

Measuring Access to Home and Community Care and to Mental Health and Addictions Services in Canada

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Abstract

Federal, provincial and territorial governments endorsed agreements in August of 2017 to focus on the shared health priorities of home, community, mental health and addictions care (Government of Canada 2017). The related \$11 billion federal investment over a 10-year period aims to improve access for Canadians to effective and appropriate services in these areas (Government of Canada 2019).¹

As part of this work, health ministers agreed to work collectively and with the Canadian Institute for Health Information (CIHI) to develop and report on a focused set of common indicators to measure pan-Canadian progress.

Key Findings

In May of 2019, CIHI released baseline results for the first three of 12 shared health priorities indicators (CIHI 2019):

- hospital stays for harm caused by substance use;
- frequent emergency room visits for help with mental health and/or addictions; and
- hospital stay extended until homecare services or supports are ready.

These indicators provide a part of the picture, but further drill-down, contextual information and other relevant indicators are required for a complete picture. Detailed results, as well as more information on data sources, data limitations and methodology, are available at <https://www.cihi.ca/en/shared-health-priorities>.

Hospital Stays for Harm Caused by Substance Use

This indicator measures harm caused from using alcohol, cannabis, opioids and other substances. It examines how many hospital stays in a year are a direct result of using these substances (Figure 1). Many factors can influence hospital stays for harm caused by substance use, such as the availability of, and access to, different substances in each jurisdiction;

population health differences; and access to harm reduction and treatment services in the community.

FIGURE 1. Key findings for hospital stays for harm caused by substance use



Source: Hospital Morbidity Database, Ontario Mental Health Reporting System and National Ambulatory Care Reporting System, 2017–2018, Canadian Institute for Health Information.

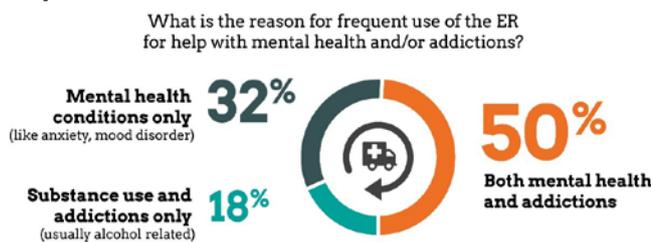
From 2017 to 2018, there were more than 155,000 hospital stays for harm caused by substance use – that is more hospital stays than those for heart attacks and strokes combined. Half of the patients hospitalized for harm caused by substance use spend five days or longer in the hospital.

Overall, nearly two out of three (64%) hospital stays are for men – with peaks observed for men of ages between 25 and 34 years and between 50 and 64 years. In every province and territory, alcohol is the major cause of hospitalization for harm caused by substance use and contributes to more than half of the overall national rate. However, the rates of harm caused by alcohol vary widely among jurisdictions, as does the mix of other drugs that cause harm. More than a third (43%) of the patients hospitalized for harm caused by substance use also received care for a mental health condition during their hospital stay.

Frequent Emergency Room Visits for Help with Mental Health and/or Addictions

This indicator measures the proportion of frequent visitors (with at least four visits a year) among those who visit an emergency room (ER) for help with mental health and/or addictions (Figure 2). Many factors can influence the frequency of ER visits for mental health and addictions, including whether the patient lives in an urban, rural or remote area; the availability of community mental health and addiction treatment services; stigmatization; and differences in population health.

FIGURE 2.
Key findings for frequent emergency room visits for help with mental health and/or addictions



Source: National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information.

From 2017 to 2018, more than 320,000 people visited an ER to seek care for mental health or addictions. Nearly one in 10 of these patients (9.4% or 30,434) were frequent visitors with four or more ER visits for help with mental health and/or addictions over the course of a year. The majority (80%) of these patients had serious conditions that required urgent medical care, including resuscitation (as measured by Canadian Triage Acuity Scale Levels 1 to 3). Nearly half visited the ER for help with disorders related to both mental health and addictions.

The highest rates for frequent visits to the ER were for men age 25 to 39 years. However, among children and youth (age = 10–19 years), frequent visitors were more likely to be female. Frequent ER visitors seeking help with mental health and/or addictions are nearly four times more likely to live in lower-income neighbourhoods than in higher-income neighbourhoods, and two-thirds of frequent ER users were admitted to the hospital at least once over the year.

Hospital Stay Extended until Homecare Services or Supports Are Ready

This indicator measures the number of days patients remain in the hospital when they no longer need that level of care but must wait there until homecare services or supports can be organized (Figure 3). Many factors can influence why hospital stays may be extended until homecare services and supports

are ready, including the availability of homecare services and supports within jurisdictions, variations in clinical practice, how care is planned and streamlined and differences in population health.

FIGURE 3.
Key findings for those with extended hospital stays until homecare services or supports are ready

Half of patients with extended stays in hospital until homecare services or supports are ready



Source: Discharge Abstract Database, 2017–2018, Canadian Institute for Health Information.

From 2017 to 2018, a total of 351,456 hospital patients in Canada were discharged with a recommendation for formal homecare. Most patients (92%) did not have an extended stay or did not wait to be discharged. The other 8% of the patients – or 1 in 12 – had to stay in the hospital until homecare services or supports were ready. Every day, on average, 1,320 patients occupying Canadian hospital beds are waiting for homecare services to be ready – the equivalent of three large hospitals filled to capacity.

The vast majority (86%) of patients with extended hospital stays are age 65 and older, and nearly three out of five are women. More than one in five patients waiting for homecare had dementia. Other conditions included diabetes, hip fractures, congestive heart failure, chronic obstructive pulmonary disease and cancer.

Moving Forward

CIHI will update the results of these indicators every year and release new indicators examining access to mental health and addictions as well as home and community care every year until 2022.

The indicators will spark many questions about what is driving the numbers and how best to improve results. To help answer these questions, the CIHI will undertake some analytical work and support researchers and health partners who want to investigate further.

Reporting will not drive change immediately. These measures represent difficult areas for the health system and reflect complex public health challenges with no simple fixes. It will take time for investments to improve care at the front lines and to better meet the needs of patients and clients in these sectors. **HQ**

Note

1. Recognizing the Government of Quebec's desire to exercise its jurisdiction in the areas of healthcare and social services and thus to assume full control over the planning, organization and management of services in these areas within its territory, in particular for the areas of mental health, addictions and home healthcare, on March 10, 2017, the Government of Canada and the Government of Quebec entered into an asymmetrical agreement *distinct from the present statement of principles* and based on the asymmetrical agreement of September 2004. Specifically, the Government of Quebec will continue to report to Quebec residents on the use of funds designated for healthcare and will continue to collaborate with other governments around information sharing and best practices.

References

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