

RESEARCH ARTICLE

Active offer of health services in French in Ontario: Analysis of reorganization and management strategies of health care organizations

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Summary

Background: The availability of health services in French is not only weak but also inexistent in some regions in Canada. As a result, estimated 78% of more than a million of Francophones living in a minority situation in Canada experience difficulties accessing health care in French. To promote the delivery of health services in French, publicly funded organizations are encouraged to take measures to ensure that French-language services are clearly visible, available, easily accessible, and equivalent to the quality of services offered in English.

Objective: This study examines the reorganization and management strategies taken by health care organizations in Ontario that provide health services in French.

Methods: Review and analysis of designation plans of a sample of health care organizations.

Results: Few health care organizations providing services in French have concrete strategies to guarantee availability, visibility, and accessibility of French-language services.

Conclusions: Implementation of the active offer of French-language services is likely to be difficult and slow. The Ontario government must strengthen collaboration with health care organizations, Francophone communities, and other key actors participating in the designation process to help health care organizations build capacities for the effective offer of French-language services.

KEYWORDS

active offer, French, health services

1 | INTRODUCTION

Although French and English have equal legal status in Canada's constitution, their parity is questionable when it comes to the Canadian healthcare system. An estimated 17% to 78% of more than a million of Francophones living in a minority situation outside of Quebec,^{1,2} Canada's only Francophone majority province, experience difficulties accessing health care in French. In Ontario, where more than half a million Francophones live in a minority situation, only 3% of health care professionals report offering services in both languages.³ In Alberta, a large proportion of Francophones living in a minority situation look for access to a French-speaking physician but do not find one.⁴ In Manitoba, lack of French-speaking hospital staff necessitates the use of family members of Francophones patients as interpreters.⁵ In 2002, the Romanow Commission⁶ showed that access to health services in one of the official languages of Canada (ie, English or French) is an important aspect of the Canadian health system and should take into account the patient's capacity to understand treatment and medical recommendations. The commission went on to suggest an expanded definition of access to services:

Although access is traditionally looked at in terms of waiting times or distance, it can also be affected by social and cultural factors such as language, gender, education, and wealth. When people are receiving care in a hospital or another health-care program, both their access and the quality of care they receive may be inhibited by problems in communication, understanding or acceptance. (p. 154)

The Romanow Commission proposed that governments at all levels engage in the organization and development of health services for Francophone minorities in all Canadian provinces and territories.

When English has a higher status than French and the social context favours English, bilingual Francophones living in a minority context will often adopt English.⁷ As a result, only 20% of Ontario's Francophone adults use French when seeking health care.⁸ Providers of services tend to reduce their offer of services in French when there is no demand or because Francophones do not use them.³ The way the demand and supply of services in French are connected creates a vicious cycle, in which weak supply results in weak demand, and this prompts providers to not offer services in French.⁹ Surveys, however, demonstrate that the overwhelming majority of Francophone respondents consider receiving health services in French as very important or important⁸ and are prepared to use them when the offer is made.⁷ The French Language Services Commissioner of Ontario suggests that preference should be given to the "active offer of services in French" to break the vicious cycle.⁹ The solution to this unhealthy dynamic involves creating an organizational climate that supports active offer and makes staff comfortable offering services in French.^{10,11}

Active offer refers to series of measures taken by publicly funded organizations to ensure that French-language services are clearly communicated and publicized, visible, available at all times, easily accessible, and equivalent to the quality of services offered in English.¹² The concept of an active offer implies the shift of responsibility from the patient, who would otherwise be expected to ask for health services in French.¹⁰ Active offer is, thus, characterized by proactive offer of services by staff from the point of first contact; by the guarantee that subsequent services will be provided in French; and by the promise that they will be equivalent in quality to the services offered in English.⁹ Active offer is expected to help create an environment that will stimulate the demand for services in French and will anticipate the needs of Francophones in their community. Therefore, active offer of services in French should become part of organizations' policies and integrated into the organizational culture, from the board of directors to direct services.¹⁰ Such measures call for changes in how services are organized and managed. Using an example of Ontario health care organizations, this study aimed to examine the reorganization and management strategies taken in the pursuit of an active offer for French-language services. To our knowledge, this is the first study of the changes undertaken by health care organizations to achieve visibility, availability, and accessibility of health services in French.

Four additional elements that emphasize the importance of an active offer of French-language services require to be reviewed: language and culture as determinants of health and access to health care, legislative context in relation to the active offer, designation for French-language services, and (organizational) health literacy.

1.1 | Language, culture, and health

Today, both language and culture are recognized as the determinants of health and access to health care.^{13,14} Linguistic barriers are associated with increased risk of hospital admission, errors in prescribed medication, greater number of reported adverse drug reactions, and lower rates of pain medication.¹⁵ Specifically, lack of comprehension poses a serious limitation on access to health care services, adherence to medication regimens, and consent to essential procedures in older Francophone adults living in a minority situation.^{16,17} When patient and health care provider cannot understand each other, the quality of service can be compromised and patient's satisfaction can also suffer.¹⁸ The use of interpreters and translation of documents do not convey cultural context and have shown to lead to diagnostic errors and inadequate treatment.^{15,19}

Active assimilation into a dominant Anglophone majority has stalled the development of institutions supporting the Francophone community and forced them to adopt English to be able to access health care.¹ Contrary to common beliefs, Francophones living in a minority situation are not always proficient in English. For example, estimated 72% of Francophone older adults in Ontario are not capable of communicating in English with their physicians.²⁰ Burgeoning research demonstrates that large numbers of Francophone minorities report poorer health, more chronic illnesses, more difficulties with activities of daily living, and higher rates of obesity than those observed for Anglophone majority.¹ (Francophones consistently exhibit more health-risk behaviors (eg, smoking, alcohol consumption, physical inactivity, and poor diet) than non-Francophones.²¹⁻²³ They also tend to be older, less educated, poorer, and living in economically disadvantaged regions.^{8,24,25} It is thus essential to assure provision of health services in French and to be forthcoming about the option to receive services in the language of the patient's choice. For health care organizations, this means making Francophone patients aware that services in French are available and accessible.

1.2 | Legislative context

In Ontario, the French Language Services Act of 1986 provides the main legal framework for the provision of health services in French. The French Language Services Act guarantees the right to receive services in French from Government of Ontario ministries and agencies in the 25 designated areas where Francophones make up at least 10% of the population.¹² To counter the effects of English dominance, the federal Official Languages Act of 1969 and the Canadian Charter of Rights and Freedoms of 1982 provided Francophones living in a minority situation with the opportunity to live and thrive in French.^{9,10,26}

However, an analysis of the legal context in relation to the active offer of services in French reveals some limitations. For example, the Canadian Charter of Rights and Freedoms does not obligate government agencies and institutions to actively offer services in both official languages. Furthermore, the French Language Services Act does not require providers to offer services in French in all circumstances. The French Language Services Act gave the government the power to designate providers of health services in French. The responsibility for designation for health services in French is shared among several organizations: the Ministry of Health and Long-Term Care; the Office of Francophone Affairs, and Local Health Integration Networks, 14 local health authorities created in Ontario in 2006 as part of the regionalization reform; French Language Health Planning Entities that work with Local Health Integration Networks to facilitate the planning and provision of health services in French; and a health service provider that delivers services in French. The Office of Francophone Affairs revised criteria for designation in 2013 to guarantee services and follow the principles of active offer. The designated agency must (1) permanently offer French-language services by employing people with requisite level of French-language skills, (2) guarantee that French-language services can be provided for all or some services and during business hours, (3) ensure that Francophones sit on boards of directors and committees in proportion to the Francophone population in the community, (4) have Francophones in senior management in proportion to the local Franco-Ontarian population, and (5) make directors and senior managers accountable for the quality of French-language services.

However, changes to the criteria are only administrative in nature and do not create legal rights and obligations.^{9,26} Moreover, while designated agencies must implement the principle of active offer, government agencies or institutions are not required to do so.

In the context of health care, the French Language Services Act has shown to be of limited usefulness: access to health services in French remains limited and poorly publicized.²⁶ It is thus necessary to adopt measures that increase the effectiveness of language rights.

1.3 | Designation for French-language services

Designation is an official recognition of organization's capability to actively offer services in French according to criteria set out by the Office of Francophone Affairs.^{12,27} It refers to organization's commitment to French-language services, either for all (full designation) or for some (partial designation) of its programs and services. Organization may

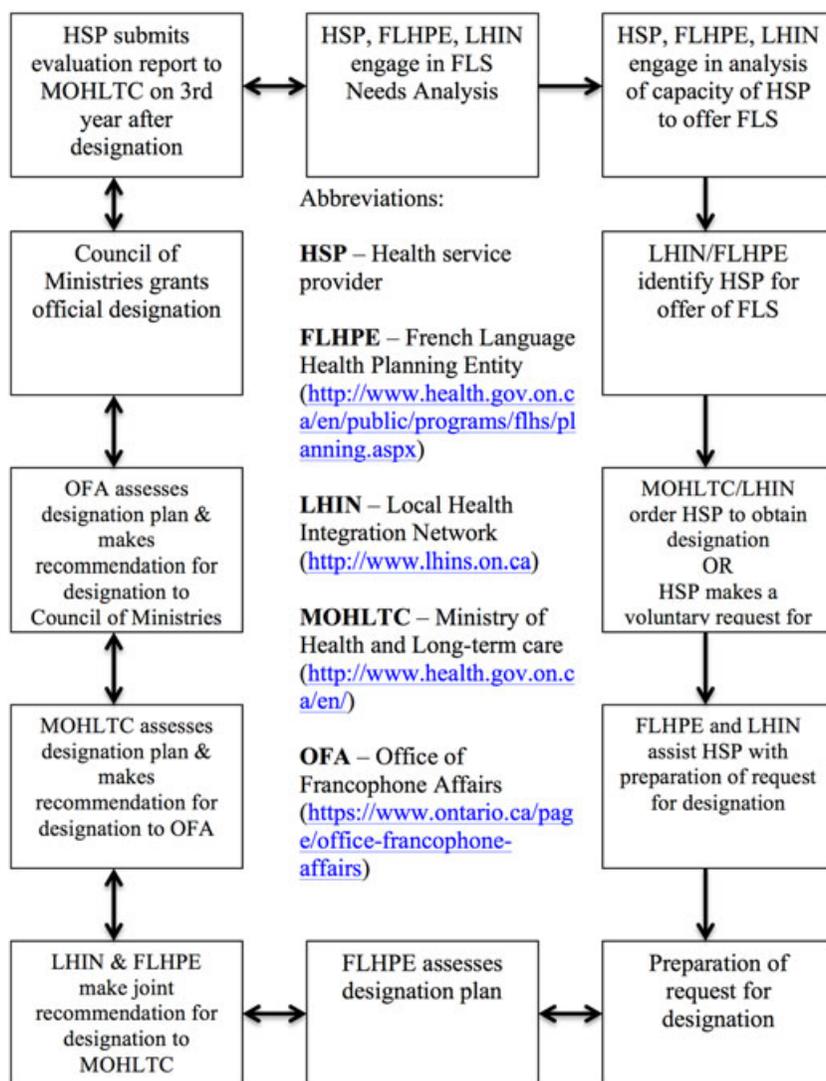


FIGURE 1 Process of designation for an active offer of health services in French [Colour figure can be viewed at wileyonlinelibrary.com]

be identified for designation by French Language Health Planning Entities and ordered by the Ministry of Health and Long-Term Care or Local Health Integration Networks to obtain designation, or choose to do it voluntarily. The designation process involves multiple steps and actors (Figure 1). Services for which the organization requests designation must be available and provided on permanent basis when designation plan is submitted. Organizations that make request for designation receive support from the French Language Health Planning Entities for preparation of the designation plan. The designation plan helps determine to what extent the health services provider meets the designation criteria. The plan is assessed by several organizations before the health service provider is granted designation. As evidence of compliance, every 3 years, designated health services provider must provide a report to the Ministry of Health and Long-Term Care in which they demonstrate how they maintain the active offer of services in French. Eighty-nine health care organizations have been designated to date, of which 22 are hospitals, 11 are long-term care homes, and 4 are community health centers.²⁸

1.4 | Organizational health literacy and active offer

Although health literacy, the capacity to obtain, process, and understand basic health information and needed services, is commonly described as an individual trait,²⁹ it is now recognized that health literacy does not only depend on individual skills and abilities but also on the demands and complexities of the health care system.³⁰⁻³⁴ Organizational health literacy describes a set of measures that can help health care organizations make it “easier for people to navigate, understand, and use information and services to take care of their health.”³¹ The framework of organizational health literacy is represented in Figure 2.³⁵

Organizational commitment is the foundation of a health-literate organization. The infrastructure level includes support systems such as financial, clinical, and health information technology to support the implementation of concrete and practical resolutions; the workforce level includes ways in which the workforce is trained and encouraged to use health-literate practices; and the policies and practices level addresses situations in which providers routinely interact with patients and use health-literate practices and procedures that facilitate top level, bidirectional

Source: Schillinger & Keller, 2011



FIGURE 2 Framework for attributes of health literate health care organizations

communication, which can be considered an outcome. Health-literate health care organizations recognize that literacy, language, and culture are intertwined, and their efforts help reduce inequities in care and improve the organization's linguistic and cultural competence.^{30,36}

The transition from health care organization to health-literate health care organization involves changes in organizational structures, processes, personnel, and technologies to improve access and quality, safety, and value of health care services. The 10 attributes provide concrete, practical actions that organizations can take to create an environment that promotes cultural and linguistic competence and facilitates active offer of care and services.³¹ A health-literate health care organization (1) has leadership that makes health literacy integral to its mission, structure, and operations; (2) integrates health literacy into planning, evaluation measures, patient safety, and quality improvement; (3) prepares the workforce to be health literate and monitors progress; (4) includes populations served in the design, implementation, and evaluation of health information and services; (5) meets the needs of populations with a range of health-literacy skills while avoiding stigmatization; (6) uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact; (7) provides easy access to health information and services and navigation assistance; (8) designs and distributes print, audiovisual, and social media content that is easy to understand and act on; (9) addresses health literacy in high-risk situations, including care transitions and communications about medicines; and (10) communicates clearly what health plans cover and what individuals will have to pay for services.

Like active offer, organizational health literacy emphasizes the shift of responsibility from an individual to the health care system to support patients in navigating information and services, steering them toward timely and appropriate care.³⁴

2 | METHODS

The study was implemented in 2 consecutive phases: (1) analysis of designation plans of a sample of health care organizations to identify adaptations made for the provision of health services in French and (2) creation of a focus group with health care administrators to explore their experience and perspectives regarding active offer of French-language services and its implementation. Results from the focus group are reported elsewhere.

2.1 | Data

Designation plans of 12 organizations that had undergone designation were provided by the French Language Health Services Network of Eastern Ontario, a French Language Health Planning Entity for Eastern and Southeastern Ontario, which advises 2 Local Health Integration Networks on all issues affecting Francophone health (<http://www.rssf.on.ca/en/>). The designation plan includes qualitative and quantitative data. Qualitative data describe strategies and best practices that allow the provision of quality health services in French. It covers administrative strategies in 9 areas: delivery of French-language services, methods of identification of Francophone clients, staffing policy, recruitment policy, hiring policy, representation of Francophones on board of directors and other committees and senior management, the French-language services committee, and accountability for French-language services; direct services in 5 areas: switchboard, reception, physicians, other direct services, and human resources plan; and other services that affect Francophone clients, including communications strategy, signage, documents and information services, correspondence, and other (RSSF, 2013). Qualitative data have been extracted and tabulated for further analysis.

2.2 | Conformity scale

In the absence of an existing measure, I developed a conformity scale to determine to what extent organizations meet designation criteria for health services in French (Table 1). Based on the French Language Health Services Network of Eastern Ontario evaluation grid for designation plans, the Ministry of Health and Long-Term Care template for

TABLE 1 Conformity with designation criteria

Conformity requirements	Conformity, 0%-100% ^a											
Organization has put in place or instituted:	A ^b	B	C	D	E	F	G	H	I	J	K	L
Administrative regulations												
1. ... a detailed announcement about the delivery of services in French	0	0	5	0	0	0	0	5	0	5	0	0
2. ... a policy on planning and provision of services in French	5	0	5	5	5	5	5	5	5	5	5	5
3. ...a committee to support the planning and provision of services in French	5	5	5	5	5	5	5	5	5	5	5	5
Direct client services												
4. ...direct services, including switchboard/reception, voice mail and other systems offered in French	0	0	5	5	5	5	5	5	5	5	5	5
5. ... a procedure to help identify linguistic identity/ language of preference of clients at first contact	5	0	5	5	5	5	5	5	5	5	5	5
6. ... a plan and/or policy and procedures to prepare the workforce to engage in the provision of services in French and monitor progress	0	0	5	5	5	5	5	5	5	5	5	5
7. ... policies and procedures for receiving and addressing language assistance concerns or complaints from consumers	5	5	5	5	0	0	5	5	5	0	0	5
Corporate identity and communications												
8. ... a French version of the official web site	5	5	5	5	5	5	5	5	5	5	5	5
9. ... external signage in French or French and English	5	5	5	5	5	5	5	5	5	5	5	5
10. ... registration, admission and other documents in French	5	0	5	5	5	5	5	5	5	5	5	5
11. ... a policy/procedure identifying employees that speak French by signage/ID cards that they wear and business cards	5	0	5	0	5	0	5	5	5	5	0	5
12. ... a policy and procedure to address active offer of services in French /language assistance in high-risk situations, including care transitions, communications about medicines, etc.	0	0	5	0	0	0	5	0	0	0	0	0
13. ... all publications and communications intended for public access are available in French	5	5	5	5	5	5	5	5	5	5	5	5
14. ... a procedure to allow organization to respond in French to correspondence received in French	5	0	5	5	0	5	5	5	5	5	5	5
15. ... a procedure to facilitate translation into French of documents intended for public distribution	5	5	5	5	5	5	5	5	5	5	5	5
Governance and accountability												
16. ... an integration of an active offer of services in French into planning, evaluation, safety and quality improvement	0	5	5	0	0	0	5	5	0	0	0	5
17. ... a consumer satisfaction and other surveys, and other means of obtaining feedback on services delivered, including services in French	0	0	5	5	0	0	5	5	0	0	0	0
18. ... a Francophone representation on a senior management committee or a similar high level management body	5	5	5	5	5	5	0	5	5	5	5	5
19. ... a high ranking manager responsible for delivery of services in French	5	0	5	5	5	5	5	5	5	5	5	5
20. ... an adequate representation of Francophones on the Board of Directors	5	5	5	5	5	5	5	5	5	5	5	5
Total:	70	45	100	80	70	70	90	95	80	80	70	85

^aTotal score is obtained by adding up all individual scores per statement, where "0" means no and "5" means yes.

^bLetters A to L replace names of healthcare organizations.

designation plan,¹² and attributes of health-literate organizations,³¹ the scale is composed of 20 items comprising 4 domains: administrative regulations, direct client services, corporate identity and communications, and governance and accountability. The sum of all the items produces a score from 0% to 100%.

2.3 | Data analysis

Data analysis was inspired by the deductive qualitative content analysis. This method allows the examination of meanings, themes, and patterns that may be manifest or latent in a particular text and make inferences from it.³⁷ It allows researchers to guide their analyses using a specific theory and understand certain reality in a subjective but scientific manner. Data were abstracted in the categories predefined in the designation plan. Based on the organizational health literacy framework and the designation criteria, data were analyzed for evidence of organizational commitment and leadership accountability for French-language services, supportive infrastructure to guarantee access to services based on the principle of an active offer, the availability staff fluent in French, policies and practices to offer quality French-language services on a permanent basis, and to support effective communication. "Horizontal" analysis (comparison of approaches across organizations) helped identify similarities and differences in the ways in which organizations operationalized domains of the conformity scale.

3 | RESULTS

3.1 | Characteristics of selected organizations

In total, 12 health care delivery organizations were included in the study. Of these, 3 were hospitals (2 medium-size community hospitals and 1 large teaching hospital); 3 community health centers and 1 community care access center; and 5 were specialty organizations (a heart institute, a long-term/continuing care facility, 2 community mental health programs, and 1 community program for substance abuse). Located in Eastern Ontario, these organizations contribute to the care provided to more than 1.6 million people, 15.4% of which are Francophones. These organizations were established between 1953 and 2007 and made numerous and significant changes over time—expanding and/or adding new programs and changing funding sources and operational models. These organizations were designated for French-language services between 2007 and 2015. Three of 12 organizations applied for partial designation and the rest applied for full designation. Two organizations (a large teaching hospitals and a heart institute) have previously received full and partial designation in 1989 and 2001, respectively, and renewed their designation in 2015 and 2008. Francophone patients with preference to be served in French make up an average of 37% (range 6%–100%) of the clientele at these organizations. Three of 12 organizations operate in French, although both French and English are used when preferred by patients and/or providers.

3.2 | Conformity to designation criteria

Organizations conformed to the designation requirements to a varying degree. An average conformity score of 77% (range 40%–100%) suggests that organizations may or may not fully and equally well (or poorly) conform to all designation criteria (Table 1). Our analysis showed that all 12 organizations had either difficulties with or failed to comply with the following criteria: (1) making a distinctive announcement about the offer and delivery of French-language health services; (2) setting policies and procedures to address active offer of French-language services/language assistance in high-risk situations, including care transitions and communications about medicines; (3) integrating active offer of French-language services into planning, evaluation measures, service users safety, and quality improvement initiatives; and (4) putting in place consumer surveys, or other means of obtaining feedback on services delivered, including French-language services. By contrast, all organizations succeeded in conforming to the following criteria: (1) put in place a committee to support the planning and provision of French-language services, (2) have a French

version of their website, (3) make external signage available in French or in both French and English, (4) make publications and communications intended for general public available in French, (5) facilitate translation of all documents intended for public use, and (6) have an adequate representation of Francophones on the board of directors.

Results of the analysis of designation plans are presented according to the domains of the conformity scale, namely, administrative strategies, direct client services, corporate identity and communications, and governance and accountability.

3.3 | Administrative strategies

As part of administrative strategies, organizations are required to support the provision of French-language services and to develop human resources plans that include provisions for the recruitment and hiring of health care providers with French-language skills and procedures to effectively identify Francophone patients. A typical French-language services policy expresses an organization's vision and commitment to offering services in both English and French. It also specifies client services that must be permanently available in French, aspects of governance and accountability with respect to French-language services, the role of the French-language services committee and its terms of reference, aspects of communication and translation services, recruitment and hiring, and French-language training. All but 1 organization (a hospital) have either developed new or revised an existing French-language services policy at the time of submitting their designation plan. The hospital missing the French-language services policy indicated that the provision of bilingual services is the mandate of this organization, so it does not need a specific policy.

Websites, pamphlets, brochures, annual reports, and signage are used as standard ways of informing the public about the availability of French-language services. Although the designation guide calls for a communication strategy to inform public about the availability of French-language services, it does not appear that organizations develop such strategies or make additional effort to announce availability of French-language services.

The human resources plans that support the provision of French-language services were included in the French-language services policies and/or staffing policies and involved internal (by senior management and/or French-language services committee) and/or external evaluations of job descriptions to determine what positions require proficiency in French (designated bilingual positions) and what level of competence in French is required for each of those positions (5 levels, from elementary to superior); adoption of practices allowing current employees to test and/or train for French; and development of procedures for new employees applying for bilingual positions to undergo appropriate interviewing and testing (typically by an external agency). Designated bilingual positions require an advanced or superior level of French and are determined based on several factors, including consideration of client's needs, the nature of contact with clients and public, and the responsibility level of the position. Some 50% to 80% of positions have been designated as bilingual at most organizations and included direct-care providers (nurses, physicians, specialists, and allied providers) and administrative and leadership staff. Primary-care clinics and community-care access centers also designated information and referral specialists, care connectors, case managers, and team assistants as designated bilingual positions. Three Francophone organizations (a teaching hospital, a Community Health Centre and a community mental health program) designated all of their positions as bilingual or primarily French. Some organizations assigned the responsibility to ensure that clients receive services in the language of their preference to managers and health care providers. However, human resource plans clearly specified that none of the currently employed staff would be dismissed due to insufficient competence in French. On the contrary, French-language training is provided by the organization to those who require or desire to improve their language skills.

To ensure the presence and availability of bilingual providers at all times and in all departments and programs, organizations used 3 distinctive strategies. A temporary *job shadowing* was used most frequently in all types of organizations to allow a bilingual provider from other departments or programs to either replace or assist a unilingual staffer to interact with or provide care to a Francophone client and/or family. For example, a community-care access center developed a procedure to engage a case manager from a centralized intake team for all locations, which did not have designated bilingual positions. Adoption of *creative scheduling* is used primarily, but not exclusively, at hospital

settings. For example, a hospital human resources plan called for a minimum of 1 bilingual professional per shift and relied on creative scheduling in all departments. Similarly, a community-care access center instituted a policy that required each client-services team to have sufficient coverage during hours of operation for bilingual employees. Organizations lacking staff or services in French also rely on *referrals* to other organizations with bilingual or Franco-phone staff.

Organizations that self-identify as Francophone appear to have well-developed strategies to successfully recruit bilingual or primarily Francophone staff compared to other organizations in this sample. They do not rely solely on bilingual advertisements for designated bilingual positions on their own or other career websites, but they hire recruitment agencies to identify and recruit health care providers, including students, residents, and recent graduates from schools and universities where French is the language of instruction and also from bilingual or French provinces (New Brunswick and Québec). They also actively engage in annual recruitment fairs in other provinces or organize them locally. When recruitment of bilingual staff is unsuccessful, the French-language services policy at non-Francophone organizations allows senior management to offer candidates a training plan under the condition that individuals hired in designated positions would learn French within 2 years. Selection processes for designated bilingual positions include interviews where at least 1 member of the selection committee is Francophone and conducts part of the interview in French, and evaluations for both oral and written proficiency in French—often by an external agency. Some organizations have developed a standard procedure to evaluate language proficiency internally by using language proficiency levels tools and the Language Proficiency Evaluation Form provided by the Ministry of Health and Long-Term Care.

3.4 | Direct client services

In order to actively offer information related to client services in both official languages, 10 of 12 organizations reported that they made efforts to assure that the switchboard (either by a person or an automated phone system and/or the receptionist) was capable of answering all inquiries in English and French on a consistent and permanent basis. Positions with responsibility for the reception and switchboard are designated bilingual positions, and staff has the capacity for providing services in both English and French. In addition, staff is using a greeting protocol and is encouraged to practice active listening. Although physician positions are included in designated bilingual positions, an estimated 30% to 50% of physicians working in these organizations possess French-language skills (from elementary to superior level). By contrast, 3 organizations that self-identify as Francophone succeeded in filling 90% to 100% of designated bilingual positions for physicians and other medical doctors. Smaller organizations, such as primary-care clinics, contend that they have a limited capacity to recruit French-speaking doctors because they do not typically bring large numbers of physicians to the geographic area. These organizations often advertise a list of physicians who speak French but state that it is up to the patients to select a French-speaking doctor.

All but 1 organization (a hospital) developed specific procedures or an algorithm to identify Francophone clients by identifying the language of preference for verbal and written communication (also referred to as *the language of service* or *mother tongue*, or both *language of preference* and *mother tongue*). Language preference is typically determined via initial contact (registration and/or admission) and recorded in a mandatory field in the client's electronic file or chart. Primary-care and specialty-care organizations also coordinate the language of preference with providers and services assigned to the client (eg, a patient self-identifying as Francophone and opting for French-language services is assigned a case manager or a provider with French-language skills).

3.5 | Corporate identify and communications

Overall, organizations met most of the designation criteria for French-language services related to corporate identity and communications (Table 1). However, several opportunities for improvement have been identified. Specifically, most organizations appear to be missing policies and procedures for the offering of language assistance in high-risk situations, including care transitions and communications about medicines. Although these procedures may be

embedded within other protocols, they have not been explicitly mentioned in the designation plans. Also, there is no consistent policy about whether employees who speak French should be identified as such by their identity cards and signage or wear badges to facilitate the active offer. As a result, clients may not always recognize French-speaking providers.

3.6 | Governance and accountability

Obtaining designation for French-language services requires organizations to make changes to governance and accountability. Specifically, organizations are expected to include representatives of the Francophone community on their boards of directors and associated committees, and also on senior management committees. According to the designation criteria, the number of Francophone members on boards of directors has to be proportional to the number of Francophones in the organization's service area but no fewer than 3. Eleven of 12 organizations declared having at least 3 or more Francophones on boards of directors. Compared to boards of directors, representation of Francophones on Senior Management Committee (SMC) is less consistent, ranging from zero to 13 members across 12 organizations. An organization (a community hospital) that did not have Francophones on its SMC had, in fact, designated 2 positions out of 5 to be bilingual but has not filled them; they contended that they relied on other bilingual resources within the organization to assist SMC when needed. The SMCs of 3 organizations were composed entirely of Francophones. The ratio of Francophone to non-Francophone members on the SMC varied from 1:1 to 1:3 in 8 organizations, respectively. A high-ranking manager, typically general director or CEO, president, or vice-president, was responsible for the planning and delivery of French-language services in all organizations.

Designation plans provide little to no evidence of an integration of active offer of French-language services into planning, evaluation, safety, and quality improvement. Half of all organizations reported monitoring the provision of French-language services via a formal complaint process and/or annual satisfaction survey. Formal complaints are presented to the French-language services committee that reports to the SMC and the boards of directors. Two organizations have connected complaints and survey results to quality improvement policies and initiatives. For example, a Francophone teaching hospital established a process where results of the survey were passed to the quality improvement committee that oversees implementation of quality improvement at the hospital. A Community Care Access Centre (CCAC) embedded monitoring of client satisfaction in their work with contractors and ensures that results are communicated back to CCAC on quarterly basis. Clients who have expressed a language preference and who have not been served in the official language of their choice can file a complaint with their case manager through the formal complaint, appeals, and feedback process or file a complaint with the provincial Office of the French Language Services Commissioner.

4 | DISCUSSION

This study examined the reorganization and management strategies taken by Ontario health care organizations in the pursuit of the designation for an active offer of health services in French. A novel theoretical framework of organizational health literacy addressing changes in organizational commitment, infrastructure, workforce, policies, and practices and communication supported this study. The analysis showed that few health care organizations providing services in French put in place concrete strategies to guarantee availability, visibility, and accessibility of French-language services. In the absence of such strategies, implementation of the active offer of French-language services is likely to be difficult and slow. Nevertheless, some organizations have made active offer a standard of health service and developed expertise in the planning of French-language services. Specifically, organizations where French was a working language employed a variety of strategies and took a comprehensive approach to the active offer compared to some of the organizations where English was a working language. Organizational culture may influence how the

management approaches the planning and operationalization of the active offer of French-language services and warrants further investigation.

The analysis revealed that plans for change with regard to French-language services are integrated only in some organizational policies and processes. Organizations that make an explicit commitment to developing responsive care must use a whole organization or systemic approach rather than permitting individual projects that are not structurally embedded in the organization.³⁸ Commitment to French-language services should be integrated with organizational and leadership commitment to effective communication, cultural competence, and patient- and family-centered care, concepts of which should then be integrated into existing policies. Organizations could also adopt organizational health literacy, the framework used for this study, as a novel approach to responsiveness to care. Organizational health literacy addresses elements such as navigation, recognition of patients with low health literacy, integration of health literacy into planning, evaluation measures, patient safety, and quality improvement, care transitions, communications about medicines, preparation of workforce, and cultural and linguistic appropriateness of services. A great number of resources have been developed to assist organizations with transition from health care organization to health-literate health care organization and could be used for promotion of French-language services (eg, Ten Attributes of Health Literate Health Care Organizations, Health Literacy Universal Precautions Toolkit). In the absence of systemic changes, it is not clear how organizations' leaderships plan to promote their commitment to quality French-language services within the organization.

All designation plans emphasize the importance of quality care for Francophone clients, but strategies for achieving it seem to be reduced to the availability of providers with (some level) of French-language skills and availability of information translated into French. These strategies will not be sufficient to assure the provision of an active offer of quality French-language services. Designation plans should address important elements of health care, such as responsiveness to the needs and wishes of patients (beyond language preference), patient participation in the care process, reduction of communication barriers, availability of understandable patient information materials, and patients' rights.^{38,39} There is very little evidence of an integration of an active offer of French-language services into performance measurements, evaluations, and quality improvement. It remains unknown how organizations intend to measure the effect that active offer will have on accessibility and quality of care. Without this information, it will be impossible to know whether organizations that offer services in French are meeting the needs of Francophones.⁹

A significant emphasis is placed in the designation plans on the development of staff or workforce to assure provision of French-language services. Language competency is a central theme in staff training available to all employees who wish to learn or improve their French-language skills. To build cultural competence and ensure successful offer of French-language services, language training should be complimented by a separate training for all staff in the provision of responsive care to diverse clients.^{38,39} Such training would allow making full use of the staff's linguistic and cultural skills to serve Francophone clients.³⁹ Approaches to organizations' cultural competence, such as CLAS (Culturally and Linguistically Appropriate Services), recommend increasing diversity among staff to make the workforce representative of the general population it serves and to help further equity by improving linguistic and ethnic concordance between clients and staff. Considering that Ontario's Francophone population is culturally diverse and includes people born in Canada and also those who emigrated from other French-speaking countries (eg France, Belgium, Haiti, Congo, or Morocco),⁴⁰ increasing diversity of health care organizations' workforce would help meet both linguistic and cultural needs of Francophone clients.

Several organizations stated that due to shortage of Francophone human resources (physicians) they use *job shadowing* and *creative scheduling* to provide services in French. Although these strategies may be effective as temporary interventions, they are unsustainable as a guarantee of permanent services and are unlikely to result in quality care. Moreover, approaches such as CLAS advise against using untrained, informal interpreters such as untrained staff or family members. Organizations that experience difficulties recruiting bilingual staff should consider language-assistance measures, such as professional interpreters or intercultural mediators. Organizations are responsible for informing clients of their right to language assistance and of ensuring its quality and competence.³⁸ A study examining

the distribution of French-speaking physicians in Ontario found that the shortage is explained by the maldistribution of such services, not by their absence.⁴¹ The authors suggest that organizations must make efforts to attract French-speaking physicians to areas where there is the greatest demand.

A study of approaches to cultural competence³⁸ identified elements that help build organizational infrastructure to improve responsiveness of services. They include the creation of an environment that reflects the populations served and involvement of clients in the development of services. Health service providers are recommended to conduct self-assessments to examine barriers to access related to physical space, signage, design of the facility, and other attributes.^{38,42,43} Although designation plans for French-language services call for translation of all signage, documentation and information used in the process of care, health service providers are not required to assure that their facilities are easy to navigate or that all information is produced at an appropriate level of literacy in French or is easy to understand. With regard to the involvement of clients and community in the development of services, the argument is simple: "A health care organization serves a community; therefore the community has to be enabled to exert influence on what happens in the organization."³⁸ Active offer of French-language health services should involve more than offering services in the French language, but rather an approach that takes into account the needs and preferences of this minority community for planning and provision of health services.³⁹ The advantage of such participation is that clients and communities can contribute to the implementation of changes and help build more responsive care. Without an infrastructure that supports cultural competence at organizational level, it will be difficult to ensure an active offer of quality French-language services.

The results from this study suggest that organizations may be underestimating the importance of active communication. The offer of services becomes active only when the organization uses all possible means to communicate and inform the public and patients that it has the capacity to offer quality services in French.¹⁰ Health service providers need a comprehensive communication strategy that includes all oral, written, or electronic communications related to the service that helps to increase awareness about availability and accessibility of French-language services. Health service providers also need protocols supporting communication in high-risk situations (eg, care transitions, stopping, or changing medications) and methods promoting patients' understanding of information (eg, teach-back, ask me three). Effective communication can encourage the demand for French-language services and promote equity and inclusion of Francophones.¹⁰

Although health care organizations play a key role in the delivery of health services in French, the development of language competencies at the organizational level requires collaboration among health care organizations, the communities, and the government/health care system.^{9,44} This collaboration can help build organizational capacities by providing a legal framework, human, material and financial resources, tools, directives, and best practices to make possible taking language into account when organizing health services.⁹ Although designation has made an important contribution to the provision of health care services in French, the results show that there is a need for effective accountability measures to not only ensure an offer of services in French, but also safeguard their quantity and quality.¹⁰ Without accountability and surveillance, it will be difficult, if not impossible, to ensure that the active offer is implemented. There is a need for the Ontario government to "take concrete measures and acquire the necessary instruments to ensure that ministries, agencies, entities and third parties that provide services on the government's behalf implement the active offer of service in French."⁹

This study has limitations. My analysis has been conducted based on the content of designation plans. Plans may have been imprecise, inaccurate, and not reflective of the actions taken with regard to French-language services. In addition, as noted by Palumbo et al,³⁴ organizations and their workforces might have introduced informal strategies supporting French-language services instead of formalizing their efforts. Interviews with the organizations' administrators and providers could help enhance the content of the plans and shed light on their implementation. We reviewed designation plans of 12 out of 89 designated health care organizations. This small sample may not be fully representative of all designated organizations. We used an unvalidated measure (the conformity scale) and introduced the researchers' bias in the constructs and domains that we measured. Future studies will need to identify wording problems, fully conceptualize constructs, and delineate the domains to purify this measure.

5 | CONCLUSION

There is room for improvement in the designation process with regard to the planning and evaluation of culturally and linguistically competent health services in French. Efforts must be made to improve the active offer of quality French-language services among health care administrators and providers. Commitment to French-language services must be integrated with organization's commitment to cultural competence, patient- and family-centered care, and organizational health literacy, a novel approach to responsiveness to care. Designation plans should address responsiveness of care to the needs and wishes of patients, patient participation in the care process, communication strategies and barriers, availability of understandable patient information materials, measurement and evaluation of French-language services, and systemic approaches to the active offer and patients' rights. If this is not done, the provision of quality French-language services and its active offer will likely remain slow and difficult. The Ontario government must strengthen collaboration with health care organizations, Francophone communities, and other key actors participating in the designation process to help health care organizations build capacities for the effective offer of French-language services. The planning and implementation of the active offer of French-language services has to be further researched to be able to make improvements in the provision of health care in French and its quality.

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CONFLICT OF INTEREST

None of the author have any conflict of interest to this work.

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