Common Challenges, Shared Priorities

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

November 2019

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About this report

There is a growing demand for Canadians to access health services at home or in the community, outside of traditional settings such as hospitals and nursing homes. Across the country, mental illness and addictions are also serious issues for Canadians. To address these challenges, federal, provincial and territorial (FPT) governments are working together to improve access to mental health and addictions services, as well as to home and community care.[1] In August 2017, they endorsed A Common Statement of Principles on Shared Health Priorities that will lead to an $11 billion federal investment over a 10-year period to help meet rising demand from Canadians for effective and appropriate services in these areas.[i, 2]

As part of the statement, FPT health ministers agreed to work collectively and with the Canadian Institute for Health Information (CIHI) to develop a focused set of common indicators to measure pan-Canadian progress on these shared health priorities, with a commitment to report back to Canadians every year on this work. This report describes how the 12 indicators were selected, why they are important to Canadians and to our health systems, and what progress has been made to date on their development.

Results from the following 3 Shared Health Priorities indicators are being published for the first time in this report, and displayed in CIHI's Your Health System web tool:

- Hospital Stays for Harm Caused by Substance Use;
- Frequent Emergency Room Visits for Help With Mental Health and/or Addictions; and
- Hospital Stay Extended Until Home Care Services or Supports Ready.

This companion report is intended to help Canadians understand the indicator results, clarify where the data is limited, and identify which age groups are most affected as well as factors that can potentially influence results. The numbers included in this report are only the beginning. They represent a baseline from which progress can be measured over time, as indicator results will be updated and reported annually to Canadians. Every year until 2022, new measures will be added, and existing indicators will be refined as more and better data becomes available.

Reporting on each of the mental health and addictions and home and community care indicators will not drive change immediately. It will take time for investments to improve care at the front lines and to better meet the needs of patients and clients in these sectors. Additionally, results in this report are based on 2017–2018 data, as indicator data is usually collected in one year and reported in the next.

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

Key pan-Canadian results for Year 1 indicators

Every day

400+ Canadians
are hospitalized
because of harm from alcohol or drugs

More than for heart attacks and strokes combined

10 Canadians
die in hospital
from harm caused by substance use

3 in **4** deaths
are due to alcohol
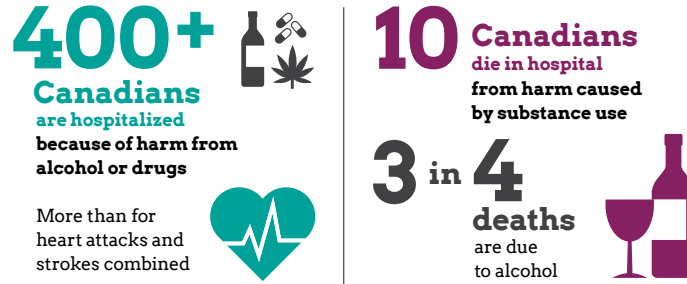
(Source: CIHI, 2017)

Nearly 1 in 10 Canadians
who visit the ER for help with mental health and/or addictions have

4+ visits a year

(Source: CIHI, 2017)

More than 90% of hospital patients
can access home care promptly, but

1 in 12
have their hospital stay extended until home care services or supports are ready

= **3** large hospitals (400-bed) every day

(Source: CIHI, 2017)

Background

Indicator selection

CIHI led a rigorous process for the selection of indicators on the priority areas of mental health and addictions and home and community care. It began with environmental scans of the care services each province and territory offered, the measures that were in place to track access to those services, and the information systems used to gather health information.

This was followed by extensive consultations with governments, stakeholders, measurement experts, and people with lived experience, through interviews, online surveys and focus groups. Members of the public who participated in consultations identified clear priorities for both mental health and addictions and home and community care. Specifically, their comments focused on the importance of

- Shorter wait times;
- The availability of appropriate services;
- Improved patient experience;
- Support in navigating the health system; and
- Prevention and promotion, for mental health and addictions in particular.

CIHI worked with sector and measurement experts to evaluate approximately 100 measures for each area and enlisted the help of 2 FPT working groups (1 for mental health and addictions, 1 for home and community care) to narrow the selection of indicators. The guiding principles for choosing the final 12 were as follows:

- Relevance — the choice was based on whether the topic was a priority for health systems and Canadians, not on how easy it was to get information on the topic;
- Balance — it was important to ensure that the indicators reflect different aspects of access to care for each priority area; and
- Impact — the indicators had to measure an aspect of access to care where improvements to the health system could be made that are meaningful to patients.

CIHI released an interim progress report on this work — *Selecting Pan-Canadian Indicators for Access to Mental Health and Addiction Services, and to Home and Community Care* — in March 2018.[3]

In June 2018, FPT health ministers officially endorsed the final list of 12 indicators proposed by the CIHI-FPT working groups.[4]

Indicator reporting

As part of our annual progress report to Canadians on the shared health priorities, CIHI plans to release 3 new indicators every year over the next 4 years in the following order:

Table 1   Indicator rollout and reporting

Year	Indicators			
2019	Hospital Stays for Harm Caused by Substance Use*	Frequent Emergency Room Visits for Help With Mental Health and/or Addictions*	Hospital Stay Extended Until Home Care Services or Supports Ready†	—
2020	Self-Harm, Including Suicide*	Caregiver Distress†	Long-Term Care Provided at the Appropriate Time†	Plus 2019 indicators
2021	Wait Times for Community Mental Health Services, Referral/ Self-Referral to Services*	Wait Times for Home Care Services, Referral to Services†	Home Care Services Helped the Recipient Stay at Home†	Plus 2019 and 2020 indicators
2022	Awareness and/ or Successful Navigation of Mental Health and Addictions Services*	Early Identification for Early Intervention in Youth Age 10 to 25*	Death at Home/ Not in Hospital†	Plus 2019, 2020 and 2021 indicators

* Mental health and addictions   † Home and community care

Considerations for indicator development and the timing of public reporting include

- The ability to build on existing work or indicators where possible and improve over time;
- Data availability, and the level of difficulty to calculate the indicator;
- Balancing the release of measures for home and community care and mental health and addictions; and
- The ability to report at the provincial/territorial level.

In September 2018, the Shared Health Priorities Advisory Council was established to guide
the development of indicators.[5] Council members include representatives from provinces and
territories, Health Canada and Statistics Canada, while observers include representatives
from the Canadian Home Care Association, the Mental Health Commission of Canada and the
Canadian Centre on Substance Use and Addiction. The collaborative process that has shaped
the development of these measures to date will continue, with CIHI facilitating discussions
and input from the provinces and territories, stakeholders, experts, patients and the public.

Year 1 indicators and results

This section of the report presents indicator results and information to assist with
understanding of the first 3 indicators released in May 2019 to measure FPT shared
health priorities.

A health indicator is a measure that helps to summarize information about a given priority topic
on population health or health system performance.[6, 7] Health indicators provide comparable
and actionable information across different geographic or organizational boundaries to track
progress over time. Indicators help identify opportunities for improvement, provide evidence
to support health programs and policies, and monitor the success of interventions.

Indicators raise questions and bring attention to issues but do not provide answers about
the cause or explain variations on their own. Indicators provide part of the picture, but further
drill-down, contextual information and other relevant indicators are required for a complete
picture. The results can, however, help decision-makers understand where improvements
are needed, lead to further investigation and facilitate the sharing of best practices.

Indicator: Hospital Stays for Harm Caused by Substance Use

Definition

This indicator measures harm caused from using alcohol, opioids, cannabis and other
substances. It examines how many hospital stays in a year are a direct result of using
these substances. This measure builds on existing work by CIHI, including the indicator
Hospitalizations Entirely Caused by Alcohol and the report *Opioid-Related Harms in
Canada, December 2018*, as well as on the Canadian Centre on Substance Use and
Addiction's definition of substance.[8–10]

Rationale

- A high rate of hospitalization may signal the need for more access to community-based prevention, mental health care or addictions services.
- This indicator can also
  - Bring awareness to the extent of harms from substance use;
  - Estimate the burden substance use puts on health systems; and
  - Assist in monitoring the effectiveness of treatment and prevention policies and services.

Calculation

$$\frac{\text{Total number of hospitalizations for harm caused by substance use}}{\text{Total population age 10 and older}} \times 100{,}000$$

Table 2   Data availability for Hospital Stays for Harm Caused by Substance Use

Data source	Fiscal year	Coverage
Discharge Abstract Database (DAD) and Hospital Morbidity Database (HMDB)	2017–2018	All provinces/territories
Ontario Mental Health Reporting System (OMHRS)	2017–2018	Ontario
National Ambulatory Care Reporting System (NACRS)	2017–2018	Where available

Note
Hospital records for mental health and addiction are collected differently in Ontario, through the Ontario Mental Health Reporting System (OMHRS).

- For the indicator Hospital Stays for Harm Caused by Substance Use, "substance" includes alcohol, opioids, cannabis, other central nervous system depressants (e.g., benzodiazepines), cocaine, other central nervous system stimulants (e.g., methamphetamine), other substances (e.g., hallucinogens, solvents) and unknown/mixed substances.
- The rate is age-adjusted per 100,000 population, age 10 and older.

Data limitations and caveats

- The indicator's definition does not include
  - Treatment for substance use outside of hospitals (e.g., in addiction treatment centres, clinics and emergency departments);
  - Deaths outside of hospital settings (e.g., a fatal overdose at home);
  - Hospital stays for conditions partially attributable to substance use (e.g., cancer, strokes, respiratory diseases, trauma);
  - Harm to bystanders who did not use a substance (e.g., victim of impaired driving collision); and
  - Children younger than 10, including neonatal abstinence, when babies exposed to drugs in the womb suffer withdrawal after birth.
- The stigma associated with substance use may influence what is recorded in hospital records and contribute to under-reporting of cases.

Key results

More than 400 Canadians are hospitalized every day for alcohol and drug harm

In 2017–2018, there were more than 155,000 hospital stays for harm caused by substance use — that's more hospital stays than for heart attacks and strokes combined. Half of patients hospitalized for harm caused by substance use spend 5 days or longer in hospital. In total, all harm adds up to 2 million days in hospital in Canada each year. Types of harm from substance use can include drug or alcohol overdoses, severe withdrawal symptoms, injuries caused by intoxication, chronic conditions such as cirrhosis of the liver, or drug-induced psychosis requiring treatment in a mental health bed.[10]

On average, 10 patients die in hospital every day because of substance use — most (77%) from health complications related to alcoholism. We know that many also die from substance use outside of hospital. For example, according to the Public Health Agency of Canada, opioid overdoses alone claimed the lives of more than 10 Canadians a day last year — but the vast majority died at home or in the community.[11]

There is wide provincial and territorial variation in rates of hospital stays caused by substance use

Figure 1   Age-standardized hospitalization rate for substance use, by jurisdiction, 2017–2018
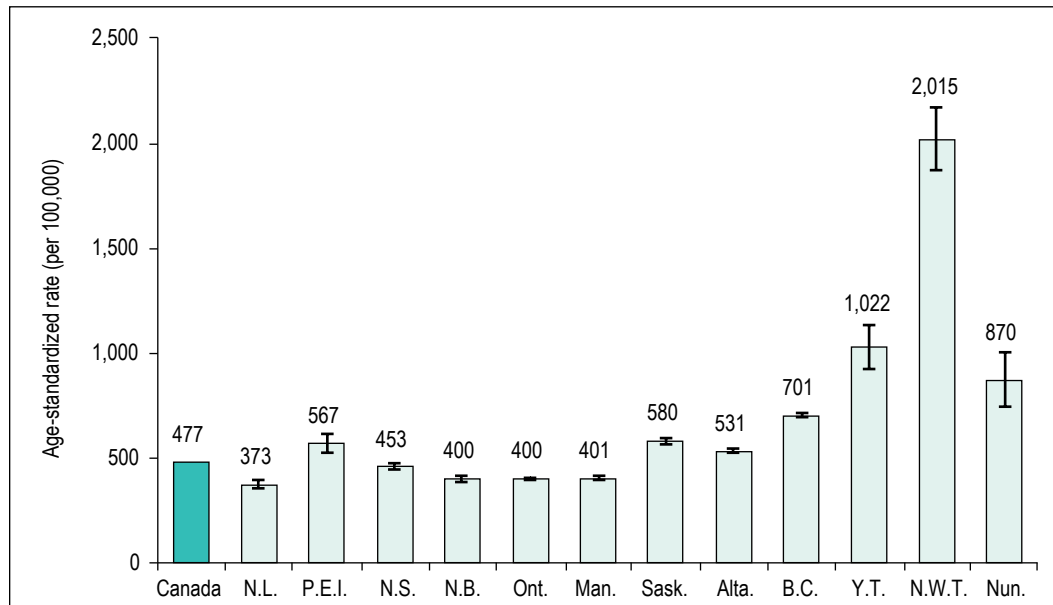
Notes

The line at the top of each bar graph shows the confidence interval (CI), which is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

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

Many factors can influence hospital stays for harm caused by substance use, including[12, 13]

- The availability of, and access to, different substances in each jurisdiction;

- Population health differences from factors such as income, education, social networks, housing, and personal and/or intergenerational trauma;

- Access to harm reduction and treatment services in the community, which can be limited, even in the biggest cities, plus difficulties providing community services in sparsely populated areas; and

- The availability and effectiveness of paramedic and emergency services prior to the hospital stay (to treat overdose or poisoning related to substance use).

Men are hospitalized more often than women

To better target prevention and treatment programs in the community, it is important to know who is most affected by substance use and what types of substances are causing harm. Adult men have significantly higher rates of hospital stays for harm caused by substance use than women: overall, nearly 2 out of 3 (64%) hospital stays are for men — with peaks observed for men between the ages of 25 and 34 and between 50 and 64. However, the rate of hospital stays for children and youth (between the ages of 10 and 19) is slightly higher for females. Rates of harm for females peak in the mid-20s, then decline with age.

Figure 2   Rate of hospital stays for substance use, by age
and sex, 2017–2018

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

Substance use impacts Canadians of all income levels. However, Canadians living in lower-income neighbourhoods were 3 times as likely to have a hospital stay for harm caused by substance use compared with those from the highest-income neighbourhoods.

Alcohol is the primary cause of hospital stays for harm attributed to substance use; the impact of other substances varies by province and territory

In every province and territory, alcohol is the major cause of hospitalization for harm caused by substance use, and it contributes to more than half the overall national rate. However, the rates of harm caused by alcohol vary widely among jurisdictions, as does the mix of other drugs that cause harm.

After alcohol, unknown substances were the second largest cause of hospital stays for harm attributed to substance use; these may include a combination of substances (e.g., cannabis and alcohol) or other drugs that clinicians are not able to identify. CIHI is exploring ways to improve future reporting of these cases. After alcohol, the top 3 known substances causing hospital stays are cannabis, opioids and other stimulants, which include methamphetamine (also known as crystal meth). It is important to note that this data was collected before the legalization of cannabis in Canada, which occurred in October 2018.[14]

Figure 3   Cause of hospital stays for harm attributed to substance use, by substance, Canada, 2017–2018

Notes
Percentages do not add to 100, as more than one substance can be documented per hospitalization.
"Unknown" is the term used for unidentified, possibly multiple, substances.
"Other stimulants" include methamphetamine, whereas "Other depressants" include benzodiazepines, or sleeping pills.
"Other substances" include hallucinogens and solvents.
Sources
Hospital Morbidity Database, Ontario Mental Health Reporting System and National Ambulatory Care Reporting System, 2017–2018, Canadian Institute for Health Information.

The types of harm experienced by patients can differ by type of drug. For example, cannabis hospitalizations were often related to symptoms of psychosis or distress, whereas poisonings were more common among those using opioids or depressants. Other than alcohol, substances most often linked to hospital stays vary by province or territory.

The type of substance causing harm varies by age: for older males and females age 50 to 64, alcohol is the major factor (accounting for 72% of hospital stays), while cannabis is the most common substance associated with hospital stays among children and youth age 10 to 19, accounting for nearly half (45%) of all cases.

Figure 4 Top 3 substances causing hospital stays, by province and territory, 2017
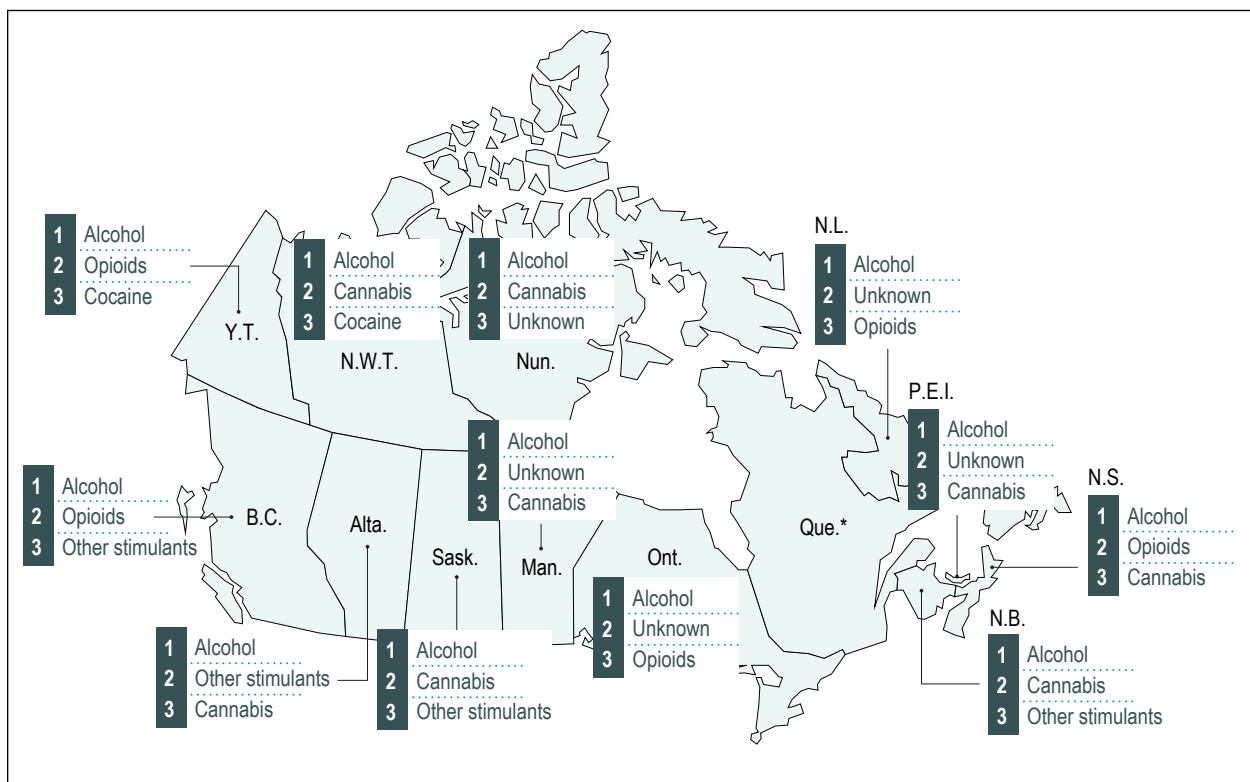
Notes

* The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

"Unknown" is the term used for unidentified, possibly multiple, substances.

"Other stimulants" include methamphetamine.

Sources

Hospital Morbidity Database, Ontario Mental Health Reporting System and National Ambulatory Care Reporting System, 2017–2018, Canadian Institute for Health Information.
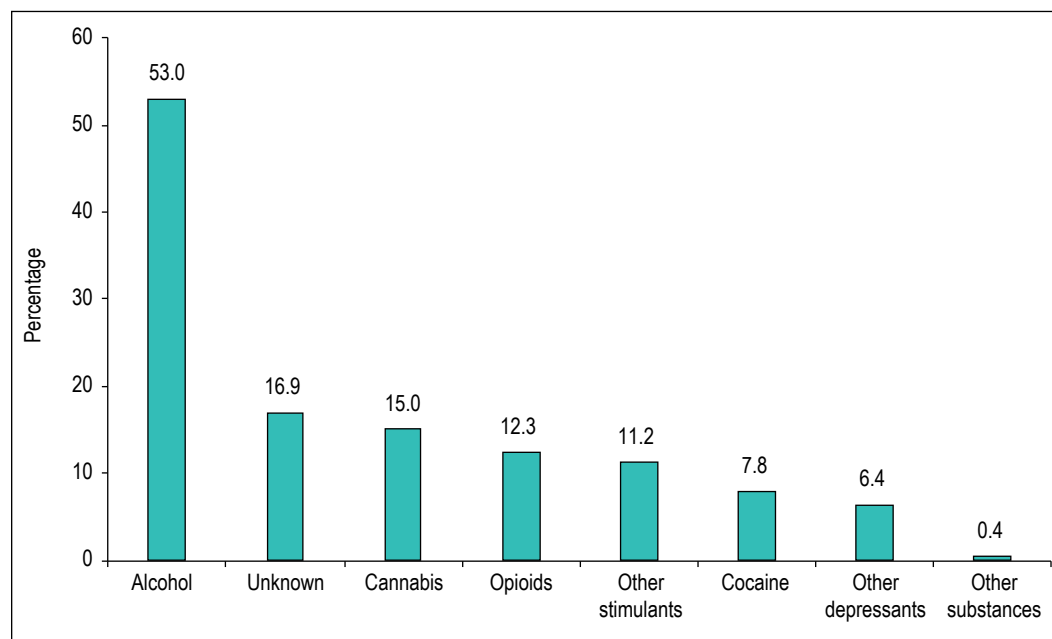
More information on the number of hospital stays for each substance, broken down by province and territory, can be found in Appendix A and the downloadable Excel file in Your Health System: In Brief.

4 in 10 Canadians with a hospital stay for substance use also have a mental health condition

Table 3   Hospitalizations for substance use with a co-existing mental health condition

Mental health condition	Percentage of patients hospitalized for substance use who also received care for a mental health condition
Any mental health condition	43%
Mood disorders	16%
Schizophrenia and other psychotic disorders	12%
Anxiety disorders	8%

Note
"Any mental health condition" also includes personality disorders and other behaviour disorders, involving eating or sleep.
Sources
Hospital Morbidity Database, Ontario Mental Health Reporting System and National Ambulatory Care Reporting System, 2017–2018, Canadian Institute for Health Information.

Mental illness and addictions have a complex relationship. Poorly treated mental health conditions can lead people to self-medicate by using alcohol or drugs, while chronic substance use can lead to mental illness, such as anxiety, depression or psychosis.[15] More than a third (43%) of patients hospitalized for harm caused by substance use also received care for a mental health condition during their hospital stay. The substance a patient is most likely to have used varies depending on their condition. For example, those hospitalized for using cannabis or stimulants were more likely to be treated for schizophrenia, while those hospitalized for depressants such as benzodiazepines were more likely to be treated for anxiety.

The typical length of stay for those hospitalized for substance use with a co-existing mental health condition was 6 days in hospital. This is longer than for patients without a mental health condition, who had a typical hospital stay of 4 days.

Links to other CIHI resources

- Hospital Stays for Harm Caused by Substance Use indicator
  - Your Health System: In Brief — indicator results, infographics and downloadable tables
  - Indicator Library — definitions and methodology
- Data holdings and resources
  - Mental health and addictions information
  - Hospital Morbidity Database metadata
  - Ontario Mental Health Reporting System metadata
- CIHI's existing work
  - Hospitalizations Entirely Caused by Alcohol — indicator with results available at provincial/territorial and health region levels in Your Health System: In Brief
  - *Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm* — report that examines alcohol policies and interventions across Canada, and provides additional analyses on alcohol use and harm
  - Opioid-Related Harms in Canada

Indicator: Frequent Emergency Room Visits for Help With Mental Health and/or Addictions

Definition

This indicator measures the proportion of frequent visitors (with at least 4 visits a year) among those who visit an emergency room (ER) for help with mental health and/or addictions. This measure builds on an existing CIHI indicator, Repeat Hospital Stays for Mental Illness.[16]

Rationale

- Frequent visits to ERs or urgent care centres may indicate that people are not getting access to the services or the support they need in the community for mental health and/or addictions.
  - This could suggest that people had conditions that were poorly managed in the community.
  - It might also suggest that they were unaware of services in their communities, had difficulty accessing them, or had poor experiences or outcomes with community care.

Calculation

$$\frac{\text{Total number of individuals who had 4 or more ER visits in a year for mental health and/or addictions}}{\text{Total number of individuals with at least 1 ER visit in a year for mental health and/or addictions}} \times 100$$

Table 4 Data availability for Frequent Emergency Room Visits for Help With Mental Health and/or Addictions

Data source	Fiscal year	Coverage
National Ambulatory Care Reporting System (NACRS)	2017–2018 (with a lookback period into 2016–2017)	Complete: Ontario, Alberta, Yukon Partial: P.E.I., Nova Scotia, Manitoba, Saskatchewan, B.C.

- "ER visits" refers to any combination of visits to urgent care centres and hospital emergency departments; this includes visits made by the same person to different hospitals.
- "Mental health and addictions" include mood disorders, anxiety disorders, schizophrenia, personality disorders, substance-related and addictive disorders and other behaviour disorders, involving eating or sleep.

Data limitations and caveats

- The level of detail submitted to NACRS varies between jurisdictions, and this affects how diagnostic information is captured.
- Results are based on all available data reported to CIHI. 3 jurisdictions (Ontario, Alberta and Yukon) have complete ER data. For provinces that have partial data (P.E.I., Nova Scotia, Saskatchewan and B.C.), repeat visits are likely underestimated because records cannot be linked across all hospitals. While results for provinces with partial data are based on substantial numbers of cases, they must be interpreted with caution. Therefore, results should not be compared. For Manitoba, results are not shown due to insufficient data coverage.
- The indicator does not include dementia or problems related to brain injuries, such as concussion or stroke.
- It is not always possible to confirm a diagnosis in the ER. For example, presenting symptoms of chest pain or shortness of breath may be reported instead of the related mental health and/or addiction diagnoses because these require further investigation to confirm.

Key results

Nearly 1 in 10 Canadians who visit an ER for help with mental health or addictions are frequent visitors

In 2017–2018, more than 320,000 people visited an ER to seek care for mental health or addictions. Nearly 1 in 10 of these patients (9.4% or 30,434) were frequent visitors with 4 or more ER visits for help with mental health and/or addictions over the course of a year. The vast majority (80%) of those seeking help in ERs for mental health and/or addictions had serious conditions that required urgent medical care including resuscitation (as measured by Canadian Triage Acuity Scale levels 1 to 3).

Figure 5   Rate of frequent ER visits for help with mental health and/or addictions, by jurisdiction, 2017–2018
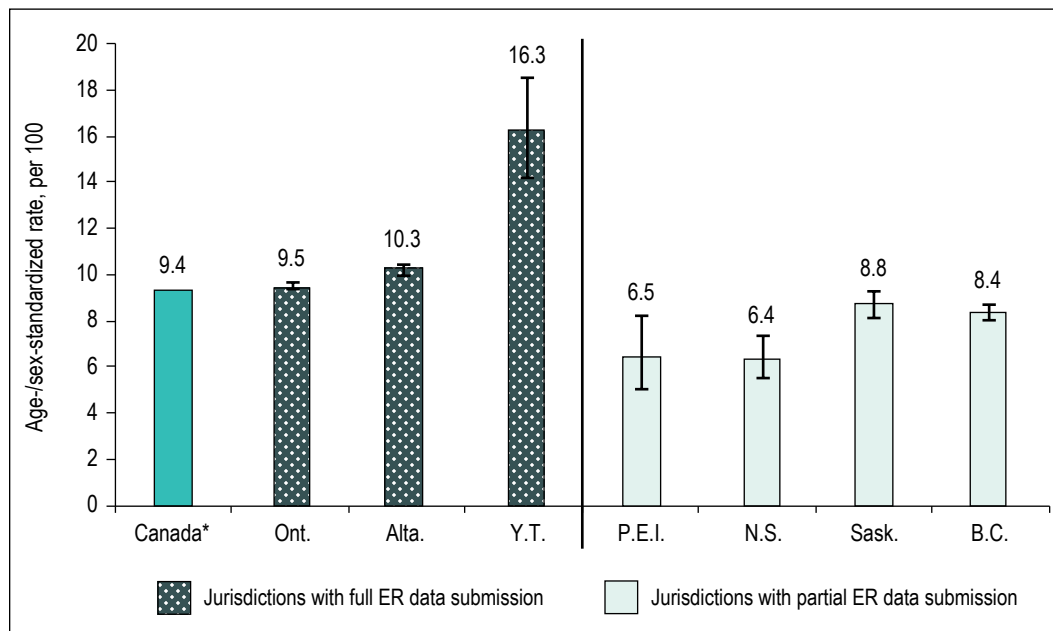
Notes
* Total includes data submitted from Manitoba.
Partial ER data submission leads to likely underestimation of repeat visits. Results should not be compared.
The line at the top of each bar graph shows the CI, which is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.
Source
National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information.

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Data related to ER visits is growing but is not yet fully available across the country. While results for provinces with partial data are based on substantial numbers of cases, they must be interpreted with caution. Results should not be compared. Where data is not submitted by all hospitals and health regions, partial results may underestimate the number of repeat visits.

Many factors can influence the frequency of ER visits for mental health and addictions, including the following:[13, 17]

- Geography, such as whether the patient lives in an urban, rural or remote area. Overall, rates of repeat ER visits for help with mental health and/or addictions in rural areas were consistently higher than rates in urban areas. Generally speaking, ER visits for all reasons tend to be more frequent in rural and remote areas, likely related to how care is organized.

- The availability of community mental health and addiction treatment services, or long wait times for available care. In some cases, these services may be available, but the ER is a care setting with more flexible hours.

- The strength of connections between community services and primary health care providers. This may impact where people seek care. As well, patients who do not have a regular family physician may not be able to connect with appropriate services in the community on their own.

- Population health differences, such as the prevalence of mental health conditions or factors that contribute to them (e.g., income, employment, education, social networks, food insecurity, housing, personal and/or intergenerational trauma). When these underlying social determinants of health, such as homelessness and poverty, are not addressed, patients are at risk of more severe illness.

- Stigmatization, real or perceived, may affect patient decision-making about whether and where to seek help.

Half of frequent visitors seek help for both mental health and addiction disorders

The co-occurrence of mental health and addiction disorders is common among those who frequently visit ERs. Among emergency patients with 4 or more visits a year,

- Nearly half visited the ER for help with disorders related to both mental health and addictions.

- One-third visited the ER solely for help with a mental health disorder — most commonly for an anxiety disorder, a mood disorder and other behaviour disorders, such as with eating or sleep.

- About one-fifth visited the ER for an addiction- or substance-related disorder — most often (84%) alcohol use.

Young adult men are most likely to be frequent visitors

While men and women were equally likely to visit the ER at least once in the course of a
year for help with mental health and/or addictions, men were more likely (56%) to have
4 or more visits than women (44%). The highest rates for frequent visits to the ER were
for men age 25 to 39. However, among children and youth (age 10 to 19), frequent visitors
were more likely to be female. Those age 10 to 19 were also more likely to visit the ER for
a mental health condition only (55%) than exclusively for a substance-related problem (3%).
Challenges in accessing mental health services for children and youth may contribute to
frequent visits in this age group.[18, 19]

Figure 6   Frequent ER visits, by age and sex, 2017–2018
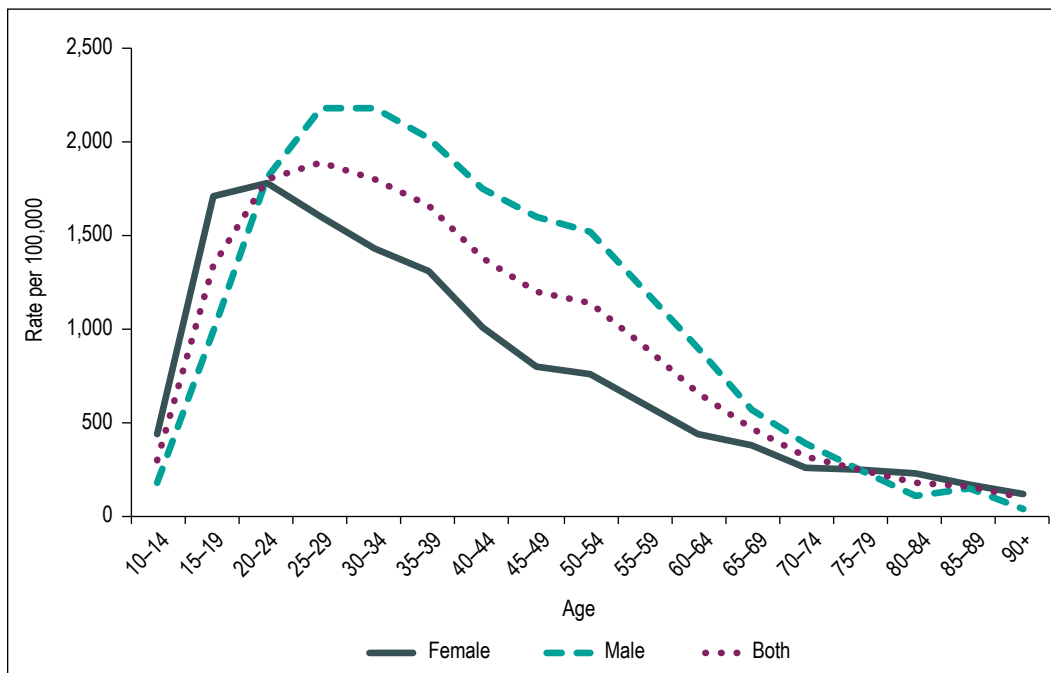
Note
Rates are for frequent ER users in Ontario, Alberta and Yukon combined.
Source
National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information.

Canadians from poorer neighbourhoods are more likely to be frequent ER visitors

While Canadians of all income levels are affected by mental health and addiction disorders, frequent ER visitors seeking help with mental health and/or addictions are nearly 4 times more likely to live in lower-income neighbourhoods than in higher-income neighbourhoods. In addition, about 7% of those who visit an ER 4 or more times a year for mental health and addictions are homeless. Other studies have shown that Canadians living with economic insecurity are more at risk of mental health or addiction problems and may have more trouble accessing the care and services they need in the community, while those with stable incomes may be more likely to purchase private care.[20, 21]

Figure 7 Percentage of patients with 4+ ER visits for mental health and addictions, by neighbourhood income, 2017–2018
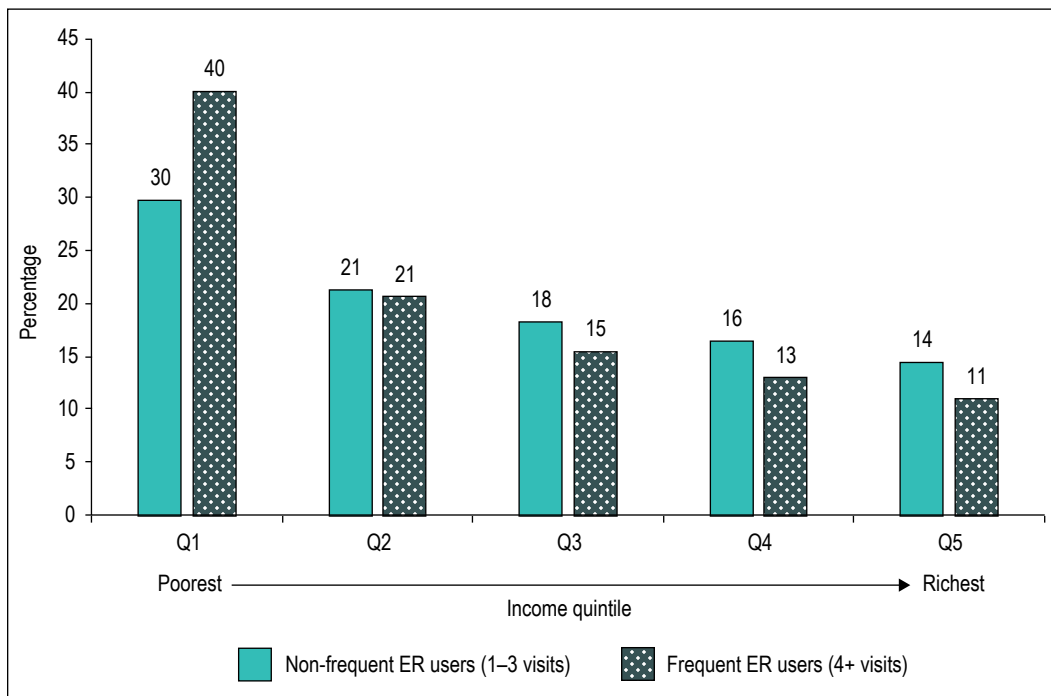
Note
Percentages may not add up to 100 due to rounding.
Sources
National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information;
Postal Code Conversion File Plus, Statistics Canada.

Frequent ER visitors are often hospitalized

Two-thirds of frequent ER users who needed help with mental health and/or addictions were admitted to hospital at least once over the year, with about one-quarter (26%) having 3 or more hospital stays within the same year. About a quarter of all hospitalizations were related to substance-use disorders, while other common conditions included mood disorders, eating disorders and schizophrenia.

As with other chronic conditions, having a well-managed care plan with support in the community can help reduce periods of crisis and therefore the need for frequent ER visits and costly hospital stays.[22, 23]

Links to other CIHI resources

- Frequent Emergency Room Visits for Help With Mental Health and/or Addictions indicator
  - Your Health System: In Brief — indicator results, infographics and downloadable tables
  - Indicator Library — definitions and methodology
- Data holdings and resources
  - Mental health and addictions information
  - National Ambulatory Care Reporting System metadata
- CIHI's existing work
  - Repeat Hospital Stays for Mental Illness — indicator with results available at provincial/ territorial and health region levels in Your Health System: In Brief
  - Child and youth mental health in Canada — infographic and companion report
  - Hospitalizations Entirely Caused by Alcohol — indicator with results available at provincial/territorial and health region levels in Your Health System: In Brief
  - *Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm* — report that examines alcohol policies and interventions across Canada, and provides additional analyses on alcohol use and harm
  - Opioid-Related Harms in Canada
  - *Types of Opioid Harms in Canadian Hospitals: Comparing Canada and Australia* — report

Indicator: Hospital Stay Extended Until Home Care Services or Supports Ready

Definition

This indicator measures the number of days patients remain in hospital when they no longer need that level of care but must wait there until home care services or supports can be organized. Home health services typically include professional services such as nursing or rehabilitation services, whereas home support might include assistance with self-care activities, homemaking (e.g., light housekeeping, laundry, shopping, meal preparation), home adaptation or other services that allow a person to return home. Time in hospital may also be extended if a person is waiting for the availability of family members or other informal caregivers.

Rationale

- This measure indicates whether Canadians are getting timely access to home care when they no longer require acute care in a hospital.

- A longer extended hospital stay may signal poor anticipation of needs, challenges in coordinating care or lack of resources in the community to provide care at home. In some cases, extended stays may become longer when a hospital increases its efforts to arrange home care before it discharges patients.

- This indicator can help to

  – Show where additional home care services or supports could help to accelerate the discharge of patients and reduce the need for more expensive extended hospital services; and

  – Raise awareness of the importance of planning for the release of the patient as early as possible during a hospital stay to ensure that services are ready for patients at home.

Calculation

> Median length of time, in days, a hospital stay is extended until
> home care services or supports are ready

- The median is the middle point where half the results are above it and half are below. It represents the typical length of stay for patients with extended stays until home care is ready.
- Specifically, the indicator measures the number of days patients spend in an acute care hospital bed when they don't need acute care (also known as alternate level of care) before they are discharged to home care.

Table 5 Data availability for Hospital Stay Extended Until Home Care Services or Supports Ready

Data source	Fiscal year	Coverage
Discharge Abstract Database (DAD)	2017–2018	All provinces/territories except Quebec

Data limitations and caveats

- There may be differences among provinces and territories in how extended hospital stays are classified and recorded. CIHI introduced standards for the alternate level of care or extended stay designation in 2016, but they may not be fully implemented across the country yet.[24] It is also possible that health professionals will differ on when to designate someone as "on extended stay" given that it requires careful assessment of care needs. (See Appendix B for more information related to data quality by province and territory.)
- There are regional challenges:
  - Quebec has no equivalent data, so results for the province are not included.
  - Nova Scotia commonly describes patients as "waiting for nursing home," which may contribute to some variation and under-reporting of patients discharged to home care.
  - In the territories, numbers of admissions overall are small, and few extended stays are reported.

- This indicator does not show whether a patient received home care after leaving hospital, just that he or she was discharged from hospital expecting to receive formal home care.

- In some cases, it may be that a patient discharged to home care was initially waiting for long-term care (or some other service). This could increase the number of patients included in this indicator.

- Hospital stays for mental health are not included because of variations in how provinces and territories collect this type of data. Where this data was available, it had little impact on the indicator results.

Key results

Most hospital patients have access to home care promptly, but 1 in 12 have an extended stay

After a hospital stay, some patients require health care visits from a nurse or other health professional while recovering at home, some need special equipment to help them breathe or to stay mobile, and others may need help with daily activities such as bathing and preparing meals. In 2017–2018, a total of 351,456 hospital patients in Canada were discharged with a recommendation for formal home care (i.e., not provided by family or friends). Most patients (92%) did not have an extended stay or wait to be discharged.

The other 8% of patients — or 1 in 12 — had to stay in hospital until home care services or supports were ready. Every day, on average, 1,320 patients occupying Canadian hospital beds are waiting for home care services to be ready — the equivalent of 3 large hospitals filled to capacity.

There is wide provincial and territorial variation in how long hospital stays are extended

Figure 8 Median length of extended stay for patients discharged to home care, by jurisdiction, 2017–2018
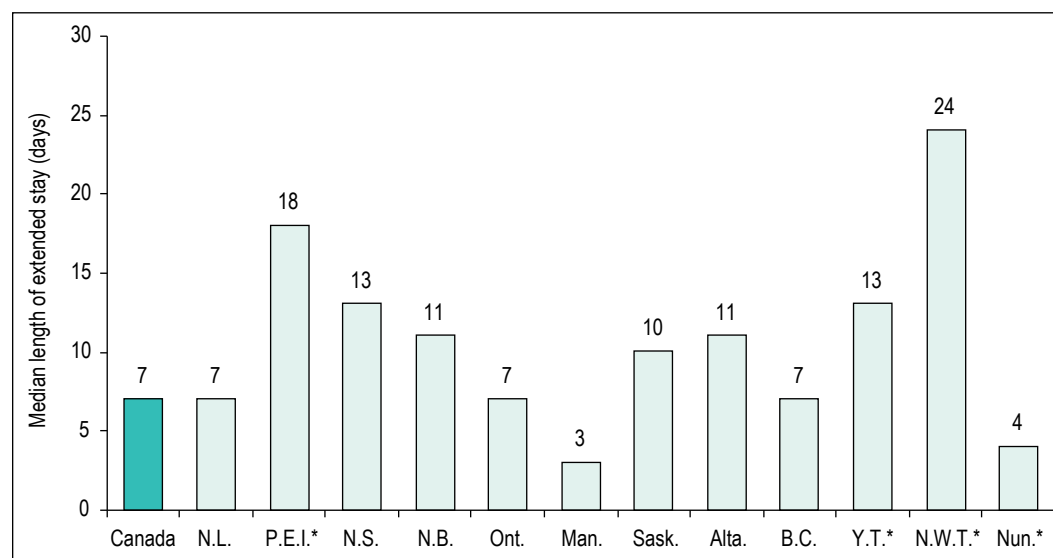
Jurisdiction	Canada	N.L.	P.E.I.*	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.*	N.W.T.*	Nun.*
Discharges to home care with extended stay	27,717	537	54	295	919	15,829	1,670	693	3,915	3,769	15	5	9
Discharges to home care without extended stay	323,738	15,041	331	10,070	10,660	213,573	8,743	7,134	29,101	28,276	161	137	332

Notes

*   Because the number of extended hospital stays is small in the territories and in provinces with smaller populations, results are not stable, and comparisons with larger provinces should be made with caution.
Most patients (92%) discharged to home care don't have extended hospital stays and are not included in this indicator.

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

Extended stay lengths vary widely among provinces and territories. Many factors can influence why hospital stays may be extended until home care services and supports are ready, including[25, 26]

- The availability of home care services and supports within jurisdictions;
- How care is planned and streamlined, such as discharge planning prior to a patient's release, and coordination with home care services;

- Differences in population health that influence home care needs, such as rates of chronic disease (e.g., diabetes); patients with multiple chronic diseases may require multiple providers and programs;

- The availability of a friend or family caregiver;

- The appropriateness of living arrangements at home for patients with mobility problems;

- Variations in clinical practice and readiness to discharge patients; health care providers must balance the risk of readmission to hospital if a patient is discharged home too soon with the overall length of stay; and

- Data quality caused by differences in how patients' extended stays are recorded.

Half of all patients have an extended stay of 1 week or less

Across Canada, the typical patient with an extended stay waited 7 days or less in hospital until home care services or supports were ready. However, 10% of extended-stay patients spent 39 extra days or more in hospital waiting for home care.

Figure 9 Length of time a hospital stay is extended until home care is ready, 2017–2018
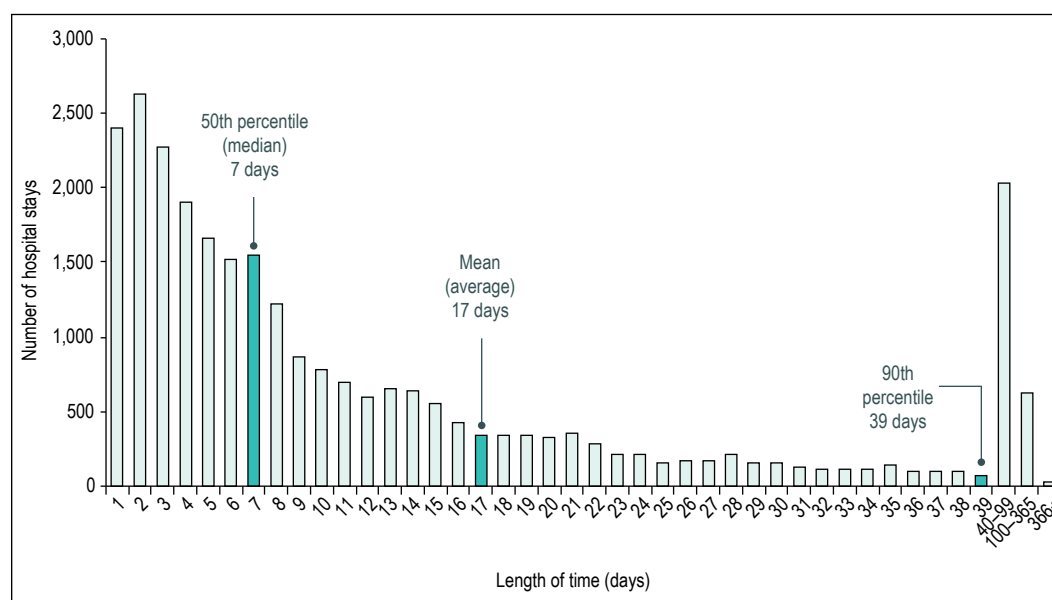
Source
Discharge Abstract Database, 2017–2018, Canadian Institute for Health Information.

Overall, the length of time hospital stays were extended did not vary significantly based on a patient's age, sex or income, or whether they lived in an urban or rural area. However, some types of patients were much more likely than others to have extended hospital stays until home care services or supports were ready.

Elderly women are most likely to have extended hospital stays

The vast majority (86%) of patients with extended hospital stays are age 65 and older, with a median age of 82 years. Less than 1% (0.2%) are children and youth under 18.

The majority of patients (nearly 3 out of 5) whose hospital stays are extended are women. This may be because women live longer than men, and chronic health conditions requiring home care increase with age. Women in traditional roles as the family's main care provider or who outlive their spouses may also be less likely to have family support at home. However, among patients younger than 65 who spent extra days in hospital waiting for home care, the proportion of men was higher than that for women.

Figure 10   Extended hospital stays until home care is ready,
by age and sex, 2017–2018

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

Patients with extended hospital stays are more likely to have conditions such as dementia

Home care offers an array of health and support services, from relatively simple, short-term ones, such as changing bandages, to more intense health care and sophisticated services such as providing and monitoring a ventilator to aid breathing. The availability of services and the complexity in arranging home care for patients with chronic conditions or high-support needs may be more difficult, and they may be more likely to have their hospital stay extended.[27, 28]

The majority (85%) of patients whose hospital stay was extended until home care was ready were hospitalized for medical, not surgical, conditions. More than 1 in 5 patients waiting for home care had dementia. Other conditions included diabetes, hip fractures, congestive heart failure, chronic obstructive pulmonary disease and cancer.

Some patients with complex needs also end up in a nursing home after a hospital stay. Last year, among patients with extended hospital stays in Canada, about twice as many (55,000) were waiting for a bed in a nursing home or a long-term care facility as for home care services or supports to be ready. Across Canada, the typical patient waits 9 days in hospital for a nursing home bed.

Figure 11   Top 5 chronic conditions for those with extended hospital stays because home care was not ready, 2017–2018
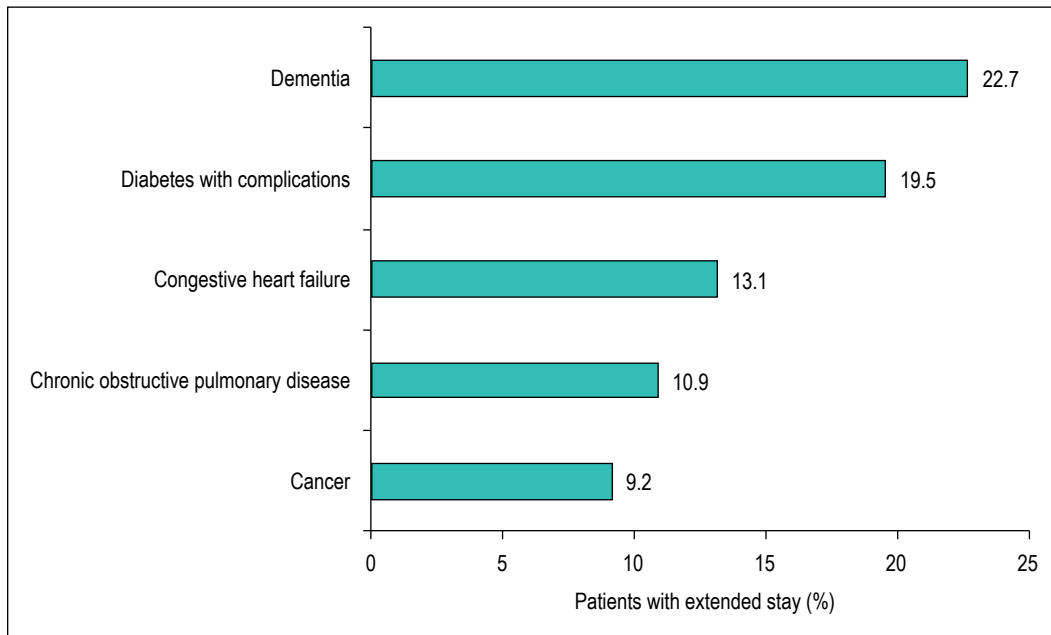
Source
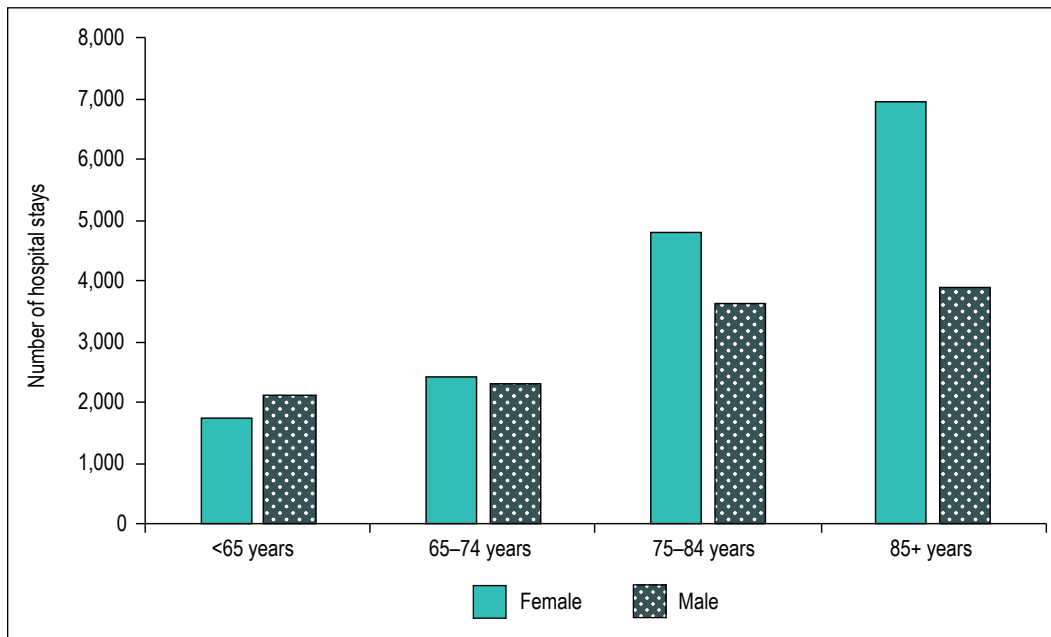Discharge Abstract Database, 2017–2018, Canadian Institute for Health Information.

Links to other CIHI resources

- Hospital Stay Extended Until Home Care Services or Supports Ready indicator
  - [Your Health System: In Brief](#) — indicator results, infographics and downloadable tables
  - [Indicator Library](#) — definitions and methodology information
- Data holdings and resources
  - [Discharge Abstract Database metadata](#)
  - [Guidelines for coding extended stays](#) (alternate level of care)
- CIHI's existing work
  - Patient Days in ALC — *[Your Health System: In Depth — Technical Notes for Contextual Measures, November 2018](#)*
  - *[Seniors in Transition: Exploring Pathways Across the Care Continuum](#)* — report

Progress report

Over the past year, CIHI and its partners — including the federal government, provinces and territories, Statistics Canada, the Mental Health Commission of Canada, the Canadian Centre on Substance Use and Addiction, the Canadian Home Care Association, as well as sector stakeholders, clinical experts and people with lived experience — have worked closely on the development of all 12 Shared Health Priorities indicators to measure access to home and community care, and to mental health and addictions services.[5] CIHI plans to report results for 3 new indicators every year until 2022, in addition to updating the results of existing measures.

Work to date on the indicators planned for release in 2020 and 2021 (see Table 1) includes

- Establishing expert advisory groups for each indicator, including clinical and subject matter experts, people with lived experience, and provincial and territorial representatives;
- Conducting literature reviews on the priority topics;
- Exploring options for indicator definitions and data sources;
- Developing approaches for patient engagement; and
- Our partner, Statistics Canada, leading the development of an indicator measuring whether home care services allowed the client receiving them to stay at home.

The goal of these efforts is to measure access to services that matter for Canadians. In order to achieve this, generating discussion about data gaps is also important. Table 6 shows where comparable data is available for reporting the 12 indicators as of the publication of this report.

Provinces and territories are starting from different places in terms of data collection and health information infrastructure. Although CIHI receives comprehensive data from across the country for hospital care, comparable data at the community level is available in some jurisdictions but not in others. As part of CIHI's Data Advancement Strategy, CIHI is working with provinces and territories, facilities and health regions to expand coverage of existing data holdings (e.g., increased participation in CIHI's Home Care Reporting System and National Ambulatory Care Reporting System), as well as exploring new ways of collecting data at the community level. This may include adapting survey tools with partners such as Statistics Canada or developing new sources of data in order to report on the indicators.

Going forward, we will continue to work with our partners to develop common information standards and explore new sources of data for public reporting. This will, over time, help to fill some of the data gaps and provide a more comprehensive picture for Canadians on access to mental health and addictions, and to home and community care.

More information on CIHI's data holdings and their coverage by province and territory is regularly updated on CIHI's website.

Table 6   Indicator development progress

Indicator	Year and stream	Status of standard definition	Standard for comparable data
Hospital Stays for Harm Caused by Substance Use	Year 1 Mental Health and Addictions	Complete	Hospital Morbidity Database; Discharge Abstract Database (In Ontario, hospital data for this indicator is captured through the Ontario Mental Health Reporting System and the National Ambulatory Care Reporting System.)
Frequent Emergency Room Visits for Help With Mental Health and/ or Addictions	Year 1 Mental Health and Addictions	Complete	National Ambulatory Care Reporting System
Hospital Stay Extended Until Home Care Services or Supports Ready	Year 1 Home and Community Care	Complete	Discharge Abstract Database
Self-Harm, Including Suicide	Year 2 Mental Health and Addictions	Building on existing work — In progress	National Ambulatory Care Reporting System (Level 3); Hospital Morbidity Database; Discharge Abstract Database Vital Statistics (Statistics Canada) (In Ontario, hospital data for this indicator is captured through the Ontario Mental Health Reporting System.)
Caregiver Distress	Year 2 Home and Community Care	Building on existing work — In progress	Home Care Reporting System; Resident Assessment Instrument– Home Care; interRAI Home Care

Indicator	Year and stream	Status of standard definition	Standard for comparable data
Long-Term Care Provided at the Appropriate Time	Year 2 Home and Community Care	Building on existing work — In progress	Continuing Care Reporting System; Resident Assessment Instrument–Minimum Data Set 2.0 (or interRAI Long-Term Care Facilities)
Wait Times for Community Mental Health Services, Referral/Self-Referral to Services	Year 3 Mental Health and Addictions	Provincial/territorial work — In progress	New provincial data collection
Wait Times for Home Care Services, Referral to Services	Year 3 Home and Community Care	Provincial/territorial work — In progress	New provincial data collection
Home Care Services Helped the Recipient Stay at Home	Year 3 Home and Community Care	Questions to be added to existing survey — In progress	Canadian Community Health Survey (Statistics Canada)
Awareness and/ or Successful Navigation of Mental Health and Addictions Services	Year 4 Mental Health and Addictions	New definition required	New, survey-based
Early Identification for Early Intervention in Youth Age 10 to 25	Year 4 Mental Health and Addictions	New definition required	New, survey-based
Death at Home/ Not in Hospital	Year 4 Home and Community Care	New definition required	To be determined

Note
All data sources are from CIHI except where noted.

Conclusion

It is not yet 2 years since the FPT governments agreed to focus on the shared health priorities of home, community, mental health and addictions care. They committed to improve access to services for Canadians and to provide accountability for Canadians, through yearly reporting of their progress. All the parties to that effort — governments, patients, members of the public, stakeholders and measurement experts — have worked hard since then to reach the stage outlined in this report: 12 indicators have been selected, 3 of them have been reported on here, and 9 others are in various stages of development.

That hard work will continue through 2022 as the remaining indicators are gradually added to annual public reporting and the others are refined. The new indicators will spark many questions about what is driving the numbers and how best to improve results. To help answer these questions, CIHI will undertake some analytical work and support researchers and health partners who want to further investigate. As the indicators begin to tell us more about access to care in the shared health priority areas and how it is evolving over time, health system planners and providers will be able to design and manage programs and learn from each other about the best way to meet the needs of Canadians.

Change won't happen overnight. These measures represent difficult areas for health systems and reflect complex public health challenges with no simple fixes. This report sets a baseline for the first 3 indicators. Improving access to effective home, community, mental health and addictions care will require careful planning and sustained effort over time. CIHI will continue to work closely with decision-makers, health stakeholders and Canadians to ensure that the information we are collecting and providing can help guide these improvement efforts, and ultimately, help improve the health and quality of life of Canadians and their families.

Appendix A: Hospital stays for harm caused by substance use — Data table

Table A1 Hospital stays for harm caused by substance use, by jurisdiction and substance, 2017–2018

Jurisdiction	Alcohol	Unknown and multiple substances	Cannabinoids	Opioids	Other stimulants	Cocaine	Other depressants	Other substances
Canada	53.0%	16.9%	15.0%	12.3%	11.2%	7.8%	6.4%	0.4%
Newfoundland and Labrador	54.8%	15.4%	8.5%	14.9%	2.6%)	9.5%	14.2%	0.9%
Prince Edward Island	47.6%	21.3%	18.4%	9.7%	3.2%	1.8%	5.7%	0.0%
Nova Scotia	69.9%	7.6%	12.1%	12.8%	1.9%	9.1%	6.1%	0.1%
New Brunswick	47.7%	12.9%	24.2%	11.1%	14.6%	9.1%	11.2%	0.4%
Ontario	53.0%	21.0%	11.4%	11.8%	5.3%	6.7%	5.6%	0.3%
Manitoba	60.8%	13.8%	11.2%	9.2%	10.3%	6.3%	6.2%	0.7%
Saskatchewan	57.0%	12.0%	22.7%	11.4%	14.7%	6.7%	5.2%	1.0%
Alberta	60.2%	12.8%	13.6%	13.1%	14.0%	6.9%	5.3%	0.5%
British Columbia	52.6%	12.9%	12.6%	20.1%	16.1%	8.5%	5.2%	0.4%
Yukon	82.4%	4.4%	3.8%	8.0%	—	6.0%	4.1%	—

Jurisdiction	Alcohol	Unknown and multiple substances	Cannabinoids	Opioids	Other stimulants	Cocaine	Other depressants	Other substances
Northwest Territories	85.8%	2.2%	16.1%	3.9%	0.9%	8.5%	2.1%	—
Nunavut	51.3%	14.1%	36.8%	2.2%	—	—	—	—

Notes

— Data suppressed due to small volumes.

"Unknown" is the term used for unidentified, possibly multiple, substances.

"Other stimulants" include methamphetamine, whereas "Other depressants" include benzodiazepines, or sleeping pills.

"Other substances" include hallucinogens and solvents.

Percentages show the contribution of each substance within each jurisdiction.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles,

based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

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

Appendix B: Methodological notes

Hospital Stay Extended Until Home Care Services or Supports Ready

- Data documentation differences may explain some of the differences in results between provinces and territories.

  – CIHI has developed methodology to estimate the number of potential missed cases — long hospitalizations with no documentation of extended stays — which ranges from 9% to 100% among the provinces and territories.

  – The typical range is between 9% and 21% of cases, but in some jurisdictions (Nova Scotia, N.W.T. and Nunavut) the percentage is greater, suggesting different documentation practices.

Jurisdiction	N.L.	P.E.I.	N.S.	N.B.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.
%	16	21	39	20	15	21	9	15	16	9	30	100

- Hospital stays for mental health are submitted to a different database in Ontario (the Ontario Mental Health Reporting System) as well as in some regions in Manitoba that do not record when patients are discharged home with support. To ensure comparability across jurisdictions, these mental health hospital stays are excluded altogether (except dementia and organic mental disorders).

  – In other provinces and territories, the inclusion of mental health hospital stays had little impact on overall results, increasing the median length of stay for extended stays in only 2 jurisdictions (Manitoba and the Northwest Territories).

Appendix C: Text alternative for images and figures

First image: Every day, more than 400 Canadians are hospitalized because of harm from alcohol or drugs. This is more than for heart attacks and strokes combined. And every day, 10 Canadians die in hospital from harm caused by substance use. 3 in 4 of these deaths are due to alcohol.

Second image: Nearly 1 in 10 Canadians who visit the emergency room for help with mental health and/or addictions have 4 or more visits a year.

Third image: More than 90% of hospital patients can access home care promptly. However, 1 in 12 have their hospital stay extended until home care services or supports are ready. This is the equivalent of 3 large (400-bed) hospitals filled to capacity every day.

Figure 1: Age-standardized hospitalization rate for substance use, by jurisdiction, 2017–2018

Jurisdiction	Rate	Lower confidence interval	Upper confidence interval
Canada	477	—	—
N.L.	373	355	391
P.E.I.	567	526	608
N.S.	453	439	468
N.B.	400	385	415
Ont.	400	397	404
Man.	401	390	413
Sask.	580	565	595
Alta.	531	524	539
B.C.	701	693	709
Y.T.	1,022	917	1,127
N.W.T.	2,015	1,869	2,162
Nun.	870	740	1,000

Notes

— Not applicable.

The confidence interval (CI) is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

Rates are age-adjusted.

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec provincial results are not included in this report.

Sources

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

Figure 2: Rate of hospital stays for substance use, by age and sex, 2017–2018

Age	Female	Male	Both
10–14	72	35	53
15–19	442	397	419
20–24	483	640	563
25–29	477	731	605
30–34	457	738	597
35–39	418	706	562
40–44	355	650	502
45–49	346	679	513
50–54	354	737	547
55–59	337	720	528
60–64	286	718	499
65–69	251	667	454
70–74	231	568	392
75–79	233	486	349
80–84	193	409	287
85–89	184	371	257
90+	163	265	193

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

**Figure 3: Cause of hospital stays for harm attributed
to substance use, by substance, Canada, 2017–2018**

Substance	Percentage
Alcohol	53.0
Unknown	16.9
Cannabis	15.0
Opioids	12.3
Other stimulants	11.2
Cocaine	7.8
Other depressants	6.4
Other substances	0.4

Notes

Percentages do not add to 100, as more than one substance can be
documented per hospitalization.

"Unknown" is the term used for unidentified, possibly multiple, substances.

"Other stimulants" include methamphetamine, whereas "Other depressants"
include benzodiazepines, or sleeping pills.

"Other substances" include hallucinogens and solvents.

Sources

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

Figure 4: Top 3 substances causing hospital stays, by province and territory, 2017–2018

Jurisdiction	First substance	Second substance	Third substance
N.L.	Alcohol	Unknown	Opioids
P.E.I.	Alcohol	Unknown	Cannabis
N.S.	Alcohol	Opioids	Cannabis
N.B.	Alcohol	Cannabis	Other stimulants
Ont.	Alcohol	Unknown	Opioids
Man.	Alcohol	Unknown	Cannabis
Sask.	Alcohol	Cannabis	Other stimulants
Alta.	Alcohol	Other stimulants	Cannabis
B.C.	Alcohol	Opioids	Other stimulants
Y.T.	Alcohol	Opioids	Cocaine
N.W.T.	Alcohol	Cannabis	Cocaine
Nun.	Alcohol	Cannabis	Unknown

Notes

The Government of Canada and the Government of Quebec agreed on March 10, 2017, to an asymmetrical agreement distinct
from the present statement of principles, based on the asymmetrical agreement of September 2004. Therefore, Quebec
provincial results are not included in this report.

"Unknown" is the term used for unidentified, possibly multiple, substances.

"Other stimulants" include methamphetamine.

Sources

Hospital Morbidity Database and Ontario Mental Health Reporting System, 2017–2018, Canadian Institute for Health Information.

Figure 5: Rate of frequent ER visits for help with mental health and/or addictions, by jurisdiction, 2017–2018

Jurisdiction	Rate	Lower confidence interval	Upper confidence interval
Canada*	9.4	—	—
P.E.I.[†]	6.5	5.1	8.3
N.S.[†]	6.4	5.6	7.4
Ont.	9.5	9.4	9.7
Sask.[†]	8.8	8.2	9.3
Alta.	10.3	10.0	10.5
B.C.[†]	8.4	8.1	8.7
Y.T.	16.3	14.2	18.6

Notes

* Total includes data submitted from Manitoba.

† Jurisdictions with partial ER data submission, leading to likely underestimation of repeat visits. Results should not be compared.

— Not applicable.

Rates are age- and sex-adjusted.

The CI is used to establish whether the indicator result is statistically different from the average. The width of the CI illustrates the degree of variability associated with the rate. For example, a province or territory might have a wide CI if there is a small number of cases and the results are less stable. Indicator values are estimated to be accurate within the upper and lower CI 19 times out of 20 (95% CI). Rates with CIs that do not overlap with the Canada result can be considered statistically different.

Source

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

Figure 6: Frequent ER visits, by age and sex, 2017–2018

Age	Female	Male	Both
10–14	436	176	303
15–19	1,712	992	1,341
20–24	1,782	1,810	1,797
25–29	1,600	2,179	1,890
30–34	1,425	2,182	1,800
35–39	1,306	2,024	1,661
40–44	1,012	1,745	1,375
45–49	797	1,604	1,199
50–54	760	1,520	1,142
55–59	601	1,212	906
60–64	438	898	664
65–69	379	566	469
70–74	264	386	322
75–79	250	247	248
80–84	229	110	177
85–89	169	147	160
90+	119	44	97

Note
Rates are for frequent ER users in Ontario, Alberta and Yukon combined.
Source
National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information.

Figure 7: Percentage of patients with 4+ ER visits for mental health and addictions, by neighbourhood income, 2017–2018

Income quintile (poorest to richest)	Non-frequent ER users (1 to 3 visits)	Frequent ER users (4 or more visits)
Q1	30%	40%
Q2	21%	21%
Q3	18%	15%
Q4	16%	13%
Q5	14%	11%

Note
Percentages may not add up to 100 due to rounding.
Sources
National Ambulatory Care Reporting System, 2016–2017 to 2017–2018, Canadian Institute for Health Information;
Postal Code Conversion File Plus, Statistics Canada.

Figure 8: Median length of extended stay for patients discharged to home care, by jurisdiction, 2017–2018

Jurisdiction	Median length of extended stay (days)
Canada	7
N.L.	7
P.E.I.*	18
N.S.	13
N.B.	11
Ont.	7
Man.	3
Sask.	10
Alta.	11
B.C.	7
Y.T.*	13
N.W.T.*	24
Nun.*	4

Notes
* Because the number of extended hospital stays is small in the territories and in provinces with smaller populations, results are not stable, and comparisons with larger provinces should be made with caution.
Most patients (92%) discharged to home care don't have extended hospital stays and are not included in this indicator.
Source
Discharge Abstract Database, 2017–2018, Canadian Institute for Health Information.

Figure 9: Length of time a hospital stay is extended until home care is ready, 2017–2018

This graph shows the number of hospital stays that were extended until home care is ready, by length of time in days. The number of extended stays was highest for those that were extended between 1 and 3 days; half of extended stays were 7 days or less. The average length of extended stay was 17 days, and only 1 in 10 extended stays was 39 days or longer. Some extended stays were up to 365 days or longer.

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

Figure 10: Extended hospital stays until home care is ready, by age and sex, 2017–2018

Age	Female	Male
<65	1,709	2,099
65–74	2,384	2,304
75–84	4,787	3,608
85+	6,932	3,889

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

Figure 11: Top 5 chronic conditions for those with extended hospital stays because home care was not ready, 2017–2018

Condition	Percentage of patients with extended stay with this condition
Dementia	22.7
Diabetes with complications	19.5
Congestive heart failure	13.1
Chronic obstructive pulmonary disease	10.9
Cancer	9.2

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

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