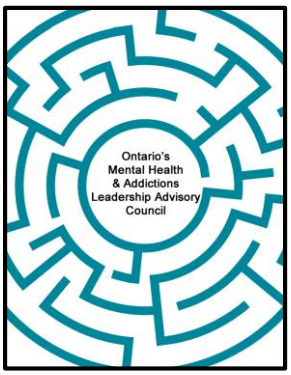

Data and Performance Measurement in Ontario's Mental Health and Addictions Sector

An initiative of Ontario's Mental Health & Addictions Leadership Advisory Council

Ontario's Mental Health and Addictions Leadership Advisory Council, with support from Addictions and Mental Health Ontario, Canadian Mental Health Association Ontario, Centre for Addiction and Mental Health and the Ministry of Health and Long-Term Care's Strategic Policy Branch, hosted a meeting on July 30, 2015, to discuss data and performance measurement for Ontario's Mental Health and Addictions System (this was the first "*data day"*). Meeting participants included experts in health systems data and performance measurement, experts in health and public policy and leaders from mental health and addictions community agencies and hospitals, representing over a dozen organizations from across the province.

The goals of the meeting were to:

- Engage and connect with stakeholders who are interested in better understanding data in the mental health and addictions sector
- Enhance collective knowledge of the current data landscape
- Identify the challenges with existing data, and the opportunities currently available for alignment
- Identify how the existing data can inform effective performance measures
- Develop recommendations for future work in this area

Below is a summary of the main discussion points and action items that arose from this meeting.

Challenges in Data Collection, Analysis, and Reporting

Meeting participants identified the data challenges they were facing at the provincial level, the regional level and at the agency level:

Province/Ministry Level:

- Duplication in data collection and a lack of consistency and standardization across the province
- Challenges around data sharing due to legislative and administrative barriers
- Data collection is not outcome focused; often it is just simple number counting without consideration for how the data relates to actual outcomes for the client
- Agencies collecting data often lack timely access to the data they collect and submit; When data does come back to agencies, it is often too late for the data to add value to improving the quality of performance
- Agencies lack capacity as well as financial and technical resources for data collection

Local Health Integration Network (LHIN) Level:

- Lack of consistency and standardization of data across all LHINs; challenges in obtaining comparable information across LHINs
- Lack of data sharing agreements create barriers to accessing data
- Current performance indicators are not as effective as they could be due to the lack of evidence-based performance indicators for the mental health and addictions sector
- Much pressure is placed on Health Service Providers (HSPs) in terms of staff time and costs associated with data collection and reporting
- Much need for developing viable and meaningful indicators that are consistent across LHIN boundaries (this is especially problematic for multi-LHIN funded agencies)

Agency Level:

- Immense documentation burden and time commitment required to complete data collection and reporting requirements, especially for agencies with a small number of staff
- Lack of capacity in the collection, analysis and utilization of data
- Technological challenges; Smaller agencies still have paper files and/or dated technology
- Multi-LHIN funded agencies have different data requirements
- Barriers due to lack of appropriate data sharing agreements

Opportunities for Data Collection, Analysis, and Reporting

Meeting participants identified a number of data initiatives currently underway across the province focused on the mental health and addictions sector. Examples of opportunities for collaboration and learning were offered and several key themes emerged.

Key Themes

It was noted that the mental health and addictions sector needs to develop a **logic model** to establish a common understanding around data collection, analysis and reporting that will effectively inform performance measurement. The logic model should:

- Consider the data currently available, and the quality of the data available
- Build in a mechanism for ensuring fidelity in the process of data collection by service providers
- Consider issues relating to client consent and privacy

It was noted that the mental health and addictions sector needs to establish a **scorecard** with a common set of performance indicators. The performance indicators should:

- Be evidence-based and focus on health outcomes
- Reflect the realities of service users, as the health outcomes for mental health and addictions clients may be very different from clients with other types of illnesses

It was noted that both the logic model and scorecard should:

- Be applicable across the continuum of services for mental health and addictions, and across hospital and community

- Be grounded in quality improvement and the attributes of a high performing health care system
- Consider equity and the impact on marginalized populations
- Be developed in collaboration and partnership with agencies across the health sector
- Be validated by service users, service providers, and funders
- Ultimately inform standards of care across the mental health and addictions sector, and across hospital and community

Meeting participants agreed to strike a small Task Group to draft the logic model and the first round of scorecard indicators for review and input by the larger group. Dr. Paul Kurdyak agreed to lead the Task Group and will connect with other partners as needed. Once the logic model (the why) and scorecard (the what) is drafted, the group will collectively determine the mechanisms for addressing the current challenges in the data landscape (the how).

Data and Performance Measurement Task Group

Overview of Task Group

The Task Group was struck over the summer months and held three meetings over the fall.

The members of the Task Group included:

- Debbie Bang, St. Joseph's Hospital Hamilton
- Frank Sirotich, Canadian Mental Health Association (CMHA) Toronto Branch
- Mike O'Shea, North East LHIN
- Mohamed Badsha, Reconnect Mental Health Services
- Naushaba Degani, Health Quality Ontario (HQO)
- Paul Kurdyak, Institute for Clinical Evaluative Sciences (ICES), Chair of Task Group
- Rachel Solomon, Centre for Addiction and Mental Health (CAMH)
- Sean Court, Ministry of Health and Long-Term Care
- Uppala Chandrasekera, Canadian Mental Health Association, Ontario

Ex-officio members included:

- Celine Mulhern, Ministry of Health and Long-Term Care
- Julie Yang, Institute for Clinical Evaluative Sciences
- Zahir Din, Canadian Mental Health Association, Ontario
- Zarsanga Popal, Canadian Mental Health Association, Ontario

The purpose of the Task Group was to:

- Map the current data landscape across the continuum of MH&A services and supports (who collects MH&A information, what data elements are collected, how the data is linked, etc.)
- Identify key challenges at the agency, regional, and system levels
- Identify and recommend opportunities to overcome challenges at each of these levels
- Identify resources to enable better data collection
- Validate recommendations with service users and service providers
- Draft logic model and scorecard for review and approval by System Alignment & Capacity Working Group of Ontario's Mental Health & Addictions Leadership Advisory Council

Outcomes of Task Group Meetings

At the first meeting, the Task Group reviewed a list of mental health and addictions performance indicators that had been compiled by ICES and CMHA Ontario, indicators that currently exist across the sector in Ontario. A total of 158 indicators were identified. The sources of the indicators included:

- CAMH Monitor;
- Mental Health and Addictions Quality Initiative Comparative Scorecard;
- Mental Health Accountability Framework (2003);
- Hospital Service Accountability Agreements, Multi-Sectoral Agency Accountability Agreements;
- Community Mental Health and Addictions Quality Improvement Plan Template (draft); and
- Toronto Central LHIN Community Mental Health & Addictions Indicators (2013).

Subsequent to the meeting, six additional sources of indicators were added to the list, resulting in a total of 216 indicators.

The Task Group agreed to use a modified Delphi method to select the indicators for the scorecard using criteria developed by Health Quality Ontario. Prior to survey roll-out, the Task Group agreed to first refine the list to a manageable few. The indicators prioritized included those that were measurable, defined as where there are available data sources that could potentially be used to measure the indicator. This resulted in 60 indicators that were eligible for inclusion in the survey.

The Task Group conducted an online survey to review and score the 60 indicators on three additional criteria: important/relevant, actionable and interpretable. Each criterion was scored along a seven-point Likert scale. The 60 indicators were also categorized into the following domains: Access, Co-ordination/Transition, Human Resources/Visit Rates, Perceptions of Care, Quality/Impact and Other. Nine members of the Task Group completed the survey.

At the second meeting, the Task Group reviewed the survey results. After a lengthy discussion, the Task Group identified about 20 indicators that were measurable, important/relevant, actionable and interpretable along three levels of measurement: population-level, system-level and organizational-level (including at the level of community-based services and hospital services).

At the third meeting, the Task Group further refined the list of indicators to 16. To align with existing quality improvement initiatives, the original indicator domains were replaced with the six quality dimensions identified by Health Quality Ontario: Safe, Effective, Client-Centred, Timely, Efficient and Equitable. With regards to the Equity domain, it was determined that all indicators calculated from ICES administrative data, and other indicators where possible, will be assessed through five equity dimensions: (1) Geography, (2) Neighbourhood income, (3) Immigration status, (4) Age, and (5) Sex.

Task Group Recommendations

1. The *Mental Health & Addictions Performance Indicators for Ontario* scorecard be used to measure the outcomes of Ontario's Mental Health & Addictions System.

2. That all of the scorecard indicators be standardized across all parts of the Mental Health & Addictions System, including hospitals and community-based mental health and addictions organizations.

3. That common data tools that yield high quality, comparable data be standardized across all hospitals and community-based mental health and addictions organizations. We believe that the data sources identified in the scorecard are currently the most effective in yielding high quality, comparable data.

4. That a standardized definition of "wait-times" be established that can capture high quality, comparable data consistently across multiple data sources such as OCAN, DATIS and ConnexOntario, as currently different definitions are being used by all three sources.

On December 14, 2015, a second "*data day"* meeting took place to discuss the Task Group's work-to-date.

Overall there was much support from meeting participants for the proposed indicators and there was general consensus that the logic model and scorecard was a good starting point. Several recommendations were made for further condensing the indicators down to 10 indicators. It was also recommended that the indicators should be categorized as currently measureable or developmental, and critical gaps should be noted.

It was agreed that a stakeholder engagement and consultation process will take place once the next set of revisions are completed on the scorecard. Participants recommended that both individuals and organizations be engaged in the consultation process, and that different types of approaches be used including on-line and in-person engagement. Participants identified several stakeholders for engagement and consultation, including service providers and service users.

Subsequently, the Task Group held a meeting to incorporate all of the feedback received to date and to develop a stakeholder consultation plan.

Stakeholder Consultations

Please review the draft logic model and scorecard attached and consider the following questions:

- What are your general impressions of the logic model and scorecard?
- What are the critical gaps?
- As a service provider, what are the considerations for data collection and reporting? (i.e. What supports are needed to adequately report on these performance indicators? What is needed at an agency- regional- and provincial-level?)
- As a service user, what information do you want to know about the performance of the mental health and addictions sector? (i.e. What do you want to know is working well or not working well about the sector?)

Your feedback on these discussion questions will inform the final logic model and scorecard of performance indicators.

Please send us your feedback online by March 31, 2016.

We are also hosting a series of webinars to gather feedback across the mental health and addictions sector. We welcome participation from service providers and service users, including people with lived experience and the consumer/survivor community. The dates of the webinars are as follows, please click on the webinar of your choice to register.

Webinar #1: Consultation with Community Stakeholders
Thursday, February 18, 1:30 pm-3 pm

Webinar #2: Consultation with Local Health Integration Network (LHIN) Stakeholders
Friday, February 19, 9:30 am-11 am

Webinar #3: Consultation with Hospital Stakeholders
Friday, March 4, 9:30 am-11 am

We look forward to connecting with you on this important initiative.

For more information, contact:

Paul Kurdyak
Core Senior Scientist and Lead, Mental Health and Addictions Research Program, Institute for Clinical Evaluative Sciences
paul.kurdyak@camh.ca

Sean Court
I/Director, Strategic Policy Branch, Ministry of Health and Long-Term Care
sean.court@ontario.ca

Uppala Chandrasekera
Director, Public Policy
Canadian Mental Health Association, Ontario
uchandrasekera@ontario.cmha.ca

Achieving a High Performing Mental Health and Addictions System for Ontario

Draft: February 5, 2016

Draft vision: A high performing mental health and addictions system that is appropriately resourced and accountable to the public ensures that services and supports are provided in a safe, effective, client-centred, timely, efficient and equitable manner.

DRAFT FOR DISCUSSION

*__Core services__ are those with dedicated funding support that are available and accessible for everyone across Ontario, and will be further defined by the Mental Health and Addictions Leadership Advisory Council's Basket of Core Services Task Group.

Mental Health and Addictions Performance Indicators for Ontario

Draft: February 5, 2016

DRAFT FOR DISCUSSION

EQUITY

Indicators calculated from ICES administrative data, and other indicators where possible, will be assessed through five equity dimensions:

(1) Geography
(2) Income by neighbourhood
(3) Immigration status
(4) Age
(5) Sex

CLIENT-CENTRED

1. Overall rating of services received by client — OPOC — MHA

A. Stigma/Discrimination indicator — TBD — MHA

B. Decrease in a client's unmet needs indicator — OCAN — MHA

C. Family/Caregiver support indicator — TBD — MHA

SAFE

2. Use of physical restraints — OMHRS — MH

D. Medication reconciliation — TBD — MHA

EFFECTIVE

3. Years of life lost due to MHA — ICES: DAD, NACRS, OHIP, OMHRS, ORGD — MHA

4. Rate of death by suicide — ICES: ORGD — MHA

E. Global assessment of functioning (GAF) scores ≥ 10 points — OMHRS — MHA

TIMELY

5. Wait times from referral to service initiation — OCAN DATIS — MHA

6. First contact in the emergency department (ED) for MHA — NACRS, DAD, OHIP OMHRS — MHA

F. Common definition of "wait times" — TBD — MHA

EFFICIENT

7. Repeat unscheduled ED visit within 30 days — NACRS — MHA

8. Doctor visit within 7 days of leaving hospital after treatment for MHA — DAD, OMHRS, OHIP — MHA

9. Rate of inpatient readmission within 30 days of discharge — DADS, OMHRS — MHA

10. Alternate level of care (ALC) — ATC — MH

G. System transitions indicator — TBD — MHA

LEGEND

- POPULATION
- SYSTEM
- COMMUNITY-BASED & HOSPITAL SERVICES
- COMMUNITY-BASED SERVICES
- HOSPITAL SERVICES
- INDICATORS RECOMMENDED FOR DEVELOPMENT

- MHA — MENTAL HEALTH & ADDICTIONS
- MH — MENTAL HEALTH
- A — ADDICTIONS
- DATA SOURCE

Ontario's Mental Health & Addictions Leadership Advisory Council

Mental Health and Addictions Performance Indicators for Ontario

Draft: February 5, 2016

INDICATOR DESCRIPTIONS

Client-Centred:

1. Overall rating of services received by client
Every organization should ensure that the following question based on OPOC is included in their client satisfaction survey: Overall, how would you rate the services/care you are receiving? (Poor, Fair, Good, Very Good)

Safe:

2. Use of physical restraints
Use of physical restraints in facilities providing acute mental health care (# of patients who had mechanical restraint use indicated on their OMHRS records / Total # of individuals who were discharged from a designated adult mental health bed

Effective:

3. Years of life lost due to MHA

4. Rate of death by suicide
# of deaths caused by suicide / Total # of individuals in Ontario

Timely:

5. Wait times from referral to service initiation
- 5.1 # of days from the point of referral/application to initial assessment for community based mental health programs
- 5.2 # of days from the point of referral/application to initial assessment for community based addictions programs
- 5.3 # of days from the point of initial assessment to service initiation for community based mental health programs
- 5.4. # of days from the point of initial assessment to service initiation for community based addictions programs

6. First contact in the emergency department (ED) for MHA
# of individuals with an unscheduled ED visit related to MHA and without prior outpatient visits, claims, ED visits or hospital admissions related to MHA in the previous 2 years/ All unscheduled ED visits related to MHA

Efficient:

7. Repeat unscheduled emergency department visit within 30 days
- 7.1 Repeat unscheduled emergency department visit within 30 days for a substance abuse condition
- 7.2 Repeat unscheduled emergency department visit within 30 days for a mental health condition

8. Doctor visit within 7 days of leaving hospital after treatment for MHA
# of patients who within 7 days of discharge following index hospitalization had at least one psychiatrist or primary care physician visit/ # of acute care discharges from episode care in which a MHA condition is coded as most responsible diagnosis

9. Rate of inpatient readmission within 30 days of discharge

10. Alternate level of care (ALC)
- 10.1 # of individuals on ALC by hospital in mental health beds whose next place of care is supportive housing
- 10.2 # of days an individual is on ALC by hospital in mental health beds whose next place of care is supportive housing

INDICATORS RECOMMENDED FOR DEVELOPMENT

Client-Centred:

A. Stigma/Discrimination indicator - Recommended development of indicator on client perception of stigma/discrimination when receiving services (i.e. Did you experience stigma or discrimination from staff at this organization? Staff did not stigmatize or discriminate against me in relation to my mental illness, and/or my substance misuse/addiction, and/or my involvement with the criminal justice system)

B. Decrease in client's unmet needs indicator - Recommended development of indicator on the decrease in client's unmet needs based on OCAN (i.e. % change in a client's unmet needs following 1 year of ongoing service)

C. Family/Caregiver support indicator - Recommended development of indicator to capture family/caregiver satisfaction with services

Safe:

D. Medication reconciliation - Recommended that every organization ensure that medication reconciliation is conducted & reported for each client at the point of admission and/or service initiation

Effective:

E. Global assessment of functioning (GAF) scores ≥ 10 points - GAF will be phased out of OMHRS by April 1, 2016 and will be replaced. An indicator that captures information such as the following is recommended: % of clients with positive difference of at least 10 points between admission & discharge GAF scores.

Timely:

F. Common definition of "wait times" - Recommended development of a standardized definition of "wait times" that can capture high quality, comparable data consistently across multiple data sources

Efficient:

G. System transition indicator - Recommended development of community-hospital transition indicator based on Community Business Intelligence demonstration project data, and development of transition to/from justice system indicator based on OCAN data (i.e. % of individuals applying for court diversion who are successfully diverted from the criminal justice system).

DATA SOURCES - GLOSSARY

ATC (Access to Care) provides high-quality information products and services to help improve performance and ensure accountability within health care organizations.

DAD (Discharge Abstract Database) is a database that contains demographic, administrative and clinical data on all separations (with the exception of stillbirths and cadaveric donors) from acute inpatient facilities in all provinces and territories except Quebec.

DATIS is the Ontario Drug and Alcohol Treatment Information System.

NACRS (National Ambulatory Care Reporting System) is a data collection tool developed by the Canadian Institute for Health Information (CIHI) to capture information on patient visits to emergency departments.

OCAN (Ontario Common Assessment of Need) is a standardized, consumer-led, decision-making tool.

OHIP (Ontario Health Insurance Plan) Billing Data collects data that includes services rendered by a physician for which an amount payable is prescribed by the regulations under the Health Insurance Act (HIA), or a service prescribed as an insured service under the HIA rendered by a practitioner within the meaning of that Act.

OMHRS (Ontario Mental Health Reporting System) contains data about individuals admitted to adult mental health beds in hospitals across Ontario.

OPOC-MHA (Ontario Perception of Care Tool for Mental Health and Addictions) is a tool to assess client satisfaction with mental health and addiction treatment services in Ontario.

ORGD is the Vital Statistics – Death (Office for the Registrar General – Deaths).