

Long Term Care Covid-19 Commission Mtg.

Meeting with the Commissioners and Franco
Ontarian Organisations
on Thursday, December 17, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 17th day of
December, 2020, 9:00 a.m. to 11:00 a.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 FRANCO-ONTARIAN ORGANIZATIONS:

10 Carol Jolin, President, L'Assemblée de la

11 francophonie de l'Ontario (AFO)

12 Bryan Michaud, Political Analyst, L'Assemblée de la

13 francophonie de l'Ontario (AFO)

14 Jean-Guy Fréchette, Partner, Solstice Affaires

15 publiques

16 Gilles Fontaine, Managing Director, Fédération des

17 aînés et des retraités francophones de l'Ontario

18 (FARFO)

19 Estelle Duchon, Executive Director, Entité 4

20 Barbara Ceccarelli, Managing Director, Centre

21 d'accueil Heritage

22 Joëlle Lacroix, Administrator, Foyer des pionniers

23 de Hearst

24 Kim Morris, Faculty of Science, Collège Boréal

25 Guy Chartrand, PDG, Bruyère Soins continus

1 Melissa Donskov, Vice President, Bruyère Soins
2 continus

3

4 PARTICIPANTS:

5

6 Alison Drummond, Assistant Deputy Minister,
7 Long-Term Care Commission Secretariat

8 Ida Bianchi, Counsel, Long-Term Care Commission
9 Secretariat

10 Kate McGrann, Counsel, Long-Term Care Commission
11 Secretariat

12 John Callaghan, Counsel, Long-Term Care Commission
13 Secretariat

14 Lynn Mahoney, Counsel, Long-Term Care Commission
15 Secretariat

16 Derek Lett, Policy Director, Long-Term Care
17 Commission Secretariat

18 Dawn Palin Rokosh, Director, Operations, Long-Term
19 Care Commission Secretariat

20 Adriana Diaz Choconta, Senior Policy Analyst,
21 Long-Term Care Commission Secretariat

22

23 ALSO PRESENT:

24 Deana Santedicola, Stenographer/Transcriptionist

25 Louise Cote, French/English Interpreter

1	Nathalie Hanako Tan, French/English Interpreter
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1 -- Upon commencing at 9:00 a.m.

2
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Well, good morning, everyone. Thank
5 you for coming. I am Frank Marrocco. I don't know
6 if you have met the other Commissioners.
7 Commissioner Angela Coke is there and Commissioner
8 Dr. Jack Kitts.

9 We are the Commission, as I suspect you
10 know.

11 We have a court reporter with us. We
12 create a -- we post on our website a transcript of
13 these proceedings so that people can follow along
14 with what we are doing.

15 We tend to ask questions, if it is all
16 right. I don't know who is leading the
17 presentation, but we tend to ask questions as we go
18 along, if that is okay, rather than trying to go
19 back and remind people what they said.

20 Beyond that, we are at your disposal.
21 We are ready to proceed when you are.

22 So who is "Juge en chef"?

23 CAROL JOLIN: The "juge en chef" is
24 Bryan perhaps.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay. Thank you. Mr. Michaud, go
2 ahead.

3 BRYAN MICHAUD: Is the interpretation
4 working now? Great. Thank you.

5 Thank you very much. Thank you,
6 Commissioners.

7 I will be very brief. We will start
8 with a short presentation to set the table, with
9 Carol Jolin, President of AFO, and Gilles Fontaine,
10 the Executive Director of FARFO, the organization
11 representing seniors.

12 So we'll start with words of welcome,
13 and then we will get into the meat of things with
14 our partners. We have several partners in various
15 fields of long-term care who are French-speaking
16 and bilingual, so you'll see the issues for
17 Francophone communities in the different sectors
18 related to long-term care.

19 I will now stop speaking and give the
20 floor over to Carol Jolin, our President, who is
21 starting her third term as a full President.
22 Carol, you have the floor.

23 CAROL JOLIN: Thank you, Bryan.

24 Good day, everyone. Just perhaps to
25 tell you how things will unfold. Bryan talked

1 about our welcome words, and then we will talk
2 about the benefits of planning French-language
3 services. We will talk about the impact of the
4 no-visit policy. We will talk about the lived
5 experience by the various sectors, lived experience
6 of the pandemic, and then we will talk about
7 solutions that we would like to suggest to you.

8 So first here I would like to thank the
9 Commission for this meeting with French-speaking
10 organizations and institutions. AFO as a political
11 spokesperson and as an organization group, together
12 with Ontarian Francophones, is well placed to
13 provide a link in terms of organizing this event
14 with the Commission and our leaders in long-term
15 care.

16 We were asked for a Francophone lens,
17 and this meeting is our opportunity to share that
18 with you.

19 Over and above the submissions you have
20 received from Francophones, we hope that the
21 presentation will help you apply a Francophone lens
22 to your activities.

23 So we have invited leaders from the
24 following sectors. The participating groups,
25 operators of long-term care, operators in the

1 second-to-last step before arriving in long-term
2 care, supporting Francophones in French-language
3 services, including long-term care, and training.

4 So we have with us a number of people.
5 I have introduced myself. We have Gilles Fontaine,
6 Director General of the Retired Franco-Ontarians
7 Association.

8 We have entities of French-language
9 planning services, operators of long-term care, Guy
10 Chartrand, CEO of ongoing care at Bruyère, and
11 Joëlle Lacroix, Director General of the Foyer des
12 pionniers in Hearst.

13 For health services and community
14 support services, Barbara Ceccarelli, Director
15 General of the Heritage Centres, and finally for
16 training, Kim Morris, Dean of the Faculty of Health
17 at Collège Boréal.

18 Long-term care are a question of safety
19 and quality of care. Several elements that were
20 problematic before COVID were exacerbated and
21 created difficulties for residents and Francophone
22 families. Our guests will speak to that further
23 later.

24 But I would like to insist on this
25 point. There is a loss of capacity to speak a

1 second language as one ages. People suffering from
2 dementia and other degenerative diseases find it
3 difficult, and not to be able to communicate
4 creates unimaginable stress.

5 According to the French language
6 commissioner in Ontario from 2018, more than half
7 of the patients in long-term care institutions have
8 dementia. The number of Francophones with
9 neurodegenerative diseases in Southern Ontario has
10 increased by 32 percent in Ontario, thereby
11 increasing the demand for specialized services.

12 A message that I would like the
13 Commission to hear and that will be validated by
14 the Francophone leaders you will hear in terms of
15 linguistic variable is that the problems caused by
16 the pandemic for Francophones have to do with
17 challenges that already existed before COVID.

18 Without further ado, I would like to
19 give the floor to Gilles Fontaine for the welcome
20 words from FARFO. Gilles.

21 GILLES FONTAINE: Yes. Thank you very
22 much, Carol. Thank you to the Commission, to the
23 Commissioners, for your invitation.

24 I just want to briefly talk about our
25 organization. We are the spokesperson organization

1 for people 50 years and more, and we represent
2 about 240,000 Francophones, 165 of whom are aged 65
3 and more, so a very diversified population, at
4 risk, especially the 65 years and more, which is
5 poorer and less educated than the average
6 population.

7 It is a population that is resilient
8 and that has been here in Ontario since before
9 Confederation.

10 Our role as FARFO is to inform our
11 community by all available means, to develop
12 solutions with our community partners, and to
13 propose solutions to the government based on needs.

14 We would like to emphasize the
15 importance of family assistance, family caregivers,
16 which is extremely important, and several comments
17 that we received from these families. I'll get
18 back to that at the end.

19 The White Paper is a document that we
20 developed with AFO, and it is a research that
21 assesses the needs of Francophone seniors or aging
22 Francophones. In September 2019, we published that
23 document on aging, and we shared that document at
24 the request of the Commission, so you have received
25 it.

1 As Carol mentioned, several problems
2 which existed before the pandemic had a stronger
3 impact during the pandemic. Here are a few numbers
4 indicating the situation at the outset of the
5 pandemic.

6 Twelve long-term centres are designated
7 under the Act. There are about 27,000 Francophones
8 in the Greater Toronto Area, but they can only
9 access 37 long-term care beds. So in 2018,
10 municipalities identified one bed for 3,400
11 Francophones compared to the average, which is one
12 bed for 170 Ontarians.

13 During the pandemic, as before, the
14 great majority of Francophone residents were in an
15 English-speaking environment.

16 So let's go into more detail on the
17 impact for families when we'll have meetings with
18 Francophone families very soon. That discussion
19 will allow us to elaborate, but we would like to
20 set the table now to illustrate the challenges of
21 families who communicated with us.

22 There is a feeling of isolation that
23 get exacerbated for Francophones especially when
24 people are in residence in a long-term care
25 institution and their family members can no longer

1 visit them. Largely, it was their only way to
2 communicate in French, through their family
3 caregiver, through their family member. So if the
4 person can no longer visit them, the senior is
5 isolated and can no longer speak French to anyone.

6 Families are informed and several
7 families have communicated with us and have
8 indicated that they have seen a deterioration of
9 the physical health and mental health of their
10 family members because they could no longer visit
11 them. They could see that their family members
12 were really depressed, and it had a big impact on
13 their health.

14 So the fact that they no longer get the
15 support of their families had an impact, and it is
16 something that will remain. It will not improve.
17 Even when the family members can go back and visit
18 them, they lost months and years actually.

19 So there is a great sadness with family
20 caregivers because they could not be with their
21 family members in these difficult times. They
22 could not hold their hand sometimes at the end of
23 their life. Thank you.

24 ESTELLE DUCHON: Good morning. Estelle
25 Duchon. Thank you for having us.

1 I would like to go into more details,
2 but before talking about the impact of COVID-19 on
3 Francophones, I would like to take a few moments to
4 talk about the importance of language in health
5 services and long-term services more specifically.

6 The first thing we can't forget is, in
7 terms of long-term care, care is important, but
8 first and foremost, the residence becomes one's
9 home. For a Francophone or any individual, it
10 becomes the environment in which that individual
11 evolves.

12 Think about the shock for someone to go
13 from an environment that is a hundred percent
14 Francophone and going into an institution or
15 residence where everything becomes English
16 speaking, where your interactions with staff occur
17 in English, interactions with other residents are
18 in English, and you lose your Francophone
19 environment completely.

20 So it is in that context that we would
21 like to think about the importance of Francophone
22 long-term care and the importance for Francophone
23 to be in an environment where he or she can be
24 understood and can live in French. The facility
25 becomes the person's home.

1 Beyond that, let's think of all of the
2 impacts not to be able to communicate in one's
3 language about health care. Several studies have
4 been made to show the impact of language, and we
5 know that the problem of lack of communication will
6 have a huge impact, for instance, on the capacity
7 to undergo treatment on the feeling of isolation.

8 But once again, these individuals in
9 long-term care can no longer communicate as well as
10 before with people around them and feel very
11 isolated, or if they can't simply interact in their
12 own language and culture, they feel isolated. It
13 has an impact on mental health, as Gilles was
14 saying, so higher depression rates when individuals
15 cannot communicate in their language.

16 And an increase in the number of falls.
17 Why? Well, because the person doesn't understand
18 what is being explained to him or her on the way
19 to, you know, stand and walk directly. It has an
20 impact on individuals who fall more frequently.
21 That is a phenomenon that has been verified whether
22 or not COVID exists, but that we have to be mindful
23 of when we think of Francophone individual
24 situations in long-term care.

25 As Carol said, we also have to think

1 that we are talking about individuals who are
2 largely aging individuals and, when one ages, one
3 reverts back to his or her mother tongue, and you
4 lose your second language, all the more so if you
5 are suffering from dementia.

6 So once again, we are dealing with
7 individuals going into long-term care facilities
8 who at the outset could communicate in English, but
9 because the disease has progressed or they are
10 aging more, they lose that capacity of interacting
11 with staff in their second language.

12 So please be mindful of that when we
13 talk about the consequences of COVID-19 because I
14 think it is that context that creates all of the
15 difficult situations that we were able to observe
16 during the pandemic.

17 In the following slide, we are raising
18 an issue that Gilles mentioned earlier, the role of
19 family caregivers.

20 During the hearings, you have heard
21 about the fundamental role that these family
22 caregivers play, communicating, supporting health
23 staff, conveying concerns of residents because of
24 deteriorating situations.

25 Once again, the context, let's not

1 forget, is that of seniors who have difficulty
2 communicating, and imagine how isolated they felt
3 when that no-visit policy was applied in
4 Francophone long-term care facilities. So they no
5 longer had communication means. So if you can't
6 communicate in the same language as the service
7 provider who comes to see you, comes to help you,
8 how can you just live and go through day-to-day
9 activities.

10 Once again, Gilles talked about
11 isolation, distress for family caregivers who can
12 no longer see their family members, but also for
13 those seniors who can no longer be understood by
14 people around them.

15 Another impact for communication is
16 that we know that for individuals who have
17 cognitive difficulties, well, there is an impact on
18 behavioural problems. So we have seen an impact
19 there because people can no longer be understood or
20 they no longer understand what is expected of them.

21 So I think the no-visit policy has been
22 very difficult for residents, but especially for
23 family caregivers who needed that contact, just to
24 have very basic communication, and very difficult
25 for seniors in long-term care facilities who could

1 no longer be understood.

2 So I would now like to go to Joëlle who
3 will tell us about the impact of COVID-19 not just
4 on individuals but also on organizations.

5 JOËLLE LACROIX: Yes. So I am a
6 Manager of Foyer des pionniers de Hearst. I have
7 held that position for 20 years. For 20 years we
8 have been running a marathon with HR trying to find
9 qualified French-speaking staff. It is a huge
10 challenge, and since the pandemic, it has been
11 crazy.

12 This lack of staff who speak French,
13 people who can work in French in Hearst, I mean,
14 there is a lot of them because we are a Francophone
15 community, but qualified workers are few and far
16 between.

17 We have had a great deal of stress at
18 the start of the pandemic from an administrative
19 point of view. We have a small residence of 67
20 beds, and so we only have five people on the admin
21 team managing all of that, so that was a challenge
22 as well.

23 So our residents did not die of COVID,
24 but they died of depression. Their morale
25 plummeted, mental health plummeted, their physical

1 health as well.

2 The fact that the third guideline told
3 us that an employee needed to select a single
4 employer created a problem for us too because
5 several of our qualified employees went to Notre
6 Dame Hospital as their single employer since they
7 had to limit themselves. That wasn't helpful.

8 At the beginning of the pandemic, all
9 of the communications were in English only, and
10 here we work in French. And so there was a lot of
11 work administratively to do translation on-site, so
12 the stress associated with equipment, PPE, masks,
13 to be able to work safely for the residents, so
14 that is what I need to say.

15 COMMISSIONER ANGELA COKE: I have a
16 question. I am just interested if there is any
17 strategies you have underway or working with the
18 Ministry in terms of how you build a pipeline of
19 qualified French-speaking staff?

20 JOËLLE LACROIX: Absolutely. We have
21 Collège Boréal in Hearst who in the past gave a
22 program on...[inaudible] and the...

23 THE COURT REPORTER: I'm sorry, I'm not
24 getting an interpretation.

25 THE INTERPRETER: Sorry.

1 JOËLLE LACROIX: The other classes, the
2 other programs, well, we're having difficulties
3 with it.

4 BRYAN MICHAUD: We will wait. Just
5 acknowledge to continue.

6 THE INTERPRETER: Can you hear me now?
7 Can you hear the interpreter?

8 COMMISSIONER ANGELA COKE: Yes. No.

9 THE INTERPRETER: Can you hear me?

10 COMMISSIONER ANGELA COKE: Yes, I can
11 hear you now.

12 THE INTERPRETER: Can you hear the
13 interpreter?

14 JOËLLE LACROIX: What I was mentioning
15 is that we have a need, a very big need, to have
16 nursing programs in Hearst. It would help us a lot
17 for the training of qualified staff.

18 COMMISSIONER ANGELA COKE: Okay. Thank
19 you.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 I also had a question. It was related
22 to the one Commissioner Coke asked.

23 Over time historically has there always
24 been this need for qualified bilingual or
25 French-speaking staff? And my question really is

1 related to that, is if there were difficulties
2 addressing that? If that problem has persisted,
3 were there difficulties in addressing it?

4 JOËLLE LACROIX: Yes, as I mentioned,
5 it has been 20 years that we are looking for
6 people. We are having a hard time to find
7 bilingual-qualified or skilled staff, and during
8 this pandemic, there is a lack of nurses everywhere
9 in Canada.

10 So unfortunately, in Hearst I had to
11 hire Anglophone nurses who did not speak French.
12 Here, we only work in French. But now we need to
13 adapt with staff that only speaks English. And it
14 is difficult for residents and also for the other
15 members of the staff.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 It can be difficult for family members
18 to communicate the needs of their parents or
19 grandparents as well, I assume.

20 JOËLLE LACROIX: Yes, when you have an
21 Anglophone nurse. Here the majority of my staff
22 could translate and speak French. In Hearst, it is
23 different. It is really a Francophone community,
24 so we work in French, and we live in French.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Commissioner Kitts?

2 COMMISSIONER JACK KITTS: Yes. I just
3 want to follow up. You began by saying that there
4 is a significant shortage of Francophone beds, and
5 we are talking about a significant shortage of
6 Francophone staff.

7 In Hearst, is there a sufficient number
8 of beds, just not enough staff, or do you require
9 more beds which would then require more Francophone
10 staff? I am just trying to -- they seem to go
11 together, and I am just wondering which one is the
12 biggest problem, or are they both problems?

13 JOËLLE LACROIX: I think I did not
14 express myself well. Here the staff is mostly
15 Francophone. There is a shortage of beds. Since
16 2014, we have been asking 12 more beds, and we have
17 64 people on the waiting list. Therefore, they are
18 waiting four years before being admitted. In
19 Hearst, we only have the Notre Dame Hospital and
20 the long-term care centre, and during a pandemic,
21 it was causing a lot of stress with respect to the
22 hospital because all the beds were all used by
23 people who are waiting on the waiting list.

24 But definitely, it is the lack -- or it
25 is the shortage of Francophone beds.

1 COMMISSIONER JACK KITTS: Right, but
2 what I am saying is if you had the 12 beds, you
3 wouldn't have the qualified staff, the Francophone
4 staff, to staff those beds as well, so it is kind
5 of a double-whammy.

6 JOËLLE LACROIX: As I mentioned, we
7 have Francophone staff. Most of our employees
8 speak French. Out of 80 employees, I only have
9 eight Anglophones right now.

10 ESTELLE DUCHON: Mr. Commissioner, I
11 would like to add to something.

12 Yes, you are right, there is a big
13 challenge. There are two of them.

14 There is a challenge with respect to
15 the number of beds all over Ontario, but in
16 summary, in all the long-term care homes, only very
17 few are structured to offer Francophone needs, and
18 they represent more than 5 percent.

19 So there is a deficit of beds, and in
20 some regions -- it could be in Hearst or in other
21 regions -- there is a big challenge to have
22 qualified bilingual staff who could work in those
23 long-term care homes. So the government has to
24 develop strategies about those two aspects.

25 So you are right.

1 COMMISSIONER JACK KITTS: Okay. Thank
2 you very much.

3 BRYAN MICHAUD: Thank you. Maybe we
4 can continue with Guy and Melissa at Bruyère, if
5 you want, if there are no other further questions.

6 COMMISSIONER ANGELA COKE: I have one
7 other question. In the current sort of bed
8 allocation that is happening now from the
9 government, do you know if there is any
10 applications in for Francophone beds?

11 ESTELLE DUCHON: Bryan, I can answer
12 that question.

13 In the announcements that were done a
14 few weeks ago, there are three homes for which
15 there were Francophone beds, one at Richmond Hill,
16 one in Barrie, and one in the south of Ontario, so
17 those are good news for Francophones.

18 I would say that the issue is that the
19 announcements from the governments are about
20 Francophone beds, but it is not always clear when
21 we talk about Francophone beds.

22 We will talk about strategies to get
23 Francophone beds later on, but the question we need
24 to ask is what is the accountability. If we ask a
25 home to have a Francophone bed, what are the

1 demands with respect to funding to make sure that
2 those beds -- that those beds are Francophone beds
3 and also that there is bilingual staff? You know,
4 a person might get a bed, a Francophone person
5 might get a bed, but not necessarily Francophone
6 staff.

7 So this is something that the
8 government should work on. We have to be clear
9 what is a Francophone bed, what is it tangibly.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 That was actually where I was going.
12 The bed is a bed. It is a question of surroundings
13 and the people speaking to you, feeding you, that
14 sort of thing. That is what I would assume makes
15 it more suitable because you can all speak to each
16 other. You could put the bed anywhere.

17 ESTELLE DUCHON: Absolutely. You are
18 right. In Ontario, we have two tools. We have the
19 law on Francophone services, and we have an
20 organization that takes care of implementing them
21 to make sure that there is bilingual staff to have
22 complaints that are made in French, so it is coming
23 out of the law on French services. It is a law
24 that allows for all the conditions that you are
25 talking about.

1 And the other tool we have is article
2 173 of rule 79.10 on the long-term care health
3 which allows priority of beds, which will allow us
4 to say that these beds are for Francophones, and so
5 Francophones have a priority for those beds, and
6 those homes will put into place the environment
7 which will allow those individuals to be served in
8 French.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 Thank you for that. I just have one
11 other question, which is a bit unrelated. How
12 long -- in your experience, how long has this
13 problem persisted because I'm a little -- you know,
14 I have not really turned my mind to it in the past,
15 but how long has there been this shortage or this
16 disproportion in terms of the number of beds per --
17 or the number of persons per bed?

18 ESTELLE DUCHON: As long as I can
19 remember, I think it has always been something that
20 we noticed.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Okay.

23 ESTELLE DUCHON: However, definitely,
24 as we said at the beginning of the presentation,
25 the pandemic created for those individuals more

1 complicated situations than they were before, so
2 this pre-existing situation has been existing for a
3 long time.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Thank you. I don't think we have any
6 further questions, so you can carry on.

7 BRYAN MICHAUD: Thank you. I will ask
8 Guy Chartrand or Melissa to speak with respect to
9 Bruyère continuing care.

10 MELISSA DONSKOV: Hello to all of you.
11 I hope that you can hear me well.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 I can.

14 MELISSA DONSKOV: My name is Melissa
15 Donskov. I am the Director of Long-Term Care
16 Health at Bruyère Soins continus. I have been in
17 this position for four years, and at Bruyère, we
18 have two long-term care sections. One offers
19 bilingual services in French and English, and the
20 other one, the Saint-Louis Residence, is designated
21 Francophone.

22 So my comments today will be more about
23 our experience at the Saint-Louis Residence --
24 there are 198 beds -- east of Ottawa. So it is a
25 big long-term care home which offers services, as

1 Joëlle said, mainly -- which offers mainly in
2 French.

3 We are lucky at Bruyère because we are
4 part of the Bruyère continuing services, and we
5 also have hospital programs, and we also have
6 ambulatory and community care services. We had the
7 opportunity during the whole pandemic to benefit
8 from some services and expertise from our
9 corporation.

10 We are in a unique situation. We are
11 lucky. However, the challenges I would like to
12 talk to you about exist, even for homes that are
13 better structured and thanks to the Francophone
14 services that we offer in this home.

15 To answer to one of the questions
16 earlier about the approvals, the recent approvals
17 to get new beds, new Francophone beds, I wanted to
18 mention that Bruyère wants to further its long-term
19 care services, to develop them. We submitted an
20 application for a long-term care home east of
21 Ottawa. The west of Ottawa is a region in Ottawa
22 that has less Francophones but still has needs for
23 Francophone services based on the population.
24 Therefore, we hope to further the long-term care
25 services which could benefit the Francophone

1 population in Ottawa.

2 Our application has not been approved
3 yet, but I wanted to mention this. There are
4 operators who have the expertise to offer
5 Francophone services and who want to further their
6 programs, so it is important to know that there is
7 a shortage of beds. But there is a desire to -- so
8 there is a -- well, so now I would like to start
9 the points I wanted to share.

10 As Joëlle mentioned, one of the biggest
11 challenges within this pandemic was the recruitment
12 and the retention of qualified Francophone staff
13 and bilingual offering French services, which is a
14 big skill. Our staff speaks enough English, enough
15 to help families who might be Anglophones or from
16 other languages.

17 So to service all of our clients is a
18 big challenge. We have many staff members, but as
19 Joëlle said, the staff had to choose one workplace
20 during the pandemic. So that was a big challenge,
21 so we need to re-organize ourselves and offer the
22 same level of services after having lost some staff
23 members.

24 The care homes who do not have the
25 Francophone designation, they have more

1 opportunities to get staff from agencies or from
2 other organizations.

3 Just to explain to you the difficulty
4 here, is that as soon as I call an agency, and I am
5 looking for staff or even if I'm looking for a
6 mobile team that help during a crisis, when we ask
7 them that the staff has to be bilingual or at least
8 have some basic French, the possibilities narrow,
9 become really narrow.

10 At first, they'll say yes, we have
11 staff, no problem. And as soon as we say that they
12 have to speak French, oh, well -- then they'll
13 answer, Well, we don't know if we have someone.
14 There is less staff that is available through
15 agencies or mobile teams and so on.

16 And furthermore, since the workplace
17 language is really French, we have safety issues
18 for the residents, because if we bring in someone
19 who could not speak with our residents and their
20 families and their teams, if they cannot read the
21 notes in the files of our residents, they cannot
22 understand everything that is happening, so that is
23 a big problem, and it is a concern for the safety
24 of the care if we do not have skilled staff that is
25 bilingual or Francophone.

1 For us, we are fine. We can still make
2 it, but I am just trying to explain to you what the
3 challenges are, which are not necessarily present
4 in the home that offers services mostly in English.
5 I think that for other cultures too it is a
6 challenge, but I can say that it is for the
7 Francophone ones.

8 During the pandemic, we had to increase
9 our staff members, so we had different types of
10 staff in our homes. So, you know, we need to test
11 everybody that comes in, so we have a whole team of
12 people who test people for COVID, and these people
13 have to speak French.

14 And to counter the concern about the
15 isolation of residents, to help, we have a new type
16 of staff that we call the assistants. So they
17 replace volunteers in the role they played before
18 the pandemic. They help us feed residents,
19 socialize with residents, et cetera, and that has
20 been amazing. It was really helpful. But once
21 again, it is more staff that we have to bring in
22 and for whom we need to meet linguistic needs.

23 But it really helps to break isolation
24 of residents, and it really helps in having the
25 right number of staff to provide care,

1 compassionate care, to residents. I know that the
2 Commission is looking at needs in terms of more
3 staff or more hours of care per resident per day,
4 but I think it is important to mention as well that
5 to really transform long-term care into care that
6 can really focus on all of the aspects of the
7 resident, care from a social standpoint, it is
8 really important to increase the number of staff so
9 that the staff really can build social interactions
10 and can really support the resident in the way in
11 which he or she needs. Otherwise, everyone is
12 much, much too busy, in a hurry, because they have
13 so many duties to carry out with very few resources
14 to do them.

15 And I think you have heard that type of
16 feedback before, but I think it is important to
17 mention it.

18 And sometimes there are challenges to
19 recruit in long-term care because of the salary.
20 It is not as high as in other sectors, right?
21 Wages are lower than in hospitals or other care
22 facilities. So that creates challenges for us in
23 finding qualified long-term care staff.

24 I also wanted to talk about the
25 challenges in terms of resources and tools in

1 French. Our staff -- and, I mean, when we do
2 training with our staff, we need to have French
3 education materials, French videos, French
4 educators, and that limits us. Even before the
5 pandemic, that was our case, but it becomes even
6 more of a challenge during the pandemic while we
7 try to provide training and education in a virtual
8 format, faster and quicker, and we have new staff
9 coming in, so we need to train a large number of
10 people.

11 And by way of example, this week we are
12 part of a pilot on vaccination against COVID, so
13 that is fantastic, but some of the resources will
14 only be put out in English. So a video, for
15 instance, for staff in how to remove certain things
16 or how to provide the required information on the
17 vaccination, very often these videos or types of
18 videos are in English only, and then they come out
19 in French a few weeks later. So that is just an
20 example to explain that sometimes that is a
21 challenge.

22 We do a great deal of translation,
23 which is fine. We have the resources to do that.
24 But it takes more time, right? It is another
25 issue. Every time we communicate, that

1 communication has to be translated, and it
2 certainly takes more time. But it is very
3 important for us that the residents, employees,
4 families, and everyone have all the information so
5 that we can answer their questions, so that they
6 know what is going on, so that we can reduce their
7 concerns. It is even more important during a
8 pandemic. We have always had that challenge, but
9 during a pandemic, we communicate on a weekly
10 basis. Lots and lots of communications go out,
11 which is very positive and everybody appreciates
12 them. And with Francophone populations, there is
13 that extra step of translating everything.

14 My other point is that a lot of
15 facilities require renovations, adaptations, so
16 that we can mitigate concerns with regard to
17 infection control and with regard to social
18 distancing.

19 The pandemic really highlighted the
20 requirements to train staff, to have better
21 practices in infection control, but also, in
22 reviewing our infrastructure, to make that we have
23 the correct infrastructure that can promote care in
24 a long-term care facility that will allow for
25 infection control. It is another aspect of the

1 challenge over and above all of the practices that
2 are required on a day-to-day basis.

3 Those are the points I wanted to make,
4 and we do appreciate this opportunity of presenting
5 all these points affecting Francophone facilities
6 where the care model is very different in our
7 long-term facilities as compared to hospitals and
8 other sectors.

9 So thank you very much, and of course,
10 I'm available for questions.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Thank you. There don't appear to be
13 any, so we are good from our end.

14 BRYAN MICHAUD: Thank you. So perhaps
15 I'll go to Barbara next, who will tell you about
16 the pandemic from the point of view of service
17 providers. Barbara.

18 BARBARA CECCARELLI: Yes. Good day to
19 Mr. Commissioners and Ms. Commissioner. I am here
20 today. I am the Director General of Heritage.

21 I would like to say that we are not a
22 long-term care facility, and that is important
23 because there are differences in the way we
24 operate. There are things that do not apply
25 exactly the same way.

1 The Centre d'accueil Héritage has been
2 open for 40 years. We provide affordable housing
3 and support services to people in communities, so
4 we have an integrated model for affordable housing
5 and for support services.

6 We serve the Francophone aging
7 population in Greater Toronto. All of our work is
8 done in French one hundred percent, and in our
9 building, in our housing, assisted living project,
10 and in our work, people who live at home in the
11 community, because we also provide community
12 support.

13 In our integrated project of housing
14 with services, we can provide services 24 hours a
15 day, and we offer transition care for people who
16 are prepared to leave the hospital but not quite
17 ready to go home yet.

18 So we offer transition services in the
19 context of temporary transitions so that people can
20 be ready to go back home safely, and also to free
21 up beds in hospitals for clients who don't need to
22 stay in acute care beds.

23 We provide community services as well
24 for any person with physical and cognitive problems
25 and their family caregivers, all of that

1 exclusively in French.

2 So we are not a long-term care
3 facility, but of course we work in very close
4 cooperation with them, especially in Scarborough
5 with Bendale Acres. We are a partner of choice,
6 and yet I would like to say that at any time, at
7 least 50 percent of our clients, whether they are
8 in the housing project or in the community, are
9 technically eligible to be transferred into a
10 long-term care facility.

11 Our approach is proactive, and we have
12 reached a point where we transfer people only when
13 they are in crisis. So we hold off on those who
14 might be technically eligible but don't necessarily
15 have to transit over into a long-term care
16 facility.

17 I would like to share some things that
18 we have done under our model. We haven't had any
19 cases of COVID so far. Let's hope it stays that
20 way. But so far we were able to have a kind of
21 different control on our physical infrastructure.
22 Our clients all have individual apartments, and
23 even those who are in a transition unit, they have
24 their own room. They share common spaces, but they
25 have their own room. So that helped in our

1 project. It was easier to implement infection
2 prevention measures.

3 Our staff. Eighty percent of our staff
4 are service workers, so they support people in
5 their day-to-day lives. From the outset, we were
6 able to have exclusivity, so most of our staff only
7 work for us. Francophone staff, we are the only
8 Francophone provider, and so there is an advantage
9 there.

10 But for those who needed to get
11 additional hours elsewhere, well, we were quickly
12 able to give them almost full-time loads, so they
13 exclusively worked for us.

14 Our staff all have paid sick leave, so
15 we have that, and if someone does not feel well,
16 then we encourage that person absolutely to stay
17 home.

18 For our residents, our clients, with
19 their families, and in French, we were able to not
20 have to impose absolute isolation. It was a
21 challenge, but from the outset we negotiated that
22 we could have at least one family -- one person
23 that could continue visiting the resident, either a
24 staff member or a family member, especially given
25 the fact that most of our clients have cognitive

1 difficulty, so total isolation would have been
2 catastrophic for them.

3 And even with partial isolation, we saw
4 an impact on their -- a pretty huge impact on their
5 cognitive health, but at least we were able not to
6 completely isolate anyone.

7 We also work in networks greatly, so we
8 set up tele-health options. People could benefit
9 from their medical follow-ups without having to
10 travel, especially with hospitals.

11 And we continued communicating with
12 individuals with their families daily in French.

13 So even if we developed systems to -- I
14 mean, the access to our building was strongly
15 limited with screening at the entrance, et cetera,
16 for the service workers.

17 We have information resources. Yes,
18 very often these resources are in English, so once
19 again we had to translate documents and that was a
20 challenge, but we could access resources, and we
21 could work with hospital teams, palliative care
22 teams, who know us well and who, with us, were able
23 to make sure that clients stayed home and continued
24 their treatment.

25 That does not mean that we didn't face

1 any challenge. We still do. Any transition into
2 long-term care stopped. So the continuum, the
3 long-term care continuum, was broken, for very good
4 reasons, of course.

5 So from our point of view, even if we
6 refer people in crisis, only those that really need
7 it. We have now several people who are on that
8 list of people in crisis who cannot transition to
9 long-term care because at this point it is really
10 not possible and families don't wish that.

11 So we had to adapt. Our staff was
12 good. Our staff rose to the challenge in an
13 organization that managed group programs
14 especially. For some of our clients, we had to set
15 up one-to-one interventions, and normally that is
16 not part of our mandate. So we had an opportunity
17 to make sure that our staff was clustered in some
18 service units.

19 But another challenge was that some of
20 our staff had to take care of clients one on one,
21 and they are still with us, and they are still
22 waiting for a transition to a long-term care
23 facility. So that created an additional challenge.

24 Without mentioning the family
25 caregivers, what stress and what anguish to know

1 that all of that was going on and especially seeing
2 what was going on in other facilities.

3 I just wanted to add a few words with
4 regard to our approach in the future, what we would
5 like to see. We would really like to see long-term
6 care facilities and programs integrated into the
7 continuum of care and support.

8 I think the pandemic has highlighted
9 all kinds of gaps and shortages in terms of our
10 capacity, but also gaps from our point of view in
11 terms of quality. There are challenges that can be
12 resolved by adding beds, by increasing capacity,
13 but there are some challenges. Especially if we
14 think about the aging population, it is really
15 exploding exponentially.

16 And so that gap between available beds
17 and people needing them will only increase. So
18 what we want to bring to the table here is this
19 idea of not just increasing capacity but
20 diversifying the approach a bit.

21 We want to see that the transfer to
22 long-term care not be, unfortunately as today, an
23 option just because there is no other option. It
24 is possible to create other options, and we like to
25 think that we are a different kind of transitioning

1 option.

2 I think there are other options,
3 especially for those with cognitive difficulties,
4 but if now we could at least see long-term care as
5 part of a continuum of care, as part of health
6 services, as part of working closely with clinical
7 health services and community support services.

8 So we wanted to share with you some
9 details of our successes, the successes our teams
10 have had. Of course, everything that was stated by
11 my colleagues here affects us too. Clearly finding
12 staff for us is a challenge, even in the Greater
13 Toronto Area. It did work this time, but it is a
14 fragile equilibrium.

15 As we know full well that we can offer
16 this service in a limited format, and we know that,
17 as Francophones, we have to work really, really
18 hard so that the language perspective be at all
19 steps of the continuum for aging populations.

20 I would like to close by thanking you
21 very sincerely for giving us this opportunity. It
22 is a great pleasure to be able to make this
23 presentation to the Commission, and of course, if
24 you have any questions, please do not hesitate.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Actually, I did have a question. In
2 terms of or with respect to the orderly movement of
3 people through a continuum of care, did you have
4 any thought about what the organization would be?
5 Like there has to be a head then or there has to be
6 a directing mind in order to achieve that, it seems
7 to me. And I was wondering if you had given any
8 thought to how that would be achieved.

9 BARBARA CECCARELLI: I would like to
10 think that the focus is the client itself, but if
11 we change our approach -- we work with health
12 coordinators. These people are key people.
13 Ideally they meet the person at any time during
14 this continuum.

15 And these people are capable of
16 guaranteeing transitions between different health
17 providers, but also these people -- people could
18 defend the needs of their clients and their
19 caregivers, and at any time they put into place the
20 team that the people need, and they know how to
21 bring together these teams for our clients. The
22 health coordinator could work with hospitals, with
23 teams within the hospitals, with the family, with
24 the caregivers, primary care, meaning the family
25 doctor that lives close, palliative care teams,

1 and when the transfer is necessary to the long-term
2 care, as well as other services that are necessary
3 in the community, so the food safety, for example.

4 And this person, this coordinator, is a
5 bit like a director who could bring in the right
6 person in the continuum at the right time and also
7 knows how to guide the client but also guiding the
8 client by helping the client making choices,
9 personal choices. So it is important in the
10 continuum of care.

11 This leadership position is an enabler.
12 Maybe it is an idea of more of a coordination of
13 health to help providers. It is not easy for
14 providers because they never know who is
15 responsible for what, and the role of our
16 coordinator could be a really good thing for the
17 client, for the caregivers, but also for the health
18 providers.

19 This would allow the process to be much
20 more efficient.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Thank you. I don't think we have any
23 other questions.

24 BRYAN MICHAUD: So very good. We will
25 get to the next part, which is the part about

1 assistance training, so Kim Morris from Collège
2 Boréal will be speaking.

3 KIM MORRIS: Hello, everybody. I'm Kim
4 Morris. I am the Dean of the Health Sciences at
5 Boréal Collège.

6 Boréal Collège is one of the French
7 language colleges in Ontario. There is La Cité in
8 Ottawa. We cover the north, as well as Toronto and
9 the southwest centres.

10 So we have campuses a bit everywhere.

11 Also I would like to say that I have
12 been Dean for nine years at Collège Boréal. Before
13 I was at the CCAC community centre, which is not on
14 the R-lists.

15 On the human resources side, I have
16 been working on that for many years.

17 Today I would like to bring you the
18 perspective on French training. We also have a
19 group from -- that group is 24 health deans, and we
20 meet regularly since March. Since the month of
21 March, we meet every two weeks or even every week,
22 so some comments I'll be making this morning
23 reflects Collège Boréal but also all the groups of
24 colleges I am talking about.

25 Joëlle from Hearst mentioned that it is

1 a big challenge, but I can tell you that since the
2 access center days, the shortage of attendants or
3 orderlies that are bilinguals was always a crisis
4 in the north. It has been more than ten years that
5 it has been a crisis. With respect to the
6 provincial level, it started being a crisis six
7 years ago.

8 And the Minister of Health would come
9 into our group heads-up, and we were asking them,
10 why aren't you training more attendants or
11 orderlies? Aren't there any incentives to put into
12 place so that colleges could train these people
13 with the pandemic? The need has exploded. It is
14 worse than a crisis because we have so much need
15 everywhere in the province, so it is not a new
16 challenge. It just became worse with the pandemic.

17 The recruitment of students is at the
18 basis of our challenges as community colleges. We
19 mentioned this this morning. I am sure you heard
20 it at the Commission from day one, meaning that the
21 position of an attendant is not very popular. The
22 recruitment of students -- these students would
23 come directly from high schools. They are very
24 few.

25 The twelfth grade students who are

1 interested to study the attendants program, the
2 practical nursing or assistant nursing is more
3 popular, but to become an attendant or an orderly,
4 these are mostly people who want to choose another
5 career, a second career, or sometimes moms who
6 decide to go back to the workplace. You know, the
7 salaries and the workplace conditions are not
8 really attractive.

9 And what we saw in all colleges, the
10 recruitment for the fall 2020 has been worse
11 because people became afraid. Students -- you
12 know, prospective or future students are afraid.
13 They are afraid to work with people who could die
14 in the centre, or they could even die themselves,
15 or they can get COVID and transmit it to their
16 families. So it was even worse. There was even
17 less enrolment during the fall.

18 With respect to practicums, it does
19 impact clinical practicums in long-term care homes
20 as well for the students and for the professors.

21 So the students when those long-term
22 care homes accept them -- but -- because it is not
23 always the case these days. It is not all
24 long-term care homes that accept practicums. So
25 our professors usually will supervise three or four

1 different homes. Now they have to limit to one
2 only. Therefore, the recruitment of professors
3 becomes a problem too.

4 I would like to make a comment about
5 the new category. Melissa mentioned it. I call
6 them health care aides. If we use them like
7 Melissa, if they could replace volunteers, what we
8 are afraid about at the college level is that those
9 people are trained for maybe four weeks. It is a
10 bigger risk. It is a bigger risk because they have
11 less training as a health care aide, and often --
12 but not in all cases, often they do the same tasks
13 as an attendant, but the attendant had a one-year
14 training, whereas the new category, the health care
15 aide, only four weeks.

16 So you have -- you know, they have a
17 lower salary than an attendant, and they have less
18 training. Therefore, the risk is even higher.

19 We saw it at our list, and there has
20 been discussions at the federal level. There has
21 been an announcement of several million dollars for
22 CIGan. It would be to do a basic training, and
23 then you would have an individual that would become
24 an attendant.

25 At Boréal, we have several offers -- I

1 will talk about it later -- that could support
2 hospitals, the long-term care homes, the Health
3 Teams, to train these people. It would be like a
4 laddering.

5 Then -- and in general, the value of
6 this profession -- I am talking about this -- for
7 me, it is a profession, but in the community, an
8 attendant is not a profession, and it is not
9 respected as much as a nurse, a registered nurse,
10 or a paramedic. Therefore, all the value -- you
11 know, it has been over ten years that we are
12 talking about having campaigns to value more the
13 attendants so that there is more respect of the
14 profession as an attendant.

15 It is not only a monetary issue. It is
16 all the aspects that has to do with -- you know,
17 that to aging at home -- there is the aging at home
18 issue. It has been a long time. We have been
19 talking about that for a long time. And in this
20 crisis, because of the pandemic, we are back to the
21 same level where the job or the profession as an
22 attendant is not appreciated. It is not valued.
23 It is not respected.

24 And I believe that it is really one of
25 the keys to this problem.

1 So everything that I said this morning,
2 try to recruit Francophones and to meet the needs
3 of Francophones, well, it doubles or even triples
4 the challenge. So we are trying from different
5 ways. It is very difficult.

6 We could add beds, such as the Foyer
7 Richelieu in Welland. We know that they will need
8 other attendants. Boréal is working with that
9 long-term care home, as well as with Kapuskasing
10 and Hearst, to train the attendants. There is a
11 big need for them, and bilingual Francophone
12 attendants that are well trained with a
13 post-secondary level.

14 And do you have any questions?

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Yes. Dr. Kitts?

17 COMMISSIONER JACK KITTS: Just a
18 question. You said the challenge has been for
19 several years, and you talked about the salaries,
20 workplace conditions, not being very conducive to
21 attracting students to a career in any of those.

22 I am just wondering, do you have enough
23 spaces for students if the conditions were ripe
24 that they would go into these classes, or would you
25 need more positions for students?

1 KIM MORRIS: Classroom and lab spaces,
2 we have sufficient space, yes, because we have
3 several long-term care homes. I could say that
4 once a month I have a long-term care home or an
5 agency that approaches me, so I could train you,
6 100, 200 attendants if the students were there and
7 if the need -- yes, if there was more need.

8 COMMISSIONER JACK KITTS: Thank you.

9 CAROL JOLIN: Bryan --

10 KIM MORRIS: Sorry, I want to add to
11 that say that we have -- you know, we have many
12 campuses all over the province.

13 CAROL JOLIN: Bryan, I would like to
14 add something.

15 NICHOLAS BAXTER: Go ahead, Carol.

16 CAROL JOLIN: With respect to the issue
17 of the shortage, I have to make a parallel with
18 what I went through when I was the President of the
19 Teachers Union. You know, there was a shortage of
20 teachers, and the solutions are not very different
21 one from the other.

22 And I appreciate the work from Boréal
23 to recruit young people, but we need a bigger
24 system, a bigger machine, that could start a
25 provincial promotion campaign in French to attract

1 young people to go to those type of jobs.

2 And I always said in my message that,
3 you know, we have to go to the base, meaning to
4 talk to orientation counsellors in high schools who
5 meet regularly the young people, and they have some
6 interests, and they don't necessarily think about
7 that job.

8 In the past, orientation counsellors
9 would meet during two, three days to talk about
10 orientation. I don't know if that happens now, but
11 that would be a place -- if it still exists, it
12 would be the ideal place to meet and to make people
13 aware of that issue. For many young people, when
14 they choose a career, they are wondering if their
15 job will exist when they will finish the training.
16 And on the Francophone side, in the province they
17 will have a lot of choice to work in because there
18 is employers everywhere in the province.

19 So it is really important that when we
20 will want to start the promotion that we do not
21 only concentrate on the different social media, but
22 we go to the base, we go to the schools, to meet
23 people who are there, and we meet the people who
24 meet the young people in the schools.

25 I really appreciate to hear the work

1 that is done with respect to the new programs. We
2 know what Quebec did. They did a blitz to train
3 within six months. They trained people to become
4 attendants as fast as possible, but also to
5 increase the salary. If we want to be attractive
6 in French or English, the salary has to be there.

7 It took a pandemic so that we start to
8 recognize the work from those people with respect
9 to long-term care homes and with respect to
10 different care for older people.

11 And another element that we need to
12 look at is we have many Francophone immigrants, and
13 we are working to get more Francophone immigrants.
14 Often, those people are looking for ways to work,
15 and if we could try to get to those people when
16 they get into the country, and if they find a way
17 to train, and if they can find a job on the
18 workplace, that is another possibility.

19 But again, we have to act to talk to
20 them when they arrive in the country and see how we
21 could help them and maybe we could see what
22 training they already have, and we could help them
23 to get into those jobs.

24 Thank you.

25 BRYAN MICHAUD: Thank you, Carol.

1 Do the Commissioners have other
2 questions to address to Kim?

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 I don't think so. No, I don't think
5 so.

6 BRYAN MICHAUD: Excellent. So we will
7 start the next phase. Carol. Carol talked to us
8 about solutions. Estelle Duchon from the health
9 services planning presented the first solution.

10 ESTELLE DUCHON: Very good. We wanted
11 to come back on the issue of planning of French
12 services for the long-term care, and you asked
13 questions about that.

14 But just to come back on the health
15 models, here we had very nice examples of long-term
16 health care providers who could offer services in
17 French, Hearst or Bruyère. So they do exist. It
18 does not mean that most Francophones these days
19 have access to those services.

20 With respect to long-term care, there
21 are different models. You have, you know, homes
22 where all the environment is in French, and in some
23 communities it is possible because they have the
24 environment from the beginning to the individual,
25 and all these people can speak French.

1 In other sectors, you have other types
2 of models. We have Anglophone homes that offer
3 French services for long-term care, and we also
4 have the Anglophone model that have Francophone
5 pavilions. For example, the City of Toronto has
6 Bendale Acres Home that has several floors, and on
7 those floors there's -- where there is 37 beds
8 reserved for French patients and for which all of
9 the staff is bilingual.

10 So not all the homes in Toronto are
11 Francophones, but they could develop a pavilion in
12 which Francophones could interact because most of
13 the staff is bilingual.

14 So we have a continuum that exists, so
15 it is 100 percent Francophone with alternative
16 models, and according to the density of population,
17 they can find services and those different
18 solutions could be used.

19 Is it working now?

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Yes. Mine was always working.

22 ESTELLE DUCHON: Did you hear the part
23 on care models, or should I come back to the
24 several examples of care models?

25 No? Okay.

1 So as I was saying, there are different
2 models for long-term care that can be adapted to
3 Francophones, that represent a continuum, so they
4 could go from a home that is French speaking with
5 French governance, French staff, to other models
6 where the facilities could be English-speaking
7 facilities with French services, or Anglophone
8 facilities with a cluster of beds for Francophones.

9 And I was giving the example of a
10 long-term care facility in Toronto that is called
11 Acres. In Bendale Acres, there are different wings
12 or clusters, and it is an Anglophone home but with
13 a French cluster, with 37 beds, and they are
14 prioritized for Francophones. There is priority
15 access for Francophones. They have bilingual staff
16 to take care of patients.

17 So it is important to understand that
18 it is a continuum. We have had very good examples
19 of what can be done in Hearst or at Bruyère for
20 facilities that serve Francophones.

21 Just to create a context for members,
22 in Ontario, as you know, there are 626 facilities,
23 long-term care facilities, 12 of which are
24 designated under the French Language Services Act.
25 What does it mean to be designated? It means that

1 the environment has adapted to Francophones, but
2 mainly it means that there is a guarantee of
3 service. So a Francophone resident in that
4 facility has a guarantee of being served in French,
5 that staff will be French, that communications will
6 be in French, that he or she can file a complaint
7 if need be.

8 So there are 12 of those.

9 Beyond that model of designated homes,
10 there are some -- and just a few in Ontario -- of
11 which are culturally designated under the long-term
12 care legislation. So they use article 173 of 19.10
13 to create priorities for Francophones. That is the
14 example of Bendale Acres.

15 So putting those two examples together,
16 the conclusion is that the offer in Ontario for
17 structured long-term care is less than 2 percent of
18 all care, so less than 2 percent are structured to
19 provide services in French.

20 If I look at Francophone seniors of
21 more than 65 years of age, they represent 5.5
22 percent of seniors in Ontario. So there is a
23 shortage in terms of structured services because we
24 have fewer than 2 percent of facilities for 5.5
25 percent of residents.

1 And we know that in some of these
2 facilities there are not only Francophones because
3 these facilities continue to get English clients
4 when there is availability. So we can see the gap,
5 the shortage.

6 What does that mean? Well, it means in
7 all of those facilities, if you are not in a
8 Francophone facility or a designated facility, then
9 it is -- it depends on the situation. It depends
10 on coincidence. You know, if the care attendant
11 that comes to see you speaks French or not because
12 the offer is not structured.

13 One other thing that we must understand
14 in terms of planning is that -- if we look at where
15 these facilities, fewer than 2 percent are located
16 in Ontario. They are in the northern-eastern
17 province or in the east around Champlain. Eighty
18 percent of these homes are in these two regions.

19 Today, we know that about 40 percent
20 are Francophone seniors aged 75 or more that are
21 outside these areas. So they are in Ontario Centre
22 and south.

23 So there is a gap overall and
24 geographically there is a huge disparity, which
25 means that overall, if you are an individual in

1 southern Ontario or central Ontario that needs
2 long-term care that are structured and that are in
3 French, it is almost impossible to access because
4 these facilities are not designated under the Act,
5 and they are not prioritized to address Francophone
6 needs.

7 So beyond a few examples, such as
8 Bendale Acres or Richelieu facilities, in the rest
9 of the territory, as an option for families is do I
10 keep my parent close to me in an English residence
11 where he or she won't be understood and in a
12 situation like COVID I won't even be able to go and
13 see him or her, or do I put him far from where I
14 live but in a home that will be Francophone?

15 So the needs are huge throughout the
16 territory.

17 Perhaps I can move to the following
18 slide, just to continue talking about solutions.
19 So one of the solutions is definitely an increase
20 in the offer of long-term beds, and when I talk
21 about beds, I mean the structure around them as
22 well. So, you know, cultural prioritization of
23 beds, applying the Act in terms of services.

24 Another solution is identifying these
25 Francophone clients and hope placement will be

1 done. Today, the assessment and placement is done
2 by...[indiscernible]; tomorrow probably by Health
3 Ontario teams. What you have to understand is that
4 staff, generally speaking, is not trained to the
5 impact of language.

6 So when families have these
7 conversations on, you know, what placement will I
8 select, the issue of language is very often not
9 even raised.

10 So you are talking about a Francophone
11 senior with cognitive difficulties, and in the
12 discussion on his long-term care, the issue of
13 language will never come up.

14 In the 2012 Sinha Report, it was said
15 that 38 percent of respondents overall of families
16 had no idea of long-term care options that existed
17 locally. So imagine if you don't even know what
18 the facilities are locally, you will certainly not
19 know where you can get French services within these
20 facilities.

21 So there is a very important aspect on
22 how to identify the needs of residents. Do they
23 need services in French and how? When placement
24 comes about, can I take into account language
25 needs, and how can I include that dimension with

1 the families, with the clients, and with the
2 facilities?

3 So I think I will stop there and give
4 the floor to Barbara.

5 BARBARA CECCARELLI: Thank you very
6 much, Estelle. I would just like to come back to
7 this idea of solutions and options there.

8 From our point of view of service
9 providers, we would like that what just happened,
10 and is still going on, be an opportunity for us to
11 really have the courage of looking at long-term
12 care facilities but moving away from the framework
13 of facilities, long-term facilities.

14 People are telling us more and more
15 that they would like to continue aging and end
16 their life at home. They don't necessarily want to
17 move to a home if it is not absolutely necessary.

18 We are hearing that more and more, even
19 before the pandemic, but clearly even more now.

20 I think that it is a solution, you
21 know, to think of different models, and when I say
22 "models", there is some -- I mean, there is some
23 mentalities that are difficult to change. From my
24 point of view, I am thinking about perhaps smaller
25 facilities, better integrated in community living,

1 in the life of the community, perhaps, you know,
2 more homes, houses, as opposed to things that look
3 like a hospital.

4 So think about different models and
5 perhaps focus more on the continuum; what happens
6 before; what can we do differently to make sure
7 that we have in long-term care facilities only
8 those people who absolutely need it, that can
9 access beds, because, I mean, the waiting lists are
10 such that people are always getting a bed late, and
11 that others get the level of support that they need
12 otherwise at a different level.

13 So that means re-invest part of the
14 resources, the engagement, and studies as well in
15 the community. Just to get back to this
16 perspective of language, very often admissions are
17 done because there are no other options.

18 They get to a point where staying home
19 safely is not possible, or perhaps not because it
20 is impossible but because they don't have the
21 necessary support, so then they are hospitalized
22 too early, or they are admitted on the emergency
23 ward repeatedly, and that brings about a transition
24 to long-term care.

25 For those who have cognitive problems,

1 if they are not supported well enough in the
2 community, they also end up in a facility when it
3 is not absolutely required, and they are brought to
4 a facility prematurely. Given the lack of services
5 in French, it is clear that for Francophones this
6 happens even more often.

7 Because of the lack of support, because
8 of the lack of understanding, they are
9 institutionalized too early, prematurely. So it
10 would be a good thing if we used this opportunity
11 now to look at the continuum of care from a broader
12 perspective and if we understood that many deferent
13 things could be done.

14 Of course, we have to increase
15 capacity, but I think that we have to diversify the
16 offer of options and focus on the community
17 especially, and from the point of view of
18 Francophones, right now there are no resources in
19 the Greater Toronto Area in behaviour support in
20 French for everything having to do with dementia
21 and their caregivers in the community.

22 So these are shortages, so these are
23 all individuals that will end up at emergency
24 sooner or later and who will be referred to a
25 facility because there are no options in the

1 community, not because they are ready or it is the
2 time. It is not the time, but there are no other
3 options. And for Francophones, the options are
4 fewer and farther between.

5 So once again, just to add to what
6 Estelle was saying, if we could take this
7 opportunity of the pandemic to look at diversifying
8 the offer of options for aging populations. Thank
9 you.

10 KIM MORRIS: I would like to speak to
11 human resources and complete what I said. I
12 mentioned earlier that Boréal has different offers,
13 and what we learned with COVID is that we can --
14 with different software, different technologies, we
15 can offer remotely a program that is robust and
16 that is a program of quality for attendants.

17 We have our regular offer, of course,
18 right now which starts in September and stretches
19 over two semesters. We have a pilot with
20 Kapuskasing, Hearst, and Welland.

21 The Richelieu Foyer, which is an
22 accelerated program. The accelerated program
23 includes 12 weeks of theory, so it is condensed, 12
24 weeks of theory with partners, such as homes and
25 hospitals, care homes.

1 We can prepare the students for
2 placement, and it is paid placement, internship,
3 and then they perfect their training. So we have
4 six who are at the Foyer Richelieu, and in Northern
5 Ontario, we have 20 registrations. This program is
6 starting in January. We have more demands for the
7 program than we had anticipated. Even in Welland,
8 we have lots of people who would like to take that
9 expedited program to get to a guaranteed job.

10 Another offer that we implemented for
11 January is a hybrid offer, which is part-time. As
12 I mentioned earlier, I talked about the residential
13 care aide. These people can work in a care
14 facility but take training at the same time.

15 THE INTERPRETER: The screen and sound
16 just froze. The interpreter can no longer hear the
17 speaker.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 We should --

20 THE INTERPRETER: Oh, it is okay. She
21 is back.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 All right. The interpreter was having
24 some difficulty hearing at the end there, which is
25 why I interpreted.

1 KIM MORRIS: For the hybrid program,
2 the...

3 [Reporter's Note: No interpretation
4 from French to English being received.]

5 THE INTERPRETER: I'm having trouble
6 hearing. It cuts in and out.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Ms. Morris disappeared off the screen.
9 I hope that was intentional. Mr. Fontaine and I
10 are the only two left.

11 KIM MORRIS: Hello?

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Oh, there you are. Hello.

14 KIM MORRIS: I think we are all here.
15 We just disappeared from the screen. I was just
16 saying that I had 40 bursaries of \$1,000 each for
17 the hybrid program, the part-time program starting
18 in January, and unfortunately, I still have 15
19 bursaries that I haven't given out. A thousand
20 dollars, that's nothing to -- I think it is nothing
21 to turn your eye against because we are really
22 hoping to have all those bursaries given out.

23 So once again, it is a matter of
24 promotion, appreciation for the position for that
25 profession.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Okay.

3 BRYAN MICHAUD: Thank you, Kim. You
4 were finished, Kim?

5 KIM MORRIS: Yes. Thank you. Those
6 are the points I wanted to make. Thank you.

7 BRYAN MICHAUD: Mr. Commissioners,
8 Madam Commissioner, did you have any questions? As
9 far as we are concerned, I think this concluded our
10 presentations, unless someone would like to add
11 something, but I think that this is the end of our
12 presentations.

13 I know there is a little bit of time
14 left should you have questions.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Well, I don't think the other
17 Commissioners have questions. So if that is
18 correct, then let me say this was very helpful
19 because so much of what we receive has an English
20 perspective to it, that it is very easy to lose
21 track of this aspect of the continuum of services
22 that are provided, and to lose sight of the fact
23 that -- the linguistic problems and what flows from
24 those problems are matters that we need to keep in
25 mind.

1 And we have had some information before
2 to the effect that the proportion of beds to people
3 wasn't right, but nothing -- nothing on the level
4 of what you have provided, which is a very complete
5 picture or perhaps as complete a picture as was
6 possible in the time frame of the environment in
7 which you are functioning.

8 And on behalf of all of us, I want to
9 thank you for that, and it has been very helpful,
10 at least from my perspective, and I think I speak
11 for the -- I can say from my perspective, it was
12 very helpful, so thank you very much.

13 COMMISSIONER ANGELA COKE: Yes, it was
14 very helpful, appreciate that.

15 COMMISSIONER JACK KITTS: Agreed.
16 Thank you very much.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Well, the other thing is someone
19 mentioned to me that you wanted to do a screen shot
20 for your -- so do you want to do that? Unless
21 someone has done it already, but if you have done
22 it already, I would like the opportunity to pose
23 for the screen shot.

24 BRYAN MICHAUD: Yes. No, I haven't
25 took it because it is hard to have all the people

1 who are looking good at the same time. So if you
2 want, I will take a screen shot. I invite maybe
3 the people who are not on their video, if they want
4 to be in the photo op, to open it. We'll count to
5 three, and at three, we'll take a good smile, and
6 we will thank the Commission obviously for your
7 time on Twitter. It was really important for us.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Thank you.

10 BRYAN MICHAUD: So we will go in one,
11 two, three...[screen shot taken.]

12
13
14 -- Adjourned at 10:42 a.m.
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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

5 That the foregoing proceedings were
6 taken before me at the time and place therein set
7 forth;

8 That all remarks made at the time
9 were recorded stenographically by me and were
10 thereafter transcribed;

11 That the foregoing is a true and
12 correct transcript of my shorthand notes so taken.

13
14
15
16 Dated this 17th day of December, 2020.

17
18 

19
20
21 _____
22 NEESONS, A VERITEXT COMPANY

23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
24
25

1	CLARIFICATIONS	
2		
3	PAGE/LINE	COMMENT
4	9/9	Replace "entities of French-language
5		planning services" to "French Language
6		Health Planning Entities"
7		
8	25/2	Replace "long-term care health" to
9		"Long-Term Care Homes Act"
10		
11	25/19	Replace "law on Francophone services"
12		to "French Language Services Act"
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