OMA Ontario Medical Association

Doctors leading you to better health

Ontario Medical Association pre-budget submission 2023

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The COVID-19 pandemic tested Ontario's health-care system in unprecedented ways, highlighting the cracks that existed before the virus arrived here in early 2020.

As we emerge from the acute or crisis phase of the pandemic, Ontario's health-care system is in dire need of immediate solutions to improve patient access to care and to increase capacity.

Too many Ontarians don't have a family doctor, so they have trouble accessing the rest of the health-care system. Waits for specialists are long, so patients can't get diagnostic tests or surgeries when they need them. Hospitals don't have enough beds to treat acute-care patients because too many of them are occupied by people who have nowhere else to recover. Emergency departments are seeing large numbers of patients turning up sicker.

The pandemic also showcased the strength of our health-care system. Ontario's 43,000 physicians and other health-care personnel worked on the front lines for three years keeping our patients and communities safe, often at risk to themselves and their families. They are burned out and cannot be expected to continue working at the same pace to get us through this phase of the pandemic and the recovery. They need better supports to enable them to care for patients as they have been trained to do and are committed to doing. We need to find ways to let doctors be doctors and lead the way to better health care.

Ontario's doctors have solutions for what ails the health-care system. We want to be partners in rebuilding our system.

The Ontario Medical Association's *Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care* is a roadmap for the future, containing 87 recommendations in five priority areas, including 12 recommendations addressing the unique needs and challenges in northern Ontario:

- **Reduce wait times and the backlog of services**
- **Expand mental health and addiction services in the community**
- **Improve and expand home care and other community care**
- **Strengthen public health and pandemic preparedness**
- **Give every patient a team of health-care providers and link them digitally.**

Our *Prescription for Ontario* sets out what the government, together with health-care stakeholders, can do in the next few years to strengthen our system. The plan is meant to be implemented in an integrated fashion, starting in the short term and completed over the longer term.

There are three things we can do now that will make a difference to patients. More than 90 doctors from across Ontario met with close to 40 MPPs in November to share these solutions. We appreciate the time and attention given to them and the steps this government has taken to address Ontario's health-care challenges.

The OMA urges the government to include our three short-term solutions in its 2023-24 budget.

Help retain doctors by reducing the administrative burden.

Increase system capacity and improve patient access to care by creating a centralized wait list and referral system for surgeries so that patients with the greatest need go to the front of the wait list.

Move more palliative patients out of hospitals into the community, embed care co-ordinators in primary care, and equip all long-term-care homes with IV and diagnostic equipment to reduce transfers to hospitals.

The solutions in this document that could be costed would total about $320 million for 2023-24.

In *Prescription for Ontario*, the OMA acknowledged Ontario's annual health-care spending has not kept up with year-over-year demand for the past 30 years. Ontario would need an investment of about $5 billion dollars to reach the average of provincial per capita spending.

The OMA has supported the province's call to increase the Canada Health Transfer payment to 35 percent from 22 percent of total health-care spending. Ontario said it would accept the new federal funding, offer including an immediate top-up to the transfer payment, even though the amount was lower than what was requested.This new funding, together with the provincial budget surplus, should more than cover the cost of our immediate solutions, and serve as a down payment to implement all 87 recommendations contained in our *Prescription*. Together they will reduce wait times, expand mental health and addiction services, improve and expand home and community care, strengthen public health and pandemic preparedness and give every patient a team of health-care providers, linked digitally.

ADDRESSING THE DOCTOR SHORTAGE

Finding and keeping doctors

Every Ontario resident deserves a family doctor

The OMA estimates that about one million Ontarians do not have a family doctor. This is based on the Ministry of Health's Health Care Experience Survey that asks patients directly if they have a regular family physician. Other estimates that look at OHIP billing data and infer who has a family doctor put the shortage much higher, at 1.8 million patients without a family physician. There's also a shortage of some specialists, such as psychiatrists.

The problem is worse in rural, northern and remote regions. As of June 2022, northern Ontario communities were recruiting for more than 350 physicians – 200 family doctors and 150 specialists. Of those family doctors, 110 need to be rural generalists who will work in rural communities, a 10-per-cent increase in the recruitment goal over the previous year.

For people who cannot find a family doctor or get specialist help, any number is too high and the problem needs to be addressed now.

Nearly 40 per cent of Ontarians surveyed by Ipsos for the OMA in November 2022 said they were concerned about the lack of doctors and other health-care workers. That's up 15 percentage points from the previous survey in April 2022. Sixty-five percent of physicians surveyed by the OMA in late 2022/early 2023 listed access to a family doctor as one of the issues that should be a top health-care priority over the next four years.

Family doctors are the bedrock of the health-care system. They provide comprehensive cradle-to-grave preventative and primary care and are the gateway to the rest of the health-care system, including specialist diagnostic and treatment. Yet family doctors are suffering from record levels of burnout, caused in large part by the demands of paperwork, electronic medical records that don't speak to one another and other aspects of the administrative burden. Many consider the current situation to be a crisis. Our existing family doctors need more support and the OMA will be making recommendations in the coming months.

The doctor shortage is expected to grow as a large number of physicians approach retirement age and others retire early or scale back their practices because of burnout. Forty per cent of Ontario doctors said the pandemic caused them to consider retiring early, according to the OMA's 2021 member survey.

The OMA welcomed the government's announcement last year that it had approved a new medical school in Brampton and was adding more medical student and residency positions to the province's other medical schools. But it takes a minimum of 10 to 12 years to fully train a doctor, so more immediate steps are also needed.

The recent government announcement that it will make it easier for doctors from other parts of Canada to work here makes Ontario the first province to move toward pan-Canadian licensure, which the OMA supports. But it remains to be seen how many physicians this will attract. The Canadian Medical Association says five million people across Canada do not have a family doctor, so there is stiff competition across the country for physicians.

We support the Feb. 2 government announcement that it would introduce a practice-ready assessment program for physicians who graduated from medical school and practised abroad and have legal immigration status in Canada.

Practice-ready assessments are supervised clinical field assessments to determine whether internationally trained physicians have the skills to work in Ontario. Such programs exist in seven other provinces and can be used to assign physicians to underserved communities.

Solution No. 1:. A practice-ready assessment program needs to be part of a broader solution to the doctor shortage. We also need formal peer mentorship programs to support physicians who are new to Canada, socially, professionally and emotionally. It is daunting for many to go to a rural or remote community and be the only doctor in that community.

Solution No. 2: With appropriate government funding to support supervisors and mentors, and co-ordination among key partners, practice-ready assessments could be implemented immediately, meaning new doctors could be seeing patients in Ontario by summer 2023, not sometime in 2024. We would also like to see the number of spots increase from 50.

We also need robust data about our physician workforce so we can plan wisely for future needs. Physician shortages can reduce patient access to health care and increase physician burnout. An excess supply of physicians can lead to underemployment or unemployment.

The OMA is developing a tool using artificial intelligence called PRIME (Physicians Resources Integrated Model) that analyzes all physician-patient interactions extracted from medical billing data. That information can be used to predict future health-care needs, such as how many family physicians and specialists will be required to meet patient needs in a specific geographic area. It will also help universities, residency programs and health-system policy-makers determine where skills gaps are and will be.

Keeping the doctors we have: reducing the adminstrative burden

Physicians identify administrative burden as one of the leading causes of burnout, which is at record levels. Alleviating this burden must be an urgent priority. Reducing the numerous hours spent on unnecessary forms and other administrative tasks will give doctors more time to be doctors and bring joy back to medicine.

The Canadian Medical Association's 2021 National Physician Health Survey found that physicians spend more than one extra working day – 10 hours a week – on administrative tasks.

Doctors Nova Scotia led an innovative project to quantify the physician administrative burden, understand its impact and identify ways to reduce it. They found that each physician in Nova Scotia spends 10.6 hours a week on administrative tasks, which amounts to 1.36 million hours annually in the province or the equivalent of 1.73 million patient visits annually.

The study identified the portion of administrative work that was unnecessary (38 per cent), work that could be completed by someone other than a physician (24 per cent), and tasks that likely could be eliminated (14 per cent).

In response, the Nova Scotia government committed to reducing physician red tape by 10 per cent – roughly 50,000 hours – by 2024. Doctors Nova Scotia estimates the time physicians will save is equal to 150,000 patient visits, demonstrating that even a relatively small reduction in red tape can have a significant impact.

The Canadian Federation of Independent Businesses extrapolated from the findings in the Nova Scotia study to estimate the administrative burden for other provinces. It found the administrative burden in Ontario was equivalent to 20.6 million patient visits, assuming an average of 20 minutes per visit or three visits an hour.

A joint OMA-Ministry of Health Forms Committee is reviewing problematic government forms identified by physicians with a similar eye to weed out unnecessary work.

A recent OMA member survey identified the most burdensome forms as:

- Medical notes for work, school or daycare
- Ministry of Transportation mobility and accessibility forms
- Private insurance forms
- Ministry of Health forms for assistive device benefits (for example, screen-reading software, Braille displays)

A bilateral OMA-Ministry of Health Burnout Task Force is examining how to reduce administrative burden from forms and the Ministry of Health has also engaged the Ministry of Red Tape of Reduction to advance this work.

Solution No. 3: We need dedicated investment to prioritize the review and streamlining of government forms to reduce administrative burden. Given the urgency, the government should follow the lead of Nova Scotia and set a target for how many government forms can be reduced and complete this work within the next year.

Another source of administrative burden for physicians is the time spent accessing various portals to get information. Countless separate portals have been established to access forms, documentation, patient information etc., each requiring a separate log-in. When physicians must use multiple standalone digital health tools requiring multiple logins and clicks to access information throughout the day, it can greatly disrupt their workflow, increasing their administrative burden and associated burnout.

Our *Prescription for Ontario* also calls for integration of electronic medical records. In Ontario, doctors, hospitals, labs, pharmacists and home- and community-care systems all use different digital medical records systems, which do not speak to one another. Nine in 10 physicians still use fax technology to share patient information with others.

Connecting these different systems would reduce the administrative burden and free up time better spent on patient care. Physicians need to be involved as key partners from the start in the procurement, design, implementation and ongoing optimization of digital health tools to ensure usability. Physicians also need comprehensive and ongoing training on using these tools, starting in medical school, and easily accessible and ongoing technical support.

The OMA's white paper on burnout, Healing the Healers: System-Level Solutions to Physician Burnout, also recommends wider use of medical scribes, who transcribe information during clinical visits in real time into electronic health records. There are increasing options for virtual scribes who listen to patient encounters virtually, and emerging technology for AI scribes.

Solution No.4: Stop building portals. Doctors have long called for the integration of digital health tools that can be seamlessly accessed from their electronic medical record. More focus needs to be put on integration.

INCREASING PATIENT ACCESS TO CARE AND BUILDING CAPACITY

Wait times for many common surgeries and procedures were too long before the pandemic, some well above the government's own recommended guidelines. The pandemic made them longer.

By analyzing historical OHIP billing data, we know that about 21 million health-care services that should have taken place during the pandemic did not. That includes everything from annual checkups and childhood immunizations to diagnostic procedures and more than one million surgeries and procedures.

Ontarians are returning to the health-care system in large numbers, booking appointments to see their family doctor to catch up on three years' of missed care or going to emergency departments. Physicians are seeing patients sicker than they ought to be because of serious conditions left undetected or untreated during the pandemic.

Sick patients don't have time to wait for diagnostic tests, surgeries or treatments. Many are frustrated, in pain, unable to work, and their condition may be deteriorating. Some may be depressed or anxious and unable to cope. Their lives are on hold.

The Ipsos survey for the OMA in November 2022 found that 82 per cent of Ontarians felt wait times for non-emergency procedures were too long, up from 75 per cent in April 2022.

In the OMA member survey, 49 per cent of Ontarian's physicians said they have a backlog of patients. Almost half of those who have a backlog feel it will take more than a year to catch up.

Whatever numbers you use, they're too big, the waits are too long and too many Ontarians are suffering. We need to deal urgently with the pandemic backlog of care and the underlying structural issue of wait times.

Ontarians agree: Thirty-one per cent of people surveyed by Ipsos said dealing with surgical wait times should be one of the government's top three priorities. (Forty-two per cent said dealing with ED wait times was also on their top three list).

The government recently announced plans to expand existing and create new community surgical and diagnostic clinics to move certain low-acuity procedures out of hospitals, starting with cataracts, diagnostic imaging and endoscopies, and then hip and knee replacements. The OMA also made comprehensive proposals for what we call Integrated Ambulatory Centres in a 2022 white paper.

We have urged the government to strike an implementation committee, including representation from the OMA, to work out details of these community clinics, such as funding, human resources, quality of care and how to move procedures safely to a day surgery setting. Physicians need to be involved as key partners from the start in the implementation of the new community clinics to ensure system integration, patient safety and quality of care.

We know these kinds of clinics can be successful. Evidence in other provinces has shown they can treat 20 to 30 per cent more patients, safely and faster.

We will be monitoring these clinics to ensure they adhere to our four guiding principles:

- They must be connected to hospitals and broader Ontario Health regions. Integration is essential to ensure a smooth patient experience, protect patient safety and procedure quality, and support health care human resource planning
- A health human resources strategy is needed to ensure these centres do not take resources away from hospitals or exacerbate existing HHR challenges including burnout
- We need to ensure that quality of care and patient safety levels are as high as in hospital settings
- These centres must offer publicly funded health-care services and operate within the *Canada Health Act*. They cannot lead to a two-tier system or queue-jumping

There are other steps the government can take now to reduce the pandemic backlog and address wait times.

Solution No. 5: Create a centralized system in each of the six Ontario Health regions to accept referrals for certain surgeries and procedures, develop criteria to triage them based on medical urgency and assign them to the next available physician or surgeon or the patient's preferred physician. This would, in effect, create a centralized wait list in each region so patients would know how long to expect to wait for general surgery, orthopedics, cataracts, mental health care, diagnostic imaging and diabetes care.

A centralized intake and referral system should be managed by Ontario Health and implemented in collaboration with the OMA, OHTs, hospitals, community-based surgery and diagnostic clinics, and primary-care practices to ensure equitable and timely access. It should be created with strong physician involvement to help build a solution that works for patients and physicians and funds will need to be set aside to cover this. Patients should be able to choose either the shortest wait time or a specific surgeon, based on known wait times.

Solution No. 6: Extend funding for the 77 COVID cold, cough and flu clinics around the province for another year beyond March 31, 2023, to help with surges in the COVID-19 virus and keep people out of emergency departments. Raising awareness of these clinics would increase usage.

These are community-based medical clinics, primarily for patients who do not have a family doctor, which can test, assess and treat patients with respiratory illnesses, such as COVID-19 and Influenza. Appointments can be made the same day or next day and some accept walk-ins. Experience has shown they are effective at diverting patients from hospitals.

In Ontario Health's Central Region alone (Mississauga, Huntsville, Orangeville, Markham), there are 26 such cold, cough and flu clinics. They had 73,360 patient visits from March 18, 2020, to Oct. 31, 2022. When patients were surveyed, 19.8 per cent said they would have gone to an emergency department had they not be able to access one of these clinics, the equivalent of diverting 14,525 ED visits.

RESERVE HOSPITALS FOR PATIENTS WHO NEED ACUTE CARE: MOVING CARE TO HOMES AND INTO THE COMMUNITY

A palliative approach to care

Palliative care is an approach that aims to reduce suffering for people living with a life-limiting illness, improve their quality of life and enable a peaceful and dignified death. It encompasses both pain and symptom management plus psychological, social, emotional, spiritual and practical support for the patient, family and caregivers. While it used to be offered only to patients in the remaining weeks or months of life by a specialized group of providers, it now includes a broad range of settings and providers, as well as people with chronic life-limiting illnesses such as ALS.

Yet 50 years after the term “palliative care” was coined in Canada, there continues to be a lack of consistent and equitable access to palliative care across Ontario. Of the more than 100,000 people who died in Ontario in 2017-18, only 61 per cent received palliative care in their final year.

When implemented across all care settings and providers, a palliative approach to care results in greater health-system integration by freeing up acute-care beds in hospitals and reducing unnecessary and disruptive transitions in care. It allows patients to remain in their preferred setting, often the home or home-like settings such as long-term care, all at lower costs to the system.

The OMA believes that every patient in Ontario deserves 24/7 access to high-quality palliative care in the setting of their choice, from the time they are diagnosed with a life-limiting illness until they die. Palliative care should be available equally and equitably throughout the province, including for vulnerable populations in the setting of choice, including home, hospice and hospital.

Many palliative patients occupy acute-care beds in hospitals only because they are waiting to be discharged to a more suitable setting such as long-term care, hospice, hospital-based palliative-care beds, or home care.

This is stressful for patients and caregivers and is a poor use of health-care resources. The average cost of one day in an acute-care bed in Ontario is $1,100 – twice the cost of hospice care and more than 10 times as much as at-home care. According to Hospice Palliative Care Ontario, the average

cost of a palliative-care hospice bed is $460 a day, excluding drug costs. Home palliative care averages less than $100 a day, excluding drug costs.

Ontario spends about $208 million a year on dying patients who are waiting for a bed in a more appropriate setting. The Auditor General of Ontario estimated in 2014 that $161 million a year could be saved if alternate level of care (ALC) patients could be moved to more appropriate settings. That figure accounts only for patients in their final 90 days of life who have agreed to be transferred and are just waiting for a bed to become available. It underestimates the potential savings from moving palliative patients who have more than 90 days to live and those who are never classified as ALC.

While dollars are important, it's also important to remember how many people we are talking about and their quality of life.

About 10 per cent of Ontarians spend at least one day in acute care, with an ALC designation, in their last 90 days of life. In 2017-18, they accounted for 190,000 patient days, or roughly 40 per cent of all ALC patient days in Ontario. Of those ALC patients:

- 44 per cent were waiting for a bed in a long-term care home
- 24 per cent were waiting for a residential hospice or palliative-care unit bed
- 12 per cent were waiting to be discharged to their homes
- 30 per cent died before they were discharged

Why can't we move palliative patients to more appropriate settings sooner?

Because of the lack of available options to care for end-of-life patients in home and community settings, the only other options for patients requiring supportive care are long-term-care homes and non-palliative home care.

Long-term-care beds typically have significant wait lists and clinical teams may be reluctant to apply for one when they suspect a patient will deteriorate substantially before they are offered a bed. Access to LTC palliative beds is often based on a patient's prognosis, but prognosis is not always clear, particularly for patients who are frail or have non-cancer-related illnesses. And, while patients dying of cancer typically don't need help with daily living until the final weeks or months of life, the 75 per cent of people dying of other illnesses typically need help for many months or years.

In addition, admissions criteria, especially for hospice, can include financial penalties when a patient's length of stay exceeds a few weeks or a few months – meaning there is a disincentive to admit patients with unclear prognoses to hospices.

Home palliative care often provides substantial support services but is also generally limited to people in the final months of life. There is evidence that home-based palliative care that involves primary-care providers, cardiologists and palliative-care physician specialists can help patients with heart failure avoid admission to hospitals and shorten hospital stays. Yet this model, which allows people to die at home, is limited across Ontario. The shortage of palliative-care physicians and other home-care professionals is not meeting growing demands for home-based palliative care. As a result, patients receive their care in expensive hospital settings, even when patient outcomes are better in the community.

In 2014, the Auditor General of Ontario recommended that Ontario should have 945 to 1,350 hospice beds, based on seven to 10 beds per 100,000 people. Many palliative-care physicians recommend 10 to 12 beds per 100,000 people.

That means Ontario should have about 755 to 1,080 palliative-care beds in hospices and 190 to 270 in hospitals. According to Hospice Palliative Care Ontario there are only 491 hospice beds across the province with another 23 now being opened. Some of those beds are funded by the community, not the government.

Solution No. 7: Take a data-driven approach to reinvest money spent on alternate-level-of care patients in acute care settings, who are nearing their end of life, into home and community settings by:

- **Creating 500 more hospice beds in Ontario and the funds to operate them**
- **Repurpose existing infrastructure to create and operate chronic palliative beds for patients who do not meet the traditional hospice criteria, in the 10 highest density regions of end-of-life care ALC days in Ontario**
- **Increase capacity to provide end-of-life palliative care in the home, including equitable access to on-call palliative specialists**

Embed care co-ordinators in primary care

The province's 4,500 care co-ordinators work mostly in administrative silos, the 14 Home and Community Care Support Service organizations. Some focus on specific populations or services, such as palliative care, geriatrics, pediatrics, acquired brain injuries or mental health and addictions. But in general, the role of these regulated health professionals (mostly registered nurses, but also physical therapists, occupational therapists, social workers) is to:

- assess patient care needs (personal support services, nursing care, occupational or physical therapy in the home, etc.)
- determine eligibility for home- and community-care services
- determine eligibility for long-term-care homes
- develop care plans for how much care should be provided and for how long
- co-ordinate and monitor care plan delivery and work with service providers

Some care co-ordinators are closely connected to a hospital and may even be physically located there. Others are based in family health teams. But most are located far from the actual delivery of care and are not integrated with primary care. Few primary-care doctors have a dedicated care co-ordinator to work with. As a result, patients deal with many different providers and the care they receive becomes fragmented.

It is critical that all physicians have seamless access to care-co-ordinators to support continuity of care and provide patient-centred care. This access must apply across the province, regardless of location and practice model.

Care co-ordinators should be embedded in Ontario Health Teams so they can be functionally part of the OHT, located alongside primary-care teams, and can support all members of the OHT hospitals, family health teams, solo-practice physicians, long-term-care homes, etc.

- This would make the care co-ordinators part of the team
- It would support continuity of care and accountability for care
- It would support better communication in the health-care team. Anecdotally, the top complaint from physicians when talking about care co-ordination is the lack of effective and efficient communication between physicians, care co-ordinators and home-care providers
- Care co-ordinators would have access to the local electronic medical records system
- Physicians could work with a dedicated care co-ordinator, whose caseload could be aligned with the physician patient roster
- Patient needs would be better supported by this team-based approach. Most people receiving home care have chronic issues, not acute ones

Solution No. 8: Ensure all physicians have seamless access to care co-ordinators regardless of their location and the model in which they practise. Move the province's 4,500 co-ordinators of home and community care to Ontario Health Teams, so they are integrated with primary care. Expand their role to include support for navigating other parts of the health-care system. Ensure physicians not connected to Ontario Health Teams can access care co-ordination services. OHTs should be permitted to innovate and redesign this care co-ordinator role so that it includes delivery of clinical care and broader system navigation beyond home and community care.

Preventing hospital transfers from long-term care

Solution No. 9: Enable the management of acute medical needs within LTC homes to prevent the need for hospital transfers.

Long-term-care residents are often transferred to hospitals for diagnostic tests or treatments that can be done safely in the LTC homes with the appropriate equipment and trained staff. This would improve the patient experience, make better use of health-care resources and reduce the strain on hospitals, as many of these patients end up occupying badly needed emergency department beds.

The OMA recommends that the government enable more diagnostic and other care in long-term-care homes, ranging from IV administration to same-day blood and urine tests to mobile diagnostic imaging clinics.

These changes could benefit a significant number of people. One-third of long-term-care residents in Ontario were transferred to an emergency department at least once in a year, according to a study published in the journal *Healthcare Policy* in 2016.

About half of long-term-care residents in Ontario who were transferred to an ED were discharged without being admitted to hospital, which means they spent their entire time in the ED, according to an earlier study. It also found that 24.6 per cent of residents were transferred for something that likely could have been treated in their LTC home, most commonly pneumonia, urinary tract infection and congestive heart failure.

To prevent unnecessary transfers to hospital of long-term care residents all 630 long-term care homes in Ontario should have access to and be equipped with:

- Mobile diagnostic imaging clinics that provide on demand (within 24 hours) access to in home X-ray and ultrasound
  - These resources must be available to all LTC homes across the province. To achieve this, the province must allocate mobile diagnostic resources according to geography and population density
  - Within each region, each home should have equal access to the equipment and trained staff
  - The advantage of having mobile clinics is that they can respond to fluctuating needs
- The ability to do same-day blood and urine tests to diagnose, treat or rule out a range of medical conditions
- The ability to administer IVs for fluids and medications
- A bladder scanner, a portable non-invasive tool that can be used to assess urinary retention, and an EKG machine, which would enable physicians to rule out cardiac issues as a source of chest pain. Once the cause of urinary retention is determined, residents can be catheterized in their long-term-care home

In rural communities, these changes could also free up ambulances to be available for more serious or life-threatening calls.

Enabling long-term-care homes to do blood and urine tests, to be picked up the same day for analysis at a local hospital or community lab, would help diagnose, treat or rule out a range of medical conditions, such as infections, electrolyte abnormalities, dehydration or heart issues (in conjunction with an EKG). This would also enable a health-care provider to know if it's safe to start a resident on medication.

Being able to give LTC residents antibiotics, medications or fluids by IV would keep more people in these homes rather than hospitals.

Mobile X-rays and ultrasounds could be used to diagnose/treat/rule out issues such as pneumonia, congestive heart failure, bowel obstructions vs. constipation, and fractures after falls (for example, hips, pelvis, knees, elbows, wrists).