
MINISTRY OF HEALTH

Mental Health Program - Community Based Services Activity

The Community Based Services Activity is administered by the Mental Health Programs and Services Group. The goal of the Activity is to develop a system that will support people with mental illness in living fulfilling lives in the community. The Activity funds Community Mental Health Programs which include community-based mental health services, children's mental health programs, residential Homes for Special Care and the community psychiatric payment program. For the 1996/97 fiscal year, transfer payments to community mental health service providers totalled approximately \$176 million.

In 1993 the government announced a 10-year strategy for reforming the province's mental health system. The Ministry's policy framework for the reform stated: "Its goal is a comprehensive, coordinated, cost-effective system of services that puts people first."

OBJECTIVES AND SCOPE

The objectives of our audit of the Community Based Services Activity were to assess whether the Ministry had adequate procedures in place:

- to measure and report on the effectiveness of the Activity; and
- to ensure compliance with legislation and that policies and procedures for the approval, processing and payment of transfer payments were adequate and were being followed in an economic and efficient manner.

In conducting our audit we reviewed the operations of the Mental Health Programs and Services Group in Toronto, and the related operations of the Fiscal Strategies Branch and the Supply and Financial Services Branch which process payments for the Activity. We also reviewed and, where warranted, relied on relevant work completed by the Ministry's Audit Branch. In addition, we visited several community mental health agencies and Homes for Special Care.

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OVERALL AUDIT OBSERVATIONS

Significant improvements are required to adequately monitor, assess and report on the Community Based Service Activity's effectiveness in developing a system that will support people with mental illness in living fulfilling lives in the community. In particular, the Ministry needs:

- to monitor its progress toward achieving the goals and objectives of mental health reform;
- to compare the costs and outcomes of community-based care with the costs and outcomes of institutional care for various levels of services/care;
- to define acceptable levels of care, establish benchmarks and standardized outcome measures for community-based mental health services, and monitor service providers against them;
- to assess the appropriateness of services provided and funding levels;
- to accelerate the development and implementation of an appropriate management information system to collect and aggregate accurate and complete service provider data for funding decisions; and
- to establish procedures to enforce operating guidelines for Homes for Special Care.

In general the Activity had adequate procedures in place to ensure compliance with legislative requirements and to ensure that payments were properly approved, processed and paid.

DETAILED AUDIT OBSERVATIONS

MENTAL HEALTH REFORM

Mental health reform initiatives began in 1988 when the Provincial Community Mental Health Committee released a report which envisioned the development of a community-focused, integrated mental health system. The Committee based its recommendations on the philosophy that a "system which emphasized community-focused mental health care services is the best model for strengthening the role of the individual and maximizing his/her health potential."

The Ministry's 1993 policy framework for a 10-year strategy to reform mental health services across Ontario stated that the first priority of reform was meeting the needs of seriously mentally ill individuals, and that the key services and supports needed were case management, crisis intervention, housing and service recipient initiatives. The framework also established targets for reducing the number of psychiatric hospital beds and shifting funding from institutional care to community care. Targets were subsequently developed for increasing the number of case managers and community housing spaces. These targets were set for the end of the fifth and tenth years. However, we were informed that the Ministry had not compared the costs and outcomes of community-based mental health care with the costs and outcomes of institutional care.

In early 1995, the Ministry released "Mental Health Reform Implementation Guidelines for Housing and Support Services." These guidelines were developed by a working group co-

chaired by the ministries of Health and Municipal Affairs and Housing and were “intended to assist the reform of Ontario’s mental health system by aiding in the provision of housing and support services for consumers of mental health services.” The guidelines provided direction for the planning of housing and support services and helped define the roles and responsibilities of key stakeholders. However, we were informed that there has been no subsequent action taken on how the housing targets established in the 1993 policy framework would be met.

At the time of our audit, the Ministry did not have province-wide data available on the current status of mental health reform or the likelihood of meeting the established mental health reform targets. In addition, no periodic evaluations had been conducted on the Ministry’s progress in meeting these targets. Such evaluations would enable the Ministry to determine whether the targets were still appropriate and/or achievable. However, in December 1996 the Ministry approved \$2.8 million to “undertake rigorous evaluation of community mental health services and supports” in order to monitor the progress of mental health reform. In addition, we were informed that proposals were requested by the Ministry for an analysis of its status in meeting the mental health reform targets on a province-wide basis.

Recommendations

To enable any needed corrective action to be taken on a timely basis, the Ministry should periodically evaluate its progress in meeting the mental health reform targets.

To enable it to better plan the future direction of mental health care, the Ministry should develop and compare the costs and outcomes of community-based care with those for institutional care for various levels of services/care.

Ministry Response

The Ministry agrees with the recommendations. The Ministry has developed an evaluation process to monitor shifts in fiscal and bed ratios. When implemented, the Ministry’s Mental Health Minimum Data Set will assist in monitoring hospitalization rates. The Ministry is sponsoring a community mental health evaluation initiative which is being carried out by the Mental Health Consortium. This initiative will supervise research projects in priority mental health reform areas. Through information aggregated from operating plans, the Ministry will also be able to monitor mental health reform targets.

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The Ministry has followed through on a previous audit recommendation to implement a management information system. Mental Health has hired information systems staff to develop mental health databases that will electronically process financial and statistical data received from mental health providers. The Ministry has started a phased implementation of the Mental Health Minimum Data Set which will allow ministry staff to analyze and compare costs of community care and institutional care. The Ministry has sponsored a number of outcome measure initiatives; however, comparisons of outcomes between community and institutional care still present a challenge. As a result, the Ministry will examine this issue further.

COMMUNITY INVESTMENT FUND

In October 1994 the Ministry announced the establishment of a Community Investment Fund to provide funding for programs aimed at diverting severely mentally ill individuals from admission to institutions to community-based services as well as supporting individuals discharged from institutions. The Ministry has allocated to the Fund \$20 million in annual funding plus an additional \$3.5 million in one-time funding. Funding of approved projects commenced in the fall of 1996, and actual expenditures for the 1996/97 fiscal year totalled approximately \$1.4 million.

In March 1996 the Ministry developed a monitoring process to determine whether the goals of the Fund were being achieved, whether funded projects were well managed, and whether funding should continue or be adjusted. However, no monitoring had been completed at the time of our audit since funding had just commenced.

COMMUNITY-BASED MENTAL HEALTH SERVICES

The Ministry began funding community-based mental health services in 1976 in response to a growing need for community-based services. According to an overview prepared by the Ministry, these services "are intended to reduce the frequency and duration of admissions to psychiatric facilities, replace inpatient treatment with outpatient services wherever possible, reintegrate discharged patients into the community environment, increase the range of choices of interventions or services available, and reduce the risk of mental disorder in high-risk groups." The services may be delivered by community agencies or sponsored by general hospitals. At the time of our audit there were approximately 350 service providers, with expenditures totalling \$131.2 million for the 1995/96 fiscal year.

Ministry staff monitor community-based mental health services through annual operating plans, quarterly financial statements and year-end settlement forms which include audited financial statements.

OPERATING PLANS

Each service provider is required to submit an annual operating plan to the Ministry and the appropriate District Health Council. The Ministry reviews and approves each operating plan after taking into consideration any comments or recommendations received from the District Health Council.

According to the Ministry's "Guidelines and Process Requirements," annual operating plans should include objectives, numerical targets and outcomes, the target population and a budget request including salary and staffing levels.

We reviewed a sample of 1996/97 operating plans and found that all plans were reviewed by the Ministry and that any budget anomalies were generally identified and followed up prior to approval. However, we also noted that, although information on objectives was included in the operating plans, 67% of the plans did not include required numerical targets and outcome criteria. In addition, providing information about the number of seriously mentally ill clients to be served was optional for the 1996/97 operating plan. We understand that it will be required for future plans.

We noted that, on average, operating plans were submitted four months into the fiscal year and approximately 40% of them had not been approved by six months into the fiscal year.

Recommendation

To facilitate appropriate and timely funding decisions for community-based mental health services, the Ministry should:

- ensure that all information submitted is in accordance with ministry requirements; and**
- require operating plans to be submitted, reviewed and approved on a more timely basis.**

Ministry Response

The Ministry has streamlined and simplified reporting requirements by refining the operating plan guidelines and process requirements it distributes to mental health provider organizations. The Ministry will ensure that information submitted is in accordance with ministry requirements by doing a more thorough review of operating plans, and following up with community programs that do not report on the necessary requirements.

The Ministry agrees that operating plans should be approved on a more timely basis. The timeframe for the operating plan process depends on the Government's Estimates/Budget process. This has an impact on the timing of the issuance of operating plan guidelines and process requirements. The Mental Health Programs and Services, as part of the new Institutional Health and Community Services Division, will consider integrating the operating plans with a view to making them more timely and effective instruments.

PERFORMANCE MONITORING

Establishing standards for and monitoring the quality of services provided is essential for assessing both the appropriateness of those services and the reasonableness of the underlying costs incurred. In addition, accurate and complete performance data are needed to make informed funding decisions.

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We noted that the Ministry did not obtain sufficient data to assess whether agreed-upon services had been provided. Although service providers were required to submit quarterly operating reports to the Ministry, these reports were primarily financial in nature and did not capture data on service levels.

The Ministry has established benchmarks for case management. For example, the elements of intensive case management include caseloads of 15 to 20 service recipients with more than 50% of contacts taking place outside the office. However, benchmarks had not been established for other core services such as crisis support, housing and social rehabilitation.

The Ministry also had not defined acceptable levels of care or implemented a set of standardized outcome measures to evaluate the effectiveness of community-based mental health services. Benchmarks would help the Ministry identify services that are not being provided economically and efficiently. They would also enable the Ministry to compare the relative performance of similar service providers. We were informed that the Ministry is currently evaluating a tool for measuring outcomes.

Performance measures proposed in the Ministry's May 1996 Business Plan included enhanced quality of life for mentally ill individuals and their families. We noted that quality-of-life indicators were not being used by the Ministry to monitor the performance of service providers. However, quality-of-life indicators such as satisfaction with living situations, housing stability and employment activities are used in other jurisdictions. We were informed that such indicators would likely be reviewed for their applicability as part of the mental health reform review. In that regard, we noted that the Ministry's initiatives to monitor the Community Investment Fund included selecting an approved project within each health planning region to pilot a quality-of-life measurement instrument.

We also found that the Ministry did not compare or otherwise analyze the costs of services among similar providers and did not maintain aggregated data on the services available, the number of service recipients or the waiting time to access services. We did note, however, that the Ministry had requested and received information from each District Health Council identifying the community mental health services currently available and needed in each region.

Recommendation

To ensure that agreed upon community-based services are being provided and that funding is reasonable and consistent, the Ministry should:

- define acceptable levels of care; and**
- establish performance benchmarks and outcome measures, and monitor programs against them.**

Ministry Response

The Ministry agrees with the recommendation. The Ministry has undertaken the development of benchmarks, targets and outcome measures for mental health services. The efficiency and effectiveness of service delivery is the current focus of further outcome measures that will span both the hospital and community sectors and will include program, client and financial data. Existing targets include provincial bed targets as well as those benchmarks developed for case management and housing.

The Ministry's Community Investment Fund indicators and Minimum Data Set will enhance the monitoring of such indicators as living situation, housing stability and employment activities.

MANAGEMENT INFORMATION SYSTEMS

A May 1996 proposal to acquire new information technology states that in order for the "Mental Health Programs and Services Group to fulfill its role and responsibilities in an efficient and effective manner, the Group needs to update its current information technology." The proposal also stated that staff must have access to relevant information to enable them to perform suitable analyses, generate reports and make informed decisions related to managing and funding the mental health system.

In 1990 and again in 1993, the Ministry's Audit Branch reported that an information system was needed to monitor the operations of community-based mental health services to enable the Ministry to take any corrective action that might be required. In addition, a 1991 consultant's report identified the Community Mental Health Branch's information requirements and suggested automated solutions. (The Branch is now part of the Mental Health Programs and Services Group.) However, we were informed that these solutions were not pursued due to other ministry-wide information technology priorities.

In the spring of 1995, a Management Information Systems Steering Committee was established to direct the development and implementation of a mental health reform information system. The Committee drafted a list of data to be collected from service providers. This list included information that could be used within the mental health system to facilitate comparisons, as well as the regional and provincial aggregation of data. At the time of our audit, this list was being updated based on comments received from service providers.

Communications and reporting between the Ministry and service providers is paper-based. Information received is manually entered by ministry staff. Data entry efficiencies could be gained through the electronic transfer of information.

Recommendation

To facilitate the monitoring of mental health reform and enable management to better evaluate the effectiveness of community-based mental health services, the Ministry should accelerate the development and implementation of an appropriate management information system.

Ministry Response

The Ministry agrees with the recommendation and is currently in the process of developing management information systems that will evaluate the effectiveness of community-based mental health services and institutional-based services. Examples are the Community Mental Health Budget System and the Community Sessional Fees System which will be implemented by the fall of 1997. The Ministry will be pursuing electronic data capture by evaluating community agencies' technology capabilities. Depending upon the results of this evaluation, the Ministry may plan to capture data initially via diskettes and in the longer term via direct electronic transfer.

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ACCOUNTABILITY

The Ministry has recognized the need to strengthen its accountability relationship with community-based mental health service providers and has drafted a new service agreement. This agreement will replace the outdated Memorandums of Understanding currently in place. At the time of our audit, we were advised that the new service agreements were expected to be in place by the end of the 1996/97 fiscal year for all providers.

The new agreements, unlike the Memorandums of Understanding, require that funds provided by the Ministry be spent in accordance with approved operating plans and budgets. They also permit the Ministry to terminate an agreement if a material breach of the agreement is not corrected within 30 days of ministry notification.

We will follow up on the implementation of the new agreements to determine whether the Ministry is holding service providers accountable for their management of public funds and for meeting operating plan commitments.

PAYMENT PROCESSING

The Ministry's Fiscal Strategies Branch processes payments to community-based mental health service providers twice monthly. The payments that we reviewed were properly approved, processed and paid.

Each service provider is required to submit year-end settlement forms, including audited financial statements, to the Ministry within four months of the fiscal year-end. The settlement forms detail revenues and expenditures. Any surplus funds (excess of revenues over expenditures) are recovered by the Ministry. Our review of this process found that surpluses represented approximately 1.6% of total payments to service providers and were generally being recovered on a timely basis.

COMMUNITY PSYCHIATRIC PAYMENT PROGRAM

The community psychiatric payment program provides funding for a variety of indirect services which are not covered by the Ontario Health Insurance Plan. These services include participation in case conferences, psychiatric department program consultations and educational services provided by psychiatrists and general practitioners through general hospitals and commu-

nity-based mental health service providers. Payments for these services under the community psychiatric payment program are referred to as sessional fees. For the 1995/96 fiscal year, funding for these services totalled \$9.1 million for general hospitals and \$2.8 million for other community-based mental health service providers.

ALLOCATION OF FUNDS

In the fall of 1993, the Ministry established a working group to assist in redesigning the community psychiatric payment program. In its October 1994 report, the working group noted that great disparities existed in the allocation of sessional funds between and among general hospitals and other community-based mental health service providers. The working group also noted that funding allocations were based “. . . more on the historical aspect than rational planning.”

We were informed by ministry staff that this issue has not been addressed. During our audit we noted that significant disparities continue to exist. For example, in the 1996/97 fiscal year, sessional funding provided to hospitals with psychiatric beds ranged from \$0 to \$423,000.

Recommendation

The Ministry should ensure that sessional funding is allocated on a reasonable and equitable basis rather than on a historical basis.

Ministry Response

The Ministry agrees with this recommendation. The Ministry will examine the question of reallocating sessional fees based on equity through current health services restructuring and system design initiatives.

MONITORING

In January 1995 the Ministry introduced new guidelines, definitions of eligible services and a quarterly monitoring report for sessional funding to improve accountability and ensure consistency with the principles of mental health reform. According to ministry guidelines, “The priority for the use of sessional fees is directed towards client-related issues and in particular to the severely mentally ill.”

We found that the Ministry did not have procedures in place to ensure that contractual arrangements and billing formats were established by the hospitals and other service providers receiving sessional funding. We selected a sample of hospitals and noted that while all of them had established billing formats, 70% had not established contracts with the doctors receiving sessional funding. These hospitals received approximately \$1.7 million in sessional funding during the 1996/97 fiscal year.

The Ministry monitors the type and quantity of sessional services delivered through quarterly reports submitted by general hospitals and other service providers. However, these reports did not include the number of severely mentally ill individuals being served even though they are a priority for the use of sessional funding.

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In addition, at the time of our audit, 73% of the reports for the two most recent reporting periods had not been submitted. For those reports submitted, we noted that the Ministry did not monitor the appropriateness of the sessional services being provided.

Recommendation

In order to ensure the appropriate use of sessional funding, the Ministry should implement procedures such that:

- **timely information is received on the use of sessional funding; and**
- **sessional funding is spent in accordance with ministry guidelines.**

Ministry Response

The Ministry agrees. The Ministry has implemented a computerized Community Sessional Fee Logging System that will enable timely follow-up. As well, the reporting of compliance is improving through ongoing verbal and written reminders to agencies. The Ministry will continue to pursue compliance through the agencies' regular reporting processes.

HOMES FOR SPECIAL CARE

The Homes for Special Care (HSC) program was established in 1964 under the *Homes for Special Care Act*. This program provides accommodation in residential homes and nursing homes primarily to former patients of provincial psychiatric hospitals. At the time of our audit, there were 161 residential HSCs which served approximately 1,450 individuals and 133 nursing homes with HSC beds which served approximately 740 residents. Expenditures for residential HSCs were \$19.4 million for the 1996/97 fiscal year. Funding for nursing-home-based HSC beds is provided under the Long Term Care Program, which is responsible for the operation of nursing homes. Accordingly, our audit did not include nursing-home HSCs.

QUALITY OF CARE

Homes for Special Care are licensed annually under the *Homes for Special Care Act* and Regulations. The Ministry inspects residential HSCs and renews their licences annually in conjunction with inspections from the local fire department and public health unit.

We reviewed a sample of files and noted that inspections were generally completed on a timely basis and that identified deficiencies were addressed. Licence renewals for the 1996 calendar year were generally issued approximately seven months late primarily due to a staff reorganization at the Ministry.

Although the Act does not stipulate any standards for the quality of resident care, the *Interim Operating Guidelines Manual* sets out the minimum standards of care along with specific indicators to be used in the assessment and monitoring of these standards. While HSCs are inspected for adherence to these guidelines, compliance is not a requirement for licence renewal.

Recommendation

To ensure that Homes for Special Care provide appropriate and consistent resident care across the province, the Ministry should mandate compliance with the minimum standards of care as a condition of licence renewal.

Ministry Response

In response to the Homes for Special Care review conducted in the autumn of 1996, the Ministry is considering possible modifications to the Homes for Special Care program, including those which would address issues related to standards of care.

PROCESSING OF PAYMENTS AND RECOVERIES

The Ministry pays operators of residential Homes for Special Care a per diem rate per resident to provide accommodation, food and supervision. The rate is set by Regulation under the *Homes for Special Care Act*. At the time of our audit, the rate was \$27.63. Additional funding is provided for residents' comforts, including toiletries, apparel and recreation. We selected a sample of payments and found that they were adequately supported, and properly approved, processed and paid.

Regulations also stipulate that residents of HSCs who are 18 years of age or older and have property are required to repay amounts paid on their behalf by the Ministry. The amounts recoverable by the Ministry are reduced by a resident's entitlement under the *Family Benefits Act*. The Supply and Financial Services Branch of the Ministry is responsible for recovering these payments from residents. Recoveries are made through the Office of the Public Guardian and Trustee, private trustees or directly from the resident. Recoveries during the 1996/97 fiscal year totalled \$16.3 million. As at March 31, 1997, the Ministry was owed a total of \$6.8 million.

From our sample of HSC accounts receivable, we noted that recoveries could be increased through more timely monitoring of residents' accounts and better communication among the ministries of Health and Community and Social Services and the Office of the Public Guardian and Trustee.

Recommendation

The Ministry should improve its procedures to help ensure that it recovers the payments made on behalf of residents of Homes for Special Care that it is entitled to.

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Ministry Response

The Ministry supports this recommendation. In response to the Homes for Special Care review conducted in the autumn of 1996, the Ministry is considering possible modifications to the Homes for Special Care program, including modifications of program administrative procedures. The Ministry has implemented a computerized Homes for Special Care information system. In order to assist in monitoring, it is our expectation that the modifications to the system will include the capability to produce ageing reports which may facilitate an efficient recovery process.

In addition, we are exploring the possibilities of an electronic interface with the Office of the Public Guardian and Trustee and the Family Benefits Branch of the Ministry of Community and Social Services to take advantage of available assets that can be offset against the amounts owing by the residents. This would considerably reduce the amounts that are currently reported as outstanding.

RESPITE CARE GRANTS

Since the 1987/88 fiscal year, each residential Home for Special Care has received an annual respite care grant of \$3,000. The primary purpose of this grant is to enable HSCs to hire relief staff to cover vacation periods to ensure resident supervision is not reduced. For the 1996/97 fiscal year, these grants totalled approximately \$480,000.

We found that the Ministry did not have procedures in place to ensure that Homes for Special Care used the respite care grant for its intended purpose. We also noted that the amount of the grant did not depend on the number of beds in a HSC (which at the time of our audit ranged from 2 to 40) or any other factor. Therefore, we question whether providing respite care grants in addition to regular maintenance payments is achieving its intended purpose.

Recommendation

The Ministry should assess whether it should continue to provide respite care grants for staff relief.

Ministry Response

The Ministry supports this recommendation. Consideration will be given to whether the funding structure of the Homes for Special Care program is as effective as possible, including whether the Ministry should provide respite care grants for staff relief.