

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

By

Jacinthe Savard

Sébastien Savard

Marie Drolet

Danielle de Moissac

Lucy-Ann Kubina

Solange van Kemenade

Josée Benoit

Yves Couturier

GReFoPS, University of Ottawa

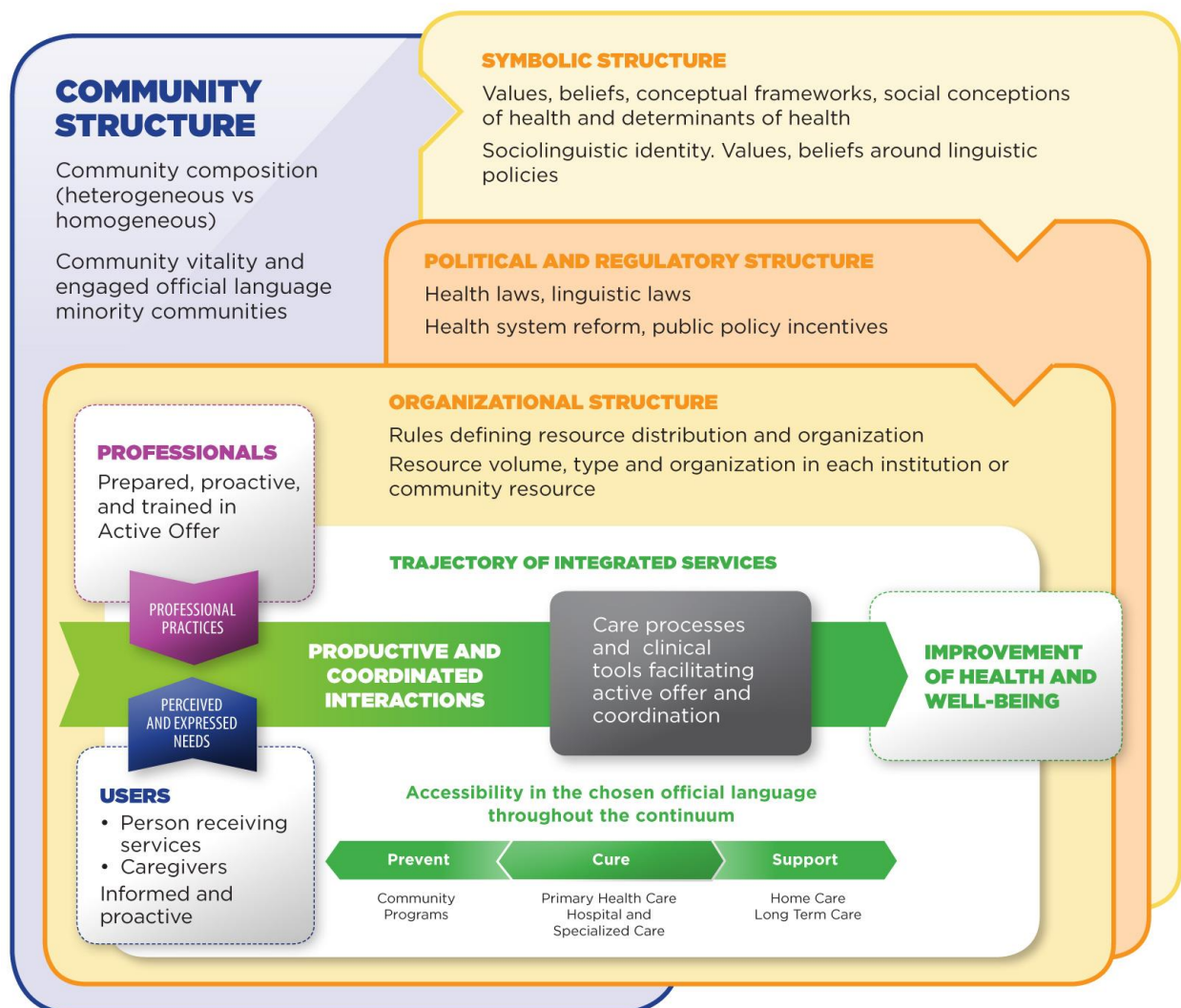
Original version in French, August 2017

Translation in English, December 2018

Revised April, 2020

Our *Framework for the analysis of health and social services access and integration for official language minority communities* (OLMC) aims to map relationships between the various structures that influence the actors in the health and social service trajectory, within the context of those communities. This framework draws on health and social service system models found in the literature and on data from previous research conducted by the GReFoPS. This document presents a graphic presentation of the framework, followed by an explanation of the concepts nascent to the framework and an explanation of its adaptation for the analysis of OLMC-specific issues.

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



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

Background concepts

This analytical framework draws from some current health and social services system frameworks, such as that of Champagne, Contandriopoulos, Picot-Touché, Béland and Nguyen (2005); the Chronic Care Model (CCM) (Wagner, Austin, and Korff, 1996) and its variation known as the Expanded Chronic Care Model (ECCM) (Barr et al., 2003; McCurdy, MacKay, Badley, Veinot and Cott, 2008); the conceptual framework for service integration (Tremblay, Angus and Hubert, 2012) and service coordination concepts found in Couturier, Gagnon, Belzile and Salles (2013); and data from previous research conducted by the GReFoPS.

According to Champagne, Contandriopoulos, Picot-Touché, Béland and Nguyen (2005), the health and social services system is considered as an organized system of actions, situated in a concrete geographic and temporal context, in which various structures (physical, organizational, symbolic) define a social space where four major groups of actors (professionals, managers, commercial representatives and political representatives) interact in order to accomplish one or more collective projects targeting the reduction of health problems (p. 18). These structures include a symbolic structure (common standards and values, perception of health, life and disease, etc.), an organizational structure (laws and regulations governing health and social services, governance rules, etc.) and a physical structure (buildings, architecture, technical platforms, public and private financial resources, etc.). This framework is useful to understand how health and social service systems operate and to determine the actors' playing field within this system. The system includes processes by which resources are mobilized and used by actors to achieve the objectives of the system.

Despite its pertinence, we note the need to propose various adaptations relative to the context in which we are interested:

- The service providers we met in the course of our studies never spoke of physical resources or technical platforms corresponding to Champagne and colleagues' physical structures. Rather, they tended to make the distinction between provincial laws and regulations and those of institutions or regional agencies mandated to distribute resources locally. The model was then adapted to include a symbolic structure, a political and regulatory structure and an organizational structure.
- At a time when person-centered care is becoming more and more important, the active role of the person requiring care and his / her caregivers within the care trajectory needed to stand out more.
- Finally, given the context of aging and the rise in chronic illnesses, the goal of the system is not only to reduce health problems, but also to maintain autonomy and well-being. There is a greater probability that a person will require intervention from several institutional and community health and social service providers in order to manage a health condition or to maintain autonomy. Integration or coordination mechanisms are required for a seamless care and service trajectory.

The interaction between these two important groups of actors (service providers and users) is highlighted in Wagner and colleagues' 1996 *Chronic Care Model* (CCM) and its variation known as the *Expanded Chronic Care Model* (ECCM) (Barr and coll., 2003; McCurdy and coll., 2008) The CCM proposes to improve service quality by establishing a dynamic relationship between care and service providers (physician, health and social service team) and the recipient (including caregivers) by adopting an approach centred

on responding to the service user's or the caregiver's needs (Bodenheimer, Wagner and Grumbach, 2002). Productive interaction and collaboration between these two partners (service provider and user) must alter the long-held paradigm of emergency or short-term health care (expert service provider and passive user) and transform itself into a person, caregiver and provider collaboration (Bodenheimer et al., 2002). The service provider becomes proactive, open to networking and a multi-pronged approach. The user and caregiver, better informed and equipped to manage chronic health problems are also invited to be proactive and make changes to their behaviours and living conditions (Wagner et al., 2001). Consequently, a person-centred approach, education, user empowerment and service continuity promote better health and well-being (Hindmarsh, 2013). The Expanded Chronic Care Model also draws on community resource utilization, the creation of favourable living environments, reinforcement of community action and the design of public policies that benefit health and well-being (Barr et al., 2003).

Finally, to address the continuity of institutional and community health and social service providers' interventions directed to an official language minority population, the literature on service integration informs our analysis. The framework for service integration proposed by Tremblay and his colleagues (2012, p.10) accounts for an integrated service trajectory in an official language minority context by accessibility to care and services in the official language of choice throughout the continuum. Couturier and colleagues (2013), for their part, underline that service continuity within this trajectory needs to be supported by tools that enable the exchange of information between organizations. This can include the establishment of linkages between various organizations, interorganizational protocols promoting the smooth flow of service users among these organizations, a case manager as the service user's preferential contact within the network, working tables, a centralized access point, the use of a standardized and multidimensional assessment tool, common individualized service planning tools, etc.

Adaptation of the Framework to Describe Access and Continuity in One's Language, in a Minority Context

Inspired by these models or concepts and their interaction with data from our previous studies, the analytical framework, visually represented at the beginning of this text, considers the health and social service system as an organized system of actions wherein several groups of actors interact to meet the system's objectives and their own purposes. These groups may include: political decision makers, community leaders, managers, health and social service professionals, interest groups, users and informal caregivers. They interact in a social realm defined by a set of structures that guide their actions: symbolic, community, political and regulatory and organizational. Their actions (professional practices, care and service processes, expressed needs and requests) are drawn from prior experiences and help define, in turn, the progression along the service trajectory.

More specifically, the **symbolic structure** is comprised of values, beliefs and social representations. It includes both values associated with health and social justice, representations and determinations of health, and values associated with identity and linguistic policies. The Government of Canada recognizes linguistic duality as a fundamental element of Canadian identity and supports several initiatives to assist official language minority communities, as demonstrated by the *Roadmap for Canada's Official Languages*

2013–2018. The importance placed on this value and its operationalization varies considerably for both Francophones and Anglophones within the Canadian population (see Vézina, 2017). Representations of health and its determinants, regulations, actors' roles and responsibilities (government role vs individual responsibility) are all symbolic elements which influence health policies and health and social service organization. They also influence each actor's perception of the role they play within the system. Current literature on health and social service policy indicates person or patient-centred care (AMC and AIIC, 2011; Lévesque et al., 2013), user satisfaction (Fondation canadienne pour l'amélioration des services de santé, 2012), vulnerable persons' access to care and patient safety (Institut canadien pour la sécurité des patients, 2016; World Health Organization, 2009) as important values. Moreover, some studies demonstrate that access to services in one's own language promotes quality of care and safety, as well as client satisfaction (Bowen, 2015), thus justifying efforts to offer culturally adapted care (AIIC, 2010; Campinha-Bacote, 2002; Office of Minority Health, 2001).

As with the symbolic structure, the **community structure** influences all actors concerned with population health improvement and well-being. On the one hand, care and services do not operate in a vacuum. Health and social service personnel and managers come from this community and share in many of its values and resources. On the other hand, improving population health is not solely the responsibility of the health system; rather, it depends on a set of multi-disciplinary and multi-sectoral actions which may include creating healthy and positive living environments, strengthening community action, and developing public policies that foster health and well-being (Barr et al., 2003). At a more formal level, community actions can be organized through various groups, who can express to the appropriate authorities the community's needs of which they have observed, or, organize ways to deal with lack of services through the creation of services that set their own rules and policies, such as economic social enterprises, and support or peer groups for those experiencing similar difficulties. It would be thus advantageous for healthcare facilities to expand opportunities for contact with linguistic minority communities. Informal neighbourly relations that promote social support among community members can have a positive impact on health. In this context, the community's vitality (Bouchard, Gilbert, Landry and Deveau, 2006) and its linguistic vitality (Johnson and Doucet, 2006) plays an important role in accessing services in one's own language. The community's role can be a possible path of exploration in the search for solutions to service access and continuity in the minority official language.

The **political and regulatory structure** comprises laws, regulations, and ministerial directives governing the health and social service system in each province and territory. This may include laws or policies specifically addressing health care and social service provision of such as the *Canada Health Act*, provincial health care and social service laws and policies, or laws with a larger scope that affect activities and operations in several fields such as Canada's *Official Languages Act*, or various provincial official language laws and policies. The latter offers a legal framework that is more or less binding for minority official language health and social service planning (Foucher, 2017). The political structure's desire for health system reforms translates into amendments to statutes, regulations and directives, which in turn, influence the organizational structure.

The **organizational structure** defines resource design, distribution and organization, as well as the volume and type of resources allocated to health care and social services and is therefore influenced by the

political and regulatory structure. But within these policies, regulations and directives, managers have a certain amount of leeway in deciding how to utilize the resources they are allocated and for which they are responsible. Resource distribution takes place among various geographical territories, public, private and community services, and primary, secondary and tertiary care, and different clienteles. When the linguistic variable is not considered at the time of resource distribution, this can negatively affect access to services in the official language of one's choice. Organizational culture and leadership can have a key role in the establishment of services in the official minority language (Forgues and Landry, 2014). Equitable access to services in the language of the minority official language is influenced by the number of service providers able to speak that language and prepared for the challenges of active offer¹, as well as attention to efficient resource planning and deployment (Savard S. et al., 2017; Savard J. et al., 2017).

Which health and social services are included in the continuum of care and the level of service integration² is frequently defined within the political and regulatory structures, and sometimes within the organizational structure.

In the centre of the model, the service user receives care from several health and social service professionals, thus delineating a **service trajectory**. The service user is frequently supported by one or more caregivers, who may or may not participate in this encounter. Productive interaction during the care and service trajectory involves close collaboration between the service user, that person's caregivers and health and social service providers as well as the coordination of all services the person will require. In the context of OLMCs, access to services in one's chosen language throughout the continuum improves the trajectory experience as well as health outcomes³.

The interaction between the service user, caregivers and service providers will be positive when:

- On the one hand, the **service provider is well prepared, proactive, trained in the active offer** of services in both official languages, able to offer the service themselves in the minority official language or refer the person to an appropriate resource. Their professional practices promote culturally adapted services as well as collaboration between providers and organizations.
- On the other hand, the **service user and caregiver** will be better informed and equipped to manage the health condition and better informed of the importance of communication for quality and safety care and services. They will thus be **proactive**, participating in the decisions that affect them, capable of putting into place the recommendations required to improve their health and living conditions, and also capable of **expressing their health needs** and need for certain interactions with health and social service providers to take place in their own language.

Clinical tools, care processes and information systems figure among the processes that influence service provider's actions and their ability to mobilize the resources of the system. Among the tools that may have an influence on the possibility of an integrated service trajectory in a linguistic minority context, we find tools promoting the active offer of services in both official languages (for example,

¹ 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." [Translation] (Bouchard, Beaulieu & Desmeules, 2012, p. 46)

² For a discussion of the levels of service integration (for example, liaison, coordination and full integration), see Valentijn et al. (2013), and Couturier et al. (2013).

³ See Bowen (2015) for a discussion of consequences of not receiving care in one's language.

identification of providers that can offer services in both official languages, collection of service users' linguistic variable as noted in their clinical record, etc.), communication and liaison tools, culturally and linguistically sensitive needs evaluation tools, coordination or service integration mechanisms (for example, a one-stop access point). These tools and mechanisms facilitate the seamless flow of service users between organizations and limit disruptions in continuity.

This framework therefore upholds that when all actors involved in these diverse structures work together in favour of minority official language service accessibility throughout the continuum, productive, quality and coordinated interactions will result and will lead to service users' and caregivers' **improved health and well-being**.

References

- Barr, V. J., Robinson, S., Marin-Link, B., Underhill, L., Dotts, A., Ravensdale, D. & Salivaras, S. (2003). The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. *Healthcare Quarterly*, 7(1), 73-82. doi:10.12927/hcq.2003.16763
- Bodenheimer, T., Wagner, E. H. & Grumbach, K. (2002). Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2. *JAMA*, 288(15), 1909-1914. doi:10.1001/jama.288.15.1909
- Bouchard, Louise, Marielle Beaulieu, & Martin Desmeules (2012). L'offre active de services de santé en français en Ontario : une mesure d'équité. *Reflets : revue d'intervention sociale et communautaire* 18(2), 38-65.
- Bouchard, L., Gilbert, A., Landry, R., & Deveau, K. (2006). Social Capital, Health, and Francophone Minorities. *Canadian Journal of Public Health*, 97, S16-S20.
- Bowen, S. (2015). Impact des barrières linguistiques sur la sécurité des patients et la qualité des soins. / The Impact of Language Barriers on Patient Safety and Quality of Care. Ottawa : Société Santé en français.
- Campinha-Bacote, J. (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, 13(3), 181-184; discussion 200-201. <https://doi.org/10.1177/10459602013003003>
- Champagne, F., Contandriopoulos, A.-P., Picot-Touché, J., Béland, F. & Nguyen, H. (2005). Un cadre d'évaluation globale de la performance des systèmes de services de santé : Le modèle EGIPSS. Montréal : Groupe de recherche interdisciplinaire en santé de l'Université de Montréal.
- Couturier, Y., Gagnon, D., Belzile, L. & Salles, M. (2013). La coordination en gérontologie. Montréal : Presses de l'Université de Montréal. Retrieved from <http://www.pum.umontreal.ca/catalogue/la-coordination-en-gerontologie/couverture>
- Forgues, É. & Landry, R. (2014). *L'accès aux services de santé en français et leur utilisation en contexte francophone minoritaire*. Moncton, NB : Institut canadien de recherche sur les minorités linguistiques (ICRML).
- Foucher, P. (2017). French-Language Health Services in Canada : The State of the Law (Chapter 3). In: Drolet M., Bouchard P & Savard J. (eds.) *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities*. Ottawa, ON: University of Ottawa Press, pp 77-98.

- Hindmarsh, M. (2013, January 29). The Chronic Care Model. www.theconference.ca. Retrieved May 6 2014, from <http://www.theconference.ca/index.php/topic-pages/conditions-and-diseases/obesity/41-conditions-and-diseases/330-the-chronic-care-model>
- Johnson, M. L. & Doucet, P. (2006). Une vue plus claire : évaluer la vitalité des communautés de langue officielle en situation minoritaire. Ottawa : Commissariat aux langues officielles du Canada.
- Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, 12(1), 18. <https://doi.org/10.1186/1475-9276-12-18>
- McCurdy, B., MacKay, C., Badley, E., Veinot, P. & Cott, C. (2008). A Proposed Evaluation Framework for Chronic Disease Prevention and Management Initiatives in Ontario. Toronto, Ontario : Arthritis Community Research & Evaluation (ACREU).
- Savard, J., Casimiro, L., Bouchard, P. & Benoît, J. (2017). Behaviours Demonstrating Active Offer : Identification, Measurement, and Determinants (Chapter 12) In: Drolet M., Bouchard P & Savard J. (eds.) *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities*. Ottawa, ON: University of Ottawa Press, pp 303-342.
- Savard, S., de Moissac, D., Benoît J. Ba, H., Zellama, F. Giasson, F. & Drolet, M. (2017). Recruitment and Retention of Bilingual Health and Social Professionals in Francophone Minority Communities in Winnipeg and Ottawa (Chapter 9). In: Drolet M., Bouchard P & Savard J. (eds.) *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities*. Ottawa, ON: University of Ottawa Press, pp 229-253.
- Tremblay, S., Angus, D. & Hubert, B. (2012). Étude exploratoire en matière de services de santé intégrés pour les communautés francophones (Rapport présenté au Réseau des services de santé en français de l'Est de l'Ontario.). Ottawa, ON : PGF Consultants Inc. Retrieved November 13 2016 from <http://www.rssfes.on.ca/files/uploads/rssfefiles/etude9nov12.pdf>
- Valentijn, P., Schepman, S., Opheij, W. & Bruijnzeels, M. (2013). Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *International Journal of Integrated Care*, 13(1 Jan-Mar), 1-12.
- Vézina, S. (2017). Active Offer, Bilingualism, and Organizational Culture (Chapter 10). In: Drolet M., Bouchard P & Savard J. (eds.) *Accessibility and Active Offer: Health Care and Social Services in Linguistic Minority Communities*. Ottawa, ON: University of Ottawa Press, pp 255-277.
- Wagner, E. H., Austin, B. T. & Korff, M. V. (1996). Organizing Care for Patients with Chronic Illness. *The Milbank quarterly*, 74(4), 511-544. doi:10.2307/3350391