

Brief

to the

Ministry of Health and Long-Term Care

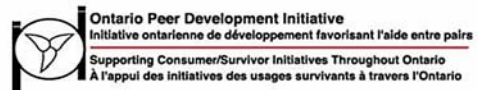
on the proposed

*Health Based Allocation Model (HBAM)
Funding Formula for LHINs*

with respect to the

Mental Health & Addictions Sector

January 2008



The Ministry of Health and Long-Term Care convened a meeting with the Canadian Mental Health Association, Ontario (CMHA) and the Ontario Federation of Community Mental Health and Addictions Programs (OFCMHAP) on October 15, 2007 to discuss a new funding formula for Local Health Integration Networks, the Ontario Health-Based Allocation Model (HBAM). The objectives of this presentation were to provide an overview of the development of HBAM and solicit feedback from the community mental health and addictions sector. We thereafter wrote to the Ministry on November 9, 2007 to indicate we would like to provide additional suggestions, by preparing a brief document for you as the basis for a follow-up discussion.

This brief responds to the information received on the proposed HBAM and is offered on behalf of the following six provincial mental health and addictions organizations, who are commonly referred to as 'the partnership':

- Addictions Ontario
- Canadian Mental Health Association, Ontario
- Centre for Addiction and Mental Health
- Ontario Association of Patient Councils
- Ontario Federation of Community Mental Health and Addiction Programs
- Ontario Peer Development Initiative.

We start by identifying several issues which require further attention during the development of HBAM for the mental health and addictions sector, and conclude by offering some suggestions for next steps.

HBAM must be aligned with Ministry policy directions for mental health reform and its commitment to enhance addiction services.

As Ontario moves forward in supporting care in the community by developing its funding formula, it is essential to articulate the true scope of the community mental health and addictions sector. The HBAM documentation received does not explicitly identify addiction treatment services, peer support, nor consumer/survivor initiatives; these important services are subsumed under the umbrella of mental health. The development of the HBAM formula for the mental health and addictions sector is an opportunity for the Ministry to put into place the government's commitment to continued investment in mental health services and support for addictions services, as outlined in a letter from Premier Dalton McGuinty to the Ontario Federation of Community Mental Health and Addiction Programs:

"Ontario Liberals listened to the addictions community, who have stressed the need for strong provincial policy direction in this area. That is why we worked closely with experts in the field to develop a provincial addictions strategy – and we will support this work with an increase in base funding for addictions services."

Premier Dalton McGuinty
September 28, 2007

A long-standing principle of the Ministry's policy directions for reform of the mental health system is the inclusion of consumers (Making It Happen, 1999). Consumer/survivor initiatives and peer support are essential elements to support recovery from mental illness. The Ministry has already acted on this principle by providing some funding for peer support and consumer/survivor initiatives. More recently, the Ministry provided additional dedicated funding

to LHINs for consumer/ survivor initiatives and it is essential that this funding be protected and included in any new model for allocations going forward. The recent Accountability Agreements signed between LHINs and the Ministry identify a range of community mental health and addictions services that must be protected and delivered through dedicated funding envelopes, including consumer survivor initiatives.

Current work taking place to develop HBAM, within the Health System Investment and Funding Division must be integrated and aligned with other policy directions and initiatives occurring in the Ministry of Health and Long-Term Care, particularly within the Health System Strategy Division and the Health System Accountability and Performance Division.

HBAM's proposed approach for constructing electronic health profiles and assigning clinical groups is not a valid indicator of utilization of mental health and addiction services

The current HBAM funding formula proposes capturing reference volume and costs from aggregated client profiles based primarily on ICD-10 codes, and potentially, physician billing. It is well-recognized that individuals with a mental illness and/or addiction experience significant stigma. Consequently, both mental illness and addiction are less likely than other health conditions to be disclosed by patients and recorded by health providers. Moreover, health providers often receive inadequate training to recognize the root cause of these health problems during a patient encounter. For example, the actual cause of a fall in a senior may be a substance abuse problem. Thus, existing ICD-10 diagnoses have limited validity and reliability in capturing use of the health system by individuals with mental health and/or addictions needs.

Persons with a mental illness and/or addiction are frequently unable to access primary health care due to the shortage of family physicians, and there are waiting lists to see psychiatrists. Even if you were to include OHIP billing data, as mentioned in our meeting, the model would not take into account the percentage of persons with mental health and/or addiction needs who are using the services of community health centres (CHCs) and other capitation models of primary care. Given that Ontario has been undergoing primary care reform for over two decades, proposing the inclusion of OHIP data alone will not capture the extent of primary care services provided in this province to persons with a mental illness and/or addiction.

HBAM must address issues of equity

According to the Ministry's presentation, HBAM will satisfy the principles of "equitable access to services" and "account for differences in health and need for service" (slide deck, page 8). Basing HBAM on ICD-10 codes and institutional utilization alone means that it will not capture the needs of Ontario's most disadvantaged populations, who have high health needs but continue to experience inequitable access to health. For instance, Steele (2007) found that increasing levels of education was associated with increasing use of family doctors, psychologists, psychiatrists and social workers by individuals with anxiety or depressive

disorders.¹ Newbold (1995) found that there was a positive relationship between household income and incidence of hospital utilization.²

When we review page 14 of the HBAM presentation, entitled, 'Sample: HBAM Acute Care Population Grouper', we note that no adjustment has been made for low socio-economic status in clinical groups with mental health diagnoses or alcohol-related disorders. This is not surprising, as individuals with a mental disorder or addictions related diagnosis using institutional services tend to be less disadvantaged than those who are not accessing these services (consistent with the findings of the above noted studies). It is essential that a funding formula such as HBAM acknowledge the current inequitable access to services and incorporate in the funding formula the use of services which have been designed to reach out to people with mental health and addiction needs – who are among the most marginalized and disadvantaged in society. Specifically, this means community based mental health and addictions services. These programs have been designed to support individuals in their recovery, responding to both episodic and long-term complex needs.

HBAM must incorporate currently available data on utilization from community mental health and addiction services and supports

HBAM does not currently include in its formulation the significant volume of services delivered in the community mental health and addictions sector. This comprehensive basket of services for mental health and addictions is consistent with current policy directions for Ontario. For example, community mental health programs include assertive community treatment (ACT) teams, intensive case management, counseling, diversion and court support, social recreational, employment support, peer support, etc. Excluding utilization data from community mental health and addiction services and supports will threaten the Ministry's goal of promoting care in the community, as what doesn't get measured is at risk of not being funded.

We caution against the assumption that one standard funding formula, i.e. the one developed for institutional settings, will support integration and can be applied to "rebalance the system by promoting care in the community" (HBAM slide deck presentation, page 7). As we have already detailed, there is inequitable access to current services and the identification of persons with mental illness and/or addictions is under-reported in the institutional and acute care system.

Data on community mental health service utilization and costs in Ontario are already being collected through the 'Common Data Set – Mental Health' and Management Information System reporting, commonly known as the CDS / MIS system. Similarly, addiction services submit data to the Drug and Alcohol Treatment Information System, (DATIS), an initiative of the Ministry of Health and Long-Term Care operated by the Centre for Addiction and Mental Health. At this critical juncture in the development of a health based allocation model for Ontario, it is imperative that the government incorporate existing sources of data which measure the vital community based system. While there is a desire to promote integration by harmonizing clinical groups between institutional and community-based services, community mental health and addiction services have unique client classifications that are not based on medical model

¹ Steele L, Dewa C, Lin E. (2007). Education Level and Mental Health Services Use in Canada: Associations and Policy Implications. *Healthcare Policy*. 3(1): 96-106.

² Newbold K, Eyles J, Birch S. (1995). Equity in Health Care: Methodological Contributions to the Analysis of Hospital Utilization within Canada. *Social Science and Medicine*. 40(9): 1181-1192.

diagnoses and these categories will need to be incorporated into the 'clinical' groups used within the funding formula.

HBAM must consider what is appropriate funding to deliver community services

The funding formula must not just focus on re-portioning the existing funding pie through a focus on reference cost, but determine what are reasonable costs for programs in order to deliver services. For instance, program standards exist for many services and agencies must meet these requirements. And, additional program standards will soon be in development.

In addition, program expansion in the community mental health sector has created challenges in health human resource recruitment and retention, as the salaries available to these programs are not competitive with those being offered in institutions and with family health teams. This situation is exacerbated in the addiction sector which has not seen the same expansion as mental health. Inadequate funding also restricts the ability of our sector to adequately address infrastructure needs, such as facilities, information technology and the anticipated costs of integration initiatives.

Focusing on utilization does not address unmet need

Referring to your presentation, Calculating Fair Share to a LHIN (slide deck, page 10), we note that you equate current reference volume with 'needs'. Using the standard language of community-based planning, need is *what people can benefit from*. It appears that the HBAM model has been created to (re)allocate existing funding using a risk adjustment approach. While we appreciate that resources for a publicly funded health system are finite, the mental health system lacks adequate capacity to respond to the needs of some of Ontario's most vulnerable and marginalized citizens, and the addiction treatment system fares even more poorly. Thus, we raise the question as to how HBAM will address unmet needs.

A recent study by Durbin (2007), funded by the Ministry of Health and Long-Term Care found that funding to LHINs for community mental health programs varied widely, from \$12 to \$104 per capita.³ This is contrary to what is identified on page 24 of your slide deck, wherein you indicate the community mental health is currently funded on a per capita basis under traditional population needs-based model. In fact, we know anecdotally that there is high demand for community mental health and addiction services, which is unable to be met with existing capacity.

HBAM currently lacks any specifics or targets that give direction on how funding decisions should address priority *unmet* needs. New Zealand is one country that is currently applying a needs-based approach to health service. Again, we strongly support the integration of the funding formula with the Health System Strategy Division of the Ministry. As this plan will establish overall directions for improving health in Ontario, it is important that health care funding be allocated in ways that support these directions.

³ Seeing a Difference: Demonstrating the Impact of New Investments in Our Community Mental Health System. June 2007. <http://www.ontario.cmha.ca/seei.asp?CID=23033>

Our Suggestions

1. The development of the mental health and addictions model for HBAM should take be fully aligned with a vision for improving health and health care in Ontario and specifically, directions for mental health reform and an addictions strategy being led by the Health System Strategy Division of the Ministry.
2. HBAM must be aligned with the expectations already established through the Ministry – LHIN Accountability Agreements with respect to dedicated and protected funding allocations for some mental health and addictions services.
3. The mental health and addictions model for HBAM should incorporate data from community mental health and addictions programs.
4. We believe there are lessons to be learned from other jurisdictions who have implemented funding formulas in regionalized systems. For example, Greg Finlayson, principal author of Manitoba’s ‘Allocating Funds for Healthcare in Manitoba Regional Health Authorities: A First Step – Population-Based Funding’, has initiated a new approach for moving beyond a user-based approach to a population-based approach.
5. Developing a funding formula across the health care spectrum is a task that requires specialized knowledge and experience with what is occurring in the field. For this reason, we recommend that the Ministry consult further with the mental health and addictions sector, including consumers of these services.

Our partnership is available to work with you to convene an ad hoc working group of both LHIN leaders and stakeholders within mental health and addictions to support the development of HBAM for the mental health and addictions sector.

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