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Ministry of Health

1st Session
42nd Parliament

Wednesday 12 May 2021

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

E-29

Comité permanent des budgets des dépenses

Ministère de la Santé

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Mercredi 12 mai 2021

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Wednesday 12 May 2021

Mercredi 12 mai 2021

The committee met at 1531 in room 151 and by video conference.

MINISTRY OF HEALTH

The Chair (Mr. Peter Tabuns): Good afternoon, everyone. We're going to resume consideration of vote 1401 of the estimates of the Ministry of Health. There is now a total of 11 hours and 24 minutes remaining for the review of these estimates. When the committee adjourned yesterday, the official opposition had 13 minutes and 29 seconds remaining. I give the floor, then, to the official opposition. I don't know which of the two of you will be speaking.

Interjection.

The Chair (Mr. Peter Tabuns): Excellent. Good, clear hand signal. MPP Gélinas, it's all yours.

M^me^ France Gélinas: Yesterday when we broke off, I was going through the surgical backlog. I forget if it was Melanie Fraser or Liz who was going through line by line as to—the premium on volume was $234 million. IHF got $5.5 million. My last question about this—I think it was Kristin, actually, who was telling me that—those predictions or projections were made on how big would be the backlog, and if they had separated the surgical backlog from the procedures backlog. So this is where we were at. I think I was talking to Kristin, but whoever wants to answer that question.

Ms. Kristin Taylor: I can certainly jump in, if that's acceptable. It's Kristin Taylor, director of provincial programs branch.

The Chair (Mr. Peter Tabuns): Thank you.

Ms. Kristin Taylor: So there's a little bit of a grey area between surgeries and procedures. We focused on what we call surgical procedures, so invasive procedures. That's what we've focused our backlog on and the funding for—that and diagnostic imaging.

M^me^ France Gélinas: And could you share with me the numbers that you used to come to $5.5 million to IHF and $234 million for premium volumes and all of this in diagnostic imaging and surgical procedures?

Ms. Kristin Taylor: Are you asking for what we are proposing for this fiscal or what was performed in last fiscal?

M^me^ France Gélinas: I would be interested in both, but let's start with what you're proposing going forward.

Ms. Kristin Taylor: Going forward.

M^me^ France Gélinas: There is $610 million in the budget allocated to backlog. I thought—we'll start there.

Ms. Kristin Taylor: Sure. So it's going to be—$300 million for surgical backlog specifically equals roughly 70,000 surgical procedures. That's on top of our normal allocation, where we do increase the volumes each year, so there will be additional.

That 70,000 is an estimate, because obviously there's a wide range of how much a surgery costs. You can have a $10,000 surgery; you can have a $1,000 surgery. So what we've done is averaged it out based on what we think the hospitals will do and based on what previous years show hospitals are capable of performing. So there's a bit of art and a bit of science here. We've worked really closely in the wait times area with our Ontario Health colleagues, who do a remarkable job managing and looking into the wait times.

So we've delved into the data and this is what we think is appropriate. And I will say, I know this was—I think the deputy did speak to this. This was what we forecast before wave 3, so wave 3 has certainly had an impact and will require us to make adjustments, but I think the numbers are still relatively accurate.

M^me^ France Gélinas: Okay. So 70,000 surgical procedures and how many diagnostic imaging?

Ms. Kristin Taylor: Roughly 100,000.

M^me^ France Gélinas: Okay. All right.

So we are now facing wave 3, where directives have been issued to the hospitals to again put a pause on non-emergent surgery. Do you think that the $300 million that you've dedicated is basically what the system can handle, or would the system be able to handle more if there was more money?

Ms. Kristin Taylor: I think that it's a little early for us to definitively say. I do think $300 million is very close to what we will need. I would say that certainly we wouldn't tell hospitals to slow down if we suddenly discover that there is a ton more capacity in the system. There are a number of things that are going to influence that, and so we're going to have to balance the HHR needs and the physical capacity needs, and take all of that into account as we move forward, trying to come up with—to sort of tweak our plan based on directive 2 and what we've experienced in wave 3.

I'll also add that we do have incremental funding that we would get every year, so we have more than just the $300 million to apply to the surgical volumes.

M^me^ France Gélinas: Okay. And this is the increase that goes to the base budget of the hospital, as well as the increase that goes to the specific surgery?

Ms. Kristin Taylor: Correct, yes. We have QPB funding, neurosurgical funding, cardiac funding, bariatric funding—all of those that are funded each year into their base, so there is that growth as well.

M^me^ France Gélinas: Okay. Very good. Just coming back again on volume, when you said $5.5 million for IHF, they were mainly diagnostic, but then you came back and said a little bit of surgery. What kind of surgery would be done in the IHF? Mainly cataract or—

Ms. Kristin Taylor: That's cataract. I would defer to ADM Dicerni for details, but yes, cataract.

M^me^ France Gélinas: Okay. I also was curious about the $23.17 million to Mackenzie Health. You said that was mainly for early opening, so basically, they were used as an overflow for all of the other hospitals. Am I understanding this right?

Ms. Kristin Taylor: Yes, that's correct.

M^me^ France Gélinas: Okay. Sounds good. All right, those were my questions about the surgical backlog. I thank you very much. If it's okay, I would like to move on to my next set of questions, which probably won't be with you, because I would like to start to talk about assistive devices.

My first question is that I saw in the estimates that there's $108 million more for assistive devices. I was wondering if this is mainly due to higher volumes of existing devices that are covered or if there is money in there to cover other new devices. The one that everybody asks me all the time is continuous glucose monitoring, so I will put it out there. What can we expect out of the $108 million more that's going into assistive devices? Minister, or Deputy? I'm not too sure.

Hon. Christine Elliott: I'll just start. Thank you very much for your question. In 2020-21, assistive devices provided approximately $471 million in funding to approximately 400,000 Ontario residents with assistive devices, so they can live independently in their communities. I believe the deputy minister will have more specific information for you on your request.

Ms. Helen Angus: Yes, I'll actually pass that fairly quickly over to Assistant Deputy Minister Patrick Dicerni, who also has ADP within his portfolio. He can give you some of the details. Certainly it's a program where we've had the benefit of a value-for-money audit from the Auditor General of Ontario as well. We're continuing to make improvements on the overall integrity and customer service in ADP, but Patrick will give you—actually, we're at a place where we've fully implemented all the recommendations made by the Auditor General, so that's good progress. But I will ask him specifically to answer your question about the inclusion of glucose monitors and where we sit with that and what the funding is aimed at.

1540

Is Patrick on? I think we've had some trouble getting some of the team into the room as well.

Mr. Patrick Dicerni: I am here, Deputy.

Ms. Helen Angus: Okay, very good.

Mr. Patrick Dicerni: Patrick Dicerni, deputy minister in our OHIP and drugs and devices division. Thank you very much for the question, Madame Gélinas. You're right: There is an increase into the Assistive Devices Program. It is a volume-based increase for, as you correctly said, additional volumes or greater utilization within the current suite of devices and products that we support Ontarians with.

I was anticipating a good, well-placed question with respect to CGM. I do get those requests quite frequently. I'm happy to say we are engaged with the manufacturer in discussions in terms of how and what is the best way to embed or bring this product into this program or others, and not to go too deep into a negotiation, but trying to strike the balance of access and cost and understanding where some potential offsets could potentially come from, not only within the program but within the health system writ large. But myself and my team definitely are well engaged and have put quite a few cycles into the negotiation and discussions with the manufacturer.

M^me^ France Gélinas: Thank you for this. I fully agree with you that what they're asking right now for their—I forgot how you call the stuff that you put on; the monitor that you put on yourself. This is not worth $100, so whatever you can do to bring that price down would be really welcome.

You said in "this program or others." What other program could be a source of funding for continuous glucose monitoring?

The Chair (Mr. Peter Tabuns): You have two minutes left.

Mr. Patrick Dicerni: Thank you. I was trying to make as expansive an answer as possible. You're probably familiar with the FGM product, the flash glucose monitor product. As you may know, that's a product that is listed on the ODB right now. There are products such as these that, one could make a case, straddle two programs I'm responsible for, being the Ontario Drug Benefit or the Ontario Public Drug Programs, and in this case the Assistive Devices Program, but we want to take a client-focused view and, I'd say, a good stewardship of public funds view in terms of where is the best client impact, met with the responsibilities we have to ensure good expenditure of funds.

M^me^ France Gélinas: Okay. I don't know if in a minute you could answer: How are the negotiations regarding CPAP and all the other PAP machines? You had indicated a price decrease as to how much the reseller could—is this still on deck for July 1?

Mr. Patrick Dicerni: Thank you for the question. It is still on deck for July 1. This being said, you are likely aware that we have allowed some delay/slippage here, given the pandemic and given the impacts to the health care system, not thinking it to be the best or responsible time to implement that price drop. We are holding on that right now. But, you are correct, July is the date that is in the public domain right now.

M^me^ France Gélinas: And is it still the same price drop as what was initially announced before the pandemic?

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, you are out of time.

We now go to the government. MPP Skelly, the floor is yours.

Ms. Donna Skelly: Thank you, and it's nice to see you again this afternoon, Mr. Chair. Good afternoon, everyone. Minister, it's our first chance to chat in this particular committee. It's nice to see you again. I would like to talk a little bit about testing. It is such a critical part of our government's strategy in response to this pandemic that has—we're now entering over a year. Can you please take us through some of the work that your ministry has done to improve testing capacity and how it helps guide our response to this pandemic?

Hon. Christine Elliott: Thank you very much for your question, MPP Skelly. It's great to see you as well.

Even as we continue to vaccinate more Ontarians, testing will remain a critical part of the province's dynamic response to the pandemic. That's why our government has made significant investments in a comprehensive testing strategy, totalling $3.7 billion over the last two years, including $2.3 billion in 2021-22. These investments are part of our continuing commitment to ensure that anyone who needs a test can get a test and to get the results as quickly as possible.

Ontarians can receive diagnostic tests at one of over 500 testing sites across the province, including assessment centres, community labs and pharmacies. The province has also introduced mobile and pop-up testing centres, targeted to vulnerable communities that face barriers to accessing care. Additionally, we have deployed more than 7.6 million rapid antigen tests to over 1,400 organizations and workplaces as an enhanced screening measure to proactively identify possible cases of COVID-19 that may otherwise have gone undetected.

Ontario will continue to leverage the full spectrum of testing tools available and ensure the right tests are used in the right situations, allowing us to sustain capacity in the provincial testing network and prioritize under-tested, high-risk and vulnerable populations.

With that, I would turn it over to the deputy minister to make some further comments.

Ms. Helen Angus: Thank you, Minister Elliott. Despite the changing landscape of the third wave and the advent of the variants of concern, as well as the rollout of the vaccine program, the ministry is continuing to work closely with the federal government's partner ministries and stakeholders across sectors to build and improve on the testing strategy. I'm going to talk a little bit about the various testing modalities that we have, and then pass it over to Melissa Thomson, who is the ADM responsible for the testing program.

Since the beginning of the pandemic, Ontario has processed over 14 million lab-based PCR tests. As a result, we actually have one of the highest testing rates in Canada. And although we faced challenges early in the pandemic as we ramped up the lab network's capacity, we worked closely with a range of health system partners to stabilize and expand the provincial diagnostic network and resolve issues related to testing supplies, transportation across the 500 locations the minister just referenced and staffing, amongst others.

We're at a point where we actually have the capacity to perform over 100,000 diagnostic tests a day, and we are exceeding our targets for turnaround times. We are regularly—as of May 3, more than 90% of COVID-19 tests are completed within two days. That allows Ontarians to get their results quickly.

We also have made investments in genetic screening and sequencing, so all positive samples are screened for known variants of concern, of which there are a few. And we perform full genome sequencing on about 10% of samples to identify new or emergent variants, of which there are also several.

We're also making considerable progress in rapid testing, and that provides a really quick result at the point of care. We've used rapid tests to diagnose COVID-19 and screen for COVID-19, and that has enhanced the laboratory network capacity. We've deployed them to over 200 sites, including rural, remote Indigenous communities, increasing access to help curb infection rates in high-risk areas.

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Finally, we're also deploying a large volume of rapid antigen tests to organizations and workplaces through a provincial antigen screening program. These tests are an effective tool to screen asymptomatic individuals for potential COVID-19 cases and providing additional safety measures and mitigating the risks of transmission. We're continuing to scale up the provincial antigen screening program, and we're leveraging the Ontario Together portal to provide a streamlined access point for intake, ordering tests and accessing resources to implement rapid screening.

We're also expanding distribution channels and supporting local programs to target rapid screening in small- and medium-sized businesses. As Minister Elliott mentioned, we've already distributed about 7.6 million rapid antigen tests to eligible sectors of workplaces and are continuing to expand them by deploying up to one million tests per week. That really puts us as a Canadian leader in the deployment of antigen tests.

I'll pass it over to Melissa Thomson, who has been leading much of the work on the testing strategy. Melissa, introduce yourself, and perhaps you can provide MPP Skelly with a little bit more information.

Ms. Melissa Thomson: Thank you so much, Deputy and Minister Elliott, for your introductions, and MPP Skelly for the question. Thank you also, Chair, for our discussion today. It's absolutely my pleasure to add a bit more detail.

My name is Melissa Thomson. I'm the assistant deputy minister of the testing, planning and implementation division. Among other responsibilities, we work really closely with countless partners across government and many sectors to lead and oversee the province's COVID-19 testing strategy.

As both the minister and the deputy just stated, testing is really a critical component in the province's overall pandemic response. Not only does testing allow us to diagnose whether someone has COVID-19, but it also

provides the province with crucial data on how and where the virus is spreading. With this data, we can make critical adjustments to our public health programs and policies and target interventions to areas and communities with highest need. Even as vaccination rates increase, timely access to testing is needed to continue identifying potential outbreaks in hotspots, detect and track emerging variants, monitor vaccine effectiveness and support the safe reopening of this province.

Ontario's testing strategy employs multiple testing methods to ensure that the right tests are used in the right situations, which the deputy and the minister just mentioned, in order to have the most significant impact. This includes diagnostic testing such as lab-based PCR and rapid diagnostic tests, as well as screening using rapid antigen screening tests. As many will know, lab-based testing is really the workhorse and the gold standard for COVID-19 testing. It's used for diagnosis of COVID-19 infection and is currently targeted to those at high risk, including symptomatic individuals, individuals with known close contact and for outbreak investigations. Individuals can have samples taken for lab-based testing at assessment centres, community labs or mobile clinics. We have also been deploying rapid diagnostic tests, which provide results at the point of care in rural, remote and Indigenous communities and for outbreak response, where every minute counts.

While diagnostic testing is targeted to individuals who are symptomatic, have a known close contact or are part of an outbreak investigation, it's also available to asymptomatic individuals who are part of certain targeted high-risk groups of the population, including school and child care staff, farmworkers and individuals who identify as Indigenous. To ensure broad access, these high-risk populations are eligible for asymptomatic testing at over 200 community pharmacies.

As the deputy mentioned earlier, the province is prioritizing rapid antigen tests for asymptomatic individuals as an enhanced screening measure in essential sectors and workplaces. When used as part of a frequent screening program, rapid antigen tests can help proactively identify possible cases of COVID-19 that may otherwise go undetected. To date, approximately 1,300 potential COVID-19 cases have been identified in organizations and workplaces across the province through our antigen screening program. However, because they are not as accurate as diagnostic tests, rapid antigen screening tests cannot be used for diagnosis of symptomatic individuals or individuals with known exposure, and anyone who tests positive on a rapid antigen must subsequently get a confirmatory lab test.

While the ministry develops testing guidance and oversees the province's testing strategy, robust, wide-scale testing would not be possible without the tireless and coordinated efforts of our many partners across the province. For example, if an individual is experiencing symptoms and needs a test, they will likely head to an assessment centre or a community lab to have a sample taken. The specimen is then transported through a network of couriers, regional transportation providers and Ornge, which provides air ambulance and medical transport services.

The sample can be processed in one of over 45 labs within the provincial network, including Public Health Ontario labs, hospital labs and community labs. Once processed, results are put into the Ontario lab information system, or OLIS, sent to the ordering clinician and made available to individuals through their provider or the provincial test results portal.

If the test is positive, the case is reported to public health units, while aggregate information is collected by the Ministry of Health, public health units and Ontario Health. As you can see from this one example, there are many people and organizations working together to implement Ontario's testing strategy, in line with guidance from the Ministry of Health and the Chief Medical Officer of Health.

Ontario Health plays a central role, and works closely with the government, regions and health system partners across the province to support COVID-19 testing. The agency's role in testing includes coordinating the operations of the province's diagnostic network, including specimen collection, transportation and lab processing, as well as securing and distributing testing supplies across the health system, such as swabs, reagents and transport media. Ontario Health also coordinates regional testing programs, such as mobile pop-up testing centres, and supports rapid testing programs in rural, northern and remote communities, where access to lab-based testing may be limited.

Public Health Ontario is another key provincial provider. In addition to operating a series of provincial labs that process thousands of COVID-19 tests daily, PHO oversees the technical aspects of testing, leading validation of new labs and test methods, as well as providing key technical expertise. The testing strategy expert panel, which provides advice through Public Health Ontario, meets with the ministry on a regular basis and provides evidence-based recommendations to inform provincial testing guidance and programs.

As noted earlier, Ontario's public health units lead case and contact management after an individual has tested positive for COVID-19, and help to identify and manage outbreaks. PHUs also identify local testing needs and implement testing programs where needed.

The federal government is another essential partner, coordinating national and cross-provincial efforts and approving certain testing devices, such as rapid tests. In fact, most of Ontario's supply of rapid tests are provided by the federal government.

And, of course, testing on such a large scale would not be possible without the thousands of health service providers and front-line staff, from assessment centre clinicians to laboratory professionals, who put in countless hours of time, effort and expertise to help save lives. As the COVID-19 pandemic evolves, the Ministry of Health continues to work closely with the federal government, partner ministries and key stakeholders across sectors to build upon and improve our robust testing network.

I'd now like to move on to talk about some of the work we've been doing to improve access to testing within vulnerable and marginalized communities. In December 2020, Ontario launched the High Priority Communities Strategy to support neighbourhoods that were hardest hit by COVID-19. Evidence shows that racially diverse, newcomer and low-income communities have been impacted more significantly by COVID-19 than others and need specific supports to help address complex barriers to accessing services and establishing core prevention measures. High-priority communities have historically had much lower testing rates and face socio-demographic barriers to accessing services.

1600

To support these communities, the ministry has provided $12.5 million to fund local lead agencies in Durham, Peel, Toronto, York, Ottawa and Windsor regions in order to increase access to testing. Agencies work in partnership with Ontario Health, public health units, municipalities and other community partners to deliver testing options tailored to the unique needs of Ontario's many and varied communities, things such as outreach in multiple languages, transportation assistance and expanded and flexible hours of operation. As a result of this strategy, by the end of April of this year, average testing rates in high-priority communities have been considerably higher than in the rest of Ontario.

Mobile and pop-up testing sites are also critical to improving access to testing. To date, mobile testing deployments have supported testing efforts in high-priority regions, airports and farms, including in Peel, Bolton, Ottawa and Windsor-Essex agri-food communities.

Another plank of our testing strategy, which the deputy mentioned, is related to variants of concern. As part of Ontario's six-point variant action plan, announced this past January 2021, Ontario enhanced screening and sequencing for variants of concern, or VOCs, which now comprise the vast majority of cases in Ontario. As part of this plan, Ontario has ramped up capacity to screen all positive COVID-19 cases in Ontario for one of three known VOCs within two to three days of initial processing. Public Health Ontario, in collaboration with the provincial diagnostic lab network, also undertakes and coordinates whole genome sequencing to identify specific variant lineages and any emerging or unknown variants by sequencing up to 10% of all positive tests. The province continues to adapt its surveillance strategy to detect known and emerging variants through genomic sequencing based on emerging evidence.

Despite our best efforts at the provincial level, we continue to be concerned about test positivity among travellers and the risk of importing variants of concern, as well as new and emerging variants. In January 2021, the Ontario government implemented a voluntary and free border testing program at Toronto Pearson International Airport for eligible international travellers arriving in the province from—

The Chair (Mr. Peter Tabuns): You have two minutes left.

Ms. Melissa Thomson: Thank you very much, Chair—and staying for at least 14 days. This program was made mandatory on February 1, 2021. Our border testing measures in Ontario preceded and were a catalyst for federal efforts in this area. On February 22, federal regulations came into effect, including on-arrival and day-10 testing for international arrivals at Canadian airports, including Toronto Pearson. We are continuing to engage with our federal and provincial/territorial partners to address risk in both international and domestic travel.

As noted by Minister Elliott earlier, Ontario has invested $3.7 billion over two years in a comprehensive testing strategy, including $2.3 billion in 2021-22. This includes funding for things like:

—the operational costs of assessment centres and testing sites;

—testing of at-risk or eligible asymptomatic individuals through Ontario pharmacies;

—testing for at-risk or eligible asymptomatic individuals through mobile pop-up locations; and

—testing at community centres, Aboriginal health access centres and home and community care settings.

I know we only have a few minutes left, but in what time remains I'll spend a few minutes now talking about the Provincial Antigen Screening Program. This program allows organizations and workplaces to employ rapid antigen screening as an additional safety measure to help reduce the spread of COVID-19. Under the program, rapid antigen tests are offered free of charge. Current participants are from many sectors and include, but are not limited to, essential industries, so things like food processing and agri-food, manufacturing, construction, mining—

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're out of time.

Ms. Melissa Thomson: That's great.

The Chair (Mr. Peter Tabuns): And with that, we go back to the official opposition. Who will be—MPP Monteith-Farrell, the floor is yours.

Ms. Judith Monteith-Farrell: Yes, thank you, Chair, and thank you for the discussion on testing. I'll lead into my next question about testing. There are many jurisdictions that are using rapid antigen testing to ensure that schools are safe. We all know that we all want to see children back in school in Ontario, and I'm sure many of us have heard from families concerned about their children's mental health and safety. I was wondering if in the provincial rapid antigen testing planning and also their investment, there is a plan to expand that program to schools.

Hon. Christine Elliott: Thank you very much for your question, MPP Monteith-Farrell. We're thinking of using the rapid antigen testing in schools, but since we've had the big news from Health Canada and NACI about the Pfizer product being available for 12-to-17-year-olds, we are working to have students in this age category vaccinated with at least the first dose before September, perhaps even with two doses. We are actively working with the Ministry of Education on this to get this started as

soon as possible so that our students will not have to be tested, but will have the actual vaccination.

But there are other ways, of course, that we can use the rapid tests in schools, so I will turn that over to the deputy minister to provide perhaps a few more comments on that.

Ms. Helen Angus: Yes, I think we have explored—it's Helen Angus, Deputy Minister of Health. I keep trying to remember to do that.

I will ask Melissa about the work that we've done with our colleagues at the Ministry of Education. We've certainly worked with them to look into the opportunities to screen children. Obviously, we have to work with local boards of health, parents, teachers and others to make sure that the testing is useful and acceptable.

Perhaps, Melissa, you can talk a little bit about the work that we've done with our colleagues and answer the question.

Ms. Melissa Thomson: Absolutely. Thank you so much, Deputy, and thanks very much for the question.

The minister and the deputy are right. While we're not doing rapid antigen testing directly in schools, since February, actually, last year, our colleagues at the Ministry of Education have really been investing a lot of energy, effort and resources to develop and launch an asymptomatic screening program across the province.

That program has, really, two main components. The first is mobile testing clinics, which remain available through this remote learning period. Those clinics are hosted by vendors contracted through EDU. To date, over 3,000 schools have been invited for testing at those clinics, and as of last month, in fact, almost 50,000 tests were completed. It might be interesting to note that of those tests, 317 confirmed cases were identified, showing that rapid antigen screening can be very effective and very important in any context, but especially with kids and in schools.

The second component to the work that EDU has been leading and that we've been working very closely with them on is in-pharmacy testing, both rapid and PCR testing, for staff and students at 346 locations, and further PCR testing for students and staff at 212 pharmacies. So while the rapid antigen isn't directly in the school setting, certainly access to rapid antigen screening and even PCR testing for students and staff is available right now.

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Ms. Judith Monteith-Farrell: If parents want it, or they're—

Ms. Melissa Thomson: That's right.

Ms. Judith Monteith-Farrell: But it's not part of a strategy to try to get kids back to school. We're looking at vaccination as that strategy. Thank you for that.

The next question I want to get on is just a call-out from nurses and respirologists who are stating that they are very interested in getting their second dose of the vaccine, especially bedside nurses who are working directly with COVID patients. I know some of them have it, but is there a concrete plan to—I heard something about that, but is there a concrete plan to get that done sooner rather than later?

Hon. Christine Elliott: Thank you very much for the question. This is something I know, because this is Nursing Week and we're really appreciating the tremendous work that our nurses are doing on the front lines, and have been over the past 16 months. We want them to be protected fully by being fully vaccinated, as well as the other patient-facing front-line health care providers like respirologists. We have, during this next phase, prioritized front-line patient-facing health care workers to receive their second doses because we are receiving a more steady supply, particularly of the Pfizer vaccine. This has been met by the nursing profession with relief, I think, in some ways, because I know people are concerned about their own health and their family's health, even though you do receive a high degree of protection with the first dose. But when you're working with COVID patients every day, it is really important that you do have the two doses, so we have made that change and they will be eligible to book their second vaccine now.

The deputy minister may have some further comments on that, but this is a change that was very well received.

Ms. Helen Angus: Yes, that was made earlier this week. It's Helen Angus, Deputy Minister of Health. I wonder whether Alison Blair, associate deputy, or Dr. Williams might want to jump in if you have any further questions related to the rollout, specifically. We had a meeting with ONA earlier this week and, again, they were very pleased with the change that we had made. But obviously—you mentioned respirologists—it does include them as front-facing health care workers in the highest-risk areas.

Ms. Judith Monteith-Farrell: With the concerns with regard to rollout, I think there are many concerns about the people who have received the AstraZeneca vaccine, now with the pause. So that is somewhat of concern on what is going to be the plan for those folks. I know we're waiting for some—but there is a lot of apprehension about that, just in the population. Maybe if Dr. Williams could shed some light—further clarity would be great.

Dr. David Williams: It's Dr. David Williams, Chief Medical Officer of Health, province of Ontario. Can you hear me okay? Thank you for that question. As Minister Elliott is alluding to, it's very much an important one for us with our health care workers to move as quickly as we can to get the second dose for the full immunization, not just the vaccination. We're very pleased so far that the one dose—especially because our hospital staff have mostly been accessing the mRNA vaccine, the Pfizer or the Moderna, in their locations and those settings—and with the high vaccine efficacy, high levels of protection, combined with the personal protective equipment, this has gone very well. But we would like to get their second dose in as soon as we can. Some have already been double—two doses already, and we're moving on, with more supply arriving. I know if Associate Deputy Minister Blair is on, she could tell you about more supply arriving shortly. So we're going to make strides to move that period up from the 16 weeks to even sooner, if possible.

I think the AstraZeneca one—for a lot of the health care workers, most of them, through their hospital setting, did

not get the AZ, the AstraZeneca vaccine. They may have gotten it through their own channels, going out to pharmacies and other settings. As we have alluded to yesterday in our presser, we are, out of an abundance of caution, pausing our initial dosing on that based on some of the cases we've seen. We want to pause and take a look at that. We are looking at reviewing quickly with our federal counterparts what we would do on the second dose. So far, international data reveals to us that if you did not get one of those rare adverse events—the so-called vaccine-induced thrombosis thrombocytopenic syndrome—that the chance of getting that on the second dose is very, very rare. Around the UK, it's about one in a million, which you can see is quite rare.

So we're looking at that, plus we're having a study ongoing at this time. We're hoping to get some early reports back on whether—some people may still choose to say, "Well, can I get an mRNA vaccine as a second one?" We're hoping to get some data and information so that we can have informed consent to the health care worker or others who want to get that second dose and could choose if they want to get the AstraZeneca vaccine as their second dose or they can get an mRNA. But we want to make sure we have enough information based on the study with the mixing of the vaccines; that is, an informed consent.

Ms. Judith Monteith-Farrell: Thank you for that. I guess I could turn it over to my colleague, MPP France Gélinas.

Interjection.

The Chair (Mr. Peter Tabuns): France, we can see you.

Interjection.

Ms. Judith Monteith-Farrell: All right. Well, maybe mute her. She obviously has something else going on at this point. Thank you.

The other area that is of grave concern in the health care file, I know, in northern Ontario is the home care situation: the amount of time and the decisions that are made about people and how much time they receive in-home care. We know that that's a big piece of also assisting our people who want to stay out of long-term care or are waiting for long-term care. I'm curious to see, in light of what we have seen during the pandemic, just the sort of bringing to light that these people are not being taken care of in the way that they should be, are we looking at expanding or revisiting the decisions on how much home care people get and who is eligible?

Hon. Christine Elliott: Thank you. The issue of home care is very important to us in health care. The Connecting People to Home and Community Care Act, Bill 175, received royal assent on July 8, 2020, and it really lays the groundwork for integrated responses in innovative home and community care.

We have seen some great models where we're trying to connect home care with hospital care so that when someone is discharged from hospital and needing home care, it will happen straight away. They won't be waiting for days. Sometimes it doesn't connect and people end up back in the hospital again before they ever receive the home care. That shouldn't happen. That's not good, patient-centred care, and so we know that we need to make some changes to that.

I would say one big change is just the work that we're doing with the Ontario health teams in having all of the providers working together so that the patient doesn't get lost in the process. We want to make sure that people know that they are part of the health care system, wherever they are in their own health care journey. I know some people feel as if they get kicked out of the system when they are released from hospital and that they have to find their own way back in. That shouldn't be the case.

We are looking to make our home care system more responsive. There have been some good examples of where this has happened really well: at Southlake hospital, working with several home care providers, getting people out of hospital and back home—which is where people want to be rather than in long-term-care homes—for as long as possible, of course.

We're putting more supports into our home care system to make sure that we can support people when they are in that situation. But there are more particulars on this and I would turn it over to the deputy minister to provide further comments on that.

Ms. Helen Angus: Yes, I'll pass it over to Mel Fraser, who you met yesterday. It's Helen Angus, Deputy Minister of Health. I'll pass it over to Mel, but there's lots going on in the home care area. Obviously, Ontario health teams provide a real opportunity to better connect home care to the other parts of the health care team, particularly for people who are frail.

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But as we've seen in the time of COVID—we've certainly seen some really interesting opportunities to deliver virtual home care. That's probably for people who have lighter care needs, but certainly that's an area that Mel may want to touch on.

We've done some things to stabilize the workforce as well, knowing that the personal support worker workforce that is the backbone of home care—there are some things that we have done to basically provide more money to recruit and retain the graduates of the program. Certainly, over time the PSWs—we train more, and some of them exit pretty quickly out of the sector, and so really trying to get them anchored into the health care system is important.

Then, of course, what we've done is also provide a more intense level of home care during the time of COVID as well, as an alternative to hospital, and looking at the intensification of home care. I think that will also, when we have a moment to look at what we've learned through that program, whether that becomes a regular feature of home care—I think those are the kinds of things that we will want to look at as we exit from the third wave and learn more.

But perhaps I'll ask Mel to talk a little bit more about what we're doing in the home care area.

Ms. Melanie Fraser: Hi, there. Thank you, Deputy. It's Melanie Fraser, associate deputy minister of health for health services. Maybe I will pick up on that high-intensity

bundle piece, given the question was around how we ensure that there are appropriate supports for those who are needing more home care. I think we recognized throughout the pandemic the pressures on other parts of the health care system, and home being a very safe and often the preferred place to receive health care.

With our colleagues at Ontario Health, we did create what we considered high-intensity bundles of care. That would include everything from support services, nursing services, PSW services and potentially even occupational therapy, physiotherapy, that sort of thing, to really take those patients who were in need and were struggling to maintain their health at home and to ensure they had the appropriate wraparound supports that kept them from having to visit the emergency room. Certainly during the time of COVID, it's not good for them, and not good for the system as well.

I think the bundles proved to be incredibly successful, and I think they also leverage previous work that we have done with short-term transitional care models. That's another feature of our home care system—

The Chair (Mr. Peter Tabuns): You have two minutes left.

Ms. Melanie Fraser: Thank you, Chair—where we provide higher-intensity supports to help folks make the transition safely from an acute-care setting, from a hospital, back to home, especially if they—

Failure of sound system.

Ms. Judith Monteith-Farrell: Your audio is—

The Chair (Mr. Peter Tabuns): Yes, I need you to know that you're cutting in and out.

Ms. Melanie Fraser: Oh, my apologies. Can you hear me now? My apologies, Chair.

The Chair (Mr. Peter Tabuns): You may turn off your video. That could increase the—

Ms. Melanie Fraser: The bandwidth?

The Chair (Mr. Peter Tabuns): Yes.

Ms. Melanie Fraser: Certainly. Maybe at this point I would turn it over to my colleague Amy Olmstead, who is responsible both for the Ontario health teams as well as for home and community care. She could provide some additional information.

The Chair (Mr. Peter Tabuns): Thank you.

Ms. Amy Olmstead: Great. Thank you. My name is Amy Olmstead. I'm acting executive lead of the Ontario health teams division. I would underscore the points that the minister, the deputy and the associate deputy have made with respect to innovative models and new models of home care that are intended to be more locally appropriate and more reflective of the needs of clients. We've seen that through the pandemic, and the new legislation that the minister mentioned is intended to support that kind of flexible care delivery. This was accompanied last year by an investment of $100 million to support—

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're out of time. I appreciate your trying to answer the question.

We go now back to the government. Who will be leading for the government in this 20 minutes? MPP Pettapiece, the floor is yours.

Mr. Randy Pettapiece: Chair, through you, I would like to ask the minister a question. We had a great announcement today in the Wellington part of my riding about more connectivity to broadband. It's going to help small communities and farms just north of a little town called Wallenstein, which is on the southeastern side, I guess, of the riding. This was great news, and it leads me to my question to the minister. You mentioned in your speech that digital health and virtual care have been a big part of your ministry's response to the pandemic. I'm wondering if you can expand a little bit more on this and explain what important developments in these areas have been made and how they are helping Ontarians during this pandemic.

Hon. Christine Elliott: Sure. Hello, MPP Pettapiece, and thank you very much for the question. The Digital First for Health Strategy has been an important part of the ministry's response to the COVID-19 pandemic. It was developed after a great deal of consultation with patients and other stakeholders to deliver what Ontarians want and expect from a modern, integrated health care system. We have been able to help patients maintain access to care virtually because of the digital health foundations that have been in place since 2019. We're continuing to evaluate and build on those foundations today, and Ontarians are going to continue to see the benefits of health system transformation enabled by digital health.

There is very concrete work under way. Some of our most exciting initiatives include improving interoperability, creating a digital front door for patients, updating our health privacy laws for the digital age and enabling Ontario health teams by supporting strong digital capabilities and innovative thinking at the front lines of clinical care.

For further details, I will turn it over to Deputy Minister Angus for further comment.

Ms. Helen Angus: Thank you. Helen Angus, Deputy Minister of Health. I always think about, what is digital health? It's a bit of a mouthful, and it's really about streamlining the flow of information between systems and parts of a system so that a patient's health record can be accessed wherever and whenever it's needed. The intent is that it's an enabler to improve safer, more integrated quality care. We've heard from patients over the years how many times they have to tell their story to different health care providers. This really means that patients and caregivers don't feel like they're starting from scratch, repeating those stories every time they meet a new member of their team, and they don't have to carry around copies of their own records. Think of the people who actually had to carry their X-rays or their images from one provider to another. That's really intended to be a thing of the past. So I think it's a really exciting opportunity, which we're capitalizing on very much as we modernize the health care system.

It's very connected into the work that the minister mentioned of Ontario health teams and providing front-

line providers with more integrated digital tools. And as the minister mentioned, we are looking at taking some pretty big steps in the digital space in health care: new regulations, tackling technical barriers that have prevented that information flow and prevented the quality of care that comes with better information.

We're also looking at how Ontarians can be provided with digital access to their own record. That's part of the work that we're doing so that patients actually can become more equal partners in managing their own health. Again, it's a platform for enabling that kind of change.

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Also, new ways of verifying digital identifies will allow patients to access that information more safely and securely, and we know that that's important to patients. We're building on the foundations for broadly available online appointment booking so that Ontarians can schedule visits with providers more quickly and more conveniently. It certainly is better for patients, caregivers and providers to have that kind of access.

Through the consultations that we've done over the past couple of years, we realized that there is a critical need to modernize the privacy legislation that governs all the information flows and the information. I think the COVID-19 outbreak has made some of the key changes to improve information sharing and access to critical data even more important, and we've taken significant progress to address those needs.

Finally, we're delivering better virtual care options to Ontarians. We've just talked about virtual home care, but the rapid increase in virtual care has been of great benefit to patients, particularly in the time of COVID—and I don't think there's much turning back from that, because people have grown to like and appreciate the kind of access that they've been able to get to their care team in the comfort of their own home.

Perhaps, with that, I will turn it over to Assistant Deputy Minister Greg Hein, who you met yesterday, to talk a little bit more about the strategy and how we're working to use digital tools to really modernize and improve health care delivery in the province.

Mr. Greg Hein: Great. Thank you very much. Maybe I'll start with just checking to see that my audio is sufficient. Is the volume good?

The Chair (Mr. Peter Tabuns): Yes, it is.

Mr. Greg Hein: Thanks. It's my pleasure to share some of the progress that we've achieved in advancing digital health and virtual care up to this point. I'd like to begin with a brief overview of virtual care.

Some of you will know that Ontario has been a global leader in virtual care for years now. The Ontario Virtual Care Program has provided publicly funded services to Ontarians for more than a decade, supporting one of the world's first and largest virtual care networks. However, while it supported specialized care models, virtual care, through this network, wasn't an integral part of health service delivery, and we sought to change this.

Under the strategy that the minister and deputy have talked about, we've worked hard to modernize virtual care delivery. These efforts have been tested through the COVID response, and they've responded well. The accelerated use of virtual care helped to make our health system more resilient and able to adapt to the challenges posed by COVID. I'll discuss some of the examples below, but I wanted to say that, looking ahead, the evolution of virtual care post-pandemic will require a measured approach based on a couple of different factors: first, the considerable benefits of virtual care, including patient choice and improved access; second, the appropriateness of care through different modalities of virtual care, like phone, video and secure messaging; and lastly, the long-term sustainability of the health care system.

Next, I'd like to share with you a new verification program that will improve how providers and patients experience virtual care. Over the past year and a half, the ministry and Ontario Health worked closely with health care providers, technology vendors and others to better understand the needs of providers and to develop new provincial standards for virtual care delivery, privacy, security and interoperability. By publishing a regularly updated listing of vendors that have been verified as meeting these standards, Ontario Health will help providers to make smart investments in virtual care solutions that enable appropriate care for patients.

In order for a product to be published online as a verified solution, vendors must attest that they are compliant with the program's standards and provide summaries of privacy and security threat assessments to ensure that patient information is protected. The ability of providers to choose between vendors on a level playing field is going to drive competition and innovation. With open standards, innovators will be able to focus on creating increasingly better solutions and better virtual care experiences for patients and providers. This will support a thriving marketplace for health care innovation and interoperability. Gone are the days of forcing providers and patients to use a single middling system.

So what's been achieved through COVID? As I said, it was not only a test but also a source of innovation. There has been a rapid implementation of regional and provincial virtual care initiatives and a nice array of them. These projects have provided patients with a variety of options to safely access health care services using secure devices in the home that transmit clinical data back to providers in the form of simple text, photos, pain scores and other forms of information.

By the end of the last fiscal year, tens of thousands of patients were enrolled in remote care monitoring, ensuring that they could receive appropriate care while reducing the risk of infection from coming into contact through front-line health care workers. A growing number of patients are being enrolled in virtual surgical transition programs, enabling surgical patients to connect with their clinicians from their own homes, giving specialists a more efficient way to deal with backlog. And 27 projects targeted front-line home and community care service providers, including First Nations, urban Indigenous organizations and community agencies to enable important supports like

virtual palliative care and virtual seniors' programs during the pandemic.

Now I'd like to talk about some other notable progress beyond virtual care. The minister and deputy mentioned the Health Care Navigation Service, and recently we've accomplished some major milestones through that project. The navigation service is going to make it easier for everyone to engage with the health system through the modernization of existing telehealth services. These changes will make it easier for Ontarians to access more of the health supports they need to stay healthier and to better navigate the health care system, all in one convenient place with connections to Ontario health teams as they roll out. When it's fully implemented, the navigation service will be a one-stop digital front door to the health system, offering a place where all Ontarians can access health information, get advice and find supports for connecting to publicly funded health care services.

The navigation service will modernize and streamline a number of the ways that people seek advice today, beginning with the notable Telehealth Ontario and health care options, with the flexibility for future enhancements to the service over time that will be guided by the needs of all Ontarians. For example, by using a single phone number and digital front door for the navigation service, Ontarians will have an easy way to connect with the mental health and addictions coordinated access system and connect with the resources and supports they need. You can expect to see the health care navigation service going live less than a year from now, and it will be accessible to all Ontarians by telephone as well as through web- and mobile-based services. It's this multi-modality format which will lead to lots of future innovations.

Speaking of innovations, another important source will be Ontario health teams. When you think about it, the Digital First for Health Strategy and Ontario health teams depend on each other for success. We know that integrating the health system depends on strong digital capabilities at the front lines of clinical care and we know that OHTs have innovative ideas born of their experiences and creative solutioning.

OHTs have told us that they're not all at the same place when it comes to digital health, so we've developed an innovation management framework to guide us in giving the right kinds of support to OHTs at different levels of digital readiness. OHTs that are in the early stages of digital transformation are going to get the support they need to build digital foundations using proven solutions to better meet the needs of their patient populations and to empower their patients with choice of how they access health care.

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We're also helping OHTs that are at the forefront of digital health to test new and novel transformation opportunities, because they have the capacity to do so. We will be issuing them with public challenges and giving them support so that they can show how they can tackle tricky health system problems with new digital technologies and approaches. We will be confirming the specifics with our partners, but our challenges will target the most timely opportunities such as understanding and managing population health, which is critical to the long-term success of OHTs. Challenge funds will allow OHTs to implement a population health solution linked to the priority population of that OHT.

As another example, we know that the COVID-19 pandemic has accelerated the application of next-generation technologies like artificial intelligence and smart medical devices that improve acute, primary and long-term care. Funding to support new initiatives in this area could deliver improved value to OHTs and better results for patients. Our challenge fund ideas will be confirmed in consultation with our partners, but the opportunities will be many. Of course, the end goal is to take the solutions to those challenges that demonstrate the best returns on investment and scale them up, spreading them across Ontario so that all parts of the province can benefit from innovation.

Next, I'd like to talk about a problem that has dogged Ontario for years, and that is the lack of full interoperability, or the technical manner in which information is shared seamlessly. Simply put, as the minister has been so eloquent in saying for more than a couple of years, we need crucial clinical information to be shared across the many systems that Ontarians have paid for. This past year, we have demonstrated national leadership by developing a new regulatory approach to drive health interoperability. With a lot of consultation and advice from stakeholders from across the system, we created a digital health information exchange. This policy is informed by global best practices for interoperability and sets the groundwork for modernizing and standardizing the way that digital health information is shared. This policy is backed by that new regulatory framework I mentioned, to give it teeth and to drive transformational change. The core regulation gives Ontario Health the ability to set standards that are going to help digital health information move more easily and securely between systems and sectors.

The first steps are already under way to develop a patient summary standard that will ensure priority clinical information can be easily shared to support safer transitions of care. When these new standards are fully implemented, health care providers will have much better access to all of a patient's health records, no matter whether they're delivering care in person or virtually.

The deputy mentioned the importance of updating privacy legislation. Transforming the health system—

The Chair (Mr. Peter Tabuns): You have two minutes remaining.

Mr. Greg Hein: Thank you.

Transforming the health system for the digital age means that our privacy laws also had to be updated. We established a new right for individuals: the right to access your personal health information in a digital format. We also created a framework for making stronger rules for digital services that work directly with consumers' health information. These new protections will be clarified

through forthcoming regulations that we will put in place after more consultation with stakeholders.

To support a more integrated health system, we also clarified the status of home and community care providers as full health information custodians. Patients will get better and more coordinated care when information can be shared effectively between all of the providers and caregivers across different sectors. We've also made changes that allowed health card numbers to be used to accurately identify individuals and link digital records. This was a long-standing change that lots of our partners asked for.

Maybe in closing, I'll note that we've worked very closely with the Ontario Digital Service on digital identities that Ontarians can use to more easily access their own personal health information. It has been a source of great collaboration and innovation with the Ontario Digital Service.

In closing, I just want to acknowledge the really important role of patient and caregiver advisers—

The Chair (Mr. Peter Tabuns): I'm sorry to say that, with that, you're out of time.

Mr. Greg Hein: Thank you.

The Chair (Mr. Peter Tabuns): Thank you. We go now to the official opposition. MPP Gélinas, the floor is yours.

M^me^ France Gélinas: Before I go back to my questions with ADM Dicerni, I would like to ask about this new virtual care coming. Is there anything in legislation or regulations that protects patients from being charged if a physician uses a virtual platform that costs money?

Mr. Greg Hein: Maybe I'll begin with a quick response, and then my colleague Patrick Dicerni may want to weigh in as well, because this implicates OHIP.

I'll say very generally that we're looking at not only the legacy virtual care program—

The Chair (Mr. Peter Tabuns): I apologize, but if you could just introduce yourself again for Hansard.

Mr. Greg Hein: Greg Hein, ADM of digital health.

The Chair (Mr. Peter Tabuns): Okay. Thank you so much.

Mr. Greg Hein: So we're looking at both the legacy virtual care program and the use of new K-codes in OHIP, and how they're being used by providers to ensure the right balance between clinical appropriateness, achieving the benefits of virtual care and, as I mentioned, the long-term sustainability of the health care system.

The issue of whether or not some vendors are being creative with the way they charge patients is being investigated. Up to this point, it doesn't seem as widespread as some might have thought, but there is some negative creativity around the margins that is being examined, and we will be looking at the right kinds of steps to address that.

M^me^ France Gélinas: Okay. And before you go, the other thing that we hear a lot about are also that whoever owns and develops those platforms wants to have access to unidentified data, so they could not identify that it was me or you or any other Ontarian, but they would have access to health data. Is this something true, or is this just fear, or is this feasible, possible—how does that work?

Mr. Greg Hein: Just to clarify your question: You're suggesting that new virtual care providers are somehow getting access to de-identified personal health information? I just want to make sure that I understand what you're saying.

M^me^ France Gélinas: Unidentified data, yes.

Mr. Greg Hein: We have not heard that. I don't really see an incentive for them to be getting access to that. They're finding all sorts of promotional ways to attract Ontarians to their service, and frankly—and I say this with a smile on my face—Ontarians, like most Canadians, are disinclined to pay for virtual care services, like health care services generally. A lot of the pay models that are outside of OHIP have not done well at all. Rest assured, the ministry is always hawkish in protecting the principles of medicare, and we're not going to let virtual care lead to those sorts of erosions.

On the data side, no, I've not heard that. I'm happy to do some follow-up, but I've not heard of that at all.

M^me^ France Gélinas: Okay. But some sites could have ads and something else while you're online? Or no?

Mr. Greg Hein: There are some kind of start-up, walk-in virtual care clinics who, during COVID—you can see advertisements through social media or good old-fashioned billboards that are saying, "Come to us. We can do quick phone-call consultations with you virtually." There would, of course, be the exchange of health care card number and they would be charging OHIP in that transaction, but they're not getting any big loads of patient data, multiple patient data. It would just be on that service basis.

1650

M^me^ France Gélinas: Okay. But for those people who take up that advertising—in my riding, they advertise on TV and say, "Connect with the good doctors and you can have access to OHIP-insured services." So who has access to that data?

Mr. Greg Hein: If someone seeks the services of one of these virtual walk-in clinics, that virtual walk-in clinic would have health data on that particular person, any health data that the patient would like to give the provider. It's actually quite limited, because these are usually quick transactions. Those small, start-up virtual walk-in clinics don't have any other data besides what patients themselves will voluntarily give those providers.

M^me^ France Gélinas: And at the end of the day there is a health provider that is a custodian of that health information?

Mr. Greg Hein: Yes. There are important policy questions about care continuity and the right way to compensate, which is Patrick's responsibility to think about. I'm just saying that there's no real privacy issue.

M^me^ France Gélinas: Okay, thank you.

Mr. Greg Hein: Thank you.

M^me^ France Gélinas: That was kind of a little parenthesis. When I last talked, I think I was talking to Assistant Deputy Minister Dicerni about the Assistive Devices

Program. You had mentioned that the flash glucose monitor is covered through ODB for people who are on the Ontario Drug Benefit. The continuous glucose monitor is available to people on ODSP and their children etc.—through assistive devices, or ODB? I got confused there a little bit. And I want to come back to the CPAP machine.

ADM Dicerni, let's start with the first question as to who pays for the continuous glucose monitor for people on ODSP. Is it ODSP which pays for it, or is it assistive devices?

Mr. Patrick Dicerni: Assistant Deputy Minister Patrick Dicerni, ADM in our OHIP and drugs and devices division. Thank you for the question, Madame Gélinas. I will have to take this back. I do not want to provide the committee or you with an incorrect answer, but to clarify: Currently, CGMs are not funded through ODB or the ADP, and not being an expert on the ODSP program, I would not want to weigh in there.

M^me^ France Gélinas: Okay. My original question was with the extra $108 million that we can see in the line for assistive devices. You answered that this is volume-based, that you are engaged in negotiations with the manufacturers—there are two big ones—of continuous glucose monitors, and decisions will be made once you find a fair price. Am I interpreting your words right?

Mr. Patrick Dicerni: I wouldn't want to presuppose the outcome of a negotiation, but broadly speaking, you are correct.

M^me^ France Gélinas: Okay. Coming back to the CPAP, there are many CPAP vendors that have reached out to me to say that the new price that you have announced for CPAPs means that vendors in the areas that I represent may not carry those products anymore, because they would not be able to make a profit and make a business of it. And then they point to all sorts of studies that show that the new price is wrong. Did you look at all to people like me who represent rural, northern ridings, where we have one vendor? If he closes, then we have none. Are they going to be affected by the price drop in the different CPAP machines?

Mr. Patrick Dicerni: Thanks for the question. Let me just step back and provide a little bit of context with respect to some of the factors that drove the new price point for the PAP machines. That was determined or set based on a number of factors, Madame Gélinas, such as market trend analysis, other jurisdictions, looking at actual invoicing, targeted margin analysis, if you will. We did speak to a number of experts in this area, as well as taking into consideration the size of Ontario and, to your point, the diverse and unique needs. I would not be able to comment on how this would affect individual providers and perhaps the ones in your region. Differential pricing models in terms of what those devices are invoiced for or purchased at I think would lead to individual business decisions needing to be made.

The only other thing I would comment on is some of the statements made by the Auditor General when her office reviewed this program, particularly related to these devices and others, which drove us to look at the pricing models here.

With respect to the overall impact on the market, OHRSA, an organization I'm sure you're familiar with, the association that represents home oxygen providers in Ontario—frequent engagement with myself and the senior leadership in the ADP area of the ministry. Certainly their views are known to us, and it is represented by the fact that we have continuously engaged them and for a number of reasons delayed the implementation of these new price points until July as evidence of our desire and willingness to work with the sector in terms of guarding against unintended consequences.

M^me^ France Gélinas: Okay. So I get from what you're telling me that you feel pretty confident that the new prices for those different types of CPAP machines are based on evidence, and you've done your homework to see the trends, the actual invoices, the experts, and you feel that Ontario is putting forward something that is supported by evidence?

Mr. Patrick Dicerni: I do. And just a little bit further on that, just to give you a sense of what the texture of that evidence-gathering and business case development on our part was and would be in the future, we did go to the point of looking at and reviewing vendor invoices from manufacturer-to-vendor costs for PAP devices and associated supplies. That gives us a pretty transparent look at what the vendor is acquiring the device for, versus our reimbursement levels.

M^me^ France Gélinas: All right. They also talk a lot about—the machine can have the ability to track usage and how often you use it in the night and concentrations and all of this that would lead to the patient not really needing to go back to the sleep lab after 30 days to have a second analysis done in a sleep lab, but simply hand in the data. They also point a lot to the fact that Ontario has I don't know how many sleep labs by 100,000 people, which is way off the charts compared to every other jurisdiction that uses at-home sleep apnea analysis. Does that make any sense to you?

Mr. Patrick Dicerni: It does make sense to me, and I'm aware of the, shall we say, disproportionate amount of sleep lab clinics in Ontario per capita and against comparator jurisdictions.

1700

M^me^ France Gélinas: Are the two related, as in if some of the CPAP machines are able to do analysis, then is it true that you wouldn't have to go back after 30 days for another sleep in a sleep lab?

Mr. Patrick Dicerni: Without wanting to comment on individual clinical situations, because what would be right and proper for patient A could very well not be for patient B, and certainly clinical decision-making would drive that, I think the overarching point that I'd like to make in connection with where I think you're going here—one of the challenges in the program, and it's multi-factoral, is staying in front of frequent and ongoing innovation in this space connected to technology and what functionality these types of devices offer now and can offer in the future.

The ability to, I'd say, reconcile those technological dividends in the system is something we're continuously trying to do across my portfolio, certainly, and others. The lag time there is to some extent—I acknowledge that, but this would be something that we would and are continuously looking at to make sure that we are optimizing the benefits of technological advancement and ensuring that those benefits do accrue to the people of Ontario where at all possible.

M^me^ France Gélinas: Thank you.

I'm switching fields completely and going into home care. I will start by telling you this—not you necessarily, ADM, but Minister, I have this really weird thing happening in my riding where a lot of people are coming with complaints that they qualify for 14 hours of home care—two hours a day, seven days a week—but they can only get one hour because the providers cannot have enough PSWs. At the same time, I have home care PSWs coming to see me to say that their shifts have been cut back; they cannot get enough shifts to make ends meet in home care. I talked to the LHINs about this, who tell me, "No, no, no. Our providers cannot recruit enough PSWs to do the shifts. We're trying really, really hard to get them all the home care that they need." I will then tie this back to estimates with the fact that there are zero increases to base budgets for home and community care agencies.

Have you heard of this, where PSWs say they're not getting shifts and the LHINs and the providers say they cannot recruit? And at the end, it's the patient who goes without and the family that is completely exhausted.

Hon. Christine Elliott: Well, I haven't heard of that exact issue, but I do know that we need more PSWs and more nurses in our system for home and community care, as well as in hospitals and, of course, in long-term care, as we're preparing to provide four hours of direct care per patient per day.

We have several programs where we are trying to recruit more nurses, more PSWs. But I would say in the home and community care area that that is an area that is maybe one where they're paid at a lesser level than in other areas, and so what we really need to do is to try and achieve some degree of equity so that we don't end up pulling people from one area and moving them into another. That's been the situation for a number of years. We have dealt with it with the temporary payments for PSWs with the increase in pay, but it's something that we're looking at going forward, to create conditions where PSWs in particular want to stay working as PSWs. Partly it's a question of pay, partly it's a question of work conditions. I guess scheduling is part of it as well, especially if they have to drive long distances from one place to the next.

I think that there are a number of issues that need to be worked out. Pay is one of them, but [*inaudible*] a number of other issues. But at this point, I would turn it over to the deputy minister for further comments, because I know that she's quite well aware of this concern as well.

Ms. Helen Angus: Yes. Thank you, Minister. It's Helen Angus, Deputy Minister of Health.

I will call on my team to answer the specific question. Obviously, paying attention to the home care workforce—

The Chair (Mr. Peter Tabuns): You have about a minute left.

Ms. Helen Angus —has been a priority for us. But they may have a line of sight as to whether this is more of a local issue or whether this is system-wide. My own mother is on home care. It's actually been incredibly reliable, to where they trimmed down to two providers over the course of the pandemic, and it has been incredibly regular. This is well outside of Toronto, so I just don't know whether this is system-wide or whether there are issues in your area specifically. I certainly would like to get to the bottom of that, because it's not unusual in the health care system where you hear two stories and you have to kind of triangulate between the two to actually find out what the truth is. I'd be happy to look into that. Maybe when we come back—

The Chair (Mr. Peter Tabuns): I'm sorry to say that you are out of time. With that, I turn it back to the government. MPP Barrett, the floor is yours.

Mr. Toby Barrett: Thank you very much, Chair, and I certainly extend a thank-you to the people testifying before the witness table. I hope this can be a valuable use of your time.

My question is around the advent of the various mutations, or variants of concern. There's obviously a continual myriad of moving targets over the past well over a year now—well, going back to January 25, when we had the first case in Ontario. I know we raised concerns then about what was coming into the province of Ontario, and in that case from, as I understand it, Wuhan.

We're very fortunate to have this health care system. We know it's gigantic. We know it's very expensive, but compared to the rest of the world, we are positioned so well. I can appreciate the challenges of the people on these calls trying to make things work. At the riding level, just today, I've spoken with professionals in ICU, in the testing system locally, our local health unit. I've talked to some very worried constituents, and my staff are talking to business people and the public. Many are not that concerned about this; they're more concerned about opening things up, as you know.

But with respect to the past year, the past 15 months, in speaking, say, with professionals today, we all agree we don't really know what's going on. There are not clear-cut answers. Sure, there are measures around prevention. There are certain measures as far as treatment. There's no cure—we know that—not at this point. With the ground moving under our feet, beyond what came in originally from Wuhan—and I get asked: Did it come from a lab? Did it come from a bat? We don't seem to have an answer on that one either. But now, the very concerning advent of other mutations, which does occur with viruses, and the various variants of concern—I would ask the people testifying today if they could spend some time walking through the original version and the variants of the original version to better explain to this committee what we're dealing with right now and, regrettably, what we will be continuing to deal with for a while yet.

Hon. Christine Elliott: Good afternoon, MPP Barrett. Thank you very much for your question about the evolution of COVID-19 and the variants of concern. There's no doubt that the COVID-19 pandemic has presented a challenge to health experts and government decision-makers around the world. In many ways, it has been unprecedented in its impact and complexity and has forced us to perpetually adapt and modify our pandemic response. And as this government's response has unfolded, its actions have been informed by evidence and data and have been guided by the advice of our experts, including our Chief Medical Officer of Health, Dr. David Williams, and his team.

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At every turn, our experts have been monitoring, reviewing, assessing and analyzing all the new and emerging science, ensuring that our decisions are supported and informed by the most up-to-date and relevant information available. This was and is, as you can imagine, no easy task. As you will hear from Dr. Williams in a few minutes, our understanding of COVID-19 and the measures needed to contain it has changed rapidly over this past year or so and it will unquestionably continue to do so. But I know that our team is up to the challenge and they will continue to provide us with their best advice as we work to end this pandemic.

I would now like to turn it over to Deputy Minister Angus to make a few remarks.

Ms. Helen Angus: Hi. I'm Helen Angus, the Deputy Minister of Health.

Yes, the pandemic has been unprecedented in many, many ways, and certainly the dynamic quality of the pandemic and the rapidly changing conditions of a pandemic means that our response has also had to evolve and adapt and be nimble. Certainly, that's the reason why we brought together as many experts and sectors as we could in order to provide the strategic, evidence-based advice that we needed in order to inform and shape the overall response as well as specific initiatives. A big part of this has actually been keeping up to date on how the COVID virus was, is and continues to evolve, and to understand how those evolutions impact on the health of the population, on the public health response, on the health care systems and, ultimately now, of course, on the vaccine rollout.

With each new variant, there are a whole bunch of questions that need to be answered. We look to our scientific and medical experts to answer those: How transmissible is this new variant? Does it move more quickly from person to person? Does it cause the same level of disease and illness that the original COVID did, or is it more significant or is it worse? And what impact might the variant have on the effectiveness of the various vaccines we've used in Ontario? All of those shape the way that we have responded, and Dr. Williams is going to tell you a little bit more about the changes we've seen, the knowledge that we've acquired both from our own scientists as well as his participation with our federal colleagues and the medical officers of health and scientists across the country.

The kind of collaboration that we've had on the science has been unparalleled, and I will just take a moment to say I'm really proud of the work that Public Health Ontario has done, and in particular Dr. Vanessa Allen. We have led much of the identification of the variants in Canada in the Ontario Public Health laboratories with our scientists, to benefit the rest of the country. I think that's something that we should all be thankful for.

With that, I will pass it over to Dr. Williams who will have a more technical and scientific view of what we've been challenged with, with the variants.

Dr. David Williams: Thank you, Deputy, and also Minister Elliott and MPP Barrett. I think your opening comments were very important in there, and as you were alluding to there when you talk to many of your constituents. It's a reflection of the public, as they're working their way through trying to understand, as both the deputy and the minister had said.

I didn't introduce myself. Sorry, Chair, it's Dr. David Williams, Chief Medical Officer of Health.

As they're trying to work through this journey that they've been on—trying to understand, trying to struggle with the issues, the changes and things that have been happening, are happening and might happen—it leaves a lot of aspects where people are struggling with components in that and how do we take it through there.

When we're looking at the variants of concern and dealing with the matters here, we look back to that aspect when we started back in basically even the end of 2019 and early in 2020. In the past, in our knowledge about pandemics, influenza was the key one; SARS was another one, and H1N1—and we were aware of these notices and things coming out from China. Part of this is the global reality that we are in, and I'll talk about that in a moment.

I will say, I do get notices even now—one to two; in a winter month, three a month—from the international group on new clusters of new viruses that are causing cases among humans, mostly from China and from the east, in there. They often tend to be the avian forms of influenza, so this wasn't uncommon in 2019 and throughout 2020 and now. There are many things, as people interact with their environments and incorporate these viruses, and they change and modify and shift.

As I've said all the way through this pandemic, from experience in the past, there's nothing like a virus to keep someone humble, because it does change and shift and move, especially as it impacts wide populations. That's something to keep in keep in mind: When we're talking about these pandemics, we talk about in public health a triangle, if you may, that has "agent," "host" and "environment." All three are there. All three have components. All three are changing and shifting and acting inter-relatedly throughout the whole process, and so we'll look at that there as we look at it.

When we were aware of this occurring and were aware of something in a fish market with a few individuals who were being incorporated into that outbreak, we had wondered about that. I know that early, when we got our notice in the first week of January, I talked to our director

then, Clint Shingler, of our health system emergency management branch. I said, "This is looking more concerning," and then when we found that things were escalating, I said, "We are not in a sprint. Get ready for a marathon." I didn't know it was going to be an ultramarathon at that time.

So as we started that process, we wondered, "Is this going to be similar to Middle East respiratory syndrome?"—MERS, as we called it. "Is it going to be like SARS?" Both of those, as they evidenced themselves, were not pandemics per se. They had affected a very much sequestered group or a part within their areas: one, more with certain areas related to camels in the Middle East; the other, SARS, was a hospital-based one, mostly among health care workers, and we remember that quite well, what happened then at that time.

But this has been different. As it moved out of that area there and as it came into our area, our comparison, evidently, was the Spanish flu back in 1918-19. That was brought on, of course, by the repatriation of forces from the European theatre in there, but after that happened, a lot of the mobility stopped. That's not the case now. We have a very mobile, international, worldwide community. We used to say at times, "There are always things that don't fly: Humans." There is obviously one to two million in the air at any time, and the mobility has very rapid and very quickly mobilized to move throughout the world. So we were dealing with that mobility at that time. That means a different approach: It wasn't a one-time spread throughout; it was multiple and continuous, and that's one of our challenges in the way forward as we look at this and try to handle that.

So when we understood that, we had to work very closely with our federal, provincial and territorial partners, the other chief medical officers of health in Canada and with Dr. Theresa Tam and her team at the Public Health Agency of Canada, who are linked tightly with the WHO. Because we have to then depend on a number of things happening: How are our other fellow workers in different countries monitoring their situation? How are we apprised of that? How open is the communication and how do we trust that? Because if one does not have much mobility from any other part, one can deal with it in a very isolated way, so your environment part of that triangle is quite limited. That's not our case, especially here in Canada, especially here in Ontario and in Toronto, so we have to face that reality and work with that.

So when we look at those three components in there, we want to understand what is the agent. What do we know about it? In the past, we would enter these things just saying, "There is a condition or syndrome of symptoms and signs and disease." As with SARS, we didn't know what the agent was. This time with the new technology, Public Health Ontario, as the deputy has already alluded to, moved very quickly with the sharing of the genetic sequencing. We actually knew the organism. We actually had a gene sequencing in a very short order. As a result, led by our team at Public Health Ontario and Dr. Vanessa Allen, we were able to develop a very good test within a very short order, a gold standard test, the PCR that you've heard so much about. That led us to be able to identify the organism much quicker and to be able to change our whole approach in dealing with the handling of this right from the get-go.

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So we knew the agent to some extent, how that was going to interact with our host—that's people—and an environment of our highly globalized mobility here in Canada, and especially in Ontario. So we had to look at how we were going to handle that. Our case contact management was critical in that type of approach, to be alerted about travel history, because other countries were reporting they had cases or no cases. As far as we were concerned in those stages, we were monitoring that. So, coordination, communication and understanding that our environment isn't just ours, it's a global environment, and how we're supposed to handle that. That's very pertinent when we get into the discussion of the variants of concerns that I know you have asked about and that people are asking at this stage about.

As we started down this approach on that one, we started to monitor the cases: Where was it moving? How was it travelling? How robust was it moving? What were the impacts on the different countries as they faced it? Because we needed to and were able to learn from their experiences as quickly as we could. And then, how is it impacting their environment? How is it impacting their hosts and their health care systems? We saw examples early on of some areas within China, within Wuhan the city, Wuhan the district and the wider area around there, and later Italy and other ones, as we saw its devastating impacts and it became very apparent that this was more like our first real pandemic that we had not seen since 1918-19.

Then we had to look at it and say, what were we going to anticipate? What were we going to have to deal with as we moved forward? As you recall, we went through our first wave; we saw the impacts. We know our pandemic plans were indicating, in a moderate or severe case, we would be expecting over the year ahead, and as we took stringent measures, to have at least 20% to 30% of our population being laboratory-confirmed in there. Of that number, a good 6% would be hospitalized, and then of that, at least 1% to 2% would be case fatalities and 3% of those would be in ICUs. Those are huge numbers, those are big challenges and those were very much intimidating as we looked at how that agent was going to interact with our host and knowing that our most vulnerable individuals in our society were the ones that were going to be most susceptible, namely the very old, those with lots of comorbidity and the very young, as our assumptions starting down on the pathway there.

As we entered into wave 1, we were assuming that the information we had received from our counterparts around the world was up to date, but unfortunately, it wasn't as up to date as we'd have liked, and we had a number of people returning to Canada carrying, in their mind, mild symptomatic cases in there. Our first cases of COVID, which

were very much our case definition of our classic COVID precautions now—it shows you how long it's been around—had very much a set of signs and symptoms that were part of the case definition that in any pandemic is very much agreed upon by our federal, provincial and territorial partners, and we were very clear on what a definition of a case was, what a probable was, what a possible was.

And so, we tried to understand what the virus was at that time: How is it impacting our public in different age groups and different groups, those with other risk factors? What are the risk factors that made you more predisposed to serious consequences? This was all very important. And, very early with our clinicians, what can you learn and know from other sectors in the world and from your own about how to handle and treat and to contain this as best as possible? We were learning about how others were doing testing, and how their understanding they could take about environmental situations to try and control—

The Chair (Mr. Peter Tabuns): You have two minutes left.

Dr. David Williams: Thank you. With our variants of concern, when you're getting to there, we'd gone through the first and second wave with the classic COVID. In December, we started seeing new ones, the so-called B117, the UK variant. We saw the B1351, which is the South African variant, and we had the so-called P1, or the Brazilian variant. Now we're working with the so-called variants of interest, the B1617, the so-called Indian variant. Even today—I'm just getting emails—we're looking at that, whether it's shifting from a variant of interest to a variant of concern. These are live, ongoing discussions, because these viruses are circulating in their respective jurisdictions. They're causing chains of mutations that are either being successful—remember, the virus is there for its survival. It finds hosts that are capable of doing that, and they impact their areas by being highly transmissible and by surviving in and with the host. But by causing that, they pick up DNA and materials from the host and incorporate them.

These variants of concern are coming into our area, and global transfer is still occurring. People are still travelling, and they bring them in. Will they impact us writ large? The B117 has. It's our major one. P1 is rising up a bit. It's staying in control. It's a big issue in BC and Alberta. B1351: limited, but now we have to watch the B1617 as well. These variants still are all workable with our vaccines and our vaccine technology, which has been amazing. We're moving on that fairly quickly, to control it. Ongoing measures, ongoing vaccination, education, critical monitoring with our labs at PHO—we monitor there to keep us up to date.

Those are our comments, I think, MPP Barrett. Stay tuned and keep—

The Chair (Mr. Peter Tabuns): I'm sorry to say that you're out of time.

With that, we go to the official opposition. MPP Gélinas, the floor is yours.

M^me^ France Gélinas: That was very interesting, Dr. Williams. Thank you for that.

I'm coming back to home and community care. We have seen a decrease in funding of $102 million to home and community care. There are multiple examples of people who cannot get the care at home that they need. Minister, I was happy to hear you say that you are looking at creating the conditions to retain PSWs in the home care system, that there need to be some degrees of equity, because PSWs in home care are paid less than in long-term care, who are paid less than in hospitals, although they often do similar work, with similar responsibility.

I guess, coming back to the money, why do we see a $102-million decrease in the home care vote, which is vote 1416-1?

Hon. Christine Elliott: I will turn that question over to the deputy minister.

Ms. Helen Angus: I'm happy to answer that and then tee up my team—Mel and Amy—to follow on and answer it more specifically.

Like many of the other lines in the health care budget, there were increases last year because of COVID, and then we're settling back to normal rates of growth. You see that in the hospital line. You see it in the home care line. The 2020-21 would have included investments made last year, including time-limited temporary pandemic pay premiums. So that was included last year. This year, the government is increasing the annual funding in the base in order to support volume increases.

I'll ask Mel and Amy to explain that perhaps in a little but more detail.

Ms. Melanie Fraser: Hi. It's Melanie Fraser again, associate deputy minister of health services. Deputy Angus, you stole my punchline there. That's precisely right: The pandemic pay increases have, I think, overshadowed the increase to the base that we normally have year over year to be able to provide increased volumes for home and community care services. So there is, in fact, an increase in the line there. I don't have the precise number at my fingertips, but it is substantial, and I'm sure that's something that we could look into getting for the committee.

To your earlier question, Madame Gélinas, about the PSW who was unable to find work and then hearing from service provider organizations or from clients saying they don't have enough workers to be able to receive services, I think our experience, I would say, in the majority of the province would be that service provider organizations are hiring as rapidly as they can to be able to staff augmented hours. And as I said, we are providing additional volumes, and we would hear that reiterated by our partners at Ontario Health and the new HCCSS, or the former LHINs, that certainly the service provider organizations are hiring.

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There has been a significant amount of work and investment also made to help increase the number of PSWs, not only in terms of recruitment but investments to aid in their retention, to ensure that we're training enough for the future ahead.

Then, finally, to your point about the wage differential between different sectors, we have also actively done some work on that to help recognize wages relative to the setting.

But at this point, I would turn it over again to Amy Olmstead, who is expert in these matters. She can provide you with more detail about each of those areas. Amy, over to you.

Ms. Amy Olmstead: Thanks, Mel, and thank you, Madame Gélinas. Amy Olmstead, acting executive lead of the Ontario health teams division. Like Mel, I have not heard the circumstance that you've raised where there are PSWs who are looking for work while providers and home and community care support services organizations are recruiting and seeking to provide additional services.

I'll speak a little bit more on some of the items that have already been raised. Certainly, we saw early in the pandemic last year that home and community care services did decline for a number of reasons. Some clients and families paused their services; some services were paused for a short period of time if they were determined to not be essential, for example. But since that time, home care services have recovered and are exceeding the service delivery levels not just of last year but of the year before; and that is the reflection of the investment in home care last year of over $100 million to expand services, particularly those for those clients with higher needs. But we recognize that service disruption in the spring of last year would have caused a workforce disruption as well, and we may still be feeling some of that legacy as our home care provider partners seek to recruit and stabilize their own workforce.

The deputy was correct, of course, as was the associate, in outlining why our estimates numbers do show a decline year over year in forecast home and community care spending. It is because of that pandemic pay amount last year, and we do expect to be announcing an additional investment in home and community care for the year coming.

Another aspect we're managing in the home and community care workforce that would be exacerbating the challenges, MPP Gélinas, that your constituents would be facing with respect to home care access is related to the pandemic, where the demand for workers in continued service delivery across sectors and in responding to the pandemic and implementing testing and vaccination programs has caused a pull on the home and community care workforce.

We have also heard from workers that the single employer or single work site public health guidelines have affected some workers in the home and community care sector who may also have been working in long-term care. Those types of factors are having an impact on capacity that my colleague ADM Michael Hillmer has been working hard to tackle with a multi-pronged short-term and long-term health human resources strategy. As the minister mentioned, that's not just the compensation pieces. The pandemic pay program last year, the temporary personal support worker wage enhancement implemented in October and continuing through June: Both of these supported PSWs in home and community care, and the ministries are continuing to review the options regarding personal support worker compensation. We're also seeing an easing of restrictions related to the single employer or single work site with the full vaccination of health care workers.

I'll just wrap by drawing attention to a couple of the health human resources strategies that are under way to support PSW recruitment, and these, of course, take into account the challenging circumstances in the north with respect to HHR capacity. There is an investment in an accelerated PSW training program, a PSW return-to-work incentive, a PSW bursary program and then a program to train supportive care workers to provide basic home care services as well.

As the minister mentioned, it's a multi-pronged strategy, both in the short term and the long term—a combination of compensation review, improving scheduling in home and community care, recruitment and retention initiatives and the team-based care support that we believe will be supported by the home and community care modernization and Ontario health teams implementation.

M^me^ France Gélinas: From what you are sharing with me, you feel that the volume increases that went on from year to year meet the demand? How do you know that?

Ms. Amy Olmstead: Amy Olmstead, acting executive lead of the health teams division. I think our experience in the past year or two in home and community care is that the investment made outstrips the capacity of the sector to respond with health human resources, and that's despite the efforts on recruitment and retention. Those efforts continue to be needed and are being expanded, but that is our sense: that a rate limiter in terms of the supports for clients at home recently seems to have been related to the HHR capacity.

M^me^ France Gélinas: Because I can tell you that I get letters from all over. I just got a letter from Bruce-Grey, a team of six physicians who provide palliative care, who have to keep their patients in hospital because they are not able to send them home with home care—and we're talking, like, basic home care is not available. So it's not just in the north; it's coming from all over that people who want to go to a home—those are palliative care patients who really want to go home—they're not able to do this because there's no home care for them.

You point the finger at the system not being able to recruit. How do we explain this?

Ms. Amy Olmstead: Amy Olmstead, acting executive lead of the Ontario health teams division. I would say a couple of things. I think, through the pandemic, we have a deeper understanding of the complexity of the clients who we would like to be caring for at home and the services that they need. That has been a learning that we are going to apply to our future planning for home and community care, certainly.

I think there's also a learning about what works to get the care team in place for those clients. What is the type of stable staffing environment that will be successful in

attracting and keeping workers for those clients? Because I think one of the challenges is a reluctance to bring people home who have high needs unless there is that really stable, for sure, continuous care team.

One of the things that we've learned through the High Intensity Supports at Home program is that if you can structure the team and the funding and delivery model for the team, you have that continuity of service provider, and that gives the hospitals, for example, the confidence to discharge those patients home. And anecdotally from workers, they really appreciate and welcome being part of that team. They know what their schedule is; they know who they're caring for on any given day.

So I think that part of the solution is looking at those types of models and expanding them and scaling them as we go on in the months and years.

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M^me^ France Gélinas: In the past, when we had—I'll take this client who lives in Chelmsford, a little town in my riding, and qualifies for 14 hours; two hours a day. Right now, it's Bayshore that has the contract and can only provide one hour a week. That's it; that's all. Before, when I would go to the LHINs, now the HCCSS, I would say, "Well, go out of contract. There are PSWs who are willing to provide that care. Just go out of contract and hire Home Instead, hire another provider that doesn't have a contract with the LHIN/HCCSS." They say that they're not allowed to do that anymore, and they point the finger at you.

We know that we're failing this family, that they're at their wits' end, they're exhausted, and she's going to end up—it's a woman—back in the hospital if we cannot support her at home: What has changed that the LHIN/HCCSS cannot go out of contract?

Ms. Amy Olmstead: Thank you for that. Amy Olmstead, acting executive lead of the Ontario health teams division. I apologize if I'm erring on the side of caution in reintroducing myself too frequently.

MPP Gélinas, I am not aware of a change with respect to the procurement and partnership rules. There is a pre-qualification list and LHINs are able to select or partner with providers on that list even if it's not a provider that they have historically partnered with. Certainly there are opportunities to bring on other providers as well if existing providers are not able to provide the services. Now, that's a generalization and we would have to look a little bit more closely at the particularities of that situation.

Another constraint can sometimes be, when we've spoken with LHINs who are in this type of situation, that sometimes they will say they have reached out to the other providers who have put their hand up, and then when they've explored it further, that actual HHR capacity may not be in place at that provider. I'm not saying that's the case here; that's just something that we do sometimes hear when we follow up on these matters. But I'm always happy to take it back and explore it further and do what we can to ensure that clients are getting the supports they need.

M^me^ France Gélinas: That answers my questions.

Sometimes people also ask for the Family-Managed Home Care Program. I'm told that there is no new money and that in our area all the money for the Family-Managed Home Care Program has all been allocated, so nobody else can be added to this. You've just talked about new money going out in [*inaudible*]. So does that mean we could add more people to the Family-Managed Home Care Program?

Ms. Amy Olmstead: Amy Olmstead, acting executive lead, Ontario health teams division. The Family-Managed Home Care Program, which as you know gives clients and their families the opportunity to hire or purchase their own services, is funded out of the same budget as home care services. If a home and community care support services organization has funding, and when they get additional funding, they can certainly put it towards the Family-Managed Home Care Program or regular home care. If a—

M^me^ France Gélinas: It is at their discretion, so they are allowed to do that on their own?

Ms. Amy Olmstead: Yes. For example, if a client right now is in regular home care and their services are transitioning to family-managed home care, that's all a part of the same—

The Chair (Mr. Peter Tabuns): You have two minutes left.

M^me^ France Gélinas: Okay. I want to use my two minutes wisely. Another complaint that I get is that when the PSW doesn't show up, they call their care coordinator. The care coordinator says, "No, you have to do the partner's scheduling as a way to manage those appointments." Dealing with the providers is not working. How did we end up there? How come the care manager is not trying to solve those?

Ms. Amy Olmstead: Client-partnered scheduling is something new that is being tried out to try to spread out the care during the day so that a PSW could have a full shift of seven consecutive hours and therefore hopefully improve the working conditions of that PSW and help make their care more reliable. In those circumstances, the client and family are expected to work with the provider organization around the scheduling. It really does mean that the care coordinator is not involved in the scheduling per se. I think it's important that the care coordinator know when visits have been missed or when there are challenges, but the process would be to work with the service provider organization. However, this is still a relatively new program. We do want to know if it is working for people, if clients find it helpful and if it has improved the reliability of the care or if it's actually causing them more difficulty. Those are the types of things we really want to know, because it is something new and we don't want it to be causing an extra burden for clients and their families.

The Chair (Mr. Peter Tabuns): I'm sorry to say, with that, you're out of time.

We go to the government for the last round today. Who do we have speaking for the government? MPP Parsa, the floor is yours, sir.

Mr. Michael Parsa: Thank you very much, Speaker—Speaker; I'm so used to it. Chair, thank you very much. I appreciate that.

The Chair (Mr. Peter Tabuns): It happens.

Mr. Michael Parsa: Yes, well, that's the amount of respect that we have for you in this committee.

My question is to the minister. Minister, my question is about mental health and addictions and, in particular, when it comes to the time period during COVID. I don't think there's going to be a single person who disagrees that it has changed the way we live, we work, we socialize, we get together with our family members, not having the opportunity to do so. You've heard medical experts and researchers across the country say that there's clear evidence that it's having a significant impact on people's mental health right across, just all over, but in particular here in Ontario.

We've also seen polling data commissioned by the CMHA, the Canadian Mental Health Association, that shows that only that only a third of Ontarians—that's just 35%—consider their current state of mental health as very good and excellent. That is a significant decrease from the 52% recorded in its first poll, and that was back in May 2020, Minister. Also, the CMHA says that the rates of stress, anxiety and depression in Ontario during the pandemic have also worsened. They're worse than ever now.

I'm wondering if you can just share with us and tell us a bit about the action that the government has taken to support Ontarians experiencing challenges, in particular with mental health during this pandemic in particular.

Hon. Christine Elliott: Thank you very much, MPP Parsa, for your question on this important topic. I know it's something that people across Ontario are concerned about. We are all aware of the damaging impact that the pandemic has had on the mental well-being of people and their mental health across the entire province. In Ontario, for example, as you indicated, the survey released by the Canadian Mental Health Association in Ontario in March 2021 found that 36% of individuals said that they're experiencing very high stress, up from 30% last summer; 36% feel very high or high anxiety, up from 30% last summer; 17% say they're always or often depressed, up from 13% in May 2020; and more than a quarter—27%—are using more substances to cope, and this is up from 21% last summer—all very concerning. Also, at the peak of the initial wave, Kids Help Phone reported three times the number of children and youth were calling or texting Kids Help Phone to prior the pandemic.

Recognizing that the need for mental health and addiction services is greater than ever, our government approved up to $194 million in one-time emergency funding over the past year to support continued and enhanced access to these critical services through strategic investments in virtual care. As Deputy Angus and Assistant Deputy Minister Kohn will explain, these investments have meant that Ontarians have had continuous access to mental health and addictions services during this unprecedented time.

The latest data shows us that over 97% of community mental health and addictions service providers remain open to serve Ontarians, and over 71,000 Ontarians of all ages, including thousands of front-line health care workers, have accessed the virtual mental health and addictions services put in place as part of our response to the pandemic. This includes over 32,000 people accessing Internet cognitive behavioural therapy.

While we know that these needs have only been exacerbated throughout COVID-19, mental health has always been a priority for our government. Recognizing the long-standing system needs, a year ago we released a provincial mental health and addictions strategy called Roadmap to Wellness. Supported by a commitment to invest $3.8 billion in new base funding for mental health and addictions services over 10 years, Roadmap to Wellness is a comprehensive plan to ensure Ontarians have access to high-quality services when and where they need them. Since 2019-20, the government has announced $525 million in new annualized funding for mental health and addictions services.

Again, thank you for your question on this very important topic. It has been important to me for many, many years, and I'm very pleased that we are addressing this with the government. But I will turn things over to Deputy Minister Angus for further detail.

Ms. Helen Angus: Thank you, MPP Parsa, for the question. I'm Helen Angus. I'm the Deputy Minister of Health. Nice to see you.

The road map was actually released two weeks before the province declared the state of emergency. Little did we know that the first milestone under the road map, the creation of the new Mental Health and Addictions Centre of Excellence within Ontario, would contribute significantly to the pandemic response efforts. I must say, I'm just really pleased with the progress on the centre of excellence. You may or may not know that I spent 10 years working at Cancer Care Ontario and saw what having a centre of excellence at CCO could do for the cancer system, and I'm just delighted by the actual achievements and the potential that creating that centre is going to have on the quality of and access to mental health services in the province.

As the minister suggested, the efforts to address the challenges posed by COVID-19 have been in the forefront of the work of the ministry over the last year. One of our primary goals, particularly in the face of the pandemic, is to ensure continuous access to the services provided by over 600 community agencies who serve children, youth and adults, and so one of the things the government did was to provide a one-time emergency investment of $194 million. That has really allowed services to remain open, and open safely, and maintained accessibility in a variety of ways.

We just talked about virtual care earlier today; sometimes providers used that funding to move from in-person care to virtual care, with great success. In other cases, agencies invested in personal protective equipment and retrofits to their physical plant in order to be able to create the social distancing and protection needed to continue in-person services safely. It has also supported significant investments in non-traditional virtual providers—the minister talked a little bit about that—whose business models really focus on online and remote-delivery care, and our data shows that Ontarians have responded very well to

these remote services. And so, like other areas of virtual care, I think it's really going to be, if anything, one of the legacies of the pandemic that we've made this shift, and it's really to the benefit of the people of Ontario.

Beyond making these emergency investments, we took other steps to make sure that services continued to be provided to people, particularly at a time that was difficult for many. Last year, we put into place an emergency staffing order that ensured that mental health and addictions agencies had the same flexibility that hospitals and other providers had to redeploy staff. In June, we flowed pandemic pay to essential front-line staff in the community mental health and addictions sector.

Since the pandemic began, we've also participated in a weekly COVID-19 provincial mental health and addictions table, convened by the Mental Health and Addictions Centre of Excellence at Ontario Health. Like all meetings that we have with people who work on the front line—they give us real-time insight into what's happening on the ground, which is so important for us, particularly at a time when we're kind of locked in our homes, many of us working virtually, to hear from the people who are actually on the front line. In general, those meetings had 50 participants from the sector on every call. It also gave us an opportunity to share the latest provincial data, how we were proceeding with the pandemic and what the context was, so that the providers could make the best decisions for their staff and for the people that they serve.

So while we've been focused on the pandemic response, the road map continues to be our plan to address the long-standing system-level challenges. We realize it's even more important now than ever. Clearly, going forward, as we recover from the third wave, the legacy of COVID and the mental health needs is something we're going to have to continue to address in the future.

Perhaps, with that, I will hand it over to ADM Melanie Kohn to make some additional remarks. We've spent a lot of time on this over the past year. Melanie?

Ms. Melanie Kohn: Thank you very much, Deputy. Good afternoon. My name is Melanie Kohn. I'm the acting assistant deputy minister of the mental health and addictions division at the Ministry of Health.

Since March 2020, we've been working really hard to ensure that mental health and addictions services and supports remain available and safe for Ontarians at every stage of life. We do take a full lifespan approach in all that we do. We've learned over the course of this work that Ontario's mental health and addictions services system is adaptable and open to innovation and, as the minister and the deputy both indicated, over 97% of community mental health and addictions service providers currently remain open for service.

We've learned the importance of having a strong provincial convenor, like the Mental Health and Addictions Centre of Excellence at Ontario Health, which, as the deputy pointed out, was able to bring this complex and far-reaching sector to a central COVID-19 response table. As previously mentioned, over the course of the last year, the government has approved a total of $194 million in one-time emergency funding to the mental health and addictions sector—a total of $122 million of this funding through the Ministry of Health, with the remainder being allocated through our partner ministries.

To demonstrate the breadth and reach of this funding, I'll take a few minutes to walk you through the emergency investments, according to a few themes: the first, community services, including child and youth mental health and community mental health and addictions; the second, virtual service supports; and the third, Indigenous mental health and addictions.

Last fiscal year, we provided $86 million into community mental health and addictions agencies to ensure their continued and safe operation. The Ministry of Health funds over 600 local agencies to deliver community-based services for child and youth mental health and mental health and addictions services and supports for people over the age of 18. These services provide essential support to children, youth and families across Ontario and are important partners in the care continuum, alongside primary care and [*inaudible*] services.

In December 2020, over $62 million was provided to support community-based mental health and addiction services and inter-professional primary care teams, including $30 million in targeted funding for child and youth mental health services. An additional $10 million was approved to support community agencies serving local high-priority populations. The funding that was provided, which was approved in December, built on previously announced pandemic emergency funding earlier in 2020.

In April 2020, the ministry flowed an additional $6.5 million in COVID response funding—

The Chair (Mr. Peter Tabuns): I'm sorry to say that that's all the time we have available for today.

The committee is now adjourned until Tuesday, May 18, at 9 a.m. We have used 13 minutes and 27 seconds.

The committee adjourned at 1800.

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