MINISTRY OF HEALTH AND LONG-TERM CARE

SESSIONAL FUNDING GUIDELINES
October 2004

Original document prepared by the Working Group on the Re-Design of the Psychiatric Sessional Fee Program, October 1994

Revised by Mental Health and Addiction Branch, Community Services Division, October 2004

TABLE OF CONTENTS

		Page
I.	Background	3
II.	What is Sessional Funding?	3
III.	Key Principles	4
IV.	Guidelines for Sessional Funding	5
V.	Service Definitions for Sessional Funding	7
VI.	Program Monitoring and Accountability Mechanisms	11

Appendix A: Semi-Annual/Annual Psychiatric Sessional Fee Report

Appendix B: Instructions for Completing Semi-Annual/Annual Psychiatric Sessional Fee Report

Appendix C: Review Criteria Guidelines for Semi-Annual/ Annual Psychiatric Sessional Fee Report

I. Background:

Psychiatric sessional funding is provided by the Ministry of Health and Long-Term Care for a variety of indirect services provided by psychiatrists and general practitioners linked with the general hospital system as well as community mental health and addiction programs.

In the Fall of 1993, the Ministry established a Work Group to assist with the re-design of the sessional funding program. The Work Group was comprised of representatives from the Ontario Medical Association, the Ontario Hospital Association, the Association of General Hospital Psychiatric Services, the Canadian Mental Health Association/Ontario Division, the Ontario Federation of Community Mental Health and Addictions Programs, the Ontario Addictions Coordinating Group, and staff from the Ministry's Mental Health Programs and Services Division and Alternate Payment Programs. The group met regularly between September, 1993 and March, 1994 and consulted widely among stakeholders.

The Work Group developed overall principles for the sessional fee program, a mechanism to monitor the program, revised service definitions and guidelines and issued a report in October, 1994 entitled Redesign of the Psychiatric Sessional Fee Program.

This document is a synthesis of the definitions and guidelines recommended in that report. These definitions and guidelines became a key component of the Ministry's accountability framework for the use of psychiatric sessional fee allocations as of 1994 and are currently in effect. They cover areas such as: recipient, location and priority of usage; method and rate of reimbursement, as well as management, accountability and monitoring requirements (including avoiding overlap with fee for service payments).

II. What is Sessional Funding?

Sessional funding accommodates a variety of "indirect" psychiatric services provided by psychiatrists and general practitioners in the general hospital system as well as community mental health and addiction programs which are not covered as insured physician services or components of insured physician services, hospital global budgets or where no other sources of funding have been identified.[Ξ] In most cases, psychiatric services in general hospitals and community programs are delivered by an inter-disciplinary team including a physician. Sessional funding compensates these physicians on a sessional rate basis for participating in indirect case management and for consulting with other

[Ξ] For example, some indirect services related to Community Treatment Orders are billable under OHIP, while others are eligible for sessional funding.

professionals (e.g. psychologists, social workers, nurses and occupational therapists) to plan, monitor and evaluate care. Sessional fees are a system resource and are not “owned” by individual practitioners.

Sessional funds are allocated by a special vote of the provincial legislature and, within general hospitals, have been assigned and administered by chiefs of psychiatry. The Board of Directors is ultimately responsible to the Ministry for the use of the sessional fee allocation.

The indirect services are divided into seven general areas: participation in case conferences, client-centred consultation, staff-centred consultation, program-centred consultation, program direction, provision of educational services and system coordination. These services are defined in section V. Services which may be provided by videoconferencing or teleconferencing are specified in section V.

III. Key Principles:

The Ministry remains committed to the vision and principles outlined in previous mental health reform documents. The following are key principles and goals of the Ministry’s current policy framework for reform, *Making It Happen* (1999), which form the basis for sessional fee service definitions, guidelines and accountability mechanisms:

- People with serious mental illness are the priority for mental health services. This group is defined in *Making It Happen* (under First Priority Population for Mental Health Reform);

- The consumer is at the centre of the mental health system;

- Services will be tailored to consumer needs with a view to increased quality of life;

- Consumer choice and access to services will be improved;

- Services will be linked and coordinated so that consumers will move easily from one part of the system to another;

- Services will be based on best practices;

- Core mental health services and supports are well-integrated with the broader continuum of care provided by health and social services;

- Services and supports facilitate a shared service approach to meeting the needs of individuals with serious mental illness who have multiple service needs;

- There is clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators.

IV. Guidelines for Sessional Funding

The following guidelines are intended to delineate the parameters by which hospitals and community mental health and addiction programs may provide and pay for these indirect services (defined in section V) in the most cost-effective manner.

Use

1. The priority for the use of sessional fees is directed toward client-related issues pertaining to the seriously mentally ill, including individuals who are seriously mentally ill and have physical and/or developmental disabilities and/or are experiencing some form of chemical dependency.

2. Sessional fee allocations are provided to general hospitals for services provided in emergency departments and crisis programs, in-patient, out-patient, day treatment, day hospitals and community settings.

   Sessional allocations are provided to community mental health and addiction programs for services provided within these programs as well as services in other community settings such as public health units, social service agencies, homes for the aged, etc.

General

3. A full session is intended to pay for services provided during a time period of three hours (minimum) to four hours (maximum). The indirect services under sessional payments may also be provided and paid for on an hourly basis by prorating the sessional fee accordingly.

4. The current rate for a full psychiatric session is $358 for psychiatrists, not to exceed $107,256 per psychiatrist in a twelve month period, and $266 for general practitioners, not to exceed $79,720 per general practitioner in a twelve month period.

Accountability

5. The management of the use of sessional allocations may be delegated by the Board to another individual within the organization (i.e. Chief Executive Officer, Hospital Administrator, Chief of Psychiatry, Program Executive Director, Program Director, etc.).

6. The manager's responsibility for the use of these funds will be consistent with the mission, mandate and strategic direction of the program(s). Where a mission and strategic direction have not been articulated, the parameters for the use of these funds should be defined.

7. The Board of a hospital or a community mental health or addiction program is ultimately responsible for the use of the sessional allocation to the Ministry of Health and Long-Term Care as the paymaster of the system.

8. Accountability between the hospital or community mental health or addiction program and those providing the sessional fee service will be supported through internal contractual arrangements and billing format. Indirect services for which remuneration is available under other arrangements must not be billed as sessional fees.

9. Internal contractual arrangements and billing formats should be used as an information base for accountability (through use of a monitoring form) to the Ministry. In all instances, the Ministry requires that the monitoring form be utilized and submitted to the Ministry on a semi-annual basis.

10. The Ministry requires that internal contractual arrangements and billing formats be signed off by the psychiatrist(s) and or general practitioner(s) providing the sessional fee service and the individual with delegated management responsibility for the sessional fee allocation. Semi-annual monitoring forms must be signed off by the individual with delegated responsibility for the sessional fee allocation. If the individual who provided the sessional fee service also has management responsibility for the sessional fee allocation, then it is desirable that signoff be obtained by another individual within the administration (the provider of the sessional fee service still signs off in the case of the internal contractual agreements and billing formats). Semi-annual monitoring forms must also be signed off by the Chief Executive Officer, Executive Director or Director of the organization receiving the sessional funding allocation.

V. Service Definitions for Sessional Funding

Indirect psychiatric services provided by a psychiatrist or general practitioner that qualify for sessional funding are divided into seven areas and defined as follows:

1. Participation in Case Conferences

Objective:

To ensure that the psychiatrist or general practitioner is involved with other members of the client's helping network and the client in order to be a resource in the coordination of planning and service delivery for the client.

Activities:

- Case conferences are usually initiated by the case manager or clinician.

- Facilitate with the client and helping network the development of congruent goals for the client, collective decisions about appropriate actions to take based on such goals, and the formulation of alterations in the treatment/care plan.

Case conferences may occur:
- on a regular and scheduled basis
- ad hoc, e.g. new staff person involved with the case, sudden decision to increase/ decrease the efforts of certain service providers, conflicting demands by service provider on a client, a major crisis occurs which impedes the client's ability to participate effectively
- Face to face or by teleconferencing or videoconferencing

Participants:

The client's entire helping network which may include psychiatrists, other physicians, social workers, psychologists, public health and registered nurses, occupational therapists, etc. It is encouraged that the client attend as well. The helping network includes service providers internal or external to the organization as well as other significant social supports to the client, as permitted by the client (e.g. family, significant others).

Exclusion: If the client is interviewed by the psychiatrist or general practitioner as part of the case conference then that specific service may be reimbursed by OHIP and should be excluded from the overall time that the case conference consumed, i.e. the remaining time of the case conference may be billed through sessional fees.

2. Client-centred Consultation

Objective:

To allow psychiatrists and general practitioners to provide specialized information and /or expertise to staff in an advisory context about a specific client

Activities:

- Provision of medical information and expertise

Client-centred consultation may occur:
- on a regular and scheduled basis
- ad hoc
- face to face or by teleconferencing or videoconferencing (including brief contacts)

Participants:

Staff in institutional or community-based settings (public health, schools, social service agencies, other physicians, community mental health programs, police, probation and parole offices)

Exclusions:
- consultation to jails (Ministry of Community Safety and Correctional Services provides funds)
- consultation to those child welfare agencies that provide for this service through their budgets
- consultation to psychiatry residents due to payment through OHIP, hospital global budgets, teaching /research budget of teaching hospitals or any other source of funding
- if the client is interviewed by the psychiatrist or general practitioner as part of the client-centred consultation, then that specific service may be reimbursed by OHIP and should be excluded from the overall time that that the client centred consultation consumed, i.e. the remaining time of the client-centred consultation may be billed through sessional fees.

3. Staff-centred Consultation

Objective:

To support, maintain, enhance and develop the clinical skills, knowledge and attitudes of staff

Activities:

- Interact with the staff and be familiar with the staff's style of practice, expertise, strengths, weaknesses and knowledge in order to provide critique, information and advice.

- Provide information about generic program issues.

- Provide instruction regarding client care.

- Guide treatment and intervention.

- Clarify potential role of staff in their clinical practice.

- Provide skill development.

Staff-centred consultation may occur:
- usually on a regular and scheduled basis
- only face to face

Participants:

Staff (including other physicians), students and volunteers

Exclusion: services to psychiatry residents

4. Program-centred Consultation

Objective:

To provide consultation in an advisory context about the evaluation, modification or creation of programs and interventions as well as to formulate program specifications and objectives which are measurable by defined standards and outcome measures

Activities:

- Conceptualize the broad vision or philosophy of the department or program as well as course of action for implementation.

- Provide information and expertise based on the planning phase and to translate the policy goals.

- Facilitate team building, conflict resolution, provision of opportunities for learning, growth and development.

Program-centred consultation must occur:
- on a time-limited basis
- face to face

May occur:
- at work group meetings, staff breakaways, retreats.

5. Program Direction

Objective:

To provide direction about the progression, effectiveness, efficiency and management of an overall program. Management is defined as " the organization and control of human, fiscal, and material resources directed towards achieving specific outcomes". Such direction is provided by a psychiatrist or general practitioner who has an authoritative rather than consultative relationship with the program and its staff.

Activities:

- Define tasks at staff and organizational level to make effective use of available skills.

- Monitor, control and evaluate to adapt the chosen means in accordance with experience.

- Facilitate coordination of the overall program with respect to the internal and external environments.

Usually conducted on an on-going basis.

Exclusion: The above activities should not be funded from sessional fees if they are funded from other sources, e.g. research funds, administrative stipends, etc.

6. Provision of Educational Services

Objective:

To provide education on clinical issues related to psychiatry

Activities:

- Seminars, courses, conferences and presentations, in-service training, skill building.

Provision of education services may occur:
- face to face
- by teleconference or videoconference in order to address geographic barriers

Participants

Community at large, consumers, family members, colleagues, staff, other hospitals' and agencies' staff, other physicians, students.

Exclusions: services to psychiatric residents; education provided during hospital rounds

7. System Coordination

Objective

For a psychiatrist or general practitioner who is not the program director to provide leadership in facilitating the coordination of the overall program with respect to the internal and external environments

Activities:

- Attendance at committee and staff meetings

- Development of program liaison mechanisms that promote inter-organizational coordination and cooperation, e.g. meetings with planning groups such as AGHPS, DHCs, Ministry, etc.

System coordination may occur:
- face to face
- by teleconference/videoconference

Participants:

Staff within hospital or community-based settings, government representatives, social service and health organizations, associations, coalitions, etc.

VI. Program Monitoring and Accountability Mechanisms

The sessional fee program is monitored through the use of the following forms :

1. *a contractual form*: is developed by each organization receiving sessional funding. The contract is between the organization and the physician and

stipulates the type and frequency of services that the psychiatrist or general practitioner plan on providing within a given timeframe.

2. *a billing form*: is developed by each organization receiving sessional funding to serve as the log for the psychiatrists and general practitioners to record sessional services and billings submitted.

3. *a monitoring form (Semi-annual and Annual Psychiatric Sessional Fee Report*): filled out by the organization and forwarded to the Ministry on a semi-annual and annual basis. The monitoring form will reflect the actual and forecasted surplus/deficit for sessional funds, the types of and context in which sessional funds are provided, the number of practitioners that provided the service, and the signed approval of the individual with delegated responsibility for the sessional allocation, as well as the Chief Executive Officer, Executive Director or Director of the organization. Organizations receive these forms (Appendix A) and instructions (Appendix B) as part of the Ministry's Operating Plan Guidelines.

4. *Review Criteria Guidelines:* for the use of Ministry of Health and Long-Term Care staff when reviewing the semi-annual and annual reports of organizations (Appendix C).