Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

F-75

Standing Committee on Finance and Economic Affairs

Pre-budget consultations

1st Session
43rd Parliament

Tuesday 14 January 2025

Chair: Ernie Hardeman
Clerk: Vanessa Kattar

Journal des débats (Hansard)

F-75

Comité permanent des finances et des affaires économiques

Consultations prébudgétaires

1re session
43e législature

Mardi 14 janvier 2025

Président : Ernie Hardeman
Greffière : Vanessa Kattar

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

https://www.ola.org/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

House Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400
Published by the Legislative Assembly of Ontario

Service linguistique et des publications parlementaires
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-4386

CONTENTS

Tuesday 14 January 2025

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 14 January 2025

Mardi 14 janvier 2025

The committee met at 0900 in the Best Western Plus Leamington Hotel and Conference Centre, Leamington.

PRE-BUDGET CONSULTATIONS

The Chair (Mr. Ernie Hardeman): Good morning, everyone. Welcome to Leamington. I'm calling this meeting to order. We're meeting to resume public hearings on pre-budget consultations 2025.

Please wait until I recognize you before you start to speak and, as always, all comments should go through the Chair.

An added announcement: We ask staff and committee members to use your WiFi limitedly. We don't have good reception here and so, in order to make sure our meeting can be properly conducted, if we refrain from using that, we would very much appreciate that.

As a reminder, each presenter will have seven minutes for the presentation, and after we have heard from all three presenters, the remaining 39 minutes of the time slot will be for questions from members of the committee. The time for the 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 member of the committee.

AIRPORT MANAGEMENT COUNCIL OF ONTARIO

ONTARIO PUBLIC TRANSIT ASSOCIATION AND LEAMINGTON TRANSIT

MS. REBECCA RUDMAN

The Chair (Mr. Ernie Hardeman): With that, we will now hear from the first presenters. The first table is the Airport Management Council of Ontario, the Ontario Public Transit Association and Leamington Transit, and Rebecca Rudman.

We ask each member, as you start your presentation, to make sure you introduce yourself, so we get the right person for the right comments.

In the seven minutes you have, I will announce "One minute" at six minutes. Don't stop, keep going, because at seven minutes, you will stop. We very much appreciate you being here this morning.

We also ask—I don't think there's any in this delegation; yes, there is one—anyone that is going to speak online, to make sure they also introduce themselves if they're asked to participate.

With that, the first we'll hear from is the Airport Management Council of Ontario. The floor is yours. Go ahead.

Ms. Rebecca Rudman: I'm the community member.

The Chair (Mr. Ernie Hardeman): Okay. Yes, we're not hearing anything.

Ms. Laura McNeice: I think I'm unmuted now.

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

Ms. Laura McNeice: I'm Laura McNeice. I'm the CEO of the Airport Management Council of Ontario. I'm here with Chris Wood and Marion Smith.

I'm just going to share my screen for a PowerPoint presentation. I hope everybody can see that.

The Chair (Mr. Ernie Hardeman): Yes.

Ms. Laura McNeice: Okay, we have one main request from this committee in your pre-budget consultations. We are asking for adoption of the Ontario Airport Capital Assistance Program. OACAP is what we're calling that. This is so that the small airports and aerodromes in the province have a reliable source of funding to maintain their infrastructure that provides public services to Ontarians. We are looking for an investment of $8.5 million to $10 million annually, on a permanent basis.

The province of Ontario is actually the largest operator of airports in Canada. The Ministry of Transportation owns and operates 29 airports, 27 of which support the remote First Nations communities. But there are other uses the Ontario government uses airports for, mainly small airports and aerodromes, which is what we're here speaking about today.

Ornge air ambulance is a large user of the small airports, as well as the Ministry of Natural Resources, with forest firefighting, fish and wildlife research, aerial rabies baiting etc. As well, the OPP uses these small airports and aerodromes. Other uses for these airports are Hydro One, CASARA with search and rescue, and flight training. These small airports and aerodromes are a conduit of tourism and economic development in the areas in which they are located. So there is a heavy reliance on having a small airport or aerodrome for all of these public uses.

There are over 40 municipally owned small airports and aerodromes as well as other publicly available airports that do not qualify for any federal assistance. With the increase in costs of operating an airport, municipalities are not able to necessarily always afford the capital investment that is

required to upkeep the safety of these facilities. For small amounts of money, the municipalities are considering divestment of these facilities. I believe that often the intention is that it will remain as an airport, but once you've sold your asset, you don't have control over what it's used for anymore. So the loss of publicly available airports will affect the public services that Ontarians have come to expect.

The main source of federal funds is through the ACAP program. However, this program is unavailable to the small airports and aerodromes that we're speaking about, as the main requirement for the ACAP program is having scheduled service with a certain level of passengers each year. However, in British Columbia, Alberta and Saskatchewan, those provinces all acknowledge the importance of community airports and have created provincial programs there to support their small airports and aerodromes. For example, in BC, they invested $11 million to cover 26 projects in 2024. The Community Airport Program in Alberta, they invested $4.6 million in provincial funding to five projects, and Saskatchewan also has a program that benefits their small airports and aerodromes.

We are proposing the creation of the Ontario airport capital assistance program to fulfill the funding gaps experienced by the airports who are ineligible for ACAP. We're suggesting $8.5 million to $10 million to be set aside for various projects for safety at the small airports and aerodromes. Eligibility criteria has been laid out in the program document we've provided to you. We would suggest that eligible projects are to be evaluated on the benefits to their community and demonstrated financial need at the airports.

We propose that there would be a cost-sharing ratio of 75% coverage with a 25% contribution by the facility owner, which could be flexible based on some criteria that we've set out in the document for you. We would also suggest that a cap of $2 million per applicant per year be implemented.

[*Inaudible*] that we believe should be eligible would be those for safety, such as runway rehabilitation, lighting, upgrades and those types of things, as well as mobile equipment such as snowplows, snow blowers, sweepers etc. as well as projects that improve energy efficiency and decrease greenhouse gas emissions.

That was what I have to present for you today. Thank you very much for your time, and we do look forward to your questions a little later.

The Chair (Mr. Ernie Hardeman): Our next presentation will be the Ontario Public Transit Association and Leamington Transit.

Mr. Bill Fuerth: Thank you for the opportunity to speak today. Good morning, everyone. I appreciate the opportunity to attend this event and speak on behalf of the municipality of Leamington's transit services, as well as the Ontario Public Transit Association, which I'll refer to as OPTA. Leamington is a member of OPTA and was asked to attend today's meeting to represent our local transit services and to speak on behalf on one of the many front-line transit service providers that make up the OPTA group. The municipality of Leamington—

The Chair (Mr. Ernie Hardeman): Excuse me just for a minute. I think you didn't introduce yourself to start speaking.

Mr. Bill Fuerth: Oh, my apologies. My name is Bill Fuerth. I'm the manager of engineering services in the municipality of Leamington. My apologies for that.

0910

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

Mr. Bill Fuerth: To carry on, the municipality of Leamington is the only lower-tier municipality in the county of Essex with a comprehensive public transit system. Therefore, it goes without saying, Leamington council and administration are strong supporters of public transit services because these services provide a vital interconnection within our complex community here.

Leamington's local on-demand transit service served 34,000 riders in 2024 and experienced a 75% rate of growth between 2023 and 2024. Moreover, our regional system connecting Leamington to the city of Windsor served nearly 13,000 riders in 2024, providing local residents with access to educational opportunities at both the University of Windsor and St. Clair College. Leamington's enormous agricultural sector employs a great number of temporary foreign labourers who utilize both the local and regional services to access opportunities that would otherwise be unavailable.

As Leamington's administration and the OPTA community look toward the Ontario government's upcoming budget, I'm here to highlight the challenges transit agencies like Leamington's face, and to share recommendations for sustainable funding that will help us meet the needs of our growing population.

Operating costs are rising steadily, which I'm sure you all understand—maintenance, fuel, wages. Though provincial transit funding has maintained similar levels since 2019, Leamington's current dedicated public transit funding, estimated at an annual value of $299,128, represents roughly 35% of Leamington's annual operating cost for only our local on-demand service. With fares representing roughly 8% of the overall cost at a value of $3 per ride, that leaves 57% of the cost to be carried by the local property tax base. If the regional fixed-route service is considered as well, the provincial funding accounts for roughly 26% of the operating cost for all transit services in Leamington.

Leamington's local transit service certainly appreciates the dedicated provincial funding. Moreover, 35% support for our local transit system, as provided by the province, is as much as we could really hope for. However, this system still creates a $540,000 annual tax burden on the local property tax base.

Furthermore, with the pressures of inflation encouraging more users to rely on cost-effective modes of transportation like transit, we anticipate the number of users to increase and the cost to increase proportionately as time goes on. Therefore, without further financial

intervention, we expect the 35% recovery position we currently have to erode over time, with the property tax base covering more and more of the transit costs. Without intervention, these financial constraints may in the future force difficult choices such as cutting service frequency and coverage, forgoing service expansion, potentially hiking fares or drawing from municipal reserves, which puts the municipalities at risk.

This is why Leamington Transit and the Ontario Public Transit Association recommend a top-up of the dedicated public transit funding, raising its funding to $725 million for the 2024-25 fiscal year. This adjustment reflects not only inflation but also Ontario's population growth. This top-up restores the fund's original purpose or is intended to restore the fund's original purpose, supporting ridership growth and ensuring that not only Leamington but all Ontario transit agencies can meet the needs of their communities.

With respect to rural transit investments, the municipality of Leamington appreciates and recognizes the efforts of the government for establishing the Ontario Transit Investment Fund as a successor to the Community Transportation Grant Program. However, Leamington Transit services serve as an example of the fate of CT grant recipients that are not likely to be successful in the application process for OTIF funding.

Leamington was a community transit grant recipient in 2019 and utilized the funding received to create the Leamington to Windsor Transit service, which has grown in annual ridership from 4,000 riders in 2019 to 13,000 riders in 2024. The CT grant funding represented roughly 30% of the total operating cost, with the province's safe restart funding supporting the service for another 30%. With the safe restart program having come to a close already and the CT grant program finishing on March 31, 2025, the total cost of this service, roughly $305,000 annually is expected to be shifted to the local property tax base.

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

Mr. Bill Fuerth: This would bring the total tax burden for transit services in Leamington to roughly $846,000 annually. While Leamington intends to carry 100% of the cost to April 30 to allow students who rely on the service to finish their winter terms, after this time we expect this program to come to a close without the CT program.

To shorten it, Leamington was hoping that the OTIF program would fill the gap of the CT program. However, when the guidelines were released, we realized that the OTIF program is intended to focus on new services and expansions to existing services, and to some extent appears to disregard CT grant recipients as potential applicants. Of course, we intend to look for ways to find—

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

We now go to Rebecca Rudman.

Ms. Rebecca Rudman: Thank you for the opportunity to address the committee. My name is Rebecca Rudman. I'm here just as a community member. I am a person with a disability, a caregiver, and I have been involved in health and social services in the community in terms of both usage and volunteering. When I did work, I also worked in the private sector, in insurance. These remarks are rooted both in the references I've provided, but also, I wanted to share some of my personal experiences, so that you can get an understanding of what Ontarians are facing on a day-to-day basis.

First of all, health care: Prioritizing primary care is critical. The Ontario government has moved in a positive direction in appointing Dr. Jane Philpott to be a part of the primary care directive. Along with this, though, it's critical that patients and caregivers be key members and decision makers in that process, so that it remains patient-centred and avoids privatization as much as possible.

We must increase our core funding and innovation funding to hospitals and clinics, and stop the privatization of health care. We might think that we're getting a more competitive deal, a more innovative project, but really, what we're doing is just adding another payer that has to be paid out in the public system. If we have to pay for services plus profits to shareholders, that actually increases cost.

Research shows that privatizing services increases wait times, and I'd like to give you an example of the ways in which local public hospitals can provide innovation. At Windsor Regional Hospital, they've developed something called the nurse-police team, where a nurse and a police officer go out on the weekends—and, I think, now the weeknights—to meet people where they are and avert visits to the emergency rooms, and it's been tremendously successful. It's also really important for our region that we move forward as soon as possible with a new hospital.

Next, I'd like to talk about increasing equity and transparency in the Assistive Devices Program. This is a program that provides disability supports and assistive technology for people. It allows them to participate in regular life and essential things like going to the doctor, going to the grocery store or going to work. Currently, what we have is a lack of transparency and disproportionate funding for assistive devices for some types of disabilities more than others. For example, if you need a walker, as my mother-in-law recently did, 80% of the cost is covered. But if you need a hearing aid, only 20% is covered and that's a much more significant cost, and something that prevents people from participating in the workplace.

Last year, I wrote a letter to my MPP, Anthony Leardi, and to the Premier about the way in which there was trying to be backdoor cuts to this program by changing who's allowed to make authorizations. I can talk about that later, but it's kind of a detail. But the point is that only five days were allowed, and that we need to have a broader consultation and transparency.

Long-term care is something that I've recently been very much involved in, as my mother-in-law just went into long-term care. I did 17 tours of local long-term-care homes over 15 agencies, which meant I went back to two of them twice to make sure. I read all of the inspection reports for the last two years and compared this to provin-

cial indicators. Without a doubt, the two publicly funded homes surpassed those of the private.

0920

But worse than that, what I found is that private homes were cherry-picking the cheapest patients, the easiest patients. My mother-in-law, because of her dementia behaviours, was rejected at most of the private homes, saying that they didn't have the capacity to deal with her. Meanwhile, the public homes accepted her.

In fact, there is a whole department of the Ontario Health atHome designed to try to prevent this cherry-picking. It's a massive drain on their resources and it's still not effective. In fact, there are people sitting in hospital beds, not just waiting for long-term-care homes, but who actually can't go to a long-term-care home because no one will accept them.

Next, I'd like to talk a little bit more in detail about universities. I think we're all aware of what's going on in health care but what's happened recently with universities is that there have been consistent cuts and freezing of funding. For example, there have been no tuition increases since 2019, and universities have responded to this by trying to recruit more foreign international visa students. When the federal government recently put a cap on this, it meant that the University of Windsor budget has a projected deficit of $30 million. Across all Ontario universities, that projection is around $600 million.

Now, we might think these are just ivory-tower things we don't need to worry about, but I want to tell you about the very concrete ways that universities help small and medium-sized communities. They have close relationships with industry. They provide targeted training. If the University of Windsor closed and the student had to go to U of T instead, they would no longer be experiencing a tuition freeze because now they would have to pay for their housing on top of their tuition. So it discriminates against students in more rural communities.

They are also more likely to leave their communities after graduation. In fact, we had a whole strategy around health care for attracting doctors by having doctors come to local communities in order to increase their willingness to stay.

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

Ms. Rebecca Rudman: Finally, the University of Windsor is a major employer in the region. I think we often overlook the role that universities play in our community, and I hope we can work towards a better solution for them.

Thank you for this opportunity.

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

We'll start the first round of questions with the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters here, in-person as well as virtual, today.

It's great to be here. As it turns out, I did a lot of my growing up here in Leamington. My grandfather was the mayor of Leamington, so we used to come down and visit quite a bit. Also, my mother was the tomato queen one year. I don't know what that means in terms of lines of succession for vegetable and fruit monarchies, but there we have it.

I wanted to start my questions with the Airport Management Council of Ontario. I wanted to ask: In your request you've asked for a $8.5 million to $10 million per year on a permanent basis. What would be the impact if you don't receive this funding from the province? What would that look like for the economy, local communities and public safety?

Ms. Laura McNeice: Local communities are currently considering divesting their airports**.** In fact, several have already been sold to private owners. We would lose publicly maintained facilities. We have lost some and we will continue to do so without funding very soon.

Mr. Terence Kernaghan: Understood. What is the overall state of these small airports and aerodromes? You've mentioned in the funding that you've asked for a rehabilitation of runways, lighting upgrades and mobile equipment. What is the current status and the current repair state?

Ms. Laura McNeice: They are quickly disintegrating. Now, I don't want to make it sound like airports are not doing their best to maintain the safety at their facilities, but it's difficult.

I don't know, Marion, if you can speak more to it as an operator yourself.

Ms. Marion Smith: With municipally owned airports, when it comes to municipal funding, we're kind of at the bottom line. When a runway comes up for rehabilitation, the question was to whether we can get the funds to even do that. Right now—

The Chair (Mr. Ernie Hardeman): Excuse me. Could we introduce ourselves before we start speaking?

Ms. Marion Smith: Marion Smith. I'm the chair of the small airports and aerodromes committee. Sorry about that.

The Chair (Mr. Ernie Hardeman): Carry on.

Ms. Marion Smith: Now I forget where I was.

When it comes to our capital expenses, it's very difficult for us to get the funding from the municipality to cover those expenses. So, even now for infrastructure, if want to develop anything here at the airport, the person that's doing the development also has to pay for the infrastructure.

Mr. Terence Kernaghan: Understood. And, as you've pointed out, I believe, the province is quite a large user of these facilities, are they not?

Ms. Marion Smith: Yes, they are. We have OPP, hydro, Ornge.

Mr. Terence Kernaghan: Absolutely, and many others were pointed out in the presentation, so as a very large user of these facilities, one would imagine that the province would also contribute money toward their sustainability. Thank you very much for your presentation today.

I would like to move over to Bill with the Ontario Public Transit Association and Leamington transit. Thank you for your presentation, Bill. You had mentioned about the community transit grant and how that provided 30% of

total operating costs. Many municipalities across Ontario are facing very dramatic and unsustainable property tax increases. In my community of London, over the next number of years, there will be a roughly 33% property tax increase. Many are pointing towards provincial downloading as a cause for this municipal tax increase. More and more municipal taxpayers are having to foot the bill for what have been historically provincial responsibilities.

Would you like the government to restore its 50% provincial funding net operational costs for municipal transit to improve reliability, affordability and accessibility?

Mr. Bill Fuerth: Of course, 50% matching of operational costs in the municipalities would be amazing. It would be a huge benefit to us. I think, as I pointed out in my presentation, our position is not nearly as bad as some other of the larger cities. Of course, the erosion of our recovery here means a much larger erosion of recovery in other locations like the city of London or larger cities. Yes, of course, if we were to get that news that a 50% matching from the provincial government for operational costs was an option, it would be amazing for us.

Mr. Terence Kernaghan: Most definitely. We've seen a new deal for municipalities such as Toronto. I also look towards cities like Hamilton, which are also facing a very dramatic property tax increase, which is quite frightening for people during an affordability crisis when everything else is going up in price. To see your tax bill going up is another thing, so I certainly hope that Leamington does not face the same property tax increase as a result of provincial downloading.

I'd like to move over now to Rebecca. Thank you for sharing your story, Rebecca, and also your family history with advocating for your parents. Ontario has a world-class health care infrastructure, and yet we've seen a lot of spending from this government to re-duplicate that infrastructure by creating these private for-profit operating suites. Can you speak about how privatization is wasteful and a misuse of public funding?

Ms. Rebecca Rudman: Yes. It's kind of like we have a house. Rather than adding an addition to our house or an additional property or fixing it up or adding a bathroom, it's kind of like we're buying a whole new lot and a more expensive thing and trying to do duplicate it.

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

Ms. Rebecca Rudman: I feel that there are so many ways. It raids staff from the public system. It erodes public confidence. Costs are higher. You get this cherry-picking that I talked about. It erodes confidence in Canada and one of the core features that is who we are. At a time when we're facing all these external international challenges, we need to focus on what it is we do best and solidify that instead of running around trying to duplicate what we have.

0930

Mr. Terence Kernaghan: Absolutely. One of the myths that is often touted when people are trying to advance privatization is that it is cheaper, it's efficient, it's more competitive. Could you say that that is the example that you've seen in long-term care with your parents?

Ms. Rebecca Rudman: Absolutely not. I'd say they get worse care. They have more violations. They're deceitful—

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

MPP Hazell.

MPP Andrea Hazell: Good morning, everyone. Thank you for coming in. I appreciate all of you presenting to the committee this morning. I'm going to take this round and start my questions off with OPTA. Thank you for everything that you do.

We know that public transit, no matter where you live in Ontario, has its major pressure points—underfunded, as you said, from 2019. We know the government is not giving the funding based on inflation. Do you know what I always say? It's like building a house in a desert from 2019 and hoping it to stay on the desert the way it is. And so, it's very difficult right now to think that we can decrease fares to make up for that funding or we can cut services, because I know that's what's actually happening throughout Ontario.

When we invest in public transit, we want to make sure it's reliable, it's safe and it's fast. We also have the congestion issues on the road, because we cannot rely on public transit because it's always delayed, it's always late. We've got these issues in Ontario.

Can you talk to me about your pressure points? I know you spoke a little bit about students. Can you talk about that? We need students to get to their universities on time. We want seniors to get to their doctor's appointments on time. So can you talk about the pain points right now in the public transit system?

Mr. Bill Fuerth: Through you, Chair: Thank you for the question.

Yes, I would say our largest pressure points in Leamington are specifically our regional system, which allows access for students from Leamington to access educational opportunities in the city of Windsor. We put our faith in the CT program for five years to assist us with that. However, at the end of the program, it didn't seem like there was going to be a funding opportunity there, with the Leamington public transit system having the lion's share of our transit costs.

We feel we're comfortable with running that system now. Of course, things could be better; they always could. But with our regional system, we do really think that there is the potential for that to expire on April 30th and for that access to education to really disappear if further funding intervention isn't available.

MPP Andrea Hazell: Thank you for putting that on the record. What are you going to be doing between now and April 30 to make sure that we do not get into that desperate situation?

Mr. Bill Fuerth: Of course. Thank you again for the question.

Coming here today to speak on this is just one of the things that we're doing. Right now, we are seeking support

from some of the other lower-tier municipalities here in Essex county, as well as from the county, to support our regional system. We are looking to build a stronger partnership with the Windsor transit service to reduce those costs as well. So we are working on these things. We have reports going to city council as well as county council soon. However, nothing is set in stone.

MPP Andrea Hazell: Okay. Well, thank you for putting that on the record.

I'll get to the other organization in my second round.

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

Mr. Deepak Anand: I want to start by saying thank you to each one of you for coming here and advocating for the members and the community at large.

Chair, I will be focusing first on the Airport Management Council of Ontario. It's good to see you, guys. We've been in touch before this committee meeting as well. I truly believe what you're asking is truly something we need for Ontario. Let's dive a little bit deeper into it to understand your need. You talked about $8.5 million to $10 million. How much of it is operational, and how much of it is going to go to the capital needs?

Ms. Laura McNeice: This program outline that we've come up with is entirely for capital funding. There would be no operational funds with this program.

Mr. Deepak Anand: Okay. And we did talk about this in the past, also: You have a lot of different MPPs, and I do remember putting that document where we went line by line, airport by airport. Have you reached out to those MPPs, outlining the suggestions and the requests line by line, based on the priorities?

Ms. Laura McNeice: Sorry. I don't know if I was supposed to have introduced myself—Laura McNeice, CEO of AMCO.

Yes, we have reached out. At one point we've reached out to all of the MPPs within Ontario, and then we have also gone back to many of the MPPs who we've met with and who have an interest in their local airports with the program that we've come up with and to go through it with several MPPs.

Mr. Deepak Anand: And you've said that you're expecting 75% from the government, 25% from the operator. Have you looked at different alternatives as well—maybe PPP, reaching out to outside partners; maybe leasing out some of the components or having some kind of program wherein they're able to take care of some of the costs?

Ms. Laura McNeice: That's not necessarily something we've actively pursued at this point, but as Marion said before, it is something that happens naturally: Those who want to participate and be located at the airport will sometimes participate in the upkeep of the facility.

Mr. Deepak Anand: And just on the other note: There are certain programs—for example, some funding that comes through Experience Ontario or through Infrastructure Ontario—which could align with these kinds of requests and needs as well. Have you looked at those as well? Have you reached out to those ministries, along with the Ministry of Transportation?

Ms. Laura McNeice: We've reached out to many of the various ministries, and there are some programs available that airports on occasion have been able to tap into. However, without a specific airport focus, it puts these airports and aerodromes in competition with other municipal needs, so municipalities have to choose which projects they want to submit for funding, and unfortunately airports and aerodromes aren't always at the top of their priorities.

Mr. Deepak Anand: You did mention that the users are OPP, Ornge and Hydro One; they're not government, but they're government agencies. How do they pay? Is it a user-fee-based model? Are they partners? How does that work?

Ms. Laura McNeice: Currently, it's a user-pay system, and so the users, such as Ornge, do pay a specific rate alongside anybody else who uses the facility.

Mr. Deepak Anand: Thank you again. I would again suggest to submit not just this submission, but submit the whole document, along with that Excel sheet, where there is a need shown by line, and reach out to your MPPs. I'm sure something will come out along with that. Thank you so much, again, for your work.

Ms. Laura McNeice: Thank you very much.

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

Mr. Andrew Dowie: Thank you, Chair. How much time is left?

The Chair (Mr. Ernie Hardeman): You have 2.4.

Mr. Andrew Dowie: Okay. Thank you.

Actually, Ms. Rudman, I'd like to focus on you, as a local resident. Thank you for your presentation. I'd like to jump to your point 2. I'll say, locally we have the Windsor Surgical Centre; it's covered a lot of ground on this committee in the last two years. Mr. Musyj, CEO of Windsor Regional Hospital, came in and spoke very glowingly of the initiative. Windsor Regional is part of it, as are Drs. Tayfour and Emara, who are the surgeons who would otherwise be doing your cataract surgery; they just own the real estate. Is that the concept that you are speaking of when you say private initiatives such as surgery centres undercut the public system?

Ms. Rebecca Rudman: Well, the private centre started out as a pandemic response. We had overflow of COVID-19 patients in our hospitals; these centres pivoted to do cataract surgery. I don't have an issue with that as an emergency response. We all have to pull up our boots and do what we can. What I do have an issue with is an ongoing funding of private centres. Because they take away funding from the current system, it's like another payer that you have to add into it. With all due respect, David Musyj is an excellent administrator of Windsor Regional Hospital, but they're trying to make ends meet wherever they can.

0940

When I look at it as a citizen from a long-term perspective or even a short-term perspective, I don't want my cataract surgery to be outsourced. In fact, if you look at the data from the Ontario Health Coalition, it shows all of the

ways in which these private centres are upcharging individuals for things that should be funded by OHIP.

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

Ms. Rebecca Rudman: We don't have the same kind of oversight that we did. I am in favour of novel programs like the nurse-police team that are run through the public system.

Mr. Andrew Dowie: Thank you for that. Can you speak to a specific case in Windsor-Essex where someone has been upcharged at the Windsor Surgical Centre?

Ms. Rebecca Rudman: I haven't investigated; I'm not a researcher. That's the problem, as a person. But as a person with a network of many elderly friends, most of them have had to pay something for their cataract surgery. I have sent them the detailed information about what can and cannot be charged, and here's the problem: It's very complicated. The average person can't wade through that and figure out, "Is this lens an upgrade? And if I get this one, is it deducted off my OHIP bill? I'm not sure."

So no, I can't speak to that, but the fact is, I think if we're even asking that question, we should look into it—

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

We will go to MPP Gretzky.

MPP Lisa Gretzky: I'm Lisa Gretzky, I'm the MPP for Windsor West, so one of the neighbouring areas. I'm going to start with Rebecca. That's not where I was going to start, but I'm going to start with Rebecca because of the last line of questioning.

The question was specifically about a particular facility in Windsor and two specific doctors. I think that it is really unfortunate that that is the focus, especially when you are talking to a private citizen, when we are seeing across the province—I don't believe you were making any type of insinuation or accusation against that particular clinic or those few doctors. That is certainly a narrative that the government side likes to push, but I don't think that's the case.

However, we do see around the province, in many areas—as the government pushes more of these private clinics and underfunds our publicly funded, publicly delivered not-for-profit health care system—places like the Shouldice clinic, who perform gallbladder surgeries—

Mr. Terence Kernaghan: Hernia.

MPP Lisa Gretzky: Sorry; not gallbladder surgeries—hernia surgeries, where they charge patients. They tell them they have to stay at their facility, rather than recovering at home or in a hotel. They charge them extra. They charge them extra for care. We've seen many places that perform various surgeries that charge people extra money for that service that they would not otherwise have to pay.

I think I'm correct—and, Rebecca, you can correct me if I'm wrong—that you were not pointing to any one particular clinic, or any particular doctors.

Ms. Rebecca Rudman: No. Right.

MPP Lisa Gretzky: The intention is not to say everybody is using or abusing the system, but in some cases, the privatization opens up that door. Am I correct?

Ms. Rebecca Rudman: That's right. Certainly, I haven't done any audits of any clinics or any people across Ontario. I certainly am in no position to call out individual physicians.

I'm talking about, first of all, the general concept of it, and secondly, preliminary data that we do know, collected across the province. Thirdly, I really want to point out the fact that I don't know what's going on in this shows the confusion in the marketplace for the individual person. Are we now going to say that before a person uses a surgery centre versus a hospital, they have to go investigate whether it's been appropriately billed or not? I think that's too much to put on the individual citizens, especially when we're talking about the most vulnerable people who need health care.

MPP Lisa Gretzky: You talked about being a caregiver in long-term care. I just wanted to know if you were aware of—in our caucus, there have been several bills, specifically around long-term care or congregate care settings. There was my bill, More Than a Visitor, when we found that family members and caregivers were being locked out of long-term care and those residents were not having access to their caregivers and how detrimental that was. The government did not support that bill. My colleague from Waterloo, Catherine Fife, several times has introduced Till Death Do Us Part, which would see that couples would stay together in a facility rather than being separated. The government again has not supported and has stalled the passage of that bill.

But I want to ask you specifically about caregivers, the cost—the emotional, the physical and the financial cost—of being a caregiver. My colleague Wayne Gates from Niagara Falls tabled a bill where there would be a caregiver benefit so those that provide care for a loved one would get some financial support. Is that something that you think would be beneficial to caregivers?

Ms. Rebecca Rudman: Absolutely. If I weren't already not working because of my disability, I couldn't hold a job and be a caregiver just for the appointments alone, having to attend and the extra things, having to do—so that's one problem.

The second problem is—I had a back surgery during the pandemic. I was doing really well, and then my mother-in-law, who has dementia, shoved me, and I almost needed another back surgery because of the danger to myself. So when we're looking at caregiving, a lot of the things centre around, "What can we do for caregivers?" as opposed to providing additional services. I think we need both.

I can speak to the couple situation in long-term care. When I visited private homes, I didn't see any couples together. When I visited public homes, I saw three cases of it. This is a small sample size, but it's another example of how the values of the public sector are different than the values of the private sector.

MPP Lisa Gretzky: Thank you.

How much time do I have left, Chair?

The Chair (Mr. Ernie Hardeman): Two point three.

MPP Lisa Gretzky: Thank you.

I'm going to pivot to Bill. The question: As you are probably well aware, in Windsor there is discussion about actually reducing public transit services. We know that the people that are impacted the most—I would hazard a guess it's very similar out here—are low-income individuals, seniors, people with disabilities, students, that kind of thing.

You talked about passing some of that cost, unfortunately, if the province doesn't step up, on to the property tax base. I'm wondering if you can tell me what that increase would potentially look like at this point in time and what property tax increases have there been in the last, we'll say, three years, based on the underfunding or downloading of services from the province to the municipality.

Mr. Bill Fuerth: Thank you for the question, through you, Chair. I can't give you exact numbers, obviously. I'm not prepared to say exact numbers of property tax increases. I can say, with doing annual budgets, we target somewhere between 3.5% to 4% annual increases, so that gives you an idea of what it may have been for the last few years.

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

Mr. Bill Fuerth: Beyond that, with respect to who is affected by the erosion of public transit service delivery, it's certainly the most marginalized members of the community. That's without a doubt.

MPP Lisa Gretzky: Is it safe to say that also a large population of the migrant workers in this area, the ones that actually work on the farms and help pick and supply food for those of us in the surrounding area and beyond—

Mr. Bill Fuerth: Of course. Absolutely. That goes without saying. They are one of the heaviest users of the local transit system.

MPP Lisa Gretzky: Thank you.

I just want to make a comment, with what little time I have left, to the airport council. It's concerning to me that the Conservative member kind of put it back on you and your responsibility, when we know that there's a great deal of usage of government agencies, as the member had said, and that, right after we heard about the detriment of private—

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

MPP Hazell.

MPP Andrea Hazell: This round of my questions is going to go to the CPA. Yes, as my colleague said, the question was actually turned back to you. But, for the record, I want you to help me to understand your funding pressures if you are not able to get the funding that you're asking for. I think it's $8.5 million to $10 million. What will that do to your services and to everyone that uses your services?

0950

Ms. Laura McNeice: I think without the funding, there will be airports divested from the municipal owners. They will have then the potential to stop being publicly available facilities. Even if they remain as an airport, they may not remain publicly available. They may be for private use only, which means that it is more challenging, more difficult for air ambulance to fuel and to land at various places within the province. It will be more difficult for the search-and-rescue users to be closer to where they are trying to find someone. The forest firefighting will not have the same abilities to be as close to the fires; they will have to go farther away to fuel up etc.

Public services will decline with the decline of these public assets. And so, without proper investment into the facilities, it will be a detriment to Ontario.

MPP Andrea Hazell: And I hear you really loud and clear, and thank you for putting that on the record.

May I make a suggestion? So, all these services that you just spoke about, that are going to be impacted—maybe what you can do is actually put it into numbers. "This is how much airport public services that can go privately." Get them the specific numbers so that they can see that and understand and relate to what's happening.

Because you did a pre-budget consultation last year, correct?

Ms. Laura McNeice: We have often submitted a pre-budget consultation document. We've not been as involved with presentations, such as we're doing today.

MPP Andrea Hazell: And so how many years have you sent in submissions?

Ms. Laura McNeice: I don't know.

MPP Andrea Hazell: It's okay if you don't know.

Where I'm going with that is there's got to be some kind of action happening this time around. I'm putting it on record that, because of your physical presentation today and your submission that you're giving in, and you're going to make it more detailed to let the committee know that if there is no funding, this is what can impact the services that you're providing today. But thank you for the work that you continue to do.

My next question is you also do work in the Indigenous communities. We cannot forget about those communities, and I think that you are doing advocacy work to support cleaner energy solutions, including the propane.

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

MPP Andrea Hazell: Can you talk about the work that you're doing in the Indigenous communities, for the record?

The Chair (Mr. Ernie Hardeman): Who was the question to?

MPP Andrea Hazell: I'm still with CPA.

I think their mike is muted. I think someone's mike is muted.

I'm asking for work that you've done in Indigenous communities as well.

Ms. Laura McNeice: From AMCO?

MPP Andrea Hazell: This is for—sorry, airport management council. I'm still with airport management council, sorry.

Ms. Laura McNeice: Okay—

MPP Andrea Hazell: Not CPA.

Ms. Laura McNeice: So, we focus on airports and aerodromes, specifically, and many of them are—

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

And we now go to the government. MPP Hamid.

MPP Zee Hamid: Thanks everyone for coming and presenting. I might as well start with AMCO as well, since you were speaking. You mentioned—I mean, you gave a pretty good background on the economic impact Ontario's airports have on local communities. I was wondering if there are any upcoming legislative or regulatory changes that you're currently addressing that you want to tell us about.

Ms. Laura McNeice: Chris, would you like to take that one?

Mr. Chris Wood: Sure. I'm Chris Wood. I'm the president of AMCO and director of the region of Waterloo airport in my day job.

Look, there are many, many new legislative burdens that have been coming on airports recently—too many to actually talk about. I think that Transport Canada is going through a full review of regulations and legislations, and are responding, quite frankly, to international audits that we're trying to comply with and get in line with the rest of the world. There are so many. Fencing comes to mind, and security of non-passengers at airports. There are lots of regulations that are impacting us.

I don't know if you want more specifics. I could talk all day about regulatory burden; that is a federal jurisdiction, not provincial, obviously.

MPP Zee Hamid: Right. I wanted to understand more the full picture, the breadth of the challenges you're facing. You talked about the challenge on the capital side of things, but if you could just touch upon them for a couple of minutes—not all day, but just a couple of minutes on some specific changes that might be impacting you negatively, or positively, for that matter.

Mr. Chris Wood: I would say that there are no legislative changes that are impacting airports positively. I think it might impact the country as a whole to comply with international standards better. However, for an example, at my airport right now, the federal government is requiring us in the next week or two weeks to upgrade all of our airside fencing, which is a cost of over $2 million to upgrade fencing. They're changing the definition of "restricted area," which means the entire inside of a fence for every small airport that has scheduled service internationally. So that's one, and that's over $2 million.

This program that we are advocating for will not impact me as an airport operator. We're too big. However, we still are subsidized by the municipal taxpayer at over $6 million a year. So it's very expensive to run an airport, and especially one that has the ability to earn revenues from passenger travel. All of these airports that were talking to you today do not have that ability, so the numbers are even more dire.

MPP Zee Hamid: That's fair. Well, thank you for sharing that.

I want to go with the OPTA, Ontario public transit, for a bit. You talked about some of the challenges. Can you just talk about the economic impact of some of the issues that are facing public transit, not just yours, but in similar communities across Ontario, like small-town, rural communities?

Mr. Bill Fuerth: The economic impact right now—to speak about the economic impact, I'll be clear that I'm speaking about the impact without further financial intervention. Essentially, we have to increase property tax on the property tax base in order to cover the costs of transit operations as the costs increase but funding levels stay the same. Of course, the differential between the rise in operational costs versus current public funding coming from upper government levels—that cost differential has to be covered by the property tax base, so you see property tax increases.

If we had to shoulder the entire burden of our regional system on the property tax base, it may look something like a 1% to 1.5% increase on that tax base, which sounds small, but it obviously doesn't feel small to the average homeowner.

MPP Zee Hamid: Thank you for that.

The last question I have is for Rebecca Rudman. Thank you for coming and presenting. By the way, thanks for everything you've done throughout COVID-19 and since then. I was curious about this, but I didn't hear much about it: What has changed for your organization since the pandemic?

Ms. Rebecca Rudman: I started, co-founded—I hate to use the word "mask-making," but at the time, it was an emergency response. I want to separate that from all the controversy that happened after. But we were only intended to be a temporary response, and one of the things that made us be able to scale up so fast and make evidence-based masks is that we had partners at the University of Windsor that were doing research on our best masks, best materials, pivoting their scientific equipment. We had the city of Windsor sharing space. We had local industry participating.

Because we had all those community resources, we were able to make more than 64,000 masks and caps, which is basically one for every five or six people in Windsor-Essex, which was quite amazing. And if those institutions like the University of Windsor were not there, they wouldn't be able to help organizations like ours. So not only are they doing their regular job, like contributing to the labour force and the economy and training doctors, nurse practitioners, social workers, engineers and scientists, they're part of the public system that's a resource that, when we need it, it can pivot to meet community needs.

1000

Our organization, I guess, back to your question, is—we kind of disbanded, but I want to say we're on standby. Knock on wood that we're not ever going to need it again, but we have all the systems and procedures, the quality-control processes that we use—it's all been documented. Part of our organization's legacy is actually at the Chimczuk Museum at the city of Windsor.

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

Ms. Rebecca Rudman: We're sort of asleep and hopefully never needed again.

MPP Zee Hamid: That's incredible. That's actually really impressive, by the way.

Ms. Rebecca Rudman: Thank you.

MPP Zee Hamid: What are some of the—not "some"; we only have a minute. But what are the biggest challenges you face in your operation so, in the future, if you were to do it again, you were more aware of them?

Ms. Rebecca Rudman: I think a lot of it had to do with reaching out to the stakeholders. We didn't have an existing relationship with the hospital and the health unit, and we had to build that very quickly. But because of the research base, we were able to build that.

So, for example, we distributed masks to temporary foreign workers through the health unit and through local action groups, and they were able to hand out our masks because they were evidence-based, they were sized, they were consistent, as opposed to just some Pinterest pattern that came up. So we were able to build the credibility, which allowed us to get donors, which allowed us to have community acceptance. And so, I think—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that question, and it also concludes the time for the panel.

We want to thank everyone who participated. Thank you for the time you took to prepare and so ably come and present it to us. I'm sure it will be of great benefit to the committee.

CANADIAN PROPANE ASSOCIATION
CANADIAN MENTAL HEALTH ASSOCIATION WINDSOR-ESSEX COUNTY
ERIE SHORES FAMILY HEALTH TEAM

The Chair (Mr. Ernie Hardeman): While we're changing the panel, we will be hearing from the Canadian Propane Association board of directors, the Canadian Mental Health Association Windsor-Essex County and Erie Shores Family Health Team—if they will come forward.

As they're coming forward, we will explain you will have seven minutes to make a presentation. At six minutes, I will say, "One minute," and at seven minutes, I will say, "Thank you." With that, we also ask that each person, as you make your presentation, you introduce yourself for Hansard to make sure we can attribute the comments to the right individual.

With that, we will start by hearing from the Canadian Propane Association board of directors.

Mr. Jason Cooper: Good morning. Thank you for the invitation to participate in today's pre-budget consultation for 2025. My name is Jason Cooper. I'm the vice-chair of the board of directors for the Canadian Propane Association.

As I was preparing these remarks and thinking about this this morning, I actually thought of my grandmother, who celebrated her 90th birthday this year. The Canada that she was born into was a beautiful place, but a very harsh life. You had to store food in the root cellar and do canning just to survive the winter. And then, as I was driving in this morning and knowing the area—looking at what we can do now and how far we've progressed. We can now grow food that requires 20-degree temperature in minus-20—quite an amazing innovation. And that is due to the affordable energy that we have in Ontario and in Canada.

In Ontario, there are over 211,000 households that use propane as their main energy source, a number that has tripled since 2018. With affordability being the top issue of Ontarians here, the CPA has the following recommendations for the 2025 budget:

(1) Include propane and renewable propane in off-oil programs. The provincial government should transition current off-oil incentive programs with an eye to expanding applications to affordable and lower-emission propane energy.

(2) Eliminate the fuel tax on auto propane—the 4.3 cent-per-litre tax. Auto propane is unfairly subject to a 4.3-cent-per-litre fuel tax under Ontario's Gasoline Tax Act. The CPA proposes eliminating this tax on lower-emission energy to level the playing field for carbon-intensive automotive fuels.

(3) Encourage the development of biofuels in Ontario. The Canadian Propane Association recommends the province provide incentives through a form of production tax credits for the development of a biofuels industry here in Ontario.

Over the last year, the CPA has been meeting with representatives of the government about the importance of propane in Ontario's energy mix. The CPA would like to recognize the government of Ontario for including homeowners that heat their homes with propane in the recently announced Home Renovation Savings Program. We look forward to hearing more about the details of that program as it rolls out in the next few weeks.

With the threat of 25% tariffs coming from US President-elect Trump, I would like to take the opportunity to highlight the impact that this could have on the propane industry.

In 2024, it's estimated that 31,000 barrels of propane were exported from Ontario to the United States every day. If 25% tariffs were implemented, it would be an estimated cost to the industry of $131 million over the fiscal year.

A report by Stats Canada commissioned by Natural Resources Canada found that an affordable energy choice is a high priority for Canadians, but especially in Ontario. In fact, in areas of Canada that are off the natural gas grid, governments at all levels have been slow to encourage more affordable, low-emission energy to heat their homes, especially propane. It highlights that Canadians from all walks of life—whether they're urban or rural, earn high or low incomes, lean left or right politically—recognize that propane, as a cost-effective, lower-emission alternative to other heating fuels, is important, especially when looking at heating oil and diesel.

Propane powers homes, schools, businesses and critical services, especially in rural and remote areas, when they're

not connected to the natural gas grid. Propane is more than a backup plan, and we see that here in Leamington. We supplement and back up this food production in the greenhouse industry, which is crucial to food security in Canada. It's more than a backup plan; it is a lifeline. Heating our homes in Canada is not a choice, as we all know. Ontarians deserve affordable, reliable and lower-emission energy.

Thank you for your time.

The Chair (Mr. Ernie Hardeman): We'll now hear from the Canadian Mental Health Association, Windsor-Essex county branch.

Ms. Nicole Sbrocca: Good morning, committee members. Local MPPs, it's very nice to see you. For those of you that don't know me, my name is Nicole Sbrocca and I'm the chief executive officer of the local Canadian Mental Health Association, Windsor-Essex county branch. Thank you for the opportunity to be here with you this morning and provide some insights in terms of budget consultation.

In terms of our local branch of CMHA, we are the largest provider of community-based mental health services in our region. Our mission is to lead and advocate for specialized community mental health services with integrated primary health care.

In speaking with you today around budget considerations, I wanted to do so in the context and in alignment with Ontario Health and the five objectives within the quintupling, which includes enhanced patient experience, improving population health, provider experience, improving value and advancing health equity. We are urging the government to increase funding for primary care and mental health and addictions to meet the ever-growing needs in each of these pillars of work. I'm going to take the next few minutes to demonstrate in each of these categories with some local examples.

In terms of provider experiences, our front-line providers are reporting that they've never seen the complexities in patients that they are dealing with now. That includes 37% that are homeless, 70% that are unemployed, and those with multiple comorbidities and multi-substance use. At the same time, our staff are paid 20% less than their peers in other areas of health care, and our team does work 24 hours a day, seven days a week, at multiple locations.

We're asking teams to do more with less. We're constantly trying to squeeze as much efficiency out of our processes that we can: more quality improvement, more partnerships. But at the end of the day, it's key investments in health human resources and operations that will allow us to build capacity and evolve best practice and certainly improve provider experience.

Some stats from CMHA Windsor-Essex, in terms of our workplace feedback, highlight some scary numbers: 92% of our workforce state they feel burnt out in their job, and 60% of our workforce state that they do not feel that they are paid fairly for the work that they do. In terms of data coming out of our HR department, 60% of our 2024 resignations moved to roles in hospitals, municipalities, education or Ontario Health for salaries, and we saw a 19.3% turnover rate of our staff in 2024.

Next category: patient experience is also faltering. Our patient experience is suffering in ways of lengthy wait times on wait-lists, and in some circumstances such as supportive housing, no realistic expectation that they'll get on service.

1010

For example, the current rent for a one-bedroom unit is $1,221. In 2019, the average rent for that same unit was $874. What that means is market rents have increased 40% since 2019. Because of these cost increases and also because once we can initiate a housing support subsidy, we rarely discontinue it, we can help fewer and fewer people without us getting a bulk increase in supportive housing. So we've currently suspended placements due to funding inefficiencies.

Additionally, we have wait-lists for core programs in our agencies that serve those with the most significant needs. Coordinated access, which is our intake, has a 250% increase since this time last year. Our dual diagnosis program is also at an 150% increase, and our early intervention program for schizophrenia is at an almost 200% increase from last year.

Improving population health, the third category: These stats are certainly front and centre, and we hear these stats all the time in terms of harms related to opioid overdoses and such. We're looking at eight people every day because of a drug poisoning or overdose. Some 90% of the deceased had a mental health diagnosis; 10% of the deceased were HIV or hep-C-positive. We're also seeing increased ED visits and increased hospitalizations. Additionally, from the primary care perspective, unattached in our region sits at 21%.

Moving to the next category, improving value, my penultimate category: Even with the 5% increase from a few years ago, which we are very, very grateful to this government for supplementing us, the funding we received has decreased 21% over the last 14 years when you consider population growth and inflation. Immediately following our last round of bargaining, CMHA was faced with staffing reductions to the tune of 3% to meet our contract obligations. As we project to 2025-26, the impacts on bargaining agreements alone are anticipated to be at $362,000. So we are really struggling to manage with a lack of funding.

In terms of value-based care, we have one program, our community treatment order program, the only one in the region that has more volume than ever before, and we need more funding to support those programs.

I want to swing a positive into the conversation: We were awarded the interprofessional primary care team funding. We received that, and we are very grateful for that. The value we have seen with that investment from this government is incredible. We have attached over 200 patients. In our shelter health program, we have seen over 1,200 patients, and finally, with our mobile medical unit, we are at over 3,200 interactions with that investment. When you invest in primary care in mental health and

addictions, you will see the results and outcomes we need from a systems perspective.

Finally, wrapping up, in terms of health equity: We have the most marginalized groups in our region, those that are certainly impacted by the social determinants of health. It's our priority neighbourhoods, and we do not receive any equity dollars to do that work, so it's on the backs of our team and using the existing funding we have to accomplish that. So we are very much asking this government to think about equity dollars as well.

On the whole, when it comes to the quintuple aim of provider health, patient experience, population health, equity and value as the pillars of our work, we absolutely need funding in all of these categories to move the needle.

The good news for committee members is that we have immediate solutions available to solve some of these problems and these challenges. We have programs and expansion ready to go in each of these categorizations. We're ready to move with supportive housing. We have private housing partner staffing and a model of care that is ready and able to go. We have community clinics in partnership with acute care. We can increase support for community treatment orders, coordinated access and other clinics. We have ED diversion plans. We have plans for unattached patients, and our primary care expansion—we've seen the value of that—will continue and will expand.

CMHA is asking for an investment of $113 million for the 2025-26 budget that will ensure wage parity that I spoke to and expanded crisis centre hubs in 20 communities.

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

Ms. Nicole Sbrocca: Thank you.

We also need base funding for primary care, and the alliance, in partnership, is looking at $500 million over five years, so an $100-million ask for this upcoming budget year, and we are certainly asking to keep our IPC team funding in perpetuity.

I appreciate the opportunity today to share the challenges and needs of our communities during these dedicated consultations. Thank you very much for making the time.

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

We now go to Erie Shores Family Health Team.

Ms. Jenna Foley: Hi, everyone. Thank you so much for having me today. It's a pleasure to speak with you. My name is Jenna Foley. I am the executive director of the Erie Shores Family Health Team. We're a team of collaborative interprofessional health care providers who provide primary care services in the Leamington and Kingsville area.

We have a shared concern about the state of health care in our province today. Comprehensive primary care is the backbone of cost-effective and high-performing health systems around the world. We are constantly being called upon to do more, to alleviate acute care pressures, to support the development of Ontario health teams, to provide enhanced care when specialists are not available, and yet we are not provided the same funding that's made available to other health care providers.

Erie Shores Family Health Team is made up of people who live and work in this community. The staff include nurse practitioners, social workers, medical receptionists and many other disciplines. Their wages have been frozen by the province since 2020-21. These are highly skilled professionals providing care and support to elderly, infirmed and vulnerable patients, and these government-funded positions are leaving some staff in a situation where they need to choose between food and utilities. I know of full-time team members who are taking second and third jobs and some accessing food banks in order to make ends meet. Nurses on my team are paid much less than just across the street at the hospital, where they're doing the exact same work.

After many years of foot care programming, we're no longer able to provide those services. Our chiropodist retired in May of 2024, and it is impossible for us to recruit a replacement at the prescribed funding rate. This has a very real effect on the lives of rural Ontarians who are now forced to either pay for private foot care, to travel much longer distances, or the reality is most are choosing to forgo that care because they cannot afford either of those options. These are real-world examples of how the difficulty to retain or recruit staff is directly leading to a reduction in services.

Primary care continues to run as well is it does based on the generosity of spirit from our staff teams. We are made up of people who care about the lives of our patients, who are often also friends, neighbours and family members. The funding of this system takes advantage of that desire to help and willingness to put everyone else's needs first.

The Ontario 2025 budget is an opportunity to address these challenges. According to the Association of Family Health Teams of Ontario, our sector has a wage gap of approximately $430.9 million. Primary care is essential to reaching the goal of right care in the right place for all Ontarians, which is why there must be equity across providers. Hospital nurses received an 11% increase. Emergency medical services received 8%, and physicians received 9.95% in year 1 of a four-year agreement. If this continues, with primary care compensation being years behind other parts of health care sector, we will see increases in hospitalizations and emergency department usage as primary care will be unable to sustain care for all Ontarians. The consequences of government inaction on this wage gap are dire: service cuts, longer wait times and increased overcrowding in emergency departments and hospitals in communities across Ontario.

Since the repeal of Bill 124, the government has paid up to $7 billion in retroactive payments to public sector employees. However, health care workers in primary care have not seen any retroactive or go-forward payments since the bill was repealed. These imbalances must be resolved in order to restore the foundation upon which a strong and stable health care system can be built. With sufficient funding, our team can start immediately attach-

ing more people to primary care to help ensure the government's vision of 100% attachment in a five-year span can become a reality. We are a proud partner of the province in our common goal of right care in the right place for all Ontarians.

In addition to the undeniable need for increased funding, there are other immediate positive changes that could be made without additional expense. Family health teams currently do have funding agreements that allow effective planning. Changing from one-year agreement extensions to longer-term funding arrangements with global budgets that allow us to spend between lines as required will increase our ability to meet the needs of our teams and our respective communities. The current system of line-by-line cost recovery is a disincentive to innovative or efficient cost care delivery.

1020

In Leamington, with unique demographics that include a high percentage of new Canadians, temporary foreign workers and Low-German-speaking Mennonite populations, our needs are different than you might experience in Oxford or Waterloo or Ajax. The unique challenges posed in each community require funding models that offer flexibility to meet specific local needs. In our areas, we see a high rate of uninsured patients, pregnant mothers and the need for expensive translation language-line services that are currently unfunded. A global budget approach would help alleviate some of those concerns.

As a family health team, we are proud to work very closely with the Erie Shores HealthCare hospital. We have a formal memorandum of understanding that outlines opportunities for partnership, information-sharing, collaborative use of resources and joint organizational planning.

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

Ms. Jenna Foley: We support each other's mandates and recognize how closely our work affects the community and our respective operations.

Our health care system should not starve one side to feed another. Primary health care workers are approaching a red line where they can no longer afford to stay in the sector. The wage gap must be addressed to ensure Ontarians can continue to rely on the care that we provide.

I recognize these are not insignificant requests and there's no single quick fix for the issues that we face. We look forward to working with the government to connect the people of Leamington, Kingsville and surrounding communities with the care they need in the right place and when they need it most.

Thank you for your time.

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

We'll start the third round of questions with MPP Hazell.

MPP Andrea Hazell: So good morning—we're still in the morning, yes—good morning, everyone. Thank you for coming in and thank you all for your detailed presentations. It's much appreciated.

I want to start my question off with the Canadian Mental Health Association. Everything that you spoke about in your presentation, it is not new at all, and I'm sure it's not new to a lot of us sitting around this table. We've got 2.5 million Ontarians without a family doctor. In my riding alone, I have over 19,000.

So, I really want to look into your presentation a little bit deeper. Do you know what pops out to me? I'll ask you a couple of questions here. It's the population health that you spoke about. That is so crucial and we're not taking that into consideration. So, for the record, can you detail that for me? And I will look back on your funding ask because that is also really, really critical to your presentation today.

Ms. Nicole Sbrocca: Yes, certainly. Thank you very much for the question, MPP Hazell. The numbers that I wanted to speak to in terms of population health are related to harms related to the opiate crisis, with an average of seven people per day who are dying due to that crisis.

As of this week, the numbers that I sort of threaded through last minute that wouldn't be in the paper document—or they might be—is a new study that came out in terms of that, and what their connection to the system was. We are seeing 90% of those who die related to a substance-related toxicity death, 90% of deceased, have a mental health diagnosis. So 10% of those who are deceased were HIV- or hep-C-positive.

There is a cross-sectoral issue that's happening. We have mental health and addictions, but there are chronic diseases. This is where I wanted to speak to the comorbidities that we're seeing. The numbers coming from CMHA Ontario indicate that we are seeing a 32% multicomorbidity incidence with these clients that we're supporting from a primary health care perspective and mental health and addictions. It's not as simple as one diagnosis that we're dealing with, or sometimes you see primary care providers that say, "One complaint today." That's not how we operationalize our business, nor would that be possible.

Did that answer your question?

MPP Andrea Hazell: Yes, it does, because I know this is a very detailed presentation and you touched on a lot of topics here.

Ms. Nicole Sbrocca: I did.

MPP Andrea Hazell: But when I look at population growth, I also look at health equity inside of that as well.

Ms. Nicole Sbrocca: Absolutely.

MPP Andrea Hazell: So can you also detail that for the record?

Ms. Nicole Sbrocca: Yes. Similar to Jenna's comments in terms of the Erie Shores Family Health Team, we have some of the most marginalized community members accessing our services. A CHC, a community health centre, is the lowest-barrier access point for primary care. Our CHC, much like the family health teams, is interprofessional in nature. We have physicians, nurse practitioners, psychiatrists, massage therapy, chiropractors and therapists, so it's a one-stop shop for those that are uninsured, unattached are newcomers, are refugees.

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

Ms. Nicole Sbrocca: So they are the most marginalized group that are most impacted by the social determinants of health, and we are the agency that supports them, and we are throughout Windsor-Essex in that capacity.

MPP Andrea Hazell: I am happy that I am seeing a lot of the presentations from the health organizations actually talking about the health equities that we're experiencing, because we need to continue to bring this to the forefront.

Ms. Nicole Sbrocca: Absolutely.

MPP Andrea Hazell: In 2025, we're still dealing with that.

Ms. Nicole Sbrocca: Absolutely.

MPP Andrea Hazell: With less than a minute I have, with the $113 million that you're asking in funding, can you for the record tell me, if you do not get that funding, what's going to happen to your budget for 2025-26?

Ms. Nicole Sbrocca: So $113 million is the composition across the province: $33 million per year for four years to stabilize those staffing costs that we mentioned; $60 million for two years to operate additional supportive housing units that I mentioned; and then $20 million to expand crisis. If we do not get base increases with the expectation for our collective agreements that we are beholden to, we will be in a reduction of staff. We can't move funding envelopes, as Jenna alluded to in her presentation, so we will be in a position where we have to look at our staff.

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

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

Mr. Andrew Dowie: Thank you to our presenters, and actually, Nicole, welcome. I'm just delighted for all the work that you and the Windsor-Essex CMHA do, certainly on the partnering—well, really, you're delivering the service with the community health centre. I know you're located in the core of Windsor, where there are very, very few practitioners, so you're ideally located for that service and ultimately I look forward to seeing the city's growth, attracting more and more of those who are unattached. As well, your operating of the youth wellness hub, which—you know what? It's interesting to see how popular that site is, and actually I make a lot of referrals through my office, so I like to get the word out more and more.

So I'm hoping to dovetail in on the importance of primary care, and especially the primary care that you deliver. Because I see you operate the two services that you mentioned. There's the mobile service and the clinical service in your building on Windsor Avenue.

Do you find that the operating that you do, meeting people where they are with the mobile service, has—I guess, what kind of metrics are you seeing from that? Are you able to see more people with that funding? Because I think you've got—call it roughly the same amount for each branch: kind of 3,200 versus 221.

Ms. Nicole Sbrocca: Yes.

Mr. Andrew Dowie: So 3,200 for the mobile service, both approximately a million dollars of investment. Is that a model that you'd say is better to replicate—having a mobile service—given that you're able to see so many more people with it?

Ms. Nicole Sbrocca: Thank you for the question, MPP Dowie, and thank you for your support of our agency, certainly.

In terms of "is that a model we want to replicate," there is an interesting dichotomy with our approach. So with the IPCT funding, you're right: There's our bricks-and-mortar facility at 1400 Windsor Avenue where we attach patients—you come in, you have the physician or nurse practitioner that provides you care. With the additional investment, it was very much equity-driven for those that were unattached. So we had the arm of the mobile unit, where we are over 3,200 when I last checked count, in terms of outreach. And you're correct: There is an avenue of need for those individuals who wouldn't otherwise access primary care. So we are going to Glengarry. We are going to Pelee. We're at areas in the county—we're headed to Chez Nous. There are a lot of unique areas in our county that if we don't do that by mobile outreach, it's challenging for the providers in that space, or those individuals will wind up in the emerg. That's why those volumes are where they are. It includes anything from primary care to vaccinations etc., and we do that in partnership with Erie Shores HealthCare, so there's very much a rural footprint to that work.

1030

The other aspect of the work and why the numbers look a little bit different is because, with that investment, we have inserted primary care in the shelters right in the core of Windsor, and we're looking to expand to the county. We have primary care operating out of the Welcome Centre, the Downtown Mission, Salvation Army and H4. That is an evidence-based model that we are just seeing pop up across the province, with the importance of those that are precariously housed or experiencing homelessness having access to primary care so they don't wind up in the emergency department. We can wrap around supports. That's why the numbers look a bit different, because it's the four locations, so unique individuals look a little bit different. But there is an absolute value to that investment, that we are seeing upstream positive impacts and outcomes for our community and the broader sector.

Does that answer your question?

Mr. Andrew Dowie: Yes. I've actually got a follow-up on that one: So now, you've got the community health centre open. I know you have others that you partner with. You mentioned so many organizations in the community, and I know you partner with the other primary care providers, the Windsor Essex Community Health Centre and the family health team as examples. What further capacity gap do you think exists for the offering of that service? Because we've heard a lot about the importance of family doctors in lieu of attending to a family health team or a community health centre. We want to invest in all of it. We're investing in medical schools for family doctors. But I'm hearing this refrain more and more that the family doctor is the only legitimate option, which I don't buy; I think your primary care service is totally a

legitimate option. So I just wanted to see what your vision was for the future. How far do you think your service could be involved in primary care? What's the limit of your capacity to grow?

Ms. Nicole Sbrocca: That's an excellent question. I would say, with Dr. Jane Philpott and her role within this government, that's going to be critical to shape the future landscape of where we need to go—short, medium and long-term goals for primary care. I would say the evidence and the dollars are best invested in interprofessional primary care team options, like you see coming through family health teams through CHCs. That's where you have wraparound supports, because sometimes it's not just a prescription-based interaction or what's within the scope of practice for a medical physician, but you need a therapist or you need an RPN just for an interaction. So the way forward to get better economies of scale and scope is to leverage each of these professionals to the extent of their scope, co-locate and work in a team-based fashion.

So as much as I keep pointing to Jenna, my partner in crime here—but it's right care, right location; it's also right provider. It is going to be many professionals that come together to solve this. We are on the right track, and we very much need to continue down that road of investing in interprofessional primary care teams.

Mr. Andrew Dowie: Thanks so much for that.

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

Mr. Andrew Dowie: Okay. I'll finish off the time. Thank you very much for that.

Just a question, actually, of Jason: Down here, the use of resources is pretty important. We do have a lot of fuels with various consequences, certainly the explosion at Wheatley was something traumatic for us. Given the lessons in the last little few years, I'm wondering if you could elaborate on ways that the government could take our role, bring in a different direction that can help to protect our citizens when involving our natural resources.

Mr. Jason Cooper: Sure. Thank you very much for the question. I can only speak for the propane industry. That's my expertise. A very, very long record of safety when you look at the scale that propane is used across the province—the TSSA does an excellent job of regulating and making sure that Canadians and Ontarians are very safe. The record speaks for itself when it comes to propane—

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

We'll go to MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters here today.

I'd like to begin with you, Jason. I want to thank you for sharing the story of your grandmother, and happy belated 90th birthday to her. I was thinking of my grandfather John Penner. He came here in the early 20th century and settled in Leamington with my great-grandmother and his brothers—all four boys, shaved heads. They came over on the SS Melita. She had $5 in her pocket, and she had recently been widowed, and yet he managed to become the mayor of Leamington. I drove by my grandparents' house last night on Danforth, but unfortunately I didn't get a chance to see the Danforth Horse.

I did want to ask you about the looming threat of Trump's tariffs, which you mentioned. The Legislature isn't set to resume until March 3, and I believe over the last seven months we've only actually met for seven weeks. Do you think it would be wiser for the province to spend an additional $150 million on an election one year early, or to recall the Legislature immediately and focus on the immediate threat of economic instability and work to protect jobs and energy resources in Ontario?

Mr. Jason Cooper: Thank you for the question. For the record, I don't think any of us in this room, or probably in this country, have an idea what to do with the implications coming from President-elect Trump and the tariffs, because they are unprecedented. In Canada, we have worked as partners with the United States for as long as I have been alive, and we're so integrated in that system of partnership. How you break that apart is something that none of us have ever thought about.

To your question: Do you know what? I'm not a politician. I can't say whether we should bring the Legislature back or not, but we definitely have to work together across the board as a team to figure out how we communicate with our partners to the south, because we need to approach it as we always have: that they are our partners. I think that's the best way forward, from a non-political guy.

Mr. Terence Kernaghan: Absolutely, and the focus would be on communication, rather than sending people to an election at a time when we should be doing that communication, doing that advocacy and making sure that we're protecting our resources and our people. Thank you very much.

I would like to now turn over to Nicole. So many people in Leamington don't have a primary care practitioner. I think about my father-in-law, who for quite some time had great difficulty receiving the health care that he deserved.

I did want to speak particularly about housing, because I believe one of your recommendations is for that housing with supports, those wrap-around supports that we hear about. The province used to have a historic responsibility to build and provide affordable housing and supportive housing. Unfortunately, this government has called the direct funding of housing construction, especially affordable co-op and nonprofit housing—they called it "communism." Instead of recognizing its responsibility, they have devolved into name-calling instead of implementing plans to build.

Would you like to see the government finally admit it has a social, moral and fiscal responsibility to provide affordable housing and supportive housing?

Ms. Nicole Sbrocca: I mean, that's a—from a non-political person—although in these positions, I'm going to steal your phraseology there. I think from a health care lens, it's housing first. If we do not have housing for those clients who need us most, I can't provide therapy for mental health and addictions. I can't provide primary care if these individuals have no place to go. So what I can tell

you is that we very much subscribe to and support the notion of housing first. Above all else, we need to ensure people have a safe place to go home to that they call their own, and then the rest we can figure out. That's how excellent this system is and how nimble we can make it.

I suppose that's not necessarily the particulars that you're looking for, but what I can tell you is the evidence base, from a health care lens, is that housing first is the way to go. And we need to get ourselves there by multifactorial approaches and a number of different avenues and streams.

Mr. Terence Kernaghan: Absolutely. Well, housing is a social determinant of health—

Ms. Nicole Sbrocca: It absolutely is.

Mr. Terence Kernaghan: —and without that foundation, not much else really matters. When we see health care institutions investing in housing, because they realize their high-frequency clients are the ones who desperately need that foundational support, first and foremost, it's a very interesting model.

I want to now turn over to Jenna. Jenna, I think your comments about the current funding models where one side is starved to feed another really had quite an impact. This government and this committee have heard year after year about the dire impact of their reluctance—actually, it's not reluctance, it's refusal to pay health care workers fairly. They've heard about the struggles that health care workers face, and I want to thank you for bringing their voices forward about having to visit food banks, taking second and third jobs. That also goes to you as well, Nicole.

1040

But I did want to ask, what impact does that have on your workers when the province outright refuses to pay them fairly? What's the impact on morale?

Ms. Jenna Foley: I think over the last four years—five years now, 2025—there's been just a continual downturn in morale overall in the health care sector. Obviously, it started with COVID-19 when people were asked to step up in unprecedented ways and provide a level of support for our community that we hadn't anticipated. I think that, across the board, our health care system showed that they were ready and willing to do that. All of our staff came to the table. I certainly don't begrudge any of the hospital increases that they've received. I think they were well-earned.

So I think that, to my point, it's about fairness. I sit across the street—our office is literally right across the street from the hospital. My staff could walk across the road and go in the door and start making $10 an hour more immediately. It's not just the hourly rate; it's also the benefits.

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

Ms. Jenna Foley: Whereas I provide an RRSP contribution, the hospital also provides a HOOPP pension. I've run the math, and it would cost me $100,000 a year to offer my staff the same benefits that they would receive at the hospital, which we're not funded for. It makes it very difficult.

Our staff do struggle with morale. Like I said, they do this job because they love the patients who they work with. They feel deeply committed to providing that ongoing care. There is a sense that, if they were to leave for the hospital or for other jobs, they would be abandoning them because, quite frankly, it would be difficult for me to recruit other staff to replace them. So we're at a crossroads right now where this is make or break. We are really looking at the potential of, like Nicole mentioned, greatly reduced services as our staff teams decrease without an ability to replace those people.

Mr. Terence Kernaghan: Thank you very much for bringing the voices of health care workers forward. I hope the government will finally listen.

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

We'll now go to MPP Hazell.

MPP Andrea Hazell: My question is going to be for Erie Shores Family Health Team. Jenna, you spoke so passionately about the repeal of Bill 124 that just happened in February of 2023, I think. Talk to me about the impact that this had on your human resources management system.

Ms. Jenna Foley: I think a number of different sectors and groups were affected by Bill 124. As I mentioned, during the COVID pandemic, we were expected to step up and respond in unprecedented ways. At the same time, we were being told that there was no additional funding to be made available to anyone, which, for some people, felt like a slap in the face—to come and expect us to put our lives on the line everyday at work and to not respect or recognize that contribution that's being made. I think, since we've seen that bill repealed, there's been a recognition that that was not the way to go. As I've mentioned, there have been a number of groups who have had arbitrated settlements now as a result.

I think what I want to point out for this committee is the liability that the province faces in not providing that wage compensation to all groups. I think where we've had those awards made—I don't want to say we would require the same level of funding. I think that primary health care would be happy to see a number that's fair. I don't think anybody in the primary health care sector is looking to get more than anyone else. I don't think anybody sees what someone else is getting and begrudges them a dime. But I do think that there is an issue of fairness and an issue of being respected. I do think that it's coming to a point where there might be further steps taken.

Really, we just want to be a good partner. We want to work with the province. We want to make sure that we're helping Ontarians receive the right care when they need it, where they need it.

MPP Andrea Hazell: Coming after COVID, we talk about our front-line staff as our front-line heroes. But that's not the message that we're giving to our front-line staff at this time, or even the hospitals. But can you bring it down to maybe two or three points of speaking about your pain points for your organization? What are they? Because it is so broad in the health care industry. But for

your organization, what are one, two, three pain points you are experiencing right now?

Ms. Jenna Foley: Number one, I'm going to tell you, is wages. Like I mentioned, the rates were set by the province—we have a salary grid that was provided to us directly by the province, and when those rates were set, they were already low. So although I mentioned our wages have been frozen since 2020-21, they were set at the 2017 levels, so our staff in 2025 are being paid wages at the 2017 levels.

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

Ms. Jenna Foley: I looked at minimum wage, which I absolutely agree needed to go up, but since that time, minimum wage has increased 22% and we have not provided any increase to these staff. And to that point, I mentioned second and third jobs; I have staff who are leaving medical professional positions to work in fast food and to work in retail where they can make similar-level hourly wages with much less stress, where they don't need to take that work home to them.

Wages are one, benefits are another, and then that directly affects recruitment and retention. When I don't have the bodies I need for the jobs that need to be done, it means a reduction in services, it means longer wait times for patients, it means less variety in the supports that we're able to offer to the community.

MPP Andrea Hazell: Where do you see your organization in 2025-26?

Ms. Jenna Foley: I see us growing and working. There is so much need that exists in the community—

MPP Andrea Hazell: Absolutely.

Ms. Jenna Foley: —and we are ready and willing to step in and provide that level of support, but we can't do it without additional funding from the province.

MPP Andrea Hazell: Don't give up. Keep fighting. Keep fighting.

Ms. Jenna Foley: Thank you very much. I will.

MPP Andrea Hazell: You keep fighting. You cannot stop. We need you.

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

We'll now go to MPP Smith.

Mr. Dave Smith: Jason, I'd like to start with you, if I could, please. You mentioned there were over 200,000 people or so in Ontario who are heated by propane. As I look around, my riding is the most northern riding that's represented here. In the top-five cities population-wise—that's Toronto, Ottawa, Hamilton, Kitchener and London—it's about eight million people. Can you give me an estimate of how many are going to be on propane in those urban centres?

Mr. Jason Cooper: In urban centres, very little, because there is natural gas infrastructure. What often gets forgotten—like I mentioned, here, just around this centre, that's all natural gas. There is a massive amount of propane that is backing up and supplementing the natural gas infrastructure for the greenhouses. The same goes for our hospitals: A lot of our hospitals have propane backup systems to make sure that when the power goes out, they have secure power backup.

Now, you take that out into the rural communities up north where there will never be a natural gas infrastructure because of the geography, propane is absolutely the next best and most affordable option for people, and when you talk about rural and remote areas, for power generation, for all those other infrastructure needs, it is the go-to fuel.

Mr. Dave Smith: I mentioned those communities because it's eight million people and the total geographic size is smaller than my riding by about 100 square kilometres. The Canadian Shield starts in my riding, so we can't run natural gas to probably 90% of the riding because it's just not effective to run a pipeline through granite. There's a problem drilling—

Mr. Jason Cooper: Very difficult. Very difficult.

Mr. Dave Smith: It's not cost-effective and I don't think we really want to have the piping on top of it.

You asked, then, could we include propane in the programs that are off oil? Oil, wood pellets—those are very predominant in the northern part of my riding, and electrical heat is as well. I'm in an area where it is possible to get heat pumps, but there are a significant number of days per year where they are not effective because of the colder temperatures. And I'm really not that far north. Everyone who lives south of the 401 says that they're going up north when they come to my riding, but anybody who is north of the French River talks about going down south to my riding, so I'm kind of in that no man's land.

If we were to include propane in the off-oil offerings, what kind of cost savings do you think there would be for the average person who's currently heating by oil right now?

Mr. Jason Cooper: Propane offers a bunch of benefits there—almost half, and that's just the heating cost. When you bring propane onto a site to power a propane furnace, for instance, now you have an energy source on site that can be used for electric backup, for a backup generator. For rural communities, that's a huge, huge need. You're far away from emergency services. You're far away from a lot. When you have propane on site, now you can have electrical backup, taking stress off the grid. You can add all those other appliances in the home that you would—same thing you would do with natural gas, you can do with propane.

1050

To your point: As a backup to heat pump, it is the go-to. It is the only way you should do that, because if you back up with electric resistance, which is very common—imagine if we took everyone that was on propane and on any other fuel source, fuel oil, diesel, and put them on the grid tomorrow. We can't do that; we can't handle that and it's going to stress our grid over the limit. That's what will happen if we change everybody over to heat pumps with electric resistance backup.

If you have the propane backup, it actually does the opposite. We now can take stress off the grid when it gets too cold for the heat pump to operate and allow that homeowner to continue to heat their home efficiently and

do all those things, but not stress our grid in the time that it would be most vulnerable. So they'll go to backup, for sure, for heat pumps.

Mr. Dave Smith: Thank you—appreciate that.

Chair, how much time is left?

The Chair (Mr. Ernie Hardeman): Three.

Mr. Dave Smith: I'll do one more and then I'll pass it on to one of my colleagues.

To CMHA: Did your area apply for a HART hub?

Ms. Nicole Sbrocca: Our area did apply for a HART hub, yes.

Mr. Dave Smith: Are you part of that application?

Ms. Nicole Sbrocca: We are part of that application, yes. We sort of have a small role in it, but certainly what I can say about the mental health and addictions sector in our region is that we certainly come together for those sorts of initiatives. So yes, we are working with the team.

Mr. Dave Smith: Okay. One of the things that I've seen with the HART hub concept and with some of the applications that have come in is that, really, this is the first time it has been cross-sections, I guess, is the best way to describe it, where we have mental health, we have addictions, we have supportive housing, we have other services. I know that there are applications in where E Fry and John Howard Society are also included, when we're looking at someone who was previously incarcerated—this being part of it.

In your experience so far in your working career, has there ever been a program that has been across sectors so much like that?

Ms. Nicole Sbrocca: That's a great question. I come from the cancer sector, and I also have experience in medical education, so I spent a number of years at Schulich medical education and with Cancer Care Ontario in my past capacity.

I think there are certainly parallels, from a health care lens, where it takes an intersectoral team of individuals to move the needle when it comes to outcomes for Ontarians—maybe not to this degree, because I can't imagine, for those that are experiencing homelessness and substance use issues that need so many social services—so we're talking health care, housing, Ontario Works, disability. It's just sort of certainly high needs.

I'm probably not answering your question the way you want me to. I think there are parallels—probably not to this extent, by virtue of the patient and client population that we're dealing with. Is that a fair answer?

Mr. Dave Smith: Thank you. That's fair.

I'll turn it over to MPP Anand.

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

Mr. Deepak Anand: Thank you so much to all the presenters for coming. I always appreciate taking time and advocating on behalf of your community and your organization.

I'm quickly going to talk to the Community Living—no, the Erie Shores Family Health Team.

Ms. Jenna Foley: I used to work for Community Living.

Mr. Deepak Anand: Perfect, so you have both the experiences. No, I'm going to leave it to the next set of teams, but technology, talking about technology—we are in 2025 now, I think. Well, we're still using faxes.

Ms. Jenna Foley: That's part of the privacy legislation, because faxes aren't considered—for example, emails are not considered part of the—we'd have to put them all on the record.

Mr. Deepak Anand: So that's my question. We were in Ottawa and one of the presenters was talking about, "We are having a labour issue, but then we have a"—

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

We'll now go to the opposition. MPP Gretzky.

MPP Lisa Gretzky: I know some of the folks at the table, but for those that don't know me, I'm Lisa Gretzky. I'm the MPP for Windsor West, and CMHA is the heart of my riding and our community. We are basically neighbours because I live downtown, some would say kind of in the ground zero of the mental health and addictions crisis that we are seeing in our region.

I have a question for Nicole. You talked about the comorbidities that you see. I believe you referenced the number of clients or patients that you see that are coming in with hepatitis, HIV. Can you tell me CHMA's view on harm reduction and the importance of—or what role harm reduction and consumption and treatment services play within the broader spectrum of care?

Ms. Nicole Sbrocca: Thanks for that question, MPP Gretzky. Harm reduction is certainly an evidence-based form of practice in the mental health and addictions sector. We work closely with our weCHC partners, and they certainly support the hep C outreach team. So we work closely with them on a number of our mobile outreach—a number of our locally driven population health models. So harm reduction is an important aspect of the work we do that has a very strong evidence base.

I can give you some numbers. We ran some health fairs recently out of our Glengarry complexes in the core of the city we're looking to expand outwards, and the number of harm reduction kits, referrals and counselling that happen by way of that outreach into those communities was quite substantial.

Working with public health in that regard has also been very important. An aspect to the work we do is certainly safeguarding our clients, our patients, and that is one core component of it.

MPP Lisa Gretzky: Thank you. I personally have a concern, and I know others within the addictions treatment realm have concerns, that the understanding is that with HART hubs, there will not be clean supplies provided and that it is more of an abstinence-based model. Many organizations have moved away from that to the harm reduction, or meeting people where they're at. So, I and many others have concerns about the fact that people will not have that access to clean supplies and we are going to see an even greater increase in HIV and hepatitis in our community and other communities around the province.

This one is both for Nicole and for Jenna, and I will probably ask Karen from Community Living Essex a similar question, although I think I already know the answer. You've talked a lot about pay and how that impacts your ability to attract and retain staff, and some of the pay inequities that we see throughout the health care sector in general.

Again, I'm going to reference Karen—when you talked about developmental services. I'm sure we're going to hear the same thing.

I was talking to education workers yesterday who will tell you that for the support staff—so for EAs, ECEs, therapists that are employed by school boards—it's the same thing. It's hard to retain them, because the job is becoming more and more difficult because of the lack of community supports, and that is certainly not a slight on you. It's when you don't have the funding, you can't provide the services. The needs then often spill over into schools and other areas, justice system.

I'm wondering, specifically—it seems to be fairly common thinking that within the health care realm, especially when you're talking about nurses and other front-line workers, that those jobs are mostly women-led positions. Am I correct?

Ms. Jenna Foley: That's correct.

Ms. Nicole Sbrocca: Yes, that's correct.

MPP Lisa Gretzky: And I just want to point out for the record and for the members on the opposite side, the same would hold true in developmental services and in the education sector. So, I think we have not only an equity issue when you look from one workplace to another, but when you specifically look at the makeup of those workplaces, women-led professions predominantly face even greater pay equity issues. As a result, we are seeing more and more of those workers accessing food banks. We have seen an increase not only in food bank usage but the number of community providers. I was at the West Indian association last night, who have their own little pop-up food bank within their own organization. I would again ask the government to look at the makeup of these workplaces and not only ensure that they have pay equity with other workplaces but that you are not further harming the economic abilities of women to thrive around the province.

1100

I guess I want to talk again about housing and the importance of housing. Nicole, I believe you said the average rent for a one-bedroom is about $1,200 a month. How many clients of yours would you say are on Ontario Works or ODSP that are accessing services, whether that's through the mobile units or—

Ms. Nicole Sbrocca: I would say the number sits around 70%—I'm going provincial numbers there—that access our services. I would say of those with supportive housing, of which we have 300 or so clients, nearly 100% of them are Ontario Works or Ontario disability.

MPP Lisa Gretzky: So they would have difficulty obtaining housing when an apartment is $1,200 a month and ODSP—the average, I believe, is about $1,300.

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

Ms. Nicole Sbrocca: In the absence of subsidy, that's correct. That's right.

MPP Lisa Gretzky: Thank you.

Supportive housing: Have you seen any real increases in the new builds or maintenance funding for the current stock of supportive housing?

Ms. Nicole Sbrocca: No. Ours is predominantly private. We work with the private, for-profit, so we build landlord relationships, if that's what you're asking, MPP Gretzky. We have landlord relationships where our team supports maintenance of the unit. We support supportive housing in terms of the client's well-being. It's goal-oriented, goal-focused. We drive them to get groceries. If there are issues in the building, we support them. So they have that whole agency that backs up the success of them in a housing environment. That's why supportive housing is so helpful to these individuals that need it.

Our team, our case managers in supportive housing do everything for their health care needs, to be successful at other—

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

Thank you all very much for the time you took to prepare to come here and ably present the presentation. I'm sure it will be of great assistance.

COMMUNITY LIVING ESSEX COUNTY
CHATHAM-KENT HOME BUILDERS' ASSOCIATION
THE SALVATION ARMY WINDSOR CENTRE OF HOPE

The Chair (Mr. Ernie Hardeman): With that, our next panel is Community Living Essex County, Chatham-Kent Home Builders' Association, and the Salvation Army of Canada's Windsor Centre of Hope.

As they're coming forward, as with others, each presenter will have seven minutes to make their presentation. At the end of the six minutes, I will say, "One minute." Don't stop, because you only have one minute left to get your punchline in because when I say, "Thank you," the microphone goes off.

With that, we also ask that as you start your presentation, make sure to identify yourself so Hansard can get the right name to the right presentation.

With that, we will start with Community Living Essex County.

Ms. Karen Bolger: Good morning. My name is Karen Bolger and I'm the executive director of Community Living Essex County. Thank you for the opportunity to participate in the 2025 pre-budget consultations.

Our agency is a not-for-profit charitable corporation supporting over 700 children, youth and adults with intellectual disabilities and their families right across Essex county. We are the largest developmental service provider in Ontario's west region. We offer a variety of

supports and services delivered by direct support workers, DSWs, members of CUPE Local 3137. Our supports are individualized and person-directed to each person's unique goals and support needs. Funding for our agency comes from the Ministry of Children, Community and Social Services, donations, and well-established fundraising events. Community Living Essex County's recommendations with rationale will follow for your consideration.

To fulfill the Ministry of Children, Community and Social Services Journey to Belonging developmental service sector reform plan, the Ontario government must commit to sustainable annual base funding increases for developmental service providers. The ministry's reform plan, Journey to Belonging, envisions people with developmental disabilities being supported by their community, support networks and government to belong and live inclusive lives. Service providers are committed to this vision, but we face a persistent shortage of critical resources. Over the past 30 years, base funding for developmental organizations has increased less than 7%, which includes roughly a 3% increase in the 2024 provincial budget—which we appreciated immensely, but the cost of living has risen nearly 70% over that time period.

It's critical that sustainable annual base funding increases are implemented to address systemic challenges, reduce the wait-list for people and ensure people with disabilities can access the support that they need to live inclusive and fulfilling lives as envisioned in the Ontario government's Journey to Belonging reform plan.

We are doing our part. I'm just going to describe three simple ways our agency is contributing to solutions by leveraging technology.

For many years we've offered Smart Support Technology Enabled Services. It's an innovative approach to adopting common technology options to empower people supported. Using a person-directed approach to assess, engage and plan, our agency ensures that the technology that people use aligns with each person's unique goals and choices and helps them to gain greater independence, enhancing their health and well-being. It also results in some efficiencies for our agency in our service delivery.

Secondly, our agency saw the need to support our sector in transformational reform by creating Real Xchange. It's a free online platform to gather and share information, proven strategies, resources and collaboration with service providers to best support people with intellectual disabilities. We have 2,600 users across the province in the developmental service sector and beyond, which helps other agencies to create some efficiencies while improving outcomes for the people that they serve.

Lastly, our agency recognized the possibilities of AI. Our agency undertook a risk-benefit analysis concluding that AI was safe to adopt within parameters contingent on the completion of a comprehensive employee training. Its implementation has significantly enhanced efficiency in both support delivery and business operations.

All this is just to say that we are not waiting for a government handout. Rather, we continue and we come to the table with viable working solutions but are asking for the government to do its part.

Developmental Services Ontario in the southwest region: In November 2024, the wait-list report for Windsor-Essex county reported 1,029 new intakes so far in the 2024 fiscal year. That was after just three quarters. The DSO in the southwest region is outpacing all other intakes for the 18-to-24-year-old age group, and many of the people who are seeking support have multiple complex needs, including significant mental health and addiction struggles. Ontario's developmental services wait-list has increased by 2,000 people since just September of 2024, raising it to 52,000 people. Without government investment, the wait-list will continue to grow, and the vision of Journey to Belonging will not be realized.

Every day, people, their support networks and developmental service sector agencies are falling into crisis because of (a) a lack of economic and social resources, and (b) they're unable to access needed services and supports. In light of these issues, Community Living Essex County is making the following recommendations for the 2025 provincial budget:

—commit to sustainable annual increases to developmental service agencies' base funding;

—provide full Passport allocations to all people eligible for the program;

—following the recent increases to the ODSP basic needs and shelter amounts, tie all ODSP benefits, including personal needs allowance and Special Diet Allowance, to inflation as well; and

—commit to a zero clawback of the Canada Disability Benefit from people receiving ODSP.

If these are implemented, our recommendation will help to offset historical underfunding, increase the developmental services sector's ability to manage the ongoing human resource crisis and provide additional stability and safety for people who have an intellectual disability. Thank you.

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

We now go to the Chatham-Kent Home Builders' Association.

Mr. Dan Van Moorsel: Hi, everyone. Thank you very much for taking the time. My name is Dan Van Moorsel.

MPP Hardeman, we sat in the office together on a Day on the Hill in the past, and I've always appreciated your time. We've been working on this—or I've been involved in this—since 2006. We're really starting to gain some ground in this space. I'm hoping that, through maybe this, some of these key messages will help strengthen and streamline the process in government when it comes to development.

Again, my name is Dan Van Moorsel, executive officer of the Chatham-Kent Home Builders' Association. Our parent organization, obviously, is the Ontario Home Builders' Association. I really appreciate the opportunity to speak with you today.

I have four key messages that I'd like to leave with you today. Our goal is to build 1.5 million homes over the next

10 years, and we need a coordinated effort between the federal government, the provincial government and our local municipalities and cities, as well as our members. We all have a role to play, and by working together we can be successful. We need a consistent and stable regulatory and policy environment.

1110

The planning and permitting process across Ontario has become a patchwork of rules and demands as each of the 444 municipalities impose their own set of studies, submission requirements and time frames, often above and beyond what's legislated. The lack of consistency in the development process hampers our ability to build at the scale that's required. Our members want to build homes that families can afford, and the province can help this by streamlining the approvals process and ensuring its consistency and effectiveness across the province.

Access to infrastructure and servicing allocation that supports the construction of new housing is one of the main impediments to building. The province has taken steps to prioritize construction of housing and its supportive infrastructure, such as sewage and water mains, but this effort needs to be maintained and enhanced.

Increasingly, funding for new infrastructure in a municipality is paid for by developmental charges, and I'm sure that anyone paying attention knows that developmental charges across the province is a very big hot button. Over the last 10 years, we have seen an exponential growth in DCs as they have become the municipalities' preferred choice to fund infrastructure. Government fees and taxes, with DCs being the largest component, now represent over 30% of the price of a new home. There's an urgent need for the province and municipalities to look at new ways to fund growth-supported infrastructure without putting the heavy tax burden on new home buyers.

Further to the recommendations as focused on DC growth, I'll provide you with an example. One of the projects listed most recently in the Chatham-Kent DC study is called the Highway 40 bypass. This will connect the 401 in Chatham, right around Kent Bridge, to north of Wallaceburg, where the 40 highway begins to work its way towards Sarnia. This project has been in the last three DC studies, estimated at $77 million in their most recent one, yet we're nowhere close to this project becoming a reality. Our municipality has been collecting these DC dollars for almost 20 years for this project, yet we have not seen a fund where the money is sitting for this allocated project.

We're trying to create more affordable housing, and the question must be asked as to why we're putting a large portion of the burden of this project on new home buyers in Chatham-Kent. There's no authority that can say, "Hey, wait a minute: That's an unreasonable expense to new home buyers that's not directly tied to growth." And then other than the Chatham-Kent Home Builders' Association going to the Ontario Land Tribunal most recently to battle to have our DC charges reduced because of such projects like this in our list, there's no accountability for them. The municipality drops them in, a group does a study—it's the same group that does every study in this province. Their name is not coming to me handily. They put it in and they come up with a calculation, and this is now your new DC charge, with zero negotiation. We found out as it was passed through council.

Now, while the municipality is collecting money for this pool, it can actually borrow those funds and spend it on other capital projects, which then causes shortfalls in projects within that DC scope, often pushing these projects, like the 40 bypass, into the next DC study cycle. Furthermore, the municipality has no obligation to pay back those funds towards that project; only to keep record of where the money's gone from project to project.

With that, I will say thank you for your time. Oh, actually, I've got one little thing that came up, and I still kind of have a minute and a half. But it came up as I listened to the people beforehand about the challenges with finding homes for the unhoused. With the accelerator fund that we have received, Chatham-Kent has received $440,000 on that build-homes-faster fund. The municipality has taken that money with our support and now is building a 50-unit, small-home community to begin to at least make an effort to find places for the unhoused where they can begin to try and flourish and do the things that people are talking about, about gaining some independence. Understanding, working with the building community and the developer community can really enhance a community in ways that we don't even think it can.

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

Mr. Dan Van Moorsel: Now, I'll get to that.

With that, I say thank you for your time. Hopefully you can see that the value in streamlining and planning these permitting processes within the different levels of government is a key pillar to creating more affordable houses and more affordable housing choices.

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

We now will hear from the Salvation Army of Canada's Windsor Centre of Hope. This one is virtual.

Ms. Marwa Al-Sahar: Thank you, everyone. My name is Marwa. I'm the residential program manager at the Salvation Army. I've been with the Salvation Army for four years. I'm going to talk about the programs that I oversee, which are the internal services for our clients. I manage the emergency shelter program, which is the permanent living for clients who are in need of a temporary home until they reach their goal to get permanent housing. I do manage the supportive housing program, which is to help our clients who permanently live at our estates.

For our shelter program, we do have 16 rooms. We get two clients per room every night, so we do have a total of 32 clients. These clients get to stay with us, and they get their immediate and basic needs, such as three meals a day. They get to have access to a shower service, and then they also have a free laundry facility at our place. Those clients get to meet with our social workers/housing workers who will be with them through their journey of searching for

housing, connect them with community resources and hopefully food and furniture resources as well.

Moving to the supportive housing program, which is the program that our clients benefit from by staying permanently at our place: Our clients, again, get their immediate and basic needs such as meals, laundry. We do have our personal support workers who oversee their files, connect them to the community meals, administer their medication to them, connect them to medical services in addition to transportation services.

Now, these are basic internal services. The one internal/external service that we have for both clients is the medical team that we have at the Salvation Army—a collaboration between the city of Windsor, University of Windsor, CMHA and the Salvation Army—which is a medical team that comes to our shelter, and they've been with us for almost nine months. During that program, clients get to benefit from having immediate and fast access to medical supports.

We do have two doctors who come every week. As all of you know, we do have a huge shortage of family doctors, so this is helping our clients to see a doctor right when they need. It is in our facility, so clients don't have to pay for transportation or take the bus or pay for a ticket to reach a doctor to help them with their medical needs. Clients are also very comfortable with talking to these doctors, because it's the same person; they're open with them, and they're comfortable to share medical needs with them. In addition to that, we do have our chaplain, who helps the client with counselling and, hopefully, spiritual counselling when the client needs, to help them with their well-being.

Moving to our external services—

Ms. Maha Salem: Hello. My name is Maha, and I'm the outreach program manager at the Salvation Army. I'll be focusing on some of the external services that we provide at the Salvation Army.

Our centre provides essential support to those in need. We run a few food security programs, including the food bank, which opens three days a week. We also have community meals every Thursday where we provide warm meals to the community. We also have our soap-with-hope program, which offers community members a safe place to enjoy a hot shower every morning every weekday, as well.

In addition to this program, our outreach department, which I oversee, plays a vital role in addressing the challenges faced by individuals in our communities, and families as well. We provide a range of services, including assisting people experiencing homelessness with obtaining a fee waiver for birth certificates. So anyone who has any troubles with getting their birth certificates, which causes lots of barriers—for example, getting their bank cards, getting any form of ID—we provide a fee waiver service to get that. We also help clients apply for affordable electricity bills through the Ontario Electricity Support Program. We also offer income tax services to those in need.

1120

One of our most impactful initiatives is the Pathway of Hope program, which uses a one-on-one case management approach. Through this program, we are able to work with clients for a longer time. We have two caseworkers who work one-on-one from six months to a year, to help clients set and achieve meaningful goals that could help them become self-sufficient in the future. We help pursue goals such as employment, education, housing goals, anything like getting a family doctor, securing child care and many other goals as well, just to help them be able to grow in the community and be able to fend for themselves.

In the last year alone, our two caseworkers under the Pathway of Hope program, which is the longer-term program, were able to serve 33 clients. In the outreach program in total, we were able to serve around 600 clients in the last year, and that's just the two caseworkers, while performing many other services.

Despite this, our demand for our program continues to grow. We are eager to expand and reach a few more people in need in the Windsor community, which is why we're requesting funding for an additional caseworker who could help in the Pathway of Hope program, but also in the outreach department. This funding would be able to enable us to help clients by providing more—

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

Ms. Maha Salem: Oh, one minute? Sorry.

This funding would be able to provide us more service to clients and provide individualized supports in creating a long, positive impact for individuals and families across our community.

So just to kind of summarize, we provide many different programs within the Salvation Army to clients, ranging from housing to food security, but also many goals that we can help with. We'd be using this funding to assist clients in becoming self-sufficient, which is why we believe this will allow us to create a stronger, more resilient Windsor community.

Thank you for your time and consideration. That's all we have for today.

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

We will now start the questions. MPP Leardi.

Mr. Anthony Leardi: I want to thank all the presenters for being here today. I especially want to thank Ms. Bolger. She's from the town of Amherstburg, my hometown. It's always a pleasure to see you again, Ms. Bolger.

I'm going to concentrate my questions on Community Living Essex. I have a series of questions. I want to perhaps provide more information to the panel here today about what Community Living Essex does, who works for Community Living Essex and, specifically, recruitment issues. Let's start with some very simple questions. There is something called a PSW and something called a DSW. Ms. Bolger, could you tell us what those are and tell us the difference between them?

Ms. Karen Bolger: A PSW is a personal support worker. Personal support workers typically work in long-term-care homes. They provide personal care to people.

Their education that they require for that is often an eight-month community college or private college program.

DSW, developmental service worker, is a college certificate program. It's a two-year program. It's focused on specifically working with people with intellectual disabilities. The focus of that work is on pharmacology, inclusion, belonging, behavioural supports, mental health issues, transitions from children services to adult services, working with families in their own homes, working within organizations.

So the scope of the education, training and field placements of a DSW is quite different than a PSW. DSW is the preferred education, training and background to work with people with intellectual disabilities, because it's quite focused.

Mr. Anthony Leardi: And I've had the pleasure of meeting a lot of your employees, a lot of your DSWs. Recently there was a wonderful celebration for somebody who had worked for your organization for 40 years—a fantastic record of service.

And that's one of the great things about working for your organization, right? You get to work with people in your own hometown. They might be your friends. They might even be your family members. Tell us a little bit about the people who work for you and why they like working for Community Living so much.

Ms. Karen Bolger: Our agency currently employs almost 700 employees. Pre-pandemic, we had over 750 employees, so we are still struggling to get back to those pre-pandemic numbers, but I can talk about that later.

Our employees typically have DSW education, or they have social service education or background—university or college. Our employees work in 24/7 operations, so they work days, afternoons, overnights; they work weekends. I believe that people who work for our organization—we have longevity typically with our employees. We used to have quite a bit of longevity with our employees because they really see the value in the work that they do. It's varied. They wear different hats every day. They may be helping somebody who lives in a small group living home that requires 24-hour supports. They may be helping someone who lives on their own who requires minimal supports—just to go to the bank, to help them do groceries, to help coordinate medical appointments, those kinds of things. We have people who help people to find competitive employment within their communities. We have people who provide out-of-home and in-home respite supports for people who live at home with their families as well. We provide a wide range of supports and services to children, youth and adults.

For our region in particular, the tri-county region, we provide enhanced specialized services through a clinical service provider, regional support associates, to provide treatment, a safe space and in-home support services to people who have significant behavioural and mental health challenges as well.

Mr. Anthony Leardi: Now, with regard to recruiting more people, there were recently-made changes to the international student—I don't know what the proper word is, but the number of international students that would be available in the province of Ontario.

Ms. Karen Bolger: Yes.

Mr. Anthony Leardi: Have those changes had any impact on your organizations? And if so, what impact has it had?

Ms. Karen Bolger: At this point—that legislation was overturned in December, so DSWs are now as of—I believe it was the 22nd of December; it could have been the 17th. They are once again included in the CIP, so they are once again included in the professions that are considered occupations that have long-term difficulty in recruiting and maintaining—so they're back in. That would have had huge impacts, because right now the majority of the students going through the DSW program are international students.

Mr. Anthony Leardi: As far as your recruitment is concerned, I'm sure that you recruit mostly from nearby colleges. Can you give us a breakdown—just an approximation—of who comes from where?

Ms. Karen Bolger: Right now, the DSW program is only through St. Clair College in Chatham. That program is in our area; it's in London and through Loyalist College online. I don't want to give incorrect numbers, but there are very few and the numbers are getting less and less, going through the DSW program through Chatham and through Community Living Chatham, Community Living Windsor, Community Living Essex County, Community Living Wallaceburg and everywhere in between. We're all fighting for the same 60 people that are graduating every year, so it's really difficult.

We often recruit from other programs at the college and university as well—the disability studies program, police foundations program. Often, we will hire students who are at least in their second year. We provide them training, education, and we are able to utilize their skills as well, generally for the short term—a couple of years. We find that our DSW graduates are the ones that are really choosing working with people with intellectual disabilities as their career of choice.

Mr. Anthony Leardi: If we can squeeze it in, with regard to the difference between DSW and PSW, is there a benefit at the college between those two?

Ms. Karen Bolger: An incentive?

Mr. Anthony Leardi: Yes.

Ms. Karen Bolger: Absolutely, there is. I've spoken with you and MPP Dowie before about it as well, and I've also spoken with Lisa about it—is there is a discrepancy. I don't begrudge PSWs the incentives that they're getting, because long-term care requires employees just as we do. However, they're being incentivized. Health is being incentivized. The DSW program—

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll have to finish that next round.

1130

MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to our presenters here in person, as well as those who have tuned in virtually.

I'd like to being with Dan with the Chatham-Kent Home Builders' Association. I want to thank you for your comments about how the government and builders can work together. The opposition call for that very thing with Homes Ontario. The government could work alongside builders, non-profits, co-ops and municipal partners. Unfortunately, the government voted against getting those shovels in the ground.

We see some very disturbing numbers in front of us. The government has missed its own housing targets every single month since they were set in February 2022. That's almost three years of failure.

I wanted to point out that Tom Parkin was looking at StatsCan numbers and showed that Ontario is losing $20 billion of investment because of this failure. He points out BC's policy implementations, which I think you might agree with. They have streamlined approval processes, they have reduced barriers to density, they have direct public investment, and they encourage non-profit and co-operative construction. This has helped them create more housing units and put more units into the marketplace.

Ontario has refused to invest in public housing construction or adapt policies to allow higher density, and thus use land more efficiently. The government has said, in their opposition to getting these shovels in the ground, that the private industry will build all the affordable housing that Ontario needs through better policies and reducing barriers, yet this thing has not happened. Do you think private builders should be solely responsible for building all the affordable housing that Ontario needs?

Mr. Dan Van Moorsel: No. I think where the challenge lies is that when you're talking about the cost, 30% of it being fees, it makes it almost impossible for—I mean, listen: They're private builders. If there was money in it, they'd be doing it, right?

Mr. Terence Kernaghan: Absolutely.

Mr. Dan Van Moorsel: That's a no-brainer.

To your point about BC: We've watched their model on multiple levels. We've watched their model from a skilled trades perspective, meaning that anybody could just build their home, but in BC, if you wanted to build your own home, which you're totally allowed to do, you would go through criteria of exams in order to be able to do that, and so we've been working towards that.

To your point, I've heard us working towards or taking things from a BC model, but until there are some concessions made—and significant concessions made—to create reductions in costs to help build a diversity of homes, it's going to be a very, very challenging landscape for private builders or us to gain any traction on. That's why I lastly added that sort of unique thing Chatham has done, where we took that building-homes-faster money and were able to parlay it into something where now, it became advantageous for the city to help figure out how to create this 50-unit project.

Mr. Terence Kernaghan: Absolutely. I think pointing out how there is an inconsistent approach across the province in terms of approvals is one that the government could look at, and make sure it is one where we can actually get shovels in the ground and get more housing built. Thank you very much for that.

I'd like to turn over to Karen, with Community Living Essex. I just want to thank you, first of all, for the work that you do as well, as all of the DSWs and all of the people in your organization. Community Living is truly a wonderful organization. We had many people reaching out to us last year, prior to our budget consultations, with the 5ToSurvive campaign. I just wanted to start off by asking: Are your employees, your workers with Community Living, paid fairly?

Ms. Karen Bolger: Um—

Mr. Terence Kernaghan: In terms of what the government gives them, not you. Let's be clear there.

Ms. Karen Bolger: No, absolutely not. I believe that the work that they do is very complex. It's much different today than it was 10 years ago. The people who they're supporting have significant challenges beyond their intellectual disabilities.

In addition to that, our employees have significant administrative duties. There are so many regulations that are now in place, and they're not necessarily to keep people safe—they should be to keep people safe. I don't disagree with that at all. We have to hold a high standard—absolutely we should—in the work that we do on behalf of people, for people. But some of the requirements take away from the support that we provide to people. That's why we introduced AI and technology: So that we could streamline some of those processes for our employees so that they could spend more time doing the work that they should be doing with people.

I was saying previously, when I ran out of time, that students do not receive those incentives to enter the DSW program like others do, and so we struggle with that. We totally appreciate the permanent wage enhancement that we received throughout the pandemic; it helped us hugely. We were losing employees right, left and centre to education, to health, to long-term care, simply because of the incentives to go into those occupations.

Those funds helped tremendously, but we also just went through negotiations with our employees, with our union. Fortunately, we were able to come to an agreement that we are able to afford, utilizing the funds from the ministry last year. That's not what they were meant for. They were meant for our base funding to help with our overhead costs in terms of housing costs and inflationary costs and transportation for people, but we had to prioritize. We had to put it there. And then we've taken every dollar that we have and we've stretched it as far as it can go; it can't stretch any father. So, we will come back to negotiations next year with our employees and we will struggle. We will struggle with that for sure.

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

Mr. Terence Kernaghan: The home-and-community-care-support-services area does so much important work, and it is good upstream work, to actually save money in the long run. You've spoken about how, over 30 years, there has been a 7% increase while there has been a 70%

increase in the cost of living. That's about a tenth of what is necessary, I believe.

But I did want to ask: What does it say to people living with disabilities when the Ontario government reaches into their pocket and claws back money from the Canada Disability Benefit?

Ms. Karen Bolger: I don't know that that's happened. That hasn't happened yet. We're concerned that it may happen, so that's our ask: to ensure that that does not happen.

But what it tells people: The majority of the people we support receive ODSP. That is their main source of income. Monthly, a single person, the maximum amount is—I think it's $1,398, something like that—

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

We'll now go to the independent. MPP Hazell.

MPP Andrea Hazell: Thank you, everyone, for coming in again and presenting to us today—really much appreciation.

I want to start my question with Community Living Essex County. I know there's a difference between DSWs' work and PSW, but for the life of me I continue to hear about PSW, and I'm wondering why the DSW line of work did not catch on with a lot of people. What's the deficit here?

Ms. Karen Bolger: We wonder the same thing. Our employees do very difficult work, and the expectations are very high. I can't answer that. I can't answer why the DSW program—why we are struggling for employees, other than, obviously, the pay structure.

As I said previously, our employees work 24/7, as does long-term care. They have a lot of responsibilities. They often work alone, or they work with another person. They work individually in people's homes, so they're not working in a large unit where there are a lot of people around. They have a lot of autonomy in their work that they do. We try our best to ensure that we appreciate our employees in different ways. We provide as many educational opportunities as we can.

We have had to hire PSWs simply because we don't have enough employees otherwise. We've created micro-credentials. We've had to do significant training with those few people that don't have the credentials that we're looking for or that we require, and there's no guarantee that they stay.

1140

MPP Andrea Hazell: I understand all of that. I kept asking all agencies and organizations the same question as well, because—

Interjection.

MPP Andrea Hazell: No, and that's why I kept asking the questions, because DSWs are very much important as PSWs.

Ms. Karen Bolger: Absolutely.

MPP Andrea Hazell: What about the health benefits, like from WSIB? Do they fall under WSIB for their benefits?

Ms. Karen Bolger: Yes, our employees do. They have a full benefits package through our organization. They have a living wage. It needs to be higher to actually retain and keep people, but it's a living wage. We provide benefits. Again, it's difficult to do when our funding is 100% from the government. Without that funding, again, we are kind of taking from Peter to pay Paul to try and figure it all out.

MPP Andrea Hazell: What's the funding criteria that you're looking at for 2025-26 of your budget?

Ms. Karen Bolger: The increase?

MPP Andrea Hazell: Yes.

Ms. Karen Bolger: We really haven't looked at that in particular. We haven't put a number out. I don't think our sector has put a number out. We are just looking for the government to come up with an annualized increase that's going to help to sustain agencies moving into the future.

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

Ms. Karen Bolger: The waiting list is significant. Organizations like ours are struggling to do what we do now, let alone add more services and supports for people and families. We just can't do it. That waiting list is going to continue to grow, and our organization, just like many across the province, is struggling with that. We have not yet had to close any of our programs. Many across the province have. Many have. We are not there yet.

MPP Andrea Hazell: Well, it means that you're still pushing through, and I hope you continue to push through, but I hope you get that increase that you're asking for.

What is the reform plan journey? This is in your document.

Ms. Karen Bolger: The Journey to Belonging: Choice and Inclusion is a transformation of developmental services. It's a 10-year plan that the Ministry of Children, Community and Social Services has developed. We are in year four of that 10-year plan—

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

We will now go to MPP Hamid.

MPP Zee Hamid: I'd like to thank, again, all the presenters. Thank you for coming up, taking time out of your day to give us some feedback.

Let's start with you, Dan, home builders' association. I was just curious; you mentioned development charges a number of times in your thing. It might vary from municipality to municipality, but on average, what kind of development charges are we looking at on a new single-family home, detached build?

Mr. Dan Van Moorsel: Oh, gosh. It can range anywhere from $10,000 to $100,000, and it's loosely unchecked. So, my friends in London to the west, they just built for—I think theirs jumped $20,000, from $40,000 to $60,000. It's just like, this is it. It's such a long process—we were almost two years battling that in Chatham—that some of our partners to the east have just decided that we just figure out how to put it into the cost of the build and move forward.

MPP Zee Hamid: And these municipalities where you pay development charges, are you ever encouraged to pay more for community development or anything else?

Mr. Dan Van Moorsel: Sorry, I don't know what you mean.

MPP Zee Hamid: There are some municipalities I've heard about where, in addition to development charges, they'll have developers put in more money for parks, recreation or other programs.

Mr. Dan Van Moorsel: When we were doing it with our municipality and sat with council, they were completely unaware of what development charges actually did. I think that's a lot of where—when I sit here, I don't think we look for money or look for funding. What we look for is time, is for MPPs, MPs and our local government to understand what development charges actually do.

Our people were unaware. The developer actually pays for the pipe, pays for the curbs, pays for the sidewalk, pays for everything, then hands it over to the municipality. The municipality is worried about a new snowplow truck or something like that. That money isn't allocated to the actual ground that's there.

When it comes to parkland, every developer has to include, based on the size of the subdivision or whatever, that land as part of the builds. The municipality is only really responsible if they want to put in a pavilion or a playground or something like that. But they're really only responsible for the life-cycle cost of that land, so if you have a 40-unit subdivision and you say, "This is the area for the park," that's all included in the developer's scope of work. If anything, without going on too long, I really encourage anyone who's curious about it in this room to educate yourself on what development charges actually pay for and what the developer actually pays for.

MPP Zee Hamid: You mentioned timelines. What's the approval timeline in general for you? Again, it's municipality to municipality, right? Are you looking at a few months?

Mr. Dan Van Moorsel: Like, approval for a subdivision?

MPP Zee Hamid: Yes.

Mr. Dan Van Moorsel: Oh, like, five or 10 years.

MPP Zee Hamid: Wow.

Mr. Dan Van Moorsel: On my way here—I mean, this is all new to me; I haven't been to Leamington in quite some time. But just driving along Bevel Line there or whatever—I think if you were to spend some time with whoever's local here and ask them, I bet you most of those subdivisions were in that pipeline for over eight years before they began.

The challenge before was, "Hey, maybe we haven't been able to get up to our home numbers that we've been seeing over the last couple of years because we have no land." If anyone's from Windsor, you've had literally no land. All the Windsor builders have been coming to Chatham. There's nowhere to build this housing subdivision in Windsor, up until most recently. So during this huge boom during COVID, when we were all like, "Let's get building. We have the trades. We have the people to build these houses," we had no land, because their hands are tied with the process.

And again, every municipality is different. I have a builder who builds in Windsor. His whole application process—the developer's whole application process—is different than it is in Chatham-Kent. So how do you run a business? How do you build these homes? How do you streamline all this stuff so that we can be on top of these numbers that we're talking about?

MPP Zee Hamid: Real quick, before we run out of time: How do you do that? What suggestion would you leave us with, that we can take back?

Mr. Dan Van Moorsel: That's a loaded question. Since 2006, I've been playing in this game to try and figure it out. Honestly, I believe that it's going to take trying to figure out what to do with the unhoused and that gap. Like, everyone looks at us as these expensive builders and big developers and all of these things. We're happy to play in whatever space the province allows us to play in.

So I think it's going to be pressure to build diverse housing offerings for people who can't afford what a custom builder could build, or—I'm sorry; I apologize. I don't want to use the wrong words. I'm not using, really, any words. But until we feel the pressure to create that diverse, affordable housing and attainable housing—that's when I think all levels of government are going to be able to sit down and understand what this actually does, and then bring the municipalities under control.

Municipalities are—it's the Wild West out there. They do whatever they want, whenever they want, and they don't care. They have no value to long-tail revenue. They want all their money upfront and that's what they tell everyone. That's why it's hard to build that, when they don't understand that the real money to be made or the real money to support municipalities and programs is through taxes. That's how this all works. If you don't put houses in, you don't have any taxes. You struggle to support your communities.

So all I can say is it's education, and someone has to champion how to take diverse housing—attainable, affordable—and make them work, and then that will force all level of government to play nice.

MPP Zee Hamid: Last question: Last year, we passed the Cutting Red Tape to Build More Homes Act, which eliminated red tape. The goal was to speed up the government process to support our commitment to build more homes. Has that been helpful? Do you think that will be helpful? Is there anything else we should do to further cut red tape and streamline the process?

Mr. Dan Van Moorsel: I've been waiting for someone to tell me what piece of red tape they cut. The whole reason, I think, they call it red tape was because it's easy to say, but what red tape got cut? I didn't see any red tape that got cut.

In fact, I think it almost—I don't want to talk out of turn here, but the government went and opened up all kinds of lands for large development and big building. We didn't open up lands or make lands accessible to attainable, affordable housing, to first-time homebuyers. I think it

almost let the big get bigger, so I really don't know. In a community like Chatham-Kent, all that bill did was help us create $440,000 to help fund a 50-unit project. That's what it did for us.

1150

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

We'll now go to MPP Gretzky.

MPP Lisa Gretzky: I'm going to start with a question for Salvation Army. For those who don't know, I'm Lisa Gretzky. I'm the MPP for Windsor West, so I represent two thirds of the city of Windsor, including downtown Windsor. I also live downtown and so often have some interaction with the folks that you provide services for here in Windsor.

I'm wondering if you can touch on if you've seen an increase in need for services, and then I believe the ask was for funding for an additional caseworker. So what would that mean for your organization and for those that you provide supports and services for if you got not just one-time funding that will go away but dedicated, sustainable, year-over-year funding for even the one caseworker?

Ms. Maha Salem: In terms of the first part of the question, we did see a rise in needs of services, and I'm sure Marwa can speak upon housing parts.

In terms of my department, the outreach, I work lots with homeless individuals, as well as many individuals who are struggling within the community. The stats that we keep—we keep record of which referrals we're putting out into the community, and we've been seeing an extreme increase in a need for employment, in need for housing, in need for just so many holistic, basic needs. It's increased quite a lot since I've been here in the last two years. Just within the last two years it's been increasing.

I'm sure Marwa can speak upon the housing; I'll hand it over to her later.

But in terms of the funding for a caseworker, the reason why we need a caseworker is because right now in the outreach department we deal with very different and extreme needs. So, depending on the clients that we get, each client is unique and their needs are unique. Because we get so many different clients, we need an extra caseworker to help assist in that regard.

So, for our Pathway of Hope Program, we have a case management style, and so we seek clients for longer time. Right now, what we're trying to do is have two caseworkers possibly on the Pathway of Hope case management, allowing them to be self-sufficient, but we also need a caseworker focusing on people who are homeless. So we're working one-on-one with the housing department in the future to have one caseworker focusing on client needs that are in the shelter but also client needs who are in the food department as well, so the food bank. We just need someone else to bridge our departments together and help clients in the community become, yes, self-sufficient, like I was saying before.

I don't know if Marwa wants to speak on the housing aspect as well.

Ms. Marwa Al-Sahar: Yes, speaking of actual service, our clients always need extra and more resources. I'm going to talk about the time when I was actually a housing worker with the clients, so I was directly—a front-line worker who worked with them. Our clients don't only need housing, which is already not there. They need a lot of help with being connected to mental health resources, addiction support workers. They need to have employment. They need to be connected to programs that teach them life skills. Clients, when they come here, yes, their main thing is housing, but as we talk to them as caseworkers, you see there is so much that they need. Unfortunately, the thing we can do, if we can help them inside the shelter—this is absolutely something we provide first before housing them. But when it's time to refer them to other community resources, the first response you'll get is, "Sure, the client will go on the waiting list." We don't know how long this waiting list is. It could be a month. It could be six months. It could be a year.

Within this time period, the clients will even struggle more, because they will stay in the shelter more. They will learn things and get involved with other people, unfortunately, who they shouldn't be involved with. A lot of our clients, when they come to the shelter, especially the ones who are experiencing the shelter for their first time, they come and they're uncomfortable, but over time, they actually adapt to that lifestyle and they become comfortable with things. And because they have to wait for services, when it's time to house them or refer them somewhere else, they get depressed because they get so much used to the place. They are connecting with clients who are here. So it's just that waiting time.

Unfortunately, we did lose a lot of clients who lost their lives because of them waiting for addiction services—to be treated. A lot of them were actually in that change stage and ready to be changed and start life. It's just the waiting time that they have to wait.

Added to that is having enough qualified people who can actually provide that service. Now, we will get to a case where we referred the client. We had the client connected to that service, but the case worker who is dealing with the client is not qualified enough to know where to take them to the next level. Clients come back to us and say, "You know what, I did not get any of the services that I need," or "I didn't get my needs met." So they come back and they collapse and we start over.

A lot of our clients—and I can tell you, we cannot even help them in the shelter. They need to be in a cycle. They need to spend time at the hospital. They need severe mental health support, which, unfortunately—we absolutely don't have enough for them.

MPP Lisa Gretzky: So, to that question—and we probably only have about a minute left—

The Chair (Mr. Ernie Hardeman): Yes; 1.2.

MPP Lisa Gretzky: I just want to ask you really quickly—we've heard the Premier himself saying about people who are on ODSP that they just need to "get off their A-S-S" and get a job. Their answer now to people

experiencing homelessness is to clear encampments and possibly fine those unhoused $10,000.

What problem do you think that is actually going to solve, if any?

Ms. Marwa Al-Sahar: Sorry. Just to make sure that I got that question—so, by banishing the encampments, what problem is that going to solve?

MPP Lisa Gretzky: Clearing the encampments or fining unhoused $10,000 and not having housing for them to go to, or community supports. What problem, if any, do you think that's actually going to solve?

Ms. Marwa Al-Sahar: It's actually going to clear the community. Our community is not as safe as what it used to be before.

I'm going to talk about our clients who live permanently here. They're actually scared to go outside and even participate in things they should participate in, like to find a job or be connected. They'd rather stay to themselves.

I'm going to talk about the vandalism that's happening over in the community. People who live in that city are now less willing to help and see those homeless individuals as humans who are actually in need. They are now scared of them more than they see them—that they actually do need help.

So, clearing the community and making it more safe—we're going to have a committee that is going to come together—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time, and that also concludes the time for this panel. Thank you—

Interjection.

The Chair (Mr. Ernie Hardeman): Oh, no. I have one more questioner.

MPP Andrea Hazell: You missed me.

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

MPP Andrea Hazell: Thank you, guys, for coming in. Again, I said that today, but we really, really appreciate you.

I'm going to start with Dan. You talked a lot today about that DC. Let me tell you, that DC name is almost becoming a common language between all the home builders in Ontario. We know the government has missed the target on building homes. I don't think the red tape has been decreased. We know the municipalities—some of them—are continuing to increase those DC charges. We also know it is being transferred to the homebuyers.

I have three kids. I came to Ontario in the mid-1980s. In my younger years, I was able to purchase my first home. I am really hoping that my three kids can be able to attain that dream as well. We've lost over 50,000 young people out of Ontario for better housing opportunities and better jobs.

And so, these are not good stories that we are hearing. I know you took the DC issues to the Ontario tribunal—

Mr. Dan Van Moorsel: The land tribunal, yes.

MPP Andrea Hazell: Can you talk about that? Were you successful? Where is that right now?

Mr. Dan Van Moorsel: So, a couple of things: As much as we take away from what the government has done, I will say this is the first government that's paid attention to us. I've been doing this for a long time, and no one paid attention to us until this most recent government. So as much as you want to poke a little bit about where we're at in the stats, please understand, they're the first ones to take us seriously and give us a seat at the table. They've understood that we are strong collaborators. Everyone before made decisions before us. This government has come to us as collaborators.

Has it all worked? Absolutely not. Can it work better? Yes, it can. I believe we're on the path to doing that, and it's great to see that other parties have decided that building homes for young people and for different people—attainable, affordable—is super important for our province.

Now, I've said that, and I forgot your question—no, I think it's come back to me. What I will say: A step in the right direction is now we're allowed secondary suites, we're allowed to build multiple units on properties. Do I think, right now, there's a fix in the next five years so that your kids—my son is 19; my daughter is 18. My son, 19, will probably be looking for a home very soon. Do I think he is going to be in the fixed generation? Absolutely not. But do I think giving him the ability for us to build maybe a secondary unit on our property or a suite on our home—listen, our goal is always to have our kids out of the house, but it's just not going to be our reality over the next five years.

So I believe that some things have been put in place to help us be creative as a—bit of a loose term—"band-aid" until we can begin to educate ourselves and figure out how to—not cut red tape, but how to create a process that is streamlined from top to bottom, meaning understanding where our money is going, understanding that municipalities—we do have to find a creative way for municipalities to fund themselves without relying on DCs.

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

Mr. Dan Van Moorsel: I think that, in the interim, we have an opportunity to at least try to retain kids and people, with allowing multiple people on properties, that we didn't have before or weren't allowed to do before. But I think that the true fix in all of this is figuring out, "This is your process. Each municipality, this is how we get to the end." Giving municipalities or governments options or creative ways to fund projects and attraction the way that private people do—that is what is going to put us in a spot where we can begin to bring home costs down.

Listen, when a development charge in Chatham-Kent is almost $27,000, if maybe that could be $10,000, it puts $17,000 off a home just that quickly. And it's totally doable. If you start looking at everything that way, from a provincial standpoint and a federal standpoint, you can really begin to reduce costs of homes and—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time for that question, and it also now concludes the time for this panel. We thank all the panellists for the time you took to prepare it and the time you took to come present it. I'm sure it will be a great asset to the committee as we continue the deliberation.

With that, we now are in recess until 2 o'clock.

The committee recessed from 1203 to 1400.

LAKESHORE COMMUNITY NURSE PRACTITIONER-LED CLINIC

WEST ELGIN COMMUNITY HEALTH CENTRE

MR. MIKE FISHER

The Chair (Mr. Ernie Hardeman): Good afternoon and welcome back. We will now resume public hearings on pre-budget consultation 2025. Our first group of delegations this afternoon is the Lakeshore Community Nurse Practitioner-Led Clinic, the West Elgin Community Health Centre and Mike Fisher.

As everybody is coming to the table—there may be not many coming; it looks like we have some virtual presentations—we should set the ground rules. You will have seven minutes to make your presentation. At six minutes, I will say, "One minute," and at seven minutes, I will say, "Thank you." We ask that as you start your presentation, give us your name, to make sure we can attribute the presentation to the right person.

With that, we'll start with the Lakeshore Community Nurse Practitioner-Led Clinic. The floor is yours.

Ms. Kate Bolohan: Hello, everyone, and good afternoon. My name is Kate Bolohan. I'm a nurse practitioner lead at the Lakeshore Community Nurse Practitioner-Led Clinic. For your reference, I will probably use the acronyms LCNPLC and NPLC within the presentation. We are located in the town of Belle River.

For your background, I am a clinician. I've been providing primary care in the NPLC setting since 2012 and primary care since 2011. I'm here today to address the wage gap in the community health care sector.

The Lakeshore Community NPLC has a co-leadership model. At this time, I'd like my partner to introduce herself.

Ms. Sharon Bevington: My name is Sharon Bevington and I am the administrative lead of the Lakeshore Community Nurse Practitioner-Led Clinic. Today, I will be addressing operational budget pressures in the community health care sector.

Ms. Kate Bolohan: Thanks, Sharon. Sharon and I would both like to thank the members of the committee for having us present today.

For your record, we are a primary care office. We care for approximately 2,350 people, patients within the municipality of Lakeshore. Our interprofessional team of providers includes nurse practitioners, registered nurses, a registered social worker, a registered dietitian, a physiotherapist, a respiratory therapist, medical secretaries and, of course, our admin lead, Sharon Bevington. This is a comprehensive team of clinicians who work to their full scope of practice, focusing on mental and physical well-being, health promotion, disease prevention, and managing acute and chronic conditions.

Unfortunately, the incredible work of all our staff members does not result in a fair and equitable salary amongst counterparts across the health sector, and we're losing skilled staff to other sectors. Not only is recruitment and training costly to any organization, but losing staff creates gaps in the provision of health care services. The current level of human resource funding is not adequate and does not keep up with inflation or the cost of living, which makes recruitment and retaining staff a significant challenge.

The Lakeshore Community NPLC, along with community partners, are asking the 2025 Ontario budget to invest $165 million to address the wage gap, to reach the 2023 recommended salaries. Interprofessional teams have faced lower pay grades than other parts of the health care sector. The cost of living keeps increasing, salaries remain stagnant, and there has been no salary increase in the interprofessional teams since 2020.

I'd like to thank the Ontario government for investing in interprofessional team-based care and recognizing the value of interprofessional primary care. Investing in primary care is the foundation of an integrated health system. Ontario needs that investment of $165 million for recruitment and retention in 2025.

Moving forward, a modest 0.9% increase each year over five years will bring us close to closing the gap. It will not address the fact that compensation to workers through Bill 124 was not given to those providers in interprofessional primary care in retroactive or go-forward payments. As our colleague mentioned earlier this morning, minimum wage has increased 22% since 2020 and our wages remain at or below the 2017 rates. Now is the time for investment in comprehensive interprofessional primary care. Inaction now will lead to less healthy Ontarians in years to come. I thank you for your consideration.

I'd like to bring Sharon Bevington forward to discuss the operational budget pressures.

Ms. Sharon Bevington: We are proud primary care sector leaders and believe this Ontario government is committed to ensuring all Ontarians get equitable, connected, comprehensive and convenient care. Lakeshore Community Nurse Practitioner-Led Clinic and our community health sector colleagues working at family health teams, community health centres and other nurse practitioner-led clinics propose that the 2025 Ontario budget invest in interprofessional primary care teams through base budget funding increases of 5%, totalling $33.7 million.

We acknowledge and appreciate the government's investment of $20 million, or 1.9%, in budget funding for the previous and current fiscal years. That funding ends on March 31, and it did not cover the permanent 3% operating decrease many NPLCs received in 2019, including our clinic. We are doing everything we can to keep the doors open, and I mean that sincerely. But inflation and no budget increases for 15 years has threatened our capacity to deliver services at a time where we can, and we want to do more. Operating costs continue to rise. Utilities, insurance, property maintenance, rent and medical supplies

have all increased significantly in the last 15 years, with an even steeper increase over the last two years.

With high-profile cyber security incidents in our region, we know first-hand the importance and value of robust protection rather than the cost of recovery, and more importantly, the negative impact of cyber incidents on the delivery of care. The cost of current industry-standard cyber security tools was not in our budget 15 years ago.

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

Ms. Sharon Bevington: Integrated digital tools are a key component in this government's health care transformation plan. These tools, such as online appointment booking, secure patient messaging and data collection, were not in our budgets 15 years ago.

We need sustainable and adequate funding to maintain our capacity to deliver primary health care. Ontario needs to invest in interprofessional primary care teams, whose costs are ballooning due to inflation, through a 5%—totalling $37 million in base funding. We believe in investing in and adequately funding interprofessional primary care teams as the foundation of an integrated health system, and after 15 years without an increase, now is the moment to address this crisis. Thank you for your consideration.

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

Our next presenter is the West Elgin Community Health Centre. The floor is yours.

Ms. Dawn Maziak: My name is Dawn Maziak. I am the West Elgin Community Health Centre board chair. Thank you for allowing me to present and provide input into the Ontario budget process.

For context, the West Elgin Community Health Centre was officially incorporated with letters patent granted in 1992. We consider 1994 our official birth date as that's when we started delivering services in a local building in West Lorne. After approximately 10 years, we moved in January 2004, and in February 2012, we moved some of our programs and offices next door into the Heritage Homes hub. We're proud to state that in July 2024, we celebrated our 30th anniversary in operation.

The centre has a small primary care team comprising three physicians and four nurse practitioners. One position of an NP we cannot fill, so we operate with three nurse practitioners, registered practical nurses, registered nurses and three mental health clinicians.

Our community health centre is unique in that it is one of the only centres in Ontario to receive community support service funding, which means our health team of six staff and 40 volunteers provide Meals on Wheels, congregate dining such as Soup's On, friendly visiting and accessible transportation for the community.

1410

Our assisted living units for approximately 30 seniors reside next door to the Heritage Homes. These residents' primary care and socialization are paramount, and the centre's personal support workers provide 24/7 care. This is the integrated primary care model that Dr. Jane Philpott envisions for [*inaudible*] as per her book, Health for All.

The centre also has a county mandate to provide diabetes care through registered nurses and dietitians from the east to the west end, as well as recently receiving funding for the First Five, which is dedicated to primary care services for unattached children ages one to five. This team is for the entire Elgin county community, which is 600 square kilometres.

Our catchment area is indicated in our letters of patent, and it's approximately 9,000 people. We serve 7,200. When Ontario Health was formed, they advised that we must accept unattached patients from elsewhere; therefore, individuals living in Chatham, Wallaceburg, St. Thomas and even London are on our wait-list for primary care. Every person served outside our original area takes away from a local rural senior, farm families and youth. As our community is 40 minutes west of St. Thomas, we're growing. We have young families working for Amazon and the new battery plant. Our wait-list is 423 people, with Chatham accounting for 40%, Middlesex making up 14%. We also have two local physicians that are long past retirement age, with a caseload of 2,700 apiece.

If the community health centre cannot provide ongoing care for these individuals from outside our community, with outside people from our community taking these places, it will have negative ramifications for the CHC and the local community. Given these circumstances, we are considering reducing the wait-list by no longer accepting individuals outside of our area.

In the spring of 2024, the board and the executive director launched an aggressive advocacy campaign, and in that we've lost valuable long-term staff. The issue arises from the pay rates that have remained unchanged since 2017. My colleague spoke very eloquently towards that. So the community health centres are facing significant challenges, and there's been a 7% increase in base funding over the past 16 years while the inflation rate rose 40% during that same period.

We cannot continue providing care and competitive salaries. And to give you a concrete example: We have registered practical nurses who are making [*inaudible*] amount as a registered-practical-nurse new grad. Their counterparts in long-term care in hospital have a difference of $28,000 per year. That is substantial. We require an annual base funding increase of 5% to address this issue and maintain our current staffing model. We've educated and engaged the public through our local fall fairs and collected a petition. It's signed by nearly 800 unique individuals, from Rodney, West Lorne, Dutton, Eagle, Ridgetown and Glencoe area. The public's reaction to this reality was one of shock, disbelief and anger.

We have a board member who is also a local reporter. We've contributed eight articles to the Chronicle and one to the London Free Press.

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

Ms. Dawn Maziak: The London Free Press article elicited a response from Minister Jones and MPP Flack that expressed that they value our organization but empha-

size that community health centres are independent employers responsible for their staff compensation package. This statement is misleading, because CHCs are fully funded by the Ministry of Health and Ontario Health, which oversee any funding changes to salary line. Therefore, because of our accountability agreement, our budget must be balanced and any funding changes require prior approval.

In conclusion, the community health centres must receive an increase of 5%. Our patients face some of the most significant barriers. They have the poorest health outcomes—

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

Our next presenter will be Mike Fisher.

Mr. Mike Fisher: Hello and good afternoon, members of the committee. My name is Mike Fisher. I'm speaking to you today as an individual and as president of the Friends of Ojibway Prairie.

The Friends of Ojibway Prairie is a registered charitable organization of volunteers established in 1992 that partners closely with the city of Windsor, as well as Ontario Parks and Parks Canada, in support of the Ojibway Prairie Complex, which is soon to be Canada's second national urban park. We're also a proud member of Ontario Nature's Nature Network. That includes over 150 conservation organizations from across the province.

I'm here today to urge the committee to include recommendations for significant investments in protecting and restoring nature in the 2025 budget.

Here and in Windsor-Essex, we know the value of supporting biodiversity and providing our community with opportunities to access nature. No area in Ontario has a greater concentration of rare species than our Ojibway Prairie Complex, which serves as an important example of our natural heritage and tallgrass prairie ecosystems.

The trails of Ojibway and the nature recreation opportunities at parks and natural areas across our region provide critical outlets for both mental and physical health. There is no better way to get the heart pumping and clear your head than a kayak excursion at Hillman Marsh or a bike ride along our greenway trails to visit county townships.

Across the province, I'm sure many members of the committee can share similar stories about the benefits of nature in your own communities. It may be enjoying the waters of Laurel Creek Conservation Area in Waterloo, going for a bike ride along the Thames River in London, taking in the stunning views of Kelso Conservation Area in Milton, or enjoying a back country canoe trip through Kawartha Highlands Provincial Park. At Ontario parks across the province, many families share camping trips as a favourite summer highlight.

As Dr. Anneke Smit, co-lead of the University of Windsor National Urban Park Hub, indicates, the research tells us that having more access to parks and biodiversity is good for people as it provides options for healthy living activities, social interaction and connection to the natural world. With the majority of Ontarians now living in cities, ensuring that access to nature is possible, even in urban areas, is all the more important.

While we have access to some wonderful parks in our province, there is more that we can do to protect our natural areas and address the interrelated crises of biodiversity loss and climate change. That is a fundamental imperative for all of our society.

We know from a number of polls that Ontarians overwhelmingly support creating more protected areas and that the province should invest in protection, restoration and sustainable use of biodiversity for climate, human health and economic benefits. As the impacts of climate change become more and more apparent across the province, increased investment in nature-based climate solutions is urgently needed.

In 2022, Canada was one of the countries that signed the Kunming-Montreal Global Biodiversity Framework, which sets out 23 action-oriented targets to halt and reverse biodiversity loss. I'm proud to note that the city of Windsor was one of the first 50 municipalities in the world to sign a similar pledge for municipal governments. Ontario's Biodiversity Strategy contains many of these targets, but the government of Ontario has not yet committed funding to effectively implement this strategy.

Ontario is falling behind provinces like Quebec and British Columbia in commitments and investment to protect and restore nature. British Columbia has matched federal government investments of $500 million until 2030, while Quebec has budgeted $922 million over four years. It is for these reasons that the Friends of Ojibway Prairie will be joining nature organizations from across Ontario in making the following recommendations for budget 2025 to help protect and restore nature and bridge the funding gap with other provinces.

We ask the committee to recommend funding the actions of Ontario's Biodiversity Strategy in alignment with national efforts. Specifically, we request the commitment to, at a minimum, match Quebec's annual investment of $230 million a year for the next four years. The investment could be allocated to address biodiversity targets through efforts such as:

—restoring 30% of degraded ecosystems;

—protecting 30% of Ontario's land and water area;

—protecting threatened and endangered species;

—minimizing the impacts of climate change on biodiversity;

—enhancing biodiversity in urban areas; and

—ensuring sustainability of agriculture, fisheries and forestry.

We also ask the committee to recommend a commitment to reviewing provincial subsidies provided across ministries that negatively impact nature and subsequently develop a plan to phase out these harmful subsidies, transitioning investments to nature-positive incentives instead.

1420

We are confident that with this investment, Ontario can close the gap with other large provinces on nature conservation and restoration. Ontario's protected areas networks

have historically seen significant expansion under Progressive Conservative governments, and we urge the current government to build on that legacy and commit to a larger conservation framework. Ultimately, these investments will benefit the economy and the people of Ontario and ensure the province's long-term sustainability.

Thank you very much for your time today. We hope to see these recommendations acted upon in Ontario's 2025 budget.

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

We now will start with the questions. We'll start with the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to our presenter here in person, as well as those virtually, today.

I'd like to begin with Sharon from the Lakeshore Community NPLC. The official opposition are big, big supporters of NPLCs. I think the quality of care and the model of care you provide is quite exceptional.

I want to first talk about wage disparity. Year over year, presenters have spoken about the massive disparity among health care sectors, and it's gotten far worse, especially now with the affordability crisis. The problem of wage disparity was even recognized and admitted by this very committee in last year's pre-budget report. Can you speak to what wage disparity looks like for people working in your clinic?

Ms. Sharon Bevington: Could I have my colleague Kate brought back up on the screen, please? For questions, Kate will address wage questions, and I'll address operations questions, if that's okay for the committee?

Mr. Terence Kernaghan: Sounds good.

The Chair (Mr. Ernie Hardeman): Just refer them to whoever you like.

Ms. Sharon Bevington: Okay, Kate will answer. Kate, did you hear the question?

Ms. Kate Bolohan: I heard the question. If I could paraphrase or clarify, the question was surrounding what wage inequity looks like for members of my team.

Mr. Terence Kernaghan: Yes.

Ms. Kate Bolohan: Sure. I can tell you that we have a vacancy because the wages were more competitive in another sector. We lost a pretty significant member of our team—huge loss for us, for the members of our community. As well, we have a few members of our team working more than our job here, so it's taking two jobs or more in order to be sustainable in paying for the cost of living.

Mr. Terence Kernaghan: Understood. That is—

Ms. Kate Bolohan: Did that—

Mr. Terence Kernaghan: I'm sorry?

Ms. Kate Bolohan: Did that answer your question?

Mr. Terence Kernaghan: Absolutely. We have heard from other presenters saying that individuals at their locations have to work two and three jobs and then sometimes visit food banks, so I'm hoping the government members are listening at this time.

I also wanted to ask if—according to your record, does it make any sense that your clinic has seen a 3% operational funding decrease since opening in 2012? That I'll put to you, Sharon.

Ms. Sharon Bevington: Does it make sense? Was that the question?

Mr. Terence Kernaghan: Yes, since 2012.

Ms. Sharon Bevington: We opened in 2010, received an operational decrease in 2019 and are thankful to this government for the one-year increases last year and this year. As an administrator, it doesn't make sense, to answer your question, but I don't know what else to add.

Mr. Terence Kernaghan: I also noticed, from your written materials, that Lakeshore Community NPLC needs $366,000. What will happen if the government should happen to say no to this request?

Ms. Sharon Bevington: There are two asks here; that is our wage increase ask. Kate, do you want to answer what would happen if we didn't get the wage increase ask?

The Chair (Mr. Ernie Hardeman): Go ahead.

Ms. Sharon Bevington: She's just getting off mute.

Ms. Kate Bolohan: You can hear me? Perfect.

Without the wage increase, what I'm fearful of is that the team that Sharon and I have built here will leave the organization for other sectors or other health care sectors that would provide a living wage. And like I've pointed out already, in terms of that service provision, gaps start to form, and continuity of care is important in all sectors of health care, particularly primary care. It's costly to the organization to hire and to train for the revolving door to happen again, until something better comes along with a higher wage and then we're starting the process all over again. I don't want that to happen.

In terms of services, Sharon and I have really had to look at what our team looks like. Where can we cut? We are as lean as we possibly can be, and I give the best credit out to Sharon for looking at every avenue to save a dollar, but ultimately, that doesn't help the providers at the end of the day.

Mr. Terence Kernaghan: Most definitely. Thank you very much.

I'd like to next turn my questions to the West Elgin Community Health Centre and Dawn. Dawn, thank you for your presentation. I believe that you were cut off a little bit towards the end. Would you like a little bit of an opportunity to finish your presentation?

Ms. Dawn Maziak: Yes, please, if I could.

Basically, what I wanted to get across was that at the community health centre board and as our executive director team, we have been advocating locally to the Dutton/Dunwich council, the West Elgin council, county council and we've been repeatedly to the MPP's office. We are very fearful that we are not going to maintain our current ability to provide care. We have unfilled positions, such as a chiropodist. We've lost two 10-year mental health clinicians who did not want to leave; however, they were offered a 30% increase from a hospital.

That continuity of care, particularly with rural individuals and mental health and addictions, is critical. When you build that relationship and then that provider leaves for another job, it just perpetuates the situation, so these

clients cannot grow any further. I speak with a social work hat: We will not be able to continue on with fulfilling our mandate.

The other aspect is that we do have the community support service side, and that's incredibly important. We're very, very proud of that. It's very unique, and we would like to spread the model across Ontario, certainly with the support of the Ontario government, because we believe that primary care is the foundation, and that if these people who were at risk were living within a close proximity, or they were assigned to a specific primary care model, that they would receive—

The Chair (Mr. Ernie Hardeman): Thank you very much. I hate to do this a second time, but the time has expired.

We'll go to MPP Hazell.

MPP Andrea Hazell: Thank you to the presenters for coming in and presenting to this committee today.

My questions are going to start off with the Lakeshore Community Nurse Practitioner-Led Clinic. When I look at your physical presentation and then hear you present it to us, I can't help but imagine the pressures to your operational budget. And then your staffing retention: You stated that that 3% operational funding decrease—it decreased since 2012. Your wages haven't increased or have stayed at par since 2017, and for 15 years you have had no budget increase. I'm worried about how you continue to keep your doors open.

Ms. Sharon Bevington: Thank you for the question. And to acknowledge, in 15 years—I want to be really aware of the fact that we're speaking to the Ontario government as a whole, which is all of you working together, and that in 15 years we've seen different parties. So when we say "Ontario government," we truly mean all of you working together to help us.

1430

So, what do we do? We change phone providers, we change Internet providers, we decrease benefits, and we do all those kinds of things to keep our doors open. We find efficiencies, but what I want to get across to you is those are done. The reason why you haven't seen me here before speaking is because I was able to find efficiencies, and you should want that of us. You haven't seen me here before because we did what was asked of us and we have found, I believe, all of the efficiencies. We have become as lean as we can, and as taxpayers—we're all taxpayers too—I want that of us. I take that very seriously, that I receive taxpayer money, and I am a taxpayer.

I take that very seriously and we have become lean. We're here today because we don't have any more tricks in our pockets with trying to retain staff or with trying to get this budget to work. That is why we're here today, and that's what we would like you all to hear equally and for all of you to work together on that.

MPP Andrea Hazell: And you are here, and I am here, and I want to help you to detail and bring out more information for the record. For me, you've mentioned since 2015, and I wanted to lock in on that. It doesn't matter what government was here before. My focus is on you and your organization right now and hoping that this government is going to provide some funding for you.

Especially, you're in the sector of health care. We know how that is right now in Ontario. For me and my party, we're calling it a health care crisis. We're calling it the way it is. I just wanted to find out how are you able—and you said you've cut deficiencies to help you to improve on efficiencies and help you to keep dollars in your pocket.

How are you going retain your staff that eventually will leave your organization if you're not able to take care of the emotional state and their salaries in your budget?

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

Ms. Sharon Bevington: As of April 1, we are in a deficit for this next fiscal year. We do not have the dollars to operate on the operation side, and in 2025, we will lose staff. For the first time ever, we're not losing health care staff to other health care sectors; we're losing compassionate, loving humans to other sectors entirely. We are not losing them to other health care; we are losing them to other sectors, and that's what I want you to hear.

MPP Andrea Hazell: And that's what's painful. Thank you for putting that on the record. Thank you.

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

We'll now go through the government side. MPP Leardi.

Mr. Anthony Leardi: Kate and Sharon, thank you very much for being here today. It's a pleasure to see you and a pleasure to hear people from my own riding come and present to this committee. I'm very happy to have you here today.

I want to ask you a series of questions. I want to start with the basics. I always start with the really simple questions just to keep—because not everybody here is as familiar with the health care sectors as others. Let's start with the type of approach that is used at a nurse practitioner-led clinic. I will call it patient-centred and team-based. Could you please let everybody know what is meant by patient-centred and what is meant by team-based?

Ms. Kate Bolohan: Sure. So, Kate Bolohan, nurse practitioner and nurse practitioner lead speaking to answer the question.

"Patient-centred" is allowing or including your patient in decision-making within the health care plan of care. We can provide options, treatments, resources, but ultimately at the end of the day with the patient well informed, they make their own decisions. We assist them in fulfilling those decisions and provide education in making those decisions.

In terms of team-based care, we have a lovely complement of clinicians, and each of us plays a role in helping the patient through their health journey, whatever that may be. For physiotherapy, for instance, if a patient has a musculoskeletal injury, that patient can be seen first by the physiotherapist and managed and treated by the physiotherapist.

This is a collaborative effort, so if the patient has a concern and wants to see a nurse practitioner, that is absolutely open to that. If the physiotherapist wants to

collaborate in terms of a treatment plan with their primary care provider, their nurse practitioner, that is open to them as well. That goes for all of the providers: the RNs that are providing care, the registered respiratory therapist. This is a collaborative effort. At the end of the day, it's all in the best interest of the patient in which they are driver of their care journey.

Does that help to answer that question?

Mr. Anthony Leardi: Yes, it does. Now I want to talk about budgets, capital costs and operational costs. I would presume that in your budget, most of your costs, if not all of your costs, are operational costs. Do you have any capital costs?

Ms. Sharon Bevington: We do not have any capital costs.

Mr. Anthony Leardi: That's what I thought. So let's talk about operational costs only. With regard to your operational costs, a percentage of your operational costs would be what I call payroll expenses. That's my background, so I would use that word in my background. So payroll expenses are things like wages, contribution to pension, payment for benefit plans, vacation pay, stuff like that, then there would be other operational costs such as related to medical supplies, rent, utilities.

I want to concentrate just on payroll costs right now. From your operational budget, what percentage would be eaten up by payroll costs only?

Ms. Sharon Bevington: We're one-third operations, two-thirds HR.

Mr. Anthony Leardi: So payroll would be approximately two thirds?

Ms. Sharon Bevington: That is correct.

Mr. Anthony Leardi: Okay. Now without disclosing any confidential information—I don't want to hear anybody's name—what would be the range of the compensation packages paid by your organization? You might only be able to give me an estimate. So a compensation package would consist of the wages plus the value of the benefits plus the value of the annual contribution to the pension. What would be the range from, let's say, the lowest to the highest? If you can only estimate, feel free to estimate.

Ms. Sharon Bevington: Sorry, I was just using my calculator. So the range is $27 to $80 an hour.

Mr. Anthony Leardi: That would be—

Ms. Sharon Bevington: All-inclusive, full compensation.

Mr. Anthony Leardi: Okay. Now when we talk about $27 an hour, are we able to peg an average hours a workweek on that? Is it average 35? Is it average 40? Is it average 44?

Ms. Sharon Bevington: Our full-time equivalent is 1,950 hours per year.

Mr. Anthony Leardi: It's 1,950 hours. So if I'm going to do some quick math, it's $37,000?

Mr. Dave Smith: That would be about $52,000 for the bottom one.

Ms. Sharon Bevington: It's $52,650.

Mr. Anthony Leardi: That would be the lower range?

Ms. Sharon Bevington: That is correct.

Mr. Anthony Leardi: Okay. Now let's talk about the high range, $80 times 1,950. I just want to get some ideas here.

Ms. Sharon Bevington: That's $156,000.

Mr. Anthony Leardi: Okay—

Ms. Sharon Bevington: Sorry, that includes CPP, EI, everything, just so we're clear.

Mr. Anthony Leardi: Yes, that's all payroll.

Ms. Sharon Bevington: Okay, perfect.

Mr. Anthony Leardi: Okay—ranging from $52,000 to $156,000. Thank you very much; that's for information purposes.

Now let's talk about the staff complement. There are two full-time nurse practitioners, correct?

Ms. Sharon Bevington: We have 3.0 equivalent, which is being covered by four humans. But we have 3.0 full-time-equivalent nurse practitioners.

Mr. Anthony Leardi: And you've got four covering?

Ms. Sharon Bevington: Correct.

Mr. Anthony Leardi: And you talked about—I'm familiar with Belle River; I can't imagine anybody would want to live anywhere else in the province of Ontario except Essex county. It's just inconceivable in my mind.

Mr. Dave Smith: You're forgetting God's country, though.

Mr. Anthony Leardi: My colleague here comes from God's country; perhaps that might be almost as nice as our area.

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

Mr. Anthony Leardi: With regard to what you said, is that you're losing people to other sectors. So it's not necessarily that they're being coaxed away by one of the area hospitals; they might actually be coaxed away by, let's say, GreenShield, right?

Ms. Sharon Bevington: Something like that, yes.

Mr. Anthony Leardi: Yes. Are you at liberty to tell us how many staff, let's say, over the last five years have been coaxed away?

Ms. Sharon Bevington: So we have a small team of between 10 and 12 people. We'll keep it easy at 10. Over the last five years, off the top of my head, I believe we have lost eight to nine staff, either to other health care sectors or to other sectors entirely.

1440

Mr. Anthony Leardi: All right. Those are all my questions. Thank you very much.

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

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

MPP Lisa Gretzky: Thank you. I have a question. Hopefully, I'll have the time to talk to the other presenters, but I have a question for Mike Fisher. I want to start, Mike, by saying thank you for all the work that you have done for many, many years around preserving natural areas in our region and the push, along with the Wildlands League, Caldwell First Nation and my federal riding mate, Brian Masse, to create Ojibway National Urban Park. We haven't seen that across the line yet, but my hope is that it will happen sooner rather than later.

My question is around comments that you made about the biodiversity strategy. I'm wondering if you could provide some additional information about the importance of the provincial government investing in Ontario's Biodiversity Strategy.

Mr. Mike Fisher: Sure. Thanks so much for the question, MPP Gretzky. Yes, Ontario does have a biodiversity strategy, which comes from Ontario's biodiversity council, which is largely made up of a number of environmental NGOs, as well as certain government ministries and organizations. We have a clear strategy for addressing issues related to biodiversity laws, which is significant, certainly, globally and in the province of Ontario, as well as protecting and expanding our natural areas and dealing with the challenges of climate change.

We know how much it costs at the back end to deal with climate change after the fact. There are so many nature-based climate mitigation strategies that do exist, and we have developed a strategy for that. The hope is, seeing what's happening around the country and seeing what's happening both nationally and globally and with other provinces, and providing some funding to address those strategies—we're hoping to see that happen in Ontario as well, to follow through with that. It's very important, again, for biodiversity and ensuring that we have natural areas for the health of people, for physical well-being, for mental well-being.

We're also seeing a lot of great work on reconciliation, with opportunities for Indigenous peoples and First Nations and co-management in our protected areas. It's very important for reconciliation and that's well addressed within the biodiversity strategy, and really allowing our province to align, again, nationally and internationally with what's being done in terms of ensuring we're taking care of our protected areas, slowing the reduction and the loss of biodiversity, and really ensuring we're following best practice in climate change adaptation, which really makes sense for sustainability and for the economy as well.

Hopefully that helps clarify a bit. Thanks so much for the question, MPP Gretzky.

MPP Lisa Gretzky: Thank you. I have a supplemental for Mike. I'm wondering if you could talk a little bit about what potentially could happen—I mean, we've seen two once-in-100-year storms that caused mass flooding in our region. The county has had more flooding than—specifically in Windsor. If you can kind of touch on what it would look like if the strategy isn't properly funded.

The other piece of that: You had mentioned a review of provincial subsidies and policies, or subsidies that harm nature. Are you able to touch on, maybe, some of the policies that you think are harmful? I can point to one where they were going to develop the greenbelt, the government was going to develop the greenbelt. But I'm wondering if you can touch on maybe some other policies that you see currently in place and subsidies that could be reviewed by the government and potentially ended.

Mr. Mike Fisher: Just to answer the first part of your question, MPP Gretzky, thanks for the follow-up. Certainly, we're aware that—whether it's wetlands or other nature-based solutions, in terms of water retention and preventing the flooding that we see—unfortunately, as you mentioned, with more and more common what we used to call once-in-100-year storms—there are a lot of those nature-based solutions that allow us to mitigate climate at a very inexpensive cost. If we leave nature to its course, it could be very effective in climate change adaptation and preventing some of the flooding and some of the issues that we see, unfortunately, as an outcome of climate change.

In terms of broader policy and subsidies, I'll say Ontario Nature will be following up with a written submission [*inaudible*]. I think what we're really requesting, as one member of the Nature Network across Ontario, is for a more fulsome review of what those subsidies are, just across all departments. It may touch on some aspects of, certainly, the energy sector, critical minerals, perhaps a little bit in agriculture. But we're really looking for something across the board ensuring that, when something is subsidized, we're considering nature and impacts in terms of biodiversity and climate when making those decisions.

MPP Lisa Gretzky: Thank you. I just again want to thank you for your work. I've been involved in the work around Ojibway National Urban Park. You mentioned Hillman Marsh as well. I was out at Hillman Marsh just last week. There's not an awful lot to see there right now, but it sure is good for your mental health to get out and walk amongst nature, I can tell you that much.

I'm going to go back about the wage disparities, because that has been a theme, I will tell you, since the first presenters this morning, those providing community-based supports in health care. Sorry—I'm not sure if I heard properly. I've recently been ill, and my one ear is still plugged. But did I hear there was about a $28,000 wage disparity? I'm assuming that's per year, between—

Ms. Sharon Bevington: That was from West Elgin.

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

MPP Lisa Gretzky: Okay. I think that's what I heard—$28,000 a year that they're getting paid less than their counterparts, perhaps, in hospital. I just want to point out that, especially in this economy, $30,000 is an awful lot of money, and we have seen an increase in health care workers and others who are accessing food banks. Meanwhile, they are providing very important services, health care services, and the cost of people not having that care and ending up in hospital is much more expensive. If you invest in people in the front end, in things like nurse practitioner-led clinics, I believe that is well worth the investment so that they can not only put a roof over their heads and feed their children but keep people out of the emergency departments, and we would save money on that end.

With that, I'm just going to thank you all for the work that you do.

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

We'll now go to MPP Hazell.

MPP Andrea Hazell: My question this time around is going to be to West Elgin Community Health Centre and Dawn—I guess if I could get back Dawn on the screen.

First of all, congratulations on the 30 years the organization has been serving the community. I notice you have a large pool of volunteers; you've got 40. And so also congratulations on that too, because it's really, really difficult to find a lot of volunteers to fit in, to meet the needs of the services that you provide for your community.

I want to turn to your challenges with retaining the staff that you have on board currently. How many staff do you have on board, and what are some of the retention challenges that you're facing with staffing?

Ms. Dawn Maziak: Okay. So, what we found is that we are attracting young new grads from across the board, from physicians down to PSWs. We have, in total, 50 full-time equivalent staff, and in the last two years alone, I have seen approximately seven to 10 different individuals leave. Because I'm the board chair, I try not to get into the operations, but I'm definitely aware of constant cycles.

What we've considered is perhaps we should become an academic community health centre that focuses on rural health care. If that's what we're going to constantly see as a cycle, then maybe we need to look at some innovative ways, because obviously we do a great job of educating.

The question that came about around the $28,000 is for a registered practical nurse.

1450

MPP Andrea Hazell: Do you want to add some more to that, Dawn?

Ms. Dawn Maziak: Sure. We do know that we have graciously received funds for PSWs, personal support workers, and so those increases across the province have been—we have gratefully accepted them. And that would be under our community support services. But it's our primary care team—so there is mental health, RNs, registered practical nurses and our entire health promotion team and volunteer coordination—that has not seen those increases since 2017.

And so, we are losing them to neighbouring communities and to other sectors similar to the Lakeshore community nurse practitioners. We are rural, so we struggle with that. And so, if we're constantly recruiting, then there is that cultural disconnect because somebody who is from the city may not truly understand some of the challenges and the realities of living in a rural area.

We also have a significantly higher population of seniors, and that in itself is—their care is becoming much more complex. We're seeing more seniors with dementia and chronic respiratory illnesses, and again, you know, that continuity of care is critical.

MPP Andrea Hazell: Of course it is critical. And so, if you look at 2025, 2026, 2027, are you going to be able to continue to provide that primary care that your community needs?

Ms. Dawn Maziak: No. We would not be able to accept new people off our wait-list, and we would really need to drill down and—

The Chair (Mr. Ernie Hardeman): Thank you very much. That counts three for me.

With that, we'll now go to the government. MPP Dowie.

Mr. Andrew Dowie: Thank you, everyone, for being here.

Let's start with Mr. Fisher. Welcome to the committee. I just wanted to understand a bit of where you see things going. I did hear your call for the funding of Ontario's Biodiversity Strategy.

Some of the initiatives that have been reported recently by the province of Ontario have been, for example, the new urban provincial park in Uxbridge; the $10-million contribution agreement between the federal and provincial governments to expand protected areas in Ontario and improve the accounting and reporting of private and municipal protected and conserved areas; another five-year agreement for caribou conservation, which is $35 million; ongoing agreements, for example, the COA for the Great Lakes and $72.6 million for 575 different projects to safeguard the Great Lakes.

So, I wanted to get your take on what the current program looks like. Especially relative to other provinces, you know, mentioning Quebec and some of their commitments but, you know, other provinces, like—how does Ontario fare based on your perspective from the investments that are being made today?

Mr. Mike Fisher: Thanks so much for your question, MPP Dowie. I'm certainly a fan of the urban provincial park program and the efforts there for biodiversity in urban areas and some of the other projects as well you mentioned.

I think this is a concern that we're hearing across the province in terms of environmental NGOs, just keeping up with that level of funding that we're seeing in other provinces and ensuring that the Ontario biodiversity strategy specifically is well-funded and just confirming that we have the strategy there, we have the approach there. It's expert-created, expert-driven, and just having the understanding that we're working with that framework in order to meet—you know, to work with the federal government and international partners on meeting global biodiversity goals.

So I think there's a lot of opportunity there for partnership and looking at some of the models that are in place in other provinces—I think I mentioned Quebec and British Columbia—and ensuring that we can roll out that plan to really deal with issues of biodiversity loss and climate change to the extent we need to across the province.

Mr. Andrew Dowie: Thank you for that. So building on that, if there are certain items that are a bit more challenging—I'll use the example you mentioned, the 30% figure for setting aside protected areas. I attended, earlier this year, a meeting with the first ministers on this and I can say a substantial number of those provinces are not able to meet the 30% for a variety of reasons. They set 20%, they set 10%—it's case by case.

Is there a mechanism to achieve that 30% without it being, say, a purchase or a reduction of available land in

the province? Could that be achieved, from your understanding, through additional partnerships with private landowners? I know here in Essex county, the Essex Region Conservation Authority has that type of program, where agricultural lands can be set aside and protected for a set period of time with planting. So I just want to get your further thoughts on that.

Mr. Mike Fisher: Thank you so much for the follow up, MPP Dowie. And yes, I think part of what we hear across the province, part of it is having—and you may have mentioned it in some of your remarks—the funding available for municipalities and other organizations to better quantify, for beating those 30% targets, what land is protected and how it's being protected. So I think that certainly a part of it, is working with private landowners, municipalities, other levels of government to identify that and quantify it, ensure that it's really showing that commitment. Showing that we're committed to the 30% target is certainly very important.

I think expanding protected areas is critical as well. We do want to be able to quantify what we have, understand where we are, understand where we are against the 30% target, as well as have those opportunities to expand protected areas. Certainly, I think what's in Ontario's Biodiversity Strategy, that's a key component as well, as we know what the value is in protecting nature for people, for climates and for reconciliation. So hopefully that helps answer your question.

Mr. Andrew Dowie: Yes, absolutely. You mentioned Hillman Marsh earlier, and I can't think of a better place to go kayaking here in Essex county. It's actually not too far from here, for the committee members.

But I know in the last number of years—I've been able to visit many of them—you've seen new conservation reserves and provincial parks, not just Uxbridge, but the Alfred Bog and Monarch Point. Bigwind Lake is getting an expansion. And then there's the Greenlands Conservation Partnership. It's $30 million over the last four years to support partners—for example, say, the Schad Foundation, the Nature Conservancy Canada and others. So that's with $20 million more over the next four years running into 2028. And on top of that, the wetlands conservation program: five years, $31 million.

I just wanted to give you the assurance this is an issue that the government of Ontario is taking seriously. The funds have been planned for in the budget for a number of initiatives related to biodiversity, so you're heard and we're certainly taking your comments back.

So thank you very, very much for your presentation. I want to see if there are any final asks. You mentioned the Ojibway National Urban Park project, something you would like to see the province do with that. I know you've spoken to then Minister Piccini, and I know he's heard your call. We've set in motion, certainly, that partnership with the federal government to ensure the realization of that park. So I just wanted to see if you had any further comments on it.

The Chair (Mr. Ernie Hardeman): Speak up or forever hold your peace, but we're not hearing any—

Mr. Andrew Dowie: Oh, his microphone is muted.

The Chair (Mr. Ernie Hardeman): Mike is not on.

Mr. Mike Fisher: My apologies to the Chair and MPP Dowie, I'm just not able to unmute my own microphone, so thank you so much to the coordinator who just unmuted me.

Thank you so, so much. I appreciate your follow-up, MPP Dowie, and I appreciate you identifying those initiatives and I look forward, certainly, to your review of Ontario Nature's submission and some more detail on where the $230 million ask comes from. So thank you for outlining that. I look forward to the written submission.

And thank you for your opportunity, personally, to discuss locally. Certainly, with the Ojibway National Urban Park, we're very eager to see that created with the integration within federal legislation of the Ojibway Prairie Provincial Nature Reserve, and we're looking for collaboration from the province in terms of consolidating the lands there as well to ensure that both the current boundaries of the provincial nature reserve as well the proposed expanded boundaries are properly consolidated to update the land boundaries of that park. I know that's something we spoke with Minister Piccini about—

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

1500

That not only concludes the time for that question, it also concludes the time for this panel. So I want to thank all the presenters for a great job and taking the time to prepare it, and coming here and so ably presenting it us.

ONTARIO SOCIETY OF CARDIOLOGY TECHNOLOGISTS

WINDSOR FAMILY HEALTH TEAM

The Chair (Mr. Ernie Hardeman): With that, as we're changing tables here, the next table will include the Ontario Society of Cardiology Technologists and Windsor Family Health Team. As we're coming forward, the instructions will be the same: You will get seven minutes to make your presentation. At six minutes, I will say, "One minute." Don't stop, because at seven minutes is when I say, "Thank you," then you stop.

With that, we also ask, as you start your presentation, that you give us your name for Hansard to make sure that the comments are attributed to the right name.

With that, we will start with the Ontario Society of Cardiology Technologists. The floor is yours.

Ms. Karen Rondinelli: Thank you for having me. My name is Karen Rondinelli. I am a registered cardiology technologist with the Ontario Society of Cardiology Technologists. We'll go by RCT for short and OSCT for our association.

I think you've all been given a written submission for pre-budget consultation that gave you a few cases that were sent out of what is happening within our field of work.

Registered cardiology technologists, RCTs, are medical professionals trained specifically in the testing, monitoring and evaluation of the function of the patient's heart and are vital in the prevention, diagnosis and treatment of cardiac conditions. In Ontario, RCTs are required to be registered with the OSCT and fulfill annual requirements for continuing education units. However, there is no formal standardization process at the provincial level other than in New Brunswick. Within Ontario, medical personnel who are untrained to perform cardiology technology duties and tasks are being allowed to administer these tests in both hospitals, clinics, office settings—wherever—and formal education and training as an RCT is not required.

Why does this matter? Physicians frequently rely on our expertise and skill to assist in the assessment and treatment of cardiovascular and conduction disease. We gain this expertise through years of study and practice, ensuring proper technique while testing and interpreting thousands of ECGs, Holter monitor studies, stress testing, pacing, and we even get into ultrasound, which is echocardiography of the heart.

What happens if ECGs or other cardiac tests are administered improperly by untrained medical personnel? Incorrect sticker placement and misinterpretation are commonplace, which can often trigger a cascade of unnecessary testing and specialist appointments for the patient. Hospitals often receive ECGs with no patient identification, meaning these cannot be interpreted and assigned to a patient. Patients may be sent home or for treatment without having a correctly interpreted ECG. Failure to recognize emergencies: very dangerous and potentially fatal. Inaccurate test data adds to labour costs and reinterpretation and re-testing, thus increasing more cost. This is a waste of time and money. It also causes undue stress on the patient and their families.

With our specific cardiac knowledge, cardiology technologists would have prevented these patients from advancing through our health system. RCTs speak the language of cardiology. We're here not to ask for money; we're here to save you money in the tests that we are doing.

What can the provincial government do? We are seeking full standardization under the Regulated Health Professions Act, 1991. A ministerial order is needed for the OSCT to go into the college of medical radiology technology association of Ontario, or we need special accommodation in the oversight authority that would address our task.

What we have found: I have been in cardiology for over 30 years. I've seen a lot of issues where other groups are doing our testing. We are not here to take their jobs. We just want to make sure that everybody is standardized and doing the simple test of ECG. This affects all nurses, either in emerg, ICU, CCU, your paramedics and your med labs. They get some training of cardiology in the basic test of ECG, but they don't know how to read the cardiogram.

I can show all of you how to do a cardiogram. It's on how you read it and interpret it. There's been so much misinformation and miscalculation, lead reversal, that it has actually caused deaths of our patients of Ontario. So we're here to try and prevent that.

It also advances not just with ECG, but takes into the effect of Holter monitors, proper prep, stress testing, and also when you get into echocardiography. Our techs have a two-year program, and they can advance into echo. Echo is now regulated with the CMRITO. They got regulated a number of years ago because of the high-end equipment that you have to use.

We are the eyes of the doctor, so what we do and present to the doctor—that's what they see. We are even talking med labs. Not taking any work away from med labs—they are tested, and they are given education for ECG, but their main concern is blood work.

All we're asking is to please standardize this. We can save you millions of dollars in this whole area that we do. We have talked to numerous cardiologists. If you go to our website, the Ontario Society of Cardiology Technologists, or OSCT—just go in there and go to YouTube. We've got YouTube events of what has happened. We have had issues where nurses have done ECGs and patients have died.

Just even in my own area myself, my mom—I thought she was stroking out. I had a paramedic come in; they came in and started to do the test. They are telling me—you've heard the word, atrial fibrillation. You see it on TV with Kardia: put that little—stick your fingers on there. My mother has muscle tremor disease. You are going to get shaking on that cardiogram. She does not have atrial fib. I understood the whole reading, and that paramedic was incorrect. If I had left it with him, she would have been drugged and taken to the hospital, and I was able to stop it.

This is what we are trying to prevent, and to save Ontario health care money. We are here to help you do that with standardizing everything that we do.

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

We will now hear from the Windsor Family Health Team.

Ms. Margo Reilly: Good afternoon, Mr. Chair and members of the Standing Committee on Finance and Economic Affairs. My name is Margo Reilly, and it is my privilege to serve as the executive director of the Windsor Family Health Team. Thank you for the opportunity to present today.

The Windsor Family Health Team is a fully integrated health care organization dedicated to advancing the health and well-being of the Windsor-Essex county community. As a community family health team, we operate uniquely compared to other family health teams. Our members of our team include primary care providers. They are all employees of the organization. This structure fosters a collaborative team culture, encourages innovation, enables the early adoption of digital solutions, and positions us as nimble champions of change.

Our mission is to realize these goals through two core programs, which are the family practice program and our team care centre program. The family practice program

serves over 11,000 enrolled and attached patients, offering comprehensive care that includes preventative services, chronic disease management and acute care. While resembling a traditional physician's medical clinic, this program is distinguished by its interdisciplinary team-based approach to care.

The team-care-centre program supports patients referred by 180 primary solo physicians and nurse practitioners in the region, delivering specialized interdisciplinary care in areas such as mental health, addictions and chronic pain management.

The Windsor Family Health Team is also a proud and active member of the Windsor-Essex Ontario Health Team. Our leadership in collaborative initiatives and our trusted community partnerships have strengthened our ability to deliver integrated, patient-centred care.

As a constituent and local health leader, I extend my gratitude to the government for its ongoing investments in our community. These contributions play a vital role in supporting and enhancing the work we do to improve health care for the people of Windsor-Essex.

I would like to acknowledge my colleagues from the Canadian Mental Health Association Windsor-Essex, Erie Shores Family Health Team and Lakeshore NPLC for their presentations today. Together, we represent diverse health care needs of both rural and urban communities in Windsor-Essex, each leading unique team-based primary care models while contributing complementary perspectives to this vital discussion.

1510

The primary care sector in our region thrives on collaboration and respectful dialogue, ensuring we collectively address the needs of our patients in our community. My colleagues have already highlighted critical challenges, including compensation equity and the need for targeted investments in the primary care workforce and infrastructure. Building on their presentations, I will focus on my team's priorities and how our existing infrastructure can provide solutions.

On the topic of health care sector pay equity, I can attest to the significant barriers in retaining talent across all roles but especially in administrative roles, social work and nursing. Compensation disparities, rising cost of living and competition from higher-paying publicly funded sectors have created an urgent staffing crisis, threatening timely access to care for patients. Recruitment of talent is becoming increasingly more difficult, especially with so many available positions in hospitals.

I am seeking fair, equitable pay for my employees in alignment with wages negotiated by our provincial government with the unions. The positions that received increases in the provincial negotiations are attached to publicly funded health care organizations just like ours. My organization is in alignment with Ontario's Pay Equity Act—equal pay for equal work. It is my responsibility as the leader of the Windsor Family Health Team to advocate for my team. I would like to keep my employees. I value them. Please help me do so by supporting our pleas for compensation increases.

At the Windsor Family Health Team, successful program development is one of our core strengths. Our Team Care Centre program began as a pilot, initially designed to support 91 physicians within the city of Windsor. However, due to the growing demand for access to team-based care, we now collaborate with 180 referring primary care providers. While this overwhelming demand has resulted in wait-lists that exceed the original scope of the model, our services continue to make meaningful impact on the lives of those we are able to reach.

Innovative programs such as One Team Recovery, oral health education, social prescribing, the memory clinic and trans health clinics are embedded within our primary care setting to address specific and diverse community needs. However, these programs rely heavily on one-time funding and grants, leaving them vulnerable to instability without sustained funding and the retention of skilled facilitators.

The expansion of team-based primary care, existing organizations such as the Windsor Family Health Team and both of our programs, family practice and Team Care Centre, presents a practical and impactful solution to address pressing local health care challenges. The Windsor Family Health Team's 2023 expression of interest submission to Ontario Health underscores our readiness for expansion, supported by well-established governance, comprehensive policies, proven leadership expertise and extensive community partnerships that enable integrated care and improve patient outcomes. To achieve this, we advocate for an increase in the number of approved family physicians to strengthen our patient attachment and broaden access to care. Additionally, we propose expanding Team Care Centre to support solo physicians in our community. While establishing satellite sites across the region, we can meet demand.

The Windsor Family Health Team is more than just a health care organization. We are a trusted medical home dedicated to delivering comprehensive, accessible and patient-centred care to the Windsor-Essex community.

I would be remiss if I didn't include the necessity of addressing inflationary pressures and the need for modernization through technology and digital solutions, which require increased base operational funding.

Again, I would like to thank the government for the one-time funding we received in 2023-24 and 2024-25. Securing this base funding will allow us to make important decisions for digital investment and prioritizing cyber security.

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

Ms. Margo Reilly: On behalf of the Windsor Family Health Team, I want to thank the Standing Committee on Finance and Economic Affairs for considering our recommendations and for your commitment to improving health care in Ontario. We look forward to continuing this important dialogue and working together to build a stronger, healthier community.

I urge the committee to prioritize investments in primary care to safeguard both the health and economic resilience of our communities. A healthy population is the

foundation of a thriving economy. By addressing workforce challenges, expanding interdisciplinary care and stabilizing funding, we can ensure equitable, timely and high-quality health care for all Ontarians. Thank you.

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

We'll start with the independents. MPP Hazell.

MPP Andrea Hazell: To both organizations, thank you for coming in and presenting to us—very detailed presentation.

But I'm going to start off with Windsor Family Health Team. Thank you for detailing that; this is a very robust and detailed presentation, and nothing that you're saying in this presentation is new to anyone sitting around these tables. But I want to spend some time on pay equity from your point of view, because we've heard from health care sectors yesterday and just before you presented: It's the same challenge on pay equity. It's also the same challenge that they are experiencing on their funding models.

So before you talk about the pay equity, how are you coping with your funding gaps right now and keeping your doors open, and still providing the care that your community needs?

Ms. Margo Reilly: I have to give all the credit to my team. We are a very innovative team. We find ways and strategies through digital solutions. We create systems to create efficiencies by upgrading our EMR, using Ocean eReferral, using all types of digital solutions first. We create streamlined standardized processes.

How are we coping? We are coping just like all of my colleagues: We're doing the best we can with the resources we have. We are a very creative group. We are a passionate group. When you are in leadership in primary care in community, you don't do it because of the dollars. You do it because you love it. You do it because you want to make an impact.

As I mentioned, it is a privilege to be the executive director of my team. They are incredible. They are creative. They are innovative. They create solutions and groups for their patients, so we can see more patients in a very short period of time. I'm involved in research; I'm embroiled in program development. I work the extra hours because I believe in it. It's a whole-team effort. It is from the top of the organization's org chart to every level of the org chart. Our board is even involved.

MPP Andrea Hazell: I want to follow up with another question, because the funding pressures for all health care sectors across Ontario—they're being financially punished right now. My heart goes out to you. I think we are putting a price on people's health, and that is something we have to reconsider here.

I remember when I came to beautiful Canada—this country is beautiful. I came here in 1988, and never had I heard of health care in so much crisis as it is in currently right now. But funding might be a wish list. I don't know if you are going to get funding; I don't know who is going to get funding, really and truly. But if you do not get at least part of the funding that you are here presenting for, what does 2025, 2026—I'm not even going to mention 2027. How are you able to operate or continue to operate?

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

Ms. Margo Reilly: MPP Hazell, I think I'll continue doing what I have been doing. I've been writing grants. I've been fundraising. I've been begging third-party community foundations. I offer myself as a resource so I can fund my staff. That's what we do in community leadership: We sacrifice ourselves so that we can do better for our patients and for our community. We look at synergies. We look at partnerships. We look at ways of better serving patients: "I'll partner with you; I'll trade you off. I'll give you a space if you give me the people." That's how we do it.

MPP Andrea Hazell: You're brilliant. When women lead, amazing things happen. But it shouldn't be that difficult.

The Chair (Mr. Ernie Hardeman): For the government, MPP Anand.

Mr. Deepak Anand: First of all, thank you to both of you for being here and representing and advocating on behalf of your community and Ontarians at large.

Because you both are from health care, I'm going to start by saying and acknowledging that today's the first time my daughter actually went to the hospital. She's studying nursing at the University of Windsor, for the clinical—whatever they call it—and she's very excited. She sent me a message. She said, "Dad, I am so excited," so I said, "Aw."

I just want to say thank you to you and all the health care professionals, especially when we're talking about the cardiology technologists. I compare it with more like a firefighter or a saviour. When something happens, everyone is looking up to you, because you have split seconds to save somebody. I agree with you having—it's kind of saying that you practise what you need to practise for those critical, crucial moments. That's where all the education is coming into play.

1520

I'm just trying to understand: What are you trying to say? That it should be more regulated? Your profession should be more regulated? Is that what your ask is?

Ms. Karen Rondinelli: We have tried to regulate, a number of years ago, and we got just so far and then, of course, government changes again. We came back in and it's, "Okay. We're hearing a lot about deregulation, so let's just standardize the understanding of how to do a cardiogram." That's one of the basic tests that we do, but from that you're getting all of the other testing: Holter, stress, whatever.

If we can standardize the proper training with all the other groups like paramedics, with nursing staff—I mean, they have a very, very important job to do, but they're also getting dumped on with extra stuff from the hospitals, because they're there too with the patient. Instead of waiting a few minutes to get an RCT in, who might be busy somewhere else, they'll go ahead and do it. The unfortunate part is, if you're not trained properly on landmarking—it means so much for landmarking, just to

do a cardiogram. If you're off by one millimetre, that will throw your cardiogram off and give you totally different meanings, no different than if you cross your limb leads, if you put them on the wrong spot on the leg and you get a tremor. This is where it can confuse you: on a sheet of paper where they're telling you it's atrial fib and it is not.

That was the episode with my mother. I argued with the paramedic. I said, "Show me the lead. Show me your cardiogram." I read it off to her. I teach this. I've been in it for 30 years, so I think I what I'm doing. Basically, it was, "Oh, yeah. You're right." So let's get the proper standardization of training across all groups.

My daughter is a nurse practitioner. She started as an RCT, but she told me too, "Mom, we don't get enough training in what you guys do. We get told how to put the leads on." Go in and ask your doctors in emergency. One of our doctors who spoke to us is an emergency doctor who realized he did not know how to read the cardiograms properly, so he went in, trained himself and then started to train the other emergency doctors. That's all we want: Make sure everybody is standardized with their training.

We've got four regulated, accredited programs at the college level here in Ontario, and we're willing to set out more programs and go into these groups and say, "Hey, guys. This is what you need. Let us help you." Let's save the government money, because every ECG, when you think about it, is only maybe $11, but that $11 adds up. We did a calculation, and it was close to $40 million that is being lost per year in Ontario just in cardiograms alone. I have a cardiologist who reads 80 ECGs from a lab. You've got Dynacare. You've got LifeLabs. He reads 80 ECGs at night, at home, and he would just say, "Karen, I can't believe this. Half of these, I can't even read: limb leads are crossed; misinterpretation; so much garbage on it, we can't read it; Holter monitors that are coming out." There are all these new ones where the patch is just slapped on the chest. If you don't prep that skin properly, you are going to get artifacts and you can't read it, so it's a repeat process again.

Over and over, you're repeating these tests, even with echo. Echo is over $300 a crack. I do echo too, and I've had patients come in: "Why are you here? I did your echo six months ago." "Well, the one doctor said this." And I've gone in to the doctor's: "Why are we repeating this man? His echo was perfect the other time." So we do major decisions—

Mr. Deepak Anand: Absolutely. So let me understand it again. My mom is in long-term care. I went to see her, and there was a technologist who came. She did some tests. I didn't even ask her, "Do you have training?"

Ms. Karen Rondinelli: Exactly.

Mr. Deepak Anand: I didn't ask for the certificate. I believed she has the training, and she does have a certificate.

Ms. Karen Rondinelli: You assume she has the training.

Mr. Deepak Anand: Well, this is trust. We apply the brake when I'm driving—

Ms. Karen Rondinelli: Right. You trust the brake is going to work.

Mr. Deepak Anand: I would trust that when I apply the brake, the car will stop, right? There was an engineer who built that.

Ms. Karen Rondinelli: Exactly.

Mr. Deepak Anand: So I think trust is important. All I'm trying to understand is, you're trying to say that we need more training and we need standardized training. So let's go a little further back: Do you need regulations for that, do you need a college of RCTs for that or do you just want standardized testing and training? What do you need?

Ms. Karen Rondinelli: To get regulated will take forever. Echo did get put into the CMRITO because it is a very high-skilled test also. If we can standardize—forget regulation. Everybody gets proper standardization training, we will go out to all these other groups—the med labs themselves, paramedics—and teach them properly.

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

Mr. Deepak Anand: Perfect. I'm sure we can look into the Ministry of Health, some of the programs which can support you to fund that training piece.

But you can look at the Skills Development Fund. Typically, we usually have SDF for trades, but we have seen SDF in other areas as well. So maybe you can look at SDF—

Ms. Karen Rondinelli: STM?

Mr. Deepak Anand: SDF—Skills Development Fund; that's one choice.

The other one is the Ontario Trillium Fund. Now, the Ontario trillium fund is not like continuous oxygen; it's like a shot of energy, so it's limited—it's given on a project-by-project basis. If you think it can save value, it can save money, it can save somebody's life—it can give somebody an extra tool to give back and progress in their life—that's where you can actually use OTF.

Ms. Karen Rondinelli: Thank you.

Mr. Deepak Anand: I don't have much time, but I quickly wanted to say to the family health team—

The Chair (Mr. Ernie Hardeman): I'm afraid you've already passed that.

MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to our presenters here today. Karen, it's very good to see you.

Ms. Karen Rondinelli: Good to see you.

Mr. Terence Kernaghan: I want to thank you for your presentation because it shows true care and respect for the discipline itself. You're here at the finance committee, not asking for money, but asking that the province actually save money. What was the number you used? I believe it was $40 million.

Ms. Karen Rondinelli: We did a calculation just talking with different doctors, and we calculated about $40 million a year that's being wasted that could go somewhere else. And that's one test.

Mr. Terence Kernaghan: Right. And that could just be the tip of the iceberg.

Ms. Karen Rondinelli: Yes. That's actually the tip of the iceberg because—Holter monitors too; that's another thing: We put on Holter monitors and like I said, prep

means everything and if it's not put on properly—what a lot of the companies are doing is rip it off, throw it in an envelope, throw it in the mailbox and away it goes. But if it comes back and there's some damage or no prep, you're getting garbage. So it's a repeat test again.

So you've got all your codes for Holter, and I know way back—P1, P2—I used to have my own Holter business and it's 65 bucks just to scan. That's not talking about prep and hook-up, and if I can't read that because of the garbage, it's a waste of my time and we've got to start right from scratch again—that's with that.

Then you have stress testing. Then you have pacemakers. You've got cases in here of pacemakers that, if the resident or nurse doesn't understand the rhythm itself, they can jeopardize and put the patient into another rhythm thinking they're going into a heart attack; in reality, it's a conduction delay on the ECG that they don't understand. It's no different with echo, same thing.

I've been at this 30 years, guys. I've seen an awful lot and I've seen a lot of things where patients have died that wasn't necessary; that's what it's all about.

Mr. Terence Kernaghan: Thank you for sharing your expertise with the committee. Also, you considered the financial impact as well on the patients themselves who've gone to prepare themselves to get ready for that test, and there's so many added costs to it. It seems pretty obvious that the government would want people completing the assessments to make sure that they're doing them properly. I can't imagine why anyone would actively allow mistakes to be made.

But I'd like to know: Can you speak a little bit to the potential moral injury of health care providers who might not administer this test properly and then find out, as a result of that, that they've compromised the health of someone?

Ms. Karen Rondinelli: It's difficult. We have got cases that have come through to us and people will not give their names because nobody's going to rat on anybody on—this happened to this patient, and I've seen it. You bring it to the attention of the doctor: "Okay, this didn't get read properly. What's going to happen?" Well, we'll retrain the nurse or whatever. A lot of it gets sloughed under the rug, and it's unfortunate, but what else can we do? We're techs, and when I taught Mohawk, the interpretation and Holter—you are the eyes of the doctor. You see all of this prior to the doctor, so if you think the patient is having a cardiac arrest, get that right into them.

1530

What we're finding is a lot of people that, if they're untrained, it sits on a desk. And that has happened. One gentleman came into emerg—one of the surgeons in emerg. He was complaining, chest pain. It was not done by an RCT; it was somebody else in emerg. They put it on the desk, others got put on top, and it just happened to be an RCT who was coming around looking for one of hers and saw it.

Mr. Terence Kernaghan: Oh, my goodness. Wow.

Ms. Karen Rondinelli: That was an hour later. This man ended up going into the cardiac cath lab and having a stent put in immediately. This is what happens.

The same with implants—if you don't understand pacemakers and how they work, and the rhythm strip is read incorrectly, you can cause—where one nurse did, started to call a code, gave him a defibrillator. Well, guess what? You just zapped his whole heart into a different rhythm and put him into a rhythm of ventricular tachycardia, where they tried to revive him. He did not come back. He ended up in ICU on respirator for three days, and life supports were withdrawn. So, it is happening.

These are some of the major cases that we hear. A lot of our techs will give us cases but no names, because they don't want it coming back on them and the fact that they could lose their jobs.

All we're asking is, help us out here. We're here to save you money. Let's standardize this. Let's get out there with all the other groups and get them well trained, from medics right up to your lab people. It's not their fault; it's just lack of training and understanding. We are in it for two years, three years and more. That's all you do—read this stuff and learn how to do it properly.

Mr. Terence Kernaghan: Definitely. This has been something that has been outstanding for the last 15 years, I understand.

Ms. Karen Rondinelli: Honey, I've been in this since the 1980s, so I'm ready for retirement. But it's because I love my job so much. I love my job. And the money—right now, I don't care about the money. It's, "Get this on the table." Let's get it working properly.

Any one of you, you go into emerg; you'd better be asking, "What credentials do you have? Are you an RCT?"

Interjection.

Ms. Karen Rondinelli: Yes. "Make sure you're placing the electrodes on my chest properly." Because you don't know.

So, I'm not in it for the money. Our organization, we're all volunteers. I'm busting my butt. I saw the list and said, "Okay, our guys can't come; I'll meet every one of you, wherever." And trying to find this place was something else, trust me.

Mr. Terence Kernaghan: I did want to ask: I understand you put a letter forward to Minister Jones for a meeting. Did you have that meeting, and how did it go?

Ms. Karen Rondinelli: No, we have not had that meeting yet. Trying to get meetings is not easy.

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

Mr. Terence Kernaghan: I also understand you had a press conference at Queen's Park recently. I'm sorry that I was not able to attend. I think anyone who hears your presentation cannot help but nod their head in agreement. It makes good sense. Have you received any attention from the government since that media event?

Ms. Karen Rondinelli: Not at this point, because, you know, Christmas and everything else, right? Everybody is on holidays.

We're pushing ahead. We understood there was a list for you guys, and I think I was on every spot, almost, only

to find out we're only one organization so you only get to see me once, unless—I've got my card; I'll be handing them out to you too, if you want to talk on the side. This is what I'm here for: to make you aware of what we do and how vital we really are.

Mr. Terence Kernaghan: Thank you so much—really appreciate it.

Ms. Karen Rondinelli: You're welcome.

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

Now we'll go to MPP Hazell.

MPP Andrea Hazell: Oh, I got another round. Thank you so much.

I want to go to Ontario Society of Cardiology Technologists. I was making sure I have that word correctly. You have educated me today.

Ms. Karen Rondinelli: Thank you.

MPP Andrea Hazell: And thank you so much. Now I'm actually scared to do an ECG if I ever have to do one for my physical.

Mr. Deepak Anand: I'm certified; I can do it.

Ms. Karen Rondinelli: I could have brought the machine in with you and just said, "Okay. Lay on the bed and I'll do one for you."

MPP Andrea Hazell: But thank you for helping me to get that courage to ask for credentials, because I didn't know this was a thing out there in that field. I know you're in this field for a really, really long time, so you're coming with a vast knowledge of experience.

But what I want to do with my time—I know you spoke about a lot of cases and what can happen and what you have seen. What are one or two things that are really on your wish list that you can pull from the sky and talk to this government about that are going to really increase the efficiency of this line of work?

Ms. Karen Rondinelli: We have four accredited programs, four colleges, going. We've already started implementing courses for other groups like med lab techs to increase their knowledge. We're willing to go out to wherever they are. We want to sit down with these other groups and say, "Okay, can we look at your curriculum and see what you're missing? And we'll come in and train your people." That's what it's all about. It's the training; it's the actual going into the classroom. Even your paramedics—they're out there. What are you actually getting for your training? You get very basic.

It's a lot of hands-on. Our techs are—you lay on the bed, and this is how you feel the rib. Placement is key. It's literally feeling down the ribs and where the leads are to go, because if you're out by a little millimetre, you can cause major problems with reading the cardiogram. So, we are willing, as our group, in teaching and going out to what other groups are out there.

Even when I was working at St. Joe's in London, we had issues where emerg nurses were doing the cardiograms. The patient would come up to me—I'm doing their echo, and the first thing I see is their electrodes stuck to them. I'm going, "Those are all wrong. Who put those on?" "The nurse in emerg." "Great." Rip, rip, rip, rip. "They're wrong." I'd call down and I'd speak to who was in charge and say, "Okay, we need to sit down with your staff and go through this."

We were able to implement that, but with the changing-over of staff and with COVID coming, it's just spread out so far now that a lot of staff aren't being trained properly enough. It's like, "We'll show you." I can show you, but can you read it? That's the whole bottom line.

So, it's getting that proper training across to these groups. The biggest wish is to bring everybody in, do a weekend thing and just say, "Okay, this is the way it has to be done properly to standardize. Here's the recommendations. This is what you need to study. We will literally sit there and walk you through it properly to get it done, and everybody will be safe."

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

Ms. Karen Rondinelli: It's all about safety to the patient. We don't need anymore people dying. That's the whole thing. It's even worse farther up north because there's a lack of techs. Everywhere, there's a lack of techs, lack of nurses in every field, in what you're going through, trying to find people. But this is what we're all trying to achieve, making sure it's standardized.

MPP Andrea Hazell: Thank you for putting that in the record and thank you again for coming in. Thank you so much.

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

MPP Zee Hamid: Thank you, both, for coming and taking time out of your day. This has been really helpful. I'll just give you a break here and so I'll just go to you for a bit.

We're seeing a health human resource shortage across the industry and across the province as well. As a result, we just launched a Learn and Stay grant that I'm sure you're familiar with. Are there any other programs that we should consider to help recruit and retain more health care staff in general, not just nurses?

Ms. Margo Reilly: Absolutely. I think that the Learn and Stay program is effective. If I may, there is a limitation to the grant. From my understanding, you have to have the positions in order to support that program, and when you don't have the positions, then you're not able to benefit from the program. Those programs work really well for hospital settings, but for primary care, a lot of the initiatives that are out there really don't benefit us because we don't qualify unless we have a much bigger team.

When you're looking around within Windsor-Essex county, those initiatives and our teams are quite small, and we're very grassroots. Again, we do a lot of work ourselves and we wear a lot of hats just to make everything work. So yes, nursing, administrative assistants, receptionists, those are skilled workers. We just had a full turnaround because hospitals increased their comps. Schools, academia increased their compensation packages. Different parts of the health care sector increased their compensation packages.

1540

Even the 5%—we lost 98% of all of our receptionists all at once, and then it happened again because there were more compensation increases with the announcements. So that created administrative burden for our physicians. That created a really interesting situation where you had management trying to take over the phones or try to help with the front desk. That's something I haven't done in 20 years. So we don't want to do that again. We made it work because that's what we do: We make it work.

But we did have many complaints. We had to take a step back. We had to reduce our hours temporarily until we could increase our human resources complement. Those are the barriers that we're facing.

It's the same with social work. A lot of social workers are seeing the benefit of being solo practitioners.

MPP Zee Hamid: I'm not from that field, so it's not a loaded question; I'm genuinely trying to learn. Is there technology or tools and stuff that we can use to reduce reliance on, I guess, human beings for administrative work?

Ms. Margo Reilly: We are looking at everything. I've actually taken an artificial intelligence course, so I can speak to the topic of artificial intelligence and health care. I co-led a stakeholder event at the St. Clair College. We're doing a research study, and we applied for a collaborative stakeholder application to the federal government to look at strategies for an integrated system throughout Windsor-Essex. We're hoping for an investment that will help all of Windsor-Essex through not just our Ontario health team partners but everybody to have a stake in the game, so we can look at those efficiencies, look at strategies.

We've come up with all sorts of ideas to finding AI that will help us with forms. A lot of the work that goes on behind the scenes and takes a lot of the administrative time that must be done by a primary care provider is forms: medical forms, WSIB forms. So, we're trying to look at that AI. We're looking at AI scribes. We're looking at strategies to streamline our online booking. We're looking at secure messaging. We've done an analysis for our communications plan. We've changed our phone systems. We've looked at messaging that helps direct patients to our website. We've created a whole FAQ section where all the frequently asked questions are.

We've looked at Google searches to see, "Why are people calling us thinking we're a walk-in clinic?" So we're investing in that. I don't know how to do that yet; I don't know how to change it. So we're hiring a consultant to help us.

Those are things that we do because I don't have the knowledge, but I go to school, and I try to find out so that I can help inform next steps so we can be creative.

MPP Zee Hamid: I've got to tell you, I'm really impressed, by the way. We need to have you educate everyone else across Ontario, because it's really cool—as you were throwing out all the things.

How can we better leverage the research you did but also, in general, groups like yours? How can the government of Ontario better leverage your group and your organization and other groups like that to improve health care across Ontario?

Ms. Margo Reilly: We've offered our expertise and our feedback over and over. Our team care centre is innovative. Our family practice program, I've never worked with a better group of people. They are just so committed to their work, and you have to be that way in this community.

I will say that, at any time, if anyone wants to connect with us, we will give you the model. We've applied for an expression of interest. We offered the model. It is a cost-effective way to spread the team-based primary care elements—not necessarily having a physician at every satellite site—but we could create a hub in different communities. We had 20-plus partners sign off on our EOI, municipalities, all of our acute care centres. Everyone wanted to be part of this vision.

We even worked with TMC as they looked for temporary, unattached patients, and we're looking through team care. Let's create a strategy. We will create a position where that individual, when they are referred to our team, we'll connect them to a nurse practitioner. We'll help them find a primary care provider that is their key person. We put that all in our application. It was denied.

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

Ms. Margo Reilly: But there is more that we can offer. When there are gaps in service, I will say that we create programs. The oral health education program, we created it. I'm a co-developer. We're now doing research. We're embedding it in acute care. We were the recipients of the WE-SPARK grant, for example.

Social prescribing, that's how you connect holistic care and you create a system where you have an attachment from primary care to the social services in our community and you are looking at all these publicly funded agencies and bringing them together, and you're all taking care of that one person. That's patient-centred care.

The same with a memory clinic. We're looking at primary care-embedded services for people who have early signs of dementia that can't get into a general clinic, that can't get into those services at hospital, but we have it and we trained our staff and we created those synergies.

We're part of the lower limb preservation strategy. We're part of so many things—

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

We'll now go to MPP Gretzky.

MPP Lisa Gretzky: I want to start by thanking you both for your presentations.

I learned a lot, Karen. I just had one of those Holter monitors on not long ago and I'm due for a stress test, but I had pneumonia so I rescheduled, but now I'm wondering if you should come with me just to make sure it's done right.

Ms. Karen Rondinelli: I'll do every test on all of you if you want to make sure it's done right.

MPP Lisa Gretzky: I have a question for Margo. This is going to start with a comment, specifically the comment,

to Margo, about OTF. That's an application for a grant. It is a competitive process. It's one-time funding and it is also one large pot of money that is divided amongst many people, so I'm concerned that that was a recommendation from the government side—as opposed to properly funding health care services.

The other comment I'm going to make, because there's been a very unfortunate underlying theme through the entire day, which is about the wage inequities in health care—and it wasn't just health care. We had Community Living here. I was with education workers yesterday who will tell you the same thing about their support staff. It's really disheartening, and I want to point out that the majority of those positions are held by women. When my colleague across the way mentioned firefighters—you're like firefighters. I do want to point out that male-led positions, careers, like firefighters and police, don't have to come to our pre-budget hearings and beg for proper wages and funding year after year after year, so I just want to point that out. And yet we have consistently—I've been an MPP for 10 and a half years—and it's every time, under two governments, that's what we're hearing from women-led professions, where they're coming and begging to be paid appropriately. We've heard today about health care workers having to go to food banks, and that's something that really needs to change.

I want to say to Margo, you talked about oral health care. I was a dental assistant before I got elected, so yay that you're teaching oral health care. But I also think it's very important that we have universal dental care and that it's funded appropriately so that when you're teaching oral health care or you flag an issue, people are able to go to the dentist and actually get the care they need before it becomes urgent and they end up in the emergency department where often they can't be treated.

My colleague had said that trust is important. Margo, you were talking about how you are constantly facing staffing issues where people are leaving to go somewhere else in the sector. We've heard others say they're leaving the sector altogether. Can you talk about that piece, about trust being important and what it means to people that come to you for supports and services, for care, to have that consistency with staff, the people that they talk to or the people that they see?

Ms. Margo Reilly: I'll answer your question in two parts. One from the perspective of the patient and also one from the perspective of the employee. Trust is important from both elements because as a patient, you do want the continuity of care. You want to see that same person behind the desk, your nurses being the same, your primary care providers the same, social workers, the whole team. You want that consistency. I know that Kate, from the NPLC, did speak to the continuity of care and the importance of the continuity of care, especially for a primary care provider. And we do hold regular annual patient and family advisory focus groups and we ask these important questions. The patients do note when there are changes and they do note when there is a political change that leads to those changes in our health care force, and their responses are not negative. Their responses are supportive because they can see that we're trying.

From a staffing perspective, we do conduct regular engagement surveys, MPP Gretzky, and our very last engagement survey has indicated that 90% of our staff are engaged; nearly all of our staff want to be at the Windsor Family Health Team.

When we do exit interviews, the reason why they leave is because they got an offer they can't refuse, and I can't blame them. What we do now, at the Windsor Family Health Team, is look at strategies to grow staff members so that they are being built up to serve in other community agencies because we know that's where we are now. We are a learning ground because our compensation is lower than the rest. We hope that with time, they trust us and they are loyal to our organization and they will stay. We have a lot of really loyal, excellent staff members that believe in our mission, believe in the programs and services that we offer and so they stay, despite the compensation variances.

But I'll tell you, if I was getting a 20% or 30% increase, I would think about it too. It's really hard to say no when inflation is eating away at your monthly income, so that would be my response to the trust element. My staff trust me to advocate for them and one of the feedback elements of that engagement survey is that they trusted that we are advocating on their behalf, which is what motivated me to come here today and to advocate as a leader in the OHT, advocating for primary care and in the different roles that I play in the community.

MPP Lisa Gretzky: I appreciate that response. I have no doubt that they trust you and they want to be there and providing the care.

Ms. Margo Reilly: They do.

MPP Lisa Gretzky: Can you talk about the importance of that trust and that continuity of staff when it comes to your patients? You talk about mental health and addictions and stuff like that, so what does that mean for patients to have that continuity of staffing—familiar faces?

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

Ms. Margo Reilly: Yes, of course. Part of the experience is your patient experience. When you walk in that door, you do want to have that sustainability and you don't want to tell your story over and over again. You don't want to have to talk to another person and share perhaps what's really uncomfortable to share with that individual. When you have that history with a patient, it makes for a very efficient exchange; you know what that patient is coming in for. It does create efficiencies in the system by having a sustainable workforce because you do build those relationships. Those patients trust their primary care providers. They trust the organization and they know that if the service doesn't exist within our family health team, we're going to find a way to help them get to the service they need in order to be successful—

The Chair (Mr. Ernie Hardeman): That concludes the time for that question. That concludes the time for this table. We want to thank you very much for the time you

took to make your presentations and the information you brought us will be of great assistance as we work towards the report.

With that, I want to thank all the presenters since lunch, and even the ones before lunch, for presenting. As a reminder, the deadline for written submissions is 7 p.m. Eastern Standard Time on Wednesday, February 5, 2025. Those that have made an oral presentation can also write in if you have more information, or if you would like to reinforce what you said, send it in and if it gets there before that time, it will be part of the report.

The committee is now adjourned until January 15, 2025, in St. Catharines, Ontario.

The committee adjourned at 1554.

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

Chair / Président
Mr. Ernie Hardeman (Oxford PC)

Vice-Chair / Vice-Présidente
Ms. Catherine Fife (Waterloo ND)

Mr. Deepak Anand (Mississauga–Malton PC)
Ms. Patrice Barnes (Ajax PC)
Ms. Catherine Fife (Waterloo ND)
MPP Zee Hamid (Milton PC)
Mr. Ernie Hardeman (Oxford PC)
MPP Andrea Hazell (Scarborough–Guildwood L)
Ms. Christine Hogarth (Etobicoke–Lakeshore PC)
Mr. Terence Kernaghan (London North Centre / London-Centre-Nord ND)
Mr. Brian Saunderson (Simcoe–Grey PC)
Mr. Dave Smith (Peterborough–Kawartha PC)

Substitutions / Membres remplaçants
Mr. Andrew Dowie (Windsor–Tecumseh PC)
Mrs. Lisa Gretzky (Windsor West / Windsor-Ouest ND)
Mr. Anthony Leardi (Essex PC)

Clerk / Greffière
Ms. Vanessa Kattar

Staff / Personnel
Mr. Alex Alton, research officer,
Research Services