

## **Integrated Ambulatory Centres**

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

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.<sup>i</sup>

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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<sup>i</sup> 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.

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## ABBREVIATIONS USED IN THE PAPER

AHS	Alberta Health Services
CCG	clinical commissioning groups
CPSO	College of Physicians and Surgeons of Ontario
HHR	health human resources
IHF	independent health facility
IAC	Integrated Ambulatory Centre
KEI	Kensington Eye Institute
NHS	National Health Service
OHIP	Ontario Health Insurance Plan
OHP	out-of-hospital premises
OMA	Ontario Medical Association
RFP	request for proposal
RNAO	Registered Nurses Association of Ontario

## 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.<sup>1</sup> 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.<sup>4,68,69</sup> 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.<sup>2–5</sup> 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 credentialing 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.<sup>ii</sup> 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.

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<sup>ii</sup> *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.<sup>6</sup> 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 coordination, 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.<sup>iii</sup>

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<sup>iii</sup> 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.

## INTRODUCTION

Canada is known for its universal, publicly funded health-care system, and in many ways, the system performs well. However, a notable exception is its long-standing problem in providing timely access to care.<sup>7,8</sup> The problem of lengthy wait times for scheduled procedures is not new or specific to COVID-19; it is one that Canada has been grappling with for decades. Provinces have varied in their performances on wait times over the years.<sup>9</sup> Focused investments contributed to improved patient access after the 2004 Health Accord; however, the combination of increasing clinical demand and constrained health-care spending since the 2008 fiscal crisis has caused wait times to creep up steadily over the past 10 years in most provinces. These access challenges have been amplified by the pandemic because system-wide disruptions were necessary to rapidly mobilize, organize and deploy resources to provide effective COVID-19 care while continuing to manage essential non-COVID-19 care safely.

### Not measuring up: Comparing Canada to other countries with universal health care

**Health-care expenditures:** Second highest spending out of 28 countries in terms of percentage of GDP, and eighth-highest spending per capita (after adjusting for age).

**Health human resources:** Health human resources: Ranked 26th out of 28 countries for availability of physicians and 14th out of 28 countries for availability of nurses.

**Timely access:**

- Ranked 10th out of 10 countries for wait times over four weeks for a specialist appointment
- Ranked 10th out of 10 countries for wait times over four months for elective surgery<sup>8,10</sup>

Compared to many other provinces, Ontario was doing relatively well with respect to wait times prior to the pandemic.<sup>9</sup> However, COVID-19 exposed a key vulnerability in Ontario's surgical and procedural delivery model: the high number of procedures that are performed in hospitals.<sup>11</sup> When hospitals were required to shift their focus from daily operations to managing and containing COVID-19, many scheduled surgeries and procedures were cancelled or delayed due to limited intensive-care capacity. This has resulted in an immense backlog that is estimated to take years to clear in Ontario.<sup>1</sup> This modelling does not account for the fact that the growth in demand will make wait times longer even if the "current" backlog is cleared.

The strains on Ontario's health-care system will only continue to grow in the coming years. The demand for surgeries and procedures continues to increase, and backlogs will only continue to accumulate in the wake of disruptions such as COVID-19. Further, clearing the backlog does not address the fundamental issues of service demand and constrained supply that led to increasing wait times in the decade before the pandemic. COVID-19 has demonstrated that Ontario's health-care system is not nimble enough to navigate a changing landscape. The province needs a whole-of-system model to have a sustainable surgical and procedural care delivery system that maximizes resources and productivity to the benefit of both patients and health-care professionals.

The systematic HHR shortages currently being experienced in Ontario have been exacerbated by pandemic-associated burnout. Therefore, it is not sustainable to attempt to address the COVID-19-induced backlog without also addressing the shortages of qualified staff and their burnout.

OMA member surveys conducted in March 2020 found that two-thirds of physicians were experiencing burnout, with 29 per cent reporting high levels. By March 2021, almost three-quarters of survey respondents were experiencing burnout, and 35 per cent said they were experiencing high levels.<sup>12</sup> The Registered Nurses Association of Ontario (RNAO) has identified the impacts of burnout on its members during the pandemic, and is projecting attrition as a result. For example, 16.4 per cent of registered nurses reported that they were either likely or very likely to leave the profession after the pandemic.<sup>13</sup> These findings illustrate that we cannot rely on health-care workers further extending their own capacities to address the surgical and procedural backlogs. The system changes outlined in this proposal are necessary, and must be implemented through a provider wellness lens to allow for health-care workers' own recovery from the pandemic and support their ongoing well-being. This, in turn, will enable sustainable improvements to Ontario's health-care system. (The OMA issued recommendations to directly address burnout in its 2021 white paper, *Healing the Healers: System-Level Solutions to Physician Burnout*.<sup>12</sup>)

Given the immense backlog and the resulting strain on health-care professionals, there is clearly an opportunity to innovate within the hospital system by shifting some cases to an outpatient model. The expectation that the backlog can be eliminated by ramping up existing hospital capacity is unrealistic. Despite long-standing and countless efforts, experience over the past 30 years has shown that because of the complex mixture of inpatient and outpatient care they provide, hospitals cannot achieve the efficiencies that ambulatory centres can. Therefore, there is a need to consider non-hospital delivery options to supplement the existing delivery system.

The recent value-for-money audit by Ontario's auditor general on outpatient surgeries— together with case studies of care in Ontario (e.g., KEI), in other provinces (e.g., Saskatchewan, Alberta, British Columbia) and in other countries—demonstrate that ambulatory centres can perform a range of surgeries and procedures safely and more efficiently than in hospitals can. Studies have shown efficiency gains ranging from 20 to 30 per cent compared to inpatient care in hospitals.<sup>4,68,69</sup> Yet Ontario has been very slow to modernize and embrace a broad expansion of its ambulatory care centres (e.g., IHFs) to target wait times in high-volume areas. The audit made it clear that the Ministry of Health had not done enough to implement potential best-

practice surgery outpatient models, despite the clear benefits to both patients and the health-care sector overall.

The creation of KEI in 2005 to tackle cataract wait times is a notable exception. For more than 15 years, KEI has been a leader in providing high-quality outpatient cataract surgery in a non-hospital ambulatory facility and has served thousands of patients. KEI works closely with neighbouring hospitals to ensure continuity of care for patients and timely access to surgeries. Given its success, it is surprising that Ontario has been so slow to endorse this best-practice model for use by other non-hospital facilities and to expand it to other surgery types and geographies.

Through consultations with clinical experts and health system leaders across the province, it has become clear that Ontario has a real opportunity to fundamentally rethink how to meet the growing demand for surgeries and procedures. Among those engaged to inform this report, there was a nearly universal view that the province needs to expedite the transition to a more distributed, integrated, ambulatory-based delivery system. Key informants acknowledged that Ontario has been slow to embrace this transformation due to concerns that introducing ambulatory-based specialty centres could further fragment the province's health system, lead to poor integration of care between centres and public hospitals, and place hospitals, IHFs and OHPs in financial competition for low-acuity, high-reimbursement care. However, these concerns are not insurmountable. They can be addressed through purposeful public policy that drives alignment between existing hospitals and new ambulatory centres that are closely connected to the broader system.

Clearing Ontario's backlog will require sustained focus, policy revision and targeted investment along with new models of care to streamline processes and optimize the use of scarce resources. The recommendations in this report are intended to inform the use of recently announced government investments, increase throughput by improving productivity, and address system-level inefficiencies to improve patient outcomes and health professional experiences, expand service delivery, and decrease costs.

## THE CHALLENGE OF SURGICAL AND PROCEDURAL CARE DELIVERY

Ontario's primary strategy to address wait times over the past two decades has focused on expanding capacity in public hospitals. This has involved billions of dollars in targeted funds to increase surgical and diagnostic volumes and improve surgical efficiency.<sup>5-8</sup> The fact that Ontario's wait times—while poor by international standards—have been lower than those of its provincial peers in recent decades is a testament to the ability of provincial hospitals to become hyper-efficient. Indeed, according to the Ontario Hospital Association, provincial expenditure on hospitals in 2019 was lower in Ontario than in any other province, at \$1,494 per capita. Ontario also had the lowest hospitalization rates, shortest hospital stays and lowest cost per inpatient stay in the country.<sup>14</sup>

A major strategic question going forward is: Is it realistic to expect hospitals that are already efficient, operating at full capacity, and still dealing with COVID-19 to ramp up surgical volumes to well above pre-COVID-19 levels for years into the future?

In July 2021, Ontario committed \$324 million to tackle surgical wait times. The bulk of this investment supports hospitals to run operating rooms and diagnostic suites overtime (at 115 per cent of normal capacity), with the goal of delivering 67,000 additional surgeries and procedures and 135,000 more diagnostic imaging hours. Such an approach may be viable in the short term, but is likely unsustainable, given the extent to which the pandemic has exacerbated pre-existing burnout issues among health-care workers.

Ontario's model of surgical and procedural care delivery is far behind those used by many other provinces, and it needs to evolve to better integrate and utilize ambulatory care centres. Many inpatient procedures currently performed in Ontario hospitals can be done either without an overnight stay or in an ambulatory surgical facility.<sup>15</sup>

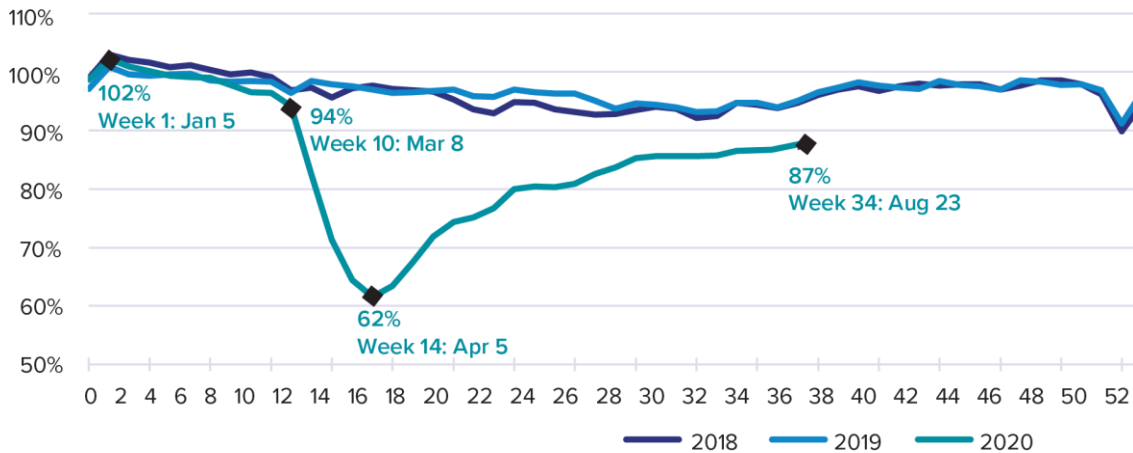
The move toward outpatient care has been steady and clear in several jurisdictions (e.g., British Columbia, Alberta and Saskatchewan) and outside of Canada (e.g., U.K., U.S. and Australia), driven by value-based payment models that incentivize the treatment of patients in lower-cost settings when appropriate.

Integration and collaboration between hospitals and Integrated Ambulatory Centres is essential not only to clear the immense backlog and address HHR issues, but to keep pace with the demands of a growing and aging population. Ontario will see its population grow to a projected 20 million people by 2041 from 14 million now. While seniors (aged 65 years and older) currently represent 17 per cent of the province's population, this figure will increase to 24 per cent by 2041.<sup>16</sup>

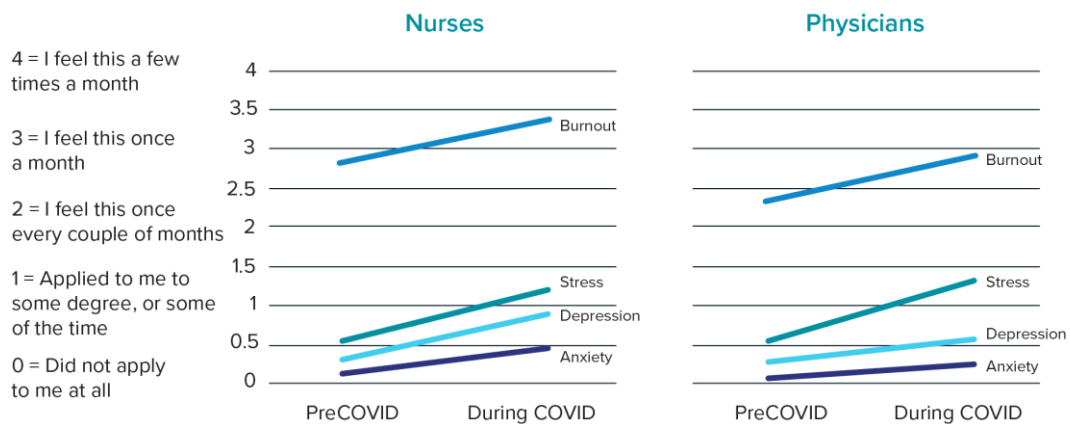


Without taking into account the pervasive pre-pandemic wait times, the Financial Accountability Office predicted that Ontario could clear the pandemic-induced surgical backlog in 3.5 years. This prediction assumes that hospitals will operate at 11 per cent above pre-pandemic volumes for all surgeries.<sup>1</sup> This would be quite a feat, considering that pre-pandemic hospital occupancy levels have averaged far above the recommended 85 per cent occupancy rate with no base funding increase over the past four years<sup>17</sup> (Figure 1) and that COVID-19 has caused extreme burnout and shortages among Ontario physicians and nurses (Figure 2).<sup>18</sup>

**Figure 1: Acute care occupancy rates in Ontario hospitals by week<sup>17</sup>**  
**Seven-day provincial average to August 23, 2020**



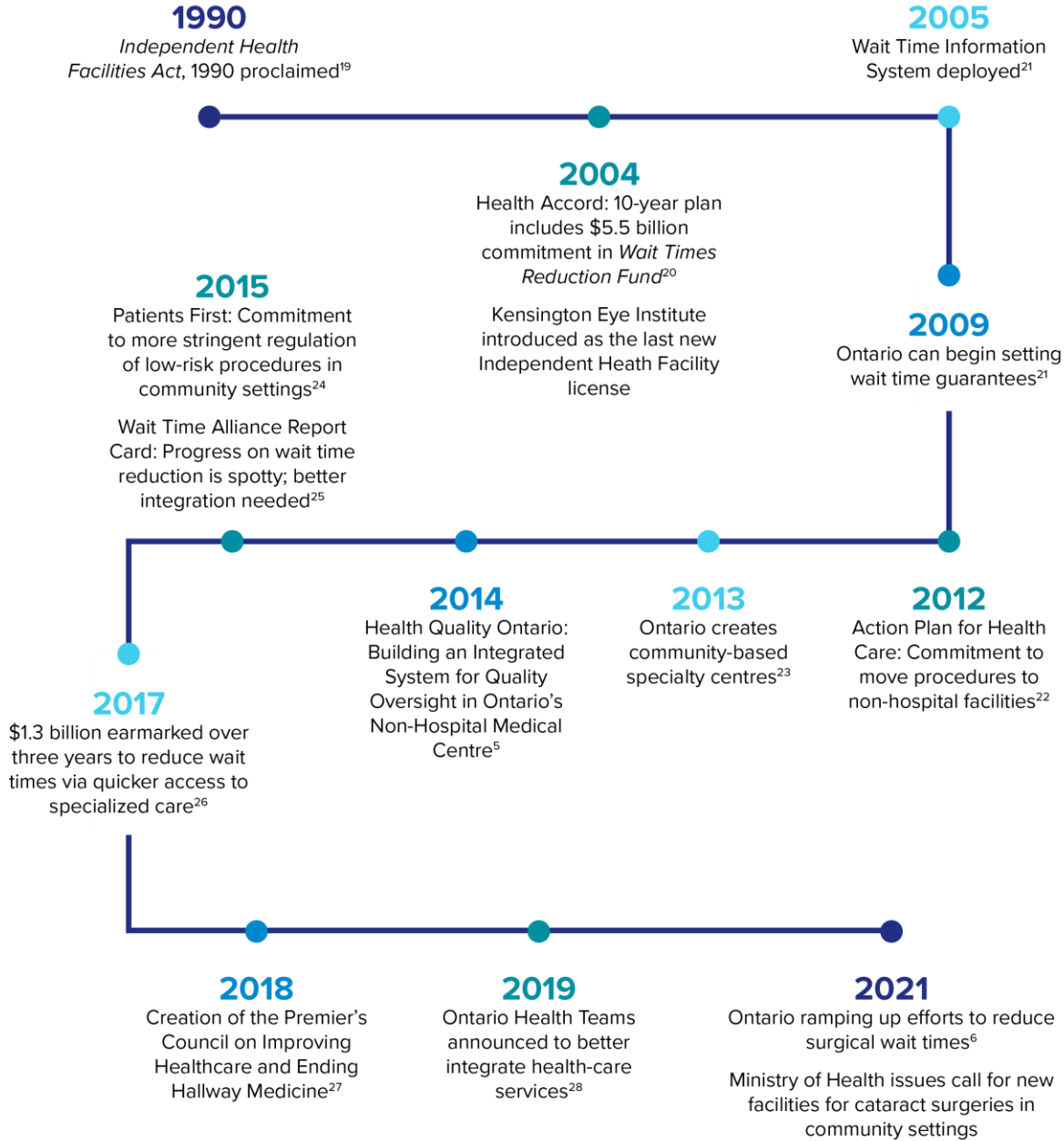
**Figure 2: Increases in stress, anxiety, depression and burnout among providers<sup>18</sup>**



Ontario’s ability to clear the current surgical and procedural backlog and sustainably address the access to care issue will require fundamental system changes. These changes must address several vulnerabilities highlighted during COVID-19. The next section unpacks these issues.

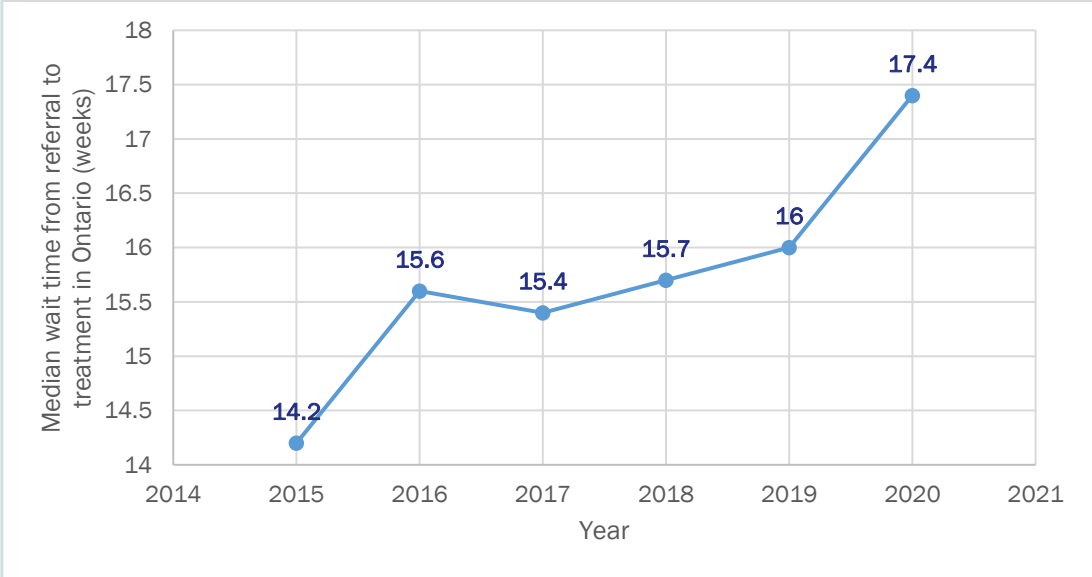
# THE CONTEXT IN ONTARIO BEFORE COVID-19

The recognition that wait times in Ontario are an issue—and the associated research- and policy-based efforts to address backlogs in surgical and procedural care—are not new. The work done previously helps us not only to understand the evolution of this challenge in the province, but to inform our efforts now (see timeline graphic).



Since the discussion of Ontario’s wait times began in 2003, critical work has been done to enable more effective delivery of surgical and procedural care. Public reporting of wait times has improved our understanding of the challenges at hand and allowed better tracking and goal-setting to bring the province to a higher standard of care. At the federal level, the Wait Times Alliance (established in 2004) supported progress by setting national benchmarks and targets for service delivery and providing reports that aligned data on wait times across the country.<sup>29</sup> Between 2003 and 2012, surgical wait times were halved in Ontario, establishing the province as the frontrunner in the country.<sup>22</sup> On top of this work, other government strategies have focused on ending hallway health care, such as by moving Ontario toward a more integrated health-care delivery system (e.g., Ontario Health Teams).<sup>27,28</sup> However, despite ongoing reports, investments and focus, Ontario has fallen behind its provincial counterparts in its efforts to eliminate hallway health care.<sup>30</sup> This may be due to the fact that, compared to other provinces, Ontario has not prioritized moving surgeries out of hospitals, and instead continues to focus on maximizing operating room time and other hospital-centric solutions.

**Ontario’s wait times, 2015 to 2021:** Ontario has consistently been a strong performer compared to other provinces and territories, with wait times below the national average. In 2020, the national average wait time was 22.6 weeks while Ontario’s average was 17.4 weeks.<sup>9</sup>) However, a lack of meaningful system transformation to cope with increasing demand and other challenges has resulted in a decline in Ontario’s performance, especially in the last few years.



9,31–35

## ONTARIO TODAY

Under the province's current structure, hospitals have been regularly operating at 100 per cent or greater capacity.<sup>17</sup> OMA analysis suggests that the health-care system would need to work at 120 per cent capacity for up to 31 months to clear most of the backlog (see Table 1).<sup>36</sup> The OMA data follows a recent report by the province's Financial Accountability Office that showed it will take more than three years and \$1.3 billion to clear the backlog of surgeries and diagnostic procedures in Ontario. Persistent delays have detrimental impacts on both patients and providers that compound the challenges that need to be addressed.<sup>37</sup>

**The case for change:** The Ontario auditor general's recent value-for-money audit of outpatient surgeries identified several significant shortcomings in the current outpatient care model, including slow progress on practices to improve wait times for outpatient surgeries, inconsistent oversight and co-ordination, and inadequate quality monitoring. The overall conclusion was that the Ministry of Health and Ontario Health have been slow to implement potential best practices that could shorten wait times and improve access to surgery.<sup>8,10</sup>

Whether as a direct result of the pandemic or due to inefficiencies in the system more broadly, treatment delays cause patients to experience a variety of severe consequences,<sup>38</sup> including greater deterioration in their overall health, physical pain and longer recoveries after treatments.<sup>39</sup> These effects are tied directly to increased rates of complications and worse clinical outcomes. Ultimately, the results include significant surgical cost increases (which further affect hospital finances and resources) and greater strain on the health-care professionals who care for these patients.<sup>37</sup> As Ontario attempts to ramp up surgical and procedural volumes to address the backlog, the health-care system must be equipped not just to cope with the consequences of delayed care, but to support the surrounding services required. Increases in post-operative care needs, as well as increased surgical costs (due to more infections or the requirements for more intensive treatment due to disease advancement) are all likely outcomes of surgical delays.<sup>40,41</sup>

## Outcomes of longer wait times

A study published in *PAIN Reports* was conducted to understand the impact on patients of surgery delays prompted by COVID-19. Looking at multiple studies of the deferral of joint replacement surgeries, their findings suggest that surgeries delayed by more than 6 months (significantly less time than many patients have already waited during the pandemic) may lead to 50 per cent greater odds of worse outcomes for patients, including more pain and difficulty with functional activities after surgery. Patients waiting for surgery also often experience chronic pain, which has been linked to decreased quality of life, increased comorbidities (such as anxiety and depression) and increased susceptibility to substance-use disorders.<sup>42</sup>

The task of allocating limited surgical resources also becomes increasingly challenging for surgeons and hospital administrators as they navigate decisions regarding which procedures should be conducted.<sup>37</sup> Despite enormous efforts over the past 30 years, the mixing of inpatient and outpatient, elective and non-elective surgeries and procedures in hospitals still does not allow the demonstrated efficiencies that ambulatory centres can offer.<sup>43,44</sup> In fact, as currently practised, hospital-based care delivery creates constant and inevitable competition between acute and non-acute care—and the lack of separation between scheduled and unscheduled care inevitably impedes the ability to deliver timely care.

Further, the lack of appropriate public reporting and transparency in Ontario's health-care system means the statistics on wait times may not paint a complete picture.<sup>45</sup> Poor integration not only limits the availability of comprehensive data on wait times, but means the patient experience can vary significantly.<sup>46</sup> On top of this, system-wide reductions in overall screening, treatment and surgeries over the last year mean we do not yet know how many individuals have been affected by decreases in the volume of non-emergency or COVID-19-related care over the past year, as outlined below.<sup>47</sup>

- 1. Geographic inequities in access to care:** There are significant regional variations in wait times for certain surgeries and procedures.<sup>48</sup> Less access to care in northern and rural regions in Ontario can have significant negative impacts on patients' well-being, and the need to travel greater distances for specialist services is a significant barrier to care for many.<sup>49</sup>
- 2. Unaccounted demand:** Many diagnostic procedures were delayed or put on hold at various times during the pandemic, meaning that many individuals who should be on wait-lists have not yet been identified, which will compound the surgical and procedural backlog.<sup>50,51</sup> Decreased trips to the emergency room likely mean that fewer abnormalities have been identified throughout the pandemic.<sup>52</sup> At least some part of the last years' increased mortality during the pandemic may be attributed to surgical delays. Due to the poor integration of our data structures and health-care system, Ontario may have lost

track of a significant number of patients, and system actors must act quickly to correct for this.<sup>47</sup>

**Table 1:** Estimated time to clear the backlog of four high-volume surgeries in Ontario<sup>36</sup>

Type of surgery	Size of backlog	Time to clear backlog at 120% capacity:
Cataract surgery	108,736	26 months
Knee replacement	52,492	31 months
Hip replacement	22,308	19 months
Heart bypass surgery	4,296	16 months

COVID-19 has highlighted fundamental barriers in how Ontario’s health-care system is structured, managed and funded that are hindering the province’s ability to transform the system and address the challenges. To create an accessible and sustainable surgical and procedural delivery system that is flexible and scalable enough to meet Ontarians’ evolving needs, these fundamental barriers—which were made evident during consultations with external health-system stakeholders in Ontario and other provinces and with Ontario’s physicians —need to be addressed.

## **STRUCTURAL BARRIERS**

### **1. Hospital-reliant health-care system**

Prior to the pandemic, hospitals were over-capacity and straining to meet the growing demands of Ontario’s population, with many hospitals continually exceeding the province’s maximum occupancy target of 85 per cent. During the pandemic, hospitals were further stretched by the need to treat COVID-19 patients and maintain a lower occupancy rate while also providing non-COVID-19 care. Hospitals also took on additional roles to support the health system, such as providing staff and oversight to long-term care homes and, through the Surgical Innovation Fund, providing solutions to address the immense backlog of surgical and diagnostic procedures. Hospitals are increasingly seen as “system managers” at the centre of integrated care systems. However, with the need to divide resources across such a diverse portfolio of services, hospitals have limited ability to increase efficiencies. Their existing structures do not incentivize collaboration for greater efficiency, such as by shifting surgeries and procedures to external centres or establishing cross-privileges for physicians.

## 2. Deficiencies in IHF and OHP models

Key informants were widely concerned that the current IHF and OHP models do not provide a scalable platform upon which to expand ambulatory service delivery.

Differences between the models creates unnecessary complexity, and the lack of clear performance metrics is a barrier to setting standards and identifying red flags when they arise. This added complexity and lack of scalability for oversight translates to potential major quality and safety gaps within these models when expanded.

## MANAGEMENT BARRIERS

### 1. HHR supply challenges

Ontario is experiencing profound HHR shortages. Vacancies are at an all-time high, especially among operative and perioperative nurses. Overall, Ontario is lagging compared to other provinces with respect to the number of hospital staff, and would need to hire 45,000 more hospital employees to close the gap.<sup>53</sup> Current management systems make it difficult for physicians to work in multiple settings (e.g., hospitals and ambulatory centres). While Ontario has made significant progress through recent investments and programs to strengthen its nursing workforce, immediate solutions are required to address this issue more effectively. Implementing Integrated Ambulatory Centres would require regional HHR planning, with co-ordination between hospitals and centres to ensure optimal HHR alignment and distribution. In the long term, when the HHR crisis is less acute, appropriate patients will shift to Integrated Ambulatory Centres. This shift will mean that hospitals experience fewer HHR pressures (due to declining demand).

### 2. Lack of integration

The need for integration is not new in Ontario, and even though the province is working toward this goal through Ontario Health Teams, the province remains behind many other provinces and countries. There is a need for more centralized wait-lists, referrals and scheduling across hospitals and between hospitals, ambulatory centres and primary care, with consistent systems in place across the province. Data interoperability and integrated planning among all providers and ministry policy-makers are essential for proper integration. From a regulatory point of view, the complex IHF and OHP space has created disincentives for integration into the broader health-care system.

## FUNDING BARRIERS

### 1. Lack of a coherent funding model

The current funding structures do not incentivize hospitals to shift procedures to ambulatory centres. Hospitals generate a positive margin on activity-based procedures,

but the price does not include the full cost of care. The current funding model also does not incentivize hospitals to deal with certain areas where the need is highest and wait times are longest.

## 2. Public-private debate

The idea of non-hospital care can elicit emotional reactions and give rise to concerns about privatized, two-tier medicine. However, there is unclear differentiation between privately and publicly *paid* services, and privately *delivered* services (which includes most existing physician practices, IHFs and OHPs). This report recommends that Integrated Ambulatory Centres provide publicly funded, Ontario Health Insurance Plan (OHIP)-insured surgeries and procedures. Models like the Prairie View Health Centre in Saskatchewan (for-profit delivery) and KEI in Ontario (non-profit delivery) suggest that corporate status is not the determining factor regarding whether an ambulatory clinic can improve patient access and health system efficiency. Both models operate through public funding and are consistent with the principles of the *Canada Health Act*. Both have strong clinical oversight regimes and strong partnerships with neighbouring public hospitals. Both reduce wait times and improve patient outcomes and experience. Ultimately, it is a political choice as to whether ambulatory clinic expansion is confined to non-profit delivery or may include for-profit organizations that meet quality standards.<sup>iv</sup> Thus, irrespective of the political resolution of this issue, Integrated Ambulatory Centres are needed.

With the current health-care system transformation underway and the provincial government's recent acknowledgement of the challenges at hand, Ontario has a timely opportunity to make meaningful change in these critical areas.

## ONTARIO'S RECENT RESPONSE

During the 2019–20 fiscal year, before the COVID-19 pandemic hit, Ontario's Ministry of Health was \$466 million under budget.<sup>55</sup> The 2020–21 fiscal year brought many disruptions to planned spending and initiatives due to the unprecedented demands of the pandemic. Notably, Ontario spent \$1 billion *less* than initially budgeted for health, citing reduced service demands and less spending required than anticipated to contain the COVID-19 crisis due to improving trends.<sup>54</sup>

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<sup>iv</sup> This paper is agnostic on the question of whether Integrated Ambulatory Centres should be incorporated as non-profit or for-profit organizations. It argues that considerations regarding model design and integration with the broader system of care are more important than corporate status. Both non-profits and for-profits would be required to comply with an enhanced legislative and regulatory regime and fully support the principles of both the *Canada Health Act* and Ontario's Commitment to the Future of Medicare Act.

\*Since publishing this paper, the OMA has clarified its position that IACs should provide OHIP-funded services as not-for-profit clinics.



On March 24, 2021, just over a year after the start of the pandemic, the Ontario government released its 2021–22 budget, which included funding of about \$1.8 billion on top of previous investments in the hospital sector. Some of this funding was targeted directly at reducing the surgical backlog. On July 28, 2021, the Ontario government announced additional details about its \$324 million surgical recovery plan, including further investments since the budget announcement. The breakdown is shown below.

### **\$324M Total investment:**

- Hospital care: \$300 million from the 2021 Budget dedicated to help the hospital sector recover and perform thousands more surgeries and diagnostic imaging hours and help reduce wait times.
  - \$216 million: extend operating room hours - perform up to 67,000 additional surgeries on top of the typical volume of 650,000 scheduled surgeries that happen in main operating rooms each year. New surgeries funded may include up to 33,000 new cataracts surgeries, up to 4,300 new orthopedics surgeries and up to 9,000 new pediatrics surgeries.
  - \$35 million for MRI and CT imaging, enabling over 75,000 additional hours of MRI scanning and over 60,000 additional hours of CT scanning, on top of the 577,000 hours and 550,000 hours that happen each year, respectively. This represents a 12 per cent overall increase in available hours.
  - \$18 million investment in centralized surgical wait-list management to increase use of electronic referrals and support work to enable efficient tracking of surgical information, making better use of specialist and hospital resources and reducing patient wait times.
  - \$1 million: surgical smoothing coaching
  - \$30 million for the [new Surgical Innovation Fund](#)
- Increase health system capacity through community alternatives to hospital care: Up to \$24 million to increase volumes of low-risk, publicly funded surgical and diagnostic services in independent health facilities and to support the licensing of new independent health facilities for existing services. <sup>56,57</sup>

It is clear from these investments that Ontario understands the challenge at hand and the urgent need to reinforce its surgical and procedural delivery system to recover from the direct and indirect impacts of the COVID-19 pandemic. These investments are integral steps to help Ontario address the surgical backlog exacerbated by COVID-19 by increasing volumes, efficiency and integration in alignment with the approach and timing outlined in this report.

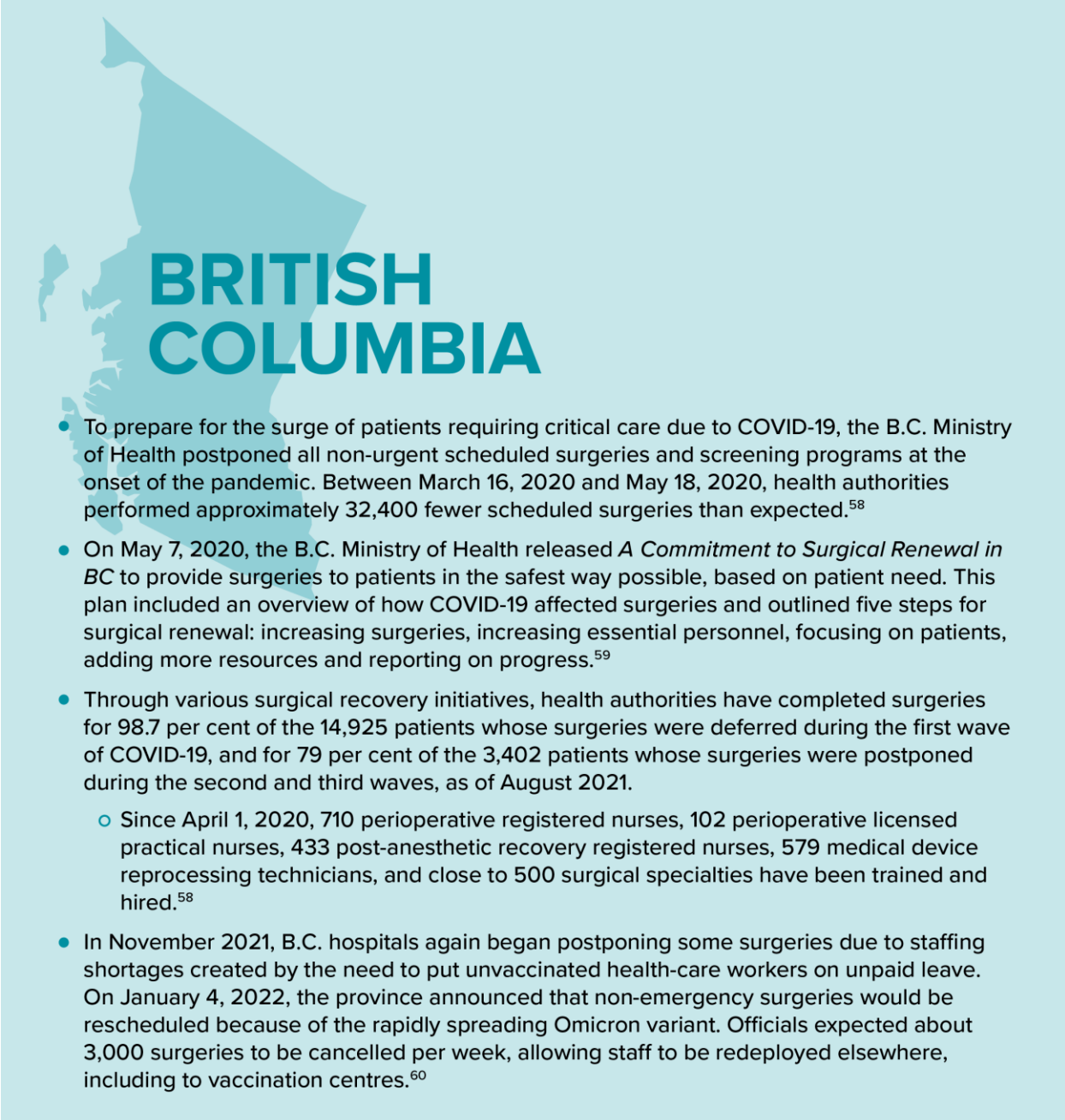
To further inform what an ideal model looks like for Ontario, our consultations focused on the approaches taken by other provinces and countries to understand what works, what could be improved upon, and what would be most appropriate in the context of Ontario’s provincial health ecosystem.

# LEARNING FROM OTHERS

## WITHIN CANADA

While many provinces have increased the number of non-hospital facilities providing surgical services, there is considerable variation in the approaches taken to regulate and contract these facilities. Appendix 4 provides more detailed information about the legislative framework, regulation and payment structure, comparing Ontario with British Columbia, Alberta, Saskatchewan and Manitoba. The stakeholders we consulted characterized these provinces as more advanced in integrated service delivery.

### COVID-19 backlog recovery statistics for comparator provinces



**BRITISH COLUMBIA**

- To prepare for the surge of patients requiring critical care due to COVID-19, the B.C. Ministry of Health postponed all non-urgent scheduled surgeries and screening programs at the onset of the pandemic. Between March 16, 2020 and May 18, 2020, health authorities performed approximately 32,400 fewer scheduled surgeries than expected.<sup>58</sup>
- On May 7, 2020, the B.C. Ministry of Health released *A Commitment to Surgical Renewal in BC* to provide surgeries to patients in the safest way possible, based on patient need. This plan included an overview of how COVID-19 affected surgeries and outlined five steps for surgical renewal: increasing surgeries, increasing essential personnel, focusing on patients, adding more resources and reporting on progress.<sup>59</sup>
- Through various surgical recovery initiatives, health authorities have completed surgeries for 98.7 per cent of the 14,925 patients whose surgeries were deferred during the first wave of COVID-19, and for 79 per cent of the 3,402 patients whose surgeries were postponed during the second and third waves, as of August 2021.
  - Since April 1, 2020, 710 perioperative registered nurses, 102 perioperative licensed practical nurses, 433 post-anesthetic recovery registered nurses, 579 medical device reprocessing technicians, and close to 500 surgical specialties have been trained and hired.<sup>58</sup>
- In November 2021, B.C. hospitals again began postponing some surgeries due to staffing shortages created by the need to put unvaccinated health-care workers on unpaid leave. On January 4, 2022, the province announced that non-emergency surgeries would be rescheduled because of the rapidly spreading Omicron variant. Officials expected about 3,000 surgeries to be cancelled per week, allowing staff to be redeployed elsewhere, including to vaccination centres.<sup>60</sup>



# ALBERTA

- Alberta hospitals performed about 2,800 fewer surgeries per month during the first 16 months of the COVID-19 pandemic versus pre-pandemic levels, with 40,000 surgeries delayed during this time. At least 15,000 surgeries were cancelled due to the pandemic's fourth wave this fall.<sup>61</sup>
- In April 2021, Alberta Health Services (AHS), along with the Government of Alberta, implemented a surgical recovery plan (now integrated into the Alberta Surgical Initiative) that aimed to increase access to surgeries across the province while balancing the health-care system's COVID-19 pandemic response.<sup>62</sup>
- Surgical teams were able to support surgical activity at about 92 per cent of pre-COVID-19 levels during the 2020–21 fiscal year through strategies implemented under the surgical recovery plan, including:
  - Resuming surgical services at AHS sites where activity needed to be slowed
  - Increasing the volume of surgeries in chartered surgical facilities already under contract with AHS
  - Establishing new, publicly funded contracts with existing and new Alberta vendors to expand the scope of surgeries, including orthopaedic day procedures, plastic surgery and general surgery
  - Creating focused sites of surgical care to maintain capacity<sup>62</sup>
- As of December 2021, Alberta's surgical wait-list, which includes both postponed and newly required procedures, had levelled off to about 81,600 people, about 14,000 above pre-pandemic levels.<sup>63</sup>

# SASKATCHEWAN

- The COVID-19 pandemic has had a significant impact on the delivery of surgical service in Saskatchewan. The disruption in service resulted in about 20 per cent fewer surgeries being performed in 2020–21.<sup>64</sup>
- In response to the fourth wave of COVID-19 starting in September 2021, surgeries were significantly reduced again so personnel could be redeployed to other areas. However, since late November 2021, surgical programs have been returning to their previous volumes. During 2021–22, surgical volumes returned to about 95 per cent of their normal (pre-pandemic) volumes.<sup>65</sup>
- In December 2021, a target was set to perform 7,000 more surgeries in 2022–23 versus pre-pandemic levels. Volume targets were intended to grow over the following few years, with an emphasis on meeting the needs of long-waiting patients.
  - The plan includes new measures to increase capacity in Saskatchewan Health Authority hospitals and publicly funded, private surgical centres, including expanding and optimizing operating room hours and making greater use of regional surgical sites.
  - By building on existing contracts with private surgical providers, additional surgeries and more types of surgeries will be performed through third-party contracts. In December 2021, the province released a request for information to test the market for “additional third-party surgical providers for day procedures, overnight inpatient surgeries, and post-operative care including therapies and home care.”<sup>65</sup>



# MANITOBA

- The impact of the pandemic response on Manitoba's hospitals has resulted in a massive backlog of surgery and diagnostic procedures. Between March 2020 and October 2021, the backlog of surgical procedures was estimated to be 56,181. If including diagnostic imaging tests, this figure increases to 152,116. Both the surgical and procedural backlogs increased throughout October and November 2021 in all areas.<sup>66</sup>
- The Manitoba government has established a task force to address the diagnostic and surgical backlogs as the top priority. This will include identifying the priority needs of patients and implementing local and out-of-province services as a temporary initiative to deal with the wait-lists, including:
  - creating a centralized information management system for health-care providers that will include surgical and diagnostic wait-list information
  - ensuring health-care providers (e.g., licensed practical nurses) are working to their full scope of practice
  - identifying patients who are ready for their procedures and could travel to another jurisdiction, they could be treated there sooner<sup>67</sup>
- As of November 20, 2021, it had been reported that surgery schedules were once again being disrupted because nurses were being redeployed to support the pandemic response. This was expected to add another 100 to 150 cases to the backlog each week.<sup>66</sup>

While direct comparisons are difficult because these jurisdictions have different contexts, there are common features and lessons learned that offer some considerations for Ontario. The key themes emerging from the consultations with other Canadian jurisdictions are summarized below.

- **Centralized regional structures:** For efficient surgical and procedural management, quality assurance, patient satisfaction and optimal reporting of services and incidents, other provinces noted that regional authority management was required. They noted

that centralized patient wait-lists and single intake, referral and triage management systems are essential.

- **Consistent patient-selection criteria:** Consistency helps drive efficiency, with high-volume procedures and low-acuity patients diverted to Integrated Ambulatory Centre settings.
- **Physician cross-privileges:** Physician cross-privileging allows systems to expand their capacity with a larger, more flexible pool of physicians. They can leverage physician capacity by removing siloed physician workforces. This also helps ensure quality of care, which can be influenced by factors like site capacity, adequate facilities, equipment and the number and type of qualified support staff and other resources.
- **Optimized funding structures:** By reassessing and optimizing funding structures, the health-care system can incentivize the optimal operation of facilities and support the formation of hospital-ambulatory clinic partnerships.
- **Slack capacity in ambulatory settings:** When establishing a new structure and model of Integrated Ambulatory Centres, it is critical to allow for increased capacity for planned future expansion and additional surgeries performed in non-hospital settings.

## OTHER COUNTRIES

Wait times for surgeries and procedures in Canada have been consistently longer than wait times in many other high-income countries. The evidence from peer jurisdictions suggests that it is possible to maintain universal health care without the long wait times that plague our system. Countries such as Switzerland, the Netherlands, Germany and Australia all share Canada's goal of universal access to care and spend roughly the same amount on health care (as a percentage of GDP). Yet all of these peer jurisdictions generally have more medical resources and significantly shorter wait times than Canada.<sup>30</sup> Although not directly comparable due to differences in health systems and structures, there is great value in understanding the strategies and approaches that have enabled other countries to effectively address issues that are similar to Ontario's. Other countries have demonstrated the effectiveness of shifting more surgeries and procedures to outpatient centres (see Appendix 3).

**Table 3: The metrics behind Canada’s challenges<sup>8</sup>**

Country	Spending as a % of GDP	Physicians per thousand population	Patients waiting 4 weeks or more for an appointment with a specialist	Patients waiting 2 months or more for specialist appointment	Patients waiting 4 months or more for elective surgery
Canada	10.8%	2.72	62.8%	30%	18%
Germany	11.5%	4.31	28.1%	3%	0%
Australia	9.3%	3.75	42.6%	13%	8%
United Kingdom	10%	2.84	46.4%	19%	12%
Netherlands	10%	3.67	33%	7%	4%

## A NEW VISION FOR INTEGRATED SURGICAL AND PROCEDURAL CARE

In its current state, Ontario’s system does not allow scheduled surgical and procedural care to be delivered as efficiently as possible. In recent years, ambulatory centres have evolved in other jurisdictions due to the growing sophistication of surgical tools and techniques, new pain management and diagnostic techniques, a boom in the development of care delivery options, and patient demand for convenience and access. As such, an increased role for ambulatory centres in providing scheduled surgeries has the potential to provide additional capacity to the system in an integrated way while enabling hospitals to work more efficiently. In this model, hospital oversight can play a valuable role in safeguarding quality of care and maintaining high clinical standards.

Overall, we envision a new and integrated model for Integrated Ambulatory Centres that will supplement and support the province’s strong hospital delivery system. This model reimagines and streamlines existing surgical and procedural IHFs’ frameworks to offer a broader spectrum of services that can be provided safely and efficiently on an outpatient basis. These centres would be fully integrated into a high-functioning regional health system that is accessible and able to meet the increasing demand for care in Ontario. Through this regionalization, and with the right funding structures, Integrated Ambulatory Centres can also help the province move the needle on equitable access to services by ensuring that centres are located in urban, rural and remote areas.

The key characteristics of this integrated model of surgical and procedural care are outlined below.

- **Integration:** Integration and connection between hospitals and Integrated Ambulatory Centres must be prioritized across the system, with a commitment to reporting on an aligned set of common initiatives, such as centralized wait-lists, a single entry model for the integration of assessments, triage and referrals, and consistent clinical criteria.
- **Collaboration, not competition:** All aspects of the surgical and procedural delivery system must be founded in encouraging collaboration. Partnership with clinical leadership in hospitals on this approach is essential to drive system transformation. At maturity, Ontario Health Teams can play a valuable role here, creating a collaborative ecosystem that encourages increased partnerships and alignment on, for example, HHR capacity.
- **Improved quality:** Hospital partnerships will ensure a consistent clinical program and quality across sites in hospital and ambulatory care centres. This will allow access and volumes to be managed and outcomes to be tracked at a cross-facility level, improving overall management and oversight.
- **Increased performance:** Making use of Integrated Ambulatory Centres will allow hospitals greater capacity to focus on backlogged, new and emergent services that must be performed in hospitals and to explore innovative hospital-based strategies (e.g., “surgical smoothing”) to maximize operating room and resource utilization, increase throughput, improve outcomes and minimize competition between emergency and scheduled procedures in hospital.
- **New funding models:** The funding and incentive structure for surgeries and procedures in Ontario must provide hospitals a net-positive result in terms of both increasing efficiency and shifting procedures to centres. There needs to be proper funding in place to ensure that centres are distributed equitably in urban, rural and remote locations where there are substantial gaps in care. Additionally, the funding model must clearly demonstrate the lower total cost for ambulatory clinic procedures and incentivize and appropriately compensate hospitals for high-complexity cases, given that such procedures comprise a greater total percentage of the surgeries performed within hospital settings. New funding must be linked to co-ordinated care models that align outcomes with value and be contingent on successful partnerships built between hospitals and Integrated Ambulatory Centres.
- **Improved oversight and transparency:** A working group should guide the development of a framework for data collection and reporting for a more integrated system. Further,



real-time analytics are needed to improve the tracking of backlogs, with greater transparency on volumes and patient outcomes. Alignment of measurement with the Quadruple Aim domains may be valuable, along with price, quality and value. (The centralization of referrals should provide better transparency due to improved integration.)

## PRINCIPLES UNDERLYING A NEW MODEL

The development of a new model for surgical and procedural care delivery must be rooted in the realities of the current system, building on its strengths and proposing pragmatic solutions for improvement. The recommendations outlined in this paper were developed from a starting point of the principles outlined in Table 4.

### Table 4: Guiding principles for consultations, recommendations and policy paper

The new model should:



#### Achieve consistency and integration with the current public system

- Comply fully with the principles and guidelines of the *Canada Health Act* (e.g., no user fees, no queue jumping)
- Be fully integrated within the publicly funded, publicly administered health system (e.g., do not disrupt care and services elsewhere)
- Be embedded in open and transparent public reporting processes (e.g., patient satisfaction, wait times, quality outcomes)
- Align with current health system transformation efforts, including Ontario Health Team's service planning and care integration goals
- Have a robust and collaborative governance and accountability framework that is connected with the broader health system and hospital regulatory framework and aligned with the hospitals as key partners.



## Focus on quality

- Comply with generally accepted quality, safety and facility standards as outlined in relevant legislation and policy, including appropriate infection prevention and control policies
- Adhere to quality standards that are either comparable or superior to the standards of services delivered in hospitals



## Account for HHR considerations

- Consider HHR capacity and sustainability across the health-care system and minimize negative impacts on capacity to provide care in other settings (e.g., health professional burnout, additional burden on health professionals)
- Be developed with physician participation and input regarding requirements, barriers and facilitators to using ambulatory facilities to address the surgical and procedural backlog



## Align with current system needs and considerations

- Be data-driven and evidence-informed, with a patient-focused approach, and aligned with public need
- Be developed through an equity lens to recognize where the current system disproportionately disadvantages certain populations, and avoid perpetuating or exacerbating those gaps
- Be cost-effective and create net new capacity
- Align with the Quadruple Aim to improve the experience of patients and their caregivers, the health of populations, the provider experience, and to reduce the per capita cost of health care
- Allow for the continuation of service delivery even amid substantial disruption of hospital services due to external challenges (e.g., outbreaks, requirements to maintain flex capacity in hospitals in anticipation of surges)

## BENEFITS OF MOVING SURGICAL AND PROCEDURAL CARE TO INTEGRATED AMBULATORY CENTRES

Shifting the delivery of surgeries and procedures would not only help address several major pain points in Ontario's health-care system, but create numerous opportunities that would be beneficial now and into the future. Further, an integrated system structured to elevate resource and volume management across facilities will improve the health-care system's resilience to future crises, providing adaptive surge capacity and nimbleness.

### IMPROVED PATIENT OUTCOMES

Ontario's health-care system has the potential to streamline processes and focus resources to support more effective, patient-centred practice throughout the continuum of care, improving health outcomes. Research suggests that under a system with well-established standards of care and regulations, surgeries performed in ambulatory centres can deliver shorter perioperative times and decreased post-operative complications.

*A Swedish study published in 2020 in the International Journal of Environmental Research and Public Health looked at more than 5,000 patients receiving a specific scheduled surgery and found that greater hospital focus on the specific surgery (e.g., a higher proportion of surgery patients in the hospital and within the hospital department) was associated with improved outcomes, as demonstrated through reduced patient complications and shorter procedure times.<sup>44</sup>*

### INCREASED PRODUCTIVITY

Shifting high-volume, low-complexity procedures into Integrated Ambulatory Centres will alleviate the competition between urgent and scheduled surgeries. Current examples suggest Ontario could realize a productivity gain of 20 to 30 per cent if more hospitals shifted surgeries to ambulatory care settings, which can offer high efficiency through streamlined processes and dedicated, specialized staff.<sup>4,68,69</sup>

*A study published in Health Affairs in 2014 looked at data on outpatient surgery in hospitals and free-standing surgery centres in the U.S., with information on approximately 52,000 visits to 437 facilities. They found that procedures performed in **ambulatory surgery centres took an average of 25 per cent less time compared to those performed in hospital.**<sup>69</sup>*

### DECREASED COSTS

Integrated Ambulatory Centres have the potential to reduce the costs of health-care delivery and enhance the quality of care by concentrating expertise associated with increased specialization.<sup>4,23,70</sup>

*In 2012, Saskatchewan Health compared the cost of performing 34 procedures in private centres and in hospitals. The results showed that in all cases, the centres were less expensive, in some cases, they were half the cost. Overall, the **total cost of performing 34 procedures in the centres was 26 per cent less than the cost would have been had the procedures been performed in the hospital.**<sup>70</sup>*

*The Drummond Report from 2012 recommended that Ontario build on the success of the KEI and use community-based specialty centres for procedures that do not require the infrastructure of a hospital. The report noted that specialty centres should be encouraged because they can cost less and provide better-quality care.<sup>71</sup>*

## A Three-Stage Framework: Developing Integrated System Capacity in Ontario

The purpose of the three-stage framework is to shift Ontario's current model of delivering surgeries and procedures to include a robust and Integrated Ambulatory Centre model. The plan calls on the province to continue to maximize existing hospital capacity, implement regional wait-list management models and, over time, leverage the efficiency and capacity of new Integrated Ambulatory Centres that would work in partnership with public hospitals. This multi-year approach would offer patients more options for timely care while enhancing the integration of care across the system (see Table 5).

### **Stage 1 (2022 to 2023): Take advantage of existing resources and capacity**

Leverage existing system capacity within hospitals and physician services outside of hospital settings through further funding and improved co-ordination in the short term while conducting the necessary foundational planning to ensure Ontario has a successfully designed and implemented surgical and procedural delivery system in the long term.

### **Stage 2 (2023 to 2025): Develop the infrastructure for a regional approach to surgeries and procedures**

Work toward a regional approach to surgeries and procedures by reducing and/or streamlining the number of legislations and regulations that govern what and where clinical services can be conducted and creating a centralized wait-list and triaging management system.

### **Stage 3 (2026 to 2030): Full system integration for the management of surgeries and procedures**

Once strong foundational structures and capabilities for a regional approach have been established, Ontario's surgical and procedural service delivery system will be fully integrated with clear regional governance and operations management structures. Ontario Health Teams could be a potential vehicle to take on such a responsibility after they reach a sufficient level of maturity.

Table 5: Snapshot of the staged blueprint for an integrated surgical and procedural delivery system

Impacts on	Current state	Stage 1: 2022 to 2023	Stage 2: 2024 to 2025	Stage 3: 2026 to 2030
Hospital structure	Heavily relied upon	No change	Improving	Optimal
HHR	Very poor	Initial foundational changes	Better	Optimal
IHF model	Inconsistent and deficient	Initial foundational changes	Improving	Optimal
Integration	Insufficient	Initial foundational changes	Better	Optimal
Funding model	Poor and inconsistent	Initial foundational changes	Better	Optimal

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

System transformation takes time. Because surgical and procedural backlogs cause patients' conditions to worsen as they wait, expanding capacity in the short term is essential.

The government has shown an understanding of the urgency of the situation with its continued focus on and investment in addressing the health-care services backlog. The fundamental element of this stage is in line with the government's focused investments and initiatives that have already been undertaken. For example:

- Issuing RFPs to expand IHFs' ability to provide cataract surgeries.<sup>74</sup>
- Approving the establishment of Alternate Health Facilities to create additional hospital capacity by working collaboratively with Ontario Health regional planning tables to ensure alignment in the planning and tracking of the costs of added capacity.<sup>75</sup>
- Authorizing IHFs to redeploy staff to hospitals on a voluntary basis to help meet capacity needs under the *Emergency Management and Civil Protection Act*.<sup>76</sup>
- Announcing new funding of \$1.8 billion to reduce the surgical backlogs that resulted from surgeries and procedures being delayed or cancelled due to COVID-19.<sup>6</sup>
- Investing \$30 million through the Surgical Innovation Fund for hospitals to address barriers that impede their ability to deliver services (e.g., investing in valuable

technologies, developing hospital-led partnerships and enabling shifts to new outpatient models of care).<sup>56</sup>

- Providing \$24 million to increase the volumes of low-risk, publicly funded surgical and diagnostic services offered in IHFs.<sup>6</sup>

Short-term recovery investments to combat the immediate and critical backlog in Ontario are essential; however, these investments should be accompanied by foundational planning to ensure the successful design and implementation of an updated, integrated surgical and procedural delivery system. The gaps that we currently see in provincial recovery planning are covered in the Stage 1 recommendations provided below. Not only do they attempt to leverage existing capacity and infrastructure, but they have a more targeted focus on building the foundations required to make better use of available ambulatory care centres and allowing for greater fluidity of scarce health-care professionals to support hospitals through load-sharing procedures that can be done safely outside of the hospital.

### **STAGE 1 RECOMMENDATIONS:**

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 required to increase capacity. Prioritization should be transparent and communicated openly, not only with regard to an analysis of wait times and volumes, but also 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 the 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 high-priority areas as defined above (while ensuring that increased volumes in high-priority areas do not lead to decreased volumes in other areas). Funding and volume allocation should continue to be locally led so that regions can make decisions based on current realities, such as HHR, in each region's 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 ambulatory centres to develop partnerships, work together to remove inefficiencies 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 for

hospitals to assume oversight of the new model of surgical and procedural service delivery (Integrated Ambulatory Centres) and remove that responsibility from the CPSO.

5. **Introduce and scale innovative models of care** that have high potential to maximize current HHR, such as expansion of the physician-led model of anesthesia care using, for example, anesthesia assistants and other team-based models of care. There remains a profound need to address HHR supply challenges and avoid further straining an already burned-out health-care workforce or displacing human health resources 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 investments from government to support increased enrolment in health-care training, for example, nursing education.
  
6. **Optimize the use of virtual care** where not already implemented to allow teams of hospital and ambulatory providers to work together more effectively by determining situational appropriateness for virtual care and providing mechanisms for improving collaboration and flexibility in accessing and connecting with patients on an outpatient basis.

If these recommendations are implemented in 2022–2023, Ontario should see the following shifts in key success factors (Table 6) that will start building the foundation needed to accelerate the province toward a more integrated and sustainable surgical and procedural delivery system.

**Table 6:** Impacts of Stage 1 recommendations on key success factors

Impacts on:		2022 to 2023
Hospital structure	No change	Existing hospital infrastructure and IHFs are utilized to expand surgical and procedural capacity by improving patient prioritization and load-sharing between hospitals and IHFs.
HHR	Initial foundational changes	HHR models are assessed, and chosen models are starting to be implemented. This would include, but not be limited to: investments; implementing models (e.g., team-based models of care, anesthesiologist-led care teams, building on COVID-19 responses such as the <i>Emergency Management and Civil Protection Act</i> ); and ensuring sufficient availability and capacity of physicians and allied health professionals, including anesthesiology assistants for intraoperative assistance and extender roles and nurse practitioners for pre- and post-operative extender roles (such as pre-op centres

		or pain services). Advocacy for increased family medicine training to optimally support the Integrated Ambulatory Centre model and facilitate comprehensive patient care throughout the care pathway would be of benefit as well.
IHF model	Initial foundational changes	Partnerships between hospitals and IHFs are increased through funding incentives.
Integration	Initial foundational changes	Increased partnerships between hospitals and IHFs incentivize initial work on data and system integration (e.g., the potential implementation of the National Surgical Quality Improvement Program, or establishing Enhanced Recovery After Surgery practices).
Funding model	Slight improvement	Funding is directly linked to addressing identified access challenges and could include the use of the existing Surgical Innovation Fund.

## STAGE 2 (2023 to 2025): THE MEDIUM TERM—BUILDING THE INFRASTRUCTURE FOR A REGIONAL APPROACH

Stage 2 will further solidify the foundational infrastructure for an efficient, sustainable, integrated surgical and procedural delivery system to begin addressing the variations in health status and clinical practices within Ontario’s populations and geographies. This will also be essential because increased demand is expected due to Ontario’s aging population and the corresponding increased likelihood of comorbidities. If a more efficient regional approach that incentivizes collaboration between hospitals and ambulatory care centres is not undertaken, Ontario’s surgical and procedural demand will inevitably make wait times longer, causing increased resource use.

The provincial government is aware of the need to integrate and centralize service delivery systems. This awareness was evident in its \$18 million investment in centralized surgical wait-list management.<sup>6</sup> That investment focuses on increasing the use of electronic referrals and supporting work that enables more efficient tracking of surgical information and better use of specialist and hospital resources to reduce patient wait times. The government’s focus aligns with the recommendation below to centralize wait-lists and establish single intake, referral and triage management systems and the drive to mutually reinforce a regional approach and collaboration between hospitals, physician services and ambulatory care centres. These ideas are outlined in more detail below.



## STAGE 2 RECOMMENDATIONS:

7. **Allocate surgical and procedural volumes by region**, with Ontario Health Regions assuming responsibility for and oversight of all new volumes through accountability agreements with partnering hospitals and Integrated Ambulatory Centres.
8. **Centralize wait-lists and establish single intake, referral and triage management systems** by making use of Ontario's \$18 million investment (announced in the 2021 budget) for surgeries and procedures in each region, working in collaboration with hospitals, physicians and Integrated Ambulatory Centres to improve equitable and timely access.<sup>6</sup> These tools provide an opportunity to enhance transparency regarding expected wait times and 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 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-based IHFs and local hospitals to improve system co-ordination, HHR alignment, quality oversight and data integration to reduce inefficiencies. 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.<sup>v</sup>
11. **Develop new ambulatory capacity**, allocated by Ontario Health, by issuing regional Integrated Ambulatory Centre calls for proposals to perform surgeries and procedures that can be done safely outside the hospital. These RFPs should be for multi-specialty service centres that would be required to have detailed partnership agreements with

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<sup>v</sup> 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 whether legislative changes may be required for the more than 900 IHFs that are licensed exclusively for diagnostics. This is a critical consideration for the Ontario government because COVID-19 has severely affected diagnostic services. Several previous policy reviews have called for updating the overarching IHF/OHP regulatory regime for all centres.

local hospitals to ensure consistent quality and patient experience standards. New Integrated Ambulatory Centres would be free-standing and operationally separate from hospitals (to achieve the necessary efficiencies) but would operate in partnership with hospitals on physician privileges, quality oversight and funding alignments. Decisions on the locations of 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.

If these recommendations are implemented from 2023 to 2025, Ontario should see more substantial shifts on the key success factors (Table 7) that will start solidifying the infrastructure required for an integrated surgical and procedural delivery system.

**Table 7: Impacts of Stage 2 recommendations on key success factors**

Impacts on:		2023 to 2025
Hospital structure	Improving	Governance arrangements in hospital settings are streamlined to remove the factors that hinder access in hospitals (e.g., better response to emergency surgical cases; reduced competition between emergency and scheduled procedures; incentivizing collaboration/load-sharing between hospitals and ambulatory facilities; flexible scheduling).
HHR	Better	Physician cross-privileging across hospitals and Integrated Ambulatory Centres is required; the implementation of HHR innovative care models is expanded; new roles are introduced (with a no-poaching requirement); allied health professionals (pre- and post-care) are supported; investments are made in targeted training to provided needed services in urban, rural and remote communities (e.g., family practice anesthesia, family physician endoscopists).
IHF model	Improving	Governance arrangements are streamlined by reducing, modifying and/or removing the various legislations and regulations surrounding IHFs for surgeries and procedures that govern care, depending on what and where care is provided.  Clinical oversight and responsibility rest with the hospital partner instead of CPSO, but there is independent governance among the partnership.

Integration	Better	<p>Hospitals manage and provide accountability for overall partnership and service provision (e.g., system manager role).</p> <p>The regionalization of centralized wait-lists and/or the creation of single intake, referral and triaging management systems incentivizes standardized approaches across the patient journey (e.g., standardized referrals, consistent and standardized patient criteria, updated guidelines, and care pathways to match new HHR models of care).</p>
Funding model	Better	<p>Hospital funding is aligned with a regionalized approach to the new surgical delivery system. Bundled funding is available, potentially through a competitive bid process.</p>

### STAGE 3 (2026 to 2030): THE LONG TERM—FULL SYSTEM INTEGRATION FOR THE MANAGEMENT OF SURGERIES AND PROCEDURES

Throughout stages 1 and 2, the essential enablers of success are slowly modified to work toward the future model of full system integration to manage surgeries and procedures. This future state is built upon (and will accelerate) existing initiatives by taking a regional approach to priorities and planning.

One potential and optimal vehicle for this approach would leverage Ontario Health Teams, given that at maturity, they intend to provide the care and health management for their designated populations. Ontario Health Teams are envisioned to provide greater access to care and reduce hospital utilization and system duplication. Providing the teams with the responsibility and authority to align with and oversee surgeries and procedures, when they are ready and fully designated, would be a logical next step.

Ontario Health Teams are ideally constituted by a broad group of providers and organizations that encompass the patient’s entire care continuum, including primary, home and community care, hospitals, surgeons and other specialists, and regional resources, such as regional cancer programs and Ontario’s five health regions. When ready, Integrated Ambulatory Centres should be integrated with Ontario Health Teams.

It will be important that partners within Ontario Health Teams and decision-makers at the regional level are engaged and collaborate in the design and implementation of the Integrated Ambulatory Centres. Indeed, Ontario Health Teams are well-positioned to support a rapid and effective implementation of the centres. The teams' local health-care system knowledge should be utilized in regional planning discussions and when assessing the need for new centres, deciding on geographical locations and facilitating local integration.

At the patient level, the infrastructure of Ontario Health Teams could help streamline and smooth transitions between providers, which often cause gaps in care. For example, when expanding the ambulatory care model, it will be crucial to have proper pre- and post-operative care and communication with the patient. The most successful ambulatory programs have adequate nursing support to follow up on patients and address urgent concerns. Primary care plays an important role here in facilitating patient transitions post-procedure and is an essential partner to specialized and hospital care. Ontario Health Teams would be well suited to implement strategies that would streamline the post-op ambulatory and community care pathway and provide appropriate resource support to providers.

The Ontario government should continue to regionalize and modernize surgery in Ontario, with the option to shift regional responsibilities and authority to Ontario Health Teams when they are designated and have mature governance models in place.

### **STAGE 3 RECOMMENDATIONS:**

- 12. Continue to implement and scale the infrastructure** needed to achieve a seamless regional model, shifting resources and adapting funding models as appropriate based on new data regarding the cost of care.
- 13. Update hospital funding** to reflect the newly regionalized system, re-evaluating the costing methodology to appropriately balance services delivered in hospital settings and similar services delivered outside hospitals. These changes will focus on system sustainability and enable partnerships among hospitals and ambulatory settings. They will enable hospitals of all sizes to provide quality oversight and allow large urban hospitals to focus on what they do best: 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. 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 Regional Office and to the lead hospital or the Ontario Health Team, once designated. Any funding model would need to address funding distortions, given that these could incentivize hospitals to complete procedures that can be done more efficiently in an ambulatory clinic setting.
- 15. Conduct joint planning and integration** to build a resilient system that can meet the future needs of the population and to better integrate acute care episodes with primary care, rehab care, community care and home care.

If these recommendations are implemented from 2026 to 2030, Ontario will create a fully integrated and optimal surgical and procedural delivery system, as demonstrated in Table 8. Ontarians will benefit from improved health outcomes due to a more sustainable, consistent, scalable system that has redefined access and service capabilities.

**Table 8:** Impacts of Stage 3 recommendations on key success factors

Impacts on:		2026 to 2030
Hospital structure	Optimal	<p>New legislation is created to formalize regional governance and fund-holding responsibilities (prerequisite) through or in partnership with hospitals. (This will require amendments to the oversight role.)</p> <p>Hospitals’ core focus is on providing specialized, complex emergency services and serving high-acuity/complex patients. Other patients are redirected to partnered centres.</p>
HHR	Optimal	<p>A high-performing health workforce is integrated and working at full scope by leveraging innovative HHR models.</p>
IHF model	Optimal	<p>In the new model, multi-service ambulatory centres are an identified sector.</p> <p>At the time of contract expiration, surgical and procedural IHFs transition to Integrated Ambulatory Centres in a phased manner.</p> <p>CPSO’s role is redefined to focus on physician practice instead of facility quality oversight.</p>
Integration	Optimal	<p>Regional clinical governance with full system integration is enabled by supporting new models of care, continuously embracing new technology (e.g., learning system), and identifying emerging best practices for efficient and effective delivery.</p>
Funding model	Optimal	<p>Innovative funding models are implemented, such as bundled care and activity-based funding, to incentivize more co-ordinated care and reduce fragmentation between hospitals and Integrated Ambulatory Centres for the benefit of patients. An understanding of case-costing is a prerequisite.</p>

## NEXT STEPS

It is clear there is an opportunity to support the provincial government with a path forward on how to address Ontario's immediate clinical backlog and create a health-care system that can sustainably manage surgeries for a growing and aging population while also improving the well-being of health-care workers.

To optimize the benefits and mitigate the challenges involved in making this much-needed transformation, the Ontario government should bring together a handful of clinical experts and health-systems leaders under an OMA co-chaired Expert Advisory Implementation Group. The purpose of this expert panel would be to support the provincial government through this paper's proposed stages and recommendations by developing an implementation plan to move Ontario toward an integrated and sustainable surgical and procedural delivery system.

Ultimately, this advisory group would be committed to working closely with government and other allied health professionals to develop practical solutions for the short, medium and long terms to align Ontario's health-care system and its subsystems in a collaborative and integrated way to provide the surgical and procedural treatments that Ontarians need.

## LONG-TERM BENEFITS

As discussed, implementing a strategy to shift more procedures to ambulatory settings has many benefits. A handful of these are outlined below. Their expected impacts on key outcomes are outlined in Table 9.

### For patients:

- Shorter wait times for surgeries and procedures, resulting in decreased pre-operative pain and disability and improved mental health
- Higher-quality care and better access to highly specialized surgeons and health-care professionals
- Convenience and faster access
- Less time spent in hospital and reduced risk of hospital-acquired infections

### For health professionals:

- Improved experience and reduced burnout
- Improved inter-professional collaboration
- Optimal physician cross-privileging, consistent with modernized and integrated systems

### For hospitals:

- Reduced pressure

- Reduced lengths of stay for most surgery patients
- Increased capacity over the long term because of established partnerships with Integrated Ambulatory Centres
- Increased rate of day procedures and associated reduction in inpatient costs

**For the system:**

- Opportunity to clear the clinical backlog in the immediate future
- Sustainably reduced wait times for scheduled surgeries
- More consistent public reporting and greater transparency across the system
- Higher quality of care in ambulatory centres, with dedicated staff, equipment and expertise

**Table 9:** Overall outcomes of moving toward an integrated surgical delivery system approach

Impacts on	Now	Stage 1: 2022 to 2023	Stage 2: 2023 to 2025	Stage 3: 2026 to 2030
Wait times	Growing	Minimal—growth may level off	COVID-19 backlog eliminated	Wait times are within benchmarks
Health outcomes/quality	Declining	Decline halted	Stabilized	Improved
Efficiency	Poor	Minor improvement	Improving	Optimal
Access/patients	Very poor	Slight improvement	Better	Improved
Health-care providers	Very poor	Slight improvement	Better	Improved

## References

1. OMA Economics, Policy and Research analysis, conducted February 2022.
2. Allin S, Sherar M, Church Carson M, et al. *Rapid Review: Public Management and Regulation of Contracted Health Services*. North American Observatory on Health Systems and Policies; 2020.
3. Auditor General of Ontario. 2012 Annual Report of the Office of the Auditor General of Ontario. Published online 2012.
4. Office of the Auditor General of Ontario. *Value for Money Audit: Outpatient Surgeries*; 2021.
5. Health Quality Ontario. *Building an Integrated System for Quality Oversight in Ontario's Non-Hospital Medical Centers*. Health Quality Ontario; 2015.
6. Ministry of Health. Ontario Ramping Up Efforts to Reduce Surgical Wait Times. Ontario Newsroom. Published July 28, 2021. Accessed August 19, 2021.
7. Schneider E, Shah A, Dooty M, Tikkanen R, Fields K, Williams II R. *Mirror, Mirror 2021 - Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries*. Commonwealth Fund; 2021. Doi:10.26099/01dv-h208
8. Barua B, Moir M. *Comparing Performance of Universal Health Care Countries, 2020*. Fraser Institute; 2020.
9. Barua B, Moir M. *Waiting Your Turn: Wait Times for Health Care in Canada, 2020 Report*. Fraser Institute. Published 10 2020. Accessed August 22, 2021.
10. Canadian Institute for Health Information. *How Canada Compares: Results From The Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries*. CIHI; 2017:11.
11. Sulkers P. *Integrating Ontario's Healthcare System: A Point of View*. Longwoods. Published online January 13, 2020. Accessed August 23, 2021.
12. Ontario Medical Association. *Healing the Healers: System-Level Solutions to Physician Burnout*. Published online August 18, 2021.
13. RNAO. *Work and Wellbeing Survey Results March 2021*. RNAO; 2021.
14. Ontario Hospital Association. *Ontario Hospitals - Leaders in Efficiency*. Ontario Hospital Association; 2019.
15. CADTH. *Environmental Scan: Surgical Interventions Performed Outside the Hospital Operating Room*. CADTH; 2015.
16. CCO Health. *Access to Care Plan 2019–2023*. CCO Health. Published January 15, 2019. Accessed August 19, 2021.
17. Ontario Hospital Association. *Understanding the Impact of COVID-19 on Ontario Hospital Finances*. OHA; 2020.
18. Lou NM, Montreuil T, Feldman LS, et al. Nurses' and Physicians' Distress, Burnout, and Coping Strategies During COVID-19: Stress and Impact on Perceived Performance and Intentions to Quit. *J Contin Educ Health Prof*. 2021; Publish Ahead of Print. Doi:10.1097/CEH.0000000000000365
19. Government of Ontario. *Independent Health Facilities Act, R.S.O. 1990, c. I.3*. Ontario.ca. Published July 24, 2014. Accessed September 22, 2021.



20. Health Canada. First Minister's 2004 meeting on the future of health care. Government of Canada. Published February 22, 2012. Accessed August 23, 2021.
21. MacLeod H, Hudson A, Martin M, Kramer S. The Times They Are A-Changing: What Worked and What We Learned in Deploying Ontario's Wait Time Information System. *Longwoods Healthcare Q.* 2009;12(Sp):8-15.
22. Ontario Ministry of Health. *Ontario's Action Plan For Health Care.* Government of Ontario; 2012.
23. Lavis J, Neves J, Pi L, Gauvin FP. Evidence Brief: Creating Community Based Specialty Centers in Ontario. *McMaster Health Forum.* Published online May 22, 2013:71.
24. Ontario Ministry of Health and Long-Term Care. *Patients First: Action Plan for Health Care.* Government of Ontario; 2015:16.
25. Eliminating Code Gridlock in Canada's Health Care System: 2015 Wait Time Alliance Report Card. WTA ATA. Published 2015. Accessed August 19, 2021.
26. Office of the Premier. Ontario Delivering Shorter Patient Wait Times. News.ontario.ca. Published May 2, 2017. Accessed August 19, 2021.
27. Ministry of Health and Long-Term Care Government of Ontario. Improving Health Outcomes and Ending Hallway Medicine. Accessed August 19, 2021.
28. Ministry of Health. Ontario Introduces 24 Ontario Health Teams Across the Province to Provide Better Connected Care. Ontario Newsroom. Published December 8, 2019. Accessed August 23, 2021.
29. Wait Time Alliance. About Us. Wait Time Alliance. Published 2014. Accessed August 22, 2021.
30. Bacchus B, Eisen B. Ontario no longer has shortest health-care wait times in Canada. Fraser Institute. Published December 5, 2018. Accessed August 19, 2021.
31. Barua B. *Waiting Your Turn: Wait Times for Health Care in Canada, 2017 Report.* Fraser Institute; 2017:98.
32. Barua B, Ren F. *Waiting Your Turn: Wait Times for Health Care in Canada, 2016 Report.* Fraser Institute; 2016:100.
33. Bacchus B. *Waiting Your Turn: Wait Times for Health Care in Canada, 2015 Report.* Fraser Institute; 2015.
34. Bacchus B, Jacques D. *Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report.* Fraser Institute; 2018.
35. Bacchus B, Moir M. *Waiting Your Turn: Wait Times for Health Care in Canada, 2019 Report.* Fraser Institute; 2019.  
<https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2019-rev17dec.pdf>
36. Ontario Medical Association. OMA estimates pandemic backlog of almost 16 million health-care services. OMA. Published June 9, 2021. Accessed August 19, 2021.
37. Fu SJ, George EL, Maggio PM, Hawn M, Nazerali R. The Consequences of Delaying Elective Surgery: Surgical Perspective. *Ann Surg.* 2020;272(2):e79-e80.  
Doi:10.1097/SLA.0000000000003998
38. Ontario COVID-19 Science Advisory Table. Excess Mortality in Ontario During the COVID-19 Pandemic. Ontario COVID-19 Science Advisory Table.  
Doi:10.47326/ocsat.2021.02.29.1.0
39. Wait Time Alliance. Timely access to care for all Canadians: The role of the federal government. WTA ATA. Published 2014. Accessed August 19, 2021.

40. Canada's surgery backlog could lead to wave of new chronic pain and opioid dependencies. *Financial Post*. <https://financialpost.com/globe-newswire/canadas-surgery-backlog-could-lead-to-wave-of-new-chronic-pain-and-opioid-dependencies-according-to-inagene-diagnostics-inc-genetic-testing-can-help-mitigate-the-risk-of-chronic-pain-and-reliance>. Published July 21, 2021. Accessed August 19, 2021.
41. Vogel TR, Dombrovskiy VY, Lowry SF. In-hospital delay of elective surgery for high volume procedures: the impact on infectious complications. *J Am Coll Surg*. 2010;211(6):784-790. Doi:10.1016/j.jamcollsurg.2010.08.009
42. Cisternas AF, Ramachandran R, Yaksh TL, Nahama A. Unintended consequences of COVID-19 safety measures on patients with chronic knee pain forced to defer joint replacement surgery. *PAIN Rep*. 2020;5(6):e855. Doi:10.1097/PR9.0000000000000855
43. Butler C. How surgical smoothing could help ease the medical backlog created by COVID-19. *CBC News*. <https://www.cbc.ca/news/canada/london/elective-surgery-wait-times-covid-surgical-smoothing-1.5641819>. Published July 13, 2020. Accessed August 23, 2021.
44. Svarts A, Urciuoli L, Thorell A, Engwall M. Does Focus Improve Performance in Elective Surgery? A Study of Obesity Surgery in Sweden. *Int J Environ Res Public Health*. 2020;17(18):E6682. Doi:10.3390/ijerph17186682
45. Blackwell T. Death, pain and soaring wait lists: How surgery backlogs have become pandemic's lingering collateral damage. *National Post*. <https://nationalpost.com/health/death-pain-and-soaring-wait-lists-how-surgery-backlogs-have-become-pandemics-lingering-collateral-damage>. Published May 19, 2021. Accessed August 23, 2021.
46. Yang J. They were hardest hit by COVID-19. Advocates now fear 'post-pandemic recovery' plans will leave these same communities behind. *The Toronto Star*. <https://www.thestar.com/news/gta/2021/08/13/they-were-hardest-hit-by-covid-19-advocates-now-fear-post-pandemic-recovery-plans-will-leave-these-same-communities-behind.html>. Published August 13, 2021. Accessed August 23, 2021.
47. Kitts D. 'It makes your head spin': Tackling Ontario's surgical backlog. *TVO*. <https://www.tvo.org/article/it-makes-your-head-spin-tackling-ontarios-surgical-backlog>. Published May 19, 2021. Accessed August 19, 2021.
48. Ge E, Su M, Zhao R, Huang Z, Shan Y, Wei X. Geographical disparities in access to hospital care in Ontario, Canada: a spatial coverage modelling approach. *BMJ Open*. 2021;11(1):e041474. Doi:10.1136/bmjopen-2020-041474
49. Health Quality Ontario, Qualité des services de santé Ontario. *Health in the North: A Report on Geography and the Health of People in Ontario's Two Northern Regions.*; 2017.
50. Hogan S, Glanz M. Oncologist fears "tsunami of cancer" after COVID-19 lockdowns limited screening. *CBC News*. <https://www.cbc.ca/news/health/cancer-tsunami-screening-delays-covid-1.5844708>. Published December 17, 2020. Accessed August 23, 2021.
51. Payne E. Missing cancer cases a worrying pandemic trend. *Ottawa Citizen*. <https://ottawacitizen.com/news/local-news/missing-cancer-cases-a-worrying-pandemic-trend>. Published February 4, 2021. Accessed August 23, 2021.
52. Grant K. COVID-19's collateral damage: What happens when Canadians with other illnesses miss out on medical care? *The Globe and Mail*.

- <https://www.theglobeandmail.com/canada/article-covid-19s-collateral-damage-what-happens-when-canadians-with-other/>. Published March 27, 2021. Accessed August 23, 2021.
53. Ontario Council of Hospital Unions, CUPE. *Over-Capacity Hospitals Face 8 Years of Budget Cuts Set out in March Ontario Budget.*; 2021.
  54. D’Mello C. Ontario spent \$466M less on healthcare than planned ahead of COVID-19 pandemic | CTV News. *CTV News*. <https://toronto.ctvnews.ca/ontario-spent-466m-less-on-healthcare-than-planned-ahead-of-covid-19-pandemic-1.5042104>. Published July 28, 2020. Accessed August 19, 2021.
  55. Jones A. Watchdog says Ontario spent \$10.3 billion less than planned during last fiscal year | The Star. *Toronto Star*. <https://www.thestar.com/news/gta/2021/07/21/watchdog-says-ontario-spent-103-billion-less-than-planned-during-last-fiscal-year.html>. Published July 21, 2021. Accessed August 19, 2021.
  56. Ministry of Health. Ontario Launching New \$30 Million Surgical Innovation Fund. Ontario Newsroom. Published June 23, 2021. Accessed August 19, 2021.
  57. The Honourable Peter Bethlenfalvy, Minister of Finance and President of the Treasury Board. *2021 Ontario Budget — Ontario’s Action Plan: Protecting People’s Health and Our Economy*. Ministry of Finance; 2021. Accessed December 8, 2021.
  58. BC Ministry of Health. A Commitment to Surgical Renewal in B.C. Published online May 7, 2020. <https://www2.gov.bc.ca/assets/gov/health/conducting-health-research/surgical-renewal-plan.pdf>
  59. BC Ministry of Health. A Commitment to Surgical Renewal in B.C. Progress Report #15: June-July 2021. Published online September 24, 2021. <https://news.gov.bc.ca/files/surgical-renewal-progress-report-June-July-2021.pdf>
  60. CBC News. Surgery delays on horizon as B.C. COVID-19 cases spike. *CBC News*. <https://www.cbc.ca/news/canada/british-columbia/bc-surgery-delay-covid-19-december-1.6295948> Published December 22, 2021. Accessed January 11, 2022.
  61. Snowdon, W. Alberta surgeries cut back by 2,800 per month in first 15 months of pandemic. *CBC News*. <https://www.cbc.ca/news/canada/edmonton/surgeries-cancelled-covid-alberta-canadian-institute-for-health-information-1.6279893> Published December 9, 2021. Accessed January 11, 2022.
  62. College of Physicians and Surgeons of Alberta. From AHS: Surgical COVID-19 Wave 2 Recovery Plan. <https://cpsa.ca/news/from-ahs-surgical-covid-19-wave-2-recovery-plan/> Published April 8, 2021. Accessed January 11, 2022.
  63. Bennett, D. Alberta says surgery backlog has stabilized at 81,600 following latest COVID outbreak. *The Globe and Mail*. <https://www.theglobeandmail.com/canada/article-alberta-says-surgery-backlog-has-stabilized-at-81600-following-latest/> Published December 9, 2021. Accessed January 11, 2022.
  64. Canadian Press. Canada’s surgery backlog heightens inequities in health care: advocacy group. *Comox Valley Record*. <https://www.comoxvalleyrecord.com/news/canadas-surgery-backlog-heightens-inequities-in-health-care-advocacy-group/> Published December 2, 2021. Accessed January 11, 2022.
  65. Saskatchewan Surgical Initiative. Improved Access to Surgical Care – Progress Update. *Government of Saskatchewan*. N.d. <http://www.sasksurgery.ca/sksi/progressupdate.html>

66. Doctors Manitoba. Surgery & Diagnostic Backlog Dashboard. Published online January 13, 2022. <https://doctorsmanitoba.ca/about-us/advocacy-policy/backlog>
67. Government of Manitoba. News Release: Task Force Established to Address Diagnostic and Surgical Backlogs. Published online December 8, 2021. <https://news.gov.mb.ca/news/index.html?item=52823>
68. Bell B. Will the future of Ontario surgery be private or public? *The Toronto Star*. <https://www.thestar.com/opinion/contributors/2019/03/20/will-the-future-of-ontario-surgery-be-private-or-public.html>. Published March 20, 2019. Accessed August 23, 2021.
69. Munnich EL, Parente ST. Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Aff (Millwood)*. 2014;33(5):764-769. Doi:10.1377/hlthaff.2013.1281
70. MacKinnon J. Learning from the Saskatchewan Surgical Initiative to Improve Wait Times in Canada. *Fraser Inst*. Published online April 2016:50.
71. *Commission on the Reform of Ontario's Public Services*. Ontario Ministry of Finance; 2012:145-202. Accessed December 6, 2021.
72. Statistics Canada. Profile of immigrants in nursing and health care support occupations. Published May 28, 2021. Accessed August 19, 2021.
73. Young L. Facing COVID-19 staffing crunch, some Ontario hospitals offer cash bonuses to new nurses. *Global News*. <https://globalnews.ca/news/7954398/nurse-shortage-signing-bonus/>. Published June 16, 2021. Accessed August 19, 2021.
74. Ministry of Health. Call for Applications to License Independent Health Facilities for the Provision of Cataract Surgeries in Ontario. Published online January 15, 2020.
75. Angus H, Anderson M. Use of Alternate Health Facilities and Temporary Structures such as Field Hospitals and Conference Centres. Published online April 6, 2020.
76. Ontario Executive Council. Order in Council: Appended Regulation under the Emergency Management and Civil Protection Act. Published online April 21, 2021.
77. Kumar P, Parthasarathy R. *Walking out of the Hospital: The Continued Rise of Ambulatory Care and How to Take Advantage of It*. McKinsey; 2020. Accessed August 23, 2021.
78. Peckham A, Rudoler D, Bhatia D, Fakim S, Allin S, Marchildon G. *Accountable Care Organizations and the Canadian Context*. North American Observatory on Health Systems and Policies; 2018.
79. NHS. Clinical commissioning groups (CCGs). NHS. Accessed August 23, 2021.
80. NHS. NHS's £160 million 'accelerator sites' to tackle waiting lists. NHS England. Published May 13, 2021. Accessed August 23, 2021.
81. NHS. *The NHS Long Term Plan*. NHS England; 2019.
82. Day Hospitals Australia. *Day Hospitals: Leading the Recovery Post COVID-19*; 2020.
83. Duckett S. Expanding the breadth of Medicare: learning from Australia. *Health Econ Policy Law*. 2018;13(3-4):344-368. Doi:10.1017/S1744133117000421
84. Aubusson K. Massive wait lists for elective procedures despite operating theatre blitz. *The Sydney Morning Herald*. <https://www.smh.com.au/national/nsw/massive-wait-lists-for-elective-procedures-despite-operating-theatre-blitz-20210316-p57b8o.html>. Published March 17, 2021. Accessed August 23, 2021.

## Appendix 1: Definitions

**Surgeries and procedures:** When discussing surgeries and procedures in this report, the focus is on scheduled surgeries and procedures that can be done safely and effectively on an outpatient basis. This includes minimally invasive diagnostic, therapeutic or biopsy procedures. Appendix 5 includes a robust list of a range of lower-complexity orthopedic, gynecological, urological, plastic and ophthalmologic surgeries and procedures that could be moved to the new Integrated Ambulatory Centre settings outlined in this report.

**Independent health facilities:** Governed by the *Independent Health Facilities Act, 1990* and related College of Physicians and Surgeons of Ontario (CPSO) policies, these facilities mainly provide diagnostic services, including ultrasound, radiology, nuclear medicine and sleep studies. However, for the purpose of this report, the focus is on the smaller portion of independent health facilities (IHF) that have licences to conduct surgical and procedural services, such as ophthalmology, dialysis, abortion and plastic surgery, to name a few. IHFs deliver services at no charge to patients who are covered by the Ontario Health Insurance Plan (OHIP); the Ministry of Health and Long-Term Care pays physicians who work in IHFs a standard professional fee for each service. The ministry also pays facility owners specified amounts for each service to contribute to overhead costs, such as rent, supplies and equipment.

**Out-of-hospital premises:** Governed by regulation 114/94 of the Medicines Act, 1991 and related CPSO policies. Oversight under this act applies to facilities where certain types of anesthesia or sedation are used to perform procedures.” (e.g., plastic and cosmetic surgery, endoscopy and interventional pain management procedures).

**Ambulatory centres:** These centres perform medical services on an outpatient basis without admission to a hospital. They can be for-profit or non-profit. Currently, such centres focus on services for certain high-volume procedures that do not require overnight hospital stays, such as low-risk cataract procedures and colonoscopies. These centres operate under existing legislation and quality assurance frameworks.

**Integrated Ambulatory Centres:** This term reflects the new integrated service delivery model proposed in this report. Such centres would be free-standing and operationally separate from hospitals to achieve the necessary efficiencies, but would partner with hospitals on physician credentialing, quality oversight and funding alignments. This model has the potential to broaden the spectrum of surgeries and procedures that could be performed safely and efficiently on an outpatient basis.

## Appendix 2: Consultation Participants

The views and recommendations in this report are the Ontario Medical Association’s own. However, we would like to thank the following individuals for taking the time to provide insights and advice on how to address the mounting surgical and procedural backlog in Ontario.

ORGANIZATION	NAME	POSITION
ALBERTA MEDICAL ASSOCIATION	Dr. Allan Florizone	Senior advisor, policy and economics
	Dr. Doug Stitch	Senior director, health system transformation
AMERICAN MEDICAL ASSOCIATION	Berardino (Dean) Parisi	Director, international business development
	Sherry Smith	Director, physician payment policy
CADTH	Suzanne McGurn	President and CEO
	Lesley Dunfield	Acting vice-president, medical devices
CLEARPOINT HEALTH	Dr. Chris Cobourn	Chief medical officer
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO	Craig Roxborough	Director of policy
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO	Daniel Faulkner	Former deputy registrar
DOCTORS OF BC	Dr. Sam Bugis	VP, physician affairs and specialist practice
DOCTORS MANITOBA	Dr. Ian Foster	Medical remuneration officer
KENSINGTON HEALTH	John Yip	Former president and CEO

MCMASTER HEALTH FORUM	Dr. John Lavis	Director
ONTARIO HEALTH	Chris Simpson	Past chair, Wait Times Alliance
ONTARIO HEALTH TORONTO REGION	Tess Romain	Former transitional regional lead
ONTARIO HOSPITAL ASSOCIATION	Imtiaz Daniel	Chief, research and analysis
	Melissa Prokopy	Director of legislative, legal and professional issues
ONTARIO MEDICAL ASSOCIATION	Multiple participants	Surgical Assembly and Diagnostic Assemblies and Section on Anesthesiology; Health Policy Committee
ROYAL UNIVERSITY HOSPITAL (SASK.)	Dr. Myong Younghusband	Director of surgical operative care
UNIVERSITY OF TORONTO	Dr. Jim Waddell	Professor, orthopedic surgery
SUNNYBROOK HOSPITAL, HOLLAND CENTRE	Andy Smith	President and CEO
TRILLIUM HEALTH PARTNERS	Karli Farrow	Executive VP and COO
UHN	Kevin Smith	President and CEO
UNIVERSITY OF TORONTO	Dr. Jonathan Irish	Vice-president, clinical, cancer programs, Ontario Health – Cancer Care Ontario
UNIVERSITY OF SASKATOON	Dr. Bill Dust	Professor, orthopedic surgery
WESTERN UNIVERSITY	Dr. Brian Rotenberg	Professor, otolaryngology, advanced surgical operator
WOMEN'S COLLEGE HOSPITAL	Dr. David Urbach	Chief of surgery, director of perioperative services

## Appendix 3: Take-Aways from the Jurisdictional Scan

Table 1: Other countries' strategies to build system capacity

<p><b>United States</b> <i>Embracing ambulatory care models</i></p> <p>In 2020, 75 per cent of hospitals in the U.S. with 200+ beds had more than one ambulatory surgery centre, and low-acuity patients were in ambulatory care settings for 75% of cases.<sup>77</sup> Accountable Care Organizations are groups of health-care providers partnered to deliver more co-ordinated care to patients (with similarities to the Ontario Health Team model). The model was established to allow providers to realize the savings delivered by improvements in care delivery.<sup>78</sup></p>	<p><b>United Kingdom</b> <i>Strategies for effective integration and innovation</i></p> <p>To provide informed resource allocation, Clinical Commissioning Groups are responsible for deciding what services are needed in local areas and for commissioning hospital and community National Health Service (NHS) services.<sup>79</sup> Further, the NHS announced a \$160 million investment to tackle wait lists in March 2021. Indicators suggest that elective activity was already at four-fifths of pre-pandemic levels in April, well ahead of the 70 per cent target.<sup>80</sup> The NHS has also identified boosting out-of-hospital care as a key priority in its long-term plan.<sup>81</sup></p>
<p><b>Australia</b></p> <p>Day hospitals play an essential role in delivering surgical and procedural care in Australia.<sup>82</sup> Better integration and co-operation across providers in the system has afforded Australia additional invaluable flexibility.<sup>83</sup> When COVID-19 prompted the Australian government to partner with the private health sector to increase capacity for elective surgical procedures, “10 times the volume of public scheduled surgeries [were] performed by the private sector compared to the previous year.”<sup>84</sup></p>	



## Appendix 4: Provincial Operating Frameworks, Regulation and Payment Structures

	Ontario	Alberta	British Columbia	Saskatchewan
Legislative framework	<p>In 1990, the <i>Independent Health Facilities Act</i> began permitting the funding of IHFs in the provincial health insurance program. In 2017, that act was repealed by the <i>Oversight of Health Facilities and Devices Act</i> (part of the <i>Strengthening Quality and Accountability for Patients Act, 2017</i>), but the latter has still not been proclaimed.</p>	<p>Since 2000, the <i>Health Care Protection Act</i> has permitted the funding of non-hospital surgical facilities in the provincial health insurance program; however, it explicitly forbids private hospital ownership.</p>	<p>In 1999, Lions Gate Hospital contracted an eye centre for insured cataract surgery, and the model remains today. The <i>Health Professions Act</i> requires that the College of Physicians and Surgeons of BC establish, maintain and enforce bylaws that regulate non-hospital medical and surgical facilities.</p>	<p>Since 1999, the <i>Health Facilities Licensing Act</i> has permitted the funding of non-hospital health facilities in the provincial health insurance program; however, there was no activity in this sector until the Saskatchewan Surgical Initiative in 2012.</p>
Accreditation	<p>The Ministry of Health and Long-Term Care issues the licenses, but the College of Physicians and Surgeons of Ontario maintains the standards and performs the inspections.</p>	<p>Accreditation is the responsibility of the Medical Facility Accreditation Committee of the College of Physicians &amp; Surgeons of Alberta.</p>	<p>The Non-Hospital Medical and Surgical Facilities Accreditation Program, managed by the College of Physicians and Surgeons of BC, is responsible for all accreditation decisions.</p>	<p>The College of Physicians of Saskatchewan has adopted the Non-Hospital Surgical Facilities Standards &amp; Guidelines set out by the College of Physicians &amp; Surgeons of Alberta.</p>

Facility funding	Contracts include a facility fee to cover overhead costs and non-physician staffing.	Contracts include a facility fee to cover overhead costs and non-physician staffing. Fees vary by procedure.	Contracts include an undisclosed facility fee to cover the overhead or indirect costs of providing insured services in a non-hospital setting, excluding physician costs.	Contracts include an undisclosed facility fee to cover overhead costs and non-physician staffing.
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Note: This information is taken from the North American Observatory on Health Systems and Policies, *Rapid Review: Public Management and Regulation of Contracted Health Services*.<sup>2</sup>

## Appendix 5: Surgical Procedures That Can Potentially Be Moved to Specialty Centres

This section provides examples of procedures that can potentially be performed in ambulatory centres. OMA member physicians identified these procedures through a survey in spring 2021. Physicians stated that a variety of less invasive surgical procedures can be done safely on an outpatient basis in a clinic affiliated with a hospital. A patient's medical history and the advice of the surgeon and anesthesiologist or other physician are important in determining whether the procedure is best performed on an outpatient or inpatient basis.

The list below is intended as an illustrative example. Further validation of procedures and consideration of several important factors will be necessary to make decisions about the most appropriate setting. These factors include: the qualifications and experience of the teams performing the procedures; patients' medical status (such as comorbid conditions); the infrastructure of the setting; the clinic's affiliation with hospital and access to emergency department resources; and the availability of post-operative nursing support at home.

**Examples of surgical procedures that can potentially be performed (or performed to a larger extent) in specialty centres affiliated with hospitals include:**

- **Dermatologic procedures**, such as blepharoplasty, Moh's micrographic surgery
- **General surgery**, such as endoscopy, colonoscopy, simple mastectomy, segmental resection of breast, sentinel node biopsy, hernia repair, varicose vein procedures, thyroidectomy

- **Gynecologic procedures**, such as endometrial ablation, therapeutic abortion
- **Ophthalmologic procedures**, such as cataract surgery, corneal cross-linking, corneal transplant, glaucoma surgery, retina surgery
- **Orthopaedic procedures**, such as repair and reconstruction of ligaments, meniscal repair, amputation, arthrodesis, arthroplasties, osteotomies, and tendon, muscle and joint repairs (note: in Ontario, hip and knee replacements are increasingly done on an outpatient basis, and may be appropriate for delivery within hospital-affiliated ambulatory centres in the future)
- **Podiatric procedures**, such as amputation, arthrodesis, arthroplasty, fracture and dislocation repairs, and neoplasms
- **Plastic surgery**, such as grafts, flaps, tissue expansion, lipectomy, excision of deep tumours, repair of the eyelid, nose, breast and more
- **Otolaryngologic procedures**, such as nasal and sinus surgery, thyroid and parotid surgery, and treatment of facial skin cancer