FOR THE RECORD

Published at www.cmaj.ca between Mar. 9 and Mar. 23

Factors affecting mental health readmissions

Most hospital readmissions for mental health occur within 30 days after discharge, according to a report from the Canadian Institute for Health Information.

Readmissions are more common in general, rather than psychiatric, hospitals and are more typical for the unemployed, said the report, *Depression in Ontario: What Predicts a First Mental Health Rehospitalization?*

The type of hospital — general or psychiatric — in which an individual is hospitalized for the first time could affect whether there's a readmission, CIHI said in the report (http://secure.cihi.ca/cihiweb/products/depression_in_ontario_aib_2010_e.pdf). The study found that individuals admitted to a general hospital were more likely to be readmitted within 30 days.

Unemployed patients were 1.4 times more likely to be readmitted within 30 days, while employment status had no significant impact on a patient's readmission past the 30-day mark.

In the report, out of the 3500 individuals admitted for depression between Apr. 1, 2006, and Mar. 31, 2008, 19% were readmitted within one year. Risk factors including socio-demographic status, treatment, clinical and discharge environment all play a role in the tendency of psychiatric re-admission.

Individuals with a higher severity level of depression at the time of their discharge were 64% more prone to readmission within the 30-day period. A diagnosis of depression tagged with another disorder, such as anxiety, was more likely to result in a later readmission.

"The presence of a comorbid anxiety disorder makes the treatment of depression more difficult than a diagnosis of depression alone," the report stated.

"A lack of support with managing illness" in an individual's discharge environment was proven to be a significant factor in readmissions 31 to 365 days after the initial hospitalization, the report added.

Continued social support in the form of help managing daily activities, stressers, and illness "may reflect diminishing follow-up care," and avoid readmission in the long run, the authors said. — Kat Guerin, Ottawa, Ont.

Canada to update influenza vaccine supply strategy

The Canadian government has issued a request for information to vaccine manufacturers as part of an initiative that may move Canada away from its current single-supplier system for delivering pandemic influenza vaccines (www.merx.com/English/SUPPLIER_Menu.asp?WCE=Show&TAB=1&PORTAL=MERX&State=7&id=PW-%24%24PH-873-50155&src=osr&FED_ONLY=0&ACTION=&rowcount=&lastpage=&hcode=UrXjzHawaO4EuNsgzec%2F7w%3D%3D).

In 2001, the federal government signed a 10-year contract with GlaxoSmithKline Inc. to supply influenza vaccine in the case of a global flu outbreak. That contract, worth about $300 million, expires on Mar. 31, 2011. Some health officials questioned the contract during the pandemic (H1N1) 2009 flu outbreak, when GlaxoSmithKline Inc. experienced production delays at its flu vaccine plant in Ste.-Foy, Quebec.

According to the information request, published Mar. 15, the federal government is working with provincial and territorial governments to update its influenza vaccine supply strategy. The strategy will include three main components:

• "A new, long-term pandemic supply contract with a domestic manufacturer for the supply of 100% of Canada's pandemic vaccine requirements and an appropriate portion of seasonal vaccine;

• Consideration of a second pandemic supply contract, if feasible and of demonstrated value to Canada, to serve as a back-up to the primary domestic supplier and to possibly include a portion of seasonal vaccine supply; and,

• Additional suppliers for seasonal influenza vaccine as necessary."

To assist the development of this strategy, the government held a two-day forum in Ottawa, Ontario, on Mar. 30–31 to allow members of the vaccine manufacturing industry to meet with members of the Federal/Provincial/Territorial Pandemic Vaccine Supply Task Group. Industry members were to present information about their existing vaccine products, production and supply capabilities, research and development activities related to seasonal and pandemic influenza vaccines, future plans to enhance production and interest in supplying influenza vaccines in Canada. — Roger Collier, *CMAJ*

Further delay in restart of nuclear reactor

Atomic Energy of Canada Ltd. has announced that it will again push back the restart date for the medical isotope-producing National Research Universal reactor in Chalk River, Ontario.

Restart has been delayed by at least another month, into May, as "the very complex nature of the remaining repairs requires that extra precautions be taken," AECL said in a statement announcing the delay (www.aecl.ca/NewsRoom/Community_Bulletins/100310.htm).

The reactor was shut down in May 2009 as a result of a heavy water leak and officials initially projected that it would again be operational within three

months. But its restart has been repeatedly pushed back.

AECL indicated that repairs are 46% complete.

"Preparations for the final repair sequence continue. This next series represents the greatest level of complexity and will incorporate the installation of plates welded to the vessel wall combined with the application of horizontal weld build-up. The project team continues to work with third-party experts to finalize detailed repair procedures."

"Every effort is being made to return the NRU to service as soon as possible. The program is driven by safety, producing a quality repair, conservative decision-making and completion of all the necessary analyses," the statement added.

"Each of these repairs presents unique and more difficult challenges that require first-of-a-kind technical solutions. To ensure that the repair process itself does not cause damage to the vessel an additional level of preparation is necessary to program the welding sequences and to qualify the welders."

The delay will further compound a scramble for medical isotopes, particularly in the wake of the closure of the High Flux Reactor in Petter, the Netherlands, which is shutdown until August to repair cooling water pipework. — Wayne Kondro, *CMAJ*

Ontario to adopt patient-based funding of hospitals

Health care will gobble up 70% of every Ontario tax dollar within 12 years, from a current level of 46%, the province's Liberal government asserted in its Mar. 8 Speech from the Throne.

To rein in those skyrocketing costs, Premier Dalton McGuinty's government is proposing to make hospitals compete for health care funding and focus their services on surgeries and treatments that they can do cheaper than their rivals.

"Patients will have greater choice about where they can access the best quality treatment," Lt.-Gov. David Onley stated in the speech (www.premier.gov.on.ca/news/event.php?ItemID=11282&Lang=EN).

The speech argued that a "money-will-follow-the-patient" model of funding hospitals would yield efficiencies. But critics contend that system will compromise the availability of medical services in rural and remote areas, while shifting the focus of health care facilities toward increasing patient volume at the expense of quality of care (*CMAJ* 2008. DOI:10.1503/cmaj.080594).

The Throne Speech also proposed to appoint an expert panel to "provide recommendations on clinical practice guidelines. It will ensure that future investments get results and improve patient health." The government also said it will overhaul the Public Hospitals Act "to create a hospital system that taps into the expertise of community partners and all health care professionals."

The latter is much needed, says Tom Closson, president of the Ontario Hospital Association. "It is a very old piece of legislation. It hasn't been updated to reflect the changes in the way health care is interprofessional today."

Currently, hospital care doesn't link enough to primary care and home care, Closson says. "It needs to be well-connected to the rest of the health care system in order to be an efficient, high quality system."

Closson also indicated that his association will swing firmly behind the move toward patient-based funding of hospitals: "We've supported it for a while."

The association also supports the creation of an expert panel to improve patient care. Evidence isn't being used consistently enough around the system and there is a greater need for the use of best practices, Closson says. "It's an excellent package to provide more affordable and higher quality health care for patients. The recommendations will achieve efficiency in the system."

While the long-term reforms are introduced, Ontario's hospitals will continue to grapple with short-term financial challenges. They're now mulling cuts to programs, services and staff in fiscal 2010/11 as a result of Health Minister Deb Matthews December 2009 demand that facilities provide budget plans based on a zero, 1% and 2% increase in hospital funding (*CMAJ* 2010. DOI:10.1503/cmaj.109-3154). — Kat Guerin, Ottawa, Ont.

Ottawa sketches management plan for emergencies

The federal government has released a national emergency response plan to deal with "the traditional spectrum of natural and human-induced hazards," including disease outbreaks and pandemics.

Logistical in nature, the management plan sketches the responsibilities of government departments during emergencies (www.publicsafety.gc.ca/prg/em/_fl/ferp-eng.pdf). Government responses will be developed by Public Safety Canada's operations directorate, with approval of measures moving up the proverbial chain of command from the Assistant Deputy Ministers' Emergency Management Committee to, ultimately, a committee of cabinet.

The plan sketches the criteria for declaring an "emergency response level" that is "calibrated to the scope and potential impact of the incident and the urgency of the required response."

A Level 1 emergency response is required when the "potential" exists that an integrated federal response will have to be developed. When declared, "detailed authoritative reporting of significant information from a multitude of sources about the event is developed and disseminated to federal emergency response partners to support their planning or response efforts."

A Level 2 response is required when it appears an integrated federal response "is more likely." In such instances, a risk assessment must be performed. "This assessment, conducted in consultation with subject matter experts, identifies vulnerabilities, aggravating external factors and potential impacts, and may be formalized in an Incident Risk Analysis Report."

A Level 3 response involves a declaration that an integrated federal response must be developed. It activates all manner of federal planning, including departmental emergency response plans. As well, material and resources are "readied in anticipation of provincial or other requests for federal assistance, and the GOC [Government Operations Centre, which is housed within Public Safety Canada] maintains

constant communication with those activated centres."

"The Federal Emergency Response Plan will help ensure the Government of Canada's response to an emergency is seamless, and that key decisions can be made quickly when disasters strike," Public Safety Minister Vic Toews said in a press release. "Canadians can be assured that we have the right plan and the right decision-making structures in place in the event of an emergency." — Wayne Kondro, *CMAJ*

DOI:10.1503/cmaj.109-3221