



Grouping and Weighting Methodology for Adult Inpatient Mental Health Care in Ontario

Summary Report from the JPPC Mental Health Technical Working Group

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Ontario Joint Policy and Planning Committee

415 Yonge Street, Suite 1200 Toronto, Ontario M5B 2E7

Tel: 416-599-5772 • Fax: 416-599-6630 • Web: www.jppc.org

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Mental Health Technical Working Group

Karim Mamdani (**CHAIR**), Whitby Mental Health Centre
Brenda Antliff, MOHLTC
Andrew Arifuzzaman, CAMH
Chuck Botz, London Health Science Centre
Michelle Caplan, OHA
Yuriy Chechulin, JPPC
Lezlee Cribb, CIHI
Imtiaz Daniel, JPPC
Sue Garton, St. Joseph's Healthcare – Hamilton
Darren Gerson, CIHI
John Hirdes, University of Waterloo
Steve Isaak, JPPC
Ian Joiner, CIHI
Peter Kennedy, Hotel Dieu Hospital – Kingston
Cathy Langlois, Sudbury Regional Hospital
Margaret Mao, Sunnybrook Health Sciences
Patty Montague, University of Waterloo
Kevin Murphy, CIHI
Edgardo Perez, Homewood Health Centre
Jason Sutherland, MOHLTC
Sue Turcotte, MOHLTC
Peggie Willett, CAMH
Kevin Yu, MOHLTC

All inquiries pertaining to this document should be directed to:

Imtiaz Daniel
Joint Policy and Planning Committee
415 Yonge Street, Suite 1200
Toronto, ON M5B 2E7
Tel: 416-599-5772
Fax: 416-599-6630
Email: idaniel@jppc.org

Executive Summary

Background

The Ontario Joint Policy and Planning Committee (JPPC) is a partnership between the Ontario Ministry of Health and Long-Term Care (MOHLTC) and Ontario hospitals through the Ontario Hospital Association (OHA). One of the JPPC's roles is to promote the development of an integrated funding model incorporating all patient activity in hospitals. To date, this model includes information from acute inpatient, day surgery and complex continuing care. The JPPC is working to incorporate emergency, mental health, ambulatory care and adult inpatient rehabilitation into the model.

The inclusion of inpatient mental health into the integrated funding model has progressed in recent years. As of October 1, 2005, all Ontario hospitals with MOHLTC-designated inpatient mental health beds began collecting inpatient mental health activity data using the Ontario Mental Health Reporting Systems (OMHRS). The implementation of the OMHRS was mandated by the MOHLTC as per the recommendations of the former JPPC Psychiatric Working Group (PWG).

JPPC Mental Health Technical Working Group

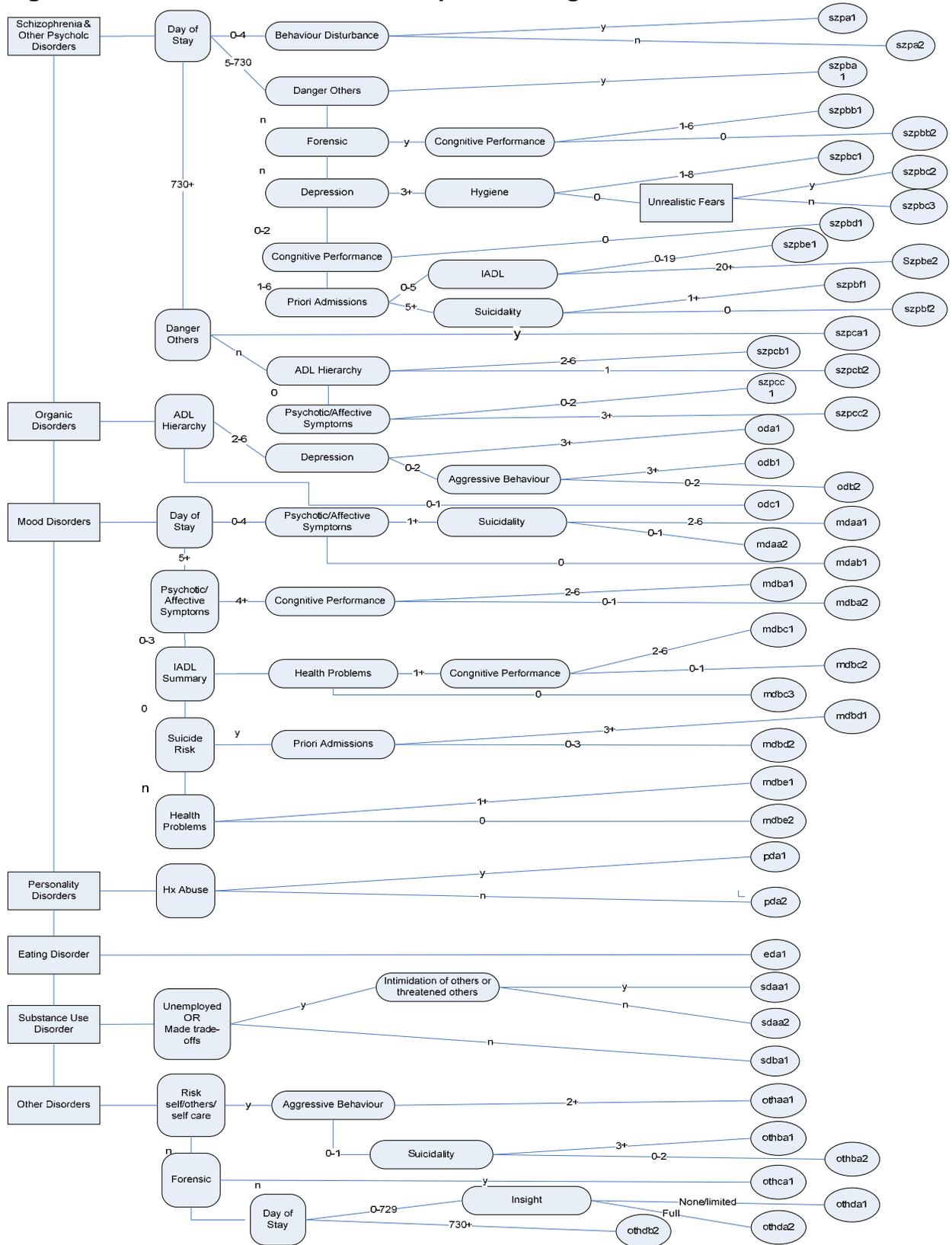
In 2006, the JPPC formed the Mental Health Technical Working Group (MHTWG) with the mandate to evaluate and refine the System for Classification of In-Patient Psychiatry (SCIPP) grouper and develop the associated weights, and to recommend an appropriate basis for funding inpatient adult mental health care in Ontario.

The MHTWG's membership includes management and clinical representation from facilities with inpatient adult mental health programs, secretariat staff of the Ontario Hospital Association (OHA) and the JPPC, and representatives from the Ministry of Health and Long-Term Care (MOHLTC), interRAI and the Canadian Institute for Health Information (CIHI). The MHTWG has also utilized a technical sub-group with members who were chosen based on their statistical, costing and case-mix experience. Additional physician participation, when required, was obtained on an ad hoc basis.

Overview

The MHTWG reviewed the original research SCIPP grouper developed in 2002. A few changes were recommended to be made to the grouper. The MHTWG recommended that records with no provisional diagnoses be assigned to a SCIPP category called Ungroupable (category 8) and that records for Short Stay episodes be assigned to a category called Short Stay (Category 0). As well, splits within the "Substance Use" category were modified. In addition to these changes to the research SCIPP grouper, the MHTWG made a few changes to the grouper to improve consistency across groupers and to correct minor cross-walk issues. The recommended SCIPP grouper is shown below.

Figure 1. Overview of the SCIPP Groups and Weights



The weights shown for the groups are the same published in the STM study with the minor changes for the substance use disorder groups. The MHTWG recommended SCIPP associated weights to be used for funding. These weights were derived from a model where the SCIPP group CMI are adjusted by $1 + \alpha * \text{CMI}$. The model coefficient, α , will be updated annually using the Ontario Case Costing Initiative (OCCI) data. In the review, the MHTWG examined the 2005/06 OCCI data where the model had an alpha of 0.215.

Summary of Recommendations

General Recommendations

The MHTWG recommends that:

1. *the SCIPP classification methodology be adopted by MOHLTC for adult inpatient mental health activity.*
2. *the associated weights, developed by the JPPC based on model $1 + \alpha * \text{STM CMI}$, be adopted by the MOHLTC.*
3. *the facility CMI for new admissions be used for short stay mental health patients.*
4. *the MOHLTC request that CIHI include the SCIPP classification methodology and its associated weights with OMHRS vendor specifications for 2009-2010, which are scheduled for release in the Fall of 2008.*
5. *the MOHLTC works with CIHI to provide OMHRS SCIPP reports on a quarterly basis to participating Ontario facilities.*
6. *the MOHLTC request that CIHI include facility comparative information in the OMHRS SCIPP quarterly reports with the associated case weights to participating facilities beginning with the Quarter 1 2009-2010 reports. To ensure usefulness and data quality, MOHLTC and CIHI facilitate a process to provide hospitals with reports in the interim.*
7. *the Cost per SCIPP weighted patient data be issued by the MOHLTC in 2008 to the field for a transition period no less than one year before being used for funding.*
8. *the MOHLTC work with the LHINs, JPPC, CIHI and the OHA to coordinate the education on the SCIPP classification methodology and its associated weights starting in the Fall of 2008.*
9. *further work be conducted on forensic populations, through the JPPC, to validate the appropriateness of the recommended grouper system for measuring the resource impact of these populations.*

10. the MOHLTC, CIHI and the JPPC continue to explore methods to improve the quality of the OMHRS and Mental Health OCDDM data and the interface between data quality and funding.

Technical Recommendations

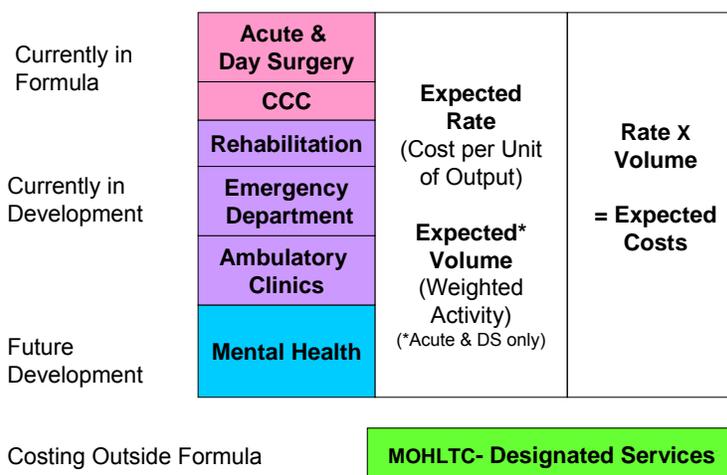
- 1. re-calculate the weights on an annual basis by the MOHLTC.*
- 2. In the long term the JPPC MHTWG explore using hospital patient level costing data to compliment the STM data.*
- 3. re-visit the weighting of patients, including short stay, based on more current data.*
- 4. the MOHLTC review the data quality of reported service interruption days and explore auditing processes.*

Background

Over the past decade, the Ontario Joint Policy and Planning Committee (JPPC) has gained considerable expertise in the development and implementation of hospital funding methodologies based primarily on hospital statistics and data from inpatient acute care and day surgery. (For a detailed overview of the JPPC, see Appendix A). A key contribution of the JPPC has been the development of the Integrated Population Based Allocation (IPBA) methodology.

The IPBA was first developed in 1999. It was adopted by the Ministry of Health and Long-Term Care (MOHLTC) and has since been used to allocate over a \$1 billion in incremental funds to hospitals. The IPBA methodology is comprised of two independent models: the Rate model and the Volume model. The 2005/06 and 2006/07 IPBA funding methodology is based on a formula of *Expected Rate x Expected Volume*.

Figure 1: JPPC Funding Model



The figure above is a schemata of the work of the JPPC Hospital Funding Committee (HFC) and its working group(s) whose mandate is to develop a comprehensive and harmonized funding methodology for Ontario. One of the key priorities set by the JPPC is to increase the comprehensiveness of cost and utilization models. Patient grouper and weighting tools to reflect acuity, resource intensity and volume of services are required in order to accomplish this priority. To date, the JPPC has incorporated acute inpatient, day surgery, and complex continuing care into the rate model and eventually intends to capture almost all hospital activity under the funding formula. Current work is related to evaluation and/or development of weighting methodologies for emergency department, selected ambulatory clinic procedures (cardiac catheters, dialysis, and oncology services) and rehabilitation. Regarding mental health, the

MOHLTC has recently mandated the collection of inpatient mental health activity using the Ontario Mental Health Reporting System (OMHRS); the first full year of data collected will be 2006/07, with some data from 2005/06. Hence, it will be possible for the JPPC to begin work evaluating inpatient mental health data next year.

JPPC Mental Health Technical Working Group

As of October 1, 2005, all Ontario hospitals with MOHLTC-designated adult mental health beds began collecting and submitting adult inpatient mental health activity data to the Canadian Institute for Health Information's (CIHI) Ontario Mental Health Reporting System (OMHRS). The implementation of OMHRS was mandated by the MOHLTC as per the recommendations of the JPPC Psychiatric Working Group in early 2003 as follows:

The classification and assessment tool for use as a basis for hospital mental health resource allocation, quality indicators, outcome measurement, and care planning in Ontario should be based upon the RAI-MH instrument.

During the fall of 2006, the JPPC established the Mental Health Technical Working Group (MHTWG). Members for the MHTWG were selected after consultation with the Ontario Hospital Association (OHA) and the Ontario Ministry of Health and Long-Term Care (MOHLTC). Members of the MHTWG had experience regarding various aspects of working with mental health care including clinical research, outcome measurement, quality indicators, reliability and validity testing, and implementation. The MHTWG held its first meeting in December 2006 during which the terms of reference (see Appendix C) and work plan were produced.

Mandate

The mandate of the MHTWG was to evaluate the SCIPP grouper and weights developed by interRAI in 2003 and to recommend a methodology that makes it possible to incorporate adult inpatient mental health activity into the Ontario hospital funding formula. Since the OMHRS dataset is relatively new, the MHTWG reviewed the current MIS and OCDM data related to mental health to ensure consistency and appropriateness of data reporting for use with OMHRS data.

Presentations

In order to become familiar with the data sets used in the evaluation and selection of case mix systems used for funding, the MHTWG reviewed components of the current inpatient acute funding system including:

Management Information Systems (MIS) - The MIS Guidelines, supported by CIHI, provide a standardized framework for collecting and reporting financial and statistical

data on the day-to-day operations of health service organizations. Core components of the MIS Guidelines are: Chart of Accounts, Accounting Guidelines, Workload Measurement Systems, Indicators and Management Applications.

Ontario Hospital Cost Distribution Methodology (OCDM) - The primary objective of the OCDM methodology is to allocate a hospital's costs across discrete and comparable patient activity categories or "buckets" at the facility level and at the departmental level. These patient activity categories are: Acute Inpatient, Newborn and Same Day Surgery, Rehabilitation, Chronic and Respite Care, Mental Health, Elderly Extended Care Program (ELDCAP), Emergency Department, Hospital Outpatients including Outpatient Mental Health, and Other Hospital or Community Outpatients. The allocation model is dependent on financial and statistical data provided in hospital MIS submissions.

Ontario Case Costing Initiative (OCCI) - The OCCI database is a patient-specific case cost database of acute inpatient and day surgery data from participating hospitals. For each patient there are two sources of data that make up the case cost record. The first is the cost data from hospitals that has been produced based on the OCCI costing methodology. The second is the patient discharge abstract collected by CIHI. The discharge abstract contains patient descriptive, demographic and clinical data. The patient descriptive component contains the data elements required for grouping patients by patient classification systems, e.g., CMGs (case mix groups), DRGs (diagnosis related groups).

Currently there is no specialty mental health facility that participates in the Ontario Case Costing Initiative project. The MOHLTC has recently recruited one specialty mental health facility.

Work Plan Overview

The following are the deliverables/milestones established by the MHTWG:

- **Review the current SCIPP grouper and weights** – Investigate and review the SCIPP grouper and weights developed in 2003 using the OMHRS data collected from October 2005 to March 31, 2007;
- **Recommend grouper and weights** – Perform statistical analyses regarding the grouper and weights development.
- **Review the quality of the data** – Perform analyses on the current MIS and/or OCDM data related to mental health to ensure consistency and appropriateness of data reporting.
- **Review success factors** – Discussion of issues including data quality that lead to final recommendations of grouper and weighting methodologies.

- **Prepare high-level implementation plan** – Discussion of suggested timelines for education within the field and feedback from parent committees of the JPPC will be established as well as suggested timelines for implementation.

The following sections deal with each of these deliverables in detail.

Mental Health Technical Working Group Workplan	2006/07		2007/08				2008/09			
	Fall	Winter	Spring	Summer	Fall	Winter	Spring	Summer	Fall	Winter
Review of Terms of Reference, Work Plan and Membership	✓									
Initial look at criteria, including background discussion	✓									
Perspectives from CIHI, MOHLTC and other jurisdictions		✓								
Orientation to MIS/OCDM, OCCI and CIHI CCRS			✓							
Funding formula development overview			✓							
Overview of grouper methodology		✓								
Review of Changes to SCIPP			✓	✓	✓					
Review of Weights - Explore difference between OCCI and STM weights				✓	✓	✓	✓			
Short Stay Patients Analyses			✓	✓	✓	✓	✓			
Recommend the adoption of a grouper					✓	✓	✓			
Recommend the adoption of associated weights					✓	✓	✓			
Prepare implementation plan							✓	✓		
Proposed education plan							✓	✓	✓	

The System for Classification of In-Patient Psychiatry (SCIPP)

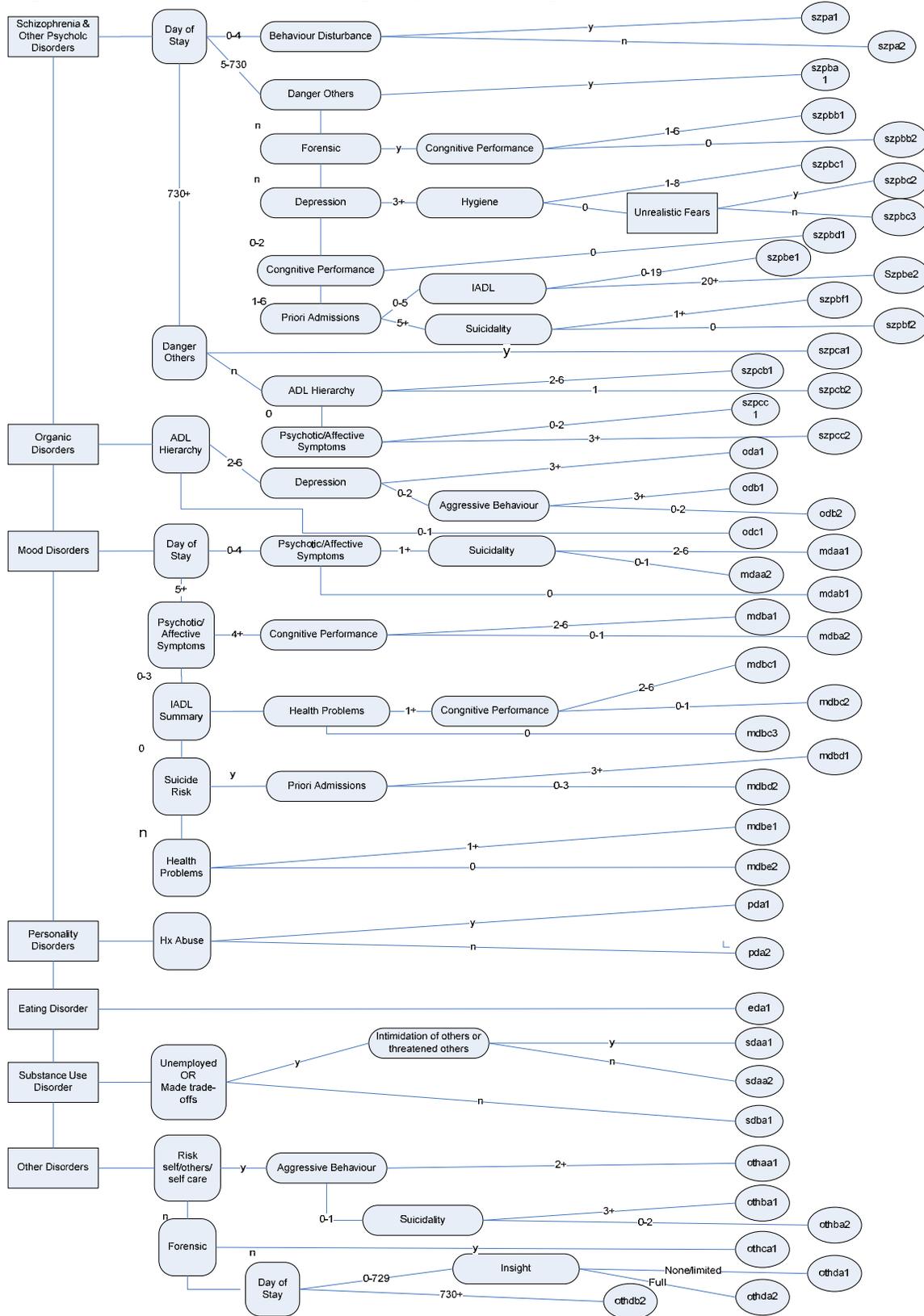
SCIPP Background

In 2003 the JPPC and interRAI developed the System for Classification of In-Patient Psychiatry (SCIPP) based on the RAI-Mental Health (RAI-MH). (See www.jppc.org for more details). A Staff Time Measurement (STM) study was used to develop a per diem case mix model for describing resource use in all adult in-patient psychiatric setting in Ontario including acute, long stay, forensic and geriatric psychiatric units. Data on psychiatric in-patients were gathered with the aim of describing per diem resource use, clinical characteristics based on the RAI-MH, and length of stay. The sample was comprised of adult psychiatric in-patients aged 18 years and over in 34 psychiatric facilities in 3 Canadian provinces (Ontario, Manitoba and Alberta).

Figure 2 presents the final System for Classification of In-patient Psychiatry (SCIPP) case-mix model for use with the RAI-MH. The SCIPP is a seven-level hierarchical model that divides patients into 47 groups with CMLs ranging from 0.26 to 2.17 – over an eight-fold range between the extreme groups.

SCIPP divides patients first according to the provisional psychiatric diagnosis recorded in the RAI-MH. The primary diagnostic categories considered in hierarchical order are schizophrenia and other psychotic disorders, organic disorders (e.g., Alzheimer's disease and related disorders), mood disorders, personality disorders, eating disorders, and substance-abuse disorders. The remaining general DSM categories (e.g., adjustment disorders) were too small in number to warrant a separate category independent of these other diagnoses. The balance of the splits in the decision tree were made primarily in relation to clinical variables such as aggression, depression, suicidality, psychotic and affective symptoms, extrapyramidal symptoms, disability, and medical problems. Day of stay was used in a limited number of cases, particularly because the earlier bivariate analysis had shown a substantial difference in per-diem costs in the initial days of the episode. In addition, in the case of individuals with schizophrenia, a substantial proportion of patients had long stays. The clinical factors affecting care for these individuals was found to differ across long episodes of care.

Figure 2. Overview of SCIPP groups and weights



The JPPC Psychiatric Working Group (PWG) reviewed the original research SCIPP grouper developed in 2002 (See The System for Classification of In-Patient Psychiatry (SCIPP): A New Case-mix Methodology for Mental Health, www.jppc.org). The PWG, as part of the review, recommended that a number of changes be made to the RAI-MH assessment tool used for the research. The changes to the RAI-MH were accepted and implemented for OMHRS. The research SCIPP methodology was subsequently cross-walked from the research assessment tool to the OMHRS tool.

SCIPP Refinement

The MHTWG reviewed the 2003 SCIPP grouper using the OMHRS data for Ontario. A few refinements to the original SCIPP grouper are recommended. The MHTWG recommended that

- Assessments with no provisional diagnoses should be assigned to a SCIPP category called Ungroupable (category 8).
- Short Stay assessments (usually with little clinical information) should be assigned to a SCIPP category called "Short Stay" (category 0).
- A minor inconsistency within the "Substance Use" category was identified and the splits within that category have been modified.
- Modify the Cognitive Performance Scale (CPS), the Aggressive Behaviour Scale (ABS), "Danger to others" and "Behaviour Disturbance" calculations within the SCIPP methodology so that the calculations are consistent with updated interRAI standards for these indicators.

These changes are discussed below.

Ungroupable, Category 8

The SCIPP categories are derived from a hierarchical algorithm that uses psychiatric diagnostic information as an organizing principle to cluster together patients with similar clinical profiles. In figure 1, the variables to the right of the major categories define the resources used. Therefore, data with missing values for SCIPP variables, particularly provisional diagnosis, are problematic and may lead to episodes being "ungroupable". If a patient comes with more than one diagnosis, the grouper works on a hierarchy and will look at all diagnoses and assigns the patient to the highest diagnostic section of SCIPP regardless of the position of the diagnosis. For example, even if the third diagnosis is schizophrenia, the patient will be in the schizophrenia groups.

As of December 1, 2006 OMHRS data, there were many assessments with no diagnostic information. There are approximately 9,266 short stay assessments from 11,760 that have no Q1 diagnosis. Q1 is the provisional assessment diagnosis and is not the definitive diagnosis. The provisional diagnosis is currently optional for short

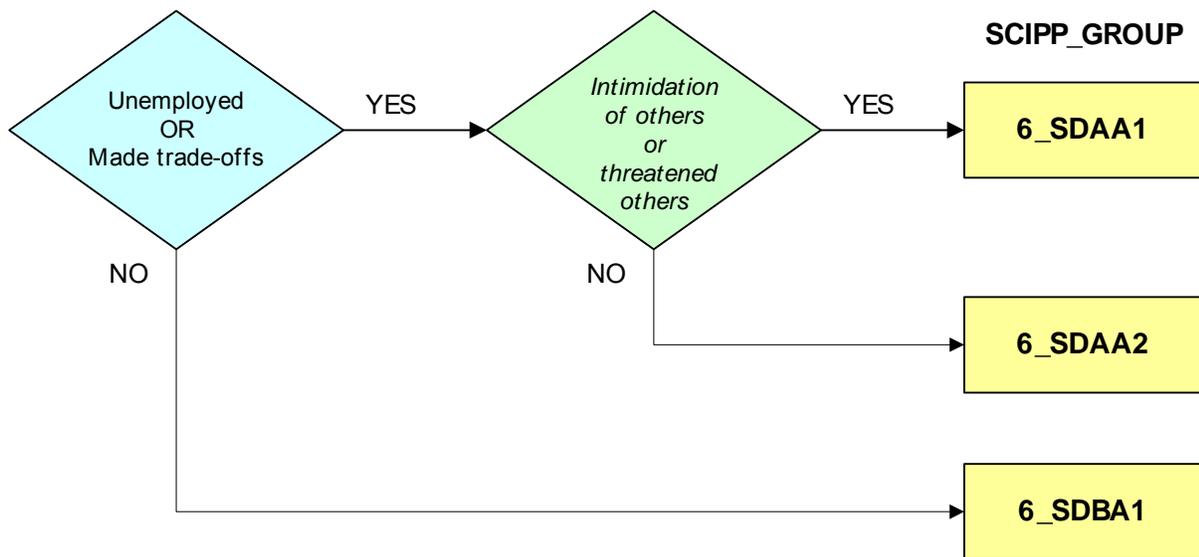
stay patients. The MHTWG recommended that records with no provisional diagnoses be assigned to a SCIPP category called Ungroupable (category 8). Although the committee did not recommend mandating the reporting of provisional diagnosis, the MHTWG encourage hospitals to report more information for short stay patients, thus lowering the number of records in this category. Provisional Diagnosis is mandatory for full assessment.

Substance Related Disorder

The research SCIPP algorithm had 3 groups in the substance use disorder category. After the provisional diagnosis of substance use disorder is reported, the first split point is the presence of any symptoms/impairment. If no, economic status is used to split patients into two terminal cells.

A minor problem was identified with the research methodology - no differentiation was made between "some" and "many" symptoms/impairment. OMHRS records with "many" symptoms/impairment were grouped in the same way as those with "zero" symptoms.

To address this issue the MHTWG recommended that the grouper be reworked using the research data. For the new splits within Substance Use category, the first split will be on Economic Hardship; "no" are the lowest cost group; "yes" are further split based on D2b (intimidation of others or threatened others). These changes are more intuitive and the explained variance is higher at 30%.



Other Changes

A few changes to the SCIPP 2003 grouper were necessary. These changes were necessary to achieve consistency across other sectors, and to allow clinicians and users to easily follow the methodology by changing some variable names.

As stated earlier, the data in the original SCIPP 2003 grouper was crossed walked from the RAI-MH version 1 to the RAI-MH version 2. During the review, the MHTWG identified corrections to the cross walk program. These changes including the previously discussed changes were reviewed by the MHTWG. The accompanying technical report (SCIPP Grouper for Adult Inpatient Mental Health Activity in Ontario) describes these changes in more detail.

Segmented SCIPP grouping methodology

The MHTWG discussed how to use OMHRS assessments for the production of weighted patient day reports. An important consideration in mental health data is that the first days of stay are typically the most resource intensive. Since a typical OMHRS episode begins with an assessment after three days followed by another much later the challenge is determining which SCIPP group from which assessment should cover the patient days after the admission assessment.

The MHTWG recommended that each assessment be assigned three SCIPP group values associated with a patient day of stay and the appropriate value be used with the weighting. These are:

SCIPP_1_TO_5

SCIPP_6_TO_730

SCIPP_731_PLUS

Please see the accompanying Technical Report for more details.

Development of Cost Weights for Funding

During the development of the SCIPP grouper in 2003, CMIs for each of the 47 groups were established. These CMIs represented the nursing, non-nursing and total staff costs and excluded fixed costs such as administration, meals, environmental services (e.g. heating, lighting), laundry, and non-clinical staff. In order words, the CMIs dealt

with the variable portion of patient-specific costs excluding psychiatrists, drugs and diagnostic procedures.

Since the funding formula required total cost per diem, the MHTWG reviewed methods to establish the total cost per diem. Using an assessment framework to assist with the final decision, the MHTWG recommended using a model which calculates the weight for each group to be used for funding and accountability purposes. The model is $\text{Cost/day} = \$404 + \$83 * \text{SCIPP CMI weight}$ or the new weight per group is $1 + 0.215 \text{ SCIPP weight}$. Development of SCIPP grouper associated weights to be used for funding is described in the accompanying technical report (Adult Inpatient Mental Health Case Mix Classification Methodology and Weighting System).

Calculation of cost/SCIPP Weighted Patient Day (SWPD)

Calculation of SCIPP Weighted Patient Days

In the funding system being developed for Inpatient Mental Health in Ontario, the basic units of patient volumes are days of patient care (patient days). The MHTWG assumes that funding equity will be introduced by weighting the days of care for patients by the resource intensity of their care relative to that of the “average” Mental Health patient in Ontario. These SCIPP case-mix index weighted patient days are labeled as SCIPP weighted patient days (SWPD).

Calculation of SCIPP-weighted patient days involved the following five distinct steps:

1. SCIPP classification for each OMHRS assessment associated with an episode of care.
2. Derivation of the Short Stay Facility CMI using admission assessments.
3. Calculation of the patient days associated with the SCIPP classification for each OMHRS assessment within an episode.
4. Weighting of patient days
5. Calculation of the facility total SWPD and a facility summary score, the Facility Case-Mix Index.

Linkage of SCIPP-weighted Patient Days to Facility Cost Data from the Management Information Systems Data

Based on financial data supplied by all hospitals to the Ontario Ministry of Health in compliance with Management Information Systems (MIS) requirements, the Ontario Cost Distribution Methodology (OCDM) is used to allocate costs to Direct Care costs and Overhead costs. (For a detailed examination of the OCDM applied to 2006/07 data, see MOHLTC OCDM Document, www.mohltcfim.com). Hospitals with different levels of care (e.g. mental health, chronic care, rehabilitation, acute care) must

appropriately allocate costs to the different levels of care when submitting their MIS data to the MOHLTC. The MIS data submission process is audited by the MOHTC. Direct Care Costs and Total Costs allocated to inpatient mental health were derived for each hospital with adult inpatient mental health beds. The data were divided by Total SWPD to yield facility Total Cost per SWPD (Appendix).

Short Stay episodes

Short Stay episodes are periods of time where the patient was an in-patient for less than 72 hours. Typically, there is very little clinical information available for these periods of care. However, the costs of these Short Stay episodes in a hospital are captured in the OCDM. To calculate the cost per SCIPP weighted patient day for a hospital, the MHTWG recommended that a Short Stay facility CMI be developed by computing the facility CMI for newly admitted patients in a fiscal year. Therefore, the number of short stay weighted patient days in a hospital is computed using the short stay facility CMI and the number of short stay patient days.

Summary of Recommendations

General Recommendations

The MHTWG recommends that:

1. *the SCIPP classification methodology be adopted by MOHLTC for adult inpatient mental health activity.*
2. *the associated weights, developed by the JPPC based on model 1 + alpha * STM CMI, be adopted by the MOHLTC.*
3. *the facility CMI for new admissions be used for short stay mental health patients.*
4. *the MOHLTC request that CIHI include the SCIPP classification methodology and its associated weights with OMHRS vendor specifications for 2009-2010, which are scheduled for release in the Fall of 2008.*
5. *the MOHLTC works with CIHI to provide OMHRS SCIPP reports on a quarterly basis to participating Ontario facilities.*
6. *the MOHLTC request that CIHI include facility comparative information in the OMHRS SCIPP quarterly reports with the associated case weights to participating facilities beginning with the Quarter 1 2009-2010 reports. To ensure usefulness and data quality, MOHLTC and CIHI facilitate a process to provide hospitals with reports in the interim.*
7. *the Cost per SCIPP weighted patient data be issued by the MOHLTC in 2008 to the field for a transition period no less than one year before being used for funding.*
8. *the MOHLTC work with the LHINs, JPPC, CIHI and the OHA to coordinate the education on the SCIPP classification methodology and its associated weights starting in the Fall of 2008.*
9. *further work be conducted on forensic populations, through the JPPC, to validate the appropriateness of the recommended grouper system for measuring the resource impact of these populations.*
10. *the MOHLTC, CIHI and the JPPC continue to explore methods to improve the quality of the OMHRS and Mental Health OCDM data and the interface between data quality and funding.*

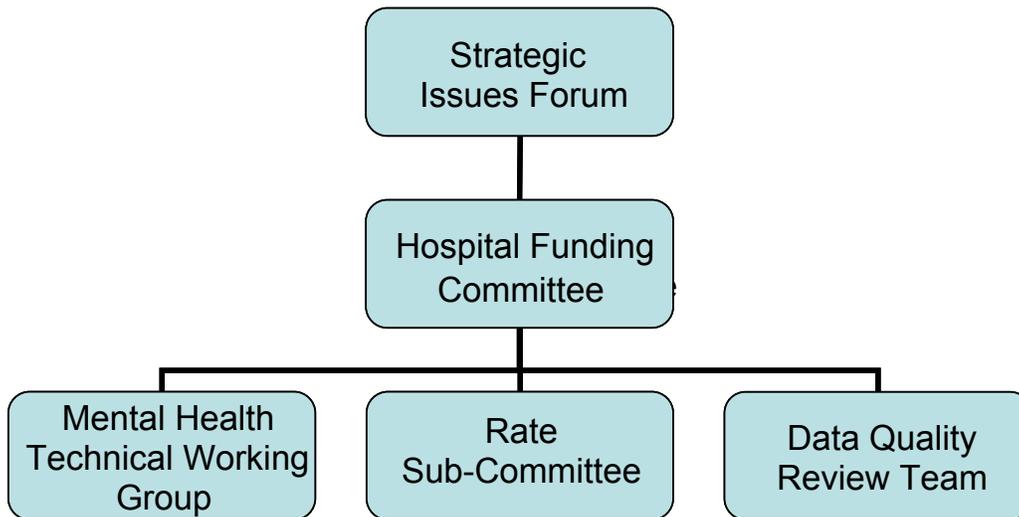
Technical Recommendations

1. *re-calculate the weights on an annual basis by the MOHLTC.*
2. *In the long term the JPPC MHTWG explore using hospital patient level costing data to compliment the STM data.*
3. *re-visit the weighting of patients, including short stay, based on more current data.*
4. *the MOHLTC review the data quality of reported service interruption days and explore auditing processes.*

JPPC Report Approval Process

The JPPC has a formal reporting structure and approval process. The MHTWG is a working group of the JPPC Hospital Funding Committee (HFC), which is charged with the development of funding methodologies for Ontario hospitals. The organizational chart below shows the relevant committees / groups discussed in this report and their reporting relationships.

JPPC Committee Structure



The MHTWG reports will be reviewed by the HFC and the Strategic Issues Forum (SIF) in Summer, 2008. Once approved, the reports will be submitted to the MOHLTC for implementation.

Proposed Implementation Plan

Once the JPPC releases this report, implementation of the recommendations will require timely action by many stakeholders. The MHTWG recommends that the MOHLTC request that CIHI adopts the SCIPP grouper and its associated weights and provide reports on a quarterly basis to participating Ontario facilities. Additionally, the JPPC Data Quality Review Team (DQRT) will need to review the quality of refreshed inpatient mental health cost per SCIPP weighted patient day using 06/07 data.

The MHTWG recommends that data should be issued to the field on a one-year trial using 07/08 data before 08/09 data are incorporated into the funding formula. From experience with the acute and complex continuing care data, it is known that some time is required to improve data quality before it is considered suitable to be used in the funding formulae. After the DQRT approves the quality of mental health data to be used in the funding formulae, the JPPC will pursue the incorporation of mental health cost into the Ontario Cost Distribution Methodology and hospital funding formulae.

Because of the above, the MHTWG proposes that the earliest time by which the MOHLTC could fund hospitals using a JPPC integrated formula that includes mental health cost and activity data is 2010/11. It is the JPPC's intent to create a permanent working group to receive and consider recommendations and/or advice from the field on an ongoing basis after this report is adopted.

A long term development of the SCIPP grouper and weights is recommended. Some of the longer term activities include:

1. Exploring including groups for forensic patients;
2. Further exploring the differences of the STM weights and OCCl derived weights;
3. Exploring other methods of determining the short stay CMLs using provisional diagnosis.

Education Plan

The MHTW recommends an education plan to assist stakeholders to understand the grouper and weights. Some of the venues suggested are:

- Healthcare Financial Managers Working Group Meeting (September, 2008)
- Utilization Managers Network of Ontario (UMNO) (Fall, 2008)
- LHIN Senior Directors Meeting (Summer, 2008)
- Standard CIHI OMHRS education workshops (regularly throughout 2008-2009 and beyond)
- OHA Provincial Mental Health Group meetings
- OHA Convention (November, 2008)
- Provincial Mental Health Networks, for example CORE(Summer, 2008)

APPENDIX A

1. Original JPPC Mandate and Organization:

The JPPC was established in 1992 as the “Joint Ontario Hospital Association/Ministry of Health Policy and Planning Committee”. Its original mandate was to establish a partnership with hospitals through the Ontario Hospital Association and the Ministry of Health in order to:

- Foster a co-operative environment between hospitals and the Ministry of Health to assist the Ministry in making appropriate strategic planning, policy and management decisions for the hospital system and to ensure high quality health care for the people of Ontario;
- Support and assist in the definition of the evolving role of hospitals within a reformed and restructured health care system;
- Contribute to an orderly and systematic shift in direction and development of policy to influence the reforms in the hospital system within a broader health care system; and
- Establish processes whereby stakeholders can be brought together to contribute to a sound policy framework for the institutional health care system.

2. Current JPPC Role and Mandate:

The role, mandate and structure of the JPPC have remained fairly stable over the years, allowing for changes in emphasis and different project priorities. More recently, in recognition of the changing structure of the Ontario health care system, Local Health Integration Networks (LHINs) now participate fully at all levels of the JPPC.

The JPPC consists of:

- A forum where senior leaders of the MOHLTC, OHA and LHINs can discuss urgent issues of the day, as well as emerging and strategic issues (Strategic Issues Forum); and
- A unique collaborative process that fosters partnerships with providers to engage and leverage their expertise and leadership at the health system level.

This collaborative process:

- o Involves knowledgeable stakeholders in key policy initiatives on which the MOHLTC seeks expert input or provider validation, providing a neutral meeting ground to pursue selected collaborative/partnership initiatives;
- o Provides an effective tool for collaboration and communication between the MOHLTC, LHINs and health sector providers; and
- o Allows direct involvement in health policy development, building consensus among stakeholders on important policy/reform initiatives.

At any given time, there are several hundred individuals from hospitals, the Ministry, LHINs and other related organizations who contribute their expertise and leadership through the JPPC. These industry experts are supported by a small secretariat, with close working relationships with Ministry, OHA and LHIN staff.

The JPPC's work is characterized by methodological rigor, built on a solid analytical and research base, which supports a consultative, collaborative, stakeholder-based process. The JPPC's success is built on a track record of providing objective and credible information, coupled with an ability to forge strong relationships with stakeholders, in order to seek their expertise and obtain validation.

APPENDIX B

JPPC Mental Health Technical Working Group Members

		Title	Organization
Karim	Mamdani (CHAIR)	VP Corporate Services and CFO	Whitby Mental Health Centre
Brenda	Antliff	A/Lead, Data Access and Release	MOHLTC
Andrew	Arifuzzaman		CAMH (No longer member of MHTWG)
Chuck	Botz	Co-ordinator Case Costing	London Health Science Centre
Michelle	Caplan	Policy Analyst, Policy and Research	OHA
Yuriy	Chechulin	Consultant	JPPC
Lezlee	Cribb (observer)	Program Lead, Ontario Mental Health Reporting System	CIHI
Imtiaz	Daniel	Consultant	JPPC
Sue	Garton	RAI Coordinator	St. Josephs Healthcare, Hamilton
Darren	Gerson	Senior Consultant, Case-mix	CIHI
John	Hirdes	Associate Professor/Scientific Dir. Homewood Research Institute	University of Waterloo
Steve	Isaak	Executive Director	JPPC
Ian	Joiner	Manager, Rehabilitation and Mental Health	CIHI
Peter	Kennedy	Registered Nurse	Hotel Dieu Hospital, Kingston
Cathy	Langlois	Clinical Manager, Acute Inpatient Psychiatry	Sudbury Regional Hospital
Margaret	Mao		Sunnybrook Health Sciences
Patty	Montague	Consultant	University of Waterloo and Homewood Research Institute
Kevin	Murphy	Consultant - Case Mix	CIHI
Edgardo	Perez	President and CEO	Homewood Health Centre
Lou	Reidel	Director, Health Finance and Research	OHA
Jason	Sutherland	Consultant	MOHLTC
Sue	Turcotte	Mgr, Data Quality & Standards Unit of Health Data Branch	MOHLTC
Peggie	Willett	Director, Decision Support	CAMH
Kevin	Yu	Information Management Coordinator	MOHLTC

APPENDIX C

JPPC Mental Health Technical Working Group – Terms of Reference

PREAMBLE

As part of the MOHLTC goal of having comprehensive high-quality case mix tools for measuring patient activity for hospital system planning and funding, all Ontario hospitals with MOHLTC-designated adult inpatient psychiatric beds have recently started collecting adult inpatient mental health activity data using CIHI's Ontario Mental Health Reporting System (OMHRS).

At this point in time, there exists three quarters of a year of OHMRS data since October 1st, 2005. Both the MOHLTC and CIHI are currently implementing data quality processes for these data and would like to have validation and feedback from hospitals regarding further development of the existing grouper and weights, previously developed by JPPC's RAI-MH committees, in collaboration with InterRAI. Thus, the JPPC has decided that a working group be convened as soon as possible to begin this process.

DELIVERABLES

The Mental Health Technical Working Group will:

1. Review the current SCIPP grouper and weights and provide advice to CIHI and MOHLTC regarding any changes for application to Ontario data.
2. Review the current MIS and/or OCDM data related to mental health to ensure consistency and appropriateness of data reporting for use with OMHRS data.
3. Review critical success factors for implementation of weighted activity for potential planning, funding and/or accountability purposes (i.e., data quality, financial information, and auditing mechanisms).
4. Prepare high-level implementation plan.

REPORTING STRUCTURE

This working group will report directly to the HFC to evaluate progress against each of the deliverables.

MEMBERSHIP

10 – 15 members:

MOHLTC Staff

OHA Staff

CIHI Staff

JPPC Staff

Hospital representation:

Management,

Programs, Operations,

Finance

Academia, Clinician(s)

or others if necessary

APPENDIX D

Glossary of Terms

Management Information System (MIS)

The MIS Guidelines, developed by CIHI, provide a standardized framework for collecting and reporting financial and statistical data on the day-to-day operations of health service organizations. Core components of the MIS Guidelines are: Chart of Accounts, Accounting Guidelines, Workload Measurement Systems, Indicators and Management Applications.

Ontario Case Costing Initiative (OCCI)

The OCCI database is a patient-specific case cost database of acute inpatient and day surgery data from participating hospitals. For each patient there are two sources of data that make up the case cost record. The first is the cost data from hospitals that has been produced based on the OCCI costing methodology. The second is the patient discharge abstract collected by the Canadian Institute for Health Information (CIHI). The discharge abstract contains patient descriptive, demographic and clinical data. The patient descriptive component contains the data elements required for grouping patients by patient classification systems, e.g., CMGs (case mix groups), DRGs (diagnosis related groups).

Currently there is only one freestanding chronic/rehabilitation facility (West Park Healthcare Centre) that participates in the Ontario Case Costing Initiative project. The MOHLTC has recruited other speciality mental health facility for future participation.

Ontario Hospital Cost Distribution Methodology (OCDM)

The primary objective of the OCDM methodology is to allocate a hospital's costs across discrete and comparable patient activity categories or "buckets" at the facility level and at the departmental level. These patient activity categories are: Acute Inpatient, Newborn and Same Day Surgery, Rehabilitation, Chronic and Respite Care, ELDCAP, Hospital Outpatients, and Other Hospital or Community Outpatients. The allocation model is dependent on financial and statistical data provided in hospital MIS submissions.