

Hospital Report



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07

MENTAL HEALTH TECHNICAL MANUAL

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CONTENTS

PAGE

Overview	2
Hospital peer group categories	2
Participating hospitals (all quadrants)	2
Risk adjustment	3
Indicators in the Hospital Report 2007: Mental Health	3
Hospital Report Mental Health information sources:	
Databases	5
Survey sources	6
Describing the survey process:	
System Integration and Change (SIC)	9
Patient Perception of Care (POC)	10
Data quality	11
Developing the indicators	13
Dropped indicators	13
Added and modified indicators	15
System Integration and Change quadrant	16
Clinical Utilization and Outcome quadrant	20
Perception of Care quadrant	21
Financial Performance and Condition quadrant	24
Methodology to determine relative performance in Hospital Report 2007: Mental Health	25
Peer group differences	26
Appendices	
Appendix A: SIC Survey	31
Appendix B: Director Inpatient MH/Chief of Psychiatry Survey	36
Appendix C: ICD-10 Codes	39
Appendix D: OHIP Codes	47
Appendix E: List of Participating Hospitals	48
Appendix F: Average Length of Stay	51

OVERVIEW

This technical manual provides information about the 23 indicators and 14 contextual variables included in Hospital Report 2007: Mental Health. The data collection, verification processes, and method for calculating each indicator (including the formula and information source) are described.

The Report summarizes results at the provincial, LHIN and peer group levels (where possible), as well as reporting hospital specific results. This is available on www.hospitalreport.ca.

HOSPITAL PEER GROUP CATEGORIES

Acute:

1. Community hospitals with large psychiatric units (=> 30 designated mental health beds)
2. Community hospitals with small psychiatric units (1-29 designated mental health beds)
3. Teaching (acute hospitals with a membership in the Council of Academic Hospitals of Ontario which also are affiliated with a medical or health sciences school and have significant research activity and postgraduate training).

Specialty: These hospitals serve individuals with more complex treatment and behavioural management needs, who typically require a longer length of stay. Specialty hospitals include both dedicated mental health hospitals and mixed service hospitals (that also provide acute care for mental health and other conditions).¹ Many specialty facilities are former Provincial Psychiatric Hospitals.

PARTICIPATING HOSPITALS (ALL QUADRANTS)

Out of seventy-two (72) Schedule 1 hospitals² on the Ministry of Health and Long Term Care (MOHLTC) list, fifty-seven (57) received an invitation to participate in the 2007 Mental Health Hospital Report. Excluded were two correctional facilities and three children's hospitals that did not match the inclusion criteria, and hospitals that were named in the Ministry list but were actually part of a larger hospital corporation that was invited to participate.

Fifty-seven hospitals (57) signed the agreement with the Canadian Institute for Health Information (CIHI) to allow access to clinical database records and trial balance data for their organization, and to publish the results in the publicly accessible document. They were also approached to participate in the system integration and change, and perception of care surveys.

Table 1 reports the total number of eligible facilities, and the number of hospitals that participated in each reporting level by quadrant and data source. Indicator values are calculated and presented for provincial and LHIN levels based on data for 22-56 Schedule 1 hospitals (depending on the quadrant). Individual hospital values are reported for 19 to 53 hospitals (depending on the quadrant) that gave consent for that level of reporting. The variation in the number of hospitals in different quadrants is due to the availability and presence of data in administrative databases used for the report. Two specialty hospitals did not report to the DAD during the reporting period. Several hospitals declined to complete the SIC survey, hence were excluded from CUO quadrant reporting as well. A subset of 22 Schedule 1 hospitals participated in collection of inpatient satisfaction data, a rate that may grow as the field becomes more familiar with this relatively new survey tool.

¹ Baycrest Centre for Geriatric Care was grouped with specialty facilities due to its focus on the elderly who often have complex needs that require a longer hospitalization. Also, while St. Joseph's Health Care Hamilton delivers both acute and specialty services, it is classified as a specialty facility in this report.

² These hospitals are designated under the Mental Health Act as Schedule 1 facilities. Hospitals with this designation are required to deliver specific mental health services (i.e., inpatient, outpatient, day care, emergency, consultative and educational) (Designated Psychiatric Facilities under the Mental Health Act, Ontario Ministry of Health and Long Term Care. <http://www.health.gov.on.ca/english/public/contact/psych/designated.html>) As the list of Schedule 1 health facilities is updated when there are additions and/or exclusions of designated psychiatric facilities, any current list on the MOHLTC website may have been updated since 2005/06.

Table 1. Hospital Participation Rates by Quadrant

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

NR=not reported

* Data are reported in the Performance Allocation tables.

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

RISK ADJUSTMENT

Risk adjustment was done using direct standardization for age and sex for those indicators where these variables were available, specifically for those based on Discharge Abstract (DAD) and Perception of Care (POC) data. The population used for standardization was the total group of adults who had a mental health or addiction (MH/A) inpatient discharge for the 2005/06 fiscal year. Provincial and many of the Local Health Integration Networks (LHIN) level results were unadjusted since the important information was often the true magnitude of the indicator. For hospitals, however, results were risk-adjusted wherever possible.

INDICATORS IN THE HOSPITAL REPORT 2007: MENTAL HEALTH

System Integration and Change (SIC)

- SIC1: Inter-Organizational Networking
- SIC2: Notification of Hospitalization
- SIC3 (A, B): Use of Guideline Care for Tracer Conditions (Core (A) and Expanded (B))
- SIC4: Use of Clinical Data (Staff provided)
- SIC5: Use of Clinical Data (Client Provided)
- SIC6 (A, B, C): Discharge Plans Completed with Client (A)/Family (B)/Community Provider (C) Involvement
- SIC7: Regular Client Input in Hospital/Functional Centre (FC) Governance

Clinical Utilization and Outcomes (CUO)

CUO1:	Hospitalization for Psychotic Diagnoses
CUO2:	% of discharges with Length of Stay (LOS) of 3 days or less
CUO3:	Alternative Level of Care (ALC) Days
CUO4:	Ontario Health Insurance Plan (OHIP) Care within 30 Days Post-Discharge
CUO5 (A, B):	Emergency Department visit within 30 days post-discharge (but not admitted). All triage levels (A) and Urgent, emergent, resuscitation (B)
CUO6:	30-Day Readmission Rate
CUO7:	Repeat Inpatients

Perception of Care (POC)

POC1:	Perception of Staff Responsiveness
POC2:	Discharged Against Medical Advice (AMA)
POC3:	Perception of Appropriateness of Care
POC4:	Perception of Treatment Outcomes
POC5:	Perception of Participation in Treatment and Discharge Planning

Financial Performance and Condition (FPC)

FPC1:	% Nursing Worked Hours
FPC2:	% Sick Time
FPC3:	% Registered Nurse (RN) Hours
FPC4:	% Management and Operational Staff Hours

Contextual Variables

1. Rate of Ontarians Hospitalized per 100,000 adult population (by age, sex, LHIN)
2. Number of Schedule 1 hospitals by LHIN area
3. Schedule 1 bed availability per 100,000 population – acute and specialty – by LHIN area
4. Schedule 1 hospital Mental Health/Addiction (MH/A) discharges by LHIN area
5. MH/A discharges as % of all discharges in Schedule 1 facilities by LHIN area
6. MH/A bed days as % of all bed days in Schedule 1 facilities by LHIN area
7. % MH/A discharges from non-Schedule 1 facilities by LHIN area
8. % MH/A bed days in non-Schedule 1 facilities by LHIN area
9. % of MH/A inpatient days received by LHIN residents in non-LHIN hospitals by LHIN area
10. % of LHIN MH/A discharges for non-LHIN residents by LHIN area
11. Number of general practitioners (GPs) and psychiatrists per 100,000 population by LHIN area
12. Per capita community mental health service funding from MOHLTC by LHIN area
13. Availability of selected ambulatory hospital mental health services by LHIN area
14. Average Length of Stay – by hospital corporation.

HOSPITAL REPORT MENTAL HEALTH INFORMATION SOURCES

Databases (in alphabetical order)

Canadian Management Information System (MIS) Trial Balance The Ontario Financial and Statistical System (OHFS) is the database for the Management Information System (MIS). It contains financial and statistical data from integrated healthcare programs (Hospitals, Community Care Access Centres (CCAC), Children's Treatment Centres (CTC) and some Community Mental Health and Addictions Programs). OHFS is used in conjunction with the Ontario Healthcare Reporting System (OHRS). The OHRS outlines the requirements for data collection for planning, monitoring and reporting on health service activities. The OHFS contains the following types of information:

- **Financial and statistical data** for transfer payment agencies (hospitals, CCAC's, CTCs, community mental health agencies and addiction programs)
- **Balance sheets** Delivery cost of health care services (i.e., compensation costs, operating expenses, equipment cost information, referred out costs, sundry costs)
- **Employment skill mix and employment status** Financial and statistical data for producing performance indicators at both the facility and functional centre level.

Note: Only submissions that have passed all edit stages will exist in the database. If a facility resubmits, the previous submission data will be replaced by the new submission when it has passed all edit stages.

Data capture period: April 1, 2005-March 31, 2006

Census Every five years, Statistics Canada conducts a census. It is a statistical portrait of the country containing information on demographic, social and economic characteristics of its population. *Hospital Report 2007: Mental Health* is based on the 2001 Census.

Data capture period: Not applicable

Population selection criteria: Adults (15 +)

Community Mental Health Budgets and Programs Inventory (CMHBPI) This database of annual budget submissions from community mental health agencies is maintained by the MOHLTC. The database is updated annually in the summer, based on agency budgets taken from operating plans submitted to the Ministry in April for the upcoming fiscal year. The last few years has seen a transition in recording budget information from the Inventory to the MIS-CMH&A database. However for the fiscal years covered in this report, data quality was better in the CMHBPI (estimated participation: 92-94% of funded agencies) than for the MIS database (estimated participation: 30-35% of funded agencies). Any future reporting will need to migrate to the MIS.

Data capture period: April 1, 2005-March 31, 2006

Discharge Abstract Database (DAD) DAD contains demographic, administrative and clinical data for hospital discharges: acute inpatient, day surgery, chronic, and rehabilitation. CIHI receives data directly from participating hospitals in every province and territory except Quebec. Information collected in the DAD is used in the creation of parts of other databases. DAD in Ontario now contains only Acute Care. All other care types are now reported in their own systems.

Data capture period: April 1, 2005-February 28, 2006 for CU05, CU06 and CU07.

For all others April 1, 2005-March 31, 2006

Population selection criteria: Adults (15 +)

National Ambulatory Care Reporting System (NACRS) NACRS includes data for all hospital-based and community-based ambulatory care. These include surgical day/night care, outpatient clinics and emergency departments. Most of the data comes from Ontario, although other provinces submit as well. Currently, data submission to NACRS has been mandated in Ontario for Emergency Rooms (ER), Surgical day/night care, Dialysis, Cardiac Catheterization and Oncology (including all regional cancer centres).

Data capture period: April 1, 2005-February 28, 2006

Population selection criteria: Adults (15 +)

Ontario Health Insurance Plan (OHIP) Database The OHIP Database provides information on physician fee-for-service claims paid for services provided to Ontario residents. For each record, the database contains patient and physician identifiers (anonymized and then encrypted), a code for the service provided, date of service, associated diagnosis, and fee paid.

Data capture period: April 1, 2005-March 31, 2006

Population selection criteria: Adults (15 +)

ICES Physician Database (IPDB) Maintained by the Institute for Clinical Evaluative Sciences (ICES) and comprises information from OHIP, Corporate Provider Database (CPDB), Ontario Physician Human Resource Data Centre (OPHRDC) and OHIP database of physician billings. It contains information on physician demographics, specialty training and practice location. The data in the CPDB is validated against the OPHRDC database, which verifies physician specialty and practice location information through periodic phone interviews with physicians.

Data capture period: April 1, 2005-March 31, 2006

Survey Sources

System Integration and Change Survey – Mental Health Programs After the previous report, the investigators met with a selection of hospitals to review results and data sources. Based on their feedback as well as input from the project Advisory Committee, revisions were made to the 2004 SIC survey. New features of the survey are described in the paragraphs below.

The survey was redesigned to obtain information about service delivery practices within each of the functional centers for inpatient mental health hospital care in MIS trial balance dataset. Functional centres are subdivisions within a hospital that are used in functional accounting system to record the budget and actual direct expenses, statistics, and/or revenues, if any, which pertain to the function or activity being carried out. (Ontario Case Costing Initiative. Ontario Case Costing Project (OCCP) glossary of terms. [Online]. 2005 Sept [cited 2005 Aug]; Available from: URL: <http://www.occp.com/costing/glossary.htm#FunctionalCentre>).

Functional Centres/SIC survey sections were the following:

1. Acute functional centre (7127625)
2. Addictions functional centre (7127645)
3. Forensic functional centre (7127655)
4. Psychiatric Crisis (7127690)
5. Longer Term (7127695)

Each section consisted of the same set of 38 questions (*see Appendix A*). A sixth section of the survey was targeted to hospitals' respective Directors of Mental Health Services/Chief of Psychiatry and can be found in *Appendix B*.

The SIC survey questions (except those for the Director of mental health services section) pertain to hospital practices in the following areas:

1. Use of standardized guidelines and best practices – e.g., delivery of family psycho-education, delivery of patient training in illness self-management, and use of standardized guidelines for treatment of patients with three tracer conditions (Major mood disorder, Bipolar disorder and Schizophrenia).
2. Collection and use of clinical data on patient functional status or symptoms for continuous quality improvement.
3. Consumer, family and community provider participation – in hospital discharge plans and in program governance, planning and delivery.
4. Practices to support service integration and patient continuity of care – e.g., inter-organizational networking and notification about hospitalization and discharge of a patient.

Each section (including the Chief of Psychiatry/Director of Mental Health Services) was followed by a request for contact information of the respondent and a brief evaluation to estimate the burden of survey completion.

Compared to the 2004 survey, a number of changes were made. Fifteen questions were eliminated that were not used in indicator calculations in 2004, mainly due to quality problems. There were six new questions added about the delivery of evidence-based practice and the strategies for including consumers in program governance. Four questions were expanded to capture more detail – e.g., whether responses were ‘guestimates’ or based on systematically gathered data. Programs were also asked to specify the tools used for clinical assessment. The Chief of Psychiatry/Director of Mental Health Services section consisted of items included in 2004 SIC survey, with some items added/expanded regarding bed capacity within functional centres and funded mental health programs (other than inpatient care).

SIC Survey data capture period: April 1, 2005-March 31, 2006
(information gathered via March/April 2007 survey)

Patient Perception of Care Survey The Perception of Care survey was developed through a collaboration led by NRC+Picker Group Canada with a consortium of diverse stakeholders that included Hospital Report Research Collaborative³ researchers. A widely used US tool – the Mental Health Statistical Improvement Program (MHSIP): Consumer Survey – was the starting point for development. Initial revision occurred during 2002/03, followed by field-testing and reporting of preliminary performance data in the 2004 Mental Health Hospital Report. A second pilot occurred in the fall of 2005, resulting in further measure refinements as well as development of a systematic strategy for including surveys in the analytic sample. Survey development work occurred during 2002/03.

Given that patient needs and treatment goals vary somewhat across care settings, slightly different questionnaires were created for ‘long-stay’ inpatients (more complex conditions typically requiring longer length of stay and where expected discharge is not imminent) and ‘short-stay’ inpatients (those with relatively short stays for treatment of acute conditions). A core set of items was included in both measures. Additional items on the admission and discharge experience were added to the shorter stay program version.

The survey items were grouped to create four indicators, presented in the following table. A fifth patient satisfaction indicator – discharged against medical advice- is not included in the following table as it is based on routinely collected administrative data from the DAD rather than primary survey data.

POC Survey data capture period: Fall 2006

³ Renamed in Fall 2007 to Health System Performance Research Network.

Table 2. Perception of care survey evaluative items and subscale composition

POC question	Long stay	Short stay
ACCESS INDICATOR		
Admission process organized		•
Wait a long time for room		•
Able to see a psychiatrist as often as you want	•	•
Able to see staff as often as you want	•	•
Know who to talk to if you have any questions or concerns	•	•
PARTICIPATION IN TREATMENT INDICATOR		
Staff respectful of cultural background	•	•
Feel comfortable asking staff questions about your treatment	•	•
Staff give you reassurance and support about ability to recover	•	•
Get confusing answers from the staff	•	•
Staff help you to deal with problems	•	•
Involved as much as you want in decisions about your treatment	•	•
Involved as much as wanted in planning discharge		•
APPROPRIATENESS OF CARE INDICATOR		
Understand your treatment plan	•	•
Told about possible medication side effects	•	•
Explained to you your legal rights as a patient	•	•
Understand plan for treatment after you leave hospital		•
Told about other services/supports available in the community		•
Told whom to contact if problem or crisis after leave hospital.		•
Have enough privacy in this hospital	•	•
Feel unsafe in this hospital	•	•
OUTCOME INDICATOR		
Feel better prepared to deal with daily problems	•	•
Feel more ready to participate in your work, school, or other usual activities	•	•
Are your symptoms bothering you less	•	•
How much are you being helped by your hospital stay/ program	•	•
TOTAL ITEMS	19	25

* An item on patient perception of being 'able to refuse treatment' was removed after stakeholder feedback indicated ambiguity in how this item was interpreted by respondents.

Item coding and indicator calculation:

- There were four response options per item (e.g., never, sometimes, usually, always).
- All negatively framed survey questions were reverse-coded prior to data analysis.
- An indicator score was the mean percentage of usually/always responses across the relevant items per index per respondent.
- For each hospital, a mean sample score per indicator was calculated (hospital-specific result). In the e-scorecard, hospital specific results will be risk adjusted for age and gender, and sample sizes will be indicated.
- In the Report, mean scores for the entire provincial sample of long stay and short stay surveys are reported. However, hospital specific results are NOT reported.

DESCRIBING THE SURVEY PROCESS

System Integration and Change (SIC)

Data collection for the SIC survey happened during March and April 2007. Respondents were asked to answer the survey questions based on the hospital's performance during fiscal 2005/06. The survey was offered on-line for the first time using the Survey Monkey tool. Using an on-line tool effectively reduced administrative costs such as mailing and printing. It also significantly reduced the time and personnel costs spent on quality checks and follow up calls to hospitals for data validation.

Survey Monkey links were distributed via email to the CIHI Hospital Report Contact at each organization together with pdf copies (to print for reference). The Hospital Report Contact disseminated the sections of the survey to the person or persons in the organization who possessed the most knowledge about the topics in that section. At the end of each section one hospital staff was required to sign a statement of accuracy confirming that the responses were accurate and reflected the current operating circumstances.

Hospitals were given six weeks to complete the survey. Three reminder notices were sent two weeks before, a week before and on the deadline date. Data collection continued for two additional weeks after the deadline with 10 selected hospitals that needed to finish their submission. Eighty one percent of hospitals finished data collection within the initial six weeks deadline.

The overall SIC survey participation rate for the Mental Health sector was excellent. A total of 54 out of 57 Schedule 1 hospitals submitted the survey (95% participation rate). Hospitals were asked to complete one survey for the entire corporation. As it was mentioned earlier, three hospitals dropped out of the study during data collection: two due to the fact that their designated beds were relocated to another hospital during 2005-06, and one made a decision not to participate in *Hospital Report 2007: Mental Health* in the middle of data collection. Another hospital allowed the inclusion of their data only in the aggregate data analyses. Therefore, individual hospital level results are reported for 53 hospitals. *Table 3* lists participation rates by LHIN region and hospital peer group.

Table 3. SIC survey participation rates for LHIN and peer group reporting

	# of Surveys sent	# of Responses	Response Rate (%)
LHIN			
1 Erie St. Clair	4	4	100
2 South West	6	6	100
3 Waterloo Wellington	2	1	50
4 Hamilton Niagara Haldimand Brant	5	4	80
5 Central West	1	1	100
6 Mississauga Halton	3	3	100
7 Toronto Central	8	8	100
8 Central	4	4	100
9 Central East	6	6	100
10 South East	3	3	100
11 Champlain	5	5	100
12 North Simcoe Muskoka	3	3	100
13 North East	4	4	100
14 North West	3	2	67
PEER GROUP			
Acute	47	45	96
<i>Community (29 or fewer MH beds)</i>	21	20	95
<i>Community (30 or more MH beds)</i>	15	15	100
<i>Teaching</i>	11	10	91
Specialty	10	9	90
TOTAL	57	54	95

Patient Perception of Care (POC)

Survey strategy. In programs considered to serve ‘long stay’ patients (i.e., specialty facilities), a census sample of current inpatients was approached to complete a survey. In programs considered to serve short stay patients (general hospital units and some units in specialty facilities), patients were asked to complete a survey at discharge. A snapshot sampling strategy was used, with the short stay survey administered to discharges over a three month period and the long stay survey administered to inpatients on a defined census day.

All clients were eligible to complete the surveys. Clients were approached either at discharge or while in hospital. The main reasons for non-participation included: variable hospital procedures for surveying clients (e.g., for planned versus unplanned discharges); client refusal; client not available on survey day; client too ill to engage in interview. Due to variable reporting of results, actual rates of non-response could not be calculated. However participation rates were estimated to be about 10-30 percent of potential clients, hence these data represent only a subset of client views on perception of care.

Survey responses. There were 22 hospitals that participated in the short stay survey, submitting 986 usable surveys (see next data quality section for inclusion criteria). Excluding two outliers, sample sizes ranged from 15 to 96 per hospital. Six hospitals surveyed patients in long stay programs (census sample) submitting 429 usable surveys (37 to 117 per facility). Our total samples of usable data were 429 census surveys and 986 for the discharge cohort. Strategies to increase survey participation need to be explored, including timely notification of the field so that hospitals have sufficient budget and time to prepare.

Reporting. Because only a subset of hospitals participated and sample sizes varied per facility, individual hospital results are not provided in the Report. Rather aggregate results are reported. These results highlight some important quality of care issues as well as demonstrate the potential benefit of the tools. Based on the suggestion of the project advisory committee and with individual hospital agreement, hospital-specific results are reported in the e-scorecard, along with sample size per facility, to highlight the small sample size limitation.

DATA QUALITY

System Integration and Change Survey

Responses to the SIC hospital survey are vulnerable to “social desirability” bias, that is, consciously or unconsciously, respondents may answer questions in a way that puts their organization in the best possible light. To counteract this bias, an effort was made to construct survey questions that focused on specific and measurable hospital practices. Despite this focus, without related data systems hospitals relied heavily on estimates for many questions and some degree of interpretation may still be reflected in the answers.

The Hospital Report Mental Health team checked to see that all questions answered were within a valid range and appropriately addressed the question. Follow-up occurred with 50 percent of hospitals to complete missing responses or for response clarification. Eighty-two percent of clarifications pertained to skipped or missed questions, partially completed questions as well as typos. The Mental Health SIC survey did not have any skip logic – rather, all questions had to be answered. “Not applicable”, “Do not know” or “Other” answers with the possibility of elaboration were provided where necessary to capture all possible responses. Therefore Mental Health SIC survey did not have the technical issues that occurred in other Hospital Report SIC surveys resulting from the skip logic.⁴ Given the switch to reporting by Functional Centre within the SIC survey, the team had to work with seven hospitals to clarify whether specialized programming (e.g., for addictions problems) was supported through a separate MIS functional centre (FC) or was included within the acute care FC.

Random manual checks were conducted to compare the SIC data records with paper survey responses to ensure a high level of reliability. In addition, hospitals checked the SIC-based indicator results during the private report verification process.

Perception of Care Survey

Long-stay survey respondents were asked an additional four initial questions before completing the survey to help assess competency to provide meaningful responses.

- What is the survey about? A. “What I think about the care I receive at the hospital”
- What can you do if you don’t want to answer a question? A. “Not answer”
- Will your care be affected if you do not answer a question or finish the survey? A. “No”
- Who at the hospital will know your answers? A. “No one”

During the analysis, respondents with missing data (coded as –9s) and/or those who responded with multiple answers (coded as –8s). More than 40 percent of the survey questions were excluded from further analysis. In addition, surveys were excluded if two (2) of the four (4) initial questions were not answered appropriately (long stay survey respondents only).

⁴ Hospital Report 2007: Acute Care System Integration and Change Technical Summary. http://hospitalreport.ca/downloads/2007/AC/2007_AC_sic_techreport.pdf

NRC+Picker convened a stakeholder meeting in September 2007 to review the survey tools. Based on meeting feedback, a survey question on being 'able to refuse treatment' was removed. This was due to concerns about ambiguity in how this item was interpreted by respondents. In addition the scoring approach was changed to report percent of usually/always responses per item from an initial recalibration of responses to a 0-100 scale. This change addressed concerns about appropriateness of the mapping of responses onto the 0-100 scale. Finally, the two participation indexes were combined to create one index only.

Private Report Verification

Private reports went out for hospital verification on June 25, 2007. Canadian Institute for Health Information (CIHI) representatives at each hospital received password-secured Excel files with that hospital's indicator data along with the technical manual. The aims of this exercise were to do final quality checks of the report data, make necessary adjustments to the indicators where discrepancies were found and get hospital sign-off on their own data accuracy. Hospital data in private reports was not risk-adjusted so that hospitals could verify their DAD, NACRS and MIS submissions against their own data sources. Data published in e-scorecard and the Report contains age and sex adjusted values (where applicable).

Hospitals were given three weeks to complete their verification. Due to technical problems with the computer network at Centre for Addiction and Mental Health (CAMH) that prevented access to the project files for 15 working days, the verification deadline was extended for two more weeks.

The response rate for the private report verification was 52 percent (28 of the 54 hospitals that completed SIC surveys and were approached for data verification). The majority of received verifications (82.1%) were extremely detailed. Discrepancies in indicator values (and questions on indicator calculations) were most frequent for SIC quadrant indicators (12 hospitals), followed by Perception of Care quadrant (7 hospitals) and Clinical Utilization and Outcome quadrant (3 hospitals). Financial Performance and Condition was the only quadrant with no differences in indicator results except missing data for one hospital.

Discrepancies in indicators originating from administrative databases such as DAD or NACRS were due to the cleaning that databases go through at CIHI and ICES. For example, records are eliminated for out of province individuals or invalid OHIP numbers. Discrepancies were checked in cases where the difference was more than five percent between the ICES/CIHI hospital data and the data originally submitted by the hospital to CIHI

Resulting from the private report verification process, the following changes have been made to the indicators:

- Indicators resulting from SIC survey and pertaining to the Longer Term functional centre for all of the hospitals have been recalculated. There was a mistake originating in transfer of data from Excel to SPSS.
- An error in POC indicator calculation was corrected.

Hospitals provided valuable information for the technical manual content needed to support the verification process.

DEVELOPING THE INDICATORS

This section compares the indicator set reported in the 2004 Report and the present report. Indicators were either dropped, added or the methodology of their calculation modified. The table below provides a summary of introduced changes. Other details of indicator development can be found in the description section.

Table 4. Indicator development summary

	No methodological changes – can be compared with 2004	Methodological changes since 2004 – compare with caution	New Indicator for 2007
SIC Quadrant	SIC1, SIC2, SIC3 (A, B), SIC4, SIC5, SIC6 (A, B)		SIC6(C), SIC7
CUO Quadrant	CUO1, CUO3, CUO4, CUO5A, CUO6, CUO7		CUO 2, CUO 5B
POC Quadrant	POC2		POC1, POC3, POC4, POC5
FPC Quadrant	FPC1, FPC4	FPC3	FPC2

Hospital specific results for all indicators are available in the e-Scorecard.

Hospital Report: Mental Health 2007 provides values for Longer Term and Forensic functional centres only since there were too few hospitals with Addictions and Psychiatric Crisis functional centres to report. Indicators for the Longer Term and Forensic functional centres are provided for the SIC quadrant only.

As indicated in *Table 4*, comparisons with 2004 results can be made for the majority of indicators. Modifications were made to FPC3 – % of Registered Nurse Hours, hence caution should be used when comparing 2007 results with 2004 results. Several indicators, such as SIC6(C), SIC7, CUO2, CUO5 (B), FPC2 and four POC indicators are new for 2007 report and therefore cannot be compared.

DROPPED INDICATORS

In this section, we report indicators that were reported in Hospital Report 2004: Mental Health but were dropped for the 2007 report because subsequent research revealed methodological and conceptual shortcomings that limited their validity. This information is provided as a reference for individuals wishing to compare previous Reports with this one and also for those interested in the developmental process of creating and refining performance measures.

‘Training and Continuing Education Support’, ‘Average length of stay’, and ‘Rate of Ontarians Hospitalized per 100,000 Adult Population’ were dropped as indicators because no ‘target’ value could be identified. The latter two were retained as contextual variables because they provided useful background information and, in the case of Average Length of Stay, because of hospital request. Four out of seven human resource management indicators from the Financial Performance and Condition quadrant from 2004 report were also dropped (see below for the reasons under each indicator).

SIC Quadrant

Average Length of Stay This indicator counted the number of days between program admission and discharge, regardless of whether the discharge is to the community or another inpatient service. This is a commonly used indicator and in 2004 report it was intended to measure hospital efficiency. ALOS is easily measured but has major shortcomings for application such as absence of evidence-based benchmarks and the lack of clarity if ALOS actually reflects the optimum resource use. Despite a long history of being used as a performance indicator, the appropriate value for the hospital length of stay is unknown and there are no specific benchmarks that are universally agreed upon. Prolonged hospitalization does not necessarily benefit an individual, although optimal length of stay depends on

many factors, including availability of professional and family supports post-discharge. Unfortunately, existing databases do not allow tracking of discharged patients who may have been transferred to the community sector, and thus it is difficult to suggest benchmarks around the length of stay that would not compromise patient stability. However, because Average Length of Stay is widely used for performance measurement across North America (U.S. Veterans' Administration – VA, Healthcare Effectiveness Data and Information Set (HEDIS), Canadian Institute for Health Information – CIHI) and Europe (National Research and Development Centre for Welfare and Health – STAKES) and is of an interest to the hospitals, we have retained it as a contextual variable but discontinued it as an SIC indicator. For the Hospital Report: Mental Health 2007, this measure was replaced by "Percentage of discharges with Length of Stay of 3 days or less".

Training and Continuing Education Support This measure from the previous reports examined the extent to which hospital nurses and other health professionals have continuing education or professional development (CE/PD) opportunities with higher scores indicating greater hospital investment in human capital. Each hospital was asked whether on-site or off-site CE/PD activities were supported through either financial reimbursement or time off for these two staff groups. This indicator assesses an important performance domain and is of interest to the hospitals, but it provided only a crude measure of CE/PD activity. Although 2004 results indicated that Schedule 1 hospitals in Ontario offer near full support to pursue training and education activities for nurses and other health professionals, this measure ceased to be an indicator because it captured only general program support for CE/PD activities. It did not measure details of the practice, such as the portion of staff who participate in such initiatives, or how participation is reflected in practice or what proportion of budget was devoted to CE/PD.

CUO Quadrant

Rate of Ontarians Hospitalized per 100,000 Adult Population This is an indicator traditionally used to evaluate equity of access, where equity is defined simply as numeric similarity. While it is useful for highlighting groups or subpopulations with large disparities where further investigation would be useful, it is a very crude measure particularly in the absence of measures of need. In addition, because there is no gold standard for what proportion of need (or what proportions within different types of need) requires inpatient care, it is difficult to identify a desired direction or number suitable for either quality improvement or accountability purposes. It is retained as a contextual variable since it can provide comparative information on how service use differs across geographic or demographic groupings.

FPC Quadrant

Patient Care Hours This indicator measured the percentage of all hospital worked hours for staff who were available to carry out activities that contribute directly to the care of mental health patients. The numerator included worked and purchased service hours for all hospital staff who provided care to mental health patients (funded through the hospital's operating funds, i.e., Ontario Health Reporting System (OHRS) fund types 1 and 5). The denominator included worked and purchased service hours for all hospital staff, excluding medical personnel hours (OHRS fund types 1 and 5). This indicator was dropped because it could not be reported for all participating hospitals due to the difficulties of isolating OHRS data and because of variations in physician reimbursement and personnel reporting methods among hospitals. For example, in some hospitals, information systems personnel work in nursing units and their expense was reported under inpatient nursing, but in other hospitals, systems personnel expense is reported under corporate services. The method for reporting these hours affected this indicator. There were also variations in the reporting of purchased service hours and the methods of allocating these hours to corporate services or direct patient care functional centres. Values for this indicator could have been affected by staff mix, collective agreement requirements, the supply of labour available in a community, management strategies, case mix, and variations in the types of personnel included in mental health nursing functional centres. In addition, this indicator was only calculated for the specialty hospitals, and thus the sample was too small to calculate on a regional level.

Nursing Purchased Service Hours as a Percent of Nursing Worked Hours This indicator measured total purchased service hours as a percent of total worked hours for inpatient mental health nursing staff who provided patient care. The numerator was the total purchased service hours, that is, agency nursing. The denominator was calculated as total worked and purchased service hours for unit-producing nursing personnel. This indicator had to be dropped because it was more of a reflector of nursing shortages and of the supply of agency nursing staff than of hospital performance indicator of human resources. It was also dropped because it mainly reflected the decisions made by management regarding a hospital's staff mix, and it was highly dependent on a regional variation of purchased service personnel in different regions of the province.

Full-Time Registered Nurse Hours as a Percent of Total Registered Nurse Hours This indicator measured the proportion of nursing unit-producing activity that was provided by full-time registered nurses. The numerator included earned hours (worked, benefit and purchased service hours) for full-time registered nurse unit-producing personnel who provide care on the inpatient mental health unit. The denominator included earned hours for all registered nursing unit-producing staff (full-time, part time/ job share and casual/relief registered nurses) who carried out activities in the unit. Higher values reflected higher use of full-time registered nurses and less use of part-time, casual or agency registered nurses. This indicator was dropped because it was too dependent on the supply of registered nurses in the region and management practices regarding a hospital's staff mix.

Nursing Worked Hours as a Percent of Inpatient Care Worked Hours This indicator measured the proportion of all unit-producing staff that are nursing staff on inpatient mental health units. Unit-producing personnel (UPP) are staff who provide direct patient care. An example is a nurse or therapist engaged in treatment activities. The numerator included worked and purchased service hours for nursing staff (registered nurses, registered practical nurses and unregulated workers) who provide patient care on inpatient mental health units. The denominator included worked and purchased service hours for unit-producing nursing and therapy personnel (e.g., physiotherapists, occupational therapists and social workers) who provide patient care on inpatient mental health units. Higher values reflected a higher proportion of care provided by nurses and less care provided by therapists. This indicator was dropped because it reflected more of a patient care delivery or staffing models than hospital performance in the human resources area.

ADDED AND MODIFIED INDICATORS

- SIC7: Regular Client Input in Hospital/Functional Centre (FC) Governance
- CU02: Percentage of Discharges with Length of Stay (LOS) of 3 days or less
- CU05B: Emergency Department (ED) Visit Within 30 Days Post-Discharge (but not admitted) – Urgent, Emergent, Resuscitation
- POC1: Perception of Staff Responsiveness
- POC3: Perception of Appropriateness of Care
- POC4: Perception of Treatment Outcomes
- POC5: Perception of Participation in Treatment and Discharge Planning
- FPC2: % Sick Time
- FPC3: % Registered Nurse Hours (*modified*)

The next section contains information on each indicator, including sources, reporting level and their development.

- GP/nurse practitioner **with** hospital privileges
- GP/nurse practitioner **without** hospital privileges
- External ACT teams
- Other community mental health agency/service
- Home care
- No standardized protocols
- Other (please specify)

Numerator: Total number of points earned from SIC survey answers

Denominator: 3

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 for a total of three possible points.

For the peer group, LHIN functional center, and provincial levels indicator value is the average of hospital scores within a group expressed in percentages.

Indicator Development: Same indicator as SIC9 in 2004. Two-year comparisons are possible.

SIC3

Indicator Name: Use of Guideline Care for Tracer Conditions (core (A) and expanded (B))

Information sources: SIC survey

Reporting level: hospital, peer group, LHIN, functional centre, province

Question source for the indicator: Which of the following written guidelines does your Functional Centre usually base Patient treatment decisions on? Check all that apply.

Major Depressive Disorder	Schizophrenia	Bipolar Disorder
<input type="checkbox"/> CANMAT	<input type="checkbox"/> CPA	<input type="checkbox"/> CANMAT
<input type="checkbox"/> APA	<input type="checkbox"/> APA	<input type="checkbox"/> APA
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)

Numerator (core): “Yes” means a checkmark in at least one of CANMAT, APA or CPA boxes for any of the conditions.

Numerator (expanded): “Yes” means a checkmark in the abovementioned boxes or “other” if the suggested guideline was endorsed by an external professional organization.

Denominator (both): Not applicable on the hospital level

For the peer group, LHIN, functional centre and provincial levels, indicator values were calculated by dividing the number of “yes” responses by the total number of responses in a group.

Indicator development: Same indicator as SIC2 in 2004. Two-year comparisons are possible.

SIC4 & SIC5

Indicator Name: Use of Clinical Data (Staff Provided) (SIC4)

Indicator Name: Use of Clinical Data (Client Provided) (SIC5)

Information sources: SIC Survey

Reporting level: hospital, peer group, LHIN, functional centre, province

Question source for the indicator: For each of the following items, please indicate whether these data were collected and whether they were reviewed and used for continuous quality improvement between April 1, 2005 and March 31, 2006.

	Were these data collected on your patients?	Were these data reviewed and used for CQI?
STAFF assessed symptom or functional status of one or more patient groups.	YES NO	YES NO
PATIENT assessed symptom or functional status of one or more patient groups.	YES NO	YES NO

Numerator: "Yes" response if the data was *reviewed and used* for continuous quality improvement, "No" otherwise.

Denominator: Not applicable on the hospital level

For the functional centre, peer group, LHIN and provincial levels, indicator values were calculated by dividing the number of "yes" responses by the total number of responses in a group.

Indicator Development: Same indicators as CUO6 and CUO7 in 2004. Two-year comparisons are possible.

SIC6

Indicator Name: Discharge Plans Completed with Client (A)/Family (B)/Community Provider (C) involvement

Information sources: SIC survey

Reporting level: hospital, peer group, LHIN, functional centre, province

Question source for the indicator:

SIC6A: What percentage of your Functional Centre's psychiatric discharge plans had formal, documented CONSUMER or SUBSTITUTE DECISION MAKER involvement (If none, enter "0", if you do not know, enter "DK")

SIC6B: What percentage of your Functional Centre's psychiatric discharge plans have standardized documentation of FAMILY involvement (If none, enter "0", if you do not know, enter "DK")

SIC6C: What percentage of your Functional Centre's psychiatric discharge plans have standardized documentation of COMMUNITY PROVIDER involvement (If none, enter "0", if you do not know, enter "DK")

Numerator: Hospital answer to each of the questions is the crude value for this indicator.

Denominator: Not applicable on the hospital level

For the functional center, peer group, LHIN and provincial levels the average of hospital responses was taken (sum of responses in a particular group divided by their number). "Don't know" responses were excluded from calculations.

Indicator development: Same indicator as SIC3 in 2004. Two-year comparisons are possible.

SIC7

Indicator Name: Regular Client Input in Hospital/Functional Center Governance Originally in 2004 – Hospital Advisory/Steering Committees with Consumer or Family Representation

Information sources: SIC Survey

Reporting level: hospital, peer group, LHIN, functional centre, province

Question source for the indicator:

1. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services: Mental Health steering or advisory group.
 at least weekly at least monthly at least quarterly at least annually
 we do not have Advisory Group
2. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services: Focus Groups.
 at least weekly at least monthly at least quarterly at least annually
 we do not have Focus Group
3. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services: Retreats.
 at least weekly at least monthly at least quarterly at least annually
 we do not have Retreats
4. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services: Regular Consultations.
 at least weekly at least monthly at least quarterly at least annually
 we do not have Regular Consultations
5. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services: Other (Specify).
 at least weekly at least monthly at least quarterly at least annually
 we do not have Other activities

Numerator: The minimum frequency observed for all of the activities reported by each hospital.

Denominator: Not applicable on the hospital level

Peer group, LHIN, functional centre and provincial levels calculations:

Weekly: number of hospitals whose minimum frequency for involving consumers into hospital governance was weekly, divided by the total number of hospitals in the group (expressed as percentage).

Monthly: number of hospitals whose minimum frequency for involving consumers into hospital governance was monthly, divided by the total number of hospitals in the group (expressed as percentage).

Quarterly: number of hospitals whose minimum frequency for involving consumers into hospital governance was quarterly, divided by the total number of hospitals in the group (expressed as percentage).

Annually: number of hospitals whose minimum frequency for involving consumers into hospital governance was annually, divided by the total number of hospitals in the group (expressed as percentage).

Indicator development: This indicator has been redesigned since 2004 and significantly expanded due to hospital feedback received during private reports verification. Such components as Retreats, Focus Groups, Consultations and Other activities were added because advisory committees were not the only method used by hospitals to involve consumers into hospital/program governance. This indicator evolved from reporting the presence of the Advisory Committee with consumer involvement in 2004 to the frequency of various activities that consumers participate in (weekly, monthly, quarterly, annually). Because the methodology for this indicator has changed significantly, comparisons with 2004 are **not** possible.

CLINICAL UTILIZATION AND OUTCOMES QUADRANT

General Notes

1. CUO indicators were using event-level data (e.g., inpatient discharges, OHIP provider visits) calculated for individuals who were age 15 and older at the midpoint of fiscal 2005/06.
2. The codes used to define eligible events are based on those used in the previous Reports and are listed in *Appendix C* of this Technical Manual.
3. The list of eligible hospitals (i.e., Schedule 1) and the included subunits is provided in *Appendix E*.

CUO1

Indicator name: Hospitalization for psychotic diagnoses

Information sources: DAD

Reporting level: hospital, peer group, LHIN, province

Numerator: Number of discharges where most responsible diagnosis was psychotic diagnosis

Denominator: Total number of MH/A discharges

Indicator Development: Same indicator as SIC1 from 2004. Two-year comparisons are possible.

CUO2

Indicator Name: Percentage of discharges with length of stay (LOS) of 3 days or less

Information Sources: DAD

Reporting level: hospital, peer group, LHIN, province

Numerator: Total number of hospital mental health or addiction (MH/A) discharges where LOS less than or equal to 3 days.

Denominator: Total number hospital MH/A discharges

Peer group, LHIN and provincial levels calculations are identical to the hospital level ones – we divide the total number of mental health or addiction (MH/A) discharges where LOS less than or equal to 3 days by the total number of hospital MH/A discharges in a group.

Indicator Development: This is a new indicator replacing Average Length of Stay. Comparisons with 2004 are not possible.

CUO3

Indicator Name: Alternative Level of Care days (ALC)

Information Sources: DAD

Reporting level: hospital, peer group, LHIN, province

Numerator: Total ALC days for MH/A discharges

Denominator: Total inpatient days for MH/A discharges

Indicator Development: Same indicator as SIC6 in 2004. Two-year comparisons are possible.

CUO4

Indicator Name: OHIP care within 30 days post-discharge

Information Source: DAD, OHIP

Reporting level: hospital, peer group, LHIN, province

Numerator: Number of MH/A (mental health and addictions) discharges followed by OHIP MH visit within 30 days

Denominator: Total number of MH/A discharges

Indicator Development: Same indicator as CUO2 in 2004. Two-year comparisons are possible.

CUO5A & CUO5B

Indicator Name: Emergency Department visit within 30 days post-discharge (not admitted) – (CUO5A)

Emergency Department visit within 30 days post-discharge: Urgent, emergent, resuscitation (not admitted) (CUO5B)

Information Source: DAD, NACRS

Reporting level: hospital, peer group, LHIN, province

Numerator: Number of MH/A discharges followed by ED MH/A visit to any Ontario facility within 30 days which did not have hospitalization as outcome

Denominator: Total number of MH/A discharges

Indicator Development: CUO4 is the same indicator as CUO3 in 2004. Two-year comparisons are possible for CUO4. CUO4B is a new indicator for 2007. Comparisons with 2004 are not possible.

CUO6

Indicator Name: 30-Day readmission rate

Information Source: DAD

Reporting level: hospital, peer group, LHIN, province

Numerator: number of MH/A discharges which are followed in 30 days by a MH/A admission to any Ontario hospital where the 2nd admission is not a transfer

Denominator: Total number of MH/A discharges

Indicator Development: Same indicator as CUO4 in 2004. Two-year comparisons are possible.

CUO7 (Hospital-level contextual variable)

Indicator Name: Repeat inpatients

Information Source: DAD

Reporting Level: hospital, peer group, LHIN, Provincial

Numerator: Number of individuals with more than one psychiatric discharge within the reporting period

Denominator: Number of individuals with at least one psychiatric discharge

Indicator Development: Same indicator as CUO5 in 2004. Two-year comparisons are possible.

PERCEPTION OF CARE QUADRANT

POC1

Indicator Name: Perception of Staff Responsiveness

Information Source: POC Survey

Reporting level: peer group, province

Score Calculation: Patient

Long-Stay Survey:

Numerator: Of the three questions below, the number answered as 'usually' or 'always' by the patient

Denominator: 3

Coding Notes: All three questions must have been answered to calculate an index score

Short-Stay Survey:

Numerator: Of the five questions below, the number answered as 'usually' or 'always' by the respondent

Denominator: The total number of questions the client responded to which pertain to the indicator (i.e., 3-5).

Coding Notes: Minimum of three of the five questions must have been answered to calculate an index score. The response to Q2 was reversely coded prior to indicator calculation.

Score Calculation: Reporting unit (i.e., peer group, province)

Numerator: Mean index result across all patients in the reporting unit

Denominator: NA

Access	Long-Stay	Short-Stay
Q1. Admission process organized		•
Q2. Wait a long time for room		•
Q3. Able to see a psychiatrist as often as you want	•	•
Q4. Able to see staff as often as you want	•	•
Q5. Know who to talk to if you have any questions or concerns	•	•

Indicator Development: New indicator since 2004. Comparisons with 2004 are not possible.

POC2

Indicator Name: Discharged Against Medical Advice (AMA)

Information Source: DAD

Reporting level: hospital, peer group, LHIN, province

Numerator: Number of MH/A discharges against medical advice

Denominator: Total number of MH/A discharges

Indicator Development: Same indicator as PPC1 in 2004. Two-year comparisons are possible.

POC3

Indicator Name: Perception of Appropriateness of Care

Information Source: POC Survey

Reporting level: peer group, province

Score Calculation: Patient

Long-Stay Survey:

Numerator: Of the five questions below, the number answered as 'usually' or 'always' by the patient

Denominator: The total number of questions answered which pertain to the indicator.

Coding Notes: Minimum of three out of five questions must have been answered to calculate an index score. The response to Q8 was reverse coded prior to indicator calculation.

Short-Stay Survey:

Numerator: Of the eight questions below, the number answered as 'usually' or 'always' by the patient

Denominator: The total number of questions answered which pertain to the indicator.

Coding Notes: Minimum of five out of eight questions must have been answered to calculate an index score. The response to Q8 was reversely coded prior to indicator calculation. If a respondent answered "rights not explained" for Q3, this result was coded a 0 (i.e. "not at all"). In addition, if a respondent answered "not applicable" for Q2, this result was excluded from the analysis.

Score Calculation: Reporting unit (i.e., peer group, province)

Numerator: Mean index result across all patients in the reporting unit.

Denominator: Not applicable

Appropriateness of Care	Long-Stay	Short-Stay
Q1. Understand your treatment plan	•	•
Q2. Told about possible medication side effects	•	•
Q3. Explained to you your legal rights as a patient	•	•
Q4. Understand plan for treatment after you leave hospital		•
Q5. Told about other services/supports available in the community		•
Q6. Told whom to contact if problem or crisis after leave hospital		•
Q7. Have enough privacy in this hospital	•	•
Q8. Feel unsafe in this hospital	•	•

Indicator Development: New indicator since 2004. Comparisons with 2004 are not possible.

POC4

Indicator Name: Perception of Treatment Outcomes

Information Source: POC Survey

Reporting level: peer group, province

Score Calculation: Patient (long stay and short stay)

Numerator: Of the four questions below, the number answered as 'usually' or 'always' by the patient

Denominator: The total number of questions answered which pertain to the indicator (i.e., 3 or 4)

Score Calculation: Reporting unit (i.e., peer group, province)

Numerator: Mean index result across all patients in the reporting unit

Denominator: Not applicable

Outcomes	Long-Stay	Short-Stay
Q1. Feel better prepared to deal with daily problems	•	•
Q2. Feel more ready to participate in your work, school, or other usual activities	•	•
Q3. Are your symptoms bothering you less	•	•
Q4. How much are you being helped by your hospital stay/program	•	•

Coding Notes: Minimum of three out of four questions must have been answered to calculate an index score.

Indicator Development: New indicator since 2004. Comparisons with 2004 are not possible.

POC5

Indicator Name: Perception of Participation in Treatment and Discharge Planning

Information Source: POC Survey

Reporting level: peer group, province

Score Calculation: Patient

Long-Stay Survey:

Numerator: Of the six questions below, the number answered as usually or always by the patient

Denominator: The total number of questions answered which pertain to the indicator

Short-Stay Survey:

Numerator: Of the seven questions below, the number answered as 'usually' or 'always' by the patient

Denominator: The total number of questions answered which pertain to the indicator

Score Calculation: Reporting unit (i.e., peer group, province)

Numerator: Mean index result across all patients in the reporting unit

Denominator: Not applicable

Treatment Participation/Empowerment	Long-Stay	Short-Stay
Q1. Staff respectful of cultural background	•	•
Q2. Feel comfortable asking staff questions about your treatment	•	•
Q3. Staff give you reassurance and support about ability to recover	•	•
Q4. Get confusing answers from the staff	•	•
Q5. Staff help you to deal with problems	•	•
Q6. Involved as much as you want in decisions about your treatment	•	•
Q7. Involved as much as wanted in planning discharge		•

Coding Notes: Four of the above questions must have been answered to calculate an index score for the long stay patients and five for the short stay. Responses to Q2 and Q4 were reversely coded prior to indicator calculation. If a respondent answered "someone else makes my decisions for me" for Q6, this result was excluded from the analysis.

Indicator Development: New indicator since 2004. Comparisons with 2004 are not possible.

FINANCIAL PERFORMANCE AND CONDITION QUADRANT

FPC1

Indicator Name: % Nursing Worked Hours

Information Source: MIS

Reporting level: hospital, peer group, LHIN, province

Numerator: Nursing Worked Hours * 100

Denominator: Nursing Earned Hours

Coding notes (OHRS Accounts):

The numerator includes UPP and nurse practitioners worked and purchased service hours, excluding medical personnel hours. UPP are staff who provide patient care, such as a nurse engaged in treatment activities for a patient. Sick time and educational time are examples of earned hours that are spent engaged in activities not directly related to the provision of patient care. [Numerator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 6351**1, 6351**2, 6381**1, 6381**2]

The denominator includes earned hours (worked, benefit and purchased service hours) for the same group of staff. [Denominator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 6351*, 6381*]

Indicator Development: Same indicator as 'Nursing worked hours as a percent of nursing total hours' from the 2004 *Report*. Two-year comparisons are possible.

FPC2

Indicator Name: % Sick Time

Information Source: MIS

Reporting level: hospital, peer group, LHIN, province

Numerator: Sick Hours * 100

Denominator: Full-Time Earned Hours

Coding notes (OHRS Accounts):

The numerator includes the paid sick hours for management, patient care and support personnel in mental health inpatient services of a hospital. [Numerator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 631**13, 635**13 and 638**13]

The denominator includes earned hours for full-time management, patient care and support personnel in mental health inpatient services of a hospital. [Denominator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 631**1*, 635**1* and 638**1*]

Indicator Development: New indicator for the 2007 *Report*. Comparisons with 2004 are not possible.

FPC3

Indicator Name: % Registered Nurse Hours

Information Source: MIS

Reporting level: hospital, peer group, LHIN, province

Numerator: Registered Nurse Earned Hours * 100

Denominator: Nursing Earned Hours

Coding Notes (OHRS Accounts):

The numerator includes mental health inpatient services registered nurse unit-producing personnel and nurse practitioners earned hours; [Numerator Codes include: Sector codes 1*, primary accounts 71276 excluding 7127695 and secondary statistical accounts 63511*, 63513*, 63514*, 63515*, 63516*, 63816*]

The denominator includes mental health inpatient services total unit-producing personnel and nurse practitioners earned hours. [Denominator Codes include: Sector codes 1*, primary accounts 71276* excluding 7127695 and secondary statistical accounts 6351*, 6381*.]

Indicator Development: Close indicator to 'Registered Nurse Hours as a Percent of Nursing Total Hours' from 2004. Results comparison is possible with FPC5 from 2004 although with a certain caution. Starting from April 2005 hospitals are required to submit earned hours by occupational class. It allows for a more detailed reporting of the earned hours of staff by the type of health provider. The specifications of % of Registered Nurse Hours indicator were changed to take advantage with the new level of detail.

FPC4

Indicator Name: % Management and Operational Staff Hours

Information Source: MIS

Reporting level: hospital, peer group, LHIN, province

Numerator: Management and Operational Staff Hours * 100

Denominator: Total Earned Hours

Coding Notes (OHRS Accounts):

The numerator includes hours worked for management and support staff, as well as benefit and purchased service hours, excluding medical personnel hours. [Numerator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 631*]

The denominator includes worked, benefit and purchased service hours for all staff (management, unit producing personnel and nurse practitioners) excluding medical personnel hours. [Denominator Codes include: For sector code 1*, primary accounts 71276* except 7127695 and secondary statistical accounts 631*, 635* and 638*]

Indicator Development: Same indicator as 'Management and Operational Support Staff Hours as a Percent of Total Hours' from 2004. Results comparison is possible with FPC4 from 2004.

METHODOLOGY TO DETERMINE RELATIVE PERFORMANCE IN HOSPITAL REPORT 2007: MENTAL HEALTH

For this *Report*, high performance was evaluated only for the CUO and FPC indicators. These were the quadrants where the data were the most complete (available for over 98% of Schedule 1 hospitals) and reliable. The CUO and FPC indicators used to identify high performers are those where a desirable direction or value can be defined, and it should be kept in mind that the comparisons used to make these judgments are only among Ontario hospitals.

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

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

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

PEER GROUP DIFFERENCES

Below we provide more detailed data on each indicator at the hospital group level. Data are provided for different groups so that hospitals can situate themselves relative to their peers. Please note that these data are not intended to facilitate comparisons *between* different hospital groups.

CU01: Hospitalization for Psychotic Diagnoses

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	33.4	35.5	27.3	35.5	34.7
Minimum	4.7	19.0	14.9	21.0	4.7
25th Percentile	25.6	27.4	23.8	29.7	37.0
Median	32.5	38.2	26.1	33.6	42.0
75th Percentile	41.9	46.2	32.5	42.6	49.3
Maximum	61.4	51.9	35.0	59.3	61.4

CU02: Percentage of Discharges with LOS of 3 days or less

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	27.6	28.4	31.5	31.6	15.8
Minimum	0.7	17.8	11.1	18.4	0.7
25th Percentile	20.6	19.1	26.0	25.8	3.5
Median	27.2	20.9	31.4	29.6	12.2
75th Percentile	34.5	28.7	38.1	34.6	17.8
Maximum	55.3	55.3	41.8	44.7	21.6

CU03: Alternative Level of Care Days

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals ⁽⁵⁾
Valid N	55	10	21	15	9
Mean	4.2	9.6	8.4	7.8	0.4
Minimum	0.0	3.0	1.0	4.0	0.0
25th Percentile	3.5	3.5	3.9	4.6	0.0
Median	6.0	9.6	7.0	7.9	0.0
75th Percentile	9.2	12.5	8.4	11.4	0.2
Maximum	26.1	13.7	26.1	20.5	3.5

⁵ Specialty hospitals, unlike acute Schedule 1 hospitals, are not required to report ALC days.

CU04: OHIP Care within 30 days Post-discharge

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	52.6	52.9	51.6	55.3	50.1
Minimum	8.1	21.4	33.5	38.4	8.1
25th Percentile	45.5	47.6	42.2	49.3	19.2
Median	54.2	59.8	54.2	54.7	41.1
75th Percentile	59.8	62.6	59.5	59.7	58.5
Maximum	75.1	65.5	62.2	75.1	61.5

CU05A: ER visits within 30 days post-discharge

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	9.0	9.8	8.3	9.6	8.0
Minimum	0.0	6.7	5.4	6.1	0.0
25th Percentile	6.8	8.5	6.6	7.9	2.8
Median	8.7	9.2	8.5	9.0	5.2
75th Percentile	10.4	12.2	10.4	10.1	7.7
Maximum	18.1	18.1	11.6	15.7	14.5

CU05B: ER visits within 30 days: Urgent, emergent, resuscitation

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	6.3	7.1	5.6	7.1	5.0
Minimum	0.0	4.0	2.0	4.2	0.0
25th Percentile	4.2	6.1	4.2	5.9	2.5
Median	6.2	6.8	5.7	6.6	4.0
75th Percentile	7.8	8.9	7.2	8.0	4.2
Maximum	13.8	13.8	8.7	11.9	9.0

CU06: 30-day readmission rate

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	12.5	12.7	11.6	14.0	11.1
Minimum	0.6	7.8	8.7	7.9	0.6
25th Percentile	10.1	10.4	9.5	12.2	8.0
Median	12.3	12.7	10.8	12.7	12.8
75th Percentile	14.0	14.2	12.8	14.7	15.2
Maximum	20.2	17.7	17.3	20.2	16.4

CU07: Repeat Inpatients

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	26.4	28.6	24.5	27.3	26.8
Minimum	4.2	21.6	14.1	20.0	4.2
25th Percentile	22.3	23.8	21.6	23.9	22.0
Median	25.2	26.5	22.8	25.5	28.5
75th Percentile	29.1	29.9	25.6	28.6	33.5
Maximum	55.3	44.8	37.1	55.0	44.2

POC2: Discharged Against Medical Advice

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	55	10	21	15	9
Mean	5.8	6.1	6.5	5.4	5.2
Minimum	0.0	3.1	2.9	2.9	0.0
25th Percentile	3.5	3.6	3.6	3.8	2.1
Median	5.3	5.4	6.6	5.3	4.5
75th Percentile	7.1	7.7	9.2	6.5	6.0
Maximum	13.1	8.9	13.1	9.6	9.7

FPC1: Percentage Nursing Worked Hours

	All Hospitals	Teaching ⁽⁶⁾	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	56	10	21	15	10
Mean	83.8	85.1	85.3	84.6	82.5
Minimum	77.2	79.0	77.8	80.9	77.2
25th Percentile	83.2	83.2	84.5	83.2	80.8
Median	85.1	85.3	85.1	85.2	83.3
75th Percentile	86.8	87.1	86.8	85.8	85.4
Maximum	90.5	88.4	90.5	87.1	89.0

FPC2: Percentage Sick Time

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	56	10	21	15	10
Mean	6.9	6.2	5.3	7.8	7.1
Minimum	1.3	3.2	1.3	4.2	1.6
25th Percentile	4.9	4.7	4.6	5.3	6.1
Median	6.5	5.7	5.4	7.3	6.9
75th Percentile	8.0	8.2	7.3	10.5	7.9
Maximum	14.1	9.6	11.6	14.1	8.9

FPC3: Percentage Registered Nurse Hours

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	56	10	21	15	10
Mean	73.0	87.3	76.2	83.8	62.9
Minimum	38.1	57.8	47.2	65.6	38.1
25th Percentile	68.1	74.6	67.8	75.3	48.5
Median	77.2	100.0	74.4	82.2	63.7
75th Percentile	99.5	100.0	96.6	97.7	74.6
Maximum	100.0	100.0	100.0	100.0	100.0

6 Baycrest Centre for Geriatric Care is included in the teaching hospitals peer group for ALL four financial indicators.

FPC4: Percentage Management & Operational Staff Hours

	All Hospitals	Teaching	Community (29 or fewer MH beds)	Community (30 or more MH beds)	Specialty Hospitals
Valid N	56	10	21	15	10
Mean	7.8	11.1	9.7	10.2	5.2
Minimum	0.0	2.1	2.5	4.6	0.0
25th Percentile	6.7	8.2	6.4	7.7	1.7
Median	8.5	11.5	9.7	8.5	6.6
75th Percentile	12.5	17.5	19.9	10.3	7.6
Maximum	19.6	19.4	16.6	19.6	11.3

APPENDIX A: SYSTEM INTEGRATION AND CHANGE SURVEY BY FUNCTIONAL CENTRE

Dear Madam/Sir,

We welcome your hospital's participation in the data collection process for the System Integration and Change (SIC) quadrant – Mental Health. This year, for the first time, the survey is available online. Results will be reported in Hospital Report 2007, due to be released on the e-Scorecard in the Fall 2007.

This year SIC Mental Health survey consists of six sections that have to be filled separately. You were identified by your hospital's CIHI contact as a person responsible for completing the Acute Functional Centre (7127625) section of the survey.

PDF copies of surveys were sent to you by email. These can be used for reference so that you can gather the information you need to prepare answers. However, the final surveys **MUST BE COMPLETED** and submitted online. Surveys do not have to be done in one sitting, but each section must be completed on the same computer in order for previously entered answers to be saved. Instructions on how to use Survey Monkey are provided on the next page.

This survey has to be submitted by **March 1, 2007**.

The next page gives you instructions how to use Survey Monkey in case you have not worked with it before. It is an easy and user-friendly tool to use. If you experience problems with it please contact Natalia Zaslavska at Natalia_Zaslavska@camh.net or call her at **416-535-8501 x 4031**.

You can also contact principal investigators for the Hospital Report Card Mental Health project, Drs Elizabeth Lin x 4102 (elizabeth_lin@camh.net) or Janet Durbin x 6229 (janet_durbin@camh.net) if you have issues with the survey. Thank you, in advance, for your cooperation in ensuring the success of this project.

Sincerely,

Natalia Zaslavska

Research Coordinator
Hospital Report: Mental Health

Use of Standardized Guidelines and Best Practices

1. For the following guideline-based interventions, please indicate the number of FTE staff equivalents who were trained to provide them and the frequency that these interventions were offered to patients/clients or their families between April 1, 2005 to March 31, 2006 –

Interventions:

	Intervention	
	1.1 Family Psychoeducation (e.g. 0.5)	1.2. Training in illness self-management (e.g. 0.5)
Physicians		
Nurses		
Social Workers		
Other		

Frequency:

	Frequency	
	1.1 Family Psychoeducation (e.g. 0.5)	1.2. Training in illness self-management (e.g. 0.5)
Rarely or Never		
Sometimes		
Often		
Always or almost always		

2. Which of the following written guidelines does your Functional Centre usually base Patient treatment decisions on? *Check all that apply.*

Major Depressive Disorder	Schizophrenia	Bipolar Disorder
<input type="checkbox"/> CANMAT	<input type="checkbox"/> CANMAT	<input type="checkbox"/> CANMAT
<input type="checkbox"/> APA	<input type="checkbox"/> APA	<input type="checkbox"/> APA
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Not Applicable (we do not treat clients with MDD)	<input type="checkbox"/> Not Applicable (we do not treat clients with Schizophrenia)	<input type="checkbox"/> Not Applicable (we do not treat clients with bipolar)
<input type="checkbox"/> Other (Please specify):	<input type="checkbox"/> Other (Please specify):	<input type="checkbox"/> Other (Please specify):

Collection and Use of Quality of Care Data

3. For each of the following items, please indicate whether these data were collected and whether they were reviewed and used for continuous quality improvement between **April 1, 2005** and **March 31, 2006**.

	Were these data collected on your patients?		Were these data reviewed and used for CQI?	
STAFF assessed symptom of functional status of one or more patient groups	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
PATIENT assessed symptom of functional status of one or more patient groups	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

4. How frequently were STAFF and PATIENT assessed data reviewed and used for CQI?

	Quarterly	At least yearly	Infrequently – as needed	Never
How frequently were STAFF assessed data reviewed and used for CQI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How frequently were PATIENT assessed data reviewed and used for CQI?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. What measures were used for assessment by STAFF and PATIENT? *Check all that apply.*

	GAF	PANSS	MCAS	BPRS	RAI-MH	None	Other
Measures used for assessment by STAFF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Measures used for assessment by PATIENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Other, Please specify:							

Consumer, Family and Community Provider Participation

6. What percentage of your Functional Centre's psychiatric discharge plans have formal, documented **consumer** or **substitute decision maker** involvement between April 1, 2005 and March 31, 2006?
(If none, enter "0", if you do not know, enter "DK")

_____ This number:

- Was calculated from systematically gathered data
 Is a "guestimate"

7. What percentage of your Functional Centre's psychiatric discharge plans have standardized documentation of **family** involvement between April 1, 2005 and March 31, 2006?
(If none, enter "0", if you do not know, enter "DK")

_____ This number:

- Was calculated from systematically gathered data
 Is a "guestimate"

8. What percentage of your Functional Centre's psychiatric discharge plans have standardized documentation of **community provider** involvement between April 1, 2005 and March 31, 2006?
(If none, enter "0", if you do not know, enter "DK")

_____ This number:

- Was calculated from systematically gathered data
 Is a "guestimate"

9. Please indicate the methods, their scheduled frequency, and associated process for incorporating consumer input into your Functional Centre's governance, planning, and/or delivery of services.

	at least weekly	at least monthly	at least quarterly	at least annually	we do not have this activity
Mental health steering or advisory group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process for incorporating input from steering committee/advisory group into your Functional Centre activities					
Focus groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process for incorporating input from focus groups into your Functional Centre activities					
Retreats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process for incorporating input from retreats into your Functional Centre activities					
Regular consultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process for incorporating input from regular consultations into your Functional Centre activities					
Other (specify at the bottom)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Process for incorporating other input into your Functional Centre activities					
If <i>Other</i> , Please specify:					

10. Please indicate which of the following your Functional Centre had between April 1, 2005 and March 31, 2006 – ?

	Primary Care	ACT	Other Community MH Program	Other Hospitals	Long-term Care	None	Other
Formal written agreements as part of a collaborative arrangement to provide mental health/addictions services with...							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <i>Other</i> , please specify							
Staff or personnel who are members of steering/advisory committees or on the boards of other organizations delivering mental health/addictions services in...							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <i>Other</i> , please specify							
Staff or personnel who spend more than one-half day per week working in a program/-unit external to your hospital as part of a collaborative arrangement to provide mental health/addictions services in...							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <i>Other</i> , please specify							

11. Does your Functional Centre have a standardized protocol (given patient/substitute consent) in place to notify the following groups about a patient's admission to hospital, stay while in hospital, and discharge after hospital stay? (*Note: this can include a hospital-wide protocol which the Functional Centre participates in.*)

	GP/nurse practitioner with hospital privileges	GP/nurse practitioner without hospital privileges	External ACT teams	Other community mental health agency/ service	Home care	No standardized protocols	Other
Automatically upon admission to hospital.							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatically about the course of care and progress while in hospital.							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatically at discharge (within 24 hours).							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upon request (including by remote electronic access)							
<i>Check all that apply</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If <i>Other</i> , please specify							

Statement of Accuracy

These statements are accurate and reflect the current normal operating circumstances at our organization. I am authorized to make these statements on behalf of our organization.

Your name _____

Title _____

Phone number _____

Email _____

Hospital Name _____

Site (if applicable) _____

Program Name _____

Date _____

Address _____

Thank you for your participation!

Please take a few moments to provide us with feedback about this survey.

How much time did it take to complete this survey (round off to the nearest half hour)? _____

How many persons (including yourself) did you need to consult in order to answer this questionnaire? _____

Please indicate how burdensome completing this survey was on the following scale:

1	2	3	4	5	6	7
Not at all			Average			Extremely

Please provide any additional comments about this questionnaire here:

APPENDIX B: SYSTEM INTEGRATION AND CHANGE SURVEY DIRECTOR INPATIENT MH/CHIEF OF PSYCHIATRY

Dear Madam/Sir,

We welcome your hospital's participation in the data collection process for the System Integration and Change (SIC) quadrant - Mental Health. This year, for the first time, the survey is available online. Results will be reported in Hospital Report 2007, due to be released on the e-Scorecard in the Fall 2007.

This year SIC Mental Health survey consists of six sections that have to be filled separately. You were identified by your hospital's CIHI contact as a person responsible for completing Chief of Psychiatry or Director of Mental Health Services section of the survey. PDF copies of surveys were sent to you by email. These can be used for reference so that you can gather the information you need to prepare answers. However, the final surveys **MUST BE COMPLETED** and submitted online. Surveys do not have to be done in one sitting, but each section must be completed on the same computer in order for previously entered answers to be saved. Instructions on how to use Survey Monkey are provided on the next page.

This survey has to be submitted by **March 1, 2007**.

The next page gives you instructions how to use Survey Monkey in case you have not worked with it before. It is an easy and user-friendly tool to use. If you experience problems with it please contact Natalia Zaslavska at **Natalia_Zaslavska@camh.net** or call her at **416-535-8501 x 4031**.

You can also contact principal investigators for the Hospital Report Card Mental Health project, Drs Elizabeth Lin x 4102 (elizabeth_lin@camh.net) or Janet Durbin x 6229 (janet_durbin@camh.net) if you have issues with the survey. Thank you, in advance, for your cooperation in ensuring the success of this project.

Sincerely,

Natalia Zaslavska

Research Coordinator
Hospital Report: Mental Health

Available Mental Health Services

1. How many psychiatric inpatient beds does your hospital have which are:
(Please enter a number to a corresponding field below).

	Designated	Operating
Adult		
Child/Adolescent		

2. Please indicate the number of ADULTT census bed days as reported on the MOHLTC census between April 1, 2005 & March 31, 2006 for each functional centre in your hospital (if none, enter 0):
Please enter a number to a corresponding field below.

_____ 7127625IP Mental Health – Acute
 _____ 7127645 IP Addiction
 _____ 7127655 IP Mental Health – Forensic
 _____ 7127690 IP Mental Health – Psychiatric Crisis Unit
 _____ 7127695 IP Mental Health – Longer term

3. Which of the following mental health care or addictions services is your hospital CURRENTLY FUNDED to provide? Answer required for each row.

	Inpatient	Outpatient	Both	None
Psychiatry crisis team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assertive community treatment team (ACT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatry outpatient services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatry day hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgent clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric psychiatry program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric consult liaison services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child/adolescent psychiatric program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addictions program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concurrent disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dual diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forensic services/program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please indicate if your hospital is CURRENTLY FUNDED to provide the following mental health services?

	Yes	No
Psychiatric holding beds in the ER	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric holding beds in an inpatient unit	<input type="checkbox"/>	<input type="checkbox"/>

Sessional Fees

Sessional fees are used to reimburse psychiatrists for non-billable activities in general hospital psychiatric units.

5. What was the amount spent on these sessions between April 1, 2005 and March 31, 2006?

Schedule 1 Funded

Extra Vote Funded

6. What were the total amounts of your program/unit's Schedule 1 and Extra Vote budgets including sessional fees for mental health and addictions between April 1, 2005 and March 31, 2006?

Total Schedule 1 Budget

Total Extra Vote Budget

Statement of Accuracy

These statements are accurate and reflect the current normal operating circumstances at our organization. I am authorized to make these statements on behalf of our organization.

Your name

Title

Phone number

Email

Hospital Name

Site (if applicable)

Program Name

Date

Address

Thank you for your participation!

Please take a few moments to provide us with feedback about this survey.

How much time did it take to complete this survey (round off to the nearest half hour)? _____

How many persons (including yourself) did you need to consult in order to answer this questionnaire? _____

Please indicate how burdensome completing this survey was on the following scale:

_____	1	2	3	4	5	6	7	_____
_____	Not at all		Average			Extremely		_____

Please provide any additional comments about this questionnaire here:

APPENDIX C

ICD-10 equivalent	ICD-10 name	ICD-10 equivalent	ICD-10 name
F01	Vascular dementia	F09	Unspecified organic or symptomatic mental disorder
F01.0	Vascular dementia of acute onset	F10.0	Mental and behavioural disorders due to use of alcohol, acute intoxication
F01.1	Multi-infarct dementia	F10.1	Mental and behavioural disorders due to use of alcohol, harmful use
F01.2	Subcortical vascular dementia	F10.3	Withdrawal state
F01.3	Mixed cortical and subcortical vascular dementia	F10.4	Mental and behavioural disorders due to use of alcohol, withdrawal state with delirium
F01.8	Other vascular dementia	F10.5	Mental and behavioural disorders due to use of alcohol, psychotic disorder
F01.9	Vascular dementia, unspecified	F10.6	Mental and behavioural disorders due to use of alcohol, amnesic syndrome
F02.0	Dementia in Pick's disease	F10.7	Mental and behavioural disorders due to use of alcohol, residual and late-onset psychotic disorder
F02.1	Dementia in Creutzfeldt-Jakob disease	F10.8	Mental and behavioural disorders due to use of alcohol, other mental and behavioural disorders
F02.2	Dementia in Huntington's disease	F11.0	Mental and behavioural disorders due to use of opioids, acute intoxication
F02.3	Dementia in Parkinson's disease	F11.1	Mental and behavioural disorders due to use of opioids, harmful use
F02.4	Dementia in human immunodeficiency virus [HIV] disease	F11.2	Mental and behavioural disorders due to use of opioids, dependence syndrome
F02.8	Dementia in other specified diseases classified elsewhere	F11.3	Mental and behavioural disorders due to use of opioids, withdrawal state
F03	Senile demential uncomp	F11.4	Mental and behavioural disorders due to use of opioids, withdrawal state with delirium
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances	F11.5	Mental and behavioural disorders due to use of opioids, psychotic disorder
F05.0	Delirium not superimposed on dementia	F11.6	Mental and behavioural disorders due to use of opioids, amnesic syndrome
F05.1	Delirium superimposed on dementia	F11.7	Mental and behavioural disorders due to use of opioids, residual and late-onset psychotic disorder
F05.8	Other delirium	F11.8	Mental and behavioural disorders due to use of opioids, other mental and behavioural disorders
F05.9	Delirium, unspecified	F11.9	Mental and behavioural disorders due to use of opioids, unspecified mental and behavioural disorder
F06.0	Organic hallucinosis	F12.0	Mental and behavioural disorders due to use of cannabinoids, acute intoxication
F06.1	Organic catatonic disorder		
F06.2	Organic delusional [schizophrenia-like] disorder		
F06.3	Organic mood [affective] disorders		
F06.4	Organic anxiety disorder		
F06.5	Organic dissociative disorder		
F06.6	Organic emotionally labile (asthenic) disorder		
F06.8	Other specified mental disorders due to brain damage and dysfunction and to physical disease		
F06.9	Unspecified mental disorder due to brain damage and dysfunction and to physical disease		
F07.0	Organic personality disorder		
F07.8	Other organic personality and behavioural disorders due to brain disease, damage and dysfunction		

ICD-10 equivalent	ICD-10 name	ICD-10 equivalent	ICD-10 name
F12.1	Mental and behavioural disorders due to use of cannabinoids, harmful use	F13.8	Mental and behavioural disorders due to use of sedatives or hypnotics, other mental and behavioural disorders
F12.2	Mental and behavioural disorders due to use of cannabinoids, dependence syndrome	F13.9	Mental and behavioural disorders due to use of sedatives or hypnotics, unspecified mental and behavioural disorder
F12.3	Mental and behavioural disorders due to use of cannabinoids, withdrawal state	F14.0	Mental and behavioural disorders due to use of cocaine, acute intoxication
F12.4	Mental and behavioural disorders due to use of cannabinoids, withdrawal state with delirium	F14.1	Mental and behavioural disorders due to use of cocaine, harmful use
F12.5	Mental and behavioural disorders due to use of cannabinoids, psychotic disorder	F14.2	Mental and behavioural disorders due to use of cocaine, dependence syndrome
F12.6	Mental and behavioural disorders due to use of cannabinoids, amnesic syndrome	F14.3	Mental and behavioural disorders due to use of cocaine, withdrawal state
F12.7	Mental and behavioural disorders due to use of cannabinoids, residual and late-onset psychotic disorder	F14.4	Mental and behavioural disorders due to use of cocaine, withdrawal state with delirium
F12.8	Mental and behavioural disorders due to use of cannabinoids, other mental and behavioural disorders	F14.5	Mental and behavioural disorders due to use of cocaine, psychotic disorder
F12.9	Mental and behavioural disorders due to use of cannabinoids, unspecified mental and behavioural disorder	F14.6	Mental and behavioural disorders due to use of cocaine, amnesic syndrome
F13.0	Mental and behavioural disorders due to use of sedatives or hypnotics, acute intoxication	F14.7	Mental and behavioural disorders due to use of cocaine, residual and late-onset psychotic disorder
F13.1	Mental and behavioural disorders due to use of sedatives or hypnotics, harmful use	F14.8	Mental and behavioural disorders due to use of cocaine, other mental and behavioural disorders
F13.2	Mental and behavioural disorders due to use of sedatives or hypnotics, dependence syndrome	F14.9	Mental and behavioural disorders due to use of cocaine, unspecified mental and behavioural disorder
F13.3	Mental and behavioural disorders due to use of sedatives or hypnotics, withdrawal state	F15.0	Mental and behavioural disorders due to use of other stimulants including caffeine, acute intoxication
F13.4	Mental and behavioural disorders due to use of sedatives or hypnotics, withdrawal state with delirium	F15.1	Mental and behavioural disorders due to use of other stimulants including caffeine, harmful use
F13.5	Mental and behavioural disorders due to use of sedatives or hypnotics, psychotic disorder	F15.2	Mental and behavioural disorders due to use of other stimulants including caffeine, dependence syndrome
F13.6	Mental and behavioural disorders due to use of sedatives or hypnotics, amnesic syndrome	F15.3	Mental and behavioural disorders due to use of other stimulants including caffeine, withdrawal state
F13.7	Mental and behavioural disorders due to use of sedatives or hypnotics, residual and late-onset psychotic disorder	F15.4	Mental and behavioural disorders due to use of other stimulants including caffeine, withdrawal state with delirium
		F15.5	Mental and behavioural disorders due to use of other stimulants including caffeine, psychotic disorder

ICD-10 equivalent	ICD-10 name	ICD-10 equivalent	ICD-10 name
F15.6	Mental and behavioural disorders due to use of other stimulants including caffeine, amnesic syndrome	F17.4	Mental and behavioural disorders due to use of tobacco, withdrawal state with delirium
F15.7	Mental and behavioural disorders due to use of other stimulants including caffeine, residual and late-onset psychotic disorder	F17.5	Mental and behavioural disorders due to use of tobacco, psychotic disorder
F15.8	Mental and behavioural disorders due to use of other stimulants including caffeine, other mental and behavioural disorders	F17.6	Mental and behavioural disorders due to use of tobacco, amnesic syndrome
F15.9	Mental and behavioural disorders due to use of other stimulants including caffeine, unspecified mental and behavioural disorder	F17.7	Mental and behavioural disorders due to use of tobacco, residual and late-onset psychotic disorder
F16.0	Mental and behavioural disorders due to use of hallucinogens, acute intoxication	F17.8	Mental and behavioural disorders due to use of tobacco, other mental and behavioural disorders
F16.1	Mental and behavioural disorders due to use of hallucinogens, harmful use	F17.9	Mental and behavioural disorders due to use of tobacco, unspecified mental and behavioural disorder
F16.2	Mental and behavioural disorders due to use of hallucinogens, dependence syndrome	F18.0	Mental and behavioural disorders due to use of volatile solvents, acute intoxication
F16.3	Mental and behavioural disorders due to use of hallucinogens, withdrawal state	F18.3	Mental and behavioural disorders due to use of volatile solvents, withdrawal state
F16.4	Mental and behavioural disorders due to use of hallucinogens, withdrawal state with delirium	F18.4	Mental and behavioural disorders due to use of volatile solvents, withdrawal state with delirium
F16.5	Mental and behavioural disorders due to use of hallucinogens, psychotic disorder	F18.5	Mental and behavioural disorders due to use of volatile solvents, psychotic disorder
F16.6	Mental and behavioural disorders due to use of hallucinogens, amnesic syndrome	F18.6	Mental and behavioural disorders due to use of volatile solvents, amnesic syndrome
F16.7	Mental and behavioural disorders due to use of hallucinogens, residual and late-onset psychotic disorder	F18.7	Mental and behavioural disorders due to use of volatile solvents, residual and late-onset psychotic disorder
F16.8	Mental and behavioural disorders due to use of hallucinogens, other mental and behavioural disorders	F18.8	Mental and behavioural disorders due to use of volatile solvents, other mental and behavioural disorders
F16.9	Mental and behavioural disorders due to use of hallucinogens, unspecified mental and behavioural disorder	F18.9	Mental and behavioural disorders due to use of volatile solvents, unspecified mental and behavioural disorder
F17.0	Mental and behavioural disorders due to use of tobacco, acute intoxication	F19.0	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, acute intoxication
F17.1	Mental and behavioural disorders due to use of tobacco, harmful use	F19.1	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, harmful use
F17.3	Mental and behavioural disorders due to use of tobacco, withdrawal state	F19.2	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, dependence syndrome

ICD-10 equivalent	ICD-10 name	ICD-10 equivalent	ICD-10 name
F19.3	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, withdrawal state	F23.9	Acute and transient psychotic disorder, unspecified
F19.4	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, withdrawal state with delirium	F24	Induced delusional disorder
F19.5	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, psychotic disorder	F25.0	Schizoaffective disorder, manic type
F19.6	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, amnesic syndrome	F25.1	Schizoaffective disorder, depressive type
F19.7	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, residual and late-onset psychotic disorder	F25.2	Schizoaffective disorder, mixed type
F19.8	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, other mental and behavioural disorders	F25.8	Other schizoaffective disorders
F19.9	Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, unspecified mental and behavioural disorder	F25.8	Other schizoaffective disorders
F20.0	Paranoid schizophrenia	F25.9	Schizoaffective disorder, unspecified
F20.1	Hebephrenic schizophrenia	F29	Unspecified nonorganic psychosis
F20.2	Catatonic schizophrenia	F30.0	Manic episode, unspecified
F20.3	Other schizophrenia	F30.1	Other manic episodes
F20.4	Schizophrenia, unspecified	F30.2	Mania with psychotic symptoms
F20.5	Residual schizophrenia	F30.8	Other manic episodes
F20.6	Simple schizophrenia	F30.9	Manic episode, unspecified
F20.8	Other schizophrenia	F31.0	Bipolar affective disorder, current episode hypomanic
F20.9	Schizophrenia, unspecified	F31.1	Bipolar affective disorder, current episode manic without psychotic symptoms
F21	Schizotypal disorder (includes latent schizophrenia)	F31.2	Bipolar affective disorder, current episode manic with psychotic symptoms
F22.0	Delusional disorder	F31.3	Bipolar affective disorder, current episode mild or moderate depression
F22.8	Other persistent delusional disorders	F31.4	Bipolar affective disorder, current episode severe depression without psychotic symptoms
F22.9	Persistent delusional disorder, unspecified	F31.5	Bipolar affective disorder, current episode severe depression with psychotic symptoms
F23.2	Acute schizophrenia-like psychotic disorder	F31.6	Bipolar affective disorder, current episode mixed
F23.3	Other acute predominantly delusional psychotic disorders	F31.7	Bipolar affective disorder, currently in remission
F23.8	Other acute and transient psychotic disorders	F31.8	Other bipolar affective disorders
		F31.9	Bipolar affective disorder, unspecified
		F32.0	Mild depressive episode
		F32.1	Moderate depressive episode
		F32.2	Severe depressive episode without psychotic symptoms
		F32.3	Severe depressive episode with psychotic symptoms
		F32.8	Other depressive episodes
		F32.9	Depressive episode, unspecified

ICD-10 equivalent	ICD-10 name	ICD-10 equivalent	ICD-10 name
F33.0	Recurrent depressive disorder, current episode mild	F43.8	Other reactions to severe stress
F33.1	Recurrent depressive disorder, current episode moderate	F44	Dissociative [conversion] disorder, unspecified
F33.2	Recurrent depressive disorder, current episode severe without psychotic symptoms	F44.0	Dissociative amnesia
F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms	F45.0	Somatization disorder
F33.4	Recurrent depressive disorder, currently in remission	F45.2	Hypochondriacal disorder
F33.8	Other recurrent depressive disorders	F45.3	Somatoform autonomic dysfunction
F33.9	Recurrent depressive disorder, unspecified	F45.4	Persistent somatoform pain disorder
F34	Persistent mood (affective disorders)	F45.8	Other somatoform disorders
F34.0	Cyclothymia	F45.9	Somatoform disorder, unspecified
F34.1	Dysthymia	F48.0	Neurasthenia
F34.8	Other persistent mood (affective) disorders	F48.1	Depersonalization-derealization syndrome
F34.9	Persistent mood (affective disorder), unspecified	F48.8	Other specified neurotic disorders
F38	Other mood affective disorders	F48.9	Neurotic disorder, unspecified
F38.0	Other single mood (affective) disorders	F50.0	Anorexia nervosa
F38.1	Other recurrent mood (affective) disorders	F50.1	Atypical anorexia nervosa
F38.8	Other specified mood (affective) disorders	F51.0	Nonorganic insomnia
F39	Unspecified mood [affective] disorder	F51.1	Nonorganic hypersomnia
F40.0	Agoraphobia	F51.2	Nonorganic disorder of the sleep-walk schedule
F40.1	Social phobias	F51.8	Other nonorganic sleep disorders
F40.2	Specific (isolated) phobias	F52.9	Unspecified sexual dysfunction, not caused by organic disorder or disease
F40.9	Phobic anxiety disorder, unspecified	F53.1	Severe mental and behavioral disorders associated with the puerperium, not elsewhere classified.
F41.0	Panic disorder [episodic paroxysmal anxiety]	F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere
F41.1	Generalized anxiety disorder	F60.0	Paranoid personality disorder
F41.9	Anxiety disorder, unspecified	F60.1	Schizoid personality disorder
F42.0	Predominantly obsessional thoughts or ruminations	F60.2	Dissocial personality disorder
F42.1	Predominantly compulsive acts [obsessional rituals]	F60.3	Emotionally unstable personality disorder
F42.2	Mixed obsessional thoughts and acts	F60.4	Histrionic personality disorder
F42.8	Other obsessive-compulsive disorders	F60.5	Anankastic personality disorder
F42.9	Obsessive-compulsive disorder, unspecified	F60.7	Dependent personality disorder
F43.0	Acute stress reaction	F60.9	Personality disorder, unspecified
F43.1	Post-traumatic stress disorder	F64.0	Transsexualism
		F64.1	Dual-role transvestism
		F64.2	Gender identity disorder of childhood
		F64.8	Other gender identity disorders
		F64.9	Gender identity disorder, unspecified
		F65.1	Fetishistic transvestism

ICD-10 equivalent	ICD-10 name	CD-10 equivalent	ICD-10 name
F65.2	Exhibitionism	F78.0	Other mental retardation with the statement of no, or minimal, impairment of behaviour
F65.4	Paedophilia	F78.1	Other mental retardation, significant impairment of behaviour requiring attention or treatment
F66.0	Sexual maturation disorder	F78.8	Other mental retardation, other impairments of behaviour
F66.1	Egodystonic sexual orientation	F78.9	Other mental retardation without mention of impairment of behaviour
F66.9	Psychosexual development disorder, unspecified	F79.0	Unspecified mental retardation with the statement of no, or minimal, impairment of behaviour
F69	Unspecified disorders of adult personality and behaviour	F79.1	Unspecified mental retardation, significant impairment of behaviour requiring attention or treatment
F70.0	Mild mental retardation with the statement of no, or minimal, impairment of behaviour	F79.8	Unspecified mental retardation, other impairments of behaviour
F70.1	Mild mental retardation, significant impairment of behaviour requiring attention or treatment	F79.9	Unspecified mental retardation without mention of impairment of behaviour
F70.8	Mild mental retardation, other impairments of behaviour	F80.0	Specific speech articulation disorder
F70.9	Mild mental retardation without mention of impairment of behaviour	F80.1	Expressive language disorder
F71.0	Moderate mental retardation with the statement of no, or minimal, impairment of behaviour	F80.2	Receptive language disorder
F71.1	Moderate mental retardation, significant impairment of behaviour requiring attention or treatment	F80.3	Acquired aphasia with epilepsy [Landau-Kleffner]
F71.8	Moderate mental retardation, other impairments of behaviour	F80.8	Other developmental disorders of speech and language
F71.9	Moderate mental retardation without mention of impairment of behaviour	F80.9	Developmental disorder of speech and language, unspecified
F72.0	Severe mental retardation with the statement of no, or minimal, impairment of behaviour	F81	Specific developmental disorders of scholastic skills
F72.1	Severe mental retardation, significant impairment of behaviour requiring attention or treatment	F81.0	Specific reading disorder
F72.8	Severe mental retardation, other impairments of behaviour	F81.1	Specific spelling disorder
F72.9	Severe mental retardation without mention of impairment of behaviour	F81.2	Specific disorder of arithmetical skills
F73.0	Profound mental retardation with the statement of no, or minimal, impairment of behaviour	F81.3	Mixed disorder of scholastic skills
F73.1	Profound mental retardation, significant impairment of behaviour requiring attention or treatment	F81.8	Other developmental disorders of scholastic skills
F73.8	Profound mental retardation, other impairments of behaviour	F81.9	Developmental disorder of scholastic skills, unspecified
F73.9	Profound mental retardation without mention of impairment of behaviour	F82	Specific developmental disorder of motor function
		F83	Mixed specific developmental disorders
		F84.0	Childhood autism
		F84.3	Other childhood disintegrative disorder
		F84.8	Other pervasive developmental disorders
		F88	Other disorders of psychological development

CD-10 equivalent	ICD-10 name	CD-10 equivalent	ICD-10 name
F89	Unspecified disorder of psychological development	T43.5	Other and unspecified antipsychotics and neuroleptics
F90.1	Hyperkinetic conduct disorder	T43.6	Psychostimulants with abuse potential
F90.8	Other hyperkinetic disorders	T43.8	Other psychotropic drugs, not elsewhere classified
F90.9	Hyperkinetic disorder, unspecified	T43.9	Psychotropic drugs, unspecified
F91.1	Unsocialized conduct disorder	T50.7	Analeptics and opioid receptor antagonists
F91.8	Other conduct disorders	T50.9	Other and unspecified drugs, medicaments and biological substances
F91.9	Conduct disorder, unspecified	T51.0	Ethanol
F93.0	Separation anxiety disorder of childhood	T51.1	Methanol
F93.3	Sibling rivalry disorder	T51.8	Other alcohols
F93.8	Other childhood emotional disorders	T51.9	Alcohol, unspecified
F93.9	Childhood emotional disorder, unspecified	T52.0	Petroleum products
F94.8	Other childhood disorders of social functioning	Z00.4	General psychiatric examination not elsewhere classified
F98.0	Nonorganic enuresis	Z03.2	Observation for suspected mental & behavioral disorders
F98.1	Nonorganic encopresis	Z04.6	General psych examination requested by authority
F98.4	Stereotyped movement disorders	Z09.3	Follow-up examination after psychotherapy
F98.5	Stuttering [stammering]	Z13.3	Special screening examination for mental and behavioral disorders
G30.0	Alzheimer's disease with early onset	Z50.2	Alcohol rehabilitation
G30.1	Alzheimer's disease with late onset	Z50.3	Drug rehabilitation
G30.8	Other Alzheimer's disease	Z50.4	Psychotherapy, not elsewhere classified
G30.9	Alzheimer's disease, unspecified	Z53.1	Procedure not carried because of patient decision or reasons of belief and group pressure
G31.0	Circumscribed brain atrophy	Z53.2	Procedure not carried because of patient decision or other unspecified reasons
G47.9	Sleep disorder, unspecified	Z54.3	Convalescence following psychotherapy
O99.3	Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium	Z55.0	Problems related to educ & literacy, unspec
Q90	Down's syndrom	Z55.1	Schooling unavailable and unattainable
Q91	Edward's syndrome and Patau's syndrome	Z55.2	Failed examinations
Q99.9	Chromosomal abnormality, unspecified	Z55.3	Underachievement in school
R48.0	Dyslexia and alexia	Z55.4	Educational maladjustment and discord with teachers and classmates
R54	Senility	Z55.8	Other problems related to education and literacy
T42.3	Barbiturates	Z55.9	Problem related to education and literacy, unspecified
T42.4	Benzodiazepines		
T42.6	Other antiepileptic and sedative-hypnotic drugs		
T42.7	Antiepileptic and sedative-hypnotic drugs, unspecified		
T43.2	Other and unspecified antidepressants		
T43.3	Phenothiazine antipsychotics and neuroleptics		
T43.4	Butyrophenone and thioxanthene neuroleptics		

CD-10 equivalent	ICD-10 name
Z56.0	Unemployment, unspec
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord w/ boss/workmates
Z56.5	Uncongenial work
Z56.6	Other physical and mental strain related to work
Z56.7	Other employ related problems
Z60.0	Problems related to social environment
Z60.1	Atypical parenting situation
Z60.2	Living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of perceived adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problems related to social environment, unspecified
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with parents and in-laws
Z63.2	Inadequate family support
Z63.3	Absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.7	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problems related to primary support group, unspecified
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war and other hostilities

CD-10 equivalent	ICD-10 name
Z65.6	Other specified problems
Z65.7	Probs related to unspecified circumstances
Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problems related to unspecified psychosocial circumstances
Z72.0	Tobacco use problems
Z72.1	Alcohol use problems
Z72.2	Drug use problems
Z73.3	Physical/mental strain/stress, not elsewhere classified
Z81.1	Family history of alcohol abuse
Z81.2	Family history of tobacco abuse
Z81.3	Family history of other psychoactive substance abuse
Z81.4	Family history of other substance abuse
Z81.8	Family history of other mental and behavioral disorders
Z86.4	Personal history of psychoactive substance abuse
Z86.5	Personal history of mental & behavioral disorders
Z91.4	Personal history of psychological trauma
Z91.5	Personal history of self-harm

APPENDIX D: OHIP CODES

OHIP Code	OHIP Code Name	OHIP Code	OHIP Code Name
G471	Electroconvulsive therapy (single/multiple)	K196	Family psychiatric care
K004	Family psychotherapy	K197	Individual psychotherapy (outpatient)
K006	Hypnotherapy	K198	Psychiatric care (inpatient)
K007	Individual psychotherapy	K199	Psychiatric care (outpatient)
K008	Diagnostic/therapeutic interview, child psychiatric problem/learning disability	OHIP	Fee Code Description
K010	Group psychotherapy	K200	Group psychotherapy (in-patient – 4 people)
K011	Group psychotherapy (hypnosis)	K201	Group psychotherapy (in-patient – 5 people)
K012	Group psychotherapy (4 people)	K202	Group psychotherapy (in-patient – 6-12 people)
K024	Group psychotherapy (5 people)	K203	Group psychotherapy (out-patient – 4 people)
K025	Group psychotherapy (6-12 people)	K204	Group psychotherapy (out-patient – 5 people)
N110	Lobectomy	K205	Group psychotherapy (out-patient – per member, 7th hour onward)
Z458	Electroconvulsive therapy (cerebral)	K206	Group psychotherapy (out-patient – per member, 7th hour onward)
Psychiatrist-only fee codes		K207	Group psychotherapy (in-patient – per member, 7th hour onward)
A191	Minor assessment	K568	Diagnostic interview of child/parent
A193	Specific assessment	K620	Mental Health Act assessment – Consultation
A194	Partial assessment	K623	Mental Health Act assessment – Application
A195	Consultation	K624	Mental Health Act assessment – Certification
A196	Repeat consultation	K629	Mental Health Act assessment – Recertification
A197	Consultation on behalf of disturbed child (interview with parents)	W195	Long-term institutional care – Consultation
A198	Consultation on behalf of disturbed child (interview with child)	W196	Long-term institutional care – Repeat consultation
A395	Limited consultation	W395	Long-term institutional care – Limited consultation
C121	Further (hospital) fees		
C192	Hospital subsequent visits (up to 5 weeks)		
C193	Hospital specific assessment		
C194	Hospital specific reassessment		
C196	Hospital repeat consultation		
C197	Hospital subsequent visit (6th-12th week)		
C198	Hospital concurrent care		
C199	Hospital subsequent visit (after 13th week)		
C395	Hospital limited consultation		
K190	Individual psychotherapy		
K191	Family psychiatric care		
K192	Individual hypnotherapy		
K193	Family therapy (inpatient)		
K194	Group hypnotherapy		
K195	Family therapy (outpatient)		

APPENDIX E: INCLUDED HOSPITAL CORPORATIONS AND SITES

Community	Sites Within Hospital Corporation (MNS)	Institution Number	Institution Type
Ajax	Rouge Valley Health System – Ajax Site	4014	AP
Ajax	Rouge Valley Health System – Ajax Site	4571	MH
Barrie	Royal Victoria Hospital (The)	1825	AP
Barrie	Royal Victoria Hospital (The)	4513	MH
Belleville	Quinte Healthcare Corporation – Belleville	3988	AP
Belleville	Quinte Healthcare Corporation – Belleville	4514	MH
Brampton	William Osler Health Centre – Brampton	4016	AP
Brampton	William Osler Health Centre – Brampton	4516	MH
Brantford	Brantford General Hospital (The)	1006	AP
Brantford	Brantford General Hospital (The)	4517	MH
Brockville	Brockville Psychiatric Hospital	2813	AH
Brockville	Brockville Psychiatric Hospital	1275	OP
Burlington	Joseph Brant Memorial Hospital	1160	AP
Burlington	Joseph Brant Memorial Hospital	4518	MH
Chatham	Public General Hospital Society of Chatham	1223	AP
Chatham	Public General Hospital Society of Chatham	4520	MH
Cornwall	Cornwall General Hospital	1872	AP
Goderich	Alexandra Marine and General Hospital	1206	AP
Goderich	Alexandra Marine and General Hospital	4522	MH
Guelph	Homewood Health Centre Inc	4523	MH
Hamilton	Hamilton Health Sciences Corp – Henderson	1983	AP
Hamilton	Hamilton Health Sciences Corp – McMaster	1994	AP
Hamilton	St. Joseph’s Health Care System – Hamilton	2003	AP
Hamilton	Hamilton Health Sciences Corp – McMaster	4524	MH
Hamilton	St. Joseph’s Health Care System – Hamilton	4526	MH
Hamilton	St. Joseph’s Health Care System – Hamilt MH	4525	MH
Hamilton	St. Joseph’s Health Care System – Hamilt MH	4282	MP
Kenora	Lake of the Woods Addiction Services	3886	TC
Kingston	Hotel Dieu Hospital	1097	AP
Kingston	Kingston General Hospital	1100	AP
Kingston	Hotel Dieu Hospital	4601	MC
Kingston	Hotel Dieu Hospital	4529	MH
Kingston	Kingston General Hospital	4528	MH
Kingston	Providence Continuing Care Centre – Kingst MH	4281	MP
Kitchener	Grand River Hospital Corp – Waterloo Site	3734	AP
Kitchener	Grand River Hospital Corp – Waterloo Site	4608	MC
Kitchener	Grand River Hospital Corp – Waterloo Site	4531	MH
Lindsay	Ross Memorial Hospital	4593	MH
London	London Hlth Sciences CTR – University Site	3850	AP
London	St. Joseph’s Health Care, London	1497	AP

Community	Hospital Corporation (MNS)	Institution Number	Institution Type
London	London Health Sciences CTR – Victoria Site	4532	MH
Markham	Markham Stouffville Hospital	3587	AP
Markham	Markham Stouffville Hospital	4535	MH
Mississauga	Credit Valley Hospital (The)	3286	AP
Mississauga	Trillium Health Centre – Mississauga Site	3917	AP
Mississauga	Credit Valley Hospital (The)	4536	MH
Mississauga	Trillium Health Centre – Mississauga Site	4537	MH
Newmarket	Southlake Regional Health Centre	2038	AP
Newmarket	Southlake Regional Health Centre	4603	MC
Newmarket	Southlake Regional Health Centre	4538	MH
Niagara Falls	Greater Niagara General Hospital	1542	AP
North Bay	North Bay psychiatric Hosp	2772	SF
Oakville	Halton Healthcare Services Corp – Oakville	3926	AP
Oakville	Halton Healthcare Services Corp – Oakville	4611	MC
Oakville	Halton Healthcare Services Corp – Oakville	4539	MH
Orillia	Orillia Soldiers’ Memorial Hospital	4540	MH
Oshawa	Lakeridge Health Corporation – Oshawa Site	3932	AP
Oshawa	Lakeridge Health Corporation – Oshawa Site	4541	MH
Ottawa	Hopital Montfort	1661	AP
Ottawa	Ottawa Hospital (The) – Civic Site	4046	AP
Ottawa	Ottawa Hospital (The) – General Site	4048	AP
Ottawa	Queensway-Carleton Hospital	1681	AP
Ottawa	Hopital Montfort	4542	MH
Owen Sound	Grey Bruce Health Services – Owen Sound	3944	AP
Owen Sound	Grey Bruce Health Services – Owen Sound	4548	MH
Penetanguishene	Penetanguishene Mental HC Oakridge Division	4550	MH
Penetanguishene	Penetanguishene Mental HC Regional Division	4551	MH
Penetanguishene	Penetanguishene Mental HC Oakridge Division	2843	OP
Peterborough	Peterborough Regional Health Centre	1768	AP
Peterborough	Peterborough Regional Health Centre	4552	MH
Sarnia	Sarnia General Hospital	1247	AP
Sault Ste Marie	Plummer Memorial Public Hospital (The)	2069	AP
St Catharines	Niagara Health System – St Catharines General	4224	AP
St Thomas	St. Joseph’s Health Care, London – St.Thomas	4283	MP
Stratford	Stratford General Hospital	1754	AP
Stratford	Stratford General Hospital	4559	MH
Sudbury	Northeast Mental Health Centre	4600	MC
Sudbury	Northeast Mental Health Centre	4561	MH
Sudbury	Northeast Mental Health Centre	2165	MP
Timmins	Timmins & District General Hospital	3414	AP
Timmins	Timmins & District General Hospital	4564	MH
Toronto	Humber River Regional Hospital – Northwestern	1468	AP
Toronto	Humber River Regional Hospital – York-Finch	1343	AP

Community	Hospital Corporation (MNS)	Institution Number	Institution Type
Toronto	Humber River Regional Hospital – Northwestern	4610	MC
Toronto	North York General Hospital	4598	MC
Toronto	Rouge Valley Health System – Centenary	4612	MC
Toronto	St. Joseph’s Health Centre	4606	MC
Toronto	Baycrest Hospital (North York)	4565	MH
Toronto	Humber River Regional Hospital – Northwestern	4568	MH
Toronto	Mount Sinai Hospital	4569	MH
Toronto	North York General Hospital	4570	MH
Toronto	Rouge Valley Health System – Centenary	4572	MH
Toronto	Scarborough Hospital (The) – Grace Site	4573	MH
Toronto	Scarborough Hospital (The) – Scarborough Gen. Site	4574	MH
Toronto	St. Joseph’s Health Centre	4575	MH
Toronto	St. Michael’s Hospital	4576	MH
Toronto	Sunnybrook & Women’s College HSC – Sunnybrook	4577	MH
Toronto	Baycrest Hospital (North York)	3310	MP
Welland	Welland County General Hospital	1583	AP
Whitby	Whitby Mental Health Centre	2822	AH
Whitby	Whitby Mental Health Centre	4613	MC
Whitby	Whitby Mental Health Centre	4579	MH
Whitby	Whitby Mental Health Centre	1648	OP
Windsor	Hôtel Dieu of St. Joseph Hospital	1076	AP
Windsor	Windsor Regional Hospital – Western Site	3844	AP
Windsor	Windsor Regional Hospital – Western Site	4581	MH
Woodstock	Woodstock General Hospital	1716	AP
Woodstock	Woodstock General Hospital	4582	MH

Note: Data was not always available for all participating sites

APPENDIX F: AVERAGE LENGTH OF STAY

Hospital	Average Length of Stay
PROVINCIAL AVERAGE	28.6
TEACHING HOSPITALS	16.4
Hôpital régional de Sudbury Regional Hospital	9.2
Hotel Dieu Hospital, Kingston	13.8
London Health Sciences Centre	11.2
Mount Sinai Hospital	24.8
St. Michael's Hospital	18.3
Sunnybrook and Women's College Health Sciences Centre	21.3
The Ottawa Hospital	16.6
Thunder Bay Regional Health Sciences Centre ¹	13.7
University Health Network	18.9
COMMUNITY HOSPITALS WITH 29 OR FEWER MH BEDS	11.7
Alexandra Marine and General Hospital	11.1
Bluewater Health	13.6
Chatham-Kent Health Alliance	12.5
Cornwall Community Hospital	16.6
Halton Healthcare	9.8
Huron Perth Healthcare Alliance	9.6
Joseph Brant Memorial Hospital	15.2
Markham Stouffville Hospital	12.8
Orillia Soldiers' Memorial Hospital	7.0
Peterborough Regional Health Centre	13.6
Queensway Carleton Hospital	16.8
Quinte Health Care	10.0
Ross Memorial Hospital	11.1
Royal Victoria Hospital	10.0
Southlake Regional Health Centre	10.7
The Brantford General Hospital	8.6
The Credit Valley Hospital	11.5
Timmins and District Hospital	7.5
Windsor Regional Hospital	17.1
Woodstock General Hospital	9.8

¹ Hospitals with Forensic Functional Centre

Hospital	Average Length of Stay
COMMUNITY HOSPITALS WITH 30 OR MORE MH BEDS	12.3
Grand River Hospital	11.8
Grey Bruce Health Services	11.6
Hôpital Montfort Hospital	15.6
Hôtel-Dieu Grace Hospital	12.2
Humber River Regional Hospital	14.2
Lakeridge Health	13.0
Niagara Health System	7.0
North York General Hospital	15.1
Rouge Valley Health System	11.1
Sault Area Hospital	11.8
St. Joseph's Health Centre	14.1
The Scarborough Hospital	9.8
Toronto East General Hospital	11.0
Trillium Health Centre	15.1
William Osler Health Centre ²	11.2
SPECIALTY HOSPITALS	114.8
Baycrest Centre for Geriatric Care ^{2,3}	82.2
Centre for Addiction and Mental Health ^{1,2}	56.0
Mental Health Centre Penetanguishene ^{1,2}	NR
Northeast Mental Health Centre ^{1,2}	23.0
Providence Continuing Care Centre ^{1,2,3}	306.5
Royal Ottawa Health Care Group	78.4
St. Joseph's Care Group ^{2,3}	229.8
St. Joseph's Health Care Hamilton ^{1,2}	31.6
St. Joseph's Health Care London ^{1,2,3}	110.8
Whitby Mental Health Centre ^{1,2}	NR

1 Hospitals with Forensic Functional Centre
2 Hospitals with Longer Term Functional Centre
3 Hospitals that do not have Acute Functional Centre
NR Not Reported