.1	4.2	16.4	44.2
Providence Continuing Care Centre	Kingston	10	61.4	2.6	0.0	34.6	4.3	3.9	8.6	27.7
Royal Ottawa Health Care Group	Ottawa	11	41.7	7.0	0.0	59.7	5.4	4.1	7.8	25.2
St. Joseph's Care Group	Thunder Bay	14	51.0	6.1	0.0	8.1	2.4	2.4	15.6	21.0
St. Joseph's Health Care Hamilton	Hamilton	4	44.0	17.9	3.5	47.6	7.9	3.1	12.3	29.9
St. Joseph's Health Care London	London	2	42.0	17.4	0.3	26.4	5.0	4.0	13.4	34.6
Whitby Mental Health Centre**	Whitby	9								

CLINICAL UTILIZATION AND OUTCOME QUADRANT INDICATORS (UNADJUSTED) BY LHIN

Ontario	33.7	28.2	4.8	53.6	9.2	6.5	12.8	26.4
1 Erie St. Clair	31.3	18.6	5.8	60.0	7.2	4.9	9.2	35.3
2 South West	27.8	26.2	2.6	43.6	9.2	6.2	14.3	29.7
3 Waterloo Wellington	26.5	29.2	1.2	53.4	7.9	6.4	11.9	29.1
4 Hamilton Niagara Haldimand Brant	29.5	30.9	5.1	49.8	8.9	5.2	12.5	25.0
5 Central West	39.1	33.9	2.6	57.7	9.8	7.3	13.6	26.0
6 Mississauga Halton	33.6	28.1	5.7	58.7	7.8	6.8	12.5	21.7
7 Toronto Central	48.0	25.1	4.6	62.4	13.6	9.6	15.3	26.4
8 Central	38.9	26.2	6.3	59.7	8.9	6.6	12.2	24.0
9 Central East	32.3	30.5	7.5	54.8	8.7	6.7	12.4	22.2
10 South East	33.5	24.9	1.6	40.4	9.5	6.3	11.0	25.1
11 Champlain	41.1	20.6	8.9	62.7	8.3	6.4	10.0	24.5
12 North Simcoe Muskoka	19.8	38.6	6.0	45.0	8.3	5.3	10.5	22.3
13 North East	28.4	39.2	6.5	52.0	8.2	4.7	17.0	37.0
14 North West	22.5	31.3	4.1	23.7	11.8	9.0	15.3	24.8

** Data not available for the fiscal year 2005-06

Source: Discharge Abstract Database, CIHI, 2005-06

Note: LHIN assignment based on LHIN of service

PERCEPTION OF CARE

Capturing the patient's perception of hospital care is an important dimension of the quality of service, and aligns with the provincial Mental Health Reform objective of consumer-centred care. This quadrant reports results for five indicators – four derived from a patient self-report perception of care survey, and one based on hospital discharge data – discharged against medical advice.

Indicator Definitions

POC1: Perception of Staff Responsiveness

This indicator reports patient views about the accessibility of inpatient staff during their hospital stay and, for the discharge sample only, about the admission experience (e.g., timeliness, organization).

POC2: Discharged Against Medical Advice (AMA)

This indicator measures the percent of patient discharges that are requested by the patient and occur against the judgment of the clinical staff. An AMA discharge can only occur for voluntary patients.

POC3: Perception of Appropriateness of Care

This indicator reports patient views about the amount and quality of information they receive about their treatment plan, medication side effects, legal rights and, for the discharge sample, resources for managing in the community after discharge. It also includes patient views about safety and privacy while in hospital.

POC4: Perception of Treatment Outcomes

This indicator reports patient views about whether, as a result of their hospital stay, they have fewer symptoms, are more ready to deal with daily problems and participate in their usual activities, and feel helped overall.

POC5: Perception of Participation in Treatment and Discharge Planning

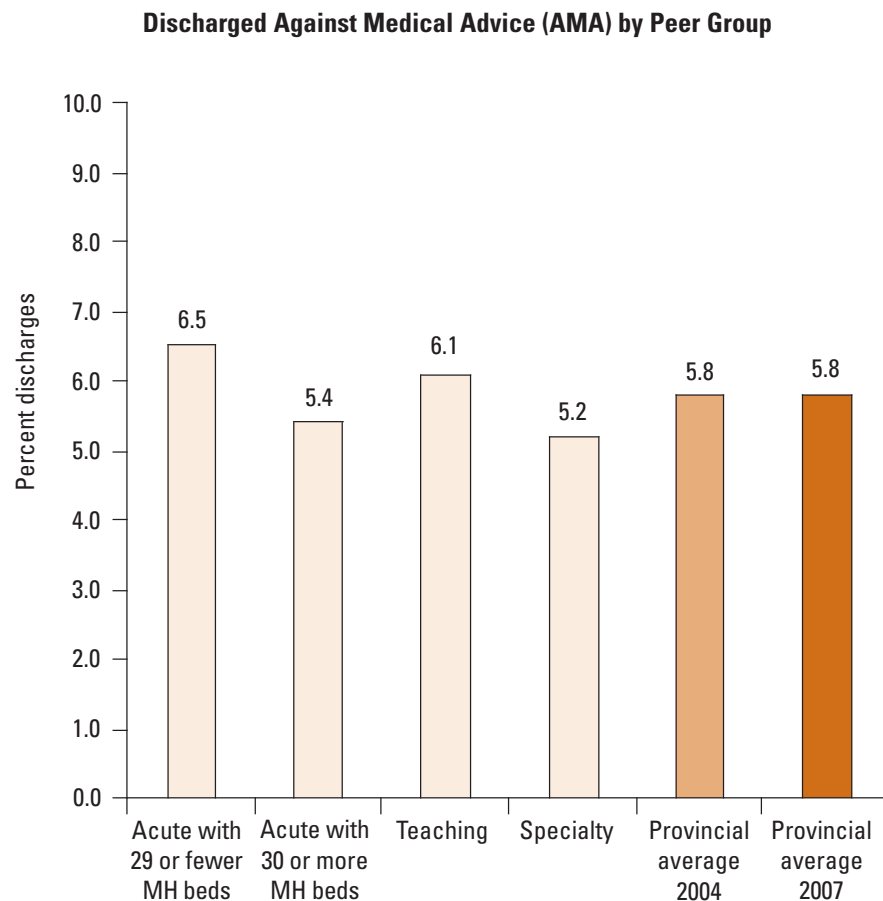
This indicator reports patient views about their participation in their treatment and discharge plans, and interactions with the staff that can support their participation (e.g., extent to which staff provide reassurance and support, give clear answers to questions, and take cultural and language into account).

SUMMARY OF RESULTS (POC)

Patient Discharges Against Medical Advice (AMA)

A discharge against medical advice may reflect inadequate staff effort to engage the patient, explain the treatment plan and address patient preferences. However there are cases where clinician views about appropriate treatment cannot be reconciled with patient preferences.

As Figure 10 indicates, the provincial AMA rate has remained stable since 2004, at 5.8 percent. Rates are slightly lower in community hospitals with larger units and specialty facilities, and higher in teaching hospitals and community hospitals with smaller units. At the hospital level, rates range from zero to 13 percent. This may reflect variation in staff and program approaches to engage patients that influence AMA rates. However patient differences may also affect rates. For example, specialty hospitals are expected to serve more complex patients, often via transfer from other hospitals. This cohort may be more accepting of inpatient care than acute care patients. Involuntary patients are not eligible for AMA discharge, hence hospitals with larger rates of involuntary admissions are advantaged when calculating AMA rates which are currently based on all, not just voluntary, discharges. In addition, use of the discharge AMA status can vary across hospitals so differences may reflect, in part, coding practices rather than actual differences in patient-staff agreement on need for hospitalization.



Source: Discharge Abstract Database, CIHI, 2005-06.

Figure 10

Perception of Care Results

These data represent the first Ontario system-wide effort to survey perception of care among psychiatric inpatients. Because only a subset of hospitals participated and sample sizes varied per facility, individual hospital results are not provided. Rather, aggregate results are reported. These data highlight some important care quality issues as well as demonstrate the potential benefit of the questionnaires. Based on the suggestion of the Report advisory committee and with individual hospital agreement, hospital-specific results are reported in the e-scorecard.

Given that patient needs and treatment goals vary across level of care, separate questionnaires and data collection methodologies were created to survey patients in 'longer-stay' programs for individuals with more complex conditions where discharge is not imminent (the 'current inpatient' questionnaire), and in 'shorter-stay' programs that focus more on stabilization and discharge (the 'discharge' questionnaire). A set of 20 core items was included in both questionnaires. An additional six items on the admission and discharge experience were added to the discharge questionnaire.^l

Patients of longer stay programs were surveyed while in hospital and patients of shorter stay programs were surveyed at discharge.^m In total, 22 hospitals administered the discharge sample survey and six administered the current sample survey. Data capture occurred during the fall of 2006 in all but one hospital. The final sample size was 1,184 for the discharge sample and 423 for the current sample. Results are reported for the province and by peer group. Due to variable hospital participation across the LHINs, LHIN level results are not reported.

- ^l The Mental health Inpatient Perception of Care surveys were developed through a collaboration of mental health stakeholders led by NRC+Picker Group Canada. A widely used US tool – the Mental Health Statistical Improvement Program: Consumer Survey (MHSIP) – was the starting point for this work. Initial revision occurred during 2002-03, followed by field-testing and reporting of preliminary performance data in the 2004 Mental Health Hospital Report. A second pilot occurred in the fall of 2005, resulting in further measure refinements as well as development of a systematic strategy for including surveys in the analytic sample.
- ^m All clients were eligible to complete the surveys. Clients were approached either at discharge or while in hospital. Main reasons for non-participation included: variable hospital procedures for surveying patients (e.g., for planned versus unplanned discharges); client refusal; client not available on survey day; and client too ill to engage in interview. Due to variable reporting, actual rates of non-response could not be calculated. However participation rates were estimated to be about 10-30 percent of potential clients, hence these data represent only a subset of client views on perception of care.

As noted earlier, the results from these questionnaires pertain to the strategic objective of consumer-centered care. The items were grouped to create four indicators. Figure 11 shows results for the discharge group and the current group. Patients in this latter group were less satisfied with care across all four domains than the discharge cohort. One might expect individuals leaving hospital to generally be more positive.

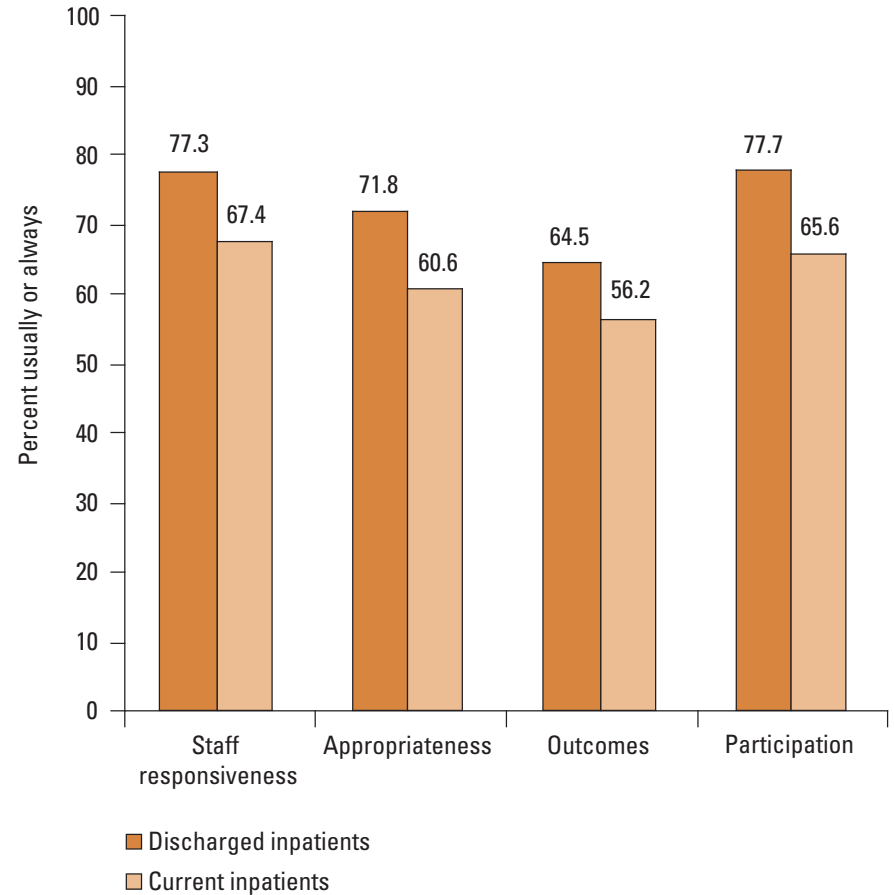
Results for responses to specific items within each index follow.

Staff responsiveness

- Many patients (78%ⁿ of discharge sample) found the admission process to be organized and timely.
- Many patients (82% of discharge sample and 70% of current inpatient sample) reported good access to non-medical inpatient staff.
- Access to psychiatrists was a concern, especially among the current inpatient cohort where 50 percent said that they did not see a psychiatrist as often as they wished.

Access is good in a number of areas. However, programs may need to consider the ratio of medical staff to patients, and also how the disjuncture between the amount of contact that patients want and receive can be addressed. Giving patients clear information about the role of the psychiatrist and the others on the treatment team may be helpful.

Perception of Care by Discharged and Current Inpatients



Note: There were four response options per item (e.g., never, sometimes, usually, always). This figure reports the mean of the percentage of respondents who answered ‘usually’ or ‘always’ for the items in each indicator. Results are reported for all of the respondents – 1,184 patients on discharge and 423 in the census sample.

Source: NRC + Picker Mental Health Perception of Care survey, 2006.

Figure 11

ⁿ Percentage of patients answering ‘usually’ or ‘always’.

Appropriateness

- Many patients (76% of discharge sample and 65% of current inpatient sample) reported understanding their treatment plan.
- However, over one third reported receiving little or no information about medication side effects. Even more reported receiving little or no information about their legal rights as a patient (38% of discharge sample and 53% of current inpatient sample).
- In the discharge cohort, 75 percent of patients reported receiving information about managing a crisis after discharge, but fewer received information about available community services and supports.
- Most patients reported feeling safe in the hospital but inadequate privacy was a concern for 45 percent of patients in long stay programs and one third of patients in acute care.

One component of patient centered care includes keeping patients informed so they have some control and can be active participants in the care they receive. Hospitals may need to increase consistency in their approaches to educating patients about various treatment issues such as medication side effects and in informing them about their rights.

Outcomes

- This area received the lowest ratings.
- More patients in the discharge cohort reported being helped overall by their hospital stay than the current inpatients (80 versus 60%).
- In specific areas – e.g., symptoms, participating in usual activities and dealing with daily problems, only about 60 percent of patients in either the discharge or current inpatient groups reported being helped ‘for the most part’ or ‘definitely’ while in hospital.

The results for the discharge patients may speak, in part, to the mandate of acute care settings, which focuses more on stabilization than rehabilitation. This reinforces the importance of inpatient staff working with patients on a plan for accessing services and supports after discharge, since many still have service and support needs. Given that symptoms are still a concern for many, follow-up medical monitoring is important. Data reported elsewhere in this report indicate that only about 55 percent of patients have a medical visit within 30 days of discharge. For the longer stay group, who are surveyed while still in hospital, these data reinforce that symptoms and functioning are still a concern.

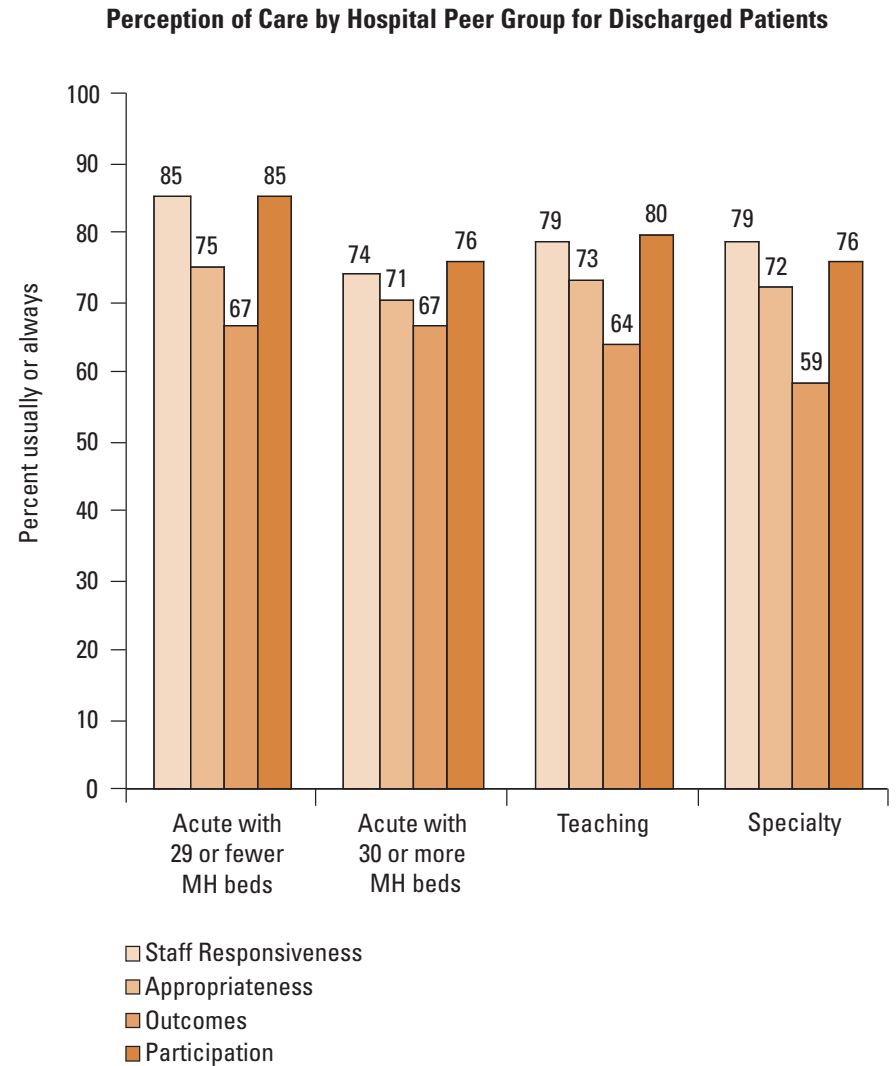
Participation in treatment

- Many patients were satisfied with their interactions with staff (e.g., 78% of discharge sample and 73% of current inpatient sample) were comfortable asking questions and received answers they could understand).
- Fewer patients were satisfied with their participation in their treatment. In the long stay sample, only about half were involved as much as they wished in decisions about their treatment and, in the discharge sample, only two thirds were involved as much as they wished in their discharge planning.

Actively involving patients in treatment planning is central to patient centered care and appears to be an area where programs may need to review their practice for some patients. While many hospital programs reported very high rates of documented patient participation in discharge planning (see SIC quadrant), staff may need to do more to make that participation meaningful from the perspective of the patient.

Satisfaction and hospital type

Figure 12 shows the level of satisfaction for the discharge sample by hospital peer group. Patient views are likely to be most positive in community hospitals with small units (29 or fewer beds), and least likely to be positive in community hospitals with large units, regarding responsiveness of staff and participation in care. The challenge of providing responsive care in larger facilities extends beyond mental health programs, as similar differences were reported in the acute care hospital report.³⁸ Satisfaction with outcomes is lowest in specialty facilities suggesting a high need for appropriate follow-up care.



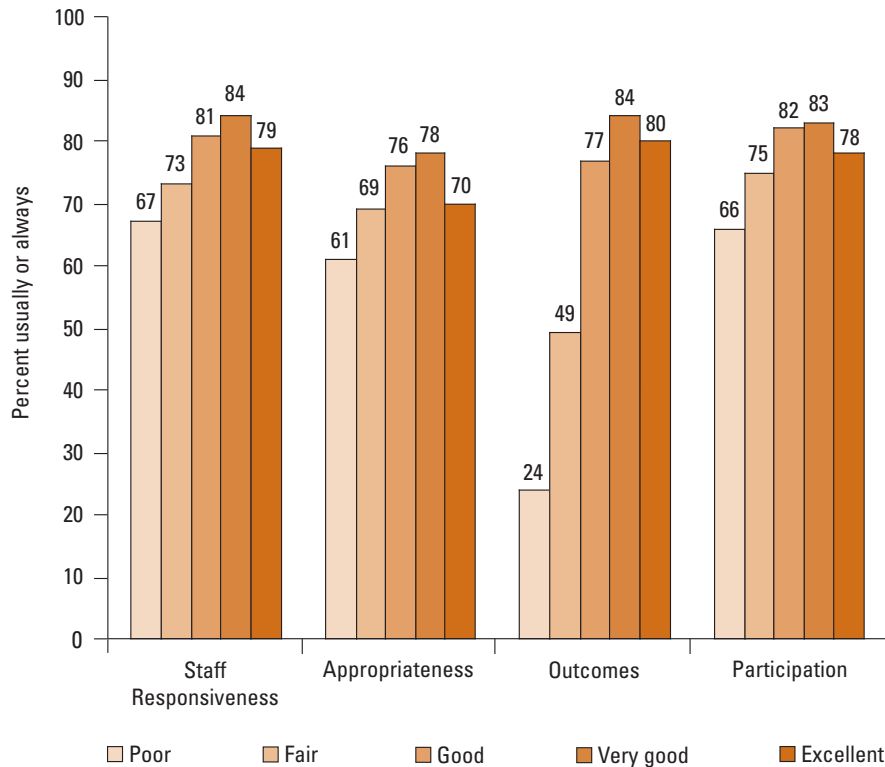
Source: NRC + Picker Mental Health Perception of Care Survey, 2006.

Figure 12

Satisfaction and Self-Rated Mental Health

For both the discharge and current inpatient samples, about 10 percent of respondents rated their mental health as poor; another quarter as fair; and two thirds as good to excellent. Figures 13 and 14 show that, among both discharged and current inpatients, views about the quality of the treatment experience are much better for those who perceive themselves to have good, very good or excellent mental health. While it is not surprising that people who report poorer health are also less satisfied with the quality of their care and their outcomes, these data cannot tell us whether less well patients are actually receiving poorer care or are expressing frustration about not improving.

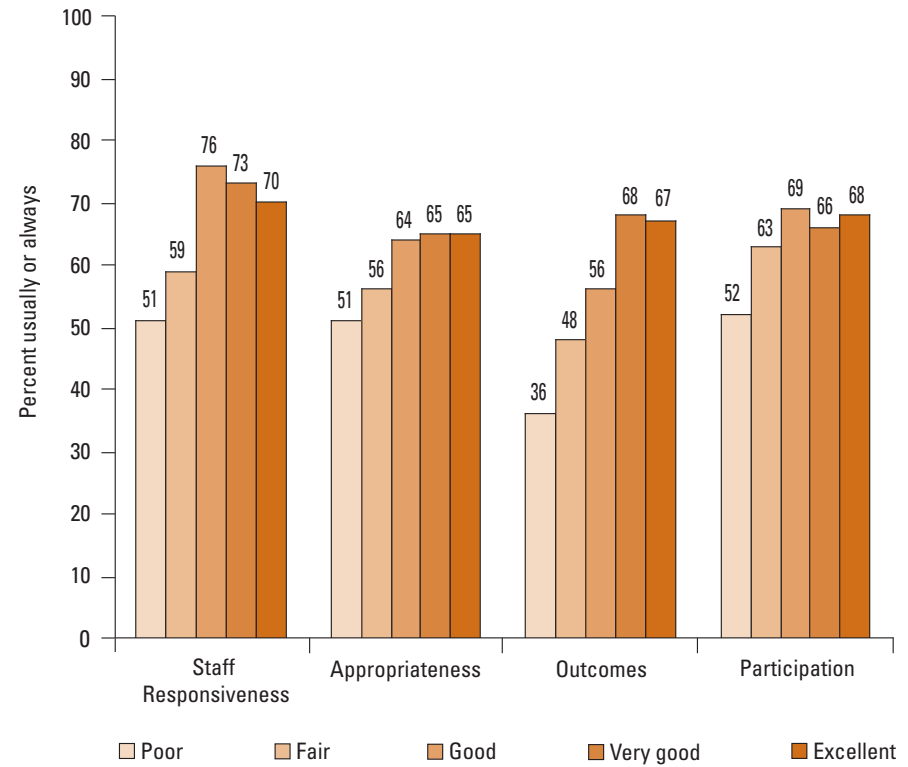
Perception of Care by Self-Rated Mental Health for Discharged Patients



Source: NRC + Picker Mental Health Perception of Care Survey, 2006.

Figure 13

Perception of Care by Self-Rated Mental Health for Current Inpatients



Source: NRC + Picker Mental Health Perception of Care Survey, 2006.

Figure 14

Indicator Definitions

FPC1: % Nursing Worked Hours

This indicator measures the proportion of time nurses spend working in the hospital on inpatient mental health activities such as direct patient care, charting, and in-service education, as a proportion of the total hours earned. The hours being measured are for those nurses who normally engage in activities related to inpatient mental health care, and excludes hours worked by nurses who fill management and administrative roles.

FPC2: % Sick Time

This indicator measures the proportion of full-time patient care personnel hours that were paid sick hours.

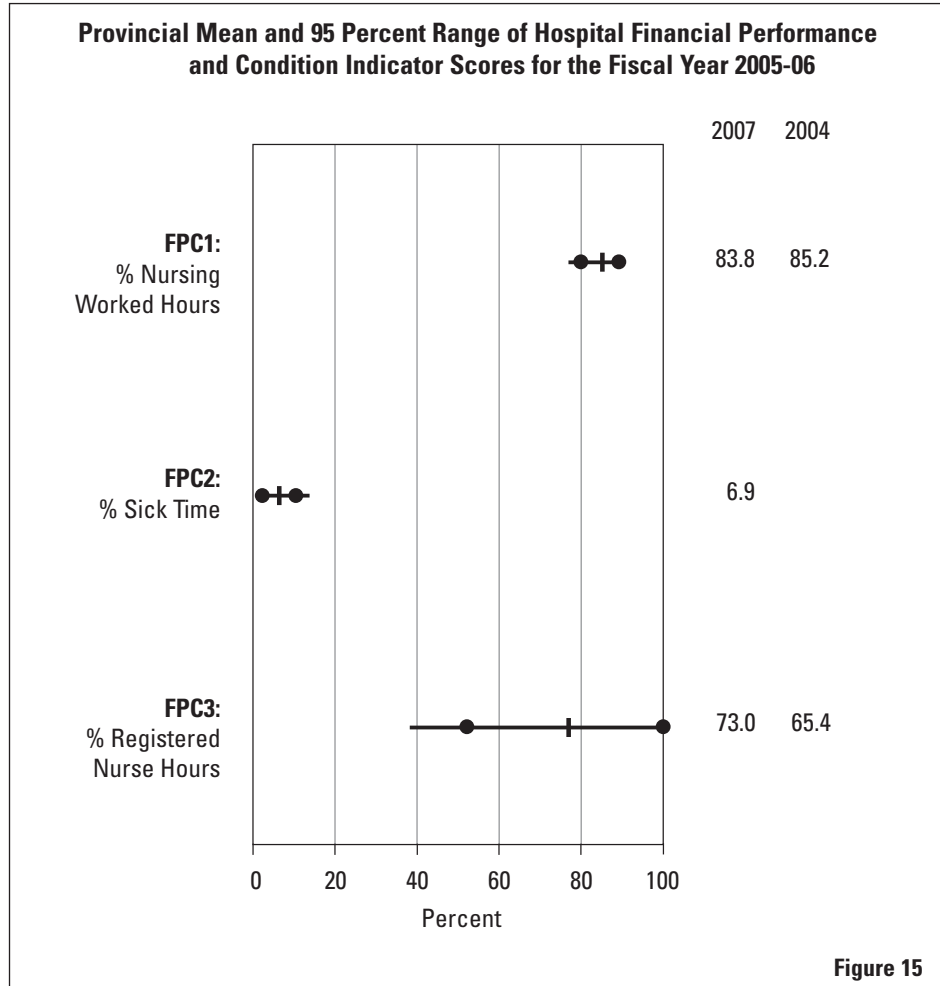
FPC3: % Registered Nurse Hours

This indicator measures the proportion of nursing care hours provided by Registered Nurses (RNs).

FPC4: % Management and Operational Support Staff Hours

This indicator measures the percentage of staff hours spent engaged in activities related to managing or directly supporting inpatient mental health care but not directly involved in providing patient care. The activities of a unit manager or registration clerk are examples of management and operational support.

PROVINCIAL RESULTS (FPC)



How to read this chart

The *ends* of the horizontal lines represent the maximum and minimum values reported for each indicator.

The *vertical bar* on the line is the median (the value which represents the middle in the distribution of results).

The *shaded circles* are the cut points used to identify exceptionally high or low scores. These are based on the distance from the mean in standard deviation units, as described in the Methods section.

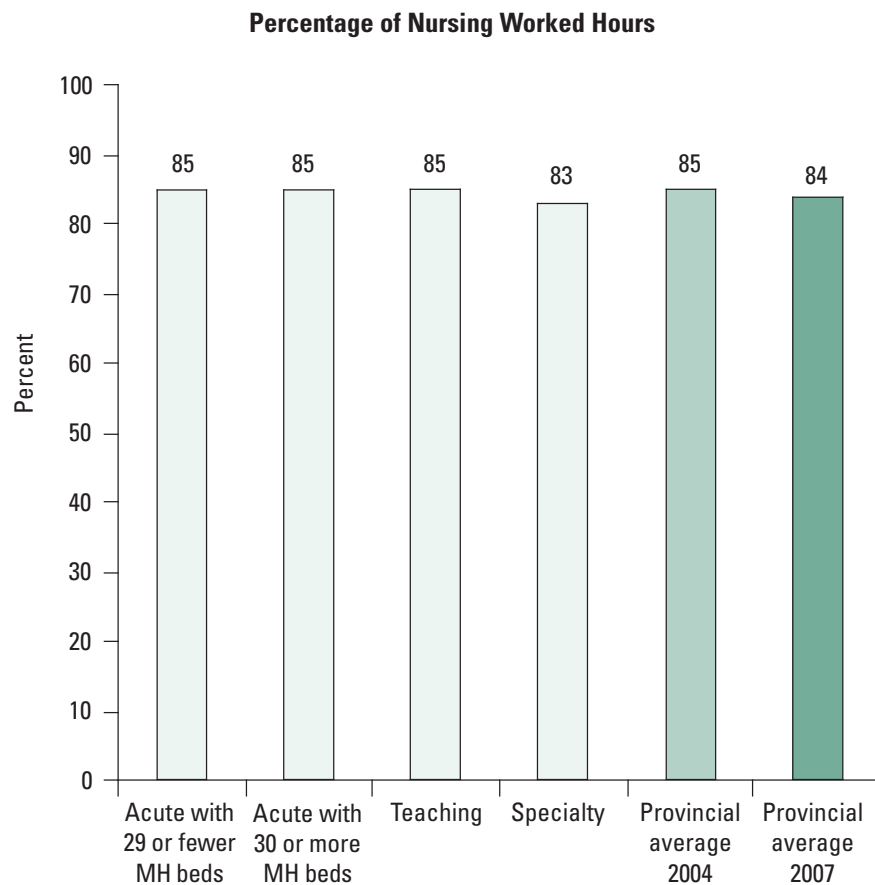
For some indicators, the cut points are the same as the maximum or minimum observed values.

Scores between the cut point and end of the line correspond to the light and very dark shaded cells in the Performance Allocation tables.

% Nursing Worked Hours

This indicator reflects unit-producing personnel (UPP) and nurse practitioner worked and purchased service hours, excluding medical personnel hours. UPP are staff who provide patient care, such as a nurse engaged in treatment activities for a patient. Sick time and educational time are examples of earned hours that are spent engaged in activities not directly related to the provision of patient care.

The higher the value, the greater the proportion of earned hours that have been worked by nurses. Sick time, maternity leave, and orientation time, are all examples of hours that are earned but not considered to be “worked”. The ability of a hospital to increase the hours for worked activities is influenced by collective agreements, the supply of labour, and other factors. A hospital with a low proportion of nursing worked hours may have inefficient staffing practices or high absenteeism, but it could also be investing in its nurses through educational leave, or have a higher proportion of nurses on maternity leave. A hospital with a high proportion of nursing worked hours may have efficient staffing practices, low absenteeism, may be making extensive use of agency nurses, or conversely, may not be investing in continuing education opportunities for its nursing staff, or have a lower proportion of nurses on maternity leave.



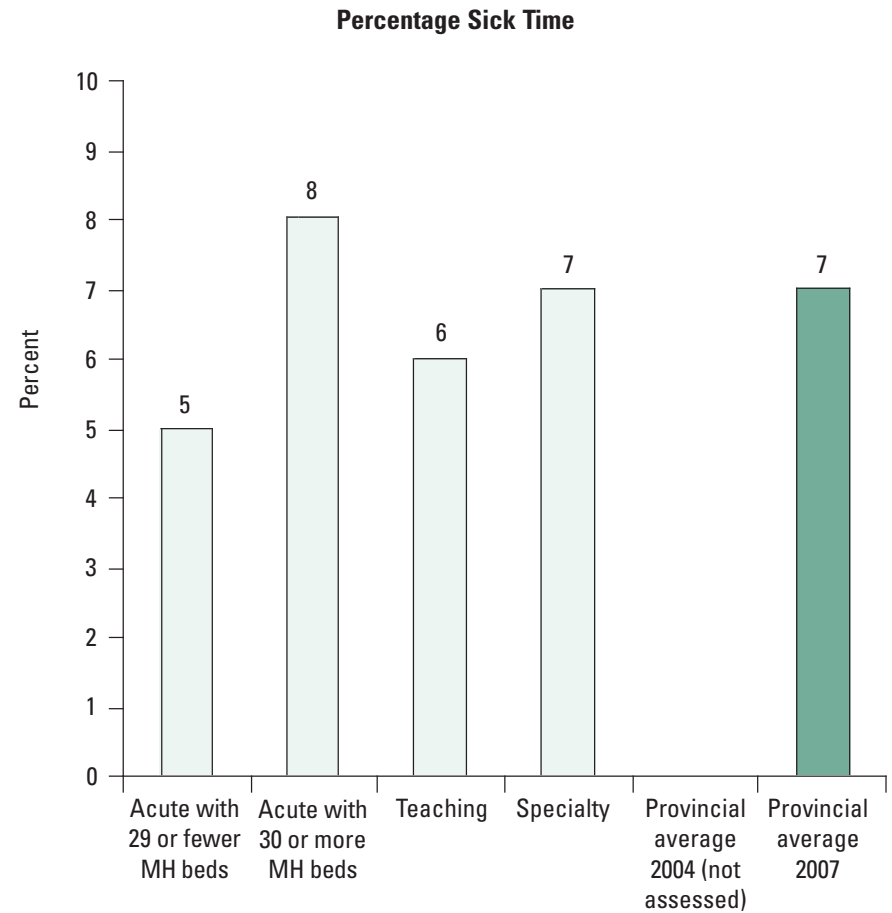
Source: MIS Database, MOHLTC, 2005-06.

Figure 16

% Sick Time

This indicator measures paid sick hours as a percentage of earned hours for full-time management, patient care and support personnel in mental health inpatient services of a hospital.

Higher than average values indicate more staff claiming sick time or longer sick time per staff member. Very high values may indicate high staff vacancy, widespread workplace illness, generous benefits, or problems in the management of human resources and technology. Lower than average values indicate less staff claiming sick time or shorter sick time per staff member. Very low values may indicate low staff vacancy, lack of widespread workplace illness, poor benefits, or strengths in the management of human resources and technology. The ability to appropriately manage sick time is influenced by prevalence of workplace illness, type and level of sick time benefits, attendance awareness programs, human resource practices, organizational climate, and other factors. Variations in the classification of sick times may affect this indicator.

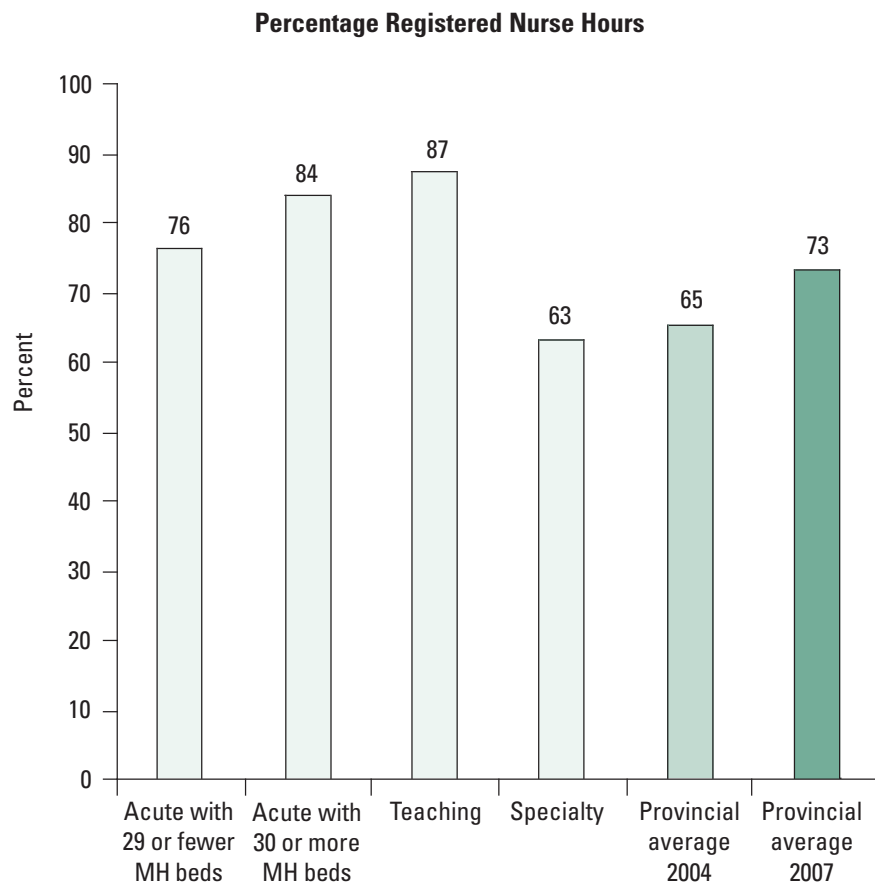


Source: MIS Database, MOHLTC, 2005-06.

Figure 17

% Registered Nurse Hours

Higher than average values on this indicator indicate greater use of RNs and less use of Registered Practical Nurses (RPNs). Lower than average values indicate less use of RNs and greater use of RPNs. The ability to use RNs in patient care is influenced by the supply of RNs, wage rates, benefits, nurse staffing models, provincial nurse staffing strategy, and other factors. Variations in the classification of staff hours due to decentralization of support functions, such as housekeeping, may affect this indicator.

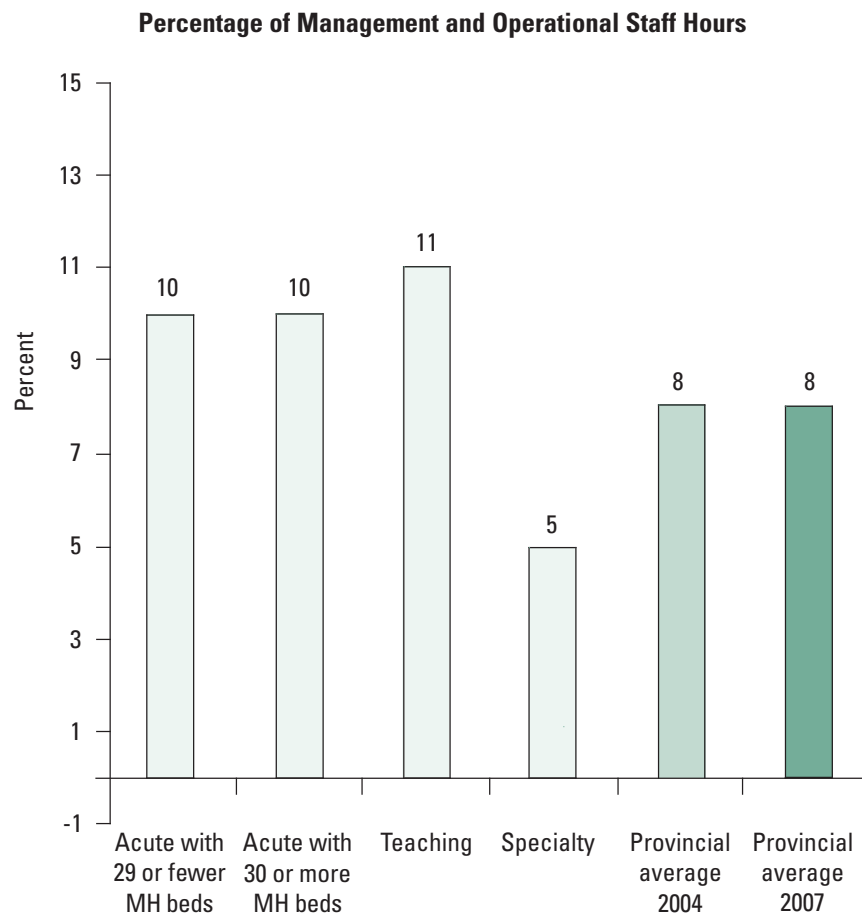


Source: MIS Database, MOHLTC, 2005-06.

Figure 18

% Management and Operational Support Staff Hours

A higher value indicates a higher percentage of management and operational support hours as a percent of total hours and a lower value indicates a lower percent. Higher values could reflect higher use of technology, program complexity, and other factors. Getting the mix of managerial and operational support to care givers is a crucial decision for a management team. Too little support may cause the operation to suffer due to lack of direction. Conversely, too much support may mean that monies which could be directed to patient care could have been better allocated.



Source: MIS Database, MOHLTC, 2005-06.

Figure 19

■ Above average "outlier" score
 ■ Average (non-'outlier') score
 ■ Below average "outlier" score
 NR Not reported

			FPC1	FPC2	FPC3	FPC4
Hospital Corporation (all sites)	Community Served	LHIN	% Nursing Worked Hours	% Sick Time	% Registered Nurse Hours	% Management & Operational Staff Hours
Provincial Average (%)			83.8	6.9	73.0	7.8
TEACHING HOSPITALS						
Hôpital régional de Sudbury Regional Hospital	Sudbury	13	82.3	9.5	66.2	19.4
Hotel Dieu Hospital, Kingston	Kingston	10	87.2	6.5	83.1	2.1
London Health Sciences Centre	London	2	84.0	9.6	99.2	8.1
Mount Sinai Hospital	Toronto	7	88.4	3.2	100.0	16.1
St. Michael's Hospital	Toronto	7	84.7	5.6	100.0	8.4
Sunnybrook and Women's College Health Sciences Centre	Toronto	7	86.9	4.7	100.0	12.2
The Ottawa Hospital	Ottawa	11	87.0	4.6	100.0	18.8
Thunder Bay Regional Health Sciences Centre	Thunder Bay	14	85.3	5.7	57.8	11.5
University Health Network	Toronto	7	79.0	6.9	100.0	8.3
SMALL COMMUNITY HOSPITALS						
Alexandra Marine and General Hospital	Goderich	2	84.5	5.1	54.7	9.9
Bluewater Health	Sarnia	1	82.3	6.7	70.4	13.0
Chatham-Kent Health Alliance	Chatham	1	77.8	10.1	47.2	13.8
Cornwall Community Hospital	Cornwall	11	85.8	5.0	50.1	9.6
Halton Healthcare	Halton	6	85.2	8.2	88.3	5.9
Huron Perth Healthcare Alliance	Stratford	2	90.4	4.7	76.5	15.4
Joseph Brant Memorial Hospital	Burlington	4	85.2	8.3	99.4	12.8
Markham Stouffville Hospital	Markham	8	N/R	N/R	N/R	N/R
Orillia Soldiers' Memorial Hospital*	Orillia	12	81.1	11.6	99.7	5.1
Peterborough Regional Health Centre	Peterborough	9	84.5	6.0	74.2	13.9
Queensway Carleton Hospital	Nepean	11	88.1	5.3	84.3	9.3
Quinte Health Care	Belleville	10	86.9	4.6	68.8	6.3
Ross Memorial Hospital*	Lindsay	9	90.5	1.3	99.8	6.8
Royal Victoria Hospital	Barrie	12	85.1	7.5	67.5	8.9
Southlake Regional Health Centre	Newmarket	8	86.1	5.4	77.2	12.9

* Hospital became a Schedule 1 facility towards the end of fiscal year 2005-06.

Source: MIS Database, MOHLTC, 2005-06

■ Above average "outlier" score
 ■ Average (non-'outlier') score
 ■ Below average "outlier" score
 NR Not reported

			FPC1	FPC2	FPC3	FPC4
Hospital Corporation (all sites)	Community Served	LHIN	% Nursing Worked Hours	% Sick Time	% Registered Nurse Hours	% Management & Operational Staff Hours
SMALL COMMUNITY HOSPITALS continued						
The Brantford General Hospital	Brantford	4	83.2	6.8	73.0	10.5
The Credit Valley Hospital	Mississauga	6	89.1	2.0	100.0	11.4
Timmins and District Hospital	Timmins	13	84.9	4.8	64.8	5.4
Windsor Regional Hospital	Windsor	1	85.0	1.3	74.5	2.5
Woodstock General Hospital	Woodstock	2	86.6	4.0	73.8	7.0
LARGE COMMUNITY HOSPITALS						
Grand River Hospital	Kitchener	3	85.8	5.3	69.3	8.5
Grey Bruce Health Services	Owen Sound	2	87.0	7.2	77.5	8.9
Hôpital Montfort Hospital	Ottawa	11	84.2	7.3	97.7	5.2
Hôtel-Dieu Grace Hospital	Windsor	1	80.9	7.8	100.0	8.2
Humber River Regional Hospital	Toronto	8	85.5	6.4	82.2	9.8
Lakeridge Health	Oshawa	9	83.4	12.0	89.6	13.3
Niagara Health System	St Catharines	4	84.0	8.1	65.6	19.6
North York General Hospital	Toronto	8	85.2	14.1	100.0	8.7
Rouge Valley Health System	Toronto	9	82.9	12.5	82.1	8.1
Sault Area Hospital	Sault Sainte Marie	13	81.4	8.6	70.6	7.7
St. Joseph's Health Centre	Toronto	7	85.7	5.1	95.3	7.8
The Scarborough Hospital	Toronto	9	86.8	4.2	83.3	10.3
Toronto East General Hospital	Toronto	7	87.1	4.2	76.1	7.1
Trillium Health Centre	Mississauga	6	83.2	10.5	100.0	4.6
William Osler Health Centre	Brampton	5	85.6	5.8	75.3	16.2

Source: MIS Database, MOHLTC, 2005-06

■ Above average "outlier" score
 ■ Average (non-'outlier') score
 ■ Below average "outlier" score
 NR Not reported

Hospital Corporation (all sites)	Community Served	LHIN	FPC1	FPC2	FPC3	FPC4
			% Nursing Worked Hours	% Sick Time	% Registered Nurse Hours	% Management & Operational Staff Hours
SPECIALTY HOSPITALS						
Baycrest Centre for Geriatric Care	Toronto	7	89.0	1.6	63.7	6.1
Centre for Addiction and Mental Health	Toronto	7	84.0	6.0	100.0	7.3
Mental Health Centre Penetanguishene	Penetanguishene	12	81.0	6.9	38.1	3.3
Northeast Mental Health Centre	Sudbury	13	86.8	7.3	71.7	7.0
Providence Continuing Care Centre	Kingston	10	77.2	8.9	46.8	6.6
Royal Ottawa Health Care Group	Ottawa	11	83.3	7.7	77.6	0.1
St. Joseph's Care Group	Thunder Bay	14				
St. Joseph's Health Care Hamilton	Hamilton	4	84.0	6.9	70.1	11.3
St. Joseph's Health Care London	London	2	80.6	6.1	54.0	7.8
Whitby Mental Health Centre	Whitby	9	81.3	8.0	50.2	0.0

FINANCIAL PERFORMANCE AND CONDITION INDICATORS BY LHIN

Ontario			83.8	6.9	73.0	7.8
1 Erie St. Clair			82.3	5.2	79.6	7.5
2 South West			83.3	6.8	70.3	8.5
3 Waterloo Wellington			85.1	5.8	55.2	11.9
4 Hamilton Niagara Haldimand Brant			83.9	7.1	72.7	13.2
5 Central West			85.6	5.8	75.3	16.2
6 Mississauga Halton			85.2	7.8	95.9	6.6
7 Toronto Central			84.7	5.5	96.3	8.0
8 Central			85.4	8.6	89.4	11.1
9 Central East			83.1	8.4	68.3	5.8
10 South East			83.1	7.5	65.5	4.6
11 Champlain			84.3	6.9	80.9	4.9
12 North Simcoe Muskoka			81.4	7.1	42.4	3.8
13 North East			82.9	8.4	60.2	7.1
14 North West			85.8	5.3	57.4	11.8

Source: MIS Database, MOHLTC, 2005-06

APPENDICES

APPENDIX A: MH/A Hospital Report Indicators by BSC Quadrant and Common Mental Health Domains

Mental Health Domain	BSC Quadrant			
	System Integration and Change (SIC)	Clinical Utilization and Outcomes (CUO)	Perception of Care (POC)	Financial Performance and Condition (FPC)
Accessibility		Contextual Variable: Rate of Adult Ontarians hospitalized/100,000 population	POC1 Perception of Staff Responsiveness	
Appropriateness	SIC3 Use of Guideline Care for Tracer Conditions	CU01 Hospitalization for Psychotic Diagnoses CU04 OHIP Care within 30 Days Post-discharge CU05 Emergency Dept Visit within 30 Days Post-discharge (but not admitted)	POC2 Discharged Against Medical Advice POC3 Perception of Appropriateness of Care	
Outcomes	SIC4 Use of clinical data (staff provided) SIC5 Use of clinical data (client-provided)	CU06 30-Day Readmission Rate CU07 Repeat Inpatients	POC4 Perception of Treatment Outcomes	
Participation	SIC6 Discharge Plans Completed with Client/Family/Provider Involvement SIC7 Regular Client Input into Hospital/FC Governance		POC5 Perception of participation in treatment and discharge planning	
System Management	SIC1 Inter-organizational Networking SIC2 Notification of Hospitalization	CU02 % Discharges with LOS of 3 days or less CU03 ALC Days		FPC1 % Nursing Worked Hours FPC2 % Sick Time FPC3 % RN Hours FPC4 % Management and Operational Staff Hours

APPENDIX B: Advisory Panel Members

Name	Position	Organization
Sue Carr	Manager, Information and Standards	Ontario Federation of Community Mental Health and Addiction Programs
Bob Cunningham	CEO	Northeast Mental Health Centre
David Haslam	Academic Director, Collaborative (Shared) Mental Health Care	Regional Mental Health Care – London and Department of Psychiatry, University of Western Ontario
Anne Howe	Senior Director, Mental Health & Addictions Program	St. Joseph’s Health Care Hamilton
Ian Joiner	Manager, Rehabilitation and Mental Health	Canadian Institute for Health Information
Fergus (Gerry) McNestry	Medical Director, Mental Health Services	Peterborough Regional Health Center
Beth Mitchell	Director, Mental Health Care	London Health Sciences Center
Pamela Prince	Evaluation/Research Manager	Royal Ottawa Health Care Group
Indra Pulcins	Director, Health Reports and Analysis	Canadian Institute for Health Information
Nancy Read	Program Director	St. Michaels Hospital, Toronto
Paula Reaume-Zimmer	Director, Mental Health and Addictions Program	Chatham-Kent Health Alliance
Joy Rogers	Senior Consultant Associate	Health Systems Research and Consulting Unit, CAMH
Janet Sillman	Vice President, Mental Health and Addictions Services	Mental Health and Addiction Services Thunder Bay
Ruth Stoddart	Manager, Mental Health and Rehabilitation Policy Unit, Population Health, Policy and Planning and Women’s Health Branch	Ministry of Health and Long-Term Care
Jean Trimnell	CEO	North Simcoe Muskoka LHIN
Bob Wales	Clinical ACT specialist	St. Joseph’s Health Care London/ Regional Mental Health London/ St. Thomas
Peggie Willett	Acting Director, Decision Support	Centre for Addiction and Mental Health, Decision Support

APPENDIX C: Example of Indicator Briefing Page

Indicator: 30-Day Readmission (RA) Rate – CUO6

Definition: The number of psychiatric discharges that are followed within 30 days by another psychiatric admission, whether to the same or a different hospital. Transfers are not considered RAs. The desired value for this indicator is as low as possible.

Rationale: This indicator^a may flag poor preparation for discharge and /or poor community follow-up resulting in inefficient/inappropriate use of inpatient resources.^{1,2} Individuals with a history of repeated admission are most vulnerable to RA and require special efforts to break the revolving door cycle.^b

Reporting Level: Provincial, LHIN/region, hospital, and unit/program levels.

Type of indicator: Outcome measure.

Ontario Findings:

Mental Health Hospital Report 2007:

Ontario	Overall	Acute	Specialty
Mean (provincial)	12.5%	12.7%	11.4%
Range (Schedule 1)	0.6-20.2%	0.6-20.2%	7.8-16.4%

1) Supporting Evidence:

Data from other jurisdictions:^c

- HCC (UK):³ **11%** (RA within 30 days of discharge to any hospital) (2005).
Differences – HCC vs. Hospital Report: Different universal health care models.
- VA (U.S.):⁴ **11%** (RA within 30 days of discharge to any Veteran Integrated Service Network facility) (2004)
Differences – VA vs. Hospital Report: Sampled veterans vs. those 15-65 years; RA to any VA facility vs. any MH facility; mixed health care coverage vs. universal.
- BHPMS (U.S.):⁵ **7.5%** (RA to the same facility within 30 days of discharge)(2005)
Differences – BHPMS vs. Hospital Report: RA same facility vs. any MH facility; mixed health care coverage vs. universal.
- SAMHSA (U.S.):⁶ **8.2%** (RA to any facility within 30 days of discharge) (2002)
Differences – SAMHSA vs. Hospital Report: Mixed health care coverage vs. universal.
- Literature:^d* Range: **7-17%**, and mode: **11%**.⁷⁻¹²

a Originally 'Percent of psychiatric discharges that are 30-day readmissions'

b Please see literature evidence related to previous admissions below.

c Please see Appendix 1 for other jurisdiction search methods in Briefing Pages, Mental Health 2007 on the website www.hospitalreport.ca

d Please see Appendix 3 for literature search methods in Briefing Pages, Mental Health 2007 on the website www.hospitalreport.ca

2) Ontario Hospital feedback:^e

Importance/relevance:

Relevant to goal: 87% (very relevant).

Already calculate it: 67% (yes quarterly) & 3% (never)

Site visit comments – 2006: This indicator was well liked and used by all visited sites.

Hospital control over indicator:

Survey results re control: 20% (completely), 75% (somewhat) and 5% (not at all)

Site visit comments – 2006: Many said that RA is significantly tied to the number of beds available. The rate is also dependent on community supports (i.e. ACT teams). Some groups mentioned that a few doctors schedule planned RAs – often through the hospital practitioner’s private practice. *Note:* A review of randomly selected hospital charts of those readmitted within 30 days, conducted for the Ontario Hospital Report 2004, found that there were very few planned RAs made by practitioners.

3) Literature:^d

Importance/relevance:

The indicator fits with the mental health reform vision held in Ontario of shifting the locus of care for individuals with severe mental illness from hospital to community, and minimizing need to return to hospital.¹³

Hospital control over indicator:

Among the seven articles found which looked at readmission within 30 days, the following significantly affected RA rates: Discharge severity (2 of the 3 studies which assessed this variable found significance),^{14,15} shorter LOS (1/5),¹¹ bed occupancy (1/1),⁹ patient turnover (1/1)⁹ and lower staff levels (1/1).⁹ Factors that increase the likelihood of 30-day readmission which should be monitored are the following: Age (younger) (3/6),^{9,11,14} diagnosis (2/6),^{9,11} previous admissions (3/4)^{8,12,15} and admission severity (2/4).^{7,8}

^d Please see Appendix 3 for literature search methods in Briefing Pages, Mental Health 2007 on the website www.hospitalreport.ca

^e Please see Appendix 2 for hospital feedback methods in Briefing Pages, Mental Health 2007 on the website www.hospitalreport.ca

Key References:

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APPENDIX D: Schedule 1 Hospital Peer Groupings

Teaching Hospitals

Hôpital régional de Sudbury Regional Hospital
Hotel Dieu Hospital, Kingston
London Health Sciences Centre
Mount Sinai Hospital
St. Michael's Hospital
Sunnybrook and Women's College Health Sciences Centre
The Ottawa Hospital
Thunder Bay Regional Health Sciences Centre
University Health Network

Community Hospitals with 29 or Fewer Designated Beds

Alexandra Marine and General Hospital
Bluewater Health
Chatham-Kent Health Alliance
Cornwall Community Hospital
Halton Healthcare
Huron Perth Healthcare Alliance
Joseph Brant Memorial Hospital
Markham Stouffville Hospital
Orillia Soldiers' Memorial Hospital^a
Peterborough Regional Health Centre
Queensway Carleton Hospital
Quinte Health Care
Ross Memorial Hospital^a
Royal Victoria Hospital
Southlake Regional Health Centre
The Brantford General Hospital
The Credit Valley Hospital
Timmins and District Hospital
Windsor Regional Hospital
Woodstock General Hospital

Community Hospitals with 30 or More Designated Beds

Grand River Hospital
Grey Bruce Health Services
Hôpital Montfort Hospital
Hôtel-Dieu Grace Hospital
Humber River Regional Hospital
Lakeridge Health
Niagara Health System
North York General Hospital
Rouge Valley Health System
Sault Area Hospital
St. Joseph's Health Centre
The Scarborough Hospital
Toronto East General Hospital
Trillium Health Centre
William Osler Health Centre

Specialty Hospitals

Baycrest Centre for Geriatric Care^b
Centre for Addiction and Mental Health
Mental Health Centre Penetanguishene
Northeast Mental Health Centre
Providence Continuing Care Centre
Royal Ottawa Health Care Group
St. Joseph's Care Group
St. Joseph's Health Care Hamilton^c
St. Joseph's Health Care London
Whitby Mental Health Centre

^a Achieved Schedule 1 status in March 2006.

^b Grouped with the Specialty hospitals in this Report because of its specialized focus on geriatric care.

^c Delivers both specialty and acute care.

APPENDIX E: SIC Indicators by Forensic (7127655) and Longer Term (7127695) Functional Centres^a

HOSPITAL CORPORATIONS (ALL SITES) WITH FORENSIC FUNCTIONAL CENTRES (7127655)	LHIN	SIC1	SIC2	SIC3B		SIC3A		SIC4	SIC5	SIC6A			SIC6B	SIC6C	SIC7A	SIC7B	SIC7C	SIC7D
		Inter-organizational networking	Notification of hospitalization	Use of guideline care for tracer conditions:		Use of clinical data provided by:		Discharge plans completed with involvement of:			Regular consumer/family input in hospital/FC governance:							
				Core	Expanded	Staff	Client	Client	Family	Provider	Weekly	Monthly	Quarterly	Annually				
Provincial Average		60	75	88	75	63	38	98	75	91	50	75	75	75				
TEACHING HOSPITALS																		
Thunder Bay Regional Health Sciences Centre	14	0	100	yes	yes	no	no	DK	DK	85	no	yes	yes	yes	yes			
SPECIALTY HOSPITALS																		
Centre for Addiction and Mental Health	7	100	33	no	yes	no	no	DK	DK	DK	no	yes	yes	yes	yes			
Mental Health Centre Penetanguishene	12	100	100	yes	yes	yes	no	100	100	100	no	yes	yes	yes	yes			
Northeast Mental Health Centre	13	50	67	yes	yes	no	no	100	100	100	yes	yes	yes	yes	yes			
Providence Continuing Care Centre	10	100	100	yes	yes	yes	yes	100	50	100	yes	yes	yes	yes	yes			
St. Joseph's Health Care Hamilton	4	100	100	yes	yes	yes	yes	90	100	100	no	yes	yes	yes	yes			
St. Joseph's Health Care London	2	33	67	no	no	yes	no	100	50	50	yes	yes	yes	yes	yes			
Whitby Mental Health Centre	9	50	33	yes	yes	yes	yes	95	50	99	yes	yes	yes	yes	yes			
HOSPITAL CORPORATIONS (ALL SITES) WITH LONGER TERM FUNCTIONAL CENTRES (7127695)																		
Provincial Average		82	70	100	100	70	50	80	66	85	10	70	80	100				
COMMUNITY HOSPITALS WITH 30 AND MORE MH BEDS																		
William Osler Health Centre	5	50	100	yes	yes	no	no	40	25	20	no	no	no	yes				
SPECIALTY HOSPITALS																		
Baycrest Centre for Geriatric Care	7	17	100	yes	yes	yes	yes	95	95	75	no	no	no	yes				
Centre for Addiction and Mental Health	7	100	33	yes	yes	yes	yes	75	75	DK	no	no	yes	yes				
Mental Health Centre Penetanguishene	12	50	100	yes	yes	yes	yes	80	50	90	no	yes	yes	yes				
Northeast Mental Health Centre	13	100	100	yes	yes	no	no	100	100	100	no	yes	yes	yes				
Providence Continuing Care Centre	10	100	100	yes	yes	no	no	100	50	100	no	yes	yes	yes				
St. Joseph's Care Group	14	100	0	yes	yes	yes	yes	50	50	100	no	yes	yes	yes				
St. Joseph's Health Care Hamilton	4	100	100	yes	yes	yes	yes	90	75	95	no	yes	yes	yes				
St. Joseph's Health Care London	2	100	100	yes	yes	yes	no	70	70	90	no	yes	yes	yes				
Whitby Mental Health Centre	9	100	67	yes	yes	yes	no	100	70	95	yes	yes	yes	yes				

^a Addictions (7127645) and Crisis (7127690) Functional Centres not reported because of very small numbers of units.

* Brockville site was designated by the Royal Ottawa Health Care Group to be their respondent for the SIC survey.

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