# **Q1 Key Points for MOH SU Beds Reporting**

## High Level Overview

* Significant change to reporting process; first time MHSU collected data in REDCap and team experienced some challenges and identified opportunities to improve.
* 100% of sites submitted partial or complete data. Difficulty obtaining median-related data from external service providers.
* Work ongoing to refine Q2 reporting process.

## **Process Overview**

### Challenges

1. Changes to Reporting
   1. Transition to REDCap reporting
   2. Decreased flexibility to change reporting measures. The REDCap survey tool takes time to build; once distributed, changes to reporting measures are not easily integrated. Any changes for annual or quarterly reporting require significant lead time to be effectively integrated into the REDCap survey.
2. Internal Capacity Challenges
   1. Our Data Admin learned and created the REDCap tools and provided all supports
   2. Administrative Lead was hired mid quarter and on-boarded by end of quarter
   3. Summer holidays created challenges on both sides for continuity and consistency
3. Ongoing challenges coordinating data from multiple sources (Cerner/Decision Support, REDCap) and programs

### How Challenges were Addressed

1. Focussed priority on data *completion* for Section A quarterly indicators
2. Multiple opportunities to submit, correct, and validate data
3. Data Informed System of Care MHSU team brought multidisciplinary lens to each part of the data cycle in collaboration with Decision Support Team

### Capacity Building towards Better Data Quality

1. Multidisciplinary lens on the data allowed for an increase in scrutiny and validation of the data submitted which allows us to have a clearer sense of the quality and reliability of the data submitted.
2. Of note: data quality priorities begin with seeking 1) high rates of data completion and then 2) focussing on increasing rates of accuracy and consistency over time.
3. Received approval from the Ministry (Heather Falikowski and Jenn Morgan; Meeting: July 20*th*, 2023) and Island Health Executive to adapt the 23/24 SU Bed reporting template. Island Health’s curated and consolidated 23/24 reporting template corresponds with REDCap reporting outputs and can align with the Ministry’s data entry process (as per July 20 meeting); thereby, minimizing overall data transfer errors.

## **Q1 Results**

### Data Completion

* 100% of sites submitted partial or complete data
  + Target **areas for improvement for Q2**:
    - ***Median Days*** (30% of submissions are missing data; all contracted providers)
      * Feedback received from some was that neither Island Health nor Contractors tracked the date a referral was received by Contractor; work underway to finalize who is best suited to track this (Island Health, Contractors, or both)
    - Cook/Pembroke SAC – missing ***indigeneity*** indicators; however our team is working with Decision Support to have this resolved for Q2

### Variability Explanations

* Cedars April Occupancy rate = 117%
  + Explanation: additional clients were approved by Island Health MHSU executive to attend the Cedars program (beyond the standard funded number of Island Health beds) due to availability of beds and in response to large waitlists.
* Ravensview has no data for April and May
  + Explanation: service was not active until June (therefore, no data from April and May)
* Second Chance Occupancy rate improved by 29% from April to May and June
  + Explanation: change in referral process - detox referrals now coming from SUITs and not from Hospital resulting in referrals coming in quicker
* Cook/Pembroke SAC Occupancy rate ≥ 137% for Q1
  + Explanation: high turnover rate at this site (e.g., a single bed may be utilized by more than one person in a day).

### Contextual Notes

1. Factors that decrease occupied bed days
   1. Staffing shortages
   2. Gradual capacity as new facilities/programs got up and running
   3. Wait times for medical detox beds creates gaps in client flows to substance use treatment
   4. No shows for scheduled intakes and unplanned discharges also create gaps in service utilization
2. Seasonal factors had variable impact on service use
   1. Warmer weather led some clients to sleep outdoors instead of attend SAC
   2. Longer days can lead people to become more intoxicated increasing use of SAC
3. Homelessness appears to be one factor influencing service engagement and use
   1. *“Our intake demographic has shifted considerably and now upwards of 95% of intakes are coming directly from several years of homelessness. This shift directly influences individual progress and/or success in our program as well as graduation outcomes. When coming directly from homelessness it can take a considerable and variable amount of time to stabilize, get started on OAT if needed and to reduce levels of substance use. We are now finding that the majority of participants are not ready to live independently and/or manage the costs and responsibilities associated with a market rental, at the time of discharge. In addition, we are finding that the majority of our participants are reluctant to attend abstinence-based treatment as they fear being discharged to homelessness if they are not able to maintain abstinence.”*
   2. *“The housing crisis impacts women’s ability to commit to recovery for fear of returning to homelessness. We have experienced challenges with comorbid MH and SU impacting women's readiness to participate in a program.”*

### Broad Overview of Q1 Data - Preliminary Analyses

Looking at the data in broad strokes, here are some early findings, or ways of thinking about the information.  The below is presented with caution due to missing data/potential inconsistent collection on part of individual programs, but it gives us a sense of the kind of info we might consider in the future as we continue to work on data quality. This data overview was completed as of August 15, 2023, a small number of additional data sets were included in the overall total after the analyses.

#### Occupancy

**SU Beds:** The data for **occupancy is largely complete** and many programs have high (70 %+) occupancy rates for most months.

For **sobering and assessment centres**, the occupancy rate is consistently high (80 %+).

#### Gender

There are some methodological issues to continue working on here including the use of consistent definitions of gender and count methodology.

**SU Beds:** Using the gender count as the baseline case count, just under two thirds are male (63%), and just over one third are female (36%). Relatively few people are reporting transgender, two-spirit and non-binary identities <1%.

\*There were gender specific beds included in this count, and ideally that would be accounted for in terms of its contribution to gender breakdown.

**SAC:** It looks like close to one third are female (33%) and just over two thirds are male (66%), which generally fits expectations if this population is made up of more unhoused and precariously housed persons.

Only one program reported a transgender member and until we are consistently using better practices of asking about gender it will be hard to know to what extent transgender and non-binary people are underrepresented in SU Beds/SAC services, but it appears they may be.

#### Indigeneity

This is another measure on which our ability to interpret results is limited due to underreporting and consistent methodology.

**SU Beds:** The percentage by program seems to range from 6%-100% (for indigenous specific beds).  Overall, 25% of persons are reportedly Indigenous (using gender as case count).  Again, ideally here we would remove Indigenous-only beds to understand the representation of Indigenous people (and relatedly, the accessibility) of non-Indigenous specific programs.

This higher representation of Indigenous persons relative to population statistics is good and expected, but data accuracy is likely an issue and it seemed that some programs had more missing demographic data than others.

**SAC:** The percentage of Indigenous persons ranged from 3%-57% using unique clients as the case count.  Using gender as the case count, 35% of persons were Indigenous. Again this higher representation of Indigenous persons is statistically expected.

#### Median Wait Times

**SU Beds:** As noted earlier, a number of programs did not supply this information, but what is available shows the median wait times from referral to service initiation ranging from 1-99 days with an average of 21 days.

**SAC:** N/A – there is no wait time for this service.