



Office of the Auditor General of Ontario

Value-for-Money Audit:
Emergency
Departments



December 2023

Emergency Departments

1.0 Summary

Emergency departments are a crucial part of Ontario's health-care system, providing medical treatment for urgent and emergent illnesses and injuries 24 hours a day, 365 days a year. The facilities, sometimes referred to as emergency rooms, are largely overseen and funded by the Ministry of Health (Ministry) and Ontario Health, the Crown agency charged with integrating health-care services between organizations. Patients can seek care at any of Ontario's 163 emergency departments at any time by either entering by their own means or calling for an ambulance. The fully accessible nature of emergency departments can make it challenging for hospitals to anticipate patient inflows with any certainty. And while emergency departments are meant to treat urgent and emergent health-care issues, managing patient flows and planning appropriate staffing levels are made more complicated because patients also may choose to use them when they cannot access care in a timely manner at another setting, such as their primary care provider or a walk-in clinic. In addition to these inherent and constant challenges, funding issues and staffing shortages exacerbated by the COVID-19 pandemic have put further strain on Ontario's emergency-department system.

We found that while patients requiring immediate life-saving care are able to access the system in a timely manner, emergency departments have otherwise often struggled to provide timely and high-quality care, with patients having to wait on average two hours just to be

assessed by a physician. Some emergency department patients who require an inpatient bed have had to wait more than 24 hours, and many continue to be treated in emergency department hallways when space is not available. Strains in the system and long wait times have resulted in delayed or missed diagnoses, leading to patients returning to the emergency department in worse health.

Some of our significant findings include:

Emergency Department Closures

- **There were over 200 temporary emergency department closures in the past year due in part to a lack of a comprehensive province-wide strategy to maintain staffing levels.** Unplanned closures of emergency departments were very rare before 2019/20. However, between July 2022 and June 2023 there were 203 temporary emergency department closures in Ontario, involving 23 hospitals primarily located in rural or remote areas, largely related to a nursing shortage and other staffing challenges. We found that there was no comprehensive province-wide and centralized strategy to help hospitals maintain nurse staffing levels to avoid closures or to reduce the duration of the closure. Instead, the Ministry and Ontario Health generally relied on hospitals to manage these situations independently, typically by closing their emergency department or using more-expensive agency staff where possible. These closures create risks to patients'

health that increase in proportion to the time needed to travel to the next nearest emergency department.

- Rural and remote hospitals relied heavily on an emergency department locum program to avoid closures even though the program was intended to be used as a temporary solution.** In 2006, in an effort to avert highly disruptive emergency department closures due to the unavailability of physicians, the Ministry created the Emergency Department Locum Program (Locum Program), which aimed to provide urgent coverage as an interim measure of last resort to hospitals facing significant challenges filling emergency department shifts. While the Locum Program has been a strong resource for hospitals facing physician shortages, many hospitals have had to increase their reliance on the program to keep emergency departments open. In 2018/19, the Locum Program provided approximately 27,400 hours of coverage, which more than doubled to over 60,200 hours in 2022/23. During the same period, the cost of running the Locum Program increased by about 108%, from about \$5.7 million in 2018/19 to over \$11.8 million in 2022/23. Ontario Health estimates that the Locum Program helped to avert over 400 emergency department closures in 2022/23.

Emergency Department Wait Times

- Wait times to see a physician spiked and varied significantly from region to region.** While wait times to see a physician were relatively stable prior to 2020, there was a significant increase following the COVID-19 pandemic. Patients waited an average of 118 minutes after being triaged to receive their physician initial assessment in emergency departments in 2022/23, approximately 30 minutes longer than the wait time in 2013/14. Patients in the 90th percentile (the longest wait time after the top 10% of wait times are removed) waited up to 257 minutes (or more

than four hours) in 2022/23, up from 183 minutes in 2013/14. We also noted that the average wait time for a physician initial assessment varied widely by region and by hospital. For example, patients living in the Champlain region waited 169 minutes, or more than twice as long as patients living in the Central region, where average wait times were 79 minutes. As a result of long wait times for a physician initial assessment, we found that some patients chose to leave an emergency department without being seen by a doctor. In 2022/23, the average left-without-being-seen rate was 5.3%, although some hospitals had higher rates. For example, one hospital had about 14% of patients leave the emergency department without being seen. The wait time for a physician initial assessment at this hospital was approximately 175 minutes (or almost three hours), one of the longest wait times among emergency departments.

- Unnecessary emergency department visits contributed to long wait times and high costs to the health-care system.** Lower-acuity patients, specifically less urgent or non-urgent cases, accounted for approximately 23% (or 1.29 million) of all emergency department visits in 2022/23. Some of these patients, such as those experiencing a sore throat or cold, did not require emergency care but chose to visit the emergency department because it was the only immediate option available or they had no primary care provider. A 2014 study by the Canadian Institute for Health Information (CIHI), an independent, not-for-profit national organization, noted that one in five emergency department visits could have been treated in a doctor's office or clinic. However, according to a 2019 health-care experience survey completed by the Ministry, only 41% of Ontarians were able to get an appointment with their primary care provider on the same or next day. Emergency department care comes at a significant cost to the health-care system as a whole—the direct cost of an emergency department visit in Ontario

was approximately \$165 per visit, almost three times higher than the cost of alternative options like primary care, which cost about \$56 per visit.

- Medical directives, which help reduce the time patients spend in emergency departments, were not used consistently across hospitals.** Medical directives are orders that emergency department physicians have developed to help nurses and other hospital clinicians begin the process of assessing patients and performing certain procedures (such as ordering blood tests) before the physician initial assessment. Empowering nurses and other hospital clinicians to act before patients can be seen by a doctor allows certain basic emergency department testing and procedures to be completed more quickly and efficiently, leading to safer care and better patient flow. However, we noted significant variations in the use of medical directives at the hospital sites we visited. There also was no formal province-wide system for hospitals to share best practices on the use of medical directives.
- Emergency department patients sometimes had to wait more than 24 hours for an inpatient bed.** In 2022/23, patients waited an average of 13 hours for an inpatient bed, a significant increase from the approximately eight hours they had to wait 10 years earlier. Patients in the 90th percentile waited as many as 35 hours for an inpatient bed, up from about 21 hours in 2013/14. We also noted significant differences across regions and hospitals. On average, patients waited at emergency departments for an inpatient bed for about nine to 19 hours in 2022/23 depending on which region they lived in, a significant increase from the five to 13 hours one year earlier. The long wait times were partly the result of the overall lack of inpatient beds in Ontario hospitals and the backlog of patients who did not require hospital-level care but were waiting for rooms elsewhere in the health-care system. Lengthy wait times have helped maintain high numbers of so-called

hallway patients, who have to be seen and treated in emergency department hallways until beds become available.

Quality of Emergency Department Care

- Strains in the system and long wait times at emergency departments resulted in delayed or missed diagnoses, leading to patients making return visits in poorer health.** To identify areas for quality improvement, in 2016 Ontario Health introduced the Emergency Department Return Visit Quality Program (Quality Program), which requires participating hospitals to report why Ontarians return to the emergency department shortly after their initial visit. We noted that there were 274 return visits with a sentinel (severe and significant) diagnosis in 2022; of these incidents, the hospitals identified a quality issue or adverse event had occurred in 104 cases. The most common causes of adverse events included patient mismanagement (for example, lack of reassessment of patients), a delayed or missed diagnosis, or an unsafe discharge decision. We also noted numerous examples of long wait times contributing to poor outcomes, including a case when a patient making a return visit to the emergency department required emergency surgery, and another when a returning patient was admitted to the critical care unit.

Staffing Shortages

- Significant staffing shortages reduced access to timely emergency care.** We noted multiple reasons for high staff turnover at emergency departments, especially among nurses. Factors included the higher pay and flexibility offered by private staffing agencies, as well as the introduction in 2019 of Bill 124, which limited annual wage increases for many employed professionals (including nurses) to 1% for three years. Since the Ministry and Ontario Health had never collected and tracked information on staffing shortages and vacancies across emergency

departments, we requested that information from a select number of emergency departments and noted that all of them experienced a significant increase in nursing vacancy rates between 2019/20 and 2022/23. For example, one emergency department's vacancy rate of full-time registered nurses increased from 6% to 26% in that time frame, and the rate for part-time registered nurses rose from 23% to 51%.

- **Worsening staffing shortages have forced hospitals to hire agency nurses at significantly higher hourly rates than permanent staff.** There has been no legislation that caps the amount for-profit staffing agencies can charge to hospitals. We noted that these agency nurses were paid significantly more than hospitals' full-time permanent nurses. For example, agency nurses that hold the position of registered nurse working in an emergency department could get paid more than \$75 an hour, compared with about \$35 to \$50 an hour for full-time permanent nurses employed by a hospital. The greater job flexibility and higher pay of agency nurses have resulted in some permanent nurses leaving hospitals. Furthermore, collective agreements with nursing staff limit the ability of hospitals to move nursing staff between units, forcing hospitals to rely on agency nurses even more to address their nursing shortages. The Ministry and Ontario Health did not track agency staff costs and instead relied on hospitals to manage their own budgets and make decisions related to agency staffing. We reviewed data on agency nurse spending across the hospitals we visited and found that in 2022/23, one hospital spent about \$8 million on agency nurses in the emergency department, compared with \$2.4 million in 2021/22, and less than \$1 million in 2019/20.
- **Inconsistencies and flaws in the physician payment structure could impact the timeliness and oversight of emergency department care.** The majority of emergency department physicians were compensated through an

alternative funding arrangement (AFA), while some used a fee-for-service (FFS) model to bill the Ontario Health Insurance Plan directly. Under the AFA, there is typically a base funding component, which is essentially a salary divided among the physicians. We found that there had been a lack of oversight of pay and performance of individual physicians who were part of an AFA and the Ministry does not review information on the funding provided to each physician or the volume of patients seen by each physician. We also noted that the FFS model appeared to incentivize physicians to see more patients in order to receive payment, which in turn resulted in shorter patient wait times. For example, even though only 15% of emergency departments used the FFS model, three of the top five hospitals with the shortest physician initial assessment wait times were using an FFS model while all five of the worst-performing hospitals were on an AFA. We also noted that one of the hospitals indicated it had relatively shorter wait times to see a physician as a result of process improvements, which were easier to implement under an FFS model.

Oversight of Emergency Department Performance and Funding

- **Hospitals continued to get funding for a program that has had mixed results in improving patient flow through emergency departments.** The Ministry created the Pay for Results (P4R) program in 2008 to incentivize hospitals to improve patient flow through the emergency department. We reviewed historical data and found that in the early years of the P4R program, some key performance indicators showed a reduction in wait times, helping patients move more quickly through their emergency department visits. However, we found that performance deteriorated leading up to the December 2018–November 2019 period, the most recent full-year results before

the COVID-19 pandemic. Of the five indicators related to wait times that use historical performance as a benchmark, a significant number of hospitals had a worse performance in 2019 than when they first joined the P4R program. For example, in almost half of the 74 hospitals participating in the program as of 2019, admitted patients spent longer overall in the emergency department and there was a longer wait time for an inpatient bed. Despite this, hospitals with worsening performances continued to receive funding through the program.

Emergency Department Diversion Practices and Virtual Urgent Care

- **Unique diversion practices that have helped some emergency departments handle patient flows more efficiently were often not shared with other hospitals.** We noted that some hospitals have developed practices to help divert patients away from the emergency department to a more appropriate setting within the hospital to receive care. These practices—which include using a rapid assessment zone for low-acuity patients that could be located outside of the emergency department—expedite and improve care for the patient involved while freeing up space and resources for others in the emergency department. While these practices have shown success, we noted that hospitals often did not share best practices province-wide. What’s more, the Ministry and Ontario Health also did not have a framework in place to track, evaluate and encourage the use of these effective strategies.
- **A virtual urgent care pilot program has had some early successes, but subsequent changes to the program may result in worse outcomes if not managed effectively.** In 2020, the Ministry approved approximately \$4 million in one-time funding to support a regionally co-ordinated a virtual urgent care program, sometimes referred to as virtual emergency department. The program was created

to support patients who had concerns about visiting an emergency department during the COVID-19 pandemic, as well as to divert lower-acuity patients away from the emergency department. In 2022/23, patients made over 50,000 virtual urgent care visits, compared with less than 20,000 visits in 2021/22. Ontario Health informed us that it planned to integrate some of the initiatives in the virtual urgent care pilot program into the provincial Health811 call services, through which patients are able to connect with a registered nurse 24 hours a day. However, we noted that some hospitals had concerns that this centralized model may not be as effective as virtual urgent care programs managed directly by hospitals. For instance, a virtual urgent care program managed by a hospital would be able to refer a patient directly for blood tests or diagnostic imaging in one of their facilities, while a patient using a centralized model who is advised to see an emergency physician might have to restart the triage process from the beginning upon arrival at the emergency department.

This report contains 14 recommendations, consisting of 23 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry of Health and Ontario Health, in conjunction with hospitals, do not have fully effective systems and processes to oversee the delivery of care at emergency departments, or to manage resources efficiently, to help ensure emergency care that is timely and meets all patient needs. While the sickest patients are able to access and receive emergency department care on a timely basis, more needs to be done to address the risks associated with long wait times and increasing patient length of stay. Furthermore, while the Ministry and Ontario Health do measure areas of emergency department performance, more oversight and assessment are necessary to ensure

hospitals are meeting intended objectives of initiatives, such as those funded through the P4R program. We also concluded that while improvements have been made in the triaging of patients through the use and implementation of eCTAS, some emergency departments over-triage patients consistently, and hospitals need to do more to safely admit, discharge and/or transfer patients to other appropriate care settings in a timely manner.

While wait times to be assessed by a physician were relatively stable from 2013/14 to 2019/20, there has been a spike following the COVID-19 pandemic and patients face increasingly long wait times, sometimes in excess of four hours. This has prompted more patients to leave the emergency department without being seen, which may have contributed to worse health outcomes. In addition, some emergency department patients need to wait in hallways, sometimes for more than 24 hours, to be moved to an inpatient bed due to a shortage of beds and the presence of so-called alternate level of care patients, who cannot be moved out of hospital beds because spots in more appropriate alternative care settings are not available.

Further, we found that many small and rural hospitals have had to rely on the Province's Emergency Department Locum Program to stay open, helping to avoid more than 400 emergency department closures in 2022/23. Despite the program, which was only meant to provide hospitals with temporary relief, there were 203 temporary emergency department closures due to staffing challenges, primarily because of a shortage of nurses. We also found that hospitals are spending millions of dollars on agency nurses at significantly higher hourly rates when they cannot address staffing shortages through internal resources.

While up to one in five emergency department patients treated and discharged in Ontario could have been treated in a doctor's office or clinic, we found that there have been insufficient efforts to try to divert or transfer patients to more appropriate care facilities. And in cases where hospitals did identify best practices to redirect patients, this information was not being effectively tracked by the Ministry and Ontario Health or shared with other hospitals across the province.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) thanks the Office of the Auditor General of Ontario for their work and sharing the report on their value-for-money audit of Emergency Departments. Ontario hospitals and emergency departments were at the forefront of the health sector's response to COVID-19 and the COVID-19 pandemic, and its unprecedented challenges have had a lasting impact on the province's health-care system. Throughout the pandemic's waves, hospital emergency departments supported the COVID-19 response, stepping up to meet new and evolving demands amid historic health human resource shortages that impacted the entire health-care system.

The Ministry acknowledges the difficult position hospitals and emergency departments were in and appreciates the role they played in supporting the health-care system response, both locally and provincially. Hospitals provided high-quality patient care throughout the pandemic response, and the effect of the unprecedented global crisis continues to put strain on the delivery of care in emergency departments. The government remains steadfast in its commitment to protect the health and safety of all Ontarians and has worked closely with Ontario Health and hospitals to implement new programs and enhance existing supports to ensure the people of Ontario have access to high-quality emergency care, when and where it is needed. Initiatives like the Emergency Department Peer-to-Peer Program will ensure health-care providers across the province are supported and feel confident in delivering care to some of the most at-risk populations in Ontario's rural, remote and Northern communities. Enhancements to the Pay for Results program will ensure the busiest emergency departments are pushed to continually improve on their performance and that small-volume sites have access to supports that incentivize better performance and the continued delivery of high-quality care.

The Ministry remains engaged with Ontario Health on strategies to support Ontario's emergency departments and ensure that hospitals across the province are able to keep their emergency departments open and able to serve all those seeking emergency care. The Ministry is committed to continue working closely with Ontario Health and Ontario's hospitals to review the findings and recommendations within the report and drive improvements where able. The Ministry also will commit to applying learnings more broadly across the entire health-care system to inform and strengthen guidelines of current and future programs/strategies to support the delivery of high-quality care.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiation process between the parties set out in the Binding Arbitration Framework.

OVERALL ONTARIO HEALTH RESPONSE

Ontario Health thanks the Office of the Auditor General of Ontario for sharing the value-for-money audit of Emergency Departments.

Ontario Health recognizes the enormous strain on emergency departments, observing increased challenges in patient complexity, and multifactorial impacts of health system capacity challenges that impact emergency department patient flow. High-quality and safe patient care is a priority.

In partnership with the Ministry of Health, Ontario Health works diligently with the emergency department community to ensure that

programs dedicated to improving quality and safety in the emergency departments are implemented and shared across the sector. Ontario Health's commitment to supporting patient care, the needs of our clinical teams/staff and access to resources is our priority.

Ontario Health commends recent new programs announced by the Ministry to support emergency departments, such as the Pay for Results (P4R) expansion, the Emergency Department Peer-to-Peer program, as well as a focus on emergency department nursing education and retention. These programs and resources ensure Ontario Health's ability to move forward with emergency department system strategy, capacity and access.

Ontario Health also has implemented innovative strategies to support patients in Ontario with initiatives such as Health811, expansion of P4R and the Peer-to-Peer program to provide system supports. Ontario Health remains committed to ensuring hospitals and regions are supported to reduce the risk of closures and impacts on communities.

Ontario Health is committed to working closely with the Ministry, hospitals and emergency department leaders to ensure that recommendations brought forward from the audit will be implemented, where feasible, to continually address the challenges emergency departments are facing in Ontario.

2.0 Background

2.1 Overview

The province's emergency departments provide medical treatment for illnesses and injuries 24 hours a day. Patients can seek care at any of Ontario's 163 emergency departments—sometimes referred to as emergency rooms—by arriving by their own means or calling an ambulance. While emergency departments are meant to treat urgent and emergency health-care issues, people also may choose to visit emergency

departments when they cannot access care in a timely manner at another setting, such as a primary care practitioner's office or a walk-in clinic.

Figure 1 shows that the annual number of emergency department visits in Ontario over the last 10 years has been relatively stable at approximately 5 to 6 million visits. Because Ontario's population is projected to increase from approximately 15.1 million people in 2022 to over 17 million people within the next 10 years, the volume of emergency department visits is expected to continue to rise.

Figure 2 shows the most common reasons for emergency department visits as well as the volume of visits for the top 10 diagnosis groupings. Of the approximately 5.6 million emergency department visits in 2022/23, these top 10 groupings accounted for 4.9 million visits (or about 88%).

2.2 Patient Flow in Emergency Department

Patient flow through an emergency department involves a number of steps. **Figure 3** shows the typical

patient journey when visiting an emergency department, while each step in the process is discussed in further detail below.

2.2.1 Triage

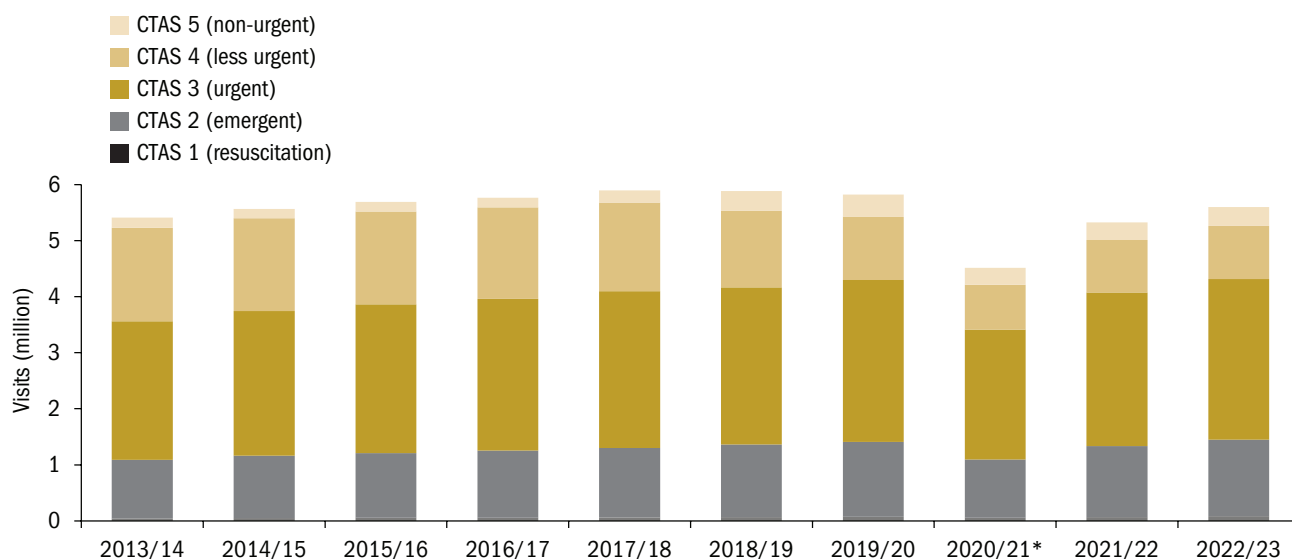
Upon arrival at the emergency department, patients are triaged, which is the process of assessing a patient's acuity level based on the five-level Canadian Triage and Acuity Scale (CTAS). The triage level assigned to a patient, typically by a nurse, determines their priority of being seen and treated. **Figure 4** shows the percentage of emergency department visits by CTAS level in 2022/23.

2.2.2 Physician Initial Assessment

After being triaged, all patients, except those assessed at CTAS 1 (requiring immediate resuscitation), have to wait for a physician assessment. Patients with a relatively higher-acuity level (CTAS 2 or 3) typically wait less time than those with a CTAS level of 4 or 5. Across Ontario, patients waited on average about two hours

Figure 1: Number of Emergency Department Visits by Canadian Triage and Acuity Scale (CTAS), 2013/14–2022/23

Source of data: Ontario Health



Note: This chart is based on data from emergency departments in Ontario that reported information centrally to databases or systems such as the National Ambulatory Care Reporting System.

* In 2020/21, the number of emergency department visits temporarily dropped during the COVID-19 pandemic to about 4.5 million when fewer patients with less urgent needs sought emergency care. The number of visits rebounded to about 5.3 million in 2021/22.

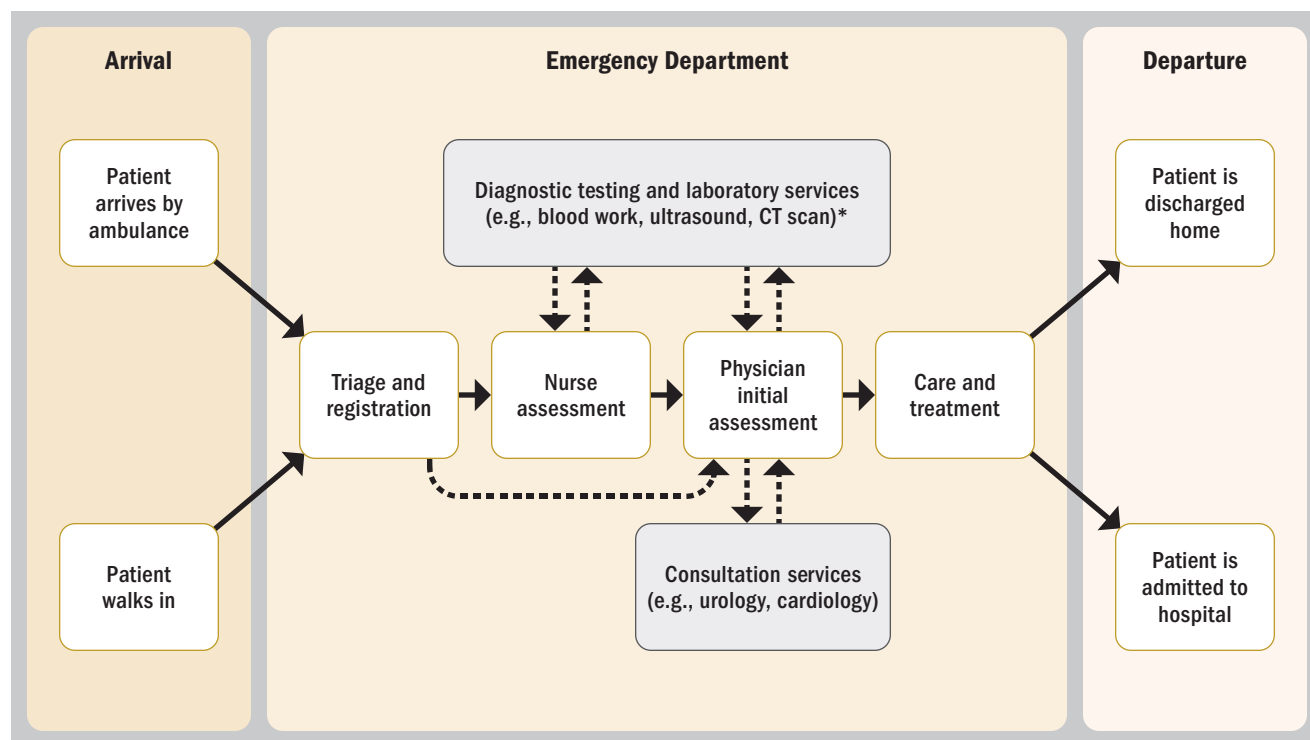
Figure 2: Top 10 Diagnosis Groupings of Emergency Department Visits, Ontario

Source of data: Canadian Institute for Health Information

Diagnosis Group	Examples	# of Emergency Department Visits, 2022/23
1. Symptoms, signs and abnormal clinical and laboratory findings	Abdominal and pelvic pain, pain in throat and chest, headache, nausea and vomiting	1,306,458
2. Injury, poisoning and other consequences of external factors	Open wounds, fractures, poisoning	1,200,126
3. Respiratory system	Asthma, pneumonia, bronchitis	532,338
4. Musculoskeletal system and connective tissue	Joint disorders, gout, arthritis	339,026
5. Digestive system	Intestinal disorders, appendicitis, hernias	315,110
6. Genitourinary system	Acute renal failure, urinary system disorders	284,829
7. Infectious and parasitic diseases	Diarrhea, herpes, warts	250,796
8. Mental, behavioural and neurodevelopmental disorders	Alcohol use, anxiety disorder, opioid use	239,564
9. Factors influencing health status and contact with health services	Surgical and orthopaedic follow-up care, counselling	221,316
10. Circulatory system	Hypertension, heart attack, cardiac arrest and stroke	211,063
Total		4,900,626

Figure 3: Patient Flow through an Emergency Department

Prepared by Office of the Auditor General of Ontario

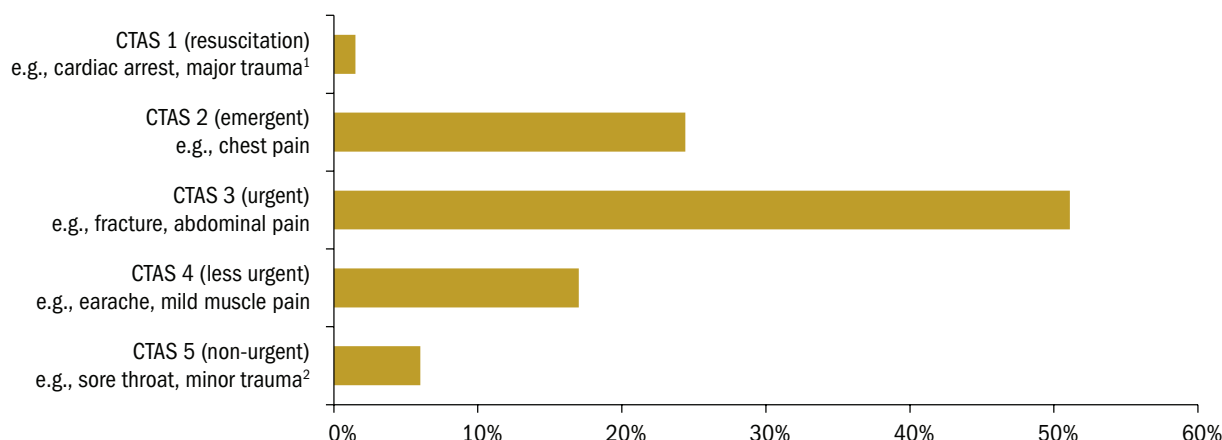


— Usually occurs - - - - - Sometimes occurs

* While waiting for a physician initial assessment, a nurse may request early testing (such as blood work) if the hospital utilizes medical directives, which allow nurses to initiate certain procedures for patients presenting specific symptoms, as discussed in **Section 4.2.3**.

Figure 4: Percentage of Emergency Department Visits by Canadian Triage and Acuity Scale (CTAS), 2022/23

Prepared by Office of the Auditor General of Ontario



1. Examples of major traumas include falls, motor vehicle accidents, head or spine injuries, and stabbings.

2. Examples of minor traumas include skin lacerations, sprains, muscle strains, scrapes and abrasions.

for an initial physician assessment, but wait times varied significantly between hospitals and regions, as discussed further in **Section 4.2.1**.

While patients wait for a physician initial assessment, nurses may begin treatment, such as prescribing medication and ordering diagnostic testing (such as blood tests), if the hospital uses medical directives that allow nurses to initiate certain procedures before a physician assessment, as discussed in **Section 4.2.3**. Wait times may be extended if patients require further testing (for example, an ultrasound or CT scan).

2.2.3 Inpatient Admission

After being assessed and treated by a physician in an emergency department, patients may be admitted to hospital for ongoing care and/or health monitoring. In Ontario, these patients typically have to wait in the emergency department for an average of nine to 19 hours until an inpatient bed is available, during which time they may become so-called hallway patients if the emergency department is overcrowded (see **Section 4.2.4**).

2.3 Emergency Department Funding and Spending

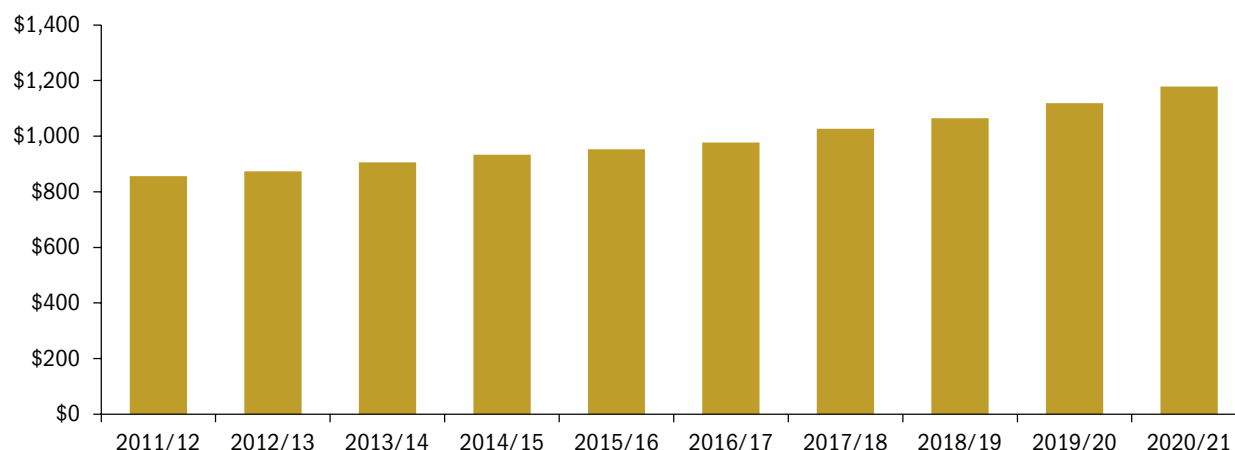
Approximately 60% of the Ministry's funding to hospitals is non-targeted global funding to support core programs and services, including the operation of emergency departments. Global funding is a base (or fixed) amount of annual funding for hospitals to deliver health-care services and cover operating expenses. Each hospital's management has discretion in how to use and allocate its global funding.

In addition to the global base funding, hospitals also may receive targeted funding by participating in performance- and activity-based initiatives or programs for emergency departments, for example, the Pay for Results, or P4R, program (see **Section 4.6**). Such targeted funding, which was approximately \$93 million in 2022/23, is minimal compared to the costs of running an emergency department. As of July 2023, 75 mid-sized and large hospitals received this funding. In July 2023, the Ministry announced changes to the P4R program that would expand eligibility, as discussed further in **Section 4.6.1**.

According to the Canadian Institute for Health Information (CIHI), which collects information directly from hospitals that report data into the National Ambulatory Care Reporting System (NACRS), emergency

Figure 5: Emergency Department Spending in Ontario, 2011/12–2020/21 (\$ million)

Source of data: Canadian Institute for Health Information



Note: 2020/21 is the latest data available.

department spending in Ontario has been consistently increasing since 2011/12, from \$857 million in that year to approximately \$1.18 billion in 2020/21 (the most recent year available), as seen in **Figure 5**.

The direct cost of an emergency department visit in Ontario was, on average, approximately \$165 per patient in 2019/20, a significant increase from \$107 reported in 2005/06. This amount excludes compensation for physicians working in emergency departments, most of whom are paid through alternative funding arrangements, or through a fee-for-service method.

- **Alternative Funding Arrangements:** These are contracts between the Ministry and physician groups that vary from one hospital to another and often involve the Ontario Medical Association, which represents the province's physicians. The contracts have provisions that specify the amount that physicians will receive and the related service levels (i.e., emergency department volumes) that need to be provided. In some cases, contracts can include key performance goals, such as improving patient access and satisfaction. We discuss alternative funding arrangements in **Section 4.5.4**.
- **Fee-for-Service (FFS):** In the FFS model, physicians do not receive compensation directly from the hospital for services provided to patients and instead bill the Ontario Health Insurance

Plan (OHIP) based on a set fee for each service provided to a patient. These fees are determined by a schedule of benefits that is part of the *Health Insurance Act*.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) and Ontario Health, in conjunction with hospitals, have effective systems and processes in place to:

- oversee that the delivery of care at emergency departments is timely and meets patient needs;
- manage resources for emergency departments efficiently to provide continuous availability of emergency care; and
- measure, assess and publicly report the performance and effectiveness of emergency departments on a regular basis.

In addition, our audit assessed whether emergency departments at selected hospitals have effective procedures and systems in place to:

- triage and assess patients appropriately based on their needs in a timely manner and in accordance with applicable standards and requirements; and

- safely admit, discharge, and/or transfer patients to the appropriate units for further care (such as a fracture clinic and for mental-health care) when necessary in a timely manner.

In planning for our work, we identified the audit criteria (see **Appendix 1**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry and Ontario Health reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between January 2023 and September 2023. We obtained written representation from the Ministry and Ontario Health senior management that, effective November 20, 2023, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

In arriving at the audit conclusion, we performed the following work at the Ministry and Ontario Health:

- interviewed management and staff responsible for managing and overseeing the delivery of emergency department services in Ontario;
- reviewed applicable policies, guidelines, legislation, reports and briefing notes related to emergency departments;
- reviewed strategic plans and related performance measure targets and results;
- reviewed funding structures and methodologies;
- obtained and analyzed various emergency department data, including number of visits, triage counts and levels, wait times and staffing counts; and
- reviewed initiatives and programs such as the Emergency Department Locum Program to help hospitals cover physician shortages, and the Pay for Results program to support innovation and practices that improve patient flow.

We also conducted site visits at the following hospital emergency departments, where we toured the emergency department, met with senior management and front-line staff responsible for the delivery of

emergency department care, including physicians and nurses, and reviewed information and files related to patient safety and critical events, patient satisfaction, health human resources, and performance measures:

- Children’s Hospital of Eastern Ontario (CHEO);
- Mount Sinai Hospital;
- The Hospital for Sick Children (SickKids);
- William Osler Health System (Brampton Civic Hospital and Etobicoke General Hospital); and
- Windsor Regional Hospital (Metropolitan campus and Ouellette campus)

Furthermore, we met with staff from the following hospitals to discuss specific initiatives and/or challenges faced in delivering emergency department care:

- Haliburton Highlands Health Services regarding their staffing challenges, use of the Emergency Department Locum Program and the permanent closure of their Minden Hospital emergency department on June 1, 2023;
- University Health Network and Sunnybrook Health Sciences Centre regarding their virtual emergency department initiative;
- William Osler Health System regarding its urgent care centre and virtual emergency department initiative; and
- Anson General Hospital regarding its use of the Emergency Department Locum Program to cover ongoing physician shortages.

We also met with staff from the following paramedic groups to discuss patient triage and ambulance off-loading challenges at emergency departments:

- Peel Regional Paramedic Services;
- Toronto Paramedic Services;
- Essex-Windsor Emergency Medical Services; and
- Ottawa Paramedic Service.

Throughout our audit, we met with and reviewed information from various stakeholders to better understand the challenges of delivering high-quality and timely emergency care:

- Institute of Clinical Evaluative Sciences, a community of research, data and clinical experts who lead research in various areas of Ontario’s health-care system, including emergency department care;

- Canadian Association of Emergency Physicians, a national advocate for emergency medicine physicians; and
- Ontario Nurses' Association, a union representing approximately 68,000 nurses and health-care professionals who work in a variety of settings, including hospital emergency departments.

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standards on Quality Management and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 No Comprehensive Provincial Strategy Was in Place to Prevent Emergency Department Closures

4.1.1 There Were 203 Temporary Emergency Department Closures in the Past Year Due in Part to the Lack of a Comprehensive Strategy to Maintain Staffing Levels

Before 2019/20, unplanned closures of emergency departments were rare. However, between July 2022 and June 2023, 203 emergency departments in

Ontario, involving 23 hospitals, closed temporarily, most in rural or remote areas. **Appendix 2** lists the hospitals that experienced a temporary emergency department closure and the total hours they were closed.

We found that most closures were for a period of 14 hours or less, typically from the evening until the following morning. Most hospitals indicated they closed their emergency department because of staffing challenges, particularly a shortage of nurses (see **Section 4.5**), and that some of these closures could have been prevented if more staff resources were available.

While many closures were short, we noted that some hospitals had to close their emergency department repeatedly. Some closures lasted for a longer period. For example, in 2022, South Bruce Grey Health Centre's Chesley site closed its emergency department for 57 days, and Glengarry Memorial Hospital closed its emergency department daily from 6 p.m. to 8 a.m. for 15 days.

According to provincial protocols and policies, when a hospital identifies an anticipated or unanticipated emergency department closure, it is required to notify Ontario Health, which in turn informs the Ministry. In addition, hospitals have to develop a patient management plan to mitigate risks to patient care while the emergency department is closed, for example by working with paramedic groups to send patients to a nearby hospital and having diversion policies to direct patients to other health-care options. However, prior to June 2023, even when the Ministry and Ontario Health learned of a pending emergency department closure, we found that there was no comprehensive province-wide and centralized mechanism or strategy in place to provide support to try to avoid the closure or to reduce its duration. (The one exception is when the closure can be addressed through the Emergency Department Locum Program, discussed further in **Section 4.1.2**.) Instead, the Ministry and Ontario Health relied on hospitals to manage these situations independently, typically by closing down their emergency department or using agency staff if possible (discussed further in **Section 4.5.3**). In June 2023, Ontario Health implemented an updated emergency department closure

policy to begin proactively identifying and addressing ongoing risks of further closures and working with hospitals to determine if there are ways to prevent or reduce closures.

Most of the emergency department closures occurred in smaller or remote communities, where the emergency department is the only viable option for local patients to access urgent care. Closures in rural or remote areas create risks to patients' health that increase in proportion to travel times to the next nearest emergency department. We noted that for the hospitals that had to close temporarily from July 2022 to June 2023 (see **Appendix 2**), the next closest hospital was typically 30 to 45 minutes away, and in one case, North of Superior Healthcare Group's McCausland Hospital, the next closest emergency department was over an hour away.

RECOMMENDATION 1

To help ensure the stability and continuity of emergency department services across Ontario, especially in smaller or remote communities, we recommend that the Ministry of Health, in collaboration with Ontario Health and hospitals, evolve and regularly update a strategy or action plan to prevent emergency department closures through mechanisms and initiatives including supporting local communities in training and retaining their health-care workforce as well as building capacity in primary and community services.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to evolve and regularly update a strategy or action plan to prevent emergency department closures through mechanisms and initiatives. On February 2, 2023, the Government of Ontario announced *Your Health: A Plan for Connected and Convenient Care*, its plan to provide people with a better health-care experience. As part of the broader Health Human Resources Strategy, the Ministry has been working with Ontario Health

to develop a strategic focus on supporting service delivery in emergency departments.

Further, part of this announcement included an investment to create up to 18 interprofessional primary care teams. This will help bridge the gap in accessing interprofessional primary care for vulnerable, marginalized and unattached patients to ensure they are able to connect to care where and when they need it. This investment of \$60 million over two years, beginning in 2023/24, also will sustain direct service delivery in existing interprofessional primary care teams that are experiencing increased operating costs.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

4.1.2 Rural and Remote Hospitals Have Been Relying Heavily on the Emergency Department Locum Program to Avoid Closures Even Though the Program Was Intended to Be Used as a Temporary Solution

To remain open, each emergency department must have at least one physician available. In 2006, in an effort to avert emergency department closures due to physician unavailability, the Ministry created the Emergency Department Locum Program (Locum Program). The goal of the program was to provide urgent locum coverage on an interim basis to hospitals facing significant challenges covering emergency department shifts. Since the introduction of the Locum Program in 2006, only four unplanned emergency department

closures were a result of physician unavailability, while the majority of the 203 closures noted in **Section 4.1.1** were caused by a shortage of nursing staff.

As of August 2023, the Locum Program had approximately 274 physicians travelling to work at emergency departments struggling to maintain physician staffing levels. To be eligible to work in the program, emergency department physicians must be actively working in an emergency department in Ontario and cannot take shifts through the Locum Program that overlap with their regular work commitments. These physicians are paid a premium hourly rate directly from the Locum Program (in addition to what the requesting hospital pays for physician coverage), and also may receive compensation for time spent travelling to and from rural and remote sites.

Figure 6 shows the Locum Program's hours of coverage and costs over the past five years. In 2018/19, the program provided approximately 27,400 hours of coverage, which more than doubled to over 60,200 hours in 2022/23. During the same period, the cost of running the Locum Program increased by about 125% to over \$9.1 million.

Generally, the hospitals that have been requesting support through the Locum Program are smaller rural and remote hospitals. In discussions with

administrators at these hospitals, we found that a primary reason for their increased use of the Locum Program has been higher rates of local physicians retiring or leaving the community in the last couple of years. That has forced hospitals to rely on the Locum Program to fill longer-term physician vacancies even though the program was intended to be used as a temporary measure.

We noted that some hospitals have become particularly reliant on the Locum Program to run their emergency departments. For example, 12 hospitals requested and received at least 500 hours of coverage through the program in each of the last five years, and two of these hospitals had over 1,000 hours of coverage in each of those years. Furthermore, in 2022/23 the top 10 hospitals using the Locum Program all requested and received at least 2,500 hours of physician coverage, as seen in **Figure 7**.

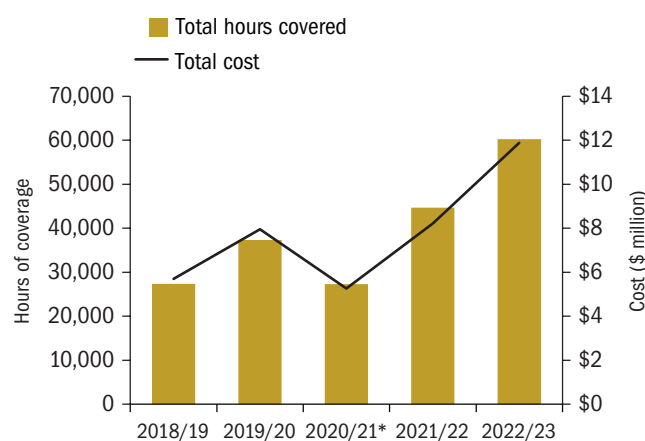
We reached out to hospitals that were regular and significant users of the Locum Program, such as Anson General Hospital, a small northern hospital in Iroquois Falls that received almost 5,000 hours of coverage through the Locum Program in 2022/23. The hospital administrators informed us that without that coverage, they would have had to shut down their emergency department frequently because they otherwise would have had no physician available.

As seen in **Figure 8**, Ontario Health estimates that the Locum Program has helped to avert over 800 emergency department closures over the last five years, with over 400 of those closures averted in 2022/23.

While the Locum Program has been a strong resource in helping hospitals avoid emergency department closures, relying on this temporary program is not necessarily a sustainable option for running an emergency department. For example, as noted in **Figure 7**, Haliburton Highlands Health Services (HHHS) has been significantly reliant on the Locum Program to operate its emergency departments at its two sites (Haliburton and Minden). In the last five years, the Locum Program provided HHHS with approximately 11,500 hours of physician coverage, including almost 4,000 hours in each of 2019/20 and 2022/23. Despite its reliance on the Locum Program, HHHS still had to

Figure 6: Emergency Department Locum Program—Hours of Coverage and Cost, 2018/19–2022/23

Source of data: Ontario Health



* In 2020/21, both hours of coverage and cost decreased because the number of emergency department visits temporarily dropped due to the COVID-19 pandemic.

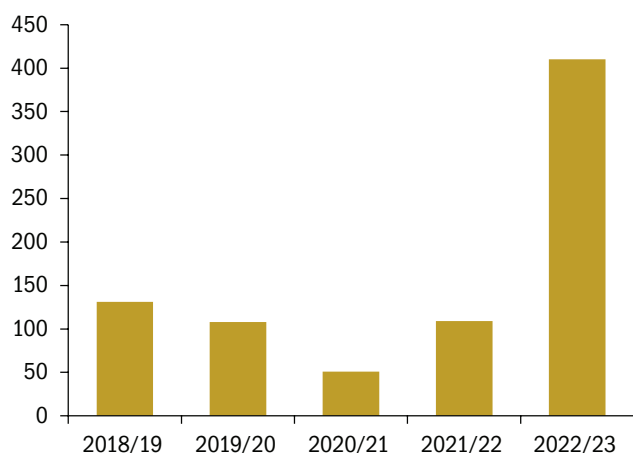
Figure 7: Top 10 Hospital Users of the Emergency Department Locum Program, 2022/23

Source of data: Ontario Health

Region	Hospital	Hours Requested	Hours Covered	% of Requested Hours Covered
North East	1. Anson General Hospital	4,981	4,873	98%
East	2. Deep River and District Hospital	6,124	4,504	74%
East	3. Haliburton Highlands Health Services (Haliburton and Minden sites)	5,476	3,936	72%
East	4. St. Francis Memorial Hospital	6,286	3,841	61%
North East	5. Notre-Dame Hospital	4,120	3,652	89%
West	6. Tillsonburg District Memorial Hospital	4,426	3,058	69%
North West	7. Sioux Lookout Meno Ya Win Health Centre	4,929	2,892	59%
East	8. North Hastings Hospital	4,211	2,855	68%
North East	9. Sensenbrenner Hospital	3,349	2,681	80%
West	10. Grey Bruce Health Services (Lion's Head site)	3,185	2,633	83%

Figure 8: Number of Emergency Department Closures Averted Through Locum Program, 2018/19–2022/23*

Source of data: Ontario Health



* Based on the number of times the Emergency Department Locum Program was able to fill a physician shift to keep an emergency department open.

permanently shut its Minden emergency department on June 1, 2023 due to ongoing challenges with hiring and retaining physicians and nurses, and then consolidate staffing resources at its primary Haliburton site. We met with HHHS administrators and noted that even with the consolidation of its two emergency departments, HHHS expects to continue using the Locum Program to cover unfilled shifts.

4.1.3 The Locum Program Cannot Keep Pace with Hospital Demand

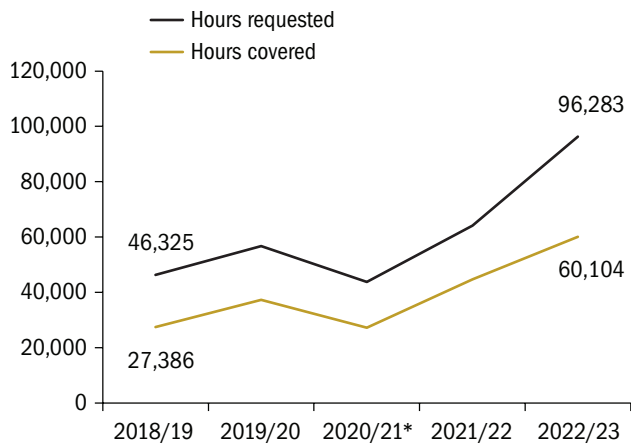
In addition to reviewing the hours covered by the Locum Program, we reviewed how well the Locum Program was able to keep up with hospital requests over the last five years. As seen in **Figure 9**, while hospitals requested over 96,000 hours of support from the Locum Program in 2022/23, the program was only able to cover approximately 60,000 hours.

Ontario Health informed us that due to an overall shortage of emergency department physicians, the Locum Program prioritizes hospitals with the most urgent needs, and considers requests from hospitals in northern communities before those in the south. In all cases, the Locum Program can only be used to fill vacant positions at emergency departments, not increase the number of overall physician positions.

When the Locum Program could not keep pace with requests, hospitals often had to reach out to Health Force (formerly the HealthForceOntario Marketing and Recruitment Agency), which is part of Ontario Health, or nearby hospitals and clinics to fill emergency department shifts and avoid closures. However, like the Locum Program, this coverage only provides temporary help and is therefore not sustainable. Hospitals told us

Figure 9: Hours Requested and Hours Covered by Emergency Department Locum Program, 2018/19–2022/23

Source of data: Ontario Health



* Both hours requested and covered decreased in 2020/21 because the number of emergency department visits temporarily dropped during the COVID-19 pandemic as fewer patients with less-urgent needs sought emergency care.

there will continue to be significant risks of closure if physicians do not start filling permanent positions in rural and remote communities.

RECOMMENDATION 2

To enable consistent and reliable access to emergency department physician care across Ontario and prevent future emergency department closures due to physician staffing, we recommend that the Ministry of Health, in collaboration with Ontario Health and hospitals:

- conduct a comprehensive review of the usage of the Emergency Department Locum Program to identify systemic issues with physician staffing across the province and develop a go-forward strategy; and
- implement mechanisms to incentivize physicians to take permanent roles in rural and remote emergency departments.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to review the Emergency Department Locum Program.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

4.2 Wait Times for Emergency Care Have Gotten Longer

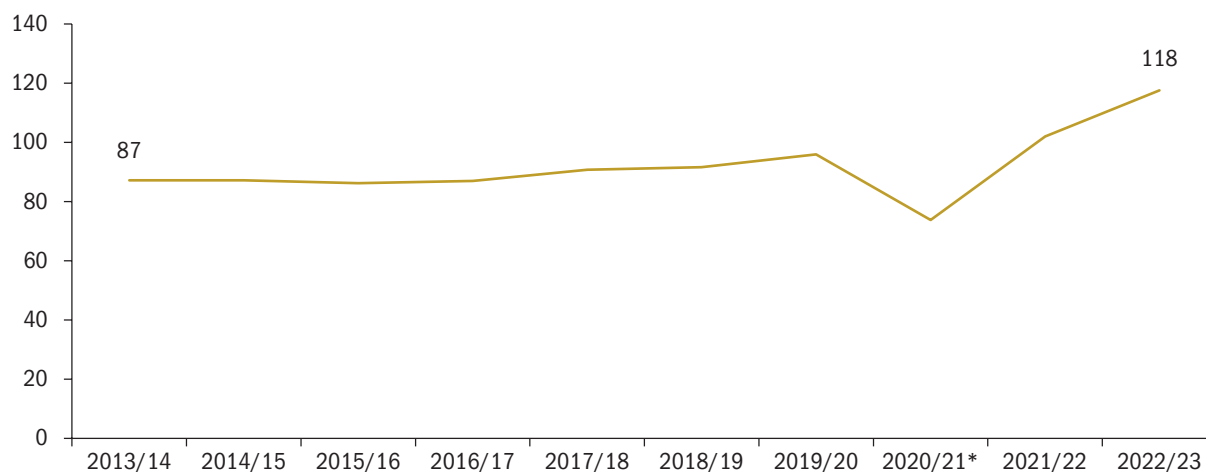
4.2.1 Wait Times to See a Physician Generally Increased, but Varied Significantly Across Ontario

Timely access to a physician assessment is critical in the delivery of high-quality patient care. A patient's first comprehensive assessment by a doctor helps determine what next steps are required, such as further testing, prescribing medication, or administering care. According to an Ontario study by the Institute for Clinical Evaluative Sciences, patients facing longer wait times for a physician initial assessment have a higher likelihood of needing inpatient admission to a hospital. The study also found that there was a slightly higher risk of death for each additional hour a patient waited in the emergency department.

Our review of wait-time data noted that the average wait times to see a physician were relatively stable prior to the COVID-19 pandemic, but have increased

Figure 10: Average Wait Time for a Physician Initial Assessment, 2013/14–2022/23 (minutes)

Source of data: Ontario Health



Note: This chart shows the average wait time for a physician initial assessment for all patients at different acuity levels (CTAS 1 to CTAS 5).

* The average wait time for an initial physician assessment declined in 2020/21 as the COVID-19 pandemic discouraged patients with less urgent symptoms from visiting the emergency department.

significantly since then. We noted that high-acuity patients (CTAS 1, as discussed in **Section 2.2**) were typically able to see a physician in less than 30 minutes. However, in 2022/23 patients waited an average of 118 minutes (or almost two hours) after being triaged to receive their physician initial assessment, as seen in **Figure 10**. This compares with approximately 87 minutes in 2013/14, which is about 30 minutes longer than 10 years earlier. We also reviewed the 90th percentile wait time (the longest wait time after the top 10% of wait times are removed) and found that patients waited up to 257 minutes (or almost four and a half hours) to be seen by a physician in 2022/23, up from 183 minutes (or about three hours) in 2013/14.

Furthermore, the average wait time for an initial assessment by a physician varied widely by region and by hospital (see **Figure 11**). For example, patients living in the Champlain region waited more than twice as long to receive their physician initial assessment compared to patients living in the Central and Central West regions.

Figure 12 shows the average wait time for a physician initial assessment across the hospitals we visited during our audit, while **Appendix 3** shows the wait

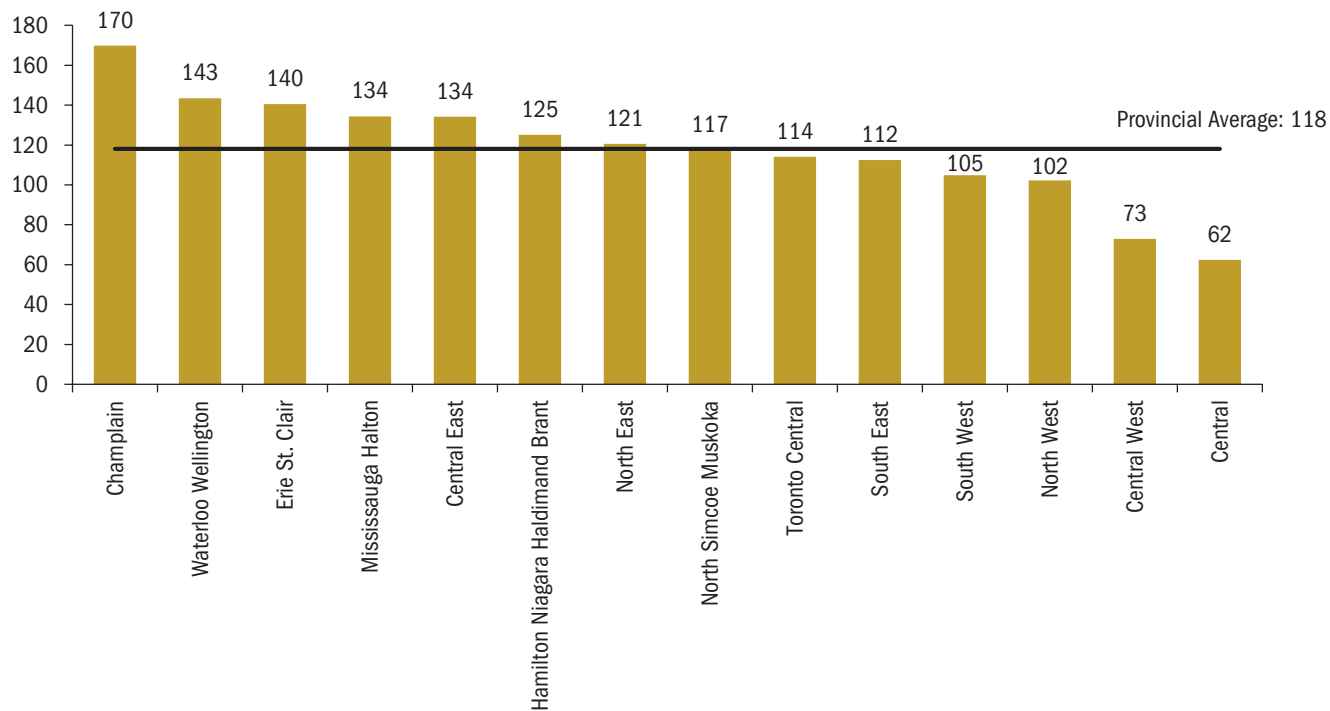
time across all of Ontario's emergency departments. Again, we noted significant variations of access to emergency care by hospital, with patients visiting Windsor Regional Hospital's Metropolitan campus waiting an average of 247 minutes (or over four hours) for a physician assessment—which was more than five times longer than the average 45-minute wait at William Osler Health System's Etobicoke General Hospital emergency department.

In speaking with administrators from Windsor Regional Hospital, we noted that one of the key reasons for their long wait times to see a physician was the lack of available primary care in the region, specifically in the evenings and on weekends. This resulted in patients using the emergency department for symptoms that would typically be treated in a primary care setting or to access diagnostic imaging. Furthermore, we found that physician payment structures may also impact the ability of patients to receive a physician assessment on a timely basis, as discussed further in **Section 4.5.4**.

As a result of the lengthening wait times, we found that the so-called left-without-being-seen rate increased as patients chose to leave an emergency

Figure 11: Average Wait Time for Physician Initial Assessment by Sub-region, 2022/23 (minutes)

Source of data: Ontario Health



Note: Regions correspond to the boundaries of the Province's 14 Local Health Integration Networks (LHINs). While the Ontario government merged the LHINs into five Ontario Health regions in December 2019, Ontario Health has continued to report regional wait-time data by LHIN.

Figure 12: Average Wait Time for a Physician Initial Assessment by Selected Hospitals, 2022/23 (minutes)

Source of data: Ontario Health

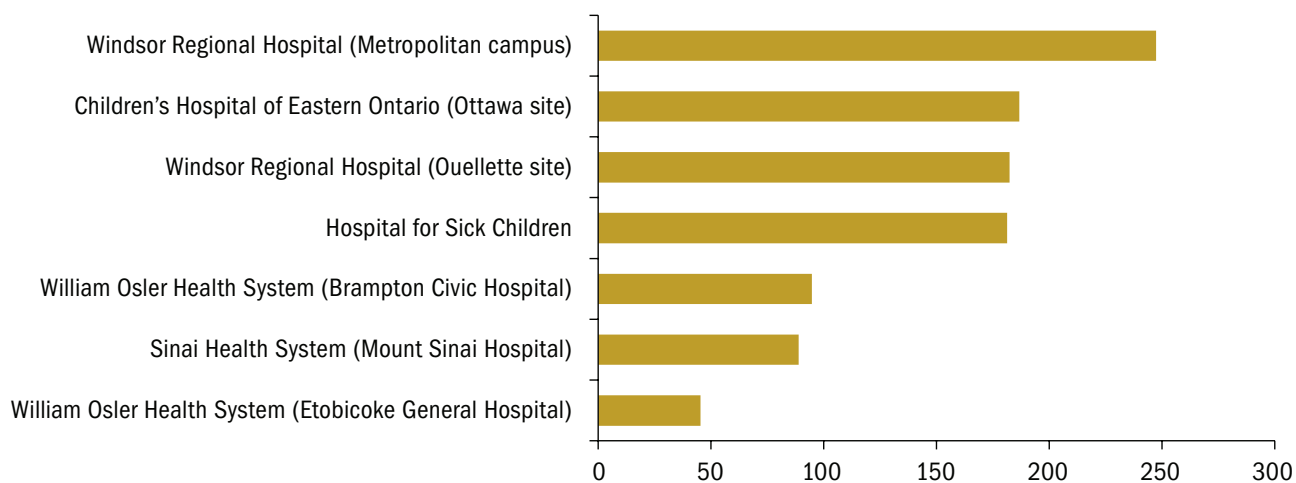
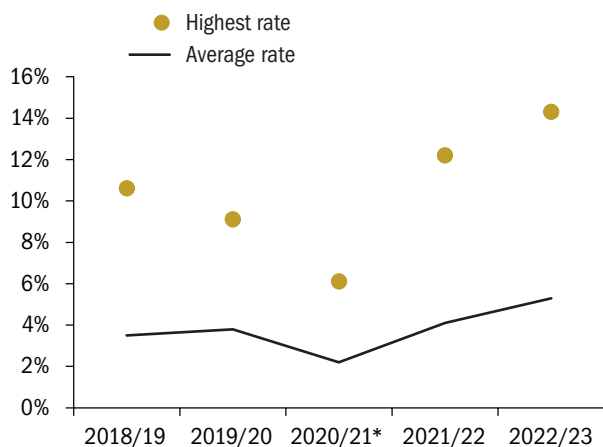


Figure 13: Percentage of People Who Left the Emergency Department without Being Seen, 2018/19–2022/23

Source of data: Ontario Health



Note: “Highest rate” means the emergency department in Ontario with the highest percentage of people who left without being seen.

* In 2020/21, both the average and highest rates of people who left the emergency department without being seen decreased as patient visits dropped due to the COVID-19 pandemic.

department without seeing a physician. As shown in **Figure 13**:

- The average left-without-being-seen rate increased from 3.5% in 2018/19 to 5.3% in 2022/23.
- Significantly long wait times to be assessed by a physician was the key contributing factor to higher left-without-being-seen rates. For example, in 2022/23 one hospital had 14.3% of patients leaving the emergency department without being seen, almost three times higher than the average province-wide rate. The wait time for a physician initial assessment at this hospital was approximately 175 minutes (or almost three hours), one of the longest wait times among hospitals.

While some of these patients chose to leave because they no longer required emergency care or decided to seek care elsewhere (for example, at their primary care provider), some patients who did require emergency care decided to leave because of long wait times and returned to the emergency department in a worse condition (see **Section 4.3.1**).

4.2.2 Unnecessary Emergency Department Visits Contributed to Long Wait Times and High Care Costs

The emergency department is typically the only option for high-acuity patients who need urgent and comprehensive care. Low-acuity patients may also choose to visit an emergency department if they have no other timely option and still want to be seen as soon as possible. Emergency departments will often safely delay care for these patients until higher-acuity patients are seen.

We noted that lower-acuity patients, specifically those assigned a CTAS 4 (less urgent) or CTAS 5 (non-urgent) level by a triage nurse, accounted for about 23% (or 1.29 million) of all emergency department visits in 2022/23, as seen in **Figure 1**. Some of these patients, such as those experiencing a sore throat or cold, chose to visit the emergency department because it was the only option available at the time. Furthermore, emergency departments do not typically refer patients to more appropriate care settings until after they have assessed and treated the patients in the emergency department, although we did note some hospitals had patient diversion practices in place for specific patient populations (see **Section 4.7.1**).

We also noted that the independent, not-for-profit Canadian Institute for Health Information (CIHI) conducted a study in 2014 that found that in cases where emergency department patients were treated and discharged, one in five could have been treated in a doctor’s office or a clinic. Some of the common issues among these patients related to colds, sore throats and ear infections. These unnecessary visits to emergency departments have continued to impact the ability of hospitals to provide timely care to other patients.

Hospital staff and emergency department physicians that we spoke with indicated that some lower-acuity patients choose to visit the emergency department to access physician care because their own primary care provider may not be available in the evenings or weekends, or they cannot get any appointment on a timely basis. For example, Windsor Regional Hospital informed us that they had many patients who chose to visit an emergency department instead of

waiting to get an appointment with their family doctor or to avoid taking time off from work. According to the most recent health-care survey completed by the Ministry in 2019, only 41% of Ontarians were able to get an appointment with their primary care provider on the same or next day.

While patients need to have unrestricted access to emergency departments when they feel they need emergency care, it would be prudent for the Ministry and Ontario Health to determine the underlying reasons why lower-acuity patients are visiting the emergency department rather than other health-care settings (for example, primary care or walk-in clinics) and then identify ways to divert those patients to those alternative care options. This will help emergency departments focus on assessing and treating sicker patients, and help reduce overall costs in the health-care system since emergency department care comes at a significant cost. According to recent data from the CIHI, the direct cost of an emergency department visit in Ontario was approximately \$165 (as noted in **Section 2.3**), almost three times higher than alternative options like primary care, which cost about \$56 per visit.

RECOMMENDATION 3

To offer equitable and timely access to emergency department care for patients who require it, we recommend that the Ministry of Health, in collaboration with Ontario Health, work with hospitals to identify and address challenges, such as the lack of timely access to primary care and lack of awareness of other health-care options, to help ensure lower-acuity patients receive care in the most appropriate care setting.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals to identify and address challenges to help ensure that lower-acuity patients receive care in the most appropriate care setting. On February 2, 2023, the government of

Ontario announced Your Health: A Plan for Connected and Convenient Care, its plan to provide people with a better health-care experience. Part of this announcement included an investment to create up to 18 interprofessional primary care teams. The Ministry will use this investment to help address the Office of the Auditor General of Ontario's recommendation by bridging the gap in accessing interprofessional primary care for vulnerable, marginalized and unattached patients to ensure they are able to connect to care where and when they need it. This investment of \$60 million over two years, beginning in 2023/24, will also sustain direct service delivery in existing interprofessional primary care teams that are experiencing increased operating costs.

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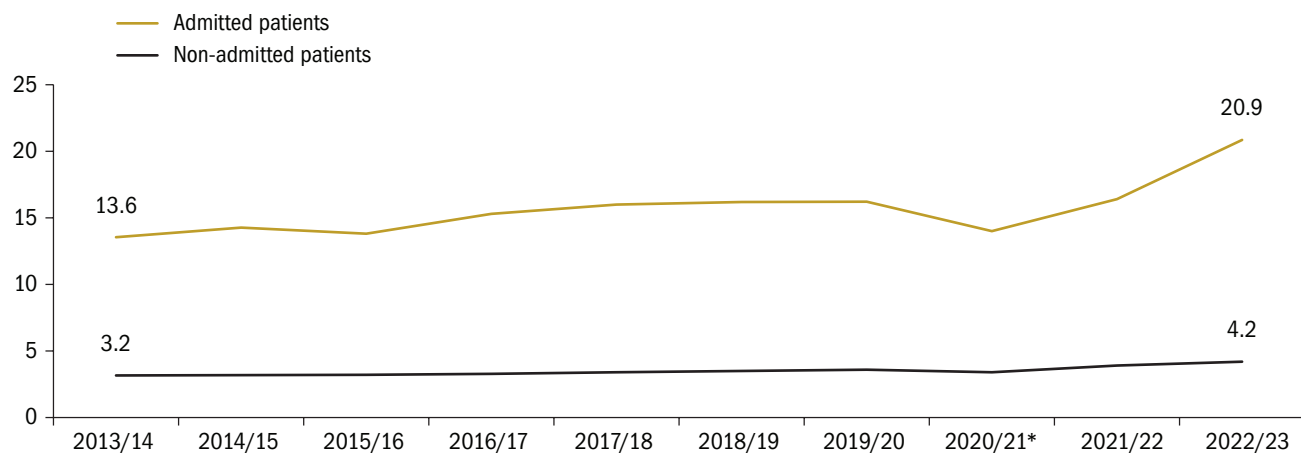
4.2.3 Medical Directives That Help Reduce the Time Patients Spend in Emergency Departments Were Not Used Consistently across Hospitals

Patients, regardless of whether they have to be admitted to the hospital or can be discharged after their emergency department visit, have had to spend significantly more time in the emergency department than they did prior to the COVID-19 pandemic. **Figure 14** shows the average time a patient spent in an emergency department for each visit over the last 10 years (2013/14–2022/23), from the time they were triaged by a nurse to when they left the emergency department. We found that:

- Patients who did not need to be admitted to an inpatient unit spent an average of 4.2 hours in an emergency department in 2022/23, over 30% more than the average 3.2 hours in 2013/14.

Figure 14: Average Time Spent in the Emergency Department, 2013/14-2022/23 (hours)

Source of data: Ontario Health



* The average time patients had to spend in emergency departments dipped temporarily in 2020/21 as the number of visits decreased during the COVID-19 pandemic.

- Patients requiring inpatient admission spent an average of almost 21 hours in the emergency department in 2022/23, or 50% more time than the average 14 hours in 2013/14. (Wait times for inpatient admission are discussed further in **Section 4.2.4.**)

While some of the time spent waiting in an emergency department is unavoidable (for example, waiting for blood tests or diagnostic imaging results), we found that hospitals do not have or use medical directives consistently to help speed up patient care.

Medical directives, which are developed by a hospital's emergency department physicians, authorize nurses and other hospital clinicians (such as physician assistants) to begin the process of assessing patients and performing certain procedures before their physician initial assessment. Common examples include ordering blood tests or imaging and administering pain control medication. For example, a hospital may have a medical directive that indicates that patients presenting with cardiac chest pain should be given specific medication and sent for blood tests while patients who experienced an acute injury, such as a fall, in the previous 48 hours should be sent for an x-ray at the time of triage.

Empowering nurses and other hospital clinicians to act before the physician initial assessment allows certain basic emergency department testing

and procedures to be completed more quickly and efficiently, leading to better patient flow as well as improved patient care because physicians can administer treatment quicker.

Based on our review of medical directives at the emergency departments we visited, we noted significant variations in their use. For example:

- While all of the sites had medical directives, the number of directives in use ranged from nine to 37 depending on hospital, with some sites using the directives to address more specific conditions such as low blood sugar level.
- While data on the use of medical directives is not tracked centrally at hospitals, we noted that some may be using the directives more frequently to initiate care. For example, one hospital indicated that medical directives were used to begin providing patient care for about 50% of emergency department visits.

While medical directives are not always applicable (such as in cases where a physician assessment is needed for a patient with multiple symptoms), there is no formal province-wide system to share best practices on the use of medical directives among hospitals to reduce the amount of time that patients spend in an emergency department.

RECOMMENDATION 4

To reduce the amount of time that patients spend in an emergency department, we recommend that Ontario Health, in collaboration with hospitals and emergency department physicians:

- review existing practices and usage of medical directives across hospitals; and
- develop and regularly update a set of standard medical directives that have shown success for hospital use when possible.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals and emergency departments to review existing practices and usage of medical directives and develop standard medical directives that have shown success. Ontario Health will continue to support sites interested in implementing medical directives where this resource is identified as an effective strategy for emergency department operations and flow performance.

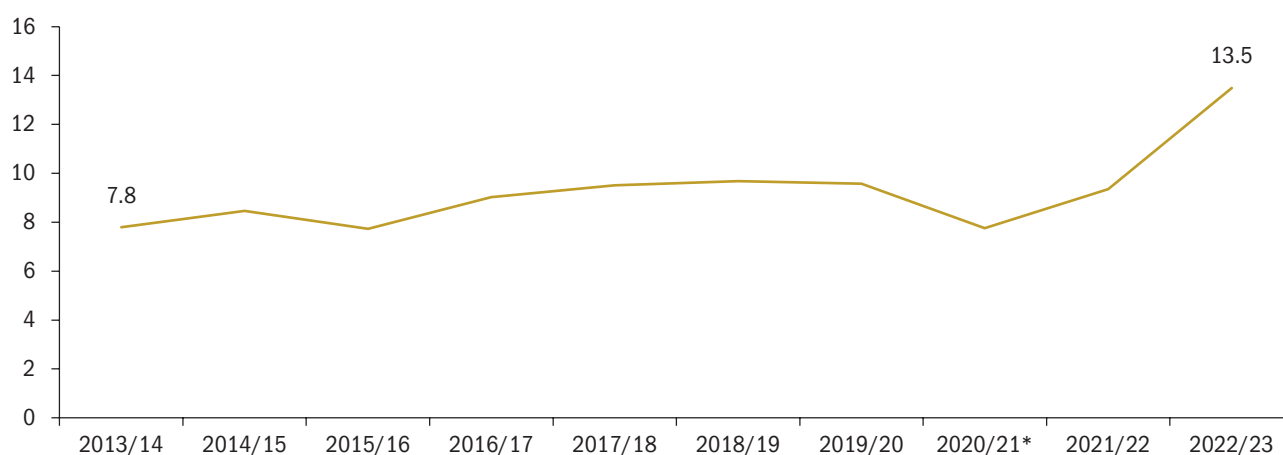
4.2.4 Emergency Patients Sometimes Had to Wait More than 24 Hours for an Inpatient Bed

Most patients who visit an emergency department are discharged the same day. However, some patients are admitted and transferred from the emergency department to an inpatient unit at the hospital for continuous monitoring or longer-term treatment. About 650,000 patients, representing 12% of all emergency department visits, required an inpatient admission in 2022/23 (compared with about 568,000 patients admitted in 2013/14).

As seen in **Figure 15**, in 2022/23 patients waited an average of 13 hours for an inpatient bed, a significant increase from the approximately eight to 10 hours they waited prior to the COVID-19 pandemic. When considering the 90th percentile wait time (the longest wait time after the top 10% are removed), patients waited 35 hours for an inpatient bed, compared with about 21 hours in 2013/14. Aside from the added strain this puts on patients and anyone accompanying them, the presence of people waiting for beds negatively affects the ability of the emergency department staff to focus on incoming patients.

Figure 15: Average Wait Time for Inpatient Bed in Ontario, 2013/14–2022/23 (hours)

Source of data: Ontario Health



* Wait times for an inpatient bed fell in 2020/21 as fewer patients visited the emergency department during the COVID-19 pandemic.

Figure 16: Average Wait Time for Inpatient Bed in Ontario by Sub-region, 2021/22–2022/23 (hours)

Source of data: Ontario Health

Region	Average Wait Time			Longest Wait Time
	2021/22	2022/23	Change	2022/23
Central West	13.0	18.8	5.8	20.8
Central East	12.4	18.9	6.5	24.4
Hamilton Niagara Haldimand Brant	12.0	15.8	3.8	44.4
Central	10.9	15.1	4.2	20.4
Mississauga Halton	10.8	21.3	10.6	28.1
Toronto Central	9.3	12.7	3.4	23.3
Champlain	9.1	10.9	1.9	32.5
North West	8.9	10.3	1.3	11.4
North Simcoe Muskoka	8.6	11.7	3.1	14.5
North East	7.8	9.9	2.1	13.8
Waterloo Wellington	7.1	12.3	5.3	15.4
South East	6.7	9.3	2.6	13.9
South West	5.8	8.8	2.9	25.1
Erie St. Clair	4.9	9.1	4.2	12.0

Note: Regions in this table correspond to the boundaries of the 14 Local Health Integration Networks (LHINs). While the Ontario government merged the 14 LHINs into five Ontario Health regions in December 2019, regional wait-time data has continued to be reported by LHIN.

We also noted significant differences in wait times for an inpatient bed across regions and hospitals. As shown in **Figure 16**:

- Patients' wait times in emergency departments for an inpatient bed ranged from about nine to 21 hours, on average, in 2022/23, depending on where in the province they lived. This was a significant increase from five to 13 hours in 2021/22. During this time, patients could be taking up an emergency assessment room or waiting in a wheeled stretcher in a hallway.
- The wait times varied widely by hospital. For example, while the average wait time for an inpatient bed in the Hamilton Niagara Haldimand Brant region was 15.8 hours in 2022/23, some emergency department patients in the region had to wait almost 44 hours.

As seen in **Figure 17**, the wait times for an inpatient bed across the hospitals we visited ranged from 10 to 21 hours for general hospitals and 3.7 to 9.2 hours for pediatric hospitals.

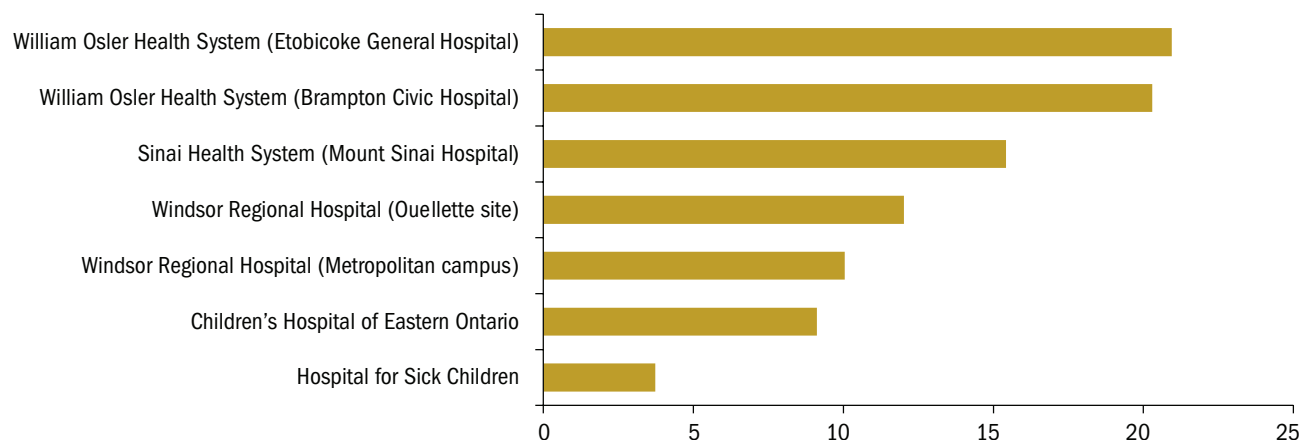
Lack of Inpatient Beds and Hallway Patients

One factor contributing to long wait times for inpatient beds is the lack of available hospital beds in Canada relative to the population. In 2021, Canada had 2.55 hospital beds per 1,000 people, placing it eighth among the 38 countries in the Organisation for Economic Co-operation and Development (OECD). In comparison, France, Germany and Poland had more than double Canada's rate with 5.5 beds per 1,000 people. The OECD does not report information on a provincial level, but Ontario is estimated to be at or lower than the Canadian average.

The long wait time for inpatient beds has been a long-standing issue in Ontario. The Premier's Council on Improving Healthcare and Ending Hallway Medicine, created by the Province in 2018, said in its January 2019 report that hallway health care was a significant problem in Ontario. The report found that on any given day, there were at least 1,000 patients receiving health care in hospital hallways, including in emergency departments.

Figure 17: Average Wait Time for an Inpatient Bed at Selected Hospitals in Ontario, 2022/23 (hours)

Prepared by Office of the Auditor General of Ontario



Based on our analysis of current data and observations at some of the emergency departments we visited, the issue of “hallway patients” continues to be a challenge, creating a significant risk to the general public because it decreases the space in which emergency department staff can treat new patients. The overcrowding also creates added stress for staff, patients and their families. A review of crowding in emergency departments published in 2018 in *PLOS ONE*, an international research journal, noted that crowding is generally associated with poorer patient outcomes.

During our site visits to emergency departments, we found that staff had to keep patients on wheeled stretchers as they waited for an inpatient bed. For example, during our visit to William Osler Health System’s Brampton Civic Hospital, we noted a significant number of elderly patients being treated in tight hallways while ambulance paramedics struggled to bring in additional patients. On the day of our tour, we noted that 46 patients were stuck in the emergency department, receiving care in hallways or assessment rooms, because of a lack of available inpatient hospital beds. Since emergency department staff continued to be responsible for these patients, their ability to treat new patients in a timely manner was impacted.

Alternate Level of Care Patients

Another contributing factor to the long wait times for inpatient beds is the relatively high number of

patients classified as alternate level of care (ALC). These patients are in a hospital bed but do not require hospital-level care and could be seen and treated elsewhere if space was available in a more appropriate facility, for example, a long-term care home. In our 2010 audit *Discharge of Hospital Patients*, we noted that ALC patients accounted for approximately 16% of the total number of days patients were hospitalized in Ontario. In comparison, the ALC rate in Ontario hospitals was approximately 15% in 2022/23, indicating a very slight improvement in reducing the impacts of ALC patients on inpatient admissions in the last 13 years.

RECOMMENDATION 5

To improve patient flow within emergency departments and reduce wait times for inpatient beds, we recommend that the Ministry of Health work with Ontario Health and hospitals to expand the capacity of inpatient beds and increase the availability of community resources to reduce the need to treat patients in hallways, and speed up the transfer of inpatients to more appropriate facilities.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario’s recommendation to expand the capacity of inpatient beds and increase the availability of community

resources to reduce the need to treat patients in hallways, and speed up the transfer of inpatients to more appropriate facilities.

The Ministry remains committed to working with Ontario Health to support the hospital sector and to improve access to the right level of care for patients. In 2023/24, Ontario invested up to \$1.5 billion in funding to support the continued operation of over 3,500 acute, post-acute and critical-care beds. The Ministry worked closely with Ontario Health to support bedded capacity planning linked to this investment to ensure that the right mix of acute and post-acute beds were provided where they are most needed and would be responsive to patient-care needs. This enables patient flow, provides access to the right level of care in the appropriate care setting, and bolsters the hospital sectors' ability to respond to arising pressures or increasing demand for services, which will help reduce the need to treat patients in hallways.

In 2022/23, the Ministry began funding Ontario Health to implement various alternate level of care (ALC) and patient flow initiatives targeting a reduction in the ALC rate. The initiatives span five categories: capacity maximization, admission avoidance, discharge supports, the development of local strategies, and home and community care. The Ministry has provided Ontario Health, as system administrators, the flexibility within these initiatives to direct funding where it is most impactful and is responsive to the evolving needs of the health system as a whole. The ALC initiatives are focused on providing the right level of care in the right setting and supporting different sectors of the health system to work in cohesion for the benefit of the patient.

The government has also been committed to ending hallway health care and has made a targeted investment into regions particularly struggling with this issue. This dedicated investment began in 2020/21 with a one-time investment to support the creation of an additional 129 hospital beds to increase hospital capacity in the Durham-Scarborough and London regions to target hallway health care. In 2023/24, this investment was made permanent.

Finally, expansion of inpatient capacity is a key component of the Ministry's 10-year capital plan. As part of this plan, the Ministry is investing in 50 major hospital development projects that will add another 3,000 new hospital beds in Ontario. Ontario's health capital investments over the next 10 years will lead to \$40 billion in health infrastructure across the province.

4.3 Long Wait Times Impacted the Quality of Emergency Department Care, Resulting in Poor Patient Outcomes

4.3.1 Some Patients Returned to Emergency Departments within a Week in Worse Health

In 2016, Ontario Health introduced the Emergency Department Return Visit Quality Program (Quality Program), which was designed to build a culture of continuous quality improvement in emergency departments across the province.

To identify areas for improvement, the Quality Program requires participating hospitals to report to Ontario Health the reasons why patients return to emergency departments soon after their initial visit. The two types of return visits as defined in the program are:

- An emergency department return visit within 72 hours of discharge, and the return visit results in an inpatient admission.
- An emergency department return visit within seven days of discharge, and the return visit results in an inpatient admission and a sentinel diagnosis relevant to the diagnosis documented in the initial visit. A sentinel diagnosis is one that is severe and significant, such as a heart attack or pediatric sepsis (a bodily response to a serious infection that is considered life-threatening).

Each year, participating hospitals are required to audit all return visits with a sentinel diagnosis within seven days as well as a random selection of return visits within 72 hours. At least 50 return visits must be audited at each hospital and a summary sent to Ontario

Figure 18: Examples of Poor Patient Outcomes

Prepared by the Office of the Auditor General of Ontario

Patient Story	Patient Outcome
A patient reporting recurring episodes of abdominal pain was discharged from the emergency department after it was determined that the blood work, vital signs and a physical exam showed no concerns. A physician only examined the patient in the waiting room and didn't provide a follow-up plan or request outpatient imaging.	The patient returned two days later with a ruptured appendix that required emergency surgery.
A patient arrived at the emergency department complaining of difficulty swallowing. The patient waited for over five hours and, due to the long wait time, decided to take a taxi to another hospital.	Staff at the second hospital determined the patient needed a breathing tube and admitted the patient to the critical care unit.
A clinic referred a patient with a possible hip fracture to the emergency department. The patient received an X-ray about an hour after being triaged but was not seen by a physician until a further nine hours later. The physician then sent the patient for a CT scan, but because of the time already spent in the emergency department the patient decided to leave the hospital.	The patient received a CT scan as an outpatient and was eventually admitted for surgery the following day.
A patient at the emergency department presented with acute and chronic abdominal pain. A CT scan was ordered, but due to a long wait time for the scan the patient decided to leave and return the next day.	After returning to the emergency department for a CT scan the next day, the patient was diagnosed with a strangulated hernia and required inpatient admission.
A patient went to the emergency department with a skin reaction to chemotherapy. While the patient was discharged after receiving treatment, there were no discharge instructions on the record. The patient returned to the same emergency department the following day with the same symptoms. However, likely due to an expected long wait time, the patient left before receiving treatment.	The patient went to another hospital emergency department on the same day and was admitted as an inpatient.
Emergency department staff determined a patient had an obstructing kidney stone, but discharged the patient with a planned follow-up because there was no inpatient bed available.	The patient returned to the emergency department the next day with increased pain and was admitted to the hospital.

Note: These examples are based on a review of the documentation related to the Emergency Department Return Visit Quality Program, as well as discussions with staff at select hospitals we visited.

Health. These return visits may be the result of patients who left the emergency department without being seen by a physician due to long wait times during their initial visit (see **Section 4.2.1**).

We noted that in 2022, 1,135, or about 20%, of the 5,198 audits of return visits identified a quality-of-care issue or adverse event such as patient mismanagement (for example, lack of reassessment of patients), a delayed or missed diagnosis or an unsafe discharge decision. These audits included 274 return visits with a sentinel diagnosis, 104 of which identified a quality-of-care issue or an adverse event had occurred.

We reviewed the details of the audits performed by hospitals over the last five years and noted numerous examples where long wait times to see a physician, a lack of access to timely patient testing and a lack of inpatient bed availability resulted in poor patient outcomes. We also noted additional examples of poor patient outcomes during our work with hospitals (see **Figure 18**). In some instances, patients left emergency departments due to lengthy wait times, but returned shortly after their initial visits and required emergency surgery and hospital admission.

4.3.2 Hospitals Did Not Consistently Track and Report Emergency Department Return Visits and Related Quality-of-Care Issues

Participation in the Quality Program is not mandatory for all hospitals with an emergency department. Only emergency departments that participate in the Pay for Results (P4R) program (see **Section 4.6**) are required to participate in the Quality Program. At the time of our audit, 75 emergency departments participated in the Quality Program, so about half of Ontario's emergency departments were not required to report their data on return visits to Ontario Health. As such, Ontario Health did not know whether those hospitals internally audited their emergency department return visits to identify any issues related to quality-of-care or adverse events.

Furthermore, while the goal of the Quality Program is to foster a culture of continuous quality improvement, we found that hospitals did not report the results of their return-visit audits on a consistent basis, making it difficult to draw conclusions on how the province as a whole is performing. While hospitals are required to indicate whether a return visit was due to a quality-of-care issue (that is, a misdiagnosis or unsafe discharge), there was a wide variation in the way hospitals defined and classified these issues. For example, we found that in two very similar cases at different emergency departments, one hospital called the event a quality-of-care issue, while the other hospital did not. This may have contributed to the wide variation of return-visit rates we found across hospitals. For instance, one hospital indicated almost 35% of its return visits were due to a quality of care issue compared to 4% at another hospital.

Based on our review of data on return visits between 2018 and 2022, we found that the rate of return visits requiring admission remained constant even though the number of emergency department visits declined over that period.

Because of a Ministry decision to expand eligibility for participation in the P4R program, as discussed in **Section 4.6**, there is a likelihood more hospitals will be required to participate in the Quality Program.

RECOMMENDATION 6

To help ensure that emergency departments provide high-quality care, we recommend that Ontario Health expand and monitor the Emergency Department Return Visit Quality Program by requiring all hospitals with emergency departments to participate and report their data on return visits and patient outcomes or issues related to adverse events consistently and on a timely basis.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation, and as a key component to the Pay for Results (P4R) expansion announced by the Ministry of Health in 2023/24, will work with hospital sites to begin planning implementation of the Emergency Department Return Visit Quality Program (Quality Program) in future fiscal years.

Ontario Health aims to maintain the goals of the Quality Program for all participating emergency departments, while designing appropriate program requirements in its expansion to include small-volume sites.

4.3.3 Ambulance Offload Times Contributed to Even Longer Wait Times for Patients and Risks to Communities

Ambulances are a critical part of the health-care system. While 80% of the patients who visited an Ontario emergency department in 2022/23 entered by their own means, 20% were brought in by ambulance. Despite the importance of the ambulance network, we noted that some paramedic groups have struggled to maintain timely service in recent years because ambulances were often stuck at emergency departments waiting to offload a patient. Since all patients arriving at emergency departments are assessed the same way, patients arriving by ambulance did not get priority to walk-ins.

We met with senior staff from various paramedic groups across the province to better understand the

ambulance offload process and challenges faced by paramedic groups when offloading patients at hospitals. While there is no formal provincial target for ambulance offload times, paramedic groups informed us that on average 30 minutes or less is considered best practice in the industry. We found, however, that this target has not been met consistently and there have been cases where offload delays were significantly longer than the 30-minute target. For example:

- Ottawa Paramedic Service experienced offload delays of as long as three hours and faced a total of about 98,000 hours in offload delays in 2022/23.
- Toronto Paramedic Services experienced delays of up to 52 minutes and indicated that they faced a total of almost 62,000 hours in offload delays in 2022/23.

Tying up ambulances poses a significant risk for communities, and it is an ongoing challenge. For example, on multiple occasions in 2023, Essex-Windsor Emergency Medical Services had to declare “code black,” a designation that signifies no ambulances are available in the community.

There are two main causes of offload delays: unavailability of nursing staff to immediately triage the patient and bring them into an assessment room; and limited assessment room space. As such, the paramedic must stay with the patient to provide support until emergency department staff take over.

To address the issue of lengthy offload times for ambulance staff, the Ministry implemented the Dedicated Offload Nurse Program in 2008. The program provides funding to some municipalities, which in turn transfer funding to local hospitals to hire nurses or other health-care professionals (i.e., paramedics) to help improve the timeliness and efficiency of the ambulance offload process so the paramedics can get back into the community in a timely manner. Paramedic groups have informed us that this program has been successful in improving offload times, but it does not address all of the main challenges. Given continuous hospital staffing issues and the unavailability of assessment rooms or

beds, offload times have remained long even at hospitals with a dedicated ambulance offload nurse.

Some paramedic groups have worked with local hospitals to address the long-standing ambulance offload delays, or shorten offload times, especially for lower-acuity patients. For example:

- Peel Regional Paramedic Services worked with William Osler Health System to implement the Fit2Sit program in October 2020. This program allows paramedics to discharge lower-acuity patients quicker if they are able to sit in the waiting area. Patients are accompanied by paramedic staff to triage, while the hospital takes responsibility for monitoring those patients. We noted that this program has resulted in offload times for patients that meet the Fit2Sit criteria of about nine minutes, significantly shorter than the 30-minute industry standard.
- Windsor Regional Hospital has directly hired two paramedics in one of its emergency department sites to help manage and monitor patients arriving by ambulance until they can be triaged and assessed so paramedics can return to the community quicker.

Despite their success, these practices and processes have not been consistently adopted across hospitals even in regions or hospitals that have experienced lengthy ambulance offload delays.

RECOMMENDATION 7

To efficiently offload patients arriving at an emergency department by ambulance and more quickly free up ambulances to address other emergency calls, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- continue to review and enhance the Dedicated Offload Nurse Program to ensure it supports improvement in offload times; and
- work with hospitals and regional paramedic groups to continue identifying other initiatives, such as the Fit2Sit program in Peel region, that

have improved the offload process, and share these practices across the province to help address lengthy ambulance offload times.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges and supports this recommendation. The Ministry remains committed to continuing to review and enhance the Dedicated Offload Nursing Program (DONP) and to identify and share best practices across paramedic services and hospitals in order to help reduce ambulance offload times.

The Ministry has made the following progress on this recommendation:

- In the 2023 Ontario Budget, the government is investing an additional \$51 million over three years to strengthen the DONP.
- In 2023/24, the DONP funding invested will help 30 municipalities provide 650,000 hours of offloading support, transferring ambulance patients to hospital care, and allowing paramedics to return to the community faster to respond to 911 calls.
- Expanded DONP eligibility to allow hospitals to also hire other types of health providers (paramedics, respiratory therapists, and physician assistants) in offloading positions, providing more flexibility to better manage ambulance offload times.
- Continue to share best practices from hospitals high performing in ambulance offload times (for example, North York General Hospital) with paramedic services and other hospitals across the province to help them improve their ambulance offload. Resources that have been shared include a Tool Kit for Promoting Ambulance Offload, created by Toronto Paramedic Services, with all paramedic services in the province.

4.4 Triage Process Has Improved but More Oversight and Further Changes Are Needed

4.4.1 New Triage System Was in Place but Some Hospitals Were Not Using It

As discussed in **Section 2.2.1**, triaging is the process of prioritizing patients based on the urgency of their symptoms or injury to help ensure that resources are allocated effectively to treat the sickest patients first.

When a patient visits an emergency department, their first clinical interaction is typically with a triage nurse. Triage nurses assess the urgency of a patient's condition based on both subjective and objective information, including the patient's presenting symptoms, general appearance and health history. The triage nurse also conducts general tests that typically include a check of the patient's blood pressure and vitals. This information is then used to assign a priority level using the Canadian Triage and Acuity Scale (CTAS).

During our 2010 audit Hospital Emergency Departments, hospitals were manually conducting triaging. At the time, we found that file documentation was sometimes lacking and triage was not performed on a consistent basis. In response to our findings and recommendations, the Ministry and Ontario Health began implementing the electronic Canadian Triage and Acuity Scale system, known as eCTAS, across hospitals in 2016 to help ensure consistency and oversight of triaging across the province. The eCTAS system allows triage nurses to input pertinent patient information to determine a CTAS level for each incoming patient.

Based on our review of eCTAS and discussion with hospital staff, we found that nurses' use of the system has generally made the triage process more consistent and efficient. Furthermore, we noted multiple studies that looked at usage of the eCTAS system and noted its benefits. For example, one study published in the *Journal of American College of Emergency Physicians* in 2020 looked at the triage process before and after the

implementation of eCTAS in Ontario and found that it improved the consistency of triaging patients, especially among patients with multiple complaints such as chest pain, fever and shortness of breath. Another study published the same year in the medical journal *Annals of Emergency Medicine* reviewed the use of eCTAS at seven Ontario emergency departments before and after implementation and found that the system had improved the accuracy of the assigned triage levels compared to an auditor's assessment of CTAS level.

Despite these improvements, and even though both Ontario Health and the Ministry have encouraged hospitals to implement the eCTAS system, 44 emergency departments do not currently use eCTAS. Ontario Health informed us that it was in the process of onboarding 11 more emergency departments as part of an eCTAS expansion project scheduled to take place in 2023/24—though, once completed, that would still leave 33 emergency departments outside the system.

4.4.2 Some Hospitals Were Consistently Overriding the Triage Level Assigned by the System, Indicating More Training May Be Needed

In some situations, nurses can decide that the triage level assigned by the eCTAS system is not urgent enough—that is, the triage nurse's observation and assessment of the patient may lead the nurse to believe the patient is sicker than what the system indicates. In these cases, it is possible for the triage nurse to manually override the eCTAS system and assign a higher triage level. For example, if the eCTAS system assigns a patient CTAS 4 but the nurse believes the patient needs to be seen more urgently, the nurse could manually assign the patient a CTAS 2. When this happens, the system tracks the override and the reason for the override based on a drop-down menu. The triage override function only allows a nurse to increase a patient's priority, not lower it.

Ontario Health, which centrally oversees the eCTAS system, monitors when triage nurses at any particular hospital override the system more than 10% of the time. When a hospital does so, Ontario Health will send information related to the overrides to the hospitals and ask administrators to explain the high number of overrides.

We noted that in the last five years, the provincial average override rate has consistently exceeded 10%, ranging from 14% to 16%. In that time, over 70 hospitals were overriding eCTAS more than 10% of the time. In 2022/23, about 13 hospitals were overriding the eCTAS levels in more than 25% of their cases, or 2.5 times the expected threshold set by Ontario Health.

Furthermore, we noted that in some cases, override rates were attributable to certain triage nurses, with some overriding the triage levels more often than others, indicating that they may not have been adequately trained on the use of the eCTAS system and its override function. For example, one of the pediatric hospitals we visited was overriding eCTAS in almost 29% of cases, with even higher override rates in earlier years. We also noted that hospitals had initiated additional training to help ensure triage nurses understood how to correctly utilize the system. However, the hospital also mentioned that eCTAS was not as well integrated with pediatric triaging. As such, the hospital indicated that it would be beneficial to update the eCTAS system by adding more symptoms aligned with pediatric care that impact triage levels.

There are situations in which increasing the triage level is valid. For example, patients presenting with non-urgent symptoms may also be undergoing significant mental distress that needs to be treated but cannot easily be captured in the eCTAS system. However, since the purpose of implementing the eCTAS was to help ensure consistency and oversight of triaging, overrides may raise the risk that patients are not being triaged equitably or in accordance with their needs. Ontario Health informed us that the eCTAS system may

not be able to capture all of the patient's concerns when they present at the emergency department, and therefore having some overrides is unavoidable, but should be limited overall.

RECOMMENDATION 8

To safely, effectively and equitably triage patients, we recommend that Ontario Health:

- work with all hospitals in the province to implement the electronic Canadian Triage and Acuity Scale (eCTAS) system;
- conduct a thorough analysis of why some hospitals, such as pediatric hospitals, have consistently high triage override rates and determine whether changes to the system are necessary; and
- ensure triage nurses are adequately trained on the use of the eCTAS system and receive regular ongoing training as needed.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation and, as a key component to the Pay for Results (P4R) expansion announced by the Ministry of Health in 2023/24, will use the opportunity to further work with hospital sites to begin planning implementation of eCTAS in future fiscal years and to analyze why some hospitals have consistently high triage override rates.

Ontario Health uses a Train the Trainer system to train a clinical lead in each of the sites using the Ontario Health eCTAS Application (Complex and Basic). Clinical Leads are responsible for training the staff at their facility in how to use eCTAS. Certification and Webservice sites have chosen the option to use their own process and documentation in their eCTAS tools.

4.5 Human Resource Shortages and Payment Structures Posed Risks to Emergency Department Accessibility

4.5.1 Significant Staffing Shortages Reduced Access to High-Quality Emergency Care

Staffing shortages and vacancies, particularly in nursing, have put many emergency departments under pressure and resulted in temporary closures in recent years (see **Section 4.1.1**).

In discussions with Ontario Health and hospitals, we noted the high staff turnover and difficulty with hiring and retaining nurses were mainly due to:

- the introduction of Bill 124, which limited wage increases for many employed professionals (including nurses) to 1% each year for three years, angering nurses, especially those working at hospitals in urban centres with higher costs of living, and leading to court challenges;
- higher pay and flexibility being offered by agencies (discussed further in **Section 4.5.3**);
- low staff satisfaction at hospitals;
- an increase in workplace violence in emergency departments; and
- nurses retiring or taking early retirement.

Since the Ministry and Ontario Health have never collected and tracked information on staffing shortages and vacancies across emergency departments, we requested staffing counts and vacancies from the emergency departments we visited and compared the information in 2019/20 (pre-COVID-19) and 2022/23 (see **Figure 19**). We noted that:

- Most emergency departments experienced a significant increase in vacancy rates between 2019/20 and 2022/23. For example, one emergency department's vacancy rate of full-time registered nurse increased significantly from 6% to 26%, and the rate for part-time registered nurses increased from 23% to 51%.
- Most emergency departments had high vacancy rates for full- and part-time registered nurses in 2022/23 ranging from 11% to 51%.

Figure 19: Emergency Department Vacancies for Registered Nurses (RNs) at Selected Hospitals in Ontario, Pre- and Post-COVID-19 (%)

Prepared by the Office of the Auditor General of Ontario

Hospital	Position	Vacancy Rate ¹	
		2019/20	2022/23
William Osler Health System (Brampton Civic Hospital and Etobicoke General Hospital)	Full-time RN	6	26
	Part-time RN	23	51
Sinai Health System (Mount Sinai Hospital)	Full-time RN	3	19
	Part-time RN	12	19
Windsor Regional Hospital (Metropolitan campus and Ouellette campus)	Full-time RN	6	17
	Part-time RN	15	25
Children's Hospital of Eastern Ontario	Full-time RN	10	11
	Part-time RN	12	20
Hospital for Sick Children²	Full-time RN	8	22

1. As at March 31 fiscal year-end.

2. The Hospital for Sick Children did not have any part-time vacancies to report.

In summer 2022, Ontario Health began surveying hospitals on behalf of the Ministry to identify overall staffing pressures in emergency departments. We reviewed the results of this survey as of May 1, 2023 and found that out of the 71 hospitals that responded, 83% (or 59 hospitals) reported having a staffing shortage in their emergency departments to varying degrees. In the survey, 69% (or 49 hospitals) described the staffing shortage as moderate, while 14% (or 10 hospitals) said their staffing situation was severe or critical. Despite this, at the time of our audit neither the Ministry nor Ontario Health had developed a long-term strategy or acted upon this information to take specific actions related to hospitals with significant staffing shortages.

4.5.2 Hospitals Had Limited Flexibility to Address Staffing Shortages at Emergency Departments Using Internal Resources

An organization can often resolve staffing shortages in a specific department by reorganizing its internal staffing resources on a temporary basis. We asked administrators at the hospitals we visited whether they were able to have nurses in other units provide temporary support in the event of a nursing shortage

in the emergency department. They informed us that hospitals' collective agreements with nursing staff provided them with limited flexibility to move nurses between units.

We noted that nurses are required to meet specific training requirements to work effectively in an emergency department. These requirements include:

- at least one to two years of hands-on training in addition to other certifications; and
- new nurses need to be overseen by an experienced and trained nurse.

While it is understandable that nurses with particular training and experience should work in areas where they have expertise, redeploying nurses from other units to fill temporary staffing gaps at emergency departments is a practical and feasible solution. We noted that the practice of redeploying nurses has been used by some hospitals we visited and was in place during the COVID-19 pandemic after a special order was issued by the Ontario government. Specifically:

- The government issued a special order during the pandemic under the March 17, 2020 declaration of emergency that allowed hospitals to temporarily reassign staff based on needs. This included redeploying staff (including nursing staff under collective agreements) within a

hospital or between hospital sites. For example, a hospital we visited indicated that because of this order, it was able to shift nurses from inpatient units into the emergency department on a temporary basis to fill significant vacancy gaps and sick leaves. The hospital indicated that it would be beneficial to continue to have this flexibility. However, this special order is no longer applicable.

- One of the hospitals we visited, where nurses were not part of collective agreements, had initiatives in place that enabled it to fill staffing gaps in the emergency department effectively without putting patient care at risk. Examples of such practices include:
 - using nurses from other units of the hospital to help fill staffing needs in the emergency department; and
 - having a trained and experienced emergency department nurse overseeing and supporting nurses redeployed to the emergency department from other units.

4.5.3 Hospitals Filled Staffing Gaps by Hiring Agency Nurses at Significantly Higher Hourly Rates

When a hospital is facing a nursing shortage that cannot be addressed by redeploying its own staff, it often has to rely on staffing agencies to fill gaps and vacant positions. This has put financial pressure on hospitals that employ agency nurses, partly because they are usually paid more than permanent staff.

While there are many staffing agencies in Ontario that provide nurses to fill positions, it is unclear how often hospitals use these agencies to fill vacancies at their emergency departments because the Ministry and Ontario Health do not collect such information. There also is no legislation that caps the amount these private, for-profit companies can charge hospitals. The Ministry and Ontario Health do not specifically track agency staff costs and rely on hospitals to manage their own budgets and make decisions related to agency staffing.

We reviewed data on agency-nurse spending across the hospitals we visited and found that in 2022/23, one

hospital spent about \$8 million on agency nurses in the emergency department, more than three times the amount it spent in 2021/22, and more than eight times its spending in 2019/20. Another hospital we visited spent \$2.7 million on agency nurses across its emergency departments in 2022/23, 4.5 times more than the approximately \$600,000 it spent in 2021/22.

Through our review of hospital finances, we found that the cost to use agency staff was significant because hospitals pay agency nurses significantly more than their own full-time permanent nurses. For example, agency nurses that hold the position of registered nurse working in an emergency department could get paid more than \$75 an hour, compared with about \$35 to \$50 an hour for the full-time permanent nurses employed by a hospital. One hospital paid agencies from \$99 to \$106 an hour to hire a registered nurse for its emergency department.

Through our Office's 2023 audit *Hospitals in Northern Ontario: Delivery of Timely and Patient-Centred Care*, we found that the significant use of agency nurses extends beyond emergency departments. For example, that audit found that of the 34 Northern Ontario hospitals that responded to a questionnaire, 30 of them used agency nurses in 2022/23 at a cost of more than \$73 million. Furthermore, that audit found that agencies charged hospitals as much as \$160 an hour for a registered nurse.

Barring Ministry intervention, agency nursing costs may continue to rise. The higher pay and flexible hours for agency nurses have resulted in some permanent nurses leaving hospitals as well as high vacancy rates (as discussed in **Section 4.5.1**), which in turn has forced hospitals to rely on agency nurses even more to fill their nursing shortages.

RECOMMENDATION 9

To efficiently and economically deliver emergency care, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- expand existing data collection to include vacancy data of emergency departments to identify staffing challenges and determine if any province-wide actions need to be taken;

- comprehensively collect and monitor hospital expenditures on agency staffing to determine the reasonableness of payments to staffing agencies and the need to negotiate or legislate such payments to ensure fairness and transparency; and
- work with collective-bargaining organizations to implement permanent mechanisms that allow for more flexibility of staff movement within each hospital in urgent and temporary situations.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to expand existing data collection to include vacancy data of emergency departments. The Ministry acknowledges the importance of effective data collection and analysis in support of effective health workforce planning. The Ministry will review the data-related aspects of the recommendation to determine how best to refine its data-collection practices in support of current and future work to support service delivery in emergency departments. Today, the Ministry already collects data regarding hospital staffing pressures, staffing positions, vacancies and staff absenteeism. Data related to compensation expenses for agency staff who provide direct care/services is collected on a quarterly basis in the Ontario Healthcare Financial and Statistical System. This information can be used to monitor the utilization of agency staff for particular service departments.

With respect to the element of the recommendation related to agency staffing, the Ontario government recognizes the role staffing agencies play in supporting a flexible workforce. The government also recognizes that agency rates in Ontario have increased significantly, creating instability for hospitals, long-term care homes and emergency departments. We are working to evaluate the issue of rising agency reliance and costs. This includes, as noted in the government's Plan to Stay Open:

Health System Stability & Recovery, engaging with frontline partners to better understand how we can bring stability to hospitals, long-term care homes and emergency departments, while protecting quality of care. The Ministry will also review mechanisms that allow for more flexibility of staff movement within each hospital in urgent and temporary situations.

4.5.4 Inconsistencies and Flaws in the Physician Payment Structure Could Impact Timeliness and Oversight of Emergency Department Care

As discussed in **Section 2.3**, the majority of emergency department physicians are compensated through an alternative funding arrangement (AFA), while some physicians use a fee-for-service (FFS) model and bill directly to the Ontario Health Insurance Plan. In cases where an emergency department is under the AFA model, all emergency department physicians working for that hospital are part of the same AFA. For physicians compensated through the AFA, there is typically a base funding component, which is essentially a salary divided among the physicians working under the AFA.

We noted that outdated AFAs can contribute to hiring and retention challenges in some communities, particularly in Northern Ontario. For example, one northern hospital indicated that its significant reliance on physicians through the Locum Program (described in **Section 4.1.2**) could be attributed to the outdated terms and conditions of the AFA, which did not adequately capture the number and complexity of patients that emergency physicians had to treat. Because many patients do not have access to primary care, the emergency department can be the only care provider in a northern community. The situation, in turn, may lead to further physician vacancies and further reliance on the Locum Program.

We also noted that there can be a lack of oversight of the pay and performance of individual physicians who are part of an AFA. Specifically, we noted that the Ministry does collect the total hours worked by physicians collectively at each hospital for adherence to AFA agreements, but does not review information on

the funding provided to each physician or the volume of patients seen by each physician. For example, there is no oversight mechanism to identify and review physicians who see a relatively low number of patients per shift or who spend longer on assessments compared to peers.

We also found that patient access to a physician could be directly impacted by whether physicians are compensated through an AFA or FFS model. Although only 15% of all emergency departments are under an FFS model, of the five hospitals with the shortest physician initial assessment wait times in **Appendix 3**, three were using an FFS model while all five of the lowest performing hospitals were on an AFA.

For example, William Osler Health System's emergency department physicians are under an FFS model. Despite the high volume of patients in its emergency department, it still had relatively short wait times for a physician initial assessment compared to all other hospitals we visited, as noted in **Figure 12**. An emergency department physician at the hospital told us that the shorter wait times to see a doctor were a result of process improvements that were easier to implement under an FFS model.

The Ministry and the Ontario Medical Association have agreed to undertake a study to evaluate the AFA, the workload of emergency department physicians and the time they spent treating patients. The study, which may ultimately impact base payments made to those physicians, was expected to begin in January 2024 and be completed in early 2025. However, we noted that there was no plan to evaluate the effectiveness of both the AFA and FFS models and to determine which model better meets patient needs.

RECOMMENDATION 10

To effectively and efficiently compensate emergency department physicians, we recommend that the Ministry of Health work with Ontario Health and hospitals to comprehensively review all current compensation structures and make changes to help ensure they are patient-focused and incentivize timely patient care.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to work with Ontario Health and hospitals to review current compensation structures and make changes as needed to ensure patient-focused and timely patient care.

The Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

4.6 Oversight of Emergency Department Performance Was Lacking and Initiatives to Improve Performance Were Not Evaluated

To incentivize improvement in patient flow through emergency departments, the Ministry created the Pay for Results (P4R) program in 2008. Managed and overseen by Ontario Health, the program provides financial incentives to help hospitals improve the performance of their emergency departments. The objective of P4R is to support hospital innovation and practices that reduce patient wait times and length of stays.

The P4R program has focused on large hospitals with a high volume of emergency department visits. To be eligible to participate, an emergency department must have had at least 30,000 annual visits in the last two consecutive years. At the time of our audit, there were 75 hospital sites participating in the P4R program. On July 20, 2023, the government announced it would invest an additional \$44 million in the P4R program and expand the eligibility criteria to

allow smaller hospitals to participate in the program, although the funding allocation was still in progress at the time of our audit.

The program assesses the performance of each participating hospital's emergency department using six key performance indicators:

- Length of stay for admitted patients
- Length of stay for non-admitted high-acuity patients
- Length of stay for non-admitted low-acuity patients
- Time to physician initial assessment
- Time to inpatient bed
- Ambulance offload times

Each year, hospitals participating in the program are ranked based on their performance compared with other hospitals. For the first five performance indicators noted above, the ranking considers each participating hospital's most recent annual performance and historical performance since joining the P4R program. For the indicator related to ambulance offload times, the ranking only considers the most recent annual performance. Once all hospitals have been ranked, they are allocated a portion of the P4R program funding, which was approximately \$93 million in 2022/23.

4.6.1 P4R Program Showed Initial Successes but It Has Become Less Effective at Improving Emergency Department Patient Flow

Despite showing some success over the years, the P4R program has not had a significant impact on improving patient flow and reducing patient time spent in emergency departments in recent years. We reviewed historical P4R program data and found that in the early years of the program, some key performance indicators showed wait time reductions at participating hospitals. However, we found that the hospitals' average annual performance had deteriorated leading up to the December 2018–November 2019 period, the most recent full-year results before the COVID-19 pandemic, and their average annual performance decreased further during the pandemic. As **Figure 20** shows, based on the five indicators that use historical performance as a benchmark, a significant number of hospitals saw their performance deteriorate in 2019 compared to when they first joined the P4R program. For example, as of 2019 almost half of the 74 hospitals participating in the P4R program at that time had a longer overall patient length of stay in the emergency department for admitted patients and a longer wait time for an inpatient bed compared to when they joined.

Figure 20: Number of Hospitals Where Performance Deteriorated After Joining the Pay-for-Results (P4R) Program by Indicator, Pre-COVID-19

Source of data: Ontario Health

Performance Indicator	Hospitals Where Performance Deteriorated After Joining the P4R Program	
	#	%*
1. Length of Stay for Admitted Patients	36	49
2. Length of Stay for Non-Admitted High-Acuity Patients	18	24
3. Length of Stay for Non-Admitted Low-Acuity Patients	32	43
4. Time Before Physician Initial Assessment	28	38
5. Time to Inpatient Bed	35	47

Note: The Ministry created the P4R program in 2008, and hospitals joined the program in different years. This chart is based on each participating hospital's performance data from the period between December 2018 and November 2019, the most recent full-year results prior to the COVID-19 pandemic. It excludes the sixth performance indicator that measures ambulance offload times because that indicator does not factor in historical performance.

* The percentage is calculated based on data from the 74 hospitals that were participating in the P4R program in 2019.

Figure 21: Length of Stay for Non-Admitted High-Acuity Patients at Selected Hospitals in Ontario (hours)

Prepared by the Office of the Auditor General of Ontario

Hospital	Year Joined P4R	Hours Spent in Emergency Department*		
		Prior to Joining P4R Program	2019	2022
Sinai Health System (Mount Sinai Hospital)	2008/09	10.5	7.9	8.2
Hospital for Sick Children	2010/11	9.2	6.6	10.4
William Osler Health System (Brampton Civic Hospital)	2008/09	9.4	6.7	7.8
William Osler Health System (Etobicoke Hospital)	2009/10	8.0	6.4	7.0
Children's Hospital of Eastern Ontario (Ottawa site)	2010/11	6.8	6.9	9.5
Windsor Regional Hospital (Metropolitan campus)	2008/09	7.9	9.6	13.8
Windsor Regional Hospital (Ouellette campus)	2010/11	6.6	9.8	11.6

* This is calculated using the 90th percentile, meaning times are calculated after removing the 10% of patients with the longest wait times.

We reviewed these indicators across the hospitals we visited and found similar trends (see **Figure 21**). For example, some hospitals had shown improvement in the length of stay for non-admitted patients in 2019 while others had gotten worse, but all had regressed between 2019 and 2022.

Furthermore, while P4R funding is allocated to hospitals based on the performance of their emergency departments, we noted that participating hospitals continued to receive P4R funding even when their performance slipped from 2019 to 2022.

Ontario Health and some hospitals informed us that demographic profiles for communities and regions have changed significantly since hospitals began joining the P4R program almost 15 years ago. For instance, population growth or increased emergency department utilization make it more difficult for hospitals to maintain or improve their performance.

Another reason that P4R has become less effective is related to the way some hospitals are using the P4R funding. Based on our review of P4R documentation and practices across the hospitals we visited, we found that instead of testing and trying new methods to help shorten wait times and the overall length of stay in an emergency department, some hospitals were using P4R funding to create and/or fill nursing or clinician positions in order to keep up with patient volumes and care needs. This approach helps address patient flow

in the short term, but may do little to improve patient wait times and length of stay in the longer term.

4.6.2 Some Performance Initiatives Appeared Beneficial but Evaluations Were Not Being Done to Confirm Viability for Expansion

Through our review of initiatives funded by the P4R program at the hospitals we visited, we noted that some appeared to be beneficial in improving patient flow and reducing the time patients spend in the emergency department. For example:

- SickKids has used some of its P4R funding to create an emergency department hub to treat ambulatory patients who are at lower acuity (CTAS 3 to CTAS 5) and likely to be discharged home. These patients comprise 76% of the patient visits to SickKids' emergency department.
- Windsor Regional Hospital used some P4R funding to create a dedicated emergency department psychiatrist shift seven days a week to reduce wait times for a psychiatric consultation and to help certain patients transition between the emergency department and the mental health assessment unit.
- Four of the five hospitals we visited used some P4R funding to hire physician assistants, who

help free up time for emergency department physicians to see more patients.

While funding for the P4R program is meant to be flexible and used by hospitals to develop initiatives that improve the performance of their emergency departments, we found that the Ministry and Ontario Health had not done a thorough evaluation of potential best practices to determine if they could be implemented on a permanent basis and expanded to more hospitals. If this evaluation had been done, hospitals would have been able to more effectively identify practices that improve patient flow.

RECOMMENDATION 11

To more effectively improve patient flow across emergency departments in Ontario, we recommend that Ontario Health, in collaboration with the Ministry of Health and hospitals:

- evaluate the effectiveness of the Pay for Results (P4R) program to determine what changes are necessary to meet the intended objectives, such as setting performance targets; and
- review hospitals' use of performance funding to ensure that these practices align with the objectives of the P4R program and that effective practices are adopted by more hospitals.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to evaluate the effectiveness of the Pay for Results (P4R) program and review hospitals' use of performance funding. In 2023/24, the Ministry announced significant changes to the P4R program. Ontario Health will work closely with the Ministry and hospital sites on implementation of the P4R expansion and will use this opportunity to continue work to address the recommendation. Ontario Health closely monitors performance of all sites participating in P4R.

4.7 Province Does Not Have Framework to Evaluate and Encourage Use of Effective or Emerging Practices

4.7.1 Effective Diversion Practices at Emergency Departments Were Not Being Shared with Other Hospitals for Province-Wide Implementation

During our site visits, we noted that some hospitals have unique practices to divert certain patients away from the emergency department to a specific unit or space within the hospital for treatment. Such practices not only can expedite care for patients in a more appropriate setting but also free up space and resources in emergency departments. Examples of these practices included:

- In September 2022, SickKids introduced the Rapid Assessment of Pediatric Patients Zone (RAPP Zone) to provide care for patients who showed up at the emergency department but did not need emergency level care and could be seen and treated by a primary care physician. Specifically, parents of lower-acuity patients arriving at the emergency department would be directed to record their child's symptoms and general health information through an online application using a QR code on their smartphone. If they met certain criteria based on symptoms and age, patients would be directed to a different area of the hospital where they would be seen by a primary care physician (without the need for triaging by the emergency department). While this service was only available during specific times, SickKids estimated that approximately 20% of its low-acuity patients were being diverted from the emergency department as a result of this initiative. SickKids indicated that the costs of delivering care in the RAPP Zone is less than the cost of delivering care in the emergency department as these patients only require limited medication administration and nursing

monitoring or interventions. While we noted there were similar rapid assessment practices at other hospitals we visited, patients at those institutions were still being treated within the emergency department, which can divert resources away from more urgent cases.

- For over 10 years, Windsor Regional Hospital's Metropolitan site has been using an initiative to fully divert pregnant patients who arrive at the emergency department with specific symptoms related to pregnancy (such as cramping and vaginal bleeding). Instead of being triaged and waiting at the emergency department to be assessed by a doctor, these patients are sent directly to the obstetrics and gynaecology unit for triage and treatment. This initiative has helped Windsor Regional Hospital divert about 6,000 emergency department patients each year.

We also noted that other hospitals had practices in place to treat specific patient conditions in a more timely and appropriate manner within the emergency department. During our site visit to Brampton Civic Hospital, we noted that patients arriving with minor complaints such as a potential fracture or orthopaedic concerns could be triaged to a separate area within the emergency department if the patients met specific medical criteria. This area was staffed with an orthopaedic technician during certain hours of the day, and if the patient required an x-ray, the imaging could be quickly reviewed and interpreted for next steps.

While these practices have shown success, we noted that hospitals did not consistently and effectively share best practices province-wide. The Ministry and Ontario Health also did not have any framework to evaluate and encourage or recommend the use of effective practices that have shown success to hospitals across the province.

RECOMMENDATION 12

To provide patients with timely access to appropriate care, we recommend that Ontario Health work with hospitals to identify initiatives that

have successfully and safely diverted lower-acuity patients, or those with specific symptoms, away from emergency departments, and share those practices for province-wide implementation.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation. Ontario Health will work with hospitals and community partners to identify initiatives and best practices to provide system level successes to ensure patients access the right care at the right time and place.

4.7.2 Urgent Care Centres Can Be Expanded to Care for Low-Acuity Patients

Urgent Care Centres (UCCs) are health-care settings specifically designed, equipped and staffed to provide care to patients seeking prompt or immediate treatment for non-life-threatening conditions and injuries without prior appointments. At the time of our audit, there were 11 UCCs in Ontario, although only seven of them were required to report data such as wait times to Ontario Health. One of the hospitals we visited (Windsor Regional Hospital) was at an early stage of planning to set up a UCC to specifically deal with lower-acuity patients due to a lack of timely access to primary care in the community.

Seen as a way to take some pressure off of emergency departments, UCCs typically handle patients with acuity levels between CTAS 3 to CTAS 5, though they still need to be staffed and equipped to deal with life-threatening situations. The goal of a UCC, which does not typically have short-stay beds, is to treat and release patients back to their home or community. If a patient does require admission to an inpatient unit or longer-term care, they would be transferred to an emergency department. Each UCC requires an agreement with an affiliated hospital to transfer patients requiring full-service emergency department care or patients who are not well enough to be sent home after receiving care at a UCC.

Figure 22: Time to See a Physician and Length of Stay at Urgent Care Centres (UCCs) in Ontario, 2022/23 (hours)

Source of data: Ontario Health

Urgent Care Centre	Time to Physician Initial Assessment	Length of Stay
1. St. Joseph's Hospital	1.4	2.4
2. Niagara Health System (Douglas Memorial Hospital site)	1.1	2.0
3. Niagara Health System (Port Colborne General site)	1.3	2.0
4. William Osler Health System (Peel Memorial Centre)	0.8	2.2
5. Trillium Health Partners (Queensway Health site)	0.9*	2.5*
6. Mackenzie Health (Vaughan site)	1.2	1.6
7. Kingston Health Sciences Centre (Hotel Dieu Hospital)	1.4	2.9
Provincial Average for Urgent Care Centres (UCCs)	1.2	2.3
Provincial Average for Emergency Departments	2.0	6.2

* Trillium Health Partners temporarily closed its UCC beginning April 2020 and has not reopened it since then. These results are from 2019/20, the most recent available data.

In 2022/23, there were approximately 230,000 patient visits to the seven UCCs that report data to Ontario Health. Patients visiting these UCCs were, on average, seen by a physician much quicker than they would have been in an emergency department and, in turn, their overall time getting the care they needed was significantly shorter. In 2022/23, patients waited an average of 1.2 hours in a UCC for their physician initial assessment compared to an average of two hours in emergency departments. Patients also spent an average of 2.3 hours in the UCC, which was over three times shorter than those visiting an emergency department. **Figure 22** provides a list of the seven UCCs and the average time to see a physician and length of stay.

Based on our visits to a UCC and an emergency department located in the same region that are both part of the William Osler Health System, we noted that the UCC at Peel Memorial Centre was able to see patients much quicker than the emergency department at Brampton Civic Hospital. Since the UCC and the emergency department are located relatively close to each other (about a 15-minute drive), we inquired whether William Osler Health System had a strategy to direct some lower-acuity emergency department patients to the UCC to help alleviate pressures on its emergency department and enable staff to focus on higher-acuity patients. While William Osler Health System did try to raise awareness and educate patients on the

appropriate use of the UCC, we noted that there was no such strategy or procedure to direct lower-acuity patients to its UCC.

RECOMMENDATION 13

To improve access to emergency care for low-acuity patients, we recommend that the Ministry of Health, in collaboration with Ontario Health:

- assess the feasibility of a review of the Urgent Care Centres (UCCs) model and determine where expansion of this model can be best utilized; and
- work with hospitals to raise public awareness of alternative care settings such as UCCs that may be more appropriate for low-acuity patients.

MINISTRY RESPONSE

The Ministry of Health (Ministry) acknowledges the Office of the Auditor General of Ontario's recommendation to improve access to emergency care for low-acuity patients. The Ministry will engage with Ontario Health to determine if a review of the Urgent Care Centre model is required. The Ministry will also work with hospitals to determine the appropriate next steps in continuing to raise public awareness of alternative care settings for lower-acuity patients.

With respect to any new or existing Urgent Care Centre physician contracts, the Ministry recognizes the Ontario Medical Association (OMA) as the exclusive representative of physicians practising in Ontario. Under the OMA Representation Rights and Joint Negotiation and Dispute Resolution Agreement, the Ministry is required to consult the OMA to seek its advice about significant health-care policy and system issues that affect physicians. Further, changes related to physician compensation, including activities and accountabilities under non-fee-for-service agreements, are subject to the negotiations process between the parties set out in the Binding Arbitration Framework.

4.7.3 Virtual Urgent Care Pilot Program Has Shown Some Early Success but Subsequent Changes to the Program May Result in Worse Outcomes if Not Managed Effectively

In 2020, during the COVID-19 pandemic, the Ministry approved approximately \$4 million in one-time funding to support a virtual urgent care program, sometimes referred to as a virtual emergency department. The pilot program was created to support patients who had concerns about visiting an emergency department in-person, as well as to divert lower-acuity patients away from the emergency department. The virtual urgent care program offers patients a convenient way to get medical advice or care using a computer or smartphone instead of going to an emergency department. Depending on patient needs, physicians working in virtual urgent care can provide a prescription, and advise patients whether to visit their primary care doctor or go to the nearest emergency department for an in-person assessment. In 2022/23, patients made over 50,000 virtual urgent care visits, compared with fewer than 20,000 visits in 2021/22.

In one example, two medical institutions in Toronto (University Health Network and Sunnybrook Health Sciences Centre) set up a virtual urgent care program in 2020. We met with staff involved in the delivery of the program and found that it was designed to offer same-day appointments to patients seven days a week, from 9 a.m. to 9 p.m. on Monday to Friday and from

9 a.m. to 1 p.m. on Saturday and Sunday. The virtual urgent care visit is meant for patients who cannot make an urgent appointment with their primary care provider but require urgent attention for non-life-threatening medical concerns. Symptoms suitable for virtual urgent care include a fever, body aches, sore throat or cough and fever.

Ontario Health engaged the Schwartz/Reisman Emergency Medicine Institute—a not-for-profit research, education and health policy institute under a partnership of the Sinai Health and North York General Hospital—to conduct an overall study of the virtual urgent care pilot program. The study, released in June 2022, highlighted a number of key outcomes:

- Over 75% of presenting complaints were low-acuity, with rash, fever, abdominal pain and COVID-19 vaccine queries representing about 30% of the issues discussed.
- Of the almost 83% of patients who had a primary care provider, about 31% indicated they contacted virtual urgent care because they could not make a timely appointment with their family physician.
- About 16% of patients were advised to visit their nearest emergency department while about 66% were discharged after receiving treatment and/or medical advice on next steps. The remainder were referred to primary care or other community care settings.
- 94% of patients rated their overall virtual experience as eight out of 10 or greater.

While the study identified positive outcomes, it also raised the concern that the program needed to be evaluated to determine if it was sustainable. In particular, the study indicated that patients, most of whom already had a primary care provider, were using the system in place of seeing a primary care provider to receive expedited medical advice. This was not the program's intended purpose and could put added strain on emergency department staff, who are responsible for running virtual urgent care initiatives.

The study also noted that a number of factors needed to be considered before a decision could be made to move forward with the virtual urgent care program. These included analyzing whether nurse

practitioners, physician assistants and primary care physicians can be utilized in the virtual program to support emergency department physicians, and whether virtual services can be amalgamated into a single provincial system, or network of regional systems, to better share resources among hospitals.

We also noted that another study, published in the *Canadian Medical Association Journal* in November 2023, questioned the overall impact of the virtual urgent care pilot program on both subsequent emergency department visits and hospital admissions. These indicate the need to better understand the inherent limitations of virtual care and ensure future virtual providers have timely access to in-person outpatient resources, to prevent subsequent emergency department visits.

Ontario Health informed us that it was integrating the virtual urgent care pilot program with the province-wide Health811 call service, which allows people to connect with a registered nurse day or night by phone to get certain kinds of medical advice. Patients who call 811 will be triaged by the registered nurse and if the patient is eligible for a virtual urgent care visit, the patient will be connected with the virtual urgent care clinic in their region and seen by a nurse practitioner. The nurse practitioner can assess the patient's needs, prescribe treatments and determine next steps, such as whether an emergency department visit is needed. This decision was based on findings from the virtual urgent care pilot program study that indicated most patients who accessed the program already had a primary care physician and also noted that nurse practitioners or other similarly trained individuals could provide the same level of care in a virtual setting.

However, there is a possibility that having a centralized model may not be as effective as virtual urgent care programs managed directly by hospitals, and further changes may be needed to move forward with the centralized model. For example:

- Through discussion with one of the hospitals we visited, we noted that the virtual urgent care clinic that the hospital previously ran was able to connect or refer virtual care patients for further assessment and treatment at the hospital if needed. For instance, the virtual urgent care clinic would be able to directly refer a patient

for diagnostic imaging, and could also provide a prescription if needed. In contrast, if the patient used the Health811 system, the patient's journey may not be as seamless. For instance, if the nurse practitioner indicates an in-person visit is needed, the patient would have to repeat the triage process upon entering the emergency department.

- The two medical institutions in Toronto that initiated the joint virtual urgent care program, as noted above, raised similar concerns about the centralized model proposed by Ontario Health. They indicated that Ontario Health and the Ministry should better incorporate local hospitals into any future virtual care program so that patients can more easily be referred to obtain further assessments and treatments (for example, booking blood tests and getting a prescription) by calling Health811 rather than having to physically visit an emergency department and restart the entire patient journey.

RECOMMENDATION 14

To reduce the number of unnecessary emergency department visits and improve access to urgent care, we recommend that Ontario Health work with hospitals and physicians that deliver virtual urgent care to determine what changes should be made to the provincial Health811 program to better address health-care system gaps and meet patient needs.

ONTARIO HEALTH RESPONSE

Ontario Health acknowledges the Office of the Auditor General of Ontario's recommendation to work with hospitals and physicians that deliver virtual urgent care to determine what changes should be made to the provincial Health811. Ontario Health will work with the Women's College Hospital Institute for Health Systems Solutions and Virtual Care to evaluate current virtual urgent care models and ensure Health811 is leveraged to its potential to support gaps in patient care needs.

Appendix 1: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

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- 1.** Effective triage, discharge and transfer processes and practices are in place at emergency departments to ensure patients have timely access to high-quality services and care that meet their needs.
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- 2.** Responsibilities and accountabilities of parties involved in the delivery of services and care at emergency departments are well defined to ensure that proper oversight is in place and patients are kept safe and provided with high-quality services and care that meet their needs.
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- 3.** Adequate and effective programs or initiatives are in place to ensure that emergency departments have stable and adequate levels of staffing and resources to provide patients with timely and high-quality services and care.
-
- 4.** Funding for emergency departments is appropriately allocated, used and monitored to address the differences in needs among hospitals, and is responsive to changes in needs on a timely basis.
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- 5.** Effective communications processes are in place to raise public awareness and understanding of options available for care based on needs.
-
- 6.** Sufficient, accurate and timely information related to emergency departments, such as service volumes, wait times and triage levels is regularly collected, assessed and used to guide decision-making.
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- 7.** Appropriate performance measures and targets are established to ensure that services and care at emergency departments are continuously monitored against intended objectives. Results are publicly reported and corrective actions are taken on a timely basis when issues are identified.
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Appendix 2: Emergency Department Closures in Ontario, July 2022–June 2023

Prepared by the Office of the Auditor General of Ontario

Hospital	Approximate Hours of Closure
1. South Bruce Grey Health Centre (Chesley)	1,884
2. Glengarry Memorial Hospital	573
3. Perth and Smiths Falls District Hospital (Great War Memorial site)	529
4. Listowel Wingham Hospitals Alliance (Wingham and District Hospital)	502
5. Huron Perth Healthcare Alliance (Seaforth Community Hospital)	352
6. Huron Perth Healthcare Alliance (St. Marys Memorial Hospital)	175
7. South Bruce Grey Health Centre (Durham)	150
8. South Bruce Grey Health Centre (Walkerton)	123
9. Carleton Place and District Memorial Hospital	116
10. Campbellford Memorial Hospital	109
11. Huron Perth Healthcare Alliance (Clinton Public Hospital)	93
12. Hôpital général de Hawkesbury et district	86
13. Kemptville District Hospital	75
14. North Shore Health Network (Thessalon)	72
15. Listowel Wingham Hospitals Alliance (Listowel Memorial Hospital)	64
16. Almonte General Hospital	54
17. North Wellington Health Care (Louise Marshall Hospital)	28
18. Norfolk General Hospital	24
19. Amprior and District Memorial Hospital	23
20. Hôpital Montfort	23
21. South Bruce Grey Health Centre (Kincardine)	14
22. Headwaters Health Care Centre (Orangeville site)	12
23. North of Superior Healthcare Group (McCausland Hospital)	10
Total Hours	5,092

Appendix 3: Time to Physician Initial Assessment by Hospital, 2022/23 (hours)

Prepared by the Office of the Auditor General of Ontario

Hospital	Time to Physician Initial Assessment
South Bruce Grey Health Centre (Durham)	0.6
Southlake Regional Health Centre	0.7
William Osler Health System (Etobicoke General Hospital)	0.8
William Osler Health System (Peel Memorial Centre)	0.8
South Bruce Grey Health Centre (Chesley)	0.8
Grey Bruce Health Services (Markdale Hospital)	0.8
Mackenzie Health	0.8
Huron Perth Healthcare Alliance (Clinton Public Hospital)	0.9
Bluewater Health (Charlotte Eleanor Englehart Hospital)	0.9
Grey Bruce Health Services (Lions Head Hospital)	0.9
Quinte Healthcare (Prince Edward County Memorial Hospital)	0.9
Huron Perth Healthcare Alliance (Seaforth Community Hospital)	1.0
Sensenbrenner Hospital	1.0
Mackenzie Health (Cortellucci Vaughan Hospital)	1.0
Grey Bruce Health Services (Meaford Hospital)	1.1
Dryden Regional Health Centre	1.1
South Bruce Grey Health Centre (Walkerton)	1.1
Niagara Health System (Douglas Memorial Hospital site)	1.1
Markham Stouffville Hospital (Markham site)	1.2
Unity Health Toronto (St. Joseph's Health Centre)	1.2
St. Joseph's Hamilton (Charlton campus)	1.2
Mackenzie Health (Vaughan site)	1.2
Timmins and District General Hospital	1.2
North York General Hospital	1.2
Niagara Health System (Port Colborne General site)	1.3
Grey Bruce Health Services (Warton Hospital)	1.3
Renfrew Victoria Hospital	1.3
Perth and Smiths Falls District Hospital (Great War Memorial site)	1.3
Scarborough and Rouge Hospital (Birchmount site)	1.3
Hanover and District Hospital	1.3
Haldimand War Memorial Hospital	1.3
Hôpital Notre-Dame Hospital	1.3
Kingston Health Sciences Centre (Hotel Dieu Hospital)	1.4
Scarborough and Rouge Hospital (Centenary site)	1.4
Joseph Brant Hospital	1.4
Huron Perth Healthcare Alliance (St. Marys Memorial Hospital)	1.4
St. Joseph's Hospital (London)	1.4
Scarborough and Rouge Hospital (Scarborough General site)	1.4
South Bruce Grey Health Centre (Kincardine)	1.4
Bluewater-Sarnia General site	1.4

Hospital	Time to Physician Initial Assessment
St. Thomas-Elgin General Hospital	1.5
Halton Healthcare Services (Milton District Hospital)	1.5
Sinai Health System (Mount Sinai Hospital)	1.5
Lake of the Woods District Hospital	1.5
Huron Perth Healthcare Alliance (Stratford General Hospital)	1.5
Strathroy Middlesex General Hospital (Middlesex Hospital Alliance)	1.5
Chatham-Kent Health Alliance (Wallaceburg)	1.6
Muskoka Algonquin Healthcare (Huntsville District Memorial Hospital)	1.6
Woodstock Hospital	1.6
William Osler Health System (Brampton Civic Hospital)	1.6
Quinte Healthcare (North Hastings Hospital)	1.6
Perth and Smiths Falls District Hospital (Smiths Falls site)	1.6
Campbellford Memorial Hospital	1.7
West Nipissing General Hospital	1.7
Collingwood General and Marine Hospital	1.7
Alexandra Hospital	1.8
University Health Network (Toronto Western Hospital)	1.8
Niagara Health System (Greater Niagara General site)	1.8
Temiskaming Hospital	1.8
West Parry Sound Health Centre	1.8
Trillium Health Partners (Mississauga site)	1.8
Thunder Bay Regional Health Sciences Centre	1.8
Grey Bruce Health Services (Southampton Hospital)	1.8
Markham Stouffville Hospital (Uxbridge site)	1.8
Georgian Bay General Hospital (Midland site)	1.9
Muskoka Algonquin Healthcare (South Muskoka Memorial Hospital)	1.9
Brockville General Hospital (Charles Street site)	1.9
Unity Health Toronto (St. Michael's Hospital)	1.9
Lakeridge Health (Port Perry Hospital)	1.9
Toronto East Health Network (Michael Garron Hospital)	1.9
Soldiers' Memorial Hospital	1.9
St. Mary's General Hospital	1.9
Lakeridge Health (Bowmanville Hospital)	2.0
Hamilton Health Sciences (West Lincoln Memorial Hospital)	2.0
Quinte Healthcare (Trenton Memorial Hospital)	2.0
Kingston Health Sciences Centre (Kingston General)	2.0
Lakeridge Health (Oshawa Hospital)	2.0
Hôpital Montfort	2.0
Health Sciences North (Ramsey Lake Health Centre)	2.1
Norfolk General Hospital	2.1
Ross Memorial Hospital	2.1
Glengarry Memorial Hospital	2.1
Niagara Health System (Welland Hospital site)	2.1

Hospital	Time to Physician Initial Assessment
Headwaters Health Care Centre (Orangeville site)	2.1
Chatham-Kent Health Alliance (Chatham)	2.2
Northumberland Hills Hospital	2.2
Stevenson Memorial Hospital	2.2
Royal Victoria Regional Health Centre	2.3
London Health Sciences Centre (Victoria Hospital)	2.3
Erie Shores Healthcare	2.3
Grey Bruce Health Services (Owen Sound Hospital)	2.3
Trillium Health Partners (Credit Valley site)	2.3
University Health Network (Toronto General Hospital)	2.3
Tillsonburg District Memorial Hospital	2.3
Grand River Hospital (Kitchener-Waterloo site)	2.3
Guelph General Hospital	2.3
Pembroke Regional Hospital	2.4
Lennox and Addington County General Hospital	2.4
Halton Healthcare Services (Georgetown Hospital)	2.5
Lakeridge Health (Ajax Pickering Hospital)	2.5
Humber River Health (Wilson site)	2.5
Ottawa Hospital (Civic campus)	2.6
Hamilton Health Sciences (Hamilton General Hospital)	2.6
Hamilton Health Sciences (McMaster Children's Hospital)	2.6
Sault Area Hospital	2.6
Brantford General Hospital	2.7
Cornwall Community Hospital	2.7
North Bay Regional Health Centre	2.8
Peterborough Regional Health Centre	2.8
Groves Memorial Community Hospital	2.8
Niagara Health System (St. Catharines General site)	2.8
Queensway Carleton Hospital	2.8
Quinte Healthcare (Belleville General Hospital)	2.9
London Health Sciences Centre (University Hospital)	2.9
Cambridge Memorial Hospital	3.0
Hamilton Health Sciences (Juravinski Hospital)	3.0
Hospital for Sick Children	3.0
Windsor Regional Hospital (Ouellette site)	3.0
Children's Hospital of Eastern Ontario (Ottawa site)	3.1
Halton Healthcare Services (Oakville-Trafalgar Memorial Hospital)	3.3
Winchester District Memorial Hospital	3.5
Ottawa Hospital (General campus)	3.5
Sunnybrook Health Sciences Centre	3.7
Hôpital général de Hawkesbury et district	3.8
Windsor Regional Hospital (Metropolitan campus)	4.1

Note: This table is based on emergency departments and urgent care centres that report wait-time information to Ontario Health; some small hospitals are not currently required to report such information.



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