Fee-for-service core mental health services: Changes in provider source and visit frequency

Research Atlas

ICES Institute for Clinical Evaluative Sciences

Fee-for-service Core Mental Health Services: Changes in Provider Source and Visit Frequency

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Key Terms & Concepts

- core mental health services
- Mental Health Reform
- psychiatric disorder
- psychotherapy
- shared care
- stepped care

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Key Messages

✔ **In 1992/93, most core mental health care users (63%) received that care from a general practitioner or family physician (GP/FP) only; 22 per cent saw a psychiatrist only; and 12 per cent saw both.**

✔ **Nearly 45 per cent of core mental health care users made only one visit during 1992/93 and consumed slightly more than 8 per cent of the core mental health care dollar. Five per cent of users made 25 or more visits but accounted for more than 38 per cent of the core mental health care dollar.**

✔ **There has been little change in either of these patterns in the five years between 1992/93 and 1997/98.**

Background

This is the second report covering fee-for-service core mental health care in the ICES Atlas Report series. While the first report[1] covered fiscal and population changes between 1992/93 and 1997/98, this report will focus on what types of physicians provide these services (provider-source) and on numbers of visits. It also provides further detail, based on the 1997/98 claims data, at the District Health Council (DHC) level, on the practice patterns of different provider sources and on the proportion of users in each DHC who make "frequent" visits.

Examining provider-source and visit frequency is important for several reasons. In Ontario, as in other Canadian provinces, the role of the general practitioner and family physician (GP/FP) is considered pivotal in the delivery of health care. This is also reflected in the province's Mental Health Reform initiatives[2,3,4] in which the desired system is one that centres on the individual user and offers an integrated continuum of care addressing all the user's health care needs—both physical and mental. One thrust of Mental Health Reform is to continue the role of the GP/FP as both family physician and source of referral to specialists (also known as "stepped care"). The specialized training of the psychiatrist in this system is reserved largely for treating the most seriously mentally ill individuals. Psychiatrists also play a consulting and supportive role for the GP/FP who provides core mental health care to those needing less intensive interventions (also known as "shared care").

It is important to get baseline information on how large a role is played by the GP/FP compared to the psychiatrist and how much overlap (and potential for coordination) there is between these two types of physicians. This will provide a framework for understanding the results of future monitoring of fee-for-service core mental health care.

The need to evaluate the number of core mental health visits is more complex. The most obvious reason is cost. Simply put, the more visits a user makes, the more money is spent. However, the goal of Mental Health Reform is to allocate resources in the best manner possible to those in need—in other words, to increase efficiency and outcomes rather than to focus solely on cutting expenditures. From this perspective, the number of visits is a rough measure of resources, and the important questions are whether resources are being distributed equitably and according to need.

Methods

The data used here are the 1992/93 and 1997/98 Ontario Health Insurance Plan (OHIP) claims data (excluding claims for laboratory services). Core mental health care was defined as the assessment, diagnosis and treatment of individuals with mental, emotional or addiction-related conditions and was measured in the same way as in the first Atlas Report[1] on core mental health care (that is, using a portion of the Ministry of Health's list of mental health care codes, see Technical Appendix). The providers of core mental health care were divided into three groups based on their medical specialty—GP/FP, psychiatrist or other. Providers were defined as any physician submitting at least one claim during the fiscal year for a core mental health service (as defined in the Technical Appendix). Physicians who identified more than one specialty were assigned a primary specialty following the method used in a previous Atlas Report on physician supply.[5] This information was then used to identify users of core mental health care who received that care from one of the following four categories of providers:

- **GP/FP-only:** saw a GP/FP but **not** a psychiatrist (may or may not have seen another non-psychiatrist medical doctor [MD])
- **Psychiatrist-only:** saw a psychiatrist but **not** a GP/FP (may or may not have seen another non-psychiatrist MD)
- **GP/FP+psychiatrist:** saw both a GP/FP **and** a psychiatrist (may or may not have seen another non-psychiatrist MD)
- **Other:** did **not** see either a GP/FP or psychiatrist, but saw another specialty of physician for core mental health care

Out-of-province physicians, who cover less than 0.1 per cent of both core mental health care users and dollars, were not included in the analyses of provider source.

The number of core mental health care visits was calculated using the OHIP claims data. A visit was defined as one or more services provided by the same physician within the same day. In other words, multiple claims by a physician for one person within the same calendar day were counted as one visit. Describing the number of visits using meaningful categories was not straightforward since no consensus existed on how many visits were "too many" and how many "not enough." For this report, individuals were grouped by the number of

core mental health visits they made in a year into five categories—1 visit, 2-4, 5-12, 13-24 or 25 or more visits. These groups correspond roughly to common patterns of scheduling appointments such as once, a few times during the year, once a month or less, twice a month or less and more than twice a month. Individuals in the 25 or more visits category were defined for this report as frequent users.

All fiscal information was converted to 1997-dollar equivalents using the method described in a previous Atlas report.[5] The age range was restricted to those who were 15 years and over during the year the claim was submitted.

Interpretive Cautions

Details about the type of care or its outcome, particularly on the individual OHIP user's level, are unavailable. For example, if a person receives core mental health care from both his/her GP/FP and a psychiatrist, the two physicians should ideally be in close communication so that the care can be properly coordinated. However, we cannot determine from the data whether individuals falling into this dual provider category are actually receiving this type of integration.

Similarly, the quality of care they are receiving and the effect it is having cannot be determined from the available data. As with the first Atlas Report on core mental health services,[1] this is an important missing ingredient that is necessary to completely evaluate the results reported here.

Also, the OHIP claims data provide no information on how severe or disabling the conditions are for which individuals are receiving care. For these analyses, we have assumed that differences in severity among age, sex and regional groups correlate roughly to differences in the prevalence of psychiatric disorder (i.e. groups with higher rates of illness will also have higher rates of individuals who are in severe need). However, this assumption will probably need to be revised for future analyses as more information becomes available. This type of information will be particularly central for evaluating the patterns of the "frequent" and "not-so-frequent" users.

In addition, the measurement of core mental health care is not precise and probably underestimates the amount and extent of this type of care. This is because the definition was based on a list of fee codes specific to mental health (e.g. psychotherapy), whereas core mental health services also include general interventions that could apply to many types of conditions (e.g. intermediate or minor assessments).

Finally, because this data only covers the core mental health care billed through the fee-for-service sector, the care delivered through the provincial psychiatric hospitals is not covered in this report. Thus, the fiscal resources devoted to core mental health care by the province are certainly underreported. However, there is likely only a small impact on the percentage of Ontarians reported as receiving care. In addition, some DHCs have higher proportions of physicians who are not paid through fee-for-service. For these DHCs, the core mental health care delivered by GP/FPs (e.g. Hamilton-Wentworth; Waterloo Region-Wellington-Dufferin) and by psychiatrists (e.g. Quinte, Kingston, Rideau Valley) is underreported.

Findings and Discussion

Source of Core Mental Health Care

Exhibit 1 shows the number of physicians delivering core mental health care, their rate per 1,000 population and the average number of patients receiving that care for 1992/93 and 1997/98. The total number of core mental health care physicians grew slightly from 11,916 to 12,170—an increase in keeping with, or slightly behind, the total population growth. The ratio of providers per 1,000 population decreased marginally from 1.01 to 0.96 for GP/FPs and from 0.20 to 0.19 for psychiatrists. The average number of OHIP users receiving core mental health services in a year increased considerably—nearly 11 additional users for GP/FPs, slightly more than nine for psychiatrists, and nearly eight for other types of physicians. However, the percentage of GP/FPs and psychiatrists who saw patients in the GP/FP+psychiatrist category (not shown) changed very little from 1992/93 to 1997/98. For GP/FPs, the percentages were 24.1 and 24.4 per cent while for psychiatrists, the percentages grew slightly from 35.8 to 38.8 per cent.

The number of users, total billings and number of visits associated with each source of provider care for 1992/93 and 1997/98 are shown in Exhibit 2. The largest group of users received core services from the GP/FP-only provider source for both 1992/93 (63%) and 1997/98 (65%).

Rates of change for each category were smallest for the psychiatrist-only category (with the number of visits actually decreasing slightly). In the GP/FP-only category, there were increases in billings (19.8%) and visits (19.5%). In the GP/FP+

psychiatrist group, billings increased by 17.6 per cent and visits by 13.9 per cent. Users seeing other physicians showed the highest rates of increase but constituted only a tiny percentage of those receiving core mental health services.

Despite these changes, the overall patterns of core mental health care between 1992/93 and 1997/98 showed little change. The majority of OHIP users of core mental health care received their care from a GP/FP, either alone (between 63.3 and 65.0%) or in combination with a psychiatrist (between 12.2 and 11.3%). The total percentage seeing a GP/FP for core mental health care in 1997/98 was 76.9 per cent, a slight increase over the 1992/93 percentage of 75.5 per cent. The total percentage seeing a psychiatrist was 32.3 per cent, a slight decrease from five years earlier.

The average number of core mental health care visits per user and the average billing per visit are shown in Exhibit 3. Similar to the findings in Exhibit 2, there were only slight changes between 1992/93 and 1997/98. Users seeing GP/FP-only or physicians other than psychiatrists for core mental health services averaged roughly three visits annually while those seeing a psychiatrist, either alone or in addition to a GP/FP, averaged between 10 and 15 visits. The gap between the highest average billing (psychiatrist-only) and lowest average billing (other physician) per visit widened from $3.78 in 1992/93 to $5.57 in 1997/98.

The first Atlas Report[1] noted that while there was a decrease between 1992/93 and 1997/98 in the percentage of Ontario's population using total OHIP services, there was an increase (from 9.1 to 9.6%) in the percentage using core mental health care. Exhibits 1 to 3 show that this increase was accomplished through physicians delivering these core services to greater numbers of their patients rather than through a rise in the number of core mental health care providers. Psychiatrists appear to be seeing more patients by slightly decreasing the average number of visits per patient. GP/FPs and "other" physicians may be adding more individuals to their caseloads or shifting to psychiatric types of care. These findings are consistent with a greater awareness of mental health issues by front-line and non-psychiatrist physicians. However, the proportions of users who see both GP/FPs and psychiatrists and the proportions of physicians participating in such "shared" care have hardly changed, suggesting that Mental Health Reform's vision of greater integration of care has yet to be realized.

Frequency of Core Mental Health Care Visits

Patients who made only a single visit comprise the largest group of core mental health care users (44.5% in 1992/93 and 42.9% in 1997/98). Nearly 90 per cent of all core mental health care users made 12 or less visits per year (Exhibit 4). Those making frequent visits (25 or more per year) were between 4.7 and 5.0 per cent of the users but accounted for 35.9 to 38.2 per cent of core mental health care billings. There were small decreases over time in the percentages of users making one visit and those making frequent visits, with parallel decreases in the percentage of billings they each accounted for.

The age-sex composition of frequent and not-so-frequent users in 1997/98 is shown in Exhibit 5. Consistent with the widely reported finding of sex differences,[6,7,8] there are larger percentages of women than men across all age groups and regardless of visit frequency. The age-sex group most likely to receive care regardless of frequency are 20 to 44-year-old women. There are some slight differences between the frequent and not-so-frequent users. The elderly are less likely to be frequent (4.8%) and more likely to be not-so-frequent users (10.1%). Women between the ages of 20-44 and 45-64 years are slightly more likely to be frequent (33.1 and 22.9%) than not-so-frequent users (31.2 and 20.5%). These patterns show little change when compared to the 1992/93 age-sex patterns.

Regional characteristics for 1997/98 (Exhibit 6) show a large disparity for the Toronto health planning region which is the source of 43 per cent of the frequent users compared to 27 per cent of the not-so-frequent users. For all of the other regions, the percentages are either roughly equal to each other or the frequent user figure is slightly lower than the not-so-frequent group.

Like the age-sex findings, regional patterns have not changed greatly since 1992/93 (not shown). There is a slight increase of frequent users in the North (from 2.4% in 1992/93 to 3.2%) and a slight decrease of frequent users in the Toronto planning region (from 45.3% in 1992/93 to 43.3%). Data from subsequent years will need to be analyzed to determine if these changes are the beginning of small trends or simply normal fluctuations.

District Health Council Findings

The percentages of 1997/98 core mental health care users, billings and visits for each provider source are shown for each of the province's 16 DHCs in Exhibits 7a through 7c. Like the overall province, the majority of core mental health service users (60 to 76%) received that care from the GP/FP-only provider source. However, there are also clear geographical differences at the DHC level. Exhibit 7a shows two general patterns: one where users are more likely to see GP/FPs only and less likely to consult psychiatrists only (e.g. Central West and North regions); and another which is the reverse (e.g. Hamilton-Wentworth, Toronto, Champlain).

The first pattern maps roughly onto the less urbanized areas of the province and the second onto the more highly urbanized areas although there are some deviations to this rule (e.g. Quinte, Kingston, Rideau). This same pattern is reflected in the core mental health billings (Exhibit 7b) for the GP-only and psychiatrist-only provider sources. The percentages of billings associated with the GP/FP+ psychiatrist provider source vary less widely across DHCs. Both the highest and lowest proportions are represented in Northern DHCs—40.4 per cent in the Algoma, Cochrane, Manitoulin and Sudbury DHC and 27.4 per cent in the Muskoka, Nipissing, Parry Sound and Timiskaming DHC. For billings by "other" physicians for core mental health care, the highest proportion (2.9% for Niagara Region) is roughly twice the provincial figure of 1.4 per cent while the lowest (0.4% for Algoma, Cochrane, Manitoulin and Sudbury) is less than one-third. However, the overall percentages for this provider source are quite small. The proportions of visits by provider source within each DHC (Exhibit 7c) closely follow the billing patterns.

When total billings is averaged over number of visits, the pattern of relatively equal average billings found for the province overall (Exhibit 3) is repeated at the DHC level (not shown). The DHCs with the widest ranges of average billings are Hamilton-Wentworth (with a $13.75 difference between highest and lowest provider source) and Algoma, Cochrane, Manitoulin and Sudbury ($10.33), differences approximately twice the provincial difference ($5.57).

Much greater variation is evident in the average visits per user (Exhibit 8). Compared to the overall provincial average, Toronto and Champlain users of core mental health services have higher average number of visits across all four provider sources. Users in the majority of the other DHCs average numbers of visits either at or below the provincial figures, the exceptions being Grey, Bruce, Huron, Perth and Thames Valley DHCs which show a higher than average number of visits to "other" physicians.

DHC data for frequent users (25 or more core mental health care visits in a 12-month period) are shown in Exhibit 9. As would be expected from the larger provincial picture (Exhibit 4), frequent users are consistently a small percentage of users but comprise a large percentage of billings. While there appears to be a rough correlation between the percentages of frequent users and related billings, closer examination of the data suggest complex patterns occurring at the DHC level. For example, Toronto and Champlain DHCs have the largest proportion of frequent users (7.2 and 5.7%) and the highest associated billings (45.8 and 40.2%) while Muskoka, Nipissing, Parry Sound and Timiskaming and Northwestern Ontario have the smallest (1.7 and 2.0% for frequent users; 17.5 and 21.7% for associated billings). However, the ratio of billings to users is lowest for Toronto and Champlain (6.4 and 7.1) and highest for the other two DHCs (10.3 and 10.9). The billing/user ratio can be interpreted as a rough measure of resource use. Thus, while there are larger percentages of frequent users in Toronto and Champlain, they use fewer core mental health resources (either through fewer visits or less expensive services) than frequent users in Muskoka, Nipissing, Parry Sound and Timiskaming or Northwestern Ontario.

While the DHC findings are broadly consistent with the provincial results described in the first section of this report, there are also important differences in how core mental health services are delivered. Likely factors related to fee-for-service providers include the availability of physicians within each DHC, the ratio of GP/FPs to psychiatrists, differences in local practice and referral patterns and the availability of other mental health services (hospital beds, community health agencies, consumer initiatives, etc.) to DHC residents. Clarifying what impact these factors have, as well as the effect of broader social forces, would be a useful focus of further analyses of OHIP and other data.

Conclusions

The major change in fee-for-service core mental health care between 1992/93 and 1997/98 has been the delivery of services to a larger percentage of Ontario's population. This has been accomplished through providers seeing more patients rather than an increase in the relative number of providers. However, there is little detectable change in who provides such care, the extent to which it appears to be shared care, or the way core mental health care resources have been distributed across age, sex or regional groups. Essentially, these findings underscore the results reported in the previous Atlas Report[1] on core mental health care—namely, that the delivery of core mental health services has expanded but not changed in the fundamental ways envisioned by Mental Health Reform. While increased coverage is desirable if it corresponds to need, even more desirable would be larger percentages of both users and physicians who appear to be involved in shared care and a distribution pattern of visits across sociodemographic groups more consistent with their pattern of need.

The effects of Mental Health Reform on the fee-for-service system appear to be weak or perhaps require more time before they become evident. To some extent, this is not completely surprising since the fee-for-service sector has not been a

central focus of Mental Health Reform. The findings in this and the previous Atlas Report on core mental health care can provide baseline information to judge whether change is occurring slowly or not at all, particularly as Reform efforts consolidate in other health care sectors. Of special interest will be the results at the DHC-level where local conditions will play important roles in the speed and shape of any changes.

However, several kinds of additional information will be needed to interpret these and future findings. More details on outcomes, severity of condition and intervention alternatives are needed to evaluate which patterns are appropriate and desirable, and which are not. In addition, at the policy level, the role of the fee-for-service sector in a reformed system of mental health care and the ways that provider practice patterns could be influenced and evaluated need more specific consideration.

Exhibit 1: Number of Providers of Core Mental Health Care per 1,000 Population and Average Number of Patients in Ontario, 1992/93 and 1997/98

	# Delivering Core Mental Health Care		Providers/1,000 population[1]		Average # Core Mental Health Care Patients	
Provider Source	**1992/93**	**1997/98**	**1992/93**	**1997/98**	**1992/93**	**1997/98**
GP/FP	8,565	8,735	1.01	0.96	75.9	86.8
Psychiatrist	1,661	1,726	0.20	0.19	222.8	232.1
Other Medical Doctor	1,690	1,705	0.20	0.19	20.3	27.9

Data Source: Ontario Health Insurance Plan (OHIP), CANSIM Matrices 6367-6379

[1] Calculated as the number of core mental health care providers per total provincial population (aged 15 years and over). Core mental health care provider is defined as any physician submitting at least 1 claim during the fiscal year for core mental health care services as defined in the Technical Appendix.

GP/FP = General Practitioner/Family Physician

Exhibit 2: Core Mental Health Care Billings, Number of Users Aged 15 Years and Over and Visits in Ontario by Provider Source, 1992/93 and 1997/98

	1992/93		1997/98		Rate of Change	
Provider Source	**(Thousands)**	**%[1]**	**(Thousands)**	**%[1]**	**(Thousands)**	**%[1]**
Billings ($)						
GP/FP-only	61,601	28.5	73,825	30.3	12,224	19.8
Psychiatrist-only	83,880	38.8	86,360	35.5	2,479	3.0
GP/FP + Psychiatrist	67,892	31.4	79,826	32.8	11,934	17.6
Other Medical Doctor	2,573	1.2	3,370	1.4	797	31.0
Users						
GP/FP-only	490.7	63.3	570.8	65.0	80.1	16.3
Psychiatrist-only	171.7	22.2	179.1	20.4	7.4	4.3
GP/FP + Psychiatrist	94.2	12.2	104.8	11.9	10.6	11.3
Other Medical Doctor	17.5	2.3	23.4	2.7	5.9	33.7
Visits						
GP/FP-only	1,335.2	29.3	1,596.0	31.8	260.8	19.5
Psychiatrist-only	1,725.1	37.9	1,718.1	34.2	-7.0	-0.4
GP/FP + Psychiatrist	1,430.5	31.4	1,628.9	32.4	198.4	13.9
Other Medical Doctor	57.4	1.3	75.4	1.5	18.0	31.4

Data Source: Ontario Health Insurance Plan (OHIP)

[1] Column totals are slightly less than 100% due to exclusion of out-of-province physicians
GP/FP = General Practitioner/Family Physician

Exhibit 3: Changes in Average Visits per User and Average Billing per Visit for OHIP Core Mental Health Services by Provider Source in Ontario, 1992/93 and 1997/98

Average Visits/User	**1992/93**	**1997/98**
GP/FP-only	2.7	2.8
Psychiatrist-only	10.1	9.6
GP/FP + Psychiatrist	15.2	15.6
Other Medical Doctor	3.3	3.2
Average Billing/Visit[1]	**($)**	**($)**
GP/FP-only	46.14	46.26
Psychiatrist-only	48.62	50.26
GP/FP + Psychiatrist	47.46	49.00
Other Medical Doctor	44.84	44.69

Data Source: Ontario Health Insurance Plan (OHIP)

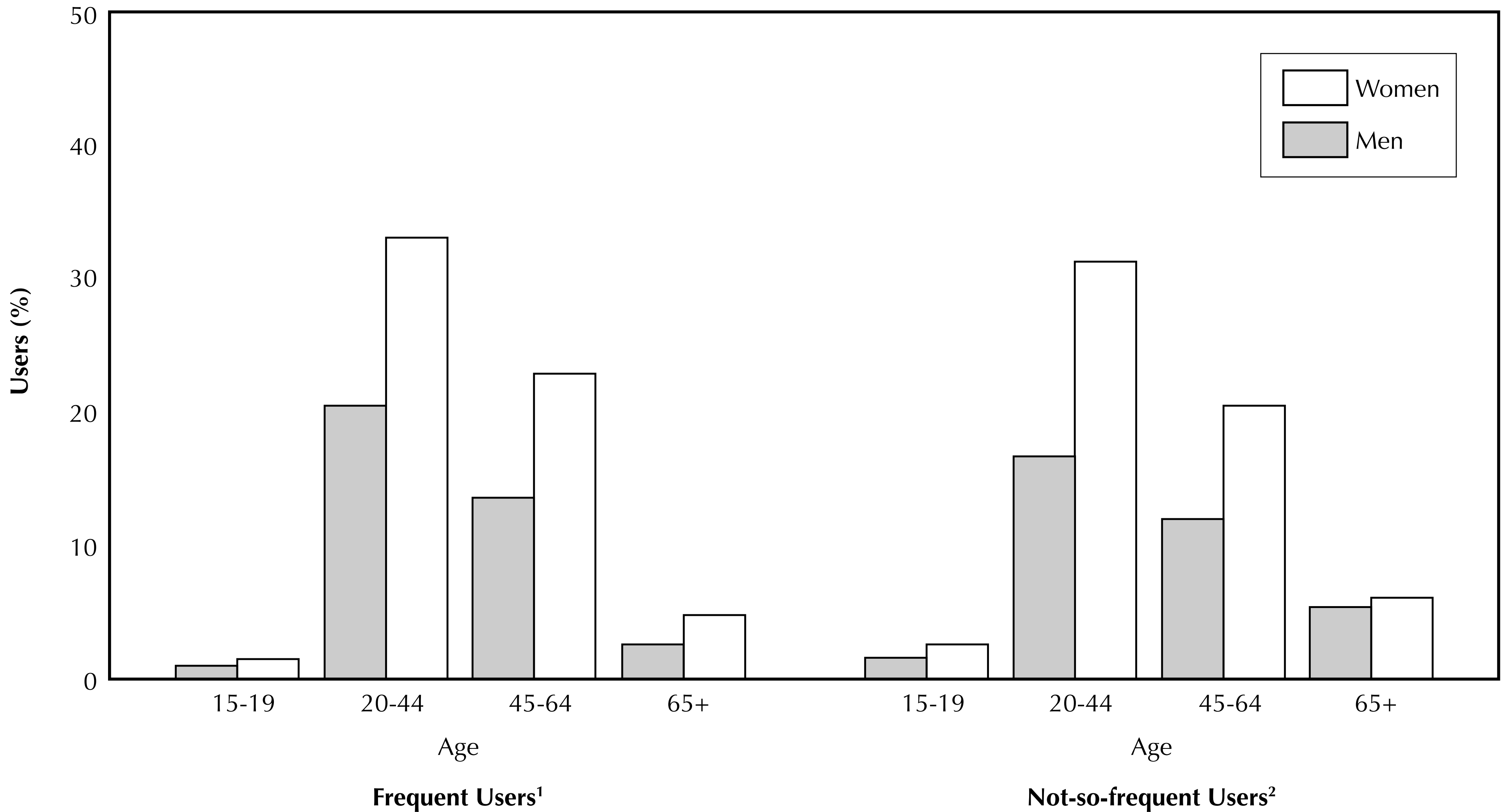
[1] All dollars in 1997 equivalents
GP/FP = General Practitioner/Family Physician

Exhibit 4: OHIP Core Mental Health Care Users Aged 15 Years and Over and Billings by Visit Frequency in Ontario, 1992/93 and 1997/98

Visit Frequency	Total # of Core Mental Health Care Users (Thousands)		OHIP Core Mental Health Care Users (%)		OHIP Core Mental Health Care Billings (%)	
	1992/93	1997/98	1992/93	1997/98	1992/93	1997/98
1 visit	344.7	377.2	44.5	42.9	8.3	7.9
2-4 visits	220.6	257.9	28.5	29.4	14.2	14.6
5-12 visits	126.0	150.4	16.3	17.1	22.0	23.5
13-24 visits	45.2	52.2	5.8	5.9	17.3	18.1
25 or more	38.2	41.0	5.0	4.7	38.2	35.9
Total	**774.7**	**878.7**	**100.0**	**100.0**	**100.0**	**100.0**

Data Source: Ontario Health Insurance Plan (OHIP)

Exhibit 5: Age/Sex-specific Distributions of Frequent vs. Not-so-frequent Core Mental Health Care Users in Ontario, 1997/98



Data Source: Ontario Health Insurance Plan (OHIP)

[1] Frequent: 25 or more core mental health care visits per year
[2] Not-so-frequent: 1 to 24 core mental health care visits per year

Exhibit 6: Regional Distribution of Frequent[1] and Not-so-frequent Users[2] of OHIP Core Mental Health Services in Ontario, 1997/98

Ontario Health Planning Region	Frequent Users (%)	Not-so-frequent Users (%)
South West	8.1	11.5
Central South	6.0	8.7
Central West	11.0	15.6
Toronto	43.3	27.3
Central East	10.4	14.3
East	17.9	16.3
North	3.2	6.3

Data Source: Ontario Health Insurance Plan (OHIP)

[1] Frequent: 25 or more core mental health care visits per year
[2] Not-so-frequent: 1 to 24 or more core mental health care visits per year

Exhibit 7a: Core Mental Health Care Users Aged 15 Years and Over by Provider Source by District Health Council in Ontario, 1997/98

District Health Council	Users (Thousands)	Provider Source (%)			
		GP/FP only	Psychiatrist only	GP/FP + Psychiatrist	Other Medical Doctor
South West Planning Region					
• Essex, Kent and Lambton	36.4	61.3	25.2	11.3	2.2
• Grey, Bruce, Huron, Perth	16.8	69.3	17.3	12.0	1.4
• Thames Valley	45.7	66.7	19.7	11.6	2.0
Central South Planning Region					
• Grand River	14.4	66.2	18.9	12.6	2.2
• Hamilton-Wentworth	35.6	61.7	22.3	11.7	4.3
• Niagara Region	25.2	61.8	22.0	12.0	4.2
Central West Planning Region					
• Waterloo Region-Wellington-Dufferin	37.6	65.7	19.8	10.6	4.0
• Halton-Peel	96.8	68.9	16.9	11.8	2.4
Toronto Planning Region					
• Toronto	245.4	60.4	24.3	12.7	2.7
Central East Planning Region					
• Durham, Haliburton, Kawartha and Pine Ridge	51.3	70.5	16.3	11.1	2.1
• Simcoe-York	71.8	68.3	17.3	11.4	3.0
East Planning Region					
• Champlain	108.2	63.7	20.5	13.2	2.6
• Quinte, Kingston, Rideau Valley	35.2	69.6	17.4	10.7	2.4
North Planning Region					
• Algoma, Cochrane, Manitoulin and Sudbury	25.3	70.2	16.5	12.2	1.1
• Muskoka, Nipissing, Parry Sound and Timiskaming	15.4	75.8	13.1	8.6	2.5
• Northwestern Ontario	13.6	73.9	14.3	8.1	3.7
Ontario Total	**879.0**	**65.0**	**20.4**	**11.9**	**2.6**

Data Source: Ontario Health Insurance Plan (OHIP)

GP/FP = General Practitioner/Family Physician

Exhibit 7b: Core Mental Health Care Billings by Provider Source by District Health Council in Ontario, 1997/98

District Health Council	Total Billings[1] (Thousands)	% of Billings[2]			
		GP/FP only	Psychiatrist only	GP/FP + Psychiatrist	Other Medical Doctor
South West Planning Region					
• Essex, Kent and Lambton	8,065.4	28.7	35.4	33.6	1.1
• Grey, Bruce, Huron, Perth	3,736.4	35.7	25.5	37.9	0.9
• Thames Valley	11,902.7	31.9	34.0	32.5	1.6
Central South Planning Region					
• Grand River	3,263.2	31.3	31.0	36.5	1.2
• Hamilton-Wentworth	9,368.6	28.0	38.6	31.4	2.0
• Niagara Region	5,493.5	31.8	30.6	34.7	2.9
Central West Planning Region					
• Waterloo Region-Wellington-Dufferin	8,531.7	34.0	30.7	33.2	2.1
• Halton-Peel	24,049.0	35.2	28.3	35.4	1.1
Toronto Planning Region					
• Toronto	86,072.9	25.8	42.3	30.6	1.3
Central East Planning Region					
• Durham, Haliburton, Kawartha and Pine Ridge	10,878.8	37.2	27.1	34.5	1.2
• Simcoe-York	18,175.4	34.1	31.5	32.7	1.6
East Planning Region					
• Champlain	33,484.9	27.5	36.2	34.8	1.3
• Quinte, Kingston, Rideau Valley	8,378.4	38.6	29.2	30.4	1.6
North Planning Region					
• Algoma, Cochrane, Manitoulin, Sudbury	5,733.4	35.1	24.0	40.4	0.4
• Muskoka, Nipissing, Parry Sound and Timiskaming	2,808.5	49.5	21.7	27.4	1.3
• Northwestern Ontario	2,357.3	42.6	25.8	29.9	1.7
Ontario Total	**243,508.3**	**30.3**	**35.0**	**32.8**	**1.4**

Data Source: Ontario Health Insurance Plan (OHIP)

[1] Includes out-of-province billings
[2] Percents may total less than 100% because out-of-province billings not included
GP/FP = General Practitioner/Family Physician

Exhibit 7c: Core Mental Health Care Visits by Provider Source by District Health Council in Ontario, 1997/98

District Health Council	Total Visits[1] (Thousands)	% of Visits[2] GP/FP only	Psychiatrist only	GP/FP + Psychiatrist	Other Medical Doctor
South West Planning Region					
• Essex, Kent and Lambton	174.5	28.7	35.5	34.7	1.0
• Grey, Bruce, Huron, Perth	77.8	36.7	24.0	38.3	1.1
• Thames Valley	238.2	34.0	32.1	32.4	1.4
Central South Planning Region					
• Grand River	63.4	34.0	29.2	35.6	1.2
• Hamilton-Wentworth	183.3	30.5	36.7	30.3	2.5
• Niagara Region	114.0	32.3	29.9	34.8	3.0
Central West Planning Region					
• Waterloo Region-Wellington-Dufferin	182.0	35.1	28.2	34.5	2.2
• Halton-Peel	477.8	37.2	27.0	34.4	1.4
Toronto Planning Region					
• Toronto	1,773.9	27.1	41.2	30.2	1.5
Central East Planning Region					
• Durham, Haliburton, Kawartha and Pine Ridge	223.0	39.2	25.8	33.7	1.3
• Simcoe-York	374.8	36.5	29.7	32.0	1.7
East Planning Region					
• Champlain	713.9	28.3	35.4	34.9	1.3
• Quinte, Kingston, Rideau Valley	170.2	40.9	27.5	29.9	1.5
North Planning Region					
• Algoma, Cochrane, Manitoulin, Sudbury	122.0	37.0	22.1	40.3	0.5
• Muskoka, Nipissing, Parry Sound and Timiskaming	58.9	52.0	20.5	26.3	1.2
• Northwestern Ontario	48.3	45.0	24.4	28.7	1.8
Ontario Total	**5,020.4**	**31.8**	**34.2**	**32.4**	**1.5**

Data Source: Ontario Health Insurance Plan (OHIP)

[1] Includes out-of-province visits
[2] Percents may total less than 100% because out-of-province billings not included
GP/FP = General Practitioner/Family Physician

Exhibit 8: Average Number of Visits per Core Mental Health Care Visits per User by Provider Source by District Health Council in Ontario, 1997/98

District Health Council	Provider Source			
	GP/FP only	Psychiatrist only	GP/FP + Psychiatrist	Other Medical Doctor
South West Planning Region				
• Essex, Kent and Lambton	2.3	6.8	14.7	2.2
• Grey, Bruce, Huron, Perth	2.5	6.4	14.8	3.6
• Thames Valley	2.7	8.5	14.6	3.8
Central South Planning Region				
• Grand River	2.3	6.8	12.4	2.4
• Hamilton-Wentworth	2.5	8.5	13.4	3.1
• Niagara Region	2.4	6.2	13.1	3.3
Central West Planning Region				
• Waterloo Region-Wellington-Dufferin	2.0	6.9	15.8	2.7
• Halton-Peel	2.7	7.9	14.4	2.9
Toronto Planning Region				
• Toronto	3.3	12.3	17.3	3.9
Central East Planning Region				
• Durham, Haliburton, Kawartha and Pine Ridge	2.4	6.9	13.1	2.8
• Simcoe-York	2.8	9.0	14.7	3.0
East Planning Region				
• Champlain	2.9	11.4	17.5	3.4
• Quinte, Kingston, Rideau Valley	2.9	7.7	13.6	3.2
North Planning Region				
• Algoma, Cochrane, Manitoulin, Sudbury	2.5	6.5	15.9	2.2
• Muskoka, Nipissing, Parry Sound and Timiskaming	2.6	6.0	11.8	1.9
• Northwestern Ontario	2.2	6.2	12.9	1.8
Ontario Total	**2.8**	**9.5**	**15.6**	**3.2**

Data Source: Ontario Health Insurance Plan (OHIP)

GP/FP = General Practitioner/Family Physician

Exhibit 9: Frequent Users[1] of OHIP Core Mental Health Services by Provider Source by District Health Council in Ontario, 1997/98

District Health Council	Total Frequent Users (Thousands)	Rate/10,000 Population	Billings/ Capita ($)	% of Core Mental Health Care Users	% of Core Mental Health Care Billings	% Billings/ % Users
South West Planning Region						
• Essex, Kent and Lambton	1.1	22.41	3.90	3.0	23.6	7.9
• Grey, Bruce, Huron, Perth	0.5	21.95	1.60	3.1	26.2	8.5
• Thames Valley	1.7	35.61	7.97	3.7	31.8	8.6
Central South Planning Region						
• Grand River	0.4	19.66	3.79	2.5	21.2	8.5
• Hamilton-Wentworth	1.4	34.99	7.61	3.9	31.9	8.2
• Niagara Region	0.7	21.52	3.64	2.9	22.4	7.7
Central West Planning Region						
• Waterloo Region-Wellington-Dufferin	1.2	22.73	4.40	3.2	26.9	8.4
• Halton-Peel	3.2	31.88	4.03	3.4	28.3	8.3
Toronto Planning Region						
• Toronto	17.7	85.17	19.03	7.2	45.8	6.4
Central East Planning Region						
• Durham, Haliburton, Kawartha and Pine Ridge	1.3	21.37	6.59	2.6	23.0	8.8
• Simcoe-York	2.9	36.71	7.31	4.1	31.9	7.8
East Planning Region						
• Champlain	6.2	72.67	15.86	5.7	40.2	7.1
• Quinte, Kingston, Rideau Valley	1.1	28.57	6.01	3.3	28.8	8.7
North Planning Region						
• Algoma, Cochrane, Manitoulin, Sudbury	0.8	22.94	4.85	3.2	29.4	9.2
• Muskoka, Nipissing, Parry Sound and Timiskaming	0.3	15.10	2.83	1.7	17.5	10.3
• Northwestern Ontario	0.3	13.24	2.54	2.0	21.7	10.9
Ontario Total	**41.0**	**44.67**	**9.57**	**4.7**	**35.9**	**7.6**

Data Source: Ontario Health Insurance Plan (OHIP)

[1] Frequent Users = 25 or more core mental health visits per year

Glossary

core mental health services
the assessment, diagnosis and treatment of emotional, mental or addiction problems by a health or allied health professional. Core mental health services are one component of a broader range of mental health services which also include prevention, education and supportive counselling.

Mental Health Reform
an ongoing initiative by the Ontario Ministry of Health to create a more systematic, integrated and rational mental health care system. The impetus of this effort began with the 1988 Graham report. To date, there have been two further publications, *Putting People First* and *Making It Happen,* which have described more fully aspects of the desired system.

psychiatric disorder
an emotional or mental illness characterized by a particular set of symptoms and problems, lasting a significant length of time, and accompanied by considerable discomfort and difficulty in normal functioning. Specific disorders and how they are defined and diagnosed are detailed, and periodically updated, in the *International Classification of Disease* (ICD) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

psychotherapy
a form of treatment for psychiatric disorders or less serious emotional, mental or addiction problems consisting of interaction (usually verbal) between the individual suffering the problem and a trained therapist. Psychotherapy may be used alone or in combination with pharmacotherapy (the use of psychotropic medications).

shared care
a practice pattern in which the care needed by individuals requiring complex medical assessment or intervention is coordinated between the individual's GP/FP and specialty physicians. This form of practice has been recently advocated in *Making It Happen,* released by the Ministry of Health in 1999.

stepped care
a practice pattern in which GP/FPs provide individuals with their general health care ("step" one) but also act as the means of a referral to specialty physicians ("step" two) when the individuals need more specialized care.

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Technical Appendix

OHIP Core Mental Health Fee Codes[1]

OHIP Fee Codes	DESCRIPTION
G471	Electroconvulsive Therapy (single/multiple)
K004	Family Psychotherapy
K006	Hypnotherapy
K007	Individual Psychotherapy
K008	Diagnostic/therapeutic Interview, child psychiatric problem/learning disability
K010	Group Psychotherapy—per member—(7th hour onward/day)
K011	Group Psychotherapy (hypnosis)
K012	Group Psychotherapy (4 people)
K024	Group Psychotherapy (5 people)
K025	Group Psychotherapy (6 to 12 people)
N110	Lobectomy
Z458	Electroconvulsive Therapy (cerebral)

Psychiatrist—Only OHIP Fee Codes

OHIP Fee Codes	DESCRIPTION
A191	Minor Assessment
A193	Specific Assessment
A194	Partial Assessment
A195	Consultation
A196	Repeat Consultation
A197	Consultation on behalf of disturbed child (interview with parents)
A198	Consultation on behalf of disturbed child (interview with child)
A395	Limited Consultation
C121	Further (hospital) Fees—visits due to intercurrent illness
C192	Hospital Subsequent Visits (up to 5 weeks)
C193	Hospital Specific Assessment
C194	Hospital Specific Reassessment
C195	Hospital Consultation
C196	Hospital Repeat Consultation
C197	Hospital Subsequent Visit (6th to 13th week)
C198	Hospital Concurrent Care
C199	Hospital Subsequent Visit (after 13th week)
C395	Hospital Limited Consultation
K190	Psychiatrist—Individual Psychotherapy
K191	Family Psychiatric Care—Inpatient

Psychiatrist—Only OHIP Fee Codes (Cont'd)

OHIP Fee Codes	DESCRIPTION
K192	Individual Hypnotherapy
K193	Family Therapy (inpatient)
K194	Group Hypnotherapy
K195	Family Therapy (outpatient)
K196	Family Psychiatric Care—outpatient
K197	Individual Psychotherapy (outpatient)
K198	Psychiatric Care (inpatient)
K199	Psychiatric Care (outpatient)
K200	Group Psychotherapy (inpatient - 4 people)
K201	Group Psychotherapy (inpatient - 5 people)
K202	Group Psychotherapy (inpatient - 6 to 12 people)
K203	Group Psychotherapy (outpatient - 4 people)
K204	Group Psychotherapy (outpatient - 5 people)
K205	Group Psychotherapy (outpatient - 6 to 12 people)
K206	Group Psychotherapy (outpatient - per member, 7th hour onward)
K207	Group Psychotherapy (inpatient - per member, 7th hour onward)
K568	Diagnostic Interview of child/parent
K620	Mental Health Act Assessment—Consultation
K623	Mental Health Act Assessment—Application
K624	Mental Health Act Assessment—Certification
K629	Mental Health Act Assessment—Recertification
W195	Long-term Institutional Care - Consultation
W196	Long-term Institutional Care - Repeat consultation
W395	Long-term Institutional Care - Limited consultation

[1]Based on original list of mental health related codes from the Ontario Ministry of Health with the exception that the following codes were deleted:

OHIP Fee Codes	DESCRIPTION
C982	Palliative Care
K002	Interview with relatives on behalf of patient
K003	Interview with CAS or legal guardian on behalf of patient
K013	Counselling (educational)
K014	Counselling (transplant recipients, donors, etc.)
K015	Counselling (relatives of terminally ill patients, etc.)
K016	Genetic Assessment
K019	Genetic Counselling (individual/family)
K020	Genetic Counselling (relatives)

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ISBN 0-9699405-8-0