Selecting Pan-Canadian Indicators for Access to Mental Health and Addiction Services, and to Home and Community Care

Progress Report

Canadian Institute for Health Information
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For permission or information, please contact CIHI:

Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6

Phone: 613-241-7860
Fax: 613-241-8120
www.cihi.ca
copyright@cihi.ca

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Executive summary

All governments recognize the need to make home care more available and mental health care more accessible. In August 2017, the federal, provincial and territorial (FPT) governments reached an agreement that will lead to an $11 billion federal investment over a 10-year period that will go toward improving access to mental health and addiction services and to home and community care. By endorsing A Common Statement of Principles on Shared Health Priorities, FPT governments committed to working together to ensure that health care systems continue to respond to the evolving needs of Canadians.

In September 2017, the Canadian Institute for Health Information (CIHI) was asked to work with the FPT governments to select and develop a set of pan-Canadian indicators focused on measuring access to mental health and addiction services and to home and community care. To ensure the process is collaborative and transparent and reflects the knowledge of the sector stakeholders and the needs of Canadians, CIHI has been working with 2 FPT work groups created for this work, subject matter experts and the public to identify the indicators that would best reflect access to services in these priority sectors.

This progress report outlines work done so far, including a summary of environmental scans undertaken to understand provincial/territorial starting points in collecting and reporting data in these priority sectors. The scans provide a current picture of mental health and addiction, and home and community care services, as well as a current picture of the measures, information standards and systems used for gathering health information across the country. The work to date indicates variation in services and measurement, as well as diverse capacity regarding information collection and use of information standards across the provinces and territories.

In January 2018, CIHI-FPT work groups and key sector and measurement experts met to choose a small number of areas related to access from which indicators could be selected for each of the 2 priority sectors. Productive discussions resulted in participants recommending the following focus areas for measuring access to home and community care: client outcomes, client and caregiver experiences, community palliative care, coordination of care, multiple contacts with the health system, unmet needs and wait times. The recommended areas of focus for measuring access to mental health and addiction services are as follows: access to prevention and promotion, integrated care/continuity of care, person experiences/ satisfaction, outcomes, unmet needs and wait times.

In February 2018, CIHI-FPT work groups and key sector and measurement experts evaluated and ranked the indicators in each sector. At the same time, a series of focus groups, one-on-one interviews and online surveys were used to gauge the priorities of the Canadian public and persons with lived experience.

Information gathering through the indicator evaluation process and public engagement is in progress, the findings of which will be presented to the CIHI-FPT work groups in March for their consideration and deliberation leading to the selection of indicators. The Conference of Deputy Ministers of Health will receive a formal recommendation from the CIHI-FPT work groups in April 2018; outcomes from this meeting will be presented to the FPT health ministers. Once the final sets of indicators have been endorsed, CIHI will continue to work with jurisdictions to define the methodology and to identify data sources for these indicators. Annual reporting is expected to begin in 2019.

A Common Statement of Principles on Shared Health Priorities

In August 2017, the federal, provincial and territorial (FPT) governments announced a 10-year agreement that will lead to an $11 billion federal investment to provincial and territorial health care systems. This investment will be used to improve access to mental health and addiction (MHA) services and to home and community care (HCC).

FPT governments recognized that there has been increased demand for mental health and addiction services and for home and community care. In particular, they recognized that mental illness and addiction are serious issues for Canadians and that early diagnosis and intervention are vital to effective treatment and recovery. As such, it is important to address gaps in treatment and recovery — for all age groups, including children and youth. Governments also recognized that older Canadians and those living with chronic diseases — 2 groups whose numbers are steadily rising — will need better access to health care services in their homes and communities in order to reduce reliance on more expensive hospital infrastructure.

A Common Statement of Principles on Shared Health Priorities outlines the common objectives of FPT governments.[i] It will also serve to inform the development of bilateral agreements between the federal government and the provinces and territories. Each jurisdiction will have its own priorities based on its unique circumstances, such as northern and remote delivery models, data capacity limitations and infrastructure requirements.

i. Recognizing the Government of Quebec's desire to exercise its own responsibilities within the health field and to fully assume the planning, organizing and managing of health services, including MHA and HCC, the Government of Canada and the Government of Quebec agreed to an asymmetrical arrangement distinct from this Statement of Principles. Based on the asymmetrical agreement of September 2004, the Government of Quebec will continue to report to Quebecers on the use of all health funding and will continue to collaborate with other FPT governments by sharing information and best practices.

The Common Statement of Principles aims to

Improve access to evidence-supported mental health and addiction services and supports for Canadians and their families

These goals will be achieved by pursuing one or more of the following actions:

- Expanding access to community-based mental health and addiction services for children and youth (age 10 to 25), recognizing the effectiveness of early interventions to treat mild to moderate mental health disorders
- Spreading evidence-based models of community mental health care and culturally appropriate interventions that are integrated with primary health services
- Expanding availability of integrated community-based mental health and addiction services for people with complex health needs

Improve access to appropriate services and supports in home and community care, including palliative and end-of-life care

These goals will be achieved by pursuing one or more of the following actions:

- Spreading and scaling evidence-based models of home and community care that are more integrated and connected with primary health care
- Enhancing access to palliative and end-of-life care at home or in hospices
- Increasing support for caregivers
- Enhancing home care infrastructure, such as digital connectivity, remote monitoring technology and facilities for community-based service delivery

The implementation of programs to achieve the access goals outlined in A Common Statement of Principles for each jurisdiction is being guided by the following principles:

Collaboration

FPT health ministers agree to work together to achieve the objectives set out in this Common Statement of Principles.

Innovation

FPT health ministers agree to continue to develop and evaluate innovations that deliver better outcomes for Canadians, and to share successes and lessons learned with a view to further stimulating improvement across health systems.

Accountability

FPT health ministers agree to measure progress on the collective and jurisdiction-specific goals under this Common Statement of Principles, and to report to Canadians.

CIHI's role

Measuring is important for tracking progress on goals. FPT health ministers agreed to work together with CIHI to identify and report on 3 to 5 indicators of access for both mental health and addiction services, and home and community care. This work aligns with CIHI's mandate to deliver meaningful, comparable information that will accelerate improvement in health care, the performance of health systems and the overall health of the population. The focus on mental health and addiction and on home and community care also aligns with CIHI's strategic plan.

CIHI has longstanding programs of work measuring the performance of health systems. As an organization, CIHI is committed to transparent and collaborative processes and does not advise or take positions on matters of policy. Given CIHI's experience, the organization is well-positioned to facilitate the selection and development of new and existing indicators to track progress on the FPT health ministers' commitments. A description of CIHI's tools related to indicator selection and development can be found in Appendix B.

Purpose of this report

This report outlines the progress made toward establishing common indicators to measure access to mental health and addiction services and to home and community care. Additionally, gaps in current measurement and information systems are highlighted that may have an impact on reporting progress on shared health priorities. Although some services for both priority areas can be paid for out of pocket, this report and the indicators being developed focus on services funded by federal, provincial or territorial governments.

The report provides the following:

- Definitions of terms;
- Details on the process and timelines for selecting and agreeing on indicators;
- An update on the progress made in selecting 3 to 5 indicators for each of the 2 priority sectors;
- An overview of how mental health and addiction services, and home and community care are organized and delivered across the country;
- Information about the state of performance measurement for both areas;
- An outline of information standards and information systems supporting performance measurement in mental health and addiction services, and home and community care;
- An overview of measurement gaps; and
- An outline of the next steps.

Definitions of terms used in this report

Mental health and addiction services

Community-based **mental health and addiction services** include assessment, treatment, education and support. Community-based services support clients to remain in settings that provide them with choices in their care, empowerment to take risks, and opportunities to engage in activities they find meaningful (such as employment or volunteering). Emergency departments, in-hospital services and psychiatric hospitals provide mental health and addiction services to individuals with severe mental health or addiction conditions, or when other services are not available. Mental health and addiction services are recovery-oriented and take a person-centred approach based on principles of hope, dignity and inclusion for people in recovery and for those who are at elevated risk of developing an issue.[7]

Home and community care

Home care comprises an array of health and support services provided in the home, retirement communities, group homes and other community settings to people with acute, chronic, palliative or rehabilitative health care needs.[10]

Community care programs are designed to help people maintain optimal health and function, to prevent or delay admission to hospital and long-term care facilities, and to support hospital discharge plans and follow-up. Community care includes home care but goes beyond it to include all health and support services provided to clients in the community (e.g., Meals on Wheels, socializing programs to prevent isolation). Home and community care organizations often coordinate the work of multiple organizations and facilitate clients' use of community services. They recognize and supplement the care provided by caregivers and other services.[11]

Access

Access refers to the availability of comprehensive, high-quality health services, as well as their ability to meet the needs of the population or an individual without undue delay or financial, organizational or geographical obstacles. Health services can include public health, health-promotion and disease-prevention services, as well as curative, maintenance and palliative services.[2]

"High-quality" health services are

- **Person-centred —** They are culturally appropriate, and respectful of and responsive to the needs and values of individuals receiving services. Person-centred services put individuals and their caregivers at the centre of delivery and ensure that their preferences guide all clinical decisions.
- **Safe —** They avoid harming individuals by the care intended to help them.
- **Appropriate and effective —** They are based on scientific knowledge of what will best reduce the incidence, duration, intensity and consequences of health problems.
- **Efficiently delivered —** They avoid wasting equipment, supplies, ideas and energy.

Information standards

Information standards are agreed-upon specifications for consolidating data from different sources and settings. They are necessary for the sharing, portability and use of data. This would include data generated during or after the delivery of health care using tools such as clinical classifications, standardized clinical assessments and survey responses.

Information systems

Information systems is a general term that may include any combination of hardware, software and network components that have the ability to store, process, retrieve, share and output information.

Metrics

Metrics are measures that yield information that is quantifiable and is reported as a number. This information has value and many uses, but it cannot be used for comparison.

Health indicators

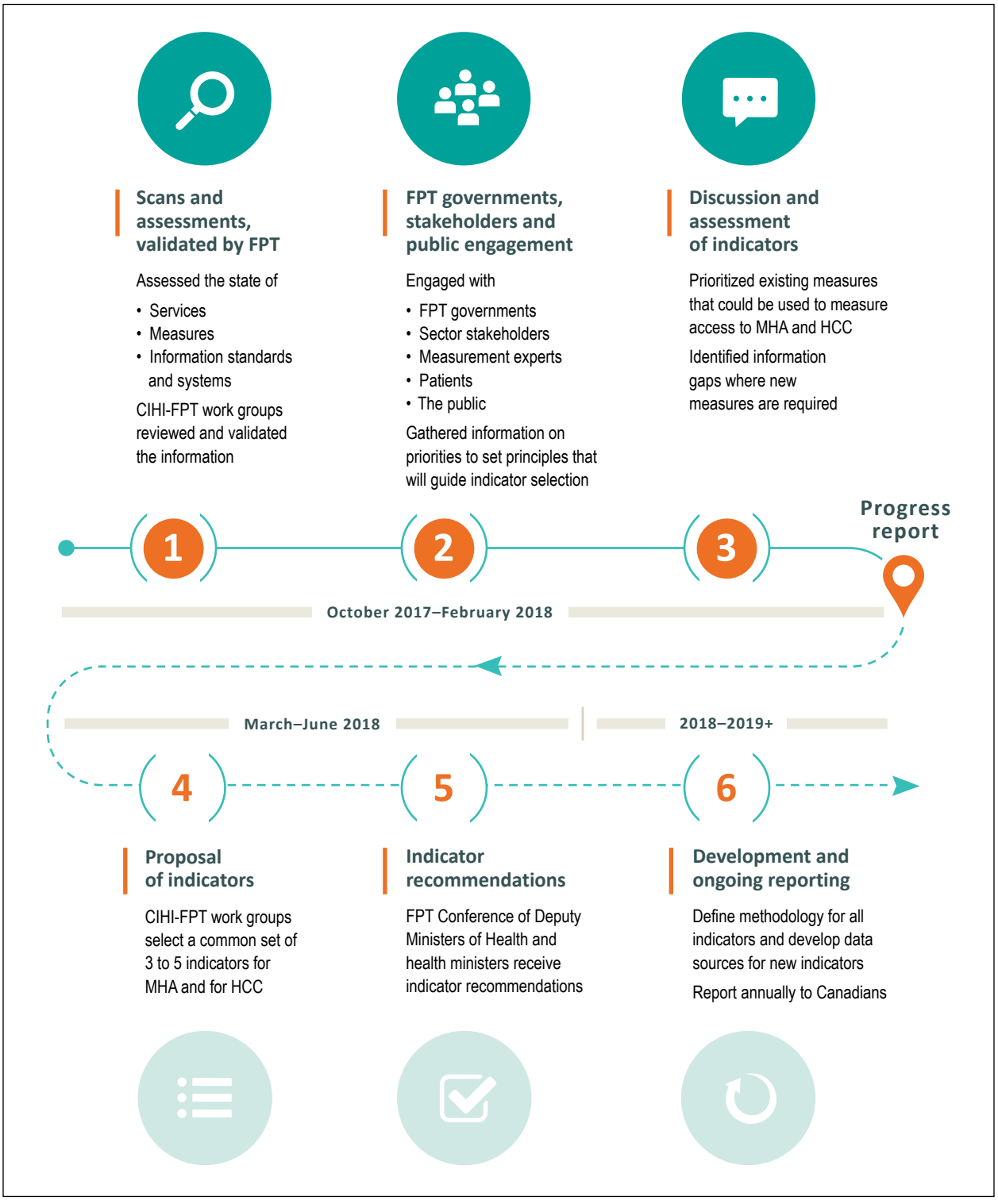
Health indicators put metrics into some kind of context, usually using a ratio (per X), and are designed to ensure comparability by being risk-adjusted or standardized. Directionality may or may not exist.

Health system performance indicators

A **health system performance indicator** is a health indicator that has a desired direction (e.g., lower is better). For more information, see CIHI's health indicators web page.

Process and timeline for selecting common indicators

This diagram illustrates the timeline for the indicator selection process. At the time of writing this report, step 3 has been completed; work on step 4 continues.



Step 1

Scans and assessments, validated by FPT

To support indicator selection, several environmental scans were conducted to better understand provincial/territorial starting points in collecting and reporting data in the priority areas. Scans were performed in the following areas:

1. **Service delivery and availability of publicly funded mental health and addiction services, and home and community care**. Data on services provided by the federal government to some population groups, including First Nations living on reserves, Inuit, serving members of the Canadian Armed Forces, eligible veterans, inmates in federal penitentiaries and some groups of refugee claimants, is excluded from the scans.
2. **Reported measures (indicators and metrics)** related to access using publicly available Canadian and international sources and information published between 2010 and 2017. Non-publicly reported measures were added when FPT representatives validated the scan results. To identify gaps in measures of access, indicators were grouped by the concept measured and mapped to CIHI's Health System Performance Measurement Framework. The framework provides a common approach for measuring health system performance.
3. **Data infrastructure and information standards** in 4 areas, including community mental health, addiction (acute and community), home care (home health and home support) and palliative care (home and hospice).

The findings were validated and updated by each jurisdiction through the CIHI-FPT work groups.

The scan findings indicate variation in indicators reported for mental health and addiction services and for home and community care across Canada. Not surprisingly, provinces and territories focus on topics of interest to their own population and needs. As a consequence, even when the topics of interest are the same, approaches to measuring them vary, using different data sources, methodologies or standards of time or need, or focusing on different groups.

Consistency in how data is collected and in information standards is key to creating sets of pan-Canadian common indicators to measure access in the priority sectors. Over the years, standardized pan-Canadian data sources have been developed. For example, CIHI hosts several databases with information related to mental health and addiction, particularly about the acute care sector and long-term home care clients. Other sources of pan-Canadian data, such as Statistics Canada and Commonwealth Fund surveys, also provide comparable information across the provinces and territories. These sources allow us to collect data on some, but not all, dimensions of access. For community-based care, information standards and systems are mostly jurisdictionally based, resulting in gaps in coverage and differences in data sources, standards of time or need, and methods of measurement. These differences pose challenges for the creation of useful pan-Canadian indicators, from the available data, that can directly address questions of access to services in the community.

A more detailed synopsis of the environment scans are presented in Step 1 in depth.

Step 2

FPT governments, stakeholders and public engagement

CIHI-FPT work groups

Both work groups established for this project are made up of 1 representative appointed by each federal, provincial and territorial deputy minister of health, and 1 representative from CIHI. The group members are responsible for representing their jurisdiction as it relates to the priority areas of measurement, the capacity and degree of readiness for reporting, and for any jurisdictional consultation required. Their task is to consider and recommend sets of 3 to 5 common indicators of access for each of the priority areas. Quebec has observer status, to share information and best practices. (See Appendix A for participants and terms of reference for both groups.)

Input from stakeholders and experts

To ensure the proposed indicators are meaningful to the health sector, consultations were held with policy-makers, care providers, measurement experts and researchers. (See Appendix D for stakeholders consulted.)

Input from the public

To ensure that the proposed indicators are meaningful to Canadians, public consultations sought to uncover how Canadians understand “access to services” and what meaningful measures of access would look like. The public consultations are in progress. At the time of writing, nearly 800 Canadians have provided their opinions through focus groups conducted across Canada, online surveys and one-on-one interviews. Focus groups included members of the general public, those who had interactions with health services and, with the support of the Mental Health Commission of Canada, youth advocates and people with lived experience of mental health problems and illnesses and/or problematic substance use.

Step 3

Discussion and assessment of indicators

The list below describes major activities that have taken place prior to the publishing of this report. These activities included extended consultations, full-day face-to-face meetings and multiple conference calls.

Time	Major activities
October–November 2017	CIHI facilitated discussions with work groups on a pathway for indicator selection.
December 2017	• Work groups validated environmental scans conducted by CIHI (scans on services, indicators/metrics, information standards and information systems). • Work groups identified sector-specific priorities within jurisdictions.
January 2018	• Work groups attended CIHI's education session on health system indicator fundamentals. • Work groups, key stakeholders and measurement experts identified a small number of focused areas of interest for indicator selection (using the validated environmental scans with indicators and metrics mapped to CIHI's Health System Performance Measurement Framework). See details below.
January–February 2018	Work groups, key stakeholders and measurement experts evaluated and ranked potential indicators within these focused areas.*
February 2018	CIHI conducted public consultations.*

Note
* In progress at the time of writing.

Progress to date

In 2 one-day sessions in January 2018, CIHI-FPT work groups and key sector and measurement experts came together to discuss and choose specific areas of access on which to focus indicator selection. From the validated environmental scans, 14 potential areas of focus were identified for home and community care, and 17 for mental health and addiction services. Additional areas (where current measurement doesn't exist) were identified and filled in by participants. Each group was asked to choose 5 to 7 areas of focus for the next step of indicator evaluation.

After productive discussions, participants chose the following areas of focus for home and community care: client outcomes, unmet needs, multiple contacts with the health system, coordination of care, community palliative care, client and caregiver experience, and wait times.

They chose the following areas of focus for mental health and addiction: wait times, integrated/continuity of care, unmet needs, person experience/satisfaction, access to prevention promotion, and outcomes.

CIHI-FPT work group members, key stakeholders and measurement experts have been asked to evaluate and rank potential indicators in each of the focus areas. This process is in progress at the time of writing. Once the evaluation and rankings have been completed, the results will be provided to the CIHI-FPT work groups for inclusion in their deliberations on final indicator selection.

Also in progress at the time of writing are the public consultations. To date, they have echoed the key areas of focus identified by sector stakeholders and measurement experts, with a stronger emphasis on wait times, aspects of lived experiences and barriers to accessing appropriate care. Once the consultations have been completed, the results will be provided to the CIHI-FPT work groups for inclusion in their deliberations on final indicator selection.

Steps 4 5 6

Decision on indicators and future reporting

Once the CIHI-FPT work groups reach consensus on 3 to 5 indicators in each priority sector, the recommendations will be made to the Conference of Deputy Ministers of Health for endorsement in spring 2018. Subsequently, the recommendations will be put before the FPT health ministers for approval at their June meeting.

It is possible that CIHI will need to establish new data transfers, adapt survey tools (with partners such as Statistics Canada and The Commonwealth Fund, if required) or develop new sources of data in order to report on the indicators. CIHI will continue to work with jurisdictions to do so. The quality of new data will be assessed using CIHI's information standards and tools.

Starting in 2019, CIHI will report annually to the FPT governments and the public on the selected indicators that are supported by available data.

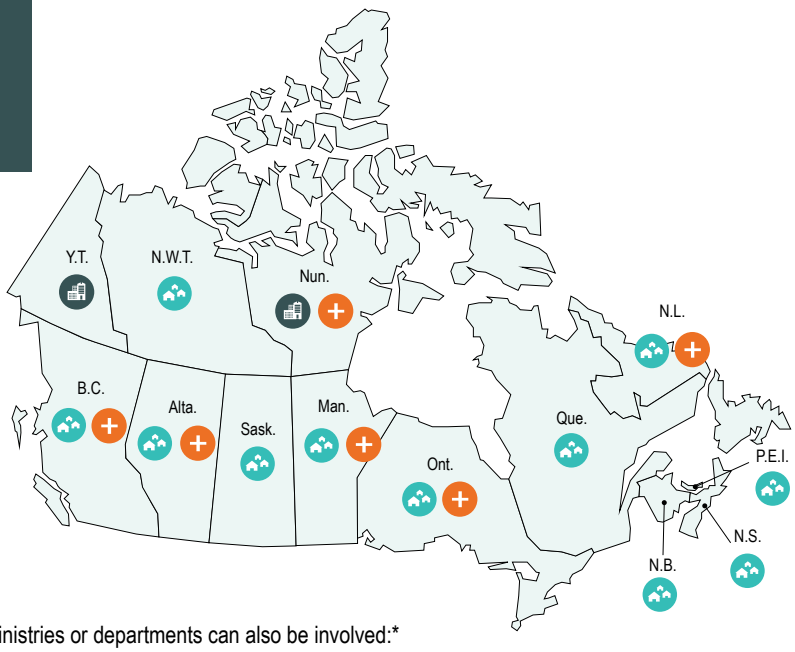
Step 1 in depth: Summary of scans and assessments

Mental health and addiction

This section offers a summary of what was learned from the 3 environmental scans — organization and delivery of services, measures, and information standards and systems.

Figure 1 Funding and delivery of community mental health and addiction services

The ministries of health are responsible for implementing MHA policies, monitoring performance and funding care among their jurisdictions



MHA services primarily delivered by local health authorities, either directly or contracted through organizations

MHA services primarily delivered through ministry of health departments

In the following jurisdictions, other ministries or departments can also be involved:*

N.L.: Department of Children, Seniors and Social Development
Ont.: Ministry of Children and Youth Services
Man.: Manitoba Families and Healthy Child Manitoba
Alta.: Ministry of Children's Services and Ministry of Community and Social Services
B.C.: Ministry of Mental Health and Addictions and Ministry of Children and Family Development
Nun.: Department of Health also provides some funding to travel to Ontario, Manitoba and Northwest Territories for services

* Other ministries, such as Education and Justice, may also be involved; however, these are out of scope for this report.

Mental health and addiction services offered

Mental health and addiction services can be delivered in a variety of settings, including inpatient settings (acute or psychiatric hospitals), emergency departments and community care settings (clinics, primary care physicians' offices, community centres and clients' homes). Community mental health and addiction services are provided in a variety of ways across (and within) provinces and territories, but community services commonly available include the following:

- Outpatient services — Non-residential treatment through day programs or teaching and counselling sessions, offered by a mix of providers.
- Residential treatment — Clients live in a specialized centre and receive counselling, life-skills training and more.
- Case management — Customized support that coordinates an individual's community care.
- Early detection and intervention — Support including self-help resources and telehealth.
- Vocational training and rehabilitation — Focused on helping clients find employment.
- Peer support — Includes informal self-help groups and peer support programs.
- Housing services — Includes financial support, assistance finding housing or placements in supported housing.

Tables 1 and 2 below summarize each province and territory's community services for mental health and for addiction.

Table 1 Community mental health services

Service type	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Information lines	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Outpatient programs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Crisis services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Health promotion and education	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Case management	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Concurrent disorders*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Early detection/ intervention	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Outreach	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community treatment order	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Consumer groups	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Home-based care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Residential treatment	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y
Skills training	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Housing support	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	N
Shared care	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Vocational training and rehabilitation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Assertive community treatment	Y	N	N	Y	Y	Y	Y	N	Y	Y	N	N	N
Telepsychiatry	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Transitional care	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N
Respite	N	N	N	N	Y	N	Y	Y	N	Y	Y	N	Y

Notes

* Concurrent disorders programs are designed for clients with both a mental illness and an addiction. For descriptions of service types, see *Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada*, Canadian Institute for Health Information, 2017 [updated 2018].

Y: The service is offered in the province or territory but is not necessarily accessible everywhere in the jurisdiction or in the same way across other provinces and territories.

N: The service is not available in the province or territory.

The federal government provides certain direct health care services to some population groups, including First Nations living on reserves, Inuit, serving members of the Canadian Armed Forces, eligible veterans, inmates in federal penitentiaries and some groups of refugee claimants.

Source

Adapted from *Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada*, Canadian Institute for Health Information, 2017 [updated 2018].

Table 2 Addiction services

Service type	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Information lines	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Outpatient programs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Crisis services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Health promotion and education	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Case management	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Concurrent disorders*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Early detection/ intervention	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N
Outreach	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Consumer groups	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Home-based care	Y	N	N	N	N	Y	N	Y	N	Y	N	N	N
Residential treatment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Skills training	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Housing support	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	N	N
Shared care	N	N	Y	Y	N	Y	N	Y	N	Y	N	N	N
Vocational training and rehabilitation	Y	N	N	Y	Y	Y	Y	Y	N	Y	N	N	Y
Telepsychiatry	Y	N	N	Y	N	Y	N	N	Y	Y	Y	N	Y
Transitional care	N	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	N
Respite	N	N	N	N	N	N	N	N	Y	N	Y	N	N

Notes

* Concurrent disorders programs are designed for clients with both a mental illness and an addiction. For descriptions of service types, see *Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada*, Canadian Institute for Health Information, 2017 [updated 2018].

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The federal government provides certain direct health care services to some population groups, including First Nations living on reserves, Inuit, serving members of the Canadian Armed Forces, eligible veterans, inmates in federal penitentiaries and some groups of refugee claimants.

Source

Adapted from *Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada*, Canadian Institute for Health Information, 2017 [updated 2018].

Accessing services

A common access point for mental health and addiction services is a family doctor who refers the patient to a specialist or hospital, or provides information on community services that do not require a referral, such as drop-in centres, counselling, psychologists or social workers.

For individuals with severe conditions and those without access to a family doctor, hospitals are often a means of obtaining mental health services. Discharge planning protocols from emergency departments (EDs) and inpatient care can connect these individuals to the appropriate community-based services. Socio-economic factors including income and employment characteristics affect how and whether people access mental health and addiction services.

The provinces and territories have various ways of facilitating access to services. For example, people can call health information lines to obtain basic information about mental health and addiction issues and services. Particularly for youth, mobile apps, texting lines, web-based chat, school counselors, Kids Help Phone and local Canadian Mental Health Association organizations serve as key first points of contact for youth and facilitate their connection to services. Some information lines offer direct mental health and addiction care, with the service staffed by workers qualified to provide it. Some provinces and territories are working to develop centralized intake for their whole jurisdiction.

Reported measures of mental health and addiction

The environmental scan of indicators for mental health and addiction services found more than 500 measures (indicators and metrics) that had been publicly reported between 2010 and 2017. Approximately half of these were grouped to categories related to access. The scan found both pan-Canadian and multi-jurisdictional efforts to collect and report on mental health indicators. This included mental health indicators published by the Mental Health Commission of Canada,[6, 7] the Centre for Applied Research in Mental Health and Addiction[12] and CIHI.

The scan also revealed that all provinces and territories report on measures for mental health and addiction treatment in acute inpatient care. Most provinces and territories incorporate reporting on mental health in annual reports or publish separate reports on mental health and addiction. Most jurisdictions report rates of suicide, self-harm and self-reported mental health. As well, many provinces and territories monitor the use of some outpatient mental health and addiction services; however, there is little overlap in the outpatient services they collect data on.

To identify gaps in measures of access, indicators were grouped by the concept they measure and mapped to CIHI's Health System Performance (HSP) Measurement Framework. Figure 2 shows examples of measures of access to mental health and addiction services found through the environmental scan.

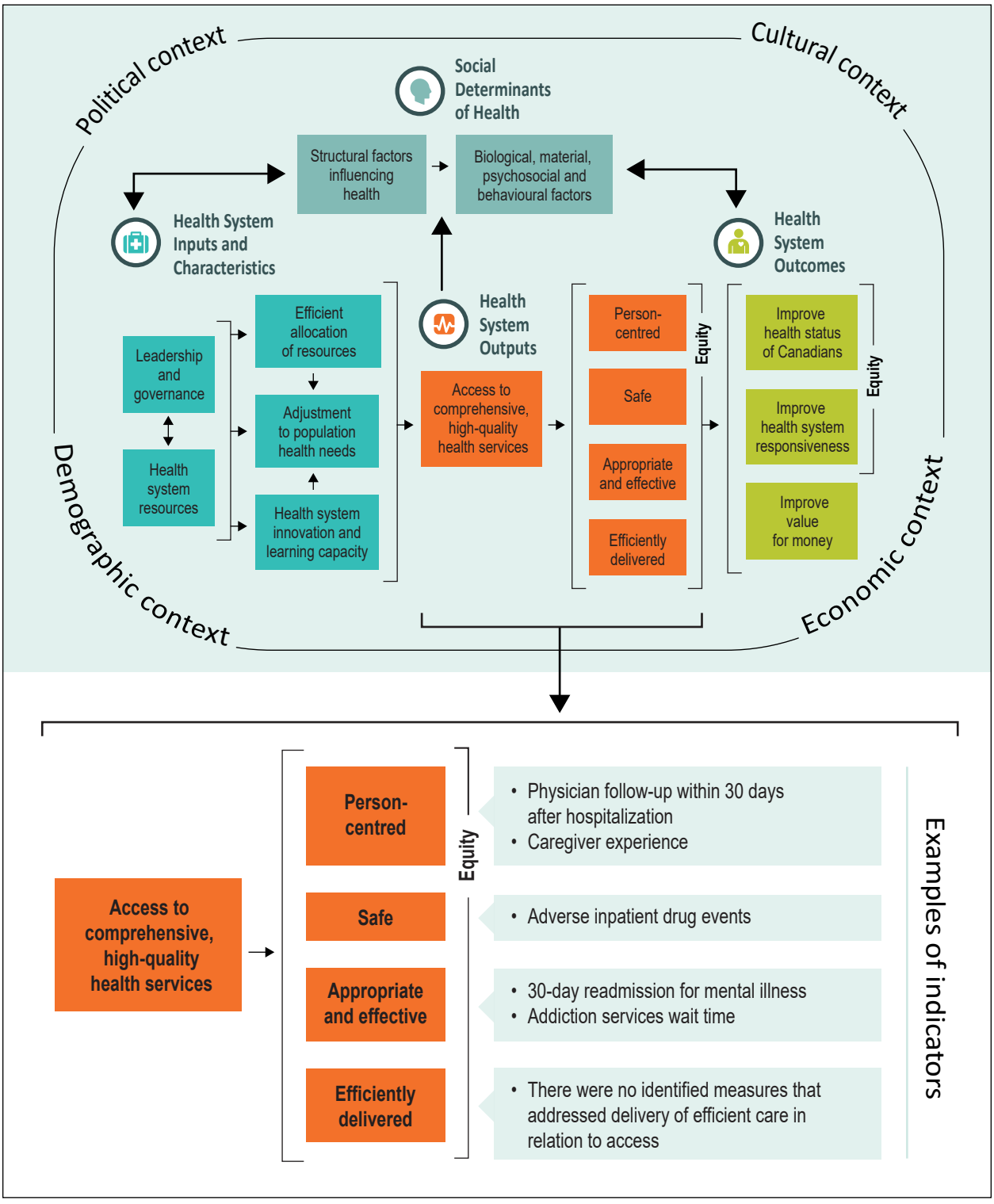
The range of topics measured is broad. Even when the topics are the same, approaches to measuring them vary, using different data sources, methodologies or standards of time or need, or focusing on different groups. These differences among the measures create a challenge for reporting at a pan-Canadian level.

Similarly, when the focus was narrowed to access, the scan found a lack of consistency in the indicators reported and how they are formulated. 6 of 10 provinces, for example, have measures relating to wait times for community mental health and addiction services. However, the data collected for these varied — with different programs and services included and different ways of measuring the wait. Some provinces measure wait times based on the severity of an individual's need, while others measure waits for specific services, such as psychiatry.

CIHI regularly reports approximately 40 measures for mental health and addiction, mainly related to hospital care. Many, but not all, are reported at a pan-Canadian level. Another common source of pan-Canadian data is Statistics Canada's Canadian Community Health Survey (CCHS), from which measures can be formulated and aggregated to the jurisdictional level. Periodically, there is a focus on mental health within the CCHS. That said not all relevant questions can be used to report by individual province or territory due to smaller sample size in some jurisdictions for the special focus surveys (see Table 5).

The CIHI-FPT mental health and addiction work group members validated the results of the scan and added measures not publicly reported. Details of all 3 environmental scans are available upon request.

Figure 2 Examples of measures of access to mental health and addiction services in relation to the HSP Measurement Framework



International measures of access to mental health and addiction services

To learn from other countries, CIHI scanned several international sources including the Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO) and the International Initiative for Mental Health Leadership.

Common indicator themes included measures of appropriate follow-up care after a hospital discharge (with a strong focus on follow-up in the community), patient outcomes, suicide and mortality, and involuntary admission to care. These indicators were similar to or the same as some in Canada and could potentially be used for international comparisons in the future. While the scan also found that coordination of care and centralizing care in the community were common priorities across international sources, it was noted that measuring performance of health systems in those areas is challenging.

Mental health and addiction information standards

The provinces and territories use a variety of standards to capture administrative, socio-demographic, clinical information and client experience about mental health and addiction services (see Appendix C). The standards differ from each other and, often, multiple standards and information collection systems are used in the same jurisdiction. Standards also vary depending on the setting (community versus acute care).

Table 3 illustrates how the use of standards and scales for mental health and addiction varies among jurisdictions. Client experience surveys are mostly province-specific and may not be comparable.

Table 3 Information standards for mental health and addiction services

Service type	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Community mental health													
Client experience surveys	N	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	N
Health of the Nation Outcome Scale (HoNOS)	N	N	N	N	N	N	N	N	Y	Y	Y	N	N
interRAI Community Mental Health	Y	N	N	N	N	Y	N	N	N	N	N	N	N
Camberwell Ontario Common Assessment of Needs	N	N	N	N	N	Y	N	N	N	N	N	N	N
Other clinical standard	Y	Y	N	Y	N	Y	N	Y	Y	Y	Y	N	N
Addictions													
Client experience surveys	Y	Y	N	Y	N	Y	N	N	Y	Y	Y	Y	N
Health of the Nation Outcome Scale (HoNOS)	N	N	N	N	N	N	N	N	Y	Y	N	N	N
Global Appraisal of Individual Needs (GAIN) family of instruments	N	N	N	N	N	Y	N	N	N	N	Y	N	N
Other clinical standard	N	Y	N	Y	N	Y	Y	Y	Y	Y	Y	N	N

Notes
Y: The clinical standard is used in some capacity but coverage may vary.
N: The clinical standard is not used consistently in this jurisdiction.

The *Standards for Management Information Systems in Canadian Health Service Organizations* (MIS Standards) provides a pan-Canadian framework for financial and statistical data in community mental health settings and to identify all costs (direct care, diagnostic and therapeutic) in the community and acute care addiction settings.

Mental health and addiction information systems

Community mental health information systems vary substantially by province and territory. The existing systems are at different levels of development and sophistication — some are simple Excel files, others are more comprehensive or extensive databases. Some are up to date, while others are older and lack capacity to manage complex data. In some jurisdictions, mental health information is integrated with other community health information systems. Even where systems are in place, the coverage may exclude some regions/areas or service providers.

Table 4 displays which jurisdictions have systems to collect community mental health and addiction information. It also indicates whether the system is local or jurisdictional. Information systems are generally unique to the jurisdiction, requiring more investigation to know how much of the data collected would be comparable across jurisdictions. For pan-Canadian sources, see Table 5.

Table 4 Information systems for community mental health and addiction

Jurisdiction	Community mental health services	Addiction services
N.L.	Jurisdictional*	Jurisdictional*
P.E.I.	Jurisdictional*	Jurisdictional*
N.S.	Local or no system	Jurisdictional*
N.B.	Jurisdictional*	Jurisdictional*
Que.	Jurisdictional*	Jurisdictional*
Ont.	Jurisdictional*	Jurisdictional*
Man.	Local or no system	Local or no system
Sask.	Jurisdictional*	Jurisdictional*
Alta.	Jurisdictional*	Jurisdictional*
B.C.	Jurisdictional*	Jurisdictional*
Y.T.	Local or no system	Local or no system
N.W.T.	Local or no system	Local or no system
Nun.	Jurisdictional*	Jurisdictional*

Note

* Jurisdictional systems and data are generally not comparable with each other.

Pan-Canadian data sources

CIHI hosts several databases with information related to mental health and addiction care (Table 5). While these databases contain pan-Canadian data, they have limitations for measuring access to community-based mental health and addiction services across the country. CIHI is using a targeted and focused approach to acquiring new data, filling gaps in existing holdings, and responding to data needs for priority populations and themes, and other stakeholder priorities. This work will address some of the current limitations of the data. There are also several population surveys such as those conducted by Statistics Canada and The Commonwealth Fund that have the benefit of capturing a broader population — including those with unmet needs — that could be used or modified to ensure representative samples.

Table 5 Pan-Canadian information systems with data on mental health and addiction services

Database/ data collection	Type of data collected	Coverage	Notes
CIHI			
Hospital Mental Health Database (HMHDB)	Clinical, administrative and demographic data on hospitalizations for mental health and addiction	Pan-Canadian	The database integrates discharge records from general and psychiatric hospitals from 4 sources (including DAD/HMDB and OMHRS). This is the most complete and comparable pan-Canadian data available; however, it does not have data on integration with community services or care after discharge.
Ontario Mental Health Reporting System (OMHRS)	Clinical, administrative and demographic data on adults receiving inpatient mental health services Clinical data is captured using the Resident Assessment Instrument–Mental Health (RAI-MH) assessment instrument	Ontario, Newfoundland and Labrador, and Manitoba, and it is being piloted in Quebec	The RAI-MH gathers clinical information on different aspects of an individual's mental health, such as depression severity, positive symptoms, functional status and risk of harm to self and others.

Database/ data collection	Type of data collected	Coverage	Notes
CIHI (cont'd)			
Discharge Abstract Database (DAD)/Hospital Morbidity Database (HMDB)	Clinical, administrative and demographic data on patients discharged from hospital	Pan-Canadian for acute inpatient care 9 provinces/territories submit day surgery cases (other jurisdictions submit to NACRS) Partial coverage of other levels of care (e.g., psychiatric, chronic, rehabilitation)	Both databases are a source of data for the HMHDB. They also contain records where mental health and addiction diagnoses were reported but were not the primary reason for the stay. They contain information on transitions to and from the hospital.
National Ambulatory Care Reporting System (NACRS)	Clinical, administrative and demographic data on patients receiving ambulatory care visits (ED visits, day surgery, and outpatient and community-based clinics)	ED: Full coverage in Alberta, Ontario and Yukon; partial coverage in 5 other provinces Day surgery: Full coverage in 4 provinces; others submit to the DAD/HMDB Clinics: Partial coverage in 3 provinces	Coverage (reporting facilities and data elements reported) varies across the country. Contains information on transitions to and from the ambulatory visit.
Canadian MIS Database (CMDB)	Organization-level financial (such as revenues and expenses) and statistical data about health care services	All provinces/territories except Quebec and Nunavut	Data providers include hospitals, regional health authorities and other organizations that provide mental health and addiction services.
National Physician Database (NPDB)	Demographic characteristics of physicians, physician payments and service utilization	All provinces/territories except Nunavut	Physician payment systems vary from jurisdiction to jurisdiction. Comparable analyses are done through mapping and algorithms.
Scott's Medical Database (SMDB)	Demographic, supply, education and migration data on physicians	Pan-Canadian	CIHI purchases data annually from Scott's Directories. The data is collected from a number of organizations.

Database/ data collection	Type of data collected	Coverage	Notes
CIHI (cont'd)			
Health Workforce Database (HWDB)	Demographic, supply, education, employment and migration data on 30 groups of health care professionals	Pan-Canadian	The HWDB contains information on many professional groups that provide services to individuals living with mental illness and addiction; these groups include psychologists, registered psychiatric nurses, registered nurses, occupational therapists and social workers. Aggregate data is available for most groups, and detailed record-level data is available for selected groups (e.g., nurses).
National Prescription Drug Utilization Information System (NPDUIS)	Prescription claims–level data, collected primarily from publicly financed drug benefit programs	10 provinces/territories and 1 federal drug program (for First Nations and Inuit) Limited to public drug program claims in most jurisdictions; population-based (i.e., private and public drug claims) data for B.C., Saskatchewan and Manitoba	Data for the seniors population is the most comprehensive due to the design of public drug programs.
Statistics Canada			
Canadian Community Health Survey (CCHS)	Contains questions about mental health status; access to and perceived need for formal and informal services and supports; functioning and disability; drug use; and covariates	Pan-Canadian	The CCHS is a population survey, so it may capture information from those not seeking help from a formal health care system. Excluded from the survey's coverage are persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Armed Forces; those living in institutions; children age 12 to 17 who are living in foster care; and persons living in the Quebec health regions Nunavik Region and Terres-Cries-de-la-Baie-James Region. Together, these exclusions represent less than 3% of the Canadian population age 12 and older.

Database/ data collection	Type of data collected	Coverage	Notes
The Commonwealth Fund			
International Health Policy Survey	Patient and provider experience with the health care system	10 provinces for Canada, and 11 Commonwealth Fund countries	Conducted annually, rotating between 2 target populations — the general population (age 18 and older) and older or sicker adults — and primary care physicians. While these surveys provide better data related to access, not all would be able to be reported by jurisdiction due to small sample size for some provinces/territories. The survey sample size is around 4,000 to 5,000 people for Canada as a whole.

Home and community care

This section offers a summary of what was learned from the environmental scans about the organization and delivery of home and community care in Canada, information standards and information systems, as well as measures of home and community care.

How home and community care are funded and delivered

Most funding, policy development, regulation and performance monitoring in home and community care is the responsibility of provincial and territorial ministries (or departments) of health, but some activities and their funding may fall under ministries (or departments) of social services. Home and community care are typically delivered by regional health authorities, either directly or through agencies contracted to deliver services. Some services like home dialysis may be provided directly by hospitals.

Out-of-pocket payment for home and community care is not uncommon, sometimes to supplement publicly funded services or to access them where they are not funded. Home nursing and palliative care, for instance, are typically publicly funded, but funding for additional services such as therapy and personal support workers varies by jurisdiction. Some require copayments by clients or private insurance.

Home and community care offered

There is a wide range of home and community care available across the country. Types of services include the following:

- Case management — Assessment of need and coordination of care.
- Nursing services — Ongoing assessment of the client, therapeutic interventions and clinical care.
- Palliative/end-of-life care — Ongoing assessment of client needs, therapeutic interventions and clinical care.
- Allied health services — From physiotherapists, occupational therapists and dietitians, for example.
- Home support services — Personal care, homemaking and home maintenance/adaptation.
- Caregiver support — Most people who receive home and community care services rely on care from caregivers, typically spouses or children, which can be very difficult for caregivers over the long term. Most provinces and territories provide respite care, financial assistance or other supports.

Table 6 provides details on types of home and community care services available in each jurisdiction. Some services are subject to client payment or copay based on criteria by jurisdictions.

Table 6 Home and community care services available

Service type	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Professional home care services													
Case management services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nursing services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Physiotherapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*
Occupational therapy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*
Rehabilitation therapy	Y	N	N	Y	Y	Y	N	N	N	Y	N	N	N
Speech–language pathology	Y*	N	N	Y	Y	Y	N	N	Y	N	Y	Y	Y*
Respiratory therapy	Y†	N	N	Y	Y	Y	Y	Y	Y	N	N	N	N
Social work	Y	Y	N	Y	Y	Y	Y	N	Y	N	Y	Y	Y
Nutrition services	Y	Y	N	Y	Y	Y	Y	Y	Y	N	N	Y	Y*
Pharmacy, diagnostic and laboratory services	Y	Y	N	Y	N	Y	N	N	Y	N	N	Y	N
Psychosocial services	N	N	N	N	Y	N	N	N	N	N	N	N	N
Palliative care services													
Palliative care services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y*
Non-professional home care services													
Home support services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Community-based services													
Adult day services	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Meal programs	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Volunteer services	N	N	N	Y	Y	Y	N	Y	Y	N	N	Y	N
Health education	N	N	N	N	Y	Y	Y	Y	Y	N	N	Y	N
Transportation	Y	N	N	N	Y	Y	Y	N	Y	Y	Y	Y	N
Adult protection	Y	Y	Y	Y	N	N	N	N	N	N	Y	N	N
Social/recreational services	N	N	N	Y	N	Y	N	N	Y	Y	N	Y	N
Behavioural management	Y	N	Y	Y	N	Y	Y	N	Y	N	N	N	N

Service type	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Other programs													
Self-managed care (client is provided funds to purchase services)	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Caregiver support and respite services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N

Notes
* Availability varies.
† One region only.
Y: The service is available in at least some regions.
N: This service is not available in this jurisdiction.
Sources
Adapted from Canadian Home Care Association, *Portraits of Home Care in Canada 2013*, 2013; Canadian MIS Database, 2015, Canadian Institute for Health Information.

Accessing services

People can self-refer for home and community care, or they may be referred by a family caregiver or a health provider. Patients are typically referred to palliative care by their primary care physician. All referred patients are assessed and, if found eligible for home care, the amount, type and schedule of services they receive are assigned based on their needs and local policy. Some provinces do income testing for some services and may require clients to pay for part of the service, based on income. Policies that define who is eligible to receive home care, how much and for how long vary among provinces and territories.

Most provinces and territories have case managers who coordinate care and referrals. Case management is often integrated with the long-term and acute care sectors to facilitate access to a range of programs and services. Case managers may also work in hospitals to support discharge-planning processes and to assess the person's eligibility for admission to residential care or home care services prior to discharge.

Reported measures of home and community care

The environmental scan carried out by CIHI found approximately 200 measures publicly reported in Canada between 2010 and 2017. Approximately half of these were grouped to categories related to access. Although this is a large number, no national or multi-jurisdictional reports with regularly reported indicators of access to home and community care were found.

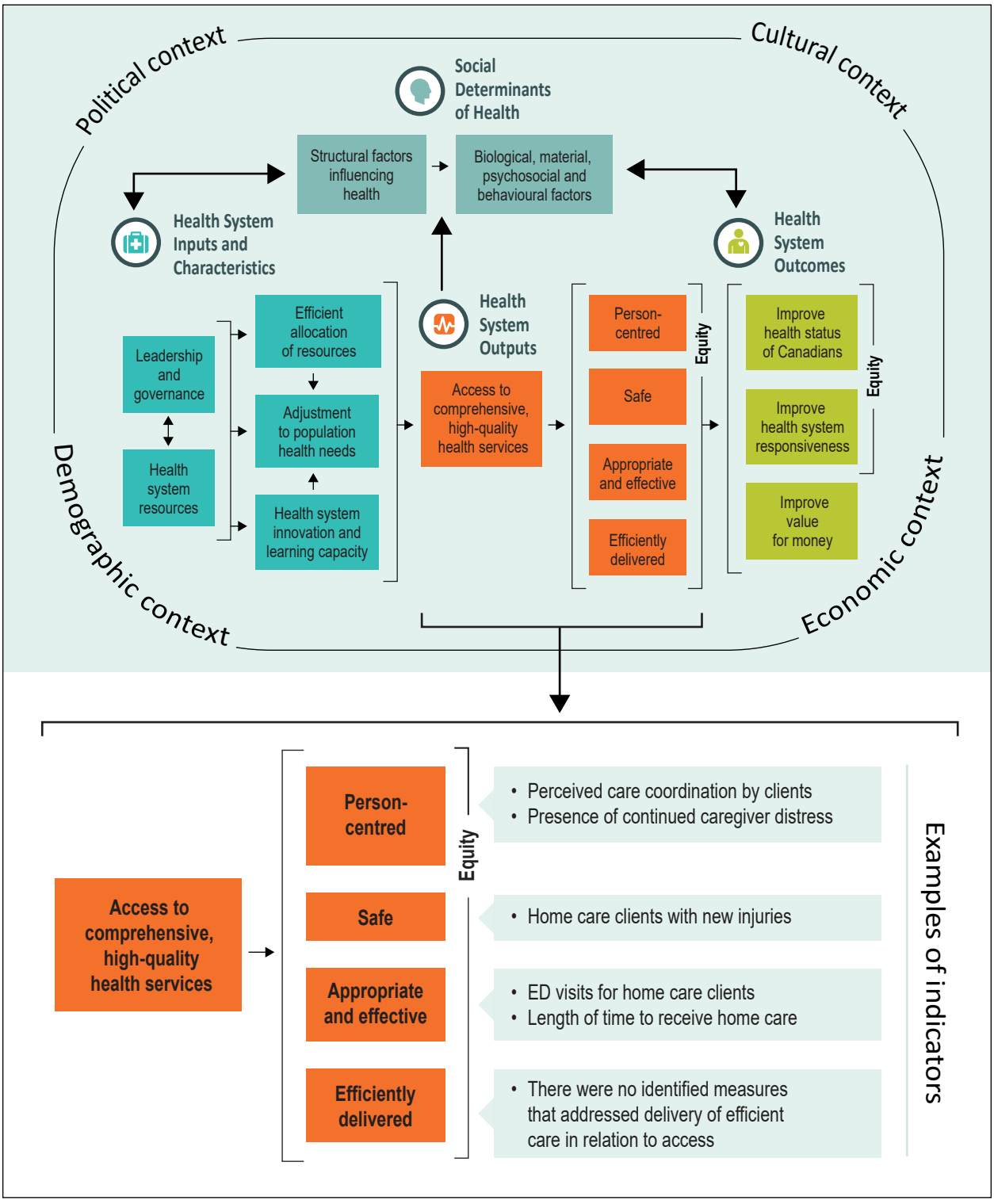
The scan revealed almost all provinces and territories collect data on the volume of home care services provided and most provinces and territories survey home care clients, but the data and areas covered differ. Some provinces report data on wait times for home care, but the methods and what is measured differ — for example, some provinces measure the wait to be assessed, while others measure the wait for services after assessment. The scan of home and community care measures found few indicators or metrics of integration with primary care; however, there were more indicators reporting clients' perceptions of coordination of care. CIHI reports on several measures related to home care, mostly about clients who receive longer-term home care services (see cihi.ca). In addition, CIHI reports on 16 quality indicators for these clients in a private tool. Currently, results for 5 jurisdictions are included, but this number continues to grow.

To identify gaps in measures of access, indicators and metrics were grouped by the concept measured and then mapped to CIHI's HSP Measurement Framework. Figure 3 shows examples of measures of access to home and community care found through the environmental scan.

With the exception of data from sources such as Statistics Canada's Canadian Community Health Survey (CCHS), The Commonwealth Fund International Health Policy surveys and Canada's General Social Survey (GSS), there is little national data available on home and community care, and therefore few pan-Canadian indicators (see Table 9). The pan-Canadian surveys and interRAI tools provide some information on the experience of caregivers.

The CIHI-FPT home and community care work group members validated the results of the scan and added indicators that are reported privately or by outside ministries or departments of health. Details of all 3 environmental scans are available upon request.

Figure 3 Examples of measures of access to home and community care in relation to the HSP Measurement Framework



International measures of access to home and community care

To learn from other countries, CIHI scanned several international sources including the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO).

Several common themes for measures were identified. However, there was little consistency in how the indicators were measured, which will make international comparisons more difficult. The indicators included specific waits (between assessment and initiation of services), rates of service use, quality of services (particularly the coordination of services) and patient outcomes.

Home and community care information standards

Provinces and territories use a variety of standards to capture clinical information, assess need and capture client experience in home and community care (including palliative care). The most common clinical standards for home care are the Resident Assessment Instrument–Home Care (RAI-HC) and interRAI Contact Assessment (interRAI CA). 8 Canadian jurisdictions use 1 of the interRAI clinical assessment tools, supported by CIHI, to assess potential home care clients, to support care provision and planning for long-term home care clients and to determine eligibility for home care or long-term care. interRAI tools focus on continuity of care, with a key set of data elements and language common to all tools. The use of the interRAI suite of tools is growing across the country, with all jurisdictions except Quebec either having implemented the tools or in discussions with CIHI about implementation. interRAI clinical information standards better support reporting on safety, quality and outcomes than on accessibility of services.

Most jurisdictions also have a client experience survey, but there is limited consistency among them. There is an interRAI palliative care clinical assessment tool, but it is only 1 of several palliative care tools used across the jurisdictions. For palliative care, the most common clinical standards are the Palliative Performance Scale and the Edmonton Symptom Assessment Scale, although many jurisdictions use other clinical standards. See Appendix C for a detailed description of standards used by jurisdictions.

The MIS Standards provides a pan-Canadian framework for financial and statistical data for health services including home and palliative care, but it is not implemented in all organizations that offer these services.

Table 7 illustrates how the use of standards for home and palliative care varies among jurisdictions.

Table 7 Information standards for home care and palliative care

Types of service	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
Home care													
Resident Assessment Instrument–Home Care	Y	N	Y	N	N	Y	Y	Y	Y	Y	Y	N	N
interRAI Contact Assessment	N*	N	N	N	N	Y	N†	Y‡	Y‡	Y‡	Y‡	N	N
Client Experience Surveys	Y	Y	N	Y	Y	Y	Y	N	Y	N	N	N	Y
Other	N	Y	N	Y	Y	N	N	N	N	N	N	N	N
Palliative care													
Palliative Performance Scale (PPS)	N	Y	N	Y	Y‡	Y	Y‡	Y‡	Y‡	N	Y	N	N
Edmonton Symptom Assessment Scale (ESAS)	N	Y	N	Y	Y‡	Y	Y‡	Y	Y‡	Y	Y	N	N
Client Experience Surveys	N	N	N	Y	N	Y	N	N	Y	N	N	N	N
Other	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N

Notes

* Newfoundland and Labrador is in the process of implementing the interRAI Contact Assessment.
† Manitoba will have interRAI CA data for the Winnipeg and Prairie Mountain regional health authorities later in 2018.
‡ Partial coverage.
Y: The tool is used in some capacity but coverage may vary.
N: The tool is not used in this jurisdiction.

Home and community care information systems

More than half the jurisdictions have a system to collect home care information at the jurisdiction level. Other jurisdictions have a centralized scheduling system or a community system for dispensed drugs. 1 jurisdiction stores home care information as part of the electronic medical record (EMR).

Most jurisdictions do not have a central repository of palliative care information. Where they exist, they are generally regional (2 jurisdictions) or only for home-based palliative care (4 jurisdictions). Again, 1 jurisdiction sends all data for manual entry.

Table 8 displays which jurisdictions have information systems about home care and palliative care clients. It also indicates whether the system is local or jurisdictional. Jurisdictional information systems are generally unique to each jurisdiction; therefore, data may not be comparable. For pan-Canadian sources, see Table 9.

Table 8 Information systems for home care and palliative care

Jurisdiction	Home care information system*	Designated palliative care information system†
N.L.	Jurisdictional‡	Local or no system
P.E.I.	Jurisdictional	Local or no system
N.S.	Jurisdictional	Local or no system
N.B.	Jurisdictional	Local or no system
Que.	Jurisdictional	Local or no system
Ont.	Jurisdictional	Local or no system
Man.	Local or no system	Local or no system
Sask.	Jurisdictional	Local or no system
Alta.	Local or no system	Local or no system
B.C.	Jurisdictional	Jurisdictional
Y.T.	Jurisdictional	Local or no system
N.W.T.	Jurisdictional	Local or no system
Nun.	Jurisdictional	Jurisdictional

Notes

* Most jurisdictions have no specific palliative care information system, and patients receiving palliative home care will be captured in the home care system information if available.

† Designated palliative care information system captures all palliative patients including those who receive home care.

‡ Jurisdictional systems and data are generally not comparable with each other.

The next section provides information on pan-Canadian data for home and community care.

Pan-Canadian information systems

CIHI hosts several databases with information related to home and community care (Table 9). These databases contain pan-Canadian data and some can be linked. While these data holdings currently may have data gaps in measuring access to short-term home and community care, significant work is under way or planned to address these gaps. However, CIHI's databases can be used to measure clinical care of long-term home care clients, including aspects of care quality, client functioning and outcomes due to their comprehensive and longitudinal nature.

Table 9 Pan-Canadian information systems with data on home and community care

Database/ data collection	Type of data collected	Coverage	Notes
CIHI			
Home Care Reporting System (HCRS)	Demographic, clinical administrative and service utilization data on clients served by publicly funded home care programs Clinical data is captured using interRAI assessment tools: • RAI-HC for long-term home care clients • interRAI CA for clients requesting home care services	7 provinces are using the interRAI assessments, and 5 currently submit the data to CIHI 3 provinces also submit administrative and/or service utilization data for their home care clients	The coverage and scope of data elements submitted vary among jurisdictions.
National Prescription Drug Utilization Information System (NPDUIS)	Prescription claims–level data, collected primarily from publicly financed drug benefit programs	10 provinces/territories and 1 federal drug program (for First Nations and Inuit) Limited to public drug program claims in most jurisdictions; population-based data (i.e., private and public drug claims) for British Columbia, Saskatchewan and Manitoba	Data for the seniors population is the most comprehensive due to the design of public drug programs.
Discharge Abstract Database (DAD)/Hospital Morbidity Database (HMDB)	Clinical, administrative and demographic data on patients discharged from hospitals	Pan-Canadian for acute inpatient care 9 provinces/territories submit data on day surgery cases (other jurisdictions submit to NACRS) Partial coverage of other levels of care (e.g., psychiatric, chronic, rehabilitation)	This is the most complete and comparable pan-Canadian data available. The databases contain information on transitions to and from the hospital (including home and community care services).

Database/ data collection	Type of data collected	Coverage	Notes
CIHI (cont'd)			
National Ambulatory Care Reporting System (NACRS)	Clinical, administrative and demographic data on patients receiving ambulatory care visits (ED visits, day surgery, and outpatient and community-based clinics)	ED: Full coverage in Alberta, Ontario and Yukon; partial coverage in 5 other provinces Day surgery: Full coverage in 4 provinces (others submit to the DAD/HMDB) Clinics: Partial coverage in 3 provinces	Coverage (reporting facilities and data elements reported) varies across the country. Contains information on transitions to and from ambulatory visits (including home and community care services).
Canadian MIS Database (CMDB)	Organization-level financial (such as revenues and expenses) and statistical data about health care services	All provinces/territories except Quebec and Nunavut	Data providers include regional health authorities and other organizations providing home and community care services.
National Physician Database (NPDB)	Demographic characteristics of physicians, physician payments and service utilization	All provinces/territories except Nunavut	Physician payment systems vary from jurisdiction to jurisdiction. Comparable analyses are created done through mapping and algorithms.
Scott's Medical Database (SMDB)	Demographic, supply, education and migration data on physicians	Pan-Canadian	CIHI purchases data annually from Scott's Directories. The data is collected from a number of organizations.
Health Workforce Database (HWDB)	Demographic, supply, education, employment and migration data on 30 groups of health care professionals	Pan-Canadian	The HWDB contains record-level data for some professional groups (nurses, pharmacists, physiotherapists, occupational therapists, medical laboratory technologists and medical radiation technologists) and aggregate data on other groups. The database does not contain information on personal support workers, who provide many home and community care services.

Database/ data collection	Type of data collected	Coverage	Notes
Statistics Canada			
Canadian Community Health Survey (CCHS)	Home care service module covers questions about type of care and services received. Also includes module on unmet health care needs.	Pan-Canadian	The CCHS is a population survey, so it may capture information from those not seeking help from a formal health care system. Non-response survey bias and sample sizes across jurisdictions to be considered. Excluded from the survey's coverage are persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Armed Forces; those living in institutions; children age 12 to 17 who are living in foster care; and persons living in the Quebec health regions Nunavik Region and Terres-Cries-de-la-Baie-James Region. Together, these exclusions represent less than 3% of the Canadian population age 12 and older.
General Social Survey (GSS)	Annual survey by Statistics Canada, rotates between 6 survey themes, 1 of which is Caregiving and Care Receiving. Questions ask about such things as • Types and amount of care family caregivers provide/Canadians receive • Unmet needs of those who need care but are not receiving it • Impact of caregiving • Socio-demographic characteristics	10 provinces	The Caregiving and Care Receiving module was last conducted in 2012. Sample size ~25,000

Database/ data collection	Type of data collected	Coverage	Notes
The Commonwealth Fund			
International Health Policy Survey	Patient and provider experience with the health care system	10 provinces for Canada, and 11 Commonwealth Fund countries	Conducted annually, rotating between 2 target populations — the general population (age 18 and older) and older or sicker adults — and primary care physicians. While these surveys provide better data related to access, not all would be able to be reported by jurisdiction due to small sample size for some provinces/territories. The survey sample size is around 4,000 to 5,000 people for Canada as a whole.

Appendix A: CIHI-FPT work groups — participants and terms of reference

The CIHI-FPT Work Group for Performance Measurement of FPT Shared Health Priorities related to **Home and Community Care** is comprised of one executive lead from each federal, provincial and territorial (FPT) jurisdiction, nominated by their Deputy Minister of Health, and one executive lead from CIHI. Members act as their Deputy's representative to work with CIHI and FPT representatives to achieve consensus on a recommended set of common indicators to measure improvements in access to Home and Community Care. The work group has been asked to make final indicator recommendations to the FPT Health Ministers, for decision. Membership includes:

Home and community care work group (list current as of February 21, 2018)

- Jodi-Anne Brzozowski, Health Canada
- Lisa Cardinal, Northwest Territories
- Jill Casey, Nova Scotia
- Michael Corman, Prince Edward Island
- Michael Harvey, Newfoundland and Labrador
- Ross Hayward, British Columbia
- Stephen Jackson, Nunavut
- Bidénam Kambia-Chopin (observer), Quebec
- Jocelyn LeBlond, Saskatchewan
- Deborah Malazdrewicz, Manitoba
- Joan McGowan, New Brunswick
- Kathleen Morris, Canadian Institute for Health Information
- Amy Olmstead, Ontario
- Amy Riske, Yukon
- Larry Svenson, Alberta

The CIHI-FPT Work Group for Performance Measurement of FPT Shared Health Priorities related to **Mental Health and Addictions** is comprised of one executive lead from each federal, provincial and territorial (FPT) jurisdiction, nominated by their Deputy Minister of Health, and one executive lead from CIHI. Members act as their Deputy's representative to work with CIHI and FPT representatives to achieve consensus on recommended set of common indicators to measure improvements in access to Mental Health and Addictions. The work group has been asked to make final indicator recommendations to the FPT Health Ministers, for decision. Membership includes:

Mental health and addiction work group (list current as of February 21, 2018)

- Kevin Barnes, Prince Edward Island
- Geneviève Boucher (observer), Quebec
- Jodi-Anne Brzozowski, Health Canada
- Lisa Cardinal, Northwest Territories
- Jill Casey, Nova Scotia
- Michael Harvey, Newfoundland and Labrador
- Ross Hayward, British Columbia
- Deborah Malazdrewicz, Manitoba
- Opal McInnis, Nunavut
- Patrick Mitchell, Ontario
- Kathleen Morris, Canadian Institute for Health Information
- Debbie Peters, New Brunswick
- Larry Svenson, Alberta
- Mary VanStone, Yukon
- Kathy Willerth, Saskatchewan

Terms of membership

Terms of membership

The terms of reference and work group membership will be renewed on an annual basis. Members of the work groups are asked to serve until common indicators are selected.

Preliminary work plan

- Project initiation and clarification of scope and deliverables
- Identification of key information needs and priorities
- Environmental scan of existing indicator and data infrastructure
- Stakeholder and expert consultation
- Indicator selection
- Progress reporting (March 2018)
- Indicator development, as required
- The end goal is recommending to the FPT Health Ministers a focused set of common indicators to measure pan-Canadian progress on the agreed priorities of mental health and addictions, and home and community care, to be reported on annually to Canadians.

Roles and responsibilities (CIHI)

- Develop and circulate terms of reference for consultation and approval by executive leads
- Provide secretariat support for the CIHI-FPT work groups including: organizing meetings, circulating meeting materials and chairing work group meetings; distributing meeting notes; soliciting meeting agenda items for discussion
- Support the development of an external engagement strategy and invite, on the advice of FPT executive leads, relevant external stakeholders and subject matter experts to inform and assist in indicator selection and development processes
- Develop and circulate preliminary environmental scans for discussion and validation by FPT executive leads
- Provide decision-making tools and facilitate the process of indicator selection and development
- As requested, provide periodic updates on behalf of the CIHI-FPT work groups to the Health Ministers Meeting, the Conference of Deputy Ministers, and its sub-committee, the Canadian Health Information Forum (CHIF).

CIHI is:

- Accountable jointly to federal, provincial and territorial governments
- Accountable, as a group with FPT executive leads, to the FPT Health Ministers through the Conference of Deputy Ministers
- Accountable to the CIHI Board of Directors

Roles and responsibilities (FPT executive leads)

- Speak knowledgeably about your jurisdictions' data sources and measurement activities
- Lead and coordinate relevant work within your jurisdiction
- Act as your jurisdiction's representative to work with CIHI and other executive leads to achieve consensus on indicator selection
- Meet regularly and actively participate in the activities of the work group
- Inform and validate environmental scans of existing data sources and indicators
- Identify and support the outreach to sector-specific subject matter experts in your jurisdiction
- Provide insight and advice on the development of the Interim Progress Report to be delivered to Canadians in March 2018
- Provide insight and advice on communication activities

FPT executive leads are:

- Accountable to their Deputy Ministers of Health
- As a group, and with CIHI, accountable to the Health Ministers through the Conference of Deputy Ministers

Meetings

- The CIHI-FPT work groups will meet at minimum once monthly. Meetings will usually be hosted by teleconference and may include face-to-face meetings. Ad hoc meetings will be scheduled as required.
- CIHI will be responsible for reimbursing the costs associated with travel and accommodations for participating in any face-to-face meetings of the committee. Work group members will submit expense claim forms to the CIHI-FPT work group secretariat as per CIHI's Travel Claim policy.
- The 2 CIHI-FPT work groups will meet jointly when the objectives are common (e.g. level setting, definition of scope, progress reporting) but will meet separately to support the selection and development of indicators for their specific sector.
- On the advice of FPT executive leads, CIHI will invite relevant external stakeholders and subject matter experts to participate in select CIHI-FPT work group meetings to inform and assist in indicator selection and development processes.

Communications

The CIHI-FPT work groups secretariat will guide its activities according to the principles of respect, transparency, collaboration, and consensus-based decision making. All decisions made by the CIHI-FPT work groups will be communicated to work group members as follows:

- Meeting minutes and action items will be circulated by the secretariat for review and approval
- Bi-annual progress reporting will be delivered to the Conference of Deputy Ministers on behalf of the CIHI-FPT work groups and will include key messages previously shared with work group members
- Executive leads and the CIHI secretariat may update members of their senior leadership teams as required.

Appendix B: Tools to support indicator selection and development

CIHI's Health System Performance Measurement Framework

- CIHI's Health System Performance Measurement Framework is designed to support the performance improvement priorities of Canadian jurisdictions by reflecting the expected casual relationships among dimensions of health system performance. The framework takes into consideration the evolving performance needs of its various users; is grounded in the current state of scientific knowledge; and is actionable because it offers an analytical and interpretative framework that can be used to manage and improve health system performance.
- The framework can be used to guide development of and provide context to health system information and reporting; to guide selection of indicators for measurement and reporting; to help identify information measurement gaps and opportunities; and to provide a common language for different stakeholders as they work toward a shared goal of measuring and delivering on health system goals and priorities.

Indicator development cycle

- CIHI regularly develops new indicators to fill gaps in data and knowledge and to provide stakeholders with a better snapshot of the Canada's health care systems. CIHI has a well-established and rigorous process for the development cycle of an indicator. Indicators are developed through a 4-stage process after an information need or knowledge gap has been identified. The 4 stages are initiate/evaluate; develop; calculate; and release. The time it takes to go from stage 1 to stage 4 varies, but the driving factor is the availability of high-quality data.

Data Source Assessment Tool

- CIHI's **Data Source Assessment Tool** (DSAT) provides a set of criteria to comprehensively assess the quality of data sources to determine their fitness for use, including whether the data is of sufficient quality to calculate meaningful and accurate health indicators.
- Assessment is done across 5 quality dimensions: relevance; accuracy and reliability; comparability and coherence; timeliness and punctuality; and accessibility and clarity. The DSAT can be used to identify data limitations for quality characteristics such as coverage of populations of interest, item availability, and jurisdictional comparability, all of which may impact the data used for indicators. This tool can be applied to many different types of data sources, and the criteria can be adapted, expanded or reduced based on the needs and priorities of an organization or program.

Information Quality Framework

- CIHI's Information Quality Framework provides an overarching structure for all of CIHI's quality management practices related to capturing and processing data that can be used for indicators and other information products.
- Organizations can use the framework as a whole to understand the scope of their own quality assurance activities — to understand, assess and communicate the quality of their data and information — and identify any areas that require strengthening to support and improve the production of health indicators and their underlying data. Key resources and tools within the framework (such as the DSAT and the indicator development cycle) will also support the development of health indicators.

Mental health and addiction data at CIHI

- This web page describes the data that is available within CIHI to address questions related to mental health and addiction. A brief section is provided for each data holding, summarizing the types of data available.

Home and community care data at CIHI

- This web page describes the data that is available within CIHI to address questions related to home and community care. A brief section is provided for each data holding, summarizing the types of data available.

Appendix C: Information standards

Community mental health information standards

Several clinical standards for adult community mental health are used across the country, with varying levels of coverage. These standards include the Health of the Nation Outcome Scale (HoNOS) (3 jurisdictions); interRAI Community Mental Health (2 jurisdictions, plus 1 considering); Level of Care Utilization System (LOCUS©) (1 jurisdiction); the Ontario Common Assessment of Need (OCAN) (1 jurisdiction); and self-developed assessment tools (2 jurisdictions). For children and youth, there is some use of the Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) (2 jurisdictions), and the interRAI Child and Youth Mental Health (ChYMH) (1 jurisdiction). The MIS Standards provides a framework for financial and statistical data in community mental health settings. Client experience information is also captured through a number of client experience surveys. Though consistency is limited, 2 have used an Accreditation Canada survey (Mental Health Inpatient and Outpatient Survey).

Addiction (acute and community) information standards

Clinical standards for various types of addiction are inconsistent across the country. While the Health of the Nation Outcome Scale (HoNOS), Global Appraisal of Individual Needs (GAIN) and Health of the Nation Outcome Scale for Children and Adolescents (HoNOSCA) are used in 2 jurisdictions, other clinical standards are used in single jurisdictions, with often partial coverage: RAI–Mental Health (acute only), Admission and Discharge Assessment Tools (ADAT), CAGE Substance Abuse Screening Tool, Alcohol Withdrawal Assessment (CIWA-Ar) and the Global Appraisal of Individual Needs Short Screener (GAIN-SS). Client experience information standards are used in 8 jurisdictions, with no overlap in standards used. The MIS Standards provides the framework to identify all costs (direct care, diagnostic and therapeutic).

Home care information standards

To assess non-acute home care clients, 8 jurisdictions have implemented either the RAI–Home Care or interRAI Home Care standard (7 fully, 1 partially), 1 has implementation under way or is working on a business case. 1 of the non-RAI jurisdictions uses the *outil d'évaluation multiclientèle* to assess the needs of anyone requiring home care services. To determine need for services, a number of jurisdictions are using the interRAI Contact Assessment. 1 jurisdiction uses this in all of its regions, 4 to 5 jurisdictions use it in some regions or pilot sites, 1 has an implementation planned, and 1 other jurisdiction is considering implementation. 1 jurisdiction uses the Seniors Assessment and Screening Tool (SAST) for screening purposes. The MIS Standards accommodates financial reporting for home care. 8 jurisdictions have collected client experience information, but there is no consistency in standards between jurisdictions.

Palliative care information standards

Most jurisdictions use the Palliative Performance Scale (PPS) to measure progressive decline of a palliative resident (4 fully implemented, 4 partial) and the Edmonton Symptom Assessment Scale (6 fully implemented, 3 partial). For palliative home care clients, the RAI–Home Care is used in 5 jurisdictions. To better understand palliative-specific needs and preferences, several jurisdictions have chosen to use the interRAI Palliative Care standard, either across the jurisdiction for palliative home care (1 jurisdiction) or through pilot projects (3 jurisdictions). Other clinical standards are used in single jurisdictions: Edmonton Classification System for Cancer Pain (ECS-CP), Folstein Mini-Mental, CAGE, Palliative Outcome Scale, FAMCARE scale, Karnofsky tools, Distress thermometer, and the Edmonton Function Assessment Tool. The MIS Standards provides a framework for financial and statistical data, but this standard has not been comprehensively used for financial information related to palliative care. Client experience information standards have not been comprehensively implemented for palliative clients. For palliative home care clients, client experience surveys of home care clients would apply. Only 1 jurisdiction had a palliative-specific client experience standard (Wascana client-centred care survey), and it was used for a single region.

Appendix D: Public and stakeholder consultations

Many thanks to Canadians from across the country who provided support, advice and recommendations to the CIHI-FPT work groups throughout this process. This includes participants in face-to-face meetings, the electronic Delphi process and interviews; the more than 100 Canadians who participated in focus groups; and the more than 650 Canadians who participated in an online survey.

Note that some consultations guaranteed anonymity to participants. As such, not all participants who were engaged in the process are listed here. We are grateful to all Canadians who shared their personal insights and experiences.

The following people and organizations were invited to provide feedback during the process:

- Aaron Sheldon, Alberta Health Services
- Amy Good, Alberta Health Services
- Amy Porath, Canadian Centre on Substance Use and Addiction
- André Delorme, Government of Quebec
- Anna Greenberg, Health Quality Ontario
- Anne-Marie Ugnat, Public Health Agency of Canada
- Anthony Milonas, Board Member, Canadian Home Care Association, CBI Health Group
- Ashley Chisholm, Canadian Nurses Association
- Brian Rush, Centre for Addiction and Mental Health
- Carla McLean, Alberta Health Services
- Carol Adair, University of Calgary
- Charlotte Waddell, Simon Fraser University
- Christopher Canning, Mental Health Commission of Canada
- Dafna Kohen, Statistics Canada
- Dawn Moynihan, CBI Health Group
- Dawn Vernon, Caregiver
- Donna Conway, Victoria Island Health
- Ed Mantler, Mental Health Commission of Canada
- Elyse Trudell, Mental Health Commission of Canada's Youth Council
- Esther Green, Canadian Partnership Against Cancer

- Evangeline Danseco, Ontario Centre of Excellence for Child and Youth Mental Health
- Florence Budden, Canadian Federation of Mental Health Nurses
- Ian Boeckh, Graham Boeckh Foundation
- Ian Manion, Royal Ottawa Mental Health Centre
- Janice Keefe, Nova Scotia Centre on Aging
- Jennifer Murdoch, Kids Help Phone
- Jennifer Shipper, Health Quality Ontario
- Jim Silvius, Alberta Health Services
- John Dick, Mental Health Commission of Canada's Hallway Group
- John Hirdes, University of Waterloo
- José Pereira, The College of Family Physicians of Canada
- Joseph Szamuhel, Canadian Mental Health Association
- Kaiyan Fu, Saint Elizabeth Health Care
- Kathy Chouinor, British Columbia Ministry of Health
- Katie Dilworth, Community Health Nurses of Canada
- Kellee Martin, Government of Newfoundland and Labrador
- Kimberly Moran, Children's Mental Health of Ontario
- Laurel Lemchuk-Favel, BC First Nations Health Authority
- Linda Courey, Nova Scotia Health Authority
- Lisa Benedet, Canadian Home Care Association
- Lori Mitchell, Winnipeg Regional Health Authority
- Marcel Saulnier, Health Canada
- Maria Gruending, Ontario Ministry of Health and Long-Term Care
- Mark Smith, Manitoba Centre for Health Policy
- Martin Hébert, ministère de la Santé et des Services sociaux du Québec
- Mary Sullivan, Prince Edward Island Department of Health and Wellness
- Mike Cass, Canadian Patient Safety Institute
- Nicholas Watters, Mental Health Commission of Canada
- Nicolette Slovitt, Toronto Public Health
- Ondina Love, HEAL
- Pamela Prince, Royal Ottawa Mental Health Centre
- Rochelle Garner, Statistics Canada
- Ruth Stoddart, Ontario Ministry of Health and Long-Term Care
- Samir Sinha, University of Toronto

- Sharon Baxter, Canadian Hospice Palliative Care Association
- Shirin Roshanafshar, Statistics Canada
- Stephen Vail, Canadian Medical Association
- Susan Brien, Health Quality Ontario
- Susan Stevens, Nova Scotia Health Authority
- Suzanne Dupuis-Blanchard, University of Moncton
- Sylvie Martin, Government of New Brunswick
- Tracy Parsons, Newfoundland and Labrador Centre for Health Information
- Virginia Toulouse, BC First Nations Health Authority
- Wendy Preskow, National Initiative for Eating Disorders
- Yves Talbot, The College of Family Physicians of Canada
- Agewell
- ALS Society of Canada
- Alzheimer Society of Canada
- Assembly of First Nations
- Baycrest Health Sciences
- Bayshore HealthCare
- Canada Health Infoway
- Canadian AIDS Society
- Canadian Alliance on Mental Illness and Mental Health
- Canadian Association of Retired Persons
- Canadian Frailty Network
- Canadian Psychiatric Association
- Canadian Psychological Association
- Canadian Public Health Association
- Fraser Health Authority
- HealthCareCAN
- Health Charities Coalition of Canada
- Inuit Tapiriit Kanatami
- Mental Health Commission of Canada’s Halliday Group
- Mental Health Commission of Canada’s Youth Council
- Métis National Council
- Mood Disorders Society of Canada
- National Pensioners Federation

- Pallium Canada
- Patients Canada
- Schizophrenia Society of Canada
- The College of Family Physicians of Canada
- Trillium Health Partners
- Voices From the Street
- VON Canada
- YMCA National Office

Appendix E: Text alternative for images

Process and timeline for selecting common indicators

The indicator selection process and activities of the Shared Health Priorities work are divided into 6 steps.

Steps 1 through 3 took place between October 2017 and February 2018. Step 1 involved scans and assessments, validated by federal/provincial/territorial work groups. They assessed the state of services, measures, and information standards and systems. The CIHI and federal/provincial/territorial work groups reviewed and validated the information.

Step 2 involved engagement with federal/provincial/territorial governments, stakeholders and the public. CIHI engaged with federal/provincial/territorial governments, sector stakeholders, measurement experts, patients and the public. CIHI gathered information on priorities to set principles that will guide indicator selection.

Step 3 involved discussion and assessment of indicators. The CIHI and federal/provincial/territorial work groups prioritized existing measures that could be used to measure access to mental health and addiction and home and community care services. They identified information gaps where new measures are required.

Steps 4 and 5 are expected to take place between March and June 2018. Step 4 will involve the proposal of indicators. The CIHI and federal/provincial/territorial work groups will select a common set of 3 to 5 indicators for mental health and addiction and home and community care services.

Step 5 will involve making indicator recommendations. The federal/provincial/territorial Conference of Deputy Ministers of Health and health ministers will receive indicator recommendations.

Step 6 is expected to start in late 2018 or early 2019. This final step will involve indicator development and ongoing reporting. This will include defining the methodology for all indicators and developing data sources for new indicators. There will be annual reporting to Canadians.

Figure 1: Funding and delivery of community mental health and addiction services

This diagram illustrates how community mental health and addiction services are funded and delivered.

The ministries of health are responsible for implementing mental health and addiction policies, monitoring performance and funding care among their jurisdictions.

For all provinces and the Northwest Territories, mental health and addiction services are primarily delivered by regional health authorities, either directly or contracted through organizations. For Yukon and Nunavut, mental health and addiction services are primarily delivered through ministry of health departments.

In some jurisdictions, other ministries or departments can also be involved. In British Columbia, both the Ministry of Mental Health and Addictions and Ministry of Children and Family development are involved. In Alberta, the Ministry of Children's Services and the Ministry of Community and Social Services is involved. In Manitoba, Manitoba Families and Healthy Child Manitoba are involved. In Ontario, the Ontario Ministry of Children and Youth Services is involved. In Newfoundland and Labrador, the Department of Children, Seniors, and Social Development is involved. In Nunavut, the Department of Health also provides some funding to travel to Ontario, Manitoba and the Northwest Territories for services. Other ministries, such as Education and Justice, may also be involved; however, these are out of scope for this report.

Figure 2: Examples of measures of access to mental health and addiction services in relation to the HSP Measurement Framework

CIHI's Health System Performance Management Framework consists of 4 quadrants: Health System Outcomes, Social Determinants of Health, Health System Outputs, and Health System Inputs and Characteristics. These quadrants are linked together to form a dynamic framework in an expected causal chain. Here is an overview of the quadrants, followed by examples of measures for each of the Health System Output dimensions. The examples were found during the environmental scan.

The first quadrant, Health System Outcomes, consists of 3 dimensions: Improve health status of Canadians, Improve health responsiveness and Improve value for money. The first 2 of these dimensions encompass equity to reflect the overarching goal of equitable distribution. Quadrant 3, Health System Outputs, has 1 dimension (Access to comprehensive high-quality health services) with 4 quality attributes of the health services delivered (attributes are Person-centred, Safe, Appropriate and effective, and Efficiently delivered), and these impact the 3 dimensions in Quadrant 1. Quadrant 1 and Quadrant 2 (Social Determinants of Health) influence each other.

The second quadrant, Social Determinants of Health, consists of 2 dimensions: Structural factors influencing health, and Biological, material, psychosocial, and behavioural factors. The first dimension influences the second dimension. Quadrants 1 and 2 influence each other. Quadrant 4 (Health System Inputs and Characteristics) and Quadrant 2 also influence each other. Quadrant 2 is also influenced by Quadrant 3 (Health System Outputs).

The third quadrant, Health System Outputs, consists of 1 dimension, Access to comprehensive high-quality health services, and 4 quality attributes: Person-centred, Safe, Appropriate and effective, and Efficiently delivered. These quality attribute dimensions also encompass equity. Access to comprehensive high-quality health services is influenced jointly by the dimensions in the fourth quadrant: Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity. Quadrant 3 influences Quadrant 2.

The fourth quadrant, Health System Inputs and Characteristics, consists of 5 dimensions: Leadership and governance, Health system resources, Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity. This quadrant comprises 2 foundational dimensions that influence the capacity of the system to improve: Leadership and governance, and Health system resources. These foundational dimensions influence one another as well as the other inputs and characteristic dimensions in this quadrant. The dimensions Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity influence each other. Quadrants 4 and 2 influence each other.

4 contextual elements — Cultural context, Economic context, Demographic context and Political context — surround the quadrants in the framework.

Here are examples of measures for each of the Health System Output dimensions:

- For the Person-centred dimension, examples are physician follow-up within 30 days after hospitalization, and caregiver experience.
- For the Safe dimension, an example of a measure is adverse inpatient drug events.
- For the Appropriate and effective dimension, examples of measures are addiction services wait time, and 30-day readmission for mental illness.
- There were no identified measures that addressed delivery of efficient care in relation to access.

Figure 3: Examples of measures of access to home and community care in relation to the HSP Measurement Framework

CIHI's Health System Performance Management Framework consists of 4 quadrants: Health System Outcomes, Social Determinants of Health, Health System Outputs, and Health System Inputs and Characteristics. These quadrants are linked together to form a dynamic framework in an expected causal chain. Here is an overview of the quadrants, followed by examples of measures for each of the Health System Output dimensions. The examples were found during the environmental scan.

The first quadrant, Health System Outcomes, consists of 3 dimensions: Improve health status of Canadians, Improve health responsiveness and Improve value for money. The first 2 of these dimensions encompass equity to reflect the overarching goal of equitable distribution. Quadrant 3, Health System Outputs, has 1 dimension (Access to comprehensive high-quality health services) with 4 quality attributes of the health services delivered (attributes are Person-centred, Safe, Appropriate and effective, and Efficiently delivered), and these impact the 3 dimensions in Quadrant 1. Quadrant 1 and Quadrant 2 (Social Determinants of Health) influence each other.

The second quadrant, Social Determinants of Health, consists of 2 dimensions: Structural factors influencing health, and Biological, material, psychosocial, and behavioural factors. The first dimension influences the second dimension. Quadrants 1 and 2 influence each other. Quadrant 4 (Health System Inputs and Characteristics) and Quadrant 2 also influence each other. Quadrant 2 is also influenced by Quadrant 3 (Health System Outputs).

The third quadrant, Health System Outputs, consists of 1 dimension, Access to comprehensive high-quality health services, and 4 quality attributes: Person-centred, Safe, Appropriate and effective, and Efficiently delivered. These quality attribute dimensions also encompass equity. Access to comprehensive high-quality health services is influenced jointly by the dimensions in the fourth quadrant: Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity. Quadrant 3 influences Quadrant 2.

The fourth quadrant, Health System Inputs and Characteristics, consists of 5 dimensions: Leadership and governance, Health system resources, Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity. This quadrant comprises 2 foundational dimensions that influence the capacity of the system to improve: Leadership and governance, and Health system resources. These foundational dimensions influence one another as well as the other inputs and characteristic dimensions in this quadrant. The dimensions Efficient allocation of resources, Adjustment to population health needs, and Health system innovation and learning capacity influence each other. Quadrants 4 and 2 influence each other.

4 contextual elements — Cultural context, Economic context, Demographic context and Political context — surround the quadrants in the framework.

Here are examples of measures for each of the Health System Output dimensions:

- For the Person-centred dimension, examples are perceived care coordination by clients, and presence of continued caregiver distress among clients with an informal caregiver.
- For the Safe dimension, an example is home care clients with new injuries.
- For the Appropriate and effective dimension, examples of measures are emergency department visits for home care clients, and length of time to receive home care.
- There were no identified measures that addressed delivery of efficient care in relation to access.

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media@cihi.ca

CIHI Ottawa
495 Richmond Road
Suite 600
Ottawa, Ont.
K2A 4H6
613-241-7860

CIHI Toronto
4110 Yonge Street
Suite 300
Toronto, Ont.
M2P 2B7
416-481-2002

CIHI Victoria
880 Douglas Street
Suite 600
Victoria, B.C.
V8W 2B7
250-220-4100

CIHI Montréal
1010 Sherbrooke Street West
Suite 602
Montréal, Que.
H3A 2R7
514-842-2226

cihi.ca

17137-0318