The Core Service Role of Small Hospitals in Ontario
Phase Two: Recommended Core Services

Report prepared by the Multi-Site/Small Hospitals Advisory Group of the JPPC for the Ontario Ministry of Health and Long-term Care

October 18, 2006
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1.0 Executive Summary

The Ministry of Health and Long-Term Care (MOHLTC) had asked the Joint Policy and Planning Committee (JPPC) to convene a joint Multi-Site/Small Hospitals Advisory Group to create a forum for focused discussion on the role of small hospitals and to provide feedback to the MOHLTC.

The Advisory Group began its deliberations by exploring the existing service utilization (i.e., to examine the current types of “core” services) provided by small hospitals. This exploration culminated in the report The Core Service Role of Small Hospitals in Ontario – Phase One: An Exploration of the Current Services.

The Advisory Group used the work of Phase One as background analysis to discuss the core services that small hospitals can be expected to provide to their communities. The Advisory Group’s recommendations are the following:

1. The basic core service role of all Ontario hospitals, both very small (<1,500 weighted cases) and small (1,500 to 3,999 weighted cases), consists of the following:
   - An Emergency Department prepared to provide care, or stabilize and transfer, medical, surgical and mental health patients entering via the ED;
   - Acute Care Inpatient Medical Beds;
   - General Practitioners/Family Physicians supported by broadly-trained Nurses;
   - Inpatient Allied Health Services, such as Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology and Pharmacy, tailored to meet the specific needs of the population being served; and
   - Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology.

2. The additional core service role for the group of relatively larger small hospitals (1,500 to 3,999 weighted cases) includes the following:
   - Physician specialty of General Internal Medicine;
   - General Surgery and Day Surgery;
   - Physician specialty of General Surgery (with anaesthesia support);
   - Obstetrics; and
   - Special care units.
The Advisory Group considered the Multi-Site corporations that were part of this analysis as equivalent to the single site small hospitals with greater than 1500 weighted cases.

- The corporation as a whole would be expected to provide the same core set of services to its catchment population as any of the single site small hospitals; this does not require every site within a corporation to provide the same complement of core services. Rather, the multi-site hospital should ensure that these services are reasonably accessible to its catchment population.

3. The identification of additional site-specific core services to be provided in any given facility will require extensive discussion and consideration of the unique position of individual facilities, the available evidence in the context of LHIN planning and the services provided by others in the catchment population.

- These include ambulatory clinics and outpatient allied health services tailored to meet the specific needs of the population being served.

The Advisory Group feels that the exploration of future opportunities for small and rural hospitals is an essential third phase of work, completing this Phase Two report, which defines core services. Defining core services provides a foundation on which to build, but does not consider the future opportunities for small and rural hospitals and their potential role as part of the larger healthcare system. The Advisory Group, therefore, has agreed to extend its work into a third phase, which will begin this exploration of future opportunities.
2.0 Background and Objectives

Subsequent to the work of the Joint Policy and Planning Committee (JPPC) on the development of a funding policy related to multi-site hospitals, the Ministry of Health and Long-Term Care (MOHLTC) had asked the JPPC to continue its work by identifying the unique role of small, rural sites within multi-site hospital corporations. In preparation for this work, the JPPC and the Ontario Hospital Association (OHA) agreed that it was prudent to expand the exploration to include all small hospitals, regardless of corporate configuration. Hence, the JPPC and OHA convened a joint Multi-Site/Small Hospitals Advisory Group to create a forum for focused discussion on the role of small hospitals and to provide feedback to the MOHLTC.

The Advisory Group began its deliberations by exploring the existing service utilization (i.e., to examine the current types of “core” services) provided by small hospitals. This exploration culminated in the report *The Core Service Role of Small Hospitals in Ontario – Phase One: An Exploration of the Current Services*.

This second report builds on this work and provides rationale for the recommended core services of small hospitals and begins the discussion of the potential future role of small hospitals in Ontario.

2.1 Objectives

The Advisory Group used the work of Phase One as background analysis to discuss the core services that small hospitals can be expected to provide to their communities.

Based on the deliberations of the Advisory Group and its exploration of Core Services, this report:

- provides a summary of the recommended basic core service role of all small hospitals in Ontario;
- the additional core service role for the group of relatively larger small hospitals;
- identifies a number of site-specific core services that are currently common to many, but not all, small hospitals in the province, which will require explicit consideration when planning the services for a particular catchment population; and
- begins to discuss the third phase of this work: the future potential core service role for small hospitals.
3.0 The Core Services of Small Hospitals

When planning small hospital services, the Advisory Group agrees with the conclusion of the Working Group involved in the Joint OHA/MOH LTC Review of the Implementation of the Rural and Northern Health Care Framework that:

“The primary focus ... should be on population needs-based planning to determine how and where hospital services should be delivered.”

However, it is important to recognize that population need for care is very difficult to determine and even more difficult to measure. Further, small hospitals in Ontario are challenged with maintaining access to health services in the midst of organizational restructuring, consolidation of health and hospital services, primary care reform, continued calls for efficient delivery of health services, increasing demands / requirements for network and referral structures, rising expectations for local access to care, increasing accountability requirements and ever-present fiscal pressures.

As a pragmatic response to these challenges, this report takes the perspective that population need for care, and the sustainability of small hospitals, is best addressed by ensuring that all hospitals provide their catchment population with a core of hospital services. The identification of these core services is not intended to define all of the services to be provided by a given facility. Rather, the Advisory Group is presenting the basic core services as a minimum set of services that are generally necessary in all facilities designated as a hospital in Ontario (see Section 3.2).

There are also other core hospital services that have been identified for small, but not very small, hospitals to which all Ontarians should have access. These core services are appropriate to be provided by small hospitals, regardless of current capacity/availability to do so, but not necessarily by all small hospitals/sites, within a particular catchment area (see Section 3.3).

In addition to the above core hospital services, there are other appropriate services that could be provided by some small and very small hospitals. The identification of these site-specific core services will require extensive discussion and consideration of the unique position of individual facilities, the available evidence in the context of LHIN planning and the services provided by other providers serving the catchment area. In particular, the overall role of each small hospital...
should be defined through a collaborative community planning process that explicitly considers the following:

- The population need for care as defined through the LHIN planning process;
- Access to the particular service by the catchment population, including consideration of the isolation of the population being served, and the complete range of services available to the catchment population;
- The capacity to provide the service; and
- Available evidence on sustainable volumes, quality of care, and patient safety (see Section 4).

3.1 Identifying Small Hospitals

In identifying the core role of small hospitals, the first challenge becomes the definition of the ‘small’ hospital. This issue and the unique role of small hospitals in relation to their larger counterparts is a topic that has received a great deal of attention in the literature and in policy discussions throughout Canada. Typically, the definitional issues focus on isolation, geographic location, and urban vs. rural catchment populations rather than strictly hospital ‘size’.

The determination of hospital size used by the Advisory Group was based on inpatient weighted cases as follows:

- Very Small: < 1,500 Weighted Cases (61 sites)
- Small: 1,500 to 3,999 Weighted Cases (30 sites)

The Advisory Group also discussed the definitions of rural and isolation extensively. Hospital ‘isolation’ has become an explicit policy consideration in provinces such as British Columbia and Newfoundland; it has also been a topic of some discussion in funding policy discussions in Ontario. Much of the literature on rural health care and the role of the small hospital focus on issues of access, sustainability and difficulties in recruiting and retaining health professionals. The literature argues that the concept of rural is perhaps best seen as a spectrum encompassing not only characteristics such as population size and density, but also geographic and professional isolation and support, and increasingly such characteristics as working conditions and community and lifestyle factors.

"Ultimately, the choice of the regional unit of analysis, and the choice of how to describe the region’s rurality, is arbitrary" (Chan and Barer, 2000). Following the discussions of the Advisory Group, for purposes of the descriptive analyses, it was determined that the appropriate label should
be ‘isolation’ rather than rural. Throughout the exploration of core services, the Advisory Group identified driving time to closest non-small hospital as the appropriate measure of isolation. For most of the analyses, the driving time was treated as a continuous variable, thus avoiding the challenge of having to label each hospital as either isolated or not isolated.

3.2 Basic Core Services for All Ontario Hospitals (Very Small and Small)

The exploration of Core Services undertaken by the Advisory Group is consistent with prior analysis that has suggested that the activity of small hospitals is focused largely on medical services. This is particularly true for the smallest hospitals. Beyond this strictly medical focus, however, the analysis and review of the literature suggests an increasing requirement for small hospitals to consider more diversified services through linkages with other providers (Moscovice et al., 2002; Christianson et al., 1998; Moscovice et al., 1997). This is often identified as a requirement as small and rural hospitals cannot take advantage of economies of scale, economies of scope and specialization to the same extent as their larger, typically urban, counterparts (Martens, 2000; Kamien, 2004); providing more diversified services through such linkages allows all healthcare providers in smaller communities to share the necessary infrastructure and support services.

In this context, the Advisory Group has identified the following basic core services to be provided by all hospitals in Ontario:

- An Emergency Department; Emergency departments must be prepared to provide care, or stabilize and transfer, medical, surgical and mental health patients entering via the ED;
- Acute Care Inpatient Medical Beds;
- General Practitioners/ Family Physicians supported by broadly-trained Nurses;
- Inpatient Allied Health Services, such as Physiotherapy, Clinical Nutrition, Occupational Therapy, Respiratory Therapy, Speech Pathology and Pharmacy, tailored to meet the specific needs of the population being served; and
- Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology.
3.2.1 Emergency Services

Essentially all acute small hospital corporations in Ontario provide emergency services. The emergency department (ED) provides a significant core service to the communities served by small hospitals while it is also an important core function of small hospitals. Currently, between 61% and 73% of all admissions to small hospitals in Ontario occur through the emergency department.

Further, the emergency departments of small hospitals support the primary care and ambulatory clinic activities of the small hospitals. Between 23% and 32% of the visits to the EDs of small hospitals are considered non-urgent as compared to between 5% and 11% in the larger facilities. Further, small hospitals are more likely to use the infrastructure associated with an ED to support other ambulatory activity: between 2% and 4% of small hospital EDs visits are scheduled visits; the larger hospital facilities have essentially no scheduled visits to the ED. This finding has strong implications for considering the primary care role that small hospitals may provide for their communities, in conjunction to and/or integrated with local Family Health Teams.

Exhibit 3.1 ED visit distribution by Triage level by hospital size (excluding scheduled visits)

<table>
<thead>
<tr>
<th>Hospital Size</th>
<th>% of Emergency Visits by Triage Level</th>
<th>% of Patients Admitted by Triage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Small</td>
<td>0.2%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Small</td>
<td>0.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Medium</td>
<td>0.4%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Large</td>
<td>0.6%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Teaching</td>
<td>0.8%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Total</td>
<td>0.5%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

The Advisory Group felt that public and community expectations of the ‘hospital’ designation should coincide with the ability to deliver emergency services.

The Advisory Group also discussed the role of emergency services in relation to the need for standard community expectations. The Advisory Group felt that public and community expectations of the ‘hospital’ designation should coincide with the ability to deliver emergency services. In most instances, particularly where distance is an issue, this will be on a 24 hours/day, 7 days/week basis. At a minimum,

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1 While all hospital corporations provide emergency services, there are a few instances where not every hospital site within multi-site hospital corporations provide ER services.
emergency departments must be prepared to provide care, or stabilize and transfer, medical and mental health patients entering via the ED. This assumes the availability of inpatient medical beds.

Despite the human resource challenges associated with maintaining an emergency service, it is an essential component of the infrastructure of all hospitals. It necessarily includes the ability, to diagnose, stabilize and accommodate a patient for observation. It therefore includes, at a minimum:

- Physician availability/ on-call;
- Staff trained in Advanced Cardiac Life Support (ACLS);
- Electrocardiogram testing and monitoring;
- Availability of Laboratory testing;
- General Diagnostic Radiography; and
- Ultrasound.

### 3.2.2 Acute Care Inpatient Medical Beds

Currently every hospital identified in this project has MOHLTC-designated acute care inpatient beds, ranging from three to seventy-five beds\(^2\) per hospital. The availability of a complete emergency service requires the ability to admit patients. An inpatient bed complement is, therefore, an essential core service of any hospital.

The number of ‘beds’ in a facility is now seldom used for planning purposes. The definition of an ‘inpatient bed’ varies widely while a common understanding of a bed that is ‘staffed and in operation’ remains elusive. Bed count was formerly an accepted measure of the size and capacity of an inpatient facility; ‘inpatient weighted cases’ is now the more typically accepted measure. This has appropriately reduced the emphasis on ‘bed count’.

In part this reflects the necessity, of particularly small hospitals, to have an ability to adjust their bed capacity to meet specific needs. For example, many rural hospitals require additional inpatient capacity in summer months as their demand for services grows with an increasing seasonal and tourist populations. Similarly, fluctuations in weekend demand, the visit of an itinerant surgeon, a holiday weekend or regular scheduled plant shutdown may require the ability to expand or reduce staffing patterns to meet demand for services. Such fluctuations make it difficult to determine ‘bed size’.

\(^2\) Based upon reported beds staffed and in operation as of December 2004.
The actual number of beds, however, is not the significant point. The ability to admit a patient for observation and care is the necessary essential service.

### 3.2.3 General Practitioners /Family Physicians

The work of the Advisory Group has demonstrated that the General Practitioner/Family Physician (GP/FP) is the Most Responsible Physician (MRP) for most small hospital inpatient cases. Physician services are essential for the provision of hospital services, particularly as necessary support for inpatient care. The work of the Advisory Group was consistent with previous analysis that demonstrates that small hospitals provide a high proportion of care in the areas of general medicine, cardiology, pulmonary, rheumatology, endocrinology and gastro/hepatobiliary. And while the availability of General Internal Medicine or sub-specialists for these patients in very small hospitals is unrealistic from a volume and recruitment perspective, the availability of broadly experienced General Practitioners is a core requirement in all small hospitals.

To meet their community’s need for care, small hospitals are typically required to sustain a broader scope of practice by their physicians. This is confounded by difficulties in accessing specialists, sufficient support staff, and appropriate medical equipment (Kamien, 2004; Martens, 2000; Chan and Barer, 2000; Hampton, 1998; Kingsmill, 1997). In this context recruitment of health professionals is also a serious and steady challenge: “work conditions in under serviced areas are a major issue, as the experience in these communities is characterized by heavy workload, burnout, and professional isolation” (Chan & Barer, 2000).

While the broadly experienced GP/FP is foundational to the provision of service in small hospitals; it is also true that small hospitals can play a key role in providing support to the General Practitioners/Family Physicians within the community. This relationship between these physicians and hospitals can foster increased support for core inpatient medical services, primary care initiatives such as Family Health Teams, and enhanced recruitment for in-hospital physician and broadly-trained nursing care.

### 3.2.4 Inpatient Allied Health services tailored to meet the specific needs of the population being served

A large majority of hospitals report Physiotherapy, Occupational Therapy, Respiratory Therapy and Clinical Nutrition activity, however the level of this activity varies greatly. For example, more detailed analysis based on
expenditures has demonstrated that some of the small hospitals provide only part time OT coverage while others may provide several full-time equivalents. A summary of the available data is presented in exhibit 3.2.

Exhibit 3.2 Percentage of Hospitals Reporting In-House Workload for Allied Health Functional Centres

<table>
<thead>
<tr>
<th>Allied Health Service</th>
<th>Very Small</th>
<th>Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Clinical Nutrition</td>
<td>80%</td>
<td>79%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>41%</td>
<td>79%</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>39%</td>
<td>71%</td>
</tr>
</tbody>
</table>

These services are considered to be necessary to support inpatient core services. The particular type and level of service required will depend upon the specific medical needs of the patients being cared for within a facility. The Advisory Group has identified Allied Health Services tailored to the needs of the catchment population being served as basic core services to be provided by all hospitals in Ontario. Appropriate Allied Health Services may include Physiotherapy, Clinical Nutrition, Occupational Therapy, Speech Therapy, Pharmacy and Respiratory Therapy.

3.2.5 Laboratory, Ultrasound, General Radiography and Non-invasive Cardiology

The exploratory analysis undertaken by the Advisory Group was limited in a number of aspects by the data available. For example, information on diagnostic and therapeutic activity was available only through the hospital MIS submissions. This data was used to identify the range of procedures and allied health services provided in each hospital. The MIS data is reported at a corporate level and therefore the analysis was limited to single site hospitals, since data for all of the sites of multi-site organizations are reported together.

Further, the data provides few details as to the nature and extent of the services available. We observe, for example, that very few small hospitals report laboratory data by lab section. We were unable to determine whether the use of the “lab combined functions” functional centre implied that individual lab services were not available, or whether a hospital simply opted to report at the combined level. Further, while most facilities reported non-invasive cardiology activity, details of the level of diagnostic activity (echo, stress test, ECG, Holter, etc.) was not available.

The Advisory Group recognized the important role of diagnostic activity in supporting basic inpatient and emergency department activity.
Exhibit 3.3 Percentage of Hospitals Reporting In-House Workload for Diagnostic Functional Centres

<table>
<thead>
<tr>
<th>Diagnostic Health Service</th>
<th>Very Small</th>
<th>Small</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Radiography</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>66%</td>
<td>71%</td>
</tr>
<tr>
<td>Mammography</td>
<td>34%</td>
<td>71%</td>
</tr>
<tr>
<td>Diagnostic Imaging Gen’l.</td>
<td>66%</td>
<td>54%</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>CT</td>
<td>14%</td>
<td>25%</td>
</tr>
<tr>
<td>Electrodiagnostic</td>
<td>9%</td>
<td>21%</td>
</tr>
<tr>
<td>Interventional/Angiography</td>
<td>2%</td>
<td>8%</td>
</tr>
<tr>
<td>MRI</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Recognizing the important role of diagnostic activity in supporting basic inpatient and emergency department activity, the Advisory Group in their deliberations has determined that all hospitals in the province should, at a minimum, provide the following core services:

- Electrocardiogram testing and monitoring;
- Laboratory services including Biochemistry, Haematology and Specimen collection activities; General Diagnostic Radiography; and
- Ultrasound.

### 3.3 Additional Core Services for Small Hospitals ( > 1500 Weighted Cases)

#### 3.3.1 Multi-Site Facilities

Typically, the multi-site corporations that have been included in this study have an aggregate volume, when all sites are considered, of greater than 1500 weighted cases. For the purposes of this report, the Advisory Group has considered these corporations as equivalent to the single site small hospitals with greater than 1500 weighted cases. The corporation as a whole would be expected to provide the same core set of services to its catchment population as any of the
single site small hospitals; this does not require every site within a corporation to provide the same complement of core services. Rather, the multi-site hospital should ensure that these services are available to its catchment area.

3.3.2 **Physician specialty of General Internal Medicine;**

Internal medicine specialists are not available in all small hospital facilities; however the case mix of small hospitals suggests a large demand for this specialty. It is observed that 53% of small hospitals over 1,500 weighted cases have Internists acting MRP (and 67 percent have Internists as procedural physician). The work of the Advisory Group, and previous analysis, demonstrates that small hospitals provide a high proportion of care in the areas of general medicine, cardiology, pulmonary, rheumatology, endocrinology and gastro/hepatobiliary. And while the availability of subspecialists for these patients is likely unrealistic from a volume and recruitment perspective, general internal medicine should be a core requirement for this large proportion of care in small hospitals, in support of the General Practitioner/Family Physician coverage of inpatient medical services. The Advisory Group recommends that, as hospital inpatient volumes increase beyond 1,500 weighted cases, consideration be given to how that support can be made available.

3.3.3 **General Surgery and day surgery in Small Hospitals**

The work of the Advisory Group suggests that surgical services, both inpatient and ambulatory, are a core activity of Small Hospitals with greater than 1,500 weighted cases. In fact, all Small hospitals above 1,500 weighted cases currently provide both inpatient and ambulatory surgery. This is true of both Small hospitals in Ontario and in other Provinces. Among the Very Small Hospitals (those with less than 1,500 weighted cases) only 42% provide surgical services. Further, it is the least isolated of the very small hospitals that provide this service. It is unlikely that this lack of surgical service in isolated Very Small hospitals arises from an explicit decision. Rather, in line with the literature on the topic, this lack of surgery provision is likely more related to professional isolation and difficulties in recruitment.

Many of the very small hospitals that do provide surgical services are able to do so through linkages with larger facilities and through the establishment of visiting or itinerant surgical programs. Many of the very small hospitals that do provide surgical services are able to do so through linkages with larger facilities and through the establishment of visiting or itinerant surgical programs. Such programs are increasingly common in Ontario and have been adopted in a number of rural and isolated communities in Ontario. The literature reports that visiting surgical services in rural communities can achieve outcomes comparable to urban hospitals (Hughes-Anderson et
al., 2003). Such a model may help explain why small hospitals account for a large proportion of care in the Orthopaedic Program Cluster Category.

While CIHI data does not support analysis of the anaesthesia role in small hospitals (GP anaesthetists vs. anaesthetists), anaesthesia capacity is clearly required in small hospitals to support General Surgery. The observation that the small hospitals have limited availability of specialist and sub-specialist physicians is consistent with the substantial literature on the issue (Iglesias & Jones, 2002; Chan & Barer, 2000; Iglesias et al., 1999; Rourke, 1998; Rourke, 1991).

3.3.4 Physician specialty of General Surgery (with anaesthesia support)

The availability of General Surgeons acting as Most Responsible Physician coincides with the availability of surgical services. The specialty of general surgery should be available in all Ontario hospitals that provide surgical services. While CIHI data does not support analysis of the anaesthesia role in small hospitals (GP anaesthetists vs. anaesthetists), anaesthesia capacity is clearly required in small hospitals to support General Surgery.

3.3.5 Obstetrics for Small Ontario hospitals

In its work, the Advisory Group observed that 83% of small hospitals in Ontario with greater than 1,500 weighted case provide obstetrics services. Further, the provision of obstetrics services is also linked to the isolation of facilities: 100% of small hospitals greater than 1,500 weighted cases that are more than an hour driving time from the closest non-small hospital provide obstetrics services.

The definition used in the analysis for ‘Isolation’ is focused on the closest non-small hospital. Clearly for some small hospitals, the closest hospital will be another small hospital. In these situations, small hospitals may jointly agree to focus obstetrics in just one of the two hospitals to increase critical mass, even though they are not formally within a multi-site organization. This appears to be the case for some of the very small hospitals that, despite some extreme driving distances, provide no obstetrical volume.

A key concern is the distance that a patient must travel to receive obstetrical care. All stakeholders in the planning

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In previous work, the ambulatory survey of 84 small hospital sites (83% response rate), reported that 66 percent of those hospitals surveyed had GP Anaesthetists available.
The Advisory Group has observed that 97% percent of the small hospitals in Ontario with greater than 1,500 weighted cases report Special Care Unit days while 87% percent of such hospitals report at least 1 ventilated case. While prolonged capability to provide this level of support is unlikely sustainable in a majority of small hospitals, the capability to provide such services on an urgent / emergent basis should be considered.

The reporting of special care unit days, however, is not standardized. The reporting of special care unit days suggests only a level of care different from a standard inpatient medical bed, but does not suggest, for example, the ability or capacity to provide Intensive Care with 24/7 staffing and monitoring on a regular basis. Some level of special care, however, should be available in small hospitals, given sufficient volumes to allow for staffing efficiencies. The high demand for cardiology services, for example, suggests that small hospitals have the ability to provide cardiac monitoring for diagnosis and assessment.

Further, the ability to provide temporary ventilation is an essential component of support required to provide a complete emergency service. Similarly, temporary ventilation may be required for some patients for a period of time post-operatively. It is appropriate, therefore, for small hospitals to have the capacity to provide temporary ventilation in situations when a ventilated patient cannot be immediately transferred due to unavailable ventilation beds at other hospitals or weather constraints; in emergent situations to ensure that patients can be appropriately stabilized and transferred; or post-operatively for otherwise stable patients who may be at risk during transport.
4.0 Additional Site-Specific Core Services

As a starting point, the work of the Advisory Group had identified a number of services that are currently common to many, but not all, small hospitals in the Province. These services will require explicit consideration when planning the services in small hospital facilities.

- Other Ambulatory Care Clinics; and
- Outpatient Allied Health Services.

4.1.1 Ambulatory clinic services tailored to meet the specific needs of the population being served

Ambulatory general and specialty clinics are currently provided by a majority of small hospitals in Ontario. Unfortunately, the reporting of this activity provides few details regarding the specific types of clinic activities. HAPS data provides information on 32 hospitals reporting ambulatory clinic activity; notably, 6 hospitals accounted for greater than 50% of all visits. The clinic types reported in this format included medical, surgical, combined medical surgical, family practice, mental health and private clinics.

OHA also provided MIS ambulatory clinic visit volumes by clinic type for small hospitals for 2004/05. This data is reported at corporation (not site) level, so analysis restricted to single site small hospitals. In total we had available MIS data from 57 single site hospitals; 6 hospitals reported no ambulatory clinic visits. The data is summarized in exhibit 4.1.
Exhibit 4.1 Small Hospital Ambulatory Clinic Visits by Clinic Type (MIS Data)

<table>
<thead>
<tr>
<th>Revised Visit Type</th>
<th>Total</th>
<th># Hospitals Reporting</th>
<th>% of Hospitals Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>107,882</td>
<td>45</td>
<td>78.9%</td>
</tr>
<tr>
<td>Surgical</td>
<td>55,180</td>
<td>33</td>
<td>57.9%</td>
</tr>
<tr>
<td>Family Practice</td>
<td>22,075</td>
<td>7</td>
<td>12.3%</td>
</tr>
<tr>
<td>Metabolic</td>
<td>17,900</td>
<td>16</td>
<td>28.1%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>17,205</td>
<td>20</td>
<td>35.1%</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>13,185</td>
<td>24</td>
<td>42.1%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>12,893</td>
<td>10</td>
<td>17.5%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>12,566</td>
<td>15</td>
<td>26.3%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>12,551</td>
<td>22</td>
<td>38.6%</td>
</tr>
<tr>
<td>Opthomology</td>
<td>9,172</td>
<td>13</td>
<td>22.8%</td>
</tr>
<tr>
<td>Oncology</td>
<td>5,625</td>
<td>9</td>
<td>15.8%</td>
</tr>
<tr>
<td>Neurology</td>
<td>4,176</td>
<td>10</td>
<td>17.5%</td>
</tr>
<tr>
<td>Paediatric</td>
<td>4,114</td>
<td>18</td>
<td>31.6%</td>
</tr>
<tr>
<td>Plastics</td>
<td>3,702</td>
<td>8</td>
<td>14.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>3,589</td>
<td>10</td>
<td>17.5%</td>
</tr>
<tr>
<td>Geriatric</td>
<td>2,115</td>
<td>8</td>
<td>14.0%</td>
</tr>
<tr>
<td>Combined</td>
<td>1,329</td>
<td>3</td>
<td>5.3%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>655</td>
<td>3</td>
<td>5.3%</td>
</tr>
<tr>
<td>Rehab</td>
<td>380</td>
<td>2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>306,314</td>
<td>51</td>
<td>89.5%</td>
</tr>
</tbody>
</table>

While a wide variety of clinics are reported, the specific types of clinics vary significantly. The ambulatory clinics available as a component of hospital services need to be considered in the context of community needs and the availability of community services.

4.1.2 Outpatient Allied Health services tailored to meet the specific needs of the population being served.

Planning should take into account the specific ambulatory clinics being provided by the local hospital as well as those services available in the community and through primary care providers. The level of outpatient Allied Health Support required in a community will vary – planning should take into account the specific ambulatory clinics being provided by the local hospital as well as those services available in the community and through primary care providers. Linkages with other such providers may offer small communities the ability to share such resources among and between providers. This should be an explicit consideration in the planning process.

The current level of activity associated with allied health services is difficult to ascertain from the available data. Currently a majority of hospitals report Physiotherapy, Occupational Therapy and Clinical Nutrition activity, however, the level of this activity varies greatly. For example, more detailed analysis based on expenditures has demonstrated that some of the small hospitals provide only part time OT coverage while others may provide several full-time equivalents. The requirements for these services in the hospital facilities need to be considered in the context of community needs and the availability of community services.
The Advisory Group began its deliberations by exploring the existing service utilization (i.e., to examine the current types of “core” services) provided by small hospitals. This exploration culminated in the report *The Core Service Role of Small Hospitals in Ontario – Phase One: An Exploration of the Current Services*. The Advisory Group used the work of Phase One as background analysis to discuss the core services that small hospitals can be expected to provide to their communities. This current report, which defines core services, represents the completion of Phase Two.

The Advisory Group feels that the exploration of future opportunities for small and rural hospitals is an essential third phase of work. Defining core services provides a foundation on which to build, but does not consider the future opportunities for small and rural hospitals and their potential role as part of the larger healthcare system. The Advisory Group, therefore, has agreed to extend its work into a third phase, and has begun this exploration of future opportunities.

The future challenge (and opportunity) for small and rural hospitals is not simply improving access to health care, but also improving health (Government of Canada, 2002). The Society of Rural Physicians of Canada have repeatedly emphasized that “geography is a determinant of health” (Konkin et al., 2004). The Romanow report has also recognized this notion citing information on disparities in health between urban and rural populations. The Commission reports that people in rural and remote communities have poorer health status than Canadians who live in larger centres. Among other indicators, the commission notes that life expectancy for people in predominantly rural regions is less than the Canadian average while disability rates are higher in smaller communities (Government of Canada, 2002).

The academic literature concurs with these observations and has further noted that this is particularly true among the elderly. Compared to urban older adults, rural older adults have a lower life expectancy by one year, greater proportions of old-old seniors (over the age of 85 years), lower income, less education, higher levels of impairment in some basic activities of daily living, lack of formal services such as hospitals, home care, physicians and other health care providers, and greater distances to travel to access health services (Forbes et al., 2004).
The Advisory Group has chosen to begin to address such challenges through the identification of core services. This approach has been advocated by the Romanow commission through its suggestion that rural health care planning should consider a basic core of services for different types of rural communities. The commission emphasizes that this approach would clearly distinguish between the core services that would be available to people in their own communities and the services they would have to access from other centres. With the caution that there is no consensus on what constitutes adequate access and what services are most important for people to be able to access, a process involving all stakeholders should attempt to identify and agree upon the core services to be available in each community or region (Government of Canada, 2002).

Two points in these comments from the commission are worth emphasizing: ‘different core services for different types of rural communities’; and ‘core services available to communities or regions’.

The notion that a basic core of services may be different for different types of rural communities is key. This highlights the importance of recognizing that rural Canada is not a single, homogeneous population. The notion that core services should be available to communities or regions emphasizes the fact that not all individual institutions need to provide all core services. The emphasis is on access to services by the population, not on provision of the service by institutions. The Advisory Group has recognized this diversity and the need to identify core services appropriate to the unique characteristics of the catchment population by emphasizing that the core service approach is an approach to addressing community needs as opposed to institutional requirements.

Combined, these notions recognize that no single strategy is appropriate for all communities. Both the health needs and the way in which they should be addressed will vary for different communities. As with many other issues in health care, there is no “one size fits all” solution. Planning for health services must take into account the diverse health needs and different circumstances of different communities.

As with the identification of core services, the future of the small and rural hospital will reflect the diversity of the communities being served. The future will require extensive discussion and consideration of the unique position of individual facilities, the needs of the catchment population and the available evidence in the context of LHIN planning as well as the services provided by others in the community and for the population.
The planning environment is challenging beyond the difficulties in identifying community need. Small and rural hospitals in Ontario are required to maintain access to health services in the face of numerous challenges:

- The trend towards increased specialization & consolidation of health and hospital services;
- Distances between patients, providers and facilities;
- Continued competition for scarce resources and fiscal pressures;
- Recruitment (scarcity) of health Human resources;
- The demographics of rural populations;
- Rising expectations for local access to care; and
- Sustainable economies of scale and scope.

The system is also experiencing a shift in the locus of care from inpatient to outpatient settings. Further, the planning emphasis is increasingly focused on the larger health care system and placing less emphasis on the hospital as the system.

These trends do not affect urban and rural institutions in the same manner. Current trends towards increasing specialization in skills and training to meet the needs of “high-tech” and research-intensive medicine, largely apparent in larger centres, is very different in small and rural communities. Larger hospitals in urban centres have a greater ability to focus activities and to define their role as providers of specialized acute services. The pressure in rural communities requires an entirely opposite approach. Rural hospitals have a need for a different kind of “specialization”: a specialization in delivering comprehensive primary and secondary care. The President of the Society of Rural Physicians of Canada has called rural practice ‘the last bastion of true generalism’ (Larsen Soles, 2006). Larsen Soles has noted that as access to specialists becomes more problematic, being self-sufficient is an advantage that avoids the need for endless referrals for basic primary and secondary medical services and promotes the continuity of care.

The necessity for such self-sufficiency also presents an educational opportunity for small hospitals. Teaching in the small hospital setting may help address some of the human resource shortages by training new practitioners in rural settings and ultimately encouraging them to establish rural practices. “The reputation of rural practice is becoming stronger within the academic community, as the benefits of rural programs for training medical students and residents are becoming evident and as distributed learning models become more prevalent” (Larsen Soles, 2006).
Small and rural hospitals must recognize the changes in the health care environment and the changing demands of their communities that require a ‘generalist’ approach. The literature further observes that rural hospitals “are being forced to shift their emphasis from filling acute inpatient care beds to providing a more diversified set of services through linkages with other institutions and provider groups” (Moscovice & Stensland, 2002; Christianson et al., 1998; Moscovice et al., 1997). While the notion of being ‘forced’ into a different role is not optimal, the comment highlights the need for small and rural hospitals to recognize the changes in the health care environment and the changing demands of their communities that require a ‘generalist’ approach.

In addition to their healthcare mission, the opportunity for rural hospitals lies in their ability to address the more general needs of this changing environment. The shift in emphasis offers the opportunity for small and rural hospitals to provide health services as an essential component of the social and economic vitality of rural communities. Successful rural hospitals are characterized by involvement in primary care networks, provision of long-term care beds and rehabilitation services (Shortell et al., 1995).

The reach of rural hospitals, however, may ideally extend in both directions; into the community and also into urban centres: an access hub for its community in both directions. Along these lines, the Romanow commission notes that while some health care services can be delivered in smaller communities, some form of networked system that links those communities with urban centres is inevitable. Smaller communities simply cannot sustain a full range of services. Specialized services will continue to be concentrated in larger centres, but their linkages to rural communities should be improved (Government of Canada, 2002). The current reality of rural health care is inextricably interwoven with essential urban linkages to provide the full range of health services (Rosenthal & Fox, 2000).

Networking gives small hospitals an opportunity to develop symbiotic relationships with all providers and patients; both within the community and in the larger urban centres. Such bidirectional networking gives small hospitals an opportunity to develop symbiotic relationships with all providers and patients; both within the community and in the larger urban centres. Networking solidifies missions, goals, and objectives for healthcare delivery systems - it defines the direct role of the small hospital and delineates the roles of the other networked providers while formalizing the relationships that provide access to these services.

The Advisory Group has chosen to further investigate this potential and future role of small and rural hospitals as an essential third phase of work that will build on the foundation of core services.
Bibliography


