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The Ontario Medical Association thanks the Ontario Chamber of Commerce and the federal Competition Bureau for the opportunity to comment on virtual care and associated issues. As a follow up to our call July 21, 2021, please find below a summary of our answers to the questions posed. Please feel free to follow up with us directly for any clarification or further discussion.

1. **Are there barriers (regulatory or non-regulatory) that are preventing the access, use and sharing of digital health data and information? How have these barriers impacted the competitive landscape for digital health care?**

In Ontario, the Personal Health Information Protection Act (PHIPA) and its past interpretation by the Information and Privacy Commissioner (IPC) create barriers to easy sharing and use of personal health information, including digital health data. Use and disclosure are severely restricted. For example, sharing between health information custodians (HICs) for non-health care purposes is limited and the definition of "health care" restrictive to immediate patient care to an individual, making coordination between health care providers challenging. For example, currently, the Ontario Ministry of Health is struggling with whether releasing names of unvaccinated patients enrolled to physicians in capitated enrollment models (Family Health Organizations, etc.) is permissible under privacy law.

Further, from a technical perspective, there is a fundamental lack of interoperability between digital health systems. Electronic Medical Records (EMRs) in Ontario are owned and operated by a plethora of vendors. While these vendors can undergo optional certification by OntarioMD, there are no regulatory requirements that they "speak" to one another to be interoperable. Similarly, Hospital Information Systems (HISs) do not speak easily to clinician EMRs, requiring a variety of intermediary technologies to fill this gap.

While standards have been developed in this area—for example, HL7-FHIR (https://www.hl7.org/fhir/overview.html) – the issue is getting vendors to fully implement across the health sector in HISs and EMRs. If vendors do not implement such interoperability standards, then it is not possible to move structured data (e.g. weight, B.P., lab results) or semi-structured data (e.g. fill fields for specific things like history) from one system to another. It is not in vendor interests to implement these non-proprietary standards because it ties physicians

and patients to their HIS-EMR ecosystem where it is possible to move data in a structured manner, since the systems are "speaking the same language".

While privacy and security are seen sometimes as barriers to access (see above), we note these can also provide the basis for standardized security and privacy expectations for interoperable systems, which increases access by establishing a common standard for systems and a level playing-field for market entrants and innovators, which can increase access. However, this requirement should be incumbent upon the vendors as opposed to the custodian-clinicians, who have little if any control over the functionality of their systems.

2. **What changes can be made to reduce barriers to the access, use and sharing of digital health data and information? How can this encourage more competition and innovation in digital health care?**

Amendments to PHIPA or its regulations to facilitate easier use and sharing of data for health care planning, quality improvement, and research would be a first step towards reducing barriers. This could require thinking about how we view the concept of a "custodian" in a novel or expanded way.

Implementing interoperability standards to facilitate sharing of information between different providers is also crucial. Successful implementation will be key to achieving interoperability in our health care system, and will require coordinated efforts between government, implementation partners such as OntarioMD and Ontario Health, technology vendors, health care organizations, and providers. When possible, systems should be integrated to facilitate better, seamless access to information (e.g. EMRs and provincial digital health assets).

3. **Are there barriers (regulatory or non-regulatory) that are restricting the range and scope of digital health products and services available for use by health care providers and patients? How have these barriers impacted the competitive landscape for digital health care?**

Currently, permanent OHIP billing codes for physician services are only available for OTN services.[1] This makes entry into the market for private providers challenging, as charging patients directly is limited by the Commitment to the Future of Medicare Act in Ontario, as well as by regulations under the Medicine Act that prohibit charging patients for medically necessary services. Moreover, patients in Ontario are rarely interested in paying for care that is freely available elsewhere or via a different platform. Further, specific elements may not be insurable—for example, secure messaging is not an insured service. The currently temporary K codes only permit video/phone as insurable. As well, in Ontario, a provider cannot bill for patient care provided virtually if the patient is out of province. Similarly, other provinces have a variety of barriers preventing billing for patients by providers who are located out of province.

Guidelines released by the Information and Privacy Commissioner on acceptable virtual care platforms may also impact the range and scope of products and services available. Balancing platforms that meet privacy/security standards with equitable access to care for patients should be a key principle going forward. Imposing strict regulatory obligations on providers to

[1] Note that temporary COVID-19 related virtual care OHIP codes are currently available as of the drafting of this reply.

only use particular secure platforms may limit access to care for patients who only have access to less secure platforms for the time being. Government should recognize that a transition time needed to get patients onto more secure platforms—both from a regulatory and compensation perspective. Patient education is needed to increase digital health literacy, particular for patients who are vulnerable and/or elderly.

Moreover, corporate models of virtual walk-in clinics have been able to leverage these barriers faced by those in established physician-patient relationships described above. For example, corporate models charge patients directly for uninsured secure messaging, thus generating revenue from providing convenience-based care. This leads to an uneven market for the delivery of virtual care, and raises the concern of how this episodic care impacts the overall continuity of care for patients in Ontario.

4. **How do rules regarding the development and approval of digital products and services impact their availability and use? What steps can be taken to facilitate the development and approval of digital products and services?**

Ontario Health verifies virtual visit solutions; it requires vendors to submit application that they meet certain standards. Having standardized process is an important step, but availability of products depends on vendors who submit and are verified. One potential concern is that the platforms that submit to verification don't actually meet the needs of providers—in other words, if preferred vendors do not submit to the process.

5. **How do procurement and commercialization processes impact the ability for businesses to innovate and compete in the market for digital health care products and services? How can more innovation and competition be encouraged?**

One issue for physicians specifically is that physicians are prohibited under the Medicine Act and College of Physicians and Surgeons of Ontario policy from advertising directly to patients about a product or service except in very limited circumstances. This hampers physicians' ability to innovate and market virtual care platforms or other health technologies even within their own practice.

6. **Are there barriers (regulatory or non-regulatory) that are restricting the ability of health care providers to deliver digital health care to patients? How have these barriers impacted the competitive landscape for digital health care?**

Please see above.

7. **How do billing codes and compensation mechanisms for health care providers impact the delivery of digital health care? What steps can be taken to facilitate digital health care delivery?**

Please see above. A primary first step would be the creation of permanent virtual care codes with an expansion of insurable services (including secure messaging).

8. **How do rules regarding medical licensing impact the ability of health care providers to deliver digital health care? What steps can be taken to further enable the delivery of digital health care?**

Currently, each province/territory sets its own licensing rules regarding the ability to deliver virtual care outside its borders (i.e., from providers outside a jurisdiction to patients within it, and vice versa). The various provinces and territories' rules are inconsistent, and there is a potential impact on continuity of care if physicians are restricted in their ability to provide virtual care across borders. Simpler interprovincial credentialing could make virtual care simpler.

9. **How do rules regarding the scope of practice for health care providers impact their ability to deliver digital health care to patients? For whom and how can the scope of practice be modified to further enable the delivery of digital health care?**

No comment from OMA.