The Network's Approaches for the Maintenance and Creation of Primary Health Services in English for the Quebec City Region

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LIST OF ABBREVIATIONS AND ACRONYMS

AHRQ	Agency for Healthcare Research and Quality
CCFSMC	Consultative Committee for French-Speaking Minority Communities
CHSLD	Centre hospitalier de soins de longue durée
CHSSN	Community Health and Social Services Network
CLSC	Centre local de services communautaires
CROP	Centre de recherche en opinion publique
CSSS	Centre de santé et de services sociaux
FCFA	Fédération des communautés francophones et acadiennes du Canada
FOLS	First Official Language Spoken
IOM	Institute of Medicine
MSSS	Ministère de la Santé et des Services sociaux
PHCTF	Primary Health Care Transition Fund
RATSPL	Réseau d'appui à la transformation des services de première ligne

SHORT EXECUTIVE SUMMARY

The Quebec City region has a network of health services organizations responsible for coordinating and providing health care to citizens who prefer health services in English (which we shall call the Network). The Network is comprised of Saint Brigid's Home, a CHSLD (Centre hospitalier de soins de longue durée) with a significant population of English speakers, and Jeffery Hale Hospital, a CHSLD/hospital which has French speakers as its majority patient clientele base but also a mandate to provide short-term geriatric and ambulatory care to English-speaking patients. These two organizations and several other private and community organizations contribute to a third organization, Holland Centre, which offers community and CLSC (community health and social services) type services to English-speaking clients.

The objectives of this interim report are to: 1) describe the social and organizational context, and changes and dynamics which are contributing to or likely to contribute to changes in the organization and health services by the English network, 2) identify the objectives and development approaches adopted by the Network in relation to these changes, and 3) discuss their pertinence and suggest additional or substitute actions which managers could consider adopting in order to attain their objectives.

Results

One important general observation is that both English-speaking and French-speaking managers in the region recognize that the Network is providing useful and often innovative health services to both the English-speaking and the general population.

The Network has adopted certain development approaches in order to strengthen its services to the English-speaking population:

1) maintenance of its clientele base;
2) integration of Jeffery Hale Hospital, Saint Brigid's Home, and Holland Centre;
3) active participation in regional clinical projects and mechanisms for regional coordination;
4) development of information and analysis concerning the English-speaking population and their health needs;
5) ongoing innovation and project creation;
6) development of a communication program; and
7) integration of recent key concepts proposed by the Ministère de la Santé et des Services sociaux (Quebec's Department of Health and Social Services, which we will refer to as the MSSS).

These development approaches are documented and discussed, and suggestions are made as to how they could be reinforced or improved. Possible indicators for evaluating progress in relation to each are noted in a table in section 5.8.

EXTENDED EXECUTIVE SUMMARY

The Quebec City region has a health services network responsible for coordinating and providing health services to citizens who prefer health services in English (which we shall call the Network). One official working for the Network describes its mandate in these words:

> "Le réseau anglophone a, entre autres, comme mandat d'offrir des services en anglais à la population anglophone de la région de la Capitale-Nationale; il a aussi la préoccupation de soutenir les quatre CSSS et les autres établissements pour s'assurer que, dans une perspective populationnelle, la population anglophone reçoive des services de qualité, accessibles et continus, partout sur le territoire, que ces services leur soient offerts par l'instance anglophone et/ou, à défaut, par d'autres partenaires, en anglais ou en français.[1]"

There is currently a single board of directors for a CHSLD with a significant English-speaking population, Saint Brigid's Home, and Jeffery Hale Hospital, a CHSLD / hospital which has a French-speaking majority patient clientele base but which also has a mandate to provide short-term geriatric and ambulatory care to English-speaking patients. These two organizations and several other private and community organizations contribute to a third organization, Holland Centre, which offers community and CLSC-type services to English-speaking clients. There is a plan to integrate at least the CLSC part of it into the current Jeffery Hale-Saint Brigid's administrative entity.

The Network is evolving within an organizational context which itself is changing. In 2004, four CSSSs were created, and the Network is planning to negotiate service agreements with the CSSS Québec-Nord and the CSSS Vieille-Capitale. As well, six regional clinical project committees have been created and the Network's managers are actively monitoring the progress of these projects and plan to provide services to the English-speaking population in relation to these projects.

Given this context, the objectives of this interim report are to: 1) describe the social and organizational context, and changes and dynamics which are contributing to or likely to contribute to changes in the organization and provision of health and social services by the English network, 2) identify the objectives and orientations of the Network in

[1] The English network has a mandate to offer services in English to the English-speaking population in the Quebec City region; it also strives to support the four CSSSs (Centres de santé et de services sociaux) and other institutions, using a populational approach, so that the English-speaking population can receive high quality, accessible and integrated services, anywhere in the region, in English or, failing that, in French, regardless of whether they are provided by the Network or its partners.

relation to these changes, 3) discuss the pertinence of these orientations and suggest additional or substitute actions which managers could consider adopting in order to attain their objectives, and 4) suggest research which could be carried out in a later phase.

Four main information gathering activities were carried out in relation to the objectives identified above: the gathering and study of local documents produced by the Network, semi-structured interviews with key regional actors in July and August 2005, the observation of two annual planning meetings in September 2005, and the consultation of certain documents pertaining to access of minority language groups to health services. A fifth information gathering activity was a guided tour of Jeffery Hale Hospital. As well, four themes guided the search for information: the organizational dynamics which influence the definition of health services, the nature and status of the clinical projects, the nature of information gathering activities about the English-speaking population, and innovation activities within the organizations.

Results

One important general observation is that both English-speaking and French-speaking managers recognize that the Network is providing useful and often innovative health services to both English speakers and the general population. Other regions appear to consider that, for its size, the Network in the Quebec City region offers an exemplary model (although this would need to be confirmed by health professionals in other regions).

In relation to the first and second objectives of the study, the dynamics which are likely to contribute to changes in the services offered by the Network and the development approaches which are being used, we should first note recent external influences such as the creation of the CSSSs and the clinical projects. The Network also has its own development practices, which it is pursuing in order to develop its services to the English-speaking population. These practices are described and discussed in detail in this report:

1) maintenance of its clientele base;
2) integration of Jeffery Hale Hospital, Saint Brigid's Home, and Holland Centre,
3) active participation in the regional clinical projects and mechanisms for regional coordination;
4) development of information and analysis concerning the English-speaking population and their health needs;
5) ongoing innovation and project creation;
6) development of a communication program, and
7) integration of recent key concepts proposed by the MSSS.

Possible indicators for monitoring progress in relation to each of these practices are noted in a table in section 5.8.

Possible Follow-Up Activities by the Network

The third objective of this study is to discuss the pertinence of the development practices and suggest additional or substitute actions which managers could consider adopting in order to attain their objectives. Our observations indicate that many objectives have been proposed (at the planning meetings) and various analyses are being carried out simultaneously. Our main suggestion at this stage of the study is that objectives be selected in order to identify those which are most strategic and most likely to improve the range, quality, and proximity of services to the English-speaking population. It would also be helpful to define what these or other current concepts mean for the Network. Also, links between current objectives do not seem to have been made explicitly, and it would be useful to do so.

The proposal to concentrate on a few key, short-term actions that are visible or affect a relatively large number of English-speaking people (for example, single access point, innovative coordination or a key person or "personne pivot" for multiple clinical projects, the general services clinical project) seems to us to be well-founded. These key actions could be integrated with the objectives which are a priority and/or the number of objectives could be reduced.

Although the members of the Network have created various new services over the past few years, increased attention to and understanding of the processes which lead to the delivery of services in English is likely to help with the management of service creation.

One of those processes which has played and will continue to play a role here is research, documentation and analysis. The Network has a particular strength in this area. However, it may be useful to strengthen qualitative analysis of health needs and broaden demographic analyses in order to include comparative and quantitative analysis of health needs in the Quebec City region specifically. Requests can be made to various regional organizations which produce statistics on the health status or problems of the population so that they can provide comparative analyses for English and French speakers. If and when computer systems capture the presence of an English speaker in the health system, new kinds of analyses will be possible, including patient trajectories (continuity), and an analyst will be required to convert data into useful information.

The Network has regularly introduced new services, but the current context may provide some new opportunities for this. This process might be improved by encouraging front-line professionals and managers, in a participatory manner, to come up with ideas for services which could meet priority objectives. Possible expectations of

implementation would need to be managed, but the generation of a pool of ideas, is the first step in eventual service creation (to be followed by prioritization, search for partners and resources, and so on). This kind of brainstorming is also likely to complement the Network's support of its human resources.

Other Possible Analyses

Our fourth objective is to outline work which could be pursued in another phase of analysis. It would be possible to concentrate on one or more specific areas: 1) how current analyses (i.e. parts of the PHCTF project) are used within the service development process, and changes which result from them, 2) changes which occur in the provision of primary (front-line) services and factors which lead to them, 3) monitoring of the extent to which private clinics and physicians provide or could provide services in English and the English-speaking population's familiarity with these services, and 4) identification and analysis of approaches adopted by other minority communities elsewhere in the world (an introduction to this is provided in an appendix).

1. INTRODUCTION

1.1. Local Health Services Context

The Quebec City region has a health services network which is responsible for planning and providing certain health services to English-speaking citizens. One official working for the network described its mandate in these words:

> "Le réseau anglophone a, entre autres, comme mandat d'offrir des services en anglais à la population anglophone de la région de la Capitale-Nationale; il a aussi la préoccupation de soutenir les quatre CSSS et les autres établissements pour s'assurer que, dans une perspective populationnelle, la population anglophone reçoive des services de qualité, accessibles et continus, partout sur le territoire, que ces services leur soient offerts par l'instance anglophone et/ou par d'autres partenaires, en anglais ou, à défaut, en français.[2]"

There is currently a single board of directors for a CHSLD with a significant population of English speakers, Saint Brigid's Home, and Jeffery Hale Hospital, a CHSLD/hospital which has a French-speaking majority patient clientele but which also has a mandate to provide short-term geriatric and ambulatory care to English-speaking patients. These organizations and several other public, private, and community organizations contribute to a third organization, Holland Centre, which offers community and CLSC-type services to English-speaking clients, and there is a plan to integrate at least the CLSC part of it into the Jeffery Hale-Saint Brigid's administrative entity in the fall of 2006. Holland Centre currently receives certain resources from the CLSC Haute-Ville-des-Rivières, which is part of the new CSSS Vieille-Capitale (created in 2004). We will refer to these three organizations, Jeffery Hale Hospital, Saint Brigid's, and Holland Centre, which provide services to the English-speaking population,[3] as the Quebec City region English language health network, or simply the Network.

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2 The English network has a mandate to offer services in English to the English-speaking population in the Quebec City region; it also strives to support the four CSSSs (Centres de santé et de services sociaux) and other institutions, using a population approach, so that the English-speaking population can receive high quality, accessible and integrated services, anywhere in the region, in English or, failing that, in French, regardless of whether they are provided by the Network or its partners.

3 The expression English-speaking population is used. It is considered more general than Anglophones and relies on self-identification by the individual. It may also include, for example, immigrants who speak neither English nor French as their mother tongue and who may be more at ease in English than in French. This highlights a need to know more about this group. This distinction is not just academic since some people (tourists or short-term residents, for instance) whose mother tongue is neither English nor French prefer services in English. This could also be the case with a certain number of students at Université Laval.

In 2004, the Quebec provincial government created, through legislation (Bill 25), organizations called CSSSs, which have a mandate to develop health and social services for their geographical population. There are four CSSSs for the Quebec City region, and two in particular, Québec-Nord and Vieille-Capitale, include the vast majority of the region's English-speaking population. These new organizations also have or will have a budget to accomplish this mandate.

The CSSS has a formal responsibility to provide health services to citizens in its geographical catchment area, including those who speak English. Actors in the Quebec City English language health network see themselves, first of all, as partners with the CSSSs in the provision of certain services to English-speaking clients. However, they also hope that some of the CSSSs' responsibilities will be delegated to them. They want to reach agreements with the CSSSs so that English-speaking clients would be referred to the English language health network. Currently, there is some discussion between representatives of the English network and two CSSSs (Québec-Nord, Vieille-Capitale) with regard to six regional clinical projects, a province-wide initiative to improve primary (front-line) services in specific areas. In the Quebec City region, these services are: General Services, Cancer, Chronic Obstructive Pulmonary Disease, Mental Health, Youth At Risk, and the Elderly. The creation of the CSSSs represents a clear change in the organizational ecology of the region and for Quebec.

1.2. Orientation of the First Phase of the Study

This analysis is the result of the Network having obtained a PHCTF project (a federal program called the Primary Health Care Transition Fund) for the Quebec City region. After discussions between the representatives of the Direction de santé publique (Louise Grégoire and Dr. Daniel Reinharz also at Université Laval) and the Network (Louis Hanrahan), a decision was made to centre this phase of work on the capacity of the Network to adapt its planning and evaluation activities to the recent and ongoing changes in its environment.

We should note that there was also an interest in acquiring a framework which could be used to implement activities for monitoring the effectiveness of the English language health services network.

The objectives of this report are to: 1) describe the social and organizational context, and changes and dynamics which are contributing to or likely to contribute to changes in the organization and health services by the English network, 2) identify the objectives and approaches adopted by the Network in relation to these changes, as well as possible indicators which could be used to monitor the development of services 3) discuss the pertinence of these approaches and suggest additional or substitute actions which managers could consider adopting in order to attain their objectives, and 4) outline other research which could be conducted. Our hope is that the observations and discussion in this report will document the context and the

Network's actions, and suggest as well possible actions which could be taken to reinforce its strategic planning and organization of health services.

2. METHODOLOGY

This study used a qualitative research methodology and employed information gathering methods commonly used in qualitative social science research. Four main information gathering activities were carried out in relation to the objectives identified above: the gathering and study of local documents produced by the Network (see Appendix 1), semi-structured interviews with key regional actors in July, August and September 2005, the observation of two annual planning meetings in September 2005, and the consultation of certain documents pertaining to access of minority language groups to health services (see references). The people who were interviewed were chosen based on their responsibility for services within the organizations in the Network or organizations directly linked to the Network (the Agence de la santé et des services sociaux, which we will refer to as the Agency, and the CSSS Vieille-Capitale), or because they were said to have extensive knowledge of the English-speaking population or its services:

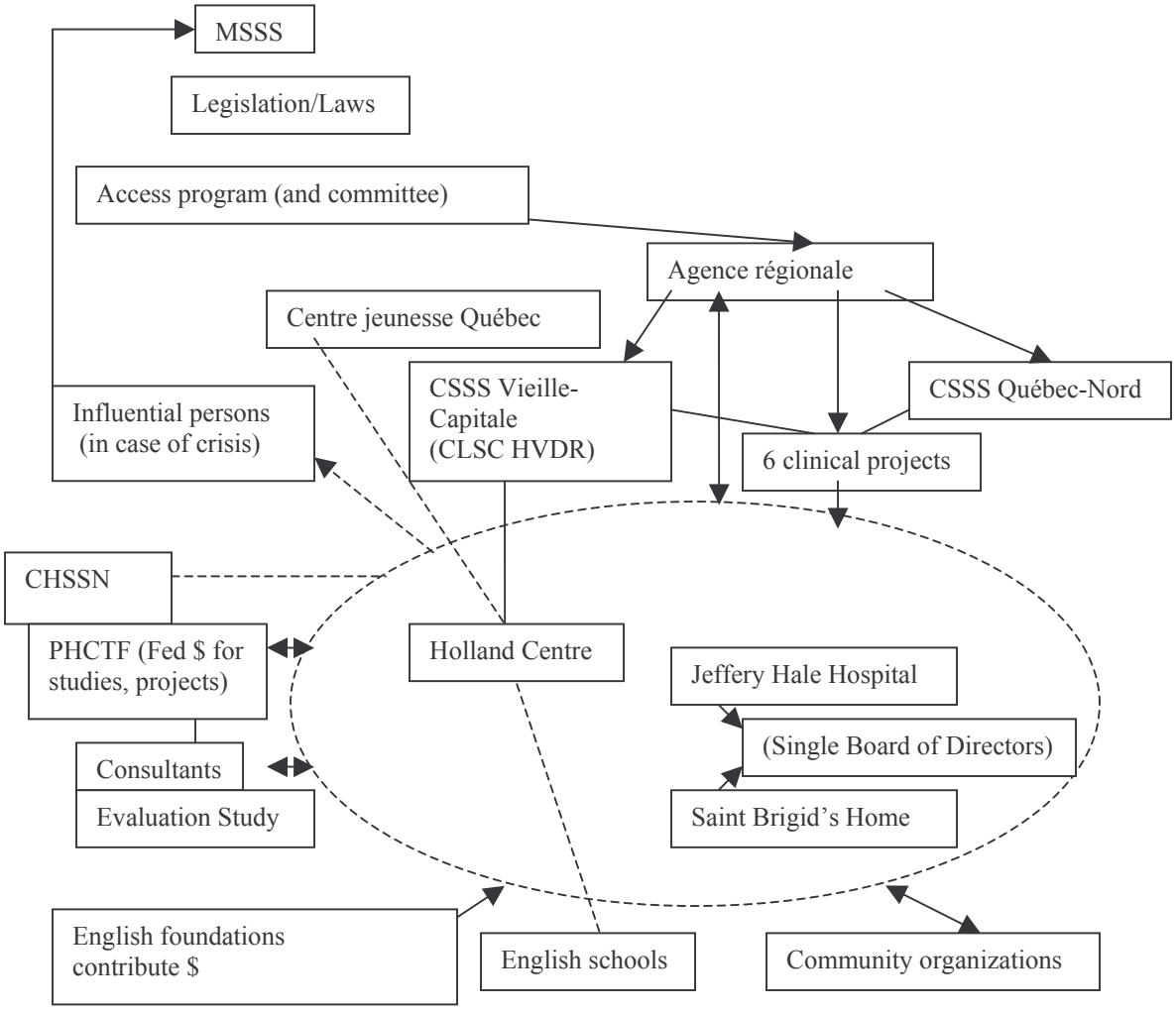
- Chair of the Board of Directors of Jeffery Hale Hospital and Saint Brigid's Home;
- Director, Holland Centre;
- Program Manager, Holland Centre;
- Coordinator, PHCTF project for the Quebec City region;
- A consultant on English-speaking demographics;
- Assistant Director, Jeffery Hale Hospital;
- Director of Professional Services, Jeffery Hale Hospital;
- An analyst of fields in information systems which could capture whether a client is English-speaking;
- Coordinator of English language services at the Agency;
- Coordinator of clinical projects, Agency;
- Executive Director, CHSSN;
- Senior Manager, CSSS Vieille-Capitale.

Generally-speaking, four topics were covered in these interviews: the dynamics in the organizations which influence the definition of health services, the nature and status of the clinical projects, the nature of information gathering activities about the English-speaking population, and innovative activities within an organization.

3. SOCIAL AND ORGANIZATIONAL CONTEXT OF THE ENGLISH LANGUAGE HEALTH SERVICES NETWORK

The description of the context of the Network needs to take into account relations between both Network members and organizations which are external to it. The following graphical representation illustrates these relationships.

Graphical Representation of the Organizational Context



This representation highlights the complex environment of the Network. Certain more salient relationships will be discussed below.

3.1. Degree of Bilingualism

An important issue should be introduced at this point: the degree of bilingualism of English speakers. This may range from zero through functionally competent to completely bilingual, which for us means appropriate vocabulary, accuracy of comprehension and expression, and no trace of an accent, in a health service context. An accent may be a factor if a health professional communicates something to a patient differently depending on whether they have an accent or not, or whether they misunderstand a patient's comment. An accent, or the vocabulary used, may influence the care which the health professional provides (although this requires more investigation, particularly in Canada). In a recent article, Epstein (2005), in commenting on an IOM study in the U.S., notes two possible ways that health care consultations by members of minorities may be altered, through discrimination, or through a break-down in communication.

The importance of determining the degree of bilingualism has been recognized by Bowen (2001). She recommends that officials: "... determine the feasibility of incorporating, as part of health system data collection, information on patient proficiency in an official language." However, no information has been found on the degree of bilingualism of English speakers in the Quebec City region.

Another aspect of this discussion is that the degree of bilingualism may vary by age group, with the elderly perhaps being less bilingual than those who are younger, although this also needs to be verified.

The concept of degree of bilingualism is potentially important in that a large portion of the English-speaking population in the province of Quebec, particularly outside of Montreal, may be receiving health services in French. This basic fact may be hindering the demand for and development of services in English. There is some evidence which suggests that health services in a second language are less effective (reported by Bowen, 2001), although little appears to be known about how the degree of bilingualism may moderate this, or about the actual impact of the degree of bilingualism on the health of segments of the English-speaking population in Quebec.

3.2. Desired Language of Service and the "Access Program"

A second important contextual element relating to the organization of services is that since the late 1980s, the Quebec government has recognized in law the right of the English-speaking population to receive services in English, although certain restrictions apply.

> "Toute personne d'expression anglaise a le droit de recevoir en langue anglaise des services de santé et des services sociaux, compte tenu de l'organisation et des ressources humaines, matérielles et financières des établissements qui dispensent ces services et dans la mesure où le prévoit un programme d'accès visé à l'article 348. " (Loi sur les services de santé et les services sociaux, 1991, chapitre S-42, article 15).

In particular, the "Programme d'accès aux services de santé et aux services sociaux en langue anglaise pour les personnes d'expression anglaise" (Program for Access to Health Services and Social Services in the English Language, which we will refer to as the access program) is a provincial government measure intended to define access to services in English in particular geographical areas. Although the access program should, by law, be updated on a three-year cyclical basis, there has been no recent update for the Quebec City region (as of January 2006). For the Quebec City region Agency, Holland Centre is considered to be one of the means for achieving the aims of the program, and for them, Holland Centre's annual report provides adequate information on the program's outcomes. However, this annual report, in itself, cannot be considered to be a wide-ranging assessment of whether or not the access program's objectives are being met, and thus the current analysis cannot draw on such an evaluation.

This program implies that there are people who wish to receive services in English, and for the authors, **this is an important characteristic which should be added to current demographic or language classifications**. There would appear to be little reason to create health services in English for English speakers who are also fully at ease in French and feel no need for health services in English. The simple categorization of someone as an English speaker is only a proxy characteristic; an unknown percentage of these people actually want services in English. The basic principle that we advocate, which to a large extent has been recognized, is that health services should be offered in the language of the recipient's choice. Very little appears to be known about this aspect, however. Statistics Canada, for example, does not have any questions relating to it, and there have been very few pertinent regional studies (Tran, 2004, however, does explore some patients' wishes to receive psychological services in English). A number of studies have examined the desire of the English-speaking population for services in English for the province of Quebec,[4] and although they may provide relevant information, they might not accurately reflect the situation in the Quebec City region.

Another aspect is how far the English-speaking population in the region are willing to travel in order to be served in English, and whether this willingness to travel may vary

[4] A question in the CROP/Missisquoi 2000 survey comes close to this issue: relative importance of service in English when received and not received; http://www.chssn.org/populationhealth/resources.html and see CROP survey.

according to health problems. For example, are elderly English speakers in Levis willing to take the ferry or drive about 40 minutes for services through the Network? Little appears to be known about this. One objective of the Network is to take services to the population instead (i.e. the mobile day centre for the elderly).

The General Director of the Network has suggested that a response to a desire for service in English should also take into account the nature of the health service required. For example, it may be less important to receive radiology services in one's primary language than psychological counselling. Similarly, services in a primary language may be very important if a person is in the middle of a health crisis.

3.3. Jeffery Hale Hospital

As noted earlier, another important aspect of the health services context in the Quebec City region is the existence of several organizations which provide services in English. These organizations have changed over the past decade. A major change occurred at Jeffery Hale Hospital in 1996, a hospital built and supported by the English-speaking community, when it was transformed from a general hospital with a wide range of services to a CHSLD (long-term care hospital). This change of mission was not unique to Jeffery Hale Hospital, and three other hospitals in the region also changed vocation. With this transformation, several previous services disappeared, such as surgery, general short-term beds, and obstetrics. However, as a sort of compensation, money was invested in Holland Centre (apparently $500,000 was earmarked for this). It is interesting to note that in 1995, the board of directors of the former Régie régionale de la santé et des services sociaux described the mission of the hospital thus:

> "Le mandat particulier d'assurer l'accès aux services de santé physique dans leur langue aux personnes d'expression anglaise dans les établissements de Québec est confié au Centre hospitalier Jeffery Hale.[5]"

In 1996, Jeffery Hale asked for and obtained a mandate for ambulatory care, as well as for short-term geriatric services. Its emergency department was maintained but was later limited to walk-in patients (no ambulances). Specialized outpatient clinics and diagnostic services were maintained, and a geriatric day hospital was created.

In 2000, the Agency proposed that Jeffery Hale Hospital be integrated into other French language hospitals. Through various means of pressure organized by leaders in the English-speaking community, Jeffery Hale Hospital was maintained as a separate institution, although the Agency also required that the hospital and Saint Brigid's Home

[5] Mission et orientations du Centre hospitalier Jeffery Hale dans le cadre de la reconfiguration du Réseau, Centre Hospitalier Jeffery Hale, September 12, 1995.

begin the transition to a single organization. One of the outcomes of this period was the creation (November 2002) of a single Board of Directors for the two organizations. Various planning activities have since taken place in an effort to ensure gradual and harmonious integration of the two organizations. For the moment, the joint Board of Directors and senior management team constitute the actual extent of the integration, although there is ongoing activity to create a single institution.

At this time, the vast majority of the hospital's clients are French-speaking. Patients are not systematically informed of the possibility of obtaining services in English in the emergency department, nor are there any signs to indicate this. However, staff may switch to English if the patient speaks English, or if an accent is detected.

There are statistics available concerning English-speaking patients that relate to out-of-province patients processed by the emergency department: for 2003/2004, 484 of the 27,481 people who visited the emergency room were from outside the province or country, and the vast majority of them spoke English.[6]

During the summer of 2005, the outpatient clinics were temporarily closed (and were still closed as of the end of September), in order to have sufficient nurses available to maintain the hospital's emergency services.

The hospital also has a mandate to serve the English-speaking population not only in its immediate area but also from rural areas in the region. An elderly person from Valcartier, for example, may need hospital services and Jeffery Hale is the hospital to which he or she is likely to turn for specific geriatric services in English.

3.4. Saint Brigid's Home

Saint Brigid's Home is a CHSLD (long-term care for the elderly) with a total of 162 beds. Private apartments house a further nine residents. The Home caters to both English-speaking and French-speaking residents, with varying degrees of autonomy. The 2003-2004 Annual Report indicates that between 50 and 60% of the residents are English speakers, although more recent information (August 2005) in the Home's computer system indicates that currently fewer than 50% of the residents are English-speaking. Saint Brigid's contributes, through Holland Centre, to an elder day centre, which had 117 users, and it would appear that these people were all English speakers. Over the past few years, the Home's residents have, on the average, been getting older and requiring more care than in previous years. Staff have also documented a situation in which Saint Brigid's has been financed to a lesser degree, given the care needs of their patients, than other CHSLDs. Staff also believe that it takes English speakers longer to

6 These statistics were kindly provided by the hospital.

get a bed at Saint Brigid's (on the waiting list longer) than French speakers in the region. The Home is cited by outside professionals as a model of services to the elderly.

3.5. Holland Centre

During the mid 1990s, a new English language organization was created, Holland Centre. Several organizations contributed to its founding, and continue to fund it or provide it with personnel: the CLSC Haute-Ville-des-Rivières (now part of the CSSS Vieille-Capitale), Centre jeunesse de Québec, Saint Brigid's Home, Jeffery Hale Hospital, and various private English philanthropic foundations through the Holland Resource Development Corporation. Because of the contributions of the foundations, the Network is an example of private/public partnership. In this case, the private part of the equation does not refer to private enterprise, but rather to philanthropic organizations. This centre provides community and CLSC-type services in English, and acts as a gateway, by referring clients to other services. The following table, taken from the 2004-2005 Annual Report, summarizes the activities of the Centre. The Annual Report only covered interventions, not distinct persons.

Interventions by Holland Centre, 2004-2005	
Intake (welcoming)	1437
Adult mental health	311
Perinatal	832
School nursing	1627
School social work	1177
Home nursing	1331
Social work	886

Holland Centre has actively extended its geographical reach (or geographic accessibility and proximity), for example by providing referrals over the telephone or mobile services such as the day centre and home care for the elderly.

It should also be emphasized that Holland Centre's approach of offering services only to the English-speaking population is unique in comparison with the other two organizational members of the Network. It appears to have been successful with this approach.

In 2003, after the Agency reconsidered the closing of Jeffery Hale Hospital, English community leaders suggested that the CLSC-type services of Holland Centre could also be included in the integration of Jeffery Hale Hospital and Saint Brigid's Home.

3.6. Creation of the CSSSs and Clinical Projects

In 2004, the CSSSs were created and given the responsibility of delivering health services to the population living on their territory. The Quebec City region was divided into four sub-regions: north, south, east and west. The majority of the English-speaking population live in the Vieille-Capitale, although there are also substantial pockets in the north (Valcartier, Shannon) and some in the west (Portneuf). As a rule, CSSSs comprise CHSLDs, hospitals and CLSCs. The hospitals associated with Université Laval form a separate network. The CSSSs are responsible for establishing and coordinating health programs for their territory, and have budget oversight for this. However, they currently have few resources to help with service planning. Although it is still too soon to say how the creation of the CSSSs will affect service provision, it would appear that at least some coordinating activities and financial decision-making will shift from former coordinating structures, such as the Tables de concertation and the Agency, to the CSSSs. The CSSSs will likely play an important role in the planning, adaptation, and creation of primary health services.

One recent activity that involves the Agency, all four CSSSs, and primary health service providers is the creation of what are referred to as clinical projects ("projets cliniques"). These projects are considered to be important ways of improving on access and continuity of care. Analysis of the development of agreements between the English network and the CSSSs, particularly in the area of the six clinical projects, will provide a pertinent example of the inter-institutional dynamics which structure the development of primary health services for the English-speaking population. The development of these projects will shed light on the ability of the English network to coordinate with key French language actors. Projects such as these will also serve as indicators of the extent to which the English network is able to innovate and adapt to the new organizational health care context in Quebec.

Six specific projects were created by the Agency, with some advice from local organizations: 1) General Services, 2) Troubled Youth, 3) Cancer, 4) Chronic Obstructive Pulmonary Disease, 5) Mental Health, and 6) the Elderly. General services are likely to include the emergency department, family medicine, prevention and promotion of public health, imaging, pharmacy, and outpatient clinics (as envisioned by Jeffery Hale's Director of Professional Services). For each sub-region and each clinical project, a committee has been formed to facilitate fact-finding and to coordinate activities among the organizations represented in the committee.

In the planning scenarios developed by senior managers, one of the potential roles of Jeffery Hale Hospital is to increase the range of general services offered to both English-speaking and French-speaking clients. None of the CSSSs in the Quebec City region has a hospital as a constituent member, although the possible association of Jeffery Hale with the CSSS Vieille-Capitale would give this CSSS access to technical facilities (labs, imaging and 24 hour services with the emergency department). It is also hoped that these same technical facilities will help to attract family practitioners to the hospital and thereby become part of the hospital's contribution to general services. The English-speaking population might then have improved access to family practitioners who speak English, as well as social and nursing services.

3.7. Financial Context of the Network

Some aspects of the financial underpinning of the network are known, whereas others are not yet clear, due to the recent creation of the CSSSs. In the short term, it appears that Jeffery Hale Hospital and Saint Brigid's Home will continue to have stable, separate budgets, although a combined budget will be allocated when total integration is achieved. This budget will continue to transit through the Agency. It has been agreed that personnel loaned to Holland Centre by the CLSC Haute-Ville-des-Rivières, now part of the CSSS Vieille-Capitale, be transferred to the Network. Whether or not new money will be available for the clinical projects appears unknown at this time. There seems to be some expectation that an agreement with the CSSS Vieille-Capitale regarding access to technical facilities at the hospital may result in some financial contribution to the network, and this would represent a change in current financial arrangements. There is an ongoing effort to redress the underfunding of Saint Brigid's Home.

3.8. MSSS' Current Discourse

In the past year, Agency and MSSS planners have placed greater emphasis on the importance of a "populational health" approach, and also on certain aspects which can be taken to be general objectives for changes in services: a hierarchy of services ("hierarchisation"), accessibility, proximity, quality and continuity. These terms have become widespread among managers and health professionals, and constitute the current discursive frame of reference for managers. Yet very often it is not clear what managers mean when they use them. In addition to the creation of the CSSSs and clinical projects, we believe that these concepts and what they will come to represent could have an impact on the organization of health services. These concepts may also become objectives with associated evaluation criteria which managers will use as benchmarks to demonstrate progress. Noticeably absent from the current discourse is any reference to efficiency. However, this omission may only be temporary.

3.9. National Health Policy

Another background element to the current study is the federal government's interest in the provision of health services to minority language groups. There is a clear federal policy trend to support research and programs in this area. As Bowen (2001) remarks:

> "A landmark ruling in 1997 by the Supreme Court of Canada determined that hospitals were required to provide interpreters for Deaf patients (Eldridge vs. British Columbia [Attorney General], 1997). This recognition, that effective communication is an integral part of the provision of health services, has focused attention on the rights of other language minorities in the country."

In a workshop in 2004, the Commissioner of Official Languages remarked:

> " I would also suggest avenues for research that, I believe, could contribute to the development of official language communities and to the improvement of the health care services available to them. These avenues include:
>
> - the need for a conceptual, methodological framework to support and monitor the health of official language minority communities;
> - the importance of updating the full range of factors that affect health care in minority communities;
> - the crucial role of language in the delivery of health care services; and
> - the organization of health care services and the importance of prevention. (Adam, 2004). "

A second key policy trend is the maintenance and improvement of primary health care services. The Romanow Report is an example of this trend, as are a recent Health Canada media campaign on Primary Health and the PHCTF project that is discussed in this report. Finally, the federal government has sponsored consultative committees on minority communities and taken together, these activities and trends indicate the federal government's concern with the provision of primary health services to minority groups.

4. DEVELOPMENT APPROACHES AND ACTIVITIES

In the previous section, we provided an overview of several organizations and changes that are likely to affect the continuity and development of health services in English in the short term. In this section, we will identify actions that the Network and its environment are undertaking in order to influence the organization of health services in the Quebec City region.

First of all, we should point out a number of influences on the network which are external to it. We have already noted that the MSSS has created certain organizations and programs which continue to influence the actions of the Network's members. The local Agency is an important organization in this regard, and will continue to interpret ministerial directives, coordinate organizations, and receive recommendations from the Network. As well, the CSSS, clinical projects, and access program may impact the development of primary health services in English. In addition, one could consider the research and communication activities of the RATSPL[7] group in the Quebec City region to be another coordination mechanism promoted by university researchers, managers, and public health officials, so that information and critical analysis is used during the development of services.

For its part, the Network also has a number of avenues through which it may influence the planning and development of services, and they will be described below. This working hypothesis will be developed further in the sections that follow.

4.1. Maintenance of a Clientele Base

Both Jeffery Hale Hospital and Saint Brigid's Home have a significant portion of their clientele who are French-speaking. For the managers of these organizations, this allows them to offer a wider range of services, better ensure service quality and employ people they would not be able to if they only served the English-speaking population.

4.2. Integration of Jeffery Hale Hospital, Saint Brigid's Home, and Holland Centre

The integration of Jeffery Hale and Saint Brigid's Home began in 2002 with a single Board of Directors for both organizations. This integration appears to have been encouraged by the Agency, and it also seems that Jeffery Hale hoped that this would help it to avoid integration with a French language institution, so it seems to have been a survival strategy on its part. There has also been a desire to preserve the English-speaking community's institutions and recognition that such institutions play an active role in maintaining the vitality of a minority community. Jeffery Hale Hospital will be

[7] "Réseau d'appui à la transformation des services de premières ligne" from Université laval linking professors/searchers from three different faculties (nursing, family medecine and public health).

integrated with Saint Brigid's, and thus inherit the latter's status as a designated institution (which appears to mean that it must provide services in English to English speakers).

Another reason given by managers for the integration is that they hope that this will increase the use of English by hospital personnel, and they believe that this is starting to occur. Other possible reasons could be advanced for the integration: a public signal that the English network is aware of the more general trend for health organizations to be networked or merged, and the possibility of some coordination of services or sharing of personnel between organizations in the network (this is already the case to a small degree).

Currently, there is one joint Board of Directors for the hospital and Saint Brigid's Home, but they remain two distinct legal organizations. The slow pace of integration has been attributed to a desire to allow a harmonious rapprochement of organizations with distinct cultures and health service approaches. The organizations are also waiting for the MSSS' formal approval. In the fall of 2006, parts of Holland Centre are also to be integrated with the other two.

4.3. Participation in the Clinical Projects and Regional Coordination

The English network has elaborated an explicit approach for participating in the clinical projects, and has appointed managers who attend the meetings for each clinical project, for both the Quebec-Nord and Vieille-Capitale CSSSs. By being present, the hope is that the English network's managers will be aware of what other organizations are planning with regard to their population, will increase the visibility of the English network, and will be able to convey their willingness to deliver services on behalf of the CSSSs to the English-speaking population. Part of the work carried out by the people involved in the clinical projects is to identify the areas of risk for each ("zones de vulnérabilité"). One of the areas of risk is care needs which may not be addressed when a patient falls between the care programs of different organizations. The main stakes in relation to the clinical projects are whether or not there is an improvement in the existence and coordination of services for English speakers and whether members of the English network will be able to integrate their services with those of the CSSSs.

The Network is proposing to help the CSSSs with their responsibility for the English-speaking population through service contracts. It is therefore likely to become involved in outsourcing contracts, some of which are liable to affect the clinical projects.

As well, members of the Network participate in regional coordination mechanisms. For example, the General Director is on a regional project planning committee involving the directors of local health organizations. This allows high-level discussions between the

senior manager of the English network and his French-speaking counterparts. He also has a working relationship with the Director of the CSSS Vieille-Capitale.

4.4. Development of Information and Analysis Concerning the English-speaking Population and Their Health Needs

The English network is engaged in several initiatives geared towards increasing information about the health needs of English speakers in the Quebec City region. This is a well-established and public practice, and serves to characterize the health needs of the English-speaking population. This practice has been clearly noted by community leaders:

> "There are two essential areas of knowledge that a community must have: knowledge of itself and knowledge of its environment. " (Walling et al., 2001, 7)

> "The more accurate information the minority community possesses the more the majority community is going to be interested and willing to listen. " (Walling et al., 2001, 10)

In addition, at a planning meeting in September 2005, it was stated that one of the objectives of the Network was to develop a thorough understanding of health needs.

In practice, the past decade has seen, for example, the sponsorship by English language organizations, of a series of local studies and research projects (for example, BDL, 2000; Blouin and Johnson-Blouin, 1995; Deschênes and Ouellette, 1993; Johnson, 1999; Hébert-Saindon, 1995; Laprise, 1992; Minh Lan Tran, 2004; Robertson, 2001). This research is noteworthy for a relatively small community, especially given the absence of an English university in Quebec City.

Studies are often followed by pilot projects (for example, new services for the elderly which followed the Laprise study, 1992), and these projects are usually financed by the foundations or with small budgets which one or another of the organizations has managed to garner. Presentations are then made to the regional health system for the purpose of obtaining stable funding.

The information gathering approach has recently been reinforced with the development of the PHCTF projects, and local managers participated in both shaping this program and the elaboration of specific projects. The PHCTF project for the Quebec City region contains several particular activities, four of which need to be emphasized: 1) development of demographic information and information on indicators used by the MSSS for financial allocations, 2) assessment of the way in which computer systems may or may not capture the fact that a patient or client prefers to speak English, in

collaboration with the regional Infocentre and Technocentre, 3) an evaluation framework in order to better understand how the English network assesses and monitors its activities (this analysis is part of this), and 4) more documentation of the relatively longer wait times of English speakers before obtaining access to a long-term care facility.[8]

In relation to item 1, a demographer will analyze trends for the Quebec City region, partly with the help of the 2001 Census. A nurse with a specialty in information systems and links to the Infocentre and Technocentre will produce a detailed document in relation to item 2. The group responsible for the present report is working on item 3. A person has been designated to document relative wait times for long-term care.

Results from a current study funded by CHSSN (Community Health and Social Services Network) into the health practices and attitudes of the English-speaking population across Quebec are expected in the fall of 2005. This is a continuation of an earlier similar study. The study findings will likely go beyond those of demographic studies and look at attitudes, although it is unlikely that the sample will allow analysis of the specific situation of Quebec City.

Another example of information gathering took place in the spring of 2005, with an inventory of all the services offered by English language organizations (sponsored by the PHCTF project as well). This allowed senior management to have a current summary of the health services offered and give this information to any managers interested.

4.4.1. Research Partnerships

Several of the research projects have been collaborations between organizations. A recent study into adult mental health was a collaboration between Holland Centre, the Direction de santé publique, and Université Laval. Similarly, the analysis of computer systems and the capture of an English-speaking characteristic is a joint project between the English network and the Agency. A recent analysis of staff perceptions of human resources at Jeffery Hale Hospital and Saint Brigid's Home was carried out as part of an MA thesis.

4.4.2. Participation in CHSSN

The Network played a significant role in setting up a separate organization, the Community Health and Social Services Network (CHSSN), which has a mandate of research and action in the health sector for the entire English-speaking population in the province. Through its ongoing

[8] An interim document was obtained that describes this: Pour un accès équitable des anglophones à l'hébergement de longue durée dans la région de la Capitale-Nationale (03), September 5, 2005.

participation, the local English network is able to communicate its expertise to other regions with small English-speaking populations. It is also able to influence research orientations and obtain research results, and stay abreast of actions taken by other organizations and communities.

4.4.3. Use of Specialists and Consultants

One of the organizations was able to hire a consultant, who helped to organize and write the PHCTF project proposal (and he is coordinating the project). Another specialist will conduct demographic analyses. An experienced physician has been added to staff at Jeffery Hale Hospital to help develop general services at the hospital and to private physicians who have English-speaking clients.

4.5. Innovation and Development of New Services

The main form in which innovation can currently be seen is the incubation and implementation of new services. Each of the three organizations has identified services which it would like to develop (several of these can be found in the annual reports). For example, Holland Centre would like to further develop services for children with special needs and its adult mental health services; Jeffery Hale hopes to add a palliative care unit and has already designated some beds as such; and Saint Brigid's Home has a project for improving the quality of life of its residents by creating smaller, adapted living areas ("îlot de vie"). The latter project is the subject of one part of the PHCTF project. In the past, several pilot projects have become valued services, and Holland Centre in particular has a reputation of being able to implement these projects relatively quickly.

Several staff have also been seconded from one organization to another, and this can be considered to be an innovative way of procuring personnel.

4.6. A Communication Program

The PHCTF project description (Nov. 2004) also mentions the following activity: "Préparer et réaliser un plan de communication avec la clientèle, les partenaires, le personnel, etc." In particular, a Powerpoint presentation has been prepared on the English-speaking population, services, service philosophy, and objectives, and has been disseminated to a variety of organizations in order to present the orientations of the English network to health service planners and other organizational partners.

4.7. Reference to Recent Key Concepts Proposed by the MSSS

The use of common concepts introduced by the MSSS and the Agency (i.e. a hierarchy of services, access, continuity, quality, populational approach) in the Powerpoint presentation demonstrates that the Network's managers are aware of these concepts

and adopting the same language. To some extent, these concepts were already part of the service approach of the Network. For example, several of the people interviewed indicated that the English language organizations already had a network and populational approach.

The above sections have identified a number of orientations adopted by the network in order to support its development.

5. DISCUSSION OF THE ORIENTATIONS

In this section, we will comment briefly on the orientations identified above.

5.1. Maintenance of a Clientele Base

The effect of the orientation of providing services to both English and French speakers is not yet known. For example, French-speaking planners at the Agency or the CSSSs may consciously or unconsciously consider that there are other organizations to service the French-speaking population, which could undercut their interest in maintaining, for example, the emergency room at Jeffery Hale Hospital. However, it is unlikely that there is or will be an excess of long-term beds for the elderly in the region, so there would be no point in eliminating the long-term care beds. Network managers have argued that the CSSS de la Vieille-Capitale does not have access to an emergency room, and this appears to be a useful argument, as long as it remains true.

The approach of serving both French and English speakers introduces the risk that the English-speaking population will not identify with Jeffery Hale Hospital in particular or realize that services are available in English, since this hospital also caters to the French-speaking population. Reflection is required on how to communicate the dual linguistic nature of these institutions in a strong and positive light.

The creation of the CSSSs has created another organizational actor with which the Network will need to negotiate service agreements, and this has been recognized by senior managers. However, such agreements will require attention and time, and it is not yet clear (as of fall 2005) how these may come about. Managers will need to be attentive to new opportunities, and some services may need to change in order to be more relevant in this new context.

5.2. Integration of Jeffery Hale Hospital, Saint Brigid's Home, and Holland Centre

The gradual integration of the three organizations may help Jeffery Hale Hospital and Saint Brigid's Home avoid criticism from various quarters in the health care system. Given the external pressure on these organizations to integrate, this activity may increase the credibility (legitimacy) of the English network vis-a-vis French language planning organizations. The Network hopes to influence the organizations which determine its long-term survival and configuration, and to some extent it has been successful at this. However, in the long term, it would be useful to have explicit objectives, even if they are modest ones, in terms of the gains for the English-speaking population and taxpayers in general. Will the possible provision of services in English at Jeffery Hale become more visible and will patients (English and French speakers alike) make greater use of it? Will integration lead to new efficiencies, and if so, what

kind? Will there be savings, and if so, in what area? Will there be improved coordination for patients who transit between the two organizations or better access to physicians for residents at Saint Brigid's? Are staff and external planners being sent a clear message regarding the likely gains of the integration process? Will it be easier for the CSSSs to negotiate service agreements with a single Network entity?

Senior managers from the three organizations meet regularly. Apart from these meetings, it is not yet clear how activities or responsibilities will be coordinated. More importantly, one could ask how service adaptation or new service offerings will emerge in this environment.

Integration is a major organizational challenge, but the Network has a measured and planned approach to it. The organizations' approach is one of mutual, ongoing adaptation, and this appears to us to be appropriate. One possible drawback of integration is that it inevitably requires time and attention and one could ask what positive outcomes actually result from it and compare these outcomes with the activities which the managers could have accomplished had they not been occupied with integration. At the planning meeting, it became clear that managers have identified a large number of activities that will be required.

5.3. Participation in the Clinical Projects and Regional Coordination

Having consulted what the six committees have prepared as statements on the population's needs (available through the Network's web site) during the summer of 2005, there was very little if any reference to the English-speaking population in these documents. Theoretically, it would have been possible to prepare and submit a couple of pages of analysis in relation to this, if such information were available. The impression that this creates is that the managers representing the English network in these projects had not yet made a formal case of the need to provide services in English in these six areas. It is not yet known if these meetings will lead to formal or informal discussions in relation to the nature of services which the English network could provide.

Although the six clinical projects cover most of the services offered by the English network, it would appear useful to consider which services fall outside of these projects (children with special needs is one example). Although the CSSSs and the Network are not limited to these projects, one could ask whether these other projects will be maintained and what mechanisms will be used to do so. We also wonder if these six projects represent the priorities of the Network.

5.4. Development of Information and Analysis Concerning the English-speaking Population and Their Health Needs

The process of conducting research undoubtedly clarifies understanding of certain phenomena, helps the English-speaking community to document and communicate the existence of certain health care needs, and likely creates a mechanism for reflecting on policy and service alternatives. Because of this, it would seem to be a proven and well-founded practice. Efforts to obtain demographic data also appear to be useful, although a wider scope is needed which would include the analysis of health needs. The Bowen study has been cited by managers of the Network as relevant research, but our reading of this report indicates that it contains very little information on the health needs of the English-speaking population in Quebec (although other information is available in the CHSSN Baseline Study). An argument has also been advanced concerning the fact that there is significant migration of the English-speaking population to and from the region. It is our view that temporal comparisons (i.e. the census at five year intervals) are largely sufficient to capture the net effect of this and overall trends. In other works, migration effects should be discernable in temporal analysis of the census data. If projections of future demographic data are desired, recent trends are likely to be indicative, although more sophisticated analyses would likely be beneficial by considering recent changes in age structure.

In particular, there appears to be some gaps in the research that has been undertaken. Demographic data should not be confused with the documentation of health needs. This appears to be a common problem in the health care sector and the English network is not necessarily more prone to it than the general health system. In the long term, it would be useful to obtain data that is richer than the general census data in its portrayal of health care needs. The 2003 Canadian Community Health Survey could have been a very useful step in this direction, and if desired language variables are not present, representations need to be made to Statistics Canada about the need for equivalent language group identification as with the census, given its repetition at two year intervals. The CHSSN-sponsored survey (CROP survey) is also promising in this regard, although the sample size may be too small to gain insight into the specific situation of the Quebec City region. At the current time, there appears to be no documentation of the number of English speakers in the region who are receiving services in French outside of the Network, or of what those services are. Nor does there appear to be any extensive analysis for Quebec of the possible impacts of being an English speaker when seeking health care. This type of information could help the Network build an argument in relation to certain geographical areas and health needs.

As well, little information concerning the English-speaking population seems to have made its way into the clinical projects' background documents, and there is a clear need for this. The practice of estimating the number of English-speaking clients based on the percentage of English speakers in the general population is one approach, but this does

not appear to have taken place. This practice may also hide significant differences between the French and English-speaking populations. Perhaps other creative analytical approaches could help to put the English-speaking population on the health needs map. For example, it should be easy to compile information on the number of elderly receiving services in English, and the nature of these services. In addition, there appears to be little formal comparison of the range of services offered to the French and English-speaking populations. Finally, although service costs do not appear to be an immediate concern, the per capita cost of services could be an eventual factor in CSSS service agreements, and it would seem that such information could be advantageous to the Network. For example, Saint Brigid's Home has argued credibly that its health care budgets are too low as a result of its care load and inequitable MSSS budgets (which create imposed spending limits).

Current efforts to identify and eventually encourage the capture in clinical computer systems of a patient's use of English would seem to be useful. For example, there is currently no capture of the fact that a person who presents to the emergency department at Jeffery Hale may receive or wish to receive services in English. This is a key location in Quebec City where the English-speaking population could be expected to go (because of the hospital's association with the English community), yet there is no information on this. It is also a location where, in theory, managers should be able to require the inclusion of such a field. Recent information (October 2005) suggests that the company which supplies the computer system may need to add the appropriate fields and make completion of these fields mandatory. More generally, the inventory of systems is part of a larger initiative to have such fields included in administrative and clinical systems and to motivate staff to enter information, and this appears highly useful.

However, if and when this data becomes available, it will open up the possibility of extensive analysis of the particular health problems of the English-speaking population and possibly help with the description of care trajectories. Descriptions of care trajectories should prove to be useful in documenting the degree of continuity of services, and allow gaps to be identified. However, there does not appear to be any current reflection on what kind of analysis will be needed, who will carry it out, or how this new type of information could be used in the justification or planning of health services. There will be an eventual need for a qualified analyst and this should be anticipated.

Another possible initiative would be to indicate to regional groups who provide health needs analysis (a current example is the professionals who are compiling statistics for the clinical projects) that there is a need for comparative analysis of the English-speaking and French-speaking populations. There may already be occasional requests to the Institut de la statistique du Québec (by French-speaking planners) and these

requests should include a comparative analysis with the English-speaking population, with the results provided to the Network. Any additional costs for this analysis should be minimal. This would be in addition to specific analyses initiated by the Network.

The Network's impressive variety of information gathering and analysis activities were highlighted at the September planning meetings. They could be enhanced by making the links between them explicit. For example, the capture of English-speaking clients in information systems could facilitate planning activities, such as obtaining background information on population needs for the clinical projects (just to use the current example). The background analysis of access to Saint Brigid's Home could also be used for the clinical project for the elderly, and this could be make explicit.

Finally, informal information gathering approaches and the discovery of health needs which result from the implementation of services should be recognized for their positive contribution and efforts should be made to strengthen them. Managers appear to have a detailed, practice-based understanding of health needs. This essentially qualitative approach to needs identification should be recognized as a legitimate approach to the discovery of needs, and the observations documented as much as possible. For example, the experience of offering a given health service may lead to awareness of other related health needs. Also, and sometimes in conjunction with the experience-driven learning process, some planning activities may allow staff to suggest health care areas which need attention. For example, this was the case at Holland Centre, where staff became aware of children with special needs, identified more of these children through the English schools, and have begun to put a program in place for children with special needs.

A significant and as yet unexploited resource could be the Canadian Community Health Survey of 2003. Consultation of the French version of the survey questionnaire available (p. 238, http://www.statcan.ca/francais/sdds/instrument/3226_Q1_V2_F.pdf) indicates that in addition to many questions about the use of health services and health needs, are questions about ethnic origin, the language spoken at home, and the first language spoken and still understood (although the documentation in English does not reveal whether these questions are in the data). The 5332 respondents for Quebec are likely to provide sufficient data for a comparison of English and French speakers in Quebec (but not specifically the Quebec City region).

Summary of Questions
Which Could Help Generate Useful Information

- What are the priority service needs as perceived by the English-speaking population?
- Does the English-speaking population have certain particular characteristics in the clinical project areas?
- Is it possible to map the pockets within the English-speaking population in the region, and could this be presented by age group?
- How far is the English-speaking population willing to travel for services in English, and for which services?
- Are there other services which could travel to the pockets of clients?
- Are there hospital services not currently at Jeffery Hale Hospital which could be provided in English at other hospitals and made known?
- What are the potential gaps in service (services offered in French versus services offered in English)?
- How many English-speaking clients receive services at the emergency room or through the hospital's other ambulatory services?
- How many English-speaking clients receive services in English from private clinics and physicians? Which physicians or clinics do this?
- What are the care trajectories of the English-speaking clients, and where are there difficulties?
- What are the experience-based views of front-line professionals regarding service needs?
- Would more bilingual health professionals (or an improvement in their English-speaking capacity) improve access to services for English speakers?

5.4.1. Research Partnerships

This practice indicates that the English network is willing and capable of working with the general health services sector, and it also allows them to lower the cost of research since other organizations also contribute. This may also increase the familiarity of other organizations with the research and reduce the time to implementation.

5.4.2. Participation in CHSSN

This appears to be a useful means of encouraging research, influencing policy, and remaining aware of initiatives in other communities.

5.4.3. Use of Specialists and Consultants

This is a common means of bolstering the expertise in an organization on an ad hoc basis. There is a need to strengthen analysis of the health needs of the English-speaking population in the region.

5.5. Innovation and Development of New Services

It would first be helpful to clarify what we mean by service adaptation, innovation, and creation. Adaptation involves relatively small changes to an existing service or program in order to accommodate client needs or changes in the organizational environment. The enlargement of the mandate of a call referral service could be considered to be an adaptation. Innovation involves significant changes to work processes or the creation of new jobs or services. On-line patient monitoring in home care would be a service innovation (since very few of these programs exist in Quebec). Service creation is the offering of a service that was previously absent, and may result from the replication of an existing service elsewhere (it may or may not be an adaptation or innovation). The introduction of a palliative care unit at Jeffery Hale Hospital would be an example of service creation at this hospital, although this service may exist elsewhere.

Although the integration of the three organizations represents a possible change in the management of health services, we consider that this is relatively commonplace in the health sector and not an innovation per se. There has been a proposal for a modified health service coordination model, in particular the use of a liaison nurse for several clinical projects, which would represent the adaptation of a known job in order to take into account the Network's low volume. For the French-speaking population, such a position is likely to be for a single clinical project, whereas the English network is considering the possibility of a liaison person coordinating referrals for several clinical projects.

Service maintenance along with adaptation, innovation, and creation should be seen as key indicators that can be used to evaluate progress on the part of the Network. Managers in the Network are familiar with services which have been put in place in the past decade, but others outside of the Network may not be. These services are significant accomplishments and a list of them could become part of the Powerpoint presentation describing the Network's orientations and activities. The projects noted above represent ideas which have been developed beyond the concept stage and are more or less ready to be put into place. If they are implemented, they would appear to be closer to service innovation and creation than adaptation. However, the label aside, the key need appears to be the introduction of services, in English, which were previously absent. They are also examples of the capacity of the Network to identify health care needs and to plan and implement services.

One might wonder though, whether any prioritization has taken place, whether all of these projects can be sustained by the Network or whether there is enough spare human resources capacity. Most of these projects could be loosely associated with one of the clinical projects, but one wonders how and if the clinical projects will further these pre-

existing projects, or whether some will not be developed because they may not fit with the clinical projects (for example, the services for children with special needs). The ability to quickly implement health services should be documented (even summarily) and could become an attractive characteristic for the CSSSs. The projects demonstrate that the organizations have plans for new services and are working to expand the range of services available to English speakers.

5.6. A Communication Program

A communication program will presumably inform the English-speaking population about the possibility of obtaining services in English, and present the ongoing organizational changes. It is not yet known to what extent these communication activities will allow for feedback from the population, although this could be possible. It appears that the English-speaking population has tended to be consulted in times of crisis, yet ongoing consultation and communication is a key mechanism for ensuring transparency, maintaining legitimacy and confidence, and obtaining feedback on planned changes. Various forms of consultation may take place, ranging from public meetings to citizen advisory groups. Evaluation criteria for communication activities could include: whether managers of French language services have a clear idea of the services which the Network wants to develop with them; the extent to which the general English-speaking population know what services they can expect from the Network; the extent to which it understands that it can expect to receive services in English; and whether citizens are encouraged to voice their perceptions of which services should be provided in English.

Other simple measures could be taken to increase the visibility of the organizations and their services. For example, there currently is no sign on Chemin Ste-Foy to indicate the location and existence of Holland Centre. For Jeffery Hale Hospital, in the emergency department and outpatient clinics, there are no signs, in any language, to indicate that patients may ask for services in English. Since patients can receive services in English at the hospital, it would be appropriate to inform them of this possibility. It is recognized that the French Language Charter (Bill 101) may limit the way in which this is done, and if after verification these signs cannot be in French and English, then at the very least it should be possible to post them in French. This initiative may have to wait until further integration of Jeffery Hale Hospital with Saint-Brigid's Home (since the designated status of Saint-Brigid's will then apply to Jeffery Hale Hospital).

In presentations, it may also be useful to note that the Network is already an example of private/public partnership (because of contributions through the foundations).

5.7. Reference to Recent Key Concepts Proposed by the MSSS

It would be useful for managers in the Network to explain to French-speaking managers what access and continuity mean for the English-speaking population. It may be necessary to indicate that the range of services is an integral part of the notion of access, and to change perceptions about the range of services offered in English. In 2004, planners for the Agency wrote:

> "Tous les participants aux consultations ont reconnu que, dans une région où ni la proximité géographique des services, ni la disponibilité de la gamme de services ne font défaut… [9]"

However, the range of services available in English is clearly much more limited than those available in French. Several departments at Jeffery Hale Hospital were cut in the 1990s and have not been replaced. There are glaring gaps in services, such as the current provision of pre and post natal services through Holland Centre, but no identified hospital where a woman can expect support in English during birth.

Access could also mean services in relative proximity to the person, which would provide an opportunity to discuss particular pockets of clients and how access can be improved for them. The concept of a populational approach provides an opportunity to state that the English-speaking population is a particular population. Thus these and other common concepts provide opportunities to introduce and discuss a range of issues which are of concern to the English-speaking population. An evaluation criterion for monitoring progress in this area would be the elaboration of definitions of these concepts from the perspective of the Network.

5.8. Summary of Key Outcomes to be Monitored

In the short and near term, several desirable objectives may be more or less attained (which is the issue for the English-speaking population and the Network). First, the most important outcome is the ability of a portion of the population in the Quebec City region, specifically English speakers, to receive appropriate and high quality health services, without unreasonable delay and without unreasonable inconvenience to them (for example, extensive travel). As well, some research suggests that the quality of services depends to some degree on the quality of the communication between patient and health professional. For example, Dyane Adam comments:

> "There is a considerable body of research showing that language barriers have negative impacts, particularly on access to health care services and

[9] Agence de développement des réseaux locaux de services de santé et services sociaux de la Capitale-Nationale, Le modèle régional d'organisation de services de santé et de services sociaux intégrés, 2004, p. 26.

> on diagnosis. The language factor also tends to reduce the exposure of some communities to promotion and prevention programs. In addition, language barriers diminish the efficiency and satisfaction of health care workers." (Adam, 2004).

In particular, the interaction between health care professional and patient is likely to be better if the patient is able to present his or her history and problem in the language with which he or she is most at ease (assuming that the health professional is also able to fully understand the information provided in that language). In the absence of this ideal communication situation, other workarounds are possible, such as communication in a second language or use of translation services, but incomplete understanding may result (Bowen, 2001) and the quality of the health encounter and follow-up may suffer (Yeo, 2004).

The second key issue is therefore the capacity of regional health organizations to maintain, adapt, and expand services in English. A full duplicate range of health services in English and French is unlikely to be economically and politically feasible, given the small percentage of the English-speaking population in the region, and possibly a limited inclination or ability on the part of French language health organizations to hire more fluently bilingual health professionals. The region is fortunate to already have a network of health organizations responsible for planning and providing services in English; services and outcomes will therefore be strongly determined by the existence and capacity of these organizations. Due to this existing organizational infrastructure, improvements in the range of services are unlikely to require more managers or buildings. Services provided in French to English speakers by French language organizations constitute existing costs in the region, so providing them in English does not necessarily mean new costs.

In turn, the capacity of these organizations is likely to be determined by a number of broad interdependent operational issues. Relevant aspects are whether the organizational members of the Network are able to do the following: maintain current services; keep and improve operating budgets; negotiate service agreements with the CSSSs (which will depend on the marketing, receptivity, and nature of services offered); influence the nature of collaborative relationships between health professionals; obtain information on service patterns ("trajectoires de services"); procure ad hoc or permanent financing for health needs analysis; prioritize health needs of English-speakers; attract and retain competent and motivated bilingual personnel; plan, develop and finance new projects and services; influence Agency and CSSS decisions and orientations relating to the Network's activities; retain the support of the English-speaking community; and influence decision makers within MSSS.

5.9. Summary of the Network's Orientations and Possible Indicators for Evaluation

The following table summarizes the Network's development orientations as outlined here. As well, suggestions are made of indicators which the Network could use to evaluate progress in each area. A large number of possible indicators are identified, and we presume the Network will need to choose which ones are most significant or which provide the best information in relation to the effort needed to obtain it.

Summary of Current Development Approaches and Possible Indicators for Monitoring Progress

Approach	Possible Indicators for Monitoring Progress
Maintaining a Clientele Base	► Whether the number of clients served is maintained (year to year statistics by organization and service); ► the number of English-speaking clients by service; ► identification of new services, each year; ► whether the Hospital and Saint Brigid's maintain or increase their percentage of English-speaking clientele; ► whether the English-speaking population from outside the administrative region is served.
Integration of the Organizations	► Identification of the main service objectives related to integration and identification of the expected and actual benefits; ► employee morale and satisfaction, turnover; ► financial efficiencies created; ► ways to measure continuity of service; ► the financial situation of the organizations, and changes from year to year.
Participation in the Clinical Projects	► Identification of service (operational) objectives for each clinical project; ► whether there are service agreements with one or more CSSSs; ► quantification of new clients and interventions provided in relation to each clinical project, by language of service; ► referrals from a CSSS to the Network; ► whether the service organization reduces "hand-offs" from one professional or program to another (and in general, improvements in continuity); ► a mechanism (or mechanisms) to improve continuity (for example, case managers); ► whether Holland Centre is able to achieve parity with other CLSCs in terms of the kind of health professionals on staff`.
Development of Information and Analysis Concerning Language Use and Health Needs	► Wether an overall plan is created to acquire information about the health needs of the English-speaking population in the region; ► the development of a framework to suggest which new services are a priority; ► the extent to which the CROP survey provides new concepts or information; assess whether it can provide information specific to the region; ► whether a map is created of clusters in the English-speaking population, and by age and major health problem;

Approach	Possible Indicators for Monitoring Progress
	▸ whether tracking is started (and maintained over time) of services requested and provided in English inside and outside of the Network, for the region; ▸ whether staff and computer systems at Jeffery Hale Hospital capture two types of information: mother tongue, and desired language of service, particularly for the emergency and outpatient clinics; ▸ whether there is more information and analysis on the health needs of the English-speaking population in the 03 region; ▸ whether more regional analysis is provided of the English-speaking population by regional planning organizations; ▸ whether there is formal capture (in a document) of service needs as derived from experience in current services; ▸ whether useful, clear background information becomes available on the needs of the English-speaking population in relation to the clinical projects; ▸ whether there is a comparison of the health needs of the French and English-speaking populations for the region; ▸ whether regional planners are aware of the characteristics of the English-speaking population; ▸ whether quality of care indicators are created and data collected; ▸ whether there is analysis of which private clinics and physicians provide services in English and of referrals to them; ▸ the number of English FOLS health care professionals, and the number and degree of bilingualism of French-speaking health care professionals; ▸ the number of partnerships with university researchers.
Development of New Services	▸ The number of ideas created, examined; ▸ what new services are implemented; ▸ what services are created at the hospital and in the Network in general; ▸ whether the new services improve the range, quality, continuity, or proximity of services to the English-speaking population; ▸ services to other regions.
Communication Program	▸ The extent of ongoing consultation in relation to priority services in English; ▸ other managers' (outside the Network) awareness of the services which the Network wants to develop with them; ▸ the awareness of the English-speaking population in the region regarding the nature of services offered in English; ▸ whether the dual linguistic nature of the hospital and Saint Brigid's Home becomes part of the organizational identity and is presented in a positive way; ▸ whether the location of Holland Centre becomes more visible and known; ▸ the existence of signs at the hospital, in compliance with any limitations set by the Charter of the French Language, indicating the possibility of service in English.
Reference to Key Concepts proposed by the MSSS	▸ Whether measurable definitions emerge for key concepts of access, proximity, continuity, and quality, and whether they take into account the range of services and often dispersed nature of the English-speaking population.

6. CONCLUSION

We currently conceptualize the development of the Network and its services as the result of the interaction of certain key dimensions. First of all, external organizations affect the development of the Network. Provincial Department of Health decisions and policies impact on the activities of the Network. Federal policy and programs affect the creation of often short-term programs such as PHCTF, which in turn affect the availability of human resources for certain front-line health programs and for temporary information gathering and analysis. The Agency and the CSSS, through their policies and programs, make decisions about some of the long-term human resources working for the Network (for example, the CLSC staff). The Agency provides some support for analysis, for example through its participation in this evaluation study and contribution to an assessment of information captured in computer systems. We believe, however, that it should play a much more significant role in terms of an understanding of the health status and needs of the English-speaking community.

The Network itself also has a significant impact on its own development. It has placed a great deal of emphasis on information gathering and analysis, as well as evaluation, and this is a key dimension. Another key dimension is the internal operational capacity of the Network, which includes its organizational infrastructure, relationships and coordination, and the capacity and motivation of personnel. It is qualified personnel who handle needs analysis; program conception, design, and completion; liaison work with other institutions; and communications with the community. Financial resources obtained through the actions of personnel, whatever the source (private foundations, the Agency, CSSS, government funding programs), can be exchanged for human resources, which in turn affect information availability and program development.

A third key dimension is the support of the Network by the English-speaking population. Some of this support takes the form of volunteer activity and financial support by philanthropic organizations. In turn, this support is likely to depend on regular and transparent communication with the community as well as the participation of community leaders. This community support may also take the form of organizational participation in the programs proposed by the Network (for example, schools, churches, community groups, and generally "partenaires intersectoriels"). Community support and the confidence that individuals have in the Network's services (and their propensity to use them) are also likely to be correlated.

A fourth dimension is the influence that the Network may have on the CSSSs, Agency, and MSSS with regard to support for its orientations and activities. Information and research can certainly be a major factor here, but the support of the English-speaking community, the third dimension, can also be useful to influence partners, the Agency and the MSSS.

It is clear that a great deal of attention is currently being paid to the integration of the three organizations. This will prove to have been a good decision if a platform is created which helps increase the range of services, their quality, or the proximity of services to the English-speaking population. Even if integration does not take place, our view is that the network members should and will still be able to act as a network and jointly create services which achieve the Network's key objectives.

There also appear to be two quite different basic strategies for realizing the objective of providing services in English. The services at Holland Centre are provided exclusively in English, whereas the other two organizations seek a certain volume of clients and thus provide services to both linguistic communities.

As well, we identified several of the Network managers' orientations which are contributing to service planning. They are: participation in the revision of the access program; negotiation of service agreements with two CSSSs; participation in the clinical projects; integration of key concepts proposed by the MSSS; offering services in English and French; development of information and analysis of the English-speaking population; participation in joint research and the use of consultants; encouraging computer system managers to include information on the English-speaking population; incubation of new services; and a communication program. Each of them was described. This was followed by a section in which certain advantages and limitations with these strategies were highlighted.

6.1. Possible Follow-Up Activities for the Network

Our observations indicate that many objectives have been proposed (at the planning meetings) and various analyses are being carried out simultaneously. Our main suggestion at this stage of the study is that a selection be made of those objectives which are most strategic or of highest priority and which are most likely to improve the range, quality, or proximity of services to the English-speaking population. It would also be helpful to define what these or other current concepts mean for the Network. In addition, the links between current objectives would not appear to have been made explicitly, and it would be useful to do so.

The proposal to concentrate on a few key, short-term actions which are visible or affect a relatively large number of English-speaking people (for example, single access point, innovative coordination or key person, or "personne pivot", for multiple clinical projects, a network of family physicians) seems to us to be well-founded. This approach and the simultaneous naming of several objectives needs to be harmonized. These key actions could be integrated with the objectives of highest priority and/or the number of objectives could be reduced.

It could be useful to identify and communicate more clearly how some of these initiatives are or could be mutually reinforcing. For example, eventual information on whether a patient prefers services in English would help with planning efforts (visualize the current planning taking place with the clinical projects). Information from the PHCTF project activities is likely to contribute to service planning and development. Analysis of access issues at Saint Brigid's Home relates to funding of the organization and to needs of English-speaking seniors. These are examples of how explicit discussion of the links between activities would likely help staff to see how individual activities support others and understand the importance and cohesiveness of the various strategic planning strands.

Significant attention is being given to information gathering, analysis and research, and this is certainly one of the Network's major strengths. These efforts could be bolstered by linking them to certain specific objectives of the Network. For example, a brief text with estimates or qualitative information on the English-speaking population could be given to the clinical projects. A summary of the study on the mental health needs of the English-speaking population could be given to the mental health clinical project. A summary of the particular needs of English-speaking seniors could be submitted to the clinical project for the elderly, and so on. More generally, federal and provincial agencies involved in the gathering of statistics related to health needs should be pressured to include appropriate questions about language use (CHSSN could be involved with this). The key concept of people who wish to receive services in English should be added to surveys.

However, once regionally useful health information has been collected and becomes available (from agencies which produce statistics or the PHCTF English-speaking field in computer systems sub-project), it will be necessary to identify the analyses which are pertinent to ongoing planning needs and to anticipate the need for an analyst to produce these.

There is also a general need to document, quantitatively and qualitatively, the current health needs of the English-speaking population in the Quebec City region. There are very few documents which could be considered to be in-depth analysis of this (a helpful example is the analysis of the health of French speakers in Ontario[10]). As well, a formal, written comparison of service offerings to the general and English-speaking populations would identify relative gaps in services for the English-speaking population (this is also an activity suggested by some analysts in the U.S.). Requests can be made to various regional groups that produce statistics on the health status or problems of the population for comparative analyses. Although the inventory of

[10] REDSP. (2000). Rapport sur la santé des francophones de l'Ontario. http://www.opha.on.ca/resources/healthstatus/french/healthstatus2000fr.pdf

services offered by the Network was completed in June 2005, it did not include a comparison with regional services in general. The CROP survey may allow some comparison of use of services by English-speaking and French-speaking people, but it is not oriented towards the complete identification of services offered.

There is a tacit concern with the services offered by Jeffery Hale Hospital to the English-speaking population. We see that the levers available to increase the range of services are limited, but that efforts are underway to do so. We also recognize that the Director of Professional Services at Jeffery Hale Hospital is working on this. Our suggestion is to continue to bring creative energy and attention to the activities of this organization in order to increase the identification of the English-speaking population with it, and to increase the range of hospital services offered in English, if not at Jeffery Hale, then in other hospitals. One could ask whether it is possible to identify doctors and nurses in departments (which no longer exist at Jeffery Hale) in other hospitals who could provide services in English, and to make this information available through the referral service at Holland Centre.

Although the members of the Network have created various new services over the past few years, increased attention to and understanding of the processes which lead to new services are likely to help with the management of service creation. Thus, as a starting point, it would be helpful to formally describe the steps taken during the creation of services and identify possible factors which could impede progress.[11] This should help project or service promoters to visualize the process, see where they fit in, and identify vulnerable junctions. The adaptation or creation of services implies: the identification and prioritization of health service needs; a plan for the adaptation or creation of new services; possibly the implication of partners; possibly approval by regional health officials; and a means of financing these services. We believe that this chain of events and the dependencies which affect service adaptation and creation need to be understood in greater detail. Better understanding is likely to facilitate effective intervention in the process.

This process would likely benefit from encouraging front-line professionals and managers, in a participatory manner, to come up with ideas about possible services which meet priority objectives. This type of brainstorming activity is likely to lead to service creation or adaptation. Possible expectations of implementation would need to be managed, but the creation of a pool of ideas is a first step in eventual service creation (to be followed by prioritization, assignment of a project, search for partners and resources, and so on). Such an activity should also complement the Network's desire to continue to create a work environment where it is possible to innovate.

[11] These steps may vary somewhat. The idea here is to look at specific services, and is meant to complement the broad community development process, as has been presented in the booklet: The Holland Centre Experience.

The key service parameters which need to be monitored in the long term are the range, quality, and geographic accessibility of services in English. Some significant improvements may be relatively simple, such as identifying professionals (e.g. private physicians) who can provide services in English. Similarly, Jeffery Hale Hospital could inform clients that services can be provided in English. In addition, Holland Centre (if it does not do so already) and Jeffery Hale Hospital could list hospital departments and physicians which could provide services in English that they do not provide themselves. This in itself would represent a significant improvement in terms of accessibility.

6.2. Future Research

Future research could concentrate on certain particular areas. First, as noted previously, the identification and prioritization of health service needs is likely to be a key activity within the process of service adaptation and creation. It would probably be useful to show how current studies (demographics, access to long-term care for the English-speaking elderly, computer system capture of the English-speaking population, the current study) are used in service planning. Second, **it is important to identify changes which actually occur in the provision of primary health services**, particularly for the clinical projects, and **to investigate the innovation process which contributes to this**. This is an important area for observation in order to answer the question of what improvements occur as a result of the current changes in front-line services. The types of information needed to address this question may be straightforward in some cases (see the evaluation criteria suggested above), but in others analysis and reflection may be needed. Third, given the Network's focus on primary health services, it could be useful to have a better understanding of the extent to which private clinics and physicians provide or could provide services in English, and how the population locates them. A related question is how to reach groups with particular needs which are not yet well identified. Fourth, it could be useful to have better knowledge of how minority language communities elsewhere in the world provide services and attempt to influence service organization (see Appendix 2 for an introduction to this). This information could provide useful models for the Quebec City region. These are suggestions, however, and the thoughts of managers in the Network will be welcomed.

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APPENDIX 2: INTRODUCTION TO CANADIAN AND AMERICAN RESEARCH CONCERNING THE HEALTH OF MINORITY COMMUNITIES

There has been recent interest in Canada and internationally in the health status of and services provided to linguistic minority communities. In Canada, this interest has taken the form of analysis and provincial and federal government policies and programs.

In terms of analysis, the Consultative Committee for French-Speaking Minority Communities (CCFSMC) and the Fédération des communautés francophones et acadiennes du Canada (FCFA) have sponsored studies, and the findings were cited in the 2002 Romanow report. The 2002 report summarizes these studies, and states that a language barrier:

- reduces the use of preventive services;
- increases the amount of time spent in consultations, the number of diagnostic tests ordered, and the probability of confusion in the diagnostic and treatment processes;
- influences the quality of services where good communication is essential such as mental health services, social services, physiotherapy, and occupational therapy;
- reduces the probability of compliance with treatment; and
- reduces the patient's satisfaction with the care and services received (Consultative Committee for French-Speaking Minority Communities 2001). (Romanow, 2002, 174).

For French-speaking minority communities, two other noteworthy studies are the Report on the Health of Francophones in Ontario (Rapport sur la santé des francophones de l'Ontario: REDSP, 2000), and La santé communautaire: Analyse de quatre modèles au sein des communautés francophones et acadiennes (Beaulieu, 2000).

The English-speaking community in Quebec has also conducted its own studies, usually under the auspices of the Community Health and Social Services Network (CHSSN). One recent example is the Baseline Data Report 2003-2004, which presents the demographic characteristics and use of health services by the English-speaking population in Québec (Pocock, 2004).

Considering the analysis and identification of health problems of minority language communities in Canada, it is not surprising to find various suggestions about how these communities could improve on their health services. We will call these suggestions strategies for improvement of services.

The Consultative Committee for French-Speaking Minority Communities (CCFSMC) suggests the following five strategies:

- the implementation of community networking between representatives of the Francophone community, Francophone health professions, officials of educational institutions, professional associations and political representatives;
- since students in health professions often do not return to their communities, practical training for students should be close to their homes;
- intake of patients into services in French, and this could be done through a variety of models which they identified;
- the increased use of new technologies to reduce isolation and increase training; and
- the improvement of information and analysis of the health status and needs of the minority population.

A Consultative Committee for English-speaking Minority Communities was also struck, and it identified similar strategies in order to strengthen health services for minority communities:

- networking and cooperation within English-speaking communities to mobilize institutional and community capacity in order to meet needs;
- strategic information to build a knowledge-based approach mobilizing resources and identifying needs;
- technology to extend provision of services to distant, dispersed or rural English-speaking communities;
- service delivery models to develop new services adapted to regional and community realities; and
- training and human resources development to promote language training and professional development, recruitment of English-language personnel, and their retention in all regions.
- www.chssn.org/sante_canada/CCESMC%20report%20LR.pdf, p. 20

Although these policies may be useful orientations for provincial and federal officials, they provide little guidance for managers or activists in the communities themselves.

Another study, La santé communautaire: Analyse de quatre modèles au sein des communautés francophones et acadiennes (Beaulieu, 2000) does provide some practical suggestions of strategies that communities could adopt. They are:

- provincial laws and policies can potentially favour local health services;
- the communities should participate in initiatives which would allow discussion amongst themselves of health issues and priorities for the organization of services;

- research should be conducted into health status, health practices, the accessibility of services, and evaluation frameworks and protocols;
- they should identify ways to improve continuing education;
- they should promote health careers for minority community students; and
- they should continue discussions with the federal government on its role in supporting minority health services.

Finally, the Atlantic Canada office of Health Canada has developed an action plan in order to better support the development of health services for the French-speaking population in Atlantic Canada, although these measures are oriented towards capacity building and remain broad (Atlantic Regional Office, 2001).

The U.S. has also become quite concerned with the health of its minorities, although there the word minorities is used to designate groups which can be constituted because of language or race. Hispanophones, for example, are considered to be a language minority, whereas blacks are a racial minority. The discussion and research are often based on health disparities. This area encompasses the health status of groups, policies (for example, http://raceandhealth.hhs.gov/), programs, and research. The Office of Minority Health provides policy advice, whereas research is supported by the Office of Research on Minority Health. One frequent subject of research in the U.S. is health differences between minority and majority populations for specific health problems. This approach can be seen in the citation below:

> "Specific information on this site include prenatal health and how to reduce infant mortality; studies of childhood and adolescent lead poisoning, HIV infection/AIDS, and alcohol and drug use; research in adult populations focused on cancer, diabetes, obesity, hypertension, cardiovascular diseases, mental disorders, asthma, visual impairments and alcohol use ..." (Office of Research on Minority Health, web site).

Many other research projects and results in the U.S. can be identified by searching a health research database such as PubMed and searching on the terms health disparities, and ethnic, minority, or racial. A specialized journal on health disparities was also published for a time, the Harvard Journal of Minority Public Health (apparently now defunct). A recent Annual Review of Nursing (Fitzpatrick, 2004) offers a series of articles which primarily characterize the kind of disparities observed, although two articles also discuss the intervention strategies of alternative medicine and community partnerships. As well, a recent (2005) and extensive list of articles compiled by the library of Georgetown University can be found at:
http://www.mchlibrary.info/KnowledgePaths/kp_race.html. These articles and those found in the medical journal databases reveal the strength of the empirical research in the U.S. and indirectly highlight the relative lack of this type of research in Canada.

One study that is significant in relation to our research was sponsored by the Institute of Medicine and suggests strategies which managers can use in order to reduce health disparities (IOM, 2002). This study has the following suggestions for managers working with minority groups:

- base decisions about treatments on published clinical guidelines;
- take steps to improve access to care—including the provision of interpretation and translation services, where community need exists;
- to the extent possible, equalize access to the same health care products and services;
- ensure that physician financial incentives do not disproportionately burden or restrict minority patients' access to care;
- use community health workers and multidisciplinary treatment and preventive care teams;
- collect and monitor data on patients' access and utilization of health care services by race, ethnicity, and primary language;
- publicly-funded health systems should take steps to improve the stability of patient-provider relationships;
- federal, state, and private stakeholders should continue efforts to substantially increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals, to improve access to care among minority patients and to reduce cultural and linguistic barriers to care;
- the U.S. Department of Health and Human Services should encourage collection, reporting, and monitoring of patient care; and
- use educational strategies; both patients and providers can benefit from education; patients can benefit from culturally appropriate education programs to improve their knowledge of how to access care and their ability to participate in clinical-decision making… cross-cultural curricula should be integrated early into the training of future health care providers. (IOM, 2002).

An extensive review in 2004 of a segment of the empirical literature was sponsored by the U.S. Agency for Healthcare Research and Quality (AHRQ). It was designed to answer two questions: 1) What strategies targeted at healthcare providers or organizations have been shown to improve minority healthcare quality? and 2) What strategies have been shown to improve the cultural competence of healthcare providers or organizations? In relation to the first question (the second appears to be less pertinent to our study), 27 articles were assessed for the strategy used and the strength of evidence for the method. The strategies which received the rating of at least fair evidence were (by decreasing strength): tracking/reminder systems; multi-faceted interventions (using more than one strategy); bypassing the physician (screening provided by a nurse); and provider education (Agency for Healthcare …, 2004).

Another relevant study examined the factors which contribute to success in community-based medicine (Siegel et al., 2001). The authors qualified the existing knowledge about community-based strategies for reducing disparities experienced by minorities, in the following words:

> "Despite the burgeoning interest in community-based approaches to reducing disparities, there is little in the available literature on the practical aspects of these initiatives." (Siegel et al., 2001, 8)
>
> "Neither is there any known resource that lays out what strategies may be most useful to community-based organizations." (Siegel et al., 2001, 54)

To counter this lack of knowledge, the authors carried out six case studies of a range of community initiatives, in order to develop a set of best practices. In their conclusion, the authors emphasize the importance of increasing the training of managers in certain areas:

- epidemiology of health disparity conditions;
- evidence-based review of community disparity reduction strategies;
- quality improvement in community-based organizations;
- practicing cultural competence;
- coalition formation techniques;
- building finance and human resource systems;
- development strategies;
- public relations and advocacy; and
- program evaluation: theory and tools.

In addition, the study indicated that good programs: 1) include a continuum of resources and provide help to patients so that they can access them, 2) provide one-to-one outreach to clients which allows for patient education and helps the individual to navigate through the health system, and 3) encourage cultural competence, including the hiring of staff from the minority community.

Another analysis, based on activities in a community research and health institute in the Bronx, suggests certain strategies for reducing health disparities. The ones that could potentially be applied in Canada are:

- a lack of trust can reduce patients' willingness to use certain services, thus trust in a health service or organization must be built up;
- cultural competence training mandatory for health professionals;
- easily accessible translation services;
- encouraging students from minority groups in health training programs; and

- increasing resources for public health education through community organizations and social marketing (Calman, 2004).

Finally, a recent research initiative (just begun) combines research, evaluation of disparity reduction programs, and active dissemination of results (Three National Initiatives …, 2005). This project, heavily financed by a foundation, consists of three inter-related projects. One of them focuses on improving cardiovascular care for African-American and Latino patients within a learning network of 10 hospitals. A second project will implement and evaluate various interventions in a mix of organizations. A third project will synthesize and disseminate results.

What conclusions can be drawn from this brief introduction to studies which examine possible strategies for improving health care services provided to minority groups in Canada and the U.S? First of all, a number of qualifications are necessary. In particular, we have concentrated on reviews or research in Canada and the U.S. which identify or analyze possible actions which could be taken to strengthen health services provided to minority groups. Other strategies could likely be found elsewhere in the world. We have not discussed another significant segment of the literature, which sets out to characterize health disparities and often attempts to identify possible reasons for them (an example is van Ryn and Fu, 2003). Some of this literature may also directly or indirectly suggest possible strategies for health services. What is more, we have not attempted to evaluate the studies or proposals of the authors, nor to assess the pertinence of these strategies in relation to the Quebec City region (more information about this setting will follow). However, taken together, they represent an initial and partial inventory of strategies which could be considered by a particular health authority that wants to bolster its services to a minority group.

Nonetheless, some general observations about this literature could be made. First, it is apparent that researchers in the U.S. have accomplished more than their Canadian counterparts in documenting in an empirical manner, both negative differences in the health status of ethnic and linguistic populations when compared to a majority population, and of the impact of programs designed to decrease these differences. A second observation is that, in Canada (and this may also hold true for the U.S.), the federal government has provided the main impetus for research and it has also been quite active in developing policies and programs in order to provide support for linguistic minorities. Third, there is a continuum of strategies that can be identified, which range from actions targeted at the individual patient (such as patient reminder systems), through the training of health professionals and managers, and on to 'political' or lobbying types of activities oriented towards influencing citizens or government officials in relation to their views on programs which should be offered in order to better support health services for minority groups. In our opinion, the

different facets of this broad continuum of possible activities should be kept in mind when developing intervention strategies.

This brief presentation of research into the situation of minority communities in Canada and the U.S. provides a conceptual backdrop for the study presented here of strategies used by health officials working with one particular minority community in Canada.

APPENDIX 3: DEMOGRAPHIC CONTEXT OF THE QUEBEC CITY REGION

A detailed understanding of the current social and organizational context of the English-speaking population along with information on recent changes in the Quebec health care system will provide baseline knowledge of the context in which changes to primary health services are being planned. At the same time, this analysis will help to identify key characteristics which need to be monitored and could become the object of later plans to structure ongoing evaluation (i.e. the evaluation planning mandate).

In attempting to provide background information on the extent and characteristics of the English-speaking population in the Quebec City region, questions arise over how to identify these people. The basic social fact on which other service and planning activity is based is the existence of an English-speaking population in the Quebec City administrative region (03). Over the past decade, demographic analyses of the English-speaking population have attempted to identify English speakers based on questions used in the Canadian census (for example Warnke, 1997). Warnke and others often use a constructed variable, the first official language spoken (FOLS), which is based on an individual's knowledge of the two official languages, the mother tongue, and the language spoken at home. However, some analyses may be based on one single language question.

In his 1997 analysis, Warnke determines that in 1996 there were 11,590 people whose primary language was English (FOLS) in the Quebec City region (region 03), in contrast to 609,970 whose first language was French.[12] He also notes a 4% decrease in the total English-speaking population between 1991 and 1996, and a 26% increase in the elderly (75+) for the same period.

In 2003, in a comparison of 1996 and 2001 and using the same area but different language parameters for the two years (personal communication), Warnke reports 12,745 for the 1996 census, and 11,053 for 2001 (Warnke, 2003[13]). This direct comparison indicates a decrease in the total numbers for the English-speaking population. Similarly, he finds a decrease in the number of persons 65 years of age or older (from 1,993 in 1996 to 1,688 in 2001; Warnke, 2003). Jedwab also notes that there was a loss of 9745 English speakers in the Quebec City region in this five year period (Jedwab, 2004, 12), but if this was the case, there must have been a few thousand newcomers or births (not mentioned). He attributes the decrease to intra and inter-provincial migration.

This information is useful in that it indicates the basic demographic fact that there is an English-speaking population, though this group is only a small percentage of the total population in the Quebec City region, and that over the past decade, there appears to

[12] http://www.veq.qc.ca/qds/report2/r2part1.html#_Toc436554734
[13] http://www.chssn.org/populationhealth/docs/CASFOLS-English.pdf

have been a slow decline in their number. This also applies to an age group which the English-speaking community is particularly concerned about, the elderly.

APPENDIX 4: EXPLANATION OF THE THEMES COVERED IN THE INTERVIEWS

The first topic concerned the organizational context and dynamics of the organizations which influence the definition of health services (the first objective). This theme is important in that the elaboration of services by the Network is intimately linked to the activities of other organizations in the region, and thus it is important to understand how these organizations have influenced the services in the past and how they may do so in the future. Part of this theme were the relationships within the network and between the network members and others (its environment). This theme is also a key one that is pursued by a regional research and management group, RATSPL (Réseau d'appui à la transformations des services de première ligne).

One current area of service development which illustrates these dynamics and which is important in its own right is that of the clinical projects, which is the second theme of the study. It provides a useful case study of how the health delivery organizations are responding to a recent initiative pursued by the provincial Department and the Agency.

The third theme was the nature of information gathering activities about the English-speaking population. There is an increasing recognition by social scientists of the critical role of information in organizational life, and this justifies this third theme. It is also an interest which emerges directly from the Network. This theme also relates to the first objective (the dynamics contributing to changes in services) in that studies and analyses are likely to highlight areas where services are needed, and can be used to provoke, guide, and legitimate subsequent action.

The fourth theme was that of innovation activities within the network. This is directly related to this study's first objective as well as the principal objective of the PHCTF program (which indirectly sponsors this study), that is the creation or adaptation of primary health services. We wish to identify service creation or adaptation and eventually the factors which may encourage or limit this. Service innovation is an important means by which the Network can change its offer of primary health services, thus it is important to identify if it is occurring as well as possible ways of reinforcing it.

We also examined the Network's objectives (presented at planning meetings and in interviews) and activities planned (Objective 2 of this study). The participation in an annual planning meeting in early September 2005 revealed the extent to which general strategic planning objectives were evolving. For example, the plan of integrating the three organizations had evolved into the identification of particular questions and issues which should be addressed. This further highlighted the dynamic context of the present study: both the environment of the Network is changing, and the plans and activities of the Network itself are also changing.