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Understanding the Long-Term Care Experience of Official Language Minorities in Canada: An Environmental Scan

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Executive Summary

Context

Members of minority and racialized communities across Canada commonly experience disparities in health and healthcare. In the context of the COVID-19 pandemic, minority and racialized individuals have been found to report poorer health outcomes and added barriers to healthcare access. While there is growing understanding of the impact of COVID-19 on individuals who live and work in residential long-term care (LTC) homes and other congregate care settings, little attention has been directed at examining inequities in the care experience and care-related outcomes that equity-seeking groups, including Official Language Minority Communities (OLMC), face within LTC. It's clear that there is a need for systemic change within LTC; the pandemic, especially in its first two waves, highlighted several pre-existing issues within this sector. To ensure high-quality and equitable care for all aging Canadians, these system-level changes must be informed by evidence.

The revelations from the impact of the pandemic has spurred the CSA Group (formerly known as the Canadian Standards Association), Health Standards Organization (HSO), and Standards Council of Canada (SCC) to come together and develop two new complementary and updated national standards for LTC: The CSA Group will tackle the standards for health infrastructure and environmental design of LTC homes, with a focus on safe operating practices and infection prevention and control; while the HSO standard will be a revision of its current *Long-Term Care Services Standard* with the aim to incorporate the latest evidence-informed, resident and family-centered requirements for high-quality care and services. SCC, a federal Crown corporation, has established the standards development process that HSO and the CSA Group are following and will approve the final standards. These organizations will work with governments, stakeholders, and Canadians to develop national standards that will help inform ongoing dialogues pertaining to and strategies for improving the quality of life of individuals needing LTC. They have committed to integrating diversity considerations (including OLMCs) as part of their process. The HSO and the CSA group released their respective draft standard for LTC on January 27, 2022 and February 11, 2022 for public review. Upon their respective public release, Canadians will have 60 days to review and provide feedback. Both organizations will also be facilitating a series of consultation sessions during this time.

Through its *Action Plan for Official Languages – 2018-2023*, the Government of Canada aims to improve access to health services for OLMCs to enhance their vitality in the official language of their choice, in accordance with the objectives set out in the *Official Languages Act*. The Official Languages Health Program (OLHP), which was funded under the government-wide *Action Plan*, focuses on supporting initiatives that improve access to services for English-speaking persons

in Quebec and French-speaking persons in the other twelve provinces and territories. Within Health Canada, the Official Language Community Development Bureau (OLCDB) is tasked to support the design and implementation of initiatives under the OLHP to improve access to healthcare services offered in both official languages.

A research team led by Dr. Amy Hsu, uOttawa Brain and Mind-Bruyère Research Institute Chair in Primary Health Care in Dementia and Investigator at the Bruyère Research Institute, was commissioned by the OLCDB to conduct an environmental scan to understand variations in care and outcomes experienced by minorities, especially OLMCs, needing LTC in Canada. Specifically, the objectives of this environmental scan were to:

1. Discover and summarize resources and community supports available to OLMCs needing LTC in Canada;
2. Examine differences in the prevalence of LTC use and barriers to access encountered by minority populations and OLMC persons, in particular; and
3. Highlight observed differences in care-related outcomes experienced by minority and OLMC persons while receiving care in LTC.

Main Findings

- While there are community-based supports available to OLMCs seeking LTC, self-conducted research is often required by the client to determine if they are eligible for residential LTC services and learn about the application process. Unfortunately, information and supportive resources are often not available in both official languages.
- Translation and interpretation services may be requested by the applicant during this process. More commonly, however, these needs are informally met; that is, language support may be provided by the community-based Care Coordinator supporting the LTC placement process and/or with the assistance of a colleague or supervisor who speaks the same language as the client. Most often, family members and care partners of the client act as the interpreter and translator.
- Once they are placed on the waitlist for LTC, time to placement tends to be longer for individuals belonging to minority groups (for example, immigrants and those waiting to move into a designated ethnocultural home).
- Overall, there is a deficit in the number of healthcare providers able to provide services to meet the needs of OLMC persons needing LTC.
- Once an OLMC person moves into LTC, their family members and/or designated care partners serve a crucial role as the interpreter for OLMC residents.

- The extent of coordination between community resources and LTC homes and availability of resources to meet the linguistic needs of OLMC residents varies from home to home.
- Existing research revealed significant differences in patient-centered outcomes (e.g., experience of depressive symptoms, reports of frequent or severe pain) in homes with language discordance (i.e., where the primary language spoken by the resident does not match the predominant language spoken in the LTC home).

Recommendations

Based on the findings from our environmental scan, we recommend the following:

Recommendation 1: To ensure residents in LTC homes and their family members or designated care partner(s) understand their rights to appropriate and high-quality care, a copy of the Residents' Bill of Rights outlined in the provincial and territorial legislations governing the provision of long-term and residential care should be provided to all residents, their family members and/or designated care partner(s) *in their preferred (official) language*, prior to or at the time of the resident's admission.

Recommendation 2: When developing individualized care plans for residents, the team should strive to conduct discussions about goals of care and present available care options to residents, families, and/or designated care person(s) *in their preferred (official) language*.

Recommendation 3: To maintain respect for equity, diversity and inclusion of residents, quality improvement methods and action plans developed and implemented by organizational leaders and teams must regularly assess for differences in care-related outcomes among residents belonging to equity-seeking groups, including OLMC persons.

Recommendation 4: Considering the widely acknowledged issue pertaining to a shortage of skilled workers within LTC, where the supply of human resources is unlikely to be able to meet the demands and linguistic needs of all residents, LTC providers should strive to create opportunities for diversity and language training for frontline staff caring for OLMC and other minorities in LTC.

Recommendation 5: In recognition of families and designated care person(s)' contribution to the quality of life for residents in LTC and their often-assumed role as the interpreter and additional support for the residents, providers should aim to create training opportunities for family members, designated care person(s) and volunteers wishing to support residents in LTC.

Conclusions

The development of effective and lasting solutions to fix LTC requires understanding of the regulatory guidelines governing care provision within this sector, LTC homes' operational practices and challenges, and the increasingly diverse population of older adults who need and receive support in this setting. However, coming up with strategies to adequately address the needs of equity-seeking groups in LTC may be particularly difficult, given the lack of research on minority populations, in general, and the little attention paid to the intersectionality of multiple identities that contributes to disparities in health and healthcare. Improving the health and healthcare for minority communities in Canada, particularly linguistic minority communities, require a major shift in practice and investment in culturally-appropriate care and research. This environmental scan aimed to inform the new national services standard in LTC; yet, this is just the beginning of a much greater task ahead. By revealing the gaps experienced by minority communities as they seek LTC, we hope this synthesis of evidence will support an equitable, diverse and inclusive approach to the future improvement of LTC in Canada.

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Abbreviations

CSA Group (formerly known as the Canadian Standards Association)

HSO: Health Standards Organization

LTC: Long-Term Care

OLCDB: Official Language Community Development Bureau

OLHP: The Official Languages Health Program

OLMC: Official Language Minority Communities

SCC: Standards Council of Canada

1 Introduction

Through its *Action Plan for Official Languages – 2018-2023*, the Government of Canada aims to improve access to health services for Official Language Minority Communities (OLMC) to enhance their vitality in the official language of their choice, in accordance with the objectives set out in Section 41 (Part VII) of the *Official Languages Act*. The Official Languages Health Program (OLHP), funded under the government-wide *Action Plan*, focuses on supporting initiatives that improve access to services for English-speaking persons in Quebec and French-speaking persons in the other twelve provinces and territories. Specifically, the OLHP contains three programmatic components: training and retention of bilingual healthcare professionals; supporting health networking among communities, decision-makers, health managers, health professionals, and post-secondary institutions; and health services access projects featuring innovative approaches to improve access to health services for OLMCs. Within Health Canada, the Official Language Community Development Bureau (OLCDB) is tasked with supporting the design and implementation of initiatives under the OLHP to improve access to healthcare services in both Canada's official languages, French and English (Health Canada, 2013).

Within the context of the COVID-19 pandemic, minority and racialized communities across Canada have reportedly experienced poorer health outcomes and added barriers to healthcare access. The experience of disparities in health and healthcare by members of minority and marginalized groups, however, is not new. While the impact of COVID-19 on individuals who live and work in residential long-term care (LTC) homes and other congregate care settings is known, little attention has been directed at examining inequities in the care experience and care-related outcomes that equity-seeking groups, including OLMCs, face within LTC. It's clear that there is a need for systemic change within LTC; the pandemic, especially in its first two waves, highlighted several pre-existing issues within this sector. To ensure high-quality and equitable care for all aging Canadians, these system-level changes must be informed by evidence.

A research team led by Dr. Amy Hsu, uOttawa Brain and Mind-Bruyère Research Institute Chair in Primary Health Care in Dementia and Investigator at the Bruyère Research Institute, was commissioned by the OLCDB to conduct an environmental scan to understand variations in the care and care-related outcomes experienced by minorities, especially OLMCs, in LTC. This

included an examination of potential barriers to access encountered by minorities and OLMC persons wishing to access LTC in Canada, as well as differences in care-related outcomes experienced by minorities and OLMC persons while in LTC. In synthesizing this evidence, we aimed to provide an evidence-based and national perspective that can inform the newly developed national services standard for LTC that would be grounded in the principles of equity, service quality and patient safety.

To this end, we examined the broad range of challenges faced by individuals needing LTC, who belong to any language, ethnic or cultural minority. This approach was chosen given the sparse research on this topic in Canada. Where possible, we stratified and highlighted unique challenges experienced by OLMC persons in Canada based on available Canadian literature and key informant interviews.

2 Context

2.1 Official Language Minority Communities (OLMCs)

Linguistic minority communities within Canada include OLMCs, First Nations and Inuit communities, Deaf and Mute Communities, and newcomers to Canada (immigrants and refugees). These four groups are all known constituencies within Canada who may face additional barriers when accessing healthcare due to linguistic discordance. For the purpose of this report, OLMCs is defined as and include Francophone minority communities outside of Québec and English-speaking communities in Québec.

The *Official Languages Act* was first enacted in 1969 and was established to ensure access to federal services was provided in both French and English for all Canadian citizens. However, as it stands, the *Official Languages Act* lacks specificity around access to health services and care delivery in both official languages, and is only applicable to federal institutions and cannot be applied to provincial or municipal governments. Nonetheless, many provinces and territories have enacted Francophone Affairs Secretariats and assemblies at the heart of their authorities to enhance the vitality of the French language and access to critical services in both official languages (see **Appendix I** for a summary of the role of existing legislations and/or policies that may affect access to services and supports needed by OLMCs across Canada).

While these provincial and territorial entities work to protect the rights and promote the interests of their local official language minority communities, most do not play a prominent role in French-language healthcare service delivery outside of Québec and English-language healthcare service delivery within Québec. As a result, there is great variability in the availability of health services in the minority official language, which leads to barriers to first contact for health services within these systems (Bowen, 2003).

2.2 Impact of the COVID-19 pandemic

As of January 30, 2022, 33,722 Canadians have died from COVID-19. A vast majority of deaths occurred in LTC homes and seniors' residences, especially during the first two waves (approximately 69% of total deaths) of the pandemic (Canadian Institute for Health Information [CIHI], 2022). The impact that COVID-19 has had on the population in LTC is tragic, and this extends beyond the mortality count. Even residents in facilities not affected directly by the disease experienced extreme social isolation and reduced services that contributed to their overall decline in health and well-being. As part of the 2020 Speech from the Throne, the Government of Canada committed to working with the provinces and territories to set new national standards for LTC so that Canadians receive the best possible care as they age.

The revelations from the impact of the pandemic has spurred the CSA Group (formerly known as the Canadian Standards Association), Health Standards Organization (HSO), and Standards Council of Canada (SCC) to come together and develop two new complementary and updated national standards for LTC: The standard being developed by the CSA Group will focus on health infrastructure and environmental design of LTC facilities, emphasizing safe operating practices and infection prevention and control; the HSO services standard will be a revision of its current *Long-Term Care Services Standard* (last updated in August 2020) with the aim to incorporate latest evidence-informed, resident and family-centered requirements of high-quality care and services. SCC, a federal Crown corporation, has established the standards development process that HSO and the CSA Group are following and will approve the final standards. These organizations will work with governments, stakeholders, and Canadians to develop national standards that will help inform ongoing discussions pertaining to and strategies for improving the quality of life for residents in LTC. They have committed to integrate diversity considerations (including OLMCs) as part of their process. HSO's draft standard for LTC was

released on January 27, 2022 for public review. Similarly, the CSA Group's published their draft standard on February 11, 2022. Upon their respective public release, Canadians will have 60 days to review and provide feedback. Both organizations will also be facilitating a series of consultation sessions during this time.

2.3 Objectives

Our experience through this pandemic once again highlighted that minority and racialized groups experience significant inequities in health and healthcare, in the community as well as in residential care. To better understand variations in healthcare and care-related outcomes experienced by individuals belonging to equity-seeking groups, especially OLMC persons, in LTC, we set out to:

1. Identify and summarize resources and community supports available to OLMCs needing LTC in Canada;
2. Examine differences in the prevalence of LTC use and barriers to access encountered by minority populations and OLMC persons, in particular; and
3. Highlight observed differences in care-related outcomes experienced by minority and OLMC persons while receiving care in LTC.

3 Methodology

3.1 Key informant interviews

In order to better understand service gaps experienced by OLMC persons in Canada, we conducted key informant interviews between July 2021 and January 2022 with community-based organizations as well as providers in LTC who support OLMCs.

As part of the pre-research for the interviews, we reviewed existing academic articles, grey literature, as well as government and relevant organizational websites and reports pertaining to the process of planning and applying for residential LTC in Canada. Key informants from across the country were contacted to verify the research team's findings with regards to available community-based resources supporting OLMC persons' access to LTC. Interviewees were also asked to help identify additional existing supports available to OLMC persons who currently reside in an LTC home.

3.2 Systematic reviews of the literature

To provide a broad overview of known challenges that minority populations may face, we conducted two systematic reviews of published international literature on barriers to accessing LTC as well as care-related outcomes within LTC.

3.2.1 Access, expectations and preferences for minority populations

The first systematic review focused on the barriers and facilitators to accessing LTC in minority populations. The full protocol is published and can be found on PROSPERO (CRD42018038662).

Our search included all studies written in English or French that evaluated LTC access in minority populations published between January 1, 2000 and January 1, 2021. We consulted an information scientist and conducted a search for relevant articles from 10 databases.

We included quantitative and qualitative studies that: (1) examined admission to long-term residential care or the influence of minority status on admission, or (2) explored barriers and facilitators of admission for minority populations. An age restriction of 65 or older was applied to the first group; however, we did not apply an age restriction to studies on preferences, including studies that assessed perceptions of participants who would be using homes in the future.

Titles and abstracts were independently screened by at least two researchers for relevance. After reaching consensus, full-text articles were obtained and uploaded to Mendeley. Two members of the team independently reviewed each article. Disagreements were resolved through discussion and the input of a third team member, when necessary. Subsequently, one team member extracted data from all relevant articles using a form specifically developed and pre-tested for the study.

3.2.2 Care-related outcomes of minority populations in residential long-term care

The second systematic review focused on studies examining differences in care-related outcomes (e.g., clients or patients' symptoms, healthcare use, medical data, quality of life, satisfaction with care) experienced by minority populations in LTC facilities compared to non-

minority populations receiving care in the same setting. The full protocol is published and can be found on PROSPERO (CRD42021269489).

For this review, we included all studies written in English or French that evaluated observed differences in care-related outcomes among minorities in LTC published between January 1, 2000 and September 24, 2021.

Our search included qualitative and quantitative observational and experimental peer-reviewed literature (i.e., cross-sectional, cohort, control trials, case-control, etc.) on residents in LTC who belonged to an identified a minority population. We excluded case reports or research solely comparing two minority populations without a comparison to the care-related outcomes observed in individuals who are part of the context-specific majority population.

A search strategy was developed with the help of an information scientist and 10 databases were searched for relevant articles: MEDLINE, Embase, CINAHL, CENTRAL, PsycINFO, Web of Science, EconLit, ProQuest Dissertations & Theses Global, Érudite/Persée, Repère, and Banque de données santé publique (BDSP). 11,254 articles were identified and the first 30 articles were reviewed by each screener to establish consensus on inclusion and exclusion criterion.

Titles and abstracts were independently screened by at least two researchers for relevance. After reaching consensus, full-text articles were obtained and uploaded to Covidence. Two members of the team independently reviewed each article. Disagreements were resolved through discussion and the input of a third team member, when necessary. Subsequently, one team member extracted data from all relevant articles using a form specifically developed and pre-tested for the study.

3.3 Analysis of health administrative data

We conducted a series of population-based retrospective cohort study using health administrative data available in Ontario (housed at ICES, formerly known as the Institute for Clinical Evaluative Sciences) to assess the impact of language discordance on care-related outcomes in OLMC residents within LTC, including rates of hospitalizations, emergency

department (ED) visits, mortality, and care quality indicators as defined by Health Quality Ontario (HQO).

We linked multiple databases containing information on LTC home residents using the Resident Assessment Instrument Minimum Data Set (RAI-MDS) and person-level data related to hospital admissions (CIHI Discharge Abstract Database) and visits to the ED (CIHI National Ambulatory Care Reporting System data). Care quality indicators were derived from the RAI-MDS data and included: (1) the prescription of antipsychotic medications in the last 7 days despite not having a diagnosis of psychosis; (2) worsening depressive symptoms since their last RAI-MDS assessment; (3) experience of moderate pain daily or any severe pain in the last 7 days; (4) falling least once in the last 30 days; and (5) being physically restrained on a daily basis.

The analysis primarily focused on LTC home residents whose primary language spoken (i.e., French) was not representative of the majority of the resident population in their LTC homes. Since data on the language of the service providers within the homes is not available, we determined the predominant language of the home by calculating the proportion of total resident-days contributed by residents who spoke either French or English. Whichever language comprised at least 50% of the total resident-days within our study timeframe was classified as the predominant language of the home.

We estimated Cox-proportional hazards models to examine time to first hospitalization, first ED visit and mortality within one year of LTC admission. We used logistic regression models with generalized estimating equations to examine the effect of language on quality indicators. All models adjusted for resident demographics and health (including age, sex, language, neighborhood income before admission, and chronic conditions), as well as facility-level variables (e.g., urbanicity, ownership, facility size, and region, where available). Cross-level interactions of the resident's primary language spoken and predominant language of the home (as a proxy for language discordance) were also examined.

4 Healthcare for Linguistic Minorities

Individuals belonging to OLMCs often experience barriers that negatively affect their ability to access health services in the official language of their choice (Bouchard & Desmeules, 2013). One qualitative study conducted across four Canadian provinces found that Francophones

reported low confidence in healthcare encounters when language discordance was identified, and they were more likely to experience adverse outcomes, including poor patient assessment, misdiagnosis, and delayed treatment (de Moissac & Bowen, 2019). These communication challenges also had a direct impact on timely access to appropriate care (Dressler & Pils, 2009), and the discrepancy may be further exacerbated in aging OLMC persons. Furthermore, research has found belonging to more than one minority community, or minority status, can have multiplicative, negative effects on individuals' health (Palència et al., 2014). As such, while this report focuses on the identity of linguistic minority, we wish to emphasize that linguistic minority status should be viewed alongside all disadvantages to account for the cumulative impact and barriers to care many equity-seeking groups face. For example, immigration is an essential part of maintaining the vitality of OLMCs, particularly the Francophone communities in Canada (Immigration Refugees and Citizenship Canada, 2021). Yet, little is known about the healthcare experiences of, and whether any discrepancies exist between immigrants and non-immigrants who speak French. Appropriate, culturally-safe care options and inclusive policies are paramount, particularly as the Canadian population continues to age and grow in diversity (Employment and Social Development of Canada, 2016; Statistics Canada, 2020).

4.1 Challenges for linguistic minorities needing LTC

The challenges that minority persons face as they seek access to LTC have not been well-studied. The research on barriers to LTC for this population is scarce, with sources being, for the most part, at the international level; there were limited studies conducted within Canada (a summary of relevant studies can be found in **Appendix II**). Furthermore, there is no published synthesis of the literature on care-related outcomes for those belonging to minority populations needing LTC.

Residential LTC facilities, often referred to as LTC homes or nursing homes, specialize in providing around-the-clock support for frail individuals with complex care needs that cannot be safely supported in their private dwelling. It has been estimated that approximately 87% of residents in LTC have some form of cognitive impairment attributed to dementia, mild cognitive impairment (MCI) and other related conditions such as stroke or trauma (CIHI, 2016). Cognitive decline negatively impacts physical abilities and executive functioning, including linguistic abilities. The loss of linguistic abilities is a common symptom among people with dementia,

especially as the disease progresses and goes from a moderate to severe stage. This can impede their ability to express their care needs and wishes. In most cases, bilingual speakers with dementia tend to revert to their first language as their cognition deteriorates.

Language discordance occurs when the provider does not speak the preferred language of the patient or resident, which makes the care of minority persons living with dementia particularly challenging (Sagbakken et al., 2018). Communication around goals of care, preferences, and social desires may be lost as residents face deteriorating health while in LTC.

5 Accessing Long-Term Care

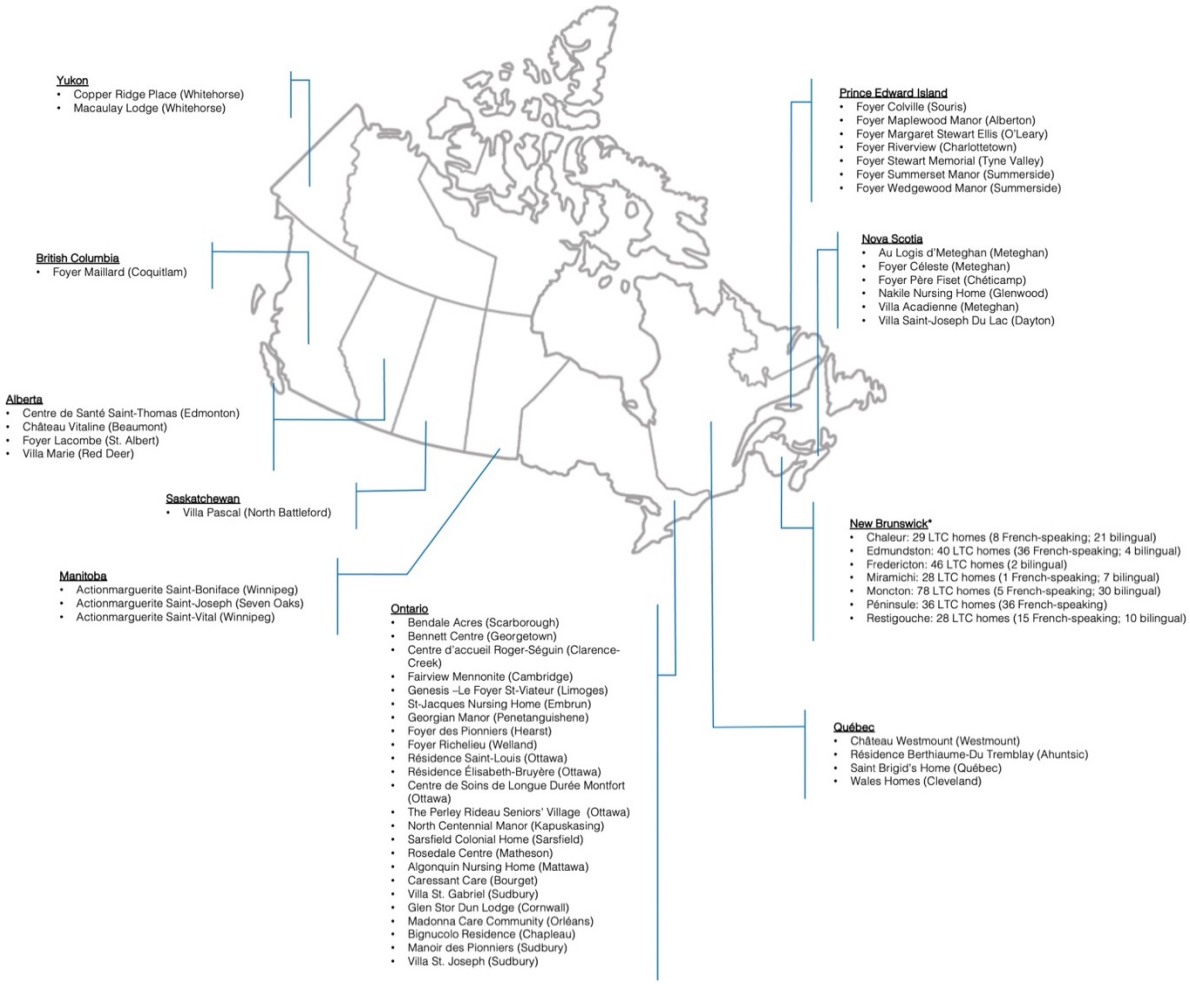
5.1 Challenges for OLMCs accessing LTC in Canada

There is a notable paucity of evidence on access to LTC for OLMCs in Canada. A commissioned report by Bowen in 2003 reported that significant barriers to healthcare exist, particularly in LTC settings, for OLMCs and other linguistic minorities. The report highlighted that more research was needed to better understand the challenges facing these populations s they age (Bowen, 2003). Sadly, this finding and recommendation remains unchanged from what we have uncovered in our environmental scan—20 years later. Our systematic review of the literature located only one study, published by Forgues et al., that examined access to LTC for francophone minorities in Canada (specifically, in the province of New Brunswick). The authors conducted a geographic survey of the availability of LTC facilities in the province and concluded that there was limited access to LTC for Francophones and particular access limitations were found in certain areas with higher population density (Forgues et al., 2011).

One approach to assess the current supply of linguistically-appropriate care is the ratio of healthcare providers who are able to provide services in a minority language per 1,000 in the population. Across Canada, a deficit in this measure has been observed (Statistics Canada, 2017). A report by Statistics Canada suggests that the number and capacity of healthcare providers equipped to offer services to OLMCs was below the number of those who belong to OLMCs across all provinces and territories, except in British Columbia (Statistics Canada, 2017).

In the LTC sector, there is a lack of information and systematic collection of data on care options available to linguistic minorities, including those in OLMCs. Health administrative data in Canada does not routinely collect information on the language spoken by healthcare providers in LTC, making the evaluation of linguistic impact and language discordance difficult to access at a population level. From our environmental scan, consultation with key informants, and health administrative data sources, we were able to identified 227 LTC homes (**Figure 1**) that were either designated ethnocultural homes or where additional supports for OLMCs is provided by the home.

Figure 1. Designed and non-designated ethnocultural LTC homes supporting OLMCs in each province and territory



*The full list of Special Care Homes in each region of New Brunswick can be found on the Government of New Brunswick's website: https://www2.gnb.ca/content/gnb/fr/ministeres/developpement_social/foyers_de_soins_speciaux/foyers_de_soins_speciaux.html

While this is not a comprehensive list, it is clear that the current supply does not meet the potential demand for care by aging OLMC persons. Of the approximately 2,076 LTC homes in Canada, the homes we identified in **Figure 1** represent just 11% of all facilities. This observation is supported by available regional data. In Ontario, for example, a report published in 2020 on the Champlain Local Health Integration Network (now known as Ontario East Home and Community Care Support Services) identified a total of nine designated French homes, which is far below the number of Francophones in the region who have an expected need for LTC—representing a gap of 405 beds (French Languages Health Services Network of Eastern Ontario, 2020). Reports such as this indicate that the demand for LTC in OLMCs may not be met by current supply.

5.2 Finding information about LTC in their preferred language

OLMC members who are planning for LTC often experience barriers to accessing appropriate information, in their official language of choice, regarding the process of applying to LTC. Publicly available information on the LTC placement process is not always available in both official languages. Extensive self-conducted research is often required to find comparable resources by OLMC seniors seeking LTC. This assumes seniors have preliminary knowledge about LTC and also that they are able to navigate through the initial application steps without linguistic support.

While there are community organizations supporting OLMC persons seeking health services in all provinces and territories (see **Table 1**), many of these organizations operate independently from publicly-funded home and community care services and representatives from these organizations are rarely directly involved in the application process for LTC. As such, we observed an underutilization of these existing linguistic and culturally-specific resources as OLMC persons apply for, transition into LTC, or while receiving care within LTC homes.

5.3 Other linguistic minorities' access to LTC in Canada

While there were more studies on the experience of Allophones (i.e., those speaking languages other than English and French) in Canada, research examining the differences between

Allophones and Anglophones was also limited (**Appendix II**). The only three published studies captured the experiences of Japanese Canadians, Chinese Canadians, and Chinese Canadians with elderly parents in China discussing expectations and preferences of residential or LTC for themselves or their parents (Gui & Koropeckyj-Cox, 2016; Lai, 2008; Metz, 2004). These studies reported language as a barrier to accessing and understanding information about LTC, receiving care or communicating with providers while receiving care in LTC, and being able to meaningfully engage in social activities while in LTC.

6 Applying for Long-Term Care

When a person requires access to LTC in Canada, the process often begins with their regional/local home and community care service provider, who will initiate the application process by scheduling a needs assessment (**Figure 2**). Individuals may also access LTC through a self-referral process or through a hospital discharge process where they are assigned to a care coordinator who screens the applicant and performs a needs assessment. For OLMCs, there are immediate linguistic barriers to this process. There are some services available to OLMC seniors who require support throughout the application process. For instance, interpretation and translation services may be requested by the applicant should they require language support. More commonly, however, language support is provided by the care coordinator (if they have some proficiency in the primary language spoken by the client) and/or with the support of a colleague or supervisor who is able to provide assistance. Often, this responsibility falls on families and caregivers. Furthermore, due to some areas not having access to home care services in both official languages, the need for LTC may be expedited in OLMC persons in order to receive the support that they need because they cannot live independently in their homes.

Table 1. Community structures supporting OLMCs' access to LTC

Province/Territory	Community Structures
Newfoundland and Labrador	- Fédération des francophones de Terre-Neuve et du Labrador - Association Francophone de Saint-Jean - ConnectAînés
Prince Edward Island	- Réseau Santé en Français Î.-P.-E.
Nova Scotia	- Réseau-Santé Nouvelle-Écosse
New Brunswick	- Réseau-action Communautaire - Réseau du Mouvement Acadien des Communautés en Santé du Nouveau-Brunswick - Société Santé et Mieux-être en Français du Nouveau-Brunswick
Quebec	- Accès Résidences - Seniors Action Québec - Québec Community Groups Network - English Coalition of Caregivers of Montréal
Ontario	- North-West Home and Community Support Services - Francophone Wellness Network of Northern Ontario - Entité 4 - AdvantAge Ontario - Réseau Franco-Santé du Sud de l'Ontario - Fédération des aînés et des retraités francophones de l'Ontario - Hélène Tremblay Lavoie Foundation - French Language Health Services Network of Eastern Ontario
Quebec	- Accès Résidences - Seniors Action Québec - Québec Community Groups Network - English Coalition of Caregivers of Montréal
Manitoba	- Santé en Français
Saskatchewan	- Réseau Santé en Français de la Saskatchewan - Vitalité 55+ - Bonjour Saskatchewan
Alberta	- Réseau Santé Alberta - Fédération dse aînés franco-albertains
British Columbia	- RésoSanté Colombie Britannique - Fédération des francophones de la Colombie-Britannique - La Maison de la Francophonie de Vancouver
Yukon	- Partenariat Communauté en Santé
Northwest Territories	- Réseau TNO Santé
Nunavut	- Réseau Santé en Français au Nunavut - Association des Francophones du Nunavut

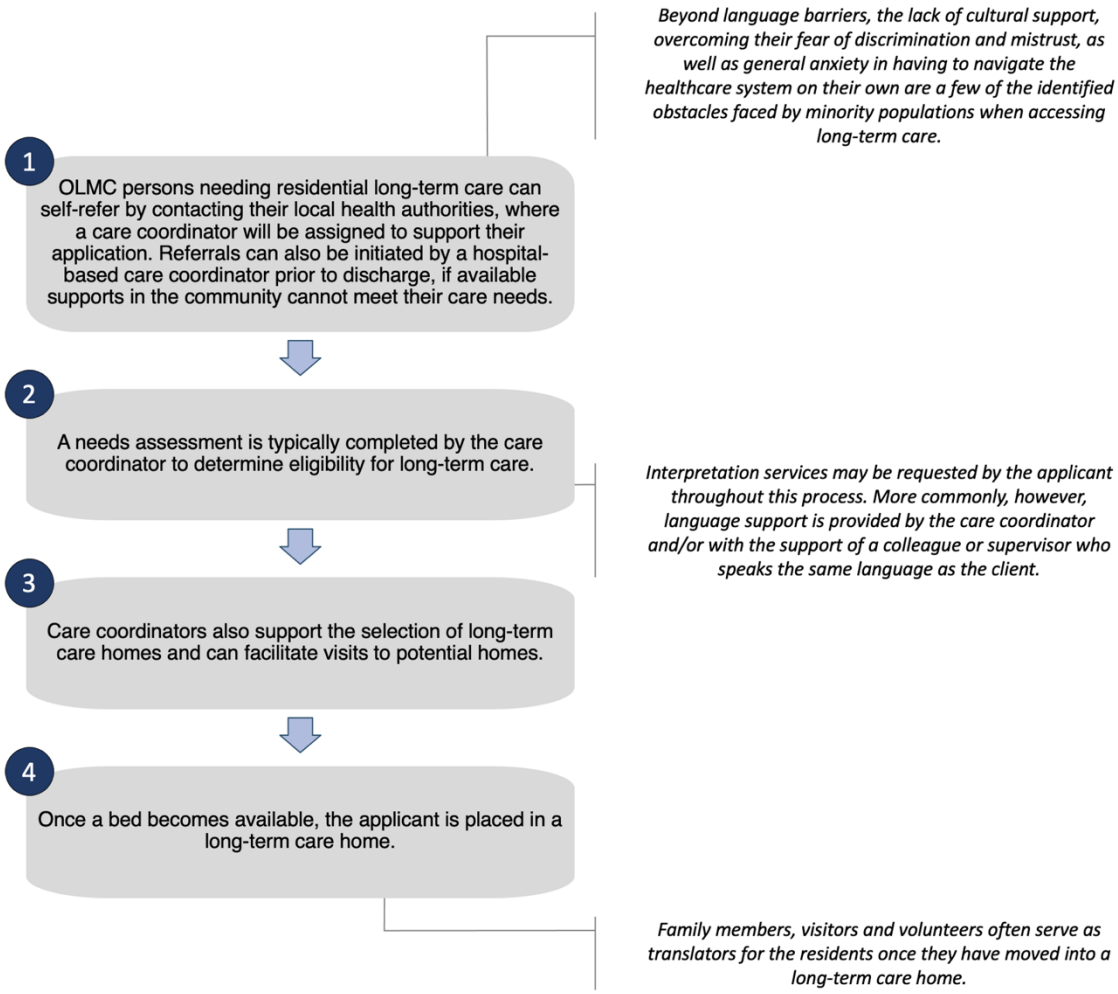
The screening and assessment (including a review of their medical history) is typically performed by a care coordinator within home and community care. In some jurisdictions, care coordinators can facilitate a planned visit to potential LTC homes where the person wishes to be placed. The client is then placed on a waitlist until a bed becomes available in any of their five chosen homes. When a bed becomes available in one of the homes, clients are typically expected to respond to the offer within 24 hours.

6.1 Waiting for placement

After an application is submitted and the needs assessment has been completed, there is often a waiting period before a bed becomes available for those who require LTC. Waiting time depends on a number of factors including geographic location, care needs, and the choices of home selected as preferred by the prospective resident.

Studies using health administrative data in Ontario found that seniors (defined as individuals over the age of 65 years) with the lowest income, and those from ethnically- and linguistically-diverse populations were among those who waited the longest for their site of choice (Um, 2016; Um & Lightman, 2017). In another study conducted by our research team, we found that wait-times for entry to LTC across Ontario was much longer for recent immigrants and those waiting for a designated cultural or an ethnic-specific bed (including French-designated homes in the province). Specifically, being a recent immigrant or waiting for a cultural or an ethnic-specific home significantly increased the average wait-time for long-term care placement by 1.22 (95% CI: 1.15–1.30) and 1.32 (95% CI: 1.11–1.56) times compared to long-standing residents, respectively (Qureshi et al., 2021).

Figure 2. General process to accessing LTC in Canada, and resources and barriers faced by OLMC persons needing care



7 Finding Support within Long-Term Care

Once they move into LTC, linguistic supports are most often provided by visitors (e.g., family members, relatives, and friends) and/or volunteers, unless the resident is placed in a designated ethnic or French-language LTC home. In Ontario, there are 35 designated cultural or ethnic LTC homes (including designated French-language homes) across the province; this represents less than 5% of the facilities in Ontario. Some LTC homes are not formally recognized as a designated ethnic or cultural home, but may be located in neighborhoods where there are high concentrations of racialized and other minority groups. Within these facilities, LTC providers often aim to match the ratio of staff to residents by their linguistic representation (e.g., in a home where 50% of the residents are Francophone, the home will strive to match its staffing such that 50% are French-speaking). However, as mentioned earlier, access to these facilities is limited and those awaiting placement experience significantly longer wait times.

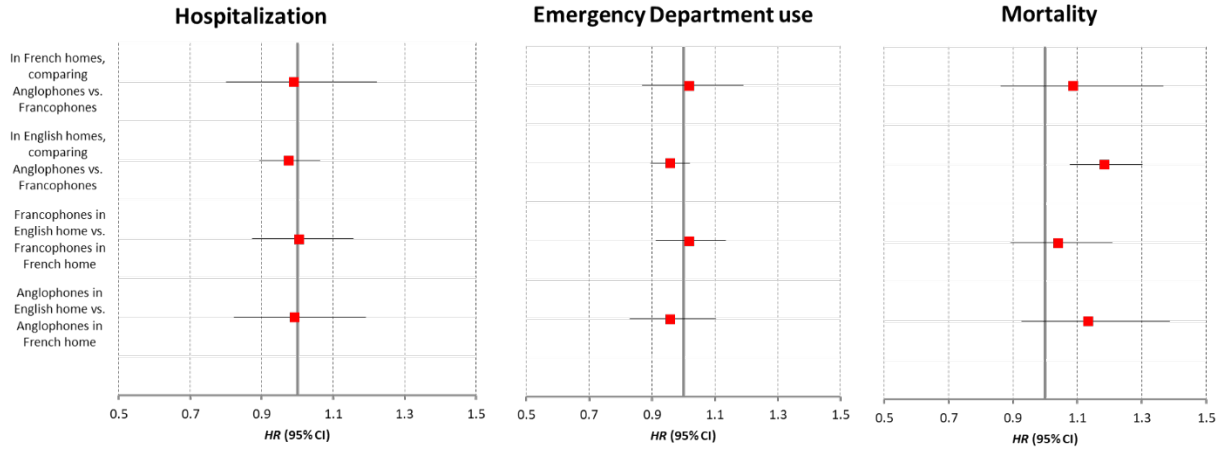
Similar to the application phase, translation and interpretation services are available in most provinces and territories. Many supports exist in the community; such as the French Language Health Services Network of Eastern Ontario, Francophone Association for Seniors in New Brunswick, Réseau Santé en Français au Nunavut, Yukon Francophone Health Network, French Health Services Alberta, Réseau Santé Nouvelle-Écosse. However, the connectedness between these community efforts and LTC homes is unclear and varies according to each home's access to these regional supports. As a result, they are not commonly sought by or provided to residents in LTC.

7.1 Experiences and outcomes in OLMC receiving LTC in Canada

To better understand the OLMC residents experience in Canada, we used health administrative data in Ontario to examine the impact of language discordance on care-related outcomes. Our analysis, which used data from the RAI-MDS between 2010 and 2016, found that Francophones in French homes had 5% lower hospitalization and ED visit rates compared to Francophones in predominantly English homes (**Figure 3**, Batista et al., 2019). Furthermore, Francophones in French homes experienced lower mortality rates than Francophones in predominantly English homes. However, these differences were not statistically significant. This may be, at least partly,

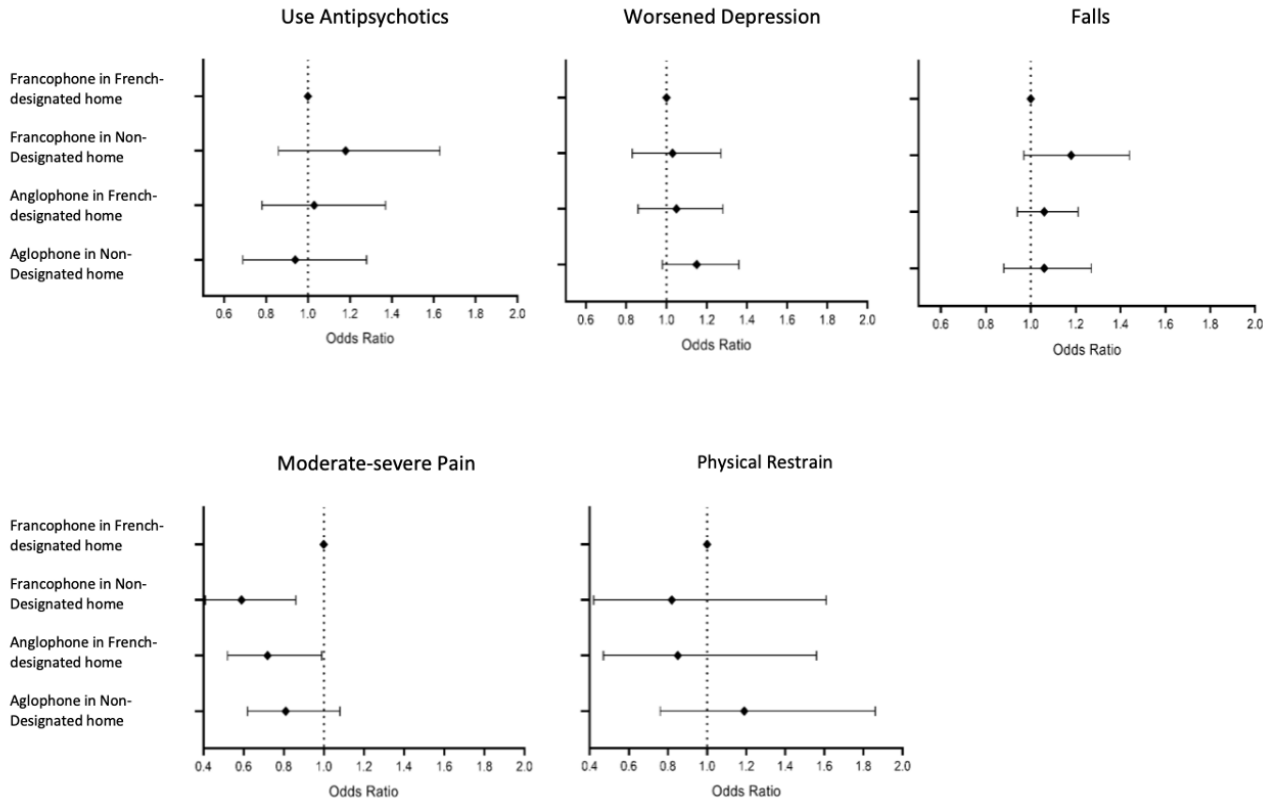
attributable to the concerted effort to reduce unnecessary ED transfers and hospitalizations within LTC. As such, since only necessary transfers are made, these outcomes may be less susceptible to the influence of language discordance. Similarly, mortality is most strongly influenced by one's age and morbidity, and language discordance may have limited effect on the vital status of the resident. Nevertheless, these are important observations that warrant further investigation.

Figure 3. Impact of language discordance on clinical outcomes (hospitalization, ED visits and mortality) within 12 months of incident LTC home admission



In a second analysis, when we examined key provincial quality indicators in OLMC residents in Ontario's LTC homes, we observed that a smaller proportion of Francophones in predominantly French-speaking homes (or provincially designated French homes) experienced worsening depressive symptoms (21.6% vs 23.6%, *P* <.001) or was prescribed antipsychotics despite not having a diagnosis of psychosis (19.1% vs 23.3%, *P*=.001) than Francophones in non-designated homes (**Figure 4**, Batista et al., 2021). Francophone residents in French homes also experienced fewer falls compared to their counterparts in non-designated facilities (14.5% vs 16.2%, *P*=.076), whereas physical restraint use among francophones was not affected by the predominant language spoken in the facility (*P*=0.295).

Figure 4. Odds of experiencing poor care quality among residents in LTC homes by language factors: effect of language discordance (cross-level interaction) on the quality indicators



These findings suggest that language concordance may play a greater and important role in affecting the care experience and quality (i.e., pain and symptom management) for OLMC residents in LTC, but not necessarily in morbidity (i.e., hospitalizations or death).

7.2 Experiences and outcomes in other linguistic minorities receiving LTC

Only a few studies in the extant literature investigated variations across linguistic minorities or ethnic and cultural minorities, instead of racial minorities (such as it is often the case of studies

conducted in the United States). No studies looked at experiences and outcomes of linguistic minorities other than OLMCs in Canada (**Appendix II**).

Evidence on health access for linguistic minorities has highlighted the importance of language for maintaining individuals' identity and culture, and how linguistic misinterpretation can have serious clinical implications. Outside of Canadian literature, only one study from Australia examined linguistic minorities in LTC (Low & LoGiudice, 2018). It found that residents born in non-English-speaking countries tended to have higher care needs compared to residents born in English-speaking countries after controlling for age, sex, remoteness, and facility size. The authors suggested this may be due to reluctance or difficulty accessing LTC and thus residents born in non-English-speaking countries enter LTC later in the progression of their care needs.

7.3 The role of families and caregivers in LTC

A consistent observation across our key informant interviews was the role of family members and designated care partners in supporting OLMC residents. Family involvement in care often continues after the admission into LTC (Ross et al., 2001). In general, relatives and friends of residents in LTC tend to visit their loved ones frequently (Ross et al., 2001) and are involved in several aspects of the resident's care, such as advocating for the resident, monitoring care of the resident by LTC staff, and providing direct unpaid personal care (e.g., assistance with grooming, mealtime, dressing, etc.) to the resident (Keating et al., 2001).

Based on our key informant interviews, we heard that caregivers serve a crucial role as the interpreter for OLMC residents. Over the course of the COVID-19 pandemic, public health measures, such as orders restricting visitor access, intended to limit viral transmission and the impact of COVID-19 on this frail population also had unintended consequences. For example, recent studies have found increased loneliness and social isolation, as well as poor physical and mental health among residents in LTC (Hwang et al., 2020). This challenge has led to the realization that unpaid caregivers, their care contributions as well as the time they dedicate to the care of their loved one in LTC have yet to be properly defined (Healthcare Excellence Canada, 2020). Where facility staff may underestimate involvement of the family and friends in resident care (Cohen et al., 2014), an appreciation for the extent and nature of their involvement within LTC could promote efforts on the part of the providers to ensure families and friends feel supported in and not overwhelmed by their care contributions.

Caregivers should have access to training and resources that can aid them in administering care and in providing interpretation as well as other supports safely and effectively. One example of such training is the Designated Care Partner (DCP) Program created at Bruyère in collaboration with the Ontario Caregiver Organization (OCO, 2022). Residents or their substitute decision maker can determine who they would like to designate as their Designated Care Partner. This can include a substitute decision maker, a loved one, a friend, or other support person of the patient's or resident's choosing. Upon selection, Designated Care Partners are required to complete an orientation and training session prior to beginning their role, which may entail supporting a resident's physical care, mental and emotional well-being; providing assistance with meals, mobility or personal care; providing communication assistance with hearing, visual, speech, cognitive, intellectual or memory impairment; assisting persons with disabilities; and supporting decision making (Bruyère Continuing Care, 2022).

In addition to providing training to residents' care partners, the DCP Program also includes policies, processes and staff training that LTC providers can use to embrace and support caregivers as partners in care. The DCP Program was developed based on OCO's *Partners in Care Pandemic Toolkit*, which includes Caregiver ID as a tool to formally recognize designated care partners. OCO has also established the *Partners in Care Learning Collaborative*, as a forum for resource sharing and knowledge exchange across organizations that have implemented the DCP Program. More programs of this nature will ensure caregiver preparedness and increase opportunities for the safe involvement of families, caregivers, and volunteers in LTC (Healthcare Excellence Canada, 2021).

8 Recommendations

In response to the experience observed in the LTC sector within the first year of the COVID-19 pandemic, there have been several commissioned inquiries and reports dissecting the readiness of providers in this sector for a pandemic (British Colombia Ministry of Health, 2021; Office of the Auditor General of Ontario, 2021; Long-Term Care Commission, 2021). Not surprisingly, systemic issues and health human resource challenges that have been observed for decades prior to the COVID-19 pandemic resurfaced as culprits and have amplified their impact on the health and mortality of the vulnerable older adults who live and receive care in this setting.

Through the collaborative effort of the SCC, HSO and CSA Group, two new complementary national standards for LTC have been developed. One of these standards is a critical revision of HSO's previous *Long-Term Care Services* standard and reflect the latest evidence-informed, resident and family-centred requirements of high-quality care and services.

We have reviewed HSO's new *Long-Term Care Services* standard (2022), published on January 27, 2022, and identified five sub-sections where considerations for the diverse needs of official language and other linguistic minority residents in LTC can be addressed directly. We acknowledge that the new HSO standards "encourages health and social services organizations to commit to … principles of equity, diversity, and inclusion in their approaches to the integrated design and delivery of equitable care and services" (Health Standards Organization, 2022); however, these principles may not be adopted uniformly across all services providers. Variability in the implementation of these principles, however well-intended, will expose residents belonging to OLMCs and other minority groups to the risk of inequities in care. Our specific recommendations are outlined below.

Recommendation 1: To ensure residents in LTC homes and their family members or designated care partner(s) understand their rights to appropriate and high-quality care, a copy of the Residents' Bill of Rights outlined in the provincial and territorial legislations governing the provision of long-term and residential care should be provided to all residents, their family members and/or designated care partner(s) ***in their preferred (official) language***, prior to or at the time of the resident's admission.

In order to ensure the rights of residents and their designated support person(s) are respected, providers must ensure that residents and their designated support person(s) understand their rights and responsibilities. However, as we have demonstrated in this report, information regarding the rights and responsibilities of residents and their designated support person(s) are not always available in their preferred language, which can be a barrier to their comprehension.

Under the Constitution of Canada and the *Official Languages Act*, English and French are the official languages of Canada and have equality of status and equal rights and privileges as to their use. While the provisions of existing legislations primarily pertain to the receipt of services in either official language from institutions of the Parliament or Government of Canada, the HSO *Long-Term Care Services* standard should encourage and set the expectation that all

Canadians needing LTC have a fundamental right to safe and high-quality care. As such, to facilitate official language minorities' understanding of their rights and responsibilities within LTC, at a minimum, all OLMC persons receiving care in LTC homes, their family member(s) and/or designated care person(s) should receive a copy of the Residents' Bill of Rights for their province or territory in their preferred official language prior to or at the time of the resident's admission. The same information should also be easily accessible and provided on the website of the LTC home, in both official languages. For this reason, we recommend the following amendments to Standards 2.3.3 and 4.1.2:

> *2.3.3 The team provides designated support persons with information about the designated support person's rights and responsibilities,* ***in their preferred official language****, as appropriate to their involvement in the resident's care.*
>
> *4.1.2 The team follows the LTC home's procedure to communicate information to residents in a timely way about their rights and responsibilities,* ***in their preferred official language****.*

While such provisions may not be available to all linguistic minority persons in LTC, providers should strive to make these resources available to residents, families and/or designated care persons in their preferred language. For example, from our environmental scan, we discovered a community-led initiative to increase access to the Residents' Bill of Rights translated into different languages (Ontario Association of Residents' Councils, 2012). Similar efforts could be supported by provincial and territorial governments as part of their response to address observed inequities in care experienced by linguistic minorities in LTC.

Recommendation 2: When developing individualized care plans for residents, the team should strive to conduct discussions about goals of care and present available care options to residents, families, and/or designated care person(s) ***in their preferred (official) language***.

Existing evidence suggests the loss of linguistic abilities is a common symptom in people living with dementia and can impede their ability to express their care needs and wishes. The misalignment between the wishes and care preferences of residents with cognitive deficits and their care outcome are often exacerbated by language discordance; that is, when the provider does not speak the preferred language of the patient or resident. Language discordance has

been demonstrated to result in lower care quality and sub-optimal care outcomes, such as more burdensome transitions (e.g., hospital transfers) and poorer management of pain and other symptoms at the end of life. While Standard 2.4.6 stipulates providers should facilitate access to translation and interpretation services, our interviews with key informants within LTC found that interpretation is most often provided by the residents' families or designated support persons, who may lack capacity or vocabulary to provide accurate interpretation during goals of care conversations. They may also be unable to detach their own values, preferences and biases from the process of supporting the resident to develop their individualized care plan.

As such, we recommend that a provision under the guidelines for Section 6.2 to include considerations for the conduct of critical conversations surrounding goals of care and advance care planning for linguistic minority residents to be held in their preferred language. At a minimum, OLMC residents should be supported appropriately in their preferred official language. This provision has the potential minimize the likelihood that residents belonging to linguistic minorities will experience goal-discordant care.

Recommendation 3: To maintain respect for equity, diversity and inclusion of residents, quality improvement methods and action plans developed and implemented by organizational leaders and teams must regularly assess for differences in care-related outcomes among residents belonging to equity-seeking groups, including OLMC persons.

Our research has found significant variation in quality of care and resident outcomes when language discordance is present in LTC homes. As such, to ensure all residents in LTC receive the same high-quality care and care outcomes, we propose that an additional standard be added to Section 10, stipulating that:

> *The organizational leaders and teams uses evidence-informed quality improvement methods to act on relevant information about variations in resident quality of care attributable to social, economic, linguistic, and structural disparities.*

Recommendation 4: Considering the widely acknowledged issue pertaining to a shortage of skilled workers within LTC, where the supply of human resources is unlikely to be able to meet the demands and linguistic needs of all residents, LTC providers should strive to create

opportunities for diversity and language training for frontline staff caring for OLMC and other minorities in LTC.

We commend the Ontario Long-Term Care COVID-19 Commission for their recommendation pertaining to expanding the provision of French-language services within LTC in Ontario. In our review of recent commissions and inquiries into LTC, this was the only report that acknowledged the service gap that currently exist within our LTC system for official language and other linguistic minorities. Specifically, the Commission recommended that:

> *To protect the rights of Francophone residents in long-term care, the [Ontario] Ministry of Long-Term Care should:*
>
> a. *Design and implement a provincial strategy to increase French-language LTC services and increase the number of French-language beds through the prioritization of designations under the French Language Services Act, and cultural designations under section 173 of Ontario Regulation 79/10; and*
>
> b. *Adopt a clear definition of "Francophone beds" that excludes LTC homes that have not demonstrated their capacity to provide services in French.*

While the creation of more French-language beds is a vital goal as we continue to build capacity to support our aging population, the development of such strategy and infrastructure will take years to come to fruition. Furthermore, while Ontario recently passed the *Providing More Care, Protecting Seniors, and Building More Beds Act (2021)* in legislature, the regulations under this Act does not focus on improving services for French-speaking residents, despite the recommendations of the Long-Term Care COVID-19 Commission (Radio-Canada, 2021). Strategies focused on education and professional development of our existing workforce may better meet the immediate needs of official language and other minority residents in LTC.

Our environmental scan revealed that there is wide variation in the availability of these resources and services across the provinces and territories. The January 2022 CSA Group's *What We Heard* Final Report highlighted the importance of providing culturally-safe care in LTC as well as the need for more education and training of management, staff, residents, and families to enable better care (CSA Group, 2020). As our current system relies heavily on the

availability of close social relations (including family members and friends) and the happenstance of multilingual staff for linguistic support, we believe that adding to the provisions under Section 9, *Enabling a Healthy and Competent Workforce*, of HSO's new *Long-Term Care Services* standard to strengthen the knowledge and competency of workers in meeting the diverse language and cultural needs of residents in LTC is critical to elevating the quality of care provided in this setting. As such, we recommend including diversity training as part of the ongoing skills development for the LTC home's workforce:

> *9.1.8 The organizational leaders demonstrate their support of the LTC home's workforce in ongoing skill and career development,* ***as well as diversity training****.*

By broadening the support for basic linguistic and cultural sensitivity training, and utilizing tools such as the Ontario Centres for Learning, Research, and Innovation in Long Term Care's (CLRI) *Embracing Diversity* Toolkit (CLRI, 2020), there is potential to augmenting current capacities within LTC to meet the needs of minority residents while more ethnic- or language-specific facilities are under development.

Recommendation 5: In recognition of families and designated care person(s)' contribution to the quality of life for residents in LTC and their often-assumed role as the interpreter and additional support for the residents, providers should aim to create training opportunities for families, designated care person(s) and volunteers wishing to support residents in LTC.

One of the first policy measures to be implemented in LTC homes at the start of the COVID-19 pandemic was prohibiting non-essential visitors from entering a home. Family and friends undoubtedly play an important role in the overall health and well-being of residents. They often also provide direct care to residents in LTC homes. However, out of concerns about visitors who could inadvertently introduce the virus into a home, in many provinces, the only visitors who have been permitted access to LTC are those who were deemed as "essential" or who were visiting residents at the end of life. The definition of an essential visitor tend to be narrow (often only including immediate family members) and varied across jurisdictions (Low et al., 2021). While these restrictions lifted over time, they have left a lasting and detrimental impact on the quality of life and well-being of residents in LTC. The absence of close social relations to

provide interpretation during care delivery may have also compromised the quality of care-related discussions over the course of the pandemic.

In recognition of the importance of their role to a resident's well-being, we recommend an additional provision in sub-section 2.3 that stipulates:

> *The team provides designated support persons with appropriate training to enable their appropriate and safe involvement in the resident's care.*

Furthermore, beyond providing residents with the opportunities to identify a designated support person, we recommend that the provider and care team proactively engage and facilitate residents' identification of designated support person(s) to support their care:

> *The organization leaders and teams have policies and procedures in place to support residents in their engagement and decision of designated support person(s) that are aligned with the goals and principles of advance care planning.*

We believe that high-quality care for LTC residents must involve their families and/or designated care person(s). Accordingly, care partners to the residents should have access to appropriate training and resources to aid them in care provision and enable their continued support for OLMC and other minority residents, safely and effectively — even in times of an outbreak within the home or during a pandemic.

9 Conclusions

In this report, we presented a rapid synthesis of the current landscape on the care experiences for official language and other linguistic minorities in Canada, as well as existing published international literature on the differential experiences of minority population in LTC. The research on barriers to LTC access and variations in their care experience for these populations is scare, internationally, and even fewer were found within Canada.

Research have shown that linguistic barriers can have a negative impact on access to and quality of healthcare, as well as a patient's health outcomes. The establishment of a culturally

appropriate environment, by providing care to LTC residents in their preferred language, is key in providing good quality LTC services.

Beyond the recommendations that pertain specifically to the new national services standard, we observed that there is a general lack of research on the needs, experiences, and outcomes of minority populations in LTC. Albeit, there are some difficulties with minority research. Most notably, “minorities” are defined depending on their context, making it challenging to summarize and generalize across different cultural contexts especially as attitudes, beliefs and discrimination laws have changed over time (Mack et al., 2019). While findings from other countries are likely applicable to our general understanding of barriers OLMC seniors may encounter while seeking or receiving LTC, there are unique challenges facing official language minorities in Canada. For example, in our review of the current literature, there are no studies examining English-speakers as an official language minority group in LTC, as would be the case in Québec or within predominantly French-speaking LTC homes in provinces or territories that have these ethnocultural homes. Furthermore, we observed that there is often an over-simplification or a lack of depth in the conclusions from this literature, as it does not highlight those who experience the intersection of more than one minority status. For example, racial disparities can be more pronounced for immigrant populations who face cultural and linguistic barriers. Thus, categorizing people solely based on race or language may incorrectly describe a diverse population that share a common language or culture.

While the main objective of our research was on OLMCs in Canada, we observed that there were many other minority populations under-represented in the extant literature, such as religious minority populations, Indigenous or Two-Spirited populations, and members of LGBTQ+ communities. These intersections must be considered along with linguistic barriers to ensure we are truly taking an approach that encompasses equity, diversity and inclusivity.

The development of effective and lasting solutions to fix LTC requires understanding of the regulatory guidelines governing care provision within this sector, LTC homes’ operational practices and challenges, and the increasingly diverse population of older adults who need and receive support in this setting. This is challenging due to issues identified earlier in the report including the intersectionality of minority status on individuals, the paucity of research on LTC and minority communities, and the variation in Canadian healthcare across provinces and territories. Improving the health and healthcare for minority communities in Canada, particularly

linguistic minority communities, require a major shift in practice and investment in culturally-appropriate care and research. This environmental scan aimed to inform the new national services standard in LTC; yet, this is just the beginning of a much greater task ahead. By revealing the gaps experienced by minority communities as they seek LTC, we hope this synthesis of evidence will support an equitable, diverse and inclusive approach to the future improvement of LTC in Canada.

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Bruyère is a multi-site academic health care organization that is maximizing quality of life and helping people stay and return home. We deliver a wide variety of services in aging and rehabilitation, medically complex, palliative, residential and primary care. Our research leads to constant innovation in the services we provide with a focus on providing care that promotes independence. This work is enhanced by our Foundation that shares our story and raises funds with the support of our generous community.

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Appendix I: Legislation and policies affecting access to services and supports needed by OLMCs in Canada

Here, we briefly summarize the role of existing legislations and/or policies that may affect access to services and supports needed by OLMCs across Canada:

- In Newfoundland and Labrador, the Office of French Services oversees the implementation of the Newfoundland and Labrador French Language Services Policy and is responsible for capacity-building with regards to French-language service delivery. The Fédération des Francophones de Terre-Neuve et du Labrador represents the Francophone community on both the provincial and federal planes and is directly responsible for the coordination of provincial services specific to healthcare (Government of Newfoundland and Labrador, n.d.).

- The Acadian and Francophone Affairs Secretariat of Prince Edward Island promotes compliance with the Prince Edward Island *French Language Services Act* and advises the provincial government on the delivery of French-language programs and services, while the Société Saint-Thomas-d'Aquin ensures consistency between the actions of government stakeholders and the interests of the Francophone community (Government of Prince Edward Island, 2018).

- In Nova Scotia, the Office of Acadian Affairs and Francophonie of Nova Scotia is a product of the Nova Scotia *French-Language Services Act* and supports government departments, agencies and Crown corporations in their development and implementation of Francophone programs and services. The Fédération Acadienne de la Nouvelle-Écosse also ensures the interests of Francophones in Nova Scotia are respected throughout the province.

- In New Brunswick, the Office of the Commissioner of Official Languages for New Brunswick promotes service delivery in both English and French as a result of the province's *Official Languages Act*, and the Francophonie and Official Languages Branch of New Brunswick's Department of Intergovernmental Affairs works in close proximity to government institutions to promote Francophone activities throughout the province.

- In Quebec, the Secrétariat aux Relations avec les Québécois d'Expression Anglaise, under the responsibility of the Premier, is responsible for ensuring that the concerns of English-Speaking Quebecers are taken into account in government orientations and decisions in collaboration with government ministries and bodies. Quebec Community Groups Network also promotes dialogue between French- and English-language institutions and leaders. *The Act Respecting Health Services and Social Services* stipulates the need for institutions to account for the linguistic diversity of the region, including providing health and social services in the English language. Designated institutions for social services are available for English-speaking individuals living in Quebec (Ministère de la Santé et des Services sociaux, 2018).

- In Ontario, the Ministry of Francophone Affairs, a product of the Ontario *French Services Act*, is tasked with developing French-language services, policies, and programs, and the Assemblée de la Francophonie de l'Ontario is the primary political voice for Franco-Ontarians and represents the community on the political sphere (French Languages Health Services Network of Eastern Ontario, 2020). The *French Language Services Act* established in 1990 outlines the requirements of providing services in the French language. The Société Santé en français is a publicly funded society that promote equitable access to healthcare. French language health networks in Ontario are identified with resources and ongoing projects outlined within the respective areas. (Société Santé en français, 2022).

- In Manitoba, the Francophone Affairs Secretariat supports all provincial government activities regarding French-language services in accordance with their French-Language Services Policy, while the Société de la Francophonie Manitobaine advocates for new legislation and policies promoting French-language service development across the province.

- The Francophone Affairs Branch of Saskatchewan is the liaison between the Franco-Saskatchewanians and the Government of Saskatchewan and provides support for the delivery of French-language services. The Assemblée Communautaire Fransaskoise increases awareness of the French language throughout the province and advocates for the Franco-Saskatchewanian community.

- In Alberta, the Francophone Secretariat of Alberta is tasked with promoting the French language in accordance with Alberta's French Policy (Government of Alberta, 2017), and the Association Canadienne-Française de l'Alberta works to further develop the province's French-speaking community.

- The Government of British Columbia established the Francophone Affairs Program to support the delivery of French services in the province and has an interactive map which lists health professionals who offer services in French, and the Fédération des Francophones de la Colombie-Britannique defends the rights and interests of Franco-Columbians and works to increase French-language service delivery throughout the province (Government of British Columbia, 2021).

- In the Yukon, the Yukon French Services Directorate supports government departments and agencies in their responsibilities under the *Languages Act* while the *Association Franco-Yukonnaise* ensures these entities fulfill their obligations to the Francophone community.

- The Northwest Territories' Francophone Affairs Secretariat works in accordance with the Northwest Territories' *Official Languages Act* and manages Services TNO, who provides government services in French to citizens of the Northwest Territories. This territory also has the Office of the Languages Commissioner for the Northwest Territories and the *Fédération Franco-Ténoise des Territoires du Nord-Ouest* who represent the best interests of the Francophone community (as well as other official language communities recognized in this territory) at the territorial and federal levels.

- Finally, in Nunavut, the Office of the Languages Commissioner of Nunavut operates under the Nunavut *Official Languages Act* and protects the language rights of Nunavummiut who speak French with the help of the *Association des Francophones du Nunavut*.

Appendix II: Summary of Findings from the Systematic Reviews

Access, expectations and preferences for any minority population

A total of 63 studies were included in our international systematic review on access to LTC for minority populations (**Supplementary Table 1**). Within those included, 18 studies discussed the expectations and preferences for future LTC placement of minority populations (**Supplementary Table 2**). The evidence spanned across 10 countries: United States (n=41), Canada (n=7), Norway (n=3), Australia (n=2), Sweden (n=2), Belgium (n=1), Hong Kong (n=1), The Netherlands (n=1), Taiwan (n=1), and the United Kingdom (n=1).

Overall, results from the quantitative studies, mostly conducted in the United States, indicate the likelihood of admission of certain minority populations to LTC appears to have high variability, yet is consistently lower among minority groups compared to the majority population. There were some studies reporting no difference in admissions and many reporting significantly lower odds of admission to LTC for minority populations. The incongruence across studies can be attributed to heterogeneity in the study designs, outcome measures, and minority populations being compared.

From the qualitative research, there was evidence of barriers to LTC for minority populations, with many studies reporting a lack of knowledge of and satisfaction with LTC services. The barriers reported were described according to the following themes: language barriers, culture, family support, and fear and mistrust. Structural barriers, precision and accuracy of translational and interpretation services, and the style and manner of individual translators were all themes identified by a qualitative study in Australia on the impact of linguistic discordance on hospice enrollment (Dressler & Pils, 2009). These results suggest there may be overlap in the experience of minorities outside of Canada and system-level barriers that exist. These qualitative findings may explain the lower rates and odds of admission to LTC among minority groups observed in the quantitative studies.

There are few Canadian studies on access to LTC for minority populations (Brotman et al., 2003; Forgues et al., 2011; Gui & Koropeckyj-Cox, 2016; Kortes-Miller et al., 2018; Lai, 2008; Metz,

2004; Qureshi et al., 2021). Many studies reported a lack of access, knowledge of and satisfaction with LTC services as the rationale for study, however no conclusions could be drawn given the broad range of study designs and minority populations.

There are quite a number of unique minority populations that reside within Canada, including those who identify as part of the lesbian, gay, bisexual, transgender, queer, and Two-Spirit (LGBTQ+) community. These communities often share similar challenges as linguistic and ethnic minorities when accessing health care. In one qualitative study by Brotman et al., they found members of the LGBTQ+ populations worried they may not be accepted by staff and other residents in the facilities and older adults reported strong fears that identifying as LGBTQ+ would result in an unsafe environment, negligent care, and social isolation. Professional and ongoing education was suggested to promote cultural awareness of LGBTQ+ groups in LTC homes (Brotman et al., 2003).

Supplementary Table 1. Included studies (60 original research articles and 3 reviews) pertaining to access to long-term care and preferences for future placement in minority populations (n=63)

Author, Year, Country	Study Design/minority population(s)	Quality Rating	Sample Size	Category*
Ahaddour et al., 2015; Belgium	Review / Turkish and Moroccan migrants	Fair	21 articles	2
Ahmed et al 2003; USA	Cross-sectional / Blacks [sic]	Good	985	1
Ahmed et al 2006; USA	Cross-sectional / Blacks to non-Blacks [sic] or Hispanics to non-Hispanic Whites [sic]	Good	19,271	1
Akamigbo and Wolinsky 2006; USA	Retrospective cohort / Blacks [sic]	Excellent	6,242	1,2
Akamigbo and Wolinsky 2007; USA	Retrospective cohort / Blacks [sic]	Excellent	6,242	1
Akamigbo 2007; USA	Retrospective cohort / Blacks [sic]	Excellent	6,242	1
Andel et al 2007; USA	Retrospective cohort / non-Whites [sic]	Good	1,943	1
Angel et al 2003; USA	Retrospective cohort / Mexican-Americans	Good	956	1
Angel et al 2004; USA	Retrospective cohort / Mexican-Americans	Good	3,050	1
Arora et al., 2020; Norway	Qualitative / Female Pakistani carers	Excellent		2
Aykan et al., 2002; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Good	6,954	1
Basic at al., 2017; Australia	Prospective cohort / Immigrants	Excellent	2,180 admissions	1
Baxter et al., 2001; USA	Cross-sectional / Rural Hispanic	Excellent	1,433	1
Berridge & Mor, 2017; USA	Cross-sectional / Blacks [sic]	Excellent	8,245	1

Author, Year, Country	Study Design/minority population(s)	Quality Rating	Sample Size	Category*
Brotman et al., 2003; Canada	Qualitative / LGBTQ+	Excellent	32	2
Cai et al., 2009; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	5,980	1
Chui et al., 2019;	Qualitative / Nepalese living in Hong Kong	Excellent		2
Chung et al., 2008; Taiwan	Cross-sectional / Mainlanders, Taiwanese Holo, and Taiwanese Hakka	Excellent	562	2
Czapka & Sagbakken, 2020; Norway	Qualitative / older adults who are migrants living in Norway	Excellent		2
Duffy et al., 2006; USA	Qualitative / Arab Muslims, Arab Christians, Hispanics, Blacks, and Whites	Excellent	73	2
Forgues et al 2011; Canada	Cross-sectional / Francophones in New Brunswick	Good	485 nursing homes	1
Friedman et al., 2005; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	4,646	1
Gandhi et al., 2017	Retrospective cohort / non-Whites [sic]	Excellent	84,212	1
Gaugler et al., 2004; USA	Retrospective cohort / African Americans	Good	667	1
Gaugler et al., 2006; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	8,125	1
Goodwin et al., 2011; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Good	1,149,568	1
Gui and Koropeckyj-Cox, 2016; Canada	Qualitative / Chinese Canadians with elderly parents in China	Excellent	20	2
Hanssen & Tran, 2018; Norway	Qualitative / older adults who are migrants living in Norway	Good	45	2

Author, Year, Country	Study Design/minority population(s)	Quality Rating	Sample Size	Category*
Harris, 2007; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	140,744	1
Harris and Cooper, 2006; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	137,632	1
Heikkilä and Ekman, 2003; Sweden	Qualitative / Finnish individuals living in Sweden	Excellent	39	2
Herat-Gunaratne et al., 2020; United Kingdom	Qualitative / female Bangladeshi and Indian caregivers living in England	Good	10	2
Mac Innes, 2020; Sweden	Retrospective cohort / Older migrants	Fair	Swedish population using homecare aged 65 years or older	1
Iwasaki et al., 2016; USA	Cross-sectional / Japanese Americans	Good	499	2
Jackson et al., 2008; USA	Cross-sectional / LGBTQ+	Good	319	2
Jang et al., 2008; USA	Cross-sectional / Korean Americans	Fair	427	2
Jenkins Morales & Robert, 2020;	Retrospective cohort / Blacks [sic]	Good	5,212	1
Kersting, 2001; USA	Retrospective cohort / Blacks to non-Blacks [sic] or Hispanics to non-Hispanic Whites [sic]	Good	7,541	1
Kersting (a) 2001; USA	Retrospective cohort / Blacks to non-Blacks [sic] or Hispanics to non-Hispanic Whites [sic]	Good	7,527	1
Kortes-Miller et al., 2018; Canada	Qualitative / Sexual and Gender Minority Older Adults	Good	3 focus groups	2
Lai 2004; Canada	Cross-sectional / Chinese Canadians	Good	2,272	2
Lehnert et al., 2019	Review / All older adults eligible for LTC	Fair	59 articles	2

Author, Year, Country	Study Design/minority population(s)	Quality Rating	Sample Size	Category*
Liu et al 2007; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	136,205	1
Mahieu et al., 2019	Review / LGBT individuals	Fair	18 articles	2
McCormick et al., 2002; USA	Cross-sectional study/ Japanese Americans	Excellent	1,244	2
McLaughlin et al., 2016; USA	Cross-sectional / Muslims in USA	Good	167	2
Metz and Naoko, 2007; Canada	Qualitative / Japanese Canadians	Excellent	12	2
Miller et al., 2011; USA	Prospective randomized clinical trial, analyzed as a cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	418	1
Min 2005; USA	Cross-sectional / Korean Americans	Excellent	144	2
Putney et al., 2018; USA	Qualitative / LGBTQ+	Excellent	50	2
Quigley, 2017; USA	Qualitative / LGBTQ+	Excellent	15	2
Qureshi et al., 2020; Canada	Retrospective cohort / recent immigrants to long-standing residents	Excellent	56,031	1
Riley, 2019; USA	Qualitative / African American women	Excellent	11	2
Rodriguez, 2004; USA	Qualitative / Hispanics	Excellent	30	2
Sharma, 2017; USA	Cross-sectional / Blacks [sic]	Excellent	595,676	1
Spillman and Long, 2009; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	1,006	1
Stein et al., 2010; USA	Qualitative study/ LGBTQ+	Excellent	16	2

Author, Year, Country	Study Design/minority population(s)	Quality Rating	Sample Size	Category*
Stevens et al., 2004; USA	Prospective cohort / Blacks [sic]	Excellent	215	1
Temple et al., 2010; USA	Retrospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Good	2,466	1
Tenand et al., 2020; The Netherlands	Retrospective cohort / Immigrants	Good	616,934	1
Travers et al., 2020; USA	Qualitative / African American, Hispanic and other individuals from minority populations	Good	464	2
Waling et al., 2019; Australia	Qualitative study / LGBTQ+	Good	33	2
Yaffe et al., 2002; USA	Prospective cohort / Blacks, Hispanics, Latinos, non-Whites or other groups [sic]	Excellent	3,859	1

USA = United States of America; * Categories: 1 = Proportion of populations in nursing homes and influence of minority status on placements and 2 = Expectations and preferences; † We did not have a suitable tool to assess the quality of a case study.

Supplementary Table 2. Studies on expectations of and preferences for LTC in individuals from minority populations

Author, Year, Country	Study Design	Sample Size; Minority Population	Key Findings
Ahaddour et al 2015; Belgium	Review	11 studies and 10 articles or reports	A lack of access to health care was reported as a serious problem for Turkish and Morrocan migrants in Belgium. Specific barriers included language, food culture, privacy, religion and dealing with sensitive issues. Policies have been recommended but no data is available on the outcomes of the new approaches.
Akamigbo and Wolinsky 2006, USA	Cross-sectional study	n=6,242, 879 Black	There were no additive differences in expectations of nursing home placement between Whites and Blacks (Beta= - 0.02), and the level of expectations has the same effect on nursing home placement regardless of race.
Brotman et al 2003; Canada	Qualitative, interviews	n=32, Gay and Lesbian Elders	Older gays and lesbians, their families, and allies identified the incredible fear experienced by gay and lesbian elders when confronted with these services and systems.
Chung et al 2008; Taiwan	Cross-sectional study	n= 562, Taiwanese Hakka and Holo	In the Taiwanese Holo, the preference for institutional care was at a rate of 12.9%, while Mainlanders preferred institutional care at a rate of 29.9% and the Taiwanese Hakka preferred institutional care at a rate of 7.9%.
Duffy et al 2006; U.S.A.	Qualitative, interviews	n=73, 57 Arab Muslim, Arab Christian, Hispanic, Black.	Avoiding a nursing home was crucial for Arabs and Hispanics. The respondents also noted reasons such as discrimination related to diagnostic categories (such as acquired immunodeficiency syndrome) and avoidance of dying people.
Gui and Koropeckyj-Cox 2016); Canada	Qualitative, interviews	n=20, Chinese	All of the respondents emphasized that their first choice was to take care of their aging parents by themselves. This was attributed to filial piety and close intergenerational relationships.
Heikkilä and Ekman 2003; Sweden	Qualitative, interviews	n=39, Finnish immigrants	The elderly Finns believed that culturally appropriate care would allow them to feel well established and settled in their changed life situation, and would help them to adjust to a new life situation.

Author, Year, Country	Study Design	Sample Size; Minority Population	Key Findings
Iwasaki et al 2016; USA	Cross-sectional study	n=264, Japanese Americans	No group differences were found with regard to caregiving experiences, exposure to nursing homes, expectation of requiring future nursing homes or physical proximity to their adult children. Young Japanese Americans, however, showed more knowledge about nursing homes, stronger preference to avoid becoming dependent on their families and a higher rate of long-term care insurance purchases. Japanese Americans ranked higher preferences on culturally universal elements (e.g. transportation services, Internet access) for their retirement and long term care facilities over Japanese cultural-specific elements. Young Japanese Americans also preferred to reside with a mixture of racial/ethnic residents.
Jackson et al 2008; USA	Cross-sectional study	n=312, 132 Gay, Lesbian, Bisexual or Transgender individuals	GLBT individuals and heterosexuals were not in agreement about the usefulness of a sensitivity training program designed to build tolerance of GLBT individuals among care facility residents. GLBT individuals believed more strongly that such a program would help build tolerance. The majority of GLBT respondents in our study reported suspicions of discrimination (66%).
Jang et al 2008; USA	Cross-sectional study	n=427 Korean Americans	Almost half of Korean Americans reported willingness to use a nursing home. Those with worse perceived health and those with a significant other living in a nursing home were more likely to report willingness to use a nursing home.
Kortes-Miller et al., 2018; Canada	Qualitative	n=3 focus groups	Participants referencing fear of entering long-term care homes was common across all focus groups. The following specific fears were identified: social isolation, decreased independence and capacity for decision-making, increased vulnerability to LGBTQ+-related stigma as well as exposure to unsafe social and physical environments.
Lai 2004; Canada	Cross-sectional study	n=2272 Chinese	Almost half of Chinese participants reported positive intention of using nursing homes, with the majority preferring to live in nursing homes with Chinese staff. Living alone, having chronic illnesses, and dependency on daily activities were significant predictors of intention to use long term care.

Author, Year, Country	Study Design	Sample Size; Minority Population	Key Findings
McCormick et al 2002; USA	Cross-sectional study	n=2,598, 1,244 Japanese Americans	Japanese were more likely to intend to use the nursing home based on logistic regression in both the scenario of hip fracture (OR=0.80) or dementia (OR=0.54).
McLaughlin et al 2016; USA	Cross-sectional study	n=167 Muslims	Muslims preferred to receive long-term care at home from family members. Preferences for nursing homes placements were low, but 78% of participants were willing to consider facilities designed specifically for Muslims.
Metz and Naoko 2007; Canada	Qualitative, interviews	n=12, Japanese-Canadian	Many participants indicated their preferred type of long- term care as community-based care and were hesitant to ask their children to provide them care. A service gap for nursing homes included limited support services for both caregivers and care recipients, lack of a centralized information system, and the absence of a culturally sensitive palliative care facility for the Japanese-Canadian community.
Min 2005; USA	Cross-sectional study	n=144 Korean Americans	Half of older Korean Americans intended to use all formal care arrangements in the scenario of stroke.
Rodriguez and Wacker 2004; USA	Qualitative, interviews	n=30, Hispanic family members	The findings of this study concluded that both Black and Hispanic caregivers continue to express strong feelings of familial obligation. The study showed that supportive informal networks diminish caregivers' feelings of burden.
Stein et al 2010; USA	Qualitative, interviews	n=16, Lesbian and Gay elders	Participants did not feel safe sharing their sexual orientation with roommates and other residents. Not only did they have the usual worries about their declining health, but they had the additional anxiety that people would discover that they were gay.

Care-related outcomes of minority populations in residential long-term care

This is a preliminary summary of existing literature, as the second systematic review is ongoing. In the process of reviewing all included articles, we have identified 111 articles on care-related outcomes pertaining to minority populations in long-term care. The outcomes of interest included: hospitalization (n=25), pressure ulcers (n=16), incontinence (n=12), function (n=8), facility-level comparisons (n=8), quality of life (n=6), hip fractures (n=5), medication (n=5), restraints (n=4), falls (n=4), length of stay (n=4), mortality (n=3), pain (n=3), diabetes (n=2), seizure (n=2), cognition (n=2), feeding tubes (n=2), depression (n=2), preventative care (n=1), and decline (n=1).

A significant number of studies on this topic were conducted in the United States; many focused on Black and Hispanic minorities compared to the White majority. There was a paucity of information on the differences of care-related outcomes for any linguistic minorities.