

May 2016



## ACCESS TO ADULT TERTIARY MENTAL HEALTH AND SUBSTANCE USE SERVICES

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# CONTENTS

<i>Auditor General's Comments</i>	<b>3</b>
<i>Report Highlights</i>	<b>5</b>
<i>Summary</i>	<b>6</b>
<i>Results of the Performance Audit</i>	<b>6</b>
<i>Summary of Recommendations</i>	<b>10</b>
<i>Joint Response from Ministry of Health and Health Authorities</i>	<b>12</b>
<i>Background</i>	<b>13</b>
<i>Audit Objective and Scope</i>	<b>24</b>
<i>Key Findings and Recommendations</i>	<b>28</b>
<i>Aspect 1: Ministry Stewardship</i>	<b>28</b>
<i>Aspect 2: Planning to Meet Needs</i>	<b>31</b>
<i>Aspect 3: Managing Patient Access and Flow</i>	<b>38</b>
<i>Aspect 4: Public Performance Reporting</i>	<b>46</b>
<i>Appendix A: Rates and Numbers of Persons with Co-occurring Disorders by Health Service Delivery Area</i>	<b>48</b>
<i>Appendix B: Overview of Adult Tertiary Care in B.C.</i>	<b>50</b>
<i>Appendix C: Sample Performance Measures</i>	<b>51</b>
<i>Appendix D: Health Authority Facility Access and Flow</i>	<b>53</b>

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The Honourable Linda Reid  
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Dear Madame Speaker:

I have the honour to transmit to the Legislative Assembly of British Columbia my report, *Access to Adult Tertiary Mental Health and Substance Use Services*.

We conducted this audit under the authority of section 11 (8) of the *Auditor General Act* and in accordance with the standards for assurance engagements set out by the Chartered Professional Accountants of Canada (CPA) in the CPA Canada Handbook – Assurance, and in accordance with Value-for-Money Auditing in the Public Sector.



Carol Bellringer, FCPA, FCA  
Auditor General  
Victoria, B.C.  
May 2016

# AUDITOR GENERAL'S COMMENTS

Mental health and substance use problems and illnesses affect people from all walks of life – our parents, siblings, children, friends, co-workers, neighbours and often, ourselves. The costs of inadequate planning and inconsistent access to mental health and substance use services are high – both personal and financial. People with mental health and substance use problems and illnesses face stigma and discrimination. They contend with obstacles to completing education, pursuing employment opportunities and obtaining adequate housing.

This audit did not examine the quality of care being provided but looked at an important part of the mental health and substance use system: access to services for people who need the most intensive, specialized mental health and/or substance use services. These patients are highly vulnerable and have substantial, complex needs. They may be homeless or at risk of homelessness, frequent users of emergency services, and/or be formerly involved in the criminal justice system. Or they may be receiving support from family, friends and clinicians and need more specialized care.

It is critical that these specialized services are available throughout the province and that people can access them when they need to. Although our audit did not look at access on an individual case-by-case basis, we hope the system-level findings and recommendations will lead to more access overall and, ultimately, save lives.

Services for this population were previously provided by B.C.'s provincial psychiatric hospital, Riverview. Over the course of many years, these services were transferred to the health authorities as part of the philosophy of providing care *closer to home*.



CAROL BELLRINGER, FCPA, FCA  
*Auditor General*

The scope of the audit starts after the closure of Riverview Hospital, in July 2012. We looked at practices in the current system and we provide recommendations on how to move the system forward.

Overall, we found the health authorities have some good practices for planning and managing patient access and flow. However, the Ministry of Health (ministry) and health authorities collectively are not doing enough to ensure that people with serious mental health and/or substance use problems and illnesses can access the care they need.

I am encouraged that the ministry is already working with the health authorities on a number of ongoing initiatives in this area. Our recommendations are forward looking to assist the ministry and health authorities to build a well-managed system that meets patient care demands now, and in the future. It is important that the ministry, health authorities and stakeholders work together to address service gaps for people whose needs do not fit the current system. Also crucial, is the need to address barriers to access, including the lack of support services such as housing for people leaving adult tertiary care.

Although we focused on one part of the mental health and substance use system, these specialized, intensive services are linked to other areas in this very complex system. We expect all stakeholders in the mental health and substance use system to consider our findings and recommendations.

The audit team met with staff who directly work with these patients and visited a number of facilities and assertive community treatment teams across the province. I would like to thank everyone we spoke with, especially staff from the ministry and the health authorities who were extremely cooperative and engaged throughout this entire audit.



Carol Bellringer, FCPA, FCA  
Auditor General  
May 2016

# REPORT HIGHLIGHTS

**SPECIALIZED SERVICES**  
for  
**HIGHLY VULNERABLE**  
patients with  
**UNIQUE NEEDS**



POCKETS OF  
**GOOD PRACTICE**

**GAPS**  
in services  
for **unique groups**

**ACCESS and CAPACITY ISSUES**  
vary by region



**LACK OF APPROPRIATE HOUSING/ SERVICES**

impacts discharge

**10**  
**RECOMMENDATIONS**  
for 7 organizations

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.

  
**TREATMENT RANGES**  
from  
**weeks to years**



**BETTER INFORMATION NEEDED:** are services meeting patients' needs?



# SUMMARY

**MENTAL HEALTH AND SUBSTANCE USE** problems and illnesses impact everyone.

The *Mental Health Commission of Canada* estimates that in any given year, one in five Canadians experiences a mental health condition or substance use disorder. These are our family members, work colleagues and in many cases, ourselves.

Although the symptoms and illnesses vary, people with mental health and/or substance use problems and illnesses are at a higher risk for poverty and other health problems. According to the *Mental Health Commission of Canada*, the potential economic impact of mental health and substance use problems and illnesses in Canada is around \$51 billion per year. This includes health care costs, loss of productivity and reductions in health-related quality of life.

Given the wide-spread, significant impacts of mental health and substance use problems and illnesses, it is important that government ensure adequate access to mental health and substance use services. Part of this is making sure everyone working within the system is clear on what they are trying to achieve and has agreement on key roles and accountabilities. In addition, they need processes to understand whether the services provided can be consistently accessed and are leading to improved health outcomes in an efficient way.

The audit examined whether the ministry and B.C.'s six health authorities adequately managed access to adult tertiary care. Adult tertiary care is the range of services for patients with serious and complex mental disorders and/or substance use disorders, who, by reason of their illness or the need for specialized staff

or facilities, cannot be managed by lower levels of care. Patients may move through several levels of care in the course of their lives, depending on the severity of their condition and intensity of services they require.

## RESULTS OF THE PERFORMANCE AUDIT

In many health authorities we found some good practices related to planning and managing patient flow. However, overall, the ministry and the health authorities collectively have not adequately managed access to adult tertiary care.

### **Work is underway, but the ministry has not established clear, province-wide direction**

The ministry set its primary vision for the current adult tertiary care system almost 20 years ago, in the 1998 *Mental Health Plan*. This plan outlined the vision for the Riverview Hospital devolvement process and the decentralization of mental health and substance use services to communities throughout the province.

## SUMMARY

In 2013, the ministry developed a strategy in response to concerns raised by stakeholders regarding people with serious mental health and substance use problems and illness in Vancouver. The ministry's plan for this population did not clearly articulate a vision, goals or expectations for access to adult tertiary care.

At the time of our audit, the ministry and health authorities did not have a province-wide, systematic and coordinated approach to managing access to adult tertiary care. The ministry had not clearly defined adult tertiary care and its services. The ministry and health authorities had begun to develop a province-wide framework with standards, including a definition for adult tertiary care and expectations for managing access. The draft standards represent a significant step towards establishing a defined system of tertiary care. Adult tertiary care patients have unique and complex needs, which make it challenging to develop a set of common standards.

However, the ministry had not decided on how the standards would be implemented, enforced or monitored. The ministry had also not established provincial performance measures and targets for managing adult tertiary care, including access.

The absence of a framework has resulted in different definitions of adult tertiary care services and inconsistent practices, measures and targets across the health authorities. The health authorities also have not regularly reported adult tertiary care performance information to the ministry. The ministry established minimum reporting requirements for mental health and substance use, but only Northern Health was reporting against these requirements for adult tertiary

care. Consequently, the ministry did not know whether adult tertiary care services were achieving long-term positive health outcomes and offering good value for the money spent across the province.

### **The ministry and health authorities have pockets of good practice, but should be more proactive in planning**

The ministry's role is to identify both short and long-term risks that may impact the ability of the provincial system to meet population needs. However, the ministry's population needs analysis for adult tertiary care has been in response to emerging issues, as opposed to proactively identifying current and future service requirements or long-term risks. The ministry was not regularly collecting information on population needs to inform planning.

The health authorities have not done enough analysis to understand whether they have the right mix of services to meet current and future needs. Although we found pockets of good practice, the majority of health authorities have not fully evaluated demographic and population trends to identify patient needs to inform planning. Health authority analysis of whether the supply of programs and services can meet current and future demands (e.g., the right number or type of services) has not been comprehensive and ongoing. There was also little evaluation of patient outcomes outside of the assertive community treatment program. As a result, the health authorities were largely unable to show that their adult tertiary care programs have been effective in achieving positive

## SUMMARY

health outcomes, or if the health authority could achieve better value for money by adjusting the mix of services in place.

### We identified gaps in services for patients with significant needs

No provincial data exists that identifies service gaps. All health authority program staff we interviewed identified populations whose needs go beyond the threshold of services currently available. These populations included:

- ◆ patients with acquired brain injury with serious mental illness and/or substance use
- ◆ patients with developmental disabilities with serious mental illness and/or substance use
- ◆ patients with histories of extreme violence and/or current aggression as well as serious mental illness and/or substance use.

At the time of our audit, there was no understanding of the size of these populations, or a provincial strategy for ensuring these patients would receive the services they need.

### Management of patient access and flow varied considerably

Health authorities managed patient access and flow differently. For example, some health authorities took the approach of flowing patients through facilities as quickly as possible, while others allowed patients to remain for an extended period because services were not available upon discharge. This means that in

some regions, beds may be occupied longer – not only because of patient readiness and circumstances – but because of the health authority’s approach to discharge.

When health authorities extend a patient’s length of stay, it impacts the ability of other patients to be admitted to adult tertiary care. But, flowing patients out can lead to pressure points in other parts of the mental health and substance use system, or be too risky for the patient, if community services or appropriate housing are not available.

A patient’s experience moving through the adult tertiary care system depends not only on their individual need but also on where they live. A one-size-fits-all approach may not be appropriate for all the varied contexts of the health authorities. However, without some consistency, health authorities are not able to ensure fair and equitable access to adult tertiary care across the province. Health authorities need to collaborate to determine the best approach to create more consistent access and flow across the province.

### Barriers to flowing patients in and out of adult tertiary care need to be addressed

Health authorities identified a number of barriers to patient access and flow. Some of these only impacted one health authority, and some were widespread and difficult to address. For example, lack of appropriate services for patients upon discharge was identified as a wide spread barrier. Patients are not able to leave adult tertiary care if there are no appropriate services



## SUMMARY

available for them in other parts of the system. If patients are unable to leave, then other patients are unable to access care.

All health authorities engaged in strategies to address long waitlists and increase flow. However, the health authorities and the ministry need to conduct more analysis to fully understand the extent of the barriers and take steps to address them.

### **The ministry and health authorities have not publicly reported on adult tertiary care**

Neither the ministry nor the health authorities publicly reported on adult tertiary care. The ministry has not established reporting requirements and, as noted above, a common set of measures and targets have not been established. Without public reporting, legislators, stakeholders and the public may not know about the adult tertiary care services available or any access and flow challenges. This may lead to misinformation and unrealistic expectations in the public realm.

# SUMMARY OF RECOMMENDATIONS

## **TO ENHANCE MINISTRY OF HEALTH STEWARDSHIP OF ADULT TERTIARY CARE, WE RECOMMEND THAT:**

- 1** the Ministry of Health collaborate with the health authorities to clarify roles and responsibilities and set province-wide direction, including a refreshed vision, goals and objectives for adult tertiary care.
- 2** the Ministry of Health collaborate with the health authorities to implement a province-wide performance management framework for adult tertiary care, including performance measures and targets.
- 3** the Ministry of Health clarify roles with the Provincial Health Services Authority to finalize and implement the adult tertiary care standards.

## **TO ENHANCE MINISTRY OF HEALTH AND HEALTH AUTHORITY PLANNING TO MEET PATIENT NEEDS, WE RECOMMEND THAT:**

- 4** the Ministry of Health collaborate with the health authorities to improve long-term planning, including improving information-sharing to better identify long-term risks and gaps in services.
- 5** the health authorities regularly identify adult tertiary care population needs and determine whether they have the right mix of current and future services.
- 6** the health authorities periodically evaluate the effectiveness of their adult tertiary care programs and share lessons learned with the Ministry of Health and other health authorities.
- 7** the Ministry of Health and health authorities work with key stakeholders to address the gaps in services for individuals whose needs are beyond the threshold of services currently funded and available.
- 8** the Ministry of Health and health authorities collaborate to create a consistent and documented approach to active waitlist management, including waitlist tracking, acceptance and prioritization of patients, and declination practices.

## SUMMARY

### **TO ENHANCE THE MANAGEMENT OF ACCESS AND FLOW, WE RECOMMEND THAT:**

- 9** the Ministry of Health and the health authorities further analyze barriers to adult tertiary care access and flow and work with each other and relevant stakeholders to address them.

### **TO ENHANCE PUBLIC PERFORMANCE REPORTING, WE RECOMMEND THAT:**

- 10** the Ministry of Health and the health authorities collaborate to develop appropriate measures to report publicly on access to adult tertiary care.

# JOINT RESPONSE FROM MINISTRY OF HEALTH AND HEALTH AUTHORITIES

**THE MINISTRY OF HEALTH (MINISTRY) AND HEALTH AUTHORITIES** would like to thank the Auditor General for reviewing how the mental health and substance use system provides access to intensive, specialized adult tertiary care mental health and substance use services. The Ministry and Health Authorities fully support the recommendations of the Auditor General report, and we are committed to ensuring that British Columbians have better access to quality tertiary care services that are effective, appropriate, safe, accessible and acceptable.

The Ministry is responsible for a broad range of mental health and substance use services and supports, including health promotion, illness prevention, early intervention services, as well as assessment, treatment and support services within the community and within acute care and specialized tertiary care services. As the Auditor General noted, mental health and substance use services funded by the Ministry are provided generally through provincial and regional health authorities and contracted service providers, and there is a shared responsibility to ensuring a coordinated approach to managing access to these services.

The Ministry recognizes that more needs to be done to enhance access to services and address service gaps for people experiencing mental health and substance use problems, including adults requiring specialized tertiary care services. That is why over next three years the Ministry is leading a strategic initiative that sets out a comprehensive approach to address the short-term and longitudinal access and service needs of all British Columbians experiencing mental health and substance use problems, including those with the most complex mental health and substance use care needs.

In 2015, the Ministry released *Primary and Community Care in BC: A Strategic Policy Framework* identifying individuals with mental health and/or substance use problems as a priority population. A core component of the Ministry strategy is to improve the integration of mental health and substance use services with primary care.

The Ministry and health authorities will also collaborate to establish inter-professional specialized care teams and associated services to better serve complex mental health and substance use patients, thereby improving patient experience through better access to coordinated, comprehensive and quality services for this highly vulnerable population. These specialized care teams will be linked to the primary care system including family physician practices and health authority services.

The Ministry believes these initiatives to strengthen primary care services and specialized services will not only enhance mental health services to all residents of the Province but also address the recommendations outlined in the Auditor General report.

Thank you for the opportunity to respond.

# BACKGROUND

## MENTAL HEALTH AND SUBSTANCE USE PROBLEMS AND ILLNESSES IMPACT EVERYONE

*THE MENTAL HEALTH COMMISSION OF CANADA* estimates that one in five people in Canada experience a mental health disorder each year. By age forty, nearly 50% of us will have or have had a mental health condition. The Ministry of Health (ministry) estimated in 2012/13 that approximately 714,000 people in B.C. have mental health and substance use needs.

The potential economic impact of mental health and/or substance use problems and illnesses in Canada is estimated to be \$51 billion per year. This includes health care costs, loss of productivity and reductions in health-related quality of life.

Mental health and substance use problems or illnesses lead to very real and personal impacts. Individuals with mental health conditions are more likely to experience educational and employment difficulties, physical health problems and violence or victimization. One American study found that individuals with serious mental health conditions were eleven times more likely to be victims of a violent crime than the general population.

People with mental health and/or substance use problems and illnesses often face significant stigma, which can lead to reluctance to seek help. The media frequently presents people with serious mental health and/or substance use problems or illnesses as violent, leading to negative attitudes. This can impact an individual's desire to seek out help.

The responsibility of caring for people with mental health and/or substance use problems or illnesses often falls to family or other supports. Families and supporters may experience significant stress due to the emotional and physical challenges of caregiving for their loved-ones.

## WHAT ARE MENTAL HEALTH PROBLEMS AND ILLNESSES?

Mental health problems and illnesses refer to a wide range of mental health conditions, from the worries we all experience as part of everyday life to serious long-term illness. Examples of mental illness include depression, anxiety disorders, schizophrenia, eating disorders and addictive behaviours.

Mental disorders are characterized by changes in thinking, mood, behaviour or a combination of the three that lead to significant distress and impaired functioning. Similar to physical illness, mental health conditions can take many forms and impact people in different ways and to different degrees.



## BACKGROUND

### WHAT ARE SUBSTANCE USE DISORDERS?

Substance use refers to the use of any substance that alters consciousness. Substance use problems, substance abuse, substance dependence, problematic substance use and substance misuse refer to patterns of substance use that pose a risk to health, security, or well-being of individuals, families or communities.

Substance use is not directly linked to the legality of the substance used. It relates to the amount used, the pattern of use, the context in which it is used, and ultimately, the potential for harm.

### CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS OR CONDITIONS

Some people experience both mental health and substance use problems at the same time. This is called a concurrent or co-occurring disorder.

Co-occurring disorders can happen with symptoms occurring at the same time or at different times with varying levels of intensity. Often, patients with both mental health and substance use problems require higher levels of care, given the complexity of their diagnosis and difficulty determining whether symptoms are related to the mental illness or the substance use.

According to one study, the highest number of people with complex, co-occurring disorders in B.C. live in the Downtown Eastside of Vancouver, see [Appendix A, Exhibit 5](#).

### ADULT TERTIARY CARE IS PART OF THE MENTAL HEALTH AND SUBSTANCE USE SYSTEM OF CARE

The focus of our audit is on adult tertiary care, the highest level of intensive, specialized services for treating patients experiencing serious mental health and/or substance use disorders. Almost all adult tertiary care services are for patients with mental health problems and illnesses as their primary diagnosis. Patients with co-occurring disorders are also eligible for admission.

Patients who require adult tertiary care are highly vulnerable and have substantial, complex needs; they may be homeless or at risk of homelessness, frequent users of emergency services, and can be involved with the criminal justice system. Patient profiles vary widely within adult tertiary care and include patients with co-occurring disorders.

# BACKGROUND

## Components of adult tertiary care

There is no commonly accepted definition for adult tertiary care in B.C. In general, this level of care refers to a range of services for patients who require more intensive care than primary or secondary services.

Adult tertiary care services may include:

- ◆ **Tertiary in-patient acute care** – short-term assessment and treatment for patients with a mental disorder who require many different specialized practitioners, and in-patient treatment expertise to meet their complex needs.
- ◆ **Tertiary in-patient rehabilitation** – long-term treatment and rehabilitation for patients with a mental disorder who require multidisciplinary, in-patient treatment expertise and consultation to meet the complexities of their mental disorder.
- ◆ **Older adult/PsychoGeriatric** – specialized in-patient beds or long term treatment and rehabilitation for seniors with age-related mental disorder(s) or those seniors with severe mental health and substance use disorders who require multidisciplinary treatment to meet their complex needs.

- ◆ **Tertiary addiction/concurrent services** – specialized in-patient services and activities organized for assessment, treatment and support for patients experiencing any combination of mental disorder and substance use disorder.
- ◆ **Tertiary specialized residential care** – specialized care in community residential facilities for patients requiring longer-term residential psychosocial rehabilitation.
- ◆ **Assertive community treatment teams** – services delivered to clients in the community through a multidisciplinary team that provides treatment, rehabilitation and support services that clients need to achieve their goals.

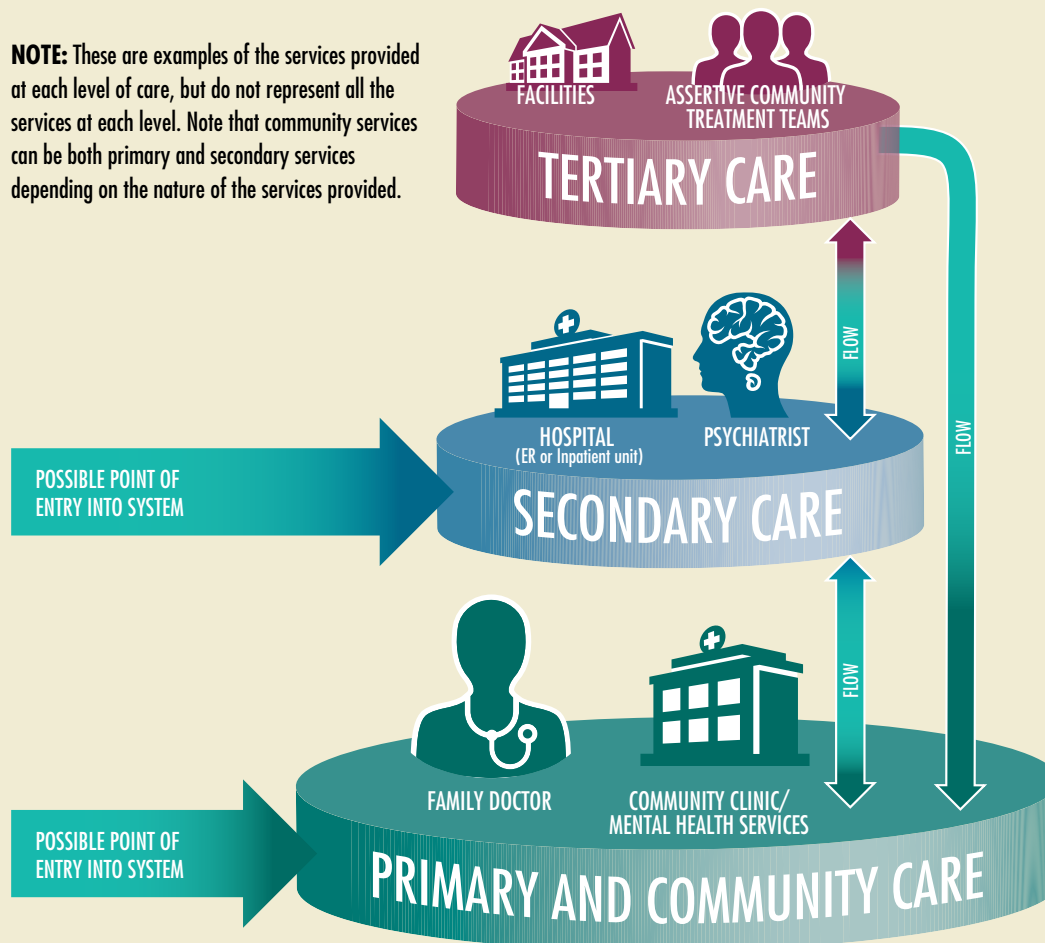
## How adult tertiary care fits in the mental health and substance use system

Adult tertiary care is only one level of care within the broader mental health and substance use system of care. Patients often move through several levels of care in the course of their lives, depending on the severity of their condition and intensity of services they require (see [Exhibit 1](#)).

## BACKGROUND

**Exhibit 1:** Mental health and substance use levels of care, and patient flow (in and out)

**NOTE:** These are examples of the services provided at each level of care, but do not represent all the services at each level. Note that community services can be both primary and secondary services depending on the nature of the services provided.



Source: Office of the Auditor General of British Columbia

Generally, the first point of contact for patients who need mental health and substance use services is primary care. Primary care is predominantly provided by family physicians, but also includes community health care services such as nurses and nurse practitioners, pharmacists, as well as a range of alternative health care providers, including naturopathic doctors and acupuncturists.

A patient who requires more specialized care can be referred to secondary care by a primary care provider. Secondary care providers may include medical specialists and mental health and substance use professionals (e.g., social workers, occupational therapists, psychiatrists). Secondary care refers to a range of services, from short-term crisis intervention to rehabilitation and housing. Patients may also go

## BACKGROUND

straight to secondary care, for example, psychiatric treatment units in hospitals.

Adult tertiary care is not the endpoint of the mental health and substance use system. Patients can flow back into lower intensity services in primary or secondary care from adult tertiary care. **The movement of patients throughout these levels of care is called patient flow.**

Because of the connections between all the services in the mental health and substance use system, pressures in one area have significant impacts on the other areas. Although our audit focused on adult tertiary care, our findings highlight challenges in patient flow through the entire mental health and substance use system.

## PATIENT PROFILES

We reviewed a sample of patient files from three different adult tertiary care facilities in B.C. Most of the patients had a lengthy history of requiring mental health and substance use services (sometimes in tertiary care, sometimes in secondary care), including many hospitalizations. All patients suffered from a serious mental disorder, many of them in combination with substance use problems. Some of the patients also suffered from other illnesses, including morbid obesity, fetal alcohol syndrome, developmental delay and brain injury.

Examples of mental disorders found in the files we reviewed as a primary or secondary diagnosis:

- ◆ Schizophrenia (symptoms may include loss of touch with reality, often with hallucinations and persecutory delusions, delusions of personal grandeur/belief of being more powerful than in reality, or a loss of touch with reality where an individual cannot speak, move or respond)

- ◆ Personality disorders, such as anti-social personality disorder (symptoms may include lack of regard for right and wrong, or the rights, wishes and feelings of others) and borderline personality disorder (symptoms may include difficulty regulating emotions and marked impulsivity)
- ◆ Post-traumatic stress disorder (following exposure to a traumatic experience, symptoms may include intrusive memories, flashbacks, or nightmares of the traumatic events, and avoidance of people, places or memories associated with the events)
- ◆ Bi-polar disorder (symptoms may include periods of abnormally elevated or irritable mood and increase in activities with the potential for painful unintended consequences)

It is important to highlight that the patient files we reviewed were only a small sample of the population that require adult tertiary care services. The diagnoses and medical histories described are not necessarily representative of the full population.

# BACKGROUND

## B.C. CONTEXT

### Roles and responsibilities

Mental health and substance use services included in the scope of this audit are delivered through a shared accountability model between the Ministry of Health (ministry) and the six health authorities. All have important roles in planning for, and providing access to, adult tertiary care services.

The five regional health authorities are:

- ◆ Fraser Health Authority (Fraser Health)
- ◆ Interior Health Authority (Interior Health)
- ◆ Vancouver Island Health Authority (Island Health)
- ◆ Northern Health Authority (Northern Health)
- ◆ Vancouver Coastal Health Authority (Vancouver Coastal Health)

The sixth health authority is the Provincial Health Services Authority (Provincial Health Services).

The ministry has overall responsibility for ensuring that quality, appropriate, cost-effective and timely health services are available for all people in B.C. Health authorities are responsible for direct health service delivery. These responsibilities are outlined in the ministry's service plan, government letters of expectations and the *Health Authorities Act*.

The ministry is specifically responsible for:

- ◆ providing direction and support to health service delivery partners – the six health authorities
- ◆ setting province-wide priorities, goals, standards and expectations

The five regional health authorities are responsible for the following in their geographical area:

- ◆ identifying population health needs
- ◆ planning appropriate programs and services
- ◆ ensuring programs and services are properly funded and managed
- ◆ meeting performance objectives

Provincial Health Services has a province-wide mandate and is responsible for:

- ◆ working with the five regional health authorities to plan and coordinate the delivery of provincial programs and specialized services
- ◆ governing and managing the organizations that provide health services throughout the province (e.g., the BC Cancer Agency)

Provincial Health Services has oversight of the British Columbia Mental Health and Substance Use Services Agency, which is responsible for leading the development and promotion of provincial evidence-informed practices and system-wide improvements, as well as the delivery of province-wide, tertiary-level, specialized mental health and substance use services.

The *Mental Health Act* gives physicians the authority, criteria and procedures for involuntary admissions and treatment at either the tertiary or secondary level. Patients who are admitted involuntarily to adult tertiary care facilities are *certified* under the *Mental Health Act*. Certified patients are generally required to remain in treatment until they are discharged. However, patients who are certified under the Act can be released to community services with conditions.



## BACKGROUND

### KEY FACTORS THAT AFFECT THE HEALTH AUTHORITIES

Each health authority has a unique strategic context that plays a role in the management of access of adult tertiary care.

Fraser Health and Vancouver Coastal Health serve a larger population than the other regional health authorities. Fraser Health is the fastest growing health authority in the province. Vancouver Coastal Health is home to the Downtown East Side, which has one of the lowest per capita incomes of any urban area in Canada, and people living there experience worse health outcomes than the general population.

Provincial Health Services provides province-wide specialized services for unique populations. For

example, the Heartwood Centre in Vancouver is a facility for women with serious substance use issues and/or mental illness. Provincial Health Services was also responsible for the devolvement of Riverview Hospital.

Geographically, Northern Health is the largest in the province and serves rural and remote communities with a high population of Aboriginal peoples. Northern Health has the highest rate of patients with complex, co-occurring disorders (i.e., both serious mental health and substance use problems) per 100,000 people. See [Appendix A](#) for more information regarding the rates of patients with complex, co-occurring disorders by region.

Both Island Health and Interior Health serve urban centres alongside several small, rural and remote communities.

### Devolvement of Riverview Hospital

Riverview Hospital, located in the lower mainland, was B.C.'s provincial psychiatric hospital from 1913 to 2012. Until the 1990s, Riverview Hospital was the main provider of mental health services in B.C. for people with serious mental health conditions, serving up to 4,630 patients at its peak in 1951.

In the late 1970s, the B.C. government undertook a detailed evaluation of mental health approaches and services in the province. During that time, many jurisdictions, including the United States and Australia, had started significant reforms to decentralize mental

health care and move away from large institutions. Throughout the early 20th century, rapid growth of institutional populations created overcrowding and raised ethical questions about the quality and effectiveness of non-therapeutic, custodial care.

In 1987, the B.C. government published the *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital*, which emphasized the shift from institution-based care to community-based care. This direction was approved in 1990 as the *Mental Health Initiative*, and implementation began in 1992.

## BACKGROUND

The 1998 *Mental Health Plan* built on previous work and reinforced the goal of continued redevelopment and decentralization of Riverview Hospital into community-based specialized facilities. This process represented a significant shift in service delivery and set the backdrop for current adult tertiary care services.

Between 2002 and 2012, beds or bed equivalents were transferred from Riverview Hospital to the regional health authorities through a *bed for bed* process, which was based on an average benchmark of 15 beds per 100,000 people. The ministry determined the type and number of patient care beds allocated per health authority, and funding was based on this allocation.

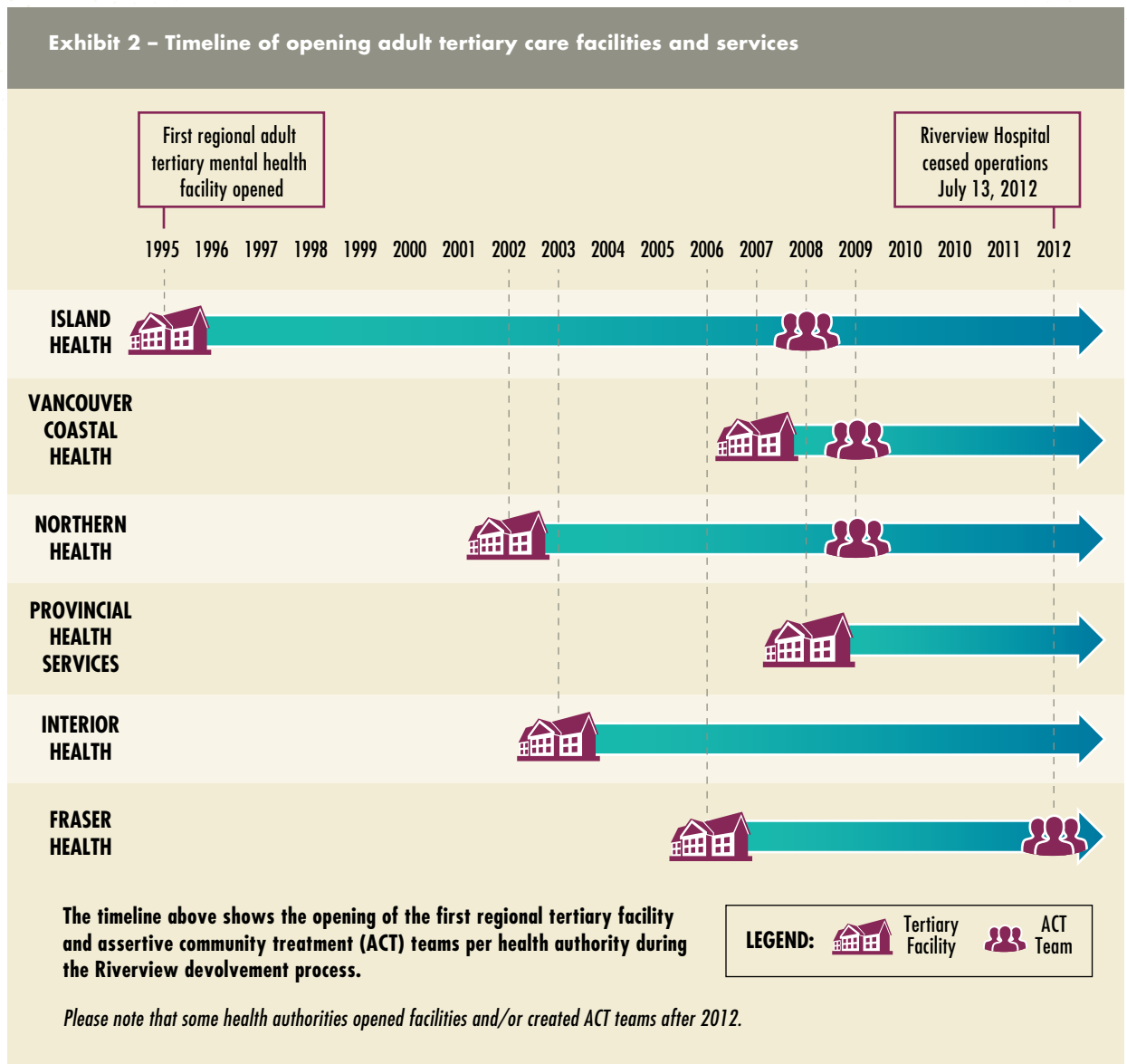
The Riverview Hospital redevelopment funding was reported to result in 864 adult tertiary beds and 11 assertive community treatment teams throughout the province. Some health authorities had existing facilities that could serve adult tertiary care patients, while others had to build new facilities. This meant that health authorities opened their adult tertiary care facilities and created their assertive community treatment teams at different times during the devolution. Health authorities have been running adult tertiary care programs for different amounts of time, meaning their level of maturity in providing these services varies across the province.

### ASSERTIVE COMMUNITY TREATMENT TEAMS – OUT ON THE ROAD

Assertive community treatment teams travel to meet with patients (known as clients) in their homes, in shelters or on the street. Staff administer medication, assist with activities of daily living (e.g., grocery shopping, laundry, attending appointments) and provide crisis intervention when needed.

Island Health (formerly known as Vancouver Island Health Authority) was the first health authority to open an adult tertiary care facility – Seven Oaks – in 1995. Vancouver Coastal Health was the last health authority to open its first adult tertiary care facility, in 2007. Island Health also established the first assertive community treatment team in 2008. [Exhibit 2](#) shows the timeline of when each health authority opened its first facility and assertive community treatment team as part of the Riverview devolvement process.

# BACKGROUND



Source: Office of the Auditor General of British Columbia

## BACKGROUND

### B.C.'s current adult tertiary care services

#### B.C.'s service model

Under the institutional model when patients received care at Riverview Hospital, the focus was on long-term residential care. Patients often remained at the facility for a long period of time. Since the devolution, health authorities have been moving towards a rehabilitation/recovery model with a focus on access and flow. In other words, patients are not expected to remain in tertiary care for their entire lives.

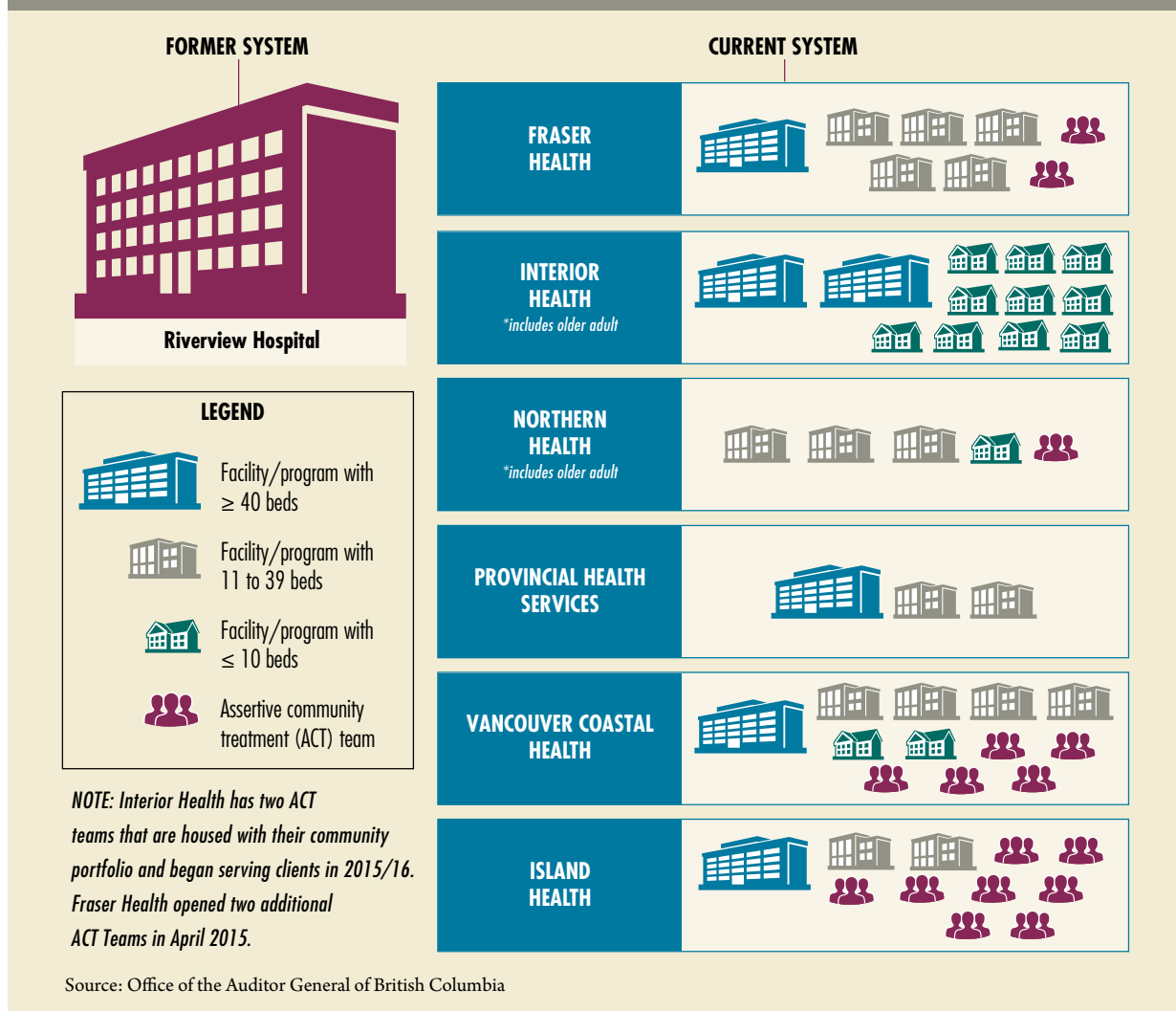
Patients receiving treatment for mental health and/or substance use have become more visible since Riverview Hospital was closed, but this does not mean they are not getting services. As one clinician explained, “society now sees the patients, not the walls.”

Traditionally, adult tertiary care programs were bed-based (in-patient services) because of the high-intensity nature of the treatment and because of the philosophy focused on long-term residential care. However, an increasingly important component of adult tertiary care services is assertive community treatment teams. These teams of multidisciplinary mental health professionals are mobile and provide intensive community-based services tailored to patients' needs, enabling more people to live in community settings.

Each health authority has a different combination of adult tertiary care facilities and services. [Exhibit 3](#) provides an overview of the current mix of services provided in B.C., as of March 31, 2015. Services provided in facilities are of a higher intensity than those provided by assertive community treatment teams. For more information on the facilities and services offered across the province, see [Appendix B](#) and [Exhibit 3](#).

# BACKGROUND

**Exhibit 3:** Overview of current mix of adult tertiary care services



## Funding

Adult tertiary care spending is captured within the health authorities' larger mental health and substance use budgets. Only some health authorities clearly track spending for adult tertiary care. The amount the health system spends on adult tertiary care is not regularly reported. However in 2013/14, the health authorities provided their spending for adult tertiary care to Provincial Health Services as part of their review on the progress of the Riverview Hospital devolvement.

The health authorities spent approximately \$13.6 billion for all health services in 2013/14. Of that, \$945 million (7%) was spent on all mental health and substance use services. According to the progress review, spending on adult tertiary care was approximately \$126 million in 2013/14, or 13.4% of total health authority expenses for mental health and substance use services.



# AUDIT OBJECTIVE AND SCOPE

## OBJECTIVE

**WE CARRIED OUT** this audit to determine whether the Ministry of Health and the province's six health authorities adequately managed access to adult tertiary care for individuals with serious mental health and substance use problems or illnesses.

To answer this objective, we assessed four key aspects of managing access to adult tertiary care:

### Aspect 1: Ministry stewardship

To assess stewardship, we looked at whether the ministry had set province-wide direction through a clear vision, goals, objectives, performance measures, policies and standards that established expectations and measured the success of the health authorities in managing access to adult tertiary care.

### Aspect 2: Health system planning to meet needs

To assess planning, we looked at whether the ministry and health authorities had analyzed and shared information on population needs and trends, including whether the current supply of programs and services can meet the demand now and in the future. We also looked at whether the health authorities evaluated the outcomes of their services, and incorporated patient and family feedback into their ongoing planning for services.

### Aspect 3: Health authority management of patient access and flow

To assess the management of patient access and flow, we looked at whether the health authorities had:

- ◆ established appropriate targets to measure access and flow
- ◆ consistently applied strategies for active management of waitlists (e.g., prioritization of admissions)
- ◆ identified and implemented strategies to address barriers to patient access and flow

### Aspect 4: Health system accountability

To assess accountability, we looked at whether the ministry and the health authorities reported to members of the legislature as well as the public on key aspects of access to adult tertiary care.

## AUDIT OBJECTIVE AND SCOPE

Given the wide-spread, significant impacts of mental health and/or substance use problems and illnesses, it is important that government ensure adequate access to mental health and substance use services. Part of this is making sure everyone working within the system is clear on what they are trying to achieve and has agreement on key roles and accountabilities. In addition, they need processes to understand whether the services provided can be consistently accessed and are leading to improved health outcomes in an efficient way.

## CRITERIA AND SOURCES

We developed the audit objective and criteria using B.C.'s ten year *Healthy Minds, Healthy People* plan, the ministry's 1998 *Mental Health Plan*, previous ministry service plans, government letters of expectations, the *Health Authorities Act*, and consultation with subject matter experts and staff from the ministry and health authorities.

## AUDIT SCOPE AND APPROACH

We conducted the audit in accordance with the standards for assurance engagements set out by the Chartered Professional Accountants of Canada (CPA) in the CPA Handbook – Assurance and Value-for-Money Auditing in the Public Sector, Section PS 5400, and under the authority of Section 11 (8) of the *Auditor General Act*.

There are many different ministries and community agencies in B.C. working with people who experience mental health and substance use problems and illnesses. But for this audit, we focused on the role of the health system: the Ministry of Health and the six health authorities (Island Health, Interior Health, Vancouver Coastal Health, Fraser Health, Northern Health, and Provincial Health Services). The First Nations Health Authority and the Nisga'a Valley Health Authority were not included because they do not provide adult tertiary care services.

The audit period started with the end of the Riverview Hospital devolvement (2012) to March 31, 2015. However, we considered evidence from before the devolvement if the information was used in decision making during the audit time period. Audit work for this report was completed on November 30, 2015.

We based our definition of adult tertiary care on the services defined through the Riverview devolvement and how health authorities defined their adult tertiary care services. Of note, Interior Health and Northern Health manage access and flow of their adult tertiary care services with their older adult tertiary services. See [Appendix B](#) for an overview of the programs and services included in scope.

Our assessment of access and flow focused on facility-based care. We did not audit the access and flow practices of the assertive community treatment teams because they follow a separate set of standards.

At the time of the audit, the ministry was also engaging in a review of all B.C. assertive community treatment teams. Our audit of assertive community treatment

## AUDIT OBJECTIVE AND SCOPE

teams included aspect 1 (ministry stewardship) and aspect 2 (health system planning to meet needs). Under aspect 3 (managing patient access and flow), our audit was limited to reviewing waitlist tracking and follow up processes only. The team also included some examples of good practice related to assertive community treatment teams to provide context.

Our work involved:

- ◆ reviewing documentation from the ministry and health authorities on both planning and managing access and flow
- ◆ conducting interviews with ministry and health authority staff, subject matter experts and stakeholders working in adult tertiary care
- ◆ visiting three adult tertiary care facilities across the province where we met with staff and reviewed a sample of twelve patient files based on differing rates of flow through the facility
- ◆ spending a day with assertive community treatment teams to see how the teams operated in the community

We excluded forensic services from our scope because they are delivered under separate legislation and follow a different admissions process.

We did not audit the physical accessibility of the adult tertiary care system, or the ease with which people with serious mental health and substance use concerns can navigate the system.

We also did not audit clinical decision making, including the decisions of clinicians to refer individuals to adult tertiary care. However, to get a more comprehensive picture of access to adult tertiary care, we considered feedback from clinicians who have referred patients to adult tertiary care (e.g., acute care managers, nurses, social workers, etc.) from each of the health authorities, as well as the First Nations Health Authority.

# AUDIT CONCLUSION

**WE FOUND SOME** good practices in the health authorities related to planning and managing patient flow. However, the Ministry of Health (ministry) and the health authorities collectively have not adequately managed access to adult tertiary care.

## Aspect 1: Ministry stewardship

- ◆ Although work is underway, the ministry has not established clear, province-wide direction for access to adult tertiary care.

## Aspect 2: Health system planning to meet needs

- ◆ While we found pockets of good practice, overall the ministry and the health authorities should be more proactive in planning to meet needs.
- ◆ We identified gaps in services for patients with significant needs.

## Aspect 3: Health authority management of patient access and flow

- ◆ Management of patient access and flow varied considerably between health authorities.
- ◆ Barriers to flowing patients in and out of adult tertiary care need to be addressed.

## Aspect 4: Health system accountability

- ◆ The ministry and health authorities have not publicly reported on adult tertiary care.

This report highlights a variety of examples to help explain the findings. It does not include all examples of good practices.

# KEY FINDINGS AND RECOMMENDATIONS

## ASPECT 1: MINISTRY STEWARDSHIP

### **Work is underway, but the ministry has not established clear, province-wide direction**

The Ministry of Health (ministry) is the steward of the health system, responsible for setting province-wide priorities, goals, standards and expectations for all health services. We expected the ministry to have set province-wide direction for access to adult tertiary care by establishing provincial:

- ◆ goals and objectives
- ◆ performance measures, policies and standards that define services
- ◆ expectations for access to adult tertiary care

We also expected the ministry to have regularly monitored and evaluated health authority performance to understand how well adult tertiary care services were performing.

A province-wide, systematic and coordinated approach to managing access to adult tertiary care was not in place. The ministry had not clearly defined the goals, objectives, measures and targets to monitor and

evaluate access to adult tertiary care services. At the time of the audit, the ministry had begun to develop a province-wide framework with standards, including a definition for adult tertiary care and expectations for managing access, but significant work was still required to implement this framework.

There were no clear policies and standards in place that define adult tertiary care services. The absence of an overall province-wide framework has led to different definitions of adult tertiary care services and inconsistent practices, measures and targets across the health authorities.

### **The ministry's vision for adult tertiary care focused on the devolvement of Riverview Hospital**

The ministry set the current vision for the adult tertiary care system almost 20 years ago, in the 1998 *Mental Health Plan*. This plan outlined the vision for the Riverview Hospital devolvement process and the decentralization of mental health and substance use services to communities. The plan was intended “to support the development of a comprehensive, integrated regional mental health care system for British Columbians with the most serious and disabling mental illnesses, their families and the communities where they live.”



## KEY FINDINGS AND RECOMMENDATIONS

The ministry reiterated this direction in the ten-year *Healthy Minds, Healthy People* plan, released in 2010. This document outlines the ministry's goals and objectives for mental health and substance use services, including adult tertiary care.

There are three overarching goals in the *Healthy Minds, Healthy People* plan, none of which specifically address access to adult tertiary care services. However, the goals do provide some high-level direction for all mental health and substance use services.

In November 2013, the ministry developed a strategy in response to concerns and recommendations outlined in the Vancouver Police Department's reports on mental health. The ministry's strategy, *Improving health services for individuals with severe addictions and mental illness*, was designed to meet the needs of people with the most complex forms of severe addiction and/or mental health conditions across the province. This included patients requiring adult tertiary care services, along with other services within the mental health and substance use system.

The ministry's strategy for this population did not clearly articulate a vision, goals or expectations for access to adult tertiary care services. Instead, it outlined a number of actions (including the development of assertive community treatment teams) and allocated \$25 million in funding for addressing risks related to service gaps for this population.

Provincial Health Services was tasked with assessing the needs of the severely mentally ill/substance using population as part of the implementation of this

strategy. This included holding an expert panel and analyzing information to understand the prevalence for this population. However, the Provincial Health Services' role in future planning for adult tertiary care had not been determined by the ministry.

**RECOMMENDATION 1:** *We recommend that the Ministry of Health collaborate with the health authorities to clarify roles and responsibilities and set province-wide direction, including a refreshed vision, goals and objectives for adult tertiary care.*

### The ministry had not established performance expectations for adult tertiary care

A province-wide performance management framework helps ensure the ministry and health authorities understand performance and can identify areas for improvement. We found that the ministry had not established a province-wide performance management framework (performance measures and targets) for managing adult tertiary care, including access.

As a result, the health authorities were not regularly reporting performance information on adult tertiary care services to the ministry and the ministry had not monitored or evaluated the performance of adult tertiary care. There is a risk that health authorities, who are responsible for delivering services, are not working toward the same ends.

## KEY FINDINGS AND RECOMMENDATIONS

See [Appendix C](#) for a sample of performance measures that could be included in a province-wide performance management framework for adult tertiary care access and flow.

**RECOMMENDATION 2:** *We recommend that the Ministry of Health collaborate with the health authorities to implement a province-wide performance management framework for adult tertiary care, including performance measures and targets.*

### Policies and standards for access to adult tertiary care are not in place yet

The ministry did not have up-to-date policies and standards for adult tertiary care. The ministry's approach to the delivery of adult tertiary care was to allow the health authorities to develop their own systems of care after the devolvement of Riverview Hospital. Since that time, the health authorities have used different definitions of adult tertiary care.

Health authorities have relied on clinical decision-making to support access to adult tertiary care services. More recently, however, work had begun to help ensure fair and equitable access across the health authorities.

In February 2015, the ministry and health authorities collaborated on draft adult tertiary care standards. These included access standards and a provincially accepted definition of adult tertiary care. Provincial Health Services was expected to complete the draft standards.

The draft standards represent a significant step towards establishing a defined system of tertiary care. Adult tertiary care patients have unique and complex needs, which make it challenging to develop a set of common standards. There are only a few jurisdictions in the world that have standards in this area (e.g., Australia and New Zealand).

However, at the time of the audit, the ministry had not decided on how it would implement the standards. It is unclear whether the standards will be considered guidelines or mandatory. It is also unclear if health authorities will be responsible for reporting performance against the standards or how performance against the standards will be monitored.

### ASSERTIVE COMMUNITY TREATMENT TEAM STANDARDS

*Assertive community treatment teams, a service within adult tertiary care, have clear standards, including admission criteria, staffing levels and frequency of patient contact.*

Further, it was undecided whether Provincial Health Services or the ministry will be responsible for coordinating the implementation of the standards, or who will continue to develop the performance measures linked to the standards. The ministry must clarify roles and accountabilities for moving the standards work forward.

**RECOMMENDATION 3:** *We recommend that the Ministry of Health clarify roles with the Provincial Health Services Authority to finalize and implement the adult tertiary care standards.*

## KEY FINDINGS AND RECOMMENDATIONS

### ASPECT 2: PLANNING TO MEET NEEDS

#### **The ministry and health authorities have pockets of good practice, but should be more proactive in planning**

As steward of the health system, the ministry identifies risks that impact services across the province, and works with the health authorities to implement strategies to meet emerging health needs.

The ministry had implemented strategies to address short-term risks. However, the ministry needs to do more to proactively identify population trends and gaps in services, as well as long-term risks that may impact service delivery.

As direct service providers, the health authorities provide the ministry with their plans to achieve positive health outcomes. They are also responsible for communicating to the ministry the service levels necessary to meet identified population health needs. To do this, the health authorities must understand the health needs of the populations they serve.

The health authorities had not done enough analysis to understand whether they have the right mix of services to meet current and future needs. Although we found pockets of good practice, the health authorities had not fully evaluated demographic and population trends to inform planning. Analysis of capacity has not been comprehensive and ongoing, and there

was little evaluation of patient outcomes. Also, the health authorities can make improvements to better incorporate information from families and patients into their planning processes.

Identifying emerging needs of the adult tertiary care population is particularly important because the needs of people requiring adult tertiary care have shifted since the Riverview Hospital devolvement. Although no specific studies have been conducted, many of the researchers and health authority staff we spoke with indicated that patients accessing adult tertiary care currently have higher rates of co-occurring disorders than when Riverview Hospital was open.

Staff and researchers suggested that this change may be due to the increased use of new stimulant drugs, like methamphetamines (crystal meth). Using crystal meth or other amphetamines can make pre-existing mental health conditions worse, or cause drug-related psychosis and/or permanent brain damage.

#### **The ministry's population needs analysis was more reactive than proactive**

The ministry's population needs analysis for adult tertiary care has been in response to emerging issues, as opposed to a proactive identification of current and future needs or long-term risks within the system.

For example, the ministry's strategy, *Improving health services for individuals with severe addictions and mental illness*, arose in response to risks identified by key stakeholders concerned with mental health and substance use problems and illnesses in Vancouver.

## KEY FINDINGS AND RECOMMENDATIONS

Although the ministry took action in response to these short-term risks, the ministry has not proactively planned and implemented strategies to address long-term risks for patients requiring adult tertiary care services. By not engaging in this work, the ministry is only able to respond to issues as they arise. This makes it challenging to develop province-wide strategies to address current and future service needs.

### The health authorities and the ministry did not regularly share planning-related information

The system of adult tertiary care in B.C. is complex and decentralized. The ministry and health authorities need to make sure that key decision makers understand how well adult tertiary care is operating, including any issues related to access.

We expected the ministry to share performance information with health authorities to drive system improvements. We also expected health authorities to share information with the ministry to inform province-wide adult tertiary care system planning and decision making. This has not occurred.

One reason is there was no consistent method of collecting and sharing relevant data between the ministry and health authorities. This includes a lack of province-wide data to track information on population needs.

Health authority and ministry staff regularly met to discuss mental health and substance use issues. However, the ministry did not regularly share adult tertiary care information to help guide health authority service delivery and planning.

The ministry had taken steps to implement consistent information collection and reporting for mental health and substance use services, including adult tertiary care; however, the ministry needs to do more work to complete the project. In 2005, a working group began to establish mental health and substance use minimum reporting requirements to integrate the collection of data and identify trends, establish benchmarks and develop performance indicators.

However, with the exception of Northern Health, health authorities have yet to implement this initiative across the province for adult tertiary care. Health authority staff from across B.C. identified some of the difficulties with implementing this initiative, including:

- ◆ health authority IT systems do not align with ministry IT systems
- ◆ the data currently collected by health authorities does not align with the ministry's requirements

### We found good practices in some health authorities, but regular needs-based planning requires improvement

We expected health authorities would regularly identify and analyze prevalence and demographic information to estimate the needs of the adult tertiary care patients they serve. Health authorities should be engaging in this work to achieve positive health outcomes and to meet the needs of patients living with mental health and substance use problems and illnesses within their region.

## KEY FINDINGS AND RECOMMENDATIONS

We found two health authorities, Island Health and Fraser Health, proactively analyzed demographic and prevalence information to estimate needs of adult tertiary care patients.

Island Health's Planning and Community Engagement group created local health area profiles for regions within the health authority. These profiles included discussions of demographic trends, as well as economic factors, education, housing, social supports, crime, chronic disease, hospital admissions and emergency department visits.

Island Health also used data on drug and alcohol related death rates, rates of child abuse and neglect, and rates of trauma to determine the service model and funding sources for tertiary services in Central and North Vancouver Island, and to clarify a proposal for sustaining rural adult tertiary services.

Fraser Health used demographic and prevalence information in their wider planning for adult tertiary care. They projected approximately 40,000 patients will require treatment for severe mental health problems and illnesses by 2020 in their *Tertiary Services Priority Action Plan 2015-2020*. Based on this information, Fraser Health established goals to rebalance adult tertiary care services and ensure their resources will meet population needs.

However, if other health authorities do not regularly analyze demographic and prevalence information, they cannot ensure that services are meeting population needs, or adapt their services to meet changing needs.

Health authority staff explained that they have not had enough time or resources to engage in this work since the Riverview Hospital devolvement. Instead, they focused on opening regional adult tertiary care facilities/services. But without analyzing prevalence or demographic needs, the health authorities cannot be certain they are providing the right number and mix of services. Also, adult tertiary care is not clearly defined, which makes it challenging to identify and analyze needs.

**RECOMMENDATION 4:** *We recommend that the Ministry of Health collaborate with the health authorities to improve long-term planning, including improving information-sharing to better identify long-term risks and gaps in services.*

### Health authorities differed in their capacity planning and none have a comprehensive approach

Adult tertiary care facilities and services require highly trained staff and specialized features, like high levels of security. As a result, costs for these services are higher per patient than many other healthcare services.

We therefore expected the health authorities would analyze rates and trends (such as current utilization of services and costs per service) on an ongoing basis to determine whether their adult tertiary care program capacity is appropriate. We also expected they would use this information to identify current and future capacity pressures.



## KEY FINDINGS AND RECOMMENDATIONS

We found that none of the health authorities have regularly done this. All health authorities did some capacity analysis when additional ministry funding was available (e.g., funding for severe substance use and mental illness) or if a significant decision was made that required capacity analysis (e.g., the sale of Willingdon lands, where the Burnaby Centre for Mental Health and Addiction currently resides). However, these analyses did not provide an accurate picture of the overall capacity of health authorities' adult tertiary care programs.

Three health authorities conducted significantly more capacity analysis than others. However, the analyses were not comprehensive, not regularly performed and/or not used to understand overall adult tertiary care capacity.

Island Health analyzed current budget pressures and closures in other mental health and/or substance use programs to allocate remaining Riverview Hospital devolvement funds. Island Health also compared per capita allocations of mental health and/or substance use resources across Vancouver Island to contribute to decision making around the sustainment of tertiary services in both the Central and North Island. However, this analysis was done to support these specific decisions, not overall adult tertiary care planning.

Vancouver Coastal Health analyzed capacity information in partnership with the Lower Mainland Facilities Management group as part of the Segal Centre project. This project is for a new 100-bed Mental Health Pavilion on the Vancouver General Hospital campus, which will replace the current

Vancouver General Hospital Health Centre and consolidate mental health in-patient and out-patient programs and services.

The project's capacity information analysis included value for money analysis, life cycle cost estimates, and a comparison of site options based on costs, procurement models and clinical viability to determine the best option. However, again, this is an example of analysis being done once for a specific decision, not part of regular planning for the entire adult tertiary care program.

Interior Health collected a large amount of utilization information and regularly produced reports that graphed and trended the information related to its two largest adult tertiary care facilities (Hillside and South Hills). According to staff, informal analysis of this information occurs. Where there are trends such as low occupancy rates that continue over a long period of time, staff advised they take action to address them.

Interior Health also analyzed both staffing needs and current costs per service to understand the capacity of their contracted facilities (16% of beds). They found that the capacity of their contracted facilities was not sufficient and facilities did not meet adult tertiary care program needs. Although these examples show Interior Health is engaging in some capacity analysis for some of its adult tertiary care facilities, it is limited to specific facilities within Interior Health, and not the entire adult tertiary care program.

One reason why the health authorities have not proactively engaged in more comprehensive capacity analysis, is the perception that additional adult tertiary



## KEY FINDINGS AND RECOMMENDATIONS

care funding is not available, so completing this type of analysis would be unproductive. In addition, staff explained that because of their high workloads, they are focused on direct service delivery. They do not have time to engage in longer-term capacity analysis.

If health authorities do not fully understand their capacity, they cannot be sure if they have the right facilities and services to meet needs now or in the future. Insufficient capacity for people with mental health and substance use problems and illnesses can mean putting already highly vulnerable people at further risk. This can result in higher costs to other public services (e.g., justice, emergency services). In addition, health authorities do not know whether they are allocating resources to higher levels of care when lower levels may provide better patient outcomes at a lower cost.

**RECOMMENDATION 5:** *We recommend that the health authorities regularly identify adult tertiary care population needs and determine whether they have the right mix of current and future services.*

### The health authorities have not analyzed program effectiveness

Ideally, the health authorities should understand the effectiveness of key services to help inform planning, ensure patient needs are met, and outcomes are achieved. We found health authorities did not know whether their adult tertiary care programs were helping to ensure positive health outcomes. We did

find that some health authorities (Fraser Health, Island Health and Vancouver Coastal Health) analyzed outcomes through evaluations of their assertive community treatment teams – one of the services provided under adult tertiary care.

Evaluations help health authorities identify where they might need additional resources and whether there are lower cost alternatives that can provide similar outcomes. In addition, evaluations will help health authorities identify whether there are trends for certain types of patients who are not benefiting from adult tertiary care, which could foster provincial discussions regarding other types of care that may be needed.

The health authorities do not need to do evaluations each year, but they should do them regularly enough to measure the outcomes of critical services and programs. The ministry and health authorities should share information from these evaluations, to optimize the use of resources.

**RECOMMENDATION 6:** *We recommend that the health authorities periodically evaluate the effectiveness of their adult tertiary care programs and share lessons learned with the Ministry of Health and other health authorities.*

### Health authorities did not consistently use patient and family feedback in program planning

Feedback from both patients and their families is key to understanding patient needs. Feedback reflects how

## KEY FINDINGS AND RECOMMENDATIONS

well adult tertiary care services are working, and offers ways to improve patient-centred care.

Most health authorities have committees focused on the entire mental health and substance use system, in which individuals/families participated. For example:

- ◆ Vancouver Coastal Health's Family Advisory Committee
- ◆ Northern Health's Consumer, Family and Stakeholder Advisory Committee
- ◆ Fraser Health's Mental Health and Substance Use Regional Advisory Committee

Vancouver Coastal Health and Provincial Health Services used information from patients and families to inform planning. Family and patients contributed to the creation of the vision, mission and mandate for one of Vancouver Coastal Health's adult tertiary care programs. Provincial Health Services held weekly meetings with patients at the Burnaby Centre for Mental Health and Addiction to gather feedback and took action on issues that patients identified.

The use of patient surveys was also inconsistent across and within all health authorities. For example, Vancouver Coastal Health piloted a survey in one facility for use within each of their tertiary programs; however, this has not yet been fully implemented. Provincial Health Services surveyed patients at Heartwood Centre for Women and analyzed the data, but it was unclear how this information was used to inform program decisions.

Health authority staff explained that there can be challenges in obtaining feedback from patients who are acutely ill. This must be taken into account when planning and administering surveys.

Nonetheless, there are opportunities for the health authorities to create consistent methods of gathering patient and family feedback on adult tertiary care, and to determine how best to use this information in program-level planning. This information can also be valuable for understanding patient outcomes.

### We identified gaps in services for patients with significant needs

All health authorities identified populations that did not have access to services that met their needs. Currently, there is no provincial picture of all the gaps in service delivery.

We found there are service delivery gaps for the following populations:

- ◆ patients with acquired brain injury
- ◆ patients with developmental disabilities
- ◆ patients with histories of extreme violence and/or current aggressive behaviour

The exact number of these patients is unknown, but we understand there is a small number per health authority. This leads to challenges in obtaining economies of scale (i.e., reducing costs while meeting needs).

## KEY FINDINGS AND RECOMMENDATIONS

Accountability for patients with acquired brain injuries or developmental disabilities, as well as mental illness and/or substance use problems and illnesses is unclear because no single program area is responsible for developing resources to meet these needs.

These patients may end up staying in adult tertiary care because the available community programs (e.g., Community Living B.C., acquired brain injury programs) do not provide intensive mental health and substance use services. This results in extended lengths of stay, preventing other patients from accessing adult tertiary care services.

This group may not need the resource intensity provided by adult tertiary care services. These patients are often unable to fully participate in adult tertiary care programming because of cognitive impairments and age differences. Further, they have different symptoms than other patients in adult tertiary care. This underscores the need for collaboration with external partners and stakeholders in this area.

Patients with histories of extreme violence and/or current high levels of aggressive behaviour create challenges that are difficult for many health authorities' adult tertiary care facilities. This group can include patients who have been involved in B.C.'s forensic psychiatric system.

Health authorities struggle to admit these patients to adult tertiary care if the facilities cannot provide secure rooms and appropriate staffing levels for both staff and patient safety. Health authority staff advised us that community facilities may not provide services of the appropriate intensity to safely meet patient needs when they are ready for discharge from adult tertiary care facilities. This again leads to extended lengths of stay, preventing optimal flow in adult tertiary care.

### FORENSIC PSYCHIATRY

Patients with mental illness who are in conflict with the law may receive services within the Forensic Psychiatric System.

Both in-patient and community-based services are provided to patients who were found Not Criminally Responsible on Account of Mental Disorder or Unfit to Stand Trial.

## KEY FINDINGS AND RECOMMENDATIONS

Five health authorities (Fraser Health, Northern Health, Island Health, Vancouver Coastal Health and Provincial Health Services) have started to implement strategies to improve services for patients with needs that do not fit within the current services. For example:

- ◆ Island Health opened the Glengarry Transitional Care Unit, which was developed for short-term transitional care for patients who suffer from combinations of mental health, physical health, behavioural and substance use problems or illnesses, who have unique needs that are

not aligned with established community service delivery models. The unit opened in March 2015.

- ◆ Provincial Health Services has plans to open an Enhanced Care Unit at the redeveloped Burnaby Centre for Mental Health and Addiction (opening in 2019). This unit will provide services for patients with serious mental health conditions and/or substance use, and co-occurring aggressive behaviour (e.g., risk of suicide, self-harm, criminal justice involvement, high risk of violence and/or repeated violence).

There was no provincial strategy for ensuring that patients with acquired brain injury, developmental disabilities or those with a history of extreme violence or current high levels of aggressive behaviours, as well as serious mental illness and/or substance use, will be able to receive the services they need. Patients who stay in adult tertiary care facilities because they cannot be discharged may cost the system more and prevent other patients from accessing services. Health authority staff also noted that keeping patients at higher levels of care than required is often not in the patients' best interest.

**RECOMMENDATION 7:** *We recommend that the Ministry of Health and health authorities work with key stakeholders to address the gaps in services for individuals whose needs are beyond the threshold of services currently funded and available.*

## ASPECT 3: MANAGING PATIENT ACCESS AND FLOW

### Management of patient access and flow varied considerably

A critical aspect of managing access to adult tertiary care is managing patient *flow* in and out of adult tertiary care. We expected health authorities would be tracking and actively managing waitlists.

To determine active management of waitlists, we asked the following questions:

- ◆ Do health authorities track and set waitlist targets?
- ◆ Do health authorities manage their admission processes?
- ◆ Do health authorities manage patient flow, and barriers to flow?

## KEY FINDINGS AND RECOMMENDATIONS

We found health authorities managed patient access and flow differently. A one-size-fits-all approach may not be appropriate for all the varied contexts of the health authorities. However, without some consistency, health authorities are not able to ensure fair and equitable access to adult tertiary care across the province.

It is important to note that each health authority has unique contextual factors that impact their ability to manage access and flow. Please see [Appendix D](#) for more information regarding health authority access and flow, including examples of flow in and out of facilities.

To ensure equal access to adult tertiary care services across the province, it is important that health authorities are consistent with their practices.

### Health authorities have tracked waitlists for adult tertiary care, but they lack consistent targets and measures

Waitlist tracking and establishing targets is important for understanding and facilitating patient access to adult tertiary care. Target setting enables health authorities to determine if what was planned was accomplished and supports the identification of issues or problems with patient flow. Without comparable targets, consistent access cannot be ensured across the province.

Health authorities have tracked waitlists for all adult tertiary care facilities. However, two health authorities (Fraser Health and Island Health) have not tracked waitlists for their assertive community treatment teams. Health authority staff told us that this is because assertive community treatment team services are still fairly new and demand has not reached a level where waitlists are required.

We also found that health authorities have not set consistent adult tertiary care access targets, which makes it difficult to understand performance across the province. Four health authorities have set some targets for access to adult tertiary care facilities and services. But the targets differ per health authority.

Vancouver Coastal Health has set waitlist targets for the BC Psychosis Program and Provincial Health Services has set targets for the Heartwood Centre for Women and the Burnaby Centre for Mental Health and Addiction. For example, Heartwood's waitlist targets include average wait time from approval to intake (target  $\leq 30$  days) and percent of admissions within target from approval to intake (target  $\geq 80\%$ ). Heartwood is a residential treatment program for women with substance use problems and illnesses.

As good practice, Provincial Health Services annually reviews Heartwood's targets to determine their continued appropriateness based on various approaches (e.g., external benchmarks or incremental reduction).

## KEY FINDINGS AND RECOMMENDATIONS

Setting targets for adult tertiary care is difficult. There are limited existing performance measures used nationally and internationally, and the adult tertiary care patient population is diverse. This makes it challenging to determine appropriate targets that apply to the entire population. Additionally, staff have concerns that setting targets will drive clinical decision-making that is not in the best interest of the patient.

We agree that there are challenges, but without targets in place, the health authorities and the ministry lack an understanding of how well the adult tertiary care system is performing. It makes it harder to identify and address gaps and challenges in adult tertiary care.

### Inconsistent adult tertiary care admissions practices across health authorities

A clear and consistent admissions process is critical to fair and equitable access. To assess admissions processes, we looked at whether the health authorities:

- ◆ use a standardized assessment instrument to assess referrals
- ◆ use consistent, formal prioritization criteria
- ◆ provide recommendations of alternative solutions for patients who are declined
- ◆ have an ongoing review and awareness of expected discharges and admissions

We found that each health authority had a unique screening and intake admissions process. There is no provincially accepted assessment tool/instrument used by all the health authorities for admission.

Finding a tool that works for all health authorities can be challenging because each health authority has unique needs. However, this increases the risk of inconsistent waitlist prioritization for adult tertiary care patients across the province. This also means inconsistent collection of information related to assessments and admissions.

### Standardized assessment and prioritization

Patients are referred to adult tertiary care services by a variety of healthcare or social services practitioners (e.g., social workers, nurses, managers of secondary services, psychiatrists, case managers, etc). These health care practitioners, known as referral sources, complete referral or admission packages that provide patient psychiatric and medical history.

It is important to highlight the flexibility required in the screening process. Each person seeking access to adult tertiary care has unique circumstances that health authorities need to consider.

All regional health authorities used a committee to screen referrals for their adult tertiary care facilities, but only one health authority, Island Health, consistently used an instrument with criteria to help standardize the assessment of adult tertiary care referrals (i.e., what services should be provided to the patient).



# KEY FINDINGS AND RECOMMENDATIONS

## STANDARDIZED ASSESSMENT TOOLS

The Level of Care Utilization System (LOCUS) is an example of a tool that can be used to help standardize assessment of adult tertiary care referrals. Provincial Health Services has provided training on LOCUS to all the health authorities, and Northern Health has begun a quality improvement project using this tool. On a provincial level, LOCUS has not been widely used and staff expressed mixed reviews regarding its effectiveness.

Island Health used Service Logic Matching in Pathways. This tool compared the patient's clinical profile against matching criteria in an electronic database to help direct referrals.

Most health authorities did not have a formal list of prioritization criteria for admitting patients to adult tertiary care facilities. This means there were no clear, formalized ranking criteria for determining which patient should sit where on the waitlist. Instead, it was done *ad hoc* by committee consensus.

All of the health authorities considered the same underlying factors (e.g., acuity, lack of community supports, homelessness, unclear diagnosis), but they weighed these factors differently in their prioritization processes.

For instance, Fraser Health staff reported that they consider the first date of admission to acute care in their prioritization process. In contrast, Vancouver Coastal Health staff reported that they consider the date the referral was received.

In an environment where there is an absence of agreed upon standards for access to adult tertiary care facilities, having a standardized approach to assessing referrals and consistent criteria supports consistent access across health authorities. It also supports a shared understanding of how to categorize patients (i.e., tiers of services), and can improve the ability of organizations to effectively plan for services that are required. All health authorities should consider formally recording how and when prioritization takes place to ensure consistency across the province.

Health authorities had differing practices for managing access to assertive community treatment teams. Although all health authorities reported using the assertive community treatment standards to help screen referrals, they reported prioritizing different factors for admitting patients.

The ministry is leading a review to help assertive community treatment teams determine if they are aligned with the assertive community treatment model and the BC assertive community treatment standards. The health authorities should consider the review's recommendations in the context of our findings.

## KEY FINDINGS AND RECOMMENDATIONS

### Practices when a patient is declined access to adult tertiary care

We found that practices staff followed when a referred individual was declined admission to adult tertiary care also varied across the health authorities. Four health authorities (Fraser Health, Island Health, Interior Health and Northern Health) provided recommendations of alternative solutions when patients were declined access to adult tertiary care facilities. The other two health authorities reported that they provide recommendations, but kept limited records, so we were unable to determine if this has occurred consistently across the province.

Staff from all health authorities reported that recommendations were made when referred individuals were declined admission to assertive community treatment teams. Of note, staff from Fraser Health reported that all potential assertive community treatment clients are met in person, even if they were declined, and an email is sent to the referral source including reasons why the patient was declined and other potential options for treatment.

Understanding the reasons why referred individuals are declined eases frustrations for both the referral sources and the individuals declined service. It also helps referral sources to better understand the services delivered by adult tertiary care programs, and which patients are the right fit, so they can be sure to refer the *right* patient in the future.

Some health authorities (Interior Health, Northern Health, Fraser Health and Vancouver Coastal Health) invited referral sources to participate in screening

meetings to discuss patient cases for admission into adult tertiary care. This inclusion fosters discussions on a timely basis. However, if the referral source is unavailable for the meeting, the screening may be delayed, which means a patient will wait longer for care.

Health authorities may want to consider formally documenting why patients are declined and potential recommendations for alternative solutions. They could then share this with referral sources to ensure everyone understands why patients are not the right fit at that time and steps to follow moving forward.

### Patient flow practices

Health authorities engaged in different strategies to improve flow through adult tertiary care facilities.

A patient's flow in and out of an adult tertiary care facility can be influenced by the health authority's approach to discharge, along with the patient's readiness and circumstances. If beds are occupied, patients waiting to be admitted are unable to access adult tertiary care. However, it is important to note that staff said there is always a percentage of patients who will need to remain in adult tertiary care services for an extended period of time.

Some health authorities took the approach of flowing patients through facilities as quickly as possible, while others allowed patients to remain for an extended period of time if a step-down service was not available. This means that in some regions, beds may be occupied longer, not only based on the patients readiness and circumstances, but because of the

## KEY FINDINGS AND RECOMMENDATIONS

discharge approach of the health authority. This impacts the ability of health authorities to admit other patients to adult tertiary care.

### DIFFERENCES IN PATIENT FLOW PRACTICES IMPACTS LENGTH OF STAY (LOS) IN FACILITIES

We reviewed twelve patient files at three adult tertiary care facilities in different regions of the province. The sample files included patients with short and long lengths of stay. The length of stay may be due to a variety of patient factors, including patient readiness, services offered at the facility, population served, lack of available housing upon discharge, and different patient flow practices.

	Shorter LOS (average)	Longer LOS (average)
Facility #1	42.5 days	175.5 days
Facility #2	134 days	1,677 days
Facility #3	275.5 days	327 days

One example of patient flow practices is the use of return or repatriation agreements. These agreements are signed by referral sources and require a patient to be accepted back to the referral community within a specific timeframe (e.g., 30 days) of his/her readiness for discharge. This promotes patient flow out of adult tertiary care, but relies heavily on the referral sources to identify an appropriate service for the discharged patient.

Health authorities that have not used this approach explained it is not appropriate in their context, and there may be no services that can adequately care

for the patient in the community, so discharging is too risky for the patient. In addition, this can result in pressure on other parts of the mental health system. This risk was corroborated by referral sources who explained that sometimes there are no secondary services available (e.g., appropriate supportive housing).

These different practices (e.g., waitlist tracking, admission practices) illustrate the need for health authorities to collaborate with each other to support fair and equitable patient access and flow across the province.

**RECOMMENDATION 8:** *We recommend that the Ministry of Health and the health authorities collaborate to identify and implement practices that need to be consistently applied across the province to enhance patient flow.*

### Barriers to flowing patients in and out of adult tertiary care need to be addressed

Barriers to access can prevent or delay a patient from getting services. Barriers to discharge can prevent a patient from leaving adult tertiary care, even though clinicians have determined adult tertiary care is no longer required. Barriers to discharge also impact access, because they reduce the number of beds and services available to other patients.

We expected the health authorities to identify barriers to access and discharge and to implement strategies to address these barriers.

## KEY FINDINGS AND RECOMMENDATIONS

The health authorities have identified a number of barriers to the flow of patients in and out of adult tertiary care, some of which only impact their health authority, and some of which are systemic barriers. Systemic barriers are those that all health authorities identified, and which are difficult for only one organization to address.

We noted that all health authorities engaged in strategies to address long waitlists and increase flow. However, more analysis is needed by health authorities and the ministry to fully understand the extent of the systemic barriers, and then address them.

### Limited appropriate services upon discharge

Staff from all health authorities identified the lack of appropriate services for patients upon discharge as a systemic barrier to flow. Patients are not able to leave adult tertiary care if there are no appropriate services available for them to go to. If patients are unable to leave, then other patients are unable to access care.

**Housing** – We found that access to appropriate housing was a key barrier throughout our audit. Housing for people with serious mental health and substance use problems or illnesses requires openness from landlords to rent to them. In addition, housing costs are high in many communities and some patients may not have the necessary funds to rent appropriate housing. These two factors impact the ability of people to get suitable housing once they are discharged from adult tertiary care.

**Long-term residential mental health and substance use care** – We heard from all the referral sources that there is a lack of long-term residential care for people that may no longer require intensive adult tertiary care services, but still require significant mental health and/or substance use services. Referral sources explained that even after receiving adult tertiary care, there are people who are still unable to live in group settings or on their own, even with significant secondary supports.

**Community services** – In the 1998 *Mental Health Plan*, government recognized that the early stages of the Riverview Hospital devolvement did not address the inadequate supply of community services relative to the demand. In 2012, academic research in B.C. indicated that capacity of community services still remained an outstanding issue. Our interviews with health authority staff and referral sources further emphasized the need for a range of additional community discharge supports for people who are ready to leave adult tertiary care.

We would not expect health authority adult tertiary care program areas to be solely responsible for addressing the lack of appropriate services upon discharge. The operation and management of these services involves other program areas within the health authorities, as well as external partners (e.g., BC Housing, Community Living B.C.). Because of the shared responsibility, we did not audit whether the health authorities are addressing these barriers.

However, it is clear from interviews that agreement is required between health authorities, the ministry and stakeholders, regarding what constitutes appropriate

## KEY FINDINGS AND RECOMMENDATIONS

services to meet patient needs, the best actions to get there, and what should be made priority (e.g., residential care).

### Other barriers and risks impacting access to adult tertiary care

Health authority staff throughout the province identified a number of other risks and barriers that may impact access and flow through adult tertiary care. It is important that health authorities take note of these other issues and engage in strategies to address them.

**Secondary system pressures** – One key risk area that staff from all health authorities and referral sources identified was the high demand for mental health and substance use services. This causes pressures in the secondary care system, which impacts referrals to adult tertiary care.

The majority of adult tertiary care services rely on the secondary system for a significant portion of their referrals. If the secondary system is overwhelmed, there is a risk that patients are not being referred to adult tertiary care. For example, if there are no appropriate beds available in hospital, patients may not

be admitted to be assessed and subsequently referred to adult tertiary care.

High demand for mental health and substance use services is an issue for all health authority emergency departments. In 2012, one health authority found that patients with mental health and substance use problems arriving in the emergency department were assessed quickly and discharged without addressing the risks identified by the person who brought them. This was because of the high volume and acuity of the patients, and the pressure to conduct assessments as rapidly as possible.

We would not expect health authority adult tertiary care program areas to be solely addressing pressures in the secondary system. However, this is an area that impacts access to adult tertiary care, which requires health authority attention and a coordinated approach.

**Long waitlists** – Health authority staff and referral sources told us that long waitlists and/or not enough beds or services are key barriers to accessing adult tertiary care. In fact, one referral source told us that sometimes they do not refer to adult tertiary care because of the long wait.

We found that all health authorities have strategies to reduce waitlists. Some examples of good practices included:

- ♦ daily bed calls/congestion calls with acute care sites within their health authorities to strategize about discharge barriers (Vancouver Coastal Health, Fraser Health)
- ♦ a formal process for the escalation of referrals/discussion of complex patients for situations requiring further problem solving (Fraser Health)
- ♦ proactive review by assertive community treatment teams of patients who had more than 50 in-patient days to determine their suitability for services (Island Health)
- ♦ detailed, length-of-stay meetings to identify and overcome barriers to patient discharge (Provincial Health Services)



## KEY FINDINGS AND RECOMMENDATIONS

### *Understanding adult tertiary care –*

We also heard from health authority staff and some referral sources that there may be a lack of understanding of what adult tertiary care is among referral sources and/or the secondary system (e.g., what services are provided, the type of patients that best fit the services, why it takes so long to access care). Lack of understanding could mean that patients are not being referred when they should be.

This is not surprising, given that there is no agreed upon definition for adult tertiary care and there is little reporting in this area. The health authorities may want to consider engaging more with the secondary system to ensure they understand the services available.

### *Communication and cultural awareness*

– Stakeholders suggested that more communication is needed between the First Nations Health Authority and regional health authority adult tertiary care programs. Further, they said that health authorities could make the adult tertiary care referral and admission processes more culturally sensitive and less complex.

**RECOMMENDATION 9:** *We recommend that the Ministry of Health and the health authorities further analyze barriers to adult tertiary care access and flow and work with each other and relevant stakeholders to address them.*

## ASPECT 4: PUBLIC PERFORMANCE REPORTING

### **The ministry and health authorities have not publicly reported on adult tertiary care**

Given the complexity of the mental health and substance use system, we expected the ministry and the health authorities to formally report on a few critical aspects of adult tertiary care performance. However, we found both the ministry and the health authorities did not report on access to adult tertiary care.

The ministry reported on output targets for *Healthy Minds, Healthy People*. For example, the 2012 *Healthy Minds, Healthy People* progress report provided an update on the number of patients served by an assertive community treatment team (over 500), and reported the completion of the transfer of Riverview Hospital patients to regional health authorities. However, this report did not provide a comprehensive picture of access to adult tertiary care.

The ministry and health authorities have not formally reported to the public or stakeholders because the ministry has not established reporting requirements. Also, as noted above, staff have faced issues in collecting data.

Without public reporting, Legislators, stakeholders and the public may not know about the adult tertiary care services available and any associated challenges.



## KEY FINDINGS AND RECOMMENDATIONS

This may lead to misinformation and unrealistic expectations in the public realm. In addition, the public is unable to hold government to account for ensuring value for money.

Furthermore, a lack of reporting on adult tertiary care can lead to a misunderstanding of adult tertiary care services by mental health and substance use clinicians. This is an issue directly impacting access, as mental health and substance use clinicians are responsible for referring patients to adult tertiary care.

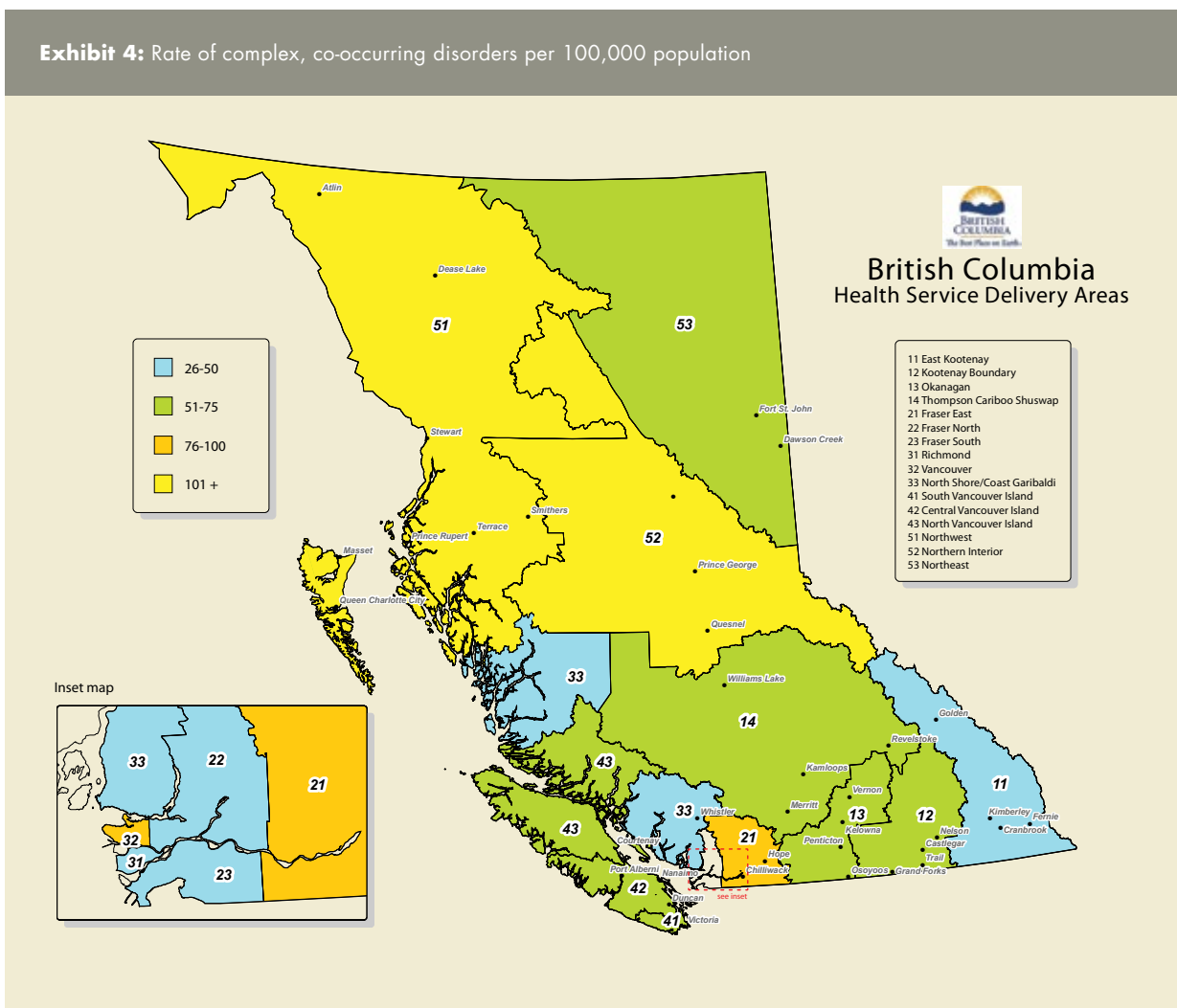
### **RECOMMENDATION 10:**

*We recommend that the Ministry of Health and the health authorities collaborate to develop appropriate measures to report publically on access to adult tertiary care.*

# APPENDIX A: RATES AND NUMBERS OF PERSONS WITH CO-OCCURRING DISORDERS BY HEALTH SERVICE DELIVERY AREA

Exhibit 4 shows the *rates* of people with co-occurring disorders out of every 100,000 people. The highest rates are seen in the Northwest and Northern Interior of the province. [Exhibit 5](#) (next page) shows the *number* of people with co-occurring disorders by region. The health service delivery areas with the highest *number* of people with co-occurring disorders are Vancouver and Fraser South.

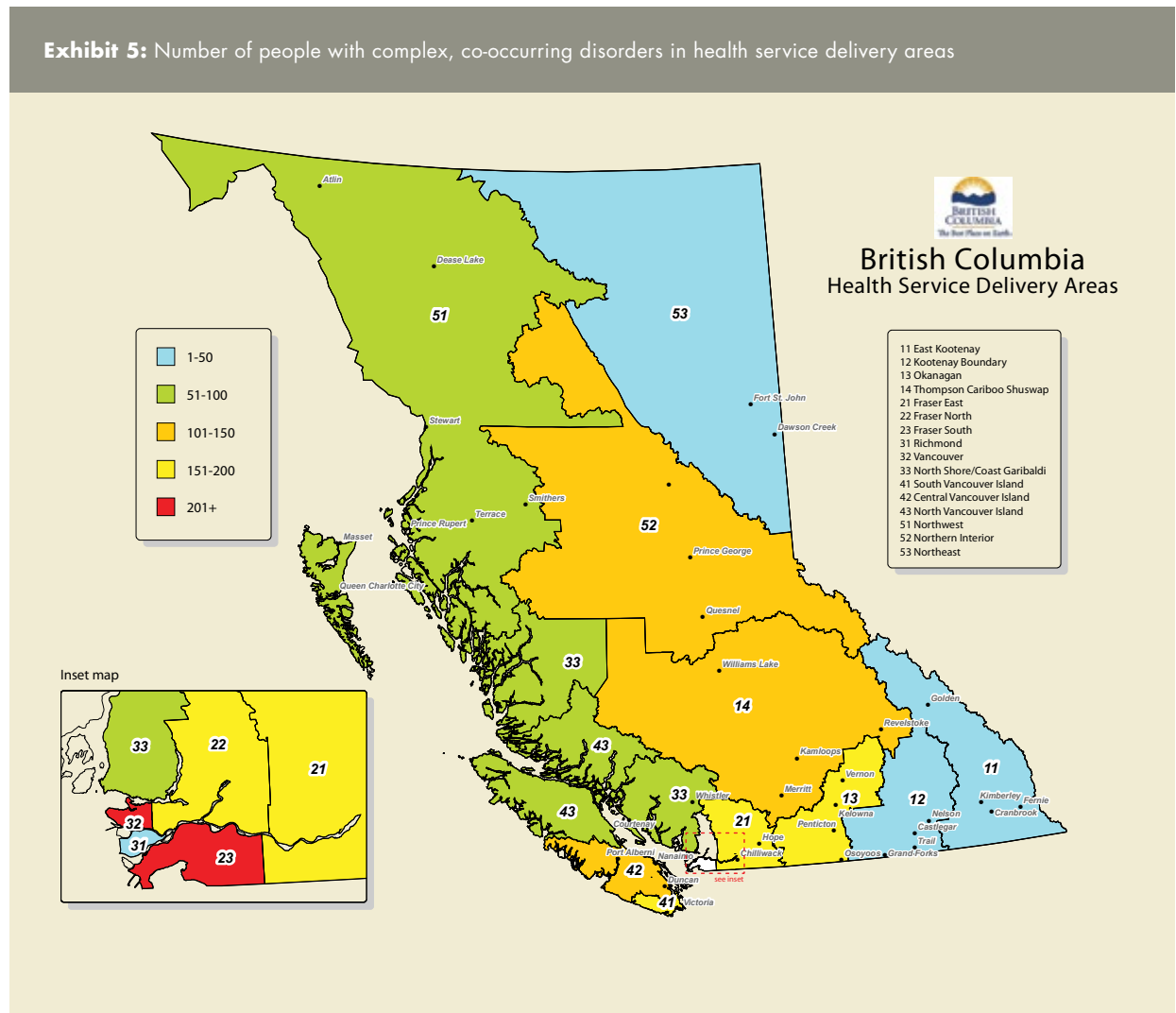
Taken together, these maps highlight that the highest number of people with co-occurring disorders are found in Vancouver Coastal Health and Fraser Health, while the greatest prevalence per population (more than 100 per 100,000 people) is found in Northern Health.



Source: Compiled by the Office of the Auditor General of British Columbia, based on the report *Estimating the Prevalence and Distribution of People with Complex Co-Occurring Disorders in British Columbia* by Somers, Moniruzzaman and Rezansoff.

# APPENDIX A: RATES AND NUMBERS OF PERSONS WITH CO-OCCURRING DISORDERS BY HEALTH SERVICE DELIVERY AREA

Exhibit 5 shows the *number* of people with co-occurring disorders by region. The health service delivery areas with the highest *number* of people with co-occurring disorders are Vancouver and Fraser South.



Source: Compiled by the Office of the Auditor General of British Columbia, based on the report *Estimating the Prevalence and Distribution of People with Complex Co-Occurring Disorders in British Columbia* by Somers, Moniruzzaman and Rezansoff.

# APPENDIX B:

## OVERVIEW OF ADULT TERTIARY CARE IN B.C.



# APPENDIX C: SAMPLE PERFORMANCE MEASURES

Below are performance measures used by some of the health authorities. We are providing these to help the health authorities and the ministry with the development of their provincial performance measurement framework. However, these measures are not used consistently across the province, and the health authorities are not reporting these to the ministry.

Measure	How it can be used
Number of referrals	<p><i>Counts the number of referrals received by a health authority for a specific program or facility.</i></p> <p>The number of referrals can help determine demand for a given service.</p>
Number of admissions	<p><i>Counts the number of referrals that were accepted to a specific program or facility.</i></p> <p>Number of admissions can be used to compare demand for a service and the number of patients accepted. It is important to note that not all referrals received are appropriate for adult tertiary care, so a difference in number of referrals and number of admissions may be explainable. The number of admissions can also give information about changes in system capacity over time.</p>
Average wait time	<p><i>Measures the time elapsed from when the intake committee received the referral to intake of that patient into the given facility.</i></p> <p>Average wait time is a good measure of timely access to a facility/program and is measured in days.</p>
Average occupancy rate	<p><i>Measures the percentage of beds that are occupied for a program throughout a given year.</i></p> <p>Occupancy rates show service use and can help with understanding patient flow and capacity. High occupancy rates indicate that beds are full and there may not be additional beds available for new patients. This measure supports program planning.</p>
Average length of stay (ALOS)	<p><i>Measures the length of time a patient remains in a program from admission to discharge.</i></p> <p>ALOS is a good indicator of flow through programs. Long lengths of stay prevent access by new patients. However, some patients may require a long length of stay as part of their treatment. ALOS can be monitored over time to identify emerging barriers to timely discharge.</p>
Alternate level of care (ALC)	<p><i>Alternate level of care is a designation given to patients who no longer require the intensity of services provided in the current setting and who are waiting for an alternate level of care to become available.</i></p> <p>Another indicator of flow – ALC illustrates challenges with moving patients to other levels of care. In addition, the number of patients in ALC can show the cost-effectiveness of a service, as typically keeping patients at a higher level of care is more expensive.</p>

## APPENDIX C: SAMPLE PERFORMANCE MEASURES

Measure	How it can be used
Average percentage of patients discharged to shelter or homelessness	<p><i>Measures the percentage of patients who reside in a shelter or are homeless upon discharge.</i></p> <p>This measure can capture difficulties with finding appropriate housing and step-down services for patients. Patients who are discharged to shelters or homelessness are at high risk of adverse outcomes.</p>
Average percentage of patients discharged to assertive community treatment teams	<p><i>Measures the percentage of patients who are attached to an assertive community treatment team upon their discharge from a program.</i></p> <p>This measure can capture links between adult tertiary care facilities and assertive community treatment teams within the health authorities.</p>

Note: Additional measures could include 30 and 90 day readmissions to adult tertiary care services and the number of patients repatriated to secondary care.

Developing relevant performance measures can be challenging. In 2010, our Office published a *Guide to Developing Relevant Key Performance Indicators*. We encourage the ministry and health authorities to review this guide.

Please see: [http://www.bcauditor.com/sites/default/files/publications/2010/report\\_10/report/OAGBC\\_KPI\\_2010\\_updated.pdf](http://www.bcauditor.com/sites/default/files/publications/2010/report_10/report/OAGBC_KPI_2010_updated.pdf)



# APPENDIX D:

## HEALTH AUTHORITY FACILITY ACCESS AND FLOW

To demonstrate access and flow throughout the province, the health authorities provided our Office with data on patient flow for their **two largest adult tertiary care facilities** for fiscal year 2014/2015.

Each health authority operates in a unique environment, with differences in geography, population size, demographics and the availability of mental health and substance use services outside of adult tertiary care. These contextual factors impact patient flow in and out of facilities.

In addition, different facilities provide different types of services. For example, Fraser Health's Facility 2 in the table below includes psychiatric intensive care unit beds, for patients requiring immediate attention, while others such as the facilities in Northern Health and Island Health provide more long-term residential services, resulting in longer lengths of stays. Interior Health uses return agreements for these two facilities, and as a result, have a faster flow through its facilities than some of the other sites.

*The data on the following page has not been audited. It is provided to demonstrate the differences in rates of patient flow. This information is not directly comparable across the health authorities, but the trends are informative.*

## APPENDIX D: HEALTH AUTHORITY FACILITY ACCESS AND FLOW

**Table 1:** Illustration of health authority facility access and flow for 2014/15

Health authority	Number of referrals	Number of admissions	Average wait time	Average occupancy rate	Average length of stay
<b>Provincial Health Services</b>					
Facility 1: > 40 beds	298	219	18 days	93.7%	150 days
Facility 2 : <40 beds	199	137	52 days	80%	59 days
<b>Fraser Health</b>					
Facility 1: <40 beds	22	22	59.95 days	96.36%	359.73 days
Facility 2: >40 beds					
Program A	18	18	29.78 days	93.47%	202.76 days
Program B	66	44	35.30 days	96.07%	238.35 days
Program C1	181	118	0.94 days	99.2%	18.06 days
Program C2	81	72	0.88 days	59.56%	25.59 days
<b>Interior Health</b>					
Facility 1: >40 beds	296	286	11 days	75%	104.5 days
Facility 2: >40 beds	74	77	13 days	71.4%	168 days
<b>Northern Health</b>					
Facility 1: <40 beds					
Program A	13 (A & B)	5 (A & B)	178 days (A & B)	96.9% (A & B)	2851 days
Program B					354 days
Facility 2: <40 beds					
Program A	20 (A & B)	9 (A & B)	41 days (A & B)	93.08% (A & B)	2315 days
Program B					249 days
<b>Vancouver Coastal Health</b>					
Facility 1: <40 beds					
Program A	86	42	45 days	94% (A & B)	240 days (A & B)
Program B	10	6	54 days		
Program C: >40 beds					
Facility 1	29 (A & B)	17 (A & B)	39 days (A & B)	99%	569 days (A & B)
Facility 2				92%	
<b>Island Health</b>					
Facility 1: ≥40 beds	22	44 (includes respite)	76.5 days	92%	415 days
Facility 2: <40 beds	12	10	51.1 days	95%	397 days



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