Ontario Health Coalition

Notes On OHA/MOHLTC Report on Core Services in Small, Rural and Remote Hospitals

June 29, 2007 ----------

The report by a Joint Policy and Planning Committee (JPPC) of the MOHLTC and the OHA has been released. The work of the committee was done in three phases:

1. An Exploration of the Current Services
2. Recommended Core Services
3. The Future

The determination of recommendations regarding core services for community hospitals through a joint committee of the Ministry of Health and the Ontario Hospital Association is unacceptable. These hospitals are funded and required by community members and the process should be an open consultative one that involved input from the communities affected.

The JPPC and the OHA agreed that it was prudent to include all small hospitals, not only those with amalgamated governance structures (ie. multi-site facilities) in this report. We agree with this decision.

It should be noted that 93 of a total 165 hospitals are considered Very Small or Small hospitals. Thus, the majority of Ontario hospitals fit into this category.

The problems with the use of a "core services" approach become more evident as one reads the reports. "Core" services is the antithesis of comprehensive care and an abdication of the Canada Health Act requirement that provinces provide accessible comprehensive medically necessary care. The danger of the use of "core services" is the implication that other services can be cut, that the "core" becomes a cap, or that one size can be made to fit all. In the report, the authors avoid clearly defining "core" and delineating how it should be used. As the committee found, after more than a decade of hospital restructuring, and a history of varying contexts and resources (financial, physical and human) hospitals are providing a wide array of services. Ultimately, many required and currently provided services are not identified as core in this report.

Phase One: An Exploration of the Current Services

Summary of OHA/MOH Report

The identification of current core services is based on the current availability of services. Any service found to be provided in at least 75% of the hospitals examined has been determined to be a current core service for that hospital group. According to the report's authors, the stakeholders with an interest in identifying "core services"are only: the OHA, the MOH, and the hospitals.

Definitions:
Very Small hospitals - < 1,500 weighted cases (62 sites)
Small hospitals - 1,500 - 4,000 inpatient weighted cases (31 sites)
Medium hospitals - 4,000 - 9,9999 weighted cases (19 sites)
Large hospitals - 10,000+ weighted cases (36 sites)
Teaching - independent of size (17 sites)

OHC Comments/Analysis:

The report's authors recognize that simply defining services offered in 75% of the hospitals as "core" is arbitrary and suggest this is only a starting point for a discussion. Regardless, it must be noted that redefining existing services as "core" is an unacceptable methodology. From our consultations it is clear that the current services provided by some hospitals are inadequate. An exploration of "core services" must start with community need, not currently offered services.

While the report notes that it is difficult to measure population need, there was no attempt to try community consultation. Notably, patients and community members are not identified as stakeholders in the identification of "core services" for their own community hospitals.

Core Services for Very Small and Small hospitals:

- General/family practitioners
- Emergency Department - prepared to provide care or stabilize and transfer medical and mental health patients entering via the ED
- Laboratory, Physiotherapy, Ultrasound and General Radiography; and
- Ambulatory Clinics tailored to the needs of the community

In addition, for Small hospital only, core services include:

- General Surgery and day surgery program
- Obstetrics
- and the provision of special care units and the ability to accommodate ventilated patients

Other Observations:

- Rural hospitals are recognized as integral hubs of local health services
- Some controversy over definitions of small, rural and remote hospitals, isolation and the use of driving distances to the nearest non-small hospital
- Limitations on data about the populations using the services
- Multi-site (ie. amalgamated) Very Small hospitals have smaller proportions of Special Unit Days and mental health services, suggesting that these services have been regionalized (ie. moved out)
- Regionalization may not always result in services being moved out, they may facilitate a broader spectrum of services in small hospitals – eg. Ontario's Very Small multi-site hospitals have a higher proportion of tertiary activity than stand-alone sites
- Wide variety of ambulatory clinics reported
- Non-invasive cardiology is provided in 66% of Very Small and 71% of Small hospitals but did not make the 75% cut off for "core services". The report suggests it may be considered.
- Obstetrical services are closely linked with the availability of surgery. The decision to provide or discontinue surgical services should be taken as a community decision with an attempt to balance the ramifications for other services, the availability of local services and the issues related to patient safety.
- May be opportunities for linkages with other providers esp. in mental health and primary care.
- May be more formal integration through multipurpose service arrangements, regional networking with urban centres, expanded use of IT linkages, and rural academic networks.

OHC Comments/Analysis:

Surgery and obstetrics are not identified as core services at Very Small hospitals. 40% of Very Small hospitals currently do obstetrics and 65% provide day surgery.

Non-invasive cardiology is done at 66% of Very Small and 71% of Small hospitals and is not identified as core because it did not make the arbitrary 75% cut off. The report suggests that these services should be considered in the following phases of research. We agree.

Internal medicine is not identified as core, but there is a recognized demand at Small hospitals, and the report's authors suggest that general internal medicine may be a core service. We agree.

The report notes that anecdotally higher volumes are generally associated with better outcomes, but there is little research on volume quality/economy in rural settings. The report describes various points of view on the questions raised, but fails to take a position. In our consultations, patients and community members described to us the risks, costs and barriers to access they face travelling for services. Their viewpoints are not included in this report. Moreover, our consultations revealed that services are frequently provided by visiting specialists who work in several hospitals further complicating the question of appropriate measurement of volumes and outcomes.

While the report suggests that the LHIN environment may provide an appropriate planning forum to identify approaches to enhance access to surgical services in the Very Small hospitals, it should be noted that the size of the LHINs are well beyond what anyone would recognize as regional. Moreover, the move towards competitive bidding for surgical procedures in hospitals threatens the type of collaborative approach suggested here.

- Variability in availability of human resources, isolation, access, availability of services by other providers, service needs of the population, demographics, differences etc.
- Recommends process of discussion at the LHIN level to determine services taking into account these variabilities and also criteria including need, access, available capacity (physical and human resource), and sustainability. Also recommends including criteria such as availability of community services, sustainable volumes and patient safety, but does not make any clear conclusions with regards to the latter two criteria.

OHC Comments/Analysis:
In addition, the LHINs are not required to engage in meaningful or accountable consultation with the community regarding decisions about what services are provided. The recommended approach should include a requirement to measure community needs through robust community consultation, the rejection of the competitive model in favour of a collaborative approach and a requirement to engage in meaningful community consultation regarding any proposed changes to services.

Phase Two: Recommended Core Services

Summary of MOH/OHA Report
The advisory group used the work of Phase One to come up with a list of core services that small hospitals can be expected to provide to their communities. Their recommendations are:

Core Services for Very Small and Small hospitals:
- General/family practitioners supported by broadly trained nurses
- Emergency Department - prepared to provide care or stabilize and transfer medical, surgical and mental health patients entering via the ED
- Acute Care Inpatient Medical Beds
- Inpatient Allied Health Services such as Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology, Pharmacy, tailored to meet the needs of the population
- Laboratory, Physiotherapy, Ultrasound, General Radiography and Non-invasive Cardiology

In addition, for Small hospital only:
- Physician speciality of General Internal Medicine
- General Surgery and Day Surgery
- Physician specialty of General Surgery (with anaesthesia support)
- Obstetrics
- Special Care Units

For Multi-Site hospitals, they recommend that the hospital corporation as a whole should be expected to provide the same set of core services across the corporation, ensuring that they are "reasonably

OHC Comments/Analysis:
Like Phase One, the Phase Two report fails to define "core" and how the notion should be used. In fact, there are two completely different definitions of core contained in this phase report. The first implies that core services are a minimum requirement, "The definition of core services is not intended to define all of the services to be provided by a given facility. Rather, the Advisory Group is presenting the basic core services as a minimum set of services that are generally necessary in all facilities designated as a hospital in Ontario." (this definition is repeated in various forms through pages 1 - 4). The second suggests that not all institutions need to provide all core services, "The notion that core services should be available to communities or regions emphasizes the fact that not all individual institutions need to provide all core services." (page 18).

Like Phase One, this report fails to start from an assessment of population need

We would not support the implication that population need for care will be adequately defined, nor adequately consulted upon through the LHIN planning process.

accessible."

Identification of core services that are site-specific, including ambulatory clinics and outpatient allied health services tailored to meet the needs of the community, will require extensive discussion in the context of LHIN planning.

Other Observations:
These services are defined as a minimum core necessary in all facilities designated as a hospital in Ontario.

The process to identify additional site-specific core services should be based on the following criteria:

- population need for care defined through the LHIN planning process
- access, including consideration of the isolation of the population and the range of services available
- capacity to provide the service
- available evidence on sustainable volumes, quality of care and patient safety

The committee agreed to use the label of "isolation" rather than "rural". The group identified driving time to the closest non-small hospital as the appropriate measure of isolation.

The emergency departments of small hospitals support the primary care and ambulatory clinics activities of the small hospitals. Between 23 - 32% of visits to small hospital ED s are considered non-urgent, compared to between 5 - 11% in larger facilities. They also have a higher proportion of ambulatory activity. The authors note that this has "strong" implications for considering the primary care role that small hospitals may provide.

Despite HR challenges associated with maintaining an emergency service, it is an essential component of the infrastructure of all hospitals. Including, at minimum:

- physician availability/on call
- staff trained in ACLS
- Electrocardiogram testing and monitoring
- Laboratory testing availability
- General diagnostic radiography
- Ultrasound

Small hospitals do more care in the areas of general medicine, cardiology, pulmonary, rheumatology, endocrinology, and gastro/hepatobiliary.

Every hospital id'ed in this project has acute care inpatient beds, ranging from 3 - 75 beds per hospital. Complete Emergency services require ability to admit patients, therefore inpatient bed complement is essential.

OHC Comments/Analysis:
In our consultations, transportation was identified as a serious problem in almost every community. The problem with using driving times as a measure of isolation is that it does not capture all those patients who are not able to drive. This includes seniors, folks with cataracts, young people, one-car families etc. Even among larger hospitals, this has been identified as a problem (eg. to get from Sarnia to Windsor by bus or train requires a stop and change at London, thus driving distance may be 1.5 hours, but actual travelling distance for many is well over 3 hours and a considerable cost). In the case of small communities, transportation to the nearest larger hospital is almost always seriously inadequate, deepening the isolation of these communities.

We agree with the potential to develop linkages between Emergency Departments and primary care providers, as well as promoting linkages such as travelling surgical services to enhance access.

The committee has recommended that multi-site hospitals not be required to provide the core services in each of their sites, simply across the whole hospital corporation. This cements the demise of several small hospitals. Essentially, it writes off hospitals that were forced to amalgamate in the last round of hospital restructuring against the will and needs of the local communities(?? committee members – I need you to help me frame our response to this – **NB. Petrolia, Glencoe and Picton – also north.)

There is another problem with larger hospitals' Emergency Departments redirecting patients travelling in from smaller hospitals, thus complicating assessment of isolation.

The authors have avoided making any conclusions about what is "reasonably" accessible obstetrical care. They have also avoided defining "availability of laboratory testing". In our consultations, we found that access to lab services is inadequate across the province.

(Definition of inpatient bed varies widely).

The availability of General Internal Medicine or sub-specialists for very small hospitals is unrealistic from a volume and recruitment perspective. The availability of broadly experience GP s is a core requirement.

A large majority of hospitals report physiotherapy, occupational therapy, respiratory therapy and clinical nutrition activity at varying levels.

Limitations on data for diagnostics.

For the purposes of this report, the group has considered multi-site hospitals with an aggregate volume of >1,500 weighted cases to be equivalent to the single site small hospitals with >1,500 weighted cases. In this case, the corporation of the multi-site hospitals would not be expected to provide all these services at every site, just across the whole corporation/catchment area.

Many of the very small hospitals that provide surgical services do so through linkages with larger facilities, through visiting or itinerant surgical programs. Literature suggests these programs can achieve outcomes comparable to those in urban centres.

The specialty of general surgery should be available in all Ontario hospitals that provide surgical services.

OHC Comments/Analysis:

In our consultations, we found additional areas in which rural hospitals' services should be ameliorated:
- access to laboratory services needs to be restored
- physiotherapy services need to be restored in the many communities where they have been cut
- social work needs to be restored in the communities where it has been cut
- services for cancer patients in high cancer areas
- palliative care services
- obstetrics
- transportation services and networks
- adequate Northern Travel Grants
- mental health services

Provision of obstetrics services is linked to the isolation of facilities. All small hospitals with >1,500 weighted cases that are more than an hour driving time fro the closest non-small hospital provide obstetrics.

A key concern is the distance a patient must travel to receive obstetrical care. Planners should ensure that this service is "reasonably" accessible.

Prolonged capacity to provide special care unit days is unlikely sustainable but the capability to provide such services on an urgent/emergent basis should be considered. Note: reporting of special care unit days is not standardized.

The high demand for cardiology services suggests that small hospitals should have the ability to provide cardiac monitoring for diagnosis and assessment.

Ability to provide temporary ventilation is also essential.

There are significant limitations on data regarding ambulatory general and specialty clinics, though they are provided by a majority of small hospitals. The committee made no conclusions about these clinics.

Similarly, the committee made no clear conclusions about the levels of outpatient Allied Heath Support, noting that it varies widely.

Phase Three: Future Opportunities for Small and Rural Hospitals

Summary of OHA/MOH Report

Unique challenges in rural communities have diminished access to care, including:

- declining numbers of rural physicians
- centralization of health services

Increasingly geography is identified as a determinant of health status.

Future challenge - improve access to care and health status in rural populations.

The authors posit the future role of small and rural hospitals to contribute to build upon the core services approach and to contribute to a "true" health care system in rural Ontario.

Strategic opportunities:

- Refocusing on primary care
- Participation in community networks
- Provision of selected secondary care services and hospital networks
- Post-acute care roles
- Use of technology

Small and rural hospitals may ideally extend their role both to provide both a broader range of health services to their community and a link for their community to specialized care in regional centres.

Small hospitals may co-locate, collaborate and/or partner with primary care providers and provide technological support in the provision on primary health care. This may increase rural physician support for core hospital inpatient medical services and ED coverage.

Small and rural hospitals must alter their self-image from a place to go when people get sick to an organization that provides health services to rural communities, through such means as facilitating proactive engagement of home and community service providers.

Development and implementation of affiliations with larger regional hospitals may provide technical support and access to the resources of the larger hospitals. It may allow small hospitals to expand their acute operations to provide a broader spectrum of district stroke centres, visiting specialists, and itinerant surgeons. These approaches are already improving diagnostics, obstetrics and general surgery.

OHC Comments/Analysis:

The Phase Three report contains many positive recommendations that we support, notably:

- Expansion of telemedicine, visiting specialists and other programs that enhance access to specialists in small, rural and remote communities.
- Investigating opportunities for co-location and collaberation with primary care providers.
- Building LTC capacity in public, non-profit hospitals closer to home.
- Support for collaborative approaches and amelioration of services, as opposed to market competition and further removal of local services.

In addition to the recommendations in the Phase Three report, there are gaps in hospital services that are missing from both the "core" services list and the future visioning.

1. Restoration of laboratory, physiotherapy, social work and dietary services was raised in virtually every community in which we conducted a consultation.

2. Palliative and mental health services were also reported as inadequate in many smaller communities.

3. In virtually all communities, transportation systems for access to care are ad hoc and inadequate.

4. Access to long term care beds was reported as a problem in many communities.

5. Emergency Departments are unstable in many of the communities we visited and require a system-wide policy response.

6. Restored/enhanced access to obstetrics and women's health services.

Diversification into LTC and other post-acute services such as rehabilitation may provide advantages such as shared administration and clinical resources.

Appropriate development of technologies such as PACS and telehealth can be key enablers for greater clinical collaboration and communication.

Specialization is the dominant model for organizing hospital medical care, but it has little value in rural communities.

The authors recognize that rural Canada is not homogeneous and planning must take into account diversities and context. Despite implying that core services are the minimum essential in Phase Two, the authors then go on to state that "the notion that core services should be available to communities or regions emphasizes the fact that not all individual institutions need to provide all core services."

The future of small hospitals will require extensive discussion and consideration of the needs of the catchment population and the "available evidence in the context of LHIN planning" as well as the services provided by others in the community.

Larger system change affecting small hospitals:

- primary care reform
- rising expectations for local access to care
- trend towards increased specialization and consolidation
- increasing demands and requirements to develop networks and formal referral structures
- organizational restructuring at the regional level
- continuous demands for efficiency
- increasing accountability requirements
- competition for scarce resources

The system is experiencing a shift in the locus of care from inpatient to outpatient settings. Further the planning emphasis is shifting away from the hospital as the system.

These trends do not affect urban and rural institutions in the same manner. Rural hospitals have a need for delivering "true generalism" and self-sufficiency. Urban centres trend towards increasing specialization, high-tech and research-intensive medicine.

- Training opportunities because of these differences.

There is a renewed interest in homecare.

Small and rural hospitals are forced to shift their emphasis to providing a more diversified set of services and linkages. Successful rural hospitals are characterized by involvement in primary care networks, provision of long-term care beds and rehabilitation services.

Small and rural hospitals need to position themselves as organizations that can assist government to create strong rural and northern communities.