

# A Balanced Approach:

## The Path to Ending Hallway Medicine for Ontario Patients and Families

Pre-Budget Submission  
2019 Ontario Budget



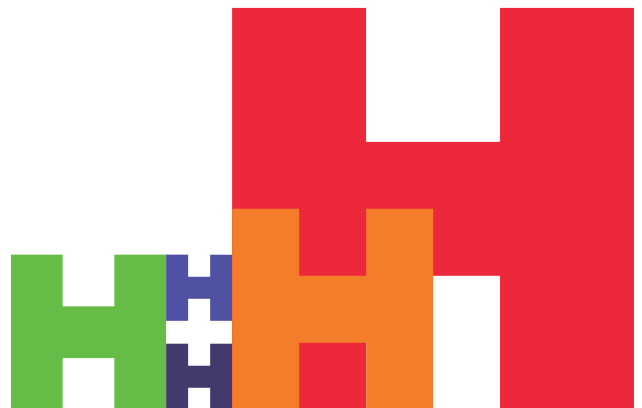
# A Time for Action

Ending hallway medicine is a top priority for the Ontario government – and for Ontario’s hospitals. The government’s recent action – including establishing the Premier’s Council on Improving Healthcare and Ending Hallway Medicine, investments in long-term care, and surge funding – are critical first steps. This is an exciting opportunity for the government to work with hospitals to solve a challenge that hasn’t previously been effectively addressed. Ontario’s hospitals continue to be resilient, innovative partners to government and are ready to accelerate the change needed to build a high-performing, patient-centred health care system of the future.

Hospitals agree that in the long-term, many of the solutions to ending hallway medicine lie outside of hospital walls, in settings like long-term care, home and community care, supportive housing or community mental health. However, it will take time to transform the health system so that sufficient capacity exists outside of hospitals. Meanwhile, it’s crucial that Ontarians continue to have access to hospital care as a safety net they can always count on.

Over the course of 23 million patient visits each year, hospitals deliver health care that Ontarians rely on while working to manage growth in spending – leading the country in efficiency. However, in recent years funding has not kept up with growing need, and Ontario hospitals need the government’s support today to stabilize care and maintain staffing levels of front-line health care workers.

The Ontario Hospital Association recommends a balanced path to ending hallway medicine focused on stabilizing and maintaining access to hospital care while making strategic policy changes to allow hospitals to innovate, smoothly transition patients to more appropriate care settings, and reduce health system costs.



A 90-year-old patient was admitted to Humber River Hospital’s Emergency Department with a left pelvic fracture and a head laceration after a fall on the stairs. Prior to hospitalization, the patient lived alone, was fully mobile and used only a cane for support. He lived independently and managed the basics activities of daily living. The patient was transferred from hospital to the Reactivation Care Centre (RCC) just under two weeks later.

The RCC’s enhanced activation program incorporates Ministry of Health and Long-Term Care guidelines for Assess and Restore. Although the patient’s mobility was initially compromised by his fear of falling again and he required moderate assistance for basic daily activities such as grooming, dressing, toileting, and bathing, the patient slowly progressed and improved with consistent occupational therapy, eventually regaining his mobility, using a single-point cane for support.

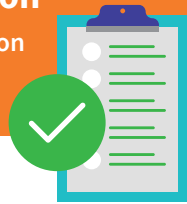
In addition to improving patient outcomes, the RCC relieves some of the pressures challenging hospitals struggling to manage the complex care needs of a rapidly aging population and a shortage of community care supports, such as long-term and convalescent care beds.

# The Hospital Sector: Leaders in Fiscal Efficiency

Hospitals have a deep appreciation for the significant financial pressures facing the province. They have a long history of working with government to responsibly manage health care spending and to make every dollar count. In fact, Ontario's hospitals are leaders in efficiency across Canada.

## Ontario's Hospital Efficiency Dividend

Ontario has the lowest per capita funding for hospitals in the country. Compared to the average of all other provinces, the Government of Ontario spends **\$401 less per person on hospital care**. This translates into **savings of \$5.7 billion annually** for the government to spend on other priorities.



Ontario hospitals accepted zero percent funding increases for four consecutive years at a time when patient volumes, labour costs, energy, regulatory requirements and other inflation grew significantly. During this period, hospitals worked hard to find efficiencies without compromising quality of care.

As a result, they lead the country in efficient use of government funding. Over the past six years, provincial government funding to Ontario hospitals has increased by only 3.5% in total, on a per capita basis. Within this increase, hospitals have had to cope with annual inflation costs, including labour, and an aging population. This is in stark contrast to the 12% increase, on a per capita basis, for hospitals in all other provinces combined, over the same period.

Front-line health professionals deliver safe, high-quality care patients rely on every single day, and staffing costs make up the bulk of a hospital's budget. Ontario hospitals voluntarily come together to negotiate on a province-wide basis, through a strong and efficient collective bargaining process. This generates economies of scale and, over the past four years, has resulted in wage increases of only 1.38% – outcomes that are well below public-sector bargaining trends.

The hospital sector continues to proactively and aggressively pursue new ways to reduce costs. Most recently, the OHA has begun consulting with hospitals, third-party benefits firms and unions to explore possible solutions and alternative models for the delivery of employee group benefits to find the most cost-effective options for the delivery of long-term disability, extended health, dental and life insurance benefits.

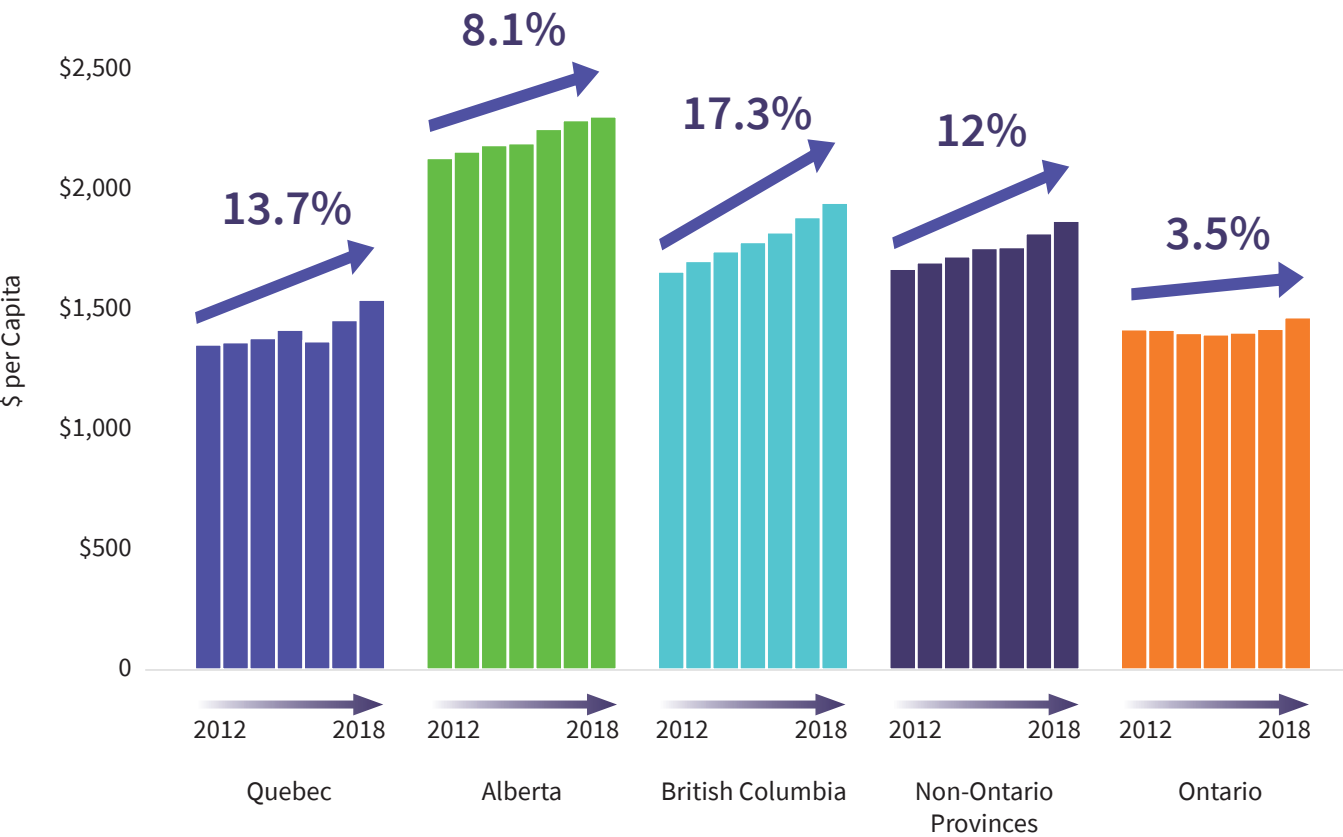


Ontario hospitals are also making strides to become more efficient through clinical innovation. For example, Niagara Health System and Women’s College Hospital are among hospitals using new techniques to perform outpatient orthopedic surgeries for procedures such as knee replacement that would normally require a hospital stay of several days. By performing surgeries on an ambulatory basis, hospitals are able to free up beds more quickly for other patients and reduce waiting lists. For patients who are strong candidates for these procedures, recovering at home is often preferable to doing so in hospital. Similarly, the University Health Network’s Transient Ischemic Attack and Minor Stroke (TAMS) program provides

ambulatory rapid access to all required tests, therapies and patient education, preventing unnecessary hospital admissions.

Hospitals have shown tremendous leadership by making their operations more efficient while improving patient care. While hospitals will continue to evaluate every expense for possible savings, there are simply no longer easy efficiencies to be found within the hospital system itself. Many hospitals are facing challenges balancing their budgets without significant cuts to services or layoffs of front-line staff, at a time when Ontario’s changing demographics mean we need them most.

Ontario Government Spends Less Per Capita on Hospitals, with a Lower Rate of Increase



# A Growing Population with Nowhere to Go

Ontario's population is rapidly growing and aging, and these population changes are already having an enormous impact on the health care system. The number of seniors aged 65 and older will grow from 2.5 million today to 3.6 million in 2028 and to 4.4 million in 20 years. In 2016, this age group accounted for 46% of all health sector expenditures and 51% of all hospital expenditures. Nearly three-quarters of seniors have at least one health condition, and as they age many develop multiple conditions and complex needs that require specialized care.

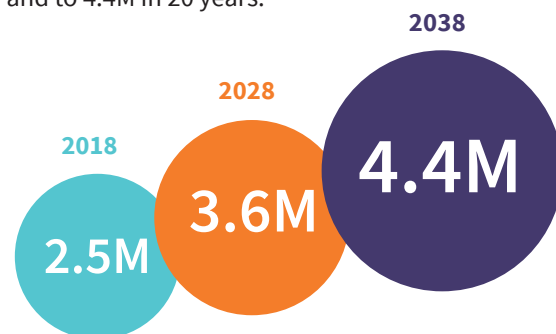
According to Health Canada, even younger Canadians are less healthy than previous generations, and often have less healthy weights, chronic diseases and more mental health concerns.

Hospitals face a number of challenges striving to meet the ever-increasing demand for care. Visits to Ontario's emergency departments have increased by 11.3% over the past six years. Emergency department wait times – one of the first signs of a larger capacity crisis – are also high. In January 2017, 10% of patients waited more than 39 hours to be admitted; by January 2018, the wait grew to 41 hours. Many hospitals regularly operate at over 100% capacity, although the widely accepted standard for hospital capacity is around 85%.

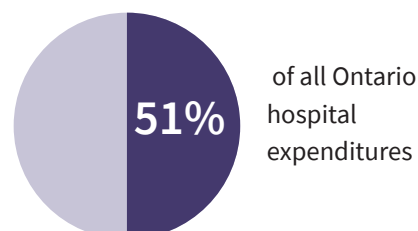
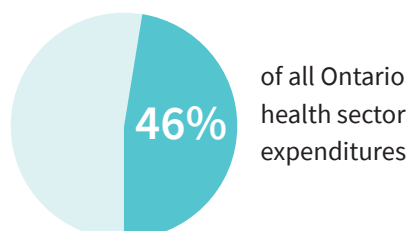
The biggest contributor to capacity challenges and hallway medicine is the fact that too many patients are waiting in hospital for care in more appropriate settings. In October 2018, there were 4,635 alternate level of care (ALC) patients waiting in an acute or post-acute hospital bed, occupying



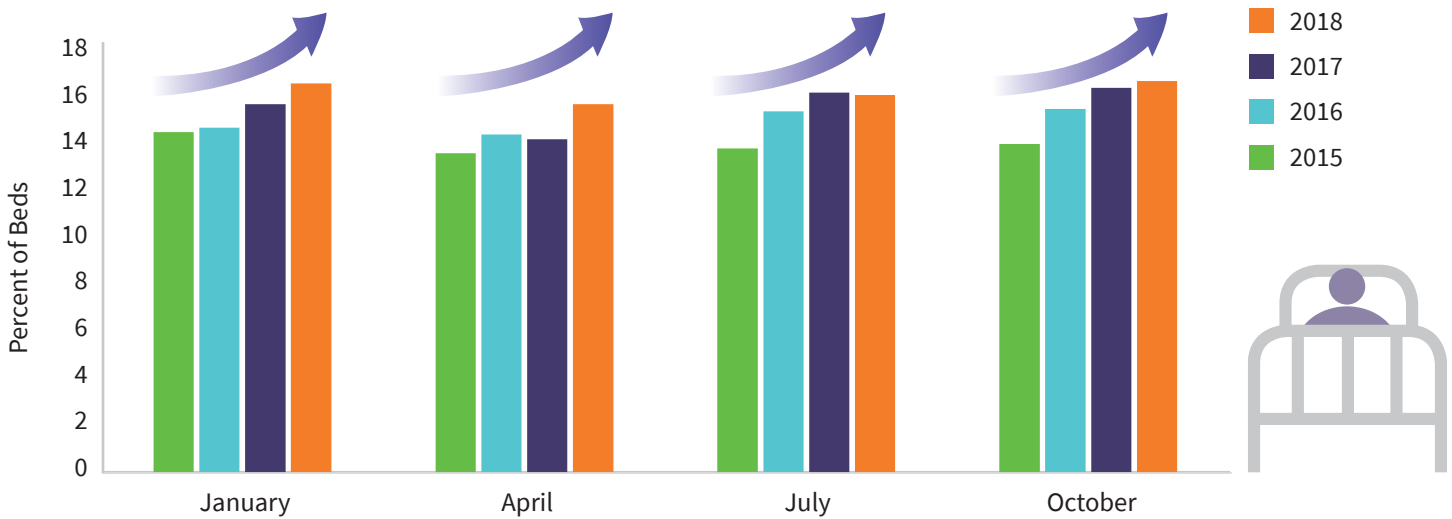
The population aged **65+** will grow from 2.5M today to 3.6M in 2028 and to 4.4M in 20 years.



In 2016, this age group accounted for:



## Percent of Acute Beds Occupied By ALC Patients



approximately one in six beds. As in previous years, this number is expected to spike during winter flu season. That's equivalent to more than 10 large hospitals, filled each day by patients who should be cared for elsewhere.

Addressing this challenge is about providing the right care in the right place – but it will also make better use of scarce health care resources. The high number of ALC patients waiting for care in more appropriate settings directly affects the province's bottom line – it costs approximately \$500 per day to provide care for a patient in hospital, \$150 in long-term care and even less for home and community care. More importantly, hospitals have less room to treat people who really need to be there, or to accommodate a sudden increase in patients during the winter flu season. Unfortunately, this means too many patients receive care in hallways and other unconventional spaces. It is impossible to end hallway medicine without addressing these rising ALC rates.

The number of patients waiting in hospital for more appropriate care is rising every year. In October 2018, there were nearly 600 more ALC cases than in 2015, an increase of almost 15%.

Hospitals, doctors, and over 200,000 nurses and other front-line health care professionals are under intense pressure. Despite these challenges, they are committed to making sure patients and families have access to the hospital care they need while longer-term solutions are put in place.

### Spotlight on Small, Rural and Northern Hospitals

Ontario's more than 60 small hospitals are experiencing increased demand and overcrowding. In many of these communities, there is little physical capacity to open surge spaces during flu season. Hospitals also require resources for additional staff. Because home and community care faces staffing shortages and new long-term care spaces will take years to complete, hospitals are a crucial safety net to fill any gaps in service, particularly in rural communities. Innovative integrated care models, including rural health hubs, have successfully closed some of these gaps, but they must expand more quickly.



# Maintaining Access to Hospital Care

For several years, the hospital sector has called for new investment across the health care system to ensure the entire system can meet the growing and changing needs of the province. We support the government's commitment to the construction of 15,000 new long-term care beds over the next five years and investing \$1.9 billion over 10 years in mental health and addictions services.

## Protecting Hospital Care

Operating pressures related to growth and inflation within hospitals total **3.45%** (\$656M).



However, it will be years before these services are available. In the meantime, these patients will continue to end up in hospitals, which serve as a bridge during health system transformation. Serious operating pressures are putting hospital care at risk today. Hospitals are simply reaching the limit of their ability to serve patients without compromising quality of care, increasing wait times, reducing services or losing front-line staff. In many cases, without increased funding a reduction in staff is, in all probability, unavoidable.

Since 1990, the number of hospital beds in Ontario has decreased by 36%. In that same period, the population has increased by 39%. Ontario now has a lower per capita acute bed count than all countries tracked by the OECD.

Long-term and home and community care has not increased at the pace needed to make up for this decrease in hospital beds, creating hospital overcrowding and hallway medicine.

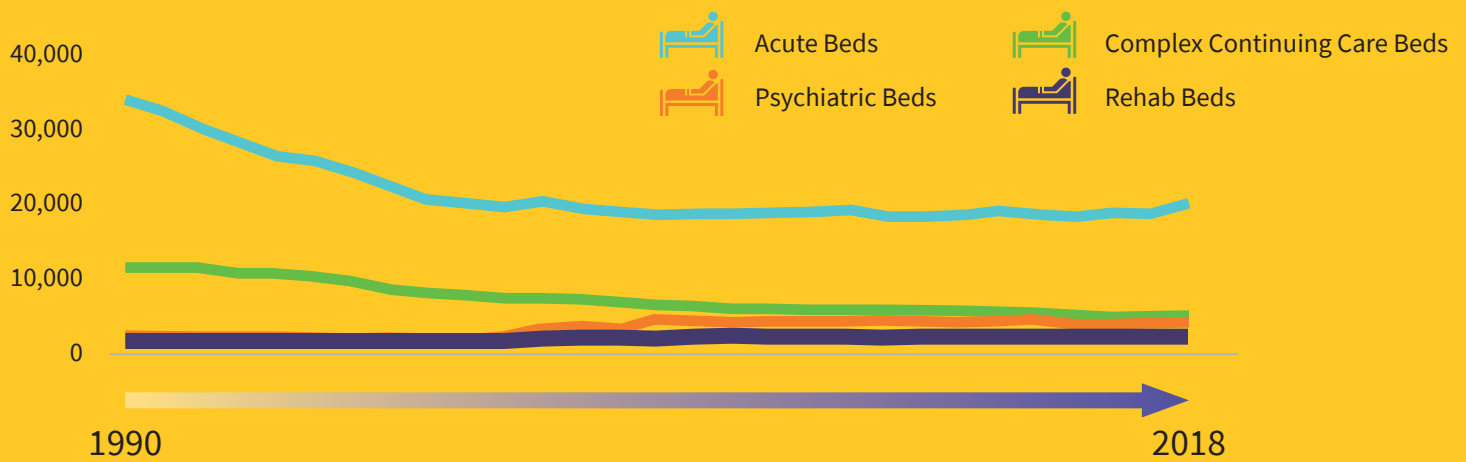
According to the Ministry of Finance, over the last 12 months Ontario's population grew by 1.8%, higher than the previous year and the fastest population growth rate in Canada. Historically, hospital funding has not kept pace with inflation and population growth, and it has put a significant strain on the system. These basic increases in hospital costs are outside of the control of hospitals themselves, meaning that predictable, consistent funding increases are required for hospitals to effectively plan to maintain staffing levels.

**This year, hospitals require a 3.45% increase in funding, a total of \$656 million, in addition to investments already made.**

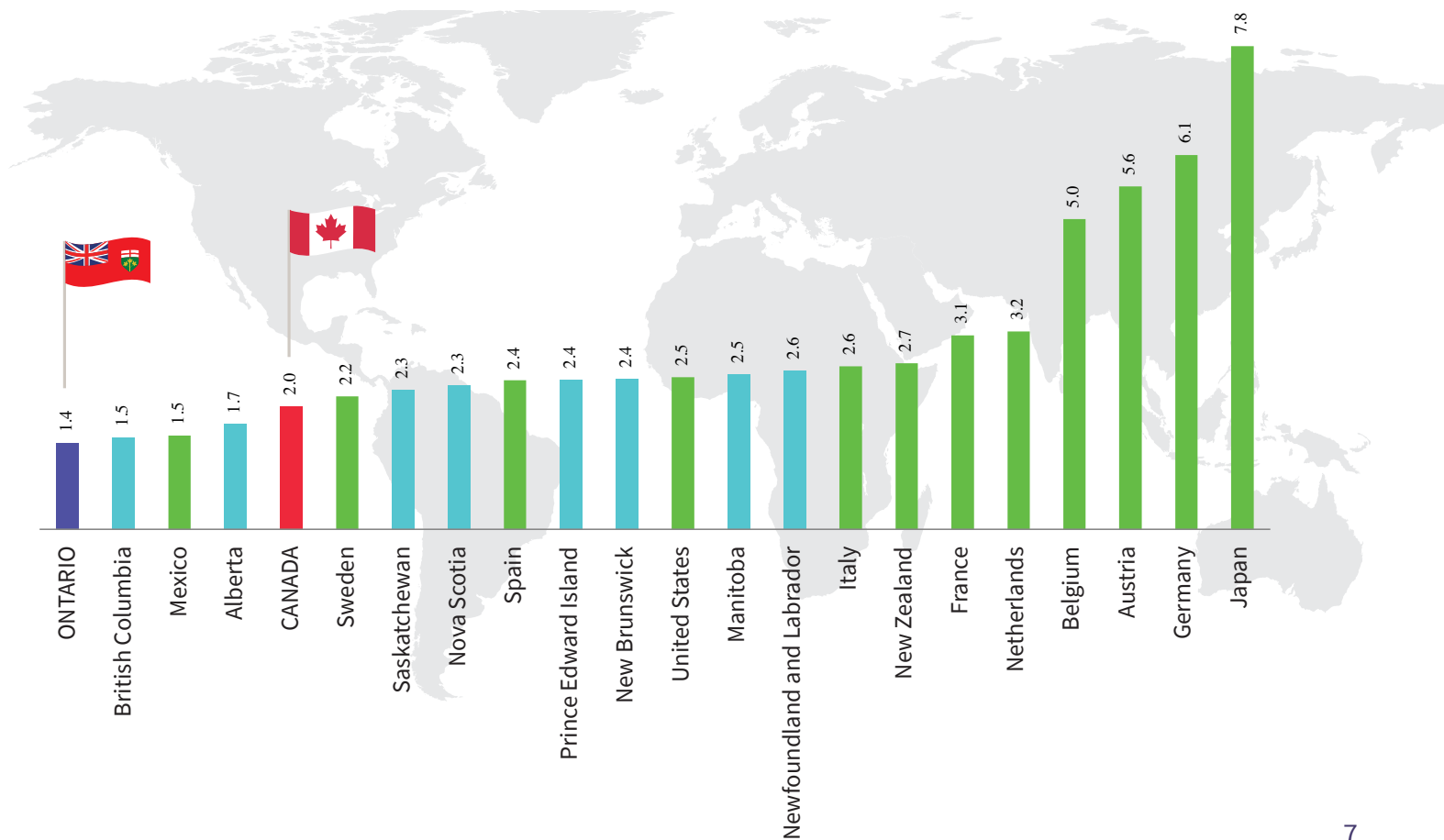
This increase takes into account only the inflation rate of 1.6% and increases related to population growth and aging. It represents the absolute minimum amount required today for hospitals to maintain existing levels of patient care and staffing. It does not include any additional funds for capital needs, patient safety or information technology.

Hospitals and our health system partners recognize that significant change is necessary to build a more integrated health system which makes the best possible use of health system resources while creating better outcomes and experiences for patients. Hospitals will continue to evaluate their expenses and seek out opportunities to create new efficiencies, but this investment is necessary to allow hospitals to continue to care for Ontario patients while the important work of larger health system transformation takes place.

## Hospitals Beds, 1990-2018



## Ontario Has Lowest Number of Acute Beds per Thousand Population





# Building A Stronger, More Integrated Health System

A short-term investment is required to stabilize hospital care, but hospitals also recognize that we need to look at longer-term, systemic solutions to build the health care system of the future and improve the flow of patients between hospitals and other settings.

## Redirecting Resources to Front-line Care

The OHA supports and has provided recommendations regarding the government's immediate action to reduce red tape and unnecessary regulation across government and within health care, so that valuable time and resources can be redirected to front-line care. An example of an area for improvement is the capital planning process, which has five discrete stages and can take years for hospitals to complete. This makes it difficult for hospitals to make necessary changes that improve patient care in a timely fashion.



Beginning now, the real potential for innovation and health system improvement is found in allowing hospitals to work more closely with other health service providers. It's time to create a more integrated system, to truly improve the care journey for patients and families, and address hospital overcrowding. Over time, these changes could also reduce costs for hospitals.

The path to ending hallway medicine is in finding better ways to move patients out of hospitals, so they receive care in the most appropriate setting. It is giving local communities the flexibility they need to innovate and break down the walls that are preventing health providers from working together. It is empowering hospitals and other health providers to find creative, cost-effective ways to solve the unique problems facing patients and families in their communities.

The following strategic and targeted policy changes would open opportunities to improve care and reduce health system costs without requiring significant new investment from government.

## Short-Term Solutions

### Facilitate Direct Hospital Collaboration with Home and Community Care

Home and community care relieves pressure on hospitals by preventing unnecessary emergency room visits and helping patients remain at home or return home quickly and safely. Most patients prefer to receive care in their own homes and communities, where it is significantly less expensive to deliver. Hospitals would like to use their funding, where appropriate, to work directly with their home and community care providers to find more cost-effective ways to care for great numbers of patients outside of hospital, particularly during flu season.

While several local collaborations between hospitals and home and community care providers have been very successful, these initiatives have not spread sufficiently to meet provincial need. The OHA is working with partners in home and community care to identify the administrative obstacles and red tape holding us back from success, and to co-design solutions that would allow providers to innovate to meet the needs of local communities. This may require removing legislative, regulatory or policy barriers. The OHA recommends that the government, including the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs), support and encourage this work.

In the longer term, there are also significant potential improvements to the administration of home and community care – including changes to scheduling limitations, heavy rationing of services and contracts that have never been modernized. These changes would give the sector more flexibility to meet the needs of patients and families, while reducing costs for the entire health system.

## Expand Service Resolution Tables to Transition Patients out of Hospital

The service resolution model brings together a cross-section of local providers in a given region, from both inside and outside of health care. These representatives cut through silos and red tape to meet the needs of individual patients, even those who have been living in hospital for several years. By pooling their resources, skills and abilities, providers find creative ways to transition these particularly complex ALC patients out of hospital and into community care settings. Early tests of this model have proven highly effective and have reduced costs to the system. More importantly, they have drastically improved the patient experience.

The OHA recommends that government direct LHINs with high numbers of ALC patients to establish Service Resolution Tables and ensure there is a dedicated facilitator attached to each table.



A 56-year-old woman in the Toronto area had been hospitalized in acute care for over three years with both physical and mental health challenges. As part of the Toronto Central LHIN's Short-

Term Transitional Care Model, a number of health service providers worked together to meet her complex needs and transition her out of hospital. Through collaborative problem solving between the hospital, Home and Community Care (HCC) and Bellwoods Centres' Transitional Team, she was discharged to the Bellwoods Reintegration Care Unit, where she received significant personal support services from Bellwoods and HCC personal support workers (PSWs) as well as services from community mental health agencies.

After a six-month transitional program, the client was able to re-learn the skills required to live safely in an independent apartment and was offered permanent supportive housing. She was successfully transitioned out of hospital, reintegrated into the community and diverted from admission to long-term care. Continued partnership and supports will be required to meet the client's needs as she lives independently in the community.



## Medium to Long-Term Solutions

### Enhance Mental Health and Behavioural Support Capacity in Long-Term Care and the Community

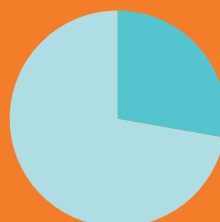
The OHA applauds the government for its commitment to invest \$1.9 billion over 10 years in mental health care.

According to 2015 research by the University of Waterloo, long-stay mental health patients are more complex and experience multiple challenges preventing them from being discharged. In addition to having severe and persistent mental health challenges, they may have

## Snapshot of ALC Mental Health Patients

There are currently **404 individuals waiting in mental health hospital beds**, many of them waiting for supervised or assisted living or long-term care.

Together, these patients represent more than 144,000 patient days – 23% of all ALC patient days.



**28%** of these patients have been waiting in hospital for more than a year.



A 58-year-old man was admitted to a psychiatric inpatient program at St. Joseph's Care Group in Thunder Bay from a small community where he had been living in a supportive housing facility. He was admitted for a specialized assessment and management of aggressive behaviours, which posed challenges in both his supportive living setting and the local community hospital, where he experienced multiple admissions.

He had multiple and complex diagnoses over many years, including a developmental disability, bipolar affective disorder, insomnia, seizure disorder, cognitive impairment, and psychosis. He also experienced hearing, visual and mobility impairments. This individual, who was assessed as ALC within six months after his admission, spent 2,300 days in hospital. After extensive intervention trials with the client and collaborations with his family and community partners (within and external to the health sector), he was ready to be discharged.

physical health issues or involvement with the law due to aggressive or sexually-inappropriate behaviour. Sub-populations at high risk of becoming ALC patients include elderly patients with dementia waiting for long-term care or younger patients with intellectual disabilities waiting for supportive housing.

The OHA recommends a portion of the funding the government has committed to mental health be directed to enhancing behavioural support capacity in long-term care and community settings, to increase the capacity to provide care for patients with dementia and behavioural challenges. This funding should be directly tied to transitioning ALC patients out of hospital and into more appropriate care.

## Amend the *Public Sector Labour Relations Transition Act, 1997* to Allow Health Service Providers to Coordinate Care

Ensuring patients have high-quality health care often involves closely coordinating services between hospital and other service providers, and hospitals have been evolving their organizations to provide seamless, integrated care to patients and make the best use of resources. However, the current legislative framework governing labour relations and health service integrations makes these efforts costly and administratively difficult, driving up costs and discouraging local innovation.

The OHA recommends that the government make amendments to the *Public Sector Labour Relations Transition Act, 1997* (PSLRTA) to remove barriers for greater coordination between hospitals and other health service providers. The OHA's recommendations include returning to the previous definition of "health services integration" so these provisions apply only to full integrations and not partial integrations or increased coordination of services. The OHA also seeks to amend the voting thresholds in this legislation to decrease disruption, lower administrative costs and maximize the success of full integrations or mergers. These changes will make it easier to create an integrated health system and deliver new models of care that meet patient needs. Details have been provided to both the Ministry of Health and Long-Term Care and the Ministry of Labour.

## Expand Innovative, Patient-Centred Models of Care

A high-performing health system features integrated models of care with smooth transitions for patients across the continuum of care. Several models have shown promising results in Ontario communities – now is the time for hospitals to build on the success of these models and expand them across the province.

The OHA recommends expanding innovative and effective models of care linking hospital and home, community and mental health services and supports, including bundled care, rural health hubs and virtual care.



**Bundled care** provides a specific package of care and services where a single provider is responsible for managing the patient's complete care journey from start to finish. This model has been shown to improve care and encourage collaboration among providers.



**Rural health hubs** formally link all parts of the health care system – including acute care, primary care, long-term care and community-based services – in a community under a single funding envelope and governance structure. This enables sharing of staff and resources and creates end-to-end integration.



**Digital health** is a key enabler for integrating care and driving system transformation. Digital health is the use of information technology, electronic communication tools, services and processes to deliver health care services or facilitate better health. For example, institutions were able to realize a 20% increase in patient flow by automating patient engagements and streamlining clinical work flows.

## Develop a Provincial Health Care Capacity Plan

To truly end hallway medicine over the long-term, Ontario needs an evidence-based, forward-thinking provincial plan that includes the right mix of care, supports and health professionals to sustainably meet the province's changing demographics and needs.

The OHA recommends that the Ministry of Health and Long-Term Care develop a provincial health care capacity plan, which was committed to by the previous government but not completed. This plan would allow the province to map the full continuum of services patients might need as their diseases or conditions progress, from acute and rehabilitative care in hospitals, to home and community-based care, to supportive housing and long-term care. It would also ensure resources are allocated wisely, now and in the future.



A 99-year-old patient, arrived at the Emergency Department after a fall in her home. She complained of leg pain and mobility issues. She lived alone without the services of a personal support worker (PSW) or other care providers and would normally be admitted, possibly becoming an alternate level of care (ALC) patient. Instead, she was discharged the same day thanks to St. Joseph's Healthcare Hamilton's Integrated Comprehensive Care (ICC) Emergency Department Admissions Avoidance pilot project.

The patient could go home because the hospital and the ICC team provide a full safety net for patients to recover outside the hospital walls. She has access to a clinician through a 24/7 hotline, and within 24 hours of her release, she was assessed in her home. The home care and the hospital team are all connected and communicate in real time through a shared digital platform to make sure her recovery is not compromised. "My PSWs help me get out of bed, they help me walk. I'm glad to be home; I want to be at home," she said. This new model of care is helping to end hallway medicine by reducing unnecessary admissions and lowering readmission and ED revisit rates while delivering a positive experience for patients.

# Conclusion

Ontario's hospitals are eager to partner with government to end hallway medicine, improve care for patients and families and responsibly manage health system spending. This system transformation will take time, and as it progresses, it is vital that hospital care remains accessible to those who need it.

A funding increase of 3.45% will allow hospitals to maintain existing services and retain front-line staff in

the face of a capacity crisis. In addition, strategic policy changes will allow hospitals to work more closely with other health service providers to create a more integrated system and reduce costs for hospitals.

This balanced approach will set Ontario on the right path towards ending hallway medicine and building a stable and sustainable health care system.

## Summary of Recommendations for 2019/20

➡ Total Operating Pressure – 3.45% (\$656M)

➡ Policy Changes to Build a Stronger, More Integrated System

➡ Short-Term Solutions

- ➡ Facilitate Direct Hospital Collaboration with Home and Community Care
- ➡ Expand Use of Service Resolution Tables for ALC Patients

➡ Medium to Long-Term Solutions

- ➡ Enhance Mental Health Supports in Long-Term Care and the Community
- ➡ Amend the *Public Sector Labour Relations Transition Act*
- ➡ Expand Innovative, Patient-Centred Models of Care
- ➡ Develop a Provincial Health Care Capacity Plan

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