

ASSOCIATION OF GENERAL HOSPITAL PSYCHIATRIC SERVICES
Mental Health Funding Working Group
March 8th 2006
7:00 PM (EST) to 8:30 PM (EST)

Mental Health Funding Group Update and Report by Dr. Gerry McNestry, President AGHPS

March 10th Deadline

There is an imminent deadline for sessional fees supplement of March 10, 2006. For this year the supplement is going to be given to each hospital on receipt of a signature from the Chief and a signature of the CEO. These signatures must be placed on a letter that was recently sent to each hospital CEO. The deadline for these signatures is March 10, 2006. Cheques will be sent out on March 13, 2006. If letters have not been received for some reason, a faxed letter will be acceptable pending a hardcopy being submitted. If a hospital misses the March 10th deadline, it will have to make a case to Sandra Bogul at 613-536-3019. There will be no guarantees that hospitals will have any success receiving funding after the deadline. The signed letters must be **received** by March 10th. The letter states that sessional fees will be distributed appropriately and that by April 28th a form will be submitted stating how the funding was split and where the money was allocated.

Background

The Mental Health Funding Working Group was formed as a result of the 2004 agreement between the Ministry of Health and the OMA. This group was formed to implement funding initiatives which would improve remuneration for services rendered for acute psychiatry services mostly within schedule 1 hospitals but also general hospitals. Effective October 1st, 2005 the new initiatives that were implemented were the sessional fee supplement - \$4.6 million in funding and a flow through called the psychiatric stipend, which accounted for \$5 million. In July 2006 there will be a further 9.4 million for distribution.

The Psychiatric Stipend

A process was started to determine eligibility to receive funds last May. A questionnaire was sent to all schedule 1 hospitals to assist them in determining how additional money should be allocated. The questionnaire was distributed in October 2005. Funding letters were sent to 30 eligible hospitals. The money for psychiatric stipend was used to raise the average amount of funding to schedule 1 hospitals so that the average amount of money was raised to \$10,400.00 per bed for adults and \$17,400 per bed for children and adolescents. Payments were completed to all eligible facilities by February 15th 2006.

Over the last year, issues and amendments with the number of beds and/or locations of beds at St. Joseph's healthcare system in Hamilton, and the Windsor Regional Hospital have now been resolved. Not all hospitals were judged eligible for the stipend.

Sessional fee supplements are simply an increase to the sessional fee rates. The stipends are not an hourly rate type of funding. The stipends are given with certain criteria attached to them, subject to the discretion of the Chief to members of the Department of Psychiatry. The stipends are a lump sum of money, but not an hourly rate. The sessional fees are paid out on a published hourly rate and the supplement is paid out similarly. Stipends are to be paid to psychiatrists who provide a level of service to a hospital which would include being on-call and providing a certain minimum time of service to the hospital (at least 7 hours per week providing hospital-based services as well as being on-call). That should cover most psychiatrists who work in Schedule 1 hospitals.

Sessional Fee Supplement

The initial communication packages were distributed in September 2005 to 181 eligible hospitals and community mental health and addiction agencies that are currently receiving sessional fee funding. By early January 2006, because of the low response rate, a decision was made to ensure that the funding was available to pay for sessions between the first of October 2005 and March of 2006, and an alternative process was implemented.

The new process involved 1 of 2 things. Those agencies whose allotment of sessional fees is less than \$10K will not be required to register. They will simply receive their payments by cheque as long as they submit a document outlining the distribution of funds to the Ministry of Health, and return any unused funds. Those agencies and facilities whose allotment is greater than \$10K will receive a cheque in March 2006 once they sign a letter that was sent to all eligible groups and hospitals on February 15, 2006. This letter can be faxed back to the Ministry of Health and a hardcopy sent after the fact. Cheques have been prepared dated March 13, 2006 and this will be distributed once the signed letters have been received back. Basically any groups that do not meet the deadline are assumed not to be interested in the supplement. Groups that miss the deadline but are indeed interested in the supplement will have to contact Sandra Bogul at the Ministry of Health at 613-536-3019. The Ministry is keeping track of various groups within various categories and is aware of how many responses have come in. That is as far as the Ministry is prepared to go.

Planning for the July 2006 distribution of services is the next phase. This amount is \$9.4 million. Part of this money will be used to fully fund allotments to hospitals where there has been a change to the number of psychiatric beds or a change to the location of beds. This funding will be used to raise the average amount of funding to eligible hospitals so that the average amount of money will be consistent with \$10,400.00 per bed for adults, and \$17,400 per bed for children and adolescents. There is also funding available for every schedule 1 hospital in the amount of \$12K per psychiatrist up to a maximum of \$96K per hospital. This is intended to be an incentive to small hospitals to help them recruit to allow at least a certain amount of sessional money available to those hospitals.

The arbitrary cap of \$96K is based on affordability and the decision that a 1:8 call rota is just about manageable. There is also a preliminary one-time funding available of an additional \$375.00 per bed to all eligible hospitals. Further, there is money that will be made available for hospitals that currently implement specialized clinics or will be able to implement specialized clinics by September 2006. These clinics will include psychogeriatrics, outpatient justice and mental services (meaning court diversion work), outpatient services for children and adolescents, and outpatient services for the dually diagnosed (those with developmental handicaps and a concurrent mental health diagnosis). For each of the specialty clinics a facility implements there is \$20K in funding available. Those clinics will be expected to assess, consult and treat patients in these categories and will be expected to have communication with community agencies which provide services for the individuals within these groups. This funding is intended as an incentive for hospitals to implement programs for outpatients that are sometimes marginalized if funds are cut. Therefore up to \$80K in funding is available for each schedule 1 facility if they can provide these services. The expectation is that every hospital will be able to provide the geriatric clinics and that fewer facilities will provide court diversion work, children and adolescents, and the dual diagnoses clinics. The expectations for these clinics are fairly minimal, only one half day per week. For hospitals that do not have the availability of people with a particular expertise, it will help to pay for the sessional component for a visiting professional. Anyone who is interested in developing specialized clinics or is currently running some may apply for this funding.

Finally, in January 2007, depending on the uptake of the specialty clinics, there will be a certain amount of funding still available from the \$9.4 million. At this time there will be a further one-time only payment per bed to eligible hospitals based on the amount of the funding still available. This amount will be calculated in January 2007. All of the \$9.4 million will be given in the form of stipends. This money will not be further sessional fee supplements.

From April 2006, all stipend monies will be sent to hospitals quarterly. The sessional fee supplements will still require bank accounts, group billing numbers, etc., and will be paid monthly under the code K400A.

This will be much like OHIP reconciliation, with the submission of a monthly statement, and then a cheque will be written back to the hospital for disbursement by the Chief. Early in 2008 there will be an additional \$3 million which will be used for the purposes of harmonization. This will be used to fill in the gaps which arise and it will be used to help with the conversion of sessional fees to something more along the lines of the stipend model of funding. The objective is convert both funds to just one fund, to offer the most value for money for both hospitals and the Ministry of Health.

The intent of all of this funding is to assist with the recruitment and retention of psychiatrists in schedule 1 facilities. This money is meant to enhance the situation financially for those psychiatrists who work within the hospital system. It is not intended for any other purposes.

Questions

1. **Is funding limited only to the specialty clinics mentioned? Is the money earmarked for these specialty clinics meant to cover sessional fees for these clinics? Early episode psychosis clinics as well as others may greatly benefit from funding if they are considered eligible. Are facilities able to apply for other specialty clinics at this time, or must they wait until January 2007?**
 - A. All of the new \$9.4 million is stipend money, not sessional fees. Funding has already been made available for early episode psychosis including physician services. Any agency that received money and is not spending it on physician services should be applying it appropriately. The 4 identified specialty clinic areas are the only 4 specialty clinics that may apply for this funding, as these were identified as the most under funded areas.
2. **Will there be any chance of losing some of this funding if it is not fully utilized for specialty clinics?**
 - A. Any clinics which implement or have already implemented one of these programs by September 2006 will receive this funding. In January 2007, any unused portions will be used to top up the funding for beds within the schedule 1 hospitals. Facilities may reapply for specialty clinic funding in September 2007.
3. **What are the qualifications to receive the 8 x \$12K stipend for psychiatrists?**
 - A. If a schedule 1 hospital has 8 or more psychiatrists who are providing 7 or more hours a week of hospital based care (direct clinical care for hospital registered patients) and providing on-call services that hospital will qualify for the entire \$96K funding allotment.
4. **Are the stipends meant to be an enhancement to OHIP? Can a psychiatrist bill OHIP for the sessional time spent within a specialty clinic and still qualify for the stipend?**
 - A. Yes. Stipends are payment for being there and doing the work. Stipends are not based solely on an hourly basis. The Chief within each facility will be responsible to ensure that hospital based psychiatrists work within their hospital. The Chiefs will allocate the stipend funding as they deem appropriate.
5. **Is the top up funding for hospital beds intended primarily for inpatients?**
 - A. Yes. With the introduction of computerization and the RAI-MH program it is recognized that psychiatrists now require sessional fee type funding to cover the time they now spend doing fairly comprehensive computer work for each patient. A recommendation will be made to Chiefs to suggest that this top up funding be applied for inpatients' care and to help the psychiatrists who work with these patients. With the new stipend money there are other ways to now help with outpatients.

- 6. If you are already receiving sessional fee funding for a court diversion program can you still apply for the stipend clinic funding?**
- A. Yes, absolutely. There will be a process developed shortly to apply for this funding because applications must be in before September 2006.
- 7. How does anyone know that a facility is using the funds as they applied for them if it appears no one is monitoring the administration of these funds?**
- A. There will be a basic level of accountability which will probably be a statement (a contract) signed by the Chief stating that the facility has the intention (or already has in place) the specialty clinic for which they have received funding.
- 8. Is it possible to apply for both the \$96K stipend and the specialty clinic stipend?**
- A. Yes, however the criteria are different. For instance, if there are psychiatrists involved in a facility's forensic clinic but they are not on-call then you may not count their numbers in your application for the \$96K stipend. However, if these same psychiatrists become involved in a court diversion clinic or another specialty clinic, then that stipend funding would become possible.
- 9. Should the full amount of the stipend go to the individual within the clinic or can the funds be distributed within the clinic in other ways?**
- A. This will not be policed, however the intent is that the full amount of the stipend should go to the individual running the clinic but it can be split amongst various individuals if there is more than one psychiatrist involved in the clinic.
- 10. Will there be a definition of what constitutes a clinic both in form and location?**
- A. There has been no agreement to date over this issue. Probably a clinic will be described as anyone who serves hospital registered patients. This issue requires more work to come up with a minimum definition which will try to capture the difference between a clinic which is hospital based or part of the hospital operation and clinics that are not. There is a gray area that exists between hospital work and non-hospital work. Some psychiatric hospital outpatients are all seen outside of the actual hospital, but their charts are still maintained by the hospital. It is likely that one possible marker would be the existence of an actual hospital chart. This funding is ultimately meant to support hospital psychiatric services, so as a bare minimum, physicians who receive this funding should be applying it towards the care of a hospital registered patient with an active hospital chart.
- There are 2 purposes for this new funding the Working Group would like to aim for. The first is the support of hospital based patients, the second is to support multi-disciplinary work. There will be occasions to stretch the rules where community agencies work with some of the groups outlined (psychogeriatrics, dual diagnoses, etc.) but these same agencies will have to be working with a hospital or very closely associated with a hospital to qualify for any funding.
- 11. Will non-psychiatrists also be collecting sessional fees through this funding? If so, is that part of the OMA and Ministry of Health settlement?**
- A. Yes, non-psychiatrists will also collect sessional fees. Sessional fee increase was part of the settlement of OMA with the Ministry of Health. To explain this, in some hospitals sessional fees have been paid to family doctors who provide on-call services and support of psychiatric patients. These fees have also been provided for family doctors who have provided outpatient psychotherapy. This funding is not meant to cover physicians doing

physicals, etc. Sessional fee funding is only meant to support physicians providing psychiatric or mental health services to patients. Because of the flexibility required regarding the services provided under the guidelines of sessional fees there is more leeway with regards to hospital or non-hospital based patients. With regards to the stipend, funds will only be allocated to those physicians and programs that directly benefit registered hospital based patients. Stipends can only be paid to psychiatrists. The differential rate for sessional fees between a psychiatrist and a general practitioner is not reflected.

Basically, every hospital receives a global sessional fee budget. It is expected that the funding increases will be distributed proportionately in the same manner that the sessional fee dollars were distributed between psychiatrists and non-psychiatrists.

12. Will a psychiatrist's supplement will be calculated by taking the number of sessions multiplied by 3.5, multiplied by 2 for the ½ hour per K unit, then multiplied by 11?

- A. Yes, that is correct. It is reasonable to make sure that the amount of the supplement received corresponds to the calculations above. Any discrepancy between these two amounts should be discussed with the finance department of the facility in question.

13. Once the sessional top ups start to be received monthly will there be forms to fill out like there were with the 6 month funding?

- A. Billing will be submitted monthly, using billing numbers, a central bank account, etc. This process is not completely set up at this time. The final details regarding how this system will work are not yet available.

14. Is there a maximum supplement amount that any one individual can qualify for?

- A. Yes, that amount was previously determined at a maximum of \$115K that is for all sessionals and stipends. At this time the integration between stipend and sessionals has not yet occurred and therefore it could be misinterpreted as \$230K available. However, people should assume that stipend and sessional funds when added together will be maxed out at \$115K, because any loopholes that exist because explicit rules have not yet been developed are currently being closed. There is concern that particular individuals may not receive all of the funding for which they qualify and how this will be handled. There are no solutions available at this time for the cap issues, but all psychiatrists and Chiefs should understand that at this point the ceiling exists.

The purpose behind much of this new funding is to promote the recruitment of new psychiatrists to schedule 1 hospitals. It would be abhorrent if in fact all of this additional funding went to existing physicians doing the same work they have always done. The stipend gives us the power with which to actively recruit with a very generous signing bonus.

15. What was the previous ceiling?

- A. The previous ceiling was \$94K. People were advised of this amount, but this amount was regularly ignored. The net result of people not understanding or blatantly ignoring the rules regarding sessional fee billings has resulted in some mismanagement of these funds. The Ministry of Health is not prepared to relax the ceiling at this time. Hopefully between now and when the harmonization happens the ceilings will either be raised significantly or eliminated altogether. The previous ceiling of \$94K was set in the mid-1990s prior to hospital amalgamations. The Working Group is hopeful that ceiling amounts will be negotiable during the harmonization.

The AGHPS is considering developing an education day for Chiefs and Directors, on how to interact with the hospital administrators to protect funding, how to interact with other

members of their departments, how to use sessional fees and stipends effectively, etc. The situation where a few members of the department are doing the bulk of the work, and yet all members are receiving basically the same stipend will be discussed during an education opportunity or retreat in the future. These discussions will hopefully result in a solution to this common problem.

- 16. Will there ever be a set amount of stipend available to Chiefs who are now doing so much more administrative work?**
- A. Some hospitals pay their Chiefs for their work. Some hospitals have a mental health services director and pay that individual out of a different medical salaries budget. Some hospitals do not currently compensate their Chiefs in the same manner. An educational retreat would help all Chiefs to understand what options they have and would inform them of what is happening in other parts of the province.
- 17. When recruiting in the north of Ontario, if there are more stipend funds available to share will it once again become more difficult to persuade physicians to move out of the bigger urban communities? Also, what about workloads that exceed the ceiling and then become a deterrent?**
- A. No. If there is an urban hospital with 24 psychiatrists and the maximum stipend is \$96K for that facility that translates into only \$4K per physician. In a more remote setting 8 physicians could each receive \$12K. The same is true for the sessional budget. A smaller facility will be able to promise each physician a much bigger slice of the sessional budget. However, money is not the only concern for new recruits moving to a under serviced area – the enormous workload covered by physicians in northern communities must be considered especially with a ceiling in place for sessional fees. There will be some funds that will not be used completely appropriately. However the AGHPS will attempt to educate Chiefs as fully as possible to help with their negotiations with their own facilities.
- 18. Can we have a written summary of tonight's conference available to all of the Chiefs to reference, especially those not on the line tonight?**
- A. There will be a summary of the teleconference available and it will be posted on the AGHPS website for easy reference. We will send out an email once this is available. There is a list of meetings available. AGHPS would like to encourage anyone who would like to attend one of these meetings to do so.

As there were no more questions presented at this time, the meeting was adjourned.