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Ministry of Health

1st Session
42nd Parliament

Wednesday 19 May 2021

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

E-31

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Mercredi 19 mai 2021

Président : Peter Tabuns
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 19 May 2021

Mercredi 19 mai 2021

The committee met at 1534 in room 151 and by video conference.

MINISTRY OF HEALTH

The Vice-Chair (Ms. Donna Skelly): Good afternoon, everyone. We are going to resume consideration—

Interjection.

The Vice-Chair (Ms. Donna Skelly): Oh. Good afternoon, everyone. I'm a rookie. We're going to resume consideration of vote 1401 of the estimates of the Ministry of Health. There is now a total of five hours and 22 minutes remaining for the review of these estimates. When the committee adjourned yesterday, the official opposition had 12 minutes remaining.

Who would like to begin for the official opposition? MPP Gélinas.

M^me^ France Gélinas: Thank you. If my memory serves me well, I think I was talking with Amy Olmstead—sorry about the pronunciation—the acting executive lead for Ontario health teams. She was explaining to me that there was $10 million last year to support the implementation of the Ontario health teams. I think she mentioned that we have $40 million this year to support. They have to show collaborative decision-making that could lead to a shared governance. And then the time ran out, and that was the end of our conversation. So, just to reopen it up, if I could, if you want to finish the talk about the $40 million and what it is for.

My other question—it still has to do with money, given it's estimates. I know that the staff, the workers, from the LHINs have migrated to Ontario Health. The workers from the old CCACs that have transferred to the LHINs that are now the home and community support services, I take it, will be going to the Ontario health teams. Where can I find the money for this?

So my two questions are regarding Ontario Health and Ontario health teams.

Ms. Amy Olmstead: Thank you, MPP Gélinas. Amy Olmstead, acting executive lead of the Ontario health teams division. I know I had technical challenges yesterday, so I'll just go back over some of the content.

Again, we have about $11 million last year for Ontario health team implementation, and about $34 million expected to go this year for Ontario health team implementation. This will be focused on, as we discussed yesterday—it's not for the services, the underlying services, that those OHTs are providing through their partners. Those funding streams continue. It's for things such as planning, implementing the partnerships, investing in digital health, investing in patient and family and caregiver engagement processes, project management, and that kind of thing. That is what we have planned in terms of Ontario health team funding for the coming year. That is found under the health quality initiatives in the estimates.

To your question about the workers at the former LHINs: As you outlined, some of those staff at the former LHINs did move to Ontario Health to support the work and the responsibilities that moved to Ontario Health related to system planning and integration and the funding of community services. The rest of the staff who are supporting home care service delivery, long-term-care home placement and access to community services—so referrals to community services—and the supporting infrastructure for them, remain with the LHINs, who are now called Home and Community Care Support Services. So that is part of the community budget line under—it's part of the home care budget line. I can find that in a minute.

The plan is, over time, for home care functions to move from the Home and Community Care Support Services organizations to Ontario health teams. The government is still working through what that process will look like, so that's still a work in progress. The focus to date has been in narrowing that mandate of the LHINs so that they are just focused on Home and Community Care Support Services and making sure that those organizations are set up to maintain the care continuity for our 700,000 or so home care clients, both through the COVID response and the wake of the COVID response, and through the health system transformation that we'll be seeing. I don't want to speak for the minister, but she has been very clear that the care continuity is extremely important, and that's what we're prioritizing right now as we make sure that those organizational structures are in place.

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I would invite the deputy or associate to say anything further—

M^me^ France Gélinas: Just before, and while your connection is good—sorry—right now, we have placement coordinators; we have care coordinators. They are all employees of who? They used to be employees of CCAC. CCAC had a board of directors in all of this. We knew where the money flowed. Who pays them right now? Who is their employer right now?

Ms. Amy Olmstead: They are employees of Home and Community Care Support Services, those organizations. That is the new name of the LHINs. The local health integration networks still exist under the legislation. They still exist as crown agencies. The employment for those really important care coordinators and placement coordinators has not changed.

We made that decision very carefully to not change that employment relationship while we were supporting the transition to Ontario Health of some services and really narrowing that LHIN mandate. We wanted to preserve that employment relationship during this really important time, deliberately. The funding stream that last year would have gone to LHINs is now going to Home and Community Care Support Services, except for the little bit that would have been carved out to follow the responsibilities that have gone to Ontario Health for April 1.

M^me^ France Gélinas: Okay. Of course, crown agencies are not part of Ontario health teams. There are six parts to Ontario health teams: hospitals, long-term care—we all know what they are. Crown agencies are not. So what happens to Ontario health teams that want to have home and community support services as part of their team if they are employed by a crown agency, and crown agencies are not part of Ontario health teams?

Ms. Amy Olmstead: These are exactly the key transition discussions that we are having. We want to support Ontario health teams in having integrated home and community care, as part of the integrated suite of services at end states. We recognize that care coordination functions are so critical to an integrated health system and so critical to supporting home and community care services in particular. What we are working through now is, what is the path from A to B? That is something that, as I say, we are focused on as we get the building blocks of the renamed LHINs soundly in place.

M^me^ France Gélinas: Do any of the 42 Ontario health teams there are now have pretty good ideas as to—we know what the A looks like: What will the B look like? Any good ideas out there?

Ms. Amy Olmstead: Yes. Some teams have put forward some new models or proposed models of how they would deliver home and community care services in the future, either for their year one priority populations or looking a little bit more broadly. What we need to do, from the ministry's perspective, is look at those different options, reflect on how well they align with our balanced commitment of continuity and modernization and then reflect back out to Ontario health teams any parameters or guidelines about the transition of home and community care to those Ontario health teams.

Another key consideration is the new legislation for home and community care that we are going to be engaging on again this summer in terms of what the regulations will look like for home and community care services. That will be an important consideration for Ontario health teams that they haven't had a chance to yet reflect on in their modelling, because of course, we're still working on the regulations and looking forward to engaging in a second round of engagement this summer.

Those are some of the factors that will need to be considered—

The Vice-Chair (Ms. Donna Skelly): Two minutes.

Ms. Amy Olmstead: —before we start that process of moving home care functions over to Ontario health units. Right now, we see—

M^me^ France Gélinas: Just one sec. From what you're telling me—let's say we have a strong relationship with a family health team or a community centre. I'll say community health centre because I like them. Could a community health centre become the host agency of the home and community support services, where the care coordinator, the placement coordinator would then transition to a community health centre? Am I dreaming out of the box here?

Ms. Amy Olmstead: We have had people propose that type of model. It's one of the types of models that I think the system is looking at where, MPP Gélinas, just as you've outlined, you would have that CHC, have care coordinators working as part of that team, and those coordinators will be working directly with home and community care service providers to create that integrated primary care and home and community care linkage that we know is so important.

That is one of the types of models that we have heard people would like to see and that we hope the new legislation would support, but we do need to still work through some considerations of how exactly that would work.

M^me^ France Gélinas: Okay. Aside from the idea that came up in my mind, what else have you seen that looks promising?

Ms. Amy Olmstead: To date within the models that people are looking at, we've seen, obviously, the hospital-home care integrated models for people who are leaving hospital. It's not about having hospitals take over—

The Vice-Chair (Ms. Donna Skelly): Thank you. That is all the time we have right now.

Now we're going to go to the government side. MPP Pettapiece.

Mr. Randy Pettapiece: Chair, through you, I would like to ask the minister about the supply chain for PPE. It was quite an issue when the pandemic first hit. I know in my riding, the lack of it and shortage in the supply was something that was quite noticeable, and certainly, it did affect our people involved in the health ministry.

Minister, when COVID was declared a worldwide pandemic, we saw that the global supply chain for PPE had become extremely strained and highly competitive. Nothing is more important than protecting the health and safety of patients, the front-line workers caring for them and our first responders. Can you please tell us how this experience has shaped how we source PPE now and into the future?

Hon. Christine Elliott: Thank you very much for your question, MPP Pettapiece. Good afternoon.

The government of Ontario made historic investments in the 2021 budget to ensure patients are cared for and the spread of the virus is controlled. Through the actions announced as part of the 2021 budget, the government is

committing an additional $6.1 billion to the fight against COVID-19. This will bring the province's total projected COVID-19 response to $51 billion over four years.

Since the beginning of the pandemic, Ontario has purchased over $1.6 billion in personal protective equipment, or PPE, and other critical supplies and equipment to strengthen the pandemic stockpile. This includes more than 1.1 billion surgical masks and more than 1.2 billion gloves, in addition to other necessary items to help keep Ontario safe.

Our government took action to secure domestic production of the supplies and equipment that the people of Ontario need the most. Through my colleagues at the Ministries of Government and Consumer Services and Economic Development, Job Creation and Trade, Ontario is also working with local manufacturers and the federal government to increase domestic production of PPE and reduce our reliance on foreign manufacturing, which can be volatile and constrained in the times of a pandemic, as we saw early on in this COVID-19 pandemic. We have seen Ontario's companies adapt and in many cases restructure their operations in order to be able to manufacture masks, face shields and other medical supplies that we needed the most. Actions by our government have helped to stabilize what was a very challenged supply chain. A recent sign of the stability was in the news a few days ago, that in response to India's urgent pandemic needs, Ontario donated 5,000 made-in-Ontario ventilators to support their pandemic response. You will know that India is in a very difficult situation right now with COVID.

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I will now ask the deputy minister to provide additional information on our work to provide essential PPE to those who need it, and in parallel, the transformation of our entire supply chain, including the creation of the new Supply Ontario agency. Deputy Minister Angus, over to you.

Ms. Helen Angus: Thank you very much, Minister. Thank you, MPP Pettapiece, for the question. I'm Helen Angus. I'm the Deputy Minister of Health.

COVID-19 placed significant pressures on Ontario's supply chain. Of course, Ontario was not unique being in that position. Like other jurisdictions around the world, we faced many challenges to secure and distribute PPE. The good news is that leaders across government stepped up to secure that PPE at a time when it was needed most, and that included partners at the Ministry of Government and Consumer Services as well as Ontario Health who worked tirelessly, many times late into the night, to secure PPE from other jurisdictions early on in the pandemic to help protect Ontarians and better manage our pandemic response.

We also leveraged the talent and expertise across the health sector and beyond. For example, I have to give a shout-out to Ontario Shared Services organizations, who were willing partners and continue to be active partners, rolling up their sleeves to source, store and distribute critical supplies to the health sector.

I think it's important to note that as we responded and continue to respond to the pandemic, we've also continued our long-term work on setting up a modern supply chain system. This was work that predated the pandemic and has accelerated over the course of the last year because of the tremendous need. That work is one that can serve not only the health sector but the entire broader public sector and meet the needs of all communities.

Back in November 2020, the Ontario government announced the creation of Supply Ontario. It was established by regulation under a new piece of legislation, the Supply Chain Management Act, 2019. Supply Chain Ontario has the mandate to unlock the potential of aggregating demand—so bringing the demand into one place to reduce the fragmentation of too many buyers trying to buy from too many disparate providers—with the intention of creating greater value for the province in purchasing as one buyer, and I think the potential of this is enormous.

Supply Ontario will ensure that the province's supply chain is secure. It's going to ensure that supplies are available throughout the province, and it is intended to work closely with stakeholders to make sure that it's responsive to the needs in the field.

The agency's inaugural board was established in January of this year. It brought together officials with strong experience in procurement and corporate governance, and we leaned on the expertise of both the public and the private sector in establishing the agency. The new Supply Ontario CEO, Frank Rochon, was appointed by the Supply Ontario board on March 1. The agency is currently building its internal operation capacity, and its first priority will be to assume the management of the PPE supply chain.

I can tell you that I've met with Mr. Rochon, and he is already off to the races and is going to be making an important impact through the organization on the work of Ontario's supply chain.

I will ask assistant deputy minister Kyle MacIntyre to give us all some more details on the PPE response, including some of the more recent successes in securing PPE, and also talk a little bit more about the longer-term vision for the supply chain work and the transformation that is well under way.

So, Kyle, why don't you introduce yourself and add some more texture to our responses for MPP Pettapiece, please.

Mr. Kyle MacIntyre: Great. Thank you very much. Kyle MacIntyre, acting assistant deputy minister, health transformation division in the Ministry of Health. I hope everyone on the line will tell me if I have something on my face. Thank you, Deputy, and thank you to the member for the question about supply chain modernization and the pandemic response.

As acting ADM of the health transformation division, my team and I are responsible for leading transformative projects such as the modernization of our health care system supply chain. As we look back and we recognize that the events of the last 18 months or so have brought a lot of challenges and frustration for people, I think we can look back and say out of these difficult circumstances

came the opportunity to work together across the health sector for the public good.

When the pandemic first started, all efforts were focused on stabilizing the province's access to PPE and making sure that our essential health care workers had the supplies and equipment that they needed to keep themselves and their patients safe. Today, we can say that Ontario's pandemic supply chain is stable. It's well-stocked and able to quickly provide the equipment and supplies that our patients and front-line workers need. But it took some work to get to this place and a lot of effort and support from colleagues, both in government and across the health sector. The deputy has spoken to some of the folks who really did work tirelessly to make this happen.

In April 2020, Ontario launched a new online intake portal for all public health sector entities to quickly and easily request critical pandemic supplies and equipment from the province. This portal also serves select organizations beyond the health sector, including community organizations such as shelters. Recognizing the urgent nature of the public health response, the ministry committed to delivering PPE and other critical supplies to health service providers and long-term-care homes within 24 hours of urgent request to our pandemic stockpile.

Early in the pandemic, many smaller, community-based health care providers faced challenges finding PPE and other supplies. These challenges included new sourcing complexities, inaccessible pricing and a lack of administrative capacity to do purchasing. Today, Ontario provides transitional support to help these health care providers acquire the PPE and critical supplies they need.

As mentioned, the government has also made important investments in the domestic supply of necessary PPE and other products, as the minister has highlighted. Investing in domestic production will help reduce reliance on foreign supplies, strengthen pandemic stockpile and support Ontario's manufacturing sector.

We have learned a lot through the pandemic on how to better protect Ontario through additional pandemic waves, and even address future health system needs over the long term. I'm going to describe some of the early challenges that we faced and the ministry's response, highlighting some things we think can help our health supply chain infrastructure enable excellent health care for the people of Ontario.

In the early months of the pandemic, as was recognized earlier, the global supply chain collapsed. Every piece of the end-to-end supply chain, from source materials to manufacturing to distribution, broke down in the face of extremely high global demand. Even though Ontario's supply chain continued to deliver critical supplies throughout the pandemic, there were some serious challenges. Countries around the world struggled to obtain pandemic supplies, and Canada was no exception.

I think COVID-19 has shone a light on the challenges in our provincial supply chain, both at the national and provincial levels. Early in the pandemic, many of the province's smaller health providers had limited access to PPE and limited supply chain capacity to support sourcing and procurement activities at the level of a large hospital, for instance. Where hospitals may have access to a global network of suppliers or a shared service organization and dedicated procurement staff, or even a national group-purchasing organization to support them, a small, independent primary care physician may not have the same purchasing opportunities.

On the industry side, we can say that many of the authorized suppliers were simply unable to meet spikes in demand at the beginning of the pandemic. This led to grossly inflated prices, particularly with N95 respirators. While reputable manufacturers tried to hold prices steady during the pandemic and maintain a flow of personal protective equipment, we did see N95 respirators that usually sell for about a dollar pre-pandemic go up to as high as $16 a unit through resellers and secondary markets.

Ontario, along with others across the world, faced issues with uneven quality of products, price inflation, delayed production and many other obstacles. So not only did demand outstrip supply, there were also further disruptions to the global supply chain, including factory shutdowns overseas and shipping challenges such as pandemic-related port congestion, border restrictions and other types of closings. This was a challenging time for all jurisdictions, Ontario included, and even in countries that are much larger than Canada with greater purchasing power.

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However, despite these many challenges, the ministry was able to supply the entire health sector with the necessary supplies of PPE and critical items, and I'd like to talk a little bit about some of the strategies and tactics that we brought to bear to help ensure that we had enough in our pandemic supply chain. To help to start to address the key challenges, the ministry relied on relationships that the deputy minister has talked about to leverage the experience and expertise needed to properly support our health care system in getting the critical PPE supplies and equipment it needed. Sourcing and distributing agents and supplies to hospitals, long-term-care homes, family physicians and numerous other organizations across a province the size of Ontario required the help of many partners.

One of the first things that we did to respond to these challenges was to mobilize the pandemic's supply chain task force to ensure that we had the supplies we needed and that they went to where the need was the most. The pandemic supply chain task force is a collaboration between the Ministry of Health, the Ministry of Government and Consumer Services, the University Health Network, Ontario Health and Ontario Shared Services organizations. These shared services organizations typically provide supply chain services to hospitals and larger networks of health care providers. The creation of the task force allowed the government to help consolidate the planning, sourcing, monitoring and distribution of PPE and other supplies throughout our province. As a result, health providers in every corner of the province benefit

from the established procurement, sourcing, warehousing and distribution solutions that have been established to better deliver health care. This centralized approach to PPE has helped health care workers more easily acquire the supplies that they need to safely operate. It gives providers one-window access to request what they need the most, while allowing for government to take a more holistic approach to supplying the province with the right supplies and equipment.

The ministry thanks these partners for providing the province with the right mixture of practical expertise, solution-driven problem-solving and sheer hard work. These teams are continuing to support the pandemic response today, as we maintain a strong stockpile of PPE, bolster intensive care unit capacity and secure vaccine supplies.

Our partners have and continue to help the ministry identify sourcing opportunities provided by some urgent procurement needs and support the end-to-end logistics of supplies in and out of the provincial pandemic warehouse. They have also helped to more aggressively pursue supplies in a global marketplace, where Ontario is a relatively small purchaser in relation to other jurisdictions. Through their support, Ontario is now able to compete with larger jurisdictions with more purchasing power. By working together in this capacity, it has allowed us to source and support smaller health providers to access key PPE.

For most sectors, the pandemic stockpile serves as a backup to their regular supply chain and serves as a last resort in case of emergencies and outbreaks. However, for very small health service providers, there was no regular supply chain for them to procure the critical supplies and equipment they need. To effectively address further supply constraints and provide better support to the health care sector, the ministry established a temporary pandemic PPE transitional support initiative. This program provides certain health sector entities with proactive access to a dedicated supply of PPE, and swab kits from the provincial stockpile, free of charge. This is a broad range of community health sectors that are eligible for the transitional support, including primary care providers, midwifery practices, community-based physicians, specialists and other community health service providers.

The ministry also owes a large thank you to Ontario Health for their work in supporting the pandemic response. As part of the government's comprehensive approach to building a modern, sustainable and integrated health care system, it created Ontario Health. Ontario Health is overseeing key areas of the health care system, improving clinical guidance and providing support for providers to help ensure better-quality care for their patients. Ontario Health was also created to improve coordination and connections across the health care system, supporting the system's ability to respond to emergent issues and acute needs, so that patients receive the most appropriate care in the right setting.

The strong relationships and partnerships and integrated care approach established by Ontario health teams and Ontario Health have helped us position the province to respond effectively to COVID-19, including helping build a responsive health sector supply chain.

One of the ways that Ontario Health has been connecting the health care system and improving our supply chain delivery is through the establishment of regional supply chain tables with local expertise and trusted relationships. These tables are often the first point of contact for health service providers, and they make it easier for organizations to escalate urgent needs. Through these tables, the ministry can better understand and respond to local supply shortages, ensuring that PPE and critical supplies and equipment are distributed at a regional level. These tables support decision-making in coordination—

The Vice-Chair (Ms. Donna Skelly): Two minutes.

Mr. Kyle MacIntyre: —with the local health system partners, including local public health units, based on local needs. The goal is to be able to provide the same equitable supply chain support so that a patient in Kenora can receive the same level of support as a patient in the greater Toronto area.

As the minister mentioned, Ontario is using lessons learned from the pandemic to improve domestic production capabilities, making Ontario less reliant on other countries for critical supplies and equipment. This reliance becomes a problem when global issues prevent those supplies from distribution to jurisdictions who need them the most. That's why Ontario has partnered with Canada and 3M to invest in Brockville's manufacturing facility to produce necessary supplies here in Ontario. This partnership and investment represented an important step to meeting current and future needs, and ensuring a readily available supply chain and stockpiled N95 respirators. This investment will result in the creation of new manufacturing capabilities, jobs and a strengthened domestic supply chain, vital for PPE.

In addition to the pieces of work I've just mentioned, the ministry continues to streamline supply chain and stockpile management. The ministry, Ontario Health and health sector supply chain partners implemented a process for delivering emergency supplies through the ministry pandemic warehouse and Ontario Health regions. As mentioned, the ministry launched a provincial survey and virtual inventory of health service providers' PPE stockpiles to help us inform demand and respond to emergency. This survey tells us how much PPE health service providers have on hand across a number of key categories.

Ontario has also worked with our public services and Procurement Canada to participate in federal bulk procurements led by the federal government. We have also shifted allocating our PPE and other necessary supplies on a weekly basis, to both proactively meet the needs of essential workers and maintain a supply to address unanticipated—

Interruption.

Mr. Kyle MacIntyre: —needs across all systems. As part of the—

The Vice-Chair (Ms. Donna Skelly): That's time.

Now we will go back to the opposition. MPP France Gélinas.

Mme France Gélinas: I don't know if Amy wanted to finish her sentence about Ontario health teams, or if she was done.

Ms. Amy Olmstead: Hi. Amy Olmstead, acting executive lead of Ontario health teams. I think, MPP Gélinas, you had asked what other types of models we might see to support better-integrated care for home care clients. You had mentioned one that was primary care-driven. We already see hospital- and home-driven ones for people who are leaving hospital. We do see deployment models where a care coordinator is employed by, currently, the Home and Community Care Support Services, but embedded in another care setting to really facilitate those hand-offs. That's something that we can see and imagine an OHT doing as well.

So those are some of the models that we've seen, talked about and that we hope our modernization process will support over time as we balance care continuity. Thank you. That was the end of my thought on that.

Mme France Gélinas: Okay. Just to clarify: If they are to be embedded in a primary care setting—or in a palliative care setting; it doesn't matter—would that mean that the crown agency would be part of the Ontario health teams, like their employer?

Ms. Amy Olmstead: I think we see two different scenarios. We have our scenario where we are in transition, and the home and community care organizations are still here supporting care continuity while functions move to Ontario health teams, and then we see the end state. At the end state, we would not see Home and Community Care Support Services organizations as part of Ontario health teams, based on what we see the future holding now.

But will they continue to be an employer during transition? For sure. They're deploying some of their care coordinators now in other settings. Will that continue? Yes. Does that mean that they're a formal partner in the Ontario health team? No. They would be one of those partners where they are working together, they're supporting integrated care delivery, but they're not necessarily part of that shared governance.

Mme France Gélinas: That's good.

I'm going to switch a little bit to the virtual care. I know that we've talked about virtual care quite a bit. I'm a little bit curious about—the federal government has committed to investing $46 million to improve Ontario virtual health services. Is there a process to determine the allocation of this funding envelope? Is it already part of the estimates and we just consider those $46 million ours already? Yes, I'm just curious to see where did that money go in the estimates and what are we going to do with it.

1610

Hon. Christine Elliott: Well, thank you very much for the question. It's a very specific one. I'm going to ask ADM Hein to speak to that.

Mr. Greg Hein: Thank you very much. I'm Greg Hein, ADM of digital health. Yes, the federal funding is embedded in the amounts that you see for digital health and virtual care. There are two main line items—votes and items—where they appear: 1403-1 and 1416-2.

We've enjoyed really good success with virtual care over the period of COVID. As I mentioned in my remarks a few days ago, virtual care helped us to respond to COVID, and at the same time we're thinking about how virtual care can further help system transformation. It picks up nicely with the comments of my colleague Amy Olmstead. She did mention digital health funding for OHTs. In fact, part of that is virtual care funding for OHTs. They're very excited to take some of the lessons learned through COVID and figure out the best way to incorporate virtual care on an ongoing basis into their efforts. The federal funding will help in that regard.

Another big theme is we're working closely with Ontario Health to figure out the best way to allocate that funding, and in turn, Ontario Health uses their regional tables. Their regional tables are made up of a mix of clinicians and digital health folks, people that have used virtual care before and have a really good sense of how it can be deployed.

Mme France Gélinas: If I look at the new fee codes that were included in OHIP and that were used extensively during the pandemic by physicians who bill OHIP, does some of the money go into this or is this a completely separate envelope?

Mr. Greg Hein: It's completely separate. There are two buckets for paying providers, paying physicians, to use virtual care. One is the Ontario Virtual Care Program, which is the long-standing one that's managed by the Ontario Telemedicine Network, which is now part of Ontario Health; and then separately, my colleague Patrick Dicerni, who runs OHIP division among other responsibilities, introduced the so-called K-codes to help ensure virtual care during COVID. So the funding from the federal government will go to the programmatic side of it, not physician compensation.

Mme France Gélinas: Okay. Maybe then my next question is more to ADM Dicerni. I see that in vote item 1405-1, payments made for services and for care provided by physicians and practitioners, we saw a $1.3-billion increase. I was wondering—during the pandemic, many physicians reached out to me to say that their volume of clients had really gone down. A lot of people were afraid to go to the hospital, to go to emergency, to go see the doctor. They all stayed home and physician practices got really quiet, yet we see that OHIP went up by $1.3 billion. How much of this was related to K-codes? Do we know? And can I see it in the estimates book? That's if ADM Dicerni is there.

Mr. Patrick Dicerni: He is. Thank you very much, Madame Gélinas, for the question. Patrick Dicerni, ADM in our OHIP and drugs and devices division. As my colleague Greg Hein mentioned, early days in the pandemic, ourselves and the Ontario Medical Association, the exclusive bargaining partner of physicians, quickly came together and negotiated the design and implementation of what has come to be known as K-codes. That's simply a section in the schedule that these codes are associated with.

To some of the comments that you made and I think what you heard from some of your physician constituents, and as we heard from ADM MacIntyre a little earlier, we were at a point in the pandemic where PPE was scarce; people were understandably fearful and reticent to go to hospitals or primary care. Quickly, the need was seen to install a ready system for people engaging with primary care and specialists in a virtual manner. As I said, that's what has come to be known as the K-codes, and those were up and running pretty early.

In some of the lessons learned that we've conducted or lessons-learned exercises that we've conducted through some key informants in the health care system and providers, I think it's fair to say that these K-codes served a very necessary purpose and, I would say, in some cases identified serious health concerns earlier than otherwise it would have been able to and, I would say, saved lives. To give you a sense, Madame Gélinas, between March 2020 and March 2021, about 28,000 physician providers provided 34 million virtual-care K-code services to over eight million OHIP patients, and K-code expenditures for the fiscal year of 2021 to date are $1.6 billion.

Now, it's important to note that that is care that has been provided, necessary care to be provided and that is really augmenting some of the, I would say, continued challenges with respect to coming into a physician's office in person. That being said, primary care and specialist care has remained open throughout the pandemic and has obviously provided an accelerator onto some of the adoption of virtual care that we had seen up to this point.

M^me^ France Gélinas: Okay. When I look at the OHIP $17 billion, 23% of the health care expenditure, and we see an increase of $1.3 billion, how do we explain this during a time where so many people stayed away?

Mr. Patrick Dicerni: Yes. Good question, and thank you for it. I think it's important to bear in mind when we look at the OHIP vote, it is not exclusively driven by the K-codes that I've just talked about. There are numerous other, I would say, COVID initiatives that, by necessity, were brought in. I would point to things like the manner in which we compensate fairly physicians for their work at assessment centres, deployment into long-term-care homes during numerous waves of the pandemic, vaccination work at mass clinics, regular fee-for-service billings as well, hospital physician redeployments—so, when we step back and look at the suite of interventions or programs that were put into place to ensure the continuity of physician services, we would not attribute it all to simply the K-code utilization.

M^me^ France Gélinas: Okay. So, I am sure you know, but I have a large group of nurses that are really ticked off that physicians are getting 10 times what they are getting to administer vaccines. I can tell you that in our mass vaccination clinic, the minute the health unit puts out, there are a whole bunch of physicians who line up for those shifts at 225 bucks an hour when there were perfectly competent nurses at 35 bucks an hour. How did we end up with that?

Mr. Patrick Dicerni: Thank you very much for the question. The rate that you're referring to: a $170-an-hour rate during business hours, if you will, and, as you said, a higher rate for what's often referred to as unsociable hours or evenings and weekends.

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With respect to how we arrived at that rate, we did negotiate that rate with the Ontario Medical Association, and it was a number that was based off of, broadly speaking, when we look at fee-for-service or compensation that a physician would be able to bill the scheduled benefits for in the course of, let's call it, normal activities. It is absolutely within the range of what is a fair and reasonable level of compensation when you look at the practitioner that is doing that and what he or she would be billing, as I said, the schedule outside of this type of environment.

It does also facilitate ease of compensation, at a time when we want physicians, practitioners to be focused on meeting the challenges of the pandemic and servicing patients. Moving to an hourly rate and the ease of billing that that creates saves time and effort on behalf of physicians and to some extent optimizes their time and availability.

M^me^ France Gélinas: What I don't get is that we already have an hourly rate for physicians. Look at all the physicians who work within community health centres. Their salaries are fixed, they're paid per hour, and they certainly do not get 170 bucks an hour or $225 an hour on weekends and late shifts.

The physicians that bill OHIP always tell me that 40% of their billing goes to paying the rent and the janitor and the secretary and everything else. So my question again: Why didn't we just take the rate that we already pay physicians when we pay them by the hour, rather than negotiate those?

Mr. Patrick Dicerni: Thank you for the question. I just step back and look at what is often required of physicians during those engagements and those shifts, if you will, whether they be assessment centres or vaccination centres. It goes beyond simply, I'd say, testing or swabbing; it's to some degree clinical assessments that are going on in those settings, addressing adverse reactions to vaccines, which is something that, in limited cases, we have seen. The applicability of some of the other hourly rates that I think you are referencing is not transferable in every sense, or fungible, if you will.

M^me^ France Gélinas: Okay. But if you're telling me that you need the knowledge and skills of a physician, then how do you explain that on other shifts, all we have are paramedics, nurses and nurse practitioners? There are no physicians to be seen, and those clinics are still administering thousands of vaccines in a 12-hour shift—3,500 to be exact in a 12–hour shift, and there's no physicians to be seen. So I have a hard time—it's either we need the physician knowledge and skills and we pay for the physician knowledge and skills, or we don't need those skills, because other clinics run just fine without any physicians around.

Mr. Patrick Dicerni: A couple of comments in response: I think it's important to bear in mind that physicians are independent contractors and not, in the main,

employees of the Ontario government, or health systems for that matter. The second point I'd raise is that public health units have been an integral part of our pandemic response, as they planned for contact tracing, testing, mass vaccination clinics, pop-up clinics etc. In terms of how they need to assess skill mix, HHR workforce to staff the various pandemic-related responses and vaccine-related efforts, staffing decisions and how they go about that are in the decision-making basket, I would say, of the public health units. What the Ontario government was trying to do was facilitate a fair level of compensation, negotiated with the Ontario Medical Association, that facilitated redeployment of physicians where necessary and access to HHR for public health units and their planning efforts.

Another point I would raise is that in the main, physicians in this province don't receive the types of ancillary benefits, health benefits that some employees would be receiving, so doing a direct, straight-line comparison to compensation levels or hourly rates that are in other areas of the health care system versus those of independent contractors, being physicians—it's challenging to straight-line those comparators.

The Vice-Chair (Ms. Donna Skelly): Two minutes.

M^me^ France Gélinas: Because the same thing happens with some of the physicians who were redeployed in intensive care units under the supervision of a registered nurse who had years of experience. They end up supervising physicians who have zero experience in the ICU, have been redeployed at four, five, six times the salary that they make. The demoralizing impact of this was just hard to witness and hard to see. I mean, the ICUs were full, you needed all hands on deck, and then you had those conflicts happening. Again, how were those decisions made?

Mr. Patrick Dicerni: Thank you for raising the question. I have seen some of the same media and outreach that you're referring to. It's important to keep in mind—and what I would say in response to that is that we, in good faith, negotiated redeployment rates or what we've referred to as the COVID hospital physician funding framework. Objectives there were, as I mentioned earlier, to ensure that there was ease and ability to redeploy, whether it be a hospital list or perhaps a surgeon who as a result of the necessary downturn in electives could be redeployed into the pandemic response effort as a hospital needed. The framework has met that; however—and I want to be very clear on this—that is a framework that is negotiated—

The Vice-Chair (Ms. Donna Skelly): That's time. Now, we're going back to the government side. MPP Thanigasalam, please.

Mr. Vijay Thanigasalam: Good afternoon, everyone. My question is to Minister Elliott regarding Ontario health teams and how they have helped our response to COVID-19.

Minister, I want to commend you for your continued steadfast leadership throughout the pandemic and beyond. As you know, our government saw the challenges facing our health care systems from many different ways: the many different ways our health care services are planned, managed and delivered at the local, regional and provincial levels. One of the innovative ways you have undertaken to improve this is by implementing Ontario health teams to better integrate all of these aspects across the continuum of care. Can you please tell us a bit more about these Ontario health teams, where we are in the process and how these teams are assisting in our response to COVID-19?

Hon. Christine Elliott: Thank you very much for the question, MPP Thanigasalam. I really appreciate the opportunity to share with you today some of the inspiring accomplishments that Ontario health teams have made in the face of COVID-19. The first 24 Ontario health teams were announced in December 2020 with a mission to transform the way that care is delivered in this province. Through more connected, better integrated care, these teams set out to improve patient outcomes and experience, provider experience and, of course, value.

Just three months later, the global pandemic changed our world. In the time since, I've approved 18 additional Ontario health teams for a total of 42, and each of them has shown exemplary resilience and resolve in the face of unprecedented system challenges. Not only have these teams advanced the implementation of the Ontario health team model, but many have also come together to support and protect their local communities against COVID-19. We look forward to sharing examples of this on-the-ground work with you today.

I will turn it over now to Deputy Minister Angus for some further remarks and discussion of this topic.

Ms. Helen Angus: Thank you very much for the question. Thank you, Minister.

It has been really encouraging to hear about how Ontario health teams have really been a galvanizing vehicle for system change and local COVID-19 response across the province. The uptake has been exceptional. We've got 42 teams representing partnerships across hundreds of providers and organizations, and a lot more in formation as well.

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The partnerships, as we've talked about here before, span across sectors. Hospitals, primary care providers, long-term-care homes, home and community support services, mental health providers, municipalities and others have come together with formal agreements to improve care for their local populations.

As we've gone on in the COVID response, we've been hearing from Ontario health teams. They're telling us that the groundwork they put in to become an approved Ontario health team gave them a head start for collaborating on their COVID response. One team told us that the COVID-19 experience was having put the Ontario health teams on steroids. Another one noted, "We couldn't have managed the pandemic without the Ontario health team work that formed the trusted relationships amongst the partners."

I will turn it over to Amy Olmstead, but highlight that in many communities Ontario health teams have also been the backbone of mobile and pop-up vaccination efforts.

They're branding themselves. It's really neat to see—you know, the "east" Ontario health team. So they're certainly identifying themselves as the Ontario health team in how they describe themselves to the outside world and to each other. They're reaching the hardest-hit, most vulnerable populations, and they've been working to reach inbound seniors and working in high-priority communities.

In the Toronto area, Ontario health teams are administering thousands of doses every day and are some of the highest-volume clinics in the city. I follow them on Twitter and I see the work in setting up, in Thorncliffe Park, for example, and in Flemingdon Park and some of our neighbourhoods, and it really is phenomenal. The energy and excitement that they have and their ability to mobilize, I think, is really a function of the work that they did in their Ontario health team work in the months prior.

We've activated grassroots structure and brought these different organizations across the system together for a common purpose. There's probably no greater common purpose than responding to COVID-19 and I think no brighter purpose, probably, than delivering the vaccine. They've really been the heart of the health care transformation. It certainly will be important in the months ahead to maintain the momentum and the energy that they've created through the COVID response and into the recovery phase.

So with that, I'll ask Amy to give you some more examples, because I think it's really encouraging. Amy?

Ms. Amy Olmstead: Great. Thank you, Deputy. I'm really pleased to provide a little bit more background on the Ontario health team initiative and then to jump into some of those really inspiring and hopeful examples of how Ontario health teams have supported the system response during the pandemic.

As we know, OHTs are groups of providers and organizations that, at maturity, will be clinically and physically accountable for delivering a full and coordinated continuum of care to a defined population. With the introduction of OHTs, health care providers are empowered to work together as one coordinated team, no matter where they provide care. OHTs will work to improve patient outcomes, strengthen local services and make it easier for patients and families to navigate the system and transition between health care providers such as hospitals, primary care, home care, long-term care and many others. The goal is for care to be centred around the patient, to implement services to improve the patient experience and to provide the patient with better, and better-connected, care and improve their health outcomes.

It's been nearly two years, as the minister mentioned, since the OHT concept was first introduced and then further developed by guidance that the ministry provided in April of 2019. Since then, as the minister said, she has approved 42 Ontario health teams, and we're really excited to see the work of these OHTs and their continued deepening of implementation. Expanding the number of approved OHTs remains a priority, and building out those partnerships of the already approved OHTs remains a priority as well.

We know from other jurisdictions that this type of significant system change requires lots of supports and resources, and that's why we have provided that implementation funding that I did refer to earlier. We also have a central program of supports which is built to meet teams where they are. So wherever they are in their development and readiness, we have supports of people, experts from different parts of the system—including, of course, Ontario Health—and research partners to support their development as they work through this new partnership framework.

The OHTs really demonstrated the difference that they can make to the people of Ontario during the pandemic response. We know, as the deputy mentioned, that their activities during the pandemic have both supported the pandemic response and supported the OHTs' own development of partnership, because people really wanted to come together. Those providers in different sectors wanted to come together and support that system response. We've heard about the pride they have experienced in being able to come together in a crisis and supporting each other by creating networks, sharing knowledge, learning about common challenges and mobilizing their resources. They're learning by doing.

We weren't sure when the pandemic—during the first wave, we weren't sure whether the system partners would continue to focus separately as they have over the years and put their OHT plans on hold, but so many really did come together. So I'd like to just provide some of those examples now.

We know that OHTs have brought together health care and community providers to support the acquisition and distribution of personal protective equipment. As ADM MacIntyre discussed, that was a challenge, particularly in the early stages of the pandemic. OHTs from all corners of the province have really been integral to the coordination and distribution of PPE to health care providers, long-term care, congregate care settings and First Nations communities.

OHTs continue to work together to combat outbreaks in their local communities and to coordinate support across local long-term-care homes and other congregate settings that have been affected by the pandemic. For example, the North York Toronto Health Partners OHT supported their local retirement homes, shelters and developmental group homes with infection prevention and control assessments, on-site mobile testing and the deployment of teams to support staffing during crises. The OHT also provided education and training by developing a community of practice to disseminate information, and provided on-site virtual education and training sessions. It's about bringing together that different expertise to support important parts of our health system in a range of health system services.

Similarly, the Peterborough OHT members provided infection prevention and control and human resource supports to their local long-term-care homes that were in outbreaks during the pandemic. Cross-sectoral members of the OHT met biweekly with long-term-care-home

leadership to ensure collaborative pandemic planning across the sectors.

Another example: Partners across the North Western Toronto OHT coordinated a strategy to provide mobile flu vaccinations and testing at key high-density senior Toronto Community Housing sites within their local neighbourhoods. I think COVID vaccination and testing was a part of that as well.

The OHT-based partnerships that have been leveraged to support the COVID-19 response activities within long-term-care homes and congregate settings have continued to strengthen the relationships across these sectors, and we know how important that is as we support our seniors through the pandemic and during our recovery. We look forward to continuing to work with OHTs and our partners, including the Ministry of Long-Term Care, as we further strengthen these partnerships in the months ahead.

OHTs are also working with local public health units, municipalities and other partners to lead testing and vaccination efforts in their local communities. You may recall that the OHTs, at the initial stages, were asking that they have hospital partners, primary care partners and home and community care partners. What we've seen during the pandemic is that those partnerships have broadened and deepened, with partners such as public health, municipalities and long-term-care homes.

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For example, the Muskoka and Area OHT has established a working group focused on vaccination planning and has been working with the public health unit and other partners to support development of two sites for vaccination clinics. The OHT's partners are working collaboratively to provide leadership in local vaccination efforts. For example, Muskoka paramedics assisted with the immunization of long-term-care homes, retirement homes and First Nations communities. The OHT's home and community care partners will be identifying and supporting homebound patients with vaccinations, with assistance from paramedics and nursing service providers. The OHT was also mobilized to be an early adopter of vaccinations in primary care offices. So we're really pleased to see these public health partnerships.

The Hills of Headwaters OHT led the implementation of a COVID-19 vaccination clinic in Caledon as part of a pilot program to administer vaccines in primary care settings. This successful pilot brought together many Caledon primary care physicians for the first time and resulted in the successful and timely delivery of vaccines.

The North Toronto OHT is mobilizing a unified vaccination approach for north Toronto, including two fixed clinic locations and two mobile teams to provide outreach to the most vulnerable, homebound and underserved populations. This has been an amazing collaborative effort amongst all North Toronto OHT members, as well as primary care and patient advisers.

Finally, Connected Care Halton OHT partners established three priority testing and assessment centres at each of their hospital sites, with testing volumes upwards of 1,000 tests per day.

I wanted to focus on vulnerable populations. The deputy alluded to this as well, or mentioned this, and it is something where we have seen the OHT partnerships really focus. I think that really validates the role that we expect to see from OHTs in terms of supporting health equity as part of their population health responsibilities.

The ministry is exploring the impact of COVID-19 on racialized communities and how this impact can be measured across OHTs to support targeted health interventions. We know that already many OHTs are leading efforts to support vulnerable populations and communities disproportionately affected by COVID-19. For example, East Toronto Health Partners OHT has created a comprehensive strategy for vaccination that includes a mass vaccination site; smaller physical testing sites for specialized populations, such as health care workers or first responders, Indigenous people and frail elderly; as well as pop-up and mobile testing to reach the hardest-hit populations.

Members of the Durham OHT are collaboratively leading a high-priority community strategy that provides community outreach and engagement, as well as increased access to testing for hot spot neighbourhoods. In addition, primary members of the Durham OHT participated in the Mississaugas of Scugog Island vaccination clinic to provide vaccines to those First Nation community members.

Algoma OHT launched a community wellness bus project that is designed to provide culturally safe services and resources to underserved populations and build trust in the communities. The bus is staffed by registered nurses, mental health and addictions services and peer workers. The project was accelerated to provide resources to local communities during the pandemic.

Finally, the Northumberland OHT has created a rural outreach clinic to help reduce barriers to care experienced by patients in small, rural areas. We know those barriers include access and transportation and outreach challenges.

During the pandemic, we, of course—and ADM Hein spoke to this—have focused on how to replace, where appropriate, in-person care with virtual care. We've heard from OHTs that COVID-19 has highlighted the importance of leveraging technologies to provide virtual visits and remote monitoring to keep patients home and provide care safely from a distance.

To address these heightened challenges, OHTs are leveraging digital health solutions to support innovative models of care delivery. For example, Hamilton Health, OHT's primary care network, has provided support and advice to assist physicians with transitioning to providing virtual care. The OHT has also developed and is delivering several remote monitoring projects to keep COVID-19-positive patients out of hospital. This COVID-at-home model has spread—

The Vice-Chair (Ms. Donna Skelly): Two minutes.

Ms. Amy Olmstead: —outside of Hamilton to other parts of the province as well, and we're looking forward to learning more about that.

I will just say a couple of quick notes about our next steps. I think we've talked about a lot of the good examples. There are lots of other positive digital examples

as well, and we really do know that the physician engagement that we've seen in the COVID response has also been reflected in greater physician engagement in the OHT partnerships. We're really gratified to see that. We've seen primary care membership in some OHTs increase as a result, which is definitely a step in the right direction.

In highlighting these many achievements and successes, it's important to note that we've also heard that OHTs need flexibility to manage the work of OHT implementation and their pandemic response. We would want to be flexible and continue to engage with the OHTs in the year ahead about how to find the right balance, and that will vary by OHT.

When we look ahead in terms of our OHT initiative, we want to continue to advance provincial coverage, both widen it out and deepen it. That means supporting OHTs in their implementation efforts. We want to be assessing the impact of OHTs and measuring how they're doing, and developing those important measurement frameworks. We want to advance equity and really take our learnings about health equity from the pandemic and build them in as we build the health system back in the recovery and rebuilding phase.

The Vice-Chair (Ms. Donna Skelly): That is our time. Now we're going to move to the opposition. MPP Gélinas.

M^me^ France Gélinas: Thank you. That was very interesting. My next series of questions will focus on—it's within primary care. I'll start with nurse practitioner-led clinics. We have had 26 of them in Ontario for quite some time. There are many parts of my riding in and around the north that would love to have a nurse practitioner-led clinic. They've lost their only practising family physician. There are nurse practitioners available in northeastern Ontario.

I looked really hard through the estimates book to see if there was any increase to the line that funds the nurse practitioner-led clinics; unfortunately, they're all lumped in together so I don't know. So I'll just ask: Is there any money in the estimates to fund at least three new nurse practitioner-led clinics in this fiscal year?

Hon. Christine Elliott: Thank you very much for your question, MPP Gélinas. Perhaps I can get started. Nurse practitioner-led clinics have been created throughout Ontario to provide comprehensive, accessible and coordinated family health care services by targeting Ontarians who have difficulty accessing primary care. We have 25 nurse practitioner-led clinics, currently serving close to 70,000 patients across multiple communities across the province.

I think for further details on that specific question that you asked, I will turn it over to Deputy Minister Angus.

Ms. Helen Angus: Thank you very much. Perhaps I'll ask ADM Patrick Dicerni to talk specifically about the financial aspects, but certainly the track record of the nurse practitioner-led clinics, in terms of having access to care, the quality and the collaboration that they have with other parts of the health care system, is impressive, and how they work with members of the team. I believe we have some nurse practitioner-led clinics that are highly involved in the Ontario health team effort as well.

Patrick?

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Mr. Patrick Dicerni: Thank you for the question. I'm Patrick Dicerni, assistant deputy minister in our OHIP and drugs and devices division.

Connected with the comments made by our minister and our deputy and where you started, MPP Gélinas, nurse practitioner-led clinics, NPLCs, absolutely play a vital role in the fabric of primary care. I agree with your statements in terms of the comprehensive nature and accessible nature of the care, comprehensive coordinated family care that nurse practitioners provide to something in the neighbourhood of 70,000 or 75,000 Ontarians in the province, many of whom, I think, previously didn't benefit from a primary care provider. In terms of the effectiveness and import of their role in the system—absolutely.

By way of your specific question related to whether there is flexibility or budget allocation for, I believe you said, three new NPLCs—

M^me^ France Gélinas: That's my wish.

Mr. Patrick Dicerni: At this point there isn't that degree of plans in place for three new NPLCs. There wouldn't be any increases this year.

M^me^ France Gélinas: Can I see if there was a base budget increase to NPLCs?

Mr. Patrick Dicerni: A base budget increase to NPLCs: I'm happy to take that back, but in looking at the estimates, there perhaps is a modest base budget increase. But if you can indulge me, I will either come back to that question or need to provide a follow-up for you.

M^me^ France Gélinas: Okay. And I'm sorry, I said 26. I knew that it was 25 because it's the one in my riding, the one in Alban that closed down and got amalgamated with the Univi community health centre. Still—

Mr. Patrick Dicerni: Sorry, MPP Gélinas. I can confirm that we do not have a base budgetary increase built into the budget this year.

M^me^ France Gélinas: Okay. So that means no base budget increase. That also means no new position for—if they have long wait-lists for their services, they won't be able to hire an extra nurse practitioner to take on new clients either?

Mr. Patrick Dicerni: With no base budget increase built into the plan at this time, without local situations, but at an aggregate or system level, I would say there is no planned base budget increase at this time.

M^me^ France Gélinas: Okay. Staying focused on nurse practitioners, but a completely other part of our health care system, we've talked a lot about funding an extra hundred nurse practitioners to work in our long-term-care homes. We've seen through the pandemic the work that they can do and how helpful it is when the long-term-care home has access to a nurse practitioner. Is there money anywhere in the estimates to hire the hundred more nurse practitioners for the most at-risk long-term-care homes?

Mr. Patrick Dicerni: I would have to defer to a colleague on that. That would not fall within the—if your

question is related to the flexibility for one of the long-term-care homes in the province to bring on a nurse practitioner on staff, if that is the question that's being asked, that would be most appropriately directed towards the Ministry of Long-Term Care, I do believe.

M^me^ France Gélinas: No, that's not the question. The question is, is there money within the health care budget to pay for a hundred nurse practitioners to go into long-term care?

Mr. Patrick Dicerni: I'm happy to take that back. I—

M^me^ France Gélinas: I think I see the deputy minister waving at me.

Ms. Helen Angus: I think those kinds of funds would be located within the Ministry of Long-Term Care's budget allocation, not the Ministry of Health. I know at the beginning you talked about long-term-care expenditures, because they're consolidated on the books of the Ministry of Health. That's largely because money goes from the Ministry of Long-Term Care to Ontario Health to fund long-term-care homes. We're the prime ministry for that agency and anything that it does. Those are consolidated on the Ministry of Health books, but we don't actually have either the policy or the operational responsibility for long-term-care homes. I think it's a little complicated, as all consolidations generally are, but that's the state of the relationship. So if there are people to be employed in the long-term-care homes, whether nurse practitioners or others, as part of an enhancement, that would be best directed to the Ministry of Long-Term Care.

M^me^ France Gélinas: Okay. Then coming back to primary care, nurse practitioner-led clinics: no increase this year. How about the other three or four—community health centres, Aboriginal health access centres, community-led family health teams, all of them: any base budget increase? They seem to be all lumped into one line in the estimates.

Ms. Helen Angus: I'm going to look back, but I think that may be best directed to Patrick again on the various primary care models.

Mr. Patrick Dicerni: Thank you. Patrick Dicerni, assistant deputy minister in the OHIP division and the drugs and devices division—which I'm sure you're coming to know by heart, but for the purposes of Hansard.

Thank you for your question. With respect to—and you're right, MPP Gélinas. We do have that, from an estimates perspective, rolled up into single line items, but I can confirm that, current in plan, there are not normative increases to the operating budgets for the various models that you listed.

M^me^ France Gélinas: Are there still opportunities for physicians to join FHOs and to be added to existing FHTs—family health teams? I'm sure you know what I'm talking about.

Mr. Patrick Dicerni: With respect to, particularly, interest from physicians to enrol in the FHO model, we do have an annual cap, if you will, by way of new entrants into the FHO model. I would have to take—it's just not at my fingertips right now in terms of the limits or the amounts that we have reached for FHO entry up to this point. But there would be a monthly migration limit, and I will have to take back where we are at in this given year.

M^me^ France Gélinas: Do you know if there have been any changes up or down, or is it the same as what we had last year, or you don't know at all?

Mr. Patrick Dicerni: I do. Those limits are something that are negotiated with the Ontario Medical Association, and therefore those limits have not changed. We are in the midst of negotiations with the Ontario Medical Association currently.

M^me^ France Gélinas: Okay. Don't tell me anything I'm not supposed to know, but how are things going with negotiations? Is part of this done that you can share? How much longer? And what happens to the goal to save—I'm going by memory—$500 million, I think it was, when I see that, quite to the opposite, the OHIP pie has grown to $17 billion?

Mr. Patrick Dicerni: Thank you for the question. With respect to our negotiations with the Ontario Medical Association for a new physician services agreement, that is under way. As I've come to learn from the talented team around me, a negotiation is not finished until it is finished, so I will take the positive: It is going well, and we are enjoying productive and frequent conversations with the Ontario Medical Association on a range of issues.

If I could, on that subject, we have worked effectively with the Ontario Medical Association since March 2020, when the pandemic took hold, on how to ensure flexibility, deployment, redeployments where necessary; and therein, to some extent, we've been in constant contact and perpetual discussions with them.

The second part of your question, MPP Gélinas, related to—I think the term you were looking for was the Appropriateness Working Group savings that came out of the last agreement with the Ontario Medical Association. That is a topic and a savings—rather, an appropriateness savings amount—that the ministry and the government are entirely seized with and work continuously with the Ontario Medical Association across a number of mutually identified areas of work or "appropriateness" savings and changes that could be brought into the schedule of benefits. The top, as we started, it was—and this predates my time in the OHIP division—a $480-million total appropriateness savings target, and we continue to work towards that.

1700

M^me^ France Gélinas: I remember, when you were talking to me about the reimbursements for the different CPAP and PAP machines, you did make a comment that it takes a long time for savings from technology to be brought to bear. Would this be something that would need to be negotiated? If I take this example of the CPAP machine and not requiring a sleep lab appointment, or second appointment, but getting the reading off of the machine, is this the kind of stuff that you need to negotiate with the OMA before it's brought forward?

Mr. Patrick Dicerni: So any opportunities for appropriateness changes or savings—and these do relate to overused medical services or outdated medical services.

Your example around CPAP machines, given some of the advances we talked about last week in this area, could potentially fit into that category. But you are right: This is a shared obligation between the Ontario Medical Association and ourselves. What we arrive at and "negotiate" in the realm of Appropriateness Working Group savings is something that, yes, is negotiated and bargained bilaterally. Ideas are brought forth from both parties, and the merits of that and the ability and time frame to implement those changes are what we work with our partners at the OMA on.

M^me^ France Gélinas: Okay. I'm changing tack, on a different health care provider and looking at community physiotherapy clinics. I'm not sure if it's your division that funds them anymore, but many of them have reached out to me to say that the ministry has clawed back some of the unspent episodes of care that happened through the pandemic. They reached out to say that other health care providers were accommodated to take different roles to continue, but the community physiotherapy clinics saw a clawback of their unspent episodes of care. How do we make sure that physiotherapy continues to be available in the areas that I serve, where we often only have one for 60 kilometres around, and sometimes none?

Mr. Patrick Dicerni: Thank you for the question. And you are right: Community physiotherapy and our agreements with community physiotherapy providers do fall within my responsibility area. The only nuance I would put on your question is related to—I would not describe the reconciliation of services not rendered as a clawback. But our contracts and agreements with community physio providers are structured in such a way that we pay for services that are rendered and delivered to clients. When those services, in this case, were not delivered to clients for a myriad of reasons—whether that be comfort, safety, ability to travel to said appointments—then you're right, there is a reconciliation to recover unspent funds for services not delivered. But I would not say that that is a new or pandemic-specific concept. That is the approach to, I'd say, volume-based service and payment for services rendered and reconciling those that aren't.

M^me^ France Gélinas: All right, then can I find out how much money came back through the ministry or through treasury, whatever came back from reconciliation this year versus previous years? Because from what they're telling me, they were ordered shut.

The Vice-Chair (Ms. Donna Skelly): Two minutes.

M^me^ France Gélinas: Through the first phase of the pandemic, it was really hard for many of them to get PPE, to get their college to review their IPAC so that they could open again. In my area, she gets 10 episodes of care. She gets 120 a year, she uses 10 a month, and she has wait-lists for years and years and years for people who qualify for those physiotherapy services, but she has none to offer because they're always booked. And this year, because of the—that's the one closest to my house, but they're all the same in northern Ontario.

So, I would be curious to see—you're telling me that this is normal procedure. They are telling me that they had to pay back and they've never paid back in the past. I'm guessing quite a bit of money came back this year that wouldn't have come back if it weren't for the pandemic, and arrangements were made with other health care professionals to keep them going through the pandemic but not with physios.

Mr. Patrick Dicerni: Thank you for the question. A couple of thoughts in response: You're absolutely right; community physio in the first wave of the pandemic a little over a year ago would have been, I'd say, impacted by directive 2, which went out at the time. Trying to move ourselves back into the time frame in which those decisions were made, we had a relative lack of familiarity with what the virus was and how the pandemic was manifesting itself, and it was a prudent decision at the time, with what we knew about the virus at the time.

The Vice-Chair (Ms. Donna Skelly): That's our time. We will now be moving to the government side. We are going to MPP Cuzzetto.

Mr. Rudy Cuzzetto: Thank you, Chair, and thank you for all the hard work you've been doing here today.

My question will be on public health units. Minister, there's no question about the role that public health units are playing in our response to COVID-19 to monitor, to detect and to contain this virus. Can you please tell us more about how our public health units function, how the province funds them and how the government has supported them financially during this pandemic so that they can continue doing the hard work they do to protect all Ontarians?

Hon. Christine Elliott: Yes, I would be happy to. Thank you very much for your question, MPP Cuzzetto. The government acknowledges the extraordinary and continuing efforts of the public health sector to monitor, detect and, of course, contain COVID-19 in the province. Ontario's public health system has demonstrated remarkable responsiveness to COVID-19 as the outbreak has evolved both locally and globally. Ontario's 34 public health units have played an extraordinary role in the pandemic response, including:

—working with health care partners, municipalities, partner organizations, businesses and community members to actively respond to the COVID-19 pandemic since January 2020;

—public health management of cases, contacts and outbreaks, which can be very complex and time-consuming;

—providing ongoing infection prevention and control support at the local level;

—providing a 24/7 on-call system to receive and respond to reportable infectious diseases of public health significance;

—launching social media awareness campaigns to promote mental health community supports and stopping the spread of COVID-19;

—maintaining critical public health programs and services throughout the COVID-19 response; and

—leading the rollout of the COVID-19 vaccination programs at the local level. The COVID-19 vaccination

program is one of the largest, most complex and most rapid mass vaccination programs in history.

Through Ontario's Action Plan: Responding to COVID-19, in 2020-21, the government invested well over $100 million in additional funding to support extraordinary costs incurred by public health units and other initiatives associated with monitoring, detecting and containing COVID-19 in Ontario. These investments ensured that there was sufficient capacity for the public health sector to undertake crucial public health interventions with clients, the public and the community in order to stop the spread of COVID-19.

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As you are no doubt aware, our government is taking a comprehensive approach to modernize Ontario's health care system, which includes public health services that are nimble, resilient, effective and responsive to the province's evolving health needs and priorities. Strengthening public health is part of the government's plan to end hallway health care and build a modern, integrated and sustainable public health care system.

In November 2019, we launched broad consultations with municipalities, emergency health and public health stakeholders. Consultations were put on hold in mid-March 2020 to allow public health and emergency health services to engage in the necessary COVID-19 response activities in their local communities. Once the COVID-19 pandemic is contained and risks are mitigated for the people of Ontario, the government will consider how to move forward with the modernization process in order to make the important changes we need to strengthen our public health services.

The government greatly values the services that public health units provide to Ontarians, and the Ministry of Health will continue to work with public health units to ensure the best possible use of our health care resources to support the very important work of public health.

At this point, I will turn it over to the deputy minister for some further comments.

Ms. Helen Angus: Thank you very much, Minister. I'm Helen Angus, Deputy Minister of Health. Thank you again for the question.

Taking into consideration the changing landscape—think about the third wave, new variants of concern and the increased demands of the rollout of the COVID-19 vaccine program—the Ministry of Health is continuing to work hand in glove, very closely, with the public health units to make sure that they've got the capacity to monitor, detect and contain COVID-19 across the province. The expectations of the public health units are high. They are expected to take all necessary measures to respond to COVID-19 in their catchment area and maintain critical public health programs and services. Certainly, part of the responsibility of a board of health includes setting priorities and determining the appropriate allocation of resources at a local level.

The government, and our ministry, continue to make significant investments to support Ontario's public health sector. I'll just go through some of those investments, and then I will turn it over to Dr. Williams.

Since 2018-19, provincial funding for public health units has increased by approximately $72 million, or 10%, and that's the net of additional COVID-19 investments.

In 2021, the last fiscal year, public health units received approximately $802 million in provincial funding to support public health programs and services that include one-time mitigation funding to fully offset increased costs incurred by municipalities as a result of the cost-sharing change during a critical time, and increased funding to support the implementation of the Ontario Seniors Dental Care Program. As the minister mentioned in her remarks, through the action plan responding to COVID-19, the Ontario government invested well over $100 million in additional funding to support the extraordinary costs incurred by public health units associated with monitoring, detecting and containing COVID-19 in the province.

We've talked a little bit around this table as well around the funding for public health units to hire up to 625 additional school-focused nurses for the 2021 school year. That was really to provide additional capacity in every public health unit to provide rapid response and support to schools, the boards and, of course, families in preventing and facilitating the public health response to children during the course of the pandemic.

I can talk a little bit about the fall preparedness plan that also included additional funding for case and contact management. You heard Rhonda McMichael talk about that yesterday. That's really to support the identification and follow-up of new COVID-19 cases and outbreaks to prevent the further spread.

We also approved funding for a temporary pandemic pay initiative. That went to front-line staff, including those who work in public health units, public health unit nurses. In addition, the government provided public health units with the authority and flexibility to make staffing decisions and in support of their important work, despite any collective agreements. As a result, public health units can extend their capacity to implement the programs they have, such as case and contact management, and were able to bring on board thousands of retired nurses and medical students who had signed up for the cause on the province's website. As our response continues, we expect that public health units will continue to incur additional expenses to support those efforts, including supporting the vaccine program and the rollout across the province.

For this fiscal year, the subject of the estimates, we remain committed to investing additional public health resources, including increased funding to the public health sector to make sure that they've got the capacity they need both to manage the pandemic and to support the rollout of the vaccine. And we are continuing to work, as always, in partnership with public health and municipal partners.

Perhaps Dr. David Williams, Chief Medical Officer of Health, can give you a few details on the public health units. David?

Dr. David Williams: Dr. David Williams, Chief Medical Officer of Health, Ontario. I appreciate having the opportunity. I thank Minister Elliott and Deputy Angus for all those comments on the valuable role of public health in

Ontario. I worked at the local level for 20 years and centrally for 12. I'd be proud to speak about public health's role in the provincial response to COVID-19.

As other ministry colleagues have already provided detailed overviews of the COVID-19 vaccine program and case and contact management, including supports for public health units in those areas, I'm going to take the opportunity to provide an overview of Ontario's public health system, including public health unit funding considerations.

What is the mandate of Public Health Ontario? The focus of public health is on the whole population. Its work is embedded in the daily lives of the people of Ontario. Public health contributes to improving and protecting the health of Ontarians through public health programs and initiatives such as child immunizations; the control of infectious diseases of public health significance; dental programming for seniors and low-income families; and ensuring safe water, education and inspections related to safe food handling, to name but a few. Public health interventions have made the food we eat safer. They have protected us from infectious diseases and environmental threats to health. They have created healthier environments to support and inform voices about risks, including those related to tobacco, vaping, recreational cannabis, alcohol and other substances. Public health also impacts the communities by developing healthier environments, responding to public health emergencies and promoting social conditions that improve health.

Through its work in addressing the social determinants of health and reducing health risks to the population, public health contributes to reducing the need for other health care services and limiting the consequences of poor health, including the need for acute medical care, long-term consequences of illness and injury, including the severity and incidences of diseases and disability and premature mortality.

What is public health like in Ontario? Ontario's public health model is unique. It is unique in Canada and it reflects the diversity of Ontario's population. It involves a shared authority and accountability at both the provincial and local municipal levels. This allows the system to be flexible enough to meet local needs, and effectively bridging the health and non-health sectors—for example, social services and education—while having the ability to coordinate measures, programs and services and responses across the province.

At the provincial level, my role as Ontario's Chief Medical Officer of Health is to provide leadership and expertise to promote and protect the health of Ontarians. The Ministry of Health provides policy direction and guidance to support population health and ensures the delivery of quality public health programs and services.

At the local level, Ontario boards of health serve populations large and small, in urban and rural settings. Each board of health has within its geographic borders, as defined by legislation, a public health unit. It's not the building or the facility; the geographical area is the public health unit.

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The Ontario Agency for Health Protection and Promotion, operating under the name Public Health Ontario, was established in 2008 as a crown agency of government and also as a key partner in the public health system. Public Health Ontario provides scientific and technical advice and support directly to health system partners, including public health units, the Ministry of Health and myself as the Chief Medical Officer of Health, and operates Ontario's public health laboratories.

What are public health units? There are currently 34 public health units in Ontario, which were established under the Health Protection and Promotion Act to deliver health promotion, health protection and disease prevention public health programs. Each public health unit is governed by a board of health, which is accountable for ensuring the provision of public health programs and services required by the Health Protection and Promotion Act and Ontario Public Health Standards, which are similar to regulations under the act.

Most boards of health in Ontario have an autonomous governance structure, meaning they're independent corporations separate from any municipal organization. There are four other board of health governance models operating in Ontario, each of which has varying degrees of connection with the local municipal organizations.

Boards of health and the public health units are aligned with municipal boundaries. All boards of health include municipal members, and the majority also include provincial members who are appointed. Boards of health must appoint a full-time medical officer of health for the local public health unit. I should mention that they are called medical officers of health, not chief medical officers of health. They report directly to the board of health on public health issues and are responsible to the board for their management of public health programs and services. Although the medical officer of health is an employee of the local board of health, his or her appointment must be approved by the Minister of Health, in accordance with legislative requirements.

The Ontario public health standards requirements for programs and services and accountability, which are published by the Minister of Health under the authority of the Health Protection and Promotion Act, identify the minimal expectations for public health units and services to be delivered by Ontario's 34 health units. Boards of health are accountable for ensuring the provision of Ontario's public health standards, including the protocols and guidelines that are referenced therein and are all part of the overall protocols and guidance documents.

The Ontario Public Health Standards consist of the following sections: defining the work that public health does, which includes foundational and program standards; strength and accountability, which includes the public health accountability framework and organizational requirements; and transparency and demonstrating impact, which includes the public health indicator and transparency frameworks.

As it relates to infectious diseases of public health significance, including COVID-19, public health units are

required to have emergency response plans, respond to health hazard complaints and respond to outbreaks of reportable infectious diseases at the local level.

Looking at funding and accountability is an important part as well. Part of the responsibility of a board of health includes setting priorities and establishing the budget for a public health unit to deliver the Ontario Public Health Standards. Under the Health Protection and Promotion Act, obligated municipalities are required to pay the expenses of the boards of health and public health units. The Health Protection and Promotion Act also requires that a board of health shall give annually to each obligated municipality a written notice that specifies the amount that the obligated municipality is required to pay and the times at which the board of health requires payments to be made by the obligated municipality.

The Minister of Health may make discretionary grants for the purposes of the Health Protection and Promotion Act, but is not legally obligated to do so. In practice, the Ministry of Health has historically provided ongoing funding to public health units for the provision of the Ontario Public Health Standards. Funding for the Ontario Public Health Standards has historically been what is termed a cost-shared arrangement between the Ministry of Health and the municipalities, which has changed over the years.

Some public health programs have also been funded 100% by the province; for example, the Ontario Seniors Dental Care Program and delivery of public health programs and services in unorganized territories, which are areas in the northern part of the province without municipal organization.

Provincial funding for a public health unit is typically based on a calendar year, which is the municipal fiscal year. Provincial funding decisions are made upon the ministry's review of budget submissions from boards of health, or public health units, and the Minister of Health's approval. Ministry funding for public health units is currently governed by the public health funding and accountability agreement, which is an evergreen transfer payment agreement that came in effect on January 1, 2014. The accountability agreement requires public health units to achieve specific, measurable results; have in place governance and administrative structures; provide periodic reports on financial status and relevant financial program results achieved; and permit the recovery of provincial funds and/or the discontinuance of ongoing funds—

The Vice-Chair (Ms. Donna Skelly): Two minutes.

Dr. David Williams: —of public health unit performance.

As was already mentioned, we have been going through a process of public health modernization. Based on some previous recommendations, like 20 years ago following SARS, the Walker report review committee, the Auditor General's reports and the expert panel's final reports on public health, they undertook that process then. Now, again, as part of the 2019 Ontario budget, which was released in April 2019, the Ontario government is committed to modernizing the public health sector in order to address these issues.

So we are in that process, as we're going through that, carrying out a number of areas of structuring and review: to adjust the provincial-municipal cost-sharing; to establish 10 regional public health entities and 10 regional boards, as a suggestion; and to protect what matters most, ensuring public health agencies focus on their efforts of providing better and more efficient front-line care by removing back office inefficiencies through digitalization and streamlining processes.

The consultation started November 2019. We received over 500 submissions on that and 300 participants took part. As you're aware, these consultations were paused due to COVID-19 in March 2020. The minister has mentioned this already, and I won't refer to that again. But that process will be resumed following COVID-19 control.

Public health unit funding decisions: The budget is announced that there is government funding of public health units that support the government's commitment on achieving fiscal balance to better coordinate access at the local level. Notably, with respect to public health units, and as mentioned earlier, the ministry proposed that it would establish 10 regional public health entities, effective as of April 1, 2020. The ministry also proposed that it would adjust the provincial-municipal cost-sharing and funding arrangement.

So we're in that process of reviewing that right now, with the current arrangement of 75% provincial and 25% municipal cost at this time. A change in provincial-municipal cost-sharing—

The Vice-Chair (Ms. Donna Skelly): That is our time. Before we go back to the official opposition, I want to mention that we are joined in the committee room by MPP Martin.

Back to MPP Gélinas.

M^me^ France Gélinas: Thank you. If I could get back to the conversations with Assistant Deputy Minister Dicerni about just making sure that the money from reconciliations from the physiotherapy and spent episodes of care—is there a way that I could have a sense of the size of this for the fiscal year that just ended compared to, let's say, the three fiscal years before that?

Mr. Patrick Dicerni: Thank you for the question, MPP Gélinas. We haven't completed the reconciliations for the fiscal year that has just passed, so comparing that, if you will, against prior year recoveries or reconciliations for services that weren't able to be completed or met—which doesn't necessarily sound like your local community physio providers, but we'd be happy to go back and pull prior years with the understanding that this year's exercise in this respect is not yet completed.

M^me^ France Gélinas: No, the one I'm very interested in is to see if there's any evidence to support what they're telling me, that in previous years, most of them used all of their episodes of care and could have used way, way more because they have huge wait-lists for OHIP-covered physiotherapy, versus this year, because they were ordered shut under directive 2. Nobody pushes back against this; that was the decision to be made at the time with the

knowledge we had about COVID and everything else. They don't argue about this. They argue more about—the wait-list is still there; the people wanting the care are still there. It was because of COVID that they were not able to provide those episodes of care, so they would like to keep them. If there's no data to support what they're telling me, if every year we get—I'll make it up—$100,000 back and this year we get $102,000 back, then there's no difference. But if every year we get $100,000 back and this year we got $10 million, then, yes, there are arguments to be made.

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Mr. Patrick Dicerni: I'm happy to take that back. I just would not want to provide you with an assumption or incorrect answer around prior years.

And MPP Gélinas, if you don't mind, I would like to confirm a previous question that you asked of me related to FHO enrolment, in an effort to provide you an answer now as opposed to coming back after the fact.

M^me^ France Gélinas: Okay.

Mr. Patrick Dicerni: You did ask a question related to—

M^me^ France Gélinas: The numbers.

Mr. Patrick Dicerni: —steady state or changes to FHO enrolment. I can let you know that there are no changes to FHO enrolment, but there are up to 20 net new FHO physicians per month in areas identified as high physician need. Perhaps anticipating a question: High physician need is determined locally, and unlimited physician enrolment in FHOs to replace retiring physicians—which perhaps you would know, but I do want to make that point more clearly.

M^me^ France Gélinas: That's what we had before. We had 20 physicians per month before, so we continue with 20 physicians per month. There's sometimes some pushback about areas of high need, but it is what it is. Okay, thank you.

The questions about the physio clawback: Can I put the questions out, and when the reconciliation is finished I get an answer, or am I not allowed to do that?

Mr. Patrick Dicerni: I'm happy to at the point that the reconciliations are completed. Not to put my colleague CAO Peter Kaftarian on the spot, but he could perhaps give us a sense of the regular pace of when those reconciliations are completed for the prior fiscal year.

If I could make just a couple of additional points that I think help round out the question you've asked around community physio, we did endeavour to extend flexibility in the form of virtual care or virtually provided physiotherapy. I appreciate that that is a useful mode of delivery for some and not all, but it is a mechanism or a method in which we try to mitigate some of the challenges that community physio faced during the pandemic. We did see some uptick there, and I think as a system we were, through the support of the community physiotherapists, able to continue some service provision in really trying times. We did also give flexibility quarter to quarter for them to move their anticipated volumes, whether it be Q1 or Q2, in the past fiscal year.

In conclusion, I'm happy to take back your specific reconciliation question relative to the size of prior years' reconciliation across the 260-some-odd community physiotherapy sites in the province that we fund $40 million.

M^me^ France Gélinas: It's $40 million?

Mr. Patrick Dicerni: It's $40 million being provided to the 258 community physiotherapy clinics currently providing services in 150 communities across Ontario.

M^me^ France Gélinas: Okay, sounds good. I'm changing topics again. As we're coming closer and closer to the end of estimates, I have a whole bunch of odds and ends.

Dr. Williams, I was happy to hear you talk about the Ontario Seniors Dental Care Program that is, I take it, under public health. I didn't know that. Again, I would be curious to see, of the money that was allocated for the Ontario seniors dental plan program, how much has been used, and where in the estimates do I see this? Is there anything you can share with me regarding this? The big, big complaint that I get all the time is that people seem to be happy with the range of services that is covered within the seniors dental plan, especially that you cover dentures, but most of them are not happy because if you have old age and CPP, you're over. Even with the new threshold at $23,000 a year and $37,000 for a couple, with old age and CPP, you don't qualify. I'm curious to see: How much money did we spend, how many dentists participated and how many clients were helped? Do we have those kinds of data anywhere?

Dr. David Williams: It's Dr. David Williams, Chief Medical Officer of Health. Thank you, MPP Gélinas, for this question. I'm pleased you were, well, surprised that we are doing the seniors dental program. But this was brought in, introduced, in 2019. We did initiate the process there because we had been involved in the previous one, with Healthy Smiles Ontario, and had spent time working on that, dealing with dental services for those in need in the province of Ontario.

The OSDCP, the Ontario Seniors Dental Care Program, is a program that provides services for low-income seniors. This is one of the reasons why we were asked to look at this, because we have an income LICO method to do that determination with the administrator. We were looking at an income of a single person of less than $19,300 annually, or a couple at $32,300. I'll talk about how we've adjusted that more recently. We tried to make this program work in partnership with public health units, none of which have dental services, and employ a DDS as well as a dental hygienist and other staff members. Community health centres are also involved in this who have those services, and at AHACs, or Aboriginal health access centres.

Right now, we are seeking, in our initial round, to deal with an estimated 100,000 eligible seniors annually, once it's fully implemented. As of April 2021, we have over 51,000 seniors enrolled in the seniors dental program. As I said, it was included in the 2019 budget and it was launched on November 20 of 2019. It was a staged implementation approach at that time.

We also announced at that time a budget of $25 million to be provided in one-time funding to help these centres, such as public health and others, to deal with capital infrastructure improvements to deliver the programs. So it's been a staged-up process, to start it going, and the registrations, and then to equip these centres to undertake this new program and delivery in that.

As far as other ones in there, as you have asked about, the OSDCP—we had program administration and our costs and our budget in the interim in 2021 was $45.255 million in there. We also then have moved on further with enhancing some of our programs and services. For example, we did just recently adjust, due to costs and issues, the eligibility criteria for the seniors applying, because of increased costs and expenditures. So now our cut-off mark went from $19,300 to $22,200, and it went from $32,300 for a couple to $37,100.

As of April 21, 2021, we have approximately 81,000 of the applicants—people apply to our system and then there's a third party that reviews those. We have received those and we have approved 52,660 applicants who are eligible, and have over 51,260 seniors who have already been fully enrolled and have been mailed a welcome package in there. Also, we have already been able to establish and deliver an estimated 100 dental services on an emergency basis to a number of seniors already, at this time, within there.

If you're asking, at the moment, about the total number of dentists, because some are on contracts, some are on part-time service, and different staffing issues there, I'd have to get back to you on the actual number of—

M^me^ France Gélinas: How about just the number, Dr. Williams, of sites that are part of the program that can deliver, the number of sites and number of communities? Do we have that?

Dr. David Williams: I'd have to check the number. We have 34 health units, of course, and we have our—I'd have to get back to you on the number of CHCs that are currently enrolled in the program as well as the AHACs that are currently enrolled in the program. I'll check to see, and I'll have to get back to you with the actual, accurate number of how many are involved at this time.

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M^me^ France Gélinas: Okay. And of the money that has been budgeted, do we know how much has been spent? Not as much on the capital infrastructure plan, but more on the service delivery side, the $45 million whatever whatever, 45 and something, that had been budgeted versus how many more dollars were actually spent?

Dr. David Williams: With that, I'm going to ask my director of finance, Elizabeth Walker, if she can come and have an update on the actuals and expenditures. That's in this fiscal year thus far. If Elizabeth Walker could join us.

Ms. Liz Walker: Hi. Thank you. We are still doing reconciliations with our health units to be able to get the actuals that they have spent, so we will have to get back to you on that once we've done the reconciliation. It would depend on that settlement process and that reconciliation process, but we're happy to get back to you.

M^me^ France Gélinas: Do you know if the amount budgeted for this year, this fiscal, 2021-22, is still $45 million for the delivery of care?

Ms. Liz Walker: I would have to confirm that with you as well, for this year. I believe it is, but I would have to confirm that.

M^me^ France Gélinas: Okay. And is there a way to—at the end, people find that access is not equitably distributed. Toronto Public Health has long had many dental suites throughout Toronto because of Healthy Smiles and because of programs that were available in Toronto—good for them; other parts of our province, the parts that I represent, not so much. So I'm curious to see how many sites are ready to go, are actually providing care and where they are, because what I'm getting is really that this program—first, it's hard to qualify because, as I say, if you come from ODSP and graduate and age into old age, it's all good; you [*inaudible*] dental before and you continue to have dental. But if you have worked and have old age and CPP, then you're over the threshold, even the threshold of $22,200. They're still over the threshold, they don't qualify, but they still can't afford to go to the dentist. That's the number one complaint.

The number two complaint is that when you get your little welcome package from—I forgot who sent it to them. It doesn't look like it comes from the health unit; it looks like it comes from—anyway. There are none available for hundreds of kilometres around. I'm interested in how much money was spent, where they are and how active they are, because to say that we now have a site at community health centre XYZ, versus other sites that are busy—this is a bit of what I'm after. I don't know if you can help me with this information.

Ms. Liz Walker: Absolutely. Thank you. I realized I didn't introduce myself: Liz Walker, director of accountability and liaison with the Office of the Chief Medical Officer of Health. Further to what Dr. Williams was saying, we're absolutely happy to bring back and get for you the actual number of sites and where they are. We do know that the last year certainly has been an unusual one for all of us with the pandemic, so I don't expect that it will be as full as we expect it to be over the next little while. Some of those areas, we fully expect, are still ramping up and have probably had varying responses over the last year or so, obviously, with the pandemic. But we are absolutely happy to take back your question about those sites, which communities, how active and the actuals as we have it.

M^me^ France Gélinas: My last question is that I'm all for public health units, community health centres and AHACs providing a dental suite. Would there be an openness for nurse practitioner-led clinics to provide dental suites, as well?

Dr. David Williams: Thank you. I will say that I did get information—in 2021, we spent $45,255,600.

I think the question you raise on access, especially in northern rural areas, has been one we've wrestled with; it's an important one. A favourite topic you've heard before is that we have put in our capital funding for the purchase of

dental coaches and how we might utilize that. So that has also been added in. We already had the one in the northwest out of Kenora, and we're hoping to utilize that in ways that would allow access for those in those rural and remote areas, as you've alluded to there.

The Vice-Chair (Ms. Donna Skelly): Two minutes.

Dr. David Williams: I'm aware of the issues that you've raised about the funding cut-off, around the amounts. We upped that a bit. And it's true: Some will receive old-age security as well as CPP, and sometimes that does put them over the amount there. We're aware of that. We're trying to deal with the most required and needy ones at this time. And then we also, as you noted before, added in the cost share around the purchase of dentures, which is also a thing that's been challenging for some of the neediest ones. But we continue to wrestle with the issue of how to make sure we get wide service, especially for those that are in desperate need of care and service.

M^me^ France Gélinas: Because I'm happy to see we have 51,000 seniors enrolled, but we have millions of Ontarians over the age of 65. Many of them don't work anymore. Many of them have a modest income. And for many of the people that I serve, they get old age and CPP and that puts them over. But even if you make $23,000 a year, you can't afford to go to the dentist.

I thank you, and I will wait for the detailed information to come back.

My next series of questions, just to plant the seeds, will have to do basically with HPRAC and some of what's going on with the 27 colleges that regulate health professions. My first questions will be: Does the ministry put any money in the Health Professions Regulatory Advisory Council? It seems to be on the way out. Was there any investment in there? Was there any investment from the government into oversight—

The Vice-Chair (Ms. Donna Skelly): And that's our time, MPP Gélinas.

We will now go back to the government side. Who's going to be asking questions? MPP Parsa, go ahead.

Mr. Michael Parsa: Minister, again, just like my colleagues, I want to thank you and your entire team once again for being here—everybody at the Ministry of Health for appearing before our committee and answering these questions. You've done a great job—very informative, good context in some of the very difficult questions that have been asked. So thanks again to all of you.

My question, Minister, is about support for hospitals in managing the surgical backlog as a result of the COVID-19 pandemic. I realize that over the course of the pandemic, undoubtedly the government has had to take unprecedented measures to be able to protect and to preserve our health care resources, including a second province-wide ramp down of non-emergent and non-urgent scheduled surgeries. I know we've talked about some key investments that the government is making to address the backlog. I'm wondering if you could share more details on how the government is planning on supporting our hospitals in order to be able to manage these surgical backlogs that we're seeing now as a result of the COVID-19 pandemic.

Hon. Christine Elliott: Thank you very much for your question, MPP Parsa. I know this is an important issue for many Ontarians.

The Ministry of Health knows how important it is to provide every citizen in Ontario with timely, high-quality health care. This pandemic has necessitated the government to take extraordinary measures across all aspects of life to halt the spread and the impact of COVID-19. In spite of these measures, hospitals across the province have ensured that those needing emergency, life-saving surgery have received it. Ontario is proud of all hospital and health care staff for their dedication to providing care this past year. Because of them, high-priority surgeries, such as those related to cancer and cardiac care, have continued throughout the pandemic, even during both ramp downs of elective surgeries.

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That said, we are aware too that, as a result of the two ramp downs implemented to preserve hospital capacity during this pandemic, there are still a significant number of deferred procedures and diagnostic imaging scans that need to be addressed. That is why my ministry and our Chief Medical Officer of Health have monitored hospital capacity very closely, with the intention of bringing on surgical capacity as soon as it is safely possible.

As a result of improvements in hospitalization and intensive care unit usage, today directive number 2 for health care providers was rescinded, to enable hospitals to perform non-emergent and non-urgent surgeries and procedures, if criteria outlined by Ontario Health are met. This will allow hospitals to begin once again to ramp up ambulatory outpatient surgeries and procedures as hospital system resources and capacity allow.

My ministry will continue to invest into what it takes to have our hospitals catch up on delayed procedures and reduce wait times for patients who need care. To date, Ontario has provided significant financial support to hospitals to allow them to ramp up their services after the first wave and throughout the summer, fall and winter of 2020-21. Our surgical resumption strategy made significant progress in keeping surgeries going throughout the second wave, and with our investments now, we know that hospitals completed over 465,000 surgeries during the 2020-21 fiscal year.

In parts of the province less impacted by COVID-19, hospitals were able to do more surgeries in November and December than they had in previous years, delivering important surgical care to Ontarians and driving progress to reduce wait times and get patients the procedures that they need.

Deputy, I was wondering if you wouldn't mind further describing how the ministry has supported and will continue to support hospitals to address the backlog of surgeries as Ontario emerges from this third wave of COVID-19.

Ms. Helen Angus: Thank you, Minister. I'd be delighted. And thank you, MPP Parsa, for the question.

As the minister noted, since the start of the pandemic, we've actually had two instances where it was necessary to preserve hospital capacity and ramp down elective surgeries and procedures. I know David is here with us, but I'll talk a little bit about the process he undertook, which was to consult with the Ontario Hospital Association and take what was a difficult decision to issue a directive to health care providers requiring them to cease non-emergent and non-urgent surgeries and procedures.

The first, as you probably recall, occurred on March 15, 2020—that was with the onset of the first wave of the pandemic—and then, more recently on April 20, 2021, during the third wave, after we saw a significant spread of the variants of concern and increased hospitalizations. In both cases, the CMOH was clear that emergent and urgent surgeries were not and should not be impacted by this directive and should continue, and that clinicians needed to rely on evidence and guidance to make decisions about which procedures are urgent and to pursue alternative management approaches for patients to manage their symptoms and actively monitor them should their needs become urgent.

I'm saying this on a day, actually—I'll diverge for a second—where that second directive has been rescinded. It was this morning that the direction went out to the hospital sector with that information, replaced by guidance from Ontario Health about the careful ramp-back-up of diagnostic procedures and surgeries. I know that the health care system is anxious to resume, and we've been supporting them all along the way.

I think I'll go back to last spring. As the impact became clear to us, we began immediately to develop a multi-pronged strategy to address the buildup of those delayed surgeries and procedures, and certainly over the course of the last year we've been working to implement that strategy to support the catch-up. As the minister outlined, we had a couple of months where we actually exceeded the previous year's throughput.

On September 25 last year, we announced our fall preparedness plan, and at that time we announced an additional $283.7 million to address the backlog of surgeries in the province. I would say, these funds have had an enormous impact on the province, as they helped hospitals across Ontario address the deferred surgeries and imaging, even as they faced challenges in responding to the COVID pandemic. Remember, this was a time when they were treating COVID patients, they were running assessment centres, undertaking COVID testing; they were assisting long-term-care homes and providing both staff and IPAC resources, as well as their expertise; and now they're running vaccine clinics. So we are in their debt.

We've been encouraged and inspired by the level of commitment. In my daily talks with people from the sector, I know that they're really ready and wanting to get back to doing those procedures, and certainly they've brought innovation and collaboration throughout. We saw this in the fall and winter as hospitals collaborated across regions to address the backlog of surgeries that resulted from the spring ramp down. I'm confident, and we're confident, that the innovation and collaboration that we've seen will continue now with the directive no longer in force.

In the 2020-21 budget, we put more money into supporting the health care system to address these deferred surgeries, and that was $300 million. I think we've answered questions here about how, as that ramp-back-up continues, of course, we will be there with the sector as they do those procedures going forward.

Certainly, as vaccination rates increase—and I would note that yesterday, we had a pretty good day, at 141,000. We're growing at about 1% of the population per day with their first dose. We expect to see COVID-related hospitalizations decrease over the coming months—and certainly, that trend is well in place—and the number of in-patients is dropping steadily. We know that we're well positioned to increase the surgical output and get Ontarians the care that they need.

I see we don't have much time, but I will ask Melanie Fraser, the associate deputy minister, to talk a little bit more about the strategies that we're using to address the surgical backlog and go into some detail.

Mel, over to you.

Ms. Melanie Fraser: Thank you. It's Melanie Fraser, associate deputy minister for health services. Maybe I'll just make a couple of introductory comments [*inaudible*] I'm not interrupted by that—we'll be lucky if my hungry children don't interrupt us.

As the deputy said, we've talked already a bit about the surgical backlog, and I think this has been a tremendously important area of focus for us since the beginning of wave 1. As the deputy minister mentioned, decisions to ramp down elective procedures were not taken lightly, and we very carefully and closely monitored the impact of the pandemic across these procedures since the very beginning. While we know that we have work to do, we know that wait times for some procedures have increased and we know that there are backlogs in some areas, I would say that we have been [*inaudible*] the past year. I think leveraging the innovation of the sector and I think the commitment of the health sector writ large to ensure that care is delivered for as many people as possible, even—

The Vice-Chair (Ms. Donna Skelly): I'm sorry, that's all the time we have for today.

The committee is now adjourned until Tuesday, May 25 at 9 a.m.

The committee adjourned at 1800.

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