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E-30

Standing Committee on Estimates

Ministry of Health

1st Session
42nd Parliament

Tuesday 18 May 2021

Chair: Peter Tabuns
Clerk: Thushitha Kobikrishna

Journal des débats (Hansard)

E-30

Comité permanent des budgets des dépenses

Ministère de la Santé

1re session
42e législature

Mardi 18 mai 2021

Président : Peter Tabuns
Greffière : Thushitha Kobikrishna

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 18 May 2021

Mardi 18 mai 2021

The committee met at 0900 in room 151 and by video conference.

MINISTRY OF HEALTH

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Good morning, honourable members. In the absence of the Chair and Vice-Chair, it is my duty to call upon you to elect an Acting Chair. Are there any nominations for the Acting Chair? I currently have MPP Tom Rakocevic in the room. MPP Gélinas?

M^me^ France Gélinas: I would like to nominate MPP Tom Rakocevic as Acting Chair for this morning.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Does the member accept the nomination?

Mr. Tom Rakocevic: I do.

The Clerk of the Committee (Ms. Thushitha Kobikrishna): Are there any further nominations? There being no further nominations, I declare the nominations closed and MPP Rakocevic elected Acting Chair of the committee.

The Acting Chair (Mr. Tom Rakocevic): Good morning, everyone. I just want to thank you for this incredible honour to now be Acting Chair for the most exciting committee in all of Queen's Park.

I'm going to go over the rules here. I think you've heard them before. We're going to begin the excitement with these rules. I hope you're all well and that everyone is staying safe and healthy. This is the pre-meeting for the Standing Committee on Estimates. I will do an attendance check and go over some of the guidelines for our new format of committee meetings that include remote participation and physical distancing. I will start with the attendance check and will ask for attendance again at the end of our pre-meeting, in case anyone else has joined us.

So that everyone is aware, the following members are present: MPP Toby Barrett, MPP Rudy Cuzzetto—

Interjection.

The Acting Chair (Mr. Tom Rakocevic): MPP Toby Barrett, do you confirm that this is in fact you?

Mr. Toby Barrett: Good morning, Chair. I'm Toby Barrett, MPP. I'm in the province of Ontario, in Port Dover.

The Acting Chair (Mr. Tom Rakocevic): Excellent. I have a friend there.

MPP Rudy Cuzzetto, is that you or an impostor?

Mr. Rudy Cuzzetto: It's MPP Rudy Cuzzetto here, and I'm in Port Credit.

The Acting Chair (Mr. Tom Rakocevic): Okay, awesome.

We have MPP Judith Monteith-Farrell. Can you confirm that that's you?

Ms. Judith Monteith-Farrell: Good morning, Chair. I am Judith Monteith-Farrell. I'm here in Thunder Bay, Ontario.

The Acting Chair (Mr. Tom Rakocevic): Amazing.

MPP Michael Parsa?

Mr. Michael Parsa: Good morning, Chair. It's Michael Parsa, and I am in the province of Ontario. It's nice to see you, as always.

The Acting Chair (Mr. Tom Rakocevic): Excellent. I thought it looked like you.

MPP Randy Pettapiece?

Mr. Randy Pettapiece: Yes, it's MPP Pettapiece. I'm in Ontario.

The Acting Chair (Mr. Tom Rakocevic): Okay.

And we have substitutions for today's committee. We have France Gélinas. Is that you?

M^me^ France Gélinas: Good morning, Chair. Yes, this is France Gélinas, in Nickel Belt, Ontario.

The Acting Chair (Mr. Tom Rakocevic): Okay. Either that, or someone took your sign and has it in the background there.

MPP Robin Martin?

Mrs. Robin Martin: It's MPP Martin. I'm here in Toronto.

The Acting Chair (Mr. Tom Rakocevic): Okay.

And MPP Kaleed Rasheed?

Mr. Kaleed Rasheed: Good morning, Chair. First of all, congratulations to you on being the Chair this morning. It's Kaleed Rasheed, from the beautiful province of Ontario.

The Acting Chair (Mr. Tom Rakocevic): Thank you.

I will quickly go over the participation guidelines, which you've heard every single time we've done this committee. For the Zoom participants, please be aware that broadcast and recording will be controlling your microphones, as they usually would in committee. Depending on the version of Zoom you are using, you may have been asked to grant permission to unmute when you joined. If you accepted, the broadcast operator will be able to activate your microphone once I recognize you. Participants using older versions of Zoom may still get a request to unmute your microphone before you are able to speak. Please wait for the unmute notification before trying to unmute.

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As a reminder to all participants, all debate should be directed through the Chair. Should you wish to speak, please raise your hand, and I will acknowledge you and provide you with the opportunity to speak.

I will go over the voting process, for clarity. If we have to hold a vote during today's meeting, it will be through a show of hands. I will start by asking, "Are the members ready to vote?" I will ask, "All those in favour, please raise your hands." The Clerk will count raised hands. I will then ask, "All those opposed, please raise your hands." The Clerk will count raised hands. I will then declare the vote. Unless someone specifically asks for a recorded vote after I have asked whether the members are ready to vote, the breakdown of the vote will not show up in Hansard.

Are there any questions? Okay.

Have any other members joined us since I did the attendance check at the beginning of this pre-meeting?

Interjection.

The Acting Chair (Mr. Tom Rakocevic): We can wait a few moments for everyone to join us, but we'll still begin the official meeting.

Good morning, everyone. We're going to resume consideration of vote 1401 of the estimates of the Ministry of Health. There's now a total of eight hours and 57 minutes remaining for the review of these estimates. When the committee adjourned on May 12, the government had six minutes and 13 seconds remaining.

We'll begin with the government for questions. MPP Parsa, please begin.

Mr. Michael Parsa: Chair, last week, when we met, I asked the minister a question about mental health and addictions and the impact that it has had on people in almost all areas of life. I also referenced a poll that was commissioned by CMHA which showed that only a third of Ontarians considered their current state of mental health as very good or excellent, which was a significant drop.

Like I said, last week, when we met, ADM Kohn was telling the committee about some of the work and the supports that are being provided for those who are experiencing mental health issues, so I was just wondering if she can continue. I very much would like to hear again about some of the supports and some of the initiatives that have since been provided. She was in the middle—it was ADM Kohn and the minister—so I would appreciate if she could continue, please.

Ms. Melanie Kohn: Good morning. My name is Melanie Kohn. I'm the acting assistant deputy minister in the mental health and addictions division at the Ministry of Health.

When [*inaudible*] I was reviewing the COVID-19 investments, and I'll continue to do so.

In April 2020, the ministry flowed an initial $6.5 million in COVID-19 response funding to community services. With this initial emergency response funding, mental health and [*inaudible*] could backfill and extend staffing hours, provide critical training to staff, purchase necessary equipment and/or technology, and support emergency accommodations for client populations in a way that met public health social distancing protocols. Another round of emergency funding flowed in September 2020, with an investment of $7 million.

In addition to flowing supports to community services, last year we flowed one-time investments of up to $24 million into virtual care. In April 2020, funding was dedicated to virtual platforms, including BounceBack, which is a self-help program using workbooks with phone coaching support; Kids Help Phone, which is a 24/7 virtual support service offering professional counselling, information and referrals, as well as volunteer-led text-based support to young people in both English and French; and Internet cognitive behavioural therapy, or ICBT. In September 2020, an additional $3 million was dedicated to cognitive behavioural therapy digital platforms and supports.

As has been remarked earlier, the investments Ontario made in virtual care during the pandemic have been very well received. More than 71,000 Ontarians have accessed these supports, including 32,900, as of the end of April, who accessed ICBT. In addition, over 6,800 health care workers have accessed mental health and addictions supports virtually, including peer group discussions, training and education, ICBT and support from clinicians, as of the end of April.

The last tranche of COVID-19 emergency funding I'd like to outline pertains to Indigenous mental health and addictions services.

In fiscal year 2020-21, one-time emergency funding of over $20 million has supported meeting the pandemic-related mental health and addictions needs of Indigenous people. In December, the Ontario government [*inaudible*] to sustain and expand access to culturally safe mental health and addictions services and complementary services. Eight million dollars of this went through the Ministry of Health, with the remainder flowing through interministerial partners.

0910

This investment built on the earlier $5 million in emergency funding for these services, supported through the Ministry of Health, in the first wave of the COVID-19 outbreak to support [*inaudible*] services for Indigenous people in Ontario, especially children and youth.

In addition to supporting the flow of emergency funding—

The Acting Chair (Mr. Tom Rakocevic): You have two minutes left.

Ms. Melanie Kohn: Thank you—the ministry engaged in other activities to support the sector to remain safe and available during the pandemic. We applied for and have renewed emergency staffing orders that allow community agencies the same degree of flexibility to deploy staff for purposes necessary for safe service continuity.

We were also successful in including front-line essential mental health and addictions staff in the pandemic pay

initiative, and we've benefited from sitting at the provincial Mental Health and Addictions COVID-19 Response Table, chaired by the Mental Health and Addictions Centre of Excellence at Ontario Health. These weekly meetings have enabled government and Ontario Health to stay aware of local needs and to address those needs in very meaningful ways. This has resulted in our ability to understand and respond to emerging system needs, which has been at the core of supporting the sector to remain safe and available during the pandemic, including understanding where the pressure points were in the system and where investments were needed to provide ongoing support.

It's critical to note that the core of our long-term plan to address system-level challenges and to support ongoing and increasing mental health and addictions needs as we move into the recovery phase is the Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System—or, as we like to call it, the road map. The road map lays out a detailed plan for creating a comprehensive and connected mental health and addictions service system, offering Ontarians high-quality services and supports through four pillars: (1) improving quality; (2) expanding services; (3) implementing innovative solutions; and (4) improving access. It's a plan supported by historic investments but also a plan focused on making long-lasting system-level improvements to this vital part of the health system.

Supporting the goal of transforming the sector is the Mental Health and Addictions Centre of Excellence within Ontario Health. The centre of excellence has been tasked with leading the implementation of the road map on the ground.

The Acting Chair (Mr. Tom Rakocevic): We're out of time.

Now we're up with the opposition for 20 minutes. MPP France Gélinas.

M^me^ France Gélinas: I will be testing everybody's memory. When I was last asking questions, I was talking about home care. I had started to share problems we were having with the new client-partner scheduling, where the patients and their families basically argue with their providers as to when they will be coming to provide the care. Don't get me wrong; for some of them it has worked and the better relationship helps—for some of them. When it does not work—the families who reach out to me feel like they will give them a time which they already know through conversations is not good, and they feel that they're using this to say, "Oh, the clients refused care." It's not the case. The case is that she needs help getting up in the morning and going to bed at night, and for the workers to come in at 10 in the morning is too late. She has to go to the bathroom before this; she has to be up. And for her to be put into bed at 3 o'clock in the afternoon is no good either. Who wants to go to bed at 3? They want the workers to come later on.

Is there a way to know that—it's Bayshore that has the contract—does not get to bill for those missed visits? I'll leave it up to you. How does that work? When is Bayshore allowed to bill for a missed visit when, really, what they were offering was not acceptable, and they knew that it was not acceptable?

Ms. Amy Olmstead: Amy Olmstead, acting executive lead of the Ontario health teams division.

This is really helpful feedback, MPP Gélinas.

I don't have the specifics regarding the rules of when a service provider organization can bill for a missed visit. They tend to be when, for example, the personal support worker shows up and the client isn't there, but I don't know the specifics of other rules.

I think you've identified a really important interaction between the rules about when a service provider organization can bill for a visit and our client-partner scheduling and these important considerations about the timing of visits. I appreciate that you've identified that for some clients this approach is working, because we do hope that it can help spread some care out during the day. But to your point, not all care can be provided in the afternoon or late mornings. Sometimes it does have to be first thing in the morning and in the evening.

What I'd like to do is take this back. I'm happy to get some additional information, and I look forward to working with Home and Community Care Support Services to reflect further on the particular issue you've identified.

M^me^ France Gélinas: If you don't mind, given that we still have eight hours, I will probably come back to you in a couple of days to see—as I say, the relationship is not good right now. The client is not happy, so they want to make sure that Bayshore does not get paid for visits that they knew full well would not work. I'll leave it at that.

Bayshore has most of the contracts in my riding. When they have not been able to get a PSW—she's scheduled to have two hours of home care every day, 14 hours a week. Bayshore can only provide one hour of home care through the entire week. They have identified a PSW who lives in the community who would be available to do the care, but I'm being told that they're not allowed to go out of contract. But last time I talked to you, you said if the regular contractor cannot do the work, then the community support sector would be allowed to go out of contract. I want to make sure of that.

Ms. Amy Olmstead: We have seen with Home and Community Care Support Services organizations where their contracted providers, providers with whom they have a current contractual relationship, aren't able to provide the care. They can go to other providers on the pre-qualification list. Things are more challenging if there isn't another provider on the pre-qualification list who is operating in that area, so that's a consideration.

Another option for families who are finding that the regular home care model is not fully supporting their needs is the Family Managed Home Care Program, where the client or their family can hire directly a personal support worker in their community. It doesn't have to be a personal support worker who is working for one of the contracted providers of the LHIN. They don't even have to be working for another employer or a service provider organization. That program, when it was originally created, was

aimed at, for example, families with medically complex children, but we have seen that Home and Community Care Support Services organizations have looked at that program where their clients are having trouble with getting the regular consistent care that is in their care plan. So that is another option for clients as well.

M^me^ France Gélinas: I'm very familiar with the Family Managed Home Care Program. I talked to my LHIN's home and community care supports—I forget the new names—HCCSS. They tell me that they have no more money for the Family Managed Home Care Program, but from what you're telling me, there isn't a set amount of money that they get for this program; they just use their resources to redirect to the Family Managed Home Care Program rather than, I'll use, Bayshore or—it doesn't matter—rather than the regular. Am I right?

0920

Ms. Amy Olmstead: MPP Gélinas, your memory is much fresher than mine of our last conversation, when we spoke about the Family Managed Home Care Program.

Yes, it is funding that is part of the regular home care pot that the Home and Community Care Support Services organizations have access to. The Home and Community Care Support Services organization may be looking at its budget for the year and forecasting that, in serving its current clients, it may not have additional funding. But because this is a client that is an existing client, that should be considered part of their ongoing service delivery.

M^me^ France Gélinas: Okay. I will pass it on to my colleague Judith Monteith-Farrell, who has a question. Thank you.

The Acting Chair (Mr. Tom Rakocevic): MPP Monteith-Farrell.

Ms. Judith Monteith-Farrell: Good morning, everyone.

I had a chance to ask this question, but I think the answer didn't meet the question because I think there was some confusion, because I was asking about two things. One was about that there was a lack of midwifery support for people who live close to places where that is available—so people who are eligible for the Northern Health Travel Grant Program cannot access midwifery programs. They can go to an obstetrician in a community to get that care, but they can't go to a midwife. That was one issue, and that's what was addressed.

The second part of my question is something that Dr. Rodrigues from Atikokan brought to my attention. Dr. Rodrigues is a woman who has done care up in the Northwest Territories and across the world, actually, and has ended up in Atikokan, and they're very lucky to have her. But she doesn't practise obstetrics there; she practises family medicine. She has brought to my attention that women can go to Thunder Bay to get their obstetric care and the Northern Health Travel Grant Program will support them, but when they're nearing the end of their gestation period, they are advised by the doctor, their family doctors and their obstetricians in Thunder Bay to come to Thunder Bay for a week or two before their due date, and there is absolutely no support for them.

For First Nations women, there are organizations and they receive support through the First Nations and Inuit health branch to get support to stay in Thunder Bay in a safe environment.

Why this is important is that it's a saving to the health care system if we would provide that care. These women are staying in Atikokan because they don't have the financial resources to stay in Thunder Bay for that period of time. They are staying there and then they are getting a crisis, so then they either have to be airvac'ed out, which is about $25,000 is my understanding, or land-ambulanced, which is also leaving their communities—because they only have one ambulance—without any ambulance for a period of four or five hours.

She described a situation—and why she feels so passionately about this—about attending in the ambulance with a woman in crisis. The baby and the mother both had complications because of that, because they weren't able to get that care immediately. To sort of give you an idea of what this problem is like, they're having a baby boom in Atikokan, and there were over 50 births. She said each one made her nervous and she was very concerned about these women's health and the health of the babies.

So I'm asking, can we consider this as an amendment to the Northern Health Travel Grant Program? It would make financial sense. If we have to evacuate these women, because they can't give birth in Atikokan in very short order, then what are we doing for those women, and why isn't the Northern Health Travel Grant Program looking at those kinds of savings, really, and also the safety of those mothers and babies?

Hon. Christine Elliott: Thank you very much for your question, MPP Monteith-Farrell. This is an issue of concern. I know we had a discussion about this in our last meeting. I would refer this to ADM Patrick Dicerni, who would be the expert in this, to answer your question, please.

Mr. Patrick Dicerni: I'm ADM Patrick Dicerni. I'm the ADM in our OHIP and drugs and devices division at the Ministry of Health.

MPP Monteith-Farrell, thank you very much for the question.

Picking up on a little bit of our dialogue from last week: As a component of our three-year agreement with the Association of Ontario Midwives, part of that is to look at areas like you speak of, where there is need, with limited obstetrical services and care provided, and to support those areas of high need for midwifery care and some unaccommodated patients. So I would like to suggest that some of the challenges that you've unpacked and walked through there will be mitigated to some degree by those targeted investments looking at how to expand, as I said, high-needs obstetrical care. At the heart of your question is some of the challenges with complex and acute services in northern Ontario.

With respect to how we would potentially look at modernizing or adapting the Northern Health Travel Grant Program, I'd want to understand a little bit more deeply about the ride-along issue that you touched on.

Apologies to you and the Chair; I did accidentally sign out of the meeting partway through your question, and that is entirely on me. I apologize to the committee and members. So I did, unfortunately, miss a portion of your patient's story, but I would be happy to take that as an undertaking and refer to Hansard, as opposed to making you repeat yourself.

Ms. Judith Monteith-Farrell: I think the crux of the matter is that we have not just one case—there was one dire case that was recent—but this is that these women receive no support when they're directed by their obstetricians to be close to the hospital or close to where they're going to give birth, and they can't afford to do that on their own. Some may have family, but there is a large group of women who are unable to do that. They wait in Atikokan for the birth and then they have to be either medevaced out or they have to have an ambulance come and get them, which leaves the community—both are expensive options.

What we're encouraging, and what this doctor is strongly advocating for, is to have those women supported in Thunder Bay, with financial support so they can actually reside in Thunder Bay for the period right before their births, so that they're close to care.

Mr. Patrick Dicerni: Thank you very much, MPP, for the details there.

With respect to Dr. Rodrigues's suggestions, previous dialogue is accurate by way of, the Northern Health Travel Grant Program does not specifically apply to the midwifery services that we were discussing time last.

With respect to patients who have transited into Thunder Bay for the purposes of giving birth, I'm happy to take that feedback. If it's more than a single case and what you are seeing is a systemic issue, the team and I would be happy to look into that matter.

Ms. Judith Monteith-Farrell: Thank you. Back to France.

M^me^ France Gélinas: I'm in the estimates, and in the estimates we see— I'm curious to see how you account for alternate health facilities. I know that facilities like Hillcrest in Toronto provide less acute care to patients. For Hillcrest, they have contracted with a home care agency. Is all of the funding for those alternate health facilities included into the hospital operations line in the estimates, or should I look for that money elsewhere?

0930

Hon. Christine Elliott: I am going to turn it over to the deputy minister for that specific question that you have, and you may refer to someone else.

Ms. Helen Angus: Helen Angus, Deputy Minister of Health.

I think I know the answer, because I don't think we have a dedicated line for alternate health facilities, but I might ask Peter Kaftarian, who is our chief administrative officer, because it's about where the HFs fit in terms of the line. Peter? I'm pretty sure it's in the hospital line.

Mr. Peter Kaftarian: Peter Kaftarian, chief administrative officer, Ministry of Health.

I'm just trying to get clarity myself from my brief.

The Acting Chair (Mr. Tom Rakocevic): We're at just about two minutes.

Mr. Peter Kaftarian: I think if you go to page 109 of the briefing book under—when you talk about alternate health facilities, are you talking about independent health facilities or is there another—

M^me^ France Gélinas: No, not IHF. I will be talking about this; if you have it now, you could tell me that now. I'm looking for alternate health facilities, as in hospitals that were allowed to open up beds in alternate health facilities, like Hillcrest did, like Health Sciences North did. A whole bunch of hospitals did that.

Mr. Peter Kaftarian: My understanding is, that would be within the hospital purview. I see Associate Deputy Minister Melanie Fraser's camera has come on, if she wanted to add. But that should be within the estimates briefing book. It should be within the hospital vote.

M^me^ France Gélinas: So line 1416-1, this is where it would all be? In there?

Mr. Peter Kaftarian: That's my understanding. I know we're almost out of time, so when we come back in the next 20 minutes, I can confirm that with certainty.

M^me^ France Gélinas: Okay. Melanie, if you have it at the top of your head, let me know.

Ms. Melanie Fraser: Melanie Fraser, associate deputy minister for health services.

Peter Kaftarian is correct. The alternate health facilities opened by the hospitals would be funded through the hospital line. What I will say is that some of that funding is being expensed as we see the pandemic evolve, and so, as we're surging up to meet demand, we would be providing reimbursement to hospitals for expenses to be submitted. We have voted estimates, as you see, for what we think those expenditures will be, but there is a reconciliation yet to happen.

The Acting Chair (Mr. Tom Rakocevic): We're out of time.

Before I go over to the government speaker, just to let you know, I will be giving you the two-minute warning, but I think I should also give you a really quick 30-second warning so you can wrap up your thought and it's not so abrupt.

Let's proceed to the government side. MPP Martin.

Mrs. Robin Martin: Thank you, everybody, for coming today.

Minister, one of the things I'm wondering about is, with our massive undertaking to roll out the vaccines, part of our effort has been really reaching into every corner of the province, and it's a huge province—and I know this is always a challenge in Ontario because Ontario is bigger than some countries. I really just wanted to ask about Operation Remote Immunity, which I've heard some things about, that I think was under the auspices of Dr. Homer Tien, and how this effort, which I understand was a collaborative effort with some of our partners, came together to administer vaccines to some of the most vulnerable and remote communities in all of our province. I wonder if you can elaborate a bit on how that went.

Hon. Christine Elliott: Good morning, MPP Martin. I would be very pleased to speak with you about Operation Remote Immunity.

Our government is continuing to roll out our three-phase COVID-19 vaccine distribution plan to ensure Ontario is prepared to receive, store and administer COVID-19 vaccines as soon as they become available to us. The plan is informed by medical experts and the COVID-19 distribution task force, and prioritizes vulnerable populations that are at the greatest risk of COVID-19 and severe illness and those who care for them. We continue to work to ensure that the vaccine gets to our most vulnerable first, followed by immunization across Ontario, where everyone can have access to the vaccine.

We know that adults in First Nations, Métis and Inuit populations living in remote or isolated areas required early access to the vaccine, as the infection can have disproportionate consequences, and we recognized the critical importance of engaging Indigenous leadership in how vaccines are offered to their communities. So we co-developed a plan, in partnership with Nishnawbe Aski Nation. The Ministry of Health, Ornge, the Ministries of Indigenous Affairs, the Solicitor General and Natural Resources and Forestry and federal government partners collaborated with NAN to develop Operation Remote Immunity.

Operation Remote Immunity was a plan led by Ornge to roll out the COVID-19 vaccine to adults 18 and over in 31 northern and fly-in communities and Moosonee. The operation began on February 1 and was completed on April 28. Operation Remote Immunity was a resounding success, administering over 25,000 vaccine doses to help ensure that remote Indigenous communities and residents are protected from the COVID-19 virus.

NAN Grand Chief Alvin Fiddler recently wrote to Minister Jones and me to convey the gratitude of the NAN executive council to Ornge for the thoughtful, collaborative and respectful approach in delivering Operation Remote Immunity to the remote communities. Because of the success of Operation Remote Immunity, health partners in the area are better positioned to continue the vaccination efforts. The letter also acknowledged Ornge's vital role as an air ambulance and critical care provider to communities like the NAN First Nation.

I'll now turn to my Deputy Minister of Health and assistant deputy minister of emergency health services to elaborate further on Operation Remote Immunity.

Ms. Helen Angus: Thanks for the question, MPP Martin.

Operation Remote Immunity was designed to support the first phase of the government's COVID-19 vaccine distribution plan and to make sure that the vaccine got to the most vulnerable first, and in particular, adults in northern and remote Indigenous communities, where we knew that infection could have devastating consequences. We learned from the H1N1 pandemic back in 2009 that Indigenous people living in remote and isolated communities in Canada were disproportionately impacted and experienced the worst outcomes, and we certainly did not want that to happen this time.

Indigenous adults in northern remote communities were prioritized to receive the vaccine, due to the unique geographic, social and infrastructure challenges that exacerbate the risks posed by the pandemic. We also recognized the critical importance of engaging the Indigenous leadership during the COVID-19 pandemic and reached out to the Nishnawbe Aski Nation to determine how the vaccines would actually be offered to the northern remote communities. We co-developed a plan in partnership with NAN, and I think that was really key to its success.

As the minister mentioned, the Ministry of Health, Ornge and our colleague ministries at Indigenous affairs, the Solicitor General and natural resources, as well as the federal government, all worked with NAN to develop Operation Remote Immunity. The plan that was developed incorporated the engagement of Indigenous leadership in identifying the remote communities that we would go to, that would actually schedule the visits, that would communicate information about COVID-19 vaccines, and that would work to address vaccine hesitancy and identify leads in each community to work with the ORI team.

I think the role of that community connection was really key to the success of the operation. I would say that, through this and other efforts, it shows how much the government values our relationship with NAN. And I would be remiss if I didn't mention our thanks to the NAN executive council and, of course, to Grand Chief Fiddler for their unwavering leadership and collaboration with the government to ensure that we developed an effective and culturally appropriate approach to vaccines in the remote communities.

Through this operation, we were able to administer over 25,000 vaccine doses and protect over 31 fly-in First Nation communities as well as Moosonee as a result.

0940

I'll ask Susan Picarello, who is the assistant deputy minister of the emergency health services division, to give you a bit more information about the operation. I think it's something that we can all be very proud of. Susan?

Ms. Susan Picarello: Susan Picarello, assistant deputy minister of the emergency health services division.

Thank you, Minister and Deputy, for giving me the opportunity to talk about Operation Remote Immunity in a bit more detail.

I think we've covered many of the highlights, but I wanted to also flag that it has been from the beginning that Indigenous remote communities have been prioritized by the government for vaccination and that Chief Archibald has been put on the task force as a wonderful voice for the Indigenous community at the vaccine task force table.

Back in November and December, the Ministry of Health, the Ministry of the Solicitor General and Indigenous Affairs Ontario as well as the Ministry of Natural Resources and Forestry met to talk about how we could deliver the vaccines to the northern communities. Right from the start, we knew that engagement with NAN and partnership with NAN was key to the success, so we co-developed the plan with NAN and developed it with the people on the ground, about how the communities would be set up and how we would work forward.

One of the things that we did right from the beginning is engage NAN in the discussions that we had. It was decided that Ornge would be the best deliverer of that service of getting the vaccines out, so we engaged with Ornge and ensured that that was something that we moved forward with. Ornge was chosen because, as everyone knows, they provide critical care services to the north and are very important and have great relationships with the NAN communities. It was also NAN's choice that Ornge be selected.

Throughout the process, we ensured that there were constant communications. Indigenous Affairs Ontario, along with Ornge, had weekly meetings with the NAN chiefs. The Ministry of Health—my division, the emergency health services division—as well as the public health Indigenous unit partnered with all of the ministries, including the Solicitor General and natural resources, and had weekly and almost daily meetings to roll out the vaccine to the north with Ornge. We wanted to ensure that Ornge and the communities had one window and one communication throughout the entire process.

In addition, we engaged the NAN chiefs in all of the different tribal councils. Dr. Tien met with each individual tribal council and ensured that we met the needs of each local community. We also ensured that they had a voice at the table every step of the way so that we could address vaccine hesitancy and ensure that the leadership was on board with what we were bringing forward. Many of the leaders, including Chief Fiddler, were at the forefront of this and were on radio shows, were tweeting and were using all types of social media to get the word out about the vaccine effort. In fact, during the soft launch that we had in January, it was Chief Fiddler's mother who had the first shot at one of the long-term-care homes in the north. He posted that and said it was one of the most wonderful times of his life, that his mother was one of the first to get the vaccine. So again, it really showed the leadership at the NAN level to make sure that people understood and wanted to get the vaccine.

We used the Moderna vaccine because, at that time, it was the easiest to actually travel with and move forward with. We ensured that before we went in to any community and before Dr. Tien and the teams went in, there was an understanding of the importance of vaccination, but also that there were questions answered. We ensured that all documentation that was provided on the vaccine was translated into the three Indigenous languages and that people had the opportunity to ask questions, not only of their leadership but also medical professionals. We did have Dr. Tien go on many different avenues and talk about the vaccine. We also had Dr. Bruce Sawadsky, who is Ornge's medical adviser, do that as well.

Again, this was really a group effort. I have to acknowledge that we also worked very closely, as did NAN, with the federal government and the First Nations and Inuit health branch, in providing them support. We also got support from the Canadian Rangers, and that was very key to helping set up the clinics prior to the teams going in.

One of the other key elements was the use of the public health units and the support of the public health units. So I do have to give a shout-out to the three public health units in the north, the Thunder Bay public health unit, the Northwestern public health unit as well as the Porcupine Health Unit; as well as the two health facilities in the north, the WAHA facility as well as the Sioux Lookout facility. They were really key in helping to distribute the vaccine but also in helping to deal with vaccine hesitancy.

The most important was the role of Ornge in helping us get to the communities but also helping us get the health human resources we needed for the mission. I have to say that, at first, we were very nervous about whether we would be able to get a lot of health human resources, but the overwhelming support we received from the medical professionals was really amazing. We got health professionals from all over Ontario. Not only did we get paramedics, but we got nurses, doctors, and we got medical students from the northern medical school and U of T and Queens. So it was really a group effort. We got such positive reinforcement and positive comments about the mission from various doctors tweeting and people saying it was a life-changing experience for them—both for the NAN community members and for the health professionals who went to the north.

All of the health professionals and everyone who went north had to complete cultural sensitivity training to learn about Indigenous communities, and we did get very positive feedback that people really learned about the Indigenous culture and Indigenous communities. I think that really helped bring everyone together in this journey to give the vaccines.

Also, we made sure that all of the health care workers who went north were doubly vaccinated. That was a request of the NAN communities, because they had been so isolated and because COVID-19 can have such a devastating impact on those isolated communities. We did ensure that that occurred. We also continually learned as we went from community to community and continually built in that public education component.

The other thing we did was we, again, throughout the whole process, continued to ensure that there was public education throughout. Again, if I can reference Chief Fiddler, who was an amazing, amazing spokesperson for the vaccine effort in the remote Indigenous communities—he also tweeted out his own shot himself, where he was given it by his sister, who is a health care professional. Again, this really helped us address the vaccine hesitancy in those communities and made it very much a community event.

As I mentioned, members of the community helped to set up the clinics. They were right there from the beginning, planning and getting all the paperwork done. If it weren't for those individuals in those Indigenous communities, we would not have been as successful as we were. They ensured that people were prepared, that they had their questions answered ahead of time and that their appointments were booked. That was a really, really important aspect. I really think that oftentimes we don't thank the people who were on the ground. We talk about the people, the names that we know—but it was those

people, on a daily basis, we talked to. So I have to really thank them—and also really thank Ornge for their leadership. If it were not for Dr. Tien and his tireless efforts, and his team, working on Operation Remote Immunity so diligently with us, I don't think it would have been such a success. Really, his tireless work in engaging the communities was very important.

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I know it sounds terrible, but I think everyone really had fun doing this, knowing that we were doing something important for the people of Ontario.

I just want to take a moment to thank again the members of the Ornge team—not only Dr. Tien, but Wade Durham, who was the CEO and did a lot of that work, as well as Todd Pittman, who was the chief of staff for Ornge Operation Remote Immunity, and Dr. Bruce Sawadsky, who is the medical director of Ornge and was key to the operation.

Again, also, to thank the public health units that were involved—and also the WAHA and the Sioux Lookout health authority. Without these tireless individuals who worked—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Ms. Susan Picarello: —in addition to their day jobs to actually make Operation Remote Immunity a success, we would not have been able to get over 25,000 shots in arms, as we say, and get so much of the communities vaccinated.

Now that the government has announced that the Pfizer vaccine can be used for youth 12 to 17, Operation Remote Immunity 2.0 is in the planning stages to actually go north and support those 31 fly-in communities and Moosonee with the vaccination of the youth in the north. So stay tuned; there will be more on Operation Remote Immunity 2.0.

Again, this, I think, was a very good example of collaboration at all levels of the government—the province, the federal government, numerous ministries, Ornge, and of course, the NAN partnership and the health care professionals who we could not have done this without.

So, again, on behalf of everyone—because it really was a collaborative effort—I just wanted to acknowledge Ornge and Dr. Tien for their important work, and Chief Fiddler for the important work of the NAN communities and making this a success.

The Acting Chair (Mr. Tom Rakocevic): MPP Martin.

Mrs. Robin Martin: Thank you very much, ADM Picarello, for all of that information about that. That certainly was a lot more detailed than I was aware of. I really can tell that it was a heavy lift to do all of that, but very necessary. It's nice to hear that all of the parts of our health care system and our governments and public health and—

The Acting Chair (Mr. Tom Rakocevic): Thank you. We're out of time.

We're going to move on to the official opposition now for 20 minutes. MPP France Gélinas.

M^me^ France Gélinas: My question continues to have to do with the estimates. I'm looking at the line item—if you're interested, 1416—in the estimates that deals with hospitals. I'm curious to know, are the four private hospitals in a separate line or are they in the same line as the 142 public hospitals, in the estimates book?

Hon. Christine Elliott: Thank you very much for your question, MPP Gélinas. I will refer this to the deputy minister, because it is a very—

M^me^ France Gélinas: I think we have five private hospitals, not four.

Ms. Helen Angus: I think that's right. I don't think that has changed over the years.

Again, I think that the vote items are at a level that the private hospitals would be. I'll just ask Mel Fraser to confirm that, but that would be my understanding.

Ms. Melanie Fraser: Again, that is my understanding, but I'm going to phone a friend on this one as well and ask Tara Wilson, who has just appeared on screen and is the director responsible for that program area, to confirm that.

Ms. Tara Wilson: Tara Wilson, director of the hospitals branch.

I actually have a team set up with my team called "call a friend," so I'm just double-checking with them. If I don't hear in the next minute or so, we can bring it back—but I believe so, as well.

Okay, it's something that I can definitely bring back. It's all in it together, within that item.

M^me^ France Gélinas: Okay. My Internet connection isn't stable, so all I got out of this is that it's all one line item.

If I want to know everything that funds the hospital, are there other lines within the estimates that fund hospitals? I'm looking at 1416-2, the cancer treatment services. Are cancer screening programs funded as part of hospitals, or are they funded into different line items in the estimates?

Ms. Tara Wilson: I might actually let my colleague Kristin Taylor answer that one, in terms of having oversight of the cancer screening program, but I would just note that in general, yes, there is more than just that one line that goes into hospitals. As an example, there might be programs that are run out of the hospitals, and that would be a priority programs line, where the funding goes to the hospital for them to run that transfer payment agency out of that hospital.

M^me^ France Gélinas: I will come back to this, but for now, if I look at 1416-2, cancer treatment services, those are funnelled through hospitals; am I right? How does it work?

Ms. Tara Wilson: I wonder, Kristin, if you might want to comment on this one.

I know, having previously had oversight over the program, that there's a good amount of the cancer system that is funded through the hospitals, through Ontario Health and the former Cancer Care Ontario. So those are funded sort of directly through there. But I believe there may also be some other clinics and whatnot that are separate from the hospitals.

Ms. Kristin Taylor: It's Kristin Taylor, director of provincial programs.

Tara is correct: The majority of cancer funding is flowed through Ontario Health—formerly Cancer Care Ontario—and then to the hospitals. So a significant portion of it does show up in a separate line.

M^me^ France Gélinas: And is it the same thing for the cancer screening programs?

Ms. Kristin Taylor: Yes.

M^me^ France Gélinas: Can one of you give me a list of all of the lines that end up being funded through our hospitals, whether it is through the old Cancer Care Ontario or Ontario Health, but ends up funding our hospitals? Do you have this handy some place, or can you put that together?

Ms. Kristin Taylor: We can certainly put that together. So you're looking for all the lines that would ultimately end up funding a hospital. Is that correct?

M^me^ France Gélinas: Yes.

Ms. Kristin Taylor: We can pull that together and have that ready.

M^me^ France Gélinas: Okay. That sounds good.

Coming back to comments that Tara Wilson mentioned: What exactly does "community and priority services" refer to? Could you give me an example of what's in there?

Ms. Kristin Taylor: I don't want to over-speak for my colleague and friend Tara, but priority services falls within my portfolio. It's a pretty broad range of services, but some of the examples would be the cardiovascular funding, neuro services funding, funding for bariatric services, funding for cochlear implants. I'm trying to remember some of the others. It is a very broad range. Those are funded on a price-times-volume basis, so we fund hospitals based on a funding rate to do X number of volumes for those procedures. That's what "priority services" means—as opposed to Tara Wilson and hospitals branch funding, which is global budgets.

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M^me^ France Gélinas: When it says "community and priority services"—does any of that money go to community agencies, or are they all flown to hospitals?

Ms. Kristin Taylor: That's a really good question.

There is more to community and priority services. I only have oversight of the priority services side, so I would look to my colleagues. It might be Peter Kaftarian who would know what falls into that line beyond the hospital services. We can certainly go back and find out.

M^me^ France Gélinas: Before I let you go, just in case you're the right person: What do you mean by "operation of related facilities"? There's a list item—I'm at 1412-1, "provincial programs." You have "operation of related facilities" under this. It looks like it's something that the hospital operates. I don't know what that title means.

Ms. Kristin Taylor: It's not an obvious title. That includes all the things that are non-hospital. We have AIDS and hepatitis C funding that goes to community. We fund Trillium Gift of Life—or formerly Trillium Gift of Life, now Ontario Health. That was under that line. CorHealth, who is the transfer payment recipient that provides guidance and expertise on cardiovascular and stroke care—those are examples of items that are within "operation of related facilities."

M^me^ France Gélinas: So they are provincial programs. I know most of them. They go under "operation of related facilities." They have nothing to do with hospitals.

Ms. Kristin Taylor: Correct, they're non-hospital recipients of funding.

M^me^ France Gélinas: Okay. Coming back to the line "community and priority services": You were very helpful with the priority services. I still don't know what's included in the community part of this.

Ms. Kristin Taylor: We can certainly go back and provide you with a breakdown.

M^me^ France Gélinas: That would be appreciated. Or would Peter have the answer off the top of his head, or no?

Mr. Peter Kaftarian: The kinds of things that would fall under "community and priority services" would be buckets including assisted living, community health centres, acquired brain injury, community mental health, addiction programs—things of that nature. There is some funding associated with hospitals, and those would be the key buckets.

M^me^ France Gélinas: Thank you. I also saw line 1405 that deals with independent health facilities. Is there anywhere where we can get a breakdown as to how much each independent health facility is either budgeted to receive or is planning to receive? And if it's not independent health facilities, maybe by groups of independent health facilities—is there any breakdown that we can get out of line 1405?

Mr. Peter Kaftarian: That's something I'm going to have to take back and look into. I don't have that off the top of my head.

M^me^ France Gélinas: Okay. Then, right under 1405, 1405-1—how much is budgeted for physician services, and what are the other practitioners that are included in 1405-1? Are there any?

Mr. Peter Kaftarian: Can you give me a page reference, please, to what you're referring to in the briefing book?

M^me^ France Gélinas: No, I can't because I'm working from—I pulled it out so that I would have my questions all together because I only have one screen.

Mr. Peter Kaftarian: Okay, apologies. Let me take that one back as well. I can look into that one for you.

M^me^ France Gélinas: Okay. And my last one in the 1405 is 1405-2. This is the Ontario drug plan. I know that we have—I'm going by memory—six or seven different drug plans, but I've never seen the breakdown as to how much money goes to the different drug plans. Are you guys able to break this down? How much money is included for the different drug plans that we have in Ontario?

Mr. Peter Kaftarian: I'm familiar with your question, the breakdown. I'm just looking into the actual estimates, because I think it's rolled up at a congregate level. You're looking for a detailed breakdown by type; is that correct, Madame Gélinas?

Mme France Gélinas: Correct. All I could find in the briefing book was under 1405-2, where you say "Ontario drug programs." I'm fully familiar with the fact that we have more than one. I can't remember if we have six or seven, but we have quite a few. I would be interested to see, on the different drug plans, how much money we spend.

Mr. Peter Kaftarian: Yes, I know that in the estimates we report it at a congregate level and there are different components. We can take that back. Unless ADM Patrick Dicerni would like to add anything, we can take away that question and see what's possible.

Mr. Patrick Dicerni: Thanks for the questions, MPP Gélinas.

Going back two questions ago: You had inquired about additional health service providers that are in the physician services line. That is, broadly speaking, dentists, optometrists, podiatry services—so the funded and insured services that are delivered by professionals other than physicians. That's what makes up that group, those are the practitioners. And as we've likely discussed in forums similar to this, emergency dental services that are provided in-hospital by dentists would fall in there, optometry and, as I said, podiatry-related services.

Mme France Gélinas: Not physiotherapy?

Mr. Patrick Dicerni: Very good question. Physiotherapy, if you would allow me to take that back, or just give me—no, physiotherapy services would not be in there, given the programmatic changes in 2013 or so.

And with respect to your question that you had most recently asked, apologies to ask, could you repeat your most recent—oh, the Ontario public drugs question, of course. You're right, there are seven Ontario public drugs programs. In the estimates it is not broken down across those, but I'm happy to provide that breakdown in subsequent discussions.

And just for your information and for the information of the committee, the vast majority of expenditures existing in the Ontario Drug Benefit Program are our seniors drug program, the ODB, and there are much smaller, I would say, condition- and population-specific drug programs. One example is a rare but significantly popular eye issue, eye disease, that we have a specific program for. But we would be happy to provide explanations and breakdowns against that.

Mme France Gélinas: Okay. Is it possible, also, in the 1405-1, the budgeted-for physician services—I understand that dentists and optometrists are in there. Is it possible to have a breakdown as to how much goes to physicians versus dentists versus whoever else is in that line?

Mr. Patrick Dicerni: Yes.

Mme France Gélinas: And how about the independent health facilities? You have been very helpful, so I will repeat the question that I had put forward. Is there any way to get a bit of a breakdown as to how much is budgeted for the different health facilities—and I would prefer by health in the IHF, but if it's not by IHF, by groups of them would be helpful also.

1010

Mr. Patrick Dicerni: I'm happy to take that back. I would be happy to commit to providing a breakdown of groups of services. I just don't want to overcommit on individual-level IHFs of the 900 IHFs there are in the province. But broadly speaking, we can apportion the budget across those categories: vision and eye care, a very small amount of surgical services, a great deal of diagnostic and imaging services, and abortion services are in there.

Mme France Gélinas: Thank you. Coming back to the different Ontario drug plans, focusing on the main one: Minister, yesterday in question period, you answered a question from MPP Cho about the review that is being done right now for some cystic fibrosis drugs with the view of adding some of those new drugs to the formulary, and I was—just an update on that, if you can share, and how much money in the estimates or elsewhere is targeted at being able to add those very expensive drugs to the formulary?

Hon. Christine Elliott: Thank you very much for your question.

I believe MPP Cho was speaking about the drugs during his statement; it wasn't actually a question to me.

We have been looking at all of the drugs for cystic fibrosis.

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Hon. Christine Elliott: I believe the deputy minister will be able to give you more specific information about the funding for the particular drugs.

Ms. Helen Angus: I'll sk Patrick to give us a little bit more. I think we would give you kind of a general idea of the class. Obviously, we're still in negotiations with many of the manufacturers, so I'm not sure we're going to—we've budgeted specifically for specific drugs. Perhaps, Patrick, you can just talk a little bit about at least the numbers of patients and the state of the negotiation.

Mr. Patrick Dicerni: I'm happy to. Thank you for the question.

As the deputy said, given that we are in the midst of negotiations with the manufacturer for many of the new and emerging drugs in this category—the manufacturer there being the Vertex company—I would not be able to go into specifics by way of allocation, given that does prejudice and, to some extent, compromise the ability for us to drive through a good negotiation.

But stepping back, I assure you that the challenges that are represented by cystic fibrosis to those patients, to their families, is something we take extremely seriously. The advent of new, innovative drugs in this space—I think a product you and your colleagues likely have heard about, Trikafta—

The Acting Chair (Mr. Tom Rakocevic): You have 30 seconds.

Mr. Patrick Dicerni: —is a new and emerging and potentially quite promising drug in this space. It is also a significantly expensive drug.

It was the second week in June 2020 that Ontario, along with the pan-Canadian Pharmaceutical Alliance, was pleased to announce that—

The Acting Chair (Mr. Tom Rakocevic): We're out of time. Sorry.

We're going to quickly go to the government, because we only have two minutes left. So I won't give the warning; we'll just cut you off at two minutes. MPP Barrett.

Mr. Toby Barrett: Thank you, Chair. I'm cognizant of the fact that there are under two minutes to initiate this, but just to get things rolling—first of all, thank you to the minister and the personnel for again continuing to take the time on this committee.

As the Minister of Health will know, the federal Temporary Foreign Worker Program is vital for our agri-food sector. Normally, something like 22,000 people come in every year to plant crops, to process and pack, and to harvest. In my riding alone, Haldimand–Norfolk, we normally get about 5,000—it's down about 1,000—and people mainly from Mexico and the Caribbean in my area. These people are fantastic. They're out in the fields right now.

The Acting Chair (Mr. Tom Rakocevic): MPP Barrett, I'm sorry. We're out of time. We'll continue at 3:30.

Everyone, we will now recess until 3:30 p.m., following the afternoon routine of the House. Thank you.

The committee recessed from 1015 to 1530.

The Acting Chair (Mr. Tom Rakocevic): Good afternoon, everyone. Now the moment you've all been waiting for: We are resuming consideration of vote 1401 of the estimates of the Ministry of Health. There's now a total of seven hours and 48 minutes remaining for the review of these estimates.

When the committee recessed this morning, the government had 18 minutes and 47 seconds remaining. We will resume with the government side now. MPP Barrett, go ahead.

Mr. Toby Barrett: Thank you, Chair. I won't repeat the beginning of my question about temporary foreign workers.

As we've seen, health is a priority for these workers. We've certainly seen this from the Ontario government and locally with my Haldimand-Norfolk Health Unit, which has gone far beyond their requirements and resulted in restrictions—probably the most stringent restrictions in North America—with respect to temporary foreign workers. For example, to transport workers from Pearson airport—they are only permitted to have three workers in a vehicle. The last farm I visited before the stay-at-home order has 600 temporary foreign workers. You can imagine the horrendous logistics of transporting that many from Toronto down our way when you're only allowed three in a vehicle. So these restrictions have been very challenging for farmers, and the farm employers have been challenging many of these local restrictions as well.

Kudos to the Ontario government for initiating testing at the airport very early on when offshore people arrived, and for vaccinating people right at the airport. Of course, many are vaccinated once they get to the destination where they are working. I have received requests from some farmers over the past month or two for the government to take over quarantine at the airport, but most of the 22,000 workers have now arrived and are on their farms and out in their bunkhouses.

So my question would require, essentially—I guess I'm asking for a summary update of the Ministry of Health's commitment to this federal program and what we've been doing to help out and to fill in some of the gaps.

Hon. Christine Elliott: Thank you very much for your question, MPP Barrett. I know that this is a particularly important issue to you and to your constituents.

Each year, we look forward to the arrival of workers from many countries to work on farms and agri-food operations during the growing season. We know that it is important to make sure this happens as safely as possible.

My ministry, in partnership with the Ministry of Agriculture, Food and Rural Affairs, has worked to establish a number of supports for temporary foreign workers as they arrive in Ontario, such as removal of the three-month wait period for OHIP, rapid antigen screening for asymptomatic individuals, supporting public health units to provide vaccination of temporary foreign workers already in Ontario and, most recently, offering vaccination upon arrival at Toronto Pearson International Airport.

Our government is making every effort to protect worker health and safety. We have learned that collaboration is key to protecting agri-food workers, which is why we are working with our public health, municipal, provincial and federal partners and the farming community to help protect workers and stop the spread of COVID-19.

I'll now turn it over to the deputy minister for her remarks on this issue.

Ms. Helen Angus: Thank you for the question, and thank you, Minister Elliott.

I will talk a bit about our most recent initiative to support temporary foreign workers arriving in Ontario, and then I'll turn it over to Rhonda McMichael, the assistant deputy minister who has been working on this, to speak in more detail about what other supports we provided to temporary foreign workers.

Just to go back a little bit: On April 6, the government announced that, with a steady supply of COVID-19 vaccines expected from the federal government, we entered phase 2 of the vaccine distribution plan. Consistent with our overall approach of prioritizing populations for vaccination based on age and at-risk, temporary foreign workers were designated a priority population under the second phase of the vaccination plan. That includes people who live and work in congregate settings, as well as people who can't work from home, including those who work in agriculture, farm and food processing. We are working with public health units on a daily basis to ensure timely access to vaccines through all vaccine delivery channels, of which there are several, including pharmacies, mass vaccination clinics and mobile teams.

On April 10, we began to offer vaccines to temporary foreign agricultural workers arriving at Toronto Pearson

International Airport, as the minister highlighted, before they left the airport for transportation to their quarantine location.

Just to give you a sense of what has been accomplished, since that time, as of May 14, approximately 3,100 workers have consented to receive a Moderna vaccine, from a total of 4,500 airport arrivals.

I think Rhonda can explain a little bit more to you about how we're approaching this and how we're going to try to get to all the temporary foreign workers over the course of their stay here.

Ms. Rhonda McMichael: Thanks very much, Deputy and Minister Elliott.

I'm Rhonda McMichael, assistant deputy minister of population health initiatives at the Ministry of Health. I appreciate having the opportunity to speak to Ontario supports for the approximately 25,000 temporary foreign workers who come to the province each year.

As part of the efforts to reduce the spread of COVID-19, the ministry has committed to ensuring that all people in Ontario, including temporary foreign workers, receive the medically necessary supports they need during the COVID-19 outbreak. On March 19, 2020, the legislation and regulations committee approved an amendment under the Health Insurance Act to revoke the OHIP three-month waiting period and related exemptions to the three-month waiting period in response to the ongoing pandemic, and that amendment was put into force the same day. The amendment permits all new and returning OHIP-eligible residents to receive insured health services immediately upon re-establishing or establishing their eligibility for OHIP. Removing this three-month waiting period helps ensure that individuals access screening or treatment as needed, supporting efforts to flatten the curve of the infection and transmission of COVID-19. As of the end of March 2021, approximately 180,000 people were exempted from serving a waiting period by this change, including temporary foreign workers.

We've also, as the minister mentioned, rolled out the use of rapid antigen screening for asymptomatic employees, which provides an additional safety measure to protect agri-food workplaces by proactively identifying potential cases of COVID-19 that may otherwise be missed by routine workplace screening. Based on the successful use of rapid antigen screening across the province, we're expanding the use of these tests in more essential workplaces and sectors to quickly identify and help reduce the spread. This includes essential sectors such as primary agriculture production, food and beverage processing and key distribution centres.

I want to also provide some details on the vaccination of temporary foreign workers. As the deputy mentioned, we entered phase 2 of the vaccine distribution plan, and we knew it would be very important to ensure that temporary foreign workers were offered a vaccine. By offering the vaccine as soon as they arrive, individuals have the opportunity to build antibodies while in quarantine. This protects not only themselves but also their close contacts and the communities in which they live. Working closely with our colleagues at the Ministry of Agriculture, Food and Rural Affairs, we took the necessary steps to make this happen.

In consultation with migrant advocacy groups, we understood that it would be important that incoming temporary foreign workers be provided with as much information as possible before departure from their home country. We also understood the importance of providing information about consent and vaccines in appropriate languages, as well as ensuring culturally appropriate resources on-site. Our ministries continue to work together with foreign consulates to provide information on this opportunity to temporary foreign workers before they travel and have invited the consulates to have representatives on-site at the airport to assist with any questions.

While vaccination is voluntary and a personal choice, we strongly encourage workers to learn about the vaccine and consider getting vaccinated. Employment and pay are not affected by whether workers choose to receive a vaccine. For temporary foreign workers who arrived in Ontario prior to April 10, public health units have already been offering the vaccines on-farm through local vaccination clinics. We're pleased to report that nearly 10,000 farm workers who live in congregate settings and who arrived prior to the airport vaccination clinic have now been vaccinated by the local public health units. Those workers who have received their first dose at the airport or local public health unit will be offered second doses at the appropriate time by public health units in accordance with the provincial vaccination plan.

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While we can all see the light at the end of the tunnel, we still need to keep our guard up and do everything we can to keep our farms and workplaces safe. The Ministry of Health, in partnership with the Ministry of Labour, Training and Skills Development, has assisted in the development of the Ministry of Agriculture, Food and Rural Affairs Prevention, Control and Outbreak Support Strategy for COVID-19 in Ontario's Farm Workers. This strategy identifies 35 recommended actions to be taken by government, agricultural industry organizations, farmers and farm workers to prevent and contain COVID-19 outbreaks on farms. The implementation plan for the strategy provides a road map of actions, roles, responsibilities and priorities that will focus on protecting the health and safety of farm workers while maintaining operational viability of farm operations and the sector.

Implementation of the recommended actions are grouped into five areas with common objectives:

—adoption of best practices for farmers and workers, which are posted online as part of a tool kit and one-stop shop;

—cultural resources for workers: The government has provided resources for workers who come to Ontario in multiple languages and educational formats through engagement with community groups and consulates;

—temporary help agencies: ensuring compliance and minimum standard of conduct for temporary help agencies;

—housing: Local public health units conduct on-farm housing inspections less than eight months in advance of the arrival of workers, as per the requirements under the seasonal agricultural worker program. Some local public health units are conducting post-isolation quarantine spot checks on farm operations in light of COVID-19;

—and for the 2021 season, there has been a recommendation for an improved process that could better support Ontario's public health policies and guidelines for the prevention and control of COVID-19 on farms, in collaboration with the government and federal partners.

The province, along with our federal and public health partners, continues to monitor closely the situation on farms as we work together to keep our workers safe, avoid disruptions in the agri-food sector and reduce COVID-19 transmission on farms.

Thank you very much for the opportunity to highlight how we're supporting temporary foreign workers through the COVID-19 pandemic. We are happy to address any questions you may have.

Mr. Toby Barrett: Yes, maybe as a follow-up question—I'm referring to the local Haldimand-Norfolk Health Unit requirement, through the medical officer of health, that during the quarantine program, a farmer was only permitted to have three workers in a bunkhouse. Many of these bunkhouses can hold, say, up to 40 workers. I've lived in bunkhouses and I've done all of this work; I worked as a migrant worker myself. There was a challenge, as I mentioned in my original question, and there is an appeal process. That process was followed through.

I just wondered if you could explain to the committee what recourse farmers would have for what some of these restrictions—that they do consider onerous and are costing them a great deal of money. Certainly, last spring a large part of crops were either not planted or—for example, asparagus—were not harvested. So is there an appeal process that is available to people who are required to comply with some of these measures?

Ms. Helen Angus: I might be able to answer your question.

If I recall the circumstances in Haldimand–Norfolk at the time, there is an appeal process—it's the Health Services Appeal Board. I might ask Sean Court; I think it's in his area of responsibility. It is an administrative tribunal that actually allows for someone, whether it's a farmer or a business, to challenge a decision of a local public health officer implementing measures, largely under their section 22 powers. It does hold hearings and can, I think, overturn a local decision. I'm not a lawyer, but I believe that from there, as in many administrative tribunals, the next level of appeal is to the court.

I will ask Sean, who I believe has carriage of the boards, to talk specifically to the Health Services Appeal Board. It has other functions in addition to the work it would do in the public health domain.

Mr. Sean Court: Deputy, I think Peter is going to jump on. He's the one responsible for this one.

Ms. Helen Angus: Okay. I'm going back from years when it was in your portfolio, then. Peter?

Mr. Peter Kaftarian: Deputy, I think your overview there was good. I don't know how much more I could add to your summary level. If there's a desire to get into a further, deeper dive into the file, I'm happy to take it offline; that may be a better place.

Mr. Toby Barrett: Just a further question—I guess we have some time. I mentioned in my preamble a more recent requirement. I mentioned the example of one farm with 600 temporary foreign workers—there are a number of farms that have an employment complement of that size—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Mr. Toby Barrett: —and the requirement to get the 600 people from the airport to the farm, but in vehicles allowing only three people. That's an awful lot of travel. We're talking about a four-hour round trip, exposing them to a number of different drivers, as well. That was implemented by the local medical officer of health, not under section 22; that was implemented under section 7.0.2, under the reopening Ontario act.

Is that also something that would be taken before the Health Services Appeal Board? What is the recourse for something that—quite honestly, the farmers feel this is impractical and does not represent common sense, and we had hundreds of tractors roll into town in protest.

Ms. Helen Angus: I'm not aware that the decisions under the reopening Ontario act, ROA, are appealable to the Health Services Appeal Board. I think there's a direct connection between the Health Protection and Promotion Act and the role of what we call in the vernacular HSARB—

The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Helen Angus: But I'm happy to look into that for you, in terms of what the appeal process may or may not be, and we certainly will be able to get back to you with an answer. Obviously, there's a balance here to the policy intent, but certainly the needs of the farmers and of the workers to get to work safely without making this an albatross is important, so I'll be happy to provide you with an answer outside of the committee meeting.

The Acting Chair (Mr. Tom Rakocevic): That's time.

Before I go to the official opposition—we're also joined by MPP Anand. Are you here on the call? If you can just identify that you're here—all right. I guess he's not here at the moment.

We will move on to the official opposition. You have 20 minutes, beginning with MPP Gélinas.

M^me^ France Gélinas: My first question, actually, is going to be to research.

In my previous line of questions this morning, there were a number of money questions that the deputy, the program director and the ADM said they would get back to me on. Am I allowed to ask you to read them back, just to make sure you have the same list as I do?

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Ms. Helen Angus: I think you are allowed to do that. I'm just checking on whether the people who are taking

the notes are actually on the speakers' list. If not, I'll ask them for that and will read it in later on. I know that you did ask a number of follow-ons. They don't count on me to take the best notes, so I'll look to my team—Peter, if you've got somebody there who can provide us with a summary of the questions that MPP Gélinas had asked this morning.

I know that you asked specifically about—

M^me^ France Gélinas: Sometimes the committee Clerk and legislative research also write them down. I see the picture of the legislative researcher. Could she be unmuted for a minute?

Peter, apparently you're the new legislative researcher, but I don't believe so.

Mr. Peter Kaftarian: I believe our communications department tracks each question for follow-up. My team, who also tracks, is messaging me. I just want to double-check with ADM Marysia Szymczak—if your team has a tracked summary of that available to read back to MPP Gélinas.

Ms. Sandra Lopes: I do have the questions here. You had asked to provide an overview of which line items in the estimates briefing book are directed to hospitals. You had asked for a breakdown of funding to independent health facilities by groups of services, for example. You had asked how much funding is budgeted for physician services and what other practitioners are included, and for a breakdown of that. You had asked for a breakdown of the funding that goes to the different drug plans. Those are the ones I had in my notes that the ministry had indicated they would respond to, relating to the estimates, specifically. There were others.

M^me^ France Gélinas: You have the same list as I do; all good.

Coming back to ADM Dicerni, when the Chair so rudely interrupted you—no, just kidding. When we came out of the end of the 20 minutes, you were talking to me about how you were finishing up the negotiations with cystic fibrosis. Your last sentence got cut off. I don't want you to share with me any negotiation. The last thing I want is to derail this thing. I fully understand. I was more interested in knowing what was the last sentence you told me, if you remember.

Mr. Patrick Dicerni: The sentence you're referring to was me expressing that I was happy that Ontario, as a component of the pan-Canadian Pharmaceutical Alliance, entered into negotiations with the Vertex company on—I would describe it as the suite of cystic fibrosis treatments and pharmaceuticals, specifically Orkambi and Kalydeco, which I'm sure are a couple of drugs that you've heard of and are familiar with. A major consideration of these negotiations was a request from our organization, the pCPA, for Vertex to submit Trikafta to Health Canada for review.

Trikafta is the newest in the portfolio of cystic fibrosis-treating drugs and one that treats underlying causes in addition to deterioration in condition. At the point of us entering into negotiations on Orkambi and Kalydeco, the Trikafta product was not yet submitted to Health Canada for regulatory approval, nor had it been submitted to our national health technology assessment organization, CADTH. Since that time, the manufacturer of the product, Vertex, has submitted Trikafta to Health Canada for approval and has also submitted to CADTH for concurrent review of the product. That's something that we see in other jurisdictions as well—where a product that is as anticipated as Trikafta is submitted simultaneously for a health technology assessment, or equivalents in other jurisdictions, and national regulatory approval. So that is ongoing.

Timelines are not firm in terms of the review that is undertaken both at Health Canada and at CADTH, but to give you a sense, that was submitted by the company on December 23, 2020, so on average, these reviews take—and I say "average" because each one is unique and different, but on average, for a priority review, about 180 days. That takes us sort of into the June time frame, ballpark-wise.

Circling back to your question: As I said, a big component of our interest and desire to negotiate on Kalydeco and Orkambi was the understanding that their new product would indeed be submitted for sales and marketing in Canada.

M^me^ France Gélinas: Good luck with your negotiations. I hope you can bring the price way down and that everybody gets access. I will leave it in your capable hands.

My next question will also be to you. Before the pandemic—if anybody can remember before—the government had announced that Ontario would switch from a biologic to a biosimilar. It was supposed to come April 1, I think, and then COVID-19 happened. Where are we at with this, and are there savings within the ODP that would then—well, where are we at, and then I'll ask the money question.

Mr. Patrick Dicerni: Thank you for the question.

Perhaps your question is brought on by what we've seen recently in the media from Quebec. Quebec has taken a move, albeit with a long transition period, towards a biosimilar switch policy, if you will. Two weeks ago, we saw New Brunswick take the same step.

We were, of course, actively looking at, as you said, the biosimilar market and the opportunities that represents in Ontario. As you pointed out, as we were coming to a final recommendation and decision-making, it was coinciding with when the declaration of emergency occurred and the pandemic first wave really took hold.

As we've seen in other jurisdictions, British Columbia as an example, there is an interaction that is required between a prescriber and a patient who is on a bio-originator drug. The government, I'd say wisely, took the position that in wave 1 of the pandemic, forcing, by policy, an interaction between an Ontarian and a prescriber while wave 1 of the pandemic was really taking hold was not the most prudent of courses—entirely agree. So until we are at a point where, for the purpose of policy and savings, bringing and initiating interactions between providers and patients—until the pandemic in some ways indicates that

that's a safe and rational thing to do, there won't be, at this point, us moving forward. Not to speak for government's future plans, but allowing the pandemic to set the pace on some of these choices is a wise and prudent approach.

M^me^ France Gélinas: Before the pandemic started, you were coming to a final decision. Had there been any money identified as savings to the ODP that could be redeployed towards CF medication or rare diseases and that kind of stuff or wherever you want it to go?

Mr. Patrick Dicerni: Biosimilars, as opposed to bio-originators, do represent an opportunity for cost reduction on drugs with no meaningful clinical difference between them. If the government were to move forward with a biosimilar switch policy against a certain number of therapies and pharmaceuticals against different conditions, there is the prospect for cost avoidance or expenditure avoidance.

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With respect to where those reinvestments could take place, it is those types of moves that I'd say create flexibility going forward to list new and innovative drugs on the Ontario drug formularies, not necessarily or solely in the cystic fibrosis space. As we've all come to see, the emergence of very expensive drugs targeting rare diseases is only going in one direction in terms of cost and, I'd say, desire to see those listed on the Ontario Public Drug Programs formularies. But with respect to where those opportunities for investment would land, I wouldn't want to speculate.

M^me^ France Gélinas: But I'm more interested in knowing the size of the difference in cost for Ontario. Do we have an idea of the difference between biosimilar and—I call them biologic; you call them bio-originator. Do we have any idea of the size?

Mr. Patrick Dicerni: Yes. In general, biosimilar drugs are 20% to 30% less expensive to public plans or private plans, for that matter, than the biologic or bio-originator drug; those terms are interchangeable. Net savings that could be represented to the Ontario Public Drug Programs are entirely dependent on which biosimilars are listed and which switches are initiated over what period of time.

M^me^ France Gélinas: So the answer is no, we don't know? If we don't even have an idea of the size, are we talking millions of dollars or hundreds of thousands, or are we talking hundreds?

Mr. Patrick Dicerni: It would definitely be millions of dollars. I'm not intentionally being coy about the number figure; it really just depends on three big factors: which biosimilars are listed on the formulary, therefore, how many patients are moved over; the nature of the drug, in terms of whether it's to be treating a chronic condition, therefore, a lifetime of drugs—so there are a number of factors that lead into what the net savings to the OPDP plans would be, but it is not insignificant.

M^me^ France Gélinas: Okay. A change of things completely: I'm not too sure—maybe back to you, Minister or Deputy Minister. I saw that in past expenditures in the Smoke-Free Ontario Strategy, we had almost $44 million, but in the 2021 estimates, we're down to $18.795 million. This is a significant decrease. Can I find out why, what programs are being cut or not funded anymore, and where this big decrease comes from?

Hon. Christine Elliott: Thank you very much for your question, MPP Gélinas.

I believe it had to do with a change in the agency that was doing the work, but I think at this point, I would turn this over to the deputy minister for confirmation of that.

Ms. Helen Angus: I am struggling to find my page that would have the details on the Smoke-Free Ontario Act, but it is in the area of public health, and I'm certainly familiar with it from my time at Cancer Care Ontario.

I'll ask Dr. Williams and/or his team to answer your specific questions about the tobacco program and SFOA.

M^me^ France Gélinas: Sure. I see Dr. Williams is there.

Dr. David Williams: Yes, with Smoke-Free Ontario and then for the actual amounts here, there was a change-over in the quit line and who was contracted to undertake that. It was changed from one agency to another, so there was some downsizing of one group and another one was equipped to do it, so there was more efficiency sought to have it through the central organization there. So they were reducing that, but the services were not lost, and working with our other components, with Telehealth Ontario, it was also agreed to pick up on that. So that's why there was a change in the funding.

M^me^ France Gélinas: The Ontario Tobacco Research Unit, as far as I know, is no more. Who does this work now?

Dr. David Williams: Well, we have some work being done, ongoing stuff, with Public Health Ontario. They have some aspects related to their action group there. There are some other federal investigators as well. There are independent researchers and that. So the Ontario Tobacco Research Unit has been downsized and moved over at this time. We're still looking for other sources of researchers.

M^me^ France Gélinas: It is a 57% decrease from the year before. This difference comes from not funding the Ontario Tobacco Research Unit anymore? It is significant, and over $25 million. Is it because we're doing that much better at helping Ontarians quit smoking? Is Smoke-Free Ontario no longer a priority?

Dr. David Williams: Sorry, I didn't introduce at the start—it's Dr. David Williams, Chief Medical Officer of Health. Apologies to the Clerk for that.

Tobacco is a priority, with our Smoke-Free Ontario Act, and we are still carrying out a number of activities in there, even in the pandemic, to ensure that we have on-going enforcement through our various public health inspectors, to look at sales to minors, as well as various communications and campaigns on that.

Linking over to the other issue: Of course, we're doing further research on the impacts of vaping and its impact with use of nicotine in that regard, as well as cannabis and other products.

So the Smoke-Free Ontario aspect is still a big priority for our area, and we continue to look at many different components in there to reduce the incidence of smoking

and tobacco, with ongoing contracts with such groups as CAMH around cessation, and cessation products being available to primary care physicians to encourage adequate cessation and treatment programs in the province.

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

M^me^ France Gélinas: So, Dr. Williams, you feel confident that Ontario had a budget of $53 million, we're now down to a budget of $18.8 million, and we will still be able to continue to do everything we used to do before?

Dr. David Williams: I will make sure we get the details correct on the numbers. I'm looking at the budget sheets here. We have been convinced that we are doing the same as we have before in there, transferring more issues over to vaping, as well as with cannabis. These are other areas that we're working on, seeking to improve not only our research, our own data collection, but also the enforcement, and to handle that in the situation with the local health units. We haven't cut back on the staff in that situation at this time.

M^me^ France Gélinas: So where did the $25-million difference use to go?

Dr. David Williams: I'll check on that and get back to you. Besides changing the provision of the quit line, as well as the counselling services—that was our main area—there may be some other components in there, to get the details for you.

M^me^ France Gélinas: I see Elizabeth Walker has come up. Mrs. Walker, would you know more about—

Dr. David Williams: She may know the financial details. Elizabeth?

Ms. Liz Walker: Liz Walker, director of accountability and liaison in the Office of the Chief Medical Officer of Health.

The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Liz Walker: Further to what Dr. Williams was explaining, we have also combined some of our funding lines to public health units, so some of the funding that was under the separate SFO line is now under the Ontario local health agencies line, if I've got that correct. We have streamlined the funding for our health units, so it has moved from one line over to the other, this part of it.

M^me^ France Gélinas: And—

The Acting Chair (Mr. Tom Rakocevic): And that's time.

We're now moving to the government side. MPP Pettapiece, please proceed.

Mr. Randy Pettapiece: It has been an interesting conversation today. Certainly, all these issues are of great interest to all of us on this committee.

Minister, one of the most innovative programs in health care that I've seen is community paramedicine. Our government made a commitment to the people of Ontario to build a sustainable and connected public health care system focused on the needs of the patient and ending hallway health care. Community paramedicine fits quite nicely by better utilizing skills of paramedics and complementing home and community services.

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Minister, could you please tell us more about how this valuable programming is benefiting Ontarians?

Hon. Christine Elliott: Thank you very much for your question, MPP Pettapiece. Community paramedicine is an extremely important component of our health care system.

Our government did make a commitment to the people of Ontario to build a sustainable and connected public health care system that's focused on the needs of patients, centred around the needs of patients—and of course, ending hallway health care.

Despite the unprecedented system pressures that emerged during the COVID-19 pandemic, Ontario has continued to support hundreds of thousands of patients in their homes. The province has invested over $107 million so far to support emergency medical services in response to COVID-19. In addition, in 2020-21, our government invested over $100 million to support patients across the province with high complex care needs to access home care services in the comfort of their own home.

At the same time, we invested an additional $10 million to expand community paramedicine services. This investment was in addition to the annual investment of nearly $6 million that the government has made since 2017 to support community paramedicine programs led by local communities.

We know that paramedics provide a variety of services to people in the community, including as part of the response to the pandemic, and we are very grateful to them for the services that they do provide.

Our government is committed to ensuring that patients continue to have access to high-quality care that helps them live independently and safely in their communities. This commitment will help guide our investments in the years to come.

This is a very important topic, and I'd like to turn it over to Deputy Minister Angus to expand further on these investments.

Ms. Helen Angus: Thank you for the question.

The minister is right; Ontario has made significant investments over the past several years to enhance service capacity in the community so that people can get the services they need in the most appropriate setting. That includes the government's continued provision of nearly $6 million in dedicated funding each year for community paramedicine programs across the province. Last year, in fiscal year 2021, the government made investments in home and community care as part of its COVID-19 response, and that enabled the province to respond to care needs of Ontarians in the community while preserving hospital capacity.

So we allocated an additional $10 million as part of the COVID-19 response to expand community paramedicine services, and although I can't speak to it specifically, the Ministry of Long-Term Care made a complementary investment, as well, in community paramedicine services to support people who were waiting for placement in a long-term-care home.

I certainly recognize the important role the minister has described—the role of community paramedicine programs working alongside home and community care and other partners to keep people out of the hospital and address care gaps by supplementing care in the community.

I have seen at close hand the way that paramedics are able to leverage their training, their mobility and responsiveness within an appropriate oversight framework to provide care and keep clients connected to other care providers.

I might spend a second talking about the future vision for the program. Over time, home and community care functions will transition to Ontario health teams and to other points of care as part of the plan to improve the patient experience and patient outcomes for people across the province. Ontario health teams will take the lead in developing and updating health service models for communities, including identifying new partners and services. I would expect that community paramedicine would be very much a part of the service offering of Ontario health teams.

Certainly, while we're looking at the results from community paramedicine models, of which we have several, we're going to—as I say, we anticipate that community paramedicine will play a crucial role in the work that Ontario health teams will do in terms of providing high-quality, sustainable services to the population of patients who really need the kind of care that they have to offer.

I will ask Amy Olmstead, who you've met before today—the acting executive lead of the Ontario health teams division—to give you a little bit more detail on how the program is rolling out across the province. Amy?

Ms. Amy Olmstead: I'm happy to provide a bit of background and more detail about the funding and the initiatives that the minister and deputy have outlined.

As the committee knows, in recent years Ontario has invested in front-line home and community care to enable people to access the health services they need as close to home as possible, and these investments have included community paramedicine programs. Community paramedicine is a model of community-based care where paramedics use their training and expertise in community-based, non-emergency care roles outside their customary emergency response and ambulance transport roles captured under the Ambulance Act.

Alongside other services, including primary care as well as, of course, home and community care services, community paramedicine can be an important support for patients, and we really saw this even before the pandemic, but during the pandemic as well. Most municipal paramedic services in Ontario are operating community paramedicine programs now, supported by a variety of funding sources. Community paramedicine programs aren't intended to replace home and community care or public health services, but they can play an integral role in addressing gaps and enhancing service capacity. They also, of course, support the broader goal of ending hallway medicine by contributing to reducing unnecessary 911 calls and emergency department visits.

It's an innovative model that allows paramedics to apply their training and skills to support patients with varying needs through a number of services. For example, community paramedicine providers make home visits to seniors and high-needs patients to conduct wellness checks or help them with a range of services such as ensuring they are taking their medication. They assess clients and refer them to local community services, including home care. They proactively reach out to known or potential high users of 911 services. They also conduct wellness clinics where they educate seniors and others, often in group community settings such as seniors' housing complexes, about how to manage chronic diseases and live more healthily. They can conduct blood pressure checks and provide flu shots and other services. These services have served as the foundation for other innovations, such as remote patient monitoring.

Services provided by community paramedicine providers can include controlled acts delegated by physicians and nurse practitioners, such as IV therapy, medication management and assessments.

And of course, community paramedicine contributes to the integration of care across providers and connecting patients with home and community care supports. I think probably anyone who has ever spoken with a community paramedicine provider knows how well they know the health care community locally and how interested they are in making those connections for their clients.

As the deputy and minister noted, we currently provide nearly $6 million a year in annual funding for community paramedicine programs. This arose out of a pilot initiative that was eventually converted to base funding across the province.

The ministry, as well, in terms of supporting community paramedicine, developed a community paramedicine framework for planning, implementation and evaluation and an indicator reporting tool to support local planning. We think this tool facilitates implementation and evaluation of community paramedicine programs, as first the LHINs, now Ontario Health and in the future Ontario health teams look at what services they might like to enhance in their communities and what role community paramedicine might play in those enhanced services.

Of course, when the pandemic hit last year, the ministry's goals of ending hallway medicine and providing care closer to home became even more important. That's when we invested, in the fall, an additional $10 million into community paramedicine programs for those clients who are already receiving some care at home, but we wanted to enhance that care and keep those clients even more connected during the pandemic response.

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The funding also supported services provided by paramedics outside of their emergency response to support episodic care. That could include point-of-care testing and swabbing supports during the COVID-19 response, for example, in congregate care settings or in home care settings. So it really speaks again to that versatility that we do see within our community paramedicine programs.

Based on their preliminary data, about 10,000 clients received community paramedicine services last year.

Before I wrap up, I'm just going to mention two examples of some community paramedicine programs. One example is a program in Greater Sudbury. It reported that it used remote patient monitoring to support people in their homes throughout the course of their illness. They developed a directed mission pathway with Health Sciences North hospital for patients with COVID-19 who were enrolled in the program, and that enabled those patients to bypass the emergency department and resulted in decreased risk of exposure for health care workers when supporting those patients. Of course, those patients were also getting enhanced support at home at the same time. The program reported that it offered mobile COVID-19 assessment services since the spring of last year, completed over 4,000 tests and ensured testing for people who were unable to go to the assessment centre themselves.

Another example in Cochrane district provided similar supports for their community and addressed the needs specific to that region. For instance, the program has been involved in the planned response for potential First Nations evacuation and COVID-19 isolation in three of the communities there. Paramedics have been involved in transporting COVID-19 patients requiring enhanced care in the ICU in Timmins and assisting in the coordination of transportation to vaccination centres—and again, it supported at-home testing as well.

So there's lots of really responsive activity on the ground thanks to the work of our community paramedic providers and local planners to keep these services integrated in the local response.

The Acting Chair (Mr. Tom Rakocevic): MPP Rasheed has his hand up.

Mr. Randy Pettapiece: My colleague can go ahead.

Mr. Kaleed Rasheed: Chair, sorry, I just want to confirm: How much time is left for this round?

The Acting Chair (Mr. Tom Rakocevic): We have six minutes and 20 seconds.

Mr. Kaleed Rasheed: Thank you so much, Chair.

Thank you [*inaudible*] entire team for the incredible work you are doing, especially during this COVID-19 time.

Minister, as you know, last year, the Connecting People to Home and Community Care Act, Bill 175, received royal assent, which laid the groundwork, I would say, for integrated, responsive and innovative home and community care. I know you and I have talked about this many, many times, with my own grandmother's personal experience.

Minister, can you please give us an update on the great work that is being done to modernize—and modernization is something I'm very passionate about—how home and community care is being delivered in our province, and also how it has played a role in assisting our province's response to COVID-19?

Hon. Christine Elliott: Thank you very much for your question.

Home and community care is a vital part of our health care system that clients rely on each and every day—your constituents and my constituents, everybody across Ontario. This has become clearer over the course of the pandemic, as we continue to rely on home and community care to support people of all ages outside of hospitals and long-term-care homes. People want to be in their own homes.

I want to acknowledge the incredible women and men working across the home and community care sector, from personal support workers, or PSWs, to care coordination staff, to nurses, to therapists and so many others. Everyone in the sector has stepped up during this pandemic. They have demonstrated leadership, agility, resilience and, of course, compassion during a very difficult time for many Ontarians. They've provided care to people with complex needs in home and community settings, created and maintained social connections for isolated seniors, delivered meals to those who couldn't leave their homes, supported caregivers and so much more. We are really, truly very grateful.

We know that in spite of the outstanding people working in this sector, though, outdated rules and structures imposed by government policies over time restrict the home and community care sector and prevent the system from keeping pace with the needs or preferences of Ontarians. That's why, in February 2020, we introduced Ontario's plan to enable integrated and innovative models of home and community care through the Connecting People to Home and Community Care Act. Our legislation received royal assent on July 8, 2020, and it will be proclaimed when the regulations are ready. We do expect that with greater flexibility, more delivery options and greater efficiencies, health care providers can better respond to the needs of our aging and increasingly complex home care population.

As we transform Ontario's home and community care sector, the care that patients and families rely on every single day cannot be interrupted. This is our top priority and one that informs every step my ministry is taking along the way. We mentioned this work already during our time today, but I'd like to ask the deputy minister to please elaborate a bit more on our plans.

I'll turn it over to you, Deputy Minister.

Ms. Helen Angus: Thank you again for the question.

I would say that the home and community care modernization is one of the most critical parts of the government's plan to end hallway health care and improve care for the people of Ontario. As the minister noted, certainly the legislation, which is outdated and overly rigid—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Ms. Helen Angus: —has created barriers to integrated care for patients, and it has, I would say, stifled the innovation that we've already heard from the sector, the things that they'd like to implement that would make things better for patients. It's really not enabling in the way that we would like the legislation to be.

The Connecting People to Home and Community Care Act embeds the key legislative provisions of home and community care into the integrated health system legislation that supports the development of Ontario health teams. And so, when combined, it really reinforces and enables the government's commitment to integrating home and community care into Ontario health teams and to do it, as the minister just talked about, in a responsible, gradual, stepwise way that preserves the important care relationship between the home care team and the people receiving care.

The intention is that through Ontario health teams, home and community care clients will experience easier transitions and better connections between one provider and another, and often between the many providers who are involved in the care of somebody who is regularly receiving home care—

The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Helen Angus: —such as between hospitals and home care providers, but not solely that.

We're certainly looking at how home and community care could be better planned, delivered and coordinated with other community care providers—whether that's home and community supports, but in particular with primary care. The intention, really, is for care delivery to be much more responsive to the changing needs of clients as many of them age at home, which is the intention of the policy. We've already seen some great examples—

The Acting Chair (Mr. Tom Rakocevic): We're out of time.

I just want to congratulate MPP Rasheed on his apparent new role. Best of luck, and make us proud Thursday night against the Habs.

We're going to move to the official opposition side. MPP Gélinas.

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M^me^ France Gélinas: I also like his background, and I was wondering where I can get one of those.

I think I was talking with Ms. Liz Walker about some of the money that used to be in the Smoke-Free Ontario Strategy line that was at $44 million, which is now at $18.8 million. Some of the money for the Smoke-Free Ontario Strategy has gone to health units directly, and I was wondering if she knew the size of that envelope.

Ms. Liz Walker: Yes, that's correct. The Smoke-Free Ontario line actually is funding for a number of organizations, of which public health units are a part. Over the last year, the funding for public health units was moved from the SFO line over to the official local health agencies line, to enable it to be captured under the same line as other public health unit funding.

There was also a slight reduction as a result of the cost-sharing change. If you remember, I referred back—I think it was last week—to the change that was made in January 2020. There was a small reduction to that, which was subsequently mitigated by the provincial government through our one-time funding to health units. So that was also picked up under that line as well.

So that is—

M^me^ France Gélinas: Do we know, moneywise, number-wise, how much money went from the Smoke-Free Ontario line to the local health agency line?

Ms. Liz Walker: I would have to come back to you with that. I would have to look back at the number you're quoting, as well. I think that may have been the approved allocation, and we'd have to take a look at that in the actuals. We can certainly take a look at that, and then we can look at bringing back a comparison across the years.

M^me^ France Gélinas: My next question also has to do with tobacco.

I know that the Ontario government is currently in negotiations with tobacco companies to settle the tobacco medicare cost recovery lawsuit. I was wondering if there was any interest on the part of the Ontario government to seek to have a measure to reduce smoking delivered, similar to what the US did in 1998, where the US government obtained a series of public health measures to reduce smoking in their settlements with the tobacco companies—just to know where we're at with this and if this is being considered.

Hon. Christine Elliott: Thank you very much for the question.

The minister's office is not a party to this litigation, and therefore Ministry of Health staff aren't able to comment. Any questions, I think, could be directed to the Ministry of the Attorney General instead.

M^me^ France Gélinas: Okay. I've already talked to the Ministry of the Attorney General about this lawsuit. This question was really to see if there is an appetite and interest in the Ministry of Health to make sure that when the other ministry does the negotiations in court—I respect that—that smoking cessation will be part of what Ontario could consider asking for? Is this something that your ministry supports or do you stay off of this completely?

Hon. Christine Elliott: I'll turn that over to the deputy minister, please, if you don't mind.

Ms. Helen Angus: I was just smiling because I was thinking that we're always interested in getting more money for health care from any possible source, including litigation, if at all possible.

I think the thirst for funds from the tobacco companies is really to offset some of the health care costs that were borne by the health care system in order to provide care as a result of tobacco-related illness. So I'm sure we'll have a discussion probably more with the President of the Treasury Board on the ultimate disposition of any funds that are, I guess, provided as a result of the litigation.

I would just note that I would be a lousy former deputy of Treasury Board if I didn't remind everybody that these kinds of funds generally go straight into the Consolidated Revenue Fund and then we have to go back and ask for them specifically. But maybe in good time we'll see what the amount is, and if we're successful it certainly wouldn't be beyond us to go and ask for money.

Hon. Christine Elliott: We've asked for it a lot.

Ms. Helen Angus: Yes, we have.

M^me^ France Gélinas: Well done.

Changing topics again, cancer screening: I think the statistic that came out was about one million fewer cancer screening tests were performed in 2020 compared to 2019. We hear of all sorts of agencies, including the cancer society, saying that there could be a tsunami of undiagnosed cancers because many families stayed away from the health care system during the pandemic.

I didn't see anywhere in the estimates where there would be money allocated, either through COVID-19 or otherwise, to address the cancer screening backlog. Is there money allocated to this? Did I miss it? Or how will that work?

Hon. Christine Elliott: This is a really important question.

Of course, we know that many surgeries and diagnostic procedures had to be postponed, including many cancer screening procedures, because of the huge influx of patients in our hospitals and the need for many health human resources to be redeployed to other areas. It is something that we're taking a look at on a daily basis—to see the numbers in our hospitals and their intensive care numbers.

We have put over $500 million into dealing with this backlog of surgeries and procedures. As soon as we're able to, we want to get back to dealing both with the surgeries—that is, of course, cataract surgeries, hips and knees, cancer surgeries and cardiac surgeries, primarily—but we also need to get back to those diagnostic procedures, because I know that there is a concern that there are many cancers that have been missed because the diagnostic procedures haven't been happening over the last year or so. So I think we need to be prepared to deal with that as well.

Those cancers that may be diagnosed through those procedures, unfortunately, may be further advanced than they otherwise would have been had the procedures been done earlier; however, this is something that we are quite well aware of. In fact, we have put $500 million into reducing the backlog and dealing with these surgeries.

We will certainly do whatever it takes to make sure that we can, first of all, diagnose people—hopefully, negative for cancer screening. But if they do have cancer, then of course we'll put the money into that to make sure that people can be treated. It is something that we're watching on a daily basis, even to see if we can go back to doing some day surgeries as soon as possible. That wouldn't be cancer surgeries, but it is part of the whole bracket of surgeries and procedures.

I think for more specific information I would turn it over to the deputy minister for comment.

Ms. Helen Angus: I spent 10 years at Cancer Care Ontario, as you probably remember.

I'll ask my team to step in, but there are three kinds of testing that are done on a regular basis. There's the fecal so-called blood test, the colon cancer check and the program there. Certainly, there's a shortfall both in the use of the FOBT across the province—and that is part of the backlog that we intend to address, and any follow-up colonoscopies as well. Those would be captured by day procedures. Hopefully, we'll be getting back to those imminently and catching up, because they have a very low probability of requiring in-patient or ICU resources.

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Mammography, the Ontario Breast Screening Program—that's certainly work that we will do with Ontario Health, on trying to deliberately catch up on breast screening and then any follow-up, as the minister suggested.

Then thirdly, Pap tests, volumes of backlog: That's largely done in primary care, so that would be mostly covered in any additional funds that are inside the OHIP envelope. It is one of the examples that I regularly give. It's hard to do a Pap test remotely, so there really is a need—virtual care is fantastic, and we've had great strides in the delivery of virtual care, but there are a few things like that that require an in-person visit. So that is one of the things that we're looking forward to catching up on as physicians, nurse practitioners and other primary care providers spend more time back in the office now that many of them are getting vaccinated and the risk is lower.

I'll hand it over to Mel and her team, if you want some more details on that in terms of the spending side.

Ms. Melanie Fraser: Thank you, Deputy Minister, and thank you, Madame Gélinas, for the question.

I think the deputy covered off really well where the funding was going, what some of the backlogs were, and how we're trying to reduce the backlog.

I know in some of your earlier questions, you were asking where in the estimates you could see the funding that was provided. I just thought I would flag for you that in vote item 1416-2, there is $92.8 million in base funding for cancer screening as well as $1.9 billion and change for cancer treatment services. Then, as the minister mentioned as well, we have made additional investments into tackling the backlog of both surgeries and procedures, not restricted to cancer alone, but cancer, cardiac etc. Again, that provides a bit more detail in terms of the funding and the investments that have been made.

I might ask my colleague Kristin. She has a lot of detail on the different cancer screening programs, where we're at and the strategies for this year—if you wanted to add on a few words to what the deputy had started to detail.

M^me^ France Gélinas: There's $92.8 million for cancer screening. I think this is the same amount that we had last year. The $1.9 million for cancer treatment—I'm not too sure where this is at. The deputy mentioned that for Pap tests, it will be through primary care; for the breast screening program, I have no idea where the money comes from—and for colon, either. So if you could focus on the money, that would help.

Ms. Kristin Taylor: Absolutely. The first piece, I would say, is that the funding for cancer screening is managed by Ontario Health, formerly CCO, so they do have flexibility within the budget to manage—if the screening volumes increase, they would manage from within, as far as they're able to, and then, certainly, we would support them if it exceeded what the targets are.

We have been in close discussions with them. They have not yet flagged a pressure for this fiscal, but that certainly is subject to change based on how many people are presenting for screening, because we know there is that uncaptured population. It just depends on when they start to become real and when they start to enter into the screening program, which is hard to estimate. At this point, we think we're okay to cover the screening program.

I would also say that part of the backlog funding is going to be going towards endoscopy, which is used to diagnose and screen for certain cancers. So there are some incentives and some funding within the backlog funding.

M^me^ France Gélinas: So some of the $500 million for surgical backlog would be funnelled through OHIP to pay for physicians to do colonoscopy?

Ms. Kristin Taylor: It would be a premium on the volume that we pay for the procedure—so not physician costs, but going towards costs of the procedure being done in the hospital.

M^me^ France Gélinas: And would some of that be done in IHF also?

Ms. Kristin Taylor: Yes. I can't speak to the IHF funding—that's outside of my area—but yes, some endoscopy is done in IHF.

M^me^ France Gélinas: Okay, so some of the $500 million goes for the procedures.

When it comes to the colon screening or check or whatever you want to call it, the FOBT, where would the money come from if there is a higher demand?

Ms. Kristin Taylor: It would come from the ministry, ultimately, but as I said, Ontario Health has the ability to move funding around if it exceeds what they have allocated.

M^me^ France Gélinas: And they would be moved from what line? What are they allowed to move around?

Ms. Kristin Taylor: It depends. Every year it's different. There's typically an underspend somewhere, whether it's QBP cancer volumes, whether it's renal; it could be some of the drug funding. It just depends on the unique situation of the year and each hospital and region.

M^me^ France Gélinas: So although Cancer Care Ontario is now under Ontario Health, the money that used to flow through Cancer Care Ontario continues to flow the same way?

Ms. Kristin Taylor: That's correct, yes.

M^me^ France Gélinas: So the flexibility that they had before within Cancer Care Ontario—I'll call it the Cancer Care Ontario envelope—stays as is, although they're part of Ontario Health?

Ms. Kristin Taylor: Yes, the cancer envelope stays. It continues to be managed in the same way, although within a larger organization and with more funding from other streams, as well, due to the consolidation

M^me^ France Gélinas: Thank you. I didn't know any of that.

I'm moving on to a completely different topic again—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

M^me^ France Gélinas: Well, I'm just going to plant the seeds and see how far we go.

I want to talk about Ministry of Health investment into assisted living and supportive housing for frail seniors, during the pandemic and after. It seems to me that the amount of money has gone down. Through the estimates—assisted living and supportive housing have gone down from last year to this year, and I was wondering why that was. I don't know who to ask that question to, so, Minister, it's all yours.

Hon. Christine Elliott: Well, thank you very much for the question.

We have made investments in supportive housing for people who are mental health clients. I couldn't tell you exactly what line that is, but we have made investments.

Perhaps I could turn that over to the deputy minister, who could probably get the specific person who would be able to respond to that for you.

Ms. Helen Angus: I'm going to go to Mel, because I think there might be two aspects to this: One would be the mental health aspect the minister just referenced, but also some of the housing programs that we fund for people who have support-service needs and frailty. I'm thinking of programs like LOFT and others, where we have funded the rent supplements, as well as the community supports.

Ms. Melanie Fraser: Recognizing that the clock is starting to wind down on this, what I'm going to do is take our next little break—I think there are probably a couple of things happening here, where we're seeing a difference in extraordinary investments made during the pandemic in a previous year versus this year, and then, as the deputy minister pointed out, different investments through mental health as well as through home and community care, so perhaps—

The Acting Chair (Mr. Tom Rakocevic): We're at time. So we now move to the government side for 20 minutes. MPP Cuzzetto.

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Mr. Rudy Cuzzetto: Minister, throughout this pandemic we've seen inequity in the distribution of cases of COVID-19 infection among certain individuals and communities. I was hoping you could talk a bit about how the province is supporting those Ontarians in high-priority communities, like the region of Peel where I live, that have been hardest hit by COVID-19.

Hon. Christine Elliott: Thank you very much, MPP Cuzzetto. I appreciate your question.

We know from the data that COVID-19 doesn't affect all populations or neighbourhoods equally. Evidence shows that racially diverse, newcomer and lower-income populations often live and work in challenging settings, and they may face language or cultural barriers as well, and they're particularly hard hit. Unfortunately, it is in these communities where we see higher rates of COVID-19, despite public health measures being put into place.

Containing this virus requires tailored community-based responses to address systemic barriers in certain communities. That is why we announced the High Priority Communities Strategy, providing $12.5 million in funding

to support lead community agencies and community partners in 15 priority neighbourhoods in Durham, Peel, Toronto, York and Ottawa. To continue this important work, additional funding is being provided to extend this strategy through September 2021 in these neighbourhoods, with an additional community in Windsor being added.

I would now like to turn it over to the deputy minister to provide some further detail on the High Priority Communities Strategy.

Ms. Helen Angus: Thank you for the question.

Certainly, it became evident through the pandemic and over the last year that there were areas of the province that had higher COVID-19 prevalence, so higher rates of COVID-19, and not just on an episodic basis, but persistent areas where we saw that they had higher rates, often lower testing rates, and also barriers to testing that were present in the community. We knew that it was important to target these communities and provide additional supports, and that the rest of the province would benefit, not only those communities, from the support being provided.

We developed a High Priority Communities Strategy where lead agencies would work in partnership with Ontario Health, with local public health agencies and with municipalities and other community partners to develop and implement interventions to reach these hardest-hit neighbourhoods. There are really three key areas of focus for the strategy: community outreach and engagement, increased access to testing and vaccines, and then wraparound supports using case management approaches.

These interventions were designed to support a number of things, like self-isolation for those who tested positive or had been in close contact with a COVID-19-positive patient or were awaiting test results. They were intended to mitigate the disproportionate negative impact of COVID-19 on vulnerable and marginalized communities by connecting individuals with wraparound supports.

You've already heard from Rhonda McMichael. This is also within her area of responsibility—to give you some details on the strategy.

Probably more important and more interesting here is also the implementation of what we've learned from the early work that was largely focused on case testing and isolation and how we're carrying that forward into our vaccine rollout, and how it's really making a difference in those communities.

With that, I will hand it over to Rhonda.

Ms. Rhonda McMichael: Thanks very much, Deputy, and thanks, Minister Elliott.

I'm thankful to speak again about another initiative, this one the High Priority Communities Strategy. As the minister noted, the strategy has rolled out in 15 priority neighbourhoods, including Bramalea, parts of Mississauga, Rexdale, Scarborough, western and eastern York, Durham west and central Ottawa. In these communities, local agencies such as community health centres, Canadian Mental Health Association branches and other agencies with a really deep knowledge of their community members are leading the work on the strategy. I'm really happy to take this opportunity to detail some of the initiatives and actions that are under way as part of each of the three key pillars that the deputy minister just outlined.

The first pillar is tailored community outreach and engagement to ensure that people are aware of the services and supports that are available to them, including information about vaccines. Developing targeted communication tools to reach community members is really important to ensure that they're aware of what is out there and what they can take advantage of or is there to help them out.

Under the strategy, the lead agencies develop communication materials and approaches that are culturally and linguistically appropriate, including flyers in many languages, social media strategies, engagement with key community leaders to ensure those messages are delivered effectively to residents from trusted sources. For example, agencies have targeted outreach through community newspapers, faith groups, news bulletins, direct mail-outs, WhatsApp, YouTube, Facebook, Instagram, TikTok and Twitter—so obviously using all of the technology and really finding out where people are and speaking to them not only in their language but in their choice of ways to communicate within their community.

Since the announcement of the strategy, lead agencies have engaged with over 700 partner organizations. They've on-boarded over 1,300 dedicated community ambassadors. They provide door-to-door and hub-focused outreach to promote the services and supports. The ambassadors have distributed more than 100,000 personal protective equipment kits with masks and hand sanitizer to those who need them the most. Our lead agencies estimate that nearly 240,000 community members have been reached by their engagement strategies. That's thousands of people who are now better informed, supported and empowered to protect themselves and their family members from COVID-19.

The second pillar of the strategy is increased access to testing and vaccines. Lead agencies are delivering a whole range of options to improve access to testing, and that includes launching mobile testing, new community testing sites at pharmacies and community labs, pop-up sites, and expanding site hours; developing partnerships with paramedic services to increase testing capacity; providing transportation assistance so people can get to and from the sites; participating in a provincial rapid antigen screening program—that program expands testing and has expanded testing significantly in essential workplaces as well as communities—and working with partners to use saliva testing to make testing more accessible.

One example of a key initiative that supported increased access to testing is the South Asian communities tool kit for sharing culturally appropriate messaging regarding testing. It was developed through a partnership between local community organizations by the Ontario Health central region, which covers Peel and York.

Another example: In Markham, they worked to establish a pop-up site at a community centre and translated promotional material to Chinese and Tamil to increase awareness among different population groups.

As a result, we're seeing increased access to testing in these communities, to the point where these neighbourhoods had lower-than-average testing rates and now they're at or above, in many cases, the provincial average. At the end of April, there were 39 community testing sites in these priority communities, which represents 25% of all the community testing sites in the province. And, as I mentioned, their testing rate is higher than the rest of Ontario, above 20 tests per 1,000 people.

Agencies have also been deeply involved in helping improve access to vaccines in high-priority communities. Agencies have created vaccine brochures, hosted town halls, and really helped to encourage vaccine uptake and education in communities. We've seen this at Flemingdon, at Taibu Community Health Centre. They've helped to organize pop-up vaccine clinics to target these populations. Community agencies like WellFort Community Health Services in Peel have helped to ensure that vulnerable individuals can access these pop-up clinics through transportation support and their outreach. And we're happy to say that as of May 17, so yesterday, 62.8% of adults in high-priority community postal codes have received at least one vaccine dose, higher than the average for all Ontario, which is at 56.6%

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Finally, the third pillar of the strategy aims to increase compliance with public health directives such as self-isolation, connecting individuals to wraparound supports—for some, it's an inability to comply without those supports rather than choosing not to comply. Using a case-management approach, lead agencies are connecting community members with available services such as emergency grocery deliveries and emergency financial assistance so they can self-isolate safely at home, in a hotel or at one of the designated isolation facilities that the province has opened.

Emergency financial assistance is being provided to those whose income has been affected by COVID-19, including individuals who need to self-isolate, so they can meet their existing obligations, including rent and other basic needs. Many individuals are eligible for federal supports, as well as up to $733 in provincial emergency assistance to help with short-term financial obligations that they may have.

Working closely with our partners at the Ministry of Municipal Affairs and Housing, we've also invested $42 million under the strategy to create about 1,500 spaces in 11 isolation centres in Toronto, Peel, York, Durham and Windsor, so people can self-isolate and keep their families and communities safe. These centres offer a range of wraparound supports and services including meals, security, transportation and links to health and social services, all free of charge.

Over these past few months, we have seen the difference that having the strategy in place can make in these communities. It would not be possible without the tremendous work of staff and volunteers across these community agencies. I've mentioned a few of them, but there are other lead agencies that should be mentioned for their incredible work: Carea Community Health Centre in Durham west; Punjabi Community Health Services in Brampton; the Dixie Bloor neighbourhood drop-in centre in east Mississauga; Indus Community Services in northwest Mississauga; the Canadian Mental Health Association Peel Dufferin branch in southwest Mississauga; Rexdale Community Health Centre in north Etobicoke; we mentioned Flemingdon and Taibu; Scarborough Centre for Healthy Communities in Scarborough south; Black Creek Community Health Centre in North York west; Vaughan Community Health Centre in western York; Carefirst Seniors and Community Services Association in eastern York; and South-East Ottawa Community Health Centre in central Ottawa.

The Ministry of Health will continue to implement this critical and effective strategy to stop the spread in our most vulnerable communities.

Thank you very much for the opportunity to speak about the strategy today.

Mrs. Robin Martin: I have a question for the minister about case and contact management, which we know has been really essential to our response to COVID-19 and to help manage and prevent outbreaks.

I'm just wondering if you can tell us, Minister, about how Ontario has assisted our public health units to enhance their ability to reach cases and contacts quickly, as we know how important that is.

Hon. Christine Elliott: Thank you very much for your question, MPP Martin.

Our government continues to use every resource at its disposal to fight COVID-19 and try to keep Ontarians safe and healthy. The ability to quickly identify, trace and isolate COVID-19 cases is critical to the health care system's capacity to effectively contain the spread of the virus.

The province's COVID-19 fall preparedness plan, called Keeping Ontarians Safe: Preparing for Future Waves of COVID-19, included $33 million in funding to add case and contact management staff to support the public health sector, to identify and follow up with new COVID-19 cases and outbreaks, to avoid further spread.

We are incredibly grateful to our public health units for the leadership role they play in case and contact management, and have provided them with significant additional support through our agile and remote provincial workforce of over 1,000 case managers and contact tracers, who have worked to keep many Ontarians safe and healthy by stopping the spread of this deadly virus.

By expanding our case and contact management capacity, we have boosted our ability to respond to surges in COVID-19 cases across the province.

There's a lot more to say about this, and I will turn it over at this point to the deputy minister to add further comments and context.

Ms. Helen Angus: Thank you for the question.

As we've all learned through the pandemic about what are the things that actually makes a difference in COVID-19—and case and contact management would be close to the top of the list. It's a critical tool in the fight against COVID-19. When done effectively, it can really prevent,

mitigate and manage outbreaks. As well, it provides important information to people who either have been exposed or have COVID-19 on the kinds of supports that are available to them. Rhonda has just talked a little bit about what we've done in some of the higher-risk neighbourhoods. Case and contact management is a fundamental function that public health units engage in across Ontario for a number of reportable diseases, but of course, COVID-19 required us to scale up case and contact management quickly.

Last summer, hand in hand with the province's comprehensive testing strategy, we released a strategy called Protecting Ontarians through Enhanced Case and Contact Management to contain the spread of COVID-19. The strategy focused on efforts to strengthen and standardize the case and contact management function by ensuring that all new cases and their close contacts were identified early, were reached quickly, were thoroughly investigated, were advised to get tested and then followed up for 14 days.

The strategy that the minister mentioned was backed by $33 million in funding through the COVID-19 fall preparedness plan, and to really augment the case and contact management capacity by supporting public health units with additional staffing resources. Much of the staffing was to enhance local response, to provide information and technology tools through one provincial case and contact management system, and to launch a privacy-first exposure notification app to alert Ontarians when they may be exposed—and some of us still carry that on our phones. We're continuing to work closely with public health units to make sure that they've got the resources they need to deliver high-quality case and contact management to Ontarians.

I think Rhonda will be able to give us, again, some more information on the implementation of the case and contact management. I think she'll also talk a little bit more about how we have provided a surge capacity and supplemented the capacity that was developed and delivered locally so that we made sure that we had the people and processes in place to do this work well and at the scale that was required by the pandemic. With that, I will hand it over to Rhonda.

Ms. Rhonda McMichael: Thank you very much, Deputy Angus and Minister Elliott.

I will provide more detail on Ontario's efforts to contain the spread of COVID-19 through case and contact management.

Contact tracing notification and follow-up is a process that's used to identify, educate and monitor individuals who have had close contact with someone who is infected with the virus that causes COVID-19. These individuals are at a higher risk of becoming infected and sharing the virus with others, so it's important that we implement contract tracing—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Ms. Rhonda McMichael: —as soon as possible to help individuals who have been in contact, so they understand their risk and can limit further spread of the virus.

The strategy that has been mentioned by the minister and the deputy, Protecting Ontarians through Enhanced Case and Contact Management, has enabled us to ramp up provincial case and contact management support through over 1,000 staff made available to all 34 public health units. This has helped the public health units to ensure that they can reach cases and contacts—as many as possible within 24 hours.

Most recently, despite sustained high case counts, Ontario has demonstrated the success and resiliency of the strategy by reaching 93% of cases and 79% of contacts within 24 hours. The most recent statistics show that all 34 public health units were able to meet or exceed reaching 90% of cases within 24 hours. The most recent—the 93% is the last report. The most recent report we got this afternoon shows that it's 95.6% have been reached within that 24-hour time frame.

The Ministry of Health has obviously supported ensuring that there is consistent, high-quality case and contact management. We have put in place guidance that is updated regularly so that public health units are aware of the latest scientific evidence and expert opinion that has guided the decision-making.

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The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Rhonda McMichael: While surge models are necessary at times, the Ministry of Health has made every effort to support public health units to conduct full case and contact management programs. Some 1,000 case managers and contact tracers were hired, in addition to 600 contact follow-up staff available through a partnership with Statistics Canada, so over 1,600 staff in total to provide to public health units to effectively trace and isolate new cases. Five hundred provincial staff are embedded directly into public health units—

The Acting Chair (Mr. Tom Rakocevic): We're out of time. Thank you.

Now we're returning to the official opposition. MPP Gélinas.

M^me^ France Gélinas: I will go back to money spent by the government for assisted living in supportive housing for frail seniors during the pandemic and in the 2021-22 estimates. I'm not sure who wants to answer that.

Ms. Melanie Fraser: Deputy, I hope you're okay if I jump in and continue on with this one. We did check in over the last few minutes, and I think my instincts were right.

Let me just reference the specific vote. If you're looking at vote 1416-1, "assisted living services in supportive housing"—this is the one where the 2020-21 estimates were about $341 million. The 2021-22 estimates are $341 million, but there's an interim actual of $360 million. What that reflects was, precisely as you said, investments during COVID-19 to support frail elderly and those at risk, and potentially seniors facing social isolation. The additional funding last year went to offset any expenditures and to reimburse costs associated with things like added PSW supports for those elderly or frail, or folks who

needed added supports because of isolation, or it could have covered things like PPE while they were performing those services. So we would have seen a bump up over the base amount by $20 million, and then this year's base amount is the same as last year's.

Of course, we'll monitor the program, and should any of those organizations providing the services have extraordinary expenses this year, we would be reimbursing them for those.

M^me^ France Gélinas: Are you able to tell me how many seniors in Ontario are supported by those programs?

Ms. Melanie Fraser: That is a really good question. I don't think I could get that for you today, but it's something that we could potentially look into. I'm not sure that we track it at that level of detail, but let us see what we can come up with.

M^me^ France Gélinas: Do we track the number of buildings where supportive housing and assisted living take place?

Ms. Melanie Fraser: I think there are a number of supportive housing and assisted living programs. There are some that are provided through our home and community care program. There are also some that are provided through the mental health and addictions program, which we spoke about earlier. Again, a number of these programs would be operated by transfer payment recipients of the Ministry of Health. Some may, in fact, be operated by, and in conjunction with, our partners, such as municipal affairs and housing.

I have two assistant deputy ministers here, Amy Olmstead and Melanie Kohn. They can speak to both of those programs respectively: home and community care supportive living programs, as well as the programs funded through mental health and addictions.

But to answer your question of, could I tell you precisely how many buildings or do we track how many buildings or apartment spaces are being funded—again, we wouldn't have that at our fingertips, but we could endeavour to try to get that.

M^me^ France Gélinas: I was just curious. I saw that on the ground there were more people qualifying for assisted living, for lack of a better word—frail, elderly seniors—and I was just wondering if this is something that was going to continue. But you seem to say that it will continue to 2021, because the amount of money has stayed the same, although we see a change from $314 million to $341 million in the estimates book. But part of it is because of COVID-19; the base amount has stayed the same. Did I say that right?

Ms. Melanie Fraser: I would say the base amount has stayed the same on the home and community line, that vote that we just talked about. That went from $340 million to the interim actual of $360 million and then back to this year's base, returning to $340 million.

In mental health and addictions, which is reflected in another vote—I can pull that number up quickly for you—the government has invested an additional $175 million on top of the base, of which a proportion of that will go to supportive housing and to support those with mental health and addictions needs requiring housing through the mental health and addictions program. So there has been an increased investment there.

M^me^ France Gélinas: Okay. Actually, my next question has to do with mental health, but not necessarily with assisted living. I remember that the government made an $86-million investment for school-focused through public health—it actually doesn't have to do with mental health as much as it has to do with public health. This money went to 625 school health nurses and into basically 60 different community wellness nurses through NAN territory—so 625 school health nurses through public health and 60 community wellness nurses through NAN. Is that $86 million something that we can expect to continue? And did I get this right? Sometimes when I read an estimate and I think that's what it means, it's not the same.

Hon. Christine Elliott: Thank you very much for your question.

I think the best person to start with is to refer this to Dr. Williams for some information from him. It may need to go to Peter Kaftarian as well, but perhaps we could start with Dr. Williams.

Dr. David Williams: Thank you for the question on aspects related to mental health conditions and that.

As you know, when we went and expanded the school nursing program in response to the COVID-19 outbreak, and especially our concern about the health and ongoing safety of our schools and programs, we endeavoured to look at that, knowing that our school nursing program has always been a valuable adjunct into the education system. We had looked at and had asked for the funding, as you noted, the amount of money that is in there, to acquire. We started off with a slightly lower number of that, but it was augmented by some federal money as well, to increase the number up to the number that you have quoted in your question.

The concept there is that by adding these school nurses into the program, into all the health units in areas, as well as to assist in some funding going to First Nations, they could add those same resources available to them to assist in the ongoing case and contact management, the ongoing infection prevention and control education and knowledge base in a school setting, where schools before had not really been involved in IPAC, or infection prevention and control. There was a need to do this transformation—if you may, a paradigm shift—and so we needed a lot more resources to go in and work with our educational partners, with the principals, administration, teachers and staff, not only within the school, but also related to the school bus transfer programs etc., and then also be a resource, primarily working with the students but mostly with the parents who might want to ask questions about infection and prevention control, questions about COVID-19 in the school setting, what they should do, and be advised accordingly.

1720

This was augmented further that when they were hired, they were allocated on a per capita basis out to the many different health units that we originally were—they

weren't certain if they were going to hire quite a few, but we actually did hire most of ours by the end of the August period, so that they were ready to be moved into the schools when we resumed full-day, in-class attendance in September 2020. It has been a very successful program. They have been a very valuable adjunct to that.

As you know, public health has a strong history of school health and is concerned about those issues there.

Those positions are there now. We have extended those into the fall, and we're looking to see if we can have some further extension in the future, because we're not sure how long the COVID-19 impact will continue to be impacting us in this regard.

The nurses have been involved in the testing, as well as moving people to get to them to go to assessment centres and doing the follow-up with family contacts back in the home setting. So even when the schools were closed, a number of the school nurses were involved in ongoing case and contact management, dealing with youth who were involved in that, and to give testing advice and direction and participating as a resource at the local level with the school staff and administration, as well as with parents who might have questions to ask and that, and then connecting themselves with the case and contact management team, which you just heard ADM McMichael talk about, and integrating with that, and with the medical officer of health if you have to do school closures, outbreak contact management, and then when you resume those services again, what you might want to do for those education purposes.

Now that we've gone through this next phase, of course, we're looking at the impact, and now that we're closed in the third wave, if we're going to consider opening, how we would do that. Again, the school nurses are involved in the discussions and actions there accordingly. Then, of course, we're concerned as we go through the summer in that, if there are some day programs that are continuing, because they also have an impact on the child care services that the schools are dealing with as well in that, and being a resource to them in their knowledge base.

Then, of course, in the fall, when we resume full classes, there are those other things that we want to measure and to assess, and have our school nurses look at those issues to say, "Are there other relevant issues besides just infection that have been impacted upon by the students and youth? Do there need to be public health initiatives to try to deal with those matters and to make them aware?"—in partnership, of course, with the principal and staff and local boards and then back up into conjunction with the rest of the health unit staff and the other existing school nurses as they start to remount those programs. Much like surgical wait-lists, there are some programs that have not been as vibrant during COVID-19, naturally, that will have to be restarted and revamped and there has to be a catch-up.

The work is not ending, and we are extending their contracts into the fall, into the rest of 2021, to the end of the year. Then we're going to be reassessing that situation on a go-forward basis.

M^me^ France Gélinas: So, until December 31, 2021, we know for a fact that the 625 school health nurses and the 60 community wellness nurses through NAN—their contract will stay and they will continue to be available to our schools. After December, is it your decision to make? Who makes the decision as to whether we're keeping them or letting them go?

Dr. David Williams: That will be part of the overall submissions as we go through the whole process in the fall of 2021 to look for extensions and budgets.

M^me^ France Gélinas: There's sort of a gap there from January to March?

Dr. David Williams: Yes. We have to get that approved, yes.

M^me^ France Gélinas: Do you know if it's the same amount? I was able to track down $86 million for school-focused in public health. If I was better at looking through estimates, would I be able to find this $86 million someplace?

Dr. David Williams: Yes.

M^me^ France Gélinas: Okay.

Dr. David Williams: It was in the financial estimates there. We can get that for you, but it's that amount.

M^me^ France Gélinas: Okay. I agree with you that they have been very well received by the school system, which does not want to let them go. They have been very helpful and very well received by the school system.

I know that lots of immunizations that are usually done in schools did not get done because the kids were not there, the students were not there. Would those school health nurses be available to help with this? Or can only the previous public health nurse do that?

Dr. David Williams: It's a very good question, Madame Gélinas.

The vaccine-preventable disease teams at each of the health units do set up those programs for carrying out the grade 7/8 vaccination program on a regular basis. They're also involved in the Immunization of School Pupils Act. That means a lot of catch-up work to be done. So you have raised a very good point.

There's no doubt the regular VPD team is going to have to do a lot of catch-up, and they'll be relying on the services of the nurses to assist in that and the report of that to get those caught up, because a number of the youth perhaps did not get to their primary care physician's office to continue the childhood vaccines, and there may be some incomplete records that need to be, I would say, in a proper way—a dialogue and a constructive one with parents and that on how to orchestrate and get that caught up with the primary care sector and the pediatricians and nurse practitioners, to make sure those are caught up. So there's a lot of work to be done to get that back up and running and to do any catch-up in identifying the gaps in that, as students have moved around, of course, and class lists and all these things have to be addressed. So the work is not over at all.

M^me^ France Gélinas: Agree.

I am changing topic again, and this is a big one: the Ontario health teams. I have gone to the minister about

smaller areas that are interested in putting forward a proposal for an Ontario health team, but they have been deemed to be too small and asked to connect with bigger areas.

The last one that I went to see the minister with was with my colleague Michael Mantha about North Shore, which already worked more or less as an Ontario health team—the two hospitals, the family health teams, the long-term-care home, the home and community support, as well as mental health. I don't think they have anything for palliative care in that area, but everybody else worked. But they haven't been able to move forward. Your ministry wants them included with the Sault Ste. Marie Ontario health teams.

Is there an opportunity for smaller areas to have Ontario health teams, or are we still at the size that was originally shared with me?

Hon. Christine Elliott: Thank you very much for your question. This is a very important issue.

We are very happy with the creation of the Ontario health teams because they now cover about 86% of Ontario's population and they responded very quickly in dealing with COVID-19. Because they were a connected group of people, they knew where the gaps in the system were and they knew how to fill in those gaps, and so they were very helpful with the terrible situation in long-term care, for example. A lot of the hospitals that were parts of these teams moved people into the long-term-care homes to help provide infection prevention and control, nursing and other services. In some cases, they actually even took over the management of the long-term-care home.

We are still putting this together. We have several that are ready to proceed in the next short while.

I am aware of the situation in the Algoma area, I believe it is—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Hon. Christine Elliott: —looking at connections to other areas. Our team is still working with several of the smaller groups, but they're looking at putting groups together that make sense, that work together naturally. That situation hasn't been finalized yet. I think there are several Algoma groups, actually, that they're looking at, and trying to bring those groups together rather than putting them with Sault Ste. Marie. The work is continuing, and I think that there are still some discussions that are happening.

I will turn it over to the deputy minister to add, maybe, more specific information on that particular area of forming an Ontario health team.

Ms. Helen Angus: Thank you, Minister. I'll probably ask Amy to weigh in.

Obviously, when we first thought about Ontario health teams, we thought about general parameters around all the functions we wanted to have included that did have a notion of size. It was maybe less about the size of the population and more about the comprehensiveness of the service offering—to make sure that they could really meet the needs of their population with the service providers and collaboration they had. I think that has been a challenge.

1730

Maybe Amy can talk specifically about the Algoma area.

It's a fine balance. Obviously, we want to be responsive and encouraging of local innovation, local initiatives and the coming together as a voluntary group to collaborate deeply around the population of patients.

Amy, you might want to go into the specifics around Algoma as much as you can.

The Acting Chair (Mr. Tom Rakocevic): Sorry; we're out of time.

M^me^ France Gélinas: Deputy, before you go—so you're telling me that there isn't a population size cut-off?

The Acting Chair (Mr. Tom Rakocevic): A quick answer. We've got a second. Okay, we're done. Sorry.

We're now going back to the government side for 20 minutes. MPP Parsa, please proceed.

Mr. Michael Parsa: It's hard when you're in a pandemic to see the positive, but eternal optimist individuals will always see it. I guess one of the positive aspects of this pandemic is how it has allowed the IT sector to shine and really foster rapid innovation in the health sector.

I'd be interested to know if the ministry's IT area has been and, I suppose, continues to be actively involved in the work of supporting Ontario's response to this pandemic.

Before you get to this—I believe it was ADM McMichael who was answering my colleague Robin Martin's question on case and contact management, and she ran out of time. If there's anything else you'd like to add before we get to the IT question, you're more than welcome to start off with that.

Ms. Rhonda McMichael: Absolutely, yes. For sure, I can provide more information on case and contact management. I'm happy to do that.

I'll pick up talking about the staff that we had hired as well as the partnership with Statistics Canada providing over 1,600 additional staff. Recognizing the diversity and the local contexts of 34 different public health units, a full spectrum of support is provided through a very flexible staff and support model, and it provides provincial resources that are easily integrated into the workflows of public health units.

I talked about the 500 provincial staff who are embedded directly into a number of the public health units. In addition, 500 additional staff are working centrally in a pool that is managed by the Ministry of Health. Public health units can directly transfer cases for end-to-end follow-up using a standardized process and script. Eleven public health units currently receive support through that model: Brant; Durham; eastern Ontario; Haliburton, Kawartha, Pine Ridge; Leeds, Grenville and Lanark; Niagara; Ottawa; Peel; Simcoe Muskoka; and Toronto Public Health.

To date, the centralized pool of staff has handled over 70,000 cases on behalf of public health units, enabling the

health units to focus on the more complex outbreak investigations and, more recently, immunization. We talked about the statistics earlier.

Both the centralized and directly assigned staff have played a critical role on best practices in case management, particularly the effective use of technology, which I know my colleague Karen McKibbin will speak about in a moment.

The deputy had mentioned surge capacity. The pool allows us to provide consistent support to hot spot areas like Peel and Toronto, but also allows us to be able to move very quickly to help public health units like Porcupine, which has recently, over the past week or two, experienced a rise in cases. So we can quickly pivot to allowing them to very simply share cases with us to be able to do the case management as well as the contact follow-up. So it's seamless, and that has allowed us to stay well above the 90% average of reaching cases within 24 hours.

I can talk a little bit more about the program through Statistics Canada. They have 600 skilled multilingual interviewers. They have performed the critical function of contact outreach, following up with all contacts for 14 days, monitoring for symptoms and directing to get tested. This labour pool comes at no cost to the provincial government, and it's currently being used by almost all 28 of the public health units.

We also have redeployed 150 Ontario public service staff. They work on temporary rotations and have made over 200,000 calls to travellers returning to Ontario to ensure that they're aware of the supports available and comply with their 14-day quarantine.

We also launched COVID Alert last summer. It uses Bluetooth technology to detect when users are near each other, and they can choose—it allows those who have downloaded it to anonymously let others know that they have been exposed without sharing any personal information. It has had 6.5 million downloads nationally. Most of those are in Ontario. Nearly 23,000 Ontarians have uploaded a one-time key, which allows them to alert others. So even though we don't have 100% downloaded across the province, there was an Oxford University study that showed that even uptake rates around 20% to 25% can make an important contribution to slowing the spread and protecting people. We estimate that approximately 20% of Ontarians have downloaded and use the app.

I also want to mention that we have worked closely with Indigenous partners. We have worked to provide 30 case managers and contact tracers to the First Nations and Inuit health branch of the federal government. We have also provided direct funding to the Indigenous Primary Health Care Council to form partnerships with public health units so they can have a culturally safe approach to contact tracing and case management with Indigenous communities.

I thank you very much for the opportunity to provide some more detail, and I'm happy to pass it back to the MPP.

Mr. Michael Parsa: If you don't mind, the question about the IT support and how it has helped—if I can get someone to address that, that would be great, please.

Hon. Christine Elliott: I can start, MPP Parsa. Thank you for this question.

Ontario's response to the COVID-19 pandemic would not have been possible without information technology. It was critical to our provincial COVID-19 response.

Specific technology supports have been needed for self-assessment of COVID-19 symptoms, recording and transmission of laboratory test results, case and contact management, tracking the administration of doses and inventory and, of course, booking appointments. The data contained within these solutions have also informed the ministry's overall pandemic strategy, planning and reporting, supporting data-driven decision-making.

Technology for these types of functions can be complex to implement under normal circumstances, but the pandemic added to the complexity because the technology was needed right away, and in an environment with many, many unknowns. It also needed to adapt at a moment's notice to change and scale up to volumes when required. There are many technology firsts for the province, including making provincial lab data available to patients for test results, standing up not one but four large IT solutions in record time, and having provincial vaccine data administered from all health sectors available in real time in one common tool, to name a few.

Our stats show the tremendous benefits that these IT solutions have delivered, with over seven million doses captured in real time at point of administration; over five million appointment bookings, with over 530,000 in one day alone; tracking over one million case investigations and contacts; and over 3.5 million patients accessing their lab results online—not to mention replacing manual data entry with over 22 million lab records electronically integrated into our case and contact management system.

The efforts of my ministry team, along with key partners, have enabled and continue to enable the public health units and other front-line responders to focus on the health and safety of Ontarians, while using modern and flexible IT solutions.

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I would now like to invite Deputy Minister Angus to elaborate on what has been done in very short order.

Ms. Helen Angus: Thank you, MPP Parsa, for the question.

I think about the rapid speed of technology and how it has demanded of us the need for rapid deployment. Certainly, the pandemic has challenged us to pick up speed and be responsive to emerging business needs as we go through the various phases of the pandemic. The minister just enumerated a number of the systems that we've had to stand up in very short order.

Certainly, as I think back to the beginning of the pandemic, we thought that working with key partners in the public and private sectors would be important, as would be leveraging the ministry's public health IT assets and some additional investment in technology supports—that we would be able to lead the development and implementation of IT solutions to respond to the pandemic and

also contribute to the integrated health care system that supports Ontarians.

I'll go back to some remarks I made at the beginning of this: These are going to be the legacy of the pandemic, in terms of the kinds of tools that we have that really will be enhancements to the care and the quality of care that's delivered to the population long after the pandemic is gone.

The priority for the ministry, obviously, has been the health and safety of the population of Ontario and putting these tools into the hands of health care providers in order to enable them to focus on the needs of patients, while having the tools and the information readily available. We also talked a little bit earlier in the estimates about the Ontario Health Data Platform. Much of the by-product of some of these tools has been to enhance the quality of the data collection and be able to, again, adjust our response to be more effective through the use of that information.

We've collaborated with leaders and experts in a wide variety of sectors. We've conducted environmental scans of the best-in-class technology solutions. We've looked at other jurisdictions. We're leveraged the IT expertise and resources, both within the public and the private sector. And even within the public sector, this goes beyond the Ministry of Health, although I'm very proud of the team that we've got here. We've looked at the whole IT cluster. Our collaborations with the Ministry of Government and Consumer Services and other parts of government have been enormously helpful to us. We've made investments in the public health IT solutions as well. All of this has been done in the middle of incredible time constraints and requiring the buy-in and collaboration from lots of stakeholders and providers, while delivering and operating what has become, really, a 24/7 service.

Karen McKibbin, the ADM and chief information officer, has been the leader in all of this, and she'll give you some more details.

It has been nothing short of heroic to get this amount of work done in such a short period of time.

Karen?

Ms. Karen McKibbin: Thank you, Deputy Angus and Minister Elliott.

I'm Karen McKibbin, the chief information officer and assistant deputy minister for the Ministry of Health.

I certainly appreciate this time to share our technology journey in support of our battle against the pandemic and our broad COVID-19 programs, many of which you have heard about over the last several days.

The journey started with launching the COVID-19 lab results viewer, where patients could get their results securely online as soon as lab results were submitted to the Ontario Laboratory Information System, OLIS. This allowed Ontarians to quickly quarantine and protect their families and co-workers. In partnership with Ontario Health, the lab results viewer was securely launched on April 2, 2020. This marked the first time lab results from the OLIS system were made available to the public, and today there have been over 28 million queries, with close to 3.5 million unique patients accessing the tool.

Recognizing the need for primary care doctors to have access to their patients' COVID-19 results, again in partnership with Ontario Health and OntarioMD, we enabled a service to alert doctors of their patients' results, and as of yesterday it now provides alerts for COVID-19 vaccination data.

In April 2020, it became apparent that the integrated Public Health Information System, or iPHIS, our existing reportable-disease tracking system, although designed for pandemics, was not designed for this pandemic and the volumes we were seeing with COVID-19. By the end of May 2020, after rapid review of case and contact management systems in use across the world, the ministry was able to recommend a product, one that was implemented successfully and in use in both Massachusetts and California. This case and contact management product, CCM, was stood up in Ontario in 10 days, a huge accomplishment in the IT world, enabling Ontario to then customize for our specific needs, launching our version in the second week of July to our four early adopters, which included Peel, our second-largest health unit.

By early August 2020, the OLIS data was integrated directly with CCM, reducing manual data entry of lab results and providing near-real-time alerting to public health units, or PHUs, of positive cases, further strengthening their ability to ensure cases moved into quarantine quickly to reduce the spread. Thus far, CCM has performed over 22 million transactions against the OLIS database. By the end of August 2020, all but three health units were using the new CCM tool. These remaining PHUs on-boarded throughout the fall, with Toronto completing their work by the end of January 2021.

Since its launch, CCM has supported close to one million case investigations and contact tracing. Additional system features and functions have been added in over 40 releases, including guided scripts for both case and contact managers to simplify the investigation and tracking process.

The virtual assistant tool, or VA, enables health units to send a text or email to a case or contact with a secure link to a survey for the individual to complete through guided workflow and integrate results directly into the CCM tool. This virtual assistant has significantly reduced the average call-handling time, and has now been sent to 62% of cases and growing daily. Yesterday, all 34 public health units met or exceeded the 90% target for reaching cases within 24 hours, despite cases being over 2,000 a day. This speaks to the value of the virtual assistant tool and the great work by our case managers.

CCM has the flexibility needed to make changes quickly, including acting on variants of concern and tracking adverse events following immunization, all supporting and enabling the best response possible to the ever-changing pandemic. Without CCM, the health units and the province would never have been able to keep up with the volumes of case and contact management that COVID-19 has required. We are now expanding the system to capture other reportable diseases, including flu, and with this work we can soon see an end to faxing lab results.

Now I would like to focus on the second half of our COVID-19 technology journey: that is, the vaccine program and supporting clinic operations, or getting shots in arms.

In November 2020, we embarked on a review of potential clinic operation software, with the principle that this software was to be used in every clinic setting across the province in real time, by every clinician administering vaccines, [*inaudible*] the core tool for understanding the vaccine rollout and developing the most responsive plan. So the search began, with the initial focus on supporting mass immunization clinics, with the flexibility to evolve to other models. In addition, the search was narrowed to solutions that could easily align with our CCM solution on the same cloud platform, to minimize health unit training, support needs and operational requirements, and fast-track integration of components—

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Ms. Karen McKibbin: —such as adverse events following immunization and case data.

We also knew we needed a solution that could scale quickly, could manage the provincial volume, could be deployed as the one and only provincial solution and could be accessed in real time anywhere via the Internet. By December 7, COVaxON was selected. It has now become the little engine that could. Now it's the authoritative and dependable source of all COVID-19 vaccine administration data across the province—an approach envied by many other jurisdictions.

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The plans originally had a January 4, 2021, system launch in a few mass immunization clinics. However, when Pfizer arrived earlier than first anticipated, we needed to quickly pivot, and by December 15, 2020, COVaxON was in use in the first two mass immunization clinics in Ottawa and Toronto, the first mass immunization clinics in Canada. This was a true IT miracle. COVaxON was up and running in seven days.

Not only was it operational in seven days, but it was well received by the clinics, stating its ease of use and its great support for clinic flow and needed throughput. The system supported receiving inventory, checking registration, consent management, dose administration and check-out with a printed or emailed vaccination receipt.

The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Karen McKibbin: An accompanying result of the solution was Clinic in a Box. This Clinic in a Box provisioned an entire turnkey for the clinic, comprised of all the necessary IT equipment: iPads, printers, scanners, network hubs to ensure clinics were secure and can function anywhere, power bars and carts to easily move equipment and to secure the equipment when not in use. The Clinic in the Box saved hours in set-up time and supported quick on-boarding of end users. This was critical to meet the fast pace and demand for new clinics.

It also—

The Acting Chair (Mr. Tom Rakocevic): We're out of time. Thank you to you and all the IT people out there.

We're going to move on to the official opposition for the last about seven, eight minutes we have. Please proceed, MPP Gélinas.

M^me^ France Gélinas: I would like to go back to my question about the Ontario health teams and, specifically, if there is a population size minimum or a target for Ontario health teams or not. And then I have money questions.

The Acting Chair (Mr. Tom Rakocevic): You're muted.

Is she unmuted?

Interjections.

The Acting Chair (Mr. Tom Rakocevic): Okay. So you're unmuted on our end, but you appear to be muted on your end.

Ms. Amy Olmstead: I'm not showing as muted.

The Acting Chair (Mr. Tom Rakocevic): We hear you now.

Ms. Amy Olmstead: Great. I need some of ADM McKibbin's IT geniuses to come and help me today, so my apologies.

M^me^ France Gélinas: All good.

Ms. Amy Olmstead: I'm going to stay off-camera, if that's all right, due to my IT troubles.

Thank you so much, MPP Gélinas, for your question.

You're correct that the population size is a factor in determining what OHT groupings do make sense. But it is not a hard and fast rule. Certainly, when we look at the north, we are open to some learning here.

As you probably know, of our 42 approved OHTs, four are in the north, including the Algoma OHT. We know that there are many other teams that are seeking to be OHTs or to participate in an OHT model. When we've worked with those teams, we have indicated that we are looking for a full continuum of services at maturity, a sufficient population size to support the model, and we are looking at patient access patterns.

Two other Algoma teams did apply to be Ontario health teams. We asked the north Algoma team to work with the approved Algoma OHT based on their patient attribution model. For east Algoma, based on the geography, that team could align with either Algoma or a Sudbury team.

We're pleased that east Algoma is working with Ontario Health to facilitate partnerships locally.

Ontario Health is a really key partner for us, for OHTs at all stages of development, as we look to continue to support implementation.

We do know, obviously, that in the north and in rural areas, we have to take a look at the OHT model and make sure it is balancing particular geographies while still supporting our goals for the model. Ontario Health, in the work that they're doing with teams both in the northeast and northwest, is really considering these issues of geography and population density in the north as we look at the model and seek to support the effectiveness of the model while being responsive to the geography.

M^me^ France Gélinas: I appreciate your answer.

For many areas of the north, like in my riding—if you look at the French River area, if you look at east Algoma,

if you look at many different parts, they're being asked to either go to Sault Ste. Marie or to Sudbury, when, really, they have all six parts: they have hospital; they have long-term care; they have family health teams; they have care and community—I don't know how to call them anymore; they have home care; and they have mental health. They already work together. They have always worked as a health team—never been recognized as such because it did not exist, but they always worked well with one another. Now they're having a tough time saying that they'll have to link up to Sudbury or to Algoma—which they consider Sault Ste. Marie. And just the driving distances are—those people don't know one another. The physicians who work in the Sudbury or in the Algoma health teams could not name two physicians who work in Elliot Lake or in the North Shore or—anyway, it's not easy.

If I look through the estimates book, I don't see any money going to Ontario health teams. Is it because everybody is still being funded through their old program? Do long-term care by long-term care, hospital by hospital, community health centres, family health teams, nurse practitioner-led clinics, independent physicians continue to be funded the same way? Have any of the Ontario teams started to get integrated governance or integrated financing?

The Acting Chair (Mr. Tom Rakocevic): Two minutes.

Ms. Amy Olmstead: MPP Gélinas, you are correct in that the funding for partners within Ontario health teams is still coming to them as individual partners. That is a big reason why you won't see a budget line associated with Ontario health teams at this time.

However, we have provided funding to approve teams to support their implementation. In 2020-21, it was approximately $10 million, and then growing to $34 million in 2021-22. This implementation funding is designed to support that hard work of creating those partnerships, creating new processes, investing in things such as patient engagement and digital health. That is the step we have taken at this time.

For teams to be eligible for that implementation funding, they do need a collaborative decision-making agreement in place. We can imagine that as a first step around that shared governance and accountability that we will see at end state. Through this collaborative decision-making arrangement, the teams have to collaboratively—

The Acting Chair (Mr. Tom Rakocevic): Thirty seconds.

Ms. Amy Olmstead: —decide how to spend—

Failure of sound system.

M^me^ France Gélinas: I lost her again.

Okay, with $10 million in 2020-21—and what was the amount this year?

The Acting Chair (Mr. Tom Rakocevic): It's intermittent, the connection.

Ms. Amy Olmstead: I do apologize for my Internet glitches this evening.

The Acting Chair (Mr. Tom Rakocevic): Sorry; we're out of time now. We'll have to reconnect at our next date.

That's all the time we have available today. The committee is now adjourned until following routine proceedings tomorrow. Have a great evening.

The committee adjourned at 1800.

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