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Strategies to Improve French Language Health and Social Service Continuity for Seniors in Ontario and Manitoba

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Résumé de l'article

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Strategies to Improve French Language Health and Social Service Continuity for Seniors in Ontario and Manitoba

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Abstract

Access to health and social services in one's official language of choice is an important component of quality and safety of care for seniors. Access can be fragmented, even in the context of legislation guaranteeing the right to receive such services, and in areas with a higher proportion of bilingual providers. Using a community-based participatory approach, we identified mechanisms promoting or impeding the clinical integration of health and social French language services intended for seniors living in two Canadian Francophone minority communities. Thirteen recommendations highlight the possibility for new initiatives to promote a continuum of French language health and social services in a minority context, involving collaboration among a variety of actors at all levels of our analytical framework: service trajectory (providers); francophone communities; organizational; political and regulatory; and symbolic (values) structures.

Résumé

L'accès aux services sociaux et de santé dans la langue officielle de son choix est un aspect important de la qualité et de la sécurité des soins destinés aux aînés. L'accès à ces services demeure fragmenté même dans des provinces ayant des lois qui garantissent des services en français et des régions bénéficiant d'un nombre élevé de fournisseurs de soins bilingues. Une étude participative communautaire a permis de dégager des mécanismes facilitant ou limitant l'intégration clinique de services sociaux et de santé offerts en français aux aînés de deux communautés francophones en situation minoritaire du Canada. Treize recommandations font ressortir la possibilité de nouvelles initiatives pour favoriser un continuum de services sociaux et de santé en français en contexte linguistique minoritaire par la collaboration des divers acteurs œuvrant au sein des structures décrites dans notre cadre d'analyse: trajectoire de services, communautés francophones, structure organisationnelle, structure politique et règlementaire, et structure symbolique (valeurs).

Numerous international studies have documented the negative impact of linguistic barriers during the health care user–provider encounter (Bowen, 2015) including, but not limited to, diagnostic errors; reduced understanding of and compliance with care and medication directives; difficult trust building; and a tendency to delay care (Bowen, 2015; Schwei *et al.*, 2016). Seniors may be more affected by linguistic barriers, due to second language proficiency deterioration caused by age-related conditions, such as hearing loss or neurological damage (Madoc-Jones, 2004; Martin, Wood, & Williams, 2019).

Despite the high rate of bilingualism among Francophones in official language minority communities in Canada (87% according to Lepage and Corbeil, 2013), a majority (74%) consider receiving health care in French as important (Gagnon-Arpin, Bouchard, Leis, & Bélanger, 2014). One cannot assume that bilingual persons can express themselves at the same level in both languages; they are generally more comfortable and have a higher level of language proficiency in one of the two languages they speak (Boudreau & Dubois, 2008; de Moissac & Bowen, 2017). The Consortium national de formation en santé (n.d.) published many testimonials of bilingual individuals facing difficulties when using their second language in a health care context. Hence, access to health and social services in one's official language of choice is an important component of quality and safe care.

Furthermore, with an aging population presenting numerous co-existing health conditions (Canadian Institute for Health Information, 2011), there is a greater need for integration of services from all types of health and social service providers. However, prior research has demonstrated that Francophone seniors in minority communities in Ontario experience limited and fragmented access to French language health and social services (Drolet *et al.*, 2017; Savard *et al.*, 2020a). In the case of an official language minority community, access to services in one's preferred official language along the service continuum enhances not only the service trajectory experience but also health outcomes (Tremblay, Angus, & Hubert, 2012).

The present study was conducted to identify which mechanisms promote or hinder French language services (FLS) access and integration and to co-construct guidelines to facilitate FLS continuity for seniors from Canadian official language minority communities.

Integration of Health and Social Services

According to Tremblay *et al.* (2012), integration positions the individual and informal caregivers at the core of the health and social service system, with linguistic integration manifested by access to services in one's chosen official language along the continuum of care.

While there are many types of integration (MacAdam, 2008), three forms of clinical integration are pertinent to our research: full integration, coordination and liaison. Full

clinical integration addresses the needs of seniors experiencing severe or moderate loss of autonomy via wide-ranging multidisciplinary teams, case managers, computerized, shareable clinical records (Leutz, 1999), and an administrative structure for resource management and funding along the service continuum (Kodner, 2009). Coordination targets individuals, caregivers and service providers, by planning care and service provision in the least fragmented way possible (Curry & Ham, 2010; MacAdam, 2008). It is aimed at seniors who experience diminished autonomy demonstrated by considerable functional impairment, risk of frequent hospitalization and placement (Lafortune, Béland, & Bergman, 2011), and higher use of services. As a structured and interorganizational approach, it includes shared objectives, common tools and mechanisms for communication, information-sharing and collaboration, administrative processes and assessment criteria for direct service provision (Lafortune *et al.*, 2011; MacAdam, 2008, 2011) and local ownership, allowing partners and service providers to negotiate and create regional solutions for improved service access (MacAdam, 2011) or access to French language services (Tremblay *et al.*, 2012). Liaison refers to a level of clinical integration geared to seniors with mild to moderate loss of autonomy where relationships between providers are less formalized and evolve on a more ad hoc basis, depending on system constraints (Leutz, 1999; Kodner, 2009, p. 12). To our knowledge, research on various forms of health and social services integration has not been conducted in Francophone minority communities in Canada.

Research Objectives and Questions

The study's objectives were to identify mechanisms promoting the clinical integration of French language health and social services intended for Francophone seniors living in linguistic minority communities in two Canadian provinces (Ontario and Manitoba), as well as obstacles to such integration, and to co-construct guidelines for FLS integration along the continuum of care. Since health and social services come under provincial jurisdiction, the research was implemented in 5 sites with varying Francophone population densities and realities, in 2 provinces which have legislation supporting FLS. This increases the probability that results and recommendations will be relevant to other similar provinces.

The research questions included:

1. Are there formal or informal care and service coordination or integration mechanisms and/or networks to integrate the linguistic variable and ensure FLS continuity for seniors and their caregivers?
2. What are the success factors, strategies and practices for, or obstacles to, networking, service continuity and system navigation within existing FLS for these seniors?
3. How can ongoing knowledge transfer pertaining to service integration for Francophone seniors be ensured between research and practice communities?

Study context

In Canada, the *Official Languages Act*[1] recognizes French and English as two official languages. Official language minority communities are composed of English-speaking Quebeckers and Francophones in the other provinces and territories.[2]

Profile of Francophone Seniors Living in Minority Communities

Recent Canadian studies report that Francophones living in minority communities age proportionally faster than the Canadian population as a whole and are increasingly more frequent users of health and social services such as home care (Bouchard *et al.*, 2015; van Kemenade, Bouchard, & Bergeron, 2015). However, these services are not always readily available in both official languages, nor are they provided coherently along the continuum of care (Bouchard, Beaulieu, & Desmeules, 2012; de Moissac, Giasson, & Roch-Gagné, 2015). Most French-speaking Canadians living outside of Quebec are expected to be bilingual, due to the omnipresence of the majority language. However, many Francophones living in minority contexts are hindered by language barriers when confronted with English-only service options (Bouchard, Chomiène, Benoit, Boudreau, Lemonde, & Dufour, 2012; de Moissac & Bowen, 2017). Stress, which frequently accompanies medical consultations, is accentuated in situations of linguistic discordance (Zhao, Segalowitz, Voloshyn, Chamoux, & Ryder, 2019) and can contribute to reduced mastery of a second language.

Legislation Influencing French Language Health and Social Services in Ontario and Manitoba

In Ontario, the *French Language Services Act*[3] provides members of the public the right to receive services in French from provincial government departments and agencies in 26 designated areas, such as the Champlain[4] region of eastern Ontario. However, partially publicly funded para-governmental organizations, such as hospitals, children's aid societies, home care and long-term care facilities for seniors are not automatically subject to the Act; they may voluntarily ask to be completely or partially designated (targeting only some of the organization's services). Institutions may be strongly advised to ask for designation by Local Health Integration Networks (LHINs) and the regional French Language Health Planning Entity (FLHPE). FLHPEs are mandated to advise the LHINs about French

1. RSC 1985, c 31 (4th Supp).
2. According to the 2016 national census, there were 1,103,480 individuals in Quebec whose first official language is English, and 1,024,195 individuals living outside Quebec whose first official language is French. (Statistics Canada, 2017b)
3. RSO 1990, c F.32.
4. The Champlain geographical area refers to a large part of the Ottawa Valley, located in eastern Ontario. See http://www.champlainlhin.on.ca/AboutUs/GeoPopHlthData/Geography.aspx?sc_Lang=en

Language Services (FLS) organization in their region (Ministry of Health and Long-Term Care, 2016), while LHINs aim to improve care provision through regional resource funding and allocation.

In Manitoba, *The Francophone Community Enhancement and Support Act*,[5] adopted in 2016, and the French-Language Services Policy allow Manitoba's Francophone population to access comparable provincial government services in either French or English (Francophone Affairs Secretariat, 1999). In health and social services, this Policy applies to designated bilingual health facilities and regional health authorities (RHAs). The *Regional Health Authorities Act*[6] requires that, every five years, designated bilingual RHAs submit a FLS plan for approval.

Despite this legislation, 50 to 55% of Francophones living in a minority community report having no or very limited access to French Language Services (FLS) in their community (Bouchard, Gaboury, Chomienne, Gilbert, & Dubois, 2009). Many hesitate to ask for services in their own language (de Moissac *et al.*, 2015; de Moissac & Bowen, 2017); others get discouraged by the shortage of FLS or fear their request may delay access to care (Drolet *et al.*, 2014), and therefore opt to use readily available English services instead (de Moissac & Bowen, 2017). Historical forces of assimilation continue to influence seniors in particular. Therefore, requesting services and filing a complaint when services are unavailable in French are not common practice (de Moissac *et al.*, 2015). Consequently, more than 20% of Francophones living in minority communities across Canada will not seek care because of language barriers (de Moissac & Bowen, 2017). As described for other language minorities (Bowen, 2015; Schwei *et al.*, 2016), language barriers may have a substantial impact on accessibility, safety, satisfaction and quality of health services for Francophones living outside of Quebec (de Moissac & Bowen, 2019).

Previous research has demonstrated that despite a relatively high number of bilingual care providers practicing in eastern Ontario, Francophone seniors who have access to FLS in this region encounter breakdowns in linguistic continuity when several service providers are involved in care delivery (Drolet *et al.*, 2017; Savard *et al.*, 2020a). Service providers within health and social service organizations, even if bilingual, often have little knowledge of services available in French, making it difficult to refer individuals to other French-speaking health professionals (de Moissac *et al.*, 2012; Drolet *et al.*, 2014; Savard *et al*, 2013). This places an additional burden not only on seniors, but also on caregivers who assist Francophone seniors seeking health and social services in their official language.

5. SM 2016, c 9.

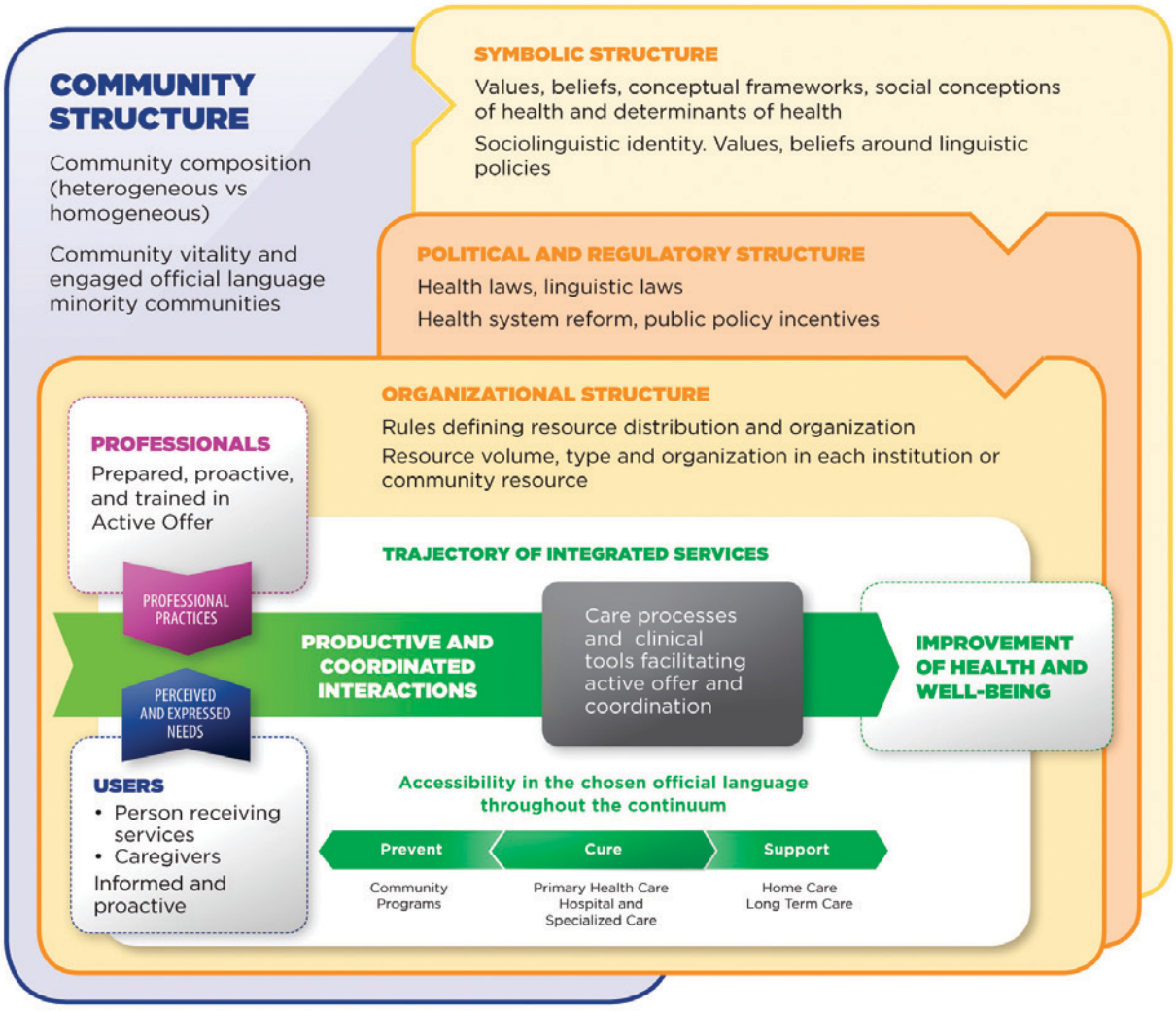
6. SM 1996, c 53.

Analytical Framework

The *Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities* (Savard *et al*, 2020b), developed in 2017 by the research team to map relationships between the various actors who influence the health and social service trajectory in official language minority communities, was used to guide this study. It is illustrated in Figure 1, followed by a brief summary.

Figure 1

Framework for the Analysis of Health and Social Services Access and Integration for Official Language Minority Communities



Source: Savard J. et al. (2020). www.grefops.ca/cadre_analyse_en.html.

Drawing on health and social services system models found in the literature (Champagne, Contandriopoulos, Picot-Touché, Béland, & Nguyen, 2005; Barr *et al*, 2003; McCurdy, MacKay, Badley, Veinot, & Cott, 2008), this framework conceptualizes health and social services as an organized system of actions, where several groups of actors, such as political decision makers, community leaders, managers, health and social service providers, interest groups, service users and their caregivers interact to meet the system's and their own objectives (Champagne *et al*, 2005, p. 14). This interaction occurs in a social realm defined by a set of structures that guide their actions: symbolic (associated with values), community (composition and resources), political and regulatory (related to laws and regulations), and organizational (resource distribution and organization).

These structures frame the service trajectory where two main groups convene, namely service providers and users. A user is frequently supported by one or more caregivers, who may or may not participate in all trajectory encounters. A productive interaction calls for collaboration between users, caregivers, health and social service providers, as well as service coordination to facilitate service continuity in one's preferred official language along the continuum.

Processes within the system structure the way by which resources are mobilized and used by actors (Champagne *et al*, 2005). To ensure continuity of FLS during a care trajectory, care processes will include clinical tools, professional practices, and information systems (Couturier, Gagnon, Belzile, & Salles, 2013), as well as supports or resources to facilitate the active offer[7] (Savard, Casimiro, Bouchard, & Benoît, 2017).

Methodology

Research Method

A participatory community research approach (Israel, Eng, Schulz, & Parker, 2013; Minkler & Wallerstein, 2008) was chosen for this study. Representatives from the Fédération des aînés et des retraités francophones de l'Ontario (FARFO), Ottawa region; the French Language Health Services Network of Eastern Ontario; Hôpital Montfort (Ottawa, Ontario) and the Centre de santé communautaire de l'Estrie (counties of Prescott and Russell, eastern Ontario) formed the Advisory Committee and collaborated in all stages of this project. The committee was based in Ottawa, Ontario, which facilitated participation of eastern Ontario organizations. Consultations with Manitoba organizations (Fédération des ainés et ainées du Manitoba, Centre de santé Saint-Boniface and Actionmarguerite) took place on an ad hoc basis.

7. Simply defined, active offer is "a verbal or written invitation to speak in one's preferred official language. The offer to speak in the preferred official language must precede the service request." [Loose translation] (Bouchard, Beaulieu & Desmeules, 2012, p. 46).

Types of Participants

Following ethics approval, individual interviews and focus groups were conducted with three types of participants: 1) managers from health or social service institutions or community organizations that have a Francophone clientele or are able to provide services in French; 2) health and social service providers who work in these institutions or community organizations; and 3) Francophone seniors and caregivers who had used at least one health or social service in the last year and who preferred receiving services in French.

Data Collection in Eastern Ontario and Manitoba

To account for Francophone population variations, research was conducted in four eastern Ontario regions, where Francophones account for 5 to 42 % of the total population (Local Health Integration Network, 2017), and in the federal electoral district of St. Boniface, in the city of Winnipeg, Manitoba, which has the highest Francophone population in the province at 12% (Statistics Canada, 2017a). Table 1 lists the study recruitment regions.

Table 1

Recruitment Regions in Eastern Ontario and Manitoba

Eastern Ontario			
Type of Setting	**Francophone Population Density**	**Percentage of Francophones** (LHIN, 2017)	**Region**
Urban	High	13	Ottawa Centre
		31	Ottawa East
Urban	Low	7	Ottawa West
Rural	High	42	Champlain East (County of Prescott-Russell)
Rural	Low	5	Champlain West (Renfrew County)
Manitoba			
Type of Setting	**Francophone Population Density**	**Percentage of Francophones** (Statistics Canada, 2017)	**Region**
Urban	High	12	St. Boniface

A map of Winnipeg, including St. Boniface, is available at http://www.elections.ca/res/cir/maps/mapprov.asp?map=46902&prov=46&b=n&lang=e

A map of the Eastern Ontario study area is available at http://www.rlisschamplain.on.ca/GoalsandAchievements/OurStratPlan/SubRegions.aspx?sc_Lang=en

Eastern Ontario recruitment targets were determined with the help of the Advisory Committee. Invitations were sent by mail to managers and, following manager interviews, to service providers, including physicians. An invitation to seniors and caregivers was relayed by local Francophone organizations. Recruitment proved to be a challenge in urban environments with a low Francophone population.

Interviews with managers and service providers were held in their workplace; interviews and focus groups with seniors or their caregivers were held in locations provided by Francophone community organizations. Interviews were in French or English, depending on participant's preference. Most were facilitated by the research associate and one of the principal researchers. Two senior and caregiver focus groups and four interviews were conducted by students in the University of Ottawa Master of Social Work program, under the supervision of a research team member.

In Manitoba, seniors and caregivers were recruited during an event organized by the Fédération des aînées et aînés franco-manitobains and through an email invitation sent to French community organizations. Service providers and managers from institutions that support Francophone seniors were recruited through previous contacts and a snowball effect. Invitations for individual or group interviews were sent by mail or email to potential participants, with follow-up telephone calls. Focus groups were conducted at Université de Saint-Boniface, while individual interviews with caregivers, service providers and managers were held in their workplaces. Discussions were facilitated by two researchers from the St. Boniface project team. Table 2 provides participant interview and recruitment details. All interviews and focus groups were audio-recorded and fully transcribed.

Table 2

Eastern Ontario and Manitoba: Interviews and Participants

Semi-structured individual interviews				
	Eastern Ontario		Manitoba	
Type of participants	Interviews	Participants	Interviews	Participants
Managers	17	19	6	6
Service providers	4	4	10	10
Seniors/caregivers	6	6	3	3
Subtotal	**27**	**29**	**19**	**19**
Focus groups				
	Eastern Ontario		Manitoba	
Type of participants	Groups	Participants	Groups	Participants
Service providers	5	23	n/a	n/a
Seniors/caregivers	7	31	2	8
Subtotal	**12**	**54**	**2**	**8**
Total Interviews and Focus Groups	**39**	**83**	**21**	**27**

Data Collection Tools

Individual interviews with managers and group interviews with service providers were guided by questions and case studies depicting complex situations to encourage reflection and discussions about existing integrated or informal practices, both in general and in French. These questions also explored current collaborations between actors, locations and organizations, as well as opportunities favourable for French language service integration. With seniors and caregivers, individual interviews and focus group questions focused on facilitators of FLS access, service navigation and communication of personal health information along the service trajectory. The interview guides can be consulted in the research report, available online[8] (Kubina, de Moissac, Savard, Savard, & Giasson, 2018).

Qualitative Analysis

All transcripts were imported into the NVivo 10 analysis software (QSR International, 2012), to facilitate content analysis focused on a careful and systematic data review to understand the meaning of participant experiences (Krippendorff, 2012). Data coding followed a predefined procedure to ensure thoroughness and in-depth analysis: 1) an initial reading of 20% of transcripts to identify categories and emerging themes (Paillé & Mucchielli, 2008); 2) reaching consensus among team members around categories and themes; 3) developing and defining a code list; 4) validating the code list; 5) using this list to code three transcripts (one each from managers, service providers and seniors), and calculating interrater agreement (Huberman & Miles, 2002); 6) coding remaining data according to the code list, allowing for the emergence of new codes. Researchers from both provinces proceeded to a second level of analysis, noting similarities and differences in findings between study areas. In a third level of analysis, the analytical framework presented above was used to group together facilitators and barriers, and develop guidelines to improve French language health and social service continuity.

Results

Results are organized around three themes: 1) issues experienced by Francophone seniors; 2) facilitators of FLS continuity; and 3) barriers to FLS integration and continuity. Following the results, guidelines to improve French language health and social service continuity are presented.

8. http://www.grefops.ca/uploads/7/4/7/3/7473881/complete_health_social_services_francophone_seniors_grefops_29mar2018.pdf, p. 67.

Issues Experienced by Francophone Seniors Living in Minority Communities

Francophone seniors, in both Ontario and Manitoba, commented on their socioeconomic reality and the personal barriers they faced regarding health and social services access and continuity. In addition to experiencing the vulnerabilities associated with aging, both service users and providers named financial insecurity as a barrier; seniors would forego transportation and services they could not afford.

Further, limited schooling and literacy among many Francophone seniors impacted their ability to interact with a service provider and understand processes and instructions in either official language. Low levels of digital literacy meant that online information was not accessible.

Isolation and geographic distance from French services, for seniors living in rural areas with low Francophone populations, was reported in both provinces. Conversely, providers in some areas seemed unaware of the presence of Francophones in their midst. Urban residents faced issues if they moved to a sector of the city where French services were less available or nonexistent.

Facilitators of French Language Service Continuity

Participants identified several mechanisms that promote health and social FLS access and continuity, described below in keeping with the analytical framework presented above.

At the organizational level, facilitating processes include formalized linguistic variable data collection practices, which appeared to be widespread in eastern Ontario designated organizations, and in settings that recognize the importance of the linguistic variable; shared communication tools, such as electronic records and common assessment software used by community support agencies; and directories of bilingual services and service providers, when such formal or informal directories were available.

Formal interagency agreements were more common in eastern Ontario between designated or partially designated health and social service organizations. In the health and social service sector, working groups, especially when intersectoral, were opportunities for FLS to be addressed. In eastern Ontario, the active participation of Francophone managers in these working groups, and the participation and role of the French Language Health Services Network of Eastern Ontario were identified as key to reinforcing awareness of the Francophone population's presence and needs. In Manitoba, few such formal agreements are in place; however, informal understandings are more common. Linguistic continuity appears also to be facilitated when services are provided by multidisciplinary teams and when new initiatives include community support services.

For Francophone seniors living in St. Boniface, senior support service providers tend to communicate better with each other, when the senior's care is managed by a bilingual case manager from home care services; this contributes to care integration. These examples illustrate that, where key players have the will to do so, integration of client-centred services is conceivable.

At the service provider level, informal and regular awareness-raising actions with service partners and community members, as well as networking to develop informal working arrangements, were common mechanisms used by managers and front-line staff to reach out, provide and coordinate FLS. Enthusiasm for innovation and collaboration, as well as a history of trusting and close relationships were cited as key components of partnership success.

At the community level, continuity of FLS is also enhanced by the vitality of the Francophone community and commitment of its members, including service providers and managers who belong to this community. Participants highlighted the enthusiasm for innovation and collaboration on the part of those managers for whom FLS provision to seniors is important. Many of them also referred to the close relationships built, due to the solidarity that brings Francophone service providers and managers together in minority communities and the trusting relationships that encourage cooperation and mutual assistance.

Barriers to French Language Services Integration and Continuity

Participants also identified several barriers to health and social FLS access and continuity, described below.

At the symbolic level, barriers related to a lack of understanding, seemingly inherent in the health system, of the impact of language barriers on access to safe, satisfactory and quality care. A common assumption was that Francophone seniors are bilingual and thus could get by with services in English.

At the political and regulatory level, service continuity in the minority language is infrequently considered. In Ontario, for instance, while designation is the main mechanism that promotes the provision of FLS, it imposes no obligation on organizations to work together to provide a continuum of FLS, and no mechanism specifies that a Francophone has priority access to designated services. For example, ambulances are directed to the nearest hospital able to accept the senior, regardless of designation. The instrumental approach of triage by condition or by geography (postal code) does not take into consideration the senior's linguistic needs. In addition, agencies providing privately paid home health care in eastern Ontario are under no obligation to provide services in French, even in areas with a higher proportion of Francophones, which creates a lack of linguistic continuity once seniors leave

hospital and require more home care than that provided by the publicly-funded designated agency.

Funding for French language services in eastern Ontario and Manitoba is precarious at best. Francophone organizations find themselves competing with larger Anglophone organizations for public funding. Where linguistic barriers for Francophones are unrecognized, few funds are earmarked for FLS. This has an impact on the organizational level, where a shortage or lack of optimization of bilingual human resources, very few assessment tools in French and few resources for translating and producing French documentation were reported. A shortage of bilingual service providers limits access to a continuum of FLS, particularly in areas with small Francophone populations. In all areas, a lack of specialized services available in French was reported. Existing communication tools, such as electronic records, are not compatible across sites, making timely sharing of health-related information for seniors receiving hospital, community health and home support services difficult. Moreover, to ensure language compatibility of this shared information, health records are written in English; Francophone seniors and their caregivers consequently have an added barrier to accessing information in their own records.

At the service provider level, the lack of an active offer of French language health and social services was identified as an indicator that linguistic needs of Francophone seniors are not always considered, generating communication and comprehension breakdowns along the care trajectory. Even in institutions with bilingual staff, seniors and their caregivers report limited active offer: staff aren't always trained in active offer or are not assigned to Francophone seniors. While seniors and caregivers expect to be informed of available FLS, they find that service providers are not kept apprised of such service availability.

Recommendations: Guidelines to Improve the Continuity of Health and Social FLS

With these key findings in mind, and following an iterative comparison of study results with the analytical framework, research team members and Advisory Committee members developed a set of concrete recommendations that can be adapted to local realities and support decision makers, managers, service providers and Francophone community members. These recommendations are summarized in Table 3 and discussed below according to the different structures of the analytical framework, viewed here as drivers of action.

Table 3

Guidelines to Improve the Continuity of Health and Social French Language Services

For Francophone, Francophile, and Anglophone Service Providers
1. Gain the knowledge and skills required to practise active offer.
2. Take part in establishing formal or informal relationships and collaborative networks between Francophone and bilingual service providers, and between individuals or organizations that can provide services in French.
Organizational support for providers
3. Contribute to service providers' enthusiasm and sense of belonging to the Francophone community.
For Francophone Communities
4. Increase the Francophone community's visibility within the health and social service sectors in linguistic minority settings.
5. Develop connections between the community and organizations that provide health and social services in French, to expand their visibility and enhance the community's use of these services.
For Managers and Senior Administrators within the Organizational Structure
6. Raise awareness about, and train managers in, active offer.
7. Organize resources to enable active offer.
8. Encourage Francophone managers and professionals to continue championing the Francophone cause in English-speaking committees and working tables of which they are members.
9. Formalize liaison and coordination processes among French language health and social service providers to promote service continuity.
For Decision Makers within the Political and Regulatory Structure
10. Integrate the concept of active offer into laws and policies overseeing French language health and social services in Canadian provinces and territories.
11. Implement policies that account for the linguistic variable in the organization of health and social services.
At the Symbolic Structure, for Every Actor in the System
12. Draw on values such as patient safety, client-centred services, quality of care, and universal access currently conveyed by health and social service organizations to promote access to services in French.
13. Value the participation of Francophone seniors when looking for solutions to improve the continuity of their intended health and social services.

Francophone, Francophile, and Anglophone Service Providers

Recommendations for Francophone, Francophile and Anglophone service providers aim to increase their knowledge and skills to practice active offer, including securing readily available tools to facilitate FLS, to strengthen existing informal agreements, establish formal service provider networks, and promote these services to Francophone seniors. Supports from managers and organizational practices should foster providers' sense of belonging to the Francophone minority community, when appropriate, and is believed to raise their pride in offering FLS.

Francophone Communities

Recommendations for Francophone communities highlight the significant role they can play in improving FLS integration. Involvement of Francophone seniors' associations in health and social service organizations is essential to making their members' needs known. This can be achieved by volunteering for working groups, user advisory committees or public health boards, or organizing a Francophone day in their leisure programs. Partnerships between service providers and users (Tremblay *et al*, 2012) have been identified as key to achieving FLS integration. The active engagement of the Francophone community is thus essential in all efforts aimed at improving FLS continuity. Since community services are an important entry point, the establishment or reinforcement of connections between Francophone organizations and health and social service community organizations could lead to better knowledge of FLS availability. Dissemination of information via networks (television, radio, newspaper) and in Francophone seniors' gathering places (*e.g.*, parishes, associations, social clubs) (Pécore-Ugorji, 2016) could promote greater visibility of these services.

Administrators Within the Organizational Structure

The organizational structure plays a crucial role in the quantity and distribution of human, material and financial resources earmarked for health and social services. Organizational cultures also have considerable influence on the provision of FLS (Bouchard, Savard, Savard, Vézina, & Drolet, 2017). Policies, regulations and guidelines developed within the political and regulatory structure influence the organizational structure within which administrators and managers organize and distribute resources. Four recommendations suggest concrete steps for managers and senior administration within the organizational structure.

First, raising the awareness of managers of the importance of active offer and FLS continuity in partially designated as well as non-designated organizations that provide services to Francophone seniors is essential. They are the ones who will be able to facilitate

resource adaptation that may be needed to promote the practice of active offer, or support their employees to do so. Concrete tools have been developed to guide managers with such adaptations (Savard *et al*, 2019; Savard, Savard, van Kemenade, Benoît, & Tabor, 2020c; Société Santé en français et Réseau Franco-santé du Sud de l'Ontario, n.d.; Tremblay, 2015). Active offer training in both official languages (Reflet Salvéo, 2017) can be made available to managers and employees, including by means of free online resources (Association des collèges et universités de la francophonie canadienne, 2019; Réseau du mieux-être francophone du Nord de l'Ontario, n.d.)

Second, managers can organize resources to enable FLS and active offer. For example, the ability to rely on up-to-date directories of bilingual service providers and intentionally deploy FLS (*e.g.*, through a policy of pairing Francophone seniors with bilingual or French-speaking staff) would allow for more regular delivery and coordination of an organization's FLS. It would also prevent the dispersal of limited Francophone or bilingual resources. For managers to track emerging needs and plan services and resources for a population that is often geographically scattered, it is essential that they be able to actively identify its members. Identification of Francophone seniors can be carried out by interacting with Francophone seniors where they live and gather. In regions with low Francophone populations and in rural areas, Contant (2014) suggests an individualized approach to build trust and foster service acceptance. Identification of Francophone seniors could also be automated at the regulatory level (see below).

Some Canadian health regions have developed policies on interpretation services (Winnipeg Regional Health Authority, n.d.; Silversides & Laupacis, 2013). In areas with low Francophone populations, community or remote interpretation services (via telemedicine) are frequently used (L'Accueil francophone de Thunder Bay, n.d.; Canadian Volunteers United in Action, n.d.). Minimal standards for interpretation practice have been identified and are strongly recommended: 1) coordinated organizational policies and practices; 2) use of trained interpreters only; 3) interpreter screening and linguistic evaluation; 4) interpretation services information availability for users and service providers; and 5) a data collection method enabling service evaluation (de Moissac 2016; Healthcare Interpretation Network, 2007; Regional Language Access Committee 2006-2007,). Whether provided by community or regional organizations, these minimal standards are essential to ensure accurate, safe and complete communication.

Third, inspiration from senior administration is needed to encourage Francophone managers and professionals to champion the Francophone cause at all levels, in their own organization, as well as within regional committees or working tables to facilitate coordination of FLS.

Fourth, while the process of French language health and social service integration may vary based on regional needs, these services must be easily identifiable and accessible. Formal agreements could be put in place by the senior administration of organizations providing FLS, to ensure the continuity of available French services and systematic documentation of linguistic preferences in referral forms. In addition, the use of navigators in French language health and social services could be explored. A navigator, familiar with all FLS, could help seniors and their caregivers determine service availability. The navigator role is increasingly acknowledged and validated as an essential element of continuity for seniors and caregivers (Manderson, McMurray, Piraino, & Stolee, 2012; The Change Foundation, 2012). Research highlights the contribution of navigators to improving access to quality services in minority linguistic communities (Natale-Pereira, Enard, Nevarez, & Jones, 2011; Shommu *et al*, 2016). Given the multiplicity of navigation models and pilot projects, Prud'homme, Gagnon, Bilodeau, Hubert, & Leduc (2016, p. 19) prioritize the standardization of navigation and support a network of Francophone navigators in Ontario's health services. This approach, we believe, should also include social services to ensure a more concerted and continuous transition between the social and health sectors.

Decision Makers within the Political and Regulatory Structure

French language health and social services laws and policies support FLS in many Canadian provinces, including Ontario and Manitoba. However, FLS are not always made readily visible or available to service users. Enforcement mechanisms are required, as several studies reveal that, despite good intentions and legal frameworks, active offer remains relatively unknown (Office of the French Language Services Commissioner, 2016).

There are several avenues for policy implementation. For example, a pilot project aimed at collecting the linguistic identity information of health service users was led in Ontario by the French Language Health Services Network of Eastern Ontario (Réseau des services de santé en français de l'Est de l'Ontario, 2019).[9] In Prince Edward Island, the linguistic variables of users are now recorded on the health card (Société Santé en français, 2018). This is an example of process improvements to support the distribution of health resources based on the needs of the Francophone population. Implementing these recommendations could generate new organizational competencies around active offer (Office of the French Language Services Commissioner, 2016). In this respect, discussions are emerging in several provinces where Francophones live in a minority context, and merit follow-up.

9. At the time of writing, and following this pilot project, a motion has been voted by Ontario Legislature asking the government to add linguistic identity to the data contained in the OHIP card (see Office of the French Language Services Commissioner, 2018).

Furthermore, Francophone governance of French language health and social services is increasingly widespread (*e.g.*, the Centre de santé communautaire Hamilton/Niagara in southern Ontario and the Orléans Health Hub in eastern Ontario) and appears to facilitate FLS continuity and coordination (CSCHN, n.d.; Orleans Health Hub, 2019). In Manitoba, Centre d'accès—Access St. Boniface Centre, created in the spring of 2016, brings together bilingual health and social services under one roof (Government of Manitoba, 2016); it appears to be a promising structure for the promotion of service continuity for the neighbourhood's Francophone seniors.

Developing linguistic and cultural competency standards for the accreditation of health and social service institutions is a favourable mechanism for improving FLS access. The Health Standards Organization and Société Santé en français recently created the *Access to Health and Social Services in Official Languages Standard* (Health Standards Organization, 2019), as well as an Organizational Competency Recognition Program (Health Standards Organization, 2017). These initiatives should improve service provision to Francophones in minority communities.

Although provincial guidelines establish geographical triage, regional managers could choose to honour exceptions and work with other agencies operating in neighbouring territories to facilitate FLS access. In addition, where waiting lists exist in organizations that provide FLS, measures could be taken to allow priority access for Francophones in a given number of places, to ensure that bilingual resources are optimized and improve Francophones' access to these services.

Finally, bilingual designation could be supported by concrete and accurate monitoring and updating mechanisms, such as provided by French language planning authorities in Ontario. Designation mechanisms should also include elements to promote collaboration between designated organizations to improve FLS continuity.

At the Symbolic Structure, for Every Actor in the System

The symbolic structure influences actors at all levels in the health and social services system. Two recommendations are proposed, so that linguistic accessibility can become a priority for all organizations and be reinforced with decision makers. First, we suggest raising awareness and disseminating key information to decision makers, service providers and community members, especially regarding the association between safety of care and spoken language (Bowen, 2015).

Secondly, we recommend that Francophone seniors participate in consultations and research projects pertaining to FLS improvement and continuity. To ensure this, Francophone community members must be adequately informed and consulted when such opportunities arise, so their specific needs can be brought to light.

Discussion

This study enabled us to capture undocumented knowledge from various actors (professionals, managers, seniors and caregivers) of their experience with continuity of health and social FLS for seniors. While coordination practices ensuring linguistic services continuity were our research focus, participants spoke more frequently of challenges in accessing FLS. In part, this may be a result of system fragmentation and absence of mechanisms for FLS provision along the continuum of care. It may also be linked to the difficulty of achieving full integration (Couturier *et al*, 2013) in areas with small Francophone populations.

Thus, it appears more relevant to consider *continuity* rather than *integration* of French language health and social services. As a dimension of integration (Kodner, 2009), continuity refers to the experience of individuals and caregivers along the service trajectory (Haggerty *et al*., 2003). The degree of continuity may vary according to the coherence and interconnection between services addressing the service user's personal and sociomedical conditions (Haggerty *et al*., 2003; Kodner, 2009). Since it pertains to the relationship between service providers, seniors and their caregivers, the concept of continuity can be co-constructed by and evolve among these parties (Parker, Corden, & Heaton, 2011). Continuity of FLS can be an outcome of formal and informal networking among various Francophone actors who operate within these systems.

Numerous actors are involved in the service trajectory, many of whom adopt informal behaviours and practices to promote FLS continuity. As participants noted, these include the use of bilingual service providers and service directories; networking among bilingual service providers; the active offer of FLS; and a genuine commitment on the part of bilingual professionals to provide those desiring it as many services as possible in their own language. Except in two areas with the lowest Francophone density, participants highlighted the existence of numerous FLS and many bilingually designated agencies. Overall, managers working in these organizations know each other and are open to working together whenever possible.

However, it appears that barriers to integration are more widespread at the macroscopic level. Health and social service systems are complex; agencies have different financial structures and organizational cultures. Employees from various organizations are not used to working together, and leadership seems to be lacking in terms of implementing strategies that promote FLS along the continuum. At the organizational level, in most regions we studied, few mechanisms or formal service agreements aimed at offering FLS on a continuum seem to exist. On the contrary, participants found that, most of the time, agreements were informal and at risk of disappearing due to staff turnover. Participants stated that it would be important that such informal practices or networks be formalized, to ensure stronger and permanent bridging between services. In addition, as organizations designated to provide FLS do not cover the entire continuum of services that a Francophone senior may require,

there is a need for mechanisms fostering linguistically adapted services in non-designated organizations. Specifically, in Ontario, the traditionally voluntary nature of designation does not ensure a comprehensive complement of designated services, although the FLHPEs and LIHNs are now working alongside many organizations to fill the gaps. Existing gaps were experienced by our participants in various situations including emergencies, where linguistic competencies are often put to the test (CNFS, n.d.) and where individuals cannot choose their care organization according to their official language of choice.

The partial designation of some institutions is also problematic, given that designated services within these institutions are not well known to the public. It would be beneficial to have one FLS access point. Furthermore, political orientations as to which services are funded by the government will impact FLS access and continuity, a consequence not always considered in decision making.

Although well-documented for minority language populations in the international sphere (Bowen, 2015; Schwei *et al*., 2016), the impact of linguistic barriers for Francophones living in minority communities in Canada is less present in the scientific literature, but is emerging (de Moissac & Bowen, 2017, 2019). Decision makers and managers at all levels who are unaware of linguistic issues faced by a Francophone clientele will not understand the need to develop and maintain coordination mechanisms for services provided in French. Indeed, in some cases, Francophones seem to be part of an invisible community, partly due to being predominantly bilingual and often geographically dispersed. Nonetheless, interviews with some Anglophone managers demonstrated that, when made aware of the difficult circumstances experienced by Francophone seniors, they grasp the importance of language for safe and quality care. Thus, it is essential to raise awareness among managers and service providers through innovative training approaches.

Study limitations

The study took place in two provinces which have legislation supporting FLS. Results should be extended to other jurisdictions with caution. Without legislation supporting FLS, service access barriers may be more numerous and mechanisms to foster FLS continuity almost nonexistent. We believe the analytical framework would still be useful to study such contexts and formulate context-specific recommendations.

Future directions

Despite laws and policies on health and social FLS in the two regions studied, there are no policies for service continuity in French; this matter should be further explored. In Ontario, a few participants reported that collaborations exist between the planning entity (the French Language Health Services Network of Eastern Ontario) and the local LHIN to

support French language services. Their role should be reinforced to promote service integration, giving priority to the community services sector, a frequent entry point for service users.

In general, social services seemed more integrated than health services. Could this be related to social services' inherent ability to facilitate interactions and coordination between seniors, families, service providers and the community? It raises the question as to whether different strategies, such as those used in social work, should be considered in the health field.

As a natural next step for our research team, the study results spurred several new projects targeting organizations, service users and care providers: a) the creation and experimentation in four Canadian provinces of the *Organizational and Community Resources Self-Assessment Tool for Active Offer and Continuity of French Language Healthcare and Social Services*, which is designed to stimulate reflection on areas for improvement in the provision and delivery of services in the user's chosen official language (Savard *et al*., 2020c); b) the creation of the *Handbook of Innovative Practices on the Integration of Social and Health Services in Official Languages in a Minority Context*, a complementary resource to the Organizational and Community Resources Self-Assessment Tool (Savard *et al*., 2019); and c) the creation and validation of a tool designed to capture service user perspectives on the availability and quality of FLS (ongoing).

Conclusion

This study identified critical issues influencing French language health and social services access and continuity for Francophone seniors living in minority communities. The struggle of pairing bilingual service providers with seniors who wish to be served in French is particularly evident in areas with a low Francophone population; consequently, FLS use along the continuum of care is minimal. To establish and maintain productive, coordinated French language interactions between users, who are characterized as an invisible minority, and the range of health and social service providers they encounter, active offer must become widespread. In this regard, some mechanisms and communication tools already exist. There is a palpable enthusiasm among organizations whose close, historic connections help generate collaborative strategies. However, complex health and social service systems, limited resource allocation to FLS, shortage or lack of optimization of bilingual human resources, services and tools to support the active offer of FLS, and the lack of formal intersectoral mechanisms to ensure service continuity in French pose substantial challenges, highlighting the need to further explore how a continuum of French language health and social services can be implemented in a minority context.

Liaison, coordination and full integration seem central to meeting the health and social service needs of the senior population; these approaches propose tools and practices

to facilitate the seamless navigation of users through the service trajectory. However, in the current organizational context and given the barriers mentioned earlier, full service integration for Francophone populations living in a minority context is a complex and unlikely outcome. Nevertheless, this study points to some strategies, primarily aimed at liaison and coordination between existing services, to more adequately meet this population's needs.

In addition, the proposed recommendations highlight the possibility of new collaborative approaches promoting French language health and social service continuity. This can take the form of adopting policies that consider the linguistic variable in service organization, or an organizational structure that values and endorses leadership on this issue, in which senior administration and managers establish formal collaborative agreements between designated institutions, and foster networking among various Francophone actors throughout health and social service systems, while promoting an active offer essential for safe and quality care. Service providers and communities have a significant role to play in maintaining this dynamic and collaborative spirit. The strength of the Francophone minority community and its members' involvement and networking abilities could be drivers for change. Current and future initiatives show promise in enabling French language health and social services continuity.

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