Canadian Centre for Healthcare Facilities
Breaking through the bottlenecks: Unlocking health capacity

Rising to the Challenge:
Identifying Opportunities in New Care Models to Meet Future Needs

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Gavin Wardle, PhD
Partner, Preyra Solutions Group

Mélanie Potvin
Executive Lead, Planning and Business Development
Hawkesbury and District General Hospital

preyra solutions group

HGH

What Are Essential Components of Health System Planning?

1. **Improve Provider Efficiency**
   - *Reduce unit costs, length of stay, adverse events*
   - *Prioritize populations and effective services*

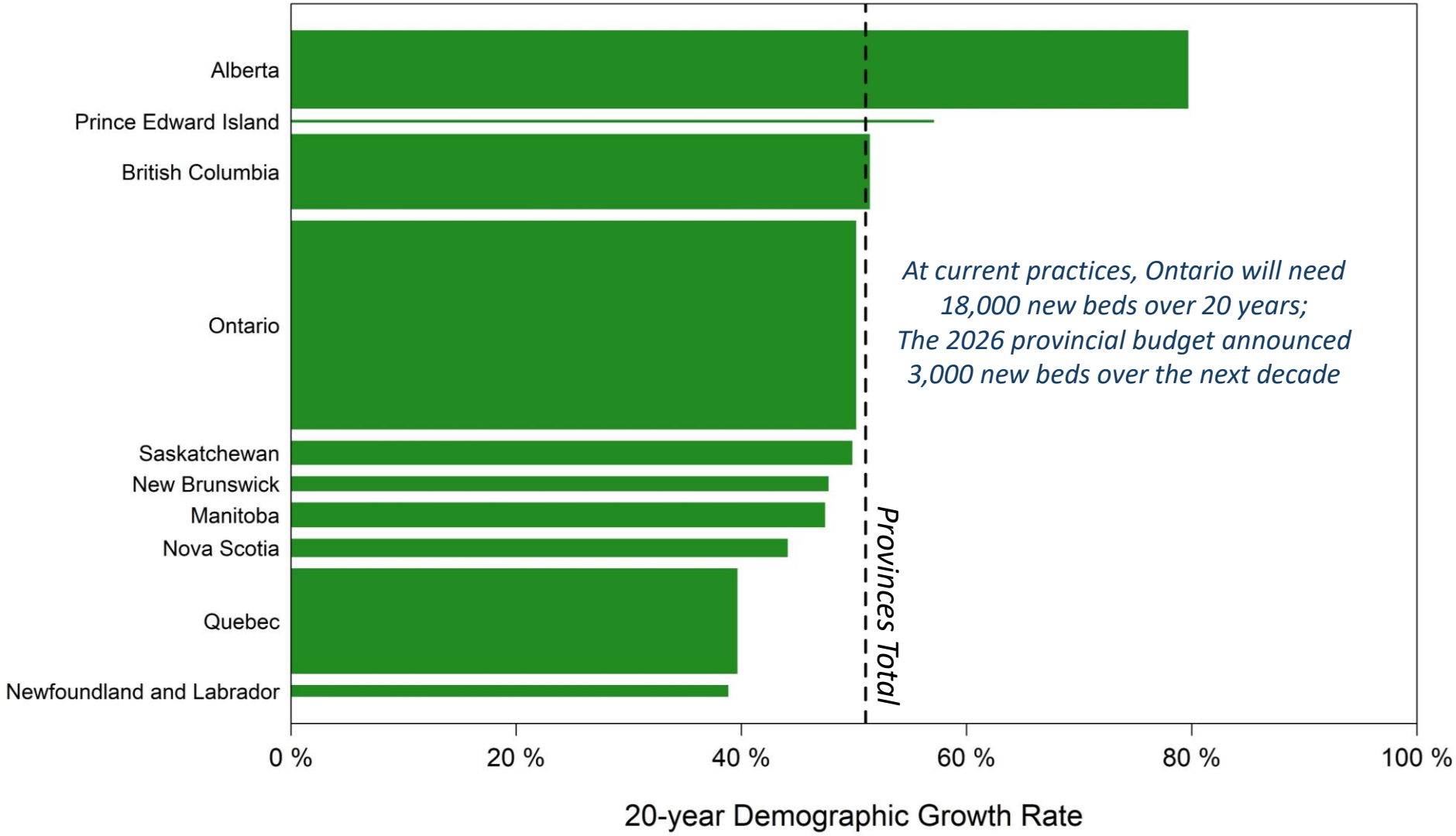
2. **Improve System Efficiency**
   - *Redistribute care among sectors*
   - *Increase emphasis on long-term support services provided in the community*
   - *Rationalize programs and services based on comparative advantages*

3. **Improve Population Health**
   - *Improve health to reduce future demand*

4. **Add New Capacity**
   - *Add new capacity across the system based on expected improvements in 1, 2, 3 above*

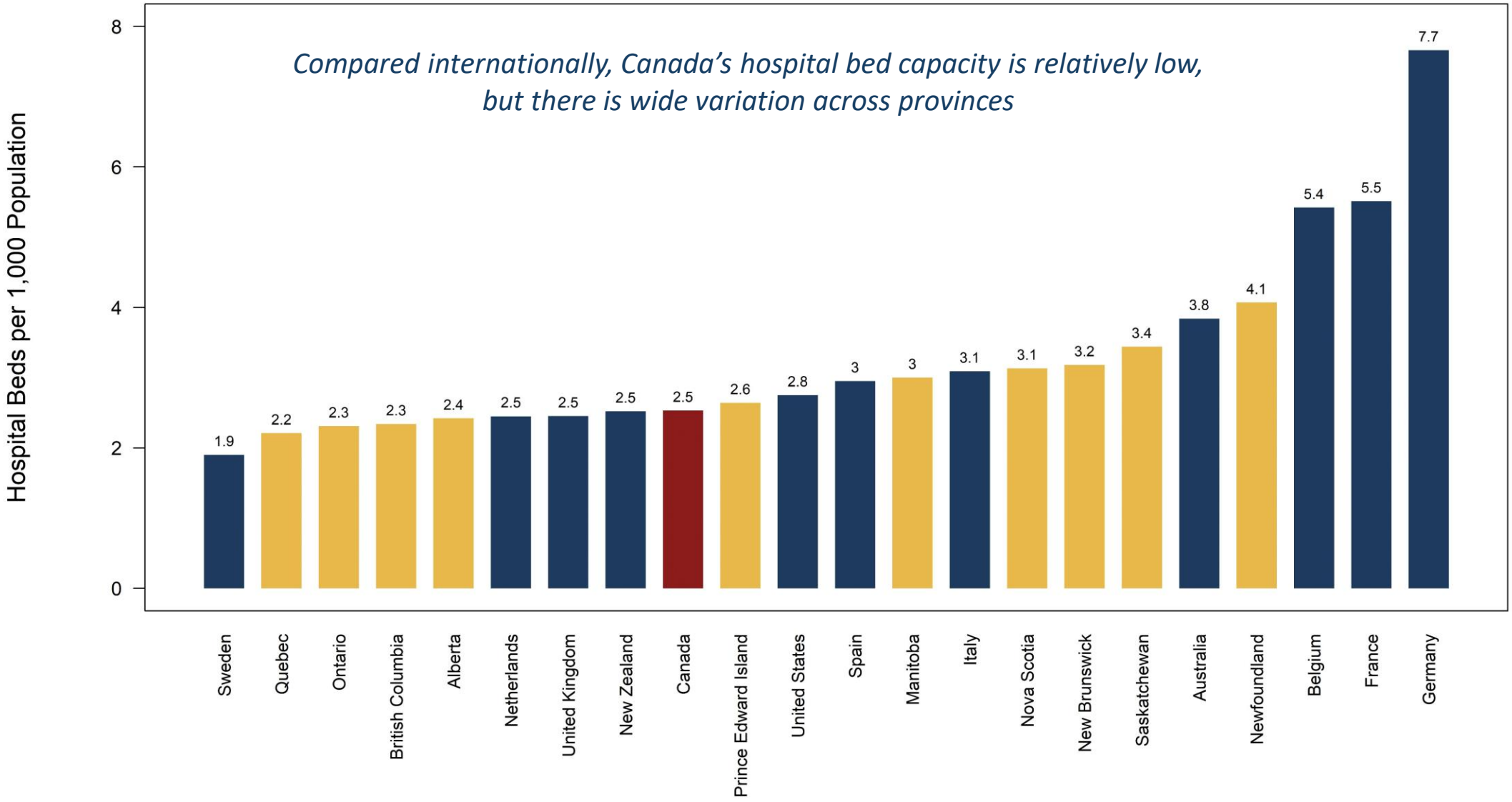
Without Change in Practices, How Fast Will Hospital Bed Demand Grow?

- This shows estimated increases in hospital bed demand over the next 20 years, without changes in practice
- The provinces will need roughly 50,000 new hospital beds to keep pace with population growth and aging
- 20-year population growth by provinces ranges from near 0% in Newfoundland and Quebec to 36% in Alberta, and averages 13%



Sources: Statistics Canada Population Projections 2024-2044 M1 Growth Scenario, CIHI BSIO Dataset, PSG Calculations; Bar widths are scaled by 2044/45 bed need
https://budget.ontario.ca/2026/chapter-1b-services.html#section-1

What Can Provinces Learn From Other Countries and From Each Other?



Sources: Ontario Hospital Association Ontario Hospitals – Leaders in Efficiency; CIHI Your Health System - In Depth; OECD Health Statistics as of May 2025; CIHI Hospital Beds Staffed and In Operation 2023-24; CIHI Hospital Stays in Canada

How Do Improvement Opportunities Vary Across the Provinces?

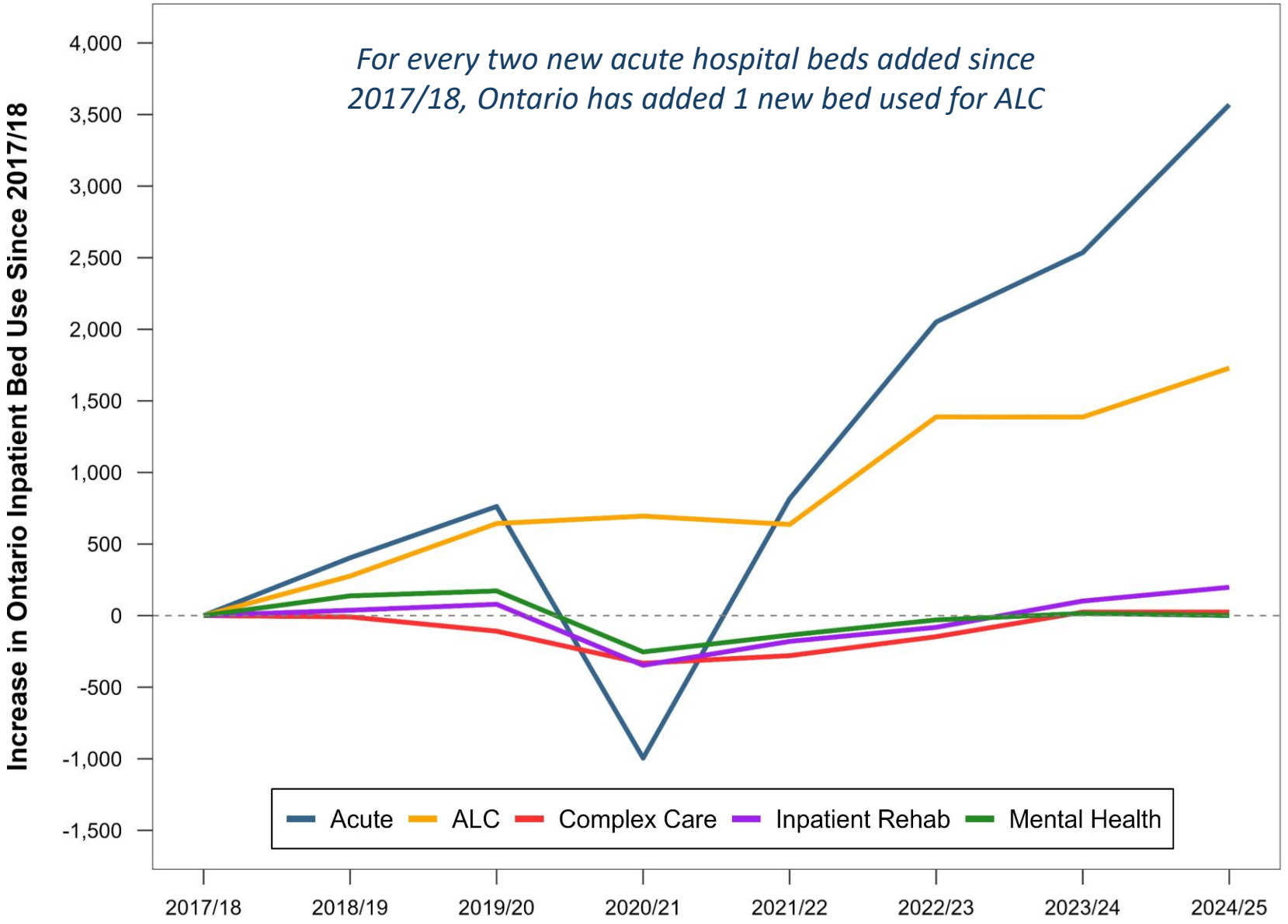
Percent Difference From Province With Lowest Value

Jurisdiction	*Acute Care Admission Rate* *(age-sex standardized)*	*Acute Care Average Length of Stay* *(age standardized)*	*Hospital Beds per Capita*	*Cost of a Hospital Inpatient Stay*	*Government Expenditure on Hospitals per Capita*
Ontario	0.6%	**0%**	5%	**0%**	**0%**
Quebec	0.8%	2%	**0%**	13%	7%
British Columbia	2%	10%	6%	20%	12%
Alberta	10%	18%	10%	34%	9%
Prince Edward Island	10%	34%	19%	15%	32%
New Brunswick	8%	25%	44%	11%	28%
Manitoba	3%	49%	36%	17%	13%
Saskatchewan	42%	4%	56%	31%	17%
Nova Scotia	**0%**	35%	42%	15%	67%
Newfoundland	8%	19%	84%	9%	68%
Canada	**6,992**	**7.3**	**2.53**	**$7,826**	**$2,103**

Sources: Ontario Hospital Association Ontario Hospitals – Leaders in Efficiency; CIHI National Health Expenditure Database, 2024 forecast; CIHI Your Health System - In Depth; OECD Health Statistics as of May 2025; CIHI Hospital Beds Staffed and In Operation 2023-24; CIHI Hospital Stays in Canada

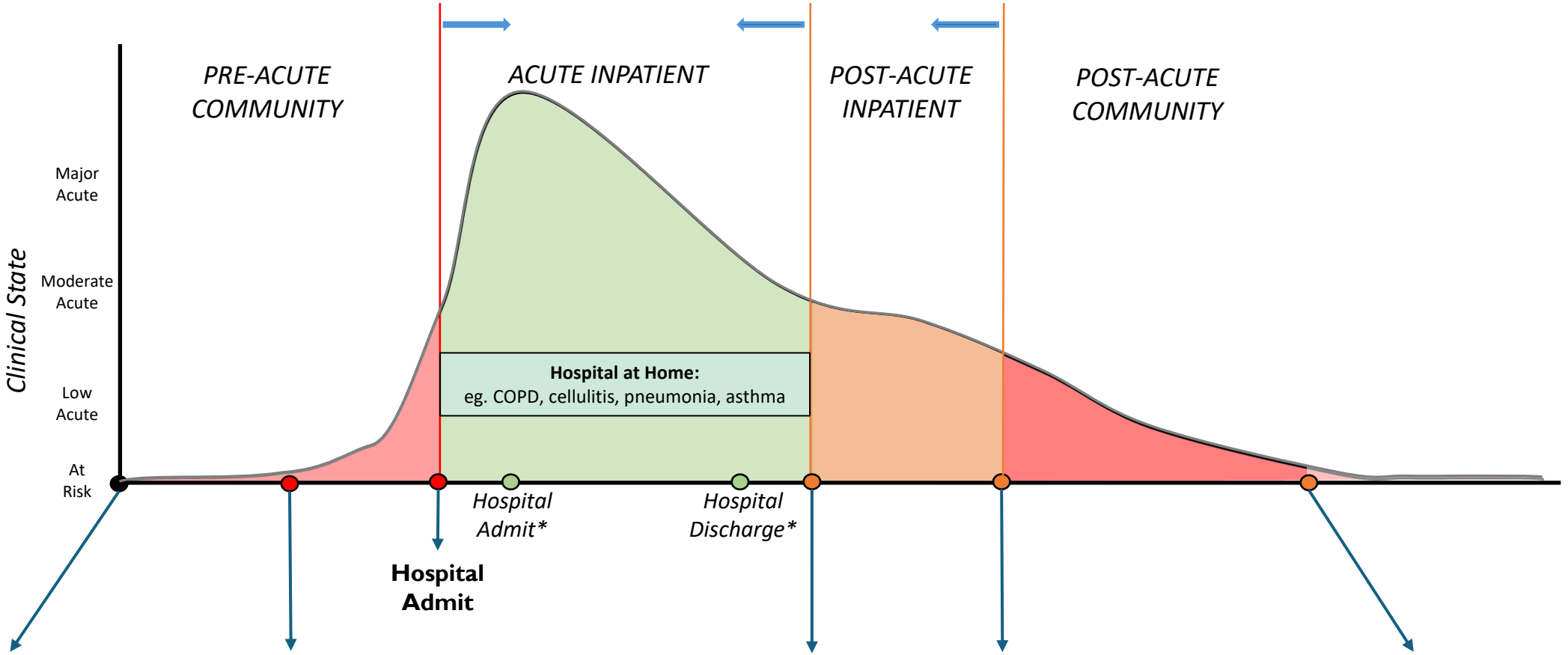
What New Capacity Has Been Added to the Ontario Hospital System?

- This shows Ontario's absolute increase in total hospital bed use since 2017/18
- Between 2017/18 and 2024/25, Ontario patients used roughly 3,570 additional acute beds and 1,730 additional ALC beds in the acute care setting
- Over the same time, Inpatient Rehab bed use increased by 200 beds, while Complex Care and Inpatient Mental Health bed use remained constant



Sources: DAD, NRS, CCRS, OMHRS 2017/18 – 2024/25

How Can New Care Models Better Meet Future Demand?



Prevention and Maintenance:
Primary Care
Chronic Disease Management
Screening and Diagnostics

Admission Avoidance:
Rapid Diagnostics
Outreach Teams
Day Hospitals
Community Paramedicine
Social Care

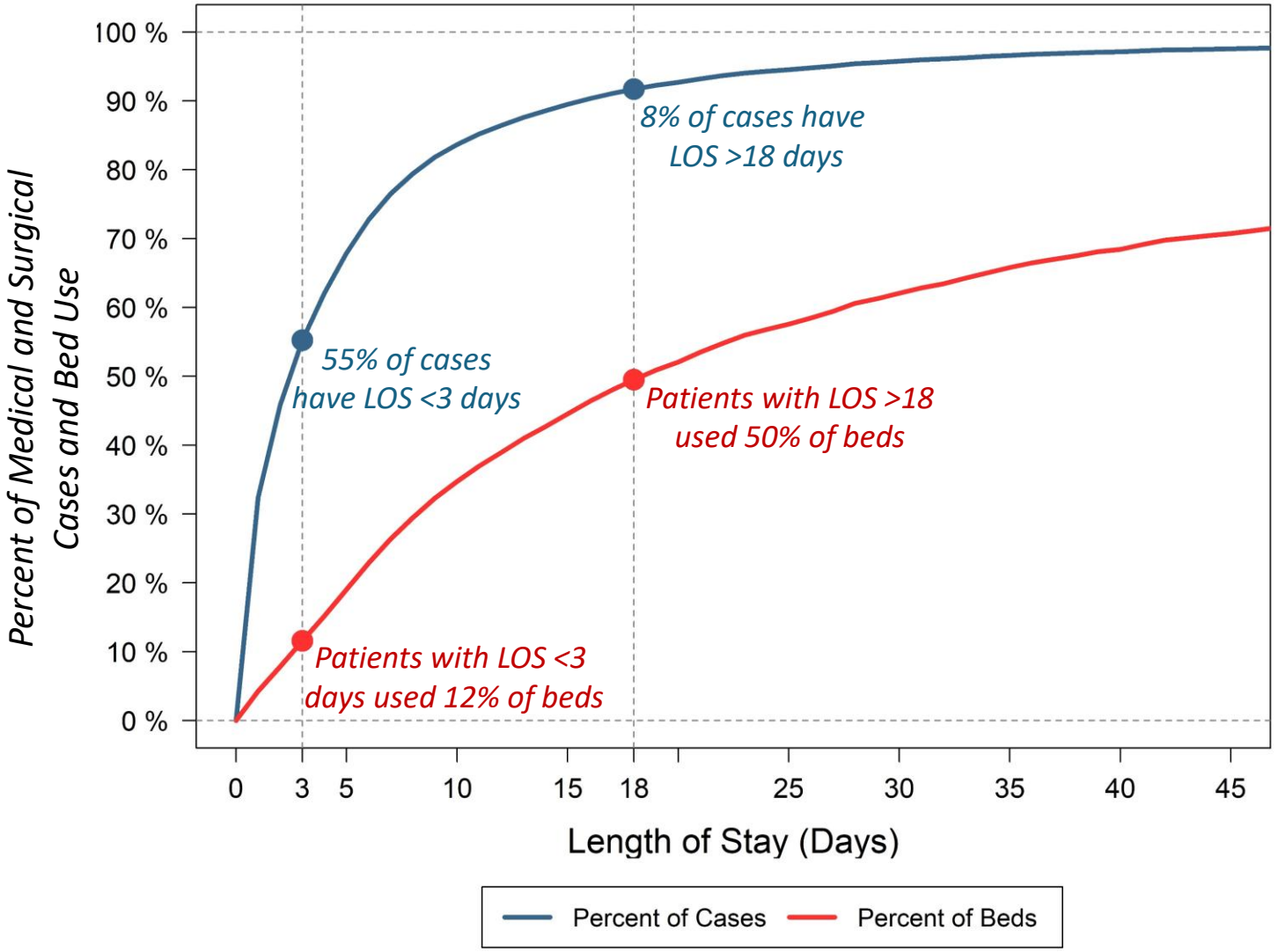
Discharge To Specialized Post Acute:
IP Rehab
Complex Care
Palliative

Discharge To Community Post Acute Care:
Palliative
Nursing Home
Home Care
OP Rehab
Specialized Geriatric Services

Prevention and Maintenance:
Outpatient Follow-up
Secondary Prevention
Chronic Disease Management
Primary Care

Are the Best Opportunities In Admission Avoidance or In Post-Acute Transitions?

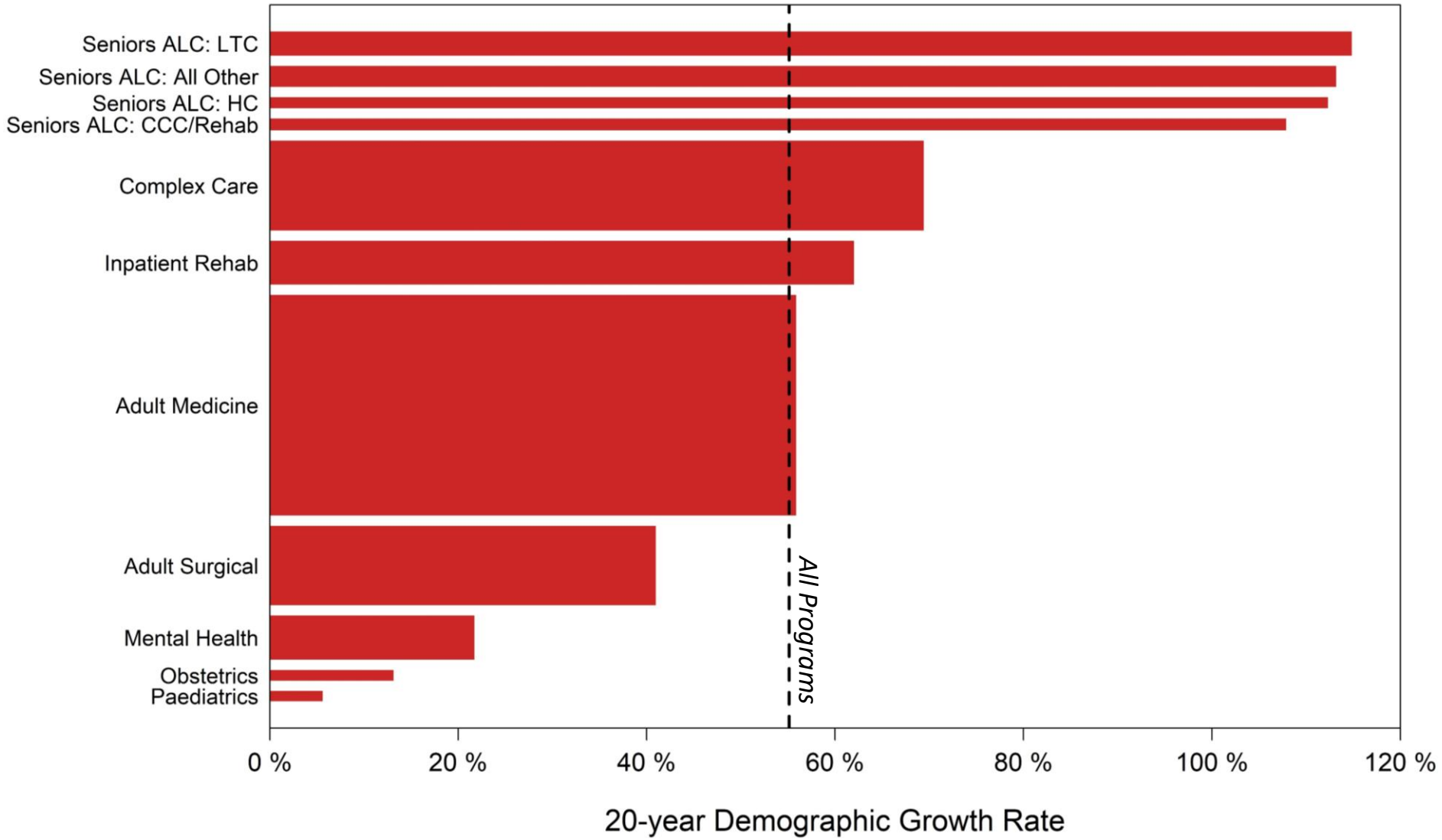
- This shows the cumulative distribution of cases and bed use at a large Ontario academic hospital
- Patients with a length of stay of 3 days or less accounted for 55% of cases but only 12% of beds
- Patients with a length of stay of 18 days or longer accounted for only 8% of cases but 50% of bed use
- This implies that the most promising opportunities to attenuate growth in inpatient resources are in accelerating transitions to post-acute care



Sources: DAD 2023/24; PSG Calculations; Note: RCC Days excluded

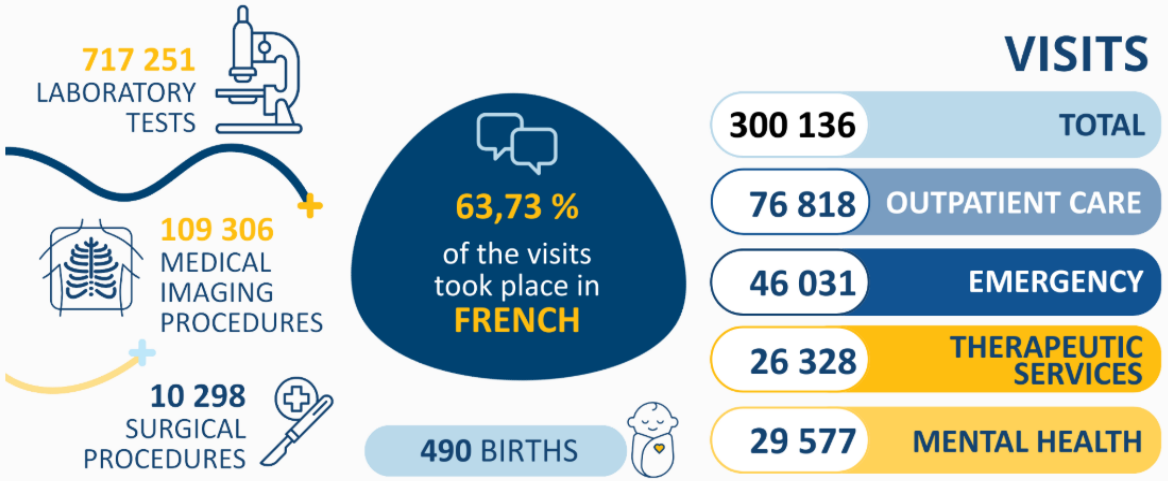
Which Components of Hospital Demand Growth Are Mutable?

- This shows 20-year projected growth rates for hospital beds by care type
- At current practices, ALC days for seniors in acute settings will more than double
- More beds will be used for ALC care for seniors than for all surgical programs combined
- New care models will be needed to meet future needs



Sources: DAD, NRS, OMHRS, CCRS 2024/25; MOF Population Projections Summer 2025 Release; Bar widths are scaled by 2044/45 inpatient days

HGH by Numbers



Why are we doing a Master Program and Plan?

- Ensure resources for the **right regional health service capacity**
  - Why?
  - What?
  - Where?
  - When?
  - How Much?

Critical Success Factors to Plan for a Sustainable Healthcare System

- Quality population-based analysis for insights into current utilization and future demand
- Knowledge of forthcoming innovative care models that are likely to materialize
- Pulse on current capacity and likely future shifts from other regional care providers across the care continuum
- System efficiency explorations
- Collaborative Leadership
- Courage

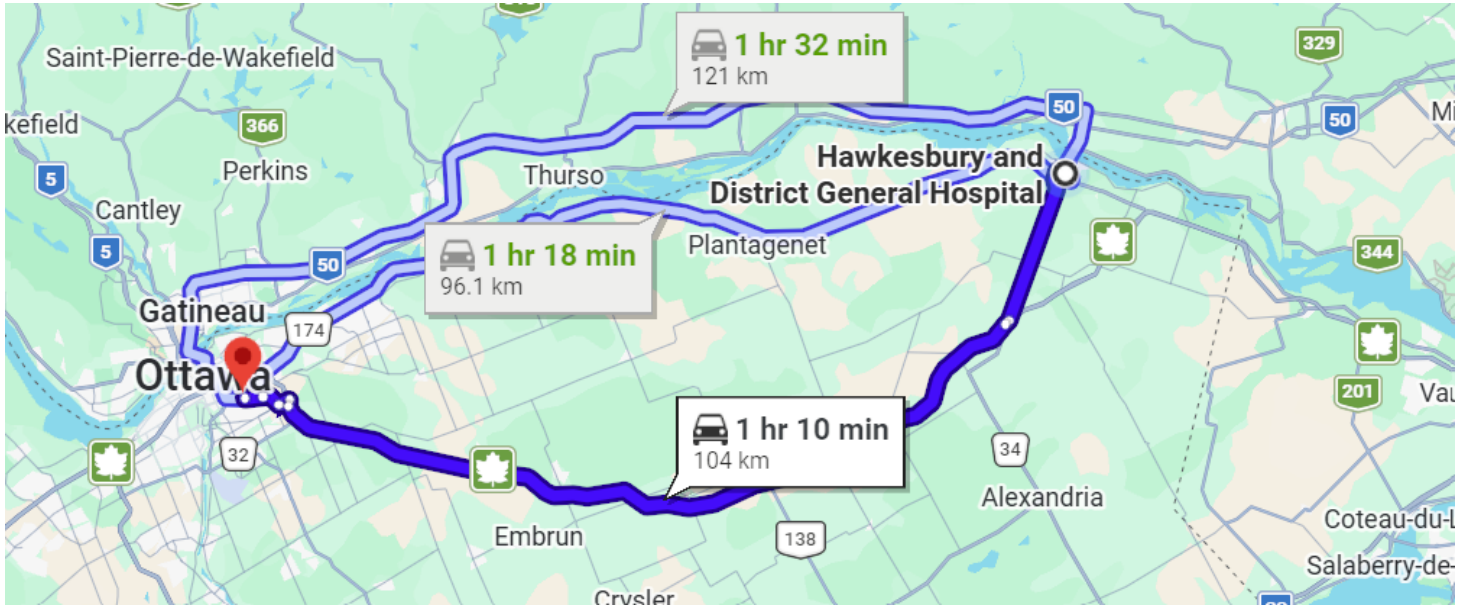
A Dream

- **A true, regional-focused planning program**
- Has the ability to **shift capital and operational funding across providers** along the care continuum
- Works towards **common, broad goals** that are **incentivized**
- Shared, collective interest in our **system's sustainability**
- Pulls from **standardized parameters** across the country. Examples:
  - Standardized programs for types and size of hospitals
  - Critical mass for program delivery
  - Reasonable travel distances & assumptions
  - Standardized designs & layouts as a starting point
- **Includes** providers, planners, developers, funders, researchers, and innovators
- Tied to a **public marketing campaign** to Canadians

Common Planning Discussion Point #1

What do we truly mean by care close to home?

- What **needs** to be offered locally?
- What **volume** ensures operational sustainability and efficiency?
- What should be **duplicated** across sites vs consolidated?



Proposed Strategic Role of HGH

- Close enough to a major center to **tap into its specialists**, but far enough that **every transfer is a burden** on patients, families, and limited transport capacity.
- Be a **highly connected, high-touch, & right-sized center.**
- Ensure **robust acute primary and secondary care locally**
- Do **more stabilizing, sub-acute, and chronic care locally**
- Use city hospitals for **highly specialized, high-acuity episodes (tertiary care)**
- Ensure robust **virtual and outreach services** so hospital is one node in a wider network
- Ensure **sophistically integrated, robust care transfer processes**

Implications for Planners

PROVIDE THE **ANALYTICAL PICTURE OF THE REGION**

FACILITATE THE DEVELOPMENT OF A **CLEAR REGIONAL ROLE OF THE FUTURE** WITH EXECUTIVE LEADERSHIP **BEFORE PROGRAM-LEVEL PLANNING**

SOPHISTICATED **VIRTUAL CONNECTIONS** BETWEEN PROVIDERS AND PATIENTS FACILITATED BY DESIGN

Common Planning Discussion Point #2 ***Acute Care for Seniors***

- For HGH served populations:
  - In less than 20 years, over 85% of those coming through our doors will be over 65, and 71% over 75.
- What models of care should be offered at HGH for seniors in the future?

Relevant Service Models of Interest for HGH

Model	Primary purpose	Where care happens	Digital intensity	Fit for rural hospital approx. 75 min from city
Virtual wards for frail/chronic patients	Prevent admissions, enable early discharge	Home/community	High (remote monitoring, virtual visits)	Excellent: reduces travel, supports remote patients
Hospital-at-Home (HaH)	Provide hospital-level care at home	Home (within defined radius)	High (virtual + in-person)	Strong, especially for those who would otherwise need transfer
Enhanced sub-acute / transitional unit	Step-down from acute, step-up from home	On-site hospital unit, residence or LTC	Medium	Strong: protects acute beds, avoids transfers to city
Integrated ED, Geriatric ED	Manage more locally, comprehensive episodic care, avoid city ED	On-site ED/urgent care + virtual consults	Medium–High	Strong: especially with virtual specialist backup
Shared specialist "hub-and-spoke" clinics	Bring specialty closer to home	Local hospital + virtual from city	High (telehealth)	Excellent: leverages city expertise without moving patients
Geriatric/frailty program (inpatient + outreach)	Optimize care for older adults	Hospital + home/outreach	Medium	High: aligns with aging rural population
Integrated palliative & end-of-life program	Support dying closer to home	Home, hospital, LTC, hospice	Medium	High: reduces transfers to city at end of life

Implications for Planners

CROSS-FUNCTIONAL PLANNING BETWEEN HEALTHCARE SECTORS

INNOVATORS IN DIGITAL SOLUTIONS AT THE TABLE

DIGITALLY ENABLED ENVIRONMENT ACROSS ALL PROGRAMS

PLANNING FOR COORDINATION CENTERS WITHIN DELIVERY ENVIRONMENT

RESIDENTIAL-BASED CARE AS IMPORTANT AS HOSPITAL PLANNING

Common Planning Discussion Point #3
ED wait times, ALC utilization, ALOS / ELOS targets

- What capacity will grow in the community to help solve this regional issue?
- What programs should HGH take on in the future?
- How much diversion should we bake into our hospital plan to account for community service capacity and shifts?

HGH Considerations

- Integration with primary care and community services, facilitated by co-location with ambulatory care onsite
- Hospice development
- Prioritizing ambulatory care, rapid access services, and day procedure growth before inpatient developments
- Little shift or reductions in inpatient projections other than what is imposed by the Ontario Ministry of Health

Implications for Planners

01

Hospital efficiency embedded into operational planning and design layouts

02

Integration of community providers on hospital campus beyond placeholders, and collaboration facilitated by design

03

True flexibility for facility use

- Amb care vs ED vs primary care vs admin collaborative spaces

In Summary

- There has never been a more burning platform to make changes in the way we plan to preserve an equitable and sustainable system
- We all have a role to play

Discussion Questions

1. Beyond simply adding new capacity, what are the most promising ways to meet growing demand for acute inpatient care? These might include:
   a. Shifting care from hospitals to home, ambulatory and community settings
   b. Reducing the acute portion of hospital lengths of stay
   c. Increasing access to post-acute services to reduce ALC days
   d. Increasing availability of long-term supports provided in the community

2. What successful initiatives should be scaled across the country?

3. Why have some past initiatives failed to achieve their intended outcomes?

4. What new approaches to health capital infrastructure can help meet demand at lower system cost?

5. In your current role, what specific changes can you make to help build a sustainable healthcare system that maintains the right level of capacity?