OMA Ontario Medical Association

Integrated Ambulatory Centres

A Three-Stage Approach to Addressing Ontario's Critical Surgical and Procedural Wait Times

Executive Summary

Feb. 16, 2022

ABOUT THIS REPORT

In response to the challenges involved in managing wait times for surgeries and other procedures, the Ontario Medical Association engaged Santis Health in early 2021 to co-develop an innovative, fundamentally different approach to caring for patients who require surgery and procedures.[i]

The aim was to enhance health system capacity while addressing the limitations of the current models, ultimately ensuring improved patient access and care experience, enhanced well-being and job satisfaction for health professionals, and improved value for the public. This report provides a comprehensive blueprint for how the health-care system can best expand surgical and procedural service capacity across Ontario.

Consultations explored various options that could build a better, more efficient health-care system. These consultations included:

- One-on-one interviews with clinical experts, key system stakeholders (e.g., the Ontario Hospital Association, the College of Physicians and Surgeons of Ontario, other provincial health authorities, medical associations)
- Robust surveys of OMA specialty groups (e.g., surgical and medical specialties, anesthesiology)
- Focus group sessions with OMA specialty groups and consultations with the OMA Health Policy Committee

23 one-on-one semi-structured interviews with clinical experts and health system leaders

3 customized physician surveys with 25 questions, with 373 survey respondents in total

4 focus group sessions with approximately 30 physician leaders

Relevant studies, reports, medical journals, academic institutions, research organizations and news outlets, along with other reputable sources with information about Ontario's health system environment, were used to further inform the consultation findings and, in turn, the development of the recommendations in this report.

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[i] *While this paper focuses on Ontario's surgical and procedural backlog, it is important to acknowledge that navigating a post-pandemic health system recovery will also require consideration of the full continuum of pandemic impacts, including the diagnostic backlog, primary care backlog and exacerbation of existing and new conditions, such as mental health and addiction conditions. Furthermore, the expansion of surgical and procedural services will place additional demands on other areas of the health system, such as laboratory services and home and community care. While out of scope for this paper, complementary work needs to be done in these areas to support the system and realize the proposed model of care.*

Table of Contents

EXECUTIVE SUMMARY

Even before the COVID-19 pandemic, Ontario was expending significant effort and resources to deliver surgeries and procedures in a timely manner. COVID-19 has compounded Ontario's access to care issues. Thousands of patients across the province now face additional delays in care and are not getting the procedures or surgeries they need within the recommended timelines. In addition, an unknown number of "missing" patients require care but have not yet even entered the health system. Physicians are reporting that, due the pandemic, patients who would have been diagnosed and treated sooner are coming in later and sicker.

OMA analysis shows that approximately one million fewer surgeries were performed in Ontario from February 2020 until December 2021.[1] With the arrival of the Omicron-driven COVID-19 wave, hospitals across the province have once again paused all surgeries and procedures deemed non-urgent, adding to the backlog of surgeries and procedures. This means that many patients will face additional delays in care that could cause worsening health conditions, poorer health outcomes and the risk of earlier mortality.

One high-potential opportunity to address the current backlog of surgeries and procedures while also growing our system's capacity to meet future demand is to expand the province's ambulatory system so more cases can be handled in ambulatory centres. We need a system that does not routinely mix acute and non-acute surgeries and procedures while running near or at capacity at the best of times. We need a system that is flexible enough to deliver timely care and handle unexpected increases in demand reasonably well.

In 2012, the non-partisan Drummond Report proposed that health care shift its emphasis away from hospitals toward ambulatory surgical centres to improve quality of care, wait times, efficiency and other operational quality measures. However, a recent report from the Office of the Auditor General of Ontario found that the province has made little progress in leveraging this model of care. Case studies from Ontario (e.g., the Kensington Eye Institute [KEI]), other provinces (e.g., Saskatchewan, Alberta, British Columbia) and other countries demonstrate that ambulatory centres can perform a range of outpatient surgeries and procedures safely and efficiently.

Compared to inpatient settings, ambulatory centres can provide surgery or procedure times that are shorter, with faster recoveries, lower infection rates and efficiency gains ranging from 20 to 30 per cent.[4,7,8] Ontario lags virtually every other jurisdiction in the use of such centres.

The province introduced the independent health facility (IHF) model more than 30 years ago to support a shift in service delivery toward publicly funded ambulatory centres in the community. However, the framework for IHFs has not substantially changed to meet the shifting needs of Ontario's patients. Nor have they been able to capitalize on profound changes in how health care is delivered in the 21st century. There is persuasive evidence from peer jurisdictions that a range of procedures formerly provided on an inpatient basis can now be performed safely, efficiently and with high quality in ambulatory settings. Unfortunately, Ontario's outdated IHF regulatory regimen is poorly designed to capitalize on this opportunity to shift care delivery. Several reviews have highlighted issues with IHF oversight. These have identified a lack of integrated policy and regulatory administration of IHFs and other non-hospital medical centres, such as those defined as out-of-hospital premises (OHPs) by the Ministry of Health.[2–5] Additional concerns have been raised in proposals to expand IHFs, including around inadequate health human resources (HHR), funding implications for hospitals and an insufficient quality and safety framework.

The OMA recommends a new model of care we call the Integrated Ambulatory Centre. Integrated Ambulatory Centres represent a significant modernization of the policy, funding and regulatory model for ambulatory facilities. These centres would initially operate alongside existing IHFs and OHPs and offer a new option to progressively shift a broad array of ambulatory service volumes out of over-burdened acute care centres. Under this new model, the proposed centres would work in close partnership with (or as part of) local hospitals to provide a seamless experience for patients. In the future, Ontario Health Teams will be well-positioned to work with Integrated Ambulatory Centres to streamline the care experience for patients, from primary consultation and surgical care to post-operative care and follow-up at home.

The current hospital-based care delivery model creates constant and inevitable competition between acute and non-acute care, which is problematic for the delivery of timely care. While some centres may be directly under the control of hospitals, Integrated Ambulatory Centres would generally provide needed separation between acute and non-acute care and be free-standing and operationally separate from hospitals to achieve the necessary efficiencies and meet population needs. These centres would still work in partnership with hospitals to ensure credentialling of physicians, quality oversight (including that the right cases are done in the right setting), and appropriate funding alignments. As noted above, while some centres may be part of hospitals, to achieve the needed efficiencies, Integrated Ambulatory Centres must be physically separate from inpatient operating suites and staffed with separate staff—for example, nurses who specialize in ambulatory surgeries and procedures.

Ontario is experiencing profound HHR shortages. Vacancies are at an all-time high. A comprehensive strategy from the Ontario government with targeted efforts to increase the supply of health-care professionals will be critical to ensuring sufficient capacity across hospitals and ambulatory centres. Implementing Integrated Ambulatory Centres would require regional planning with hospitals, including HHR capacity alignment, to ensure that staff are not diverted from hospitals. In later stages—when ideally the HHR crisis is less acute, appropriate patients will shift to Integrated Ambulatory Centres, reducing the need for HHR in hospitals.

THE VISION: INTEGRATED AMBULATORY CENTRES

Our proposal, developed through consultations with clinical experts and health system leaders, imagines a fundamentally different model for ambulatory centres. Integrated Ambulatory Centres would enhance efficiency, improve quality oversight, address funding issues and ensure equitable access through public financing. This is a significant departure from Ontario's IHF framework, now more than 30 years old. The vast majority of the province's nearly 1,000 IHFs are licensed for diagnostics, such as x-rays and ultrasounds; however, only a small minority are licensed to deliver publicly funded surgeries or procedures. The IHF model is not purpose-built for the integrated, multi-specialty ambulatory centres proposed in this paper.

In contrast to IHFs, Integrated Ambulatory Centres would offer a broad spectrum of surgeries and procedures that could be done safely and efficiently on an outpatient basis.[ii] For example, a range of lower-complexity surgeries and procedures in orthopaedics, gynecology, urology, plastics, otolaryngology or ophthalmology could be moved to ambulatory settings (see Appendix 5 for more examples).

As a result, Integrated Ambulatory Centres that focus on surgeries and procedures would not operate in a siloed manner, but instead be fully integrated into regional health systems and over time in Ontario Health Teams. A single regional intake and triage process based on the government's recent announcement would, at maturity, determine which surgical cases and procedures could best be done in ambulatory settings and which should remain in the hospital. There would be a consistent quality framework across hospitals and Integrated Ambulatory Centres to share best practices and ensure a high-quality patient experience no matter where care is delivered. In short, the model envisions a completely new approach to delivering surgical and procedural services to ensure improved access and meet the demand for care of our population. The surgeries and procedures would still be publicly funded, integrated within the publicly funded health system, and embedded in open and transparent public reporting processes. Thus, they would fully comply with the principles of the *Canada Health Act*, with no user fees or queue jumping.

For the current system to evolve into this integrated future state, the proposed model outlines three stages that span five to eight years, each designed with system stability in mind. Stage 1 focuses on the immediate response needed to expand capacity within existing system structures, given the current HHR shortages. Stage 2 begins to build new infrastructure that will allow for an efficient, regionalized approach to surgical and procedural management. Stage 3 continues to scale the model, embedding the key structures into the health system and ensuring seamless integration for patients.

[ii] *This paper does not consider diagnostic imaging (e.g., CT scans, MRIs, etc.) because the legislative requirements regarding how to approach challenges in the diagnostic community are different and require their own focus.*

STAGE 1 (2022 to 2023): ONGOING RESPONSE TO EXPAND CAPACITY

1. Build on existing progress made through the Ontario Surgical Recovery Strategy to identify the highest-need patients and scheduled surgeries and procedures where targeted investment is needed to increase capacity. Patient prioritization should be transparent and communicated openly, not only in terms of wait times and volumes, but also in terms of clinical impact and health-equity implications. Leverage existing capacity in smaller and rural hospitals, where there is room to perform more surgeries. Hospitals that are already enhancing efficiency in their delivery of surgeries and procedures would be encouraged to continue their efforts, such as through the Surgical Innovation Fund.

2. Continue to provide targeted funding beyond current investments in Ontario hospitals and existing IHFs, with clear ties to increased volumes in the high-priority areas defined above (while ensuring that increased volumes in high-priority areas do not lead to decreased volumes in others). Funding and volume allocation should continue to be locally led so regions can make decisions based on the current realities (such as HHR) in their hospitals.

3. Test new structured partnerships between hospitals and IHFs to showcase proofs of concept on how partnership agreements could and should work under this model. Structured partnerships will ensure that all funding allocated to surgical and procedural backlogs requires hospitals and future ambulatory centres to develop partnerships, work together to remove inefficiencies and maximize HHR capacity, and further expand capacity in priority areas.

4. Create a co-ordinated quality assurance and patient safety framework focused on surgeries and procedures in ambulatory centres. This framework would allow hospitals to assume oversight of the new model of surgical and procedural service delivery (i.e., Integrated Ambulatory Centres). It would remove that responsibility from the College of Physicians and Surgeons of Ontario (CPSO).

5. Introduce and scale models of care that have high potential to maximize current HHR such as expansion of the physician-led model of anesthesia care using anesthesia assistants and other team-based care models. There remains a profound need to address HHR supply challenges and to avoid further straining an already burned-out health-care workforce or displacing HHR from other parts of the health-care system. Consultations with clinical experts will be critical to propose, continually assess and support the implementation of such models along with government investments to support increased enrolment in health-care training, for example, nursing education.

6. Optimize the use of virtual care, where not already implemented, by determining situational appropriateness for such care and by providing mechanisms to improve collaboration and flexibility in accessing and connecting with patients on an outpatient basis. This would enable teams of hospital and ambulatory providers to work together more effectively.

STAGE 2 (2023 to 2025): BUILDING THE INFRASTRUCTURE FOR A REGIONAL APPROACH

7. Allocate surgical and procedural volumes by region, with Ontario Health Regions assuming responsibility for and oversight of all new volumes.

8. Centralize wait-lists and establish single intake, referral and triage management systems for surgeries and procedures in each region using the funding announced in the province's 2021 budget. This should be managed by Ontario Health and implemented in collaboration with the OMA, hospitals and IHFs to improve equitable and timely access.[6] These tools provide an opportunity to enhance transparency regarding expected wait times and to empower clinicians and patients to make informed choices about where to access quality care in a timely manner. It is crucial to maintain patient and provider choice—for either provider or location—as a foundational principle as models are introduced. Existing referral patterns would be maintained, alongside centralized referral, where existing referral relationships between primary care and specialists are lacking.

9. Establish partnership agreements between existing surgical and procedural IHFs and local hospitals to maximize HHR capacity and reduce inefficiencies by improving system co-ordination, quality oversight and data integration. Partnerships would be a requirement for IHFs at the time of contract expiration. Surgical and procedural IHFs would begin to transition to Integrated Ambulatory Centres in a phased manner.

10. Introduce new legislation to create Integrated Ambulatory Centres. Changes must include making the accreditation of Integrated Ambulatory Centres mandatory and shifting responsibility for clinical quality oversight to local hospitals. The sub-group of IHFs that deliver publicly insured surgeries and procedures and OHP would become subject to new IAC legislation in a phased manner. A new, streamlined regulatory regime for ambulatory care would ensure consistent quality and accountability standards across the province and reduce system complexities and inconsistencies.[iii]

[iii] *This paper suggests that the existing IHF legislative and regulatory regime is insufficient to support the development of a robust network of Integrated Ambulatory Centres that would perform a range of surgeries and other procedures. The paper does not consider legislative changes that may be required for the more than 900 IHFs that are licensed exclusively for diagnostics. This is a critical consideration for the Ontario government, given that the COVID-19 pandemic has also severely affected diagnostic services and that several previous policy reviews have called for an update of the overarching IHF/OHP regulatory regime for all centres.*

11. Develop the new ambulatory capacity allocated by Ontario Health through regional calls for Integrated Ambulatory Centre proposals for surgeries and procedures that can be done safely outside hospitals. These requests for proposals (RFPs) should be for low-complexity, multi-specialty service centres that would be required to have detailed partnership agreements with local hospitals to ensure appropriate HHR planning as well as consistent quality and patient experience standards. New Integrated Ambulatory Centres would be free-standing and operationally separate from hospitals (to achieve necessary efficiencies), but would partner with hospitals on HHR planning, physician privileges, quality oversight and funding alignments. Decisions on locations for centres would be based on regional needs assessments and input from providers, including Ontario Health Teams. Significant regional planning will need to occur in rural areas to meet the needs of low-density populations.

STAGE 3 (2026 to 2030): FULL SYSTEM INTEGRATION FOR THE MANAGEMENT OF SURGERIES

12. Continue the implementation and scaling of infrastructure needed for a seamless regional model, shifting resources and adapting funding models as appropriate based on new data about the cost of care. Funding models would consider the financial impact to hospitals of shifting lower-acuity and less complex procedures to Integrated Ambulatory Centres and would disincentivize "cream skimming."

13. Update hospital funding to reflect the newly regionalized system, re-evaluating the costing methodology to appropriately balance the services delivered in a hospital setting against similar services delivered outside of hospitals. These changes will focus on system sustainability and enable partnerships among hospitals and ambulatory settings to allow large, urban hospitals to focus on what they do best: acute and highly complex care.

14. Designate an integrated funding pool for surgeries and procedures to incentivize and maximize integrated care, shared accountability and quality improvement, structural efficiency, and patient outcomes conducive to shared-care models. Current physician payment models would be maintained (and any potential changes would be part of a Physician Services Agreement and governed by the Binding Arbitration Framework); facility costs, such as overhead, surgical supply expenses and staff remuneration, would be assessed. There are several viable policy options to create an integrated funding envelope that would optimize case allocation at the regional level between hospitals and ambulatory centres, including by flowing an integrated funding allocation through the Ontario Health Region and to the lead hospital or the Ontario Health Team, once designated. Any funding model would need to address funding distortions that could have the unintended effect of incentivizing hospitals to complete procedures that could be done more efficiently in an ambulatory clinic setting.

15. **Conduct joint planning and integration** to build a resilient system that is prepared to meet the future needs of the population, and to better integrate acute and ambulatory care episodes with primary care, rehab care, community care and home care. For teaching hospitals, arrangements between hospitals and Integrated Ambulatory Centres would need to consider educational opportunities for learners.

SUPPORTING IMPLEMENTATION

Implementing the staged approach recommended in this paper will take several years and require a number of policy, funding, regulatory and statutory changes. A comprehensive strategy from the Ontario government to resolve immediate HHR shortages will be essential. Success will require close and ongoing collaboration between the Ontario Ministry of Health, Ontario Health, and the delivery system itself.

For this reason, the report recommends the creation of an **Expert Advisory Implementation Group** to support the government through the change process. This group could be co-chaired by a physician lead and a health system leader and include key clinical experts from medicine and nursing as well as health service administrators, with representation from rural and urban communities and from Ontario Health, Ontario's five health regions and the Ministry of Health.

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