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Standing Committee on Finance and Economic Affairs

Comité permanent des finances et des affaires économiques

Committee business

Pre-budget consultations

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Consultations prébudgétaires

1st Session
43rd Parliament

Monday 30 January 2023

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43e législature

Lundi 30 janvier 2023

Chair: Ernie Hardeman
Clerk: Vanessa Kattar

Président : Ernie Hardeman
Greffière : Vanessa Kattar

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Monday 30 January 2023

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Monday 30 January 2023

Lundi 30 janvier 2023

The committee met at 1001 in the Holiday Inn, Sudbury.

COMMITTEE BUSINESS

The Chair (Mr. Ernie Hardeman): Good morning, everyone. I see the most important people in the room have just arrived and sat down, so I will call this meeting of the Standing Committee on Finance and Economic Affairs to order. We're meeting today to continue public hearings on pre-budget consultations, 2023.

Are there any questions before we begin? MPP Crawford.

Mr. Stephen Crawford: Thank you, Chair. Good morning. It's great to be in Sudbury. I'd like to move a motion.

I move that the Standing Committee on Finance and Economic Affairs meet for public hearings on Bill 46, An Act to enact one Act and amend various other Acts, on February 2, 2023, following pre-budget consultations; and

That witnesses who requested to appear for public hearings on Bill 46 in Timmins on February 3 be invited to appear in Timmins on February 2 during the allotted time; and

That witnesses appearing be permitted to participate in person or participate remotely; however, a maximum of one individual may appear in person on behalf of an organization, and any additional representatives of that organization shall participate remotely; and

That witnesses shall be scheduled in groups of three for each one-hour time slot, with each presenter allotted seven minutes to make an opening statement followed by 39 minutes of questioning for all three witnesses, divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members, and two rounds of four and a half minutes for the independent members of the committee.

The Chair (Mr. Ernie Hardeman): You've heard the motion. Any discussion? MPP Fife.

Ms. Catherine Fife: Thanks to the member for the motion. There are just a few things. We've had to do this a number of times, and so I just think that when we are finished this entire tour, that we should revisit travelling a bill with budget committee, because we've learned some lessons along there.

And also, we've received some anecdotal feedback thus far that the policy of witnesses appearing to be permitted to participate in person or participate remotely and that only one individual from an organization be allowed to present has dissuaded some people from coming to committee—one example I will say is that if you have an executive director and then a board chair of a not-for-profit, the fact that they can't both present at the same time, I think we should be revisiting that as a policy for this committee.

With that said, though, we are doing our best to accommodate people and to ensure that they can present to the finance committee, and so we'll be supporting this motion.

The Chair (Mr. Ernie Hardeman): Okay. Further debate on the motion? If not, all those in favour? Opposed, if any? The motion is carried.

PRE-BUDGET CONSULTATIONS
CONSULTATIONS PRÉBUDGÉTAIRES

The Chair (Mr. Ernie Hardeman): Going on with the meeting here: As a reminder, I ask that everyone speak slowly and clearly. Please wait until I've recognized you before starting to speak.

Each presenter will have seven minutes to make an opening statement. After we've heard from all the presenters, there will be 39 minutes for questions from members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members, and two rounds of four and a half minutes for the independent members as a group. With that, we will start, if there are no further questions on the direction.

GREATER SUDBURY PUBLIC LIBRARY
SUDBURY DISTRICT NURSE PRACTITIONER CLINICS
ONTARIO ASSOCIATION OF PROSTHETICS AND ORTHOTICS

The Chair (Mr. Ernie Hardeman): If there's not, we will go to the first panel, and it is the Greater Sudbury Public Library, Sudbury District Nurse Practitioner Clinics and the Ontario association of prosthetics and orthodontics. If they would all take the seats, and obviously the explanation of how this is going to work is seven minutes for each presenter. With that, at the six-minute mark of each presentation, I will say, "One minute." At the end of

that one minute, I will say, "Thank you very much for your presentation. Time's up." And we'll go on to the next presenter.

We'll start with the representative. We ask that you each introduce yourself for Hansard to make sure that you're properly recorded in Hansard, so all the good things you have to say will be attributed to you. With that, we'll start with the Greater Sudbury library.

Mr. Brian Harding: Thank you, Mr. Chair, and thank you to the standing committee for having me here today. My name is Brian Harding. I am the chief executive officer and chief librarian at the Greater Sudbury Public Library. I'm proud to work alongside passionate librarians and library staff who make an impact for millions of regular people across Ontario, in communities large and small every day.

Public libraries are Ontario's farthest-reaching and most cost-effective public resource. Millions of Ontarians rely on public libraries in their communities to work, to learn, to connect to community and government resources, and to find or train for a job. We saw this on display in communities throughout Ontario over the past several years as public libraries pivoted from pandemic lockdowns to reopenings to gradual return to normal services.

Public libraries across Ontario maintained access to critical services throughout the pandemic, while responding to the evolving needs of our community, whether it was introducing a WiFi hot spot lending program to keep library users connected and bridge the digital divide, or printing and laminating proof-of-vaccination certificates for tens of thousands of senior citizens, or ensuring that residents could safely and continuously access technology and physical resources. It's a testament to our mission of service and inherent flexibility to respond to what our communities need.

But many Ontarians who depend on public library services are still falling through gaps, gaps that we are continuously striving to bridge. For example, the Greater Sudbury Public Library is on the front line of our community's response to individuals experiencing homelessness, individuals often in immediate need of resources or specialized human services. In 2022, our library introduced an initiative to embed a social worker at our main library branch. We also built a critical partnership with our colleagues at the city of Greater Sudbury to have their client navigators regularly visit the library to make services such as ID clinics available in our branches. These are initiatives designed to support the unique needs of vulnerable individuals within the safe and welcoming environments that public libraries provide.

Many of these gaps existed prior to the pandemic, but the experience of the past several years have brought them to a critical point. The situation is even more challenging for the many First Nation public libraries where an unsustainable provincial funding model has left many libraries closed or with severely reduced access. By investing in public libraries, Ontario will directly support people, their communities and local economies, no matter where they live in the province.

We are strongly advocating for three critical investments that will stabilize our public libraries and ensure that they can continue to perform their vital role in the communities recovering from COVID-19. First, keep local public libraries across Ontario sustainable by maintaining existing provincial operating funding for public libraries. Unlike most sectors in Ontario, public library funding has been frozen for over 25 years. While the majority of the public library budget is municipally supported, the provincial portion of funding is critical to support operations—such as the Public Library Operating Grant—shared resources, broadband connectivity and pay equity support. Continuing to maintain this critical provincial funding at existing levels is vital to supporting the sustainability of local public libraries and the services they provide.

Second, but equally important, work alongside First Nation public library leaders to implement a sustainable funding model for First Nation public libraries to ensure that these important local hubs are fully funded and viable.

1010

Early in my career, I worked directly with First Nation public libraries across northern Ontario. Through that work, I saw both the life-changing impacts First Nation public libraries have on their communities but also the significant barriers they face due to a lack of resources.

As an immediate first step, the First Nation Salary Supplement must be increased to ensure all existing First Nations public library staff are fairly compensated for the work they perform.

Public libraries on-reserve serve as an accessible gathering place and information-sharing resource for First Nation communities. They are deeply important to maintain a sense of community and to minimize social isolation in these communities, many of which are remote or face systemic social and economic challenges. Provincial funding through the provincial library operating grant and primarily the First Nation Salary Supplement grant provides an average of $15,000 a year to the existing libraries on-reserve. While band councils may provide some support for utilities, Internet and phone services, there is little to no funding available for collections, programming and technology resources. Many public libraries on-reserve operate with only one staff person, who is expected to perform many functions and sometimes contribute personally to purchase programming supplies out of their own pocket. The modest investment of $2 million annually would sustainably fund library operations for existing First Nation public libraries and ensure a living income for front-line library staff in these communities.

Finally, provide critical e-learning support and fair access to modern digital resources for all public libraries by creating an Ontario digital public library. The Ontario government has recognized the crucial importance of public libraries to broadband Internet access, making a historic $4.8-million investment to install or upgrade broadband connectivity at over 100 public libraries across the province. However, many Ontario public libraries, particularly in small or First Nation communities, struggle to afford and cannot provide high-quality e-resources and e-

books that people in their communities need. These resources are expensive, especially when purchased on a patchwork library-by-library basis.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Brian Harding: With significant pressures on our operating budget each year, the Greater Sudbury Public Library must make difficult decisions regarding our digital resources and the resources we can make available to our users. An Ontario digital public library would ensure that our community has access to the same digital resources as all other communities in Ontario, while allowing our library to focus our existing resources to other areas of local community need. By leveraging the province's significant purchasing power to create this provincially funded resource, we can ensure all Ontarians have access to a common set of high-quality e-learning and online resources and more e-books through their local public library.

The partnership between the Ontario government and local public libraries is vital, providing these critical supports that are needed for us to continue to work together to deliver important government services, locally relevant resources and economic development close to home in the communities where people live.

Thank you for your time today.

The Chair (Mr. Ernie Hardeman): Thank you very much for that.

We'll now go to the Sudbury District Nurse Practitioner Clinics.

Ms. Jennifer Clement: Good morning. I appreciate the opportunity to present to this committee as the government develops its 2023 budget. My name is Jennifer Clement, and I am the executive director and nurse practitioner lead of the Sudbury District Nurse Practitioner Clinics. I am also one of the founders of the Nurse Practitioner-Led Clinic Association of Ontario.

Primary care is at the heart of a high-functioning, successful and sustainable health care system. Studies show that access to primary care teams can lead to longer, healthier lives for individuals and is also vital to the communities that they live in. In order for this to happen, primary care must be supported adequately to provide care, and the reality is that this is not happening. Thousands of Ontarians are relying on piecemeal care at walk-in clinics or emergency departments, since they can't find a provider, and teams are struggling to retain and attract staff.

I would like to bring forward three recommendations for your consideration.

Recommendation 1: Invest in primary care by increasing health care funding to expand existing nurse practitioner-led clinics and fund new NPLCs for communities in need of primary care.

When funding for the Sudbury District Nurse Practitioner Clinics was announced in 2007, there were approximately 40,000 individuals that did not have access to primary care. While today we are very fortunate to see that number decrease to approximately 3,000 people, statistics in Sudbury show that 19% of physicians within the Greater Sudbury region have been practising for over 30 years, and they're expected to retire within the next few years. These providers carry a very large roster of patients, and when they retire, their patients run the risk of becoming one of the 1.8 million Ontarians who can't find a primary care provider. Unfortunately, that number is expected to rise to three million by 2025.

Despite SDNPC actively doing new patient intakes each week at our sites, our wait-list holds the names of a large number of people waiting up to a year to be called for an intake appointment, so we have had to stop accepting new forms until we catch up. Every day we are having to advise people that we are unable to accept new intake forms and we encourage them to put their name on the Health Care Connect wait-list, but that wait-list is very long as well. Understandably, people are upset with the long wait for an intake appointment to the point where we have had one individual protesting outside our office saying we are violating the right to care.

Once a person does become a patient with SNDPC, however, they receive exceptional primary care from our interdisciplinary team, and our statistics highlight that we are exceeding provincial quality outcome indicators.

The success of Ontario's 25 nurse practitioner-led clinics has prompted at least 15 communities across the province to reach out to the Nurse Practitioner-Led Clinic Association to ask how to get an NPLC in their region.

Recommendation 2: Address the health human resources crisis. SDNPC has an exceptional team, but they, like many working in primary care today, are feeling overwhelmed, underappreciated, under-valued and tired of being asked to do more despite going above and beyond for patients throughout the pandemic. We are seeing staff leave for other positions because we can't offer salary increases, so we are asking the government to develop a comprehensive health human resource strategy that provides wages at current market rates that will also keep up with inflation and the cost-of-living increases.

Recommendation 3: Provide funding to nurse practitioner-led clinic overhead budgets to reflect cost-of-living adjustments. SDNPC has been open for 15 years and in that 15 years we have not seen an increase to overhead funding despite rising costs year after year. We've actually seen a decrease with a clawback in funding. We have become very adept at managing our budgets to ensure we don't run a deficit; however, at times, this has come at a cost of patient care when positions go unfilled in order to move money to overhead lines, in order to pay rent or utilities. In order to ensure capacity and continuity, base funding needs to be increased to keep up with inflation.

I appreciate the time to speak. Thank you very much.

The Chair (Mr. Ernie Hardeman): We'll now go to the Ontario Association of Prosthetics and Orthotics.

Ms. Kristin Schafer: Hi. Thank you. Thank you all for the opportunity to speak today at the 2023 pre-budgetary consultations. I am Kristin Schafer. I am a certified prosthetist at Health Sciences North for about 20 years. I'm also the volunteer communications officer for the Ontario Association of Prosthetics and Orthotics, or OAPO.

OAPO is the not-for-profit professional association representing Ontario's prosthetic and orthotic health professionals. Respectfully, it's not "orthodontics;" it's orthotics.

Certified prosthetists and orthotists are the only health care professional recognized with the Ontario Assistive Devices Program, or ADP, with the authority to provide prosthetic and orthotic treatments. Our members are critical front-line health care professionals that tens of thousands of patients across Ontario rely upon to evaluate, build and fit the medically necessary, custom-made prostheses—or artificial limbs—and orthoses—or braces—that they need to live, work and learn independently. This includes people born with missing or underdeveloped limbs; those who have lost limbs to injury or medical amputation for causes such as diabetes or necrotizing fasciitis; patients with neuromuscular conditions like multiple sclerosis or muscular dystrophy; and individuals impacted by many forms of muscular weakness or imbalance, including the effects of long COVID. These patients deserve prosthetic and orthotic treatments that are up to the current standards of care and are medically appropriate for their condition for improved quality of life.

Unfortunately, Ontario's outdated funding for prosthetic and orthotic treatments is putting an unsustainable burden on our patients. The ADP prosthetic and orthotic policies and pricing have not received any meaningful change or updates for 15 years. Orthotics is still using a fee schedule from 2005, prosthetics from 2007. There were updates in 2011 and 2012 in orthotics and prosthetics respectively, but the changes were minimal. As a result, prosthetic and orthotic patients are receiving proportionally less funding support every year from ADP and orthotic patients are also unable to receive ADP funding for many necessary treatments, forcing them to face an ever-increasing out-of-pocket cost burden.

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Some examples: A patient has been prescribed a locking knee-ankle-foot orthosis because he presents with a diagnosis that leaves him incapable of keeping his knee straight when walking. His knee buckles and he falls. The joints he needs are called locking knee joints; however, he is outside of the 220-pound weight category for the locking joints that ADP will pay for. He requires titanium joints because he is 275 pounds and 6 foot 4—he is a big man. ADP will not allow the orthotist to access ADP funding because there is no maximum contribution rule in effect in orthotics. Now the choices are to provide the lower-weight-category joints and risk harming the patient when they snap—which we would never do—or we have the patient fundraise on his own to pay for the whole brace with no funding assistance from ADP. This is not equitable access to care.

A second example in prosthetics—and this, in fact, is my own patient: A patient required an above-the-knee prosthesis. There is maximum contribution in prosthetics, but her portion of the cost of the prosthesis was simply not manageable. She opted not to have the prosthesis, even though she is a non-diabetic, non-smoking, 50-year-old woman and who is otherwise healthy since her cancer prognosis has cleared. Hospital social work was able to source out additional funding through two charities to help her fund her very basic prosthesis. She is now walking and using her prosthesis daily. Her quality of life has improved tremendously because she has the freedom to move.

Why did she need to ask charities to assist with a basic prosthesis? ADP funding is detrimental to patients who are close to the poverty line and who do not qualify for ODSP funding. Using charitable donations is not a good long-term strategy.

We know that we are not alone in recognizing the impact of this worsening situation for our patients. In 2018, the Auditor General of Ontario identified inconsistent and outdated pricing reviews as a major problem with the Assistive Devices Program, resulting in patients receiving compensation for prosthetic and orthotic devices well below the actual cost and leaving them ineligible to get funding support for more appropriate treatments. However, ongoing dialogue with ADP also leads us to believe that there is a shared recognition of the impact that this shortfall in funding for prosthetics and orthotics is having for vulnerable patients.

That is why ADP is currently undertaking a review of the funding available for both orthotics and prosthetics. OAPO supports this review and we have and will continue to contribute our expertise and insight to this effort. But make no mistake: We believe that an immediate investment of $9.7 million annually in additional funding through ADP for prosthetic and orthotic treatments is required to address over a decade of significant underinvestment that is preventing thousands of patients from receiving a standard of care.

Furthermore, we continue to advocate for harmonizing ADP's reimbursement policies for orthotics with those of prosthetics by implementing the maximum contribution model. This means that patients will no longer have to make unfair "take it or leave it" decisions about their treatment of whether to access ADP funding for inferior treatments that do not represent the standard of care for their condition or pay the entire cost of these treatments out of pocket, even when the cost is beyond their means.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Kristin Schafer: Short-term cost containment does not only hurt patients' pocketbooks and quality of life; it leads to long-term cost impacts. Inappropriate or ill-fitting treatments will always lead to patient complications. This may require the replacement with a new device at a greater cost due to skin abrasions, infections or poor compensatory gate mechanics which may have arisen.

As front-line health care providers, we understand that there is a tremendous pressure on every dollar invested in the Ontario health care system. However, the ongoing and growing pressure on our patients, which has only continued through the pandemic, cannot be ignored. We urge the government of Ontario to make this modest but important investment to ensure that patients who require prosthetic and orthotic treatment have access to the care and can afford the treatments that they need—

The Chair (Mr. Ernie Hardeman): Thank you very much for that. That concludes the time and maybe we can finish it in the first round of questioning.

We will start the questions with MPP Gélinas.

M^me^ France Gélinas: Thank you for coming and presenting. My first round of questions will be to nurse practitioner Clement. I would like you to share with the members of the committee, what difference does it make when you get one more full-time nurse practitioner and this nurse practitioner takes on 900 people who did not have access to primary care before? What kind of impact are you having on the people and on our health care system here in Sudbury?

Ms. Jennifer Clement: As France mentioned, when we bring new nurse practitioners into our offices, each NP carries a roster of 800 to 900 patients. That's patients that haven't had access to primary care, that have been going to walk-ins, that have been using the emergency departments. We had seniors—this is why I became a nurse practitioner—going to emergency departments at 3 in the morning to get a prescription renewal because they thought, "Well, it's not going to be busy; I'll go get it. I'll go get my prescription." These are people that haven't had blood work in years, that haven't had vital signs—they haven't had their blood pressure taken; they haven't had blood work done.

We're catching diagnoses. It feels overwhelming for our patients when they first come in, because they say, "My gosh, we see you so much." But it's because they haven't had access to really good, comprehensive care. They get that in nurse practitioner-led clinics. They get that in primary care teams. They have access to social workers, dietitians, pharmacists, registered nurses, registered practical nurses. We're able to diagnose treatment early and, by doing education as well, try to prevent bad outcomes. So I think that's what we bring to our communities. We're able to help provide care where they need it and when they need it.

M^me^ France Gélinas: Do you have any statistics you can share with us as to: the clients that are rostered with you, that are your patients, are they using the emergency department more or less than the rest of the people in Sudbury?

Ms. Jennifer Clement: Unfortunately, we don't have access to those statistics. Currently, right now, nurse practitioner-led clinic patients are rostered to the clinic as a whole, not to the individual nurse practitioner, so I have no way of accessing that data. When they go to the emergency department, we will get notifications if they're asked who their nurse practitioner is. Unfortunately, a lot of times, they get asked, "Who is your doctor?" So we have no way of knowing a lot of times if our patients have gone to the emergency department unless they call in and let us know that they need to be seen and follow up.

So that's one thing we're really advocating for as well. We would like to see our patients rostered to the individual NP so that we have access to these data banks.

M^me^ France Gélinas: Can you talk a bit about the different sites that you guys manage and the clientele that you try to help?

Ms. Jennifer Clement: We're very fortunate to have three sites in Sudbury. We have an office in Lively. We have an office co-located right beside a homeless shelter at 200 Larch Street. And we have an office right beside a retirement residence in Sudbury at Ste. Anne Road. So our patients come from all walks of life, all ages. I think our youngest patient right now is a week old and our oldest is about 95. We're very fortunate to see a wide variety of patients.

Our most recent office we opened, literally the week before the pandemic was declared, at 200 Larch Street. As I mentioned, that's right beside a homeless shelter. So we are working with our homeless, our marginalized. We're very fortunate that because our funding model allows us not to have to bill OHIP, we're able to see new immigrants coming into Sudbury. Word of mouth is very large in the community, so we're dealing with a lot of new immigrants to Canada, which has been absolutely fantastic—all walks of life, all ages, which has been tremendous.

The feedback that we get from our patients has been really good. We get told on a daily basis, "Wow, I haven't had such thorough, comprehensive care in such a long time." Our model also allows us to spend at least a half an hour with our patients so that we're able to deal with more than one issue at a time, because we know that all these health concerns are interlinked. Your foot pain maybe isn't your foot pain, but it's because you hurt your back and you're trying to compensate. Our model allows us to be able to spend the time and do a lot of really thorough health teaching, which has been really tremendous for our patients.

M^me^ France Gélinas: You've talked about the health human resources crisis. If you were to get funding for one, two or three new nurse practitioner positions within your organization, would you be able to recruit?

Ms. Jennifer Clement: Yes. I currently have a nurse practitioner going on maternity leave, and I have six resumés sitting on my desk right now. It won't be hard to fill those positions.

The Chair (Mr. Ernie Hardeman): MPP West.

1030

MPP Jamie West: Thank you, Jennifer.

With time, I'm going to move on to Kristin from prosthetics. You had mentioned some stats early on, and all I was able to write down was "15 years." I was stunned by how long the funding has been frozen on it. So your requests—it sounds like a large amount of money, but it's basically because the fees have been frozen for so long.

I was wondering, in terms of prosthetic care, when you're not able to get prosthetics or when you're using ill-fitted or not what should be recommended for you, is that the sort of thing that leads to other injuries that increase health care? What I'm thinking about is, my dad had a back injury, and by not getting that addressed for a certain amount of time, he had both knees replaced because he had

shifted his weight and he had other issues. Is that the sort of thing that happens with prosthetics as well?

Ms. Kristin Schafer: We provide prostheses that are absolutely functional devices. For the majority of my clientele—I have more of a geriatric population that I serve—that's fine and good. But when I have younger clients—if I have a young 20-year-old, say—those are the clients who absolutely need access to devices that will allow them to participate in recreational activities. To let them get in and out of their shower, they need a wet-use prosthesis. That's not funded. Yes, absolutely. They need to have access to things that keep them healthy, that keep them mobile.

MPP Jamie West: Okay. And how much would they have to pay, in general?

Ms. Kristin Schafer: For an example, for a traditional basic transtibial prosthesis—so, below the knee—basic devices would range—the patient portion would be between about $3,000 and $4,000. If you wanted a higher-end foot, you might be looking at upwards of $12,000 to $15,000. In some cases, if you want a microprocessor component, whether it's a knee or an ankle, you're looking up into $40,000, $50,000, $60,000 for a prosthesis.

MPP Jamie West: I know we have limited time, so, Brian, I want to thank you for all the work that the library does for people who are in poverty and homelessness. I think it's important to remind our colleagues here, in case they're not aware—they may be. But the access to technology; the DVD rentals; being able to go online, especially during COVID-19; the access to the vaccine certificates and everything—so thank you very much.

The Chair (Mr. Ernie Hardeman): We will now go to the independent. MPP Bowman.

Ms. Stephanie Bowman: My first question is for Brian. I'm wondering if you could talk a little bit about the impact of the municipal funding changes over the years. Your request is to hold the funding provincially for libraries. Has the total funding shrunk or stayed the same overall? Do you know? Can you speak to speak to that, in terms of the overall status of libraries in the province?

Mr. Brian Harding: I can, yes. Thank you. The total amount of funding that we've received from the province has remained effectively static for those 25 years. Year over year, we've been able to count on receiving that additional Public Library Operating Grant, which, of course, has been very welcome. But with inflationary pressures that we see year over year, essentially the money that we have to direct toward resources gets smaller and smaller every year. Typically, what happens is that the municipal portion of that funding has had to increase.

This year, I presented the library's budget to our local council a couple of weeks ago, and it's a good example where we're essentially holding our budget flat in any area that we have discretion, but we're still coming in at a 7.4% increase in the municipal funding portion. So the municipality is having to pick up that larger and larger portion each year, basically, to offset the static revenue that we're receiving from other sources.

Ms. Stephanie Bowman: Okay, thank you. I'm a big fan of libraries. I love going to libraries. Visually, just seeing the expansion of services—could you talk a little bit about the shift in services from core programming, I'll call it, to other community outreach and community services? Again, libraries are playing a bigger role in many of our communities, especially those that maybe lack other resources. So could you talk about how, maybe 20 years ago, what a library and the funding—how it would have been spent versus today?

Mr. Brian Harding: Absolutely. Thank you, yes. One of the phrases that we often repeat is, "We're no longer book repositories." Of course, libraries were never just book repositories, but certainly a significant portion of the resources that we had were dedicated to circulating books and DVDs and other materials like that. It's really hard to encapsulate all of the services that we provide to our communities. I will ask you how much time you have in order to run the gamut. I can give you a few examples, though. One really innovative program that we're very proud of is the circulation of WiFi hot spots. During the pandemic, isolation was obviously a critical issue; digital exclusion is a critical issue. I think there's an assumption that everyone has access to Internet connectivity, everyone has access to a smart phone, and that's certainly not the case. So we implemented a program where you could come to the library and borrow a WiFi hot spot for a week. You can bring that home and you have a dedicated, unlimited Internet connection that you can then use to apply for jobs, to do your school work, to connect with your family—a wide range of uses.

Another good example: Our space is a resource. In Greater Sudbury, we have 13 library branches across the four corners of Greater Sudbury. Just as people have thought that everything is going digital and that everyone is online, we're recognizing, especially post-pandemic, that there's a great desire to gather in person and to work outside of the home. A lot of people are working from home, but sometimes they want to go somewhere else to get their work done. So we're seeing a bit of a resurgence on that front in public libraries, and that there's a demand for in-person space and in-person resources.

Ms. Stephanie Bowman: Great, thank you.

I know I just have a few seconds. I would like to turn to Jennifer next, just to give you a heads-up. I would love to hear more about how you think your clinics can work with family doctors. I know that there's often debate about what that model should look like and would love to hear a little bit about that.

Ms. Jennifer Clement: We're very fortunate that we do work very closely with physicians in our office. The physicians that we have come on site are actually—they call themselves primary care specialists. They are able to work in other areas of health care and then come on site one or two afternoons a month to provide consult with our NPs. They like the fact that they are able to—we have somebody who works at the hospital. We have—

The Chair (Mr. Ernie Hardeman): You'll have to save the rest of the answer for the next round.

We now go to the government. MPP Crawford.

Mr. Stephen Crawford: Thank you to all the presenters today. I'm going to share my time with MPP Byers in the first round.

I wanted to start off with my first question to the Sudbury district nurse practitioners, if I could. There's no doubt; I think everyone recognizes there's a human resources staff shortage of health care practitioners in Ontario—and not only in Ontario, I might add, but across Canada and indeed around the world. This is a global phenomenon. What we're concerned about, of course, is Ontario, being in this province, and particularly in northern and remote communities. I know, being in Oakville, there are issues there, but I know there are perhaps more issues up in the northern communities.

We've launched a "learn and stay" grant program, which is paying for tuition for students for two years if they serve in an underserved community. Is there anything more that the provincial government can do to incent any sort of medical practitioners, whether it be doctors, nurses, any form, to help these communities?

Ms. Jennifer Clement: We're very fortunate, I think, from what I've seen here in the north. We work here in the community. We've lived here, we know our community members, so we have a vested interest in staying in the north. I think that's really important, to provide more of these opportunities. When I was in the nurse practitioner program, there was only maybe one or two. I think it's providing more access to these supports, because tuition, unfortunately, is not cheap. To do these programs, you're having to take a leave of absence from your job, so you're taking out second mortgages to be able to go into these programs. I think it's fantastic that the government is willing to consider these options.

Mr. Stephen Crawford: Okay, thank you.

My next question is for the Sudbury public library. It's great to see you here. Thank you for presenting today. You had mentioned about the funding being static over the years and whatnot. I'm just trying to get a sense, first of all, of what percentage of the funding to the Sudbury public library system would be provincial versus municipal. And is there any other funding?

Mr. Brian Harding: Thank you for the question. Yes, so I can break it down. Our budget this year is approximately $9.5 million. We receive $400,000 from the province, so it's a fraction of the funding that we receive. Other funding sources—in the budget presentation that we provided to our local council, one of the things that we're very focused on this year as a project is diversification of revenue. Absolutely, there are other potential sources. The Public Libraries Act explicitly prohibits public libraries from charging for certain services. That's the spirit of public libraries, to provide free and equitable service to our resources. But we're trying to get creative and find other ways that we can support our budget. One of the ways we're looking at is fundraising and planned giving opportunities, for example, and grants that we can apply for.

1040

Mr. Stephen Crawford: Where do you see your strongest demand now, and how has that changed over the last, say, 10 years?

Mr. Brian Harding: Demand is interesting. Again, historically, our demand would have been focused on print resources, on circulating materials, and what we've seen is a decline in the demand for print generally. That varies community to community, but as people's preferences have shifted and with some individuals' ability to access information digitally online without print books, that demand has declined.

What we've seen, though, is a diversification of demand. Several years ago, needing to come in and borrow the Internet wasn't really an area of demand, and that's one of the areas of greatest demand. We created our WiFi hot spot lending program two years ago, and we know that we continue to have unmet demand. We think that if we could continue to purchase more units and make more units available, we likely wouldn't struggle to continue to keep up with the demand.

There's demand for e-books and other digital resources, as I mentioned earlier in my presentation. Things like 3-D objects: We call them "3-D objects," which is a bit of a strange name, but we lend a really wide range of resources, like snowshoes, for example. We're a northern community and one of the things we like to do is promote health and wellness during the winter months, and so we provide snowshoes for people to come in and borrow so they can get outside as a family. We're seeing increased demand with many of those services. Fishing rods are another long-standing program.

Mr. Stephen Crawford: Just one quick question before I pass it over: In terms of actual foot traffic, so the people entering the greater Sudbury libraries in person over the last—I know COVID might have skewed that, but aside from that, what does that trend look like?

Mr. Brian Harding: Yes, COVID absolutely skewed it. We were closed to in-person visits for times throughout the pandemic. What I can tell you is that last year, in 2021, in the first quarter of the year we continued to see some pandemic restrictions, but then saw a recovery curve through the rest of the year. Our in-person visits increased in 2022 by 80% over the previous year, so we're bouncing back in terms of that in-person demand. What we're striving for in the next year or two is to get back to our 2019 numbers.

Mr. Stephen Crawford: And, sorry, the 2019 numbers, were they—what was the trend before COVID, then? Was it less people entering the library system, more, the same?

Mr. Brian Harding: Trending for print circulation was generally down. I've only been here for a year—I don't exactly know the stats—but my guess is that it was sort of a flat line or potentially increasing.

One of the other areas where we are seeing demand is for things like programming, use of our study rooms and meeting rooms, and all of that is sort of increasing demand for in-person visits.

Mr. Stephen Crawford: Thank you.

The Chair (Mr. Ernie Hardeman): MPP Byers.

Mr. Rick Byers: Thank you all for your presentations this morning, and more importantly, thank you for the great work you're doing in your community. It's terrific hearing you all.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Rick Byers: A question for Jennifer: I want to make sure I understand the model. Prior to being elected, I was on the board of what was called the southeast Grey community health clinic. Our clinic had mostly nurse practitioners practising, and visiting physicians. How does that compare? Is that the same model as yours or a little different, if you could help explain?

Ms. Jennifer Clement: Very similar. What is unique about nurse practitioner-led clinics is we have nurse practitioners embedded in our leadership model. Our executive directors are the nurse practitioners of the office. A fun fact is that nurse practitioners in our model are also expected to carry patient load as well as being executive director. And then, our boards are composed of 51% nurse practitioners, as well. So it's a very strong nurse leadership model.

Mr. Rick Byers: I see. Interesting. Is that your choice, or is it that the province defines this model?

Ms. Jennifer Clement: The province defines the leadership model for the executive team, but for our boards, we design that as a collective.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll leave that for the next round.

We'll go to the official opposition. MPP Fife.

Ms. Catherine Fife: Thank you, Chair, and thanks, everyone, for being here—very informative presentations.

I just want to say very quickly on the nurse practitioner issue: We've heard from primary caregivers and the Ontario Medical Association across the province at these sessions, and the doctor shortage in Ontario is very, very real. Bill 124 obviously has had a trickle-down effect on that culture of recruitment and retention of all medical staff.

Our health critic brought forward a call for a human health care resources strategy, which we definitely need, so we fully support that.

We also very much see nurse practitioners as part of the solution going forward, and you've already proven your return on investment. So thank you for that today.

I want to turn very quickly to Brian Harding on the libraries. I've been on this committee off and on for the last 10 years. Libraries have proven their worth to government after government after government, and the fact that your funding has essentially been static for 25 years is quite something, I have to say. You mentioned that you had to go to the municipality to make up some of the difference. You have a new diversification around fundraising and philanthropy. I just want to ask you, how sustainable is this? You have stretched your dollars as far as you can. You have proven, especially on the digital exclusion piece, how important that is. And we definitely see libraries as a door to job potential, school potential, education potential.

When you go to the municipalities, do they have extra money? The government seems to think that they do, and we know that they don't.

Mr. Brian Harding: Yes, they do not have extra money, I've learned very recently. We presented our budget, and we're having some difficult conversations around our ask to the municipality.

Your question about whether this is sustainable—I would say no, it's likely not sustainable. In trying to be good partners to the province and good partners to our local municipality, our library system has a very can-do attitude. What we are trying to do—our philosophy is to continue doing more with the same amount of resources, but realistically, we know you can only do that for so long.

In particular, one of the challenges that we're seeing is record inflation. We know that the cost of books and other resources that we're buying is ranging between 10% and 12%, and our book budget is frozen for this year. Effectively what that means is, we'll be buying 10% less books with the budget we get.

Ms. Catherine Fife: Thank you, Brian.

Over to my colleague MPP Kernaghan.

The Chair (Mr. Ernie Hardeman): MPP Kernaghan.

Mr. Terence Kernaghan: Thank you very much to the presenters who have come to share with us today.

My question is to Brian. In the late 1990s, the Ontario government removed trades classes for children in elementary schools. For many, this was their introduction to the trades.

As a former teacher-librarian myself, I was hoping you would be able to explain to this committee how makerspaces actually fulfill this government's stated goal of getting more individuals in the trades.

Mr. Brian Harding: Thank you for that question.

Makerspaces are near and dear to my heart. One of the first things I did when I started working here at the Greater Sudbury Public Library was to put a makerspace in place at our main library branch, which is still going very strong.

We talk about a maker movement. It really is sort of a wave that has cascaded over the province and public libraries. Makerspaces are designed, as you've suggested, to teach people, to give people experience in hands-on learning experiences, which we know is fundamental to what learning in the trades is.

I think one of the ways that we frame makerspace education is around STEAM or STEM programs—science, technology, engineering, arts and math—and the programming that we deliver is designed to give individuals an introduction to those various areas.

One example to give you is 3-D printing. When 3-D printing was introduced a few years ago, it was seen as this very futuristic thing that was really neat and you could sort of envision what you could do with it. What we know now is that if you're a plumber, 3-D printing technology is really attractive. You can custom-make your own parts and potentially put them into use. It's not just a distant futuristic tool that you can sort of dream about using. I

think by introducing technologies like that to individuals, you can really inspire them to see how they can change their work and how they can shift their work to meet 21st-century skills and demands.

Mr. Terence Kernaghan: Absolutely. Thank you very much for that.

I'd like to pass my time over now to MPP Gélinas.

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: My question is for Ms. Schafer.

I'd like you to share with the group, if you have one in mind, an example of how much money out of pocket—so I'll give you an example. The northern road maintenance being what it is—lots of accidents, above-knee amputation. He's 25 years old. He has a job. He's healthy. He needs an above-knee prosthetic. How much would the government pay, and how much will he have to pay out of his own pocket to get a prosthetic so he can walk again?

1050

Ms. Kristin Schafer: So that patient you would want to give the world to. That patient will be living the rest of their life on one limb. Compensations arise over the next 40 to 50 years for that fellow, so you want him to have something that most closely mimics normal walking, normal gait pattern.

Out-of-pocket expense for a microprocessor knee for an above-the-knee prosthesis, just for the knee, is anywhere from $50,000 to $60,000—for the knee. You also have to pay for the socket. You have to pay for interface products, liners that get rolled onto the limb. There has to be a way of suspending the prosthesis on the person. There are feet that have to be attached as well. On top of that, there are socks that they usually have to wear. There are skin conditioners they need to use. There's absolutely regular follow-up that has to happen every three to six months. These are components. They don't last forever. Our bodies do not stay the same. So within a year, they're going to need an entirely new socket. Within three to five years, they will need new components. These devices do not last a lifetime. It is not a one-time-fits-all device. They require constant maintenance and regular follow-up so that we don't have skin conditions develop.

M^me^ France Gélinas: What's the maximum he can get through the government, through ADP?

Ms. Kristin Schafer: Through the government, for a knee like that—the knee itself is only about $4,500 that ADP will fund. So we're looking at the price of a car—a good car—for a prosthesis for that 25-year-old.

M^me^ France Gélinas: And those prices haven't changed in a long time.

Ms. Kristin Schafer: Yes. This is necessary. It's beyond necessary

M^me^ France Gélinas: The Auditor General has talked about this. We've made recommendations—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time.

We'll go to the independent. MPP Bowman.

Ms. Stephanie Bowman: I'd like to come back to Jennifer just to talk more about the model and how it would work—or how it works and how we can make it an even better model with physicians and nurse practitioner-led clinics.

Right now, the NPLCs are for communities in need of primary care, and again, you could argue that that's the whole province, given the impact of Bill 124 and the shortage of health care professionals etc.

Could you talk a little bit about the impact of Bill 124 and what you're seeing here in health care in Sudbury? And then also come back to the question around what lessons can be learned from the current model of how the clinics work with family physicians, that the government might want to consider putting it in places even like Toronto, where they have not been in the past.

Ms. Jennifer Clement: First, Bill 124, unfortunately—nurse practitioner-led clinics haven't even seen a raise for HR dollars, so we actually can't even give our staff a 1% raise because we've been capped. We're hearing from colleagues who work in other sectors that it's really impacting—especially because of the pandemic—the choices they make when it comes time to where they are going to work.

In terms of putting nurse practitioner-led clinics across the province, we're very fortunate—we do work very closely with collaborative physicians in our communities, and as I mentioned, our physicians like the fact that they're able to work in other areas of the communities. We have physicians who are working in the hospital. We have physicians who are working in other primary care sectors. They're able to come on-site to our offices a few times a month to provide consultation. As I said, they call themselves primary care specialists. They come in and answer the questions, if we've reached the end of our scope, which is very rare, because our scope is so broad now. But if we just want to run some cases, if we have some difficult cases in the clinics, they're there to help support us and give us some guidance.

We know that there's a health human resources crisis. We know that there are not enough physicians to go around so that everybody has access to primary care. Nurse practitioner-led clinics can offer their support, working closely with physicians.

The nice thing, too, is we've been able to bring a psychiatrist on to our team, we've been able to bring a pain and addictions specialist, as consulting physicians—because this is the reality of our patient base today. We're seeing high numbers of mental health. We're seeing high numbers of opioid dependency. So let the nurse practitioners provide the care, and let us bring in the collaborative specialists to provide that care and support as well.

Ms. Stephanie Bowman: So you're confident that this model could work in larger cities and communities where we might not have traditionally had those clinics in the past.

Ms. Jennifer Clement: Yes, we're very fortunate. We've got 25 now across the province. We go as far as Thunder Bay and White River, Ontario, down to Sarnia. It works in rural areas. It works in urban areas. It's just making sure you get the right team, and I'm biased, but I

think we've been able to do that successfully across the province.

Ms. Stephanie Bowman: Excellent. Thank you. How much time left, Chair?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Stephanie Bowman: Okay, that's fine. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you. MPP Kusendova.

Mr. Rudy Cuzzetto: Cuzzetto. Thank you, Chair, and thank you to all the presenters here. I would like to ask Jennifer questions, but before that, I noticed you worked in Mississauga and Texas before?

Ms. Jennifer Clement: I did. When I graduated in 1997, there were not a lot of full-time jobs in the region, so I moved to Texas, where I worked for two years and I had an amazing experience. And then I moved to Credit Valley and worked at Credit Valley for two years, and then decided to come back. The lure of the north was strong.

Mr. Rudy Cuzzetto: Well, I live in Mississauga–Lakeshore, so the new hospital that will be built in my riding will be the largest in Canadian history. The most that any government has ever invested in infrastructure in Canadian history is coming to Mississauga–Lakeshore, so I'm very proud of that project.

The Ontario Learn and Stay grant we were talking about here: We're putting in $61 million into that to keep people in the areas that they train. Have you ever heard of a program like this before in the province of Ontario?

Ms. Jennifer Clement: Not to that extent. We had the "grow your own" fund when I was a nurse practitioner, but it came with certain criteria, so I think this is fantastic. I think Ontario has a richness of staff, and if you put the money in the communities where it's needed, where, like I mentioned, the health care professionals are in that community, you have a better chance of keeping them in that community as well. So I think that's absolutely fantastic.

Mr. Rudy Cuzzetto: That's good to hear. Our target is to train approximately 2,500 people in this—do you think this program will do that?

Ms. Jennifer Clement: I have high hopes it would. I can't say for sure, but I really would hope that it would do that.

Mr. Rudy Cuzzetto: That's about it. I'll pass it on to my colleague here.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: Thank you for the opportunity. First of all, I just want to say thank you to all the presenters here. Jennifer, I really see the passion in what you do, and it's really good to see the passion.

I just want to start with Sudbury. This is my second time in Sudbury. We came a little late in the night. We were picked up by Vikas, who is an immigrant from India, and received by Namrata, who is, again, an immigrant from India. I woke up in the morning, had a great breakfast, and Mohammad from Pakistan greeted us—and the janitorial staffers from South America. So I see a lot of acceptance for the newcomers or the people from across the world here. So I just want to acknowledge that. I want to thank Sudbury for doing this.

My question is, when people talk about not having enough people, I have the opposite problem. My riding is Mississauga–Malton. We actually receive around 11% of the riding every year—new people walking in through those doors and looking for places and opportunities outside.

My first question would be, with respect to many of them, they are foreign-trained professionals, foreign-trained nurses. It takes so long for them to get their licence here in our country, our beautiful province. What can we do to fast-track that? We know there is an issue. We know there is a problem. We know there is a supply available in Mississauga–Malton. What is something we can do to expedite, to get them into the workplace?

Ms. Jennifer Clement: I think it's working with professional colleges. I've been hearing stories from colleagues that are working in the States coming back to Ontario, that the hoops that they have to jump through are astronomical. I was a teacher as well, and teaching physicians from China have to become nurses because their credentials were not accepted. I think it's really working with professional colleges because the hoops that people have to jump through are high. So I think that, really, we need to put the effort into that because we have really great trained professionals that have better education, sometimes, than some of our new grads, and the experiences would be phenomenal.

Mr. Deepak Anand: Thank you so much.

Brian, I just briefly heard from the MPP on the other side talking about the Makerspace. When you talk about the Makerspace—as we all know, skilled trades are something that we really need; one in five jobs, plus, in 2025 is going to be in skilled trades, and the government is working hard to make sure we invest the money required, whether it is through the Skills Development Fund or whether it's the OYAP program or Better Jobs Ontario.

1100

Just a quick question: You said that they come, they get a hands-on training. Is it connected to real trade professionals which are in the profession, so that they can come back and impart some of the support—number one.

Number two, are you connected to the industry, so that—yes, the kids can come, the people can come and learn, but what if it's connected to industry?

And the last one is, is it connected to the unions?

Mr. Brian Harding: Thank you—great question. We've talked about what our role is, and we envision that there's a pipeline there to get people into that process of learning trades and eventually working. We see ourselves as being at the very front end of that. Our job is to inspire and to give an opportunity for individuals to explore things that they haven't experienced before.

We're really thankful that we have such a strong network here in Greater Sudbury—organizations like NORCAT and the various colleges. We see that we have an opportunity to work with youth and inspire them to become engaged in these STEM or STEAM fields, start

building their skills, but then to shift them off into the areas where there are educational supports to be able to move them through their career.

Mr. Deepak Anand: Thank you.

Back to Jennifer—quick question with respect to newcomers: One of the things which I've seen and noticed whenever I go—and I always talk about, being a first-generation immigrant myself—it's not the job opportunity. There's sometimes the cultural integration. It is the support which people get emotionally that is something which keeps them here or any other place. Is there anything—because we in the Ministry of Labour, Immigration, Training and Skills Development and my colleague Dave Smith, who is doing an incredible job as well, and under the leadership of Premier Ford and Minister Monte McNaughton—is there anything we can do in that space as well where we can support the newcomers so that when they come here they have that support and that they feel they're part of the community and they don't feel like going and leaving once they get the wonderful opportunities?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Jennifer Clement: Thank you. I think it's really important to have multicultural centres set up in communities, so that they have a place to go. It's having health care providers who know the resources that are available in our communities. We're very fortunate that we work with a really strong team at our offices that have the resources, and they know who to connect with in the community. I think that's really important

And having the trauma-informed training for staff as well, because we know that they come from areas that aren't necessarily—they've led hard lives before they come to our communities, so it's having those resources available for them.

Mr. Deepak Anand: Thank you. Over to MPP Dowie.

The Chair (Mr. Ernie Hardeman): Well, it will have to be for the next presenter, because we're 15 seconds; there's not time for a question.

With that, I want to thank the panel for taking the time to prepare and for presenting to us this morning to help us with this pre-budget consultation.

CANADIAN MENTAL HEALTH ASSOCIATION

CAPREOL NURSE PRACTITIONER-LED CLINIC

YMCA OF NORTHEASTERN ONTARIO

The Chair (Mr. Ernie Hardeman): Our next panel is the Canadian Mental Health Association, Capreol Nurse Practitioner-Led Clinic and the YMCA of Northeastern Ontario.

As you are getting ready: As with the directions for the others, everybody will get seven minutes to make a presentation. At six minutes, I will let you know that there is one minute left, and at the end of that minute there will be nothing left.

With that, we thank you very much for being here; the floor is yours. We start with the Canadian Mental Health Association.

Ms. Patty MacDonald: Hi. Thank you for allowing CMHA Sudbury/Manitoulin the opportunity to address the committee. I'm Patty MacDonald; I'm the CEO of CMHA Sudbury/Manitoulin. Many of the challenges I'll be sharing here today have already been echoed by my colleagues to this committee in other parts of the province.

Our branch strives daily to provide the highest quality of care to the individuals we serve, but this priority has become a difficult challenge due to decades of underfunding, the increased need for service due to the pandemic, and the ongoing impact of Bill 124.

The funding model for our sector has been broken for decades. This needs to change if the province truly wishes to champion community mental health and addictions care.

In terms of funding, CMHA Sudbury/Manitoulin has received just a 2% budget increase over the past 10 years. At the same time, we know that more people need our services and require more complex care than ever before. When you consider inflation, since 2014, it has been about 24%. This means we are being asked to do much more with less. This lack of appropriate annualized operating funding has a negative ripple effect on our staff and the individual we serve.

Over the past few years, our branch has increasingly faced ongoing health human resource challenges. While staff and leadership are constantly working to minimize and mitigate these challenges, these staffing pressures are now resulting in significant negative impact to individuals served, front-line staff and leadership, the agency and also the broader health, housing and social service sectors.

The root cause of this challenge is that the compensation that we can offer does not match the skills and experience required for our essential programs. Many of our staff are leaving the mental health and addictions sector for jobs that are paying significantly more. Often, we're losing people to hospitals, public health and other areas of health care that we can't match when it comes to salary and resources to do their jobs.

At our branch, we are managing a staff vacancy rate of approximately 17% and a turnover rate of over 50%. A large majority of these numbers are directly from our essential services, and we're not alone. Latest calculations indicate that the average vacancy rate across CMHAs is about 5%. That amounts to more than 250 positions going unfilled. This includes residential workers, counsellors, addiction workers, social workers, nurses, nurse practitioners, psychiatrists and others who seek to help people in our community, including some of the most marginalized members. CMHAs are negotiating reduction in their service volumes and targets with Ontario Health and managing vacancies. We simply can't do anymore or provide even the same level of service when we aren't resourced properly, and we know this will only get worse as we come out of the moderation period from Bill 124. Staff will be expecting, and quite frankly, deserve greater wage parity with their broader health care colleagues.

Each CMHA branch needs at least an 8% increase in base funding as an immediate emergency stabilization investment to be prepared for these challenges. From our branch, that's at least $900,000 annually.

These issues are impacting our community through a few specific examples that I'd like to mention here today. The first can be seen through our Off the Street Emergency Shelter here in Sudbury. The low-barrier shelter operates year-round and offers 35 beds, providing a safe, warm place to sleep, with outreach and wraparound referral services to adults of all genders who are homeless and unable to access other shelter services.

Unfortunately, right now, the shelter is also a pressure point because of the health human resource issues our sector is facing. The shelter needs a minimum of two staff members and one security guard to remain open. Due to the current staffing shortages, if a staff member calls in sick unexpectedly, we may have no choice but to plan on closing the shelter. This has occurred six times in 2022. That's six times that 35 individuals did not have a safe place to sleep. It's often only due to the flexibility of our team and support from the city that we are able to keep the shelter open when those situations arise. It would be helpful if we could pay our shelter workers more, but we're bound by Bill 124, which allows for just a 1% increase for any of our staff. Our staff are extremely dedicated and work in our sector because they want to help people, and it pains us when we're in this situation.

The opioid epidemic is another pressing issue our community is facing. Northeastern Ontario, including Sudbury, has the worst death rate related to opioid poisoning in the province: 44.7 per 100,000 people. While it's been overshadowed by the pandemic, in any other period of time, the opioid overdose situation in Ontario would be considered a major public health crisis. We need a comprehensive, integrated, cross-sectoral and coordinated provincial drug strategy that addresses this crisis, which continues to impact our community and other communities across the province.

1110

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Patty MacDonald: As you can see, we are facing a number of imperative challenges. Our dedication to providing quality care means that we are constantly recognizing resources, reorganizing resources, and redeploying staff to meet our individuals' needs, but we are struggling to meet this increased demand in service with our current budget allocations.

In closing, I would like to thank the committee for finding time to hear from CMHA Sudbury/Manitoulin and other stakeholders in our community. I appreciate the opportunity to share the challenges and needs of our community during these dedicated consultations, and I welcome the questions.

The Chair (Mr. Ernie Hardeman): Thank you.

Next is the Capreol Nurse Practitioner-Led Clinic.

Ms. Amanda Rainville: Hi. Thank you for having us. I'm Amanda Rainville, the executive director and a nurse practitioner, representing the Capreol Nurse Practitioner-Led Clinic. We are here to request an investment in team-based primary care, including an increase in funding for our clinic.

I just wanted to start by telling you a little bit about our community. Capreol is located in northeastern Ontario. We're part of the city of Greater Sudbury. We're approximately 35 kilometres north of downtown Sudbury, about 40 kilometres from here. If you go north of Sudbury, there is not much else. It's a couple of mining roads, a railroad and nothing, so it is just us there.

The residents of Capreol are a vulnerable population, based on the social determinants of health. The average total income is less than the provincial average, 56% of the population do not have any post-secondary education, and the unemployment rate is higher than the provincial average. There are limited services and networks available in Capreol. There are no other primary care providers. There are no walk-in clinics in Sudbury or in the surrounding area. I've included a map in your package and circled where Valley East and Hanmer are. There aren't any walk-in clinics there as well. There are no mental health providers in Capreol or surrounding areas, and the nearest medical imaging location is in Sudbury.

Transportation is challenging for many of our residents who don't drive and the only public transportation is our transit bus system. It takes over an hour to get to downtown Sudbury, and that doesn't include the time it takes to transfer if you have to go to our hospital, Health Sciences North, for any imaging or testing. Even driving by car, it took me over an hour to get here today and that's without traffic or trains to slow you down.

Our clinic consists of two management positions, so I have a full-time administrative lead and then myself, the executive director, which also splits my time; I have a patient roster as well. And then I have three full-time nurse practitioners, a registered nurse, a registered practical nurse, a social worker, a receptionist and admin staff. We have a vacant dietitian position because we are having a hard time recruiting for that position. Right now we have a temporary nurse practitioner until the end of fiscal.

We currently provide comprehensive, primary care to 3,020 patients from Capreol and the surrounding area. We're funded for 800 patients for each full-time nurse practitioner, including myself, so 3,200 patients. Our full-time NPs currently have 855 active clients and I have 455 active clients. Our social worker cares for approximately 60 clients and she has a wait-list of 75 clients. It takes approximately one year for our clients to see her when they're on the wait-list and about a year to see a psychiatrist here in Sudbury.

We offer same-day appointments, Monday to Friday, and offer an after-hours clinic on Tuesday evenings. As I mentioned, there are no walk-in clinics in Capreol, so there's a very high demand for those appointments.

Sudbury doesn't have an urgent care clinic, so there are many people who use our emergency room as a walk-in clinic or to present for non-urgent needs if they don't have a primary care provider. This is very taxing on our health care resources, and our hospital is not in a position to see

non-urgent patients as they are often operating above 100% occupancy. We strive to provide same-day access for our patients and reduce the number of visits to emergency rooms, crisis interventions or walk-in clinics.

We continue to grow and intake new patients while still trying to provide timely access for our current patients. This is becoming increasingly difficult to balance. This respiratory season has been very difficult as there has been an increased demand for our same-day and urgent appointments. Many of our existing patients are older adults with complex medical histories and multiple comorbidities. Some of our patients avoided seeking care during the pandemic, and the majority of our new intakes are adults who have not had any medical care for years, including individuals with serious mental health issues. All of these things have increased our follow-up rate, and we're often diagnosing and treating new medical conditions.

Over the last two years, we have had an increase of new intakes. There have been three physicians who have closed their practice in the Valley East/Hanmer area. We're receiving approximately 30 new intakes every week. According to the city of Sudbury, 19% of our family physicians are set to retire in the next few years, which is going to leave thousands of patients without access to a primary care provider. Currently, we're accepting patients from three physicians who are in the process of closing their practice.

Even during the pandemic, we didn't close our doors. We continued to see people face to face and we were taking new intakes. In 2020-21, we had 213 new clients; in 2021-22, 277 new clients. In this fiscal, we've had 394 new patients, as of Friday, and we have more people booked for the next few months. So our roster has increased substantially over the last couple of years. We estimate that if we continued on this trajectory, we could intake another 768 new patients next year.

We offer comprehensive primary care services—everything that you would expect from a primary care provider as well as some specialized services, such as lesion removal, cortisone injections, IUD insertions, medical abortions and gender-affirming care.

We are requesting an investment of $292,585 annually so that we can hire another nurse practitioner, another social worker and an admin staff so that we can intake another 800 patients for our clinic.

Thank you so much for your time.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

Our next presenter is the YMCA of Northeastern Ontario.

Ms. Helen Francis: Thank you, Chair Hardeman, Vice-Chair Kernaghan and all committee members for the opportunity to present to you today. My name is Helen Francis. I am the CEO for the YMCA of Northeastern Ontario. Our charity operates across and between the three primary communities of Sudbury, North Bay and Timmins.

Today, our association focuses on four key areas: early learning and child care; employment services and immigrant newcomer settlement services; camping and youth leadership; and health and wellness, which includes aquatics. Our actions are centred around improving the social determinants of health in a broad and holistic manner. The recommendations I bring forward to the committee for your consideration are specific to our YMCA but would be recommendations shared by my colleagues across Ontario, which houses 14 individual YMCAs.

I'll focus on four key areas for recommendations: (1) the early childhood educator workforce pipeline; (2) support for health and wellness availability; (3) support for health and wellness affordability; and (4) inflationary supports.

The early childhood educator workforce pipeline: Most importantly, our association is 55% focused on early learning and child care. We work across 29 centres and can also license up to 75 home child cares. We are absolutely thrilled to see the Canada-wide Early Learning and Child Care plan come into effect, which will help ensure child care—which has been proven to be a strong economic driver—becomes increasingly affordable, accessible and inclusive for all families in Ontario.

We would request that the standing committee consider recommendations that will support the development and growth as well as retention of our early childhood educators. Today, in our YMCA, we cannot maximize our licensed space capacity of 1,686 child care spots as we are 165 staff short. Not only does this mean we are not meeting current targets, but we are unable to contemplate any growth, which will not help the province meet its targets for 86,000 additional spaces across Ontario.

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With that in mind, we would recommend the entire pipeline of early childhood educators be reviewed and recommend the following.

Recommendation 1: Invest in child care work with compensation on par with municipalities and school boards, fully fund benefits and pensions, fund gaps to turn split-shift roles into full-time positions and enhance compensation for all educators, including registered early childhood educators and early childhood educator assistants.

Recommendation 2: Invest in an early childhood education workforce public recruitment campaign and incentivize colleges and universities to grow their ECE programs and develop different levels of credentials and/or specializations.

Recommendation 3: Recruit new immigrants to the early childhood education sector and recognize home country credentials. We have been particularly successful in our staff recruitment for childcare in Timmins with our relationship with Northern College, and it does attract a high number of immigrant students.

Recommendation 4: Focus on greater child care funding predictability and consistency at the municipal level, allowing operators to develop optimal staffing plans and reduce the administrative burden on child care staff.

Recommendation 5: Exempt charities like the YMCA from Bill 124 so operators can raise compensation at a time when it is needed most.

For health and wellness availability, the YMCA supports the government's focus on helping Ontario's children and youth catch up after years of learning disruptions. Pandemic cancellations and lockdowns resulted in fewer young people training as lifeguards and fewer children participating in swimming lessons. Today, there are growing wait-lists for swimming lessons, but we cannot find enough qualified staff to teach kids and adults how to swim.

Recommendation 6: Fund charitable and non-profit aquatics organizations to provide free certification and training for lifeguards and swimming instructors. In addition, and of particular importance in northern Ontario, as we see an increase in the number of immigrants and newcomer families, we know there is a growing demand for adult learn-to-swim classes. This is critical, not just for building a sense of belonging and enabling newcomers to enjoy the wonders of Ontario, namely the over 250,000 lakes in the province, but it is critical in ensuring that we can prevent loss of life by preventing accidental drownings.

For health and wellness affordability: As a charity that is focused on physical, social and mental well-being, we also see an urgency to focus on preventative health measures. The YMCA has prided itself on being able to remove the financial barriers for community members who need it and ensure our programs are accessible to all. However, YMCAs are struggling with rising costs of operations and this reduces how much financial support we can afford.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Helen Francis: We would thus recommend establishing a community health fund with grants available to charitable non-profit providers to deliver free and/or low-cost programming to equity-deserving communities.

Finally, inflationary supports: We are always thrilled to receive provincial funding, whether through infrastructure grants such as ICIP or the Ontario Trillium fund. However, we would ask for consideration to provide an inflationary support fund for large-scale and small-scale capital projects, as well as building in inflationary pressure release valves to multi-year funding agreements with charitable service providers.

Thank you. We remain committed to working with government in building a strong, resilient Ontario. Again, I thank you for your time and consideration for those recommendations.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We now will start with the independent. MPP Bowman.

Ms. Stephanie Bowman: Thank you all for being here today and for the good work you're doing.

I'll start with Patty, with CMHA. As you mentioned, we have heard from other members from the CMHA, and some of the problems certainly are consistent. I know it's a tough time to be in that field, and you've got a lot of people in need of your services.

I wondered if you could just talk a little bit about the transition or the path that people can take from care in your organization to more independent living and getting to a place where they are at a higher-functioning state. Is that something that you see happening today with the current funding, or are you really kind of just having to, again, do that critical—I'll use the word "emergency"—kind of care? You talked about that need growing. I wonder if you could talk a little bit about that.

Ms. Patty MacDonald: Yes, absolutely. Thank you for the question. I would say that what I coined as "emergency funding," the 8% increase, is really just to provide the operations and the staffing and to be able to provide that closer to wage parity for our staff as well as for recruitment and retainment. So it's a really necessary part of the priorities for us.

I would say that for your other part of the question, about supportive housing, at CMHA Sudbury/Manitoulin, we offer a variety of housing options. We offer independent living, which is our rent supplement program: People have safe, affordable housing, and we partner with landlords to supplement a portion of that rent so that they can pick anywhere they would like to live.

We have a 24-unit apartment complex, which is also independent living, but we're finding that as our population ages, there are more people who are requiring additional support for that independent living.

We have some transformational and transitional housing. The transitional is up to eight months, so when someone is coming from homelessness, it's really just trying to support them, to get them stabilized financially, to learn some of the skills to be able to live independently, and then to support them as they transition into their own housing. We have some transformational housing, which is, I think, 14 hours of support a day, and that's for individuals who have typically come out of hospital. It's permanent housing, but they're requiring longer-term support in housing.

We have our Off the Street shelter, which I had mentioned, which is for just that: It's a low-barrier emergency shelter. It provides that connection, that safe place to stay and hopefully the connection to the Housing First strategy, working with individuals to connect them, so that they can actually receive housing and receive some support in that housing.

We have our managed-alcohol program, as well, our Healing with Hope program, that provides—again, it's a treatment program, but it's permanent—housing for individuals who had a primary diagnosis of alcohol, but also those who have polysubstance use. What we are finding now is that there are much more instances of opioids as the primary substance use and alcohol as the secondary, so it's looking at that transition as well.

Ms. Stephanie Bowman: Great. Thank you.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Dowie.

Mr. Andrew Dowie: My question is for Helen. Thank you very much for your presentation. Just before coming here, I was reading the Sudbury Star, and it mentioned the love and support that Sudbury has for the downtown facility and the struggles with that. I know I've seen that in my hometown of Windsor, where our facility—there is

competition with the municipality, and unfortunately they have drastically reduced their presence. They still do the immigrant services and a lot of the services you've described, but there's an ongoing struggle, clearly.

I guess my question for you is: I know the YMCA has been resilient over many years, and undoubtedly I've heard what you've said in your presentation. Could you tell the committee a little bit about the kinds of partnerships that you have established in order to keep yourselves going with the YMCA and what some of the working relationships that you have are like with the different partners, whether it be funders or donors or just your volunteer base?

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Ms. Helen Francis: I could probably take the rest of your session, so you'll have to cut me off on this one.

We're really proud of the fact that we are always looking to create more collective impact by working with partners in a variety of different ways. In our child care centres, it tends to be relationships with the various school boards—as well as the families, obviously, and often public health that step in, both with funding and often some awareness and education advice.

When it comes to our health and wellness centres, where today it is typically bricks and mortar that's the challenge, along with the recovery in our membership from the pandemic lockdowns that were necessary, we are finding that we are really trying to bring in similar service agencies or agencies that have some shared values around holistic health and wellness so that we can obviously defray some of the operating and, ideally, capital costs, but more importantly, for our community, meet them where they're at and deliver even greater programming and services. Some of the recent examples we have range from more of the private sector elements, such as physio and chiro practitioners, through to another not-for-profit group called Compass, which is the provider of free mental health services for youth and teens here in Sudbury and Manitoulin Island.

Again, for us it's really about, how do we connect and do all of that upstream health work preventively? We all know there are so many measures as well as anecdotal stories around how our youth and teens have really struggled with all kinds of different aspects of both physical and, most particularly, mental health during the last few years, and so we're really keen to support that and then, hopefully, it eases some of the downstream workload that Patty and our friends at the nurse practitioners' clinic are also picking up.

There are many further examples, but that's the way we're going, along with our work with the city to really compare and contrast and combine our programming and services.

Mr. Andrew Dowie: I'll pass to MPP Smith.

The Chair (Mr. Ernie Hardeman): MPP Smith.

Mr. David Smith: Thank you very much for being here, Amanda, Patty and Helen, and for the work you've been doing in the region. I'm glad I'm here this morning to hear your concerns.

Last evening, we arrived here very late, and we had a very informed, vocal taxi driver who showed us some spots along the way. I saw that area where it's like a memorial or a place where many crosses are placed in dealing with some of the mental health issues here in Sudbury, and it's not a real good sight. When you want to highlight a city or a place, you don't want that to be the first thing anyone would show you.

My question is to Patty. It concerns me that the opioid overdose crisis is an ongoing public health problem here and that it has been intensified by COVID and the pandemic we have had. That is why we are responding by investing in services across the continuum of care. Since 2019-20, we have invested over $93 million in community addictions services and an additional $9.5 million for Youth Wellness Hubs to deliver developmentally appropriate substance use services for children and youths aged 12 through 25.

Can you comment on the existing initiatives for youth and what we need to consider moving forward?

Ms. Patty MacDonald: I would say that we're very appreciative of what the government has already invested in addictions and our opioid crisis.

For Sudbury, specifically, we have an active community drug strategy that is made up of many partners within our community and, of course, strongly led by public health, which is very appreciated.

We also were recently—in the fall, the application for our safe consumption site was approved and was opened through one of our community partners, Réseau Access Network. I think that those are very important steps towards working on the opioid crisis. I would say that there are some pilot programs, I think, going on in the province for safe supply, and I would love to see more of those throughout the province and possibly up in the Sudbury area.

As Helen said, we work closely with Compass, which is the child and youth mental health services. So we do talk about our different strategies and how we can support children and youth. We have an overlap in services, with youth in our shelter as well as in some of our justice services. So it's really just trying to connect with them and connect them to the services that are there. A lot of it is navigation, but a lot of it, as well, is building relationships. If the services are there, eventually they will come.

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll now go to the official opposition. MPP West.

MPP Jamie West: I'll continue with Patty as well. I think that it is a shock when people see the crosses when they come into town, but I actually want to acknowledge city council: The original placement for the crosses was sort of hidden, and I think being very aware of where they are and what's happening is a reflection of this community that really cares about people who are struggling.

You had talked about Réseau Access Network's supervised consumption site. While preparing for this, I learned that they haven't received the provincial funding yet. They are short about $1.1 million, which is being covered by the municipality. I know it's not the same area,

but you have a lot of experience with opioid addictions and what it means in the community. With the downloading of developmental service charges to municipalities, if the municipality of Sudbury can no longer carry the provincial portion of that responsibility, what does it mean if that supervised consumption site were to close?

Ms. Patty MacDonald: Well, I think that that would be extremely devastating for our community. I know that it hasn't been long that it has been open, but there is research showing the success rates of saving lives. It's about saving lives and, again, about building the relationship with individuals coming into the site. Eventually, you ask enough times, and someone will say, "Yes, today is the day. Today is the day that I want to be connected. Today is the day that I want to change something in my life to work towards something healthier."

MPP Jamie West: When you were giving your presentation earlier, you were talking about compensation that doesn't match the skills required and losing staff, the high turnover rates. You said it's a 17% vacancy and a 50% turnover. Other areas downtown—I had meetings with NISA, meetings with SACY—which are other mental health organizations in Sudbury, for my colleagues—and they mentioned the same thing, that they have a difficult time holding on to staff. They have the staff who love the work and the work that they're doing but can't afford to make ends meet, so they end up going to hospital or other also publicly funded organizations. I just wanted to know if you wanted to expand on what impact that means in terms of the high turnover, and just in terms of CMHA being successful.

Ms. Patty MacDonald: I would say that the high turnover rate has been very difficult for us. Yes, the 17% vacancy rate as well as the over-50% turnover rate—typically, that is in our lower-paying positions, and those are the ones that are in our essential services, so the services that need to stay open. I would say that all of our services are essential, but the ones that require that 24-hour support or the overnight support are absolutely essential.

We've tried different strategies for recruitment and retaining, but it is either—low wages are 66% of the reason why people leave, and it's also staff burnout. When you have that much of a vacancy rate and turnover, it's harder for the staff that are staying. It's more difficult because they're taking on extra loads of work, they're stretching what they are doing. They've also been in this pandemic like everyone else, and they've been heartfelt and worked passionately to keep services running.

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MPP Jamie West: Right. You had also mentioned Bill 124 and the impact that had on the ability to compensate people even if you had the resources. Could you expand on that a little bit?

Ms. Patty MacDonald: Yes. We've been in the moderation period for almost three years. We were already behind, I think, in comparators on wages, and so this has just accelerated that disparity between wages. We've done some comparators, and there's between a $3 and $10 wage difference from other organizations that are comparable to ours.

MPP Jamie West: You talked about the low-barrier shelter—I'm going to pass it on to MPP Gélinas in a minute—but I just want to remind my colleagues: They arrived last night; it was really cold last night. But actually comparatively for the week it was warm, because on Tuesday it's going to be minus 23 degrees and on Saturday it's going to be minus 33 degrees. So think of the impact when they don't have the dollar value to keep the staffing, to keep the warming shelters open. Literally, people can die from being out in the cold. It's more of a comment than a statement.

I'll pass it on to France so that she has time as well.

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: Thank you all for presenting.

I would like to ask NP Rainville from the Capreol Nurse Practitioner-Led Clinic: You mentioned that you have one NP that's until the end of the year, until March 31. Why is it that this NP won't stay on April 1?

Ms. Amanda Rainville: We have permission from the ministry to use our dietitian funding up until March 31, which is the end of our fiscal. The NP would love to stay on if I had funding to keep her on.

M^me^ France Gélinas: So you've described a situation where you are in a part of Sudbury where it is northern and rural, where a lot of poor people live, where there is no other access to primary care—there's no other access to any care; you are it—the wait list to get into your service grows by 30 patients every day, and yet you cannot secure $100,000 to get another nurse practitioner. Did you ask?

Ms. Amanda Rainville: Yes. We submitted a proposal in May. We're allowed to submit with our annual operating plan. Then in October, I sent a revised proposal to my ministry rep just outlining the influx in intakes that we've been having with the physicians who have been leaving their practice within our community.

M^me^ France Gélinas: And what was the answer to your October one?

Ms. Amanda Rainville: That it is still in the process of being reviewed.

The Chair (Mr. Ernie Hardeman): One minute.

M^me^ France Gélinas: Okay. I want you to take this one minute that's left to really explain to the people here the difference it will make to the people of Capreol if you do not have this $100,000 coming to keep the nurse practitioner.

Ms. Amanda Rainville: The people of Capreol don't have access to go to Sudbury to see a primary care provider, and quite often we're the only people that they have. We have people who walk in with digits in a bag or hanging off, because they don't know where else to go, and we call ambulances for them, or they're having a heart attack. So we really need to be there for these people who have nowhere else to go.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Ernie Hardeman): We'll now go to the independents. MPP Bowman.

Ms. Stephanie Bowman: I wanted to talk to Amanda; I'll give you some more time as well—a similar question to MPP Gélinas. But before I do that, I just wanted to come back to, Patty, a statement that you made around the safe-injection site.

We had some dialogue in past hearings about that, and there is some controversy around them. I know that some people are not convinced, but I am convinced that they work, and I think you just summed it up very well when you said that you ask every day, and one of those days, you hope—and you support those people to get to a place where they can say yes. I just wanted to acknowledge that you described that very well, and that is, in essence, what they are there for, to support people until they can get to that place where they're ready to take the next step in their lives. That's great.

Amanda, I wanted to come back to you and, again, I think we've got an answer now to my first question, which was, what was the response that you got in October? You're still waiting. Is there any sign of why you haven't been approved? Did they say this is the normal time? That was October. November, December, January—three months to get an answer about $100,000 in continued funding. Is there any indication about why?

Ms. Amanda Rainville: I followed up in December just to see where things were at, and I received the same reply: that it was still under review and they couldn't provide any other update. Our fundholder will be moving to Ontario Health from the Ministry of Health as of April 1. I don't know if that is causing some of the delay or if this is their normal process.

Ms. Stephanie Bowman: Again, just to be clear: The three practitioners who are retiring or cannot continue their practice—will they then be the last family physicians in Capreol, or are there others still practising?

Ms. Amanda Rainville: There are no family physicians in Capreol. There haven't been any family physicians in Capreol since before 2011, when we opened our clinic.

Ms. Stephanie Bowman: The three you're talking about who are in the process are ones in the Sudbury—

Ms. Amanda Rainville: In the Sudbury area, yes.

Ms. Stephanie Bowman: All right. Again, the money that you've asked for, $292,585, is really just to maintain the current patient load plus a little bit more, as you're doing this new intake, but it's likely that you will need more funding given that these three doctors are also retiring. Is that correct?

Ms. Amanda Rainville: That's correct. That's just the minimum that we were asking for, and it doesn't touch operations. That's just purely HR funding that we were requesting.

Ms. Stephanie Bowman: What about your space? If you were to get full funding, operational funding, to allow you to have the right number of people to serve your community of approximately 3,000 people, would your space be sufficient or would you need to be asking for money for that as well?

Ms. Amanda Rainville: We could make it work. We are on an upper level of the building, and our landlord would love it if he could give us the basement area as well, so there would be an opportunity to expand if funding allowed. But if we were to get the HR money, we could make our existing room work for us.

Ms. Stephanie Bowman: I would just ask you again—you can get our contact information—to keep us informed of what's happening with your case and your status, because we obviously want that to be approved. As opposition members and independent members, we'll do whatever we can to make sure that the government is making sure that that ministry request—that you get a response, and hopefully that it's one in the positive.

The Chair (Mr. Ernie Hardeman): We'll now go to the government side. MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you to all of the three presenters for being with us today. All of you presented a very compelling case about the needs of the community here, and we hear you. It's so important to be able to support you, because you're supporting people who are often in crisis.

One of the things I think you would be pleased to know is that when our government was elected, we recognized that there was a huge deficiency in the human resources and also in hospital infrastructure, and in the last few years, we've worked very, very diligently on the issue of being able to recruit nursing students into colleges and universities. Some 12,000 new nurses were registered to work in Ontario just last year alone, and another 30,000 nursing students are in colleges or universities today, as we speak, including at Laurentian University. So we're on the right track and we're making progress. We haven't seen the results yet with some of the graduates, but they're coming.

Also, with respect to the nurse practitioners, the government made a one-time investment this year, for 2022-23, of $400,000. That money is going to be allocated to train an additional 38 nurse practitioners, starting this coming year. I hope and I'm optimistic that the nurse practitioners will come to this community, because obviously there's a great need.

Part of the challenge, as you heard from my colleagues earlier, is how we attract health care workers, including nurses, to come into northern and more rural, remote communities. So I wonder if any one of you—I'll start with Amanda, Patty and Helen: How do you think that that retention and attraction can come to some of the more rural and northern communities?

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Ms. Amanda Rainville: I think it is important to invest in our universities, because if you train here, you're more likely to stay here. We do have a really strong sense of community in the north, so northern nurses often like to stay where they are born and where they train.

And then just make sure that nursing students and nurse practitioners have support, so that they have mentors. Invest in mentorship, because it is very difficult to start as a novice nurse practitioner without having anyone to lean

on, so making sure they are working in places where there are other nurse practitioners or somebody they could call on if they have questions.

Ms. Effie J. Triantafilopoulos: Does anyone else want to comment on this?

Ms. Helen Francis: I'm just going to jump in and just say I think it's another opportunity to recognize the economic driver that child care provides. We can want as many people in the workforce as possible, but if we aren't providing child care, then there are going to be a good number of parents who are going have to stay at home.

We also have to think about how we build that early childhood educator pipeline, because the demand is there and we know it's a huge economic driver.

Ms. Effie J. Triantafilopoulos: As well, I think one of you maybe mentioned earlier in the comments that there are going to be some physicians in the coming years who are going to be retiring, and how do you fill that pipeline going forward? One of the areas, again, that the government has been focused on is making announcements—in fact, the Premier, just a couple of days ago in Brampton, announced that there will be a new medical school there. There will be three new medical schools being built in the coming years in Ontario. Again, that pipeline of physicians going forward will be there. I think part of our challenge will be how we encourage them to look at a smaller community like Sudbury as a place to be able to live, raise a family and also give that kind of care.

I think you mentioned as well that the partnerships that you all build with your own organizations would be key to that, so I wonder if you would care to comment on that as well.

Ms. Patty MacDonald: I would say that yes, I think the partnerships are very important. I think as a community organization, we do engage with—at the first session you had heard from Jennifer of the Sudbury District Nurse Practitioner Clinics. They work with us very closely, and we're so appreciative of the work that they do with our organization and with 200 Larch, our managed alcohol program.

We are also partnering with several of the primary care clinics to work with them, so hearing that there's going to be an infusion of more physicians is very welcomed news. Thank you.

Ms. Effie J. Triantafilopoulos: And then, just my final question: As you know, going forward, this new model of Ontario Health Teams is being integrated throughout the province. How have you been able to work with and be part of this new Ontario Health Team for this region?

Ms. Helen Francis: Well, I can add that even as a charity obviously in more of the proactive health and wellness side, we're at the table as a supporter for Ontario Health Teams. I do think there is merit in it; we have just got to make sure we are getting some traction. Obviously, we are starting with pilot populations and pilot—or more chronic disease focus, but then we need to understand how we can expand it.

Ms. Effie J. Triantafilopoulos: Thank you. Those are all my questions.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: Thank you, Chair. It is always a pleasure to have that opportunity.

Amanda, I'm so sorry to hear about the delay that you were talking about. I just want to say that you have a local champion right here, your MPP. Reach out to him and we'll be happy to look into it as well. We do have another local champion who is actually the health critic as well, so anything we can do as a team, we'll be happy to do it.

A question to you: I just want to understand—and that is why I usually think about—I'm from Mississauga. We have big buildings. A few things which I want to quickly ask you: Do you have big buildings in your locality or your area?

Ms. Amanda Rainville: Like high-rises?

Mr. Deepak Anand: High-rises.

Ms. Amanda Rainville: No, not in Capreol.

Mr. Deepak Anand: Okay. And the traffic jams during the rush hours?

Ms. Amanda Rainville: We have trains.

Mr. Deepak Anand: Yes. So I'm just thinking, when we think about all these things, we think that you actually live in heaven compared to us, but I hear from you that the cost of living in heaven is very high.

I have a very simple question. You talk about this—and especially with the Internet and other things going on, and now people are more able to work from anywhere but want to stay where they belong to. So have you considered going to your local schools, local community centres, locals in your own community and starting to tell them how important these jobs are, how important these skill sets are, and how important it is to—

The Chair (Mr. Ernie Hardeman): It's a great question, but there's no time for an answer.

We're now going to the opposition. MPP Fife.

Ms. Catherine Fife: To my colleague across the way: Even heaven needs health care investment. That's the key part that we're getting from today's presentation.

The government talks about new recruitment strategies that are getting off the ground. They talk about building new buildings for getting new doctors in. But at the same time, this province is bleeding out talented, experienced health care professionals.

This is the message that needs to get through to this government—to invest in retaining the good people across the entire spectrum. So can you please tell the government why it's so important to invest in retaining the staff that we have right now?

Ms. Patty MacDonald: I can start.

It's very important. The benefit to the hospitals—that they have received some funding—has been so important, but when people are discharged from hospital, they need that community support. They need the wraparound support. They need support in connecting to other services, that navigator. They need supportive housing. It's so important. You need that community support and that infrastructure just as much as you need it within the formal, bigger institutions.

Ms. Catherine Fife: Thank you.

Ms. Helen Francis: Every time we lose anybody, it's probably four times as expensive for us to recruit and retrain and build that competence.

Ms. Catherine Fife: A key point, yes. Thank you.

Ms. Amanda Rainville: There are hospitals that have had to close their emergency rooms because they didn't have staff. If the emergency room doesn't have staff or primary care doesn't have staff, there's no place for patients to go.

Ms. Catherine Fife: Thank you very much.

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: I have taken the Capreol ask to the Minister of Health. I have asked a question in the House about the Capreol Nurse Practitioner-Led Clinic. I did a member's statement about the nurse practitioner-led clinic. Everybody knows that they need funding, but it's not coming—just so people know.

I would like to ask Ms. Francis—I'll declare my conflict of interest: I've been a member of the Y for 40 years and I'm a big supporter. Could you give us an idea, per hour—you were saying that you're 165 staff short in early childhood education. Are we talking about people who make 100 bucks an hour here?

Ms. Helen Francis: No, our registered early childhood educators make between $21 and $24 per hour.

M^me^ France Gélinas: How much would you need to pay them in order to recruit and retain?

Ms. Helen Francis: We'd have to be more comparable to the school boards, which are our biggest form of competition. I would hesitate to remember the number exactly, but it's closer to $26 to $28, if not more.

M^me^ France Gélinas: So we're talking about people who have a three-year college education making $21 an hour?

Ms. Helen Francis: Yes.

M^me^ France Gélinas: Most of them women?

Ms. Helen Francis: Absolutely.

M^me^ France Gélinas: And $28 could solve the problem for daycare for many, many people.

Going to the Canadian Mental Health Association: It's kind of the same—you said that it is mainly your lower-paid employees who leave, and where the vacancies are. What kind of salaries are we talking about?

Ms. Patty MacDonald: Currently, we're talking about around $19 an hour, and it ranges up to about $21 an hour. Comparable to other organizations, they're making at least $5 more per hour, and those are for our residential shelter workers. We have had turnover as well in some of our case management social worker positions. Again, there are variances. With our nursing staff, there are variances of $10 an hour.

M^me^ France Gélinas: The base budget freeze—you talked about a very low increase over a very long period of time. Can you explain why it is that community mental health and addiction is always the poor cousin of the poor cousin in health care? Why is it that you cannot get pay increases? Why is it that you cannot pay for the skills of the people that you need?

Ms. Patty MacDonald: Because we haven't had those increases, we need to work within our current budget. So we've had to work within that current budget, other than the one 2% increase in 2018. We've just had to make things work. I guess that CMHA cannot continue to make things work. We recognize that this has been just a ripple effect and it's had a negative impact on many of our staff and our community, the services that we provide and—

M^me^ France Gélinas: This is something that, with an 8% increase to CMHA, you feel confident that we would see a better outcome for people and easier recruitment for you?

Ms. Patty MacDonald: Definitely an increase in recruitment and retainment. Just as an example, last year, we had 200 interviews. We had 25 people that didn't show up. We had 25 people who rescinded prior to—accepted the offer and then rescinded. We are just constantly recruiting, and we would love to spend our time on the services and building our teams. We do provide quality services, but it's getting more difficult to recruit quality and expert staff.

M^me^ France Gélinas: MPP West?

The Chair (Mr. Ernie Hardeman): One minute, and MPP West.

MPP Jamie West: I'm going to ask Helen Francis to update—there's a really great overview of Sudbury, and one of these I want talk about. She talked about the importance of swimming lessons, and MPP Anand talked about newcomers coming. But as well, there are 300 lakes in greater Sudbury. There are six of them within a 10-minute drive from here, so the importance of that. Just with the amount of time we have, can you talk about the importance of health and wellness affordability?

Ms. Helen Francis: Absolutely. We have seen that, prior to COVID, of our membership base, about 20% to 25% of our members would ask us for financial assistance, and we'd be glad to provide it. Those numbers today are closer to 40% of our member base as we're coming out of COVID, and part of that, we see, is the demographic. We have a lot more youth, a lot of young adults and lots of newcomer and young families attending the Y, which is fantastic. But they're at the beginnings of their career trajectories and building their foundation, so they don't have that discretionary income. They need the support. And, obviously, we all know, there are inflationary pressures everywhere. Sadly, looking after yourself, that proactive health and wellness, is often the first thing that people cut—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time for this panel. I want to first of all thank the panel for taking the time to prepare, to come to the meeting and to express their opinions here. We very much appreciate that and will take them forward in our preparation for the upcoming budget.

With that, we recess until 1 o'clock. I believe lunch is available somewhere, and we'll find that out as we leave.

The committee recessed from 1203 to 1300.

The Chair (Mr. Ernie Hardeman): Good afternoon, everyone. Welcome back. We will resume public hearings for pre-budget consultation 2023.

As a reminder, each presenter will have seven minutes for their presentation. After we've heard from all the presenters, there will be 39 minutes for questions from members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the opposition members, and two rounds of four and a half minutes for the independent members as a group.

We'll now call on the next presenters to begin.

ALZHEIMER SOCIETY OF ONTARIO
L'ARCHE SUDBURY
UNIVERSITÉ DE SUDBURY

The Chair (Mr. Ernie Hardeman): The next group of presenters is the Alzheimer Society of Ontario, L'Arche Sudbury and Université de Sudbury. Take a seat. The first presenter will be the Alzheimer Society of Ontario.

As I said, the presentations will be seven minutes long. At the point of six minutes on the dot, I will say, "One minute." Don't stop talking, because the minute starts ticking. But at the end of the last minute, I will stop the talking and we will then go to the next presenter. And when we've gone through all the presenters, we will then start the round of questions. As I mentioned, two rounds of questioning.

With that, Alzheimer Society of Ontario—and I would ask you to state your name for the Hansard to make sure that all your wealth of information is attributed to the right person. The floor is yours.

Mr. Kyle Fitzgerald: Thank you. Good afternoon, Chair Hardeman, committee members, and thank you for the opportunity to speak with you today. My name is Kyle Fitzgerald. I am the director of public policy and government relations with the Alzheimer Society of Ontario. Joining me virtually today, but just down the road, is Stéphanie Leclair. She is the executive director of the Alzheimer Society of Sudbury-Manitoulin North Bay and Districts.

The Alzheimer Society is a federation of 26 health care providers, serving every community in Ontario. Last year we supported over 95,000 Ontarians living with dementia and their care partners. While Alzheimer's disease is the most common form of dementia, accounting for about 70% of cases, we support families affected by any form of dementia, even those who do not have a diagnosis. There is an Alzheimer Society serving every single one of your constituencies, and we would encourage you to see us as a resource whenever someone affected by dementia reaches out to your team.

Here in Sudbury-Manitoulin, there are over 800 people living with dementia, and across the province, there are over 275,000. That number will triple within the next 30 years. Around 150,000 Ontarians are unpaid family care partners for someone living with dementia. That number, again, will triple by 2050. We are not effectively, efficiently or compassionately caring for Ontarians living with dementia today, and are alarmingly unprepared to care for thrice that number in the coming decades.

In Ontario today, dementia is hallway health care. Half of all alternate-level-of-care, or ALC, beds in Ontario hospitals are attributed to an older adult living with dementia. Here in the northeast, dementia is the number one cause of ALC status in our hospitals. That's around 3,000 hospital beds province-wide occupied on any given day by someone living with dementia who does not want or need to be there but has nowhere else to go.

To put that into context, after this committee has finished your work and you're back at Queen's Park preparing your report, take a look down University Avenue. Take a look down hospital row. Look at Toronto Rehab, Toronto General, SickKids and Mount Sinai. Imagine every single one of those hospitals filled to capacity with people living with dementia who are ALC status and who do not want to be there, and then double it. That will get you close to where we are in Ontario today.

Research out of the University of Southern California last year found that Ontario will spend just under $28 billion in avoidable long-term-care and ALC costs for people living with dementia over the next 20 years. The total cost of dementia, including direct health care costs borne by taxpayers and lost wages borne by unpaid care partners, is over $11 billion annually here in Ontario.

The choice we face is not whether we can afford to provide the care and services needed to support Ontarians with dementia in their desire to live at home. That choice has already been made. If families don't get the care they need to stay at home, their care needs do not simply disappear. Instead, they go to the one place that cannot say no: They go to hospital. The choice, instead, is whether we want to continue with the status quo of hospitals and long-term-care homes spending far more than is necessary to care for people who do not want, need or choose to be there, or whether we want to challenge that status quo and shift dementia care back to the community and get Ontarians living with dementia out of emergency departments and out of ALC beds.

The Alzheimer Society has three priority recommendations tailored to challenging this status quo and alleviating the pressure on our hospitals. These are recommendations 4, 5 and 6 in the submission you have before you. Each of these recommendations is cost-positive; we will save more in avoided hospital visits than we are asking for in funding. One of them is already making a difference right here in Sudbury.

To explain more, I will turn it over to Stéphanie.

Failure of sound system.

Interjections.

Mr. Kyle Fitzgerald: I'll just carry on and we can go back to Stéphanie at the end.

What Stéphanie was going to mention is a program here up in Sudbury, North Bay, Timmins, Algoma and Sault Ste. Marie. This started over two years ago as a result of

COVID and as a result of the HISH funding in a previous budget. This program has an Alzheimer Society staff member support somebody living with dementia in the two weeks before and the two weeks after they transition to long-term care. Of that population, we'd expect 35% to be hospitalized within six months of the move into long-term care. It is a deeply stressful and traumatic experience. What we saw in the northeast was zero people. Out of the approximately 500 who have been supported by this program, none of them have been hospitalized within six months of moving into long-term care. That saved about 175 hospital visits of those we would have expected to be hospitalized otherwise. The ask before you in the budget submission is to expand this successful program that is now base-funded through Ontario Health north and get that into long-term-care homes province-wide.

Our other two priority recommendations would also, if funded, save money and avoid unnecessary hospital visits. First Link care navigation, our flagship province-wide program, has been found by ICES, which is funded by the Ministry of Health, to avoid 0.29 hospital visits per client supported; so, near as makes no difference, for one in three clients we support, we avoid a hospital visit. With our budget ask of $3.26 million, we would avoid an estimated 1,012 hospital visits, 405 hospital admissions, and $4.89 million in associated costs—a net return on this investment of $1.63 million, without even considering delayed long-term-care admission and improved quality of life.

Our final priority ask, and the one about which I am personally most excited, would avoid 2,504 hospital visits. This would expand a successful program that started in Brantford General Hospital, which has now been expanded to Niagara and Norfolk, by embedding Alzheimer Society staff within a hospital's emergency department. This program was able to achieve a diversion rate of 62.7%. So of the roughly four in 10 people with dementia who would be admitted to hospital following a visit to the emergency department, we avoided 63% of those admissions. Expanding this program province-wide would avoid an estimated $30.22 million in hospital costs—a net return on this investment of $6.25 million, again, only including avoiding hospital visits, not including quality of life and long-term care.

While our priority recommendations will all save money, they are about more than that. We are asking to be a partner in providing person-centred care, and a partner in keeping Ontarians living with dementia where they want to be: at home.

We thank the committee for your time. We welcome your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to L'Arche Sudbury.

Ms. Jennifer McCauley: Thank you all for being here in our wonderful city. On the screen, Jennifer, Darrell and Chantale are going to join me.

Chantale, I just want to highlight, is one of our community members we support. She has been a big voice for people with intellectual disabilities around our project, and she really wants to see this come to fruition. It's her birthday this week, and she keeps saying, "My birthday wish is to move into an apartment in the new building, Jennifer." So let's make that happen.

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L'Arche is an international organization. We share a life with people with disabilities here in Sudbury. We've been operating since 1982; it was our 40th anniversary last year. We have three homes and we also run a successful community participation program where we help people with employment supports, vocational supports, volunteerism, as well as meaningful activities.

There is a huge wait-list in our city—huge wait-list—that I can't even emphasize enough. Last year in October, the numbers have doubled in the amount of people that are needing supports. When we look at the wait-list numbers, we met and looked at our strategic plan and thought, "How can we be a solution to this problem?" So listening to the voices of our members and looking at the wait-list, we've purchased already a 4.5-acre piece of property in the city and we want to build an affordable housing complex. We will call it L'Arche Sudbury Place. It will house 28 shared-living apartments, some for people with intellectual disabilities and also for people without intellectual disabilities. We envision a good neighbour model where everybody wants to live interdependently in the building and share life together.

We have a training unit designated. Many young people are aging out of their home or out of the sector and they are quickly propelled into living independently without the skills that they have to do it successfully. We want to have a training unit where they can grow their skills, learn how to do what they need to do to be successful in independent living. And then the respite unit is just a significant need. When I talked about the wait-list information earlier, our wait-list numbers have almost doubled in a year. Families are burning out. We know that COVID has had such an impact on people at home, and so that unit is of particular need.

Additionally, we would like to move our administration space and have a gathering place, a place for people with intellectual disabilities, and without—our whole neighbourhood—to come together and house activities within the space and also on the property. This is a unique model that will fill a gap. It's more than just a housing complex. We really listened to the Ministry of Children, Community and Social Services, referred to the document Journey to Belonging and to the guiding principles. We want to align with our largest funder. People with developmental disabilities are supported by their communities and networks and also their government to belong and have inclusive lives. The cost of the building is $24 million and we propose to achieve this through federal support, municipal support, provincial support, and we have already raised, to date, $1.3 million in a capital campaign.

You can see from our list of supporters that we have our new mayor, Paul Lefebvre, strongly behind the project; Marc Serré, our member of Parliament for Nickel Belt; Viviane Lapointe, who is our new member of Parliament for Sudbury; and I also point to Jamie West and France Gélinas, two huge supporters of our community.

So how can you help? We're here today to ask that we need our Ontario government, our closest partner in our existing programs, to come to the table. Help us to obtain the commitment of $8 million in capital financing and ongoing operational funding. We need you to create a dedicated fund for this and other similar projects for addressing the housing and care needs of the most vulnerable of Ontario residents. We have learned through our process that MCCSS does not have a dedicated capital fund; they have to go to the Treasury Board to access the dollars. We need your support to make that happen and we need you to call on all our community members and experience what L'Arche has to offer.

Last night on CBC, there was a documentary in regard to Huronia and the closing of the institutions and I will call you to say that we've come so far in our province to close those institutions and integrate people into their home community, but we can do much better and this project is one of the ways that we can help to do that. Thank you.

The Chair (Mr. Ernie Hardeman): Now we'll go to the Université de Sudbury.

M. Serge Miville: Bonjour. Merci. Mon nom est Serge Miville. Je suis recteur de l'Université de Sudbury. J'aimerais remercier le comité de m'avoir invité à proposer des recommandations de notre institution pour le budget de l'Ontario pour 2023-2024. Je suis d'autant plus content d'être ici que l'université a d'ambitieux projets pour son avenir et pour l'avenir économique du grand Sudbury et de la francophonie ontarienne.

Vous n'êtes pas sans savoir que l'Université de Sudbury faisait partie de la fédération de l'Université Laurentienne jusqu'en 2021, moment de la dissolution unilatérale de cette fédération. De fait, le financement d'enseignement de l'établissement a été entièrement coupé, et ce, malgré le fait qu'on avait 1 700 étudiants et une centaine d'employés.

Il y a presque deux ans, en mars 2021, l'Université de Sudbury s'est engagée à devenir une université de langue française par et pour la communauté francophone du grand Sudbury. Nous sommes choyés de l'appui massif de la communauté francophone et des autres communautés du Nord et d'ailleurs en Ontario pour ce projet de société structurant. C'est un projet de société qui est véritablement porté par la communauté. Cette communauté souhaite depuis plus d'un siècle de réaliser cette université de langue française ici à Sudbury pour répondre aux besoins d'éducation universitaire en français des jeunes afin de les préparer, les outiller, pour le marché du travail et pour contribuer activement à la prospérité économique et sociale de notre province. Après un siècle, il est enfin temps de réaliser ce rêve.

Mesdames, messieurs, l'Université de Sudbury a livré. Nous avons déposé avec succès l'automne dernier une demande d'accréditation pour devenir cette institution francophone auprès de la Commission d'évaluation de la qualité de l'éducation postsecondaire, CEQEP, que l'on connaît en anglais comme le PEQAB. Il s'agit de l'instance qui évalue les programmes et les institutions postsecondaires comme la nôtre.

Après analyse de notre dossier, la CEQEP a envoyé sa recommandation à la ministre des Collèges et Universités, Jill Dunlop, qui doit donner son approbation. Son ministère évalue présentement notre dossier. Nous avons fait tous nos devoirs et nous avons rencontré toutes nos obligations du ministère. Le temps du choix est arrivé.

Je suis extrêmement fier de cette communauté. Je suis fier de la solidarité. Je suis fier de l'unanimité autour de ce projet d'importance capitale pour la revitalisation du secteur postsecondaire dans le nord de l'Ontario.

Je souhaite aujourd'hui vous proposer deux recommandations. Notre première touche le financement du gouvernement de l'Ontario pour l'ensemble des institutions postsecondaires publiques.

Notre première recommandation est de dire oui. Il faut dire oui aux aspirations légitimes de notre communauté. Il faut dire oui à notre relance. Il faut dire oui à la revitalisation du milieu postsecondaire de langue française dans la région du Moyen-Nord et de dire oui à la revitalisation économique de la région.

En anticipation de notre accréditation par le ministère des Collèges et Universités, il est primordial de prévoir dans le budget l'intégration de l'Université de Sudbury comme institution publique de langue française avec sa juste part de financement. Ces sommes sont critiques afin que l'Université de Sudbury puisse réaliser l'audacieux projet de relance et de modernisation de la programmation universitaire de langue française. C'est pourquoi l'Université de Sudbury recommande donc que la province travaille avec elle pour son intégration à part entière dans le système postsecondaire de l'Ontario avec le financement qui s'y rattache.

La deuxième recommandation touche le programme des langues officielles en éducation, le PLOE—plus précisément, les Fonds complémentaires en éducation postsecondaire en français du gouvernement fédéral. Ce programme fait partie de l'entente fédérale-provinciale et il permet de débloquer des millions de dollars pour faire de l'Ontario la province la plus forte, la plus concurrentielle et la plus rayonnante en matière d'éducation postsecondaire en français au pays et ailleurs dans le monde entier.

Pour que l'Université de Sudbury puisse bénéficier pleinement des fonds fédéraux, nous recommandons que le gouvernement se présente comme un levier et prévoie dans son budget une contrepartie afin d'assurer que des institutions comme la nôtre puissent débloquer ces fonds essentiels au développement de nos communautés.

L'Université de Sudbury a été créée en 1913. Ça veut donc dire qu'elle célèbre cette année son 110e anniversaire. C'est un siècle de succès auprès des étudiants. C'est un siècle de développement social, culturel et économique pour le nord de l'Ontario. Nous sommes un employeur important et nous investissons dans la communauté des millions de dollars chaque année, et ce, même en période de transition.

Avant la dissolution, l'université accueillait 1 700 étudiants dans sept programmes avec 34 options de diplômes. Elle avait 8 millions de dollars de revenus en moyenne par année. Et chose très importante : après plus d'un an depuis la dissolution de la fédération—ça veut dire un an après avoir perdu accès à tout son financement public pour son enseignement—l'Université de Sudbury n'a aucune dette.

Let me repeat that: The University of Sudbury, despite having the entirety of its budget for education cut, has no debts.

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L'Université de Sudbury est la preuve que la gestion prudente des fonds publics, avec une mission et une vision stratégiques claires, précises et basées sur des objectifs réels, livre toujours des résultats pour les étudiantes, les étudiants et l'ensemble de la région.

Je conclurais en vous disant que l'Université de Sudbury sert aussi de rempart à l'exode des jeunes vers le Sud puisqu'ils y restent pour y étudier et y travailler par la suite. L'université participe pleinement à un Nord ontarien fort, solide et durable, mais pour réaliser nos engagements, nous avons besoin de traduire l'unanimité qui existe autour de ce projet en appui financier du gouvernement, et ce, au même titre que les autres institutions publiques de l'Ontario et d'ailleurs.

Encore une fois, je vous remercie de m'avoir donné la chance de partager mes recommandations avec vous. Je suis prêt à répondre à vos questions si vous en avez.

Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. We will start with the government side. MPP Byers.

Mr. Rick Byers: Thank you very much—merci beaucoup—for all your presentations and all your great work in this community. I have a question for Kyle. As it turns out, this past Saturday, I was at the Alzheimer Society of Grey-Bruce, an event in the community there. It was a fantastic fundraiser called Soup's On. They asked me to judge, and I consumed 23 different types of soup in the space of 90 minutes. It was quite something.

M^me^ France Gélinas: That's dedication.

Mr. Rick Byers: Yes, dedication. Public service, you know; you've got to do it.

I was quite struck by your figures of the occupation of ALC beds in the hospitals. I wonder—I think you said recommendations 4, 5 and 6, but could you just expand a little bit on where they go? What's the solution for where they would go and how we would make that happen?

Mr. Kyle Fitzgerald: Thank you, MPP Byers, and thank you for your support of our event over in Grey-Bruce. It sounds like a soup-er time. I'm sorry.

The recommendations: The first one would be for our First Link Care Navigation. That one would be $3.26 million. That will enable us to hire 34 FTEs, so at least one in every community of Ontario. So every single one of your ridings would benefit from this. What data from ICES shows is for every person we're able to touch through First Link—we looked at their health care data from one year before and one year after, and on average, there were 0.29 fewer emergency department visits, accounting for all variables except them being connected to the Alzheimer Society. We would be able to support, I believe, 4,590 additional clients. Do the math on that; it works out to just over 1,800 avoided hospital visits, and that works out to about $4.89 million in cost savings. So there's a clear link there: If we can avoid people going to hospital for reasons they don't need to be there, then it saves capacity for people who actually do. We're not saying we can stop people going there with a broken arm; we're saying we can stop people going there with caregiver burnout in need of respite. We can keep those people at home.

The other priority ask is actually embedding a staff member in the emergency department. There would be an Alzheimer Society staffer in the ED who would identify people living with dementia, have a conversation with them and say, "Right, this is our last chance to keep this person out of hospital." That was the one that started out in MPP Bouma's riding actually, at Brantford General Hospital. We had him, MPP Kusendova and Laura Smith out there to tour that a couple of weeks ago. That had just under a two-thirds diversion rate. Scale that up province-wide and we'd be avoiding just about $30 million in hospital visits, even assuming that we don't do any better than we did in Brantford. That's a very direct link there, because we're actually in the hospital, getting people out.

The final one that Stéphanie was going to speak to, that's currently taking place here in Sudbury, Algoma and Sault Ste. Marie, and that is for two weeks before and two weeks after someone transitions to long-term care, we work with that person. We get them ready for their move to long-term care, and we've avoided 100% of rehospitalizations. This government has put a tremendous amount of effort into getting people out of hospital and into long-term care; it's all for naught if they end up back in hospital. That's what happens about one in three times, because it's a stressful, traumatic experience. Everything changes: your environment, your routine, your support network. Just having that one consistent face walk with you for two weeks before and two weeks after is usually impactful. Again, that would be a cost-positive investment, and that one would be $21.98 million.

Mr. Rick Byers: Excellent. Thank you very much. It sounds like Stéphanie can hear now.

Relatedly, the solutions you're describing relieve our hospitals, which is an important part. You're an important part of the primary care network, if you will—sorry; I assume that's a fair statement. But I'd be curious on the other partnership opportunities you see in the primary care network, and maybe describe them. But I'm curious as to how we can better stitch those great providers together to make sure that they're providing care that folks need and relieving the hospitals, as you've described.

Mr. Kyle Fitzgerald: Maybe I'll put Stéphanie on notice and turn it over—

The Chair (Mr. Ernie Hardeman): If I could interrupt just for a moment, the technicalities have been solved. If the panellists want to use the people in the virtual realm, go for it.

Mr. Kyle Fitzgerald: Sure. Thank you, Mr. Chair.

Maybe I will actually pass it over to Stéphanie, because I know she does some great work. I was at her office before this, and it is actually embedded in a health care complex here in Sudbury, so it's a great example of what you're talking about.

Stéphanie, do you want to field that one?

Ms. Stéphanie Leclair: Yes, sure, Kyle. Thank you.

One of the things we've done here in northeastern Ontario is work closely with our family health teams and our CHCs, the community health centres. The First Link program that Kyle is talking about: We have a First Link care navigator embedded into some of our more rural communities. It supports primary care with making sure that families are being navigated and supported in more rural communities in terms of that dementia journey that they're on.

The other opportunity that we have, of course, is through OHTs, Ontario health teams, to work closely with our providers.

The other example I would use is: The transitional supports program that we are doing in the northeast is actually inter-agency. We don't work alone; we work with our clinical partners, with our local geriatric centre and our Behavioural Supports Ontario teams—really closely with them. We can't do this work alone. We do it closely with our health care partners.

Mr. Rick Byers: Perfect. Thank you very much.

I'm going to pass my time to Andrew.

The Chair (Mr. Ernie Hardeman): MPP Dowie.

M. Andrew Dowie: Ma question, c'est pour Serge. Merci beaucoup pour votre présentation. J'aimerais bien savoir le rôle de l'Université de Sudbury pour la communauté francophone. Moi, j'ai été étudiant à l'Université d'Ottawa. Aussi, je connais le Collège Glendon, l'Université de l'Ontario français, alors je crois que la différence sur la gouvernance est strictement « pour les francophones et par les francophones ». Est-ce que je comprends ça bien, que c'est ça la différence contrairement aux autres?

The Chair (Mr. Ernie Hardeman): One minute.

M. Serge Miville: Je pourrais dire que pour l'Université de Sudbury, c'est 110 ans, hein, qu'on a fait de l'enseignement postsecondaire en français et, pendant un certain moment, bilingue également. La gouvernance est entièrement de langue française présentement, et c'est une institution qui cherche réellement à créer des liens et à collaborer avec les autres acteurs du milieu postsecondaire afin d'augmenter la capacité d'offre en français pour l'ensemble des étudiantes et des étudiants.

C'est aussi un établissement qui veut être extrêmement inclusif pour promouvoir l'apprentissage du fait français, qu'on soit anglophone, francophone, allophone ou peu importe.

M. Andrew Dowie: Et votre relation avec l'Université Laurentienne depuis 2021, effectivement, est-ce qu'il n'y a rien tout de suite, ou est-ce qu'il y a encore une relation?

M. Serge Miville: Malheureusement, la Loi sur les arrangements avec les créanciers des compagnies a créé un environnement où il était impossible d'avoir des communications et même des collaborations fructueuses—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes that question.

We'll now go to the official opposition. MPP Fife.

Ms. Catherine Fife: Just to Jennifer, I just want to say I love L'Arche. I think you should put it on a T-shirt. I would wear it. I would buy one. Your proposal is exactly the kind of housing that this government should be investing in. It was a major part of our platform—because the return on investment to the overall community, it can't be questioned. Hopefully, the government listens to your request on this. The wait-list news is heartbreaking, though. Really, it is.

My question is for Kyle. Kyle, I want to thank the Alzheimer Society for sending in petitions to my office. I really do appreciate it. It does show, your stat here, that 31% of voters in Ontario have a close connection with someone with dementia or Alzheimer's, and that's showing up very clearly in the response to the petition.

Your recommendation number 6, that the government expand diagnostic capacity through a $10-million investment in PET scan: We do know that over 50% of people are never fully diagnosed. They don't get a full diagnosis with Alzheimer's, which also leaves them in limbo. So your request for the PET scan centres to be expanded—we do know that this is key in diagnosing. Are the PET scan diagnoses or tests covered by OHIP?

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Mr. Kyle Fitzgerald: Thank you, MPP Fife, first, for circulating that petition. It's certainly tremendously important, and we're pleased to show our support for it and continue to support it.

In terms of PET scans, currently it isn't. It used to be covered for clinical trial. It's now only covered if you're associated with a clinical trial, and this is going to be especially pertinent as we prepare for disease-modifying therapy. We don't currently have one in Ontario. We're expecting there will be a treatment within two years—within the mandate of this current government.

Ms. Catherine Fife: Okay. So that's a key piece for the government to understand: This key diagnostic test is not covered, and it means so much to people to actually have a clear pathway to deal with this. I wanted to thank you for bringing that to our attention, and I'll pass this over to my colleague MPP Gélinas.

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: Thank you. Merci beaucoup d'être venus aujourd'hui.

My first question is for you, Jennifer. I am very excited about the new affordable living complex that you have put together. I know that you need $24 million. What is the share of the provincial government that would make sense to your agency?

Ms. Jennifer McCauley: We're asking for $8 million, where $2 million would come from NOHFC and $6 million would be a capital investment we're asking for from the province. We've had that needs assessment in with the ministry for over a year now, and we're still waiting to hear an answer back. Hopefully we can do that and have all levels of government with us on the project.

M^me^ France Gélinas: Okay. Since you submitted a year ago, have you heard anything back at all?

Ms. Jennifer McCauley: No.

M^me^ France Gélinas: Crickets. Okay. Well, you're talking to the right people. Thank you for sharing that.

J'aimerais poser une question similaire à M. Miville par rapport à l'Université de Sudbury. Vous avez parlé que vous voulez vous servir d'un peu de fonds du provincial pour aller chercher des fonds fédéraux. On parle de combien d'argent?

M. Serge Miville: Le programme des langues officielles en éducation et le fonds complémentaire, c'est un programme qui permet à la province d'utiliser, mettons—ça peut être des programmes, des fois, où c'est 75 % payé par le fédéral, 25 % par la province. Au début, c'était 90 % par le fédéral et 10 % par la province. Ce sont des très petits montants, finalement, de la province qui permettraient de promouvoir une relance efficace de l'Université de Sudbury et d'augmenter l'accès à l'enseignement universitaire de langue française pour une entièreté de la population du Nord.

Mme France Gélinas: Ce qui s'est passé à l'Université Laurentienne, ça a été dévastateur pour toute notre communauté; mais vraiment, pour la communauté francophone, ça a été super difficile. Comment sûr êtes-vous que la population francophone va être là?

M. Serge Miville: C'est une excellente question. On a consulté plus de 300 élèves du secondaire du nord de l'Ontario sur ce dossier pour être capable d'assurer de promouvoir une programmation et d'accréditer une programmation qui va répondre à nos besoins, puis qui va répondre aux besoins de l'économie locale et pour l'avenir également. Donc, on a fait nos devoirs, madame Gélinas, et puis on est prêt à livrer de nouveau.

Mme France Gélinas: Puis quand est-ce que vous seriez prêt à commencer? Parce que, moi, il n'y pas une semaine qui passe que je n'ai pas des francophones qui me demandent : « Je n'ai pas d'argent pour aller à Toronto. Je n'ai pas d'argent pour aller à Ottawa, mais j'aimerais ça, avoir une éducation universitaire. » Quand est-ce qu'on pense que vous pourriez commencer à répondre à ce grand besoin-là?

M. Serge Miville: Malheureusement, je n'ai pas les moyens de répondre à cette question, parce que cette réponse-là dépend que le gouvernement accepte notre proposition, et puis on enchaîne avec le financement nécessaire pour être capable de bâtir la programmation. Nous, on est engagés de le faire dès que possible.

Mme France Gélinas: OK, « dès que possible ». Est-ce qu'on peut donner des espoirs pour cet automne?

M. Serge Miville: Dès que possible, ça va être : dès qu'on a une réponse positive du gouvernement, on va être capable de travailler puis avoir une plus grande clarté sur à quoi ressemble un calendrier réel pour les étudiants du Nord.

Mme France Gélinas: OK, merci.

I would like to ask Kyle from the Alzheimer Society: I'm not very familiar at all with the program that you were describing in two southern Ontario hospitals where there are people from the Alzheimer Society who work in the ER. What exactly do they do?

Mr. Kyle Fitzgerald: That's an Alzheimer Society staff member. They will be embedded within the emergency department.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Kyle Fitzgerald: When somebody comes into the ER and it looks like they are either diagnosed with dementia or they're presenting as if they have undiagnosed dementia, then they would go have a conversation with that person. They'll say, "What brings you to the hospital today?" Most times it's what's called "failure to cope"—which I don't like, but that's how it's coded. We'll have a conversation and say, "What do you need to get back home?" In Hamilton, where this program started, we offer 12 hours of in-home respite per week for one year after the hospital visit, and that's enough for two thirds of people to say, "I think I can manage with that." Otherwise, they're just an Alzheimer Society staff member, so when there isn't someone with dementia in the ER, they're doing phone consultations; they're doing office work; they're doing their full eight-hour workday, Monday to Friday, from a hospital emergency department. And then when someone comes in who they can help, they're going to have a conversation with that person, working very closely with the ER team as well.

Mme France Gélinas: Is the 12 hours of respite over and above the cap that is given to home care?

Mr. Kyle Fitzgerald: Yes. This would be in addition to what they get, because obviously what they're getting isn't enough if they're showing up to the ED.

The Chair (Mr. Ernie Hardeman): Thank you very much for the question. That concludes the time.

We'll go to the independent. MPP Bowman.

Ms. Stephanie Bowman: I'll start with Kyle. Kyle, it's good to see you again.

I want to just confirm my understanding of the numbers in here. You're saying on page 6 that there's $10 billion in direct care costs spent on dementia. If I look at the recommendations around what it will take to improve the situation—is it about a billion dollars, when I add that up quickly here—

Mr. Kyle Fitzgerald: Yes. All of our recommendations add up to about that. It's important to say that not all of that is for dementia. The biggest chunk in there would be for all home and community care.

Ms. Stephanie Bowman: Fair enough. To support those living with dementia—

Mr. Kyle Fitzgerald: In addition to anyone else supported by home and community care.

Ms. Stephanie Bowman: Right. So it's a $1-billion investment to save about $10 billion, to avoid the $10 billion in costs or—

Mr. Kyle Fitzgerald: Not all of it would be. There still would be costs to care for people living with dementia. What we're asking for is, instead of spending $710 a day to keep them in a hospital, where we can, let's spend $130 a day to care for them at home, in the community.

Ms. Stephanie Bowman: It's really well laid-out. You talk about the goal for Ontario to become a world leader. How far along do you think this would get us in that? Is this the beginning? Are we getting halfway down? How far behind are we in terms of our progress against other countries?

Mr. Kyle Fitzgerald: I would say this is the low-hanging fruit. If this was funded, we could do it tomorrow. If the budget drops on March 31, on April 1 we'll be posting positions and supporting clients.

CanAge, a national advocacy group we work with, published a report a couple of months ago on dementia in Canada, and Ontario was, unfortunately, not alone in failing that report. I'd say we're in the middle of the pack for provinces in Canada, but unfortunately that pack is fairly far behind the international community.

Ms. Stephanie Bowman: So this is a good start, but we will still have a long way to go, and people like you and your team will keep prodding, I guess, to get us in that direction. Thank you.

If these requests are not implemented this year, what is the kind of—again, it feels to me like it's almost like a fan, then exponentially, again, things get worse, because people end up needing alternative care for longer, and it means other people who need care can't get those beds and those services. What kind of repercussions do you see if these aren't implemented?

Mr. Kyle Fitzgerald: I would say, maybe not next year, maybe not the year after, but if we continue on the current trajectory, eventually Ontario's hospitals will exist solely to support living with dementia.

Ms. Stephanie Bowman: Wow.

My next question is for L'Arche. Thank you again. I know that you guys do great work.

I want to understand a little bit more about the other parts of the housing in your new development. There would be housing for those living with intellectual disabilities and then those who are not, the greater community, and then the facilities within them—those would be open to other members of the community. So is it a bit like a community hub in a way?

Ms. Jennifer McCauley: Like a gathering space, yes, indeed. Other agencies in the city, other organizations, groups, could come and utilize the space. People have asked us, "Why aren't you making use of excess property in the city?" We always say, "Accessibility is really one of the things that we need to target in the building. Accessibility by regular standards does not mean accessibility for all people." We need to have places where there are change tables and people can come, stay for a longer length of time and actually spend, you know, a significant moment with people without having to go and access those supports outside of the building.

1340

Ms. Stephanie Bowman: Right, okay. And so the cost to build this building—I mean, it is a higher cost per unit, but that's because, again, it is meant to be a comprehensive kind of care etc. So we shouldn't look just at the dollars in terms of the cost to build; it's not comparable to other facilities or other housing units.

Ms. Jennifer McCauley: Correct, yes. The increased costs also reflect that need for accessibility features. We really want to highlight them in the building and make sure that everybody's needs can be met.

Ms. Stephanie Bowman: Okay, great. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to the government. MPP Smith.

Mr. David Smith: My question is to Jennifer. What a great organization, and I think you guys are doing great things. I have a question. I would like you to explain to my colleagues—the ask is $8 million, is that correct? Could you tell me how that money would be distributed in terms of your organization and what you plan to do with that?

Ms. Jennifer McCauley: Yes, so that $8 million is a specific ask for this project. It's a capital ask to go into the building. It would pay for the two units that I identified, the respite space and the TIFS unit—the Trying It on for Size, the training apartment. We can get affordable housing for residential space; we need this money for the excess space outside of the residential space. It would cover that community gathering area that we're talking about and the admin office spaces right now.

Many people have Passport dollars, so the ministry has said each person with an intellectual disability can have a minimum of $5,000, but people don't have the staff to help them do that or a place to come or activities to engage in. We really want to lean into that Passport area and create a space, create activities inside and outside of the building for people to really make use of that funding and have places to go to contribute their gifts and to have meaningful activities.

Mr. David Smith: Great. And could you tell me and the committee how many persons you think you would be able to help with that addition?

Ms. Jennifer McCauley: I added up the wait-list before I came and I think there was almost 1,000 people in our Sudbury catchment that are waiting for some level of supports, be it intensive supports, family homes, SIL—supported independent living—day supports. The highest number on the list was for those respite supports. Last year, I said it was 171 people waiting; it's over 230 people now. So it's just been a significant leap for the respite needs.

Mr. David Smith: I do have one further question: How has the ongoing increase in investment, including more than $1.8 billion for residential support, helped support adults with developmental disabilities?

Ms. Jennifer McCauley: Yes, so we have seen some of that money come and we appreciate it. I think this shift from residential group home living to people living independently in the community—there's a cost, there's a dollar to make that happen. We know when people are living in congregate settings, it's cheaper overall. We want to shift people to apartments and be able to live in this building as a collective. That comes with more money, but it also comes with a greater sense of people feeling like they're contributing, feeling like they're part of a community. Not everybody wants to live in a home with other people but want to have that sense of interdependence.

I turn to Chantale on the screen because, again, she's that person, she's that voice that says, "I don't want to live in a traditional group home or L'Arche home, but what I really want to do is live close to my friends. Wouldn't it be nice if I had an apartment and I could go downstairs and engage in activities or come and have lunch with people

and then go back up?" We say independence is one thing, but it doesn't solve everything. During COVID, we really highlighted those people living independently in their own apartments; they were the people that kept me up at night. They're the people I worried about because you can have all the skills you want—turn on a crockpot; you know, I can cook and I can get myself meds, but when I'm all alone and I'm having social isolation, my mental health is at risk and I'm at risk.

Mr. David Smith: Thank you very much. I'll pass the time over to—

The Chair (Mr. Ernie Hardeman): MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you, Chair. That was a great effort.

Laughter.

Ms. Effie J. Triantafilopoulos: No, the Chair has improved; every time he pronounces my name, it gets better and better. Thank you.

Thank you so much, Jennifer. I really appreciated your presentation. I must say that I think that that model is very worthwhile looking at. In fact, in my own community of Oakville North–Burlington, there is a somewhat similar submission with the ministry, and it has been some time since we've heard about that too, so we'll push along.

I actually had a question for Stéphanie and Kyle, specifically on the presentation you made, Kyle, on what you would recommend going forward. You mentioned that currently there are about 3,000 patients in hospitals who really are alternate-level-of-care patients and should properly be either in a home setting or perhaps in long-term care. I know from my own past experience as the parliamentary assistant in long-term care that we understood that something like 60% of residents in long-term care have some form of dementia today, and so the nature of care in long-term care has also had to change.

You may be aware that the government moved ahead very recently to ensure that ALC beds and patients in hospitals are going to be transitioning directly into long-term care, which will then free up many of those beds that are really currently needed for acute patients going into hospitals. I'm assuming, then, you're aware of this initiative on the part of the government; is this moving in the right direction?

Mr. Kyle Fitzgerald: Thank you, MPP. That underscores one of our recommendations, specifically long-term care and transition. If and when people are successfully moved from ALC hospital beds into long-term care, that's not the end of the conversation. That person needs to be successfully transitioned into a bed, which, under the proposed legislation, would not be their first choice of bed, so we would have to make sure that they would have even more support.

That's what we're trying to do here. That's what we're doing. That's what Stéphanie and her team are doing in Sudbury and throughout northeastern Ontario: We'll work with people, whether they're transitioning into long-term care from community or from hospital. We'll work with that person for two weeks before and two weeks after. Certainly we recognize that there is a push to get ALC patients into long-term care, and we're trying to help make that as effective a transition as possible.

Ms. Effie J. Triantafilopoulos: And did Stéphanie want to add to this? Because we haven't given her much of a chance yet.

Ms. Stéphanie Leclair: Thank you. As Kyle said, we know that transitions are one of the most traumatic events for a family when someone is moving to long-term care, so making sure that we're there to support them, the patient living with dementia, to successfully and sustainably transition doesn't just support them; it also supports the family. I just want to add that bit.

This program really has a quadruple aim to it. It's good for the patient, it's good for the caregiver and it's also good for the health care workers working in long-term care. We know they're strained, but this program actually offers a warm hand-off that really supports those working in long-term care as well.

Ms. Effie J. Triantafilopoulos: I think that—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you very much to the excellent presenters today. My question is for Kyle. I've worked with Carol Walters from the Alzheimer Society Southwest Partners. I think you've really shown some staggering numbers: the human cost, the real impact on people's lives and the economic impacts, whether it's decreased productivity because of care partners having to be overworked and overburdened—so thank you for your work on that.

I did want to ask, on your $3.62 million to expand the personal navigator program, when was that first requested of the government?

Mr. Kyle Fitzgerald: Good question. Thank you, MPP Kernaghan, for your support of our society locally. That was actually part of the initial Ontario dementia strategy in budget 2017. That was meant to be a three-year escalating program. It was frozen at year 2 levels, so we're currently operating with the same funding for First Link as we were in 2019. The result of that is—our personal navigators operate best when they have a caseload of about 200-ish clients; they are currently operating closer to 300, so we're not able to give effective, proactive follow-up. We don't turn people away. We don't graduate clients. Right now we're not able to give the intensity of support that we'd like, and even with that caveat, we're still avoiding hospitalizations.

Mr. Terence Kernaghan: I see. So it was money that had been promised but was not delivered and, therefore, was cut.

I just want to thank you for all the work with Dementia Friendly Communities, informed kindness and all the wonderful things you do. At this time, Chair, I would like to pass it over to MPP West.

1350

The Chair (Mr. Ernie Hardeman): MPP West.

MPP Jamie West: Ma première question est pour M. Miville. Bonjour, Serge. Merci pour votre discours.

Quand vous parlez, c'est difficile pour moi, comme personne anglaise, de faire des traductions dans ma tête. Aussi, parce que je pense que ma question est importante, si vous préférez, je demande en anglais et vous répondez aussi en anglais.

For my colleagues who are English, I very clumsily talked about the difficulty of translating in my head and wanting to ask the question and get a response in English—because this is sort of the core of the importance of French-language education. Very often when it's bilingual, as in this case right now, it's French when possible, but even if there's a single English person, it defaults to English. And so when you're in a course of professional study like post-secondary education, what does it mean if all day you're translating versus learning in your primary language, especially with the number of French newcomers coming to Sudbury and the population of Franco-Ontarians?

Mr. Serge Miville: I think one of the important aspects of having a French-language university institution in Sudbury is that it's focused. It's very clearly focused on its mandate. It's very clearly focused on what it wants to achieve, so it is 100% driven for that success, and that success will translate to student success. We're not confused. We're not deliberating on where we need to put resources per language. We're not having that tension. That tension is completely relieved.

It is a great way to promote bilingual and tricultural education, to have focused institutions that collaborate with one another. I think that once you give a student the opportunity to choose that pathway, and through collaborations, being able to give multiple different pathways should they wish to include English-language education within their university education, then the student will win and the institutions will succeed. So we're talking about clarity: clarity of mandate, clarity of mission, clarity in all the walks of this institution. And I think that's a very important path forward for healing. I think it's an important path forward to modernize our post-secondary education sector in northern Ontario.

MPP Jamie West: As a follow-up question—because sometimes I'll hear there is a northern French university in Hearst: just for perspective, for those who aren't familiar with Sudbury, the distance or the difficulties of having that amount of people go to Hearst versus having one in Sudbury.

Mr. Serge Miville: It's about 800-some-odd kilometres. I'm personally from Smooth Rock Falls. That's 500-some-odd kilometres up north. That's a pretty steep ride for someone trying to go to university in French, so it is an accessibility issue. Students tend to not leave more than 100 kilometres from where they are, so they will continue—they will either drop out of the educational map, or they will continue in English and not gain functional bilingualism, which will be key for our future economic development. Sudbury is very well placed in Ontario, greatly placed, for that huge international market and the economic development that stems from a bilingual economy. So I think we're part of that solution.

MPP Jamie West: Thank you, sir. Merci beaucoup.

Jennifer, it's good to see you again. I have joined Catherine at L'Arche all the time, as you know, and Darrell and everybody knows. Before I forget, please tell Katie I said hi.

One of the things that you had mentioned earlier, you were talking about the change facilities—and it was an aha moment when you first talked to me about this, that as someone who is able-bodied, I forget the need for adult change stations. Can you put in context—we've all been here today drinking and eating and stuff. What does it mean for accessibility and being able to participate in your community when you don't have the proper change facilities?

Ms. Jennifer McCauley: I guess the best example I can give you is that people think there's a grab bar in a washroom—and that grab bar is for people who can actually transfer their own body. But for people who are completely dependent on someone else to support them, we need tracking in the ceiling so that they can use their lift and the assistant that's there to help them is not at risk of getting hurt. So the person needs to come off, and sometimes people can go onto the toilet, yes, or sometimes people actually need a change table that can be lowered or risen for the height of the assistant that's helping them so that they can have their personal care looked after.

The Chair (Mr. Ernie Hardeman): One minute.

MPP Jamie West: The other thing that resonated with me is the integration of having people who need assistance and able-bodied people together, because that often doesn't mesh together.

Just because I only have a minute, can you just talk about the respite and how important it is to have that sort of caring environment for respite care?

Ms. Jennifer McCauley: Yes, again, I can't emphasize enough that families are burning out. People just need a weekend. I always say, I had two young boys growing up and if it weren't for my mom and dad welcoming them on weekend so we could get away, I don't know how well we would do. Same thing for families of people with intellectual disabilities—that weekend away, where the person can have a break from family and family can have a break from them.

I also just think of the friendships that are grown in those moments where people come and spend holiday time with us or come and spend a couple of days in the community. They grow a friendship, they grow a circle that's outside of just their immediate family. So it's an introduction to life outside of home, and our hope is that people can maintain that as we go forward, and then look at the activities that we'll be hosting—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

Now we'll go to the independent. MPP Bowman.

M^me^ Stephanie Bowman: Merci. Serge, je vais essayer en français, après un moment. You talked broadly about the impacts to the community, to the students. Mais je veux vous demander, est-ce que vous pouvez nous dire quelques exemples des étudiants qui ne peuvent pas étudier ici à Sudbury en français à cause que l'Université de Sudbury ne fonctionne pas en ce moment, pour faciliter notre compréhension de l'impact spécifique ici à Sudbury?

Mr. Serge Miville: If I may, I will answer this question in English simply because it's the human toll. The human toll of that is—I was a professor teaching in history, and I have students who have left Sudbury because they could not pursue their post-secondary education in French here. Some of them have left for New Brunswick. Some of them have left for eastern Ontario.

The thing is, when you lose someone in the north, you're losing all the potential: the business they could have created or the people they could have taught. The economic impact of a single student lost is very difficult to surmount for our region as opposed to a region in Toronto where a student lost is a student gained elsewhere within a very small, constrained region. We need these students and we need to be able to foster their development. I have lost students. I still speak to them. They wish they could come back, but they probably, statistically, will not come back. So we have lost them essentially forever.

Ms. Stephanie Bowman: Yes, and we heard a little bit about that earlier in terms of that the nurses who study here will stay here. They want to be here.

I know you talked a little bit earlier about the length of time it might take for you to get back up and running once you get the decision. Again, back to the staff and the people who have may have left or moved onto other things—that, I presume, will have an impact on your longer-term operations and the feasibility of you being viable—what's your plan around that?

Mr. Serge Miville: Well, I think, once we get a green light, we're going to have a lot of interest within the institution because it is so broadly supported. It is a non-partisan issue. It has support, not just from the francophone community, but also the English-speaking communities all over the north. That is very encouraging because it does mean that we'll get a lot of traction once we get a green light. But getting that green light and getting that green light funded in the budget is something that's extremely important so we can start planning that effectively.

Ms. Stephanie Bowman: Excellent. Thank you. Nothing further.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes this panel.

I want to thank all the panel members, both those at the table and those joining us virtually. Thank you very much for all the time you put in in preparing for today and the efforts of coming out here to present to our committee. I'm sure we will take it forward and make sure that the people who can make it happen here—that you want it done. With that, thank you again for being here.

1400

INDIGENOUS PRIMARY HEALTH CARE COUNCIL
WEST NIPISSING GENERAL HOSPITAL
PLAY ON! CANADA

The Chair (Mr. Ernie Hardeman): Our next panel, as we move forward is the Indigenous Primary Health Care Council, the West Nipissing General Hospital, and Play On! Canada, if they will come forward. My understanding is that everybody on this panel, except the West Nipissing General Hospital, is here with us. Is that right?

Interjection: Yes.

The Chair (Mr. Ernie Hardeman): And the others are all on virtual. So with that, the first one is the Indigenous Primary Health Care Council. We will ask the participants, as they speak—before they speak, or when they start speaking—make sure you introduce yourself for the Hansard so it can be recorded.

You will all have seven minutes to make your presentation. I will let you know at six minutes that you have one minute left; don't stop speaking, because at the end of that one minute I'll stop you from speaking.

With that, we'll carry on and start with the Indigenous Primary Health Care Council.

Ms. Allie Kinnaird: Hi there. My name is Allie Kinnaird. I'm the director of policy and government relations for the Indigenous Primary Health Care Council. I'm joined today by Pamela Kimewon. We are expecting our board chair, Angela Recollet. If she does come on, I'll hand it over to her, but I'll continue on for now.

The IPHCC is requesting an investment totalling approximately $112 million over five years. There are two separate initiatives in our total budget request. Additional details are included in our pre-budget submission, which we have shared with the committee.

The disparities in health outcomes between Indigenous and non-Indigenous people in Canada are well-documented. These include lack of access to basic social determinants of health, such as proper housing, job security, nutritious food, clean drinking water, education and access to health care services. Not only do social determinants impact the health outcomes of Ontario's Indigenous population, but not addressing these inequities limits their potential to be part of a thriving economy. We have an opportunity today, as you deliberate about the budget, to make investments that will impact the next three years and for years to come.

First, we are asking the province to invest $37 million over three years to support a provincial Indigenous integrated health hub. This proposed hub will build capacity and a program of supports and resources to successfully integrate and involve Indigenous perspectives and peoples in the ongoing rollout of Ontario Health Teams.

Why is this needed? The ongoing provincial health system transformation efforts that are aiming to create efficiencies in the system and transform the way that people residing in Ontario receive health care lack a way to consistently and effectively coordinate and enhance health care delivery for First Nations, Inuit and Métis people in the province. This hub will ensure First Nations, Inuit and Métis peoples are directly involved in the self-determined planning, design, delivery and evaluation of provincial health care planning for Indigenous peoples, as committed to under the Connecting Care Act. We are ready and willing to work with the government and its main health agency, Ontario Health, and—most importantly—our members and First Nations, Inuit and Métis people and communities to help improve health outcomes.

This hub will provide the adequate infrastructure and resources to make that happen and to ensure Indigenous health planning includes Indigenous voices, which is critical.

Second, we're asking that the provincial government expand equitable access to Indigenous primary health care by investing $75 million annualized over five years toward a comprehensive network of Indigenous primary health care organizations. This investment will continue to build on a provincial network of Indigenous primary health care organizations across the province. Equitable access for Indigenous peoples to primary health care as the first point of care across all communities will also ease the burden on an already overstretched hospital system and strengthen the ability to keep people in their own homes and communities.

There are presently only 21 IPHCC—Indigenous Primary Health Care Council—members across the province delivering culturally appropriate services and care to Indigenous peoples. New sites, adding satellite sites, or investing in the capacity of existing sites will ensure they can meet the demands of their clients and communities and focus on improving health outcomes.

To put the current gap into perspective: Only two members of the Standing Committee on Finance and Economic Affairs have an Indigenous primary health care organization in your ridings. As per a 2018 Ministry of Health and Long Term Care report, 85.5% of Indigenous peoples live off-territory. We must ensure that access to these culturally appropriate services are available to all Indigenous peoples no matter where they reside. We would be pleased to have each of you visit some of our members' sites throughout the province to learn why the investments are so critical to address the health needs of Indigenous peoples.

We would be happy to take any questions that you have, and we hope to continue the discussions beyond the time provided today. That's all we have in terms of our initial introduction. We're happy to take questions at the end of it.

The Chair (Mr. Ernie Hardeman): The next presenter is West Nipissing General Hospital. I believe they're here in person.

Please introduce yourself as you start speaking, to make sure we have your name in Hansard. You will have seven minutes to make your presentation. I will let you know at six minutes, and I will stop you at seven minutes.

With that, the floor is yours.

Ms. Sue LeBeau: Thank you very much for listening today. My name is Sue LeBeau. I am the president and CEO of West Nipissing General Hospital, and until very recently I was also the same at Red Lake Margaret Cochenour Memorial Hospital. I'm at week 4 at West Nipissing. I'm here to talk to you as a nurse practitioner, as a CEO, and as a person who has contributed 30 years of experience in the health care system. This is a time of opportunity. It is also a time of challenge for northern hospitals.

I'll start with a story that illustrates our top two concerns: health human resources and finance. As the president and CEO of the Red Lake hospital, my team and I lived through two fire evacuations, including hospital evacuations; through a flood that blocked our only road of egress out of the community for a number of weeks; and, of course, the COVID pandemic, as that simultaneously happened. But the most harrowing experience that I had and that our team had during my time there was the closure of our emergency department due to lack of staffing. It was a scary time, it was a short time, and it is something that we would not want to relive, and it is something that—my colleagues and myself in the north have struggled to maintain core services and to be able to manage to keep serving our communities.

I'm going to speak to you about HHR and finance in three areas: the impact of agency nursing, the impact of physician staffing, and other cost pressures that we're facing. In all of these areas, competition is driving prices up. It's a sellers' market. These unfunded expenses are unsustainable and will likely cause both of my hospitals to post a deficit, the first in many years.

In terms of agency nursing, to paint the picture locally, our hospital, West Nipissing, has expended $1.5 million for agency nursing over the first three quarters of this fiscal year. That represents about 10% of our budget, for 10 nurses. Those costs, of course, are not budgeted. Agency nursing has become a necessity in northern Ontario. However, it is not a long-term solution. Our loyal local nurses are impacted by these agency nurses. They see them working with higher pay, they see them having housing remunerated, and they often have to reorient them as they turn over. It is a challenge, and it is one that we're looking for some support on.

In terms of physician staffing, a number of us have had to pay top-ups and stipends and compete with other northern communities to keep our emergency departments open and to keep our hospital core services going. At West Nipissing, that has represented about $330,000 of our budget in the first three quarters of this fiscal year. These costs, along with agency nursing costs, come from our global budgets, and they typically aren't budgeted and eat into the reserves that we utilize to maintain our buildings and to continue to offer core services.

Other cost pressures include rising overall hospital expenses—15% for food, for instance, and 5% to 10% for energy, drugs, supplies and equipment for my hospital alone. This is not atypical for northern hospitals.

We have other pressures as well, such as Meditech Expanse. Most northern hospitals are meeting this foundational digital interconnectivity that has been identified by patients, families, staff and physicians as being foundational to be able to work together in an integrated system. This cost, for my hospital alone, represents about $600,000 per fiscal year over the next 10 years. We also have the impacts of Bill 124 and pay equity, which are still to be determined.

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I bring to you three asks when you think of hospitals in northern Ontario, especially small, rural and northern. The first is legislative support in addressing costs for agency and physician remuneration. We need help to keep these costs from spiraling out of control and to mitigate the unintended consequences of competition.

The second ask is funding to enable hospitals to face the financial pressure that I've talked to you about in four key areas to continue our high-quality care. The first is in stabilizing hospital services, the second is in addressing labour costs, the third is in addressing rising overall expenses due to inflation and the fourth is to manage the ongoing expenses that continue because of COVID. We're grateful that we've had support to contribute to COVID expenses; there are some expenses that will continue for the health care system.

Finally, the last ask is to use 2023-24 as a learning year during which hospitals and government work in partnership to understand the ongoing funding costs associated with COVID and with adjustment of staffing needs and strategies.

I'm delighted to serve our communities in health care. It is something I have done my whole career and want to continue to be able to enjoy. I want to make sure that we can do it effectively and efficiently and to continue to work in partnership with our communities, but we do need adequate funding to be able to continue it.

The Chair (Mr. Ernie Hardeman): One minute left.

Ms. Sue LeBeau: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We'll now go to Play On! Canada, and I believe that's virtual again too. Scott Hill? The floor is yours, Scott.

Mr. Scott Hill: Thank you.

The Chair (Mr. Ernie Hardeman): There you go.

Mr. Scott Hill: I was just waiting to be unmuted.

Honourable committee members, it's a privilege to be here today. Thank you very much. My name is Scott Hill, chairman of Play On! Canada. On behalf of our board, I present today a request seeking $6 million in funding over two years—$3 million in each of 2023 and 2024—to fund 18 mass-participation street-sports events, to be held in communities throughout the province between 2023 and 2025.

In case you are not familiar with it, Play On! Canada is a federally registered not-for-profit organization based in Ontario. The organization has a long history. It was previously sponsored by the CBC and operated as Hockey Night in Canada's Play On! until 2017. It became the largest participatory sports event in Canada's history, with 179 events held in 39 communities involving an estimated two million Canadians. Since 2018, we have been working to establish new funding pathways, new media partnerships, and to build the project back even better.

In May, we finalized a new six-year partnership with Sportsnet. In August, with generous one-time tourism recovery funding provided by federal, provincial and municipal governments, we successfully relaunched the Play On! Canada program, and the launch was so successful that we now have 41 cities requesting the opportunity for Play On! to visit their community.

The ask we've presented will make this project operable and, we believe, sustainable throughout Ontario for many years to come. Without this commitment, we will not have funding to support any Ontario programming.

Play On! Canada has a mandate to connect and strengthen Ontario communities through mass-participation street-sports events that provide economic benefits, health benefits and community-building opportunities for Canadians. We also have a responsibility to preserve street hockey as an important cultural pastime in Ontario. When organized and offered safely, Play On! Canada mass-participation street-hockey events have the proven capacity to inspire, to lift and to energize Canadians.

Let me share some of the benefits. Well-respected Canadian author Roy MacGregor wrote, "There is something pure and sweet about" street "hockey that is worth preserving for generations to come. The game has meant more to young Canadians than any other game in any form."

As we all know, COVID-19 has been difficult for Canadians, particularly our youth. Patterns of play and behaviours have changed. The already strong forces that encourage our youth to be sedentary, playing virtually on screens, have only been strengthened as schools and sports and other activities have been interrupted. As our recovery from the pandemic continues and as virtual gaming gets more and more attention and investment, we can no longer expect that our youth will prioritize opportunities to play outside. So how about a proven, popular, province-wide mass-participation sports event to help bring people out to the streets? How about we provide a reason for all to play, for all of our youth, again? How about we play some of these events on Indigenous territory? How about a proactive province-wide approach to prevent so many of the negative impacts of addictions and substance abuse?

Our youth have spoken: They love Play On! events, they need them and they want them back. So why not a tangible province-wide gathering that invites all to join in and to fight back against the social, the physical, the emotional and the mental health challenges that are impacting our youth province-wide?

Pre-COVID, a typical Play On! event in Ontario attracted between 3,200 and 4,500 participants and 10,000 to 20,000 community spectators. Think for a moment of a typical Sudbury Wolves hockey game and the number of people in the crowd sitting to watch. Now consider how it would look if we organized all of those people onto teams, brought them outside and onto the streets downtown, placed them all into divisions based on gender, age and experience. And what if we put sticks in the hands of each of them, including the newcomers from Ukraine and Syria? What if we put goggles on their eyes and T-shirts on their backs and provided each one the opportunity to laugh and to play Canada's favourite pastime for an entire weekend? How would those newcomers feel as they experienced Ontario's game with the rest of Ontario? Well, this is what we will do, and these are the impacts that this program delivers.

We want to think about doing that in up to 18 different communities throughout the province, including on Six Nations, Whitefish River or other Indigenous territory. We've formed a partnership with Indigenous Sport and Wellness Ontario. We are prepared to work together on

this plan, and we will visit the communities that the government would like us to visit.

A $6-million investment would be leveraged into additional support from federal and municipal governments and the private sector. Part of that investment would be used to finish a technology solution designed specifically for this type of mass-participation event, a solution that does not currently exist and which is now patent-pending in Canada and the United States. This platform, once complete, will unlock new revenue streams that will ensure the project is sustainable after 2025 and be an Ontario-made export that opens up possibilities for mass-participation team-sports events like Play On! all over the world.

According to research conducted by Brock University, each Play On! event that attracts 4,000 participants generates a $3.3-million benefit to the local economy, so an investment of $6 million over two years, if successful and once again attracting 4,000 participants per community, would stimulate a $59-million benefit to the Ontario economy.

We requested the opportunity to make this presentation in Sudbury for a specific reason: Sudbury is home to the nickel that was used to create the Canada Cup. The Canada Cup is a trophy that means a lot to Canadians of my generation and to the generation older than mine. They remember where they were when Wayne Gretzky dropped the puck to Mario Lemieux, who scored to beat the Russians in 1987. The Canada Cup trophy is a symbol of Canada and of hockey in Canada, and it belongs to the people of Canada. That trophy has served a unifying purpose in the past, and it can do so again now. While the Canada Cup has sat idle since 1991, the new board of directors of Hockey Canada is considering a proposal to present the Canada Cup to the winners of the Play On! Canada national street hockey championship, which is currently proposed to be held in Brampton this September and televised on Sportsnet. What a great way to bring Ontario and all of Canada together.

The Chair (Mr. Ernie Hardeman): Thank you very much, Scott. That concludes the time. With that, we will start the round of questioning. Hopefully, with the first or second question, you can finish your presentation in your answer.

With that, we start with the official opposition this round. MPP Kernaghan.

Mr. Terence Kernaghan: I'd like to thank all the presenters for appearing at committee today.

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My first question will be for you, Scott.

I think everybody has fond memories of street hockey, playing in the suburbs, yelling "car" and having to move the net off to the side of the road. I think you summed it up well when you say that after COVID-19, people have a desire to reconnect safely to rebuild that sense of community, and I think you've laid out well the economic impact of a modest $6-million investment.

I also want to congratulate you on your Guinness World Record.

Unfortunately, we ran out of time to hear your words. Is there anything that you wanted to finish that you didn't have an opportunity to say?

Mr. Scott Hill: Thank you very much. The last sentence that I hoped to communicate before I ran out of time was just to say that the first event we will hold will be in Sudbury to commemorate the history of the Canada Cup.

Mr. Terence Kernaghan: That's excellent. We just also received the news that Bobby Hull, one of the greatest hockey players of all time, just passed at 84.

I want to thank you for your time and your presentation—although I am disappointed that you won't be hosting it in London, but Sudbury is a great place too.

At this time, I'd like to pass it over to MPP Gélinas.

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: My first questions will be to you, Ms. LeBeau.

You were very clear that no matter the challenges that you were faced with at Red Lake, the biggest challenge was to have a closure of the ER because of a lack of staff. You talked about agency nursing. Could you give us an idea as to, per hour, how much you pay a nurse and how much you pay an agency nurse?

Ms. Sue LeBeau: I can give you a ballpark. Per hour, it's in the $50-to-$60 range for nurses, and almost double that for agency nurses. The other hidden costs that are there are housing and transportation, which are necessitated by many agency nurses. Our hospital alone has paid over $150,000 for housing alone for agency nurses.

M^me^ France Gélinas: When they come to northern Ontario, to West Nipissing where you are, I take it that continuity of care must be an issue. I take it that they're not moving to northern Ontario. How long do they come for?

Ms. Sue LeBeau: It is a challenge. Certainly, in my short time at Red Lake, we had three agency nurses in three months, with three different shifts. At West Nipissing, we've managed to keep them a little bit longer, like in the six-to-12-month range, but that's the exception. So, yes, for continuity of care, it's challenging. It's challenging as well to build the relationship that nurses need to build with physicians to get to know each other, to work together efficiently and, of course, to get to know those long-term patients who are a fair chunk of our hospital population.

M^me^ France Gélinas: You mentioned that the cost of food at your hospital has gone up 15%. Is this 15% over the last 10 years or 15% over the last 10 months?

Ms. Sue LeBeau: More like 10 months, in the last couple of years.

M^me^ France Gélinas: Could you tell us, in the last few years, how much of an increase you've seen in the base budget of your hospital?

Ms. Sue LeBeau: I can't speak for West Nipissing, but I can say that for Red Lake, 1% to 2% is what we've seen.

M^me^ France Gélinas: Red Lake, a small rural hospital, was allowed. Most other hospitals have seen zero base budget increases for eight years in a row. I saw a 2%

increase once and that's it, that's all, while they see the cost of food going up 15%.

You also talked about the cost of drugs and energy going up 10%. If we put those together—food, drugs, energy, every cost that is not labour—what percentage of your budget are we looking at?

Ms. Sue LeBeau: I'd have to get back to you on the specifics for this hospital. I'm just three weeks in, but I will.

M^me^ France Gélinas: That's okay. It's just to show that, year after year, a zero-based budget increase to our hospital has been really hard. The cost of electricity in northern Ontario and the cost of heating have gone up, yet their base budget stays flat, which means that you have to take from care to pay the hydro bill. Because no matter who you are, you still need hydro.

[*Inaudible*] as well as inflationary, would you say that those recommendations would come from other hospitals in northern Ontario?

Ms. Sue LeBeau: Absolutely, yes. And it's remarkable how the challenges are similar. Whether I was at the extreme west or east of the province, the issues are the same. We work very closely as a CEO group, and so I would say that other CEOs from small and rural hospitals, as well as the larger, would identify those challenges as well.

M^me^ France Gélinas: I don't know if we are able to get back Angela from Shkagamik-Kwe, or Allie or Pamela, who seems to have disappeared, from the Indigenous Primary Health Care Council. Can you hear us and can you speak?

Ms. Pamela Kimewon: Yes, we can hear you.

The Chair (Mr. Ernie Hardeman): One minute.

M^me^ France Gélinas: Okay. You've asked for $37 million over three years for the hubs. Right now, there are a lot of Ontario health teams being built. Are any of the Indigenous primary care part of those?

Ms. Allie Kinnaird: Yes. Our members are Indigenous primary health care organizations across the province. Since the beginning of OHT, we've been engaging with our members in learning how they're being engaged in broader OHT planning, and it varies across the province. For example, the Thunder Bay OHT has within its terms of reference that 50% of the OHT must be Indigenous. In other areas of the province, the engagement isn't as strong, so this help will really provide the necessary infrastructure, supports, resources, capacity-building supports—

The Chair (Mr. Ernie Hardeman): I think, if we could just hold that thought until the next round, because your time is up.

We'll now go to the independent.

Ms. Stephanie Bowman: I will start with Scott. Scott, it's fun to think about kids out playing hockey in huge numbers. We know that we have a lot of serious issues to deal with, but it's certainly fun to think about that, so thank you for being here for your request.

I wondered if you could talk a little bit about the $6-million ask and what kind of opportunity about—I'm from Don Valley West. We have a large community of newcomers in Thorncliffe Park who probably have never held a hockey stick, unless they've done it maybe in gym class, but are probably not playing organized hockey. I wonder if you could talk a little bit about how you might engage—again, new Canadians; you talked about that—but in communities where there are, largely, new Canadians and how we can make sure that they could participate in an event like this as well.

Mr. Scott Hill: Thank you for your question. First off, in terms of jobs created, most of the jobs that are created as part of this project are seasonal, and many are Canada Summer Jobs. This project in Ontario would create approximately 130 opportunities for youth between the ages of 15 and 30 to have an opportunity to work in sport and recreation and those jobs would then seed the future of sport and recreation in the country. There would be an additional 76 jobs created across the country as part of this proposed national project.

In terms of newcomers, this past year we engaged closely with Ukrainian communities in each municipality where we delivered Play On! programming. We did put sticks in the hands of Ukrainian youth right across the country. Our closest event to you was in Mississauga, and we had 48 children of Ukrainian background, newcomers to Canada, with their parents and families—usually their mothers. There were, actually, a couple of fathers who were able to be there. We did put sticks in their hands and gave them the opportunity to play. It was wonderful. There has been video captured of that event, and we're happy to share that with you. I'll just emphasize, that's something that's very important to us as part of this project, and it has the power to do that.

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Ms. Stephanie Bowman: Great. Thank you so much.

My next question is for Sue. You talked a little bit about the efficiencies and effectiveness. It seems like it's something that you are interested in. I wonder if you could just talk a little bit about that: some of the things that hospitals are doing, whether it's out of need but also just in terms of innovation, especially in a time of, again, being short-staffed and those challenges. Just highlight some of the positive stories or success stories that you have had in that space.

Ms. Sue LeBeau: Thank you. There certainly are some positive success stories, and that's what puts fuel in our tank. In small hospitals, particularly, we see multi-skilled staff, so staff that can work in various areas. You may have some core areas that need some support but not full-time, so we're efficient and creative as to where we place staff.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sue LeBeau: We also look for opportunities to partner with the community. When it makes more sense for the community to lead a program or run a program, we work closely with primary care to look at these funding sources and does it make sense for the hospital to play a supportive role as opposed to a lead role. For a number of initiatives, that's exactly what we've done. To me, that's

conducive with what we're going towards with Ontario health teams anyway.

Ms. Stephanie Bowman: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you.

We'll now go to the government. MPP Dowie.

Mr. Andrew Dowie: Thank you, Sue, for being here. Thank you for the presentation. I can't even fathom how difficult it is to manage hospitals and their care here in northern Ontario, given—I know I'm from the south, where we have a large population base, but it's a struggle to fill the jobs even with a strong population base. So I appreciate all the work that you're doing.

You mentioned in your comments that you haven't seen an increase in base funding for a number of years. The province has given base funding increases to the hospitals as a whole. The most recent was 3.4% in 2021-22. But you haven't seen any of this, even—

Ms. Sue LeBeau: It was 2% for the last couple of years.

Mr. Andrew Dowie: So you did receive 2% in 2021-22? Okay.

Ms. Sue LeBeau: Where I was, yes.

Mr. Andrew Dowie: Okay. And before then, there were some smaller increases. Has this been a bit more predictable for you as an administrator, to know the government is putting at least something more into the pot? Or has this facilitated decision-making at all for the increases that have occurred to base funding?

Ms. Sue LeBeau: We typically hear in November or December, when we're planning for the next fiscal year, what we might want to plan for—a range. The range has been in the 1% to 2%. One of the things that has been more challenging is around COVID funding, and we really appreciate the support that we've had so far. At my current hospital, that has been about $1.9 million that we've incurred just in this year. But what we don't know is—quarter to quarter sometimes—how long that funding is going to extend. If you were to walk through my hospital today and if you had walked through a year ago, you would see a lot of new equipment, a lot of personal protective equipment and so forth, a screener at the door—things that weren't there or people that weren't there previously. It makes it harder to plan ahead if we don't know if that funding is going to be stable.

The other challenge is physician funding, because with COVID, we have seen a decrease in physicians coming to locum in the north. It has been challenging. Not knowing whether we're able to continue the stipends or continue the top-ups or where that's going to come from makes it hard to plan schedules. Literally, we're planning sometimes one or two months ahead of time, sometimes a lot shorter notice than that. You don't know sometimes, week to week, if your emerg is going to stay open or not.

Mr. Andrew Dowie: Just building on that—and maybe I'll also ask Angela and the Indigenous Primary Health Care Council to jump in as well—with respect to the human resources shortages in health care, particularly for northern and rural communities, just recently the government announced its learn and stay program grant. It allows people who grow up, potentially—or at least get attracted to a community, to be able to stay as a condition of being supported in their education, a full tuition reimbursement.

Do you think this is a model that is sustainable, number one, and number two, are there any ways the government can build upon that sort of strategy to incentivize practitioners staying in your communities and building a home and a career there?

Ms. Sue LeBeau: I think it's a very exciting initiative. I'm grateful that it's happened and wish it was there when I was a student.

We know that people, if they can study in their community, will be more likely to stay. When I look at the staff that was at both my hospitals, the ones that stayed the longest were locals. If we can make education accessible to them with programs such as this one, I do see potential in the mid-term for some relief.

Mr. Andrew Dowie: Thank you.

Angela, I would love to get your thoughts on this grant program. Will it be an asset and a tool for you in your community? The "learn and stay" grant program.

Ms. Allie Kinnaird: Allie here; Angela's not with us, but—

Mr. Andrew Dowie: Oh. Apologies.

Ms. Allie Kinnaird: Absolutely, I think the "learn and stay" program will be a valuable program that can lead to tangible change. I think it is both that and then making primary health care a sector that individuals—clinicians, staff—want to be part of. For Indigenous primary health care organizations, I think understanding the sector, understanding that we need to take a "two-eyed seeing" approach to embedding both Western and Indigenous-specific ways of delivering health care through a model of holistic health and well-being, understanding traditional healing, traditional medicines, traditional teachings, a focus on mental health and wellness, cultural programming, including land-based programming, including Indigenous youth in planning.

I think, as a sector and as an Indigenous primary health care sector, making this a profession that is supported and valued is something that will retain staff. We're seeing significant staffing shortages, especially in the north, but we also know that there are gaps in Indigenous primary health care organizations across the province, so I think just bolstering up the sector and making it a sector that's appreciated—understanding that, of course, we need to invest in hospitals—the acute care sector is incredibly important; it needs the investments—but the primary health care sector is one avenue in which to keep patients and clients in their homes, in their communities. So investing in the sector to make the individuals working in the sector feel valued I think is key, key, key to retention.

Mr. Andrew Dowie: Okay. Chair, how much time is left?

The Chair (Mr. Ernie Hardeman): One minute left.

Mr. Andrew Dowie: One minute. Okay.

Thank you, Allie. I just want to build on that a little bit. What kind of challenges do you find in trying to recruit in terms of specific to being an Indigenous community? Do you find that there's a bit of hesitation to go specifically to

your community versus, say, a more developed urban centre?

Ms. Allie Kinnaird: Yes, there are retention issues in northern Ontario. We know that creating a strong economy—and this is where I think health care and the economy are so closely tied. Creating that infrastructure in northern areas of Ontario is key to ensure that individuals want to work and they have an economy that's thriving, so that—

The Chair (Mr. Ernie Hardeman): That concludes the time for that question. We will now go for the next round. MPP Gélinas.

M^me^ France Gélinas: Allie or Larry—whoever wants to answer—we started with the 10 Aboriginal health access centres, Shkagamik-Kwe being one of them. We now have a few more Indigenous primary health care organizations.

I see that you're asking $75 million for a network of Indigenous primary health care organizations. It seems very timid. Could you explain to me how—so the network would be the view of covering the entire province? No matter where the Indigenous person lives, he or she would have access to a primary care organization, with the $75 million? Am I reading that right?

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Ms. Allie Kinnaird: Yes, and thank you for saying that's timid. We understand that the province is under economic constraints—and we're hesitant to say "complete network," but a more comprehensive network, just given the fact that we are under constraints with respect to health care and resources.

This $75 million, annualized over five years, will enable not only us to identify additional Indigenous primary health care organizations across the province—for example, in Durham region, we have the highest population of Indigenous people in the province, but there's no Indigenous primary health care organization, so it will both go towards creating new IPHCOs, as well as creating satellite IPHCOs, building on existing IPHCOs with new programs so they can take on more patients. So again, understanding the fiscal restraints, given the climate, we are asking for the $75 million annualized over five years to build a more comprehensive network of IPHCOs.

M^me^ France Gélinas: Aside from the 10 Aboriginal health access centres that I know well, how many more organizations do you have?

Ms. Allie Kinnaird: We have Indigenous community health centres, Indigenous family health teams, Indigenous nurse practitioner-led clinics and, of course, Aboriginal health access centres. IPHCC has only been around since 2019. We've brought on members, and we are now transitioning so that these members, inclusive of all those different types of Indigenous primary health care teams, are now referred to as "Indigenous primary health care organizations," recognizing that there are specific considerations with respect to Indigenous health planning. I hope that answered your questions.

M^me^ France Gélinas: Yes, it does. How many communities are interested in having an Indigenous primary health care organization?

Ms. Allie Kinnaird: I will get back to you on that question. I don't know, with respect to outreach. This is my second month, so I'm not sure if we've done that engagement to reach out to the specific communities, but we have mapped based on Indigenous populations and where there are gaps in services. I would have to get back to you.

M^me^ France Gélinas: Okay. Would the $75 million also be the money used to fund more positions in existing organizations? Because we just went through a heck of a rigmarole to get one more physician position funded for Six Nations.

Ms. Allie Kinnaird: Based on the population health planning needs, program needs and, obviously, patient and client needs within that given that area, monies could go potentially towards additional staffing. There are currently only a restricted number of physicians within those specific models. But yes, that wouldn't be off the table if that would lead to caring for patients in that specific area.

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

Ms. LeBeau, if I can get back to you: We've talked a bit about agency nursing and the difference between the 56 bucks—rather, it's $120 when you have to pay the agency nurse, plus transportation, plus accommodation. Could you talk about what is included when your hospital has to recruit a locum physician in top-ups and stipends that are not already included, that make up the $330,000 in the nine months?

Ms. Sue LeBeau: The top-ups vary. They can be anywhere from $50 an hour to $75 to over $100. Those are typically unbudgeted expenses, and they escalate based on urgency or need, so if you're getting closer to a shift that will not be covered and necessitate closure, the stipend goes up. So it has created competition between hospitals, especially if we're not mindful of what other hospitals are doing in our area. So it has necessitated hospital CEOs working closely together when we're determining if it to make sense to offer a top-up or not.

It's especially challenging to get physicians up north, particularly if there's a full day of travel before or after a shift, because that's typically not compensated. It's an opportunity cost that's missed in terms of their office practices, and so those are some of the challenges that we incur when we're deciding on a top-up or a stipend. The decision is really, "Do you pay the top-up or do you incur the risk of having to close an emergency department when they next one may be hours away?"

M^me^ France Gélinas: Where do most of your locums come from?

Ms. Sue LeBeau: Interestingly, it's southern Ontario. They're not typically north, although we try to reach out for those first—but certainly Toronto, Hamilton and elsewhere, so it's significant travel for them.

The Chair (Mr. Ernie Hardeman): One minute.

M^me^ France Gélinas: And do most of your locums do just locum, or do they have practices elsewhere that they close to come to work for you?

Ms. Sue LeBeau: Speaking more to my experience in Red Lake, because I'm more familiar, they typically locumed in other places, and some had practices, so we weren't typically their first priority.

M^me^ France Gélinas: So they close their practice elsewhere to come and do a locum for you? Okay.

How many of the physicians on staff come from NOSM? Would you know? No? I'm guessing most of the ones who stayed.

The government has increased the number of physicians who will be able to train in the north, but not for many years to come, and then add another six years before they graduate, so don't hold your breath on that one. But it's coming; within the next 12 years, it should help.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that one.

We'll go to the independent. MPP Bowman.

Ms. Stephanie Bowman: My question is for Allie from IPHCC. Allie, could you talk a little bit about both the challenges and the opportunities in working across ministries? I'm learning here still, but I imagine that there are conversations that you have both with the Ministry of Health as well as the Ministry of Indigenous Affairs. Could you talk a little bit about that as you seek to expand your services?

Ms. Allie Kinnaird: Yes, thank you for the question—

Failure of sound system.

Ms. Allie Kinnaird: I think the ministry staff are doing their best. I think there are so many things going on within different branches of government, and I applaud the provincial government for forging ahead and continuing on the path to develop Ontario health teams, because that, I think, is what's going to break down silos and create more efficiencies within the system.

With respect to Indigenous health planning, we have, I must say, found it somewhat challenging at times, because there's that lack of coordinated provincial/Indigenous health planning hubs or tables to address all of the different issues that we're seeing within the communities and the needs of our members. To answer your question in short, I suppose it's at times challenging, and we do hope that the proposal for the provincial Indigenous integrated health hub is a catalyst for breaking down those silos within ministries and providing an avenue where we can speak to all different branches of government in a unified way that could bring efficiencies and some uniformity to the conversations that we're having, which we hope will lead to more tangible action, instead of just speaking to different branches of government in silos, which can be challenging at times.

Ms. Stephanie Bowman: Excellent. Thank you so much.

The Chair (Mr. Ernie Hardeman): You have two minutes.

Ms. Stephanie Bowman: Okay. Thank you.

I will go back to Sue. Sue, a question about the ER closures: Could you talk a little bit about how much—I'll use the words "advance warning," but maybe "warning" isn't quite right—how much time in advance when you actually have to make that decision and what kind of resources you're trying to tap into. Are there any other last-minute measures that the government could help with in terms of preventing that decision to close?

Ms. Sue LeBeau: The notice can be anywhere from a few weeks to, really, 48 hours or less. Depending if a physician is coming from out of town, one missed flight or one COVID—and that was my experience in Red Lake when we closed the emerg; it was less than 48 hours. So in terms of tapping in, one has to have good plans ahead of time and phone networks very quickly, thinking about EMS, thinking about police, thinking about all the other regional hospitals that might be accepting those patients. In small, rural communities, you might just have one ambulance, so if EMS is out, they might be out for hours if they can't upstaff.

It's also about communicating to the community.

1450

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Sue LeBeau: It's about making sure that road signs are covered, and those "H" signs that are along the highway.

So it is a significant work effort that requires significant preplanning. HealthForceOntario has been good for helping to prioritize. There might be opportunity to refine the algorithms for prioritizing by rurality index and by distance from next health care centre and by impact on Ornge or emergency transport. Those are all some factors that we have to consider, sometimes with less than 48 hours' notice.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Crawford.

Mr. Stephen Crawford: Thank you to the presenters today. I have a couple of questions. I'll start off with Scott Hill with Play On! Canada.

Thank you for the great work you're doing and for introducing hockey to children and youth, whether they've been here for generations or are newcomers and immigrants, as you've touched on. I think it's great. It's a good part of Canadian culture, and it's important to have these kids participate after what we've been through with COVID.

I just want to get a bit more understanding of your organization and its past. You've been around for quite a few years. Have you had provincial funding? Where has the funding come from in the past?

Mr. Scott Hill: Thank you for the question.

From 2003 until 2014, the organization was funded by the CBC. The CBC had resources to fund national operations as a result of their proceeds that came from their NHL broadcast partnership. When Rogers took over, CBC left the business of hockey and was no longer in a position to support a community-based, national street-hockey program.

We did receive a one-time funding commitment of $500,000 from Minister MacLeod in Ontario last year. We had presented a similar request to this one, and we received a smaller contribution. She was a leader, and five provinces across the country followed her lead and made contributions, and we're grateful for that.

Our organization is in good standing, and we are hoping to expand upon the three events we were able to deliver in Ontario this past year and deliver nine in each of the next two years.

Mr. Stephen Crawford: You kind of answered my next question. Obviously, the Ontario government wants to support this in Ontario. So if the Ontario government supports your organization, that would be money that stays in Ontario, presumably. It's not going to go to Moncton or—other provinces are contributing for their own provincial initiatives?

Mr. Scott Hill: That's correct.

Mr. Stephen Crawford: That's good. Thank you.

My next question is for Sue at West Nipissing General Hospital. Again, thank you for all the work you do. We know you have a tough job.

Health care really is in tough shape globally, in Canada, in Ontario. Certainly, here at Queen's Park, we have been lobbying long and hard for more support from the federal government, because we believe they've been underfunding us to the tune of billions and billions of dollars. I believe the Premiers of all the provinces, of all political stripes, are standing together, and it looks like there's some progress being made on that front, so we're happy about that.

In terms of some of the initiatives our government has taken—the "learn and stay" program we've touched on; we have sped up foreign credentials for certain medical practitioners, while still keeping our standards high; we are creating a new medical school in Brampton, the first medical school in many, many years. What else do you think we can do to support getting more medical practitioners to the north?

Ms. Sue LeBeau: Certainly, the international credentialing is something to look at. We have a number of Canadian physicians who have been educated in other countries who are looking to match and to come back to Canada. I think that might be a shorter-term solution, ensuring that education is accessible in the communities where people practise. I think of our northern communities where it's difficult to leave: Can we provide education in situ? Can we do it differently? Can we do it more compressed? Can we do it in modular form so that people can start practising as they are working?

Those might be some of the short-term solutions—and I think overall acknowledgement of what our health care professionals have been through. They are tired. Their faces are long. Everybody wishes the pandemic was done, and we're still slogging away in conditions that are challenging, so I think sometimes that matters as well. And I hear them say initiatives to foster retention as well as recruitment, so things like late-career initiatives and providing people opportunities to extend and pass on their knowledge and wisdom I think would be other opportunities to support us.

Mr. Stephen Crawford: That's true, because we do have a lot of, as I think you mentioned as well, medical practitioners potentially retiring in the next decade. So that's concerning. If there's a way we can incent them, perhaps, that's a great idea.

I'll pass the floor.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: I just want to ask Allie from Indigenous Primary Health Care Council—by the way, I went through your Twitter account. I really loved that moral of self-care during winter, talking about how we can do it. And it's not just for the Indigenous community; I think it is something which we should be doing for everyone—simple things: walk, go stargazing, connect with the community, make sure you reach out to your elders, make a fire and make a sisters soup. I don't know what a sisters soup is, so maybe I'll take that from you.

In one of the documents, Indigenous Health Systems Transformation, I am going straight to point number 3. You said, "Promote and ensure that Indigenous resources are being delivered by Indigenous providers throughout health systems." So, a great idea; I just want to ask you a quick question. This is creating a vicious cycle of promoting within the community as well. As we know, we are already going through a health human resources shortage across the country, especially in the rural and northern regions as well. As a result, we've launched the "learn and stay" grant, which everybody has talked about. How can we integrate the Indigenous community? How can we work with the Indigenous community? That's one suggestion I want to ask you.

The second thing I want to talk about is the recent Skills Development Fund, SDF, which we just completed. Do you know anything about that?

Over to you. Allie, can you hear me?

Mr. Rick Byers: She's trying to unmute.

Ms. Allie Kinnaird: Sorry, I just unmuted. So I'll quickly—on the second ask, I haven't heard about that, so I would love to hear more about that specific fund.

With respect to engagement, at IPHCC specifically, we do take a "two-eyed seeing" approach to the way that we are—of course, we need to ensure that care pathways are—and especially as Ontario health teams look at creating efficiencies in the system—improving the way that Ontarians receive care. We are taking a "two-eyed seeing" approach, where traditional medicines and way of approaching health care are coupled with—

The Chair (Mr. Ernie Hardeman): Thank you very much. Unfortunately, he didn't leave you enough time to answer the question. If we had a shorter question, we would have had more time for an answer. And I say that for my colleague, not for the presenter.

With that, that concludes the time we have for the questions, and we want to thank all the participants at the table, and we also want to thank all those that lived through the challenges that technology presented us today. We thank you very much for the time you took to prepare for this and the time you took to come and present it to us, and I'm sure we will put it all as part of our findings as we report back to the minister as to what we found in pre-

budget consultations, 2023. So again, thank you very much for being here.

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MIRARCO MINING INNOVATION

The Chair (Mr. Ernie Hardeman): Our next panel is just a panel of one. It's MIRARCO Mining Innovations. Here we come. I believe you may not have been here as the others were starting their presentation, so we'll outline again that you will have seven minutes to make your presentation. Then at six minutes, I will let you know that you have one minute left. Don't stop speaking at the six minutes, because at seven minutes, I'll stop you from speaking. To get it all in, use all of the time wisely.

After that, we'll have any questions for the panel to ask you, and you can get the things in that you missed out in your presentation. You can use that time to answer and get the message out anyway. With that, then, now the floor is yours. If you start, make sure you tell us your name for Hansard so all the good things you tell us are going to be attributed to you saying them.

Dr. Nadia Mykytczuk: Wonderful. Thank you so much. And thank you to the committee for allowing me this opportunity. I'd like to acknowledge our local MPPs who support us a great deal in our work here in Sudbury. I'm Dr. Nadia Mykytczuk. I'm CEO and president of MIRARCO Mining Innovation. We are a not-for-profit with over 24 years of developing mining solutions for a number of challenges for the mining sector.

Today I want to tell you about a very exciting project to develop a centre for mine-waste biotechnology here in Sudbury. The idea for this centre stems from the very real challenge that we are facing, not only in Ontario, but everywhere in Canada and around the world. We know that the demand for critical minerals is going to increase steadily to 2030, anywhere from 3% to 14% for these battery minerals, and double again by 2040. We simply don't have the supply available right now to meet these demands as it stands.

As we talk about the Canadian mines and minerals plan as well as the Ontario Critical Minerals Strategy, we identify that increasing production is critical to meeting this demand. And we know that that comes from enhancing exploration, building new mines, expanding development, improving our extraction, but also we need to look at developing new technologies from extracting value from waste. These are materials that are already present in our mining environments, and they still contain significant concentrations of these critical minerals.

What am I talking about? You may not think about mine waste as often as I do. If we look at this image here, this is a tailings pond. This is not a sandy beach; these are materials that are high in metals but also nuisance elements like arsenic and others that can drain into the environment and cause significant impacts.

We know that Canada has a large stockpile of materials like this. In fact, you could say we are blessed with them. With over 200 active mines and over 10,000 abandoned mines, we produce over 650 million tonnes of mine waste every year. These present significant liabilities in the order of billions of dollars to our mine operators, as well as the public purse, as many of the abandoned mines require tax dollars to close out and contain these wastes. But it's not just a bad story. Through the lens of looking at meeting the critical minerals demands, we have the opportunity to extract the residual value that remains in these materials and, at the same time, address those liabilities.

Now, we can't simply do this by taking these materials and putting them back inside a smelter. That would cost too much and is not worth the value that we extract from them. So this is where the idea comes from, from developing and expanding and accelerating the commercialization of biotechnologies like bioleaching and biomining. These are not new ideas. They've existed in proof of concept and even commercial operation for over 40 years elsewhere around the world, but not yet in Canada.

So the centre for mine-waste biotechnology is looking to accelerate the scale-up de-risking adoption of these technologies where we can use bacteria to extract the metals that are in these wastes, in a low-cost, low-carbon alternative, so that we can have a green metal supply for our battery supply chain. We completed a feasibility and business case last year and we identified what the gap was. How do we accelerate proof-of-concept technologies into best practices for the mining sector? And we know we need to do this by accelerating and piloting and de-risking these technologies at larger scale so that the end users—the mining operators and mine service sector—can adopt those technologies and put them into practice. In the process, a centre like this is also looking to train new HQP in a talent pipeline that doesn't currently exist.

So when we completed our feasibility, and some of these points are included in the package that was circulated, we identified a gap—and this would be the first centre of its kind in Canada. We also have the opportunity to have a unique value proposition and the key differentiator, not only for the Ontario mines service supply and critical minerals supply, but also providing those technologies and translating them all across Canada.

We know that we have a strong financial position with this project and a high return on investment. Some of the details that I've provided in the package outline the significant GDP boost through the construction of the project as well as the operation over a 10-year period that we're projecting: an impact between $20 million to $30 million in GDP, significant job production under construction, and an average of 26 to 40 employment units per year at the centre. If we were to look at a modest increase in output of 1% for total mining output for Canada, that looks—with a significant increase in GDP, tax revenues, as well as over 2,500 FTEs created through even just a 1% increase by adopting these technologies and unlocking the value in materials like mine wastes.

The need for investment: We are looking for a $21-million capital campaign commencing this year. We hope to have shovels in the ground in early 2024. We're looking for a one-time provincial ask of $7 million. We are hoping to match this and stack this against other federal programs, municipal investment as well as the private sector. We realize that we want to build this as a showcase facility in Ontario, but we know that the federal government, with

their critical minerals plans—and many of our mine operators work across provincial jurisdictions—would have an interest in supporting this project. We've already had significant support from our municipal government. The private sector, which is already engaged with us in developing these technologies for their specific sites and challenges, is also looking to invest in the project and be key users throughout the operation.

With that, I'd like to highlight, of course, that this project is looking to advance Ontario's position as being a leader in the critical minerals supply chain, but also addressing the fact that there is a gap in the talent pipeline, not only in the mine operators but also in the mine service supply. We have a large opportunity to spin out companies and technology providers through the centre within the next five to 10 years. We know that there is a significant gap in the talent pool within the mining industry, and we look to work closely with them in making sure that our technologies are translated directly to them.

I'd like to thank the committee for this very rapid pitch of seven minutes. Scientists like to talk for a very long period of time, so I'm glad that I could convey all of that to you in a few short minutes. I'm looking forward to your questions. Thank you very much.

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll start the questioning with the independents. MPP Bowman.

Ms. Stephanie Bowman: It was very exciting. I love to hear about innovation opportunities.

Could you talk a little bit about how this investment and then the potential payback—the 1% improvement—compares to other countries that have done this? And could you talk a little bit more about the other jurisdictions that are doing this around the world?

Dr. Nadia Mykytczuk: The best example we have, globally, of biomining technology is Chile, which has used bioleaching to extract over 80% of their copper. That is total output of the copper production in Chile, and they're the third-largest producer in the world. It's actually coming through biomining.

We often get the question—"This sounds very blue-sky. These are not known technologies." But there are several commercial applications.

Globally, elsewhere, bioleaching has been used largely for refractory gold ores. These are ores that contain a lot of arsenic and can't be processed through smelting, because we would release all that arsenic. Bioleaching has been a viable technology and application there, largely in production in China, Australia, the Middle East and South Africa.

Ms. Stephanie Bowman: It seems like this is primarily geared to—I'll use the words "efficiency economic development," getting more out of what we mine. Could you talk a little bit more about the environmental benefits?

Dr. Nadia Mykytczuk: Absolutely. I don't know if you want me to pull up the slides for those who are following elsewhere.

Ms. Stephanie Bowman: Sure.

Dr. Nadia Mykytczuk: The liabilities: A lot of these materials contain elements—the element of interest, the battery mineral or the commodity, is usually less than 1% of the total volume. A large fraction of that volume is usually iron and sulphur, which produces what we know as acid mine drainage. If you've driven through Copper Cliff and you've seen the orange streams, you know that these are high-impact materials that can degrade the quality of the surrounding environment. If we can reprocess these materials, we can also extract those nuisance elements, make commodities out of those, and repurpose the residual material so that it isn't going back into a tailings pond. So we're looking to clean up these sites as well as extract that low percentage of metal that would make it more valuable.

Ms. Stephanie Bowman: Just to clarify, though, it's 650 million tonnes that we create every year, and this could help us avoid—not just the 20 to 200—how much would it help us avoid or reduce?

1510

Dr. Nadia Mykytczuk: Absolutely. If you're familiar with the Mount Polley disaster, where we had a tailings breach and we had significant environmental impact associated with that—if we can move away, toward zero-waste mining—and that is not impossible. If we are repurposing the waste and reducing the reactivity of the waste, we can actually remove tailings deposits altogether, and that would mean we wouldn't have any of that environmental impact associated with it.

That not only counts the significant impact by recovering the metals—in Sudbury alone, we have $8 billion to $10 billion in nickel; double that if we include the cobalt and copper in those same materials. Again, it's very large; it's the largest stockpile of tailings in Canada. If we can move to reprocessing that material and removing it from the environment, we have a double win. We've removed that liability and we've extracted that value.

Ms. Stephanie Bowman: Okay. And how much, I'll say ongoing research, is in this field here in Canada? You're one of them—

Dr. Nadia Mykytczuk: I am one of them.

Ms. Stephanie Bowman: One of how many? Is there scale yet in Canada, or do we need to work on that?

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Nadia Mykytczuk: We have, I'd say, a consortium of biomining applications globally. Within Canada we have several groups located at different universities and different institutions, and we've been working together as a Canadian unit now for several years to advance biomining.

Ms. Stephanie Bowman: So not to scale yet, but it has the potential? Is that fair?

Dr. Nadia Mykytczuk: Absolutely. The whole idea of this project is, how do we bridge that gap? We have a lot of proof of concept in universities and research centres, including the National Research Council and others. How do we get that out and get those solutions into practice?

Ms. Stephanie Bowman: Right. Okay. Thank you.

Dr. Nadia Mykytczuk: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. MPP Cuzzetto.

Mr. Rudy Cuzzetto: Thank you very much for that presentation. As you know, we're attracting a lot of automotive industry here to Ontario now, and we're going to be developing the EV vehicle here in Ontario. But not only are we developing the vehicle, we will be developing the battery here, and we'd hope that we can use all our natural resources. How does this technology that you're talking about compare to what they do in the Congo with cobalt and lithium? Because right now most of our materials for our batteries come from the Congo, where they do use child labour for cobalt, right?

Dr. Nadia Mykytczuk: Absolutely right. We have an opportunity; Canada has a very high ESG value for the minerals that we produce. We have a low carbon footprint. We have some of the lowest-carbon nickel, for example. If we can extend those practices across the entire battery supply chain, we will have some of the greenest, best-ESG quality minerals for battery production anywhere in the world. That is a huge label you can put on your batteries, if you can say that you've produced them in a green manner.

Extracting those minerals from a waste product that already carries a lot of liability adds even more to that. That's not to say that we don't have to build new mines; we absolutely do. But if at least part of our supply is coming through recycling and repurposing, then we're going to be able to maintain that very high ESG standard.

Mr. Rudy Cuzzetto: So you agree that we do a better job here in Canada than the Congo or other countries around the world?

Dr. Nadia Mykytczuk: We do. And as someone who has worked in this field now for over 18 years, I've visited many mines in many mining-impacted jurisdictions, and I think Canada really should be promoting not only the environmental standard but production standards, emissions standards that we've already maintained here now for several decades as a gold standard—it could be a nickel standard, but we'll call it a gold standard—on how we actually produce those metals.

Mr. Rudy Cuzzetto: Well I remember when we took office, we eliminated the incentive to buy electric cars here in Ontario, and we had a bit of pushback. But, by the looks of it, we were giving incentives to countries like the Congo that use child labour to build this battery. So in a way, we did the right thing to eliminate the incentive on that vehicle and build it now here in Canada, so we can use all these resources and all this technology here.

Dr. Nadia Mykytczuk: I would agree with you. Globally, there's a big push. It's now a wild frontier—the next gold rush, if you will. Everybody is looking to provide supply and provide those batteries.

Those automotive manufacturers are making deals with primary producers right now. Automotive companies have never made deals with mining companies to ensure that they have the supply for what they need. So I think that there's a huge opportunity for us as Ontario to say we have all the battery minerals, we have a lot of the critical minerals also, and we're going to maintain that supply and standard going forward.

Mr. Rudy Cuzzetto: Thank you very much. I'll pass it over to David.

The Chair (Mr. Ernie Hardeman): MPP Smith.

Mr. David Smith: Thank you very much, Doctor. You're amazing. Your presentation is great. Eighteen years certainly is, well, valuable here today.

My concern is, what are some of the ways Ontario can continue to stay as a competitive leader in the global mining sector?

Dr. Nadia Mykytczuk: There are several facets that I could highlight there. I think one of the important biases, perhaps, I'll acknowledge here is that innovation to commercialization is a real gap. Canada and Ontario, overall—we're very much behind in supplying and supporting and investing in fundamental research, applied research, and moving that knowledge out into commercialization. We write about it in all of our grants, but we need the supports. We're not well-trained in terms of getting the science off the lab bench and into the hands of the private sector. I think that needs to be bridged, and I think leadership from a government would be important in realizing the brain value that we have in developing new technologies.

The second one, I think, would also be echoed by a lot of our mining partners in that the red tape—a lot of the regulation, the regulatory approval. When we talk about new technologies, it's going to be very hard for new technology to be adopted as a best practice until it has received its regulatory approvals to be included as part of environmental impact assessments, various permitting that is needed for new mines. So we almost have to bring the regulators along with us as we say, "We've got new technologies. They're better because X, Y, Z," and have the regulators evaluate and approve those technologies before they get to market.

Mr. David Smith: You can tell all of my colleagues here: What is some of the red tape?

Dr. Nadia Mykytczuk: Actually, even—oh, it's gone. Well, that's okay. I was going to refer to one piece that you have in your booklet where it outlines even the financial liabilities.

Companies that operate here or anywhere are paying financial liabilities and financial assurance on those materials on their properties. Vale, for example, is one of our large mining companies here in Sudbury. It has over a billion dollars in financial assurance in Sudbury alone. If we could reduce those costs to them by saying, "We've incorporated X, Y, Z technologies, we're extracting value, we're reducing those liabilities," that's going to save money for their operator that they can invest into other portions of their operations.

I really think it's a discussion of, how do we integrate innovation into the mining sector? How do we shorten that time period? Right now, a new idea, from bench to commercialization, is looking over 10 years. That's not going to get us there. So we really have to figure out how we mature and commercialize new technologies in Ontario.

The Chair (Mr. Ernie Hardeman): MPP Byers.

Mr. Rick Byers: Thank you, Nadia, for a very impressive presentation.

I'm just curious; I saw your split between public sector funding and private sector. Given all you're doing—I think the private sector was in for $3 million to $5 million out of the $21 million, thereabouts—I was surprised, frankly, that there wasn't more private capital that would be endorsing your concept to help the industry. Do you see potential for more of that coming down the way?

Dr. Nadia Mykytczuk: Absolutely. If I had more time, I would have also shown you our operational model. We're hoping to engage the private sector in a membership model to provide the operational funds we need in a given year.

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Nadia Mykytczuk: We have three tiers of membership: super users, key users, and ecosystem members. The super users are designed to be, really, for the big mining companies investing $150,000 per year to be part of the centre. With that, they have access to the centre, the technology development, the facilities, fee-for-service use, student access, consultation. Their ask is actually going to be ongoing in a yearly investment and commitment to being members of the centre.

Mr. Rick Byers: It's smart because ESG—I heard you mention it—continues to be a huge, growing trend.

Good luck.

The Chair (Mr. Ernie Hardeman): MPP Anand.

Mr. Deepak Anand: Have you tested the technology itself on a pilot scale? And how was the response with the technology?

Dr. Nadia Mykytczuk: Yes. If I only have 10 seconds for that question, that's challenging.

We've already been working to develop pilot-scale facilities in limited spaces on campuses here, both at Cambrian College and Laurentian University. We know that it is feasible and it provides a lot of data—

The Chair (Mr. Ernie Hardeman): That concludes the time.

We're now going to the official opposition. MPP West.

MPP Jamie West: Thank you, Dr. Mykytczuk. You had me at "hello," the same as when we met in my office to talk about this.

My background—my colleagues know this—is in mining. One of the areas, when I was in safety, was the tailings dam. So to share with my colleagues, every year we build a dam around the tailings. It's just sludge. We build a dam. We build it higher and higher. If you had the time, it's a fascinating thing to see. We could literally spend the entire day just driving around it, that's how large it is. It's the size of a large lake.

1520

I wanted to talk to you about this Critical Minerals Strategy and talk about the amount of minerals that are in there and the resources available to be able to extract those and the value it would have for Ontario with these deposits that size.

Dr. Nadia Mykytczuk: Absolutely. If we look at—as MPP West describes, it's a giant bowl of material, and we build it up and it isn't stable. There's a lot of geotechnical challenges. So, we want to move away as a whole from creating those facilities.

When we look at the material that is in there, every tailings deposit is different. There are different concentrations of metals that we might extract. For the most part, it's a large bowl of aggregate, but we can't use it as aggregate because of these other low-concentration elements that make it a nuisance product or a high-risk product. There's 30% iron and sulphur in a lot of the materials; if we can separate it out from the silicates, the sandy materials that are also valuable—aggregates are hugely valuable, but when mixed together, they become a waste product and something we have to put in this giant bowl.

The idea is: If we're going to bother ripping all this material out, we're going to have processes that not only extract that tiny 1% of metal value, but we're also going to go after the iron and the sulphur. We've got streams that we can use for those. We used to have an iron ore plant here; we don't anymore, but there are other buyers for iron materials. And then those residuals, once they're cleaned up, we have aggregate that we can use and repurpose for construction, for backfill, for road construction, and others.

MPP Jamie West: This reminded me of the slag recovery that Sudbury—if you see the postcards, there used to be a slag dump on the postcards. There was a project, say 20 or 25 years ago, for slag recovery. And I remember, when they went to the company to talk about it, that they said there's no value there, and the person who came forward with the idea that year was driving a Dodge Viper with the money from the slag recovery. So there is, as they say, gold in them there hills. It's a very good opportunity for us.

The other part in terms of the environmental challenge that I think is great is: You talked about zero waste as possible. A couple of years ago, if you came to Sudbury, you would see a large plume coming out of the smokestack and that was something that would never happen with complete capture, which we did. And I think the size of this ecological footprint and being able to make that safe again is really important as well, in terms of—I think you said $60 billion worth of assurances—putting value back into companies to be competitive in Ontario.

Dr. Nadia Mykytczuk: Absolutely. Being able to reduce the cost and liability associated with wastes, we can attract more companies to places like Canada, right? For start-ups, for junior mining companies, for them to pay the financial assurance on their operations before they've even mined a single bar of metal will preclude them from even entering into production. So I think it's an important discussion to say zero waste—waste is a very human concept. If we design to have no waste, then we're going to save ourselves a lot of the costs associated with managing a high-volume material.

MPP Jamie West: I'm going to pass it on to MPP Gélinas in a minute, but I think, as well, when you think of the economic impact of—if there's a spill and the devastation. So, ours here—part of the wall is on the other side of a park in Lively. But there was a spill in Brazil, I think in Itabira, where they basically destroyed the town. So you have that impact, plus having to relocate people. It ends up being a government responsibility to take on that

as well. And so I think you have the economic impact of the return on investment, plus return to the environment and then the surety of the citizens who live nearby. I think that's great.

France?

The Chair (Mr. Ernie Hardeman): MPP Gélinas.

M^me^ France Gélinas: I know very little about mining, although I live in a mining town. Right now, we mine. We send it to Clarabelle Mill, crush it. We bring it to the smelter and we get the minerals out.

How does it work in the biomining?

Dr. Nadia Mykytczuk: Merci, France. When we go to Clarabelle Mill, we concentrate the minerals so that what we're sending to the smelter is a much lower-volume material. The rest, actually, gets spit out a spigotted pipe and it goes right out into the heart of the tailings facility and it's deposited as a sludge. That sludge is what's making up the tailings pond.

The pyrrhotite material that we started rejecting in the 1970s because it was very high in sulphur: That's the waste that's now been pumped out every single day and accumulating in the centre of that facility, and that's where a lot of the metal value still is located. If we were going to build a bioleaching facility, we could actually make it adjacent to Clarabelle Mill and capture the wastes that are being rejected already, putting them through a secondary process recovering that value, and then there isn't anything going back out to the tailings facility; we've already found homes and uses for those other materials.

M^me^ France Gélinas: Wow!

Laughter.

The Chair (Mr. Ernie Hardeman): You asked.

M^me^ France Gélinas: I like that very much. Sorry; that was my little question.

Dr. Nadia Mykytczuk: No, it was a genuine reaction. This is good.

MPP Jamie West: Just with the remaining time, I really want to emphasize the importance of this, because it is something that's going to be world-class and an opportunity for Ontario to shine.

You had mentioned cobalt and copper—actually, my colleague mentioned copper. But with the price of metal being cyclical—I remember at one point, we didn't focus on copper. We're known as the nickel capital, but we actually probably produce more copper than that. That return on not focusing on extracting that in the past—there are probably valuable minerals that we've dumped into our tailing ponds, right?

Dr. Nadia Mykytczuk: Absolutely. Copper and cobalt: If you know the history of Sudbury, they came for copper. They found nickel and didn't know what to do with it initially, and then it took over.

But yes, the copper extraction: Vale and Glencore do have a copper stream, but it is reduced. Cobalt and other platinum-group elements have not been extracted as high-efficiency as they should have. The further down you go into that bowl of material, the older the materials, the higher the value, because our processes weren't as efficient a hundred years ago as they are today, and so there is increasing value as you go deeper—which is true for mines also, but this is talking about tens of feet instead of thousands of feet underground.

MPP Jamie West: Yes. Thank you.

The Chair (Mr. Ernie Hardeman): That concludes that question. Any further questions from the independent? Any further questions from the government? Seeing no further questions from the opposition: Thank you very much to the panellists for being here and making the presentation.

That, I think, concludes the presenters and concludes our public hearings for pre-budget consultation in Sudbury. The deadline for written submissions is 7 p.m. Eastern Standard Time on Tuesday, February 14.

The committee is now adjourned until Tuesday, January 31, 2023 in Sault Ste. Marie.

The committee adjourned at 1527.

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