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.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTERS:

FRANCO-ONTARIAN ORGANIZATIONS:
Carol Jolin, President, L’Assemblée de la francophonie de l’Ontario (AFO)
Bryan Michaud, Political Analyst, L’Assemblée de la francophonie de l’Ontario (AFO)
Jean-Guy Fréchette, Partner, Solstice Affaires publiques
Gilles Fontaine, Managing Director, Fédération des aînés et des retraités francophones de l'Ontario (FARFO)
Estelle Duchon, Executive Director, Entité 4
Barbara Ceccarelli, Managing Director, Centre d'accueil Heritage
Joëlle Lacroix, Administrator, Foyer des pionniers de Hearst
Kim Morris, Faculty of Science, Collège Boréal
Guy Chartrand, PDG, Bruyére Soins continus

Melissa Donskov, Vice President, Bruyére Soins continus

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst, Long-Term Care Commission Secretariat

ALSO PRESENT:
Deana Santedicola, Stenographer/Transcriptionist
Louise Cote, French/English Interpreter

Nathalie Hanako Tan, French/English Interpreter

-- Upon commencing at 9:00 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, good morning, everyone. Thank you for coming. I am Frank Marrocco. I don't know if you have met the other Commissioners. Commissioner Angela Coke is there and Commissioner Dr. Jack Kitts.

We are the Commission, as I suspect you know.

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

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

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

So who is "Juge en chef"?

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

Thank you very much. Thank you, Commissioners.

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

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

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

CAROL JOLIN: Thank you, Bryan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As Carol said, we also have to think

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

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

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

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

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

Once again, the context, let's not

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

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

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

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

no longer be understood.

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

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

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

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

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

health as well.

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

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

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

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

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

THE INTERPRETER: Sorry.

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

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

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

COMMISSIONER ANGELA COKE: Yes. No.

THE INTERPRETER: Can you hear me?

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

THE INTERPRETER: Can you hear the interpreter?

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

COMMISSIONER ANGELA COKE: Okay. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

It can be difficult for family members to communicate the needs of their parents or grandparents as well, I assume.

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

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Kitts?

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

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

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

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

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

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

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

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

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

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

So you are right.

COMMISSIONER JACK KITTS: Okay. Thank you very much.

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

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

ESTELLE DUCHON: Bryan, I can answer that question.

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): That was actually where I was going. The bed is a bed. It is a question of surroundings and the people speaking to you, feeding you, that sort of thing. That is what I would assume makes it more suitable because you can all speak to each other. You could put the bed anywhere.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you for that. I just have one other question, which is a bit unrelated. How long -- in your experience, how long has this problem persisted because I'm a little -- you know, I have not really turned my mind to it in the past, but how long has there been this shortage or this disproportion in terms of the number of beds per -- or the number of persons per bed?

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. I don't think we have any further questions, so you can carry on.

BRYAN MICHAUD: Thank you. I will ask Guy Chartrand or Melissa to speak with respect to Bruyére continuing care.

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

COMMISSIONER FRANK MARROCCO (CHAIR): I can.

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

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

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

We are lucky at Bruyére because we are part of the Bruyére continuing services, and we also have hospital programs, and we also have ambulatory and community care services. We had the opportunity during the whole pandemic to benefit from some services and expertise from our corporation.

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

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

population in Ottawa.

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

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

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

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

opportunities to get staff from agencies or from other organizations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

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

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

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

exclusively in French.

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

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

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

project. It was easier to implement infection prevention measures.

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

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

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

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

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

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

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

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

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

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

That does not mean that we didn't face

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

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

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

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

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

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

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

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

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

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

option.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

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

This would allow the process to be much more efficient.

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

So we have campuses a bit everywhere.

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

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

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

Joëlle from Hearst mentioned that it is

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

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

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

The twelfth grade students who are

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

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

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

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

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

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

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

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

At Boréal, we have several offers -- I

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

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

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

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

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

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

And do you have any questions?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes. Dr. Kitts?

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

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

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

COMMISSIONER JACK KITTS: Thank you.

CAROL JOLIN: Bryan --

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

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

NICHOLAS BAXTER: Go ahead, Carol.

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

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

young people to go to those type of jobs.

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

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

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

I really appreciate to hear the work

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

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

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

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

Thank you.

BRYAN MICHAUD: Thank you, Carol.

Do the Commissioners have other questions to address to Kim?

COMMISSIONER FRANK MARROCCO (CHAIR):

I don't think so. No, I don't think so.

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

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

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

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

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

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

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

Is it working now?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes. Mine was always working.

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

No? Okay.

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

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

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

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

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

So there are 12 of those.

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

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

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

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

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

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

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

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

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

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

So the needs are huge throughout the territory.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For those who have cognitive problems,

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR):

We should --

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

COMMISSIONER FRANK MARROCCO (CHAIR):

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

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

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

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

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

KIM MORRIS: Hello?

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

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

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

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I don't think the other Commissioners have questions. So if that is correct, then let me say this was very helpful because so much of what we receive has an English perspective to it, that it is very easy to lose track of this aspect of the continuum of services that are provided, and to lose sight of the fact that -- the linguistic problems and what flows from those problems are matters that we need to keep in mind.

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

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

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

COMMISSIONER JACK KITTS: Agreed. Thank you very much.

COMMISSIONER FRANK MARROCCO (CHAIR):

Well, the other thing is someone mentioned to me that you wanted to do a screen shot for your -- so do you want to do that? Unless someone has done it already, but if you have done it already, I would like the opportunity to pose for the screen shot.

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

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

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

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

-- Adjourned at 10:42 a.m.

REPORTER'S CERTIFICATE

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

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

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

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

Dated this 17th day of December, 2020.

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CLARIFICATIONS

PAGE/LINE	COMMENT
9/9	Replace "entities of French-language planning services" to "French Language Health Planning Entities"
25/2	Replace "long-term care health" to "Long-Term Care Homes Act"
25/19	Replace "law on Francophone services" to "French Language Services Act"

WORD INDEX