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2020 Annual Report, Auditor General:

Ministry of Health

Ontario Health

1st Session
42nd Parliament

Wednesday 26 May 2021

Chair: Taras Natyshak
Clerk: Christopher Tyrell

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Président : Taras Natyshak
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 26 May 2021

Mercredi 26 mai 2021

The committee met at 1430 in committee room 1 and by video conference, following a closed session.

2020 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH

ONTARIO HEALTH

Consideration of value-for-money audit, virtual care: use of communication technologies for patient care.

The Chair (Mr. Taras Natyshak): Welcome back, colleagues. I will now call the meeting of the Standing Committee on Public Accounts to order. We're here to begin consideration of the value-for-money audit on virtual care and use of communication technologies for patient care from the 2020 annual report from the Office of the Auditor General of Ontario.

Joining us today are officials from the Ministry of Health and Ontario Health. You will have 20 minutes, collectively, for an opening presentation to the committee. We'll then move to a question-and-answer period where we'll rotate back and forth between government and official opposition caucuses for 20-minute intervals, with some time for questioning for the independent member.

I'll now invite each person to introduce themselves for Hansard before you begin speaking, and you may begin when you're ready. Welcome.

Ms. Helen Angus: Thank you very much. My name is Helen Angus. I'm the Deputy Minister of Health. It's a pleasure to be here today and a pleasure to return to the Standing Committee on Public Accounts to talk about what I think has been a very helpful audit—the audit of virtual care and use of communication technologies for patient care.

I've got a number of colleagues here with me today, including Mel Fraser, who is the associate deputy ministry of health services; Greg Hein, who is the assistant deputy minister for the ministry's digital division; Patrick Dicerni, the general manager of the Ontario Health Insurance Plan, and members of his team; and I see Evan Mills, who works with Greg, on the line as well.

As mentioned, we're joined here by colleagues from Ontario Health: Dr. Sacha Bhatia, population health and values-based health systems executive; and Payam Pakravan, vice-president, strategy and analytics.

As well, I want to thank the Auditor General and her team for their work on the audit. We certainly recognize the important role of the Office of the Auditor General and appreciate the collaborative relationship that we have with the Office of the Auditor General and the ministry. This particular audit has given us an opportunity to look carefully at the province's approach to delivering value through virtual care, and we acknowledge that the recommendations in the report will be helpful to us as guidance as we refine our work moving forward.

Today we're going to be talking about the ministry's Digital First for Health Strategy, our overall approach to virtual care, some of the successes we've seen in virtual care—some of them are quite recent in terms of the COVID-19 pandemic—and some lessons learned from those experiences moving forward; and the role of our partners at Ontario Health in implementing the strategy.

I do have a note that I would like to put on the record here: The Ministry of Health and the Ontario Medical Association are actively engaged in binding negotiations, so while we will do our best to provide fulsome responses to all the questions that will be asked today, we also have to respect that ongoing discussions with our OMA partner on the topic of the future of virtual care are subject to a mediation blackout. I just want to respectfully note that my remarks here and those of the team are not intended to presuppose the outcome of those conversations which will have a significant impact on the evolution of virtual care in the province. Like many facets of an insured health system, the issues we regularly have to work through are complex and transformative in nature. So we will try to be as forthright as we can be, but again, as I've just said, mindful of the blackout that both parties have committed to as part of the mediation process, and of course virtual care is a major topic of discussion there.

With that as backdrop, I'm going to provide some background on the ministry's Digital First for Health Strategy to situate the findings and recommendations of the Auditor General. Certainly, Ontario is committed to building an integrated care system that puts the patient at the centre of care and is organized around the real-life needs of patients and, I think, has been the subject of many studies and experiences in the health care system. Sharing health information across different parts of the system has for too long been made more difficult than it should be, and so the Digital First for Health Strategy is intended to rectify that situation.

What we've heard from stakeholders—and in our case, we've listened very carefully to the Premier's Council on Improving Healthcare and Ending Hallway Medicine, which recommended that Ontario leverage the full power of secure digital tools to improve virtual care options and make personal health information digitally available to patients and their providers.

From front-line health providers, we've heard that they want a better work experience that would let them spend more time delivering care. They wanted easy access to the right clinical information right at the bedside, so that they could spend less time doing paperwork and searching for patient records and more time actually in the quality interaction that they have with their patients.

From innovators in the private sector, we heard a call for a health system that would support economic growth and job creation. They wanted responsible access to the health marketplace and for that marketplace to be supportive of made-in-Ontario innovations.

Most importantly, from patients, we heard that they wanted more choices about how they could interact with the health care system, including more convenient ways to access care and communicate with their care providers and the ability to book appointments online.

The strategy was designed to address those things and is intended and is in the process of streamlining the flow of information between the various information systems so that a patient's health care record can be securely accessed, wherever and whenever it's needed, to deliver safer, higher-quality care. Better access to information for providers and patients means that patients don't feel like they're starting over each time they meet a new clinician and repeat the stories at every clinical encounter. It has been a while, but they won't have to carry hard copies of their own records with them across the transitions of care. I certainly remember times, when I was working on the campus of Princess Margaret hospital, seeing people with their big X-rays or their images, coming in for their appointments.

We're also supporting Ontario health teams and front-line care providers with investments in more integrated digital tools. We're taking a leadership role in driving interoperability between digital systems by establishing provincial standards backed up by a new regulatory framework.

A key part of the work that we're doing on the Digital First for Health Strategy is rooted in patient empowerment. We're enabling new ways for Ontarians to digitally access their own records so that they can be more equal partners in managing their own health. We're implementing a new, consistent approach to verifying digital identities to provide confidence that accessing personal health information using apps and digital portals is safe and secure. We're also building the foundation for broadly available online appointment booking so that Ontarians can schedule visits with their care providers quickly and conveniently.

Finally, and most relevant to the conversation today, through the Digital First for Health Strategy, we're delivering better virtual care options to Ontarians so that they can communicate securely with their care providers from the comfort of their own home, when clinically appropriate, with less disruption to their day.

These initiatives have proven to be crucial in maintaining access to care during the pandemic. Our health system partners have stepped up with many innovative ways to support patients virtually as we work through this challenging time together. With the lessons that we've learned over the last 16 months, we are committed to virtual care remaining a mainstream option, even after the pandemic is behind us.

The evolution of virtual care after the pandemic will require a measured approach, based on the principles of patient access, appropriateness of care, and the long-term sustainability of our health care system.

When I think about virtual care, I think it's important to recognize that Ontario has been a global leader in virtual care. The Ontario Virtual Care Program has provided publicly funded virtual care services to Ontarians for over 15 years, supporting one of the world's first and largest virtual care networks and demonstrating what is possible through innovative programs and technology solutions. Virtual visit use through this program has grown, on average, about 30% year over year, with more than 1.4 million virtual visits now delivered annually by approximately 15,000 health care providers. Virtual care can now be provided in more than 15 therapeutic areas, including mental health and addictions, primary care, surgery and, obviously, many other specialties involved in the health care system. It wasn't really a mainstream part of the health care delivery across the board until COVID-19 provided a catalyst for transformational change.

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As part of the Digital First for Health Strategy, the ministry, in partnership with Ontario Health and other health care delivery organizations, began to lead efforts to modernize delivery of virtual care. These changes became an essential support for our response during the COVID-19 pandemic, and have provided and continue to provide a strong foundation as we continue to evaluate the benefits delivered by virtual care and address the key themes and opportunities that underpin the strategy and that were also highlighted by the Auditor General and her team.

For example, in November 2019, the virtual care program began supporting video visits that could be accessed in the comfort of one's home by any participating primary care or specialist physician. This enhancement allowed the program to adapt quickly to meet the increased demand for virtual care services resulting from the pandemic and support continued access to care, while protecting patients from potential exposure to the virus.

We've also funded rapid implementation of regional and provincial virtual care initiatives, and I can give you some stats on the kinds of outcomes we've achieved. As of March 31, more than 21,000 patients, including 19,000 patients diagnosed with COVID-19, have been enrolled in a remote care-monitoring program that ensures that these patients can receive appropriate care at home and at a

distance from their providers, reducing the risk of infection for front-line health care workers and increasing, I think, the overall comfort for the patients.

The increased use of virtual remote monitoring programs has resulted in more patient care being provided in the community, and has also helped reduce alternate-level-of-care indicators for hospitals.

Here's another example: Since November 2020, more than 170 surgical patients at the Thunder Bay Regional Health Sciences Centre have benefited from using the hospital's digital patient engagement tool. The tool enables the safe discharge of patients earlier than otherwise would be the case and minimizes in-person home care services by guiding patients from pre-op preparation to post-surgical recovery with personalized education, progress tracking and remote monitoring. And the patients like it: 91% of patients surveyed recommended their experience to others, and 87.5% said the program helped them feel less anxious before surgery. Close to 5,000 patients were able to access urgent care through telephone or video visits, and 87% of these encounters were managed without escalation to unnecessary in-person emergency department visits.

Some 27 projects targeted at front-line home and community care service providers, including those in First Nations communities, urban Indigenous organizations, community agencies and home care service provider organizations, were funded to enable important supports like virtual palliative care and virtual seniors' programs during the pandemic.

Those are just a few examples, and I know my colleagues will have more that can highlight the progress that has been made.

The Auditor General's report does comment on Health Care Navigation Service. As noted in the report, we've started the work to establish a Health Care Navigation Service and program, the objectives of which are tied directly to the Digital First for Health Strategy. The intent here is to enable the ministry to deliver on the objective of supporting increased access to virtual care and improved health system navigation by modernizing several of the ministry's programs and services. I know my team will be able to talk more about that. We have accomplished some key milestones on the road to establishing a provincial Health Care Navigation Service. As mentioned, the idea there is to really improve navigation and modernize the existing telehealth services. When it's fully implemented, the new service will act as a one-stop digital front door to Ontario's health care system, giving all Ontarians new ways to access information, to seek advice, and to get connected to health care services and supports across the province.

Just on reflection—I think it has been more than a year, but who's counting? It's probably 16 months since COVID-19 arrived in Ontario, and it changed many of our daily lives in ways that we could never have imagined. We faced incredible challenges, and although it hasn't been easy, I believe that we—by we, I mean not only the government and the ministry, but also our partners in the health system—have adapted and adjusted and worked hard to keep each other safe. But it really is, at the front line, the essential workers in the health care system, the food supply system, the supply chain, who have gone above and beyond, and we owe them a debt of gratitude.

I'm going to ask Dr. Sacha Bhatia, who I introduced earlier, to speak in a couple of minutes.

I want to recognize the work of Ontario Health as partners who have worked hard to help us in the response to the pandemic. Certainly, the kinds of successes and the examples that I provided to you would not be possible without their commitment and work on behalf of the people of the province.

We continue to look forward to working closely with Ontario Health and all our health care partners to understand better how virtual care can be used in Ontario and how it can be used to improve access to appropriate health care in a safe and sustainable way.

With that, Sacha, you should introduce yourself for Hansard, and the floor is yours.

The Chair (Mr. Taras Natyshak): Dr. Bhatia, you have about three minutes left.

Dr. Sacha Bhatia: My name is Sacha Bhatia. I'm a population health and value-based systems executive with Ontario Health. I'm also a practising cardiologist at Women's College Hospital in the University Health Network in Toronto. Joining me today is Payam Pakravan, the vice-president of strategy and analytics of Ontario Health. Thank you for the opportunity to appear today.

The report recommendations of the Auditor General's value-for-money audit on virtual care are timely.

By way of background, Ontario Health was created two years ago to connect and coordinate Ontario's health system. Ontario Health has a mandate to provide health system leadership, and this includes the unification of 21 former health agencies, including the former OTN and eHealth Ontario, and implementation of an integration and transformation mandate under the Connecting Care Act of 2019.

At Ontario Health, we believe in patient-centred care and health equity as central tenets. A focus of our work is to connect the health system so that Ontarians will continue to receive high-quality services where and when they need them. Fundamentally, we support a digital-first approach to health care, and this includes enabling virtual care.

Looking specifically at virtual care, the transfer of OTN into Ontario Health on April 1, 2020, provided for the enhanced development and integration of a digital-first approach for health in Ontario that I think has served us really well during the pandemic. It supported and contributed to a rapid scale-up of virtual care across the health system over the past year, when we needed it the most.

Ontario Health, working in close partnership with the Ministry of Health, as the deputy mentioned, has responsibility for maintaining and expanding the delivery and adoption of virtual care as appropriate across the health system and particularly among priority populations. Our responsibilities include establishing recommendations and

best practices for virtual care delivery to ensure appropriate use that benefits the patient.

I'm going to quickly cover a couple of items of actions that we have taken as part of the COVID-19 response related to virtual care. The first is around enhancing primary care and remote care management in a variety of settings. We know that the pandemic, as mentioned by the deputy, has led to significant progress and rapid expansion of virtual care across the province. The number of OH-supported virtual visits in Ontario doubled, from 1.36 million in 2019-20 to approximately 2.7 million in 2020-21. Over the same time period, 22,288 physicians, nurses and allied health professionals used virtual care through specifically managed Ontario Health systems. This was up from 13,563 just one year ago.

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In Ontario, there were over 30,000 room-based and computer-based video conferencing pinpoints, 705 of which are patient portal sites, which ensure equitable access to video conferencing for patients who do not have access to the technology required in their own homes or who need support in order to participate in a video visit—

The Chair (Mr. Taras Natyshak): Thank you very much, Dr. Bhatia. I have to cut you off there.

We are now going to move on to our first round of 20-minute questions, starting with the official opposition. Madame Gélinas.

M^me^ France Gélinas: I would like to say hello to the deputy minister, who I have not seen in almost 16 hours. I missed you, Deputy. I'm so happy that you're back on air.

I have no intention of meddling with negotiations between the province and the OMA. I respect the negotiation process enough to stay away from this.

My questions will have to do with some of the data that the Auditor General shared with us, where a single physician saw 321 patients in one day. They had an average of 73 patients per day, with billings into the $3.6 millions. How was this flagged to your ministry? And how does your ministry respond to information like this that the Auditor General uncovers? Who takes responsibility for this? What steps are taken?

I see Mr. Hein has his hand up, so I think he has an answer for me.

Mr. Greg Hein: Thanks very much. I'm Greg Hein, assistant deputy minister of digital health.

Let me begin by clarifying something that may be apparent to folks, but it's worth underlining. That is that right now we have the legacy program, the Ontario video conferencing program and the new activity under OHIP, for which my colleague, ADM Patrick Dicerni, is responsible. I will speak to it just by way of saying that OHIP has a long history of an audit function and tracking billing. When it comes to the Ontario Virtual Care Program, that is something that uses the OHIP processing system but is a separate program in and of itself. I will happily declare that this is easily the most important part of the audit, from our perspective, and was really helpful to flag the overbilling problem.

Let me say that when physicians sign up for the Ontario Virtual Care Program, they have to make a series of commitments. Those are related to eligibility—of being able to actually provide the service. There are a whole series of steps they have to go through, including not overbilling, since it's, frankly, an obvious problem. If you look at the profession as a whole, clearly there are lots and lots of Ontario physicians who are good actors and are doing the best they can, but there are always some bad actors.

When it is discovered that there was some overbilling, there are a series of steps that can take place. First, the ministry and OH reach out, and if that's unsuccessful, then it's given to the College of Physicians and Surgeons to follow up. If that's unsuccessful, as has happened in the case of a few of these, the OPP is actually engaged to follow up. At that level it turns into fraudulent activity.

Let me be plain in saying that in the Ontario Virtual Care Program itself, we do not have sufficient oversight to catch those cases of overbilling. It's something that we are working on. I would say it's our top priority from the audit. We're working on a post-payment audit framework that draws the best practices from the OHIP version, and we're doing that with timeliness. The rate at which we can conclude that is partly dependent on some engagement of the profession itself through the OMA, and that will be a bit of a rate-limiter.

The former OTN part of OH, I should also say, has some fairly robust education activities it undertakes with participants of the program.

So there are some well-rounded steps that we do take, but our ability to catch those high billers needs work.

M^me^ France Gélinas: So you've explained the process.

If I drill it down to the example that the Auditor General has shared with us—physician number one, 321 visits in one day; physician number two, 296 visits in one day. I'm strong in math. That means you don't spend a whole lot of time with your patient, even if you put in a 12-hour day.

Have you followed up specifically with the example that the Auditor General brought in, and where is it at specifically for those physicians?

Mr. Greg Hein: I can provide follow-up information on the level for each of those. As I said, it has reached the Ontario Provincial Police for some of them. So the different tiers—some are with the college, and some are with the OPP, because, clearly, that's potentially fraudulent behaviour.

I will say that beyond those very extreme cases—and there aren't that many who were caught, but still, it raises the issue of appropriateness.

While virtual care has many demonstrable benefits—and this is evident in high-performing systems around the world—there is the possibility to use the technology in an unhelpful way. So that level of oversight has to match the technology.

M^me^ France Gélinas: Do you see your division being able to have oversight in a timely manner—and define "timely" as in months, years, or more than five years. The Auditor General explained to us how she extracted that data. It didn't look that difficult to do, but then again, I didn't do it; they did, so more power to them. Is this something that you also intend to do?

I support virtual care 100%. I represent people from the north. Most of the primary health care sites in my riding have been linked to OTN forever. This is how we communicate with specialists. This is our way of getting access to health care. I agree with you; there are many, many physicians who are very good and go out of their way to serve the people in Nickel Belt, and I thank them every day. But when I see things like this, it ruins it for all of the good people. So I see a bit of urgency there.

I'm wondering when you would be able to have the level of oversight needed to be able to identify those out of pattern, similar to what the Auditor General did in her report.

Mr. Greg Hein: I would offer three points.

The first one is reiterating that for those who were helpfully captured by the audit report, there is very vigorous follow-up, and we will provide that information on those extreme cases.

The second one, which I haven't mentioned yet, is, upon receiving the report itself, we've engaged different parts of the ministry, including those that sift through data from different sources, including OHIP, and we are examining those claims.

The third one is a broader policy question—and it cross-cuts to ADM Patrick Dicerni's responsibilities—and that is, this, in and of itself, underlines one of the benefits of moving virtual care into OHIP instead of leaving it exclusively in the legacy program that worked well when we were working on adoption and working through care models. Now that it has matured and has grown legs, so to speak, through COVID-19, it has become a main part of health service delivery, and therefore, in all likelihood, should be part of OHIP. So there's that important policy stream, as well.

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I would say we're pursuing all three tracks concurrently with the vigour that you're suggesting should exist. I agree with you that it could harm the credibility of virtual, and that would be an unfortunate thing.

M^me^ France Gélinas: Just to make sure that I fully understand: The government pays $31 million a year for telemedicine. Physicians have billed in the last year—the year before; the year of the audit—$90 million in OHIP billing, and then she also gave us a number for telehealth. So what you're telling me is that the $90 million that was billed was not part of the now $17-billion OHIP pie? It is separate from this, and so is the $31 million that we pay to telemedicine? It's separate from that?

Mr. Greg Hein: Let's put telehealth aside, because that's different. That's the—

M^me^ France Gélinas: No, telemedicine, I meant to say. I'm sorry if I said "telehealth."

Mr. Greg Hein: As I was saying, there are two main ways that virtual care is funded. There's the legacy program, called the Ontario Virtual Care Program, and then with COVID-19 there are the K-codes under OHIP. We have all of the numbers for our program, and ADM Dicerni has the OHIP spending.

M^me^ France Gélinas: The K-codes.

Mr. Greg Hein: Yes.

M^me^ France Gélinas: You made the comment that the time has come to move virtual care into OHIP, to move the legacy program into OHIP. Would that mean the $31 million paid to telemedicine and the OHIP that has been paid would then be added to the OHIP pie?

Mr. Greg Hein: Going back to the deputy's note on discussions with the OMA, we're getting kind of close to some issues that probably would make sense to talk about post that process.

M^me^ France Gélinas: I fully respect this. I have no problem respecting negotiations. I just wanted to know.

ADM Dicerni, we pay for the telemedicine, which has been used extensively in northern Ontario and everywhere else. We pay for the billing for the people who used this. You have paid for the K-codes—"you," as in the program that you manage.

Were you able to have any degree of oversight of the K-codes, to see if we will find the same kind of findings that the Auditor General had with 321 visits in one day? What kind of oversight do you have over those codes?

Mr. Patrick Dicerni: I'm ADM Patrick Dicerni. I'm the assistant deputy minister in our OHIP and drugs and devices division.

Thank you very much for the question, Madame Gélinas. It's good to see you again—a good 16 hours later. Thank you for the question with respect to, broadly speaking, how we ensure program integrity and appropriateness within the OHIP program, as you mentioned.

The tools and processes that are at the OHIP division's disposal for in-person billings or the topic of the day, virtual care, are the same tools that we have, so we would be able to bring that degree of oversight to this question, to K-code billings.

To go a little deeper on that with respect to the manner in which we go about ensuring program integrity, we would often go on the basis of tips that come into our OHIP office or other anomalies in the claims data and billing data that are seen. If there are anomalies to a degree to which we would want to engage one of our medical advisers in the OHIP program to look, then there's a progressive set of steps that we use to ensure the integrity of whether that service was rendered, and that includes contacting the physician, seeing clinical records.

As my colleague Greg Hein pointed out, in rare cases when we do have issues of out-and-out fraud—and I use that word very cautiously—those cases are appropriately referred to the Ontario Provincial Police.

So we would have the full suite of our program integrity capabilities that would be brought to bear on—to your question, Madame Gélinas—the K-codes, and there are a couple of instances where I know we would be looking at some of the billing patterns.

M^me^ France Gélinas: Do you feel that the oversight you have, the full suite, you called it, of oversight—do you feel that this is robust enough to make sure that if there are people who don't follow the rules out there, you are able to catch them on a timely basis and you are able to bring the money back?

Mr. Patrick Dicerni: Thank you for the question.

I would say that in the case of program integrity writ large, and given my responsibilities in the Ontario Public Drug Programs and the OHIP program, it's something that I've spent a considerable amount of time looking at, and I'd say that is thanks both to the Auditor General of Ontario's office as well as our internal audit functions here within Ontario. I say that because there can always be better tools and more resources brought to bear on looking for anomalous payments and determining the degree to which those need to be interrogated on their own.

But to answer your question, I am quite confident in the suite of tools and techniques that we have to look at program integrity and some legislative change that occurred in the province not too long ago, particularly with respect to post-payment accountability. The process that we engaged with the OMA on to enhance some of those capabilities is something that builds out our tool kit.

M^me^ France Gélinas: Don't share with us things you're not supposed to share, but I don't see why—this is government money. Why does OMA have to participate in the way that you oversee the way government spends $17 billion of OHIP money?

Mr. Patrick Dicerni: I wouldn't say that they oversee in any way, MPP Gélinas. But from a procedural fairness perspective and a clarity of understanding for providers in terms of what they will experience if they were to be the subject of the audit—is the work that we've done with the OMA.

M^me^ France Gélinas: How many people within your office have a job description to look at that, and what's their job description? Who are they, and how many are there?

Mr. Patrick Dicerni: We do have a fraud prevention unit within the division. If I could commit to returning to you in terms of the individual FTE count within that unit—I apologize; I don't have that figure at my disposal right now.

M^me^ France Gélinas: I don't mind. If you could bring it back, that would be helpful.

I'm going back to ADM Greg Hein. The auditor shared with us that of the billings through the telemedicine network, some physicians billed for 29,500 visits, but they could only find 10,401 visits on the telemedicine network. There were 19,000 of them up in the air. How do you reconcile that? What have you done with that information?

Mr. Greg Hein: As I said, there are those different tiers of responses and following up with the physician himself. There's also what we call patient verification: following up with patients themselves on a sampling basis to see if a service was actually provided. Those steps are being taken.

As Patrick cautiously used the language of—one doesn't want to reach a conclusion about fraudulent behaviour, but when it comes to those top billers who are straining the bounds of the laws of physics even, never mind operating in a super–efficient way, those are bad actors, and we're taking it very seriously. They will be dealt with through the steps that we've talked about, including the OPP.

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Really, it has put some gas in the tank of figuring out the best way to have oversight. We always do think about this, but as I said, it has made us view the movement of virtual care into OHIP in that light as well, and it's an additional benefit.

M^me^ France Gélinas: How come it took an auditor's report to find that out? How come we didn't have a system in place within the telemedicine network to reconcile what telemedicine encounter really happened versus what was billed for?

The Chair (Mr. Taras Natyshak): My apologies, Madame Gélinas. I have to move to the second portion of the first round. It will be 20 minutes to government members.

I will recognize Mr. Crawford.

Mr. Stephen Crawford: Thank you to the Auditor General for this report and also to everyone here who is representing the ministry.

There's a lot to talk about. I'll start off with a couple of questions before I pass it off to a colleague.

Obviously, the pandemic has dramatically affected the plans of countries, businesses, governments and individuals here in Canada and around the world.

Based on the Auditor General's audit of virtual care, the ministry's Digital First for Health Strategy played a key role in the early days of the COVID-19 pandemic.

How did the ministry quickly adapt to the pandemic? Second to that, what have we learned from virtual care and the evolving nature of it? Obviously, it's something that has been utilized. It has been around for 15 years, but the pandemic really brought it to the forefront in a very quick-time manner. What have we learned from it and how can we improve it?

Ms. Helen Angus: Thank you very much for the question. I'll just say a few things before I ask Greg Hein to give you a more specific answer to your question.

I think you're right; one of the reasons we were well positioned to support the COVID-19 response was because of the work that was done on the Digital First for Health Strategy and the fact that it was in place. Many of the initiatives that we were in the process of leading laid the foundation for the ministry to quickly pivot and respond to COVID-19.

We certainly accelerated the implementation of some elements of the Digital First for Health Strategy while delaying some others. We had to kind of shuffle the priorities within the strategy to make sure that we were responsive to what was required as a result of the pandemic.

I would say we're still learning the lessons from COVID-19. We've heard some terrific stories about the uptake and the acceptability of virtual care, both from a provider and patient perspective. But I do think we want to give some careful consideration to the lessons learned, including this audit, which is important in order to establish the right virtual care framework for Ontario and make sure that it's consistent with the principles of patient access, that the care is appropriate, and that the long-term sustainability of the publicly funded system is maintained.

I do think it's pretty clear that there are some things where virtual care is brilliant: consults, mental health, others. Certainly, in the course of the pandemic, we've watched some procedures and things that can only be done with an in-person visit: breast examinations—I spent some time in

the cancer system—Pap tests, and other things that have to be done in person. It really is about getting to the right balance and the appropriate use of virtual care and in-person care.

Greg, maybe you want to take it from here and answer MPP Crawford's question.

Mr. Greg Hein: Building on the deputy's remarks, I wanted to go through the four other pillars of the Digital First for Health Strategy to give a sense of how the one pillar, virtual care, fits with the other ones, because they really do hang together and, as a whole, are guiding the way we think about the future of virtual care.

The second and third pillars of our strategy focus on providing patients with access to modern digital tools; namely, online appointment booking and digital access to their own health information. In both cases, there are many different kinds of technology available on the market to meet these needs. We don't have to start from scratch.

Through Ontario health teams, we are providing the health system with the financial supports and other incentives needed to adopt these technologies to improve patient care. While these tools are readily available, we know that we can't have a Wild West approach to implementing them; otherwise, we'll have a disconnected patchwork of solutions. We are setting standards that will ensure a common level of interoperability, privacy and security protection, and a consistent patient experience when those tools are used.

A key enabler for all patient-facing elements of the strategy is our work to create digital identities for patients to use in Ontario's health system. In partnership with the Ontario Digital Service and in alignment with government-wide efforts on digital identity, we have successfully launched a proof-of-concept patient digital identity service led out of the Niagara Health System and Southlake Regional Health Centre earlier this year. Over the coming year, this service will expand to additional communities and enable patients to use a single, secure digital identity to access a range of services, from appointment booking to virtual visits—our topic for today—and accessing personal health information.

I will also add that in certain jurisdictions like British Columbia, generating digital identities and all of the rules around them have helped to lower the cases of fraud, and this is also something that—picking up on our conversation leading up to the meeting to date and the meeting so far—is really important to us.

The fourth pillar of our strategy focuses on improving information-sharing within our health system and improving the tools available for front-line health care providers. There's a large number of initiatives under way in this space, and I will speak to just three of them now: interoperability, e-services, and cyber security.

To accelerate the connectivity of digital tools in our health system, Ontario has developed its first-ever regulatory framework for interoperability, what we refer to as the digital health information exchange policy, or DHIEX for short. This exchange gives Ontario Health the mandate to develop interoperability standards. The initial use case for the exchange is modelled on the international patient summary standard. It will enable our common set of information about patients to be shared more easily between any digital health system in the province. I just want to underline that those are the rules of the game for how information is shared that we have not had up to this point. The previous eHealth Ontario had weaker levers in order to back up the standards that they promulgated. This is the first-ever that has real regulatory heft.

Moving to the second example: Last year, Ontario launched the Ontario eServices Program, designed to accelerate the availability of eConsult and eReferral in our health system. Now, eConsult and eReferral digitize existing clinical workflows and use digital tools to help clinicians get patients faster access to special advice and specialized care. The results can be striking, with response times for e-consults often less than two business days, compared to what can often be several weeks on a waiting list for referrals, or longer. I'm pleased to say that in the first year of the Ontario eServices Program, over 150,000 new referrals and over 80,000 e-consults were set up in Ontario.

1520

Now I'll touch upon a worrisome trend. We have all seen media reports of cyber security becoming a growing threat to many sectors of the economy, and health care is no different.

We have partnered with the Ministry of Government and Consumer Services and Ontario Health to improve the supports that are available to Ontario's health care providers to help protect them from cyber threats. One tangible example of this work will be the creation, on a pilot basis, of regional security operations centres, or RSOCs. Once established, RSOCs will ensure that scarce cyber security expertise is deployed as efficiently as possible, and this in turn will improve preparedness, protection, response and recovery times in the event of a cyber attack. Again, this tracks back to the topic for today, virtual care, in that like other services, it's vulnerable to attack. As we improve how information is shared across the system, as we improve digital and virtual solutions, we also have to step up our cyber security.

The fifth pillar of our strategy focuses on improving the use of health data for research and analytics purposes. One of the principal initiatives of the last year has been the creation of the Ontario Health Data Platform. We've established an authoritative, secure and privacy-protected big data platform that gives researchers and public health the data they need to generate timely, actionable insights to inform the government's response to the COVID-19 pandemic.

Enabling all parts of the Digital First for Health Strategy is complementary work the ministry is undertaking to ensure that the province's health privacy laws are ready for our digitally connected health system. In this evolving landscape, there was a critical need to modernize Ontario's health privacy legislation to update information-sharing in the health sector of the digital age and to ensure that

patients' rights to protect and access their own information are supported.

The COVID-19 outbreak has made some of the key challenges to improved sharing and accessing of critical data even more urgent, so since 2019 we have made substantial amendments to PHIPA to enhance privacy protections; improve patient access to a patient's own information; enhance information-sharing to build a better, more integrated health system; assist in better access to data; and help with tracing, tracking and predicting how COVID-19 and other pandemics spread and evolve over time.

With that overview in place, I would like to return squarely to the topic of virtual care and to round out our response to this question. Virtual care initiatives have proven to be crucial in maintaining access to care during the pandemic, and our health system partners have stepped up with many innovative ways to support patients virtually as we work through this challenging time together. With the lessons we're learning, we're committed to virtual care remaining a mainstream option even after the pandemic is behind us.

Some examples of accelerated work include:

—increased adoption of virtual care, as we've noted;

—launching a virtual visit solution verification process, which has nine solutions already and more in the queue—more importantly, the solutions range from homegrown Ontario ones to big, national companies like Telus and even multinationals, so it has that full range;

—funding for regional virtual care initiatives, which the deputy touched upon;

—online appointment booking; and

—as I mentioned, patient identity authentication and authorization.

The accelerated use of virtual care has helped make our health system more resilient and able to adapt to challenges.

The evolution of virtual care post-pandemic will require a measured approach based on the principles of patient access, appropriateness of care, and the long-term sustainability of our health care system.

In closing, I'd like to note some exciting work that we're undertaking this year. One is the spread and scale of digital technologies in Ontario health teams, another is research and policy options to address digital health equity, and a third is policy on modernizing digital health legislation.

Mr. Stephen Crawford: I only have limited time left, so if I could get a quick response from you, Mr. Hein, or whoever from the ministry, in terms of a couple of key take-aways, on what we've learned about virtual health through the pandemic, so that it will help us in the future. What are the key points that we've learned? Obviously, it has been used in such high demand in such a short time. There have to be a few things we've learned. So what would be those few key things?

Then I'll pass it over, for the remaining time, to my colleague MPP Parsa.

Ms. Helen Angus: I might jump in and suggest that we ask Dr. Bhatia to give us some observations, because he would see this both from a clinical perspective—so you're talking to a real, live clinician, as well as a system leader. I think, Sacha, you had some examples that might be helpful, given your history and where you sit, which is a little different than the ministry—just to round it out a bit for you. Would that be helpful?

Mr. Stephen Crawford: Sure. That makes sense. He's hands-on; he's dealing with it.

So if you could, Dr. Bhatia, just in a minute or two, please.

Dr. Sacha Bhatia: As a practising clinician in the middle of this pandemic, as well as, in my prior life, a researcher in the area of virtual care, I've seen this [*inaudible*] impact, literally, of virtual care as part of our pandemic response.

When I think back to March 2020, we didn't know what we were dealing with in terms of COVID-19. We didn't really know how it would spread, and we didn't really understand the impact that it was going to have on our patients. As a cardiologist, I have to see my patients with chronic diseases, with heart failure and coronary disease. How do we keep the balance of keeping our patients safe on the one hand, while on the other hand also being able to treat them for the needs that they have with their chronic illnesses? Virtual care really was a critical pandemic tool that allowed us to safely shift—especially the outpatient management of the majority of our patients.

To give you an example: In the first quarter, after the K-codes that the ministry initiated—we saw that 70% of the ambulatory volume or the ambulatory visits that happened in the first quarter of 2020, right during the pandemic, were virtual visits. And yet, the volume of overall visits that we saw means the number of actual patients seen dropped only modestly. So what we did was—

The Chair (Mr. Taras Natyshak): Two minutes left.

Dr. Sacha Bhatia: —our strategy of being able to see patients virtually; while at the same time being able to get their prescriptions, being able to take care of their symptoms, being able to hear their concerns and manage their care; while at the same time keeping them out of busy waiting rooms, and protecting our fellow patients as well—

Failure of sound system.

The Chair (Mr. Taras Natyshak): Dr. Bhatia has frozen.

Mr. Parsa, did you want to ask a last question? You've got about a minute left.

Dr. Sacha Bhatia: —our health care staff, and I think that's really critical, that patients really like virtual care. Many of them were afraid to come to the hospital. Many of our patients didn't want to be in waiting rooms. Many [*inaudible*] care, and so they come downtown. They didn't want to come to downtown Toronto. So being able to manage them at home was a fantastic opportunity. We learned that patients really liked it. In fact, when you look at our satisfaction survey, by and large, in primary care, over 98% of patients found virtual visits to be an excellent substitute for an in-person visit. So I would say patients like it.

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The other thing I would say is, contrary to what many people thought, which is that if you do it virtually, there will be a gap in health equity—

The Chair (Mr. Taras Natyshak): Thank you very much, Dr. Bhatia. I have to cut you off there.

We are going to move to the independent member for three minutes. Mr. Blais.

Mr. Stephen Blais: Thank you, everyone, for your presentations today.

Mr. Hein, you mentioned the virtual visit solution process that you're going through to verify solutions and vendors. I'm wondering if you're able to, either today or shortly in the future, in writing, provide us a list of what those solutions are and who the vendors are that you're in discussions with or who you're evaluating.

Mr. Greg Hein: Thanks very much for the question.

Let me begin by saying that it was truly an excellent process and partnership with Ontario Health, OntarioMD, the former Ontario Telemedicine Network that then became part of Ontario Health, and the OMA itself—to sit down with other experts and figure out what are the best starting standards on interoperability, security and privacy to open up the market, to move away from the quasi-public utility model of just relying on what was called OTNinvite for years, and to open it up to a wide range of vendors.

We can absolutely provide that to you. I do have the list of nine at fingertips, but I think it would probably be easier to share with you after the meeting, offline, with all members, of course.

The more exciting thing is, beyond the nine itself—my OH colleagues can correct, but I think that there are another more than 10 in the queue. It really is an impressive list of vendors that will be helping to make this a more open Ontario market for innovation. By that, I mean you have a competition amongst all those companies to offer an easier solution for providers—providers have, fairly, been kind of grumpy about wanting virtual care solutions to be really simple for them—and also a better user experience for patients themselves.

Mr. Stephen Blais: Yes, I think it would be helpful to get the list of vendors and then also what their solution actually is, and then those future vendors as well.

I don't have any other questions, Mr. Chair.

The Chair (Mr. Taras Natyshak): We'll move to the second round. We'll go back to the official opposition for 20 minutes, starting with Madame Gélinas.

M^me^ France Gélinas: I would like to give Dr. Bhatia a chance to finish his sentence.

Just so that you know, Dr. Bhatia, your Internet connection froze for some of it, so I want you to go back to—you were telling us that 70% of ambulatory care visits had gone to virtual. Of those 70% of visits that went virtual, what were the virtual—was it mostly phone, text, email, visual? How were they done?

Dr. Sacha Bhatia: Of the 70% of visits, the large majority, about 90%, were phone visits, which I think you [*inaudible*], as I am experiencing right now. Although I'm in downtown Toronto, the connection isn't always great.

I think the phone provides a fairly safe and stable and easy to—

The Chair (Mr. Taras Natyshak): Dr. Bhatia, can I stop you there? Pardon me. I wonder if you could shut your video off. It would maybe give you a little more bandwidth.

Dr. Sacha Bhatia: Sure. Can you hear me now?

The Chair (Mr. Taras Natyshak): Yes, we can hear you.

Dr. Sacha Bhatia: Is that better?

The Chair (Mr. Taras Natyshak): Yes.

Dr. Sacha Bhatia: Sorry about that. I'm even at the hospital, so I don't really know what's going on.

What I would say is, the phone is a safe and secure mechanism by which patients can engage, and for our older patients particularly. As a cardiologist, most of my patients are over the age of 65. For them, the phone is a relatively easy way of connecting. Having said that, it's not always the best option for everyone. Sometimes you need to physically see patients. The OTN program did see a significant increase in video visit volume over the course of the pandemic—a substantial number, as has been mentioned. We can also talk about opportunities that are going to expand that network more.

One thing I wanted to get to before I got cut off was this belief that virtual care can actually lead to a widening of the digital divide or equitable gap. In fact, the research that we've done didn't show that to be true, I think for a few reasons. One is that we're meeting patients where they are. Many patients—essential workers, for example, or people with child care issues, or people from northern Ontario or rural parts of the province—often have to travel to see specialists, often have to take time off work, have to find child care for their children. The truth is, virtual care allows us to bring care to them, which again makes it more patient-centred. Providing options, as we did during the pandemic with phone or video, allows patients the option to pick the technology that works for them, which again I think allows us to meet them where they are.

The other thing, to be honest, is that there are a lot of costs. MPP Gélinas, as you know, patients sometimes have to get on a plane or take a bus or something all the way to see specialists from far away up north. This allows us an opportunity to bring cases to them and reduce their out-of-pocket costs. In fact, in our research, we did find that virtual care actually demonstrated a fairly equitable distribution—so again, a positive part of our pandemic response.

M^me^ France Gélinas: I'm shifting back to the Auditor General's report. I'm at recommendation number 2, if anybody is following, where the auditor talks to us about the uptake of Maple. I can tell you that this fee-for-service company advertised tremendously during the pandemic, a lot to the people I serve, who, for the same reason as everybody else, did not want to leave their houses, did not want to go to a clinic, did not want to be in a waiting room. They were charged, and sometimes were charged a lot of money, for what is supposed to be an Internet connection, because the care itself is supposed to be paid for. And the physicians who provided that care did not know northern Ontario whatsoever. To tell somebody from Foleyet that they should go to Thunder Bay—an easy 10 hours' drive, if the weather is good.

That put aside, I was wondering, Deputy—or whoever wants to answer—do you have any idea how many of the physicians who billed the K-codes, I'm guessing for having provided virtual care, did it through a platform that charged the patient?

Ms. Helen Angus: I'll ask Greg to talk to that, but I think it's pretty important that the services be insured.

Greg, do you want to talk about—

Mr. Greg Hein: Yes, and Patrick may as well, given that K-codes are under OHIP.

Let's put it this way: COVID-19 led to lots of positive innovation, and it led to some negative innovation. As you say, MPP Gélinas, you can't privately bill for something in OHIP, but there are some clever uses that they've come up with to charge for other things, like secure messaging.

1540

I will pass it off to Patrick to round out that answer. But needless to say, this is something that the ministry as a whole recognizes and wants to address on a timely basis.

Mr. Patrick Dicerni: As my colleague ADM Hein mentioned, there are instances, I would say, unfortunately, of private sector interest and enterprise finding, as Greg said, creative ways to charge for things that are not insured services. Secure messaging is a good example of something where there would have been a leverage point to charge a patient.

To answer your question directly, in terms of isolating the platform that virtual—or certain virtual—interactions would have been experienced or provided on, that's not a level of precision that we have in terms of identifying. We obviously can identify the provider but not the service in which they access that patient interaction.

M^me^ France Gélinas: So for the K-codes, it made no difference if the physician offered virtual service by phone, by email, by video—it's the same code?

Mr. Patrick Dicerni: Yes, from a compensation perspective, you're correct. We aren't differentiating the platform or the modality of the service provided, as we are providing on-par compensation for the four K-codes that are in the system right now.

Mr. Greg Hein: Not to sound naive, but these companies like Maple have, over the past year and a half, come to see us to talk generally about their road map and find out where we're headed as a ministry. They often complain that Ontarians, like other Canadians, aren't really in the mood to pay for services virtually. They face—to use maybe cold analytical language—some business model problems. That's not to say that the ministry shouldn't find new ways to ferret it out and to work with the profession to figure out how to deal with it. But I just wanted to make that point.

M^me^ France Gélinas: I know that physicians in community health centres, Aboriginal health access centres, get their salary and use whatever method they want to reach out. For a physician under PHO—are they allowed to use the K-codes or no?

Mr. Patrick Dicerni: Yes, they are.

M^me^ France Gélinas: So not only do they get paid for looking after a group of patients, they also can bill—okay; I just wanted to make sure.

My next one was that the auditor shared with us that British Columbia went to—basically, they put software in place quite quickly that allowed their providers to provide virtual care. Is this something that Ontario looked at? And what did we decide? Well, we decided it's not there. But did we look at that at all? It seems to work pretty well in BC.

Mr. Greg Hein: Prior to the pandemic, we had already started working on this model to open up virtual care in Ontario to whatever number of vendors could meet the right level of standards, because it's not a green field; it's a brown field, and there are lots of good solutions and lots of people saying, "We can compete."

I can tell you, for virtual care and beyond, the day is done to pick one solution. It is too risky in the end to pick a single solution. You get provider complaints or patient complaints. It sounds elegant and quick. Let's wait and see what happens in British Columbia. We are going to have a highly competitive environment where there's lots of competition—and it's not just Wild West; it's against those standards that protect privacy, security and interoperability.

I can tell you that Canada Health Infoway and other provinces are looking very seriously at the work that we've done—Ontario Health is now leading operationally—and are trying to figure out ways to implement it.

M^me^ France Gélinas: Tell me if you don't want to answer this question. Tell me what virtual care could look like in Ontario two years from now. Can you give me an idea as to what we can expect? What are we shooting for? I won't hold you to account if we're not there in two years, but give me an idea of what our end goal looks like.

Mr. Greg Hein: I would say that we want it to continue to be a regular part of health service delivery. We want an approach that reflects all of the benefits of virtual care, including improved access, including patient convenience, but also addresses some of the pitfalls like the bad actors we've been talking about today. The long-term sustainability of health care is important, and so we have to achieve that balance.

The other point—and it's probably something that Sacha will talk about as the meeting continues—is the ability to use all of the three modalities and face-to-face, so video conferencing, telephone, and secure messaging. Jurisdictions that have really locked this down figure out how to support all of those modalities based on considerations of clinical appropriateness, patient choice, provider choice.

The last point I'll make is, the user experience—both provider and patient user experience have to be like the products we use in everyday life, and we've set up the environment for that to happen.

M^me^ France Gélinas: ADM Dicerni, did you want to add anything? Is this also your vision?

Mr. Patrick Dicerni: I think my colleague did a nice job of articulating what could be the road ahead. I'll hold

any additional future comments a little bit considering our place in bargaining.

MPP Gélinas, I do want to come back to an earlier question you raised about Ontarians being charged for services via video platforms or virtual platforms. ADM Hein and I mentioned an example of something that is not an insured service. Secure messaging was the example that was used. Given how important this matter is, and given that we have legislation in Ontario to protect against the very example that you raised, I feel compelled to—the Commitment to the Future of Medicare Act does prohibit any person or entity from charging or accepting payment for an OHIP-insured service. If somebody was, I would say, inappropriately and illegally charged for an insured service in this province, we would encourage them to get in touch with us. That's a matter that, obviously, you would take very seriously. Medically necessary physician services provided, whether they be by video or telephone, are currently insured under OHIP via our K-codes. It's illegal for a patient to be charged for those services when they're provided by an Ontario physician.

M^me^ France Gélinas: Well, I may send you some of the copies of the billings and you can see for yourself. But yes, for messaging, for—anyway, I don't want to take too much time.

I'm hopeful that whatever becomes available follows the vision that ADM Hein put forward, where it is easy to use for the patient and makes sense, so that it becomes the platform of choice, rather than continuing to have—Maple is not the only one that is advertising lots in northern Ontario, and they all charge.

1550

In order to get to a place of quality care through virtual care that is equally accessible, what work has the government done to evaluate the impact of virtual care on patient outcomes, for one, and on the health care system as a whole? I know Dr. Bhatia shared what Women's College Hospital has done. Do we have ongoing evaluations? How is that done? What is part of those evaluations? I'm looking at virtual care and patient outcomes, as well as the functioning of the health care system.

Ms. Helen Angus: Dr. Bhatia would be in a great position to answer that question, given that the ministry has turned to him in times past to actually do those kinds of evaluations. I hope, Greg, that you agree, and then maybe we can put a ministry perspective on that. But for the kind of evaluation that you're talking about, we often would have contracted with Sacha and his group before he joined OH, so he'd have a really good line of sight into the kind of work that we've asked them to do, and some results probably at his fingertips.

Dr. Sacha Bhatia: Thank you, Deputy, and thank you, MPP Gélinas, for the question.

The ministry, in its wisdom, actually did fund an evaluation through the Centre for Digital Health Evaluation in the [*inaudible*] summer of the pandemic, to really evaluate the impact of virtual care.

As was mentioned, I think, by the deputy, virtual care exploded, obviously, during the pandemic. When we think about it, we're talking about 26-to-30-fold increases in overall volumes, which I think is something that we had that has been seen across the world. This is really a new phenomenon. Virtual care is not new, but the level at which it was used was quite new.

So the ministry did undertake an evaluation—again, contracting ourselves and other groups to do the work. This work had been done looking at, for example, utilization using ICES data, as well as outcomes and impacts. So there has been an analysis, looking particularly at a couple of conditions like mental health and heart failure.

In mental health, actually, virtual visits or access to virtual care was demonstrated to reduce emergency department utilization; however, with conditions like heart failure, we actually saw an increased use of diagnostic testing and some utilizations, suggesting again that virtual care is complex. It's not one simple thing; it's actually a tool that is used differently across a variety of health conditions, which makes some of the questions about how it's used difficult to answer, because again, how it's going to be used by a psychiatrist, how it's going to be used by a family doctor and how it's going to be used by a cardiologist or a surgeon is going to vary. But what we—

The Chair (Mr. Taras Natyshak): Thank you very much, Dr. Bhatia. I'm sorry to have to cut you off again.

We will move now to the government side for a 20-minute rotation, starting with MPP Parsa.

Mr. Michael Parsa: As always, I want to thank the Auditor General and her staff for the advance briefing. It's always very helpful. Thank you very much, Auditor, for that.

I also want to thank every member for joining us today, including the deputy minister and her team. As Madame Gélinas said earlier today, they're working overtime, answering questions at multiple committees. It's nice to see all of you again here today.

Deputy, my question is about the Auditor General's recommendation that the ministry evaluate the effectiveness of virtual care services. She recommended the development of metrics. Would you be able to tell me what the ministry currently measures and if the ministry refines them regularly?

Ms. Helen Angus: Yes, there's nothing I like talking about better than metrics, actually, but I will let Greg Hein give you a more detailed answer.

We've been measuring the uptake of the patient experience and, specifically, the patient experience with virtual care both before and after the pandemic. We measure the uptake, and I'm on the board of Canada Health Infoway—they also look at the uptake and experiences with virtual care. We look at their results as well as those of other organizations.

Greg, maybe you'll want to talk specifically about what metrics we use. If we can give MPP Parsa some examples of what we know about the performance of the health system for patients, that would be very helpful.

Mr. Greg Hein: Let me begin by saying that my division has a strong record of measuring results through something called a digital health scorecard. If I can be blunt,

we really don't think we should be spending tax dollars if we're not measuring the results. We do this through our partner, Ontario Health, and track metrics related to virtual care, but also the full panoply of digital health activities.

The metrics and their associated targets in various areas had been created prior to the pandemic; you won't be surprised. We use a couple of different sources of data, including virtual care utilization through the OHIP claims system; OTN, now part of OH technology; and utilization data, as well as through the health care experiences survey that's conducted by the Institute for Social Research at York University.

One of our principal virtual care metrics is the percentage of Ontarians who have had a virtual care visit in the past 12 months. Prior to COVID-19, we thought we were being quite ambitious in having 25% to 30% within three years through the launch of the Digital First for Health Strategy. As we well know from our helpful discussion today and from just being consumers of the media during the pandemic and consumers of health care services too, that adoption has gone through the roof for all sorts of reasons, including, obviously, the absence of face-to-face care for a while.

As the deputy said, as Dr. Bhatia said, it has been an interesting experience, and now we're in the mode of reflecting on how the metrics could change based on what we've seen during COVID-19. I would say that the good news is that the health care experiences survey has already been changed, at least in one dimension. For example, throughout the survey, it previously referenced "seeing one's provider" and has since been replaced, as appropriate, with "receive care" or "have an appointment," to account for virtual visits.

I should say that of the metrics we do currently track, some of them are related to the legacy program which we've been talking about, the Ontario Virtual Care Program. Through that, we look at the number of unique physicians who provide virtual care, the number of unique patients who receive care, and the number of virtual visits that have taken place through the program.

Shifting gears a little bit, the deputy mentioned that the ministry created, with Dr. Bhatia's leadership, the Centre for Digital Health Evaluation, centred at Women's College Hospital. The evaluations that he started to talk about have unearthed some interesting metrics that we may think about applying more generally and on a regular basis. Those include the percentage of ambulatory care services being delivered virtually, utilization rates of virtual care services in high- and low-income groups, and what the outcomes of virtual visits are—for example, does it lead to prescription renewal, what kind of health information is generated, and referrals to specialists.

In closing, I'd like to add that one of the reasons we track such metrics is to use the results for considering the level of investment in virtual care and digital health more broadly. We have what's called an investment management framework that we use. It underlines the ministry's commitment to shift dollars to where they have the greatest impact on health services and outcomes.

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Mr. Michael Parsa: I'll pass it along to my colleague Vijay Thanigasalam.

Mr. Vijay Thanigasalam: Thank you, MPP Parsa.

Again, I would like to thank the Auditor General and her team, and the deputy minister and the Ministry of Health team for your presentation and for your work.

The Auditor General recommended that the ministry evaluate the feasibility of allowing physicians to bill for virtual care services provided through multiple technologies outside of the telemedicine network—for example, secure messaging or phone calls—implementing changes that protect data security and privacy and enable the ministry to monitor the reasonableness of billings. I understand that significant progress has been made in this area already. I want to know what measures are being implemented—it could be any of you from the Ministry of Health. Can you please tell me about what has already been implemented in Ontario?

Ms. Helen Angus: I'm delighted to have your questions.

We accept all the recommendations of the Auditor General, but this is one that we're particularly delighted to receive. We had some work, obviously, well under way, but having the recommendation from the Auditor General is always value-add.

I'll talk a little bit about the virtual visits verification process launched to the vendor community and how that process is a standards-based approach to verifying third-party platforms for use by physicians.

I think as was already asked—we have nine solutions listed now, including a number of larger vendors. So while the original platform of OTN has been critical, the diversification (a) seemed inevitable and (b) is a highly desirable outcome.

I'll ask Ontario Health and Payam to talk a little bit about how we have brought on new vendors into the world of virtual care and how that's benefiting the people of Ontario.

Mr. Payam Pakravan: Thank you, Deputy, and thank you for the question, sir.

I am Payam Pakravan, vice-president of strategy and analytics at Ontario Health, in the population health division.

The province has indeed, as mentioned, introduced the virtual visits verification process. Ontario Health worked closely with stakeholders to develop standards on virtual care solutions that outline the technical, privacy, security and interoperability requirements of virtual visit solutions. This gives providers and patients confidence that they are using virtual care solutions that meet these standards and minimum requirements.

As has been mentioned already on this call, there is a publicly available list of verified solutions that we'll make available to the members of the committee afterwards, and we expect that list to continue to grow. In addition to what has already been mentioned, there are 16 proposals right now actually being worked on by our vendor partners.

The virtual visits verification program provides, at its essence, health care organizations and providers with the

opportunity to use their technology platform of choice, and in particular, platforms that are integrated with their own clinical information systems that form the backbone of those organizations, while ensuring that the virtual visit solution that's being chosen meets these functional, privacy and security standards.

Clearly setting out direction and guidance at a provincial level while encouraging regional and local innovation and knowledge-sharing across the province will help us to accelerate and advance virtual care while providing choice. As the program accelerates, there will be multiple options for clinicians to use, and we expect more and more clinicians to integrate virtual care into their practices, as we've been discussing today.

The virtual care funding programs—I should mention that one of the great ways in which this program is being used is that we have been supporting the growth and the use of virtual care through the pandemic. One of the conditions that we've made for the solutions that are being used to support those programs is that the solutions chosen either have been validated through this verification program or are in the process of being validated. So that's a practical example early on, going with the requirements of the pandemic to make sure that this program is being effectively used in this one early use case for this program.

The verification program has helped ensure that the solutions that are being used through these programs in response to the pandemic are high-quality, that they protect the privacy and security of sensitive personal health information, and that they have the right technical foundation to integrate, eventually, over time, with other digital health solutions, such as electronic medical records.

Mr. Vijay Thanigasalam: I'll turn it over to my colleague MPP Hogarth.

Ms. Christine Hogarth: Hi, Chair. How much time do I have left?

The Chair (Mr. Taras Natyshak): You have seven minutes and 48 seconds.

Ms. Christine Hogarth: Thank you very much. I find this one is an extremely interesting topic today.

Going back to the late 1990s, when I was a staff member at the Ministry of Northern Development and Mines, one of the policy files I worked on was Telehealth Ontario. It was a pilot project. Originally, I was from northern Ontario; Thunder Bay was my hometown, where I was born and raised. You couldn't find doctors anywhere. You couldn't get doctor's appointments. So we were trying to figure out how you help all these northerners and people in rural Ontario get service. A proposal came across our desk for the Northern Ontario Heritage Fund. Clinidata was the name of the company. I went to Moncton to study this woman's thesis that would help us bring some of this telehealth to northern Ontario. Because we were not the Ministry of Health, it was a much smaller budget, so for $5 million we were able to start Telehealth Ontario and what was the project that I worked on way back in the 1990s—which makes me wonder what has happened over the last 15 years that we have not moved the benchmark forward.

Finally, today we are now talking about virtual care. It's not just care for people in big communities like I live in now, Toronto—and my parents moved here for health care. This is about everyone in Ontario getting health care. That always has to be top of mind. How do we look after everyone?

So I'm very excited about being part of this conversation today, very excited to see this move forward, but a little bit dismayed that nothing was done for quite a bit of time—a long start.

One thing I would be a little bit concerned about is virtual care. As we saw when one of the doctors was speaking, his Internet was in and out, in and out—we're not sure. Not everybody has top-notch Internet. Sometimes right in downtown Toronto, we don't have Internet. So I want to make sure that virtual care is for everyone. I'm just wondering—I'm not sure who to ask this question to—how does it benefit everyone? I don't want this, in the future, as we fix our glitches, to just benefit people with smart phones or higher digital literacy. This has to be for everyone. So I'm wondering if somebody can talk a little bit about making sure that virtual health care is for everyone.

Ms. Helen Angus: That's a great question. I think one of the things that has happened in the pandemic is that it has really laid bare some of the equity issues and access issues. I think you raise a really good point.

As we think about virtual care—and you heard Dr. Bhatia talk a little bit about some of his research; some of that has been commissioned by the ministry to make sure that our policies and programs are done in a way that does enhance the equity of access to services.

I took a picture of my own mother booking her COVID-19 vaccine online, at 84, on her iPad, well outside Toronto. So that was encouraging to me—that we can find ways to make sure that the technology is available and actually helps reduce the barriers.

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Perhaps, Greg, you might want to go into some more detail about some of the work that has been done, and if Sacha wants to jump in as well and finish some of his thoughts, that would be most welcomed, I'm sure.

Mr. Greg Hein: I was going to say the same thing, Deputy, because we are now in this delightful, unique situation of having the former head of our evaluation group, Dr. Bhatia, as a senior person at OH and a part of this discussion in a great way.

I will start off by saying that we were thrilled that, outside of the Ministry of Health, the Ministry of Infrastructure is making investments in broadband, because there is an appreciation that—not just for health care services, but look at education as well. There are so many services now that depend on virtual interaction, and there is an acknowledgement that that needs to be done.

Equity issues surface in all sorts of interesting ways. For example, in some respects, virtual care is a friend of equity, because there are lots of folks, some of whom have been hit hard by COVID-19, who, any time they take a morning or afternoon off, whenever it is, earn less money,

so finding ways to allow them to secure health services in ways that fit with their lives is really helpful. On the other hand, it does have the potential to exacerbate. Knowing this, it was one of the questions in the major evaluation that Sacha and his group did. I will just brag on his behalf, before handing it over to him, that this is another case where Ontario's Centre for Digital Health Evaluation is being recognized by the country. They want to gobble up some of the insights and capacity, in a good way, and to figure out how to ask and answer some of these questions across Canada.

Over to you, Dr. Bhatia.

The Chair (Mr. Taras Natyshak): Just under two minutes, Dr. Bhatia.

Dr. Sacha Bhatia: Very briefly, because I could talk about this all day, MPP Hogarth—just to say you're exactly right. The thing this pandemic has unearthed, especially as it is related to virtual care, is that virtual care is just care; the point is, we need to be going to where the people are and where our patients are. Up until now, in fact, it has been inequitable, because we force patients to come to us. We force them to come to our doctors' offices, to our hospitals. We force them to only be able to engage with health care in one way, and sometimes that has been at great cost to patients and their families, particularly in places like northern Ontario.

I think the opportunity here is to consider, with all the things you've heard, to ensure that phone, video, secure message, and in person where necessary—all of those tools are going to be done, but we're using it by arranging care around the patient. I think that's critical. When we evaluate what we do to make sure that patient care is maintained and is in fact improved, and importantly, we ask the patients about their experience so that we know that we're doing right by them—it's that sort of system we're going to put in place that the ministry nodes are working on collaboratively that I think will get you exactly where you want to be.

The Chair (Mr. Taras Natyshak): We have 20 seconds left on the clock. Mr. Anand, did you want to say something in 20 seconds?

Mr. Deepak Anand: Absolutely, Chair. I want to say thank you to everybody here. I'll be asking my questions next time, but it will be on the health care navigation services.

The Chair (Mr. Taras Natyshak): Perfectly said. Thank you very much—

Ms. Christine Hogarth: Thank you very much, everyone, for your answers and for the work you're all doing. I know you're all working double time.

The Chair (Mr. Taras Natyshak): We're now moving to a three-minute round for the independent member. MPP Blais.

Mr. Stephen Blais: I don't have any questions. You can move on.

The Chair (Mr. Taras Natyshak): We'll go to the lightning round, which is the division of the remainder of the time that carries us to 4:40, which is 13 and 13.

Back to the opposition members for 13 minutes: MPP Gélinas.

M^me^ France Gélinas: I would like to talk a little bit about Telehealth—so not telemedicine, but Telehealth. It is a program that is very well-known and very well-used in my parts of the world. Through the pandemic, the Auditor General showed us that the services, for what is being measured, which is time to return a call, went to 38 hours before a call would be returned for non-COVID-19 and—I'm going by memory—I think 31 hours for COVID-19 calls.

I know that Telehealth has been contracted out, that the company that contracts them out is called Skype telehealth or something like this. Do they hire their own staff or do they subcontract this out? What is the relationship between the government and Telehealth to make sure that Telehealth—it's supposed to be nurses answering those calls; I know full well that many of them are not. Not judging the quality of the answers, because I don't think we assess any of this—how come we don't? Who wants to take the lead? I will drill down on Telehealth.

Ms. Helen Angus: Well, it's your lucky day. You get to ask ADM Dicerni a whole lot more questions.

M^me^ France Gélinas: Oh, good.

Ms. Helen Angus: We're going to be back tomorrow on blood services too, so you're going to be tired of us by the end of tomorrow.

You're right. At the pre-pandemic level, I think Telehealth was taking on about 1,600 calls, some kind of slow ramp-up of questions in late January 2020, which was pretty manageable, and then all of a sudden in March—if you remember last year, the declaration of emergency was on March 17—we went from 1,600 to well over 1,200 calls a day, so that required some pretty fast maneuvering. That was Patrick's area of responsibility. Patrick, you might engage with MPP Gélinas. I'm sure you'll have a few questions back and forth for him.

Mr. Patrick Dicerni: Thank you very much, Deputy.

Thank you for the question, MPP Gélinas. The only correction dare I put on the deputy is, she mentioned that we increased up to 1,200 calls a day; we increased up to 12,000 calls a day early in the pandemic. So we'll move the decimal point on that one. But in all seriousness, that's what led to some of the unacceptably long call-back and wait times that the Auditor General pointed out in her report.

Not to retread, but we have—and you're right, MPP Gélinas; Sykes is our vendor that supports this program, and they do hire their own staff who work full-time. It's a mix of both nurses and customer service relationship individuals who handle the incoming calls.

As the deputy said, in the course of normal volumes pre-pandemic—1,600 or so calls a day. During those at times confusing and challenging early days of the pandemic, when we were collectively, as a province, country, globe, trying to determine how the virus spread, what were the risk factors, how were people going to continue to access health care services when often we were so challenged from a personal protective equipment perspective, Telehealth did become the venue of choice or often the area where people sought out medical advice and information.

So we did see in mid-March those volumes ramp up to 12,800, 13,000 calls a day.

In response to this, 325, 330 additional registered nurses and more than 100 additional intake agents were added to Telehealth to conduct symptom assessments, referrals, all in an effort to decrease the time it takes to speak to a Telehealth representative or a nurse. We also worked quickly with our vendor in this respect to put in IVR, the automated attendant, with updated scripts, often updating the information in those scripts on a daily or weekly basis as more information became apparent.

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Recognizing the increasing demand on Telehealth, additional phone lines were also added because a challenge that we suffered was just overloading the actual infrastructure—people getting fast busy signals. As I recall, we, essentially overnight—and there are many people to thank for that—worked with telecommunications providers and our vendor to create capacity. We added over 3,750-some-odd lines. We kept 600 lines in reserve, because what we saw was, depending on the time of day and information that was in the media, big surges in the call volume. So we kept some lines in reserve in that respect.

To this day and throughout the pandemic, we've continued, as closely as possible, to monitor the daily call volumes, watching the call-back times and actively working with our vendor to review all of the measures that we have as well as to identify any additional, I'd say, immediate or future actions that could be implemented—

The Chair (Mr. Taras Natyshak): Sorry, Mr. Dicerni.

Auditor General, did you have a question or comments?

Ms. Bonnie Lysyk: I just wanted to correct, for the record—in our report, figure 25 and figure 26 speak to the volume of calls. Although there were fluctuations on days, the calls in the month of, let's say, March were up to 50,000; April, around 50,000.

Just as a point of reference for the committee, figures 25 and 26 indicate the calls during the period of January to August 2020.

The Chair (Mr. Taras Natyshak): Madame Gélinas?

M^me^ France Gélinas: ADM, could you clarify for me the relationship between—Ontario gives Telehealth $28 million a year to provide telehealth services. Telehealth gets overwhelmed through the pandemic. Who paid for the 3,700 lines? Who paid for the 330 extra RNs and the 100 extra intakes? That's my first; my second is, how do we know that we got value for money for that $28 million we spent for Telehealth?

Mr. Patrick Dicerni: With respect to your well-placed questions around value for money and how we went about the supernumerary or additive on top of the volume: Our contract with the provider, Sykes, is, let's say, a complex one insofar as we pay a base rate for a certain volume of calls. We pay à la carte, if you will, after that, once those call volumes have been eclipsed and exceeded.

To the centre, to the heart, of some of these questions: We experienced a massive influx in calls, and therefore we exceeded in short order the thresholds that up to that point had been very durable within our contract.

To answer your question in terms of who paid, the province of Ontario did, appropriately, have to pay for what was over and above the contracted service with Sykes.

With respect to an earlier question around hiring and staff: They do hire their own staff, and they do pay their own staff. That being said, in those early days of the pandemic it was truly an all-hands-on-deck effort. We did call upon many partners—including the RNAO, including sector partners—to access HHR, whether that be customer service relationship management folks, whether that be registered nurses, retired nurses. We spent an awful lot of time leveraging the health care system network and directing those individuals, trying to stay in front of the pace of calls—particularly those who desired a call-back from a nurse.

M^me^ France Gélinas: It is my understanding that with Telehealth they always worked from home, so they did not have to do the switch to home; they were already at home.

Mr. Patrick Dicerni: It's a mixed model. With the Sykes provider, they do have physical infrastructure where staff are in a call centre, if you will, and they also have a model where some are working from home. Given some of the at that point new requirements that I'd say were much less understood than those we have today, there was an immediate need to start spacing some of those individuals—physical distancing started to need to apply—so there was a migration, similar to many government programs at the time, to people working from home.

I would also say those additional resources that we assisted our vendor with bringing on to their employ were often working from home. That in itself presented some logistical and technical challenges, but we worked through those as best we could at the time.

M^me^ France Gélinas: Are you allowed to share with us part of the contract, as in the $28 million that we pay yearly—up to how much of a call volume does that pay for? I don't know if you're allowed to share that with us.

The Chair (Mr. Taras Natyshak): Two minutes left.

Mr. Patrick Dicerni: I don't have those details at my disposal—apologies—but I would be happy to take that request back.

M^me^ France Gélinas: Thank you. And how did we end up with a model where we contracted that out? Why wasn't it a transfer payment agency that became Telehealth Ontario? How did we end up where we are now?

Mr. Patrick Dicerni: It's a good and fair question, Madame Gélinas.

It predates my time in the program. I think, as we heard from MPP Hogarth, it is an older program within the Ontario government, so I don't have the information to answer some of the decision-making at the time—transfer payment agency or a contracted-out service.

M^me^ France Gélinas: My next question is, do you see a future for Telehealth Ontario, or can we see an integration of Telehealth Ontario with the other virtual care that takes place over the phone?

Mr. Patrick Dicerni: That's a really good question.

I think when we look at the assets that we have in our current system, Telehealth being very much one of them—as we start looking into the future, what does a more, I'd say, integrated health care navigation footprint look like in this province? Perhaps Greg and I can tag-team this one to some extent.

Greg, could I ask you to give some thoughts around health care navigation in the future and where we see that going?

Mr. Greg Hein: Yes. In fact, even if we run out of time—maybe there's a chance to talk about it.

Absolutely, that was one of the great recommendations that we're receiving heartily, because for some time we've thought, why would you want different silos of telehealth as a telephone triage system—

The Chair (Mr. Taras Natyshak): Mr. Hein, you are out of time. The members of the government might want to allow you to continue. It is their time on the clock now for 13 minutes.

Mr. Anand.

Mr. Deepak Anand: I want to say thank you to the whole health team and, of course, our Auditor General for doing an incredible job. Nowadays, how we balance ourselves is based on the cares we have. If we can manage our cares, we can manage ourselves. That's the new norm for the COVID-19 stay-at-home.

The auditor's report recommends that the ministry consider integrating the Ontario Telemedicine Network and Telehealth Ontario. Who could have thought 50 to 68 years back that we could virtually be at places where doctors cannot reach? Through these systems, we can still get access to health care.

I know for a fact that the ministry described starting work on the Health Care Navigation Service. So can you tell me more about the Health Care Navigation Service and how it will integrate everything, how it will make better health care for our province of Ontario?

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

You're exactly right, and I think Madame Gélinas's question was also going to the same place, of the idea of having a navigation service.

I think we've conceptualized this as a digital front door to the health care system, as a place where you can get access to health information, get advice and get supports connecting to publicly funded health care services—and certainly make it easier for Ontarians to get the health supports they need in order to stay healthy and to navigate the system.

I don't think the idea of having to do this in multiple places in the new digital world makes an awful lot of sense. So that's exactly what we're trying to do—is to streamline it, and I think the starting point for us will be Telehealth Ontario, which we've just been talking about, and then health care options, with the idea that there might be some future enhancements over time.

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Maybe, Greg, you want to talk a little bit about the work that we've been doing on the health care navigation framework, and where we are in the process of implementing a better service for people.

Mr. Greg Hein: I'm happy to do so, because it really is an exciting project that reflects the input of Ontario Health as our principal partner and operator, and a lot of folks in the field. Through their advice and advice from procurement experts, we embarked some time ago on an innovative procurement in order to end up with a health care navigation service which does exactly what the auditor's report suggests, because it's intuitively powerful, which is to find an integrated model that has different modalities to improve navigation services for Ontarians, make it modern, and make it easy to use. We're very deep into that process. Analogous to the note about discussions with the profession, there is some sensitivity around the process, because there are big vendor consortiums that are competing for it—needless to say that it's on track and we'll be producing the first phase of the service in March 2022, is the working estimate.

I'll note a couple of points. One, building on the deputy's remark—that it takes Telehealth Ontario, Health Care Connect, Health Care Options and some other legacy phone-based programs and will consolidate them over time, and will offer different ways to access navigation services. The other exciting part of it is that there will be a provincial layer, but we'll also figure out how to support Ontario health teams so they can have their own tailored version; from a patient perspective, it might have some tailoring, but it still is part of that whole integrated system.

Interjection.

Mr. Greg Hein: Did someone want to break in?

Mr. Deepak Anand: That's it from me, Chair. I think MPP Kramp might be asking the next question. He's nodding.

The Chair (Mr. Taras Natyshak): MPP Kramp.

Mr. Daryl Kramp: Colleagues, it's certainly a very complex and challenging topic; there's no doubt about it.

I'd like to just make a reference to past, present and future.

I'd like to thank the Auditor General for the work on this extremely important issue. It's going to have long-reaching implications for us all in the future, and so you've given us a bit of a road map for where improvements could be made, and we thank you for that.

Of course, listening to all of our expert witnesses today and all of the departmental people, I'm certainly appreciative of the challenges that you're dealing with right now.

I'm wondering if I could, though, ask you to be a bit of a clairvoyant. If the Auditor General were to come in and do an analysis five years from now, what could you suggest would be the priorities for the department to accomplish? What would your accomplishments be, or your benchmarks? What would they be in the next three to five years—where you could say, "Hey, we wanted to do this and we did it"? What are your thoughts on that?

Ms. Helen Angus: That's a great question.

I might ask Sacha, as an example of this, because he's closer to the front line.

I'd really like us to use this to transform health care services for the better, so that the complexity of the navigation, particularly for people who use many health care services, is dramatically streamlined, and the care team is able to connect around some of our most vulnerable Ontarians. When we look at the patterns of health care, they have many physicians involved in their care and multiple medications. They have caregivers in their families who help take care of them, who need to know what's going on and that the whole thing works a lot better for people. I think there's a lot of synergies between this work, by design, and the enablement of the digital work and the work of Ontario health teams that is also designed to get collaboration amongst providers for the benefit of patients.

Maybe you want to talk to a real clinician who will tell you if that's achievable on the ground within the window you're talking about; I sure hope it is, and that we have the tools to really do better by the people, particularly those higher-cost higher users of the health care system who need a fair bit of coordination.

Sacha?

Dr. Sacha Bhatia: Thanks so much, MPP Kramp, and thank you, Deputy, for the question.

To make it practical, as I mentioned earlier, this is about giving the patient options about how they engage with the health system in a way that makes sense to them for where their needs are—a patient-centred system, as opposed to a provider-focused system, which is how we've been historically, with the appropriate levels of safety and appropriateness and quality embedded.

I'll make a very practical example. When you think about how you bank nowadays—if I want to pay a bill, I have a multiplicity of options for how I might pay my bill. I could pay it online, I could pay it at the ATM, but I could also go to the bank. There are a lot of people like my dad, who doesn't like to use online payment; he wants to go to the bank and go to a teller. The point is that we have options that are available to them, so the care, the service, is where they need it and how they best want to use it.

Up until now, we haven't given patients choices about how they might want to, say, for example, get their medications refilled or how they may have a question. Most of the time, up until now, patients have had to go to their family doctor, sit in a waiting room and be able to sit for half an hour, and then get their medication refilled. Well, now we can give them more choices about how they engage with their health system, how they're able to do basic tasks. But then, ultimately, at the end of the day, when there are important decisions like having surgery or questions about their health or something serious, an in-person visit is always going to be important, and we have to give patients the option to be able to get that human connection with their provider.

It's about striking a balance between giving people choices that bring care to them and make it convenient, and at the same time making sure that we've got the right quality barriers and the right guardrails around the care that we provide, so that patients get the right care at the right time and so that they always feel that human connection that, to be honest, a video visit or something can't always have. It's about striking a bit of a balance there, and then, ultimately, when we do it, care will be more efficient and, we hope, will be more cost-effective, protecting the taxpayers in this province.

Mr. Daryl Kramp: I'll just leave a quotation for you to contemplate, then, by the great Scottish poet, Browning: "Ah, but a man's reach should exceed his grasp, / Or what's a heaven for?"

I encourage all of our departmental people to keep on reaching—we all want that nirvana—and I'm sure that the Auditor General will stay on top of it, to ensure we do.

The Chair (Mr. Taras Natyshak): We have two minutes on the clock. MPP Martin, go ahead.

Mrs. Robin Martin: I just want to ask if there's any feedback on virtual care from our providers and also from patients. What kind of input are we getting from them? It's open to whoever wants to throw in.

Ms. Helen Angus: I think for a lot of people it's a measured improvement. I think that it's convenient, and I think it allows patients to get connected to their health providers without all the back-and-forth and the travel and everything else. I think it has some efficiency gains. It's not the right solution for every patient, for every interaction.

Sacha, I don't know whether you want to comment specifically, but I think—

Dr. Sacha Bhatia: We have data—MPP Martin [*inaudible*], 98% of people like these sorts of interactions, but as Deputy Angus said, it's not for everyone. Then we always have to make sure that the right patient gets the right care. So for certain conversations and for certain interactions, in-person is better, but by and large, people really do like it and providers like it too.

The Chair (Mr. Taras Natyshak): We've just got seconds left on the clock. I want to take this time to thank all those who have appeared today before the public accounts committee. Thank you very much for your appearance.

We are now going to move into closed session so that the committee can commence report-writing.

Thanks again. Be safe, and we will see you soon.

The committee continued in closed session at 1641.

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