Hospital Report Card: Mental Health
2007 Briefing Pages
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**Inter-Organizational Networking (SIC1)**

**Indicator:** Inter-Organizational Networking.

**Definition:** This measure was based on responses to three questions on the SIC questionnaire. Hospitals were allotted a total of six points if they answered “yes” to all of the following questions:
- If they had formal written agreements as part of collaborative arrangement to provide mental health/addictions services (2 points).
- If they had personnel who are members of steering committees or on the boards of other organizations delivering MH/A services (1 point).
- If they had personnel who spend more than one half-day per week working in a program external to their hospital as part of collaborative arrangement to provide MH/A services (3 points).

For each hospital, this indicator was expressed as the percentage of points earned out of a possible six points.

**Rationale:** To support client movement through a seamless system of care, hospitals are developing relationships with community service providers. This indicator reflects the extent to which hospitals are working with other service providers to share knowledge and expertise, integrate services and develop collaborative service agreements to deliver or improve patient care. The assumption is that improved inter-organizational networking enhances continuity of care enhances client outcomes.

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

**Type of indicator:** Process measure.

**Ontario Findings:**

**Mental Health Hospital Report 2007:**

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>Mean (provincial)</td>
<td>82%</td>
<td>78%</td>
<td>80%</td>
<td>89%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>17-100%</td>
<td>50-100%</td>
<td>17-100%</td>
<td>50-100%</td>
<td>17-100%</td>
</tr>
</tbody>
</table>

**1) Supporting Evidence:**

*Data from other jurisdictions*:
There are no results from other jurisdictions to present for this indicator.

*Support from other performance monitoring systems*:
NS (CAN) (6), AUS (7), BC (CAN) (8) all listed inter-organizational networking as an important indicator of quality of hospital care for mental health, even though they did not report results.

**2) Ontario Hospital feedback:**

*Importance/Relevance*:
- Relevant to goal: 85% (very relevant).
- Already calculate it: 35% (yes quarterly) and 40% (yes yearly).
- Site visit comments-2006: One group said that this was a major priority of theirs.

*Hospital control over indicator*:
- Survey results re control: 53% (completely) and 48% (somewhat).
- Site visit comments-2006: One facility noted that it had achieved good results for this indicator because they had made a formal agreement with other facilities in the area to make this a priority.

**3) Literature**:

*Importance/relevance:* Inter-organizational networking is seen as an integral way to enhance the continuity of care which is now seen in many realms as a core value in care delivery (2) and a key indicator in mental health care performance measurement (3-5). In Ontario this indicator pertains to the strategic objective to utilize a comprehensive continuum of services and supports that are linked and coordinated, or more specifically: “General hospitals and facilities will have open door policies permitting [community] service providers…to continue to provide care…to clients as developed through a shared planning forum” (10).

*Hospital control over indicator:* Ways for hospitals to facilitate inter-organizational networking are: formal agreements with external providers (10), collocation of services (9-13), shared patient records across facilities (14), and case management (15). Referrals alone have not been found to lead to coordinated care (10).

*Importance of indicator with regard to client outcomes:* Formal agreements with external providers have been found to enhance a patient’s appropriate use of needed services (10). In addition inter-organizational networking ensures timely access to needed outpatient services, which helps avoid a failure to follow through with treatment plans, homelessness, incarceration or other negative outcomes (16).

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Please see Appendix 1 for other jurisdiction search methods

Please see Appendix 2 for hospital feedback methods

Please see Appendix 3 for literature search methods
Key References:


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\[d\] ‘LIFE: A framework for prevention of suicide and self-harm in Australia’
Indicator: Notification of hospitalization.

Definition: This indicator measures whether programs have standardized protocols in place to notify external service providers (given appropriate patient/substitute consent) about a patient’s admission to the hospital, care while in hospital, and discharge. Hospitals were given one point for each phase of the patient’s course in the hospital (i.e., admission, treatment, discharge) where they indicated that they had a formal plan for notification of at least one service provider group (i.e., physicians/nurses with and without hospital privileges, external Assertive Community Treatment teams, other community mental health service providers, home care, and other providers of care), for a total of three possible points.

Rationale: System reform emphasizes continuity of care, in part, through “shared service approaches.” One benefit is that as client needs are identified or change, relevant service providers can be engaged. Another is that the stability of the provider team can be maintained, even when the client requires new levels of care. Community service providers can support a person through their course in hospital (e.g., via information sharing or consultation), and help facilitate the transition back to the community. The assumption is that improved inter-organizational networking enhances continuity of care, which enhances client outcomes.

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

Type of indicator: Process measure.

Ontario Findings:

Mental Health Hospital Report 2007:

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<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>87%</td>
<td>87%</td>
<td>87%</td>
<td>89%</td>
<td>83%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0-100%</td>
<td>0-100%</td>
<td>67-100%</td>
<td>33-100%</td>
<td>0-100%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions: There are no results from other jurisdictions to present for this indicator.

Support from other performance monitoring systems: The Australian Government Department of Health and Ageing lists a similar indicator titled “Improved information exchange, referral protocols, joint case management, shared care and discharge planning between appropriate services”.

Literature: Through a systematic literature search, three studies were found to include “notification of discharge” as part of their definition of continuity of care in mental health services (notification of admission or of hospital care were not listed).

2) Ontario Hospital feedback:

Importance/Relevance:

- Relevant to goal: 72% (very relevant), 19% (somewhat relevant).
- Already calculate it: 26% (yes quarterly), 16% (yes yearly) & 26% (yes intermittently).
- Site visit comments-2006: 50% of patients may not have family doctors, meaning (in one group's opinion) there is no one to contact. Some groups have automatic discharge and admission notices sent to a family doc. Some have protocols, but don't always follow them. One facility said that some patients ask for staff not to do this.

Hospital control over indicator:

- Survey results re control: 61% (completely) and 34% (somewhat).
- Site visit comments-2006: No site visit comments were made regarding hospital control over the indicator.

3) Literature:

Importance/relevance: This indicator is in line with the Ontario Mental Health reform stating that there should be a comprehensive continuum of services & supports that are linked and coordinated. Continuity of care is now seen in many realms as a core value in care delivery, and a key indicator in mental health care performance measurement.

Hospital control over indicator: Significant predictors of continuity of care (defined by “post-discharge contact”) were found to be pre-discharge contact and duration of hospitalization.

Importance of indicator with regard to client outcomes: As stated for SIC8, research has not been sufficiently operationalized to test whether continuity of care improves client outcomes. It has been reported however that such coordination ensures timely access to needed services, which helps avoid failure to follow through with treatment plans, homelessness, incarceration or other negative outcomes.
Key References:


\textsuperscript{d} ‘LIFE: A framework for prevention of suicide and self-harm in Australia’
Indicator: Use of guideline care for tracer conditions.

Definition: This indicator measures use of guideline care at two levels. One level tracks use of ‘CORE’ treatment guidelines published by official Canadian and U.S. professional organizations for inpatient management of schizophrenia, major depressive disorder and bipolar disorder, common reasons for psychiatric hospitalization. For depression and bipolar disorder, these are the CANMAT (Canadian Network for Mood and Anxiety Treatments) and APA (American Psychiatric Association) guidelines while for schizophrenia, they are the guidelines recommended by the Canadian (CPA) and American (APA) psychiatric associations. The ‘EXPANDED’ level also includes use of any standardized evidence-based approaches (e.g., protocols).

Rationale: A key directive of mental health reform in Ontario is that services should be based on best practices (2). Given this directive, higher values for these indicators are desirable.

Reporting Level: Provincial, functional center, LHIN, and hospital levels.

Type of indicator: Process measure.

Ontario Findings:

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<thead>
<tr>
<th>Mental Health Hospital Report 2007:</th>
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<tbody>
<tr>
<td><strong>Ontario</strong></td>
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<tr>
<td>-----------</td>
</tr>
<tr>
<td>Mean (core)</td>
</tr>
<tr>
<td>Mean (expanded)</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions: There are no results from other PMIs to present for this indicator.

Support from other performance monitoring system: The closest indicator called Treatment protocols for Comorbidity, exists in Ontario MOHLTC Indicator Project ‘Mental Health Accountability Framework’ (Canada) project. No data are currently available for this indicator.

Literature: An article on inpatient psychiatric unit management practices in the VA system reported the rates of guideline use on a program level. Similar to Ontario rates, 40% of programs reported using specific clinical guidelines and 63% reported using any practice guidelines (6). Other literature tends to report the use of guidelines on a patient level (e.g. – chart reviews). The range for guideline adherence in the literature goes up to 100% (1, 4, 5, 7). The lowest compliance is reported with psychosocial recommendations: 0-43% (6) while compliance with pharmacological recommendation ranges from 27 to 70% (1, 7).

2) Ontario Hospital feedback:

Importance/Relevance:
- Relevant to goal: 39% (very relevant) & 50% (somewhat relevant).
- Already calculate it: 61% (yes – quarterly, yearly, as needed) & 38% (never)
- Site visit comments-2006: Patient care plans might not be formalized and endorsed, but almost everybody is using some form of guideline system. Depending on who is answering the question (i.e. someone who believes the guidelines must be formalized to count, or someone who thinks any guideline is of consequence), the reported results may vary greatly. Some say that use is a continuing challenge in that it is not the standards but more the infrastructure to support guideline care that they are missing.

Hospital control over indicator:
- Survey results re control: 36% (completely) & 50% (somewhat).
- Site visit comments-2006: Nothing was said regarding hospital control over the indicator.

3) Literature:

Importance/relevance: The Ontario mental health reform expresses that services should be based on best practices (6).

Hospital control over indicator: There is evidence that guidelines’ adherence can be implemented in clinical practice, but not without specific interventions. These interventions can be costly and involve additional resources: new computer infrastructure, case management, specialty education/consultation, etc. After discontinuation of intervention, adherence goes back to pre-intervention level (1). One study found a variation among clinical specialties in guideline adherence with psychiatrists being the most compliant (5).

Importance of indicator with regard to client outcomes: The effectiveness of practice protocols counted in the EXPANDED version is unknown. While use of CORE guidelines has been recommended for improving client outcomes (2, 3, 6), results of empirical studies assessing adherence and outcomes are mixed. This may be due to the complexity of measuring adherence and the variable quality of data sources (1). Only 14-43% of patients receive guideline recommended treatment, especially if it is other than pharmacology (CBT, vocational training, counseling, etc) (1).

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1 Please see Appendix 1 for other jurisdiction search methods
2 Please see Appendix 3 for literature search methods
3 Please see Appendix 2 for hospital feedback methods
Key References:


Hospital Report Card: Mental Health Indicator Briefing Page

Use of Clinical Data: Staff and Client Provided (SIC4&SIC5)

Indicator: SIC4: Use of clinical data provided by staff and SIC5: Use of clinical data provided by client.

Definition: Assessments from two perspectives are included – staff and, following the provincial objective of client centered participatory care, clients. The numerator is number of hospitals reporting procedures for collecting staff/client ratings of outcome and routine use of such ratings for continuous quality improvements. The denominator is the total number of hospitals. The result is expressed in percentages.

Rationale: These two indicators monitor whether patient status is assessed and whether such assessments are regularly incorporated into hospital quality assurance processes. The ideal level for both indicators is 100 percent. In addition, the desired pattern is a similar level of performance for both measures (that is, staff and client perspectives both inform decisions regarding effectiveness of care).

Reporting Level: Provincial, functional centre, LHIN/region levels (as a percentage) and hospital level (as yes or no response).

Type of indicator: Process measure.

Ontario Findings:

Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAFF Mean (provincial)</td>
<td>62%</td>
<td>65%</td>
<td>47%</td>
<td>78%</td>
<td>67%</td>
</tr>
<tr>
<td>CLIENT Mean (provincial)</td>
<td>48%</td>
<td>50%</td>
<td>40%</td>
<td>44%</td>
<td>67%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

*Data from other jurisdictions*:

*Client*: There are no results from other jurisdictions to present for this indicator.

*Staff*: Timko et al. (US) [1]: 61.1% - Psychiatric, 71.9% - Substance abuse (Client outcome follow-up used as a management practice) (2003). *Differences* - Timko et al. vs. Hospital Report: Inclusion of reporting procedures in practice vs. both inclusion of reporting procedures in practice as well as routine use of data; mixed health care coverage vs. universal.

2) Ontario Hospital feedback [2]:

*Importance/Relevance*:

- Relevant to goal: *Staff*: 70% (very relevant), 22% (somewhat relevant).
  *Client*: 81% (very relevant)
- Already calculate it: *Staff*: 28% (yes quarterly), 26% (yes yearly) & 31% (yes intermittently).
  *Client*: 23% (yes quarterly), 44% (yes yearly) & 21% (yes intermittently).
- *Site visit comments-2006*: *Staff*: Some facilities are using RAI at admission and discharge to calculate this. *Staff & Client*: Groups felt that the question should be more specific by asking how this is structured and documented by the facility. *Client*: Some facilities calculate client outcome measures by unit, yet way in which this information is being used by the facilities was not detailed or discussed. One group uses outpatient/inpatient handouts and a suggestion box, where clients hear about the progress of their suggestions from the staff. One group uses a special screen of client outcome measurement three days after the admission and at discharge.

*Hospital control over indicator*:

- *Survey results re control*: *Staff*: 58% (completely), 39% (somewhat).
  *Client*: 47% (completely), 53% (somewhat).
- *Site visit comments-2006*: No comments regarding hospital control over the indicator were made.

3) Literature [3]:

*Importance/Relevance*: *Staff & Client*: This is in keeping with the provincial strategic objective to strive for informed inpatient practice and consumer-centered care.

*Hospital control over indicator*: This is an issue which hospitals can initiate through exit interviews or surveys. Gaining accurate and adequate responses is a separate issue however. When using a client outcome measurement survey via mail for example, responses can be biased. One study found that those returning a satisfaction survey were less likely to have a diagnosis of schizophrenia, were more likely to be female and had a shorter association with the ACT team under review.

*Importance of indicator with regard to client outcomes*: One study reported that client outcome measurement informs future service provision.

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[1] Please see Appendix 1 for other jurisdiction search methods
[2] Please see Appendix 2 for hospital feedback methods
[3] Please see Appendix 3 for literature search methods
Key References:


Indicator: Discharge Plans Completed with Client Involvement

Definition: Data to calculate this indicator were based on estimates of the percentage of discharge plans to have “formal, documented consumer involvement” rather than on a chart audit or file review. The target for this indicator is close to 100%, taking into consideration that some patients, by virtue of their illness or preference, will not participate in this process.

Rationale: A critical component of inpatient care is a follow-up plan that aims to include the preferences of the client.

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

Type of indicator: Process measure.

Ontario Findings:

Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th></th>
<th>Ontario Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
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<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>84%</td>
<td>81%</td>
<td>70%</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>Range (Schedule 1)*</td>
<td>0-100%</td>
<td>20-100%</td>
<td>95-100%</td>
<td>50-100%</td>
<td></td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions:

NASW (U.S.) (1): 95%- threshold (discharge plans completed with client involvement as a theoretical indicator).

Differences- NASW vs. Hospital Report: theoretical indicator vs. formal documentation of consumer involvement; mixed health care coverage vs. universal.

Support from other performance monitoring systems: The BMA (U.K.) (3), uses the indicator “% of patients who have a comprehensive care plan documented and agreed upon between individuals, their family and/or caregivers as appropriate”.

2) Ontario Hospital feedback:

Importance/Relevance:

- Relevant to goal: 84% (very relevant).
- Already calculate it: 33% (yes quarterly), 23% (yes yearly), 35% (yes intermittently) & 10% (never)
- Site visit comments-2006: Seen a valuable indicator by some since it highlights the importance of client involvement. Groups suggested that chart audits may help in collecting this data but the indicator should not be dropped entirely. One group uses this indicator regularly and feels a score below 75% should be a cause for concern. Some felt that reporting this indicator by functional centre would make for more relevant results.

Hospital control over indicator:

- Survey results re control: 74% (completely).
- Site visit comments-2006: Some felt that clients may not understand their situation well enough to be fully involved in the discharge process.

3) Literature:

Importance/relevance: As mental health reform policy stresses the importance of patient participation (2), it is important for patients to be actively involved in their discharge planning. Both the MOH & NS (CAN.) (3,4), listed ‘recorded discharge plans’ as an important assessment of quality of care, yet client involvement is not included as part of this indicator.

Hospital control over indicator: A UK (6) study assessed client integration in a national healthcare organization. It was found that if an entire organization is committed and managerial arrangements have been made, the prioritization of client involvement would be successful. To add to this, studies (9,10,11) have found that client satisfaction with treatment involvement often receives one of the lowest scores on a satisfaction survey for mental health. It has been recommended that hospitals conduct regular satisfaction surveys to maintain an understanding of whether their clients feel involved during treatment planning (9).

Importance of indicator with regard to client outcomes: A Canadian study (7), found that many clients felt a strong need to be viewed as valuable human beings by service providers and this was said to enhance their motivation to follow through with treatment goals. In addition, a recent U.S. (8) study found that a patient’s intention to carry out an action plan was highly dependent on their perceptions of involvement in the action planning. This intention to carry out the plan was necessary for the plan to be implemented.

* Excludes NA (Not Available) answers.

* Please see Appendix 1 for other jurisdiction search methods.

* Please see Appendix 2 for hospital feedback methods.

* Please see Appendix 3 for literature search methods.
Key References:


Indicator: Community provider participation in patient discharge planning

Definition: This indicator measures the percentage of inpatient records that include standardized documentation of community provider involvement in psychiatric discharge plans per facility. It is the mean percentage of inpatient cases that include standardized documentation of community provider involvement in psychiatric discharge plans across all IP Functional Centres.

Rationale: To support client movement through a seamless system of care, hospitals are developing relationships with community service providers. This indicator reflects the extent to which hospitals are working with other service providers in treatment planning and delivery to enhance continuity of care.

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

Type of indicator: Process measure.

Ontario Findings:

Mental Health Hospital Report 2007:

<table>
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<tr>
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<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>77%</td>
<td>67%</td>
<td>78%</td>
<td>82%</td>
<td>94%</td>
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<tr>
<td>Range (Schedule 1)a</td>
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<td>0-100%</td>
<td>30-100%</td>
<td>50-100%</td>
<td>75-100%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictionsb: There are no results from other jurisdictions to present for this indicator.

Support from other performance monitoring systems: NS (CAN)6, AUS7, BC (CAN)8 all listed inter-organizational networking as an important indicator of quality of hospital care for mental health, even though they did not report results.

2) Ontario Hospital feedbackc:

Importance/Relevance: Hospital feedback has not been obtained for this indicator.

Hospital control over indicator: Hospital feedback has not been obtained for this indicator.

3) Literatured:

Importance/relevance: Community provider participation in discharge planning is seen as an integral way to facilitate the continuity of care which is now seen in many realms as a core value in care delivery2,3 and a key indicator in mental health care performance measurement4-6. In Ontario this indicator pertains to the strategic objective to utilize a comprehensive continuum of services and supports that are linked and coordinated, or more specifically: “General hospitals and facilities will have open door policies permitting [community] service providers…to continue to provide care…to clients as developed through a shared planning forum”1.

Hospital control over indicator: TBA

Importance of indicator with regard to client outcomes: TBA

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a Excludes NA (Not Available) answers.
b Please see Appendix 1 for other jurisdiction search methods
c Please see Appendix 2 for hospital feedback methods
d Please see Appendix 3 for literature search methods
Key References:


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*LIFE: A framework for prevention of suicide and self-harm in Australia*
Indicator: Regular Client Input into Hospital Governance.

Rationale: 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 consultations.

Reporting Level: Relevant at the province, functional centre, LHIN/region, and hospital levels.

Type of indicator: Process measure.

Ontario Findings:

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<th>Teaching</th>
<th>Specialty</th>
</tr>
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<tbody>
<tr>
<td>Mean (weekly)</td>
<td>24%</td>
<td>15%</td>
<td>27%</td>
<td>33%</td>
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<td>Mean (monthly)</td>
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<td>46%</td>
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<td>Mean (quarterly)</td>
<td>26%</td>
<td>30%</td>
<td>20%</td>
<td>33%</td>
<td>17%</td>
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<td>Mean (annually)</td>
<td>2%</td>
<td>0%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions: No other systems have reported results for this indicator.

Support from other performance monitoring systems: The MHSIP (U.S.) and SAMSHA (U.S.), use the indicator but have not published results.

2) Ontario Hospital feedback: (on a predecessor indictor used in 2004 MH Report ‘Hospital Advisory /Steering Committees with Consumer or Family Representation’)

Importance/Relevance:

- Relevant to goal: 87% (very relevant).
- Already calculate it: 38% (yes quarterly), 30% (yes yearly), 28% (yes intermittently) & 13% (never)
- Site visit comments-2006: One group felt the question should be asked more specifically: for MH in general, or for specific programs or populations. One group mentioned that they prefer a broader version of the indicator as they may not have clients on an advisory, but may have another approach to include clients or family (i.e. focus groups on a regular basis, or other types of meetings). This indicator has been revised accordingly.

Hospital control over indicator:

- Survey results re control: 74% (completely).
- Site visit comments-2006: There were no site visit comments made regarding hospital control over the indicator.

3) Literature:

Importance/relevance: The Ontario MOH stresses the importance of “involvement of consumers in service delivery and planning” which encompasses: The proportion of communities within a region with established regional consumer advisory groups, the total amount of resources allocated to support consumer advisory structures, the proportion of regional health authorities within province/territory that have a designated person at the management level to facilitate partnerships and involvement of consumers and families and the number of consumer/family self-directed initiatives.

Hospital control over indicator: Bias and self-selection is often unavoidable in choosing consumer committee members, yet it is important to attempt having a sample of both critical and supportive clients present during collaborative meetings. Whenever possible staff should use plain language in communicating with client collaborators so as to avoid any communication barriers. It is also important to include the consumer representatives throughout the entire process (planning, implementation and evaluation), and to give the clients a complete description of their responsibilities. It is often beneficial to also have a meeting facilitator present who is skilled in group dynamics.

Importance of indicator with regard to client outcomes: Consumer representation in developing clinical practice guidelines has been said to increase patient autonomy by nurturing participation and responsibility. It has also been said that incorporating client involvement builds trust among those currently receiving client services since they feel as though their opinions and needs are being expressed in board meetings. Being on an advisory board increases independence and knowledge about the services being utilized and this has been seen to decrease client dependence upon clinical staff.

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Please see Appendix 1 for other jurisdiction search methods
Please see Appendix 2 for hospital feedback methods
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Key References:


**Hospital Report Card: Mental Health indicator Briefing Page**

**Hospitalization for Psychotic Diagnoses (CUO1)**

**Indicator:** Hospitalization for psychotic diagnoses.

**Definition:** This indicator assesses whether hospitals are reserving inpatient care for those most in need of intensive services.

**Rationale:** Psychotic disorders are being used as a proxy for serious mental illness until a system-wide measure of severity is available (see Appendix 9 in the OHA Mental Health Hospital Report (2004) for a list of diagnostic codes defined as psychotic disorders). A higher value for this indicator is desirable.

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

**Type of indicator:** Process measure.

**Ontario Findings:**

*Mental Health Hospital Report 2007:*

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<tbody>
<tr>
<td><strong>Ontario</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (provincial)</td>
<td>33.36%</td>
<td>27.3%</td>
<td>35.5%</td>
<td>35.4%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>4.7-61.4%</td>
<td>14.9-35.0%</td>
<td>21.0-59.3%</td>
<td>19.0-51.9%</td>
<td>4.7-61.4%</td>
</tr>
</tbody>
</table>

1) **Supporting Evidence:**

**Data from other jurisdictions:***

- **VA (U.S.) (2):** 44.4% (Veterans discharged from inpatient general psychiatry with schizophrenia or other Psychosis. Differences- VA vs. Hospital Report: Sampled veterans vs. those 15-65 years; mixed health care coverage vs. universal.

- **CMHS (U.S.) (3):** 58.5% (% of inpatients aged 18 or older who had schizophrenia or other psychoses). Differences- CMHS vs. Hospital Report: Sampled those >18 years vs. 15-65 years; mixed health care coverage vs. universal.

- **HES (ENG) (4):** 26% (Schizophrenia and related psychoses accounted for 26.0% of psychiatric hospital admissions. Depression and anxiety were the most common reasons for psychiatric hospital admission, accounting for 29.6% of all admissions). Differences- HES vs. Hospital Report: Different universal health care models.

- **Keown et al. (U.K.) (5):** 80% (% of bed use for those in a psychiatric inpatient facility with functional psychosis versus the 66% of bed use for those in the facility with personality disorders). Differences- Keown et al. vs. Hospital Report: Those with “functional psychosis” vs. those with any psychotic spectrum disorder; “bed use” vs. admissions/discharges; different universal health care models.

**Relationship to severity:**

Hazlett et al (2004): While 22% of visitors to ER for psychiatric problems were admitted (US 2000), among those with a psychotic condition the rate was 46% (for neurotic conditions the rate was 6%).

The CMHS (U.S.) (6): Published a rate of 81.2% as a % of those 18 or older in an inpatient program who had significant functional impairment (GAF).

2) **Ontario Hospital feedback:***

**Importance/Relevance:**

- **Relevant to goal:** 63% (very relevant) & 24% (somewhat relevant)
- **Already calculate it:** 53%% (yes quarterly) & 23% (yes yearly)
- **Site visit comments - 2006:** May not apply to geriatrics or forensics. Reporting by functional centre is recommended. Facilities read the results with caution – the data could be inputted incorrectly into the ICD 10.

**Hospital control over indicator:**

- **Survey results re control:** 10% (completely) & 68% (somewhat)
- **Site visit comments - 2006:** Some indicated that the indicator is out of their control since it is based on the demand for treatment. “Use of restraints” was a suggested indicator alternative by one facility. Results for this indicator were also said to be dependent on fluctuations in staff training and ACT team support.

3) **Literature:***

**Importance/relevance:** One provincial strategic objective is to have targeted and appropriate use of IP services – i.e., least restrictive setting based on need. The Ontario MOH (7) emphasized the importance of “service reach to persons with serious mental illness (SMI)” in their Mental Health Accountability Framework.

**Hospital control over indicator:** In practice it is often not the clinical assessment of the client that primarily leads to an admission but rather their level of “dangerousness” and their entourage upon emergency room presentation (e.g. clients escorted by police are more likely to be admitted than those presenting with their families or alone) (7,8,9). These precursors for admission are said to be inconsistent in insuring that the individuals being treated are those that require treatment the most (7,8,9). In addition, one study (10) found that there are often inconsistencies between clinicians’ opinions about the ‘appropriateness’ of a referral and referral judgments based on severity. 52% deemed ‘inappropriate’ by clinicians were judged to meet at least one of the four severity criteria, whereas 20% deemed ‘appropriate’ did not meet any criteria. Inefficiencies at the interface between primary care and secondary mental health services were said to be a main reason for the findings.

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*a Please see Appendix 1 for other jurisdiction search methods

*b Please see Appendix 2 for hospital feedback methods

*c Please see Appendix 3 for literature search methods*
Key References:


Indicator: Discharge within 3 days of admission.

Definition: This indicator counts the number of admissions proceeded by a length of stay of three days or less, regardless of whether the discharge is to the community or another inpatient service. The ideal value for this indicator is as low as possible as a high value would reflect problems in admission screening. No specific benchmark currently exists for this measure.

Rationale: This is an indicator of hospital efficiency. It reflects resource use (inpatient and outpatient) and can be used to examine the appropriate use of inpatient care as well as the availability and accessibility of adequate outpatient services. Optimal length of stay depends on many factors, including availability of professional and family support post-discharge.

System level relevance: Relevant at the province, LHIN/region, hospital, and unit/program levels.

Type of indicator: Process measure.

Results:
1) Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>27.6%</td>
<td>31.5%</td>
<td>31.6%</td>
<td>28.4%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0.7-55.3%</td>
<td>11.1-41.8%</td>
<td>18.4-44.7%</td>
<td>17.8-55.3%</td>
<td>0.7-21.6%</td>
</tr>
</tbody>
</table>

2) Other jurisdictions:\: There are no results from other jurisdictions to present for this indicator.

Evidence:
1) Importance/relevance:

Ontario policy: The indicator fits with the mental health reform vision held in Ontario of maintaining the targeted and appropriate use of IP services – i.e., least restrictive setting based on need (1).

Hospital feedback:\:
- Relevant to goal: This indicator is new – was not included into evaluation questionnaire of 2004 Report.
- Already calculate it: This indicator is new – was not included into evaluation questionnaire of 2004 Report.
- Site visit comments-2006: One group saw problems with this indicator due to the lack of NACRS and DAD data, yet another group saw the value in such an indicator as they were already collecting this data. One group asked “what about ‘the length of time in an ER bed’”? Emergency admissions may be captured as short-term discharges but some feel that this alternative will penalize hospitals with an ER.

2) Hospital control over indicator:

Hospital feedback:\:
- Survey results re control: This indicator is new and was not included in the survey questioning of 2005.
- Site visit comments-2006: No site visit comments were made regarding hospital control over the indicator.

Literature:\: No literature has been found on the indicator.

3) Importance of indicator with regard to client outcomes:

Literature:\: No literature has been found on the indicator.

Key References:


Please see Appendix 1 for other jurisdiction search methods
Please see Appendix 2 for hospital feedback methods
Please see Appendix 3 for literature search methods
Indicator: Alternate Level of Care Days (ALC)

Definition: A person is ALC “when the physician or designated other indicates that the patient no longer requires acute care” (1)

Rationale: This indicator measures the extent to which efficient use of hospital resources is compromised by inability to make timely and appropriate transfers. Possible barriers to transfer include a lack of availability of alternatives or inefficient transfer mechanisms originating in the community, the hospital or both. It is the only currently available proxy for “when the patient no longer requires the level of care provided by the facility”, and thus, is an underreport particularly for specialty hospitals in Ontario. The ideal value for this indicator is close to zero.

Reporting Level: Provincial, LHIN, hospital levels.

Type of indicator: Process measure.

Ontario Findings: Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>4.2%</td>
<td>8.4%</td>
<td>7.8%</td>
<td>9.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0-26.1%</td>
<td>1.0-26.1%</td>
<td>4.0-20.5%</td>
<td>3.0-13.7%</td>
<td>0-3.5%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions(6): Not known to be used in any other performance monitoring systems as an indicator.

Literature(6): There is no direct literature on the indicator used in Hospital Report Card. Two articles(6,12) reported the mean number of ALC days per patient in the hospital as 13-14. CIHI reports that ALOS in ALC days are 11.9 for mental health patients in acute hospitals (10). Another study reported a maximum high of 140 days for the elderly mentally ill (7). On average from 10% (younger than 65 age group) (3) to up to 30% (65+) (3) of patients are considered ALC across the studies with the range being between 7% (for younger) (10) and 46% for older patients (11).

2) Ontario Hospital feedback(7):

Importance/Relevance:

- Relevant to goal: 91% (very relevant).
- Already calculate it: 78% (yes quarterly) & 14% (yes yearly)
- Site visit comments-2006: Some suggested that “May not require hospitalization” could be more useful as an indicator. Some think that a better measure would be “No longer requires hospitalization and community services are not available” or “ready for discharge”. Some suggested that ALC may not be reported properly by institutions because of the way ALC is defined by CIHI. Tertiary care and geriatrics would be the most affected groups because of the current ALC definition used by CIHI.

Hospital control over indicator:

- Survey results re control: 33% (completely) & 61% (somewhat).
- Site visit comments-2006: Some felt they had very little control over this measure as they have a heard time getting people out of the hospital due to a lack of nursing homes. Some don’t collect ALC data since individuals may be ready and qualify for discharge but the community lacks the facilities to take them. Thus, the clients are rejected for long-term care and are kept in the acute wards.

3) Literature(8):

Importance/Relevance: The indicator fits with the mental health reform vision held in Ontario of maintaining the targeted and appropriate use of inpatient services (i.e., least restrictive setting based on need) as well as using the comprehensive continuum of institutional and community supports that are coordinated (2).

Hospital control over indicator: Literature on the topic comes mainly from Great Britain, although one study has Canadian origin (6). All studies indicate that availability of long-term, rehab, housing and other forms of tertiary care is crucial in keeping ALC days low. Hospitals can reduce ALC days by developing discharge plans upon admission (6), networking with long-term and community services (6,9,11,13), having a day hospital (7) and providing additional resources to help with community assessment and placement (6,9). Factors that complicate community placements are: family and cultural issues (9), medication side effects (4), complex needs (4,9), patient’s old age (7,32), insufficient daily living skills (11) or violence toward themselves or others (13).

Importance of indicator with regard to client outcomes: Delayed hospital discharges can lead to problems admitting new patients. Another side of the problem is that hospital environment is not fit for patients ready to be discharged. Unnecessarily long hospital stays can subject patients to the risk of hospital-acquired infections and delayed discharges can lead to depression or a decline in functional independence (5). Many patients also prefer to be in the comfort of their own homes and may find lengthy hospital stays frustrating and/or distressing. Remaining in hospital over a prolonged period of time can also begin to institutionalize patients as they become accustomed to a highly structured but artificial ward routine (5).

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1 Please see Appendix 1 for other jurisdiction search methods
2 Please see Appendix 3 for literature search methods
3 Please see Appendix 2 for hospital feedback methods
Key References:


Indicator: OHIP care within 30 days post-discharge.

Definition: This indicator measures receipt of post-discharge care. It is the proportion of psychiatric discharges that receive, within 30 days, core mental health care from an OHIP provider. Higher rates should indicate improved performance.

Rationale: This is one possible indicator of continuity of care. Given the seriousness of conditions that require hospitalization, appropriate follow-up care should include some form of medical attention or monitoring (1).

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

Type of indicator: Outcome measure.

Ontario Findings:

Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>52.6%</td>
<td>51.6%</td>
<td>55.3%</td>
<td>53.2%</td>
<td>49.8%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>8.0-75.1%</td>
<td>28.8-62.2%</td>
<td>38.4-75.1%</td>
<td>21.4-65.5%</td>
<td>8.0-61.5%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions:

- HEDIS (U.S.) (2) 67% (% psych. discharges > 6 yrs who received follow-up with any MH provider within 30 days of discharge) (2006 data). Differences- HEDIS vs. Hospital Report: > 6 years vs. 15 years; any MH provider vs. OHIP; mixed health care coverage vs. universal.
- VA (U.S.) (3) 58% (% of psych. discharges receiving outpatient MH care within 30 days of discharge) (2004). Differences- VA vs. Hospital Report: Sampled veterans vs. those 15-65 years; VA system provider vs. OHIP; mixed health care coverage vs. universal.

2) Ontario Hospital feedback: (4)

Importance/Relevance:
- Relevant to goal: 57% (very relevant), 27% (somewhat relevant)
- Already calculate it: 21% (yes quarterly), 59% (never)
- Site visit comments-2006: Indicator considered relevant, however, many hospitals questioned the validity of the measure as it does not account for the follow-up care which is not OHIP funded.

Hospital Control Over Indicator:
- Survey results re control: 13% (completely), 66% (somewhat) & 21% (not at all)
- Site visit comments-2006: One hospital mentioned the absence of primary care could influence results.

3) Literature: (5)

Importance/Relevance: Continuity of care is now seen in many realms as a core value in care delivery (4), and a key indicator in mental health care performance measurement (5-7). In Ontario this indicator pertains to the strategic objective to utilize a comprehensive continuum of services and supports that are linked and coordinated (8).

Hospital Control Over Indicator: The CEQM (9) state that “A responsive outpatient support system (i.e. a timely follow-up with a primary health care provider) for persons who have experienced an acute psychiatric episode requiring hospitalization is essential to maintain clinical and functional stability and to prevent readmission to hospital”. Beyond this, an empirical study has found that discharge planning improves the continuity of care and reduces the potential for hospital re-admissions (10). One study found that patients discharged from inpatient psychiatric care had lower readmission rates (10% versus 15-29%) if they kept an outpatient follow-up appointment- which was planned during hospital stay- after discharge (11). A separate study found that when an appointment with a GP was made-in addition to a telephone call from the discharging doctor to the GP- versus a patient being told to make their own arrangements, those under the former condition had greater continuity of care (12). Not only were there more GP consultations related to mental health and more hospital outpatient appointments made by patients in the group receiving discharge planning, but the GPs and Psychiatrists agreed when interviewed, that the discharge planning improved the continuity of care (12). No significant results were found regarding differences in hospital readmission in this particular study (12).

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(1) Please see Appendix 1 for other jurisdiction search methods
(2) Please see Appendix 2 for hospital feedback methods
(3) Please see Appendix 3 for literature search methods
Key References:


**Hospital Control over Indicator**

**Mental Health Hospital Report 2007**

**Type of indicator:** any Ontario facility for mental health reasons, which do not lead to a readmission. Lower rates are the desired direction for this indicator.

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

**Type of indicator:** Outcome measure.

**Ontario Findings:**

**Mental Health Hospital Report 2007**

<table>
<thead>
<tr>
<th>Ontario Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>6.3%</td>
<td>5.6%</td>
<td>7.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0-13.8%</td>
<td>2-8.7%</td>
<td>4.2-11.9%</td>
<td>4-13.8%</td>
</tr>
</tbody>
</table>

1) **Supporting Evidence:**

**Data from other jurisdictions**

There is no other jurisdiction that uses this measure as an indicator.

**Literature**

Bruffaerts study was the only one found that focused on ER visits within 30 days postdischarge. Their reported rate was 32.8% of all discharges, but 55% of ER visits get admitted to the hospital, making the rate of “ER visit, but not admitted”, close to 18%. However, the authors consider their study biased due to sampling issues and therefore, results are hard to generalize. Other studies focused on return visits from ER to ER within 30 days, which is a different measure. The rate of ER visits within 30 days post-discharge is hard to determine from the existing literature.

2) **Ontario Hospital feedback**

**Importance/Relevance:**

- Relevant to goal: 76% (very relevant), 8% (unrelated to our strategic goals)
- Already calculate it: 38% (yes quarterly), 33% (never)
- **Survey results re control:** 84% (completely), 70% (somewhat) & 9% (not at all)
- **Site visit comments - 2006:** The majority of hospitals we consulted thought it was a good indicator. Comments were that revolving door patients could skew the values for the hospital. Some hospitals treat high values as normal since they use their emergency room as a crisis centre for their clients and a source of a follow-up care.

**Hospital control over indicator:**

- Having an ACT team as well as a developed network of social and community supports (housing, police, case management, etc.) can lower the value for the indicator significantly.

3) **Literature**

**Importance/Relevance**

The indicator fits with the mental health reform vision held in Ontario of continuity of care and providing adequate, linked and coordinated community supports so that emergency department visits after hospitalizations are close to 0. Continuity of care is now seen in many realms as a core value in care delivery, and a key indicator in mental health care performance measurement.

**Hospital control over indicator:**

Only 1 study focused on the return to 30 days since the last contact. The following factors were associated with high rates for ED visit within 30-day hospital discharge: absence of aftercare plan, previous hospitalizations, history of short hospitalizations (less than 2 weeks), unemployment as well as personality disorders.

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*Values are reported for triage level ‘Resuscitation’, ‘Emergent’ and ‘Urgent’

Please see Appendix 1 for other jurisdiction search methods

Please see Appendix 3 for literature search methods

Please see Appendix 2 for hospital feedback methods
Key References:


**Indicator:** 30-Day Readmission (RA) Rate

**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 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\(^3\).

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

**Type of indicator:** Outcome measure.

**Ontario Findings:**

<table>
<thead>
<tr>
<th>Mental Health Hospital Report 2007:</th>
<th>Ontario Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>12.5%</td>
<td>11.6%</td>
<td>14.0%</td>
<td>12.7%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0.6-20.2%</td>
<td>8.3-17.3%</td>
<td>7.9-20.2%</td>
<td>7.8-17.7%</td>
<td>0.6-16.4%</td>
</tr>
</tbody>
</table>

1) **Supporting Evidence:**

*Data from other jurisdictions*:\(^4\)

- **HCC (UK)**\(^5\): 11% (RA within 30 days of discharge to any hospital) (2005). **Differences- HCC vs. Hospital Report:** Different universal health care models.
- **VA (U.S.)**\(^6\): 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\(^b\):** Range: 7-17%, and mode: 11% \(^7,^12\).

2) **Ontario Hospital feedback**:\(^c\)

**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 control:** 20% (completely), 75% (somewhat) & 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 dependant on community supports (i.e. ACT teams). Some groups mentioned that a few doctors will 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\(^c\):**

**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)\(^10,^11\), diagnosis (2/6)\(^10,^11\), previous admissions (3/4)\(^8,^12,^15\) and admission severity (2/4)\(^7,^8\).

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\(^a\) 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

\(^d\) Please see Appendix 2 for hospital feedback methods
Key References:


Indicator: Repeat inpatients

Definition: This indicator counts the number of individuals who have had more than one psychiatric hospital admission during one year. It is calculated by dividing the number of individuals with more than one psychiatric discharge by the number with at least one psychiatric discharge. Lower numbers reflect better performance for this indicator.

Rationale: This indicator flags a potential failure of the health care system to help patients maintain their tenure in the community. Because readmissions over a 12-month course are not necessarily a reflection of the quality of care of any one facility, this indicator is relevant only at the provincial and LHIN/ regional levels.

Reporting Level: Provincial, LHIN/region levels. A contextual variable at the hospital level.

Type of indicator: Outcome measure at the provincial and LHIN levels.

Ontario Findings:

Mental Health Hospital Report 2007:

<table>
<thead>
<tr>
<th>Ontario</th>
<th>Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>26.4%</td>
<td>24.5%</td>
<td>27.3%</td>
<td>28.6%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>4.2-55.3%</td>
<td>14.1-37.1%</td>
<td>20.3-55.3%</td>
<td>21.6-44.8%</td>
<td>4.2-44.2%</td>
</tr>
</tbody>
</table>

1) Supporting Evidence:

Data from other jurisdictions*: There is no other jurisdiction that uses this measure as an indicator.

Literature: Eleven studies were found that measure repeat inpatients within a period of 12 month after a hospital discharge (1, 3, 5, 8, 11, 13-15) and one with the period of 13 months (2). Reported rates are diverse because studies differ by the number of visits by one patient from 2 till more than 5 per 12 months. Among those that report at least 2 repeat visits per patient, the rate of repeat inpatients ranges from 7.5% (9) up to 47% (3). One study reported repeated inpatient service use of 50% among homeless population (14). Literature review articles report that across studies 10-40% of patients are using inpatient mental health services repeatedly (10,11) although observation periods vary from 30 days to 30 months.

2) Ontario Hospital feedback:

Importance/Relevance:

- Relevant to goal: 73% (very relevant), 27% (somewhat relevant).
- Already calculate it: 35% (yes quarterly), 24% (yes yearly) & 26% (yes intermittently).
- Site visit comments-2006: Some thought it would be beneficial to know what the numbers are at the hospital level for this indicator. One group wasn’t sure what this indicator was intended to measure.

Hospital control over indicator:

- Survey results re control: 19% (completely) and 75% (somewhat).
- Site visit comments-2006: No site visit comments were made regarding hospital control over the indicator.

3) Literature:

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 (12).

Hospital control over indicator: Certain patient and system characteristics are reported to be associated with inpatient readmissions across studies giving more weight on the system level (3), such as inadequate LOS (4) or presence of a day hospital (13). On a system level, finding appropriate community supports and follow up service (3,5,7,8,13) including medication management (7) was found to decrease readmissions at least by half (7). Housing support (13,14), ACT teams (11) and carefully designed discharge plans (3) as well as good coordination of inpatient and outpatient services (3,5) were shown to be particular effective to keep clients in the community without a need of hospital readmission. Certain groups of patients are at a greater risk for repeated use of inpatient services; those with psychotic diagnosis (2,9), suicidal ideation (5), discharged against medical advice (5), having a history of previous hospitalizations (2,9,14) and without informal supports (family/friends) (1). Young males were found to be more susceptible to being repeat impatiens (5) in one study, but other studies found no gender difference (11) or females being at a greater risk (8).

* Please see Appendix 1 for other jurisdiction search methods
* Please see Appendix 2 for hospital feedback methods
* Please see Appendix 3 for literature search methods
Key References:


**Indicator:** Discharged against medical advice.

**Definition:** This indicator reports discharges made against the judgment of clinical staff. A lower value for this indicator is better.

**Rationale:** Client-centered care gives priority to client participation in treatment and discharge decisions, which requires effort on the part of both staff and patients. A discharge against medical advice (DAMA) may reflect inadequate staff effort to engage the client and respect client preferences. However, there are cases where clinician views about appropriate treatment cannot be reconciled with patient preferences. The aim is to minimize the frequency of cases where client dissatisfaction leads to a discharge AMA.

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

**Type of indicator:** Process measure.

**Ontario Findings:**

**Mental Health Hospital Report 2007:**

<table>
<thead>
<tr>
<th>Ontario Overall</th>
<th>Hospitals with small psychiatric Units (29 or fewer beds)</th>
<th>Hospitals with large psychiatric Units (30 or more beds)</th>
<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>5.8%</td>
<td>6.5%</td>
<td>5.4%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>0-13.1%</td>
<td>1.9-13.1%</td>
<td>2.9-6.6%</td>
<td>3.1-8.9%</td>
</tr>
</tbody>
</table>

1) **Supporting Evidence:**

**Data from other jurisdictions:** There are no results from other jurisdictions to present for this indicator.

**Literature:** Ranges reported in the literature are from less than 1% (3,10) to up to 35% (9). Studies, conducted in Canada (9,10) or Europe (3) tend to report lower rates of DAMA (0.57% (8) – 6% (9)) than those conducted in the US (6%-51%) (1,9). Mean rate reported in the literature are around 16-20% (1,4,9). Almost half (48.5%) of patients discharged AMA even from internal medicine units in general hospitals have a psychiatric comorbidity and are more likely to be discharged AMA from medical and surgical units (9). Literature is considered to be inconsistent and more research is desired (3,4,10).

2) **Ontario Hospital feedback:**

**Importance/Relevance:**

- Relevant to goal: 71% (very relevant), 29% (somewhat relevant).
- Already calculate it: 49% (yes quarterly), 18% (yes yearly) & 28% (yes intermittently).
- Site visit comments-2006: Some commented that patients often can not stick to the rules (non-smoking, no substance, strict routine) and leave the facility/program. This is the issue especially for withdrawal management programs. One program commented that their patients can go anytime they want so they do not record DAMA. Several facilities were not sure what the indicator indicates - client engagement/treatment adherence?

**Hospital control over indicator:**

- Survey results re control: 23% (completely) and 74% (somewhat).
- Site visit comments-2006: Most groups said that this is a tough indicator to interpret and control as it depends a lot on physician judgement and on variety and extent they use DAMA. It gets the physician “off the hook” when the patient is not certifiable.

3) **Literature:** This is in keeping with the provincial strategic objective of striving for consumer-centered care (7).

**Hospital control over indicator:** Hospitals can predict risk groups prone to psychiatric DAMA and start planning their discharge and aftercare upon admission (3,6,9). These patients tend to be young males (1), other than Caucasian ethnicity (4,9), heavy alcohol and drug users (4), they leave alone or do not have social supports and they tend to be hostile to treatment (4,5) as well as impulsive (5), aggressive and antisocial (4). Diagnoses predictive of DAMA include psychotic and depressive disorders as well as general axis II psychopathology (4). Reasons why patients opt to DAMA are mainly social (3,9), but hospitals can relax rules and avoid conflict with patients at risk as well by providing caring and acceptable environment (10), which simultaneously focuses on psychological issues (5). After-care of these patients should be more aggressive than for those with formal discharges (5,10). Providing patient education enhances the success of after-care (5). DAMA patients tend to be admitted on weekends and discharged during night shifts when unit staffing is at its lowest (1). One US study found that it is “structured racism” (place of hospitalization, low income and insufficient insurance coverage) and hospital organizational culture that contributes to higher rates of DAMA (4).

**Importance of indicator with regard to client outcomes:** DAMA patients are putting themselves at a greater risk and harm to their health and consequent readmission or emergency room use (1,2,4,6,8,10). Relapse of symptoms and re-hospitalizations within 2-12 weeks after DAMA are common (6).
Key References:


Average Length of Stay (Contextual variable)

**Indicator:** Average length of stay (LOS) (excluding alternative level of care days).

**Definition:** This indicator counts the number of days between program admission and discharge, regardless of whether the discharge is to the community or another inpatient service. The ideal value for this indicator is as low as possible without jeopardizing patient stability, but no specific benchmark currently exists.

**Rationale:** This is a commonly used indicator of hospital efficiency as it is easily measured and reflects resource use. It can also be used to examine appropriate use of inpatient care. Prolonged hospitalization does not necessarily benefit an individual, although optimal length of stay depends on many factors, including availability of professional and family support post-discharge.

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

**Type of indicator:** Process measure.

**Ontario Findings:**

- **Mental Health Hospital Report 2007:**

<table>
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<th>Teaching</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (provincial)</td>
<td>22.4 days</td>
<td>11.9 days</td>
<td>12.3 days</td>
<td>16.4 days</td>
<td>106.1 days</td>
</tr>
<tr>
<td>Range (Schedule 1)</td>
<td>7-306.5 days</td>
<td>7.0-17.1 days</td>
<td>7.0-15.6 days</td>
<td>9.2-24.8 days</td>
<td>23-306.5 days</td>
</tr>
</tbody>
</table>

1) **Supporting Evidence:**

- **Data from other jurisdictions:**
  - VA (U.S.) (2)
    - 13 days (ALOS when not including patients with substance abuse).
  - CIHI (CAN) (7)
    - 34.7 days (all hospitals), 148.5 days (psychiatric hospitals), 16.9 days (general hospitals)-Pan-Canada ALOS results including all mental health disorders.
    - 9.1- Czech Republic, 6.2- Denmark, 29.7- Finland, 5.1- Hungary, 87.9- Ireland, 5.7- Lithuania, 38.6- Latvia, 2.3- Slovakia (“# of MH patients in hospitals for 1 year +/- 100000 inhabitants”).
  - STAKES (EU) (4)

- **Support from other performance monitoring systems:** Several active national systems- BPS (U.S.), HEDIS (U.S.), MHID (AUS.) - Report ALOS but have not collected results or obtained benchmarks for the indicator as of yet.

2) **Ontario Hospital feedback:**

- **Importance/Relevance:**
  - Relevant to goal: 95% (very relevant).
  - Already calculate it: 95% (yes quarterly).
  - Site visit comments-2006: One group suggested that a better indicator would look at the “legacy population” ALOS and the short-stay patient ALOS separately. Another idea would be to look at the data by unit rather than the facility as a whole and perhaps exclude forensics from this survey. To tease out crisis beds would be another option or “% of patients in the facility longer than one year”. A few groups liked how the indicator is being transformed into an explanatory variable. One group saw problems with the "within 3 days" option due to the lack of NACRS and DAD data, yet another group saw the value in such an indicator as they were already collecting this data. One group asked "what about the length of time in an ER bed"? Emergency admissions may be captured as short-term discharges but some feel that this alternative will penalize hospitals with an ER.

- Hospital control over indicator:
  - Survey results re control: 33% (completely) & 68% (somewhat).
  - Site visit comments-2006: No site visit comments were made regarding hospital control over the indicator.

3) **Literature:**

- **Importance/relevance:** The indicator fits with the mental health reform vision held in Ontario of maintaining the targeted and appropriate use of IP services – i.e., least restrictive setting based on need.
  - Hospital control over indicator: NA
  - Importance of indicator with regard to client outcomes: NA

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(1) Please see Appendix 1 for other jurisdiction search methods
(2) Please see Appendix 2 for hospital feedback methods
(3) Please see Appendix 3 for literature search methods
Key References:


Appendix 1

Search of Other Jurisdictions

A performance monitoring initiative search was conducted through the Google search engine by pairing the following key terms with the terms “Mental health indicators” and “Behavioral health indicators”: “National mental health quality of care indicators”, “Canadian mental health quality of care indicators”, “Provincial mental health quality of care indicators”, “National mental health performance monitoring indicators”, “Canadian mental health performance monitoring indicators”, and “Provincial mental health performance monitoring indicators” (July 27th – August 1st, 2006).

Inclusions Criteria:

Performance monitoring initiatives were included if they were:

1) In the English language
2) Had been updated in the past year
3) Key terms occurred in the text of the page.

Exclusion Criteria:

Initiatives were excluded if they:

1) Did not include performance-monitoring indicators
2) Were not at the national level or the Canadian provincial level
3) Did not contain indicators specific to Mental Health
4) Were child/adolescent specific

When an initiative was found through this method close attention was paid to the date of publication. In the rare occasion that the date of most recent report publication was before 2000, we contacted the publisher and requested the newest publication and results/benchmarks. If there was no new publication or data/benchmarks to be found the initiative was excluded from further analysis. That being said, the search found 24 sources, which met our criteria. An additional 7 sources were referred to us by performance monitoring experts.
Appendix 2

Hospital Feedback Methodology

There were 2 sources for the hospital feedback section: An Evaluation Survey (ES) and our Road Shows (RS).

The evaluation survey was conducted in December 2004 - January 2005 with administrators of Schedule 1 facilities, participating in the Hospital Report: Mental Health 2004. The purpose of this survey was to understand how hospital report indicators pertain to current hospital practices. The survey focused on three questions:

1. If an indicator measures a practice or an outcome that is relevant to one of the program’s/hospital’s strategic goals
2. If the program/hospital already calculate this indicator as part of quality improvement or decision-making processes
3. The extent to which a program/hospital feels they can influence the performance of this indicator.

Administrators received the survey electronically and responded by fax. Response rate was 73%.

Road shows: During September – October 2006 HRC: MH conducted a series of individual consultations with Schedule 1 hospitals that provide inpatient mental health services, which were called “road shows”. Due to time constrains and budget issues the research team could not visit each one of the hospitals, participated at 2004 report so we selected a sample of 13 hospitals to visit.

Road show sampling:

Fifty-seven hospitals were divided according to their peer group: community (35), teaching (11) and specialty (11). Community hospitals were further subdivided into small (20) and large (15). A hospital was considered small if it has less than 30 mental health designated beds and large if it has 30 and more designated beds. At the end of this exercise we had:

- 20 community small hospitals
- 15 community large
- 11 teaching
- 11 specialty hospitals.

Patient volume:

Knowing the number of beds and total mental health discharges from a hospital, patient volume was calculated (ratio of discharges from the bed). Hospitals were sorted inside their peer group from the lowest to highest. Hospitals were then selected based on the following two criteria:

1. Patient discharge volume (DV) – low, medium and high points within each peer group.
2. Geographic representation across Ontario.

The Small community hospital group was the largest in our peer-grouping scheme and therefore 4 hospitals were sampled. Chosen hospitals were the following:

- Alexandra Marine & General Hospital, Huron-Perth Hospital Partnership in Goderich – low patient volume
- Quinte Health Care Belleville General in Belleville – medium discharge volume
- Stratford General Hospital in Stratford – medium discharge volume
- Royal Victoria Hospital in Barrie – high discharge volume
Appendix 2

From the **large community** hospitals group, three were chosen for participation:
- Humber River Regional Hospital, Toronto – low discharge volume
- Lackeridge Health Oshawa – medium discharge volume
- Niagara Health System, St. Catharines General Hospital Site in St. Catharines – high discharge volume

From the **teaching hospitals** group, three were chosen:
- Mount Sinai in Toronto – low discharge volume
- Hotel Dieu Hospital in Kingston – medium discharge volume
- Hopital Regional de Sudbury/Sudbury Regional Hospital – high discharge volume

**Specialty hospitals**
- Providence Continuing Care Centre in Kingston – low discharge volume
- Whitby Mental Health Centre in Whitby – medium discharge volume
- Northeast Mental Health Center in Sudbury – high discharge volume
Appendix 3

Literature Review Methodology

Inclusion criteria:
- All sources were required to be published during or after 1995 unless otherwise specified.
- All sources came from a systematic review of bibliographic indexes - PsychInfo and Medline, unless otherwise specified.
- Expert recommendations were used to supplement unfruitful reviews of the aforementioned bibliographic indexes. When this has been the case, the literature search below will specify.

CUO5 – OHIP care within 30 days:
**Key terms**: “discharge planning” and “post-discharge follow-up”, or through expert recommendations.

CUO6 – ED visit within 30 days postdischarge:
**Key terms**: “readmission to ER or ED & mental health or substance abuse”; “ER revolving door and mental health/psychiatric reasons/patients”, “community tenure & mental health, psychiatric patients”. Along with that, “relevant articles” generated by PubMed were also searched as well as references from the retrieved articles to expand our sources.

CUO7 – 30-day Readmission Rate:
Combinations of the following **key terms** were used: ‘psychiatric’, ‘mental illness’, ‘readmission’, ‘recidivism’ and ‘rehospitalization’. The reference lists of the relevant articles were also searched. Several pertinent references were found through this method.

SIC4&SIC5- Use of clinical data (staff and client provided):
**Key Terms**: “outcome measurement by staff”, “outcome measurement by clients” and “client involvement”.

POC2 – Discharged against medical advice (Discharge AMA):
**Key terms**: “discharge against medical advice & mental health/psychiatry”, “voluntary discharge & mental health”. Relevant articles generated by PubMed on selected hits were also included.

CUO2  – Hospitalization for psychotic diagnoses:
**Key terms**: The search began with specific key terms such as, “hospitalizations for serious mental illness” or “severity admission thresholds” and became broader to capture more articles of relevance (ex: “admission severity”). Approximately 40 search terms were attempted. The term, which provided some evidence regarding the indicator under question, was: “admission severity”. All other articles were found through expert recommendations.

Additional Search: “Psychiatric emergency room decision-making”, “emergency room decision-making” “clinician decision making”, “admission decision making” and “psychiatric decision making”.

SIC3 – Use of guideline care for tracer conditions:
**Key terms**: “guideline use inpatient mental health”, “guideline use mental health”, “guideline use psychiatry”, “guideline compliance mental health”, “guideline adherence”. This strategy did not end with any results. Cited articles were retrieved from the Hospital Report Mental Health 2004.
Appendix 3

SIC6 – Discharge plans completed with client involvement:
Key terms: “discharge plans with client involvement” and “client involvement”.

SIC7: Regular client input into hospital/FC governance:

CUO4 – Alternate level of care days:
Key terms: “delayed discharge & mental health”, “inappropriate use of hospital beds & mental health”, “acute/psychiatric bed use” and “over-utilization of acute/psychiatric beds”.

SIC1 – Inter-organizational networking:
Key terms: “inter-organizational networking”, “mental health networking”, “continuity of care in mental health”. Some extra sources were found using the reference list of one found article. All other articles were found through expert recommendations.

SIC2 - Notification of hospitalization:
Key terms: “notification of hospitalization”, “notification of admission”, “notification of discharge”, “continuity of patient care”. No articles were found with the keys terms. All articles were found using the reference list of one article provided through expert recommendations.

CUO3 –% Discharges with LOS of 3 days or less
Key terms: “discharge within three days”, “length of mental health hospitalization”, “length of behavioral health hospitalization”, “length of hospitalization”, “length of stay”, “may not require hospitalization – mental health”, “unnecessary hospitalizations”, “avoidable hospitalizations”, “short hospital stay”, “brief hospitalization”, “inadequate hospitalization”, “short hospital stay” and “preventable hospitalization”.