

Depression

Chapter 5

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Project for an Ontario Women's Health Evidence-Based Report

A Tool for Monitoring and Improvement

The **P**roject for an **O**ntario **W**omen's Health **E**vidence-Based **R**eport (**POWER**) will serve as a tool to help policymakers and providers to improve the health of and reduce inequities among the women of Ontario.

Uses for POWER Study

- Priority Setting
- Building the Evidence Base
- Informing Practice and Policy
- Tool for Improvement
- Integrating Equity into Planning and Quality Improvement

Stakeholder Consultations

- Power Study Roundtables
- Consumers: representatives of community based groups and associations
- Providers: clinicians, government, health data agencies, LHINs, CHCs, CCACs
- Range of areas and interests
 - Especially cancer, cardiovascular, and depression
 - Some representation from outside GTA

Ontario Women's Health Equity Report

Volume 1

- Burden of Illness
- Cancer
- Depression
- Cardiovascular disease
- Access to Health Care
- Conclusions and Policy Implications

Volume 2

- Diabetes
- HIV Infection
- Musculoskeletal Disorders (arthritis, osteoporosis)
- Reproductive and Gynecological Health
- Special Populations (low income, immigrant and older women)
- Social Determinants of Health

Interactive data cube

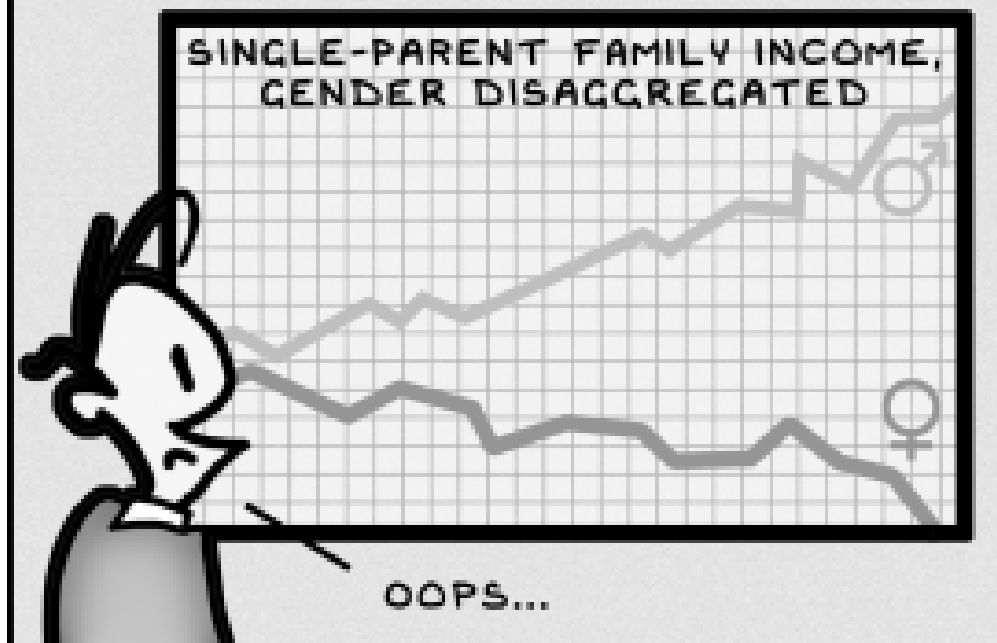
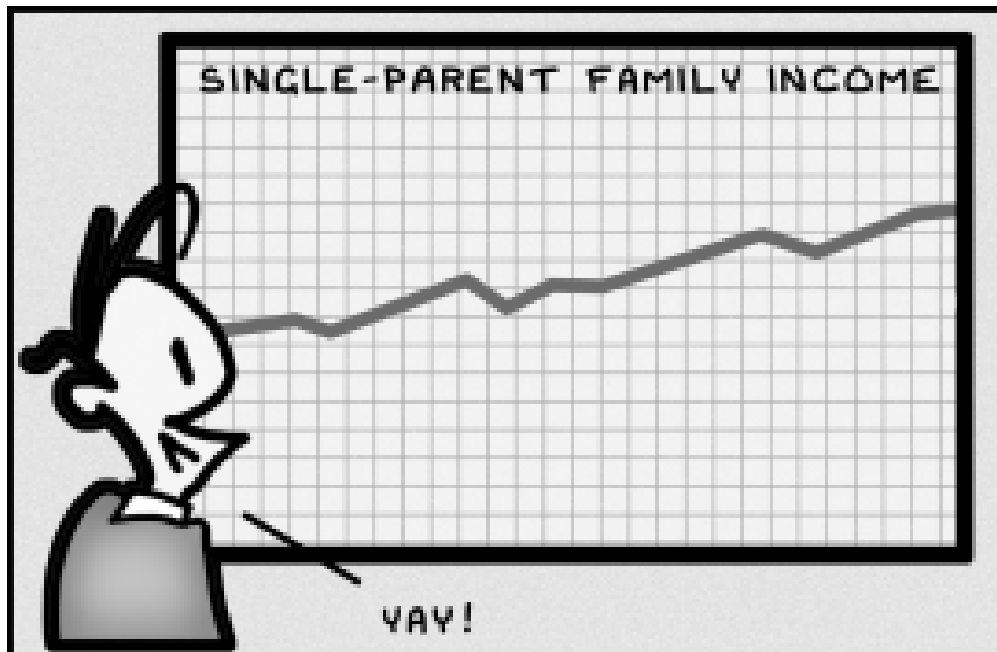
Measuring and Monitoring Gender Differences in Depression Indicators

Women and men have very different:

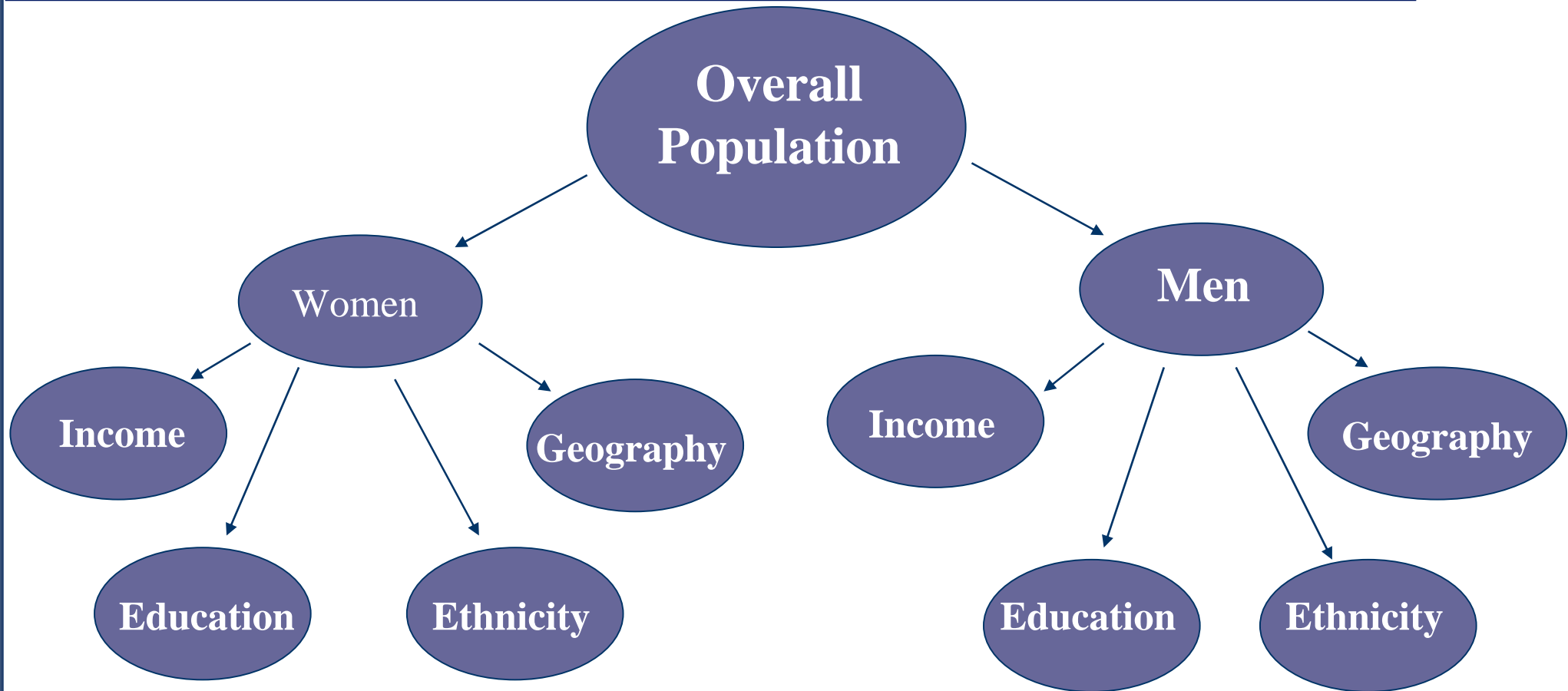
- Patterns of illness and morbidity
- Social contexts
- Experiences with health care

Health inequities among women associated with:

- Socioeconomic position
- Age
- Geography



Assessing Equity



Women's Health Reporting: Developing a New Model

- **The Ontario Women's Health Equity Report can serve as a model for:**
 - incorporating gender and equity as an integral component of improvement efforts;
 - focusing on the need to integrate efforts to improve population health and health care services;
 - building upon evidence-based analyses to provide new information on factors and pathways contributing to gender and socioeconomic differences in health outcomes.

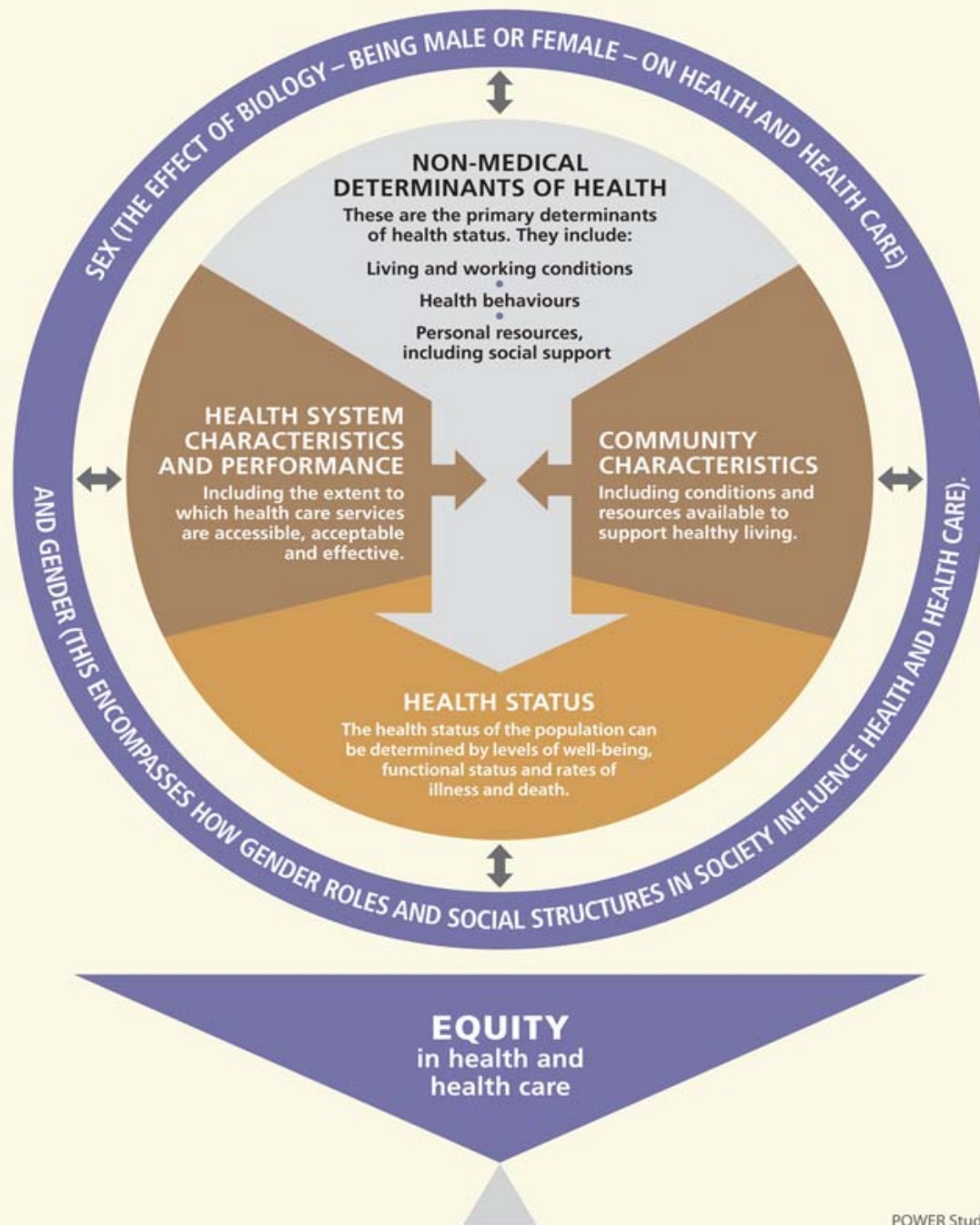
Health Indicator Measurement and Reporting: A Tool to Drive Change

- **Health indicator measurement and reporting provide essential tools for informing and monitoring efforts to:**
 - Improve population health
 - Improve access to quality and outcomes of health care services
 - Reduce inequities in health and health care

Effecting Change . . .

- Reporting by itself does not result in improvement.
- For performance measurement and reporting to result in change it needs to be evidence-based, strategy driven, linked to a commitment for change by health system leaders and providers, and mechanisms for accountability.

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- POWER Study Women's Health Equity Framework



POWER Study Gender and Equity Health Indicator Framework

- Measuring inequities in depression care

Continuum of Depression Care

CONTINUUM OF DEPRESSION CARE

Prevention/
health
promotion

Community
Services/
supports

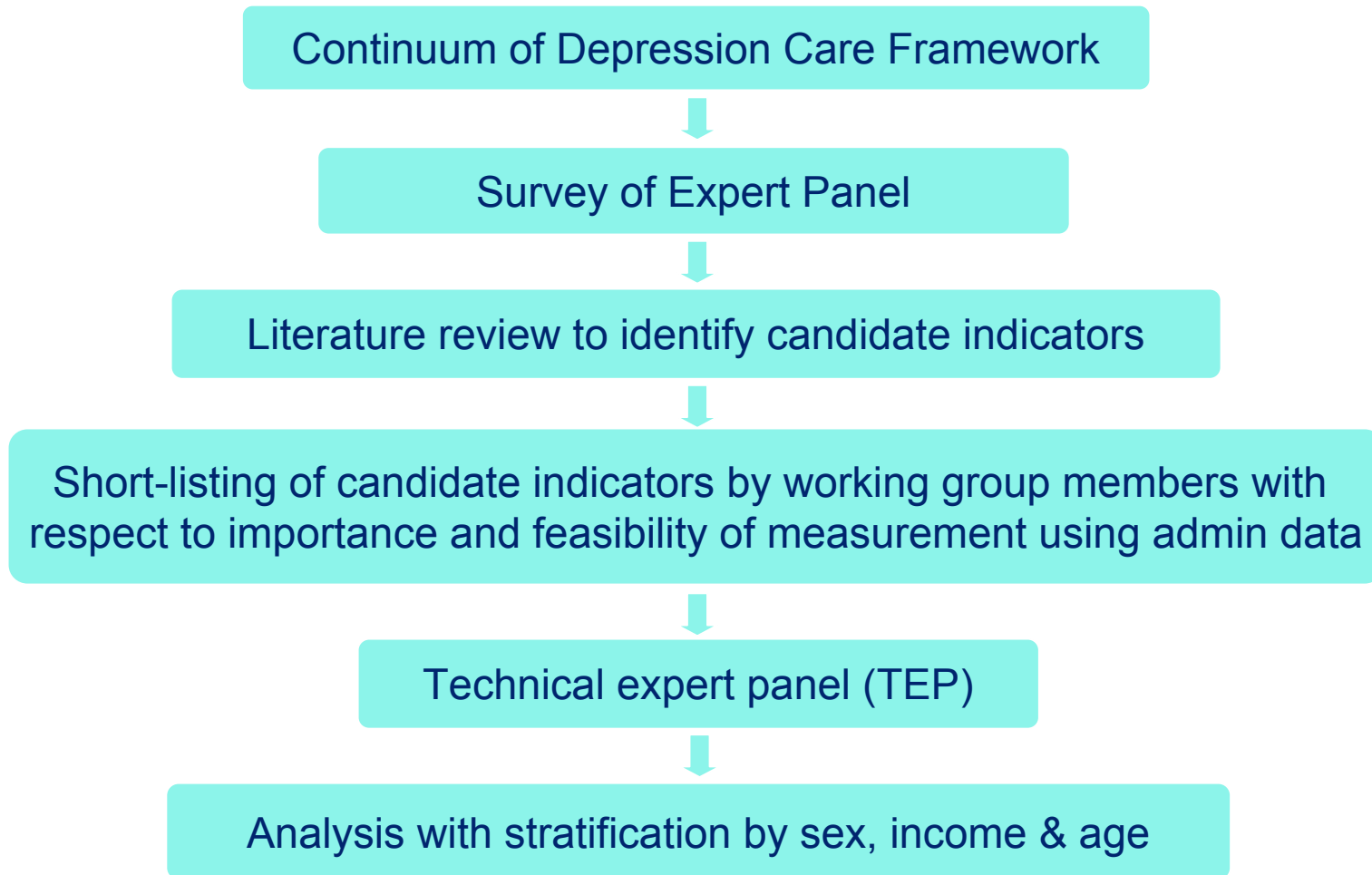
Primary
Care

Specialty
outpatient
care

Acute
outpatient
care

Specialty
hospital
care

Process for Indicator Selection



Depression Chapter Indicators

- Background Measures
(5 measures of need)
(4 measures of use)
(3 measures of supply)
- Primary and Specialty Outpatient Care
(3 indicators)
- Acute and Specialty Inpatient Care
(4 indicators)

Data Sources

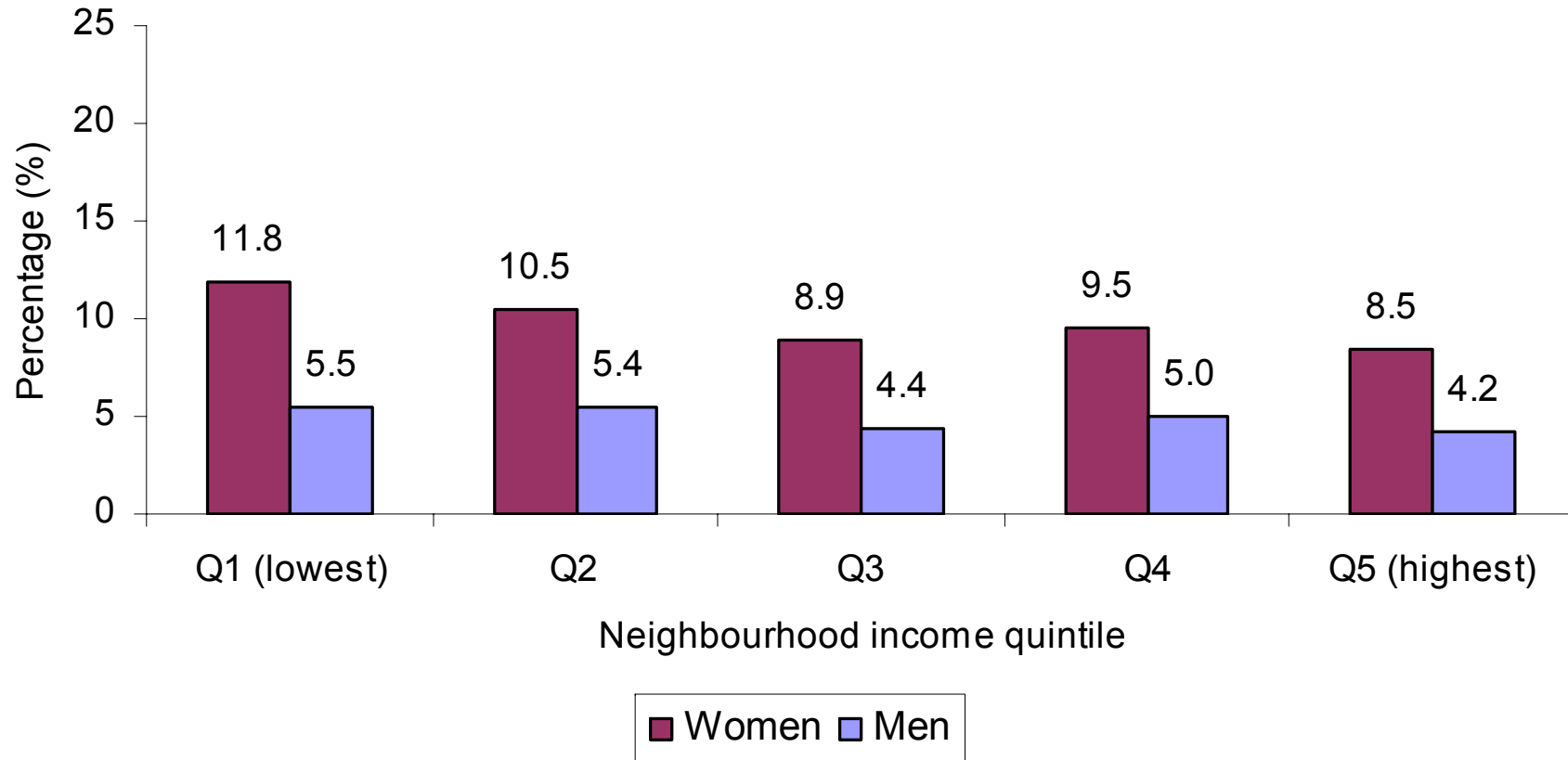
Linkable data (2001 & 2005/06) from:

- Canadian Community Health Survey (CCHS), Cycle 1.1 (2000/01)
- Daily Census Summary Report Mental Health Beds online, MOHLTC Health Data Branch
- Canadian Institute for Health Information Discharge Abstract Database (CIHI-DAD)
- Ontario Health Insurance Plan (OHIP)
- National Ambulatory Care Reporting System (NACRS)
- Ontario Drug Benefit (ODB) database
- ICES Physician Database (IPDB)
- ICES Mother-Baby Linked database (MOMBABY)
- Statistics Canada 2001 Census

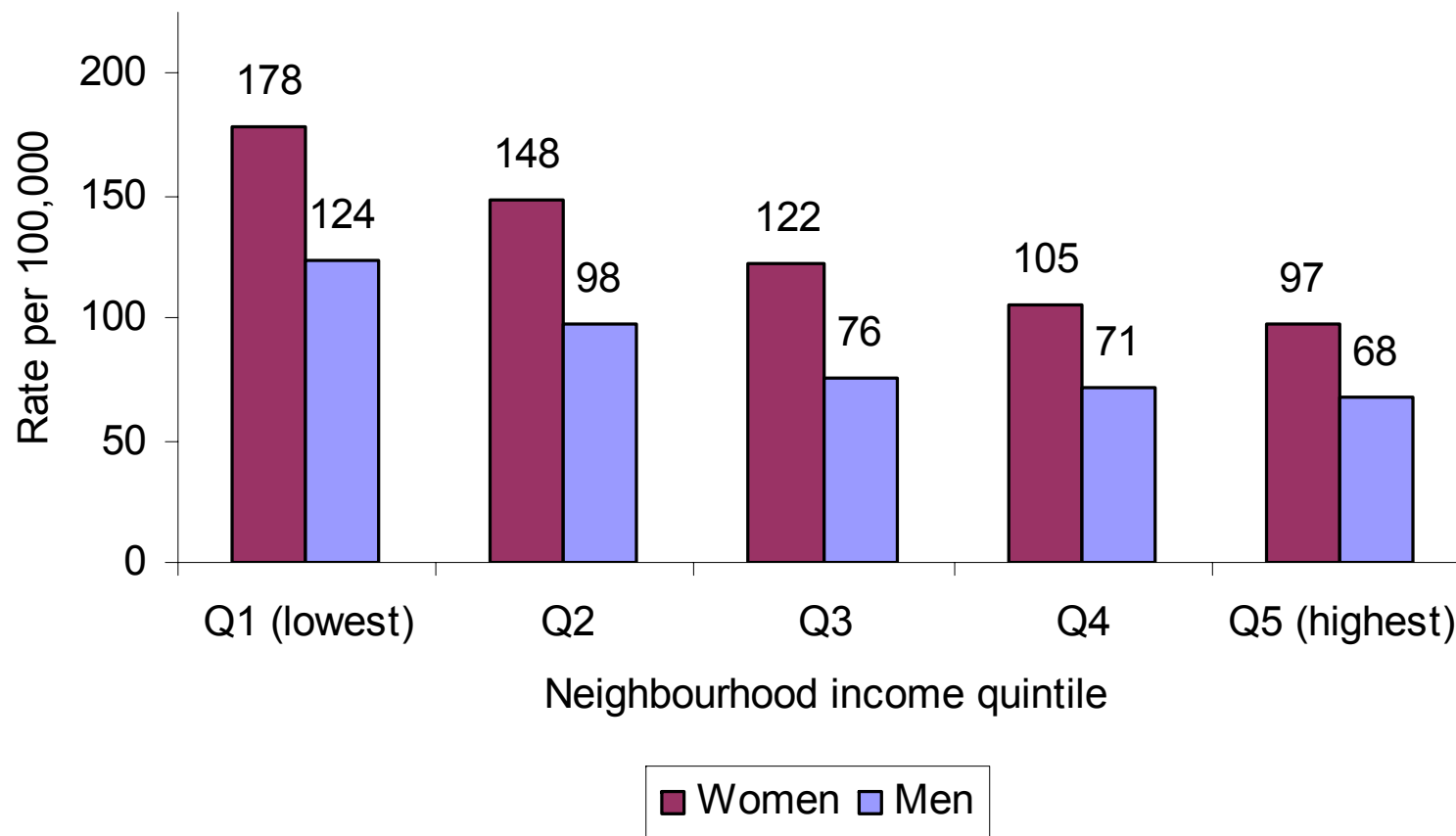
All analyses stratified by sex, then by age, income, at the provincial and LHIN levels sample size permitting

- Background Measures

Age-standardized prevalence of probable depression in Ontarians aged 15 and older, by sex and neighbourhood income quintile, 2001



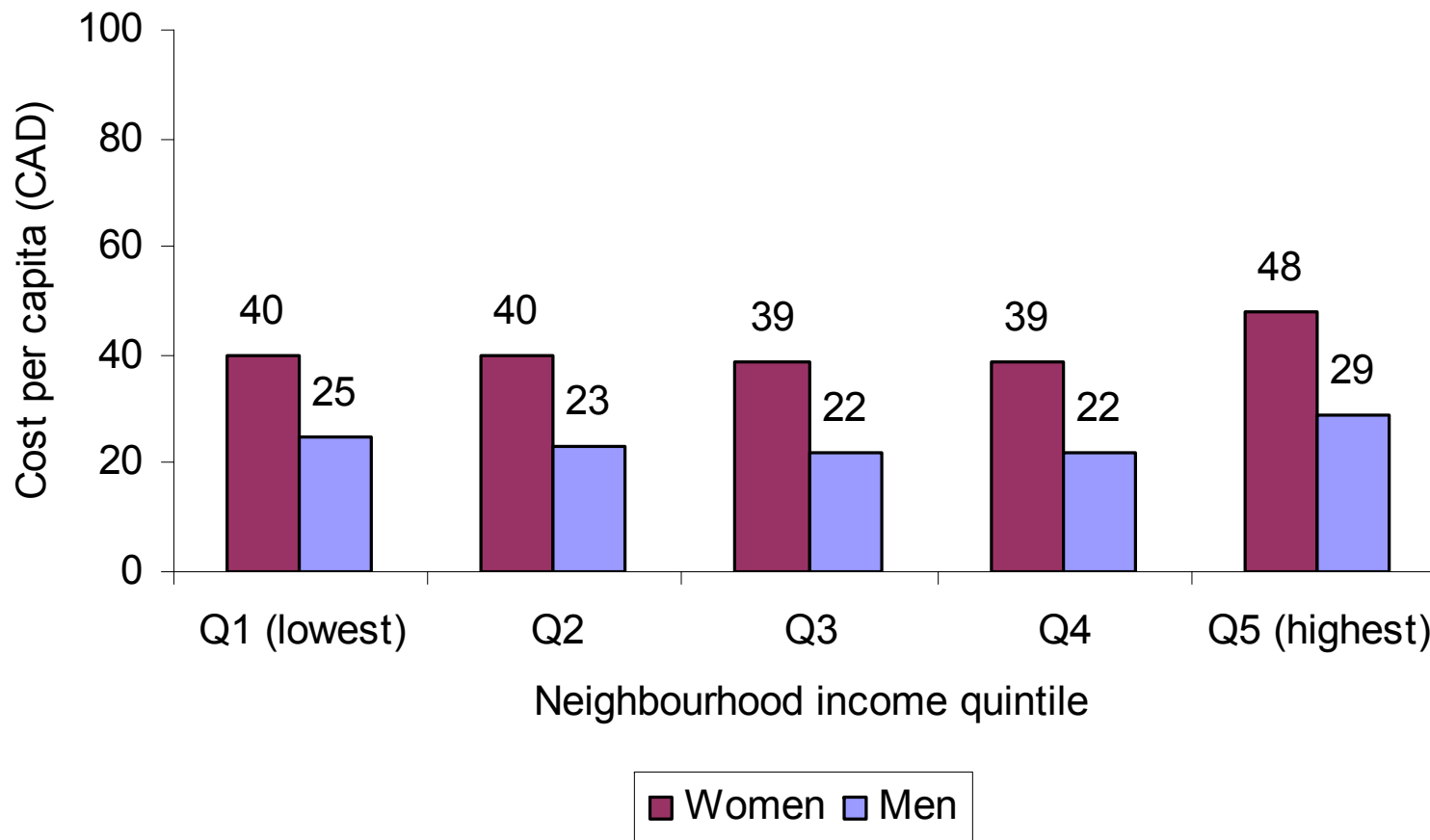
Age-standardized rate (per 100,000 population) of hospitalizations for depression in Ontarians aged 15 and older, by sex and neighbourhood income quintile, 2005/06[^]



Data sources: Canadian Institute for Health Information Discharge Abstract Database (CIHI-DAD); Statistics Canada 2001 Census; Registered Persons Database (RPDB)

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

Age-standardized Ontario Health Insurance Plan (OHIP) core mental health care costs[^] per capita, by sex and neighbourhood income quintile, in Ontario, 2005/06[†]

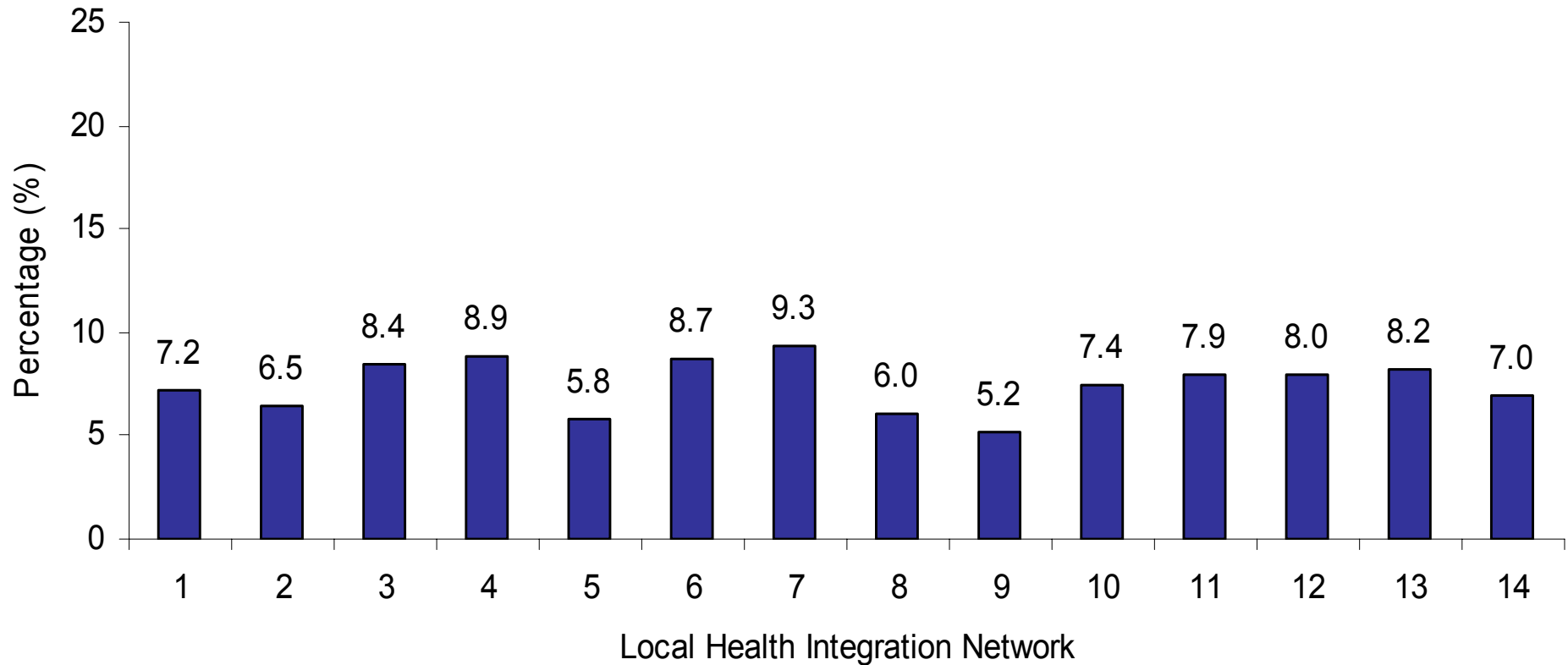


Data sources: Ontario Health Insurance Plan (OHIP); Statistics Canada 2001 Census; RPDB

[^] Based on fee-for-service OHIP billings for assessment, diagnosis or treatment

[†] People who accessed services from Mar 1, 2005 – Feb 28, 2006

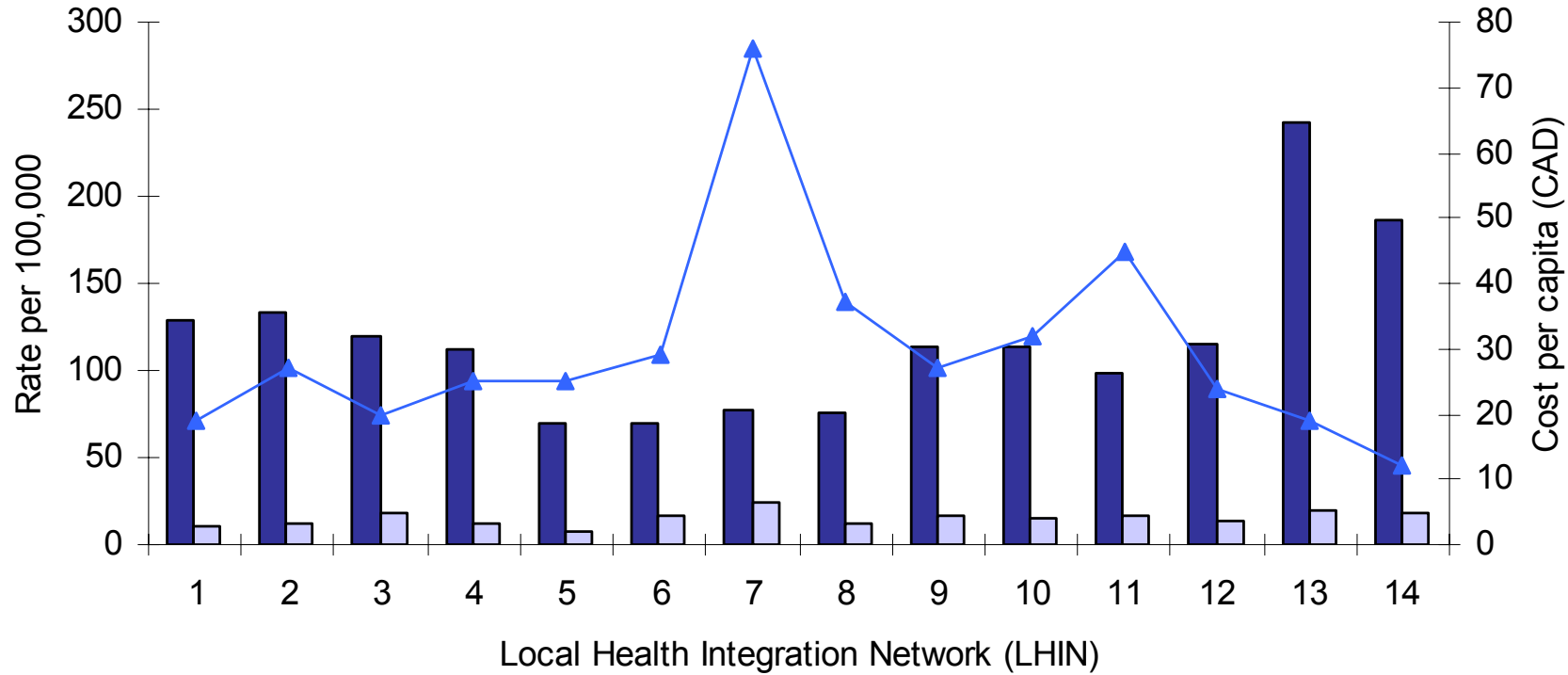
Prevalence of probable depression in Ontarians^ aged 15 and older, by Local Health Integration Network (LHIN)



Data source: CCHS, Cycle 1.1

^ Brant region did not participate in the depression module of CCHS 1.1

Treatment rates and costs associated with depression and core mental health care use in Ontarians aged 15 and older, by measure and Local Health Integration Network (LHIN), 2005/06[^]



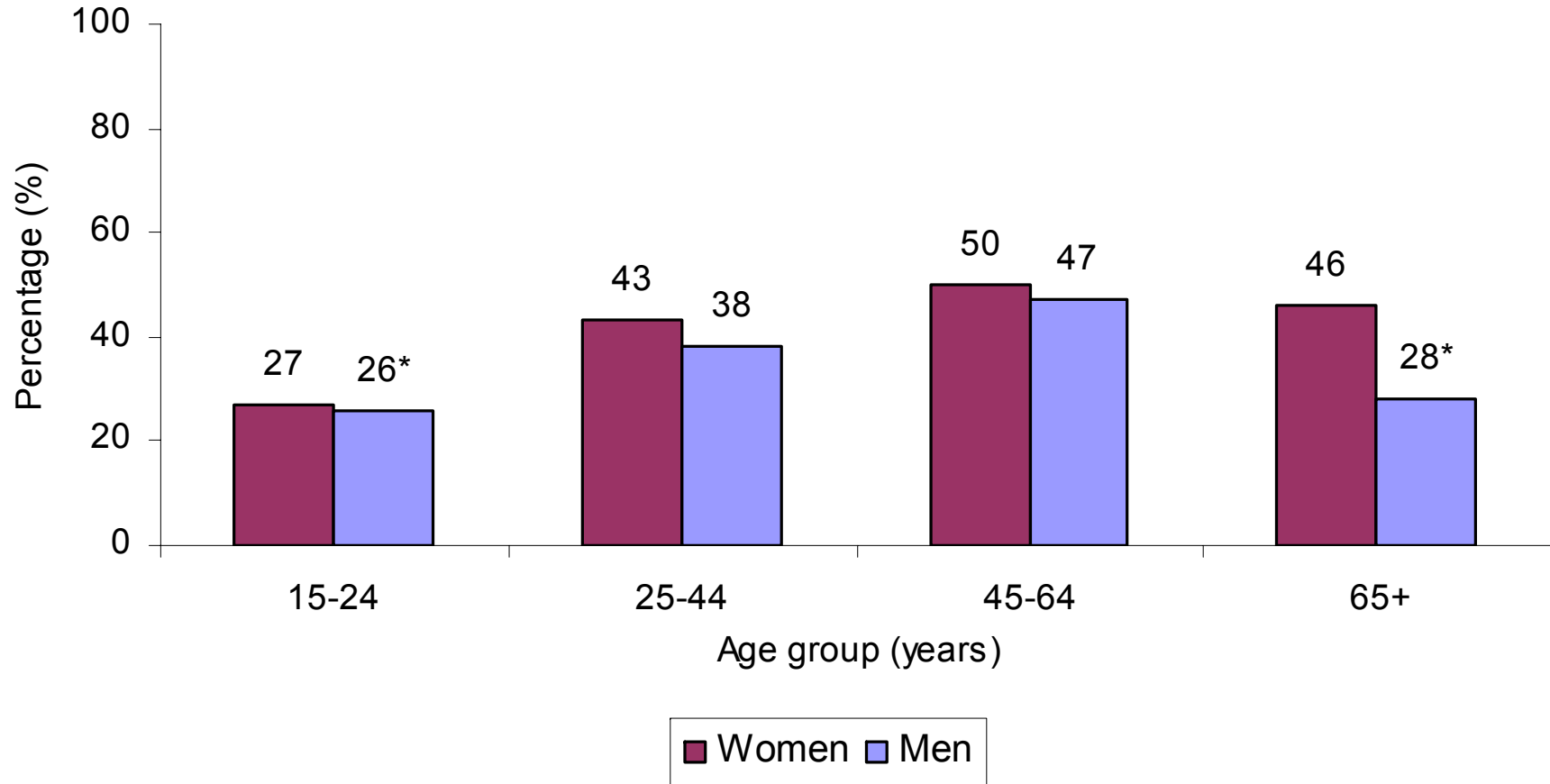
Rate of hospitalization for depression†
 ECT users‡
 OHIP core mental health costs‡

Data source: RPDB; † CIHI-DAD; ‡ OHIP

[^] People who were discharged from hospital or accessed services from Mar 1, 2005 – Feb 28, 2006

- Primary and Specialty Outpatient Care Indicators

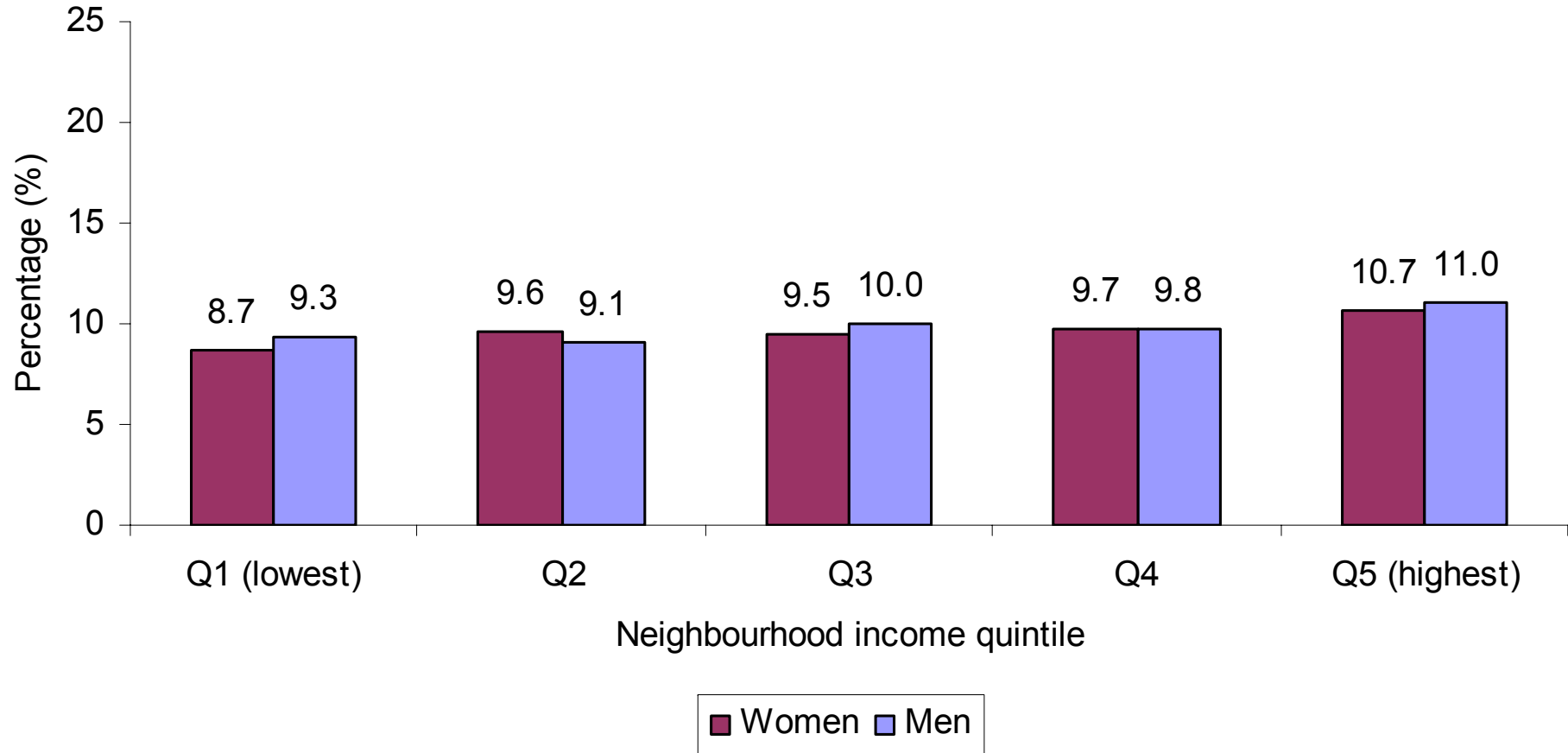
Percentage of Ontarians aged 15 and older with probable depression who had a physician visit for depression, by sex and age group



Data sources: CCHS, Cycle 1.1; OHIP

* Interpret with caution due to high sampling variability

Age-standardized percentage of adults aged 66 and older, starting a new course of antidepressants[^] who had three or more physician visits for depression within 12 weeks of starting medication, by sex and neighbourhood income quintile, in Ontario, 2005/06[†]



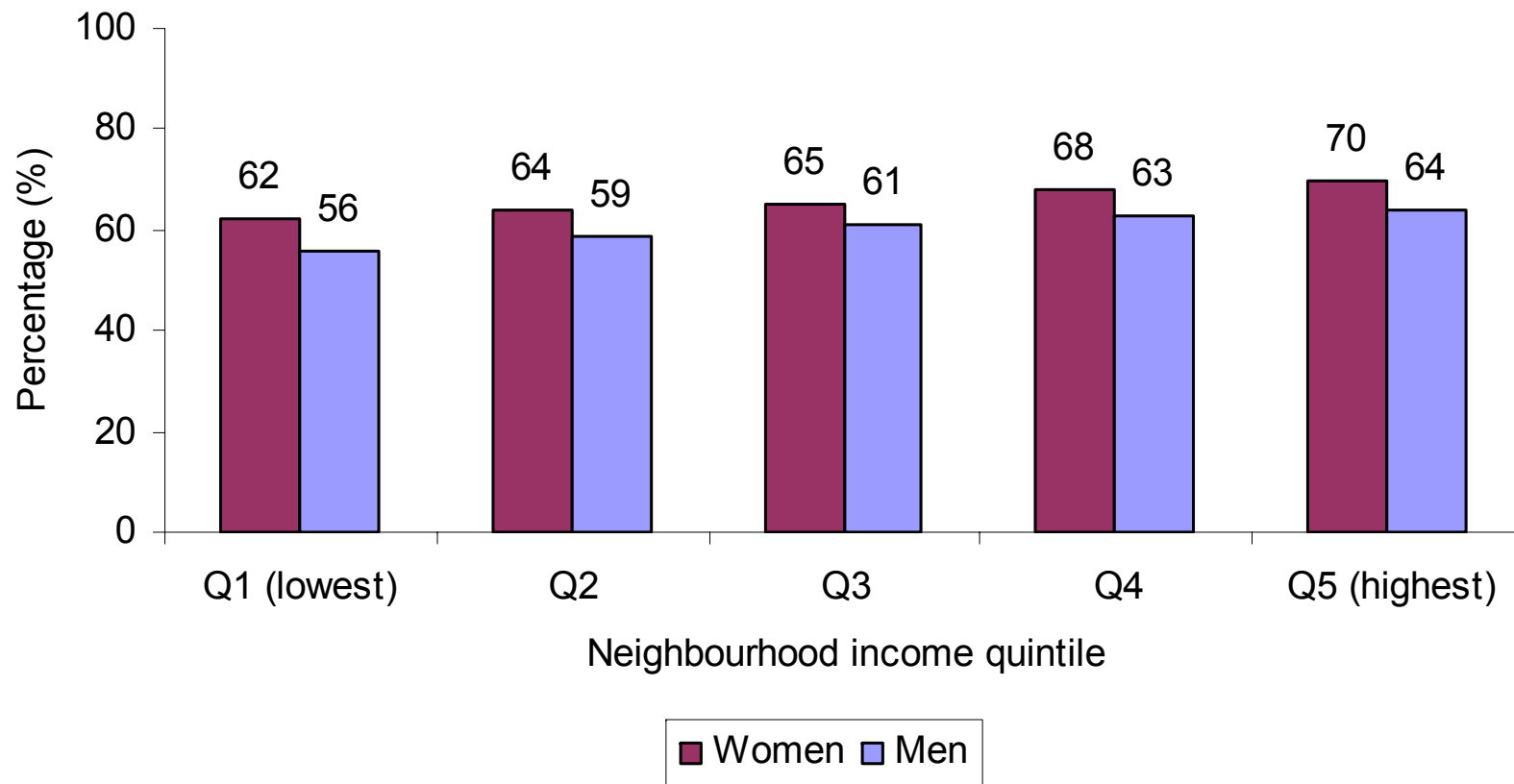
Data sources: Ontario Drug Benefits (ODB) database; OHIP; Statistics Canada 2001 Census

[^] Based on fee-for-service OHIP billings for assessment, diagnosis or treatment

[†] People who accessed services from Mar 1, 2005 – Feb 28, 2006

- Acute and Specialty Inpatient Care Indicators

Age-standardized percentage of patients aged 15 and older admitted to hospital for depression who had a physician visit for depression within 30 days of discharge, by sex and neighbourhood income quintile, in Ontario, 2005/06[^]

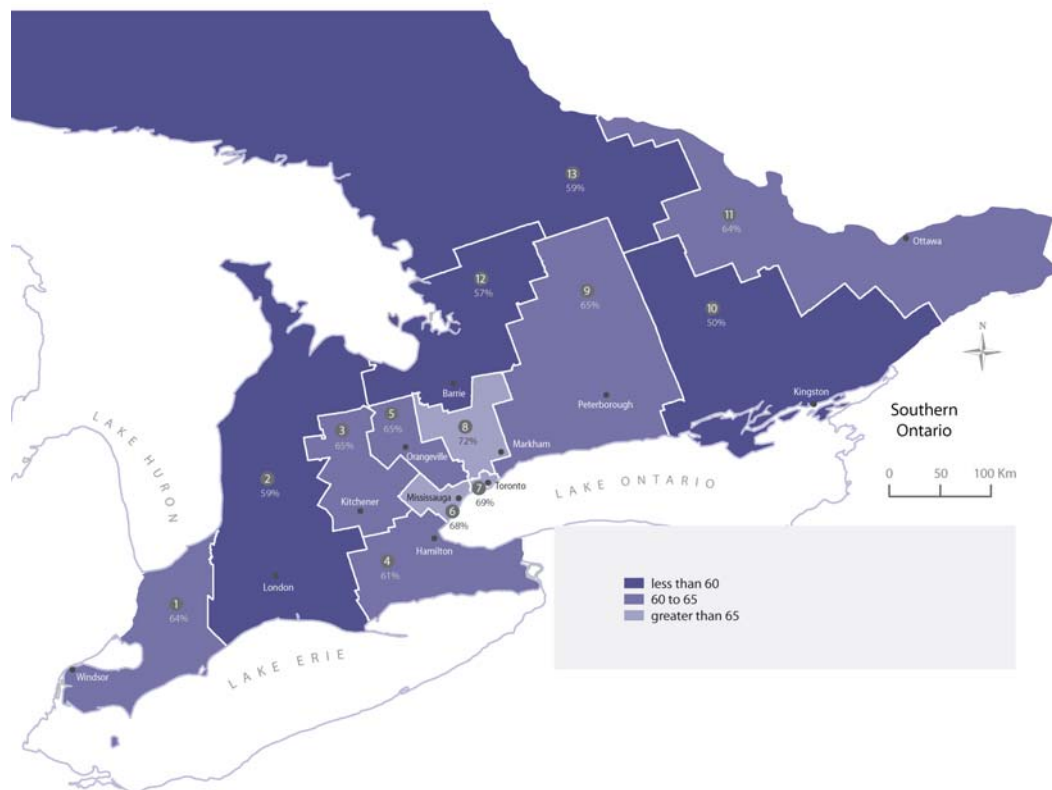
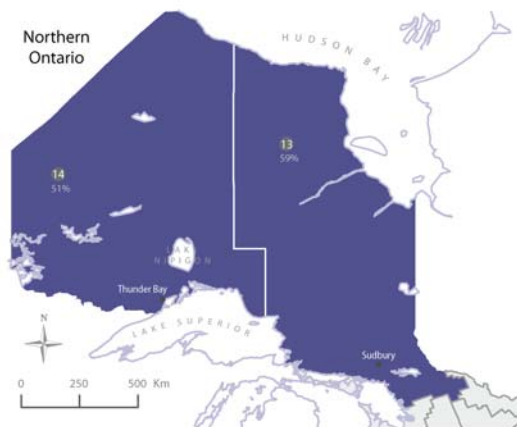


Data sources: CIHI-DAD; OHIP; Statistics Canada 2001 Census

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

Overall Ontario

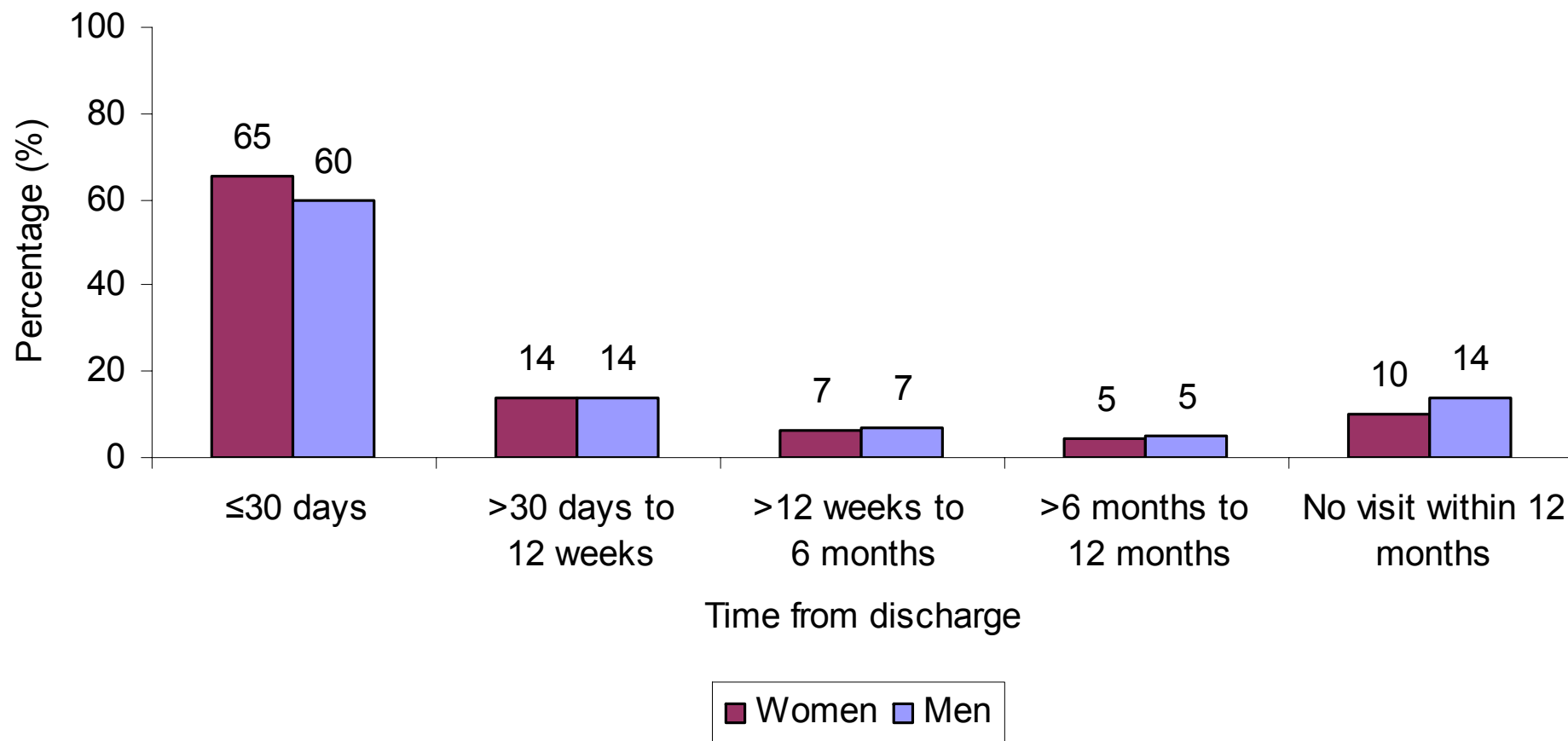
In Ontario, 63% of all inpatient stays for depression were followed by one or more physician visits for depression within 30 days after discharge.



Percentage of patients aged 15 and older admitted to hospital for depression who had a physician visit for depression within 30 days of discharge, by Local Health Integration Network (LHIN), in Ontario, 2005/06[^]

Data Sources: CIHI-DAD; OHIP
[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

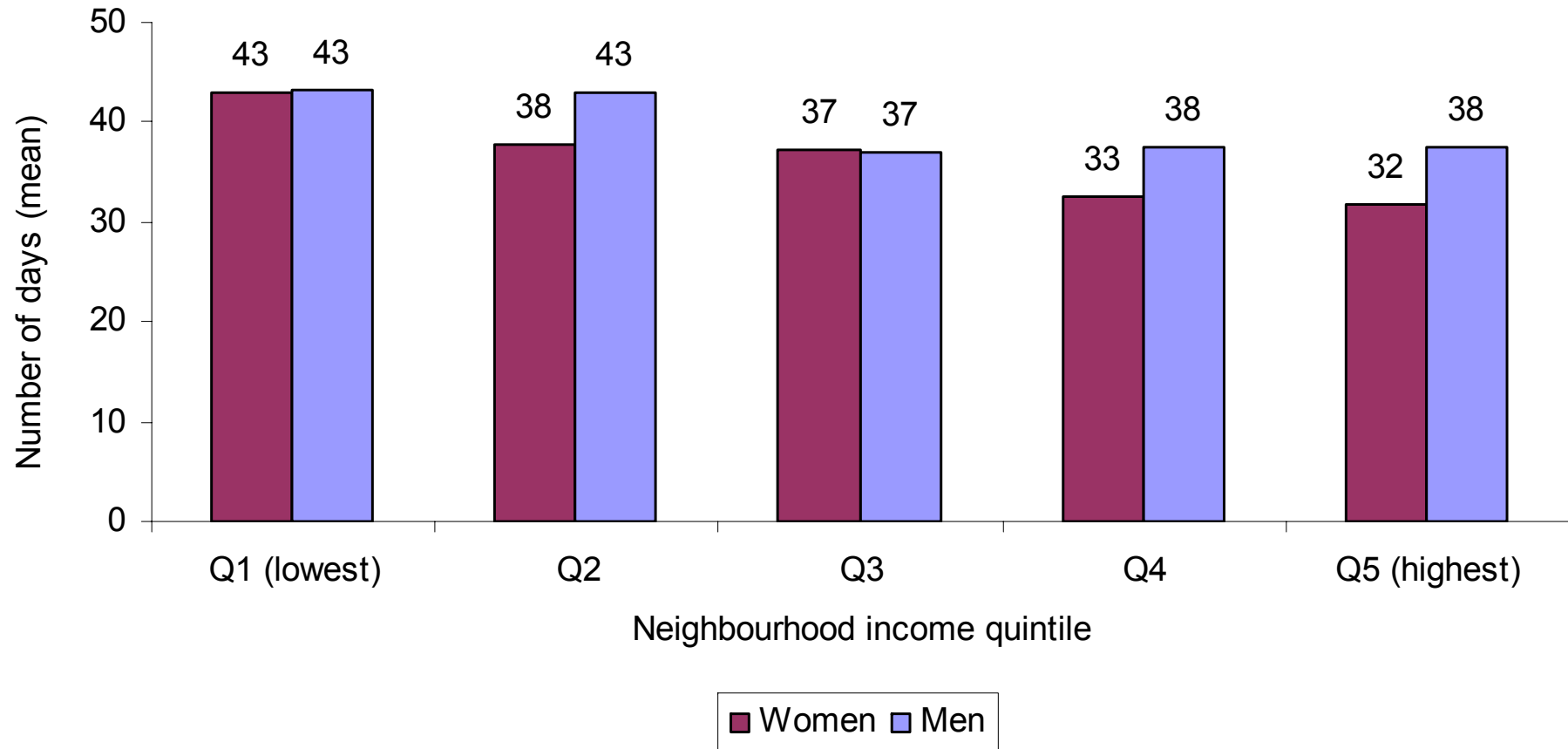
Percentage of patients aged 15 and older admitted to hospital for depression who had a post-discharge physician visit for depression, by sex and time from discharge, 2005/06[^]



Data sources: CIHI-DAD; OHIP

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

Mean number of days to a first physician visit[¥] for depression in patients aged 15 and older admitted to hospital for depression, by sex and neighbourhood income quintile, in Ontario, 2005/06[^]

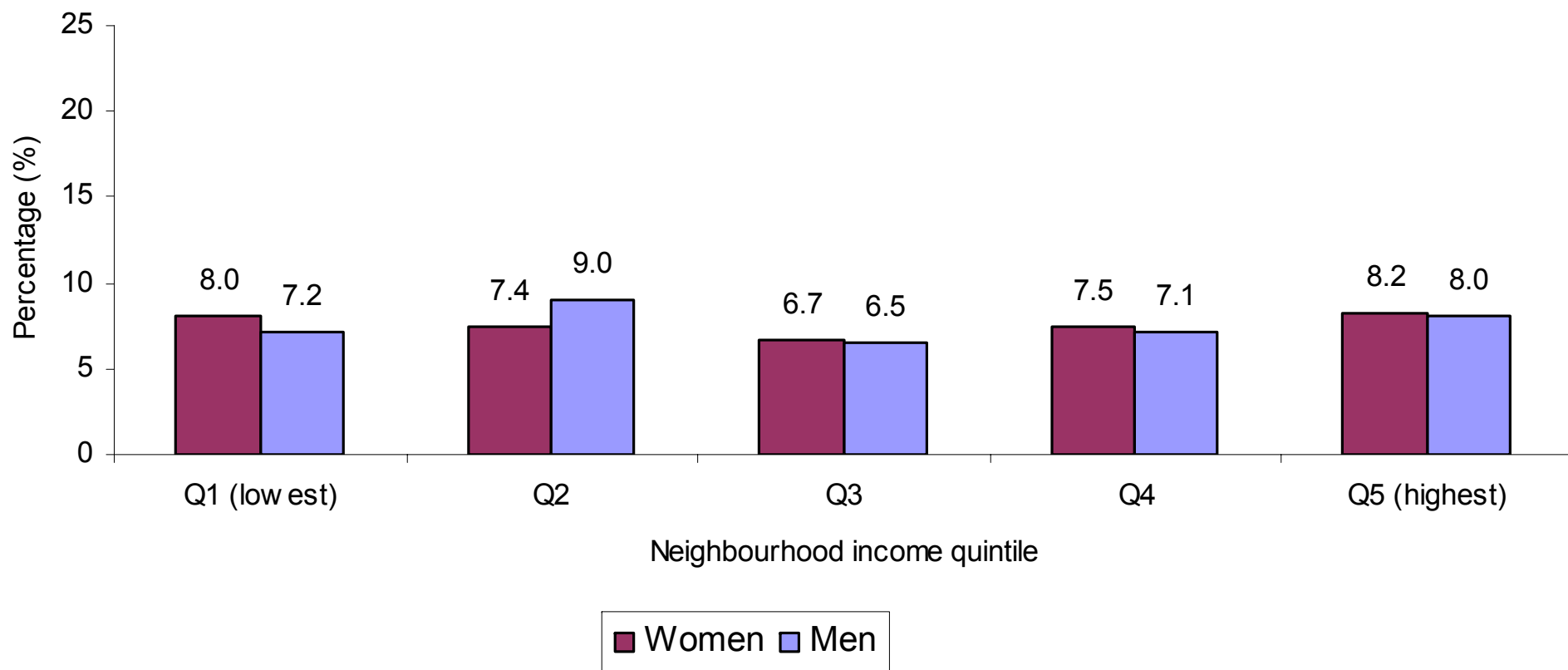


Data sources: CIHI-DAD; OHIP; Statistics Canada 2001 Census

[¥] For patients who were seen by a physician within 12 months of discharge

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

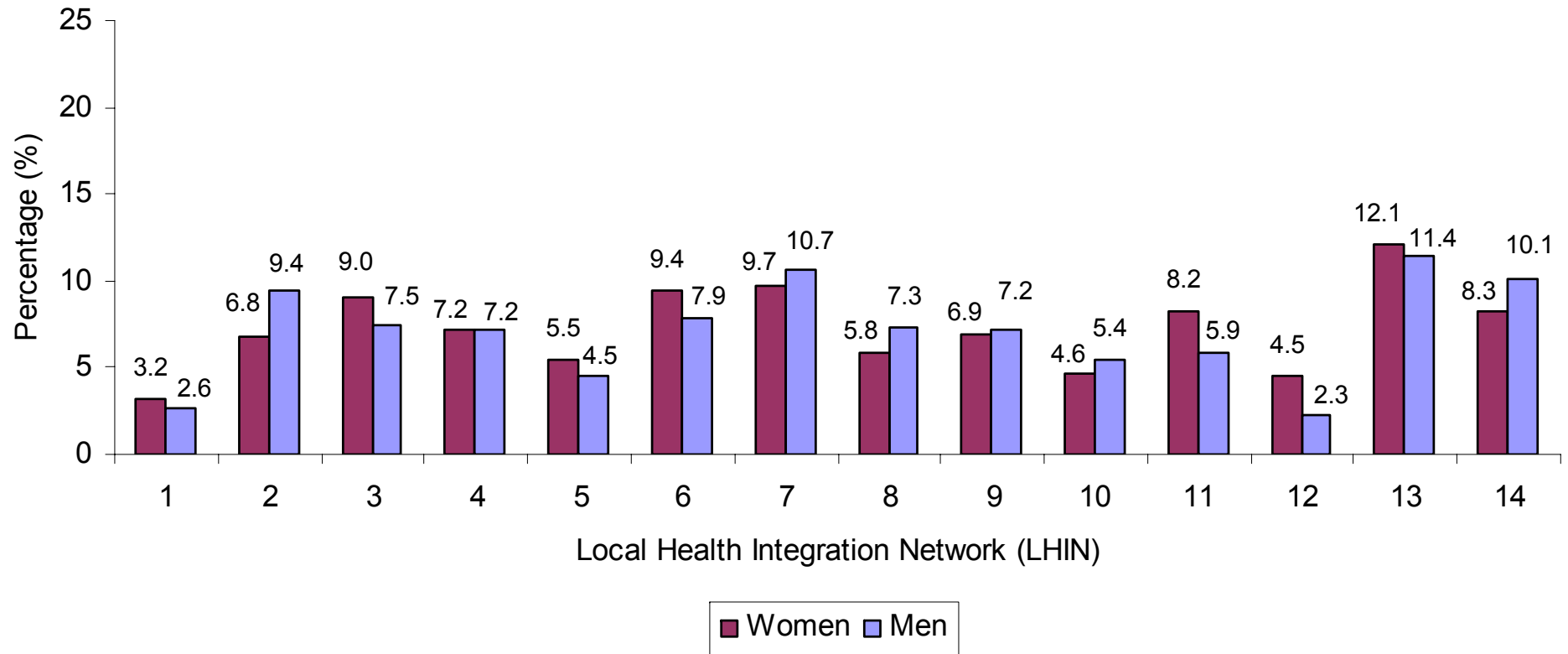
Age-standardized 30-day readmission rate (percentage) for depression among patients aged 15 and older admitted to hospital for depression, by sex and neighbourhood income quintile, in Ontario, 2005/06[^]



Data sources: CIHI-DAD; Statistics Canada 2001 Census

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

Age-standardized 30-day readmission rate (percentage) for depression among patients aged 15 and older admitted to hospital for depression, by sex and Local Health Integration Network (LHIN), in Ontario, 2005/06[^]



Data source: CIHI-DAD

[^] People who were discharged from hospital from Mar 1, 2005 – Feb 28, 2006

Study Limitations

- We indicate *where* disparities occurred, but cannot explain *why* disparities occurred
- Data sources created for administrative purposes not research or quality improvement
- Older data (2001 or 2005/06)
- Huge gaps in data availability

Conclusions

- Depression care was suboptimal for everyone
- Differences in the prevalence of depression across sex, age, income and geography
- Differences in use of services
- Patterns of use reflect supply more than need
- Disparities by income for several indicators
- Some rural/urban differences
- Variations across LHINs (largest disparities)

Recommendations/Key messages

- Develop and support collaborative care models in primary care and across depression care sectors;

Key Elements of Collaborative Care Models

- Clients involved in treatment plan and given sustained follow-up
- Primary care providers work with multidisciplinary team including MH professionals
- Systematic evaluations (client progress, team communication)
- Evaluations used to modify treatment plan and improve information flow and continuity of care

Recommendations/Key messages

- Explore developing care models for specific underserved groups (including men, younger people, the elderly, people with low incomes and people who live in rural areas) and evaluate their impact, especially when combined with targeted outreach;
- Implement models to better coordinate care across transitions between sectors particularly from hospital to home;
- Coordinate depression care with other types of health care, particularly chronic disease management, so that patients with more than one health problem do not receive fragmented care

Recommendations/Key messages

- Evaluate the effectiveness of care through routine gender and equity analyses of indicators of depression care and its outcomes
- Improve data capacity to better measure access, quality and outcomes of depression care across the care continuum

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Improving Women's
Health in Ontario

Pour l'amélioration de la
santé des Ontariennes

ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

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