~~Don't~~ Sweat the Small Stuff

Chapter 18 - Small, Rural and Northern Hospitals

Recently I have put forward that the greatest threat to our public system is the government, the opposition parties and the media. The government desperately wants to provide the appearance that the health care system is running along just fine. This is why they are obsessed with "issues management" - if there are no "issues" then everything appears to be fine. The opposition parties, aided by the media, are in constant search of "issues" so they can play their favourite game of "gotcha".

It is all rather entertaining, sells papers and diverts massive Ministry resources to dealing with the "issue" of the day. What gets lost in this little circus are the very real needs of managing the system. With no coherent approach to planning, organizing, staffing and controlling the health care system, it seems to meander along in a way that simply defaults to the status quo. When changes are contemplated and actually implemented, they are unfortunately usually sector specific, poorly thought out, and with little regard to the collateral damage they might cause. Primary care "reform" is an excellent example of this.

At the other end of the spectrum are those areas that need change like small, rural and northern hospitals, but governments of every stripe simply kick the can down the road because no one wants to deal with the fallout, ("issues") of making tough but necessary decisions.

When we look at the hospital sector in Ontario we can see that we have had around 150 hospitals in Ontario for the past fifty years. We very occasionally build a new hospital, or merge a few hospitals, but by and large the entire sector (the largest in the health care system) has had the same players for half a century or more.

Nowhere has the paralysis been more evident than in the small hospital sector. Consider the well known white H on a blue background. Everyone knows that represents a hospital. Now stop and consider - What is a hospital? - if I pull up to a building with the white H on the blue background does that represent some sort of service guaranty or the availability of certain services. Most people assume that there will be emergency care and the ability to house and heal patients. If I walk into Princess Margaret, Toronto General or Sickids I immediately realize that these massive buildings house all the care I could ever need.

Such is not the case with small hospitals. Interestingly for those in urban centres the issue of small hospitals is quite foreign. From a sheer number standpoint small hospitals make up over half of all the hospitals in Ontario. While there are an impressive number of small hospitals it should be noted that if you added the budgets of the 58 smallest hospitals together it would not add up to the annual budget of Sunnybrook. Think about that - 58

CEOs, senior teams, boards of directors, thousands of reporting requirements and in total it does not equal Sunnybrook which is a single entity.

Due to a system that has been on autopilot for 50 years we have about 75 small hospital locations. Many people would be surprised to find out that some small hospitals do not have beds and cannot and do not admit patients. Equally surprising is that many small hospitals do not have laboratories - one of the most basic tools in assessing a patient's needs. What if you were to learn that the small hospital you arrived at seeking care did not even own an x-Ray machine. (I have been told there is one hospital that shares a portable X-ray machine with the local veterinarian! – Ontario in the 21st century.)

Interesting that these facilities still get to put the H on the outside of their building. If there is no true definition of what it means to be a hospital, that is a clear failing of those in charge of planning the system. We are left with a hodgepodge of small facilities scattered across the massive geography of Ontario. The opportunity that we have missed is that well thought out and resourced correctly, small hospitals can fill a needed role in the overall system. The challenge is that there may be less than 75 sites needed and they may need to be located more strategically! Close or move a hospital? That has "INCIDENT" written all over it. Must be avoided at all costs, even if it is the right thing to do.

The one common thing that small hospitals offer is a 24 hour emergency department. (Anytime hours are curtailed or a department temporarily closes the media is on the story providing accounts of a public now placed at peril by government mismanagement.) We need to take a long hard look at these emergency departments. If there is no lab or diagnostics the best you can receive is a consultation with a physician and some relatively basic interventions - stitches, splints, etc. If you are really in need of emergency care your odds are much better if you spend your time getting to a tertiary centre. Some analysis that was done on two small EDs indicated that if you were a CTAS 1 or CTAS 2 patient, - that is a patient in imminent danger of dying, your chances of survival at the small ED were less than 10%. If you got to the tertiary centre some 40 miles away, your chances of survival were over 60%.

The role and expectations of emergency care have changed dramatically over the past 20 years. We have or are moving away from a model where the local GPs covered the ED. The role is now one of specially trained intensivists. They do not tend to live where small hospitals exist so the coverage for small hospitals EDs is provided by visiting locums more often than not. When there is a shortage of locums, bidding wars ensue, and suddenly we are paying a locum physician $5,000 or more for a 24 hour shift to keep an ED open that might only see a dozen patients in the 24 hours, few of whom would qualify as true emergencies (but we have avoided an “incident”)!

It is clear the current configuration of small hospitals does not meet the needs of the local population or the broader needs of an integrated system. The very small hospitals must be rethought. Not all small hospitals are so small as to being unable to deliver the care their

community requires. In the north, hospitals in places like New Liskeard, Kapuskasing, Elliot Lake, Kenora, Sioux Lookout, Dryden and Fort Frances offer services which I think should be the minimum to be considered an Ontario hospital. They have emergency departments supported by labs and diagnostics. They have surgical services with surgeons on call and they have obstetrics. These services mean that these facilities can meet over 90% of the needs of their local communities.

What to do with the 50 or 60 hospitals that don't offer the range of services listed above? This is where we need to be creative. If we look south of the border where the economic environment drives change it can be seen that many small hospitals have indeed closed over the past twenty years. Those that are designated as essential, usually due to the need to cover a certain geography to make sure services exist, are funded differently to ensure they can keep their doors open. One innovative idea is the micro hospital that has a fully functional ED plus 10-12 observation beds where a patient can be admitted but cannot stay for more than 72 hours. After 72 hours many are well enough to go home and if not they are transferred to a full service hospital for more intense treatment.

There is a need across this vast geography to connect patients to the care that they require. Northwestern Ontario is small by a population basis, less than 250,000 people covering 44% of Ontario's landmass. The northeast is the same size but has over 500,00 inhabitants – between the northwest and the northeast 88% of Ontario's land mass is accounted for but only 6% of the province's population. From a size perspective the northwest is three times larger than England which has a population of 65 million. It should be no surprise that the provincial air ambulance service ORNGE has three bases in the northwest and Thunder Bay is the busiest ORNGE base in the province. ORNGE does a really good job of getting patients to where they need to be to access services.

Perhaps we need an Emergency Department system across the north that is located based upon geography, populations and moving patients. We should have better resourced, (but fewer) emergency departments that offer labs and diagnostics, that exist to stabilize and move patients to get the care they require. The staffing of these EDs may be easier if there are fewer of them. There could be staffing models that look to use Advanced Care Paramedics and Nurse Practitioners to provide the front-line care. Consider when we have the most horrific or challenging accidents, we send advanced care paramedics (ACPs) to be the first on the scene. They may be well suited for a remote emergency department. For less acute patients, (the vast majority) nurse practitioners could provide the interventions. Between the two you would have a team well suited to meet the needs and a model that might be easier to staff and sustain.

What to do with the small hospitals that are no longer needed? There is a great opportunity to re-purpose these facilities. They could be urgent care centres operating 12 hours per day. They could be re-purposed to become ambulatory centres, to provide services communities currently do not have - visiting specialist services, minor procedures,

chemotherapy, dialysis, counselling and other therapies, etc. They could much better meet local needs and there would be savings from not having to offer 24-hour care.

Regardless of where we go it must start with the acceptance that our small hospitals, as currently structured, located and funded are not truly meeting the needs of a changing health care system. The people of rural and northern Ontario deserve a system that meets their needs of today, not their needs of fifty years ago. They deserve to have a system that is managed on a day-to-day basis with tangible short-, medium- and long-term plans. We need for politicians of all stripes to stop playing "gotcha" and put their joint efforts to managing the system we have entrusted to them.

Next week – Home Care – The Bubble Wrap of the Health Care System