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Groupe de recherche sur la formation professionnelle en santé et service social en contexte francophone minoritaire

HEALTH AND SOCIAL SERVICES FOR FRANCOPHONE SENIORS IN EASTERN ONTARIO AND MANITOBA:

GUIDELINES TO IMPROVE THE CONTINUITY OF FRENCH LANGUAGE SERVICES

RESEARCH REPORT

prepared by

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HIGHLIGHTS

In a minority language context, service continuity can be enhanced by favouring improvements in the liaison and coordination of French language health and social services.

Professional practices that support the continuity of health and social services for Francophone seniors living in a minority setting are: documenting the senior's language; implementing the active offer of French language services; networking among bilingual service providers; using directories of bilingual services and service providers; and a strong commitment to provide as many services as possible in French.

At the organizational level, access to French language services throughout the care trajectory is facilitated by: the provision of services in French by several agencies that are willing to collaborate and have formalized linguistic variable data collection practices; multidisciplinary care teams; interagency working tables; and shared communication tools.

The vitality of the Francophone minority community and the commitment of its members also foster integrated service delivery thanks to their innovative and collaborative initiatives with actors from social services and health care networks and the strong and trusting bonds built through shared interventions.

However, several barriers hinder the continuity of French language services, such as: the shortage of bilingual professionals and services, or the inadequate optimization of bilingual human resources; the lack of active offer, assessment tools, communication or collaboration; and the absence of a formal intersectoral French language resources directory. Other barriers include the lack of understanding of the impact of language barriers on access to safe, satisfactory and quality care for Francophones living in a minority situation, as well as lack of leadership in implementing strategies that promote collaboration and continuity.

The proposed recommendations emphasize the importance of adopting policies that consider the linguistic variable in service organization. They also highlight the need for an organizational structure that values and ensures leadership on this matter, establishes formal collaborative agreements between designated institutions, fosters networking among various Francophone actors in both social services and health systems, while promoting an active offer of French language services essential for safe and quality care.

Strengthened by the vitality of the Francophone minority community and the commitment of its members, it is entirely conceivable that continuity of French language health and social services becomes a reality.

SUMMARY

For many Francophone seniors living in Eastern Ontario and Manitoba, access to French language health and social services is critical because of this population's sociodemographic profile, precarious state of health and need to communicate in their mother tongue. In many instances, Francophone seniors and their caregivers[2] refrain from asking for French language services for fear of delaying access to services they need. Francophone seniors in minority settings face considerable obstacles in accessing care and services in French, particularly when they must deal with several service providers. Health and social service organizations' staff and professionals[3], even Francophones, frequently have little knowledge of services available in French. For many years and across Canada, efforts have been made toward needs-based service integration for seniors. Access to French language services throughout the continuum of care (e.g. acute care, primary healthcare, community social services) has only recently been highlighted as a main feature of integrated health and social services. However, our previous research on the needs of Francophone seniors has revealed key gaps in the continuum of French language services. Thus, we deem it essential to explore how service organization can facilitate system navigation and reduce fragmentation in service delivery.

This participatory community study was conducted in Eastern Ontario and Manitoba. Our partners included Francophone seniors and their caregivers as well as bilingual service providers and managers from institutions that are either designated Francophone, or bilingual, or provide services to a Francophone clientele. Through individual interviews and focus groups with 25 managers, 37 health and social service professionals and 48 seniors and caregivers, we were able to identify formal and informal mechanisms promoting clinical integration of health and social services intended for Francophone seniors living in linguistic minority settings.

Data analysis was carried out using a framework developed by the *Groupe de recherche sur la formation professionnelle en santé et en service social en contexte Francophone minoritaire* (GReFoPS) (Savard et al., 2017) to map relationships between various actors who influence the trajectory of health and social services in official language minority communities. It draws on health and social services system models found in the literature. This framework was used to develop guidelines for the implementation of clinical practices aimed at fostering French language health and social service continuity within Francophone minority communities. An illustration of this framework can be found on page 20 of this report. An overview of its key features follows.

This framework conceptualizes health and social services as an organized system of actions, within an actual context, at a given point in time. 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 objectives and their own purposes. This interaction takes place 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).

2 Informal caregivers refer to those who, informally and without pay, assist a Francophone senior throughout the health and social services trajectory.

3 The terms *professionals* and *service providers* are used interchangeably throughout this report.

These structures frame the service trajectory in which two main groups convene: a) service providers, and b) users. A user is frequently supported by one or more caregivers, who may or may not participate in all encounters along the service trajectory. Throughout the trajectory, a productive interaction calls for collaboration between users, caregivers, as well as health and social service providers. It also requires coordination among all services a person will need. In an official language minority community, access to services in one's preferred official language throughout the continuum enhances not only the experience along this trajectory, but also health outcomes. Various linguistically appropriate clinical tools, professional practices, care processes and information systems can facilitate French language service continuity.

Some research participants noted examples of behaviours or formal and informal service provider practices that support the continuity of French language health and social services, such as: networking; the use of directories of bilingual services and service providers; the Active Offer[4] of services in French; and a genuine commitment among bilingual service providers to provide seniors who so desire as many services as possible in their language.

At the organizational level, these practices are supported by: the presence of multiple French language services; several agencies that are designated bilingual or provide services in French; cooperation between some of these agencies; formalized linguistic variable data collection practices; working tables; and communication tools, which are often computerized and enable timely information-sharing. As for integration, one promising avenue is the emergence of organizations that bring together French language multidisciplinary teams under one roof to provide a greater range of services to Francophone seniors and caregivers.

The vitality of the Francophone minority community and the commitment of its members strengthens these continuity mechanisms. Participants demonstrated heartfelt enthusiasm for innovation and collaboration, especially among key actors who find it important to improve French language services for seniors. These leaders have built trusting relationships with bilingual service providers or managers, thus fostering consultation, dialogue and mutual support.

However, participants also perceived several barriers to the continuity of French language health and social services. At the care provider level, there is limited active offer provided by bilingual staff, a lack of assessment tools in French and no formal intersectoral directory of French language resources. Taken together, these factors hinder the provision of French language services throughout the continuum.

At the organizational level, the lack of bilingual service providers or the insufficient optimization of bilingual human resources is observed, along with a shortage of bilingual services, especially in communities with small Francophone populations. In a complex and fragmented health and social service system, the lack of shared communication tools between the social and health sectors leads to delays and overlaps in assessments, care and services. Financial structures and organizational cultures differ from one agency to another and few mechanisms or formal intersectoral agreements promote resource distribution to ensure the continuity of French language services. Furthermore, the precarious funding of Francophone community social and health service organizations is a substantial issue. Another significant shortcoming appears to be the lack of leadership in implementing strategies to promote the active offer of these services on a continuum.

4 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)

From a political and regulatory perspective, policy developers rarely consider the issue of minority official language in developing service continuity policies. With respect to the symbolic structure, lack of understanding of the impact of language barriers on access to safe, satisfactory and quality care persists.

While conducting this research, we found that current approaches to continuity in the delivery of French language health and social services in a minority context are much more akin to liaison and coordination mechanisms[5] than full integration. Continuity, a dimension of integration, can come into play at several levels when managing services, sharing information and building relationships between service providers, users and their caregivers. Therefore, it would be wise to engage actors from all levels to co-construct mechanisms aimed at improving service continuity, while enhancing liaison and coordination among French language services designed for Francophone seniors and their caregivers.

5 These concepts are defined on page12 of this report.

GUIDELINES TO IMPROVE THE CONTINUITY OF FRENCH LANGUAGE HEALTH AND SOCIAL SERVICES

Our guidelines set out thirteen recommendations to improve the continuity of French language health and social services. These recommendations draw on suggestions from study participants as well as members of the Advisory Committee and the research team. They relate to various components of the analytical framework that guided this research.

Francophone, Francophile and Anglophone Service Providers

1. Gain the knowledge and skills required to practice active offer.
2. Contribute to service providers' enthusiasm and sense of belonging to the Francophone community.
3. 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.

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.

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.

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.

Symbolic Structure (values)

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 Francophone seniors' participation when looking for solutions to improve the continuity of their intended health and social services.

These proposed recommendations underscore the importance of adopting policies that consider the linguistic variable in service organization. They also highlight the need for an organizational structure that values and ensures leadership on this matter, establishes formal collaborative agreements between designated institutions, fosters networking among various Francophone actors throughout the health and social services systems, while promoting an active offer that is evidence-informed and promotes safe and quality care. They emphasize the role of service providers and communities in maintaining this dynamic and collaborative spirit. Strengthened by the vitality of the Francophone minority community and the commitment of its members, it is entirely conceivable that the continuity of French language services becomes a reality.

INTRODUCTION

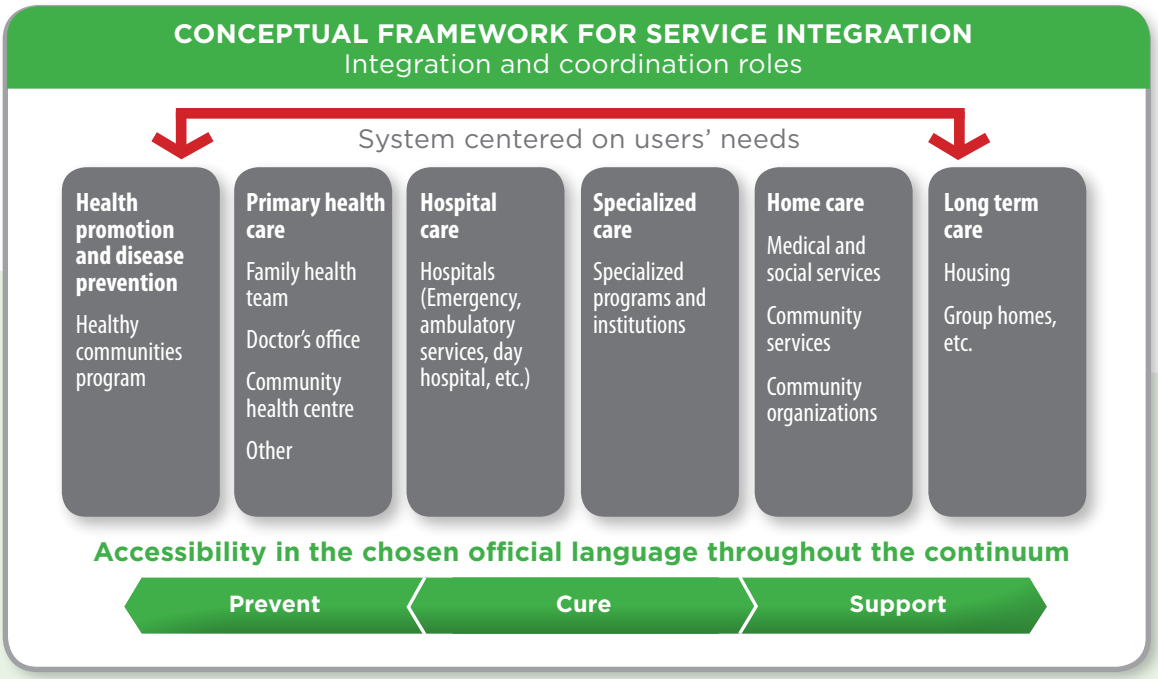
This research was conducted in two Canadian provinces where Francophones live in a minority context, namely Eastern Ontario and Manitoba. Its intent was to explore health and social service organization and factors that facilitate navigation throughout the continuum of French language services for seniors. As a participatory community research project, it involved partners such as Francophone seniors, bilingual service providers and managers from health and social service settings. Through individual interviews and focus groups, we sought to map current formal and informal mechanisms that if disseminated and replicated, could assist service integration for this population. Coordination practices ensuring linguistic service continuity and barriers to this continuity were also explored. The study's main objective was to co-construct guidelines that foster continuity and integration of French language health and social services for Francophone seniors living in minority settings across Canada.

This report begins by a brief definition of service integration and various levels of integration as described in the literature, followed by background information on how, in the two regions, health and social services for seniors are organized, as well as issues that are specific to Francophone seniors who live in minority communities. The next section introduces the *Framework for the analysis of health and social services access and integration for official language minority communities* developed by the GReFoPS. This is followed by research objectives and questions, along with data collection methods and tools developed for the study. Results are discussed as themes emerging from Francophone seniors', service providers' and health and social services managers' perspectives. In the discussion, various trends observed in the coordination between bilingual service providers, institutions, programs and health and social services intended for seniors are highlighted. Guidelines to foster the continuity of French language services are then proposed for each dimension of the previously outlined analytical framework. These guidelines were developed through consultations with participants as well as members of the Advisory Committee and the research team.

Integrated Health and Social Services

Although there is no single definition of *integrated health and social services*, this notion's purpose is to position the individual and informal caregivers at the core of the health and social service system (Tremblay, Angus & Hubert, 2012). These authors proposed an integrated service model that considers the linguistic dimension. We adopted this model, as did the Société Santé en français (2012), a leader among the Francophone minority.

Figure 1. Conceptual Framework for Service Integration (Tremblay et al., 2012, p. 10)[6]



Service integration can come into play at three levels: legislative, administrative or clinical.

From a clinical perspective, integration takes place in three ways: through full integration, coordination or liaison (Leutz, 1999). Full clinical integration targets seniors who experience severe or moderate loss of autonomy as well as health conditions that require long-term care. It mobilizes multidisciplinary teams which can provide: a wide range of care and services to the individual; case managers who handle transitions between care and services; and computerized records entirely shareable between levels of care and providers (Leutz, 1999). This type of integration requires an administrative structure for managing resources and funding the entire continuum of services and care (Kodner, 2009).

Coordination, which is our study's focus, targets individuals, caregivers and service providers by planning care and service provision in the least fragmented way possible (Curry & Ham, 2010; MacAdam, 2008; Solinís, 2008; Valentijn, Schepman, Opheij, Bruijnzeels, 2013). Coordination is particularly aimed at seniors who experience diminished autonomy: those who have considerable functional impairment, who are at risk of frequent hospitalization and placement (Lafortune, Béland & Bergman, 2011) and who, in the short and long term, use a larger share of health and social services. Coordination can be defined as a structured and interorganizational approach that includes: 1) shared objectives; 2) common tools and mechanisms that foster communication, information-sharing and collaboration between various levels; 3) administrative processes and assessment criteria for direct service provision (Lafortune et al., 2011; MacAdam, 2011 and 2008); and 4) local ownership allowing partners and local service providers to negotiate and create regional solutions for improved access to French language services (MacAdam, 2011; Hubert et al., 2012).

As for liaison, it refers to a level of clinical integration that is more suited to seniors with mild to moderate loss of autonomy (Leutz, 1999). At this level, relationships between providers are less formalized than they are at the coordination level and evolve on a more ad hoc basis, depending on the constraints of health and social service systems (Kodner, 2009, p. 12). For example, liaison takes place when an intake worker from a community service centre identifies a senior's emerging needs, refers this person to health and social services that could be of assistance, and briefly follows up to determine whether the person has been taken care of.

6 Used with the permission of Tremblay, S., Angus, D., Hubert, B. and the French Language Health Services Network of Eastern Ontario and freely translated from the original French.

Background on Health and Social Services

In Eastern Ontario

In Ontario, the 1986 *French Language Services Act* (Office of the French Language Services Commissioner, 2009) confers upon members of the public the right to receive services in French from the provincial government ministries and agencies in 26 designated areas, such as the Champlain region.[7] However, para governmental organizations, such as hospitals, Children's Aid Societies and long-term care facilities for seniors that are partially supported by public funds, are not automatically subject to the *French Language Services Act*; they may voluntarily ask to be designated. This designation can be complete or partial (meaning that designation may target some of the organization's services or programs).[8] Furthermore, in some cases, institutions may be strongly advised to ask for designation by the Local Health Integration Networks (LHIN) and their regional French Language Health Planning Entity. French Language Health Planning Entities[9] are mandated to advise the LHINs about the organization of French language services in their region (Ministry of Health and Long-Term Care, 2016), while LHINs aim to improve coordination and concertation within Ontario's health system. For this purpose, they have the authority to allocate most resources in their region, except for physicians, who are regulated under the Ontario Health Insurance Plan.

In Eastern Ontario, health and social service organization increasingly tends to collaboration and team work, as in the case of family health teams and community health centres. In such instances, a family physician, social worker or community nurse may take charge of coordinating care. Case managers from Community Care Access Centres (CCACs)[10] coordinate publicly funded home-care services and admission to long-term care facilities (Government of Ontario, 2012). In some instances, family physicians working in solo practice also monitor seniors' health. In these cases, the quality of care coordination rests on one person's knowledge about the resources provided by the health and social service system.

In Ottawa, there are two specialized bilingual community geriatric services. The Geriatric Psychiatry Community Services of Ottawa provides case management services to individuals who are 65 years and older living with mental health issues or dementia associated with behavioural problems. The Geriatric Assessment Outreach Team provides comprehensive assessments of seniors experiencing a loss of autonomy and recommends or refers individuals to the specialized services they require (Regional Geriatric Program of Eastern Ontario, 2017a; Geriatric Psychiatry Community Services of Ottawa, 2011).

Several recently implemented programs target seniors with more complex needs who live in rural or urban areas throughout the Champlain region. In some areas, these services are available in French:

- Health Links, at its initial implementation at the time of this study, brings together an array of health and social service providers with a view to designate one provider to take on the coordination role for the most frequent service users (Ministry of Seniors' Affairs, 2013);
- Geriatric Emergency Management provides rapid screening of seniors who present to emergency, identifies those who are at risk and refers them to specialized geriatric assessments and home support services (Regional Geriatric Program of Eastern Ontario, 2017b); and
- Primary Care Outreach to Seniors, a model of continuous community care provided by a registered nurse and a community health worker, is intended for at-risk and isolated seniors. These services are located in community health or resource centres across the Champlain region (South-East Ottawa Community Health Centre, 2013).

7 The Champlain geographical area refers to a large part of the Ottawa Valley, located in Eastern Ontario. See map on page 27, Figure 3, as well as http://www.champlainlhin.on.ca/AboutUs/GeoPopHlthData/Geography.aspx?sc_Lang=en

8 For a list of designated or partially designated organizations in Eastern Ontario, please see http://www.rssfe.on.ca/en/resources/find-services/designated-and-identified-organizations/.

9 The French Language Health Planning Entity for Eastern Ontario is the French Language Health Services Network of Eastern Ontario (the Réseau). http://www.rssfe.on.ca/en/about-us/the-reseau-at-a-glance/.

10 In December 2015, the Ministry of Health and Long-Term Care proposed the dissolution of the CCAC boards and their assimilation into the LHINs; these changes took effect in 2016. http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf

In Eastern Ontario, a promising model of bilingual integrated health and social services is currently being developed in Orléans. Known as the Orléans Health Hub, this organization "will bring a wide range of specialized and community healthcare services under one roof[11]". Community services (home support, day programs), as well as assessment services and specialized geriatric care will be provided to seniors. This project is funded by Ontario's Ministry of Health and Long-term Care and is headed by the Hôpital Montfort.

For their part, community services are located in some 60 agencies across the Champlain region (Ottawa Community Support Coalition—Coalition des services de soutien communautaire d'Ottawa, 2013; Community Support Coalition—Renfrew County & Area, n.d.). Community services may be provided by resource centres, support centres or community health centres or other agencies. Available services (e.g. meals on wheels, day programs, home support, friendly visits, transportation, and respite for caregivers) vary between agencies. It should be noted that seniors or caregivers can access social and community services without these being coordinated with primary or hospital care.

The *Going Home* program provides home support services for a maximum of ten days following a hospital stay. It is coordinated either by a Geriatric Emergency Management nurse or by the hospital discharge planner, in collaboration with the community support organization that provides these services (Community Information Centre of Ottawa, 2016).

Private agencies also deliver home care such as physiotherapy, foot treatment and other personalized medical care. As these agencies are private in nature, coordination with other health and social services is left to seniors or their caregivers.

Hence, health and social service delivery in Eastern Ontario, as throughout the province, uses a "fragmented approach" (Local Health Integration Network, 2016). There is no one-stop access point. As a result, an older adult or a caregiver may not know where to go for help. They may well access services at different agencies (e.g. community resource centre, physician, CCAC), but coordination between these agencies is not guaranteed.

In Manitoba

At the provincial level, the French-Language Services Policy's purpose is to allow Manitoba's Francophone population to access comparable government services in the language of Manitoba's laws, either French or English (Francophone Affairs Secretariat, 1999). This policy pertains to several areas: in health and social services, it applies to designated bilingual health facilities and regional health authorities (RHAs). Four out of the five regional authorities are designated. The *Regional Health Authorities Act* (Government of Manitoba, n.d.) requires that every five years, designated bilingual RHAs submit a French language services plan for approval.

As in Ontario, the organization of health and social services in Manitoba favours collaboration. In Winnipeg, seven access centres, managed by the Winnipeg Regional Health Authority (WRHA), are geographically distributed and bring together several government programs and services under one roof: primary care, public health, mental health, employment and income support, education and care for young children, professional rehabilitation program, community living services and homecare (Government of Manitoba, n.d.). These centres serve as one-stop access points to inform the community and support its development. Interagency collaboration is fostered by facility proximity and the organization of services by community regions. Such a centre has been inaugurated in 2016 in the Francophone neighbourhood of St. Boniface and is mandated to serve the city of Winnipeg's Francophone community.

11 https://hopitalmontfort.com/en/orleans-health-hub

Service delivery by care teams is also encouraged. Along with interdisciplinary service provider teams in community health centres, care teams are standard practice in home support, day centres for seniors and long-term care centres. A senior is frequently taken care of by a main service provider, either a community nurse or social worker, who coordinates services. Care teams often include physicians, nurses, dieticians, physiotherapists, occupational therapists and social workers. Within these teams, referral to other healthcare professionals and sharing of relevant information about a patient is straightforward.

For older adults whose primary service provider is a family physician in private practice, several care teams are available to help physicians support patients efficiently:

- The Shared Care Program enables referrals to mental health specialists (Winnipeg Regional Health Authority, n.d.-b).
- A recent initiative, My Health Team, fosters coordination of client-centred care if family physicians are part of such a health team, as they are able to tap into a multidisciplinary team of health professionals (Winnipeg Regional Health Authority, 2017).
- The Winnipeg Integrated Services project brings about the integration of government services from the WRHA, Manitoba Family Services and Housing Manitoba for seniors living with disabilities.
- The PRIME program, supported by an interdisciplinary care team, is also available for seniors with complex health problems and potential need for admission to long-term care homes (Winnipeg Regional Health Authority, n.d.-c).

Finally, a few interdisciplinary teams provide community geriatric assessment services, either through the Geriatric Program Assessment Team or the Geriatric Mental Health Team (Winnipeg Regional Health Authority, n.d.-e). Referrals to this assessment service can be made by healthcare professionals or family members.

The homecare agency managed by the WRHA is mandated to coordinate services for seniors with loss of autonomy (Winnipeg Regional Health Authority, n.d.-f). As such, seniors and their family members receive considerable support: they are assigned to a case manager, often a social worker who coordinates health and social care with the family physician and housing services. Referrals to a day program for seniors, the PRIME program, or respite services are carried out by the case manager. In addition, the case manager is responsible for transitions to hospitals or long-term care facilities, although admittance to a long-term care home as such is coordinated by the Long Term Care Access Centre (Winnipeg Regional Health Authority, n.d.-a).

Several housing facilities with support services assist seniors experiencing loss of autonomy. Besides meal and home maintenance services, some housing facilities also supply residents with medical services, medication delivery and recreational activities. For seniors registered for homecare services, coordination of services is assumed by the case manager. Otherwise, seniors and their family members are responsible for such coordination.

Profile of Francophone Seniors Living in Minority Settings

Recent Canadian studies report that Francophones living in minority settings age proportionally faster than the Canadian population as a whole (Bouchard et al., 2015). Over the past decades, this phenomenon has increased considerably. A recent data analysis of the Canadian Community Health Survey (van Kemenade, Bouchard & Bergeron, 2015) indicates increased use of home care and other services among a large proportion of Francophone seniors, especially Francophone women. However, these services are not always available in both official languages, nor are they provided coherently throughout the continuum of health and social services (Bouchard, 2012; de Moissac, 2016). As a result, 50 to 55% of Francophones living in a minority setting have no or very limited access to French language services (Bouchard, Gaboury, Chomienne, Gilbert & Dubois, 2009).

Seniors often deal with complex health issues. According to Statistics Canada (2009), 75% of Canadian seniors have at least one chronic condition such as diabetes. The minority-majority relationship exacerbates existing disparities created by certain social determinants of health (Bouchard et al., 2009; Chartier et al., 2015; Forgues, Doucet & Noël, 2011) such as irregular access to French language services and a tendency to delay care. Indeed, because of their characteristics, Francophone seniors living in a minority situation demonstrate several vulnerabilities that Lemonde, Boudreau and Dufour (2012) consider to be influential for health and social service access: aging, chronic disease, cognitive changes, as well as socioeconomic, linguistic and literacy issues.

Paradoxically, seniors from minority groups are in greater need of health and social services: in addition to higher rates of aging, Francophone seniors report poorer physical and mental health than their Anglophone counterparts. Previous research (Drolet et al., 2015; Drolet et al., 2017) demonstrates that Francophone seniors living in a minority context who have access to French language services nonetheless encounter breakdowns in linguistic continuity when several service providers participate in service delivery. Furthermore, service providers within health and social service organizations, even if Francophone, often have little knowledge of services available in French, thus 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).

Francophones in minority contexts often hesitate, for many reasons, to ask for services in their own language. Given the shortage of services available in French, some get discouraged and stop looking, preferring to use English services that are readily available nearby (de Moissac, 2016). Others fear their request may cause delays in accessing care (Drolet et al., 2014). Historical forces of assimilation have continued to influence seniors in particular; requesting services and filing a complaint when services are not available in French are not common practice (de Moissac, Giasson & Roch-Gagné, 2015). It is worth noting that more than 20% of Francophones living in minority situations will not seek care because of language barriers (de Moissac, 2016). In fact, the literature clearly demonstrates that language barriers have a substantial impact on accessibility, safety, satisfaction and quality of health services (Bowen, 2015; Schwei et al., 2016).

Caregivers

Caregivers, in this report, refers to those who, informally and without pay, assist a Francophone senior with health and social services. It is recognized that caregivers, often family members, require long-term support in carrying out this role (Lopez-Hartmann, 2012). Caregivers must often perform multiple tasks including *"mobilisation and advocacy for services and other resources, mediation with various professionals, control of the quality of the care, [and] decision-making for the person"* (Guberman, 2010, p. 4). In Ontario, one of the most critical issues raised by informal caregivers regarding their role is that of speaking on behalf of their loved ones and defending their rights throughout the service trajectory (The Change Foundation, 2012). This journey becomes even more difficult for Francophone seniors and the caregiver's role gains even greater importance because of additional issues generated by language barriers (Drolet et al., 2015).

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

Our *Framework for the analysis of health and social services access and integration for official language minority communities* (Savard et al., 2017) aims to map relationships between the various actors who influence the health and social service trajectory in official language minority communities. This framework draws on some health and social service system models found in the literature. We will briefly outline said literature and then address the analytical framework we developed and used to analyze our results.

Champagne, Contandriopoulos, Picot-Touché, Béland & Nguyen (2005) consider that health and social service systems are a set of organized actions within an actual geographical context, at one point in time, and in which various structures define a social space where four major groups of actors interact (service providers, managers, business world and political world) to reach one or more common objectives for reducing 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. However, key players are absent: service users and their caregivers.

The Chronic Care Model, developed by Wagner and his colleagues in 1996, and its variation known as the Expanded Chronic Care Model (Barr et al., 2003; McCurdy, MacKay, Badley, Veinot & Cott, 2008) inform us on interactions between professionals who provide services and individuals who use these services. According to this model, establishing a dynamic relationship between the service provider

(physician/health and social services team) and the service user (and caregivers) improves service quality, facilitates the adoption of the user and caregiver needs-based approach, and achieves better results (Bodenheimer, Wagner & Grumbach, 2002). Productive interaction and collaboration between these two partners (service provider and user) alters the long-held paradigm of emergency or short-term health care, which is that of the expert service provider and the passive user (Bodenheimer et al., 2002). According to this model, the service provider becomes proactive, open to networking and a multi-pronged approach. The user and caregiver are better informed and equipped in managing chronic health problems; they are also invited to be proactive and make changes to their behaviours and living conditions (Wagner et al., 2001). Consequently, the combination of 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, creating favourable living environments, reinforcing community action and designing public policies that benefit health and well-being (Barr et al., 2003).

Given the rise in aging and chronic disease, individuals dealing with health issues will more likely need the assistance of several health and social service providers from both institutional and community networks. Integration mechanisms are therefore required for a seamless trajectory, as described in the conceptual framework for service integration (Tremblay et al., 2012, p. 10), displayed in Figure 1 (p. 12). Others (Couturier, Gagnon, Belzile & Salles, 2013; Leutz, 1999) propose three process flow models of clinical integration. These three models of clinical integration, briefly referred to on page 12 are: a) liaison; b) coordination; and c) full integration. Liaison includes building bridges between different organizations, developing interagency protocols, ensuring efficient flow of users between various organizations, and using tools that promote sharing among organizations. Coordination includes formal mechanisms to mitigate breaks in continuity, such as working tables, a centralized access point, standardized and multidimensional assessment tools, shared personalized planning tools for interventions and a computerized information system that facilitates information exchange. In this model, the case manager is the preferred contact point for seniors and caregivers in the integrated network. Full integration is the ultimate level, where all services are provided by a single organization or entity. According to Couturier et al. (2013), its sustainability depends on the scope of service coverage. We believe that these models and their related mechanisms can foster linguistic service continuity throughout the social and health service trajectory.

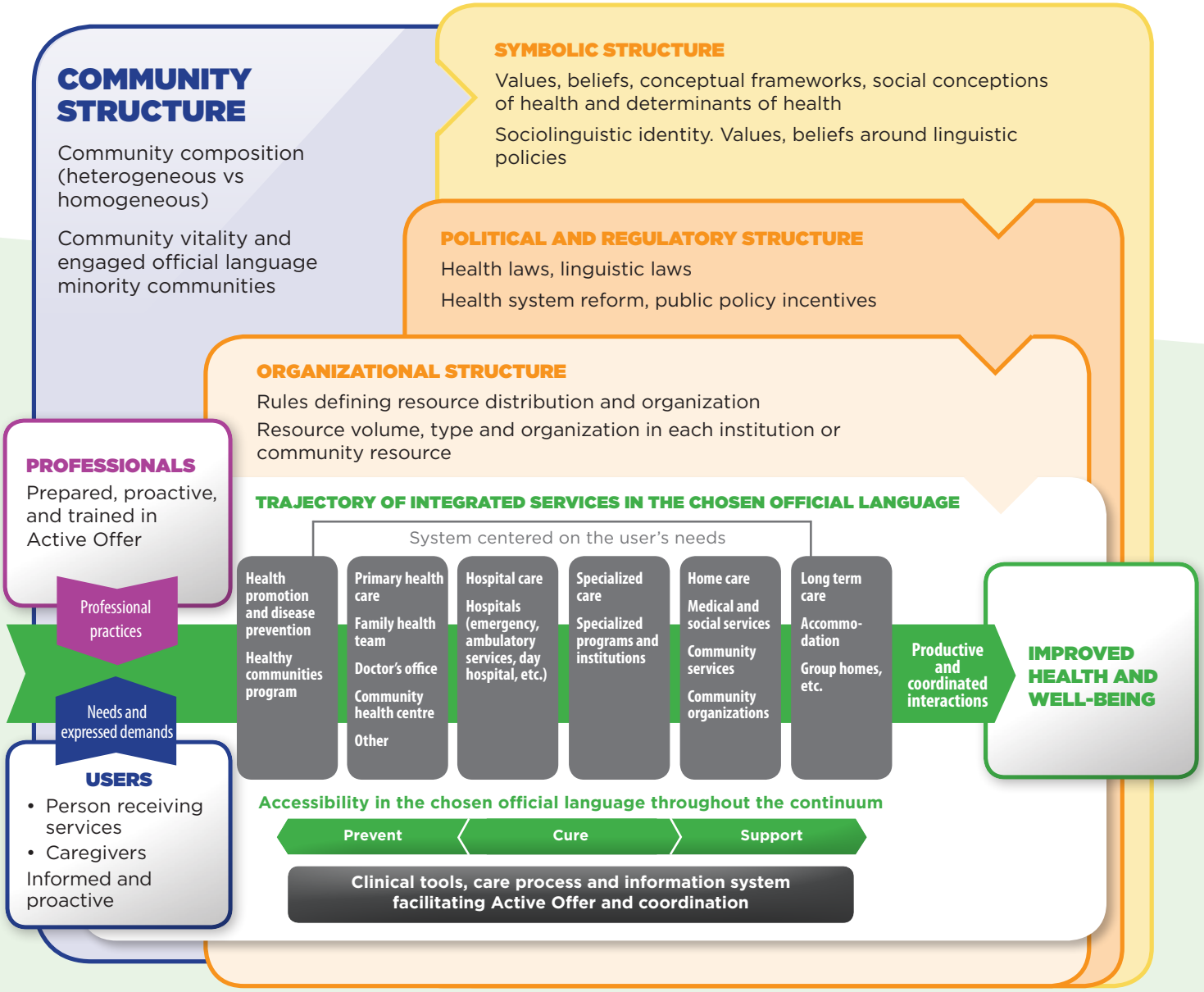
We developed our analytical framework by performing an iterative comparison of the concepts and models outlined above with data from our previous studies (Figure 2, p. 20); it will guide the presentation and discussion of our results and help develop guidelines for the implementation of clinical practices aimed at fostering the continuity of French language health and social services within Francophone communities living in a minority context. Our analytical framework considers the health and social service system as an organized system of actions where 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 (associated with values), community (composition and resources), political and regulatory (related to laws and regulations) and organizational (resource distribution and organization). Their actions (professional practices, care and service processes, expressed needs and requests) are drawn from prior experiences and help define the progression along the service trajectory. Clinical tools and information systems also influence these actions, as they can either facilitate or hinder service continuity.

Among the tools that may have an influence on the implementation of an integrated service trajectory in French, we find: those that promote the active offer of services in both official languages (e.g. identifying service providers who can provide services in both official languages, collecting data on users' linguistic variable and recording it in clinical files, etc.); tools related to information and liaison; culturally sensitive assessment tools; planning tools that promote user commitment; coordination; and lastly, service integration processes (e.g. one-stop access point). These tools and processes enable users to flow in a seamless fashion between organizations, thus reducing breakdowns in continuity.

In summary, this framework maintains that when all actors from various structures work together to promote access to French language services throughout the continuum, productive, coordinated and quality interactions will result, which will in turn lead to improved service user and caregiver health and well-being.

Figure 2.

Framework for the analysis of health and social services access and integration for official language minority communities



Source: Savard J. et al. (2017). http://www.grefops.ca/cadre_analyse_en.html. Inspired from : Barr et al. 2003; Champagne et al. 2005; Couturier et al. 2013; Tremblay et al. 2012.

Research Objective and Questions

This project's main objective is to identify formal and informal networks created by bilingual health and social service providers in two regions, Eastern Ontario and the region of Winnipeg, and to co-construct guidelines that would foster the continuity and integration of French language services provided to Francophone seniors living in a minority context.

The research questions include:

1. Are there formal coordination mechanisms for care and services provided to seniors or their caregivers which integrate the linguistic variable to ensure the continuity of French language services?
2. In the absence of formal mechanisms, what informal mechanisms are currently in place?
3. Which factors promote the implementation of formal or informal networks?
4. Which facilitators enhance service continuity and system navigation for Francophone seniors and their caregivers living in a minority context, and particularly within services that are available in French?
5. What are the success factors and best strategies and practices to promote networking among services intended for Francophone seniors and their caregivers living in a minority context?
6. What are the main obstacles that limit or hinder networking between health and social services intended for Francophone seniors living in a minority context?
7. How can ongoing knowledge transfer be ensured between research and practice communities?

These questions were addressed during individual interviews and focus groups with Francophone seniors, service users, their caregivers, as well as service providers and managers from various institutions and organizations that deliver health and social services to their senior clientele.

METHODOLOGY

Research Method

A participatory community research approach (Israel, Eng, Schulz & Parker, 2013; Minkler & Wallerstein, 2008) was adopted for this study. This well-known approach brings together researchers, organizational representatives and community members who participate throughout the research and dissemination process. It aims to: 1) increase understanding about a phenomenon; 2) root it in a community's social and cultural dynamic; and 3) integrate this knowledge into action. Active community participation enables rich and accurate descriptions and develops congruence between research and the local reality, the methodology and promising strategies and practices. Representatives from the Fédération des aînés et des retraités francophones de l'Ontario (FARFO) régionale d'Ottawa, the French Language Health Services Network of Eastern Ontario (sometimes referred to as the *Réseau* in this report), the Hôpital Montfort and the Centre de santé communautaire de l'Estrie formed the advisory committee and collaborated in all stages of this project.

Types of Participants

Following ethics approval from the University of Ottawa, the Université de Saint-Boniface and social and health services organizations in Eastern Ontario, informed consent was obtained from participants. Individual interviews and focus groups were conducted with three types of participants: 1) managers from social services or health care organizations and institutions that have a Francophone clientele or are able to provide services in French; 2) health and social service providers[12] 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

Study Areas

Research was conducted in four types of areas in Eastern Ontario:

1) An urban area with a high Francophone population density (13%, Ottawa Centre and 31%, Ottawa East);

2) An urban area with a low Francophone population density (7%, Ottawa West);

3) A rural area with high Francophone population density (42%, Champlain East—specifically the county of Prescott-Russell); and,

4) A rural area with a low Francophone population density (5%, Champlain West—specifically Renfrew County) (LHIN, 2016).

Targets for recruitment were determined with the help of the Advisory Committee; this included service providers and managers, who provide or can provide French language services or key services (bilingual or Francophone) to seniors.[13] Invitations were sent by letter to managers, then, following the interview with managers, to service providers. Invitations were also sent directly by mail to physicians; however, they were more difficult to recruit. An invitation to seniors and caregivers was relayed by various Francophone organizations. Recruitment proved to be a challenge in urban environments with a low Francophone population.

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12 The types of participating service providers were, for the most part: physicians, nurses, dieticians, physiotherapists, occupational therapists, social workers, community health workers, community workers, program assistants, support workers; a few participants were administrative support workers (secretaries).

13 In Eastern Ontario: community health centres, community service or resource centres, hospital geriatric or outpatient departments and community services specialized in geriatrics.

Interviews with managers and service providers were held in their workplace; interviews and focus groups with seniors or their caregivers were held in locations made available by Francophone community organizations. Individual and group interviews were conducted in French or in English, depending on participants' preference. Most of the interviews and focus groups were conducted by the research associate and one of the principal researchers. Two senior and caregiver focus groups (n=9) and four interviews (n=4) were conducted by students in the Master of Social Work program, under the supervision of a member of the research team. All interviews and focus groups were audio-recorded and fully transcribed.

INTERIM MAP OF CHAMPLAIN LHIN SUB-REGIONS

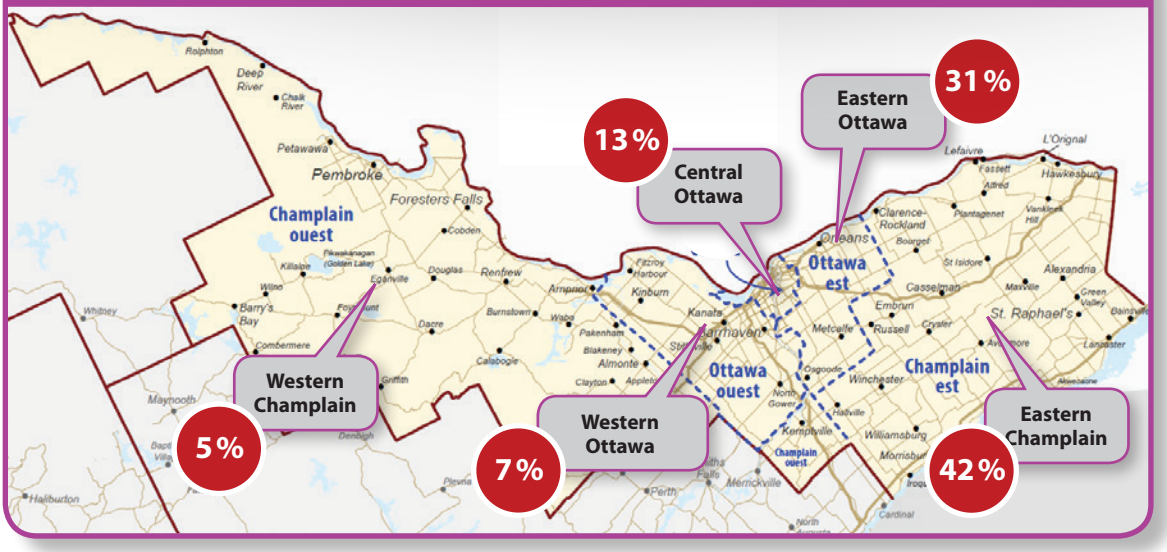

Figure 3. Map of the Eastern Ontario Study Area; yellow labels indicate the percentage of Francophones in study areas.

Reference: LHIN (2016) *Champlain Sub-Regions Consultations.* http://www.rlisschamplain.on.ca/GoalsandAchievements/OurStratPlan/SubRegions.aspx?sc_Lang=en accessed on October 6, 2016.

Table 1. Interviews and Participants in Eastern Ontario (ON)

Semi-structured individual interviews (ON)

Type of participants	Number of interviews	Number of participants
Managers	17	19
Service providers	4	4
Seniors/caregivers	6	6

Focus groups (ON)

Type of participants	Number of interviews	Number of participants
Service providers	5	23
Seniors/caregivers	7	31
Total	39	83

Data Collection in Manitoba

Study Areas

In Manitoba, the research was conducted mainly in the federal electoral district of St. Boniface in the City of Winnipeg, as most French language health organization head offices are in this area. According to the 2011 census data (Statistics Canada, 2012), the Francophone (French as first official language) population density was 13.2% compared to 3.5% for the whole province. In St. Boniface, people aged 65 and over account for 16.7% of the entire population, all languages combined, as compared to 14.3% for the province (Statistics Canada, 2012).

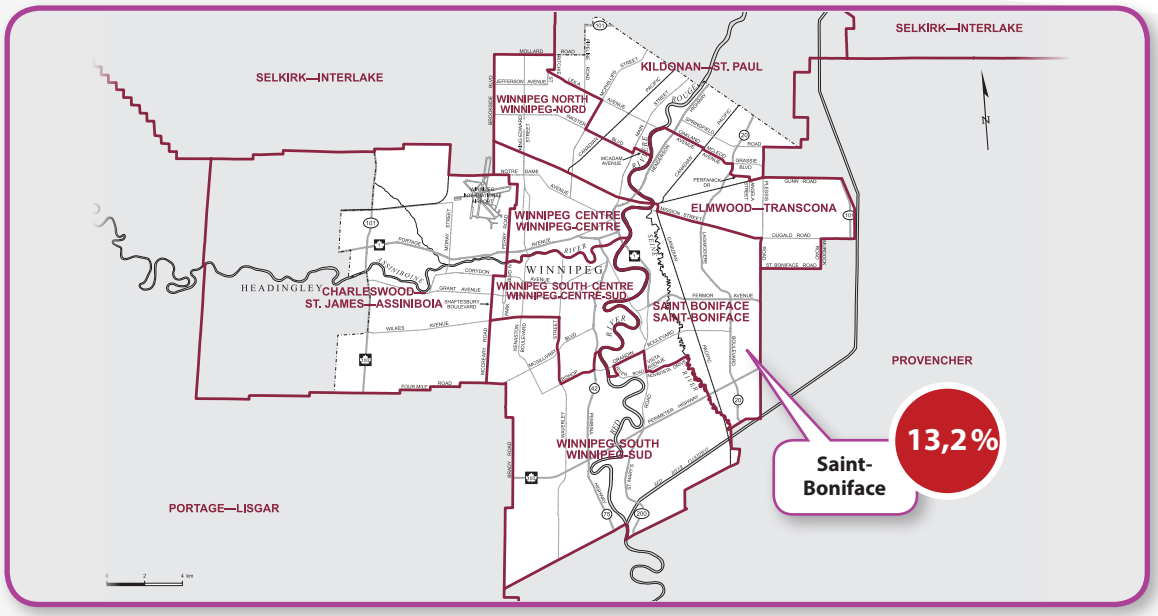

Figure 4. Map of Winnipeg; the yellow label indicates the percentage of Francophones in the district of St. Boniface.

Reference: Elections Canada, http://www.elections.ca/res/cir/maps/mapprov.asp?map=46902&prov=46&b=n&lang=e accessed on January 6, 2017.

Seniors and caregivers were recruited during an event organized by the Fédération des aînées et aînés franco-manitobains and through an email invitation via French community organizations. Recruitment of service providers and managers from institutions that support Francophone seniors was achieved by means of prior contacts established during other research projects and through a snowball effect. Invitations to participate in individual or group interviews were sent by mail or email to potential participants, with follow-up telephone calls. Types of services targeted for participant recruitment were: the neighbourhood Access Centre (including a community health centre and the WRHA's government agency responsible for homecare); a bilingually designated long-term care facility with a day centre for seniors; a hospital with a day centre for seniors; and an assisted living housing complex for seniors. Focus groups were conducted at the Université de Saint-Boniface, while individual interviews with caregivers, service providers and managers were held in their workplace. Discussions, facilitated by two researchers from the St. Boniface project team, were audio-recorded and fully transcribed.

Table 2. Interviews and Participants in St. Boniface, Manitoba (MB)

Semi-structured individual interviews (MB)		
Type of participants	**Number of interviews**	**Number of participants**
Managers	6	6
Service providers	10	10
Caregivers	3	3
Focus groups (MB)		
Type of participants	**Number of interviews**	**Number of participants**
Seniors	2	8
Total	21	27

Data Collection Tools

Individual interviews with managers and group interviews with service providers were conducted using questions and case studies depicting complex situations. This was done to encourage reflection and discussions about existing integrated practices, both in general and in French, as well as current informal practices. These questions also explored current collaborative initiatives between actors, locations or organizations as well as opportunities that are favourable for the integration of French language services.

Questions for individual interviews and focus groups with seniors and their caregivers focused on factors that facilitate access to French language services, navigating through services and the communication of personal information throughout the service trajectory.

The interview guides are provided in Appendix I.

Qualitative Analysis

All individual interviews and focus group transcripts were imported into the NVivo 10 analysis software (QSR International, 2012) to facilitate qualitative content analysis. This analysis focused on the systematic review of interview data to understand the meaning of participants' experience (Krippendorff, 2012). Qualitative data coding followed a predefined procedure: 1) an initial reading of 20% of transcripts to identify categories (general annotations describing the subject matter in citations drawn from the script) and emerging themes (annotations that specified what was addressed) (Paillé & Mucchielli, 2008); 2) reaching consensus among team members around categories and themes; 3) developing a list of codes (an abbreviated form of categories and themes) and their definition; 4) validating the list of codes; 5) using this list to code three transcripts (one from managers, one from service providers and one from seniors) and calculating interrater agreement (Huberman & Miles, 2002); 6) coding remaining data according to the determined list of codes, while allowing for the possible emergence of new codes. This procedure ensured thoroughness and in-depth information analysis. Researchers from both provinces proceeded to a second level of analysis, comparing similarities and differences in findings between study areas.

RESULTS

Issues Experienced by Francophone Seniors Living in Minority Settings

Francophone seniors, in Ontario as in Manitoba, commented on their socioeconomic reality and the personal barriers they face regarding access to and continuity of health and social services. According to participants, these issues call for better service integration to meet their needs. While several vulnerabilities associated with aging have a significant impact on access to care, such as sensory and cognitive disabilities, mobility problems, isolation, loneliness and loss of autonomy, some additional constraints are specific to Francophone seniors.

From a socioeconomic perspective, financial insecurity is a prevailing vulnerability due to the high incidence of low income Francophone seniors. Some senior participants and caregivers spoke of struggling with necessary but additional costs related to accessing health and social services, such as respite or home-based foot care. Managers and service providers in Eastern Ontario also commented on transportation costs to hospitals and day programs that seniors must pay. Managers indicated that in such circumstances, some Francophone seniors "*will do without the service*" [i] (RO-16).[14]

Furthermore, limited schooling and literacy among many Francophone seniors impact their ability to interact with a service provider and understand processes and instructions in French as in English: "*Sometimes, the French [written] language is so difficult*"[ii] (RO-78, senior) and, reports a caregiver (W-17) *"with medical communication, I feel that someone absolutely needs to be there just to translate"*[iii] even if the senior is bilingual. The importance of communicating with persons with limited schooling by using spoken and written language adapted to their level becomes essential to ensure adequate comprehension during service provision: *"When we speak to our seniors, they need to understand us. It is not intricate French, most of the time. We need to be at their level"*[iv] (RO-27, manager). Low levels of digital literacy also impact access to relevant information and the ability to navigate within the system. The technology required to find information is not available to all seniors: *"Many members of our population don't have a computer, nor will they have one in the future"*[v] (W-27, senior). Thus, service directories and online information are not available to these individuals.

Isolation due to geographical distance is a significant issue in rural areas. In Eastern Ontario, health and social services in rural areas with a high Francophone population lack sufficient resources to meet the needs of isolated Francophone seniors living outside of towns where services are available: "*we have lots and concessions where people are isolated and it's difficult to serve them*"[vi] (RO-19, manager). In Manitoba, this issue is also important for rural Francophone seniors, as described by participants who moved to Winnipeg to access better services: *"One of the reasons why they moved is that in rural areas, there is not a lot of services for the heart conditions my father had. Out in the country, homecare is difficult"*[vii], shares a caregiver (W-18). A manager echoes the same concerns: a senior who wants services in French will receive better support throughout the continuum of care if located in the Francophone neighbourhood of St. Boniface. This is a problem, particularly if the senior moves to another neighbourhood within the city limits. As explained by the same manager, *"If we have a client from St. Boniface who receives services in French, and then moves to St. James, he will lose access to French language services"*[viii] (W-4).

14 Quotes from the French language interviews were translated into English. The original French versions appear in Appendix II.

Issues are multiplied for French-speaking seniors living in areas with low Francophone populations, as these individuals are few in number and geographically scattered. Programs are challenged when trying to reach them, especially those who are not part of social networks such as the region's Francophone parish. As shared by a community worker in such an area in Eastern Ontario: *"if you aren't part of a [Francophone] church, well you're already [isolated from the Francophone network]. Because (…) you're not part of it. So, how do we reach them?"*[ix] (RO-35). It also creates challenges for participating in programs offered by bilingual institutions in Manitoba: *"programs are always offered in English and in French: since May of 2014, there has been no course in French"*[x] due to insufficient numbers of Francophone participants (W-5, manager).

There are interrelated and overlapping challenges for one Eastern Ontario rural region with a small Francophone population, resulting in the "invisibility" of the Francophone community. Over time, lack of awareness among providers about this linguistic community and its social service and health needs contributes to the Francophone community's silence about its needs:

> *They're [Francophones] just very quiet and not very vocal (....) and I think I can see why because there's just no, no acknowledgement of the fact that there should be services in French. (…) It's just never even raised when we are in meetings or, even as service providers we have a coalition of all the community service providers, if it's phrased at all, it's always, "well, we don't have [a] Francophone community (…)"* (RO-33, manager).

In addition, seniors in the area mentioned *"great tensions at the beginning"*[xi] (RO-93) between Anglophone and Francophone communities. In their view, there is less tension now, although it does persist and contribute to a low sense of welcome and respect: *"there is not a welcoming atmosphere because you're a Francophone"*[xii] (RO-93). Finally, some participants described circumstances where Francophone seniors in this region have stopped asking for health and social services in French, because they are used to not receiving them. A service provider who is familiar with the Francophone community shares her perspective: *"I know some of the Francophone community in the area as well outside of work, and that's what they say. It just gets to the point where it doesn't feel worthwhile to ask because it's so sparse"* (RO-49).

The same applies in Manitoba: *"We are quite used to it being in English, it's like you even forget to ask"*[xiii] (W-27, senior). Others get discouraged because they know that French language services are rare: "*I was disappointed because they advertise when it's bilingual, French language services available, and when you're on the phone and you wait to get these services in French, there are none. It's a letdown"*[xiv] (W-A1-59, senior). As services are provided mostly in the official language of the majority, seniors do not ask for them in French: "*Certainly, when you see an oculist, it's all in English (…) I don't know if it's good or bad. We don't fuss about it (…) It's just a reality"*[xv] (W-22, senior).

Finally, participants in Ontario mentioned a sociocultural issue specific to Francophones living in minority settings: insularity. In reporting their observations, managers and service providers commented that Francophone seniors *"don't want to bother anyone"*[xvi] (RO-38, service provider). A manager (RO-19) mentioned that for seniors, saying *"I need help"* is *"a major"* challenge[xvii]. For another manager, who goes to great lengths to plan support groups to meet the needs of Francophone seniors and their caregivers, this reluctance is perceived as a Francophone cultural trait: "*Really, what we see is that Francophones tend to be more insular, meaning that they prefer keeping their problems within the family, are afraid of asking for services"*[xviii] (RO-27).

Practices and Mechanisms That Foster Continuity of French Language Services

Participants identified several mechanisms that foster access and continuity of French language health and social services. We present them by following the analytical framework developed for this study and previously referred to in the introduction, on pages 17 to 20. At the organizational level, mechanisms are: formalized linguistic variable data collection practices; shared communication tools; directories of bilingual services and service providers; formal interagency agreements; working tables; active participation of Francophone managers (working tables), the participation and role of the French Language Health Services Network of Eastern Ontario. At the service provider level, we noted awareness-raising and networking, as well as the informal offer of French language services. These mechanisms, as described by participants, will be detailed individually.

Summary. Practices and Mechanisms That Foster Continuity of French Language Services

AT THE ORGANIZATIONAL LEVEL

- Formalized linguistic variable data collection practices
- Shared communication tools
- Directories of bilingual services and service providers
- Formal interagency agreements
- Working tables
- The active participation of Francophone managers (working tables), the participation and role of the French Language Health Services Network of Eastern Ontario

AT THE SERVICE PROVIDER LEVEL

- Awareness-raising and networking
- Informal offer of French language services

Mechanisms at the Organizational Level

Mechanisms at the organizational level include: formalized linguistic variable data collection practices; shared communication tools; directories of bilingual services and service providers; formal interagency agreements; working tables and the active participation of Francophone managers (in working tables) and the participation and role of the French Language Health Services Network of Eastern Ontario.[15]

Formalized Linguistic Variable Data Collection Practices

Recording the linguistic variable in a senior's file ensures that service providers offer services in French or, if need be, refer the senior to other Francophone service providers. It also facilitates service coordination among other bilingual service providers. In Eastern Ontario, this is a widespread practice for service providers who work in designated organizations and in settings that recognize the importance of the linguistic variable. This practice is not as widespread in rural areas with small Francophone populations, where French language services are scarce. In Manitoba, the linguistic variable is used by service providers from designated institutions. For example, it enables the Long Term Care Access Centre to refer seniors to designated long-term care facilities.

15 Since 2010, the *Réseau* is recognized by the province of Ontario as the French Language Health Planning Entity for Eastern and South Eastern Ontario 2010. Under this mandate, the *Réseau* advises the Champlain LHIN and the South East LHIN on all issues affecting Francophone health. The *Réseau* is also one of Société Santé en français' 16-member Francophone health networks. It works with the SSF to improve the health of Francophones living in minority communities throughout Canada.

Shared Communication Tools

Several shared communication tools are used to promote more efficient communication and collaboration in service delivery to Francophone seniors. Although used by both Anglophone and bilingual service providers, we will detail their use in delivery of health and social services to Francophone seniors. Tools include virtual health care and phone-based technologies, shared electronic records and common assessment software used by community support agencies.

In Eastern Ontario, the Ontario Telemedicine Network[16] is frequently used for medical consultations and follow-up with rural seniors. The service can, for instance, link an urban heart institute and a rural community health centre situated in a region with a high Francophone population. In such a region, when the consultation is conducted via Telemedicine between an English-speaking specialist and a Francophone senior, French interpretation is provided by a nurse from the community health centre. This technology ensures service continuity for Francophone seniors, while sparing them long and costly trips to specialized services located in urban areas. In Manitoba, TeleCARE[17] provides phone follow-up for persons in rural areas living with heart failure or type 2 diabetes.

Shared electronic records are another means of communicating information between agencies. In Eastern Ontario, some hospitals use shareable electronic records. Francophone seniors appreciate this, as they are not required to repeat information during appointments and consultations. Except for one designated hospital in Eastern Ontario that offers written reports in a senior's preferred official language, most records are written in English. Although this does allow for better communication when the senior is referred to specialized services which are unavailable in French, it limits Francophone users' access to information in their records.

Information exchange about a person residing in Eastern Ontario and receiving care from a community organization funded by the LHIN has been supported for a few years by shared software. This consists in a shareable computerized record (CIMS) and a standardized assessment tool.[18] Record sharing is contingent on formal agreements between organizations, and service users' consent. Service providers who use these systems find that their community work has become more concerted, and in turn, more efficient, since all providers have access to information about the service user's needs and the software automatically generates referrals to services the service user may require. Duplication and working in silos are avoided. For managers of community services funded by the LHIN, the shared software CIMS helps with report preparation and service planning.

In Manitoba, some computerized records are shared among agencies, such as *E-Health*, *E-Chart* and a few specific records between hospitals and homecare services. However, shared tools are limited. Most often, when transferred to another health facility, clients must have a copy of their record or relevant parts of the record in hand. It should be noted that family physicians usually keep complete patient records. Health records are generally written in English only.

Directories of Bilingual Services and Service Providers

In Eastern Ontario, participating managers and service providers spoke of formal and informal directories listing French language social and health services as enablers of service coordination. One example is the directory prepared by the Ottawa Community Support Coalition, which specifies which French language community support services are available to seniors.

The 211 directory[19] and the Champlain Health Line[20] were also mentioned as resources to which seniors are referred. The first can be accessed by phone or online, and the second online only. In

16 The Ontario Telemedicine Network (OTN) is a not-for-profit organization, funded by the Ontario Ministry of Health and Long-Term Care, charged with building a sustainable and responsive virtual care system. https://otn.ca/how-is-otn-making-difference-in-ontario/

17 The TeleCARE service in Manitoba is managed by the government of Manitoba and is an expansion of the comprehensive self-management program for heart failure. http://www.gov.mb.ca/health/primarycare/public/chronicdisease/selfmgnt/telecare.html

18 Canesto CIMS software and the interRAI-CHA tool (Resident Assessment Instrument—Community Health Assessment and its variations) are used by LHIN-funded social service or health organizations.

19 The 211 telephone helpline and its website provide a gateway to information about community, social, health and related government services. https://211ontario.ca/about-211-ontario/what-is-211-ontario/

20 The Champlainhealthline.ca portal is an innovative web portal that puts accurate and up-to-date information about health and community services at the fingertips of consumers and health and community services providers across Ontario's Champlain region. http://www.champlainhealthline.ca/about.aspx

Manitoba, a French language health and social services directory is available in print and online (Directory 233-ALLÔ).[21] In addition, a call centre, Info-santé/Health Links, provides navigation services. A few navigation tools are also available online: the website Myrightcare.ca[22] and the online health care services directory provided by the WRHA.

Additionally, service providers keep informal lists of community resources; these lists are created and maintained depending on staff time and availability.

Formal Interagency Agreements

In Eastern Ontario, formal interagency agreements are formal partnerships between designated or partially designated health and social service organizations. These agreements ensure equitable service offer and delivery, *"at the same level [and] the same service as provided to Anglophones"* (RO-18, manager)[xix]. A community service centre manager also confirms that these agreements lead to a more comprehensive offer of French language services: *"I don't have a beneficiary attendant, I don't have physicians, I don't have nurses. I will work with the multidisciplinary centre or the [municipality] to receive services here"*[xx] (RO-manager)

Satellite services have been put in place thanks to these agreements. For example, a French language health service is offered in a rural community health centre by a regional Anglophone hospital located more than 30 km away:

> *We have a physiotherapist from [the Anglophone regional hospital] who speaks a little French. She gets by. But she comes here two days a week, so people who are referred [from the Anglophone regional hospital] or from surrounding localities and who meet the required criteria can receive services from a physiotherapist here* [xxi] (RO-38, nurse).

This satellite service reduces the travelling distance to French language services.

In Manitoba, few formal agreements exist. One example is between the Francophone community health centre, which is supported by a professional multidisciplinary team, and a medical clinic in the same neighbourhood. This agreement simplifies seniors' access to the medical clinic, as well as to nutritionists and mental health counsellors at the community health centre. In addition, an agreement between this health centre and the Fédération des aînés franco-manitobains has been in existence for many years: the centre provides support and educational resources mainly focused on physical activity, but also on the social well-being of Francophone seniors. Besides these rare examples, very few formal agreements have been established.

Working Tables

Several working tables are active in the health and social service sectors, some of which address French language services. In Eastern Ontario, French language networks work within English-speaking intrasectoral networks, as in the Ottawa Centre-East Francophone Community Resource Directors' Network, and intersectoral networks such as the Francophone Steering Committee of the Council on Aging of Ottawa. In 2015, the Ottawa Community Support Coalition created a subcommittee for Francophone services.

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21 The directory of French language services in Manitoba is prepared by the Société franco-manitobaine and is available in print and online. http://www.sfm.mb.ca/annuaire/

22 Myrightcare.ca, a website managed by the Winnipeg Regional Health Authority, is designed to help Winnipeggers choose the right care option so they can get the right treatment, faster. www.myrightcare.ca

In Manitoba, the leadership team of the Accès-Access St. Boniface Centre is composed of managers from the Francophone community health centre, homecare services, the designated long-term care facility, Public Health Services and an assisted living housing complex for seniors. There is also a workgroup managed by the Santé en français movement that brings together representatives from the WRHA and the Ministry of Health. This group is responsible for mobilizing and identifying health and social service needs, priorities and solutions, as well as ensuring ongoing contacts with the WRHA. The WRHA, through its French Language Services, organizes meetings with designated institutions to discuss French language services challenges and strategies.

The Active Participation of Francophone Managers (Working Tables), the Participation and Role of the French Language Health Services Network of Eastern Ontario

In addition to Francophone networks, French-speaking managers actively participate in intersectoral networks to *"make sure that the Francophone reality is addressed"*[xxii] (RO-27). They raise issues concerning the identification of Francophones among their clientele, as well as possible service delivery to Francophone seniors. This awareness-raising has a significant impact, as mentioned by this community service manager in a rural region with a low Francophone population, as this makes Francophones more visible to members of the regional community agency network: "*People are saying (...) 'Oh, maybe there is a Francophone community here'*" (RO-33).

In some Eastern Ontario networks (for example, Health Links Committee, Regional Geriatric Committee, Dementia Network), another helpful mechanism for representing and raising awareness of Francophone seniors' needs is the participation of a French Language Health Services Network of Eastern Ontario representative in health and social service networks. Managers stated that by sharing data and studies, the *Réseau* reinforces awareness of the Francophone presence and the needs of this population. In Manitoba, the Réseau Santé Saint-Boniface brings together several urban Francophone organizations which results in sharing between agencies and greater awareness of the availability of French language health and social service resources.

Mechanisms at the Service Provider Level

Mechanisms at the service provider level include awareness-raising and networking, as well as the informal offer of French language health and social services.

Awareness-Raising and Networking

In Eastern Ontario, managers from designated bilingual organizations in urban areas with high and low Francophone populations highlighted the importance of raising awareness among their partners and the community, in order to reach Francophone seniors who may need French language health and social services. Awareness-raising takes place informally but regularly, as in the case of an urban community health centre in an area with a low Francophone population that relies on two service providers to serve isolated and high-risk seniors on an ongoing basis. These workers make presentations in apartment buildings where there is a greater opportunity of reaching Francophone seniors. In contrast, another seniors' program in this centre (Falls Prevention program), does not carry out this type of outreach and consequently, has a lower percentage of Francophones among its participants.

In both Eastern Ontario and Manitoba, referrals ensuring French language service continuity are optimized by years of informal Francophone professional networking, as mentioned by a

community worker from an urban Eastern Ontario region with a low Francophone population: *"since I have been working in the [community] sector for 20 years (…) I already have contacts, so I know who is Francophone and who is not"*[xxiii] (RO-35).

In Manitoba, managers observed that in the health field, informal collaborations are more common than formal agreements; they are *"natural trajectories that have always existed and therefore continue or are 'unofficially' understood"*[xxiv] (W-1, manager). Bilingually designated agencies are also well-known. They include two long-term care homes, a community health centre and a hospital. They are centrally located in Old St. Boniface, close to several housing facilities for seniors, making St. Boniface a location of choice for bilingual services and networking between services. In addition, several bilingually designated health institutions operate under the aegis of the Catholic Health Corporation of Manitoba: managers from these organizations know each other and already work together. Thus, designated institutions are recognized within the WRHA; Francophone senior referrals, particularly for long-term care, are naturally directed to bilingual facilities.

Informal networking strategies are also put in place: for instance, "Open House" activities organized by an assisted living housing complex welcomes not only a Francophone clientele, but also new home care case coordinators. Although a new manager or service provider may unexpectedly gain knowledge about French language services, networking is reinforced by working with other designated organizations, being geographically close and collaborating in shared initiatives. For an experienced administrative manager, cooperating with bilingual organizations becomes second nature.

Informal Offer of French Language Services

In Eastern Ontario, French language health and social services are less available in the urban region with a low Francophone population or, in the case of the rural region with a low Francophone population, scarce. A few managers and service providers participating in the study spoke of informally providing French language services. These informal practices vary according to service providers' linguistic abilities or, for managers or team leaders, according to the opportunity to assign bilingual staff to Francophone seniors. For example, a bilingual service provider in this area offers French-speaking seniors the opportunity to speak in French when using the Anglophone hospital emergency services:

> *R1: You see sometimes they come in, they cannot express themselves. They're talking to their companion in French. I say, "Oh, speak in French."*
>
> *Q1: Because you see that it would go a lot easier for them?*
>
> *R1: Oh yeah, much easier because sometimes they're trying to translate, telling their husband or the daughter what to tell me. And I say, "Okay. It's okay. I speak French, I understand French. You can speak in French."*[xxv] (RO-58)

In these Anglophone hospitals, the offer of French language services seems possible either by assigning bilingual staff where work schedules permit, by using a telephone translation service or by assigning dedicated staff, such as in this rural community support service: "*Yes, we did have a staff in the community that spoke French. So that became the staff member that was assigned to that [Francophone] client to make sure that there was no language barrier"* (RO-33).

Although the informal offer of French language services is not in itself a coordination mechanism, it may lead, as in the last example, to an intentional pairing between a Francophone senior and a French-speaking staff member.

Factors which Enhance Collaboration Toward Improving Access and Continuity in French

A few managers mentioned underlying conditions to developing positive health and social service co-ordination mechanisms intended for seniors in general, and for Francophones in particular: enthusiasm for innovation and collaboration, and a history of trust and close relationships among organizations.

Enthusiasm for Innovation and Collaboration

Some managers feel it is essential to show a willingness to move beyond usual practices in serving clients whose needs are increasing because of aging. This willingness is characterized by efforts aimed at transcending standard ways of doing things, *"to think differently (…) to do things differently"*[xxvi] (RO-19) and bring together *"the best-placed partners"*[xxvii] (RO-25). For these managers, collaboration and innovation go hand in hand as they seek to better meet their clientele's needs.

A History of Trust and Close Relationships Among Organizations

Some organizations have been working together for a long time, and this history of trust and close relationships becomes, for managers, a key component for promoting consultation around obtaining and coordinating resources. It is only by having *"very strong links"*[xxviii] (RO-30, manager) with each other that organizations can promote themselves to funders to obtain the necessary resources with which they can optimize service provision to seniors.

Barriers to the Continuity and Integration of Services for Francophones

Regardless of language, participants report several obstacles to the delivery of integrated health and social services. These barriers are outlined here, under the relevant level described in the analytical framework developed for this study and previously referred to in the introduction, on pages 17 to 20.

Summary. Barriers to the General Delivery of Integrated Services

AT THE POLITICAL AND REGULATORY LEVEL

- Complexity of health and social service systems
- Overuse of resources

AT THE ORGANIZATIONAL LEVEL

- Differences in organizational mandates, cultures and financial structures
- Unavailability or lack of use of ethical and confidential information sharing tools.

At the political and regulatory level, the complexity of health and social service systems and the overuse of resources were mentioned. A caregiver, who supported both her parents with loss of autonomy, is at a loss to understand how the health system works: "*Even now that I have been through it. It's as if the right hand doesn't talk to the left hand, it was really a nightmare for both my parents at various levels"*[xxix] (W-17). Managers also agree that the health system *"is a huge machine"*[xxx] (W-5). Service organization is generally departmental or institutional: they are "*working in silos: public health does their thing, homecare does their thing, we refer, but we work next to each other, not necessarily together"*[xxxi] (W-19, service provider). In addition, competition for funding also creates problems when attempting to coordinate services: *"everyone looks after their own interests"*[xxxii] (RO-15, manager), in attempting to ensure their survival.

A lack of willingness to change and the health system's complexity were also mentioned as being barriers:

> *It would take substantial reforms in restructuring a whole lot of things and up until now, there has been no great will to do that. I think it would be fun to do it as a Francophone project because our clientele is a little more identifiable. But there is no will to do it. There are still turf wars going on within the system.*[xxxiii] (W-1, manager)

Furthermore, current resources are already overused; according to a manager, "*the well is running dry*"[xxxiv] (RO-16). Thus, on the one hand, there is a wish to move forward and promote a better concertation of French language services between health and social service organizations, and on the other hand, there is a recognized depletion of resources.

In addition, the three sets of participants underline that the lack of human and financial resources creates significant staff turnover and discontinuity in service delivery. In Winnipeg, for example, the changeover of front-line workers in homecare was raised. Some participants also noticed a shortage of services, demonstrated by those who do not have a family physician or a dedicated care provider, who must wait to schedule an appointment or travel to consult a specialist. This situation can become critical for an older person experiencing loss of cognitive or physical autonomy, as described by a caregiver whose parent with Alzheimer's had to use an urgent clinic for basic medical care:

> *Yes, it could be anything, such as blood samples, often if there was a problem with mother, they told us to go to the emergency department. What a nightmare (…), sitting eight hours with someone who has Alzheimer's, horrible.*[xxxv] (W-17, caregiver)

Caring for seniors requires an approach adapted to their needs and abilities: as highlighted by two other caregivers from Manitoba, access to safe and quality services is crucial.

At the organizational level, managers and service providers mentioned that differences in mandates, organizational cultures and financial structures make it difficult to set up intersectoral concertation and coordination between services. The challenge is to find an efficient path to concertation, particularly among people who do not usually work together.

Further, the tools required to share seniors' personal information in an ethical and confidential manner are not available or not used. Managers and service providers mentioned the *Privacy Act*[23] that is often erroneously interpreted and applied, which leads to non-disclosure of relevant information about a service user between agencies. Often, computerized records created by specialized medical software are incompatible with software used by other services.

Besides these overall barriers, others are specific to linguistic accessibility. They are set out here under the relevant structural level: symbolic, political and regulatory, organizational, and service provider levels. Barriers, as described by participants, will be detailed individually.

23 The Privacy Act protects the privacy of individuals with respect to their personal information and provides individuals with a right of access to that information. https://www.priv.gc.ca/en/privacy-topics/privacy-laws-in-canada/the-privacy-act/

Summary. Barriers to French Language Service Integration and Continuity

AT THE SYMBOLIC LEVEL

- Lack of understanding of the impact of language barriers on access to safe, satisfactory and quality care

AT THE POLITICAL AND REGULATORY LEVEL

- Triage that ignores linguistic needs
  - Geographical triage, or service access according to postal code
  - Triage by condition, as service distribution is linked to medical condition
  - Limited availability of designated hospitals in emergency situations
- Precarious funding of French language services
- Private companies that are under no obligation to offer services in French

AT THE ORGANIZATIONAL LEVEL

- Precarious funding
- Shortage of bilingual service providers and French language services
- Few assessment tools in French
- Lack of resources for translating and producing documentation in French
- Shortcomings of shared communication tools
- Lack of a formal intersectoral directory of French language services

AT THE SERVICE PROVIDER LEVEL

- Lack of active offer

Barriers to French Language Services at the Symbolic Level

Barriers to French language health and social services at the symbolic level relate to a lack of understanding of the impact of language barriers on access to safe, satisfactory and quality care.

Lack of Understanding of the Impact of Language Barriers on Access to Safe, Satisfactory and Quality Care

During our interviews in Eastern Ontario, a few managers were unaware of the problems that Francophone seniors face when receiving health and social services in English. It is assumed that these seniors are bilingual and that they can get by in English. A Francophone community worker mentioned that this barrier also exists among some of her colleagues. For seniors to receive services in French, the worker must refute this assumption by raising awareness and negotiating with colleagues.

It was also observed that in some bilingual programs in Eastern Ontario, activities will be held in English only when even just one Anglophone is present among several Francophones. A manager of French language services explains the negative feedback received from seniors in this regard:

> *Of course, everybody speaks French, but if we do an activity and an Anglophone is there, we will immediately revert to English. So, some participants left and said: "No, I don't want this. I want to be in a French language day program."*[xxxvi] (RO-20)

For these individuals, this type of situation leads to a breakdown and loss of French language services, as there is a scarcity of French day programs in the region.

In Manitoba, managers and service providers who participated in the study report that in general, the health system does not recognize the impact of language on the safety of patients, service providers and on the system itself: "*Sometimes, people in the system will say: 'Access to French services is a preference, it's like wanting to be close to home… You prefer that personal care home but you don't need it.' Of course not, it's much more than that*"[xxxvii] (W-4, manager). Linguistic access is not considered a priority: *"It's the level of priority given to French language services… it is not seen as something urgent"*[xxxviii] (W-2, manager). Since it is not recognized as an essential element to providing quality and safe services, few resources are allocated to improving linguistic access to these services.

Barriers to Integrated French Language Services at the Political and Regulatory Level

Barriers to integrated French language services at the political and regulatory level include triage that ignores linguistic needs, the precarious funding of French language services and private companies that are under no obligation to offer services in French.

Triage that Ignores Linguistic Needs

For seniors and caregivers in Eastern Ontario, triage, or care distribution in an emergency, does not include the linguistic dimension. This was described in three types of circumstances: geographical triage, triage by condition and limits in the availability of designated emergency services for Francophones. They are briefly outlined here.

Geographical Triage or Service Access According to Postal Code

French-speaking seniors living in urban or rural areas with high Francophone populations shared their frustration about service access being limited to postal code, without regard for their linguistic needs:

> *If something happens to me, I call the ambulance, they send me directly to [the local Anglophone hospital]. (…) I know that the law says it should be the nearest hospital, but if the closest hospital can't meet your [linguistic] needs why is it that they don't take us and bring us to [the designated hospital]? (…) That, I don't understand and it's a huge dilemma and a big problem.*[xxxix] (RO-81, senior)

This issue also applies in Manitoba, where Francophone seniors who use home care services in St. Boniface are assigned to a bilingual case manager. If, however, they had to move to an Anglophone neighbourhood, service would be provided by an English-speaking case manager. Although Francophone seniors also live in other areas of Winnipeg, access to French language services is favoured in the St. Boniface neighborhood.

Triage by Condition or Service Distribution According to Medical Condition

Seniors also dealt with circumstances where they were referred to a hospital that treats their particular condition, regardless of their expressed wish to be sent to the designated Francophone hospital, as in the case of a senior who lives in an urban area with a high Francophone population : *"I said: 'I would prefer going to the [designated hospital]'. He [the paramedic] said: 'In your situation, we need to go the [partially designated hospital] because you need an operation immediately' "*[xl] (RO-67, senior).

Limited Availability of Designated Emergency Services

One senior living in an urban area with a high Francophone population shared her experience when she asked the ambulance to transport her to a designated hospital: *"I told them [paramedics]:'I want to go to the [designated hospital], I want to go to the [designated hospital]', and he said: 'No. At the [designated] hospital, they are too busy.' They brought me to the [non-designated hospital]"*[xli] (RO-67, senior).

One physician explained that when he needs an urgent or priority transfer, the emergency referral service CritiCall[24] prioritizes the hospital where services are available, with no consideration of linguistic needs.

Precarious Funding of French Language Services

Precarious funding for organizations that provide services to Francophone seniors is an issue both in Manitoba and Ontario. In Manitoba, managers and professionals emphasize the lack of financial resources, particularly for linguistic accessibility: *"The problem with this system is not bad intentions, it's just that at some point, we are pulled from one side to another, about what we should work on today"*[xlii] (W-1, manager). Managers must deal with several issues at once; linguistic accessibility is an additional task.

Being relatively smaller than their Anglophone counterparts, Francophone community organizations in urban Eastern Ontario face significant challenges with grant applications. The need to "*submit as many applications as possible"* in order *"to "survive in a sea of Anglophones"*[xliii] (RO-15, manager) is challenging, especially with fewer resources; hence, Francophone organizations are disadvantaged: *"When you compete with these major players [Anglophone organizations], when you look at their funding applications and then at other funding applications [from Francophone organizations], you're lightyears away"*[xliv] (RO-15). Participants also wonder if the distribution of funds is proportionally equitable, as explained by this manager: *"They're unable to give me the information at the LHIN: if 17% of the population is Francophone, is it 17% of the budget (…) that will be allocated to Francophones?"*[xlv] (RO-16)

Private Companies That are Under no Obligation to Offer Services in French

In Eastern Ontario, private companies that provide home healthcare services to Francophone seniors are not subject, unlike public service agencies, to the *French Language Services Act* (Office of the French Language Services Commissioner, 2009). These home services are often provided following an evaluation conducted by the CCAC[25] (Community Care Access Centre) and can take the form of personal, auxiliary or specialized care, such as physiotherapy. Caregivers in areas with a high Francophone population mentioned that most workers who provide homecare speak English. This can be a problem for seniors and their caregivers who are less comfortable in English: "*They [CCACs] asked me which language I spoke, and I told them that I wanted everything in French. The only thing that I find a little difficult is that we have some women who speak English that come and take care of my husband"*[xlvi] (RO-83, caregiver). A manager of designated out-patient services in an urban area notes a lack of linguistic continuity in home physiotherapy services delivered by private companies. These companies are under no obligation to ensure that their services are available in French.

Barriers to Integrated French Language Services at the Organizational Level

Managers and service providers highlighted several barriers to French language health and social services at the organizational level: precarious funding; shortage of bilingual service providers and French language services or the lack of optimization of bilingual human resources; few assessment tools in French; lack of resources for translating and producing documentation in French; shortcomings of shared communication tools; and the absence of a formal intersectoral directory of French language services.

Precarious Funding

Precarious funding at the organizational level reveals the vulnerability of resource management and service distribution intended for Francophone seniors. A case in point is the only Francophone community organization that provides services in an Eastern Ontario urban area.

24 Funded by the Ontario Ministry of Health and Long-Term Care, CritiCall Ontario is a 24-hour-a-day emergency consultation and referral service for physicians across the province of Ontario. http://www.criticall.org/Section/About-CritiCall-Ontario

25 See note on page 16 regarding the dissolution of the CCAC boards and their assimilation into the LHIN.

This organization recently made the difficult decision, based on financial and organizational considerations, to repatriate employees who were assigned to satellite services across the region. Rental costs of external locations were recouped to consolidate the organization's operations; alternative service provision was found for these settings, in the form of telephone interventions. However, according to other participants, losing these Francophone satellite services creates difficulties in tracking and identifying Francophone seniors' emergent health and social service needs:

> *If we lose these players, who were strategic in terms of really determining the health-related needs of these people (…) for Francophones, it will be a blow. (…) It's been maybe a year, but we already see the impact on the community. (…) Because if you want a good grasp of a community's problems, it's by visiting them.*[xlvii] (RO-15, manager)

Unstable funding of Francophone organizations can also jeopardize the identification of Francophone seniors. For example, in an Eastern Ontario urban area with a low Francophone population, two service providers from Primary Care Outreach to Seniors have a sizeable workload of approximately 345 seniors. In addition to their intervention functions, they take the time to actively seek and reach out to Francophones. Community organizations in this area do not have the financial means to fund additional staff to actively identify Francophones, as attested by this manager:

> *It's quite a small population [of Francophones] in the West end, and to be able to reach these people [Francophone seniors] (…) without resources to do outreach, because most of the programs do not have the funds to do it, that will be the challenge. It is not a lack of will.* [xlvii] (RO-25)

Shortage of Bilingual Service Providers and French Language Services

Several participants noted a shortage of French language health and social services for Francophone seniors and its significant negative impact on the ability to ensure integrated services for this population. Often associated with the recruitment of bilingual staff, this situation also applies to high Francophone population areas. It is difficult to recruit bilingual professionals, whether they are physicians: *"Indeed, very difficult to recruit them, because they have to be Francophone, or at least very comfortable in French"*[xlix] (RO-16, manager), or healthcare professionals: *"we posted several jobs, and we didn't get… we weren't able [to recruit a bilingual nurse]"*[l] (RO-25, manager). In Manitoba, the recruitment challenge is such that even in bilingually designated institutions, French language services are not guaranteed: *"In these locations, even if they say that services are in French, they are not. I can understand also that they must hire. They need people 24 hours a day. And there may not be that many [staff members] who speak French"*[li] (W-23, senior). For instance, case managers from the homecare agency assigned to Francophone seniors in St. Boniface are bilingual, yet the care attendants, who provide daily services, rarely are. As a manager from a bilingual institution describes, they must above all ensure that staff can work in English, as the environment is mainly English-speaking. Preference will then go to hiring a unilingual Anglophone employee, rather than a Francophone who speaks only French or is bilingual but uncomfortable in English. A bilingual workplace is generally *"managed in such a way that leans toward English"*[lii] (W-3, manager).

The scarcity of Francophone specialists is also widespread. Although some seniors asked their physician to refer them to a Francophone specialist, they had to deal with the English-speaking specialist who was available: *"you have no choice (…) you get the doctor that they give you because they are very busy"*[liii] (RO-78, senior).

Apart from the shortage of bilingual staff, participants have observed that French language services are scarce. Some of them also referred to a lack of support in French for caregivers in both urban and rural areas. Others shared their views about the lack of retirement homes

for Francophone seniors, for instance in Eastern Ontario's urban areas with low Francophone populations. In rural low francophone population areas, service providers and seniors stated that most of the services are only available in English: *"I was doing just a little presentation to a group of Francophones in the community a little while ago, (...) and I said well, unfortunately there's not very much [available in French]"* (RO-49, bilingual service provider).

In such settings, the lack of Francophone professional services in geriatrics generates an increased travel burden for seniors, and for those who cannot afford to travel, risks of breakdown in service continuity. In addition, one organization that provides a day program in French is under pressure to serve the Anglophone clientele and fears that this may reduce resources for Francophones: *"They want to make us organize a day in English, only for an Anglophone group. And this would further reduce the services that we provide to Francophones"*[liv] (RO-34$_{2,}$ coordinator).

Furthermore, seniors and their caregivers living in the Eastern Ontario urban area with a high Francophone population noted that a request for services in French results in delays: *"I ask for French and I wait. I am patient enough to wait because I really need to understand correctly"*[lv] (RO-78, senior) and "*I asked for a French-speaking [CCAC] manager, it took three months before (…) they found one"*[lvi] *(RO-61, caregiver)*. These delays lead to a breakdown in continuity; according to a manager, *"it delays follow-up"*[lvii] (RO-29).

Few Assessment Tools in French

In Manitoba as in Ontario, assessment tools are not always bilingual, which means that assessments are at greater risk of being inadequate. In some settings, professionals and service providers may turn to a translation service for these assessments, but this is not widespread practice; interpretation or translation services are not always available. Some participants decried the poor quality of translations, as described by this Eastern Ontario senior: "*documentation in French is very poorly written. It is easier to read it in English than in French. It makes me angry"*[lviii] (RO-64). In other instances, translated documents use a level of French that Francophone seniors cannot understand, as indicated by this service provider:

> *The translated French is at a much higher level than a grade three or four [years of schooling] because often, seniors, especially the people that we serve, the average age is, I would say, 86. I have several who had no formal education, so they don't understand the language used in translation. I believe it is a shortcoming.*[lix] (RO-35)

Lack of Resources for Translating and Producing Documentation in French

Resources allocated for document translation are sparse and managers note that this is a problem for seniors who, as a result, do not have access to information about French language health and social services. In an Eastern Ontario rural area with a low Francophone population, a community service manager refers to this gap as an obstacle to French language service requests: *"We just don't have the resources, or the expertise to do that. (…) I think if the information were available in French, it would make the French population more comfortable to start asking for the services"* (RO-33). Some participants brought up deficiencies in the widespread practice of asking staff members to provide interpretation services, as they are not trained and don't have the knowledge required to interpret. As an alternative, some organizations encourage the use of a telephone interpretation service.

Shortcomings of Shared Communication Tools

In Manitoba as in Ontario, shareable computerized records are incompatible between sectors or between some organizations in the same network.[26] It then becomes much more difficult to communicate and share information about a senior who simultaneously receives services from a hospital, a community health centre and community support services. It also causes gaps in the transmission of relevant information about care and services that a person receives

26 For example, in Eastern Ontario, the common software used by community agencies funded by the LHIN, Canesto CIMS, does not allow for communication between these organizations. This is also the case with the computer system used by community health centres, Nightingale on Demand (NoD). In addition, at the time of data collection, respondents indicated that the NoD system is not compatible with CIMS, nor with the shared hospital systems.

or should currently receive, along with assessment duplications and an increased burden for caregivers who must repeat the same information. Some attempts are being made to establish formal data and information sharing agreements, such as between some community services in Eastern Ontario and the CCAC. However, they are not yet reciprocal in nature nor is this practice widespread.

Lack of a Formal Intersectoral Directory of French Language Services

In Eastern Ontario, there is no formal intersectoral directory (including social services and health care resources) in French for Francophone seniors. Care providers are not always updated when new programs and services are available, which results in the possibility of information about these new initiatives *"falling through the cracks"* (RO-56, service provider). This is significant for seniors and their caregivers, who expect "*to be informed by staff members*"[lxi] (RO-90, caregiver) about available resources. A service provider from Eastern Ontario mentioned a one-time consultation effort initiated twenty years ago to produce such a directory of urban French language services. However, this directory is now out of date.

Barriers at the Service Provider Level: Lack of Active Offer

At the service provider level, participants noted the lack of active offer of French language health and social services.

Lack of Active Offer

In Eastern Ontario, intake and care management are two points in the service trajectory where seniors indicated a lack of linguistic accessibility as well as breakdowns in communication and understanding. Participants reported that the active offer of French language services is not widespread. Francophone staff members tend to use English, even in designated or partially designated institutions: *"There was this nurse (…) she comes in and (…)'Hi, I'm Francine.' I said 'bonjour Francine' (…). I answered in French. I could see that she was a Francophone speaking in English"* (RO-87, senior). The same applies to communication with unilingual Anglophone receptionists. Some seniors shared moments when the mediocre quality of spoken French by service providers hindered their understanding: "*it was such an anglicized French (…) that I had trouble understanding*"[lxiii] (RO-65). In an Eastern Ontario rural area with a low Francophone population, seniors and caregivers were disappointed by the fact that in their local hospital, bilingual signage was not associated with active offer: *"When they displayed French signage, it is fantastic, but (…) apart from that, there was no [French language service] that went with it"*[lxiv] (RO-93, caregiver).

Manitoba participants also noted the lack of active offer of French language services: *"It was just a fluke, if the nurse happened to be Francophone, she [my mother] spoke French"*[lxv] (W-17, caregiver). The difficulty in identifying a bilingual person, whether a senior or a service provider, highlights the importance of practicing the active offer of French language services, as one manager explains: *"It's a challenge… even here in St. Boniface"*[lxvi] (W-5, manager), where the majority of health institutions are designated bilingual and there is a higher Francophone population as compared to other neighbourhoods in Winnipeg.

Together, these barriers clearly indicate that the linguistic needs of Francophone seniors are not always taken into account throughout the health and social services trajectory, starting with intake and management, then referral, during intervention and follow-up. Such deficiencies generate breakdowns in communication, in comprehension during interventions and in the continuity of French language services, and create dissatisfaction among seniors and their caregivers.

Factors That Hinder the Development of Integration Mechanisms

While there are, in Eastern Ontario, formal and informal Francophone networks, and some of these cover the health and social services intended for Francophone seniors, managers spoke of certain conditions which hinder the development of service coordination, such as the lack of formal intersectoral mechanisms to ensure French language service continuity. They added that the French Language Health Services Network of Eastern Ontario is less involved in community services. We briefly present these factors here.

Lack of Formal Intersectoral Mechanisms to Ensure the Continuity of French Language Services

Managers find that there is no formal mechanism to ensure the continuity of French language health and social services. The absence of policies and processes that could facilitate coherent service delivery and continuity contribute to this gap.

> Lack of policies ensuring continuity of French language health and social services, translates, according to a manager, into a lack of *"ways of doing things"*[lxvii] (RO-20), meaning concrete actions to integrate French language services. In this manager's opinion, this flaw goes beyond the law that protects French language services. Lack of processes related to continuity in program delivery for Francophones was also noted*: "We have to put more effort and ask ourselves what we are doing to provide French language services. And that discussion, it is not there"*[lxviii] *(*RO-20*),* confirms the manager when referring to existing committees and working tables.
>
> Other managers echoed the need to further develop relationships among French language health and social service providers, noting the current lack of mechanisms to address the geographical dispersion of Francophones, develop coherence in French language service delivery and ensure follow-up:
>
> > *Francophones are a little dispersed, and when we're dispersed, well we kind of dilute our strengths (…). Currently, we have nothing that specifically brings Francophones together to bring coherence to services destined for the senior population.*[lxix] (RO-15)

The French Language Health Services Network of Eastern Ontario is Less Involved in Community Services

Although Eastern Ontario managers highlighted the positive contribution of the French Language Health Services Network of Eastern Ontario, the *Réseau*, to the LHIN and activities related to designation and delivery of French language services, it was also mentioned that the *Réseau* is less involved in community services. These provide a wide range of services to residents and are often, as described by managers, the *"entry point"*[lxx] (RO-15) enabling Francophones access to French language health and social services: *"At this entry point, you are looking for a service, well, you will be guided there"*[lxxi] (RO-15). Lack of engagement from the *Réseau* is noted by a community service manager: *"it's sort of the criticism or observations that I make with the Réseau, it's that they are less involved in community interventions, while that's where it all begins"*[lxxii] (RO-20).

Improvements to Service Integration for Seniors in General

Improvements to health and social service integration in general, as suggested by participants, relate to the political and regulatory level as well as the organizational level. They are briefly outlined here.

Summary. Improvements to Service Integration in General

AT THE POLITICAL AND REGULATORY LEVEL

- A single point of access
- User records that can be shared between health and social service sectors.

AT THE ORGANIZATIONAL LEVEL

- An interagency care coordinator
- More health centres with multidisciplinary teams

Improvements at the Political and Regulatory Level

At the political and regulatory level, improvements suggested by participants are: a single point of access and user records that can be shared between health and social service sectors.

A Single Point of Access

Several managers highlighted the need for a single point of access to health and social services to limit the number of contacts required to receive services. In Eastern Ontario, a manager of geriatric services points out that feasibility of such a one-stop access point is currently being examined by the LHIN. It is also being examined by the St. Boniface Access Centre in Manitoba.

User Records That Can be Shared Between Health and Social Service Sectors

Several managers and service providers mentioned the need for computerized user records that are shareable between health and social service sectors. In their view, such records would provide a personalized picture of all the services a senior receives. For instance, it could trigger communications when a senior is admitted to or discharged from the hospital, ensuring timely suspension and resumption of community services.

As described in the section on barriers, a few participants stated that protection of personal information is one of the obstacles to exchanging information included in a shareable record information. One manager recognizes this barrier but explains the need to frequently clarify the erroneous perception that service providers have about protecting seniors' personal information and their ability to share such information according to the scope of current legislation. Therefore, an educational approach to address this misunderstanding would be required when setting up record-sharing mechanisms.

Improvements at the Organizational Level

Improvements to integration at the organizational level suggested by participants are: an interagency care coordinator and more health centres with multidisciplinary teams.

An Interagency Care Coordinator

Some caregivers and managers mentioned the need for better agency coordination in the delivery of health and social services to seniors. For these participants, coordination could be implemented by care coordinators who would be responsible for linking organizations, thus achieving efficient integration of care and services provided to seniors. Managers consider that a key component of this change would be to reach consensus around the scope of the interagency coordinator's role.

More Health Centres With Multidisciplinary Teams

In Manitoba, participants agree that the service model adopted by the bilingual community health centre, with its bilingual interdisciplinary care team, fosters service integration, all the more so because it is located in an access centre that brings together several government agencies. However, seniors, caregivers and service providers also concede that this centre alone cannot meet the needs of all urban Francophone seniors. Consequently, it is suggested to establish a greater number of these types of health centres.

Improvements to French Language Service Integration Which Consider the Linguistic Variable

In both provinces, participating managers, service providers, seniors and caregivers suggested improvements to French language service integration that can be addressed at the symbolic, political and regulatory, and organizational levels, as well as by communities and service providers.

Summary. Improvements to French Language Service Integration

AT THE SYMBOLIC LEVEL

- Make linguistic accessibility a priority within the health system
- Gain support from universities that study best practices

AT THE POLITICAL AND REGULATORY LEVEL

- Create an authority mandated to bring together Francophone actors
- Support the planning entities (in Ontario)
- Develop more policies and formal agreements
- Add the linguistic variable to the provincial health card

AT THE ORGANIZATIONAL LEVEL

- Promote concertation efforts between agencies that provide French language services
- Create a directory of French language services and bilingual service providers

AT THE COMMUNITY LEVEL

- Consult Francophone seniors
- Continue to champion the Francophone cause (service providers and managers)
- Improve awareness of available French language services for seniors and their caregivers

AT THE SERVICE PROVIDER LEVEL

- Raise awareness of active offer
- Train and recruit bilingual service providers

At the Symbolic Level

At this level, participants suggested the following improvements: make linguistic accessibility a priority within the health system and gain support from universities that study best practices.

Make Linguistic Accessibility a Priority Within the Health System

Within the continuum of services in Manitoba, as described in the section on barriers, the health system does not seem to recognize the link between linguistic accessibility and delivery of quality and safe services. According to a manager who works in a government agency: "*I believe it is… there is only a small group of people who really think, it [the language issue] is something that they consider important… and the system is really big*"[lxxiii] (W-4).

Gain Support From Universities That Study Best Practices

Both in Manitoba and Ontario, better connections between service delivery organizations and researchers would be beneficial. A manager explains that research evidence on the needs of the Francophone senior community and best practices in access and service integration are an invaluable support to the agency's funding applications.

At the Political and Regulatory Level

At the political and regulatory level, participants suggested the following improvements: create an authority mandated to bring together Francophone stakeholders, support planning bodies, develop more policies and formal agreements and add the linguistic variable to the provincial health card.

Create an Authority Mandated to Bring Together Francophone Actors

It is crucial, according to a manager, to have an authority that brings Francophone actors together to enable a trajectory of French language service improvement and integration: *"There needs to be someone who assumes leadership and brings all these people around a table and have them work towards objectives"*[lxxiv] (RO-16). As stated in the section on barriers, such leadership is currently absent in Eastern Ontario. This manager suggests that the *Réseau* could take on this role.

Support the Planning Entities (in Ontario)

Eastern Ontario participants mentioned how important it is to "*provide ongoing support to the Réseau and its initiatives*"[lxxv] (RO-27, manager), and to value its participation as a planning entity in committees and working tables. There is also an eagerness to see the *Réseau* be more involved in community services. In this respect, a community services manager spoke of personal efforts to engage the *Réseau* to encourage this entity to examine the issue of offering French language community services.

Develop More Policies and Formal Agreements

According to a Francophone community service manager in urban Eastern Ontario, a policy is needed to go beyond funding and protecting French language services. This policy could support intentional pairing between Francophone seniors and French language services: *"A policy (…) by which the LHIN mandates, in a Francophone perspective, that when a Francophone receives home care services, is he also paired with a Francophone organization?"*[lxxvi] (RO-20).

Given staff turnover in the health field, managers in Manitoba note that relying on informal rather than formal agreements can jeopardize ongoing bonds, as well as practices that foster collaboration and continuity of French language services. However, these existing or potential agreements must be maintained and nurtured for positive interagency relations to persist.

Add the Linguistic Variable to the Provincial Health Card

A Manitoba manager suggested that adding the linguistic variable to the provincial health card, as currently done in Prince Edward Island, would simplify identification of Francophones: *"Whenever you go to the hospital, when they enter your information, it says your language"*[lxxvii] (W-2). As a result, language use is established, regardless of where the person goes for health or social services. This would increase linguistic accessibility throughout the continuum of care.

At the Organizational Level

At the organizational level, improvements suggested by participants are: promote concertation between organizations that provide French language services and create a directory of French language services and bilingual service providers.

Promote Concertation Between Organizations That Provide French Language Services

In Eastern Ontario as in Manitoba, it was suggested that Francophone organizations from the health and social service sectors meet to develop concertation[27] among their services. According to one manager, this would be *"a new way of working together"*[lxxviii] (RO-15) to *"coordinate as much as possible the linguistic dimension of these French language services"*[lxxiv] (W-1, manager) to better meet the needs of Francophone seniors and their caregivers. It could be done by creating a *"Francophone structure"*[lxxx] (RO-15) of health and social services that would be apolitical in nature. Managers envision a structure that would foster information sharing, enhance funding applications, and inform ways of working together to improve the offer of French language services. As stated by a Manitoba service provider:

> *I think that sometimes, collaboration is a little scary because people believe that it will increase their workload, but what it really means is that each one will bring their small contribution. It does not mean more work, it means having more people who contribute what they can, instead of trying to do it alone.*[lxxxi] (W-9)

Besides formal mechanisms such as committees and working tables, it was suggested to create informal but more targeted opportunities for knowledge sharing among organizations that provide services to Francophone seniors. In addition to such benefits as professional and intellectual networking, these exchanges could help organizations *"increase the Francophone capacity, better defining what we do with Francophones"*[lxxxii] (RO-20), suggests a manager.

27 Concertation is defined as "a form of dialogue and co-decision, implying mutual exchange of information, open discussion and knowledge sharing, and the signature of operational agreements" (Wiktionary, https://en.wiktionary.org/wiki/concertation).

Create a Directory of French Language Services and Bilingual Service Providers

To improve coordination among French language services, participants suggest identifying and listing services available in French as well as bilingual health and social service providers and distributing this directory to all service providers in these sectors.

At the Community Level

At the community level, suggested improvements are: consult Francophone seniors, continued support of the Francophone cause by service providers and managers and increased awareness of available French language services for seniors and their caregivers.

Consult Francophone Seniors

Managers as well as seniors insisted on the need for more opportunities to engage senior service users in service planning to ensure that such services meet the seniors' needs.

Continue to Champion the Francophone Cause (Service Providers and Managers)

Participants specified that each service provider or manager should ensure that French language services are mentioned in committee meetings and workgroups. As stated by a manager: *"as Francophones around these tables, we need to continue to champion the Francophone cause. It must constantly be at the table."*[lxxxiii] (RO-27). This responsibility cannot be shouldered by the leader alone.

Increase Awareness of Available French Language Services for Seniors and Their Caregivers

It would be wise to increase the visibility of services that are available in French, either by a referral website to French language services, by a navigator/navigation tools or by a well-known one-stop point of service. This would improve awareness of available services, among users as well as service providers who refer seniors to other services. Coordination can only take place between service providers, agencies and institutions that are aware of each other's existence.

At the Service Provider Level

At the service provider level, improvements to French language services mentioned by participants centred on raising awareness of active offer and greater focus on training and recruiting bilingual service providers in institutions that provide services to Francophone seniors.

Raise Awareness of Active Offer

Participants advocated for increased awareness among service providers of the importance of active offer throughout the service trajectory. This process must take into account the following factors: the importance of identifying Francophone users and communicating in French, using assessment tools in French and French documentation that explains conditions, care and resources; the importance of language in terms of referrals; and especially, the importance of raising awareness among Anglophone colleagues of the impact of language barriers. In this respect, a manager notes that it is essential to raise awareness among Anglophone service providers and managers about the language issue, because these persons can become our best advocates:

> *It means bringing the discussion, not only with Francophones who know what needs to be done, but to keep bringing the discussion to those who also have a responsibility, but do not see it as their responsibility. It means continuing to bring up this discussion, for it to simply become "the way it is".*[lxxxiv] (W-4)

Train and Recruit Bilingual Service Providers

To address bilingual service provider shortage, especially in services for seniors, it is essential to maintain French language professional training programs in minority settings. A few caregivers note that the needs of people with reduced autonomy (respect, dignity, specific health conditions, dementia, sensory deficits, how to live with grief and loss of autonomy) and how to intervene with these persons should be integrated into training. Furthermore, some participants suggested the development of a promotional campaign, targeting young Francophones and focusing on careers in gerontology and French language training programs. For their part, managers propose the design of an innovative recruitment strategy intended for bilingual staff and formalization of the hiring process that considers linguistic skills. These mechanisms could result in increased bilingual staff in minority settings.

DISCUSSION AND RECOMMENDATIONS

This study aimed to explore the organization of health and social services provided to Francophone seniors living in minority settings in two Canadian regions. Research questions focused on formal and informal mechanisms that integrate the linguistic variable and foster networking among services intended for Francophone seniors living in a minority context. Through individual interviews and focus groups, seniors, caregivers, service providers and managers had the opportunity to share their personal or professional experience in navigating throughout the continuum of French language health and social services. Several practices and mechanisms enabling collaboration between bilingual service providers and services were highlighted. Use of the *Framework for the analysis of health and social services access and integration for official language minority communities* (Savard et al., 2017) enabled the identification of facilitators and barriers to service continuity in the minority language. In this section, we will outline new knowledge gained during this study and some findings we consider of utmost importance. We will then detail recommendations aiming to improve the continuity of services provided in the minority official language.

New Knowledge Emerging From This Study

This study enabled us to capture undocumented knowledge from actors' (professionals, managers, seniors and caregivers) lived experience of seniors' French language health and social service continuity. While coordination practices ensuring linguistic service continuity were the focus, we quickly realized that participants spoke more frequently of challenges in accessing French language services. This may be a result of system fragmentation and lack of continuity mechanisms for French language services. It may also be linked to the difficulty of achieving full integration (Couturier et al., 2013) in regions with small Francophone populations.

Thus, it appears to be 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 individuals and caregivers' experience throughout 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 condition (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 French language services can then 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, such as users, caregivers, health and social service providers and managers. Many of them adopt informal behaviours and practices to promote French language service continuity. These include the use of directories listing bilingual service providers and services; networking among bilingual service providers; the active offer of French language services; and a genuine commitment on the part of bilingual professionals to provide those who so desire as many services as possible in their own language. Participants highlighted the existence of numerous French language services and many bilingually designated agencies. Overall, managers working in these organizations know each other and are open to working together whenever possible.

Linguistic continuity appears 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 (Manitoba), senior support service providers tend to communicate better with each other when the senior's care is managed by a bilingual case manager from homecare services; this contributes to care integration. These examples of service coordination for particularly vulnerable populations illustrate that, where key players have the will to do so, a better integration of client-centred services is conceivable. However, continuity of French language services is still a challenge given the lack of specialized services available in French.

Within structures that support seniors, caregivers and professionals throughout the service trajectory, participants reported several levels of influence on service integration. First, the organizational structure is recognized as essential in implementing practices, tools and mechanisms that foster French language service continuity. Enablers of linguistic accessibility and continuity include the formal practice of linguistic variable data collection, working tables and shared communication tools.

Continuity of French language services is also boosted by the vitality of the Francophone community and the commitment of its members. Participants highlighted the enthusiasm for innovation and collaboration on the part of some managers for whom French language service provision to seniors is important. Given organizational and budgetary limitations, some managers seek to do things differently to better meet their service users' needs. Many of them also referred to the close relationships built between organizations due to the solidarity that brings Francophone service providers and managers together in minority settings. Inspired by the shared willingness to improve French language services, they developed trusting relationships that encourage concertation and mutual assistance.

However, many participants also reported that certain barriers result in the absence of French language health and social service continuity. Foremost, because of the shortage of bilingual services, particularly in areas with small Francophone populations, access to a continuum of French language services is difficult. Furthermore, lack of translation resources creates a shortage of tools and documentation to inform seniors more adequately about services available in French.

Lack of awareness of bilingual services also seems to be an important obstacle. Francophone seniors report difficulty identifying and accessing these services. In Ontario, the partial designation of some institutions is problematic in that these designated services are not well-known to the public. It would be beneficial to have one French language service access point.

Several participants also referred to the shortage of service providers or an insufficient optimization of bilingual human resources. Even in institutions with bilingual staff, seniors and their caregivers report limited active offer: staff members aren't always trained in active offer or are not assigned to Francophone seniors. In addition, the lack of French language assessment tools, shared communication tools, and in some cases, formal intersectoral directories listing resources available in French persist. Without these tools, French language service provision throughout the continuum is difficult.

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 French language services throughout the continuum.

At the organizational level, in most of the regions we studied, few mechanisms or formal service agreements aiming to offer continuous French language services exist. On the contrary, participants found that most of the time, agreements are 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 better bridging between services.

The issue of precarious funding is also raised, as organizations must allocate resources to the greatest needs. Where linguistic barriers for Francophones are unrecognized, few funds are earmarked for French language services.

At the political and regulatory level, service continuity in the minority language is infrequently considered: participants brought up issues of the precarious funding of French language services in general, and triage based on geography rather than required language of service. Absence of formal mechanisms between health and social sectors results in fragmented services, report participants.

Designation is the main mechanism that promotes the provision of French language services. However, designation imposes no obligation on organizations to collaborate to provide a continuum of French language services. In Ontario, for instance, designation takes place on an organization by organization basis, and no mechanism specifies that a Francophone has priority access to designated services. When triage for a specific service does not consider the linguistic variable, access to a Francophone hospital is limited. We therefore question whether designation should also include collaboration between designated organizations.

Despite laws and policies on French language services in the fields of health and social services in the two regions studied, there are no policies for service continuity in this language; 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 LHIN in supporting French language services. It would be beneficial for these organizations to be more involved in service integration by giving priority to the community service sector, a frequent entry point for service users.

Finally, at the level of the symbolic structure, which relates to values and beliefs, as well as social representations of health and health determinants, participants report lack of understanding of the impact of language barriers on access to safe, satisfactory and quality care. Although well documented for minority language populations in the international sphere (Bowen, 2015; Schwei et al., 2016), the situation of Francophones living in minority settings in Canada is less present in the scientific literature (de Moissac, 2016). A manager who is unaware of linguistic issues faced by the 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 difficult circumstances experienced by Francophone seniors, managers get a better grasp of the importance of language for safe and quality care. On this matter, it is essential to raise awareness among managers and service providers. An innovative approach to training Anglophone managers has been developed by Toronto's Reflet Salvéo.[28]

28 http://refletsalveo.ca/formation-en-offre-active/ (in French)

In addition to the above, the authors observed that in general, social services are more integrated than health services. Could this be related to social services' inherent ability to facilitate concertation 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.

The authors also witnessed the vitality of the Francophone minority community and the commitment of its members. This community is rich with opportunities, and its members' involvement and networking abilities could be drivers for change. To co-construct linguistic continuity, strengthening connections between Francophone communities and services and ensuring greater involvement of Francophone seniors' associations in health and social service organizations are essential. By sharing their experience, Francophone seniors and their caregivers could provide relevant suggestions for the improvement of French language services throughout the continuum and the overall experience of service continuity.

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

These recommendations are based on participants', research team members' and Advisory Committee members' suggestions for improving the continuity of French language services. We believe these concrete actions may support decision makers, managers, service providers and members of the Francophone community, each in their own way, and can be adapted to suit local realities. We begin with recommendations for service providers.

Recommendations for Francophone, Francophile and Anglophone Service Providers

1. Gain the knowledge and skills required to practice active offer.

   Suggested courses of action:

   - Participate in training on active offer, for instance:
     - Toolbox for the Active Offer is a website that proposes a range of free quality resources and pedagogical tools (videos, case studies and online training) to better understand the underlying notions of active offer;[29]
       Training workshops on active offer for care providers in designated bilingual settings;[30]
     - Awareness-raising regarding Francophone minority communities' characteristics and needs, as diverse as they are;
     - Awareness training regarding Francophone minority communities in French college and university health and social work programs;
     - Information on assessment tools available in French.
   - Apply the principles of active offer with one's clientele, based on one's linguistic ability.

2. Contribute to service providers' enthusiasm and sense of belonging to the Francophone community.

   Suggested courses of action:

   - Identify oneself as Francophone or bilingual;
   - Participate in activities that promote Francophone culture in the community and in the workplace;
   - Obtain leadership training and apply these skills French language service promotion;
   - Promote careers in gerontology and French language training among young Francophones.

3. 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.

   Suggested courses of action:

   - Participate in these networks, and contribute to their development and sustainability;
   - Share information with colleagues about French language services, their access and business hours or times when there is a Francophone presence;
   - Seek to improve access and continuity of French language services within networks;
   - Raise managers' and the organization's awareness of the importance of these networks.

29 http://www.offreactive.com/home/

30 Online workshops offered by the Continuing Education Department, Université de Moncton: http://www.umoncton.ca/offreactive/en/node/18

These three recommendations aim at providing Francophone, Francophile and Anglophone service providers with the tools to offer French language health and social services to Francophone seniors, value their sense of belonging to the Francophone minority community and strengthen their formal and informal networks and promotion of these services among Francophone seniors.

Recommendations for Francophone Communities

1. Increase the Francophone community's visibility within health and social service sectors in linguistic minority settings.

   Suggested courses of action:

   - Designate community members to sit on public health organization boards or users' committees;
   - Offer to organize cultural activities in health and social service organizations, for example on the *Journée de la francophonie*;
   - Be aware of and share their members' experience of challenges with French language health and social services access and continuity, and bring these forward to the relevant organizations' boards or service user committees;
   - Organize a fair or an exhibition focused on French language services and invite agencies that offer some of these health and social services in French to promote their services;[31]
   - Create awards to recognize the work of Francophone service providers or key players who promote access to French services in the community's health and social service network;
   - Establish formal links between French language health and social service networks and Francophone seniors' associations to learn more about their needs.

2. Develop connections between the community and organizations that provide health and social services in French, to expand their visibility, and the community's use of these services.

   Suggested courses of action:

   - Set up sharing mechanisms among service providers and Francophone communities;
   - Remind agencies to advertise French language services and their availability on promotional documents;
   - Invite service agencies to take part in events organized by Francophone communities (e.g. health conference, health fair);
   - Reach out to Francophone communities in their gathering places (e.g. parishes, associations, social clubs) to offer service or health promotion activities.

These two recommendations highlight the significant role that Francophone communities can play in improving French language service integration. As stated by the Conference Board of Canada (2012), initiatives that foster integrated health services cannot come about without user participation. For their part, Tremblay et al. (2014, pp. 4–5) echo this notion by stressing the importance of establishing mechanisms for sharing and evaluating services, as well as partnerships between service providers and users to help achieve service integration. Thus, the active engagement of the Francophone community is essential to any effort aiming to improve French language service continuity. Given that 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 service improvements.

31 For instance, every two years, the French Language Health Services Network of Eastern Ontario organizes the French Health and Well-Being Expo. http://carrefoursante.ca/en

Furthermore, it is critical to improve French language services' visibility so that Francophone seniors and caregivers are aware of their presence and availability. Dissemination of information about services must reach Francophone seniors and their caregivers, not only through information networks (television, radio, newspaper), but also in their gathering places (e.g. parishes, associations, social clubs) (Pécore-Ugorji, 2016).

Recommendations Related to the Organizational Structure

1. Raise awareness about, and train managers in, active offer.

   Suggested courses of action:

   - Provide training to Anglophone managers and executives on active offer;
   - Establish partnerships to design French and English language training workshops on active offer that meet the needs of service providers in the workplace;
   - Gain knowledge about the social and health statistics of the Francophone community living within the organization's catchment area.

2. Organize resources to enable active offer.

   Suggested courses of action:

   - Formalize staff hiring processes to take into account linguistic skills;
   - Consider and implement recommendations for bilingual employees and employers outlined in the *Framework for Recruitment & Retention of Bilingual Human Resources in the Health Sector* (Tremblay, 2015);[32]
   - Use self-assessment tools such as:
     - *Organizational and Community Resources Self-Assessment Tool for the Active Offer and Social and Health Services Continuity* (Savard et al., 2017)[33], or
     - *A Self-Assessment Tool—Implementation of French Language Services* by Dumont and Doucet-Simard, 2013[34];
   - Make training on active offer available to employees;
   - Identify bilingual service providers and assign them in such a way that ensures equitable access to services in French and continuity of French language services within the organization;
   - Implement a policy of intentional pairing between Francophone users and bilingual or French-speaking staff;
   - Have resources for the active identification of Francophone seniors;
   - Conform to minimal standards of practice in interpretation (see Healthcare Interpretation Network, 2010).

3. Encourage Francophone managers and professionals to continue championing the Francophone cause in English-speaking committees and working tables of which they are members.

   Suggested courses of action:

   - Offer leadership training to Francophone managers and service providers;

32 Available online at https://santefrancais.ca/cadre-de-reference-pour-le-recrutement-et-la-retention-des-ressources-humaines-bilingue-en-sante-cadre-rh/

33 http://www.grefops.ca/uploads/7/4/7/3/7473881/selfassessment_tool.pdf

34 "A Self-Assessment Tool—Implementation of French Language Services", published in pages 135–138, in Dumont & Doucet-Simard (2013), French Language Services Toolkit. The Erie St. Clair and South West Local Health Integration Networks of Ontario, p. 179. Available at http://www.southwestlhin.on.ca/goalsandachievements/Programs/FLS.aspx

- Integrate activities that promote leadership into active offer training;
- Recognize that French language service continuity is fostered by formal and informal networks that facilitate information sharing between organizations and interagency referral mechanisms;
- Support managers and service providers who take part in these networks' activities.

4. Formalize liaison and coordination processes among French language health and social services to promote service continuity.

   Suggested courses of action:

   - Create a directory of French language services;
   - Develop formal agreements for referring the Francophone clientele to available French language services;
   - Systematize access to information about linguistic preferences in interagency referral forms;
   - Encourage the use of a navigator[35] in French language health and social services.

This level features a greater number of recommendations for linguistic continuity improvements. This is mainly due to the organizational structure's crucial role in the quantity, volume and distribution of human, material and financial resources earmarked for health and social services. In addition, organizational cultures have a considerable influence on the establishment of French language services (Bouchard, Savard, Savard, Vézina & Drolet, 2017). Although policies, regulations and guidelines, which are developed at the political and regulatory level influence the organizational structure, there are several areas within this structure where managers can manage and distribute resources. The four recommendations suggest concrete activities readily available to managers.

It is essential to first raise managers' awareness of the importance of active offer and continuity of French language services in non-designated organizations that provide services to Francophone seniors. Resource adaptation may be needed to promote the practice of active offer: concrete tools (de Moissac et al., 2014; Savard et al., 2017; Tremblay, 2015) have been developed to guide managers with such adaptations. Free online training on active offer[36], in both official languages, can be made available to employees. The ability to rely on up-to-date directories of bilingual service providers and to intentionally deploy French language services (e.g. through a policy of intentional pairing between Francophone seniors and bilingual or French-speaking staff) would allow for more regular delivery and coordination of an organization's French language services. It would also prevent dispersal of limited Francophone or bilingual resources.

To track the emerging needs and plan services and resources of a population that is often geographically scattered, it is essential to actively identify its members. Identification of Francophone seniors can be carried out by interacting with Francophone seniors where they live and/or gather. However, given the importance of privacy (Contant, 2014, p. 13), an individualized approach would be needed, especially in regions with low Francophone populations and in rural areas. In these settings, individual contact would be preferable to build trust and foster service acceptance. Identification of Francophone seniors could be automated if users' linguistic variable was recorded on the health card, as is currently the case in Prince Edward Island.[37] This innovative strategy would lead to systematic identification of Francophones, thus enabling service planning according to their location and needs. In this respect, discussions are emerging in several provinces where Francophones live in a minority context; this issue warrants close follow-up.

35 A navigator is an individual or a team trained in supporting users and their caregivers when they access health and social services; they help users and their caregivers overcome obstacles to accessing health and social services and facilitate service continuity (Valaitis et al., 2017).

36 http://www.offreactive.com/

37 http://www.lavoixacadienne.com/index.php/actualites/1201-chaque-citoyen-de-l-ile-recevra-une-carte-sante-bilingue (in French).

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 (via Telemedicine) interpretation services are frequently used (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) screening and linguistic evaluation of interpreters; 4) availability of information on interpretation services for users and service providers; and 5) a data collection method enabling service evaluation (Bowen, 2004; Healthcare Interpretation Network, 2007; Winnipeg Regional Health Authority, 2013). Whether provided by community or regional organizations, these minimal standards are essential to ensure accurate, safe and complete communication.

While the integration process of French language health and social services may vary according to regional needs, these services must be adequately identified and accessible. Formal agreements must be put in place to ensure the continuity of services that are available in French, and systematic documentation of linguistic preferences in referral forms must be planned for. In addition, the use of navigators in French language health and social services should be explored. A navigator, who is familiar with all French language services, could help seniors and their caregivers determine where services are available. The navigator role is increasingly acknowledged and validated as an essential element of continuity for seniors and their caregivers (Drolet et al., 2015; Manderson, McMurray, Piraino & Stolee, 2012; The Change Foundation, 2012). Research highlights the contribution of navigators to an improved access to quality services for minority linguistic communities (Natale-Pereira, Enard, Nevarez & Jones, 2011; Shommu et al., 2016). Given the multiplicity of navigation models and pilot projects, Prud'homme et al. (2016, p. 19) prioritize the standardization of navigation and supporting a network of Francophone navigators in Ontario's health services. To this, we would add "in health *and* social services", to ensure that transitions between these sectors can proceed in a more concerted and continuous manner.

Recommendations Related to the Political and Regulatory Structure

1. Integrate the concept of active offer into laws and policies overseeing French language health and social services in Canadian provinces and territories.

2. Implement policies that account for the linguistic variable in the organization of health and social services.

   Suggested courses of action:

   - Include linguistic data on health card;
   - Promote Francophone governance of French language services:
     - Entrust a structure with the mandate of promoting concerted French language services.
   - Integrate linguistic and cultural standards in institutional accreditation standards;
   - Require that third parties entrusted with the responsibility of health and social services by provincial or regional authorities conform to the same active offer norms and standards as government bodies;
   - Consider the linguistic factor in triage and eliminate barriers associated with triage based on geography:
     - Develop exception and collaboration procedures between two organizations operating in neighbouring territories.

- Facilitate the implementation of measures that prioritize access for Francophones in Francophone and bilingual organizations;
- Encourage professional bodies to document their members' linguistic competencies;
- Create incentives that support organizations seeking to improve their French language services:
  - Fund training on active offer;
  - Fund training aimed at improving or maintaining linguistic competencies in French and in English for service providers;[38]
  - Associate health and social service funding to French language service improvement goals and monitor achievement of these goals.
- Ensure concrete and accurate implementation, follow-up and update of designated bilingual institutions;
- Include, in designation mechanisms, elements that promote collaboration between designated organizations to improve French language service continuity.

These two recommendations highlight the principle of active offer; support for this practice is provided by laws and policies related to French language health and social services across the country. In addition, enforcement of these laws or policies would be required: as stated by Ontario's French Language Services Commissioner (2016), several studies reveal that, despite good intentions and legal frameworks, active offer is relatively unknown.

Implementing these policies in service organization can be done in many ways. For example, a pilot project aiming to collect the linguistic identity of Francophone users was led by Ontario's East and South East French Language Health Services Networks. This is an example of process improvements which support the distribution of health resources according to the Francophone population's needs.[39] In some cases, implementing these recommendations could generate new organizational competencies around active offer (French Language Services Commissioner, 2016).

Furthermore, Francophone governance of French language health and social services is increasingly widespread (e.g. the Orléans Health Hub[40] in Eastern Ontario, and the Centre de santé communautaire Hamilton/Niagara in Southern Ontario[41]) and appears to be the most favourable component of continuity and coordination of French language services. In Manitoba, Centre d'Accès—Access St. Boniface Centre, created in the spring of 2016, brings together bilingual health and social services[42] under one roof; it appears to be a promising structure for the promotion of service continuity for the neighborhood's Francophone seniors.

Developing linguistic and cultural competency standards for the accreditation of health and social service institutions is a favorable mechanism for improving access to French language services. The Health Standards Organization and Société Santé en français recently announced their collaboration in creating the *Organizational Competency Recognition Program* and the *Communication in Minority Language Situations Standard*.[43]

Although provincial guidelines establish geographical triage, regional managers could choose to honour exceptions and collaborate with other agencies operating in neighbouring territories to

38 For example, Dumont & Doucet-Simard (2013, p. 179) mention a French Language Training Program offered by the Southern Ontario LHIN. It is funded by the French Language Services Office of the Ministry of Health and Long-Term Care and coordinated by L'Accueil francophone de Thunder Bay.

39 http://rssfe.on.ca/en/our-priorities/inspiring-collaboration/initiatives/

40 https://hopitalmontfort.com/en/orleans-health-hub

41 http://www.cschn.ca/

42 https://centredesante.mb.ca/5-choses-que-vous-devez-savoir-sur-notre-nouvel-emplacement-acces-access-St. Boniface/

43 https://healthstandards.org/news/hso-and-ssf-collaboration/

facilitate access to French language services. In addition, where waiting lists exist in organizations that provide French language services, measures could be taken to reserve a given number of places for Francophones, thereby ensuring that bilingual resources are optimized to improve Francophones' access to French language services.

Financial incentives could be put in place to support organizations that seek to enhance French language services, by associating funding to tangible improvement objectives.

Finally, bilingual designation could be supported by concrete and accurate monitoring and updating mechanisms, as provided by French language planning authorities in Ontario (see for instance, the French Language Health Services Network of Eastern Ontario).[44]

Recommendations Related to the Symbolic Structure (Values)

1. 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.

   Suggested courses of action:

   - Among decision makers and the public, document and promote associations between satisfaction, safety and quality of services and the linguistic variable;
   - Raise decision makers' awareness of the consequences of language barriers on access to services, especially preventive services;
   - Raise decision makers' awareness of which linguistic factors positively influence patient safety.

2. Value Francophone seniors' participation when looking for solutions to improve the continuity of their intended health and social services.

   Suggested courses of action:

   - Actively seek the contribution of Francophones in public consultations about health and social services:
     - Hold distinct consultations in both official languages;
     - Advertise these consultations simultaneously, in both official languages, in Francophone and Anglophone media;
     - Organize consultation reports so they reflect the respective priorities and needs of both official language communities.
   - Promote a collaborative approach in research:
     - Include members of the Francophone community, practice settings and Francophone leadership entities in research project advisory committees.

44 http://rssfe.on.ca/en/our-priorities/supporting-designation/

We propose two recommendations so that linguistic accessibility can become a priority within the health and social service sectors and be reinforced with decision makers. First, we suggest sensitizing and disseminating key information to decision makers, including the association between safety of care and spoken language (Bowen, 2015).

Secondly, we recommend Francophone seniors' participation in consultations and research projects pertaining to French language service improvement and continuity. To ensure such involvement, Francophone community members must be adequately informed of these opportunities. Indeed, representatives of the Fédération des ainés et des retraités francophones de l'Ontario (FARFO) régionale d'Ottawa reported that consultations are often held first in English, then in French. Francophones who are present at the first meeting are not aware that consultations in French will be held later. As a result, the Francophone community's perspectives are merged with those of all participants, and the specific needs of Francophones are not brought to light.

CONCLUSION

In conclusion, this study reveals critical issues related to the access and continuity of French language health and social services for Francophone seniors living in minority linguistic 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, French language service use throughout the continuum of care is minimal. To establish and maintain productive and coordinated French language interactions between users who are characterized as an invisible minority, and the range of health and social service providers they will 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 and historic connections help generate collaborative strategies. However, significant barriers must be overcome, such as: complex health and social service systems; limited resource allocation to official language services in a minority context; shortage or lack of optimization of bilingual human resources, services and tools to support the active offer of French language services and the lack of formal intersectoral mechanisms to ensure service continuity in French. These substantial challenges highlight the need for new initiatives to foster a continuum of French language health and social services in a minority context.

In the field of health and social services, liaison, coordination and full integration seem central to meeting the needs of the Francophone population living in a minority context. These approaches propose tools and practices to facilitate users' seamless navigation through the service trajectory. Services should be focused on seniors' and caregivers' needs, as these individuals are informed, empowered and proactive participants in their quest for well-being. We should be reminded, however, that in the current organizational context and given the barriers mentioned earlier, full service integration is a complex and unlikely outcome. Nevertheless, this study brings forth some strategies, primarily aimed at liaison and coordination between existing services, to help meet our targeted population's needs more adequately. If it is at all possible to imagine new structures, then we can ask ourselves: Could the delivery of health and social services to Francophones living in a minority situation be undertaken by an organization with a Francophone governance, along the lines of the current education system (for example, Francophone school boards)? Is health and social service management for and by Francophones possible? Would existing barriers be mitigated by such an approach? This hypothesis could be explored in future research.

The proposed recommendations highlight the importance of adopting policies that take into account the linguistic variable in service organization. They also support an organizational structure which values and ensures leadership on this matter, establishes formal collaborative agreements between designated institutions, fosters networking among various Francophone actors throughout health and social services systems, while promoting active offer essential for safe and quality care. They emphasize the role of service providers and communities in maintaining this dynamic and collaborative spirit. Strengthened by the vitality of the Francophone minority community and the commitment of its members, it is entirely conceivable that continuity of French language social and health services becomes a reality.

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APPENDIX I

PART 1: INTERVIEW GUIDE FOR INDIVIDUAL INTERVIEWS (MANAGERS) AND FOCUS GROUPS (SERVICE PROVIDERS)

Introduction

- Following up on the form you have signed, I will now proceed with questions about the types of practices within your organization, both formal and informal, that are part of delivering integrated care or services to francophone seniors.
- Your experiences and opinions will enable us to better identify the formal and informal networks that francophone or bilingual health and social service professionals establish in order to provide integrated care or services in French for Francophone seniors living in a minority context.

Background/context

- Could you please briefly summarize your duties in this organization?
- In what way do these duties bring you in contact with francophone seniors?
- Which services do you offer to seniors?
- Do francophone seniors have access to these same services?

A. Discussion questions

Organizational perspectives

Our first question deals with services for seniors in general. In many cases, seniors with complex needs require services from a range of organizations.

1. To your knowledge, which mechanisms enable the coordination of services when these persons receive services from several organizations? (If needed, explain what are continuous and integrated services.)

Our second question is specifically related to francophone seniors:

2. In your region, what are the mechanisms by which these persons could receive most of their services in French?
   - What systems are in place to identify those that could benefit from services in French (offering services before they are requested)? If so, can you provide a few examples? If not, why?
   - Do service agreements exist (service corridors, services lines, pre-established service-chains, corridor programs) within organizations offering services in French?

If so, what are they and how are they implemented in practice?

If not, what do you do to answer specific needs for services in French?

- What are you doing to answer the needs of francophone seniors living in low-density francophone communities?

The following two questions relate to the French Language Health Services Network (in French: Réseau de services de santé en français), and the process of designation:

3. What role does the French Language Health Services Network play in your work regarding facilitating continuity and integration of services in French?
4. What are the effects of designation -established by the legislation on francophone services- on the availability of services in French? Can you illustrate your answer with a few examples?

Service users' perspectives

Now we would like to ask a few questions regarding service users' perspectives:

1. For a francophone senior or francophone family caregiver in need of health services, do you know if there are points of access that allow easy navigation of these systems and enable the finding of needed resources?
   a. If so, what are they, and how is this done, in practice?
   b. Do these systems mention clearly and precisely what services are available in French?
   c. If not, how can these persons obtain information?

2. Do you know if there are francophone or bilingual case managers who ensure continuous follow-up with seniors across the entire continuum of services?
   a. If so, how do they function/with which sites are they associated?
   b. If not, do you know if there is anyone informally assigned to look after this coordination?

3. Do information tools exist (clinical files, evaluation tools, planning tools) that promote information exchange between social services and health care?
   a. If so, what are they, and how is this done in practice?
   b. Do these tools specify the senior's and/or the family caregiver's preferred official language?
   c. If not, how do you share information, evaluate needs, and plan for services?

Service Improvement

The following questions are related to service improvement:

1. What are the main problems/obstacles that impede continuity and integration in services for francophone seniors?
2. What could be done in your setting to improve the continuity and integration of services in French?
3. What impedes this from being done?

B. Case studies

For interviews in hospital or rehab settings

1. Mamadou Benoit Diallo (stroke) – Please note that both the person's name and situation are fictitious

On August 2nd, Mamadou Benoit Diallo, 68 years old, found himself on the floor, unable to get up; he couldn't move his right side, and he could hardly speak. The paramedics who first came to his assistance thought of a stroke. They took him to the **emergency room**. After a few hours in the ER, the diagnosis was

confirmed. He was admitted to the **stroke acute care unit**, where his medical condition was stabilized and the first phases of rehabilitation were initiated: physiotherapy, for a physical evaluation and mobility; occupational therapy, to evaluate his daily activities; and speech therapy to assess his speech. Two weeks later, he was transferred to **in-patient rehabilitation** for a two-month period, during which the above services were continued and to which psychology and social work services were added.

Upon leaving, he will need an assessment and adaptation of his home by an occupational therapist. Also, for a three-month period, he will be required to receive physiotherapy services, out-patient speech therapy, and a weekly blood-pressure follow-up. The social worker recommends that he participate in a group activity suited to his abilities and will organize help for weekly baths and transportation (groceries, medical appointments).

A year later, having recovered quite well, he'd like to know if he can get his driver's license back. It is recommended that he be referred for an occupational therapy assessment of his abilities and of his needs for modifications to his vehicle.

Questions :

a. In such a case, how could an effective coordination of services between the different care providers be ensured?

b. To which community resources would you reach out to complement the services offered through health care organizations?

c. How could Mr. Diallo's need to receive care in French be addressed? What mechanisms are in place to ensure continuity of services in French?

For interviews in hospital and/or community settings

2. *Marguerite Côté Young (dementia) – Please note that both the person's name and situation are fictitious*

On June 15, Madame Côté Young, aged 90, suffered a fall in her home. It was the duty cleaner affiliated with the community centre XYZ who informed her daughter, who, in turn, reported the fall to the doctor. Her doctor referred her to the **geriatric assessment clinic**, where an undiagnosed type II diabetes condition was identified as the cause of the fall. The doctor tried to stabilize her condition through medication and diet. To this end, she met with a dietician, who provided instruction. After six months, it was discovered that she was not able to control her glycaemia. It was thought that she was having difficulty following through with instructions. She was again evaluated at the geriatric assessment clinic, and the initial stages of dementia were now suspected. The family was referred to the **Alzheimer's Society** to obtain support. For her diabetes, the doctor recommended insulin injections. Since the woman lives alone, the family hired a private home-care agency for nighttime surveillance and for the insulin injections. The geriatric assessment clinic also evaluated the need for shower assistance and referred her to the **Community Care Access Centre (CCAC),** which, after a 3 week wait time, offered her showering assistance three times a week. This was provided by a service agency contracted to the CCAC. Madame Côté Young thus found herself assisted by **three distinct agencies**: one for housekeeping from a community agency, one for personal help paid for by the family, and the other for showering assistance paid by the CCAC. One of these agencies regularly sends francophone workers to Madame Côté Young, the other two do not appear to consider language. Despite Madame Côté Young's difficulties in adapting to several assistance providers, the arrangement enables her to live at home for two years, with the constant support of her four daughters.

Questions:

This case study paints a picture of fragmented services. What can be done to promote a better integration or coordination of care?

a. What role can your organization play in the improvement of coordinated and/or integrated care?
   - In a situation such as this one, how could frontline public services be coordinated between themselves and the work of the family doctor or community agencies?
   - What role can you play to support families as they navigate through services?
   - *For doctors or case managers:* What mechanisms enable you to be informed of the services received from various agencies?

b. Is it possible for you to insist on services being offered in French or to find resources able to provide services in French?

c. If her condition worsens such that she needs constant supervision which the family can no longer afford, how should the transition to eventual placement in a long-term health-care facility be done, such that her need for services in French is respected?

For community settings

3. *John Boileau (poverty and abuse) – Please note that both the person's name and situation are fictitious*

Mr. Boileau, 75 years old, a smoker and relatively sedentary, suffers from hypertension and heart disease, which causes angina. When younger, he worked as a labourer and went through numerous periods of unemployment. His only income is government assistance (Old Age Security and Guaranteed Income Supplement). He lives with his 25-year-old son, since neither one would have the financial means to live in an apartment alone. Because he has a tough time making his money last until the end of the month, he regularly visits your **community centre** for X, Y, and Z activities. One day, a worker noticed that he was having trouble walking. He told her he had an ingrown toenail that caused him pain, that he had a hard time seeing because he has not changed his glasses in the last 20 years, and that he does not fully understand his medication. The workers, who with time have come to know Mr. Boileau, suspect that he may also be experiencing abuse at the hands of his son who seems to be involved with the criminal justice system. He agrees to talk about the situation and even begins considering moving into subsidized housing, though the prospect frightens him a little.

Questions :

a. Do you have a network of health resources (foot care clinic, optometrist, and pharmacist) to which you can send someone like Mr. Boileau?

b. Do you have social and community resources (meals on wheels, emergency housing, social intervention team, etc.) to which you can send Mr. Boileau?

c. How can his need for French services be considered (mechanisms)? Would it be possible to ensure that all services be offered in French (resources)?

On collaboration:

d. In a case such as this, how can health services/social services collaborate with social services/ health services to better address Mr. Boileau's needs?

e. In a case such as this, how can public services collaborate with private or community resources to better address Mr. Boileau's needs?

PART 2: FOCUS GROUP QUESTIONS FOR FRANCOPHONE SENIORS OR THEIR CAREGIVERS

Context:

- In 1 minute (per person), can you identify a circumstance where you (the senior) or (for caregiver) the family member you care for have needed social or health services in French.
- In 1 minute, tell us about the people you can rely on in times of need.

Navigating through and access to services:

- To what extent is it important for you to receive services in French?
- To what extent were you able to access or obtain all needed services in French?
- Have you had to ask for services in French, or were you offered services in the language of your choice?
- Did you experience delays in accessing or obtaining services in French? (For instance, wait times for appointments related to tests, consultations with specialists, treatments?)
- Are there any services you were not able to get in French?
- How did you obtain information regarding available services in French that could answer your needs?
    - Did you have a preferred care provider (family doctor, case manager, other)? What is his or her role? How did he or she help you?
    - Were there other resources (workers, information services) that helped you to obtain services in French? In what form?
- Do you feel sufficiently informed or prepared to navigate through the different services? (For example, know whom to contact to make an appointment with a specialist, to apply for at-home care, to inform of a change in your state of health, to know where to obtain services in French?)
- Which services have you received from community resources?

Transitions and communication:

- If you have received services from various organizations, how did the transitions occur?
- What was helpful and what was difficult (delays, need to repeat information, missing information about health, such as test results missing from the file or information missing regarding your preferred official language)?

Conclusion:

Considering your experience, what improvements could be made to better answer your needs regarding services, as a senior (or caregiver) and as a francophone?

APPENDIX II

i « *vont se passer d'avoir un service* » (RO-16).

ii « *La langue en français [écrite] est tellement dure des fois* » (RO-78, aîné).

iii « *juste la communication médicale, je trouve qu'il faut absolument que quelqu'un soit présent presque pour faire la traduction* » même si l'aîné est bilingue, rapporte cette proche aidante (W-17).

iv « *Quand on parle à nos aînés francophones, il faut qu'ils nous comprennent. Ce n'est pas un français élaboré, la plupart du temps. Il faut se mettre à leur niveau* » (RO-27, gestionnaire).

v « *Il y a beaucoup de notre population qui n'ont pas d'ordinateur et qui n'en auront pas* » (W-27, aînée).

vi « *on a des rangs, des concessions où est-ce que les gens sont isolés et c'est difficile de les desservir* » (RO-19, gestionnaire).

vii « *Une des raisons qu'ils ont déménagé c'est que dans le milieu rural, il n'y a pas énormément de services pour les conditions cardiaques que mon père avait. Les soins à domicile en campagne, c'est difficile* » (W-18, proche aidante).

viii « *Si on a un client qui est à Saint-Boniface et qui a des services en français, puis il déménage à Saint-James, il n'a plus accès aux services en français* » (W-4).

ix « *si tu ne fais pas partie d'une église [francophone], ben là t'es déjà [isolé du réseau francophone]. Parce que (…) tu ne fais pas partie de ça. Donc, comment est-ce qu'on fait pour les rejoindre ?* » (RO-35).

x « *la programmation est offerte à chaque fois en anglais et en français : depuis le mois de mai 2014, aucun cours en français* » (W-5, gestionnaire).

xi « *grosses tensions au début* » (RO-93)

xii « *il n'y a pas cette atmosphère de bienvenue parce que tu es francophone* » (RO-93)

xiii « *On est assez habitué que ça va être en anglais, on dirait que tu oublies de demander* » (W-27, aînée).

xiv « *J'ai été très déçue parce qu'ils nous annoncent quand c'est bilingue, les services en français disponibles, et tu es au téléphone et tu attends d'en avoir des services en français, il y en n'a pas. C'est la déception* » (W-A1-59, aînée).

xv « *C'est sûr quand tu vas voir l'oculiste, c'est tout en anglais. (…) Je [ne] sais pas si c'est bon ou non. On n'en fait pas de cas. (…) C'est la réalité* » (W-22, aînée).

xvi « *veulent pas déranger* » (RO-38, intervenante).

xvii Pour ces gens, le fait de dire « *j'ai besoin d'aide* », c'est un défi « *de taille* », selon un gestionnaire (RO-19).

xviii « *Vraiment, ce qu'on voit, c'est que les francophones sont plus insulaires, c'est-à-dire préfèrent garder leurs problèmes dans la famille, ont peur de demander des services* » (RO-27).

xix « *au même niveau [et] le même service que reçoivent les anglophones* » (RO-18, gestionnaire).

xx « *J'ai pas de préposé aux bénéficiaires, j'ai pas de médecins, j'ai pas d'infirmières. Je vais travailler avec le centre multidisciplinaire ou avec la [municipalité] pour recevoir des services ici* » (RO-20, gestionnaire).

xxi « *On a une physiothérapeute qui vient de [l'hôpital régional anglophone] qui parle un peu le français. Elle se débrouille. Mais elle vient ici deux jours/semaine, donc les gens qui sont référés de [l'hôpital régional anglophone] ou des alentours qui rencontrent un certain critère peuvent recevoir des soins de physiothérapeute ici* » (RO-38, infirmière).

xxii « *[s'] assurer que le fait francophone est adressé* » (RO-27).

xxiii « *étant donné que je travaillais dans le milieu [communautaire] pendant 20 ans (…) j'ai déjà les connexions, donc je sais qui est francophone et qui ne l'est pas* » (RO-35).

xxiv « *des trajectoires naturelles qui ont toujours existé donc qui se continuent ou c'est compris de façon officieuse* » (W-1, gestionnaire).

xxv R1: *You see sometimes they come in, they cannot express themselves. They're talking to their companion in French. I say, "Oh, parle en français."*

Q1: Because you see that it would go a lot easier for them?

R1: Oh yeah, much easier because sometimes they're trying to translate, telling their husband or the daughter what to tell me. And I say, "Okay. Ça va. Je parle français, je comprends français, vous pouvez parler en français."(RO-58)

xxvi « *de penser autrement (…) de faire les choses autrement* » (RO-19)

xxvii « *les partenaires qui sont mieux placés* » (RO-25).

xxviii « *liens très forts* » (RO-30, gestionnaire)

xxix « *Même maintenant que j'ai été dedans. Même maintenant je ne comprends pas. C'est comme la main droite ne parle pas à la main gauche, ça a été vraiment un cauchemar pour mes deux parents à différents niveaux* » (W-17).

xxx « *c'est une grosse machine* » (W-5).

xxxi « *travaille beaucoup en silos : santé publique font leur chose, soins à domicile font leur chose, nous on réfère, mais on travaille un à côté de l'autre, pas nécessairement ensemble* » (W-9, intervenante).

xxxii « *chacun regarde sa paroisse* » (RO-15, gestionnaire)

xxxiii *Ça prendrait d'énormes réformes au niveau de restructurer tout un paquet de choses puis jusqu'à date on n'a pas beaucoup de volonté de le faire. Je pense que ça serait le fun de le faire au niveau d'un projet francophone parce que notre clientèle est un peu plus identifiable. Mais il n'y a pas de volonté de le faire. Il y a encore des batailles de turf dans le système.* (W-1, gestionnaire)

xxxiv « *on presse déjà le citron* » (RO-16)

xxxv *Oui, ça peut être n'importe quoi comme, des prises de sang, souvent s'il y avait un problème avec maman, ils nous disaient d'aller à l'urgence. Quel cauchemar, ça, c'est une autre paire de manches. Assoie-toi huit heures de temps avec quelqu'un qui a l'Alzheimer, horrible.* (W-17, proche aidante)

xxxvi *Ben oui, tout le monde parle français, mais si on fait une activité pis qu'il y a un anglophone, on va tout de suite le faire en anglais. Fait qu'il y en a qui ont quitté pis qui ont dit : « Non, je [ne] veux pas ça. Je veux être dans un programme de jour en français.* » (RO-20)

xxxvii « *Des fois, les gens dans le système, ils vont dire, "Access to French services is a preference, it's like wanting to be close to home… You prefer that personal care home but you don't need it." Bien non, c'est plus que ça* » (W-4, gestionnaire).

xxxviii « *C'est le niveau de priorité qui est placé sur les services en français… parce qu'on ne le voit pas comme quelque chose qui est urgent* » (W-2, gestionnaire).

xxxix *S'il m'arrive quelque chose, j'appelle l'ambulance, ils m'envoient directement à [hôpital anglophone local]. (…) Je sais que la loi, elle, c'est l'hôpital le plus proche, mais si l'hôpital le plus proche ne peut pas répondre à tes besoins [linguistiques], comment ça se fait qu'ils ne nous prennent pas et qu'ils ne nous emmènent pas à [hôpital désigné] ? (…) Ça, je ne comprends pas ça, et c'est un gros dilemme et c'est un gros problème.* (RO-81, aînée)

xl « *Moi, j'ai dit : "J'aimerais mieux aller à [hôpital désigné]". Il [ambulancier] dit : "Ton cas, c'est à [hôpital partiellement désigné], parce qu'il faut opérer tout de suite"* ». (RO-67, aînée)

xli « *Je leur [ambulanciers] ait dit "je veux aller à l'hôpital [désigné], je veux aller à l'hôpital [désigné]", pis il m'a dit : "Non. L'hôpital [désigné], ils sont trop occupés". Ils m'ont amenée à [hôpital non désigné]* ». (RO-67, aînée)

xlii « *Le problème avec le système, ce n'est pas qu'il y a des mauvaises intentions, c'est juste qu'à un moment donné, on se fait tirer des fois d'un bord pis de l'autre, sur quoi on travaille aujourd'hui* » (W-1, gestionnaire).

xliii « *de faire le plus de demandes possible* » afin de « *survivre dans une marée d'anglophones* » (RO-15, gestionnaire).

xliv « *Quand tu es en compétition avec ces gros joueurs-là [organismes anglophones], quand tu regardes leurs demandes de fonds et puis que tu regardes les autres demandes de fonds [d'organismes francophones], tu es à des années-lumière* » (RO-15).

xlv « *On n'est pas capable de me donner l'information au RLISS pour dire, si on a 17 % de la population qui est francophone, est-ce qu'il y a 17 % des budgets (…) qui vont être assignés aux francophones ?* » (RO-16)

xlvi « *Ils [CASC] m'ont demandé quel langage je parlais, et je leur ai dit que je voulais tout avoir en français. La seule chose que je trouve un petit peu difficile, on a des dames qui viennent en anglais à la maison prendre soin de mon mari* » (RO-83, proche aidante).

xlvii *Si on perd des joueurs comme ça, qui étaient stratégiques au niveau de vraiment déterminer les besoins de santé pour ces gens-là (…) pour les francophones, ça, ça va être un coup. (…) Ça fait peut-être un an, mais on voit déjà l'impact au niveau de la communauté. (…) Parce que si tu veux avoir une bonne idée des problématiques d'une communauté, c'est en les visitant.* (RO-15, gestionnaire)

xlviii *C'est une assez petite population [de francophones] à l'ouest, pis être capables de rejoindre ces gens-là [aînés francophones] (…) sans des ressources à faire du* outreach, *parce que la plupart des programmes [n]'ont pas d'argent pour faire ça, ça va être le défi. Ce n'est pas un manque de volonté.* (RO-25)

xlix « *Très difficiles à recruter, en fait, parce qu'il faut qu'ils soient francophones, en tout cas qu'ils se débrouillent vraiment bien en français* » (RO-16, gestionnaire)

l « *on a fait plusieurs postulations du poste, pis on n'a pas eu… on n'a pas été capables [de recruter une infirmière bilingue]* » (RO-25, gestionnaire).

li « *Dans ces endroits-là, même si on dit que des services sont en français, ça ne l'est pas. Je peux comprendre là aussi ils sont pris à embaucher. Il faut qu'il ait du monde 24 heures sur 24. Puis y'en [n'] a peut-être pas tant de ça [de personnel] qui parlent français* » (W –23, aînée).

lii « *géré vers l'anglais* » (W-3, gestionnaire).

liii « *tu n'as pas de choix (…) tu pognes un médecin qu'ils te fournissent parce qu'ils sont très occupés* » (RO-78, aîné).

liv « *Ils veulent essayer de nous faire faire une journée en anglais juste pour un groupe anglais. Puis ce qui couperait encore les services qu'on donne aux francophones* » (RO-34$_2$, coordonnatrice).

lv « *Je demande en français et j'attends. J'ai la patience d'attendre, parce que j'ai réellement besoin de bien comprendre* » (RO-78, aînée)

lvi « *J'ai demandé pour une gestionnaire [CASC] française, ça a pris trois mois qu'on (…) m'en trouve une* » (RO-61, proche aidante).

lvii « ça retarde le suivi » (RO-29).

lviii « *la documentation française, c'est très mal écrit. C'est plus facile de lire en anglais qu'en français. Ça me fâche* » (RO-64).

lix *Le français qui a été traduit, c'est à un niveau beaucoup plus élevé qu'avoir le niveau de troisième ou quatrième [année de scolarité], parce que souvent, les personnes âgées, surtout les gens qu'on a, la moyenne d'âge, je dirais que c'est 86. J'en ai plusieurs qui n'ont pas eu l'éducation formelle, donc le langage qui a été traduit, ils comprennent pas. C'est une lacune que je trouve.* (RO-35)

lx « *passe dans les craques* » (RO-56, intervenante).

lxi « *être informés par le personnel* » (RO-90, proche aidante)

lxii « *Il y avait une infirmière (…) elle arrive et (…) "Hi, I'm Francine". J'ai dit, "bonjour, Francine" (…). Je lui ai répondu en français. J'ai bien vu que c'était une francophone qui parlait en anglais* » (RO-87, aînée).

lxiii « *c'était un français tellement anglicisé (…) que j'avais de la difficulté à comprendre* » (RO-65).

lxiv « *Quand ils ont fait l'affichage en français, c'est fantastique, mais (…) à part de ça, il n'y a pas eu le service [en français] qui allait avec ça* » (RO-93, proche aidante).

lxv « *C'est juste un adon, si l'infirmière était francophone, elle [ma mère] parlait en français* » (W-17, proche aidante).

lxvi « *C'est un défi… et même ici à Saint-Boniface* » (W-5, gestionnaire)

lxvii « *façons de faire* » (RO-20)

lxviii « *On doit faire des efforts de plus et se questionner sur qu'est-ce qu'on fait pour donner des services en français. Et ça, cette discussion-là, elle [n'] est pas là* » (RO-20)

lxix *Les francophones sont un peu éparpillés, et quand on est éparpillés, ben on dilue un peu nos forces. (…) On n'a rien de spécifique présentement qui regroupe les francophones pour mettre une cohérence dans nos services destinés à la population aînée.* (RO-15)

lxx « *la porte d'entrée* » (RO-15)

lxxi « À cette *porte-là, tu cherches un service, ben c'est là qu'on va t'orienter* » (RO-15).

lxxii « *c'est un peu le reproche ou les constats que je fais avec le Réseau, c'est qu'ils sont moins impliqués dans l'intervention communautaire alors que c'est là que ça commence aussi* » (RO-20).

lxxiii « *Je pense aussi que c'est… il y a juste un petit groupe de personnes qui pensent que vraiment, c'est [la question de la langue] quelque chose qu'ils trouvent que c'est important, puis le système est vraiment grand* » (W-4).

lxxiv « *Il faudrait qu'il y ait quelqu'un qui ait le leadership à amener toutes ces personnes-là autour de la table pis à les amener vers des objectifs* » (RO-16)

lxxv « *continuer à appuyer le Réseau dans ses initiatives* » (RO-27, gestionnaire)

lxxvi « *Une politique (…) que le RLISS mandate, comme dans une perspective francophone, quand un francophone reçoit des services à domicile, est-ce qu'il est jumelé aussi avec un organisme francophone ?* » (RO-20).

lxxvii « À chaque fois que tu vas à l'hôpital, quand il entre ton information, ça dit ta langue » (W-2).

lxxviii « *une nouvelle façon de travailler ensemble* » (RO-15)

lxxix « *coordonner en autant que possible la dimension linguistique de ces services en français* » (W-1, gestionnaire)

lxxx « *structure francophone* » (RO-15)

lxxxi *Je pense que des fois collaborer, ça fait un peu peur parce que les gens pensent que ça va donner plus d'ouvrage, mais qu'est-ce que ça veut dire vraiment, c'est que chacun va mettre sa petite goutte. Ce n'est pas plus de travail, c'est avoir plus de gens qui mettent ce qu'ils peuvent, au lieu d'essayer de le faire tout seul.* (W-9)

lxxxii « *faire grandir la capacité francophone, mieux exprimer ce qu'on fait avec les francophones* » (RO-20)

lxxxiii « *il faut, comme francophones autour des tables, continuer à être champions pour la cause francophone. Il faut qu'elle soit à la table constamment* » (RO-27).

lxxxiv *C'est d'amener la discussion, pas juste aux francophones qui savent qu'est-ce qui a besoin d'être fait, mais c'est de continuer à amener la discussion à ceux qui ont aussi une responsabilité, mais qui voient pas comme si ils ont une responsabilité. C'est de continuer à avancer cette discussion-là de manière pour que ça devienne juste « the way it is. »* (W-4)

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