Trousse d'outils sur les services en français
French Language Services Toolkit

Préparée par/Prepared by
Marthe Dumont, coordonnatrice des services en français, RLISS d'Érié St. Clair/
French Language Services Coordinator, Erie St. Clair LHIN
Suzy Doucet-Simard, coordonnatrice des services en français, RLISS du Sud-Ouest/
French Language Services Coordinator, South West LHIN

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

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Prepared by

Marthe Dumont,
French Language Services Coordinator,
Erie St. Clair LHIN

and

Suzy Doucet-Simard,
French Language Services Coordinator,
South West LHIN

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Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

July 2013

Dear Health Service Provider,

In the health care field we often talk about the importance of the right care, at the right time, at the right place. We know that this philosophy is especially applicable when language becomes a barrier to receiving quality, patient-centered care. It is well documented that health outcomes are ultimately improved if patients receive care in the language they are most comfortable with.

The French Language Services Toolkit provides information, guidelines, templates and promotional material. It is our hope that through the use of the toolkit, our French designated and identified health service providers will use the information to provide even better care to our Francophone residents, through the delivery of culturally sensitive care. For our health service providers not officially French identified, we are confident that you will also find value in the practical ideas contained in the toolkit and that you can begin to implement some of the suggestions to improve care for our local Francophone residents.

Sincerely,

Gary Switzer, CEO
Erie St. Clair LHIN

Michael Barrett, CEO
South West LHIN

Ontario

Table of Contents

Introduction

Section 1

Section 2

Section 3

Section 4

Section 5

Section 6

Section 7

Section 8

Section 9

Evaluation of Toolkit and Comments

Introduction

The Erie St. Clair and South West Local Health Integration Networks (LHINs) are proud to provide you with this French Language Services Toolkit.

The English version of the Toolkit is available in a paper format in limited numbers. The electronic version will be posted in both English and French on the Erie St. Clair and South West LHIN websites.

The Toolkit is primarily intended to support designated and identified health services providers in implementing and delivering quality services in French as per their mandate. It will also be a useful resource to other health service providers in meeting the needs of their patients/clients.

The Toolkit was developed to provide an overview on a variety of subjects related to the delivery of services in French. Each section was conceived with the intent of providing useful information and practical tools to make delivery of services in French as easy as possible. You will find basic information on the Francophone community, active offer of French language services, implementation of French language services, human resources, training, translation and interpretation, supporting legislation and thehealthline.ca. A list of resources is also included. The Toolkit also contains some flyers and fact sheets produced by outside organizations to complement the information provided. Finally, and most importantly, you will find in the Toolkit items such as badges, lanyards and signs to promote delivery of services in French. Additional quantities of these promotional items are available by contacting your LHIN's French Language Services Coordinator.

Your LHIN's French Language Services Coordinator is an important resource who can support you as you implement and deliver services in French. Whether you have a question about the templates provided in this Toolkit, you need support in reaching out to the Francophone community or you would like additional promotional items, we are here to help you.

To reach your LHIN's French Language Services Coordinator:

Marthe Dumont
Erie St. Clair LHIN
1 866 231-5446 or
519 351-5677, ext. 3241
Marthe.Dumont@lhins.on.ca

Suzy Doucet-Simard
South West LHIN
1 866 294-5446 or
519 672-0445, ext. 2612
Suzy.Doucet-Simard@lhins.on.ca

Section 1

Francophone Community

Section 1
Francophone Community[1]

The French presence in Ontario dates back nearly 400 years to the establishment of the Mission of Sainte-Marie-Among-the-Hurons (Simcoe County) in 1639.

Like the general population of Ontario, the Franco-Ontarian community is diverse and vibrant. For many years, it has welcomed Francophones from Africa, Asia, the Middle East and Europe. Today, Francophone racial minorities represent 10% of the province's Francophone population.

Ontario is home to 611,500 Franco-Ontarians. Approximately 35,000 Francophones live in the larger Southwest region, which includes both Erie St. Clair and South West LHINs. The Francophone population is approximately 21,000 people in the Erie St. Clair LHIN and approximately 14,000 in the South West LHIN.

1 Taken and adapted from the Office of Francophone Affairs' website at www.ofa.gov.on.ca.

The Franco-Ontarian community is older than the overall population in Ontario. While the median age of the general population is 40.1, the median age of the Francophone population is 44. In the larger Southwest region, this figure goes up to a median age of 50.8.

The most notable age categories among Francophones are the 45-54 and 65 and over categories: close to one out of five Francophones is included in both of these age groups. In the larger Southwest region, one out of every four Francophones, 26.6%, is a senior. Another sign of aging of the Franco-Ontarian community is that the proportion of Francophones aged 65 and older is higher than the proportion of youth aged 14 and under (17% versus 14%).

Women make up more than half of the Francophone community (53%). The situation is similar in the larger Southwest region with 53.7%. Across the province, more than two out of three couples (68.3%) are exogamous, meaning that one parent is Francophone and the other parent is not. In the larger Southwest region, 87.5% of families are exogamous. Lastly, 15.9% of Franco-Ontarian families are single-parent households.

Ontario's Francophone population is a dynamic community because of its many institutions and associations in the fields of education, culture, health, justice, the economy and communications. In the larger Southwest region, Francophones can count on a variety of community organizations, from French-language school boards, community college and day care centres to seniors clubs and community cultural centres. Health and social services sectors are where services are the most limited or quasi-inexistent. Please see Section 9 on resources for names and contact information of Francophone community organizations in the area.

> *"The cultural diversity of the Francophonie significantly enriches our discussions."*
>
> Stephen Harper, Prime Minister, Remarks at the 14th Summit of la Francophonie, October 13, 2012

Health Status[2]

In the summer and fall of 2012, the Erie St. Clair/South West French Language Health Planning Entity conducted a comprehensive health survey of Francophones to better understand the health status and health needs of the Francophone population in the Erie St. Clair and South West LHINs.

In total, 1,200 adults aged 18 years old or over responded to the survey. Three-quarters of respondents lived in the Erie St. Clair LHIN region and one-quarter lived in the South West LHIN region. Distribution of respondents at the county level is fairly representative.

2 Taken and adapted from the report *Francophone Health and Use of Health Care Services in the Erie St. Clair/South West Local Health Integration Networks*, 2013, accessible online at www.entite1.ca.

Notable results:

- Respondents were asked to rate both their physical and mental health in separate questions. Interestingly, people tended to rate their mental health as being better than their physical health: 48% of respondents rated their physical health as excellent/very good, compared to 68% who rated their mental health as excellent/very good.
- Though only 2% of respondents reported being underweight, 21% of respondents fell into one of the two obese categories (moderate obese and severe obese).
- Respondents also tended to rate their physical health differently based on their Body Mass Index (BMI) status; in particular, ratings of fair/poor health were significantly increased among respondents who fell in the obese categories.
- Nearly all respondents (93%) reported having a regular medical doctor.
- Of those with a regular medical doctor, only 6% of respondents spoke with their doctor in French.
- Of those who reported not having a doctor, the most common reason was not having tried to contact one (35%), followed by no French-speaking doctors available in the area (27%).
- When they were sick, the vast majority of respondents indicated that they usually went to their doctor's office (67%) or else to a walk-in clinic (18%).
- Similarly, most respondents indicated that they usually went to their doctor's office (54%) or to the Internet (18%) when they were seeking health information or advice.
- In the last 12 months, 26% of respondents indicated that they had visited the emergency room at a hospital.
- In particular, respondents from Grey/Bruce, Chatham-Kent, Elgin/Rural Middlesex and Sarnia-Lambton were more likely to have been to the ER in the last 12 months.
- In terms of the most recent ER visit, 39% of respondents reported going to the ER for a minor problem, and of those, 52% said the reason why they did not get treatment elsewhere was because their family doctor was not available and 21% indicated that it was because it would take too long to get an appointment.
- Overall, 37% of respondents indicated that they had at least one illness or health condition as diagnosed by a doctor.
- Of those with a health condition, the most common illnesses were bone/joint conditions (40%) and cardiovascular conditions (32%), followed by 'other' illnesses/conditions (28%).
- Most Francophones who reported having a health condition were living in Sarnia-Lambton, Pain Court/Grande Pointe, Tecumseh or Windsor.
- Having a health condition was also significantly associated with age (highest in 55-64, 65+ age groups) and with visiting the ER in the last 12 months.

- Additionally, of those with a health condition, 36% indicated that they had more than one of the diagnosed conditions listed (i.e. bone/joint, cardiovascular, diabetes, lung, mental, cancer, kidney, other).
- As well, respondents with multiple conditions were most likely to live in Windsor and be in the 65+ age group.

More specifically:

- Among those having a bone/joint illness, 73% suffered from arthritis.
- For those with a cardiovascular disease, 73% suffered from high blood pressure.
- For those with diabetes 53% suffered from type 2 diabetes.
- For those with a lung disease, 67% suffered from asthma.
- For those with a mental illness, 68% suffered from a mood disorder and 32% from an anxiety disorder.

For more information, please refer to the report titled *Francophone Health and Use of Health Care Services in the Erie St. Clair/South West Local Health Integration Networks* accessible online at www.entite1.ca.

Section 2

Active Offer of French Language Services

Section 2
Active Offer of French Language Services

Within this context [of the Local Health System Integration Act], the active offer of services in French becomes a means to correct inequities by proposing a tangible method to reconcile health services with the needs of the Francophone population. The active offer of services in French represents an equity measure specific to ensure respect of the Act: so that equal status implies equal treatment.[3] *[unofficial translation]*

Active offer happens when Francophone members of the public are informed about available services in French, have access to these services and are satisfied with the quality of these services.[4]

It is often heard that clients do not ask for services in French. Research consistently shows that people will not ask for services in French if they feel it is not easy, they will have to wait or the service will be of a lesser quality. Services in French need to be readily available and visible, hence the concept of active offer. Francophones should not have to ask for services in French. Rather it is the responsibility of health service providers to provide services in French.

An active offer of French language services would be:

- Results-oriented.
- Integrated into an organization's overall service delivery model.
- Proactive.
- Based on the result of a dialogue with the population served and ultimately reflective of their needs.
- In place for the life-cycle of the service, activity or initiative.

Key Elements of an Active Offer Approach include:

- Bilingual greeting in person and over the phone.
- Visual identification and general print material.
- Identification of Francophone patients/clients.
- Community Engagement.

3 Bouchard, Louise, Marielle Beaulieu et Martin Desmeules. *L'offre active de services en français en Ontario : une mesure d'équité* dans Reflets : revue d'intervention sociale et communautaire, vol. 18, no 2, 2012, p. 38-65.

4 *The OPS Framework for Action: A Modern Ontario Public Service*, 2006.

Bilingual Greeting in Person and Over the Phone

- **Switchboard/Reception:** Services should be offered in both languages. A bilingual greeting is a proactive way of offering services in French. It is an open invitation to patients/clients to use their language of choice when dealing with the organization.
- When answering the phone or greeting visitors, the person could add "bonjour" or "comment puis-je vous aider" at the end of the usual greeting, such "Erie St. Clair LHIN, bonjour" or "South West LHIN, Denise speaking, comment puis-je vous aider?".
  - › If the person greeting patients/clients is bilingual, he/she continues in the language of choice of the caller or visitor.
  - › If the person is not bilingual, he/she should say "Un moment, s'il vous plaît" (one moment, please) and promptly transfer the call to a French-speaking employee or ask the French-speaking employee to come and speak with the visitor.
- **Automated Greeting/Voice Mail:** Telephone greeting should be bilingual.
  - › French option - Callers should be given a choice to hear the message in French by prompting them to press a number such as "*pour le service en français, appuyer sur le 2*".
  - › French greeting following the English. "Hello, Bonjour. A French message will follow. You have reached the *name of organization*. Please leave a message at the tone and we'll return your call as soon as possible. Thank you and have a great day! Vous avez joint le *nom de l'organisme*. Laisser un message et nous vous rappellerons le plus tôt possible. Merci et bonne journée."

Visual Identification and General Print Material

- **Identification of Bilingual Staff:** Patients/clients should be able to easily recognize French-speaking staff. To do this, provide bilingual staff with buttons or lanyards saying "Je parle français". A few samples of such buttons and lanyards are included in the pockets of the toolkit bag. To obtain more, please contact the Erie St. Clair or South West LHIN French Language Services Coordinator.
- **Signage – Interior and Exterior**: All signs in public areas should be bilingual.
- **Bilingual Welcome Sign at the Reception**: A bilingual welcome sign informing patients/clients that the organization offers services in French should be placed at entrances and/or reception desks. One sample of such a sign is included in the toolkit. To obtain more, please contact the Erie St. Clair or South West LHIN French Language Services Coordinator.
- **Business Cards** should be bilingual for staff members in designated positions or capable of providing services in French.
- **Written Material**: All documents intended for public distribution should be available in both languages preferably in a bilingual format. Depending on the printing format, a note should be added in French in the English document, and vice versa, stating that "Ce document existe en français"/ "This document is available in English" or "Français au verso"/ "English on reverse". For example:

> *"It has been shown, time and time again, that active offer has a considerable impact on the demand for services. The more actively a service is offered, the more demand there is for it. This is as true for health as for any other sector".*
>
> François Boileau, French Language Services Commissioner, *Special Report on French Language Health Services in Ontario*, 2009, p. 10.[5]

5 For more information on the French Language Services Commissioner, please refer to Section 7 on legislation.

- Forms, such as assessment and intake.
- Instructions, such as pre-surgery and discharge.
- Flyers.
- Promotional material.
- Websites.
- Etc.

Health service providers need to know who their patients/clients are and what their needs are in order to serve them adequately and provide them with the best opportunity for optimal health options.

Identification of Francophone Patients/Clients

> **Definition of Francophones**
> *Those persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home.*[6]

The first step is to identify Francophone patients/clients. Health service providers should include linguistic variables as part of their intake/admission process.

Two questions are suggested in order to identify Francophone patients/clients.

1) What is your mother tongue?
   English ☐ French ☐ Other _____

2) If your mother tongue is neither English nor French, in what official language are you most comfortable?
   English ☐ French ☐

Please note that LHIN-HSP accountability agreements include requirements related to developing a mechanism to identify and track the number of Francophone patients/clients served each year.

6 Office of Francophone Affairs, www.ofa.gov.on.ca/en/franco-definition.html

Community Engagement

Community engagement refers to the methods by which LHINs and HSPs interact, share and gather information from and with their stakeholders.[7]

The second step is to engage with the Francophone community *to inform, educate, consult, involve, and empower in both health care or health service planning and decision-making processes to improve the health care system.*[8] Community engagement is important part of the day-to-day operations of health service providers as it allows them to provide quality services that are responsive to the needs of the community.

Furthermore, the *Excellent Care for All Act* stipulates that health care organizations must survey their patients/clients on a yearly basis to collect information about their satisfaction with the services provided to them.

When it comes to the Francophone community, it is important to develop and sustain a working relationship with French language services providers, the community of Francophone individuals and entities (Francophone Community groups), in order to help both understand and act on the needs or issues that the Francophone community experiences with regard to health and health care services.

Tools

The *Consortium national de formation en santé* produced a series of teaching videos on active offer for health care professionals. Available in French with English subtitles, these videos feature Francophone individuals telling about their experience with the health care system and the impact of the lack or availability of services in French. To watch the videos, please visit cnfs.net/fr/vidlist.php.

Any organization or program could include these videos in the staff orientation package or use them as part of cultural and linguistic competence training in order to create awareness around equity and delivery of safe quality services. For more information on these videos and the *Consortium national de formation en santé*, please go to page 53.

For more tips on the active offer of French language services, please refer to fact sheets developed by the North East LHIN for employees and employers on pages 55 and 57.

7 *LHIN Community Engagement Guidelines and Toolkit*, 2011, p. 5, available on the Erie St. Clair and South West LHIN websites

8 Ibid.

Section 2

List of Appendixes

LHIN Community Engagement Guidelines and Toolkit

Consortium national de formation en santé

Active Offer of FLS in Health, Employer Fact Sheet

Active Offer of FLS in Health, Employee Fact Sheet

LHIN Community Engagement Guidelines and Toolkit

January 2011

Ontario
Local Health Integration Network

Table of Contents

1. Introduction

In this document, you will find several worksheets and templates to assist in planning Community Engagement activities. These documents are considered the **Guidelines for Community Engagement.** This document is intended to be used for all LHIN community engagement activities in an effort to promote consistency across the province. These documents contain the minimum core requirements for LHINs community engagement and may be supplemented by adding more material so long as the existing minimum specifications remain the same.

1.1. Background

In March of 2006, the Government of Ontario passed legislation that created 14 Local Health Integration Networks across Ontario. In creating LHIN's, they were tasked with the job of working with local health providers and community members to determine the local health service priorities of the 14 regions they are responsible for and planning, integrating and funding local health services reflecting these priorities.

Recognizing the important role community members and stakeholders are and were expected to play in the new LHIN health care world, the role of Community Engagement was entrenched in the legislation that created and governs LHINs, the Local Health Systems Integration Act, 2006 (LHSIA).

Specifically LHSIA states the following:

> "A local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities" (c. 4, s. 16 (1))

Community Engagement was established as a core function of the LHINs, with the understanding that regional planning is a more appropriate method for assessing and interpreting the local needs of a community. Community engagement needs to be purposeful, accessible and its products transparent to the public and LHIN decision makers.

LHINs determined that community engagement needs to be purposeful, accessible and its products transparent to the public and LHIN decision makers. The following accounts for initiatives undertaken by LHINs to improve community engagement processes to date:

- In 2008, the North West, South East and Central LHINs in cooperation with the MOHLTC, undertook a project resulting in the MASS LBP report *Engaging with Impact: Targets and indicators for successful community engagement by Ontario's Local Health Integration Networks.*

- In the summer of 2009, the Ombudsman, considering complaints associated with the community engagement practices of a particular LHIN, provided the MOHLTC with a draft report and recommendations regarding LHIN community engagement practices.

- In response, referencing the *Engaging with Impact* project, MOHLTC agreed to the creation of a set of performance measurement indicators for LHIN public reporting and a set of best practices and guidelines to which LHINs would adhere and agreed to work with the LHINs in their development.

- The Ministry in partnership with LHINs moved forward to develop a set of performance measurement indicators and a guideline toolkit for LHINs. A Steering Committee was established with North West, South East and Central LHIN CEOs and MOHLTC senior management, including representation from the Health System Strategy Branch and the LHIN Liaison Branch. A Working Group was also established with representation from LHINs and MOHLTC staff. The working group worked closely with the LHIN Community Engagement Network to develop the toolkit.

- A final draft of the Guidelines was approved by the LHIN Community Engagement Steering Committee on July 14th followed by LHIN CEO approval on July 16th which was achieved through an email vote sent out by the Central LHIN.

- In late June 2010, the Ombudsman shared his final report with the ministry and in August 2010 released the report to the public.

1.2. Strategic Objectives

In developing and implementing a common Guidelines Toolkit for consistent use by all LHINs, it is expected that the following strategic objectives will be achieved:

- To achieve and sustain high quality community engagement across all LHINs by establishing a set of minimum specifications for community engagement.

- To improve public accountability and transparency of community engagement practices and products.

2. Defining Community Engagement

2.1. Definition of Community Engagement *(as approved by the Ministry of Health & Long-Term Care)*

Community engagement refers to the methods by which LHINs and HSPs interact, share and gather information from and with their stakeholders.

The purpose of community engagement is to inform, educate, consult, involve, and empower stakeholders in both health care or health service planning and decision-making processes to improve the health care system.

Community engagement activities can be ongoing or project specific, outbound or inbound.

2.2. Definition of "Community"

Section 16.2 of LHSIA defines "Community" as patients and other individuals in the geographic area of the network, health service providers and any other person or entity that provides services in or for the local health system, as well as employees involved in the local health system.

Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by the project, or anyone that may exert influence over the project or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately.

2.3. Duty of Health Service Providers to Engage

Although LHINs are responsible for ensuring that they are adequately engaging their communities, the responsibility is also shared by the agencies funded by LHINs to provide health care services. The duty of Health Service Providers to consult is stated in LHSIA, *requiring community engagement in the development of plans and setting priorities for the health services they provided. 2006, c. 4, s. 16 (6)".*

2.4. The Core Principles for LHIN Community Engagement *(as approved by the Ministry of Health & Long-Term Care and adopted from the National Coalition for Dialogue and Deliberation)*

These seven recommendations reflect the common beliefs and understandings of those working in the fields of public engagement, conflict resolution, and collaboration. In practice, people apply these and additional principles in many different ways. LHINs will adopt these principles and apply them to Community Engagement practice.

1. Careful Planning and Preparation
Through adequate and inclusive planning, ensure that the design, organization, and convening of the process serve both a clearly defined purpose and the needs of the participants.

2. Inclusion and Demographic Diversity
Equitably incorporate diverse people, voices, ideas, and information to lay the groundwork for quality outcomes and democratic legitimacy.

3. Collaboration and Shared Purpose
Support and encourage participants, government and community institutions, and others to work together to advance the common good.

4. Openness and Learning
Help all involved listen to each other, explore new ideas unconstrained by predetermined outcomes, learn and apply information in ways that generate new options, and rigorously evaluate public engagement activities for effectiveness.

5. Transparency and Trust
Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed.

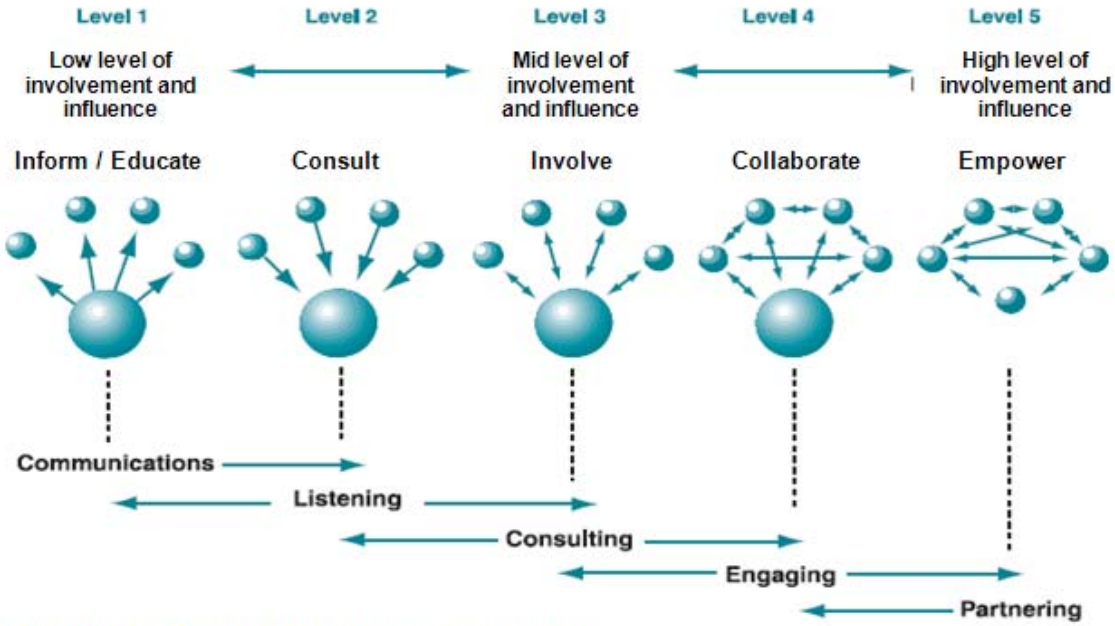
6. Impact and Action
Ensure each participatory effort has real potential to make a difference, and that participants are aware of that potential.

7. Sustained Engagement and Participatory Culture
Promote a culture of participation with programs and institutions that support ongoing quality public engagement.

2.5. Levels of Engagement

The following spectrum of engagement demonstrates the various levels of engagement LHINs may undertake with stakeholders. The spectrum shows the increasing level of impact as one progresses from 'inform' through to 'empower'.

Inform/Educate, Consult, Involve, Collaborate and **Empower** are all terms that may be used to describe engagement activities. However, each term refers to intrinsically different forms of engagement which are dependent on the overall objectives.



Adapted from the IAP2 2000 Public Participation Spectrum

See Engagement Strategies and Best Practices (pg. 21) for examples of engagement methods that correspond to each level of engagement.

3. Community Engagement Toolkit

(as approved by the Ministry of Health & Long-Term Care)

The LHIN Community Engagement Guidelines and Toolkit and attached templates are tools to be used for all LHIN community engagement activities in an effort to promote consistency across the province. These documents contain the minimum core requirements for planning community engagement and may be amended so long as the existing minimum specifications remain the same.

The Community Engagement Network will, on an annual basis review and recommend amendments to the guidelines based on updated information, user feedback and other factors. The following documents comprise the Guidelines for Community Engagement Toolkit:

1. ***Annual Community Engagement Strategy Worksheet***
    - A tool to help LHINs develop their annual Community Engagement strategy

2. ***Community / Stakeholder Assessment Worksheet***
    - A tool designed to enable community engagement planners to identify all relevant stakeholders and how they relate to a specific plan or project (with a populated sample)

3. ***Community Engagement Planning Worksheet – small project***
    - A planning tool for small community engagement undertakings (with a populated sample)

4. ***Community Engagement Planning Worksheet – large project***
    - A planning tool for larger and more complex community engagement undertakings

5. ***LHIN Community Engagement Performance Indicators***
    - A set of indicators that each LHIN will report on annually through their annual report and on both ministry and LHIN websites.

3.1. LHIN Annual Community Engagement Strategy Worksheet

LHINs are required to publish an annual community engagement plan that will be shared publicly. It is updated on an annual basis to reflect specific in year needs.

The plan contains an overview of the ongoing engagement activities within the LHIN. These activities are implemented to:

- Provide information and education to stakeholders
- Solicit input when required for decision-making
- Encourage two-way dialogue.

These guidelines will assist the LHIN in the development of an annual plan by identifying topic areas that should be included and are useful to stakeholders in their efforts to align their own plans and activities with those of the LHIN.

Annual Community Engagement Plans should include the following components:

1. **Describe your LHIN**

- In this section identify the unique aspects and challenges, related to community engagement, that exist within your LHIN (i.e. rural vs. urban, ethno-cultural diversity).

- It is recommended that you provide this description to assist stakeholders in understanding the context within which you present your plan.

2. **Where will the LHIN focus their capacity building engagement efforts/activities this year?**

- Describe the engagement activities planned for the year that are not related directly to the development of a specific project but are intended to expand both the LHINs and the community's capacity to know and understand each other.

- In this section you might identify the communities (i.e. Aboriginal, homeless) or special interest areas (i.e. stroke, maternal/newborn care) that you will engage on in the coming year.

- Describe these communities.

- Why does this plan focus on these communities at this time? (i.e. strengthen ties with the Aboriginal community, learn more about health-related issues from the perspective of the street-involved).

- Describe how you hope to engage these communities (i.e. sponsor a gathering of the local Aboriginal community, partner with the organizations that serve street involved people).

- You may also describe your plan for educating and informing LHIN stakeholders generally about the LHINs accomplishments and forward looking plans (i.e. actively solicit opportunities to present to local service clubs, we will present to municipal councils, hold a series of public information nights).

3. How will LHIN stakeholders be informed of opportunities to participate in engagement activities?

- How, where and when will you publicize planned activities?

4. How do LHIN stakeholders provide input or comment to the work of the LHIN – its plans or activities? How do they contact the LHIN?

- What are the optional feedback mechanisms made available?

- What is a reasonable expectation for stakeholders in relation to response time? (i.e. acknowledgement of receipt within 48 hours?)

5. How will the LHIN evaluate the success of this engagement plan?

6. How will the LHIN share the results of the engagement activities identified in this plan with stakeholders?

3.2. Community/Stakeholder Assessment Worksheet

Purpose of this Worksheet:
This worksheet is a tool to support LHIN community engagement project planning. It will assist project leads in early identification of stakeholders and is the first step in developing a community engagement plan to inform the project going forward. The tool is best used in the early stages of project development and is meant to inform internal senior team discussion and approval processes.

Identification of Stakeholders:
Section 16.2 of LHSIA defines "Community" as patients and other individuals in the geographic area of the network, health service providers and any other person or entity that provides services in or for the local health system, as well as employees involved in the local health system.

Stakeholders are individuals, communities, political entities or organizations that have a vested interest in the outcomes of the initiative. They are either affected by, or can have an effect on, the project. Anyone whose interests may be positively or negatively impacted by the project, or anyone that may exert influence over the project or its results is considered a project stakeholder. All stakeholders must be identified and managed/involved appropriately.

For the purpose of stakeholder identification, "communities" can be interpreted to mean geographic locations (i.e. Cambridge, Proton Station), communities of interest or communities of practice.

> **Community of Interest (COI)** - An informal, self-organized, network of individuals brought together around a common interest, issue, concern or opportunity. They need not meet physically and may only ever connect with one another on an ad hoc basis, around that common element.
>
> **Community of Practice (CoP)** - An informal, self-organized, network of peers with a common area of practice or profession. Such groups are held together by the members' desire to help others (by sharing information) and the need to advance their own knowledge (by learning from others).
>
> **Political Entity:** For the purpose of stakeholder identification, "political entity" is an individual, organization or group with known political interests or public responsibility. This may include officials in public office, or organized labour or citizens groups.

Assessing Impact & Outcomes

At the time of preparing this initial assessment, in the view of the project lead or planning team, how will stakeholders be affected by the project, if implemented? Impact on stakeholders can be categorized as "low", "moderate", "high" or "unknown" at this stage of planning.

> **Level of Outcomes Impact:** Indicates the degree to which you anticipate a stakeholder will be affected by the outcome, if implemented, of the idea you propose (i.e. by the decision being made, service being changed etc.)
>
> **Level of Influence on Outcomes:** Indicates the degree to which you anticipate a stakeholder may influence or affect change on the outcomes you propose if your idea is implemented. For example, does this stakeholder have to agree to the change? Is their cooperation important to successful implementation?
>
> **Level of Concern or Interest:** Indicates the degree to which stakeholders are aware or care about how they are impacted by the outcomes of your proposed idea, if implemented. Will they know how they might be affected or perceive themselves to be adversely or positively affected?

Issue of Greatest Concern or Opportunity: Building on what is identified as the level of concern or interest on the part of stakeholders, what is the single greatest idea, concern or concept to require communication?

Low Impact/Influence: Stakeholder is unlikely to be aware of how they may/will be impacted, if implemented and are unlikely to show interest in influencing the direction of the idea or project – as judged by project lead or planning team at time of writing.

Moderate – High Impact/Influence: Stakeholders will be aware and will know/feel the impact on themselves and would have interest in influencing the direction of the idea or project, to varying degrees – as judged by project lead or planning team at time of writing.

Unknown Impact/Influence: More work needs to be done by the project lead or planning team to understand the potential impact, influence or level of concern that a stakeholder may have in relation to the project under contemplation. This may be explored by connecting with contacts in the community, organizing a focus group, conducting a survey or other creative means.

See Appendix A (pg. 24) for sample document.

3.3. LHIN Community Engagement Planning Worksheet - Small Projects

This worksheet is meant to complement the **Stakeholder Assessment Worksheet** in planning community engagement activities. For larger and more complex activities, please also see the **Community Engagement Planning Template – Large Projects**.

Project Name:

Engagement Activity:

Proposed Date/Time/Location:

Project Description:
Provide a brief overview of the main project, plan or decision this plan for community stakeholder engagement is designed to support. Please provide enough detail so that any new person not familiar with the project will have the necessary information to understand the project's context.

Purpose:
Why are you conducting this engagement activity?

Alignment with IHSP:
Describe how this engagement plan/activity supports the delivery of the LHIN Integrated Health Service Plan.

Objectives:
Describe what you hope to attain or accomplish through this engagement activity. It is possible to have more than one objective. List in order of priority (i.e. identify as primary or secondary).

Engagement Approach:
Describe the process by which you will engage. Why is this approach recommended?

Outcomes:
Describe what you expect the end result achieved through your engagement activities will be. It is possible to anticipate more than one outcome. List in order of priority (i.e. identify as primary or secondary).

Outputs/Deliverables:
What product or material will the engagement activity yield? (Published report, results posted on website, notes transcribed from activities, etc.)

Evaluation:

Outcomes Evaluation:
What are your factors for success? How will you evaluate success?

Process Evaluation:
What are your factors for success? How will you evaluate success?

Impact Evaluation:
What are your factors for success? How will you evaluate success?

Logistics:

3.4. Community Engagement Planning Worksheet – Large Projects

This plan is a working document for large or complex engagement issues. It will provide detail on the process for engaging stakeholders first identified in the LHIN CE Stakeholder Assessment Worksheet and approved by the LHIN Senior Team or the project's executive sponsor.

Project Name:

Date:

Version #:

Lead Author:

Project Description:
Provide a brief overview of the main project, plan or decision this plan for community stakeholder engagement is designed to support. Please provide enough detail so that any new person not familiar with the project will have the necessary information to understand the project's context.

Purpose:
What is the main purpose for conducting community engagement in support of this project? What is the desired result or outcome?

Timelines:

Describe the timeframe in which community engagement will take place within the context of key project milestones.

Detailed Deliverables	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Specify deliverable												

High Level Engagement Objective:
Describe what you hope to attain or accomplish through your engagement activities. It is possible to have more than one objective. List in order of priority (i.e. identify as primary or secondary).

If this plan identifies multiple community stakeholders, is the objective the same for all? If it varies from one community stakeholder to another, how are they different and why? List the objectives alongside the community stakeholder they are associated with.

Objectives	**Stakeholder**	**Stakeholder**	**Stakeholder**
Describe objectives here	*Identify stakeholders and their interests*	*Identify stakeholders and their interests*	*Identify stakeholders and their interests*

High Level Output:
What product or material will the engagement activity yield?

High Level Outcome:
Describe what you expect the end result achieved through your engagement activities will be. It is possible to anticipate more than one outcome. List in order of priority (i.e. identify as primary or secondary).

If this plan identifies multiple community stakeholders, will the outcome be the same for all? If it varies from one community stakeholder to another, how are they different and why? List the expected outcomes alongside the community stakeholder they are associated with.

Stakeholder Identification:
The Community Stakeholder Assessment Worksheet provided an initial staff assessment of stakeholders relevant to the project, plan or decision under consideration.

Steps should be taken to ensure that the staff assessment is accurate - particularly when the initial assessment worksheet indicates that the level of outcomes impact, influence on outcomes, greatest concern or interest, or their ability to contribute were identified as “unknown”.

This can require additional research which may include some limited consultation directly with the stakeholder “community” in order to better understand their issues, concerns or ability to help the project succeed. This may also help to identify stakeholders “champions” who can help facilitate engagement within their communities.

Stakeholder:

Primary Contact:

Size of this Stakeholder Community:
How many individuals are estimated to be associated with this stakeholder group?

Key Issues, Concerns or Opportunity:
What do you see as the main area to be addressed through community engagement?

Opportunity for Inclusion:
How can this stakeholder contribute? (i.e. define the issue, contribute data, establish decision criteria, develop options, evaluate options, make recommendations).

Stakeholder Engagement Objective, Output & Outcome:
Describe the key objective for engagement of this stakeholder. What will be the specific output? How will it be used in project development, planning or decision-making? How will it be shared back with participants?

Stage in the Project:
Where in the continuum of project implementation will the engagement occur (development, execution, evaluation including timelines).

Engagement Approach:
Describe the process by which you will engage. Why was this process chosen?

Logistics:
Date, time, location.

Evaluation:

How you will evaluate the success of your engagement activities? Evaluation should reflect success relative to identified success factors for process, outcomes and impact of engagement.

Process measures: will look at whether the method(s) used were the most appropriate to gain the involvement of the community stakeholder.
Outcome measures: will look at whether the engagement activity achieved its desired outcome.
Impact measures: will look at how the outputs of the engagement activity contributed to the final results. (How will contributors to this process see themselves reflected in the project plan or decision?)

Stakeholder	**Engagement Method**	**Key Objective**	**Process Measures** *What are the factors for success?*	**Process Evaluation** *How will you assess your success?*	**Outcome Measures** *What are the factors for success?*	**Outcome Evaluation** *How will you assess your success?*	**Impact Measures** *What are the factors for success?*	**Impact Evaluation** *How will you assess your success?*

3.5. Performance Measurement Indicators for LHIN Community Engagement

The following is a set of indicators that each LHIN will report on annually through their annual report and on both ministry and LHIN websites.

1. An annual LHIN community engagement strategy or plan (i.e. a method or series of activities leading to a specific goal or result) consistent with the *Annual Community Engagement Strategy Worksheet* publicly available and reviewed on an annual basis.

   Requirements:
   - *The strategy document can stand alone or be combined with a LHIN's annual communications plan document.*
   - *The strategy document is aligned with IHSP priorities.*
   - *The LHIN's Annual Community Engagement Strategy document will be posted visibly on the LHIN's website (i.e. linked from the home page). The LHIN will ensure the document is available to the public in alternate formats when requested in keeping with the LHIN's Accessible Customer Service Policy.*
   - *An internal annual review process will be clearly defined and documented to allow for evaluation and future improvement of the strategy.*
   - *Performance against the plan will be reported in each LHIN's Annual Report.*

2. The LHIN uses the community engagement guidelines to support project planning and decision making.

   Related Issues:
   - *The Guidelines for Community Engagement Toolkit, with attached templates are intended to provide LHINs with a consistent approach to community engagement for planning and documentation.*

3. Participant evaluation must be integrated into every community engagement plan and inform future engagement planning.

   Related Issues:
   - *Participant evaluation of community engagement processes is defined as opportunities for participants to provide feedback on:*
     - *i. The appropriateness of the engagement technique (to the stated objectives of the session/meeting).*
     - *ii. Participant satisfaction with the engagement technique, location, timeframe etc.*
     - *iii. And suggestions on how to improve any of the above.*
   - *Participant evaluation is intended to provide the LHIN with feedback on the chosen approach or process to community engagement.*

- *Is the evaluation process documented and tracked to allow for improved future engagement activities?*

4. Each LHIN will establish an evaluation committee including external reviewers to which it will submit its completed community engagement templates at least once within every three-year planning cycle. Existing committees that have non-LHIN representation can be leveraged for this purpose or an ad-hoc committee can be created exclusively for this purpose.

   Related Issues:
   - *The community engagement completed templates will be measured against the Guidelines for Community Engagement Toolkit documents provided and updated by the LHIN Community Engagement Network in consultation with the Ministry to ensure alignment and consistency with the guidelines, principles and best practices.*
   - *The size and makeup of the committee, while at the discretion of the LHIN, should reflect the unique diversity of the LHIN's community and provide a balance of LHIN representatives and non-LHIN members. Non-LHIN members are people who are not employees or board members of the LHIN.*
   - *The committee can be ad-hoc (i.e. struck for this purpose alone on a time limited basis) or the LHIN may enlist the services of an existing committee where the requirements for diversity and balance will be met.*

5. The LHIN demonstrates how community engagement results have been tabled to LHIN decision-makers, including the Board for planning, funding and any decision-making process. Engagement can be rolled-up, where appropriate.

   Related Issues:
   - *LHINs will develop a feedback process to communicate results of community engagement activities to LHIN decision makers, including the Board.*
   - *The LHIN can support with documentation where and when community engagement results were communicated to decision makers.*

4. Engagement Strategies and Best Practices

(as approved by the Ministry of Health & Long-Term Care)

The following lists provide engagement strategies appropriate to different levels of involvement.

4.1. Goal: Educate & Inform

- **Web Site or Other Web Based Tools**
  - Reaches people who don't come to meetings.
  - Creates an information repository available anywhere and anytime to anyone with an Internet connection.
  - Reaches people across large geographic areas.

- **Offering a Central Information Contact**
  - This is a designated person who serves as a single point-of-contact for inquiries about the project.
  - Provides reliable access for interested parties to get information and have questions answered.

- **Briefings**
  - Presentations to organized groups to raise awareness, share information, answer questions and generate greater interest in participation.
  - Effective early in the process to create awareness, build rapport and trust.

- **Fact Sheets, Progress Reports, Newsletters, Email Updates**

- **Open Houses**

- **Fairs and Events**

- **Information Repositories/Kiosks**
  - (i.e. information provided at library sites, shopping malls – places that are convenient for community access).
  - Provides access to project background materials and ensures that project materials are available for interested parties.

4.2. Goal: Consult

- **Invite Public Comment**
  - Comment cards, encourage correspondence.

- **Focus Groups**

- **Delphi Processes**
  - Participants respond to a questionnaire or survey, responses are compiled and the compilation is returned to participants who have opportunity to add or alter their responses.

- The process is repeated until additional interaction no longer results in significant changes.
- Provides an opportunity to develop agreement without the need for face to face meetings.

- **Surveys**
  - Online, print, other.

- **Public Meetings/Symposia**
  - Including presentation of facts and specifics of which aspects of the project/decision to which input can be invited.

- **Feedback Registers**
  - Randomly selected participants are sent briefing materials and asked to provide feedback by a specific date/method (i.e. by telephone, one week later).
  - Can be used as a recruiting mechanism to identify parties interested in further involvement.

- **Interviews**
  - Would require a scripted and planned approach to ensure consistent approach.

4.3. Goal: Involve

- **Workshops**
  - Where participants work in small groups on defined assignments.

- **Computer Assisted Processes**
  - i.e. Expert Choice Decision support software.

- **World Café**

- **Open Space Meetings**
  - Participants create and design their own agenda and work groups around a specific theme.

- **Focused Conversations**
  - Allows for group involvement in a structured discussion on specific issues.
  - Can be used to explore potentially contentious issues. Conversation/questions take four stages:
    - Objective – review facts
    - Reflective – review emotional response
    - Interpretive – review meaning
    - Decisional – consider future action

4.4. Goal: Collaborate

- **Advisory Committees**

- **Consensus-Building Activities**
  - Working through options/solutions to find common ground or agreement.

- **Deliberative Forums**
  - Bring people together to make choices about difficult, complex issues where there is a lot of uncertainty about solutions and there is high likelihood that people will be polarized on the issue.
  - The goal of deliberative forums is to find where there is common ground for action.
  - A moderator who is specifically trained in this technique is important.

- **Deliberative Polling**
  - Structured means to measure informed opinion on an issue.
  - Process requires a statistically valid sample group and incorporates information presentation so that participants can offer informed opinions.
  - Group discussion takes place and then participants vote on the questions put before them.

4.5. Goal: Empowerment

- **Citizen Jury**
  - A representational group of participants is selected to consider a set of facts and relevant information leading to a decision.

- **Voting by Ballot**
  - Options are put to a vote the results of which are binding.

- **Delegated stakeholder decision-making**
  - Final decision-making authority, leading to action is assigned to a committee (ad hoc, standing) or other organized body (project-related work group or task).

5. Appendices *(as approved by the Ministry of Health & Long-Term Care)*

5.1. Appendix A - Community Stakeholder Assessment Worksheet

Stakeholder	Level of Outcomes Impact and Relationship to Project None*, Low, Mod, High, Unknown Positive? Negative?	Level of Influence on Outcomes None*, Low, Mod, High, Unknown	Level of Concern or Interest None*, Low, Mod, High, Unknown	Issue of Greatest Concern or Opportunity to Stakeholder	How can Stakeholder Contribute? Help define the issue? Contribute data? Help to establish decision criteria? Help to develop options? Help to evaluate options? Make recommendations or decisions?	Level of Involvement Recommended **Educate/Inform** (i.e. provide balanced and objective information to assist with understanding the problem, alternatives, opportunities and/or solutions) **Consult** (i.e. obtain feedback on analysis, alternatives and/or decisions) **Involve** (i.e. work directly throughout the project to ensure that concerns and aspirations are consistently understood and considered) **Collaborate** (i.e. partner in the decision process including the development of alternatives and identification of preferred solutions) **Empower** (i.e. to allow final decision-making)
1.						
2.						
3.						
4.						
5.						
6.						
7.						

*NB – "none" may still result in a plan to educate communities relative to the purpose of the project and how they are affected by outcomes.

Contents within are based on the best available information at the time of planning.

5.2. Appendix B – (Sample) Community Stakeholder Assessment Worksheet

Stakeholder Presented in no particular order	Level of Outcomes Impact and Relationship to Project None*, Low, Mod, High, Unknown Positive? Negative?	Level of Influence on Outcomes None*, Low, Mod, High, Unknown	Level of Concern or Interest None*, Low, Mod, High, Unknown	Issue of Greatest Concern or Opportunity to Stakeholder	How can Stakeholder Contribute? Help define the issue? Contribute data? Help to establish decision criteria? Help to develop options? Help to evaluate options? Make recommendations or decisions?	Level of Involvement Recommended Educate/Inform (i.e. provide balanced and objective information to assist with understanding the problem, alternatives, opportunities and/or solutions) Consult (i.e. obtain feedback on analysis, alternatives and/or decisions) Involve (i.e. work directly throughout the project to ensure that concerns and aspirations are consistently understood and considered) Collaborate (i.e. partner in the decision process including the development of alternatives and identification of preferred solutions) Empower (i.e. to allow final decision-making)
1. Local Hospitals	-Moderate to high depending on the hospital as may lead to realignment of current services -Impact will vary – some will be positively impacted others negatively	-Unknown at this time	-High	-Concern related to how current services, staff, bed numbers may change -Potential for either enhancement or reduction of same -Opportunity to improve service and clinical outcomes for stroke patients	-Contribute data. -Help to develop/evaluate options	-At minimum involve/ Ideally will collaborate

2. Regional Stroke Centre	-High – outcomes of this project may lead to redesign of service delivery model -In the short term changes may be viewed negatively but changes to clinical outcomes will be positive	-Moderate to High	-High	-Concern related to how this review will affect current service delivery model - Opportunity to improve service and clinical outcomes for stroke patients	-Contribute data -Develop decision -Criteria and options reflective of best practice in hospital-based stroke care	-At minimum involve/Ideally will collaborate
3. CCAC	-Moderate to High – outcomes of this project may lead to redesign of service delivery related to stroke care in the community -In the short term changes may be viewed negatively but changes to clinical outcomes will be positive	-Unknown at this time	-High	-Concern related to how this review will affect current service delivery model. - Opportunity to improve service and clinical outcomes for stroke patients	-Contribute data -Develop decision -Criteria and options reflective of best practice in community-based stroke care	-At minimum involve/Ideally will collaborate
4. Stroke patients/residents	-High – the overall purpose of this project is to improve the 30 day mortality rates and 30 day readmission rates for stroke -Change will result in positive impact on clinical outcomes	Low	High	-Concern related to deviating from the familiar and whether the purpose of the review is genuinely about improved patient outcomes vs. cost cutting/reduction in services -Opportunity to benefit from improvements to service delivery model and care provided leading to improved 30 mortality rates and 30 day readmission rates	-Help define the issues or concerns from a patient perspective – provide insight into "lived experience" of stroke survivors	-Educate/Inform/Consult

5. EMS Providers	-Moderate to High – outcomes of this project may impact scheduling, prioritization and timelines of service -Will be viewed as negative if changes place funding or service burden on these providers	High - EMS is not a LHIN funded service so cooperation is possibly key contributor to successful revision of service delivery model	High	-Concern related to how changes in service delivery models impact their ability to provide service within existing budgets and staff complements etc.	-Help define the issues or concerns from the perspective of EMS service provision – provide insight into the limits and impacts of proposed changes on their ability to provide the required services	-At minimum involve/Ideally will collaborate
6. Municipal Councils	Moderate to High – EMS services are municipally-funded services and any proposed changes to hospital or community-based services may be seen as negative	-High – EMS services are funded by municipal budgets	-High	-Concern related to deviating from the familiar and whether the purpose of the review is genuinely about improved patient outcomes vs. cost cutting/reduction in services. -Concern related to how changes in service delivery models impact their ability to provide service within existing budgets and staff complements etc. -Misunderstanding of scope or intended outcomes of the review could unintentionally create a municipal election issue Fall 2010 -Opportunity for their communities to benefit from improvements to service delivery model and care provided leading to improved 30 mortality rates and 30 day readmission rates	-Help define the issues or concerns from the elected municipal leadership perspective – provide insight into the limits and impacts, concerns related to proposed changes/impact on residents of their respective municipalities	-Educate/Inform/Consult
7. Physicians	-Moderate to high – likely to perceive mix of positive and negative benefit to their community of practice	-High	-High	-Concern related to how changes will support better clinical outcomes -Concern related to how changes impact their interaction with patients (i.e. privileges, distance to treatment centre etc.)	-Help define the issues or concerns from the physician's perspective – provide insight into their view of best practice and patient care management	-At minimum involve/Ideally will collaborate

*NB – "none" may still result in a plan to educate communities relative to the purpose of the project and how they are affected by outcomes.

5.3. Appendix C – (Sample) LHIN Community Engagement Planning Worksheet – Small Project

*This worksheet is meant to complement the **Stakeholder Assessment Worksheet** in planning community engagement activities. For larger and more complex activities, please also see the **Community Engagement Planning Template**.*

Project Name: Rural Health Care Review

Engagement Activity: Discussion with Rural Residents

Proposed Date/Time/Location: March 5, 2009, 7 – 9 p.m., Lion's Hall, Elmira ON

Project Description

Provide a brief overview of the main project, plan or decision this plan for community stakeholder engagement is designed to support. Please provide enough detail so that any new person not familiar with the project will have the necessary information to understand the project's context.

As part of an overarching review of clinical services in the WWLHIN, a Rural Health Care Working Group (RHCWG) has been formed as a sub-group providing input to the WWLHIN Clinical Optimization Steering Committee.

The mandate of the WG is to review Rural Health Care in the WWLHIN with the goal of developing and recommending an overall vision for rural health service provision. The WG is comprised of individuals from various perspectives and provides a forum for discussion of the unique health care issues faced by rural residents. The goal of the WG is to draft a rural health care plan that will be used to guide overall WWLHIN planning and future investment of health care funding.

Purpose:

Why are you conducting this engagement activity?

To consult with rural residents - provide education on the current state of rural health service provision and engage them in an exploration of ideas for future state service provision.

This engagement activity supports the informational needs of the WG. It is an early stage scoping activity to gain insight of the community vision for health care in rural settings.

Alignment with IHSP:

Describe how this engagement plan/activity supports the delivery of the LHIN Integrated Health Service Plan.

This activity will support the delivery of the IHSP 2010 – 2013 by contributing to a plan for rural health care that will inform WWLHIN strategies and action plans to address "improved access to primary care".

Objectives:
Describe what you hope to attain or accomplish through this engagement activity. It is possible to have more than one objective. List in order of priority (i.e. identify as primary or secondary).

1. Present current state overview from the perspective of the WWLHIN and rurally-based service providers
2. Conduct a facilitated dialogue with rural residents

Engagement Approach:
Describe the process by which you will engage. Why is this approach recommended?

An education session will be held followed by a small group, facilitated discussion.

An education session is recommended to provide rural residents with a basic understanding of local rural health care and address any questions or concerns or misconceptions they may have.

A facilitated discussion, with a short list of questions common to all groups, will ensure that the discussion stays focused on items of group concern with respect for limited time frames. Small groups will increase comfort level for individual participants and encourage contribution from each. The facilitator can encourage an appreciative inquiry (i.e. encourage elaboration or further discussion) with the full group to explore concepts, ideas or questions put forward by individuals.

Outcomes:
Describe what you expect the end result achieved through your engagement activities will be. It is possible to anticipate more than one outcome. List in order of priority (i.e. identify as primary or secondary)

1. Session participants have an increased awareness of the current state of rural health care services and the differences between rural and urban health care service provision.
2. Session participants have an increased understanding of the need to think differently about how service is provided and how consumers access services going forward.
3. Given context, session participants identify their issues and ideal future state for health care service provision.

Outputs:
What product or material will the engagement activity yield?

1. Feedback from session participants is captured and organized by "theme" for consideration by the RHCWG.
2. Questions and answers are documented for posting on the WWLHIN website.

Evaluation:

Outcomes Evaluation:
What are your factors for success? How will you evaluate success?

Factors for success:

1. Participants have an increased awareness of the issues related to rural health service provision.
2. Participants have an increased awareness of the current state of rural health service delivery.
3. Participants are able to share their experiences and comments and hear those of others.
4. Participants are actively engaged in identifying their issues and vision for an ideal future state for health care service provision.

Method: Email survey

Session Participants will be asked to volunteer their email addresses as they register and pick up their information packages. Survey link will be emailed out the day following the event. This survey will be combined with process evaluation survey questions.

Process Evaluation:
What are your factors for success? How will you evaluate success?

Factors for success:

1. Participants report satisfaction with the manner in which the session was organized (i.e. time, location, method for presenting information were conducive to participation).

Method: Email survey

Session Participants will be asked to volunteer their email addresses as they register and pick up their information packages. Survey link will be emailed out the day following the event. This survey will be combined with the outcomes evaluation survey questions.

Impact Evaluation: *What are your factors for success? How will you evaluate success?*

1. The RHCWG can demonstrate where and how participants' feedback was used in the development of the Rural Health Care Plan.

Logistics:

1. Lion's Hall, Elmira (booked/confirmed)
2. Audio visual required (sound system – outsourced, booked, screen - onsite, projector - LHIN, laptop - LHIN)
3. Minimal hospitality (booked/confirmed)
4. Theatre style plus – registration table, note taker's table, table for speakers, podium (LHIN staff setup)
5. Speakers – WWLHIN CEO, Woolwich CHC, Groves Memorial Hospital – confirmed
6. Presentation for CEO required, Woolwich & Groves will provide their own


Ontario
Local Health Integration
Network

The CNFS Materials on Active Offer of French-Language Health Services

The Consortium national de formation en santé (CNFS) is proud to present a set of training materials, produced with the financial support of Health Canada, on the *active offer of French-language health services*. We created these tools not only for students in post-secondary healthcare programs, instructors and internship supervisors, but also for working healthcare professionals, healthcare facility managers and all others involved in the healthcare industry. The training materials are intended to equip healthcare students and professionals to act with **conviction and confidence** to support and enhance the French-language health services offered in their workplaces in Francophone minority communities.

The training materials include the following tools, which are all available on the CNFS Website at www.cnfs.net under the tabs: Publications and Vidéos:

- *Reference Framework: Training for Active Offer of French-Language Health Services* (in English and French);
- *Cahier de réflexion et d'accompagnement des vidéos témoignages* (in French only);
- Sixteen videos of testimonials from Francophone patients and their families who had difficult experiences in healthcare facilities in several Canadian provinces, entitled ***Quand la santé c'est aussi la langue*** and ***My health, my language***; as well as two promotional videos based on these testimonials, in French and in English with subtitles.

The CNFS Active Offer Toolbox

This comprehensive and interactive tool will be available online in September 2013.

In order to offer high-quality French-language health services with confidence and conviction, healthcare professionals must be both **well informed** and **properly equipped**. The CNFS ***Active Offer Toolbox*** achieves two goals: 1) it **educates** healthcare professionals about the **importance** of language to health and about the **impact** of their actions, and 2) it **equips** them to incorporate active offer into their practices and to commit to providing quality, safe, ethical and equitable healthcare services to Francophone minority populations. Dynamic and accessible, the toolbox contents will include relevant literature and focus on the perspective of key players in the healthcare industry. The toolbox will offer a variety of tools, including case studies and videos.

The CNFS is a pan-Canadian group of 11 colleges and universities, six regional partners and a National Secretariat. Member institutions offer French-language education in various healthcare disciplines; the regional partners help to promote and facilitate access to these healthcare programs; and the National Secretariat plays a coordination and leadership role. This strategic alliance works to improve the offer of French-language health services in Francophone minority communities by training Francophone healthcare professionals and supporting associated research.

For more information about these CNFS tools and other publications, please visit

www.cnfs.net

Source: North East Local Health Integration Network

Active Offer of FLS in Health

Employer Fact Sheet

What is Active Offer of FLS (French Language Services)?

Active Offer happens when…

*Francophone members of the public are **informed** about available services in French, have **access** to these services and are **satisfied** with the quality of these services.*[1]

Quality French-language services are **"actively offered"** if the following elements are present:[2]

- a "client" or "service-focused" approach;
- knowledgeable and well-trained staff who have a clear understanding of their corporate and individual responsibilities regarding FLS;
- a willingness, where necessary, to look at alternative or innovative ways to meet FLS obligations and the needs of the Francophone community; and,
- time to "plan ahead".

How does Active Offer of FLS fit into the health care system?

Local health service providers who are identified or, under the *French Language Services Act*, designated to provide FLS, are encouraged to be proactive in establishing and offering services in French, **rather than relying on the public having to request them**. As crown agencies, LHINs are also accountable for providing FLS using an active offer approach.

As stated by the French Language Services Commissioner – François Boileau – in his *Special Report on French Language Health Services Planning in Ontario, 2009*: "It has been shown, time and time again, that active offer has a considerable impact on the demand for services. The more actively a service is offered, the more demand there is for it. This is as true for health as for any other sector."

How do I promote an Active Offer of FLS?

- Educate staff and management on the *FLS Act*[3] and the FLS requirements under the *Local Health System Integration Act*[4].
- Ensure visual cues in the service environment that let the public know that services are available in French (i.e. signs, name tags, etc.)
- Offer services simultaneously in French and English (i.e. on the phone, at the reception desk, at admission, in print, etc.)
- Develop mechanisms for non-bilingual staff to handle requests for services in French – in person or over the phone.
- Identify and carry out an assessment of bilingual staff and the resources needed to ensure an active offer of FLS (i.e. language testing and training, bilingual reference tools, etc.)
- Develop a mechanism to identify French-speaking clients in order to facilitate needs assessment and matching of clients with French-speaking staff.
- Engage the Francophone community as an active partner in designing programs and services that meet the community's own needs (i.e. FLS Committee, consultations, etc.)
- Integrate FLS in strategic plans and develop policies and procedures pertaining to FLS (i.e. in HR policies, complaint mechanism, etc.)

[1] From "*OPS Framework for Action: A Modern Ontario Public Service*", 2006
[2] From "*Practical Guide for the Active Offer of French-language Services in the Ontario Government*", Office of Francophone Affairs, April 2008
[3] **http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm**
[4] **http://www.e-laws.gov.on.ca/html/source/regs/english/2009/elaws_src_regs_r09515_e.htm**

Source: North East Local Health Integration Network

Active Offer of FLS in Health

Employee Fact Sheet

What is Active Offer of FLS (French Language Services)?

Active Offer happens when…

*Francophone members of the public are **informed** about available services in French, have **access** to these services and are **satisfied** with the quality of these services.*[1]

How does Active Offer of FLS fit into the health care system?

Local health service providers who are identified or, under the *French Language Services Act*[2], designated to provide FLS, are encouraged to be proactive in establishing and offering services in French, **rather than relying on the public having to request them**.

As stated by the French Language Services Commissioner – François Boileau – in his *Special Report on French Language Health Services Planning in Ontario, 2009*: "It has been shown, time and time again, that active offer has a considerable impact on the demand for services. The more actively a service is offered, the more demand there is for it. This is as true for health as for any other sector."

How do I promote an Active Offer of FLS?

- When delivering services in **person**, extend a two-language greeting, such as **Hello, Bonjour.**
- If the client/patient responds in French, continue the conversation in French. If you can't carry on the conversation in French, say **Un moment s'il-vous-plaît** (One moment please: UN MO-MON S'EEL-VOO-PLAY). Then go get someone who can speak French.
- When delivering services on the **phone,** answer in both languages. Example: **Hospital XX, Bonjour.** If you can't understand or speak to the French caller, say **Un moment s'il-vous-plaît** and transfer the call to someone who can.
- If you are bilingual, your voice mail should include a two-language greeting, such as **Hello/Bonjour. You have reached XX, please leave a detailed message…. Vous pouvez également laisser votre message en français.**
- If you speak French, wear a **badge** or **name tag** that clearly identifies you as French-speaking. That way, the French client/patient will know that they can speak to you in French.
- DON'T assume that if the client/patient is French, they will ask for their services in French or speak to you in French first. For whatever reason, they might feel awkward initiating the conversation in French. BE **PROACTIVE** by identifying yourself as French-speaking and making them feel comfortable to speak to you in French.
- DON'T be embarrassed if you feel that your French is "not good enough". Every bit helps, and the French client/patient will surely appreciate the effort. Don't worry if you don't know the "technical" vocabulary in French. Chances are that your client/patient won't know it either!
- The **active offer** of French language services is all about **good customer service**!

[1] From "*OPS Framework for Action: A Modern Ontario Public Service*", 2006
[2] **http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm**

Section 3

Implementation of French Language Services

Section 3
Implementation of French Language Services

The French Language Services Act (FLSA) guarantees members of the public the right to receive services in French from head and central offices of Ontario government agencies and ministries, as well as offices located in/or serving areas designated under FLSA. For more information on the FLSA, please see Section 7 on legislation.

The Government of Ontario has identified and designated a number of health services providers (HSPs). **Designated HSPs** have met designation criteria[9] and have received an official recognition from the Government of Ontario. They offer quality services in French on a permanent basis. At the time of printing, there are 222 partially and fully designated organizations and of those, 84 are health service providers. In the Erie St. Clair LHIN, 2 HSPs are partially designated: Assisted Living Southwestern Ontario and Community Support Centre of Essex County. A list of designated health service providers across the province can be found on pages 233–244.

Identified HSPs are working towards attaining designation. They are planning and delivering quality direct services in French. At the time of printing, there are 28 identified HSPs in the Erie St. Clair LHIN and 8 identified HSPs in the South West LHIN. A list of identified health service providers in Erie St. Clair and South West LHINs can be found on pages 67 and 69.

To achieve these goals, it is important to develop a French Language Services Implementation Plan that includes goals and actions as well as timelines. See template provided on pages 71–105. When ready for designation, complete the Designation Plan template provided on pages 107–125 and follow the procedure on page 127.

Designated and identified HSPs are also required to report on their progress annually to the LHIN. A reporting template is currently under development. It will be available in the Self-Reporting Initiative (SRI) system or provided by the LHIN. LHIN-HSP Accountability Agreements contain more details on French language services requirements.

The Ministry of Health and Long-Term Care (MOHLTC) is supporting designated and identified HSPs in delivering quality services in French by providing free translation services and French-language training. For more information, please refer to Sections 5 and 6.

9. Designation criteria:
   - Offer quality services in French on a permanent basis;
   - Guarantee access to its services in French;
   - Have French-speaking members on its board of directors and in its executive;
   - Develop a written policy for services in French that is adopted by the board of directors and that sets out the agency's responsibilities with respect to services in French.

Office of Francophone Affairs, www.ofa.gov.on.ca/en/flsa-agencies.html, April 15, 2013.

Key Results Areas

Implementation of French language services is based on four key results areas as defined by MOHLTC.

- Knowledge and Awareness.
- FLS Capacity.
- Francophone Community Engagement.
- FLS Integration and Coordination.

Knowledge and Awareness
To improve knowledge of requirements regarding French language services and of the needs and concerns of Francophone patients/clients:

- Inform new and existing staff and board members of their obligations under the FLSA. Use methods such as:
  - › Staff meetings.
  - › Orientation packages.
  - › Workshops.
  - › Lunch-and-learn sessions.
  - › Etc.

To increase awareness of patients/clients and the public of services provided in French by the health service provider:

- Have French-speaking staff members wearing badges or lanyards indicating they speak French.
- Post bilingual welcome signs.
- Post bilingual directional signs.
- Translate website, pamphlets and other written material into French.
- Have bilingual business cards for French-speaking staff members.
- Reach out to Francophones directly to inform them of services being offered. Different outreach strategies, such as presentations, meetings with Francophone community groups, organizations, schools and services providers, advertisements through French media or consultations with Francophone community about the best ways of reaching this population, can be used to inform.

FLS Capacity

To develop and maintain capacity to provide an active offer and delivery of high quality services in French:

- At the staff level, have bilingual human resources in sufficient number to provide French language services. Develop a human resources plan and policies regarding recruiting and hiring. Have tools and support mechanisms to assist staff members with providing customer service, clinical services and communications in French.
- At the governance and management levels, have an adequate representation of French-speaking individuals on the board, management team and committees. Include French-speaking representation in by-laws and policies.
- At other levels, ensure processes are in place for the recruitment of French-speaking volunteers and, if applicable, purchasing of services (when services are offered by another party on the organization's behalf).
- At all levels, develop a recruitment strategy.

Francophone Community Engagement

To ensure active participation of Francophone in public consultations, need assessments, gaps analyses, program and services development and identifications of priorities. Community engagement initiatives should be:

- Planned, specifically targeting members of the Francophone community.
- Integrated into existing community engagement strategy/plan.

The intent is to develop a long-term relationship with the Francophone community through:

- Awareness and knowledge of the Francophone community.
- Participation in its activities, as appropriate (eg. health fair).
- Consultation.
- Sharing of information.
- Etc.

FLS Integration/Coordination

To improve integration and coordination:

- Increase integration of FLSA principles into the strategic planning and policy decision-making processes.
- Take into account needs and concerns of Francophone patients/clients in the planning and delivery of services.

- Improve responsiveness to the needs and concerns of the Francophone community, including HSP's response to request for services in French.
- Improve inter-agency collaboration within and outside the LHIN boundaries to provide French language services to Francophone patients/clients, including development of referral process, partnerships and purchase of services.

Implementation of French Language Services

Implementation and delivery of French language services should be integrated into the day-to-day operations and culture of health service providers. By-laws, policies and procedures, communication strategy, planning processes, etc. should be reviewed for their fit with French language services.

By-Laws
Organization's by-laws should reflect a commitment to the implementation and active offer of services in French. A representation from the Francophone community on the board (one Francophone for a 10-member board or less; and two for an 11-member board or more as per MOHLTC guideline) should be aimed for.

Policies
Internal policies and procedures should also be reflective of the organization's commitment to quality services in French.

- Human resources policies should be revised to include designation of positions, recruitment, hiring, testing of French-language skills, French-language training, etc.
- Communications policies should be revised to include translation of documents, signage, outreach strategy, etc.

Planning
When planning the development of a new service or the closure of another service, consider the impact on the Francophone community and its needs and concerns. As done with the general population, reach out to the Francophone community to receive feedback.

It is important to develop a protocol to serve Francophone patients/clients. The protocol should be based on the identification of the language of patients/clients, adapted to the organization's capacity to deliver services in French, contained interim measures and review regularly. This could take the form of a written step-by-step procedure or a graphical path (similar to a visual stream map).

The *Self-Assessment Tool – Implementation of French Language Services* on pages 129–133 could be a useful tool.

> *"Providing service of equivalent quality in both official languages is a matter of professionalism, respect, integrity and social justice."*
>
> Dyane Adam, *National Report on Service to the Public in English and French: Time for a Change in Culture,* p. 4.

What about Non-Identified Organizations?

Non-identified HSPs have no *corporate* obligation to plan and implement services in French. However, all LHIN-funded HSPs have a requirement to serve all population groups, including the Francophone population, in a culturally competent manner and be responsive to their needs. As well, as part of all accountability agreements with the LHIN, non-identified health service providers are also required to provide a report to the LHIN that outlines how they address the needs of their local Francophone community.

Here are a few questions to consider when addressing the needs of the local Francophone community.

- Does the organization have a process in place to identify French-speaking patients/clients?
- What methods does the organization use to respond to a request for services in French?
  - › Use of family member.
  - › Use of volunteer as interpreter.
  - › Use of professional interpretation services.
  - › Refer to other HSPs that provide services in French.
- Is there a process in place in the organization to identify French-speaking staff members and volunteers?
  - › Does the organization have direct service staff able to provide services in French?

Non-identified HSPs can apply the same principles relevant to identified organizations and use the information found in this toolkit to help them serve the needs of the Francophone population.

Section 3

List of Appendixes

List of Identified and Designated HSPs for the provision of French Language Services, Erie St. Clair LHIN

List of Identified HSPs for the provision of French Language Services South West LHIN

HSP FLS Implementation Plan Template

Designation Plan

Designation Process

A Self-Assessment Tool – Implementation of French Language Services

List of Identified and Designated Health Services Providers for the Provision of French Language Services

Alzheimer Society of Chatham-Kent
Alzheimer Society of Windsor and Essex County
Amherstburg Community Services
Assisted Living Southwestern Ontario
Banwell Gardens
Brain Injury Association of Chatham-Kent
Brentwood Recovery Home
Bulimia Anorexia Nervosa Association
Canadian Hearing Society, Windsor
Canadian Mental Health Association, Lambton-Kent Branch
Canadian Mental Health Association, Windsor-Essex County Branch
Canadian National Institute for the Blind, Windsor
Chatham-Kent Community Health Centres
Chatham-Kent Health Alliance
Community Support Service of Essex County
Country Village Health Care Centre
Erie St. Clair Community Care Access Centre
Essex Community Services
Family Services Kent
Family Services Windsor Essex
Hospice of Windsor and Essex County Inc.
Hôtel-Dieu Grace Hospital
House of Sophrosyne
Leamington District Memorial Hospital
Ontario March of Dimes, Chatham
Sexual Assault Crisis Centre of Windsor-Essex
Tilbury Manor Nursing Home
Westover Treatment Centre
Windsor Essex Community Health Centre
Windsor Regional Hospital

Last update: April 24, 2013

List of Identified Health Services Providers
for the Provision of French Language Services

Addiction Services of Thames Valley

Canadian Mental Health Association, London Middlesex Branch

London InterCommunity Health Centre

London Health Sciences Centre

Mission Services of London

St. Joseph's Healthcare, London

South West Community Care Access Centre

Western Ontario Therapeutic Community Hostel (WOTCH)

Last update: April 2011

HSP FLS Implementation Plan Template

Responsibilities of Identified and Designated HSPs

To support the Ministry's compliance with the *French Language Services Act* , HSPs must provide services in French if the provider has been:

- Designated under the *French Language Services Act;*
- Directed by the former Health Services Restructuring Commission ("HSRC");
- Identified by the former District Health Councils or the LHINs to provide services in French.

HSPs required to provide services to the public in French under the provisions of the *French Language Services Act* , must submit a French Language Services Implementation Plan to the LHIN, using this template. They must also submit progress reports. A template will be provided by the LHINs to that effect.

HSPs not required to provide services to the public in French must nonetheless provide a brief report to the LHIN that outlines how the HSP addresses the needs of its local Francophone community. This information that can be included in the HSP service plan will support the LHIN in its role as a local health system planner.

Instructions - HSP FLS Implementation Plan

Colour Codes

	Titles in blue	Title or description
►	Drop-down list	Drop-down list selection or "x" a choice
	Cells in green	Type-in responses

Worksheets requiring completion

Catchment Area
Plan

"… to be completed by ..." choices

This implementation plan is to be a living document for a variety of HSP types and for years to come.

► Implementation of this Result Area to be completed by …

March 31, 2011
March 31, 2012
March 31, 2013
March 31, 2014
March 31, 2015
March 31, 2016
March 31, 2017
March 31, 2018
March 31, 2019
March 31, 2020
March 31, 2021

Excel Tips when entering text information in cells

[ALT] [Enter]	To change to next line within a cell
[ALT] [7]	To get the point form symbol "•"
[ALT] [9]	To get this symbol "○"
[ALT] [45]	To get the dash symbol "-"

For example: *Press [ALT], hold and type [4][5] and release [ALT]*

This demonstrates how one can type text information in an Excel form.
To change lines one simply types [ALT] [Enter]
Here`s another example of where it occurred again [ALT] [Enter]

Then again with the [ALT] [Enter]

HSP's catchment area

HSP's catchment area, including % of French-speaking (FS) population (Statistics Canada 2006)

Please define your catchment area by listing communities serviced, indicating the number and percentage of French-speaking population within your catchment area.

List communities below:	**Is this part of a designated area***	Total population	Francophone Population	%
<Community A>	Select Yes/NO			#DIV/0!
<Community B>	Select Yes/NO			#DIV/0!
<Community C>	Select Yes/NO			#DIV/0!
<Community D>	Select Yes/NO			#DIV/0!
<Community E>	Select Yes/NO			#DIV/0!
<Community F>	Select Yes/NO			#DIV/0!
<Community G>	Select Yes/NO			#DIV/0!
<Community H>	Select Yes/NO			#DIV/0!
<Community I>	Select Yes/NO			#DIV/0!
<Community J>	Select Yes/NO			#DIV/0!
<Community K>	Select Yes/NO			#DIV/0!
<Community L>	Select Yes/NO			#DIV/0!
<Community M>	Select Yes/NO			#DIV/0!
<Community N>	Select Yes/NO			#DIV/0!
Total		0	0	#DIV/0!

Is this part of a designated area*
Is this area designated under the French Language Services Act? If unsure, please see link below.
http://www.e-laws.gov.on.ca/html/statutes/french/elaws_statutes_90f32_f.htm#schedule

HSP French Language Services Implementation Plan

>

General Information

1,1 Name of HSP

Facility ID of HSP

Full address of HSP

1,2 Name and Position of contact person completing this plan

1,3 Are you an identified or designated HSP?

See "Glossary" tab in this document for more definition.

► Select among the 3 below

HSP French Language Services Implementation Plan

>

1,4 Do you have a mechanism or mechanisms to identify a French-speaking client?

► Choose below:

Please describe any formal or informal processes

1,5 Number of clients who received services in the last fiscal year

Total clients	
Francophone Clients	
%	#DIV/0!

1,6 Description of the HSP's most common response to a request for services in French	"X" the ones that apply
No action	
Use of family member or volunteer resources as interpreter	
Use of staff as interpreter	
Services provided in French by existing French-speaking health professional or non-health professional staff	
Professional interpretation services	
Referral to other HSPs that provide FLS	
Other	

Please describe

Key Results Areas

2,1 Knowledge and Awareness

a. Staff:

Describe HSP planned actions to improve staff awareness of the needs and concerns of Ontario's Francophone population - include resources available to staff members (including new recruits), to familiarize themselves with the principles and requirements of the FLSA.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

HSP French Language Services Implementation Plan

>

b: Public

Describe HSP planned action to improve the FS population's awareness of FL services provided by the HSP.
(include information related to availability of programs in French, complaint resolution mechanisms to support resolution of issues pertaining to the delivery of FLS)

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

HSP French Language Services Implementation Plan

>

2,2 FLS Capacity

a. Staff:

Describe HSP planned actions to improve capacity to provide an "active offer" and delivery of high-quality services in French. Please submit any relevant material with this plan.	"X" the ones that apply

The attached materials are:	
a Human Resources plan for each program or service that includes the identification of current capacity and future needs	
HR policies for FLS that describe staffing, recruitment and retention, assessment of language proficiency	
<Insert attached document name>	
<Insert attached document name>	
<Insert attached document name>	
<Insert attached document name>	
<Insert attached document name>	

HSP French Language Services Implementation Plan

>

b. Governance and Management:

Describe HSP planned actions to improve representation of FS members on its board, committees and senior management team.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

c. Other:

Describe HSP planned actions to improve representation of FS members throughout its other organizational and operational structures (e.g. volunteer services).

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

d. Purchase of Services (if applicable)

Describe planned actions to improve the purchase of services process (RFP, client satisfaction, FLS capacity)

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

HSP French Language Services Implementation Plan

>

2,3 Francophone Community Engagement

Describe HSP planned community engagement activities to ensure an active participation of Francophones in needs assessment and identification of priorities in the development of programs, services and initiatives.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

HSP French Language Services Implementation Plan

>

2,4 FLS Integration / Coordination

a. Integration:

Describe HSP planned actions to improve integration of FLSA principles and the needs and concerns of Francophone clients in the planning and delivery of services.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

b. Responsiveness:

Describe HSP planned actions to improve its response to the needs identified by the Francophone community and the LHIN.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

c. Inter-Agency FLS Coordination:

Within the framework of the LHIN's integration strategy, describe HSP planned actions to improve interaction with other HSPs or other organizations within the LHIN geographic area or neighbouring LHINS to provide services to the Francophone community.

Please indicate timeframe

► Implementation of this Result Area to be completed by …

Describe any associated risks and mitigation strategies

Additional Comments

Please describe any other planned actions/initiatives not captured above to improve Francophone access to services.

HSP French Language Services Implementation Plan

>

Data for LHIN and Ministry purposes	
Please indicate total time spent in completing this plan	
How many people were involved in completing this plan	

***** END OF HSP IMPLEMENTATION PLAN*

Glossary

Term	Definition
Active Offer	According to the Office of Francophone Affairs, an active offer of FLS is provided in the context of planned activities that are; results-oriented, integrated into an agency's overall service delivery model, proactive, the result of a dialogue with the population served, a reflection of the needs of the population, and in place for the life-cycle of the service or initiative. It is important to underline that an active offer of FLS is just that – it is offered by the agency staff; the onus is not on the member of the public to request services in French. http://intra.ofa.gov.on.ca/documents/GuidetoanActiveOfferofFLS_080424.doc
Catchment Area	The area for which the HSP provides services.
Designated HSP	A HSP designated by regulation under the *French Language Services Act* to provide services in French.
Francophone	A person for whom French is the first language or one of first the languages the person learned at home in childhood and still understands (Statistics Canada) or who has neither English nor French as his/her mother tongue but for whom French is the first official language spoken (Statistics Canada) or for whom French is the preferred official language of communication.
French-speaking Health Professional	A health professional with sufficient proficiency in French to provide quality professional services to patients and clients in that language
Identified HSP	A HSP that has been directed by the former Health Services Restructuring Commission or identified by the former District Health Council or the LHIN to provide services in French.
Partially Designated	This applies to HSPs in which some programs or services have been designated under the FLSA to be provided in French.

A list of identified and designated HSPs is available at http://www.health.gov.on.ca/english/public/program/flhs/identified_mn.html or from your LHIN website

Acronyms

Acronyms	Explanation
FL	French Language
FLHS	French Language Health Services
FLS	French Language Services
FLSA	*French Language Services Act*
FS	French-speaking
HR	Human Resources
HSP	Health Service Provider
IHSP	Integrated Health Service Plan
LHIN	Local Health Integration Network
LHSIA	*Local Health System Integration Act*
MOHLTC	Ministry of Health and Long-Term Care
OFA	Office of Francophone Affairs

Testing ALT symbols in Excel

	Arial			
1	☺	30	▲	
2	☻	31	▼	
3	♥	32		
4	♦	33	!	
5	♣	34	"	
6	♠	35	#	
7	•	36	$	
8	◘	37	%	
9	○	38	&	
10	◙	39		
11	♂	40	(	
12	♀	41	)	
13	♪	42	*	
14	♫	43	+	
15	☼	44	,	
16	►	45	-	
17	◄	46	.	
18	↕	47		
19	‼	48	↕	
20	¶	49		1
21	§	50		2
22	▬			
23	↨			
24	↑			
25	↓			
26	→			
27	←			
28	∟			
29	↔			

MINISTRY OF HEALTH AND LONG-TERM CARE

FRENCH LANGUAGE SERVICES

DESIGNATION PLAN

FINAL COPY

Name of organization:

Date:

INTRODUCTORY NOTE

The Ministry of Health and Long-Term Care French Language Services Designation Plan is a tool to be used by transfer payment agencies when requesting official designation under the French Language Services Act.

Agencies wishing to use this plan as a submission for designation, should forward a copy of the plan, approved by the agency's board, to their Local Health Integration Network who, after approving it, will forward it to the Office of the Manager, French Language Services at the Ministry of Health and Long-Term Care. The plan should be accompanied by a letter indicating that all services for which the agency intends to be designated are available on a permanent basis and that the agency accepts to be designated. The plan must then prove the availability and permanency of these services.

EXPLANATORY NOTES

Please answer all questions pertaining to your agency. In this plan, French-speaking refers to individuals capable of communicating in French, regardless of their mother tongue.

This plan has been devised to be used mainly in a hospital setting. However, it can be used/adapted by other types of health agencies. Physicians employed by the agency should be considered throughout this plan as regular employees of the agency.

If the allotted space is insufficient, please attach your answer on another page.

TABLE OF CONTENTS

Page

SECTION 1
AGENCY INFORMATION

A. HISTORY (Provide a short history of your agency)

B. AGENCY DESCRIPTION

1. Name and full address of your agency. (Name of agency as it appears in the incorporation documentation).

2. Name(s) and position(s) of person(s) completing this French language health services designation plan.

3. Name(s) and position(s) of contact person(s) within your agency, if different from above.

4. Specify the type or category of your agency and the number of beds, if applicable.

	# beds
Community hospital	
Teaching hospital	
Nursing home	
Canadian Mental Health Association	
Community mental health program	
Health service organization	
Community health centre	
Other (specify)	

5. List all programs and services your agency provides. (Hospitals refer to Appendix A).

6. Briefly describe any areas of specialized or unique services your agency provides in the community.

7. List the services for which this French language health services designation plan is being submitted.

8. Please define your catchment area and include the percentage of this population which is French-speaking. Please list Statistics Canada Census information only.

9. Indicate the number of clients requesting services within your agency in the previous fiscal year.

	Total	French-speaking	%
on an inpatient basis			
on an outpatient basis			

C. ADMINISTRATIVE STRATEGIES

1. **To ensure that your agency plans and provides services in French, your by-laws should include a detailed statement on the provision of French language services.**

   Please provide the wording or a copy of the by-laws or the statement on the provision of French language services. Appendix_____

2. **A mechanism should be in place in order for your agency to identify its French-speaking clients. This mechanism could consist of the patient information form including a question pertaining to the language preference of the client.**

   Please explain how they are identified.

3. **A staffing policy will ensure that French-speaking clients will receive services in French at all stages of their visit and/or stay within your agency. Such a policy could state the number of French-speaking employees required to provide a specific service during the hours of service availability.**

   Please attach a copy of your staffing policy highlighting the FLS component. Appendix_____

4. **Your recruitment policy should state the steps which will be undertaken to recruit employees capable of providing services in French. These steps include advertising in English and French newspapers such as La Presse, Le Droit, the Globe & Mail, the Toronto Star and your local newspaper, and indicating in advertisements that proficiency in English and French is an asset or requirement.**

   Please attach a copy of your recruitment policy highlighting the FLS component. Appendix_____

5. **Your hiring policy should state the steps which will be undertaken to hire employees capable of providing services in French. These steps include interviewing candidates in English and French and evaluating the English and French oral and written (if necessary) capability of candidates.**

   Please attach a copy of your hiring policy highlighting the FLS component. Appendix_____

6. **French-speaking representation on boards and committees ensures the needs of the French-speaking community are reflected in the decision-making process. Thus, French-speaking representatives should be culturally sensitive to issues pertaining to the French-speaking community.**

Board and committee representation should reflect the French-speaking community within the population served. However, a minimum of 1 French-speaking member for boards and committees consisting of less than 10 members and a minimum of 2 French-speaking members for boards and committees consisting of 10 members or more should be maintained at all times. This type of policy should be reflected in the by-laws of your agency.

Please indicate the total number of board members within your agency.

How many of the total number are French-speaking?

Please attach a copy of the by-laws highlighting FLS representation component.
Appendix_____

7. **To meet the needs of the French-speaking community, French-speaking individuals should be represented at the senior management level and at the management level of each department/unit which will provide services in French. This representation should reflect the French-speaking community within the population served. French-speaking representation should consist of at least one French-speaking individual at each of the management levels discussed above. This type of policy should be included in the by-laws of your agency.**

   Please attach a copy of the by-laws or policy highlighting this component.
   Appendix_____

8. **To facilitate planning for the provision of French language services, the Ministry of Health and Long-Term Care encourages the establishment of a French Language Services Committee within your agency. The Committee should consist of French-speaking health care providers, board representatives and possibly consumers. (Please refer to Appendix B for an example of terms of reference.)**

   Does your agency have a French Language Services Committee?
   Yes _____ NO _____

   If yes, please describe or attach its mandate and composition.
   Appendix_____

9. **An individual at the senior management level should be accountable for the provision of French language services.**

   Who is accountable within your agency for ensuring the provision of services in French?
   Name:

   Position:

SECTION 2
DIRECT SERVICES TO FRENCH-SPEAKING CLIENTS

A. SWITCHBOARD

In order to inform the public of the availability of French language services within your agency, the switchboard should be capable of answering all inquiries in English and French, such as "Hospital XYZ, bonjour" and "Un moment s'il vous plaît" (one moment please). Until the switchboard is capable of providing this service in French on a permanent basis, a mechanism could be in place to transfer the call to an employee capable of handling the call in French.

(i) Identify the capabilities of your employees to provide oral services in French by completing Appendix C (Parts 1 & 2).

(ii) Indicate the hours during which this particular service is provided, such as 24 hours a day or from 8:00 a.m. to 5:00 p.m. weekdays.

(iii) How does your current human resources enable you to offer this service in French during hours of operation?

B. RECEPTION (OVER THE COUNTER SERVICES

Services at the main reception, as well as in areas that have been identified to provide French language services, should be provided in French. The following must be answered for every reception area in each department or unit which has been identified to provide services in French. (Please photocopy as required.)

(i) Name of reception area (such as main reception or reception for a particular department or unit).

(ii) Identify the capabilities of your employees to provide oral services in French by completing Appendix C (Parts 1 & 2).

(iii) Indicate the hours during which this particular service is provided, such as 24 hours a day or from 8:00 a.m. to 5:00 p.m. weekdays.

(iv) How does your current human resources enable you to offer this service in French during hours of operation?

C. PHYSICIANS

(i) Please indicate the total number of physicians with privileges at the following oral French proficiency levels. (Please refer to Appendix D for a description of the levels.)

_____ no proficiency
_____ elementary level
_____ intermediate level
_____ advanced level
_____ superior level

(ii) When granting privileges, how does your agency strive to consider French-speaking physicians?

(iii) What mechanism does your agency have to recruit or attract French-speaking physicians from within Ontario, other provinces or countries?

D. OTHER DIRECT SERVICES

The following must be answered separately for every service which will be provided in French, such as emergency, psychiatry, and physiotherapy. Please also address how auxiliary services will be provided in French. (Please photocopy as required.)

(i) Name of service. (Please indicate if the service is unique in your region.)

(ii) Identify the capabilities of your employees to provide oral services in French by completing Appendix C (Parts 1 & 2).

(iii) Indicate the hours during which this particular service is provided, such as 24 hours a day or from 8:00 a.m. to 5:00 p.m. weekdays.

(iv) How does your current human resources enable you to offer this service, including auxiliary services, in French during hours of operation?

SECTION 3
OTHER PERTINENT SERVICES TO FRENCH-SPEAKING CLIENTS

A. COMMUNICATION STRATEGIES

1. **A strategy should have been developed to inform the public of the services offered in French within the agency. This may include the publication of brochures listing the services available in French.**

   What is your agency's strategy to inform the public of the services offered in French within the agency?

2. **This section should be completed for all services and related services which will be offered in French to French-speaking clients.**

(A) INTERIOR SIGNAGE

All interior signage in areas accessible to the public and where services will be provided in French should be available in French. Please note that this includes directional signs leading to the service which will be provided in French, as well as the main and floor directories. English and French or international symbols are acceptable.

i) Is all your interior signage identifying or leading to areas where services will be provided in French available in English and French or international signage.

Yes _____ No _____

EXTERIOR SIGNAGE

Exterior signs in areas accessible to the public, such as your agency's main sign, should be available in English and French or international symbols. For agencies which are or will be providing a limited number of services in French, the availability of English and French exterior signs is encouraged.

i) Are all your exterior signs accessible to the public currently in English and French or international symbols?

Yes _____ No _____

(B) I.D. BADGES

A mechanism should be in place to inform the public and clients of employees capable of communicating in French. Examples of mechanisms include employees capable of providing services in French wearing English and French I.D. badges, or wearing a button indicating they speak French, such as 'Je parle français' (I speak French).

i) Does your agency have a mechanism to inform the public and clients of employees capable of providing services in French?

Yes _____ No _____

Please describe or provide sample.

(C) BUSINESS CARDS

In order to inform the public and clients of their ability to communicate in French, the business cards of employees capable of providing services in French should be available in both languages.

i) Does your agency have English and French business cards for staff capable of providing services in French?

Yes _____ No _____

Please describe or provide sample.

(D) FORMS AND DOCUMENTS

All forms and documents destined to the public and clients should be available in French. Whenever possible, documents should be available in bilingual format. These include stationery, letterhead, pamphlets, brochures, reports, annual reports, and standard forms.

i) Are all of your agency's forms and documents destined to the public and clients available in French?

Yes _____ No _____

(E) INFORMATION SERVICES

All information destined to the public and clients should be available in French. These include audio-visual materials, exhibits, speeches, news releases, and advertisements.

i) Are all of your agency's information services destined to the public and clients available in French?

Yes _____ No _____

Please list if there are any exceptions.

(F) SUPPLIES AND EQUIPMENT

Appropriate supplies and equipment are needed to provide services in French. These may include word processors, typewriters with French keyboards, software, dictionaries, and reference documents.

i) Are the appropriate supplies and equipment necessary to provide services in French available within your agency?

Yes _____ No _____

Please describe.

B. CORRESPONDENCE

Correspondence destined to the public or clients should be available in French. All correspondence received in French must be answered in French.

1 - DRAFTING OF FRENCH WRITTEN MATERIALS

i) Please indicate how this service is provided.

2 - TYPING OF FRENCH WRITTEN MATERIALS

i) Please indicate how this service is provided.

3 - REVISION AND APPROVAL OF THE FINAL VERSION OF FRENCH WRITTEN MATERIALS

i) Please indicate how this service is provided.

SECTION 4
OTHER INFORMATION

State any other information you believe is pertinent to the provision of French language services within your agency.

DATE COMPLETED:

SIGNATURE:

SECTION 5
DOCUMENTATION CHECKLIST:

Copy of agency's incorporation certificate _____

Copy of agency's letters patent _____

Letter from agency requesting designation _____

Letter from the LHIN re: designation request _____

Agency's Board resolution requesting designation _____

APPENDIX A
LIST OF HOSPITAL DEPARTMENTS/SERVICES

(Please note that this is not an exhaustive and complete list of hospital departments / services).

Ambulance
Ambulatory care
Anaesthesia
Audiology
Cardiology
Cardiopulmonary care
Cardiothoracic surgery
Chiropody
Dentistry
Dermatology
Detoxification
Diagnostic imaging
Dietetics
EEG
Emergency
Endocrinology/metabolism
Family medicine
Forensic medicine
Gastroenterology
General psychiatry
Gerontology/geriatrics
Gynaecology/obstetrics
Infertility
Intensive care
Laboratory
Neonatology
Nephrology
Neurology
Neurophysiology
Neuropsychiatry
Neuropsychology
Neurosurgery
Nuclear medicine
Occupational therapy
Oncology
Ophthalmology
Orthopaedic surgery
Orthotics & prosthetics
Otorhinolagyngology
Paediatrics
Paediatric psychiatry
Palliative care
Pastoral
Pharmacy
Physiotherapy
Plastic surgery
Psychiatric rehab.
Psychology
Rehabilitation
Research
Respiratory therapy
Respite care
Rheumatology
Social work
Specialized psychiatry
Speech therapy
Surgery
Urology
Vascular surgery
Vocational rehab.
Volunteers

APPENDIX B
(SAMPLE) TERMS OF REFERENCE

FRENCH LANGUAGE HEALTH SERVICES COMMITTEE - HEALTH AGENCIES

(*Please note: The following is an example of Terms of Reference for the French Language Health Services Committee of health agencies. The Committee may use this example as a reference.)*

GOAL: To establish and maintain effective French language health services in the agency, and ensure the continued availability, permanence and quality of these services.

OBJECTIVES:

1. **To assist the Local Health Integration Network in meeting its objectives of ensuring access and accessibility of French language services within its geographic area.**

2. **To provide direction and advice to the French language services coordinator (if applicable) in the development of an implementation plan for the agency or in the preparation of a designation submission.**

3. **To establish time frames within which implementation plans or designation submissions will be submitted.**

4. **To develop and implement policies and procedures which facilitate the provision of French language health services.**

5. **To maintain an effective organizational structure to provide for the appropriate flow of information to the Board concerning French language services.**

6. **To review annually the current status of French language services.**

7. **To advise the Local Health Integration Network through the coordinator (if applicable) on the continued development and maintenance of French language health services within the agency.**

MEMBERSHIP:

- **2 members from the Administration Department of the health agency,**
- **French Language Services Coordinator,**
- **3 members from the Paramedical and Support Departments,**
- **2 members from the Department of Patient Services,**
- **other resource persons could attend as needed.**

APPENDIX C
HUMAN RESOURCES PLAN - PART 1

Name of Service: _____

Specify category of personnel, total number of each and work schedule.

APPENDIX C HUMAN RESOURCES PLAN - PART 1		
PERSONNEL	**FULL-TIME**	**PART-TIME**
Physicians: (specialty)		
Audiologists		
Dieticians		
Laboratory technicians		
Occupational therapy		
Orderlies		
Pastoral services		
Pharmacists		
Physiotherapists		
Psychologists		
Psychotherapists		
Radiology technicians		
Respiratory technicians		
RNs		
RPNs		
Secretaries		
Social workers		
Speech pathologists		
Stenographers		
Volunteers		
Other: (specify)		

APPENDIX C
HUMAN RESOURCES PLAN - PART 2

Name of Service: _____

Positions for which French language proficiency IS REQUIRED (SEE APPENDIX D & E FOR LEVELS):

POSITION	WORK SCHEDULE	PRESENT FRENCH LANGUAGE CAPABILITY LEVEL		REQUIRED FRENCH LANGUAGE CAPABILITY LEVEL	
	FT, PT, Other	ORAL	WRITTEN (if required)	ORAL	WRITTEN (if required)

APPENDIX D
FRENCH LANGUAGE ORAL CAPABILITY LEVELS

No proficiency:

At this level one possesses no ability to work or communicate in French.

Elementary level:

At this level one has no real autonomy of expression. The ability to speak is limited to some memorized material on familiar topics related to work. One is able to verbalize isolated words, expressions of two or three words, and express simple, unconnected sentences. The range of vocabulary is limited and the delivery is slow and awkward. One can handle greetings, leave taking, and other expressions of courtesy. The limited vocabulary, the frequent errors, and slow delivery severely inhibit communication.

Intermediate level:

At this level one possesses some ability to work in French. One shows some spontaneity in language production but the fluency is very uneven resulting in halting speech. One is able to participate in simple conversations on a one-to-one basis. The vocabulary is limited to that used in simple, non-technical, daily conversational usage. One can make and answer requests for information or directions, give simple instructions and discuss simple needs. When addressing this person the speaker may have to slow down and repeat if he/she wishes to be understood.

Advanced level:

At this level one has the ability to participate in conversations and satisfy many work requirements. One can discuss work related matters with some ease and facility, expressing opinions and offering views. One is able to take part in a variety of verbal exchanges and to participate in meetings and discussion groups. However, one still needs help with handling complications and difficulties. One is generally good in either grammar or vocabulary but not in both.

Superior level:

At this level one has the ability to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations on practical, social and professional topics. One is able to give verbal presentations in both formal and informal settings. One masters some idioms and specific vocabulary relevant to a variety of contexts.

APPENDIX E
FRENCH LANGUAGE WRITTEN CAPABILITY LEVELS

No proficiency:

At this level one possesses no ability to write in French.

Elementary level:

At this level one is able to write a few words, maybe sentences on topics related to work, maybe with the help of a dictionary. One can fill in forms, give general information such as time and location of meetings and notices of cancellation using a standard format. Vocabulary is limited to daily use with no mastery of idiomatic expressions. One has no practical communicative writing skills. One cannot produce French text.

Intermediate level:

At this level one is able to write words and simple sentences. One can make and answer simple requests for information. The vocabulary is limited to that of daily general use. One often experiences problems with grammar and spelling. One is able to meet some practical elementary writing needs but cannot produce acceptable French text.

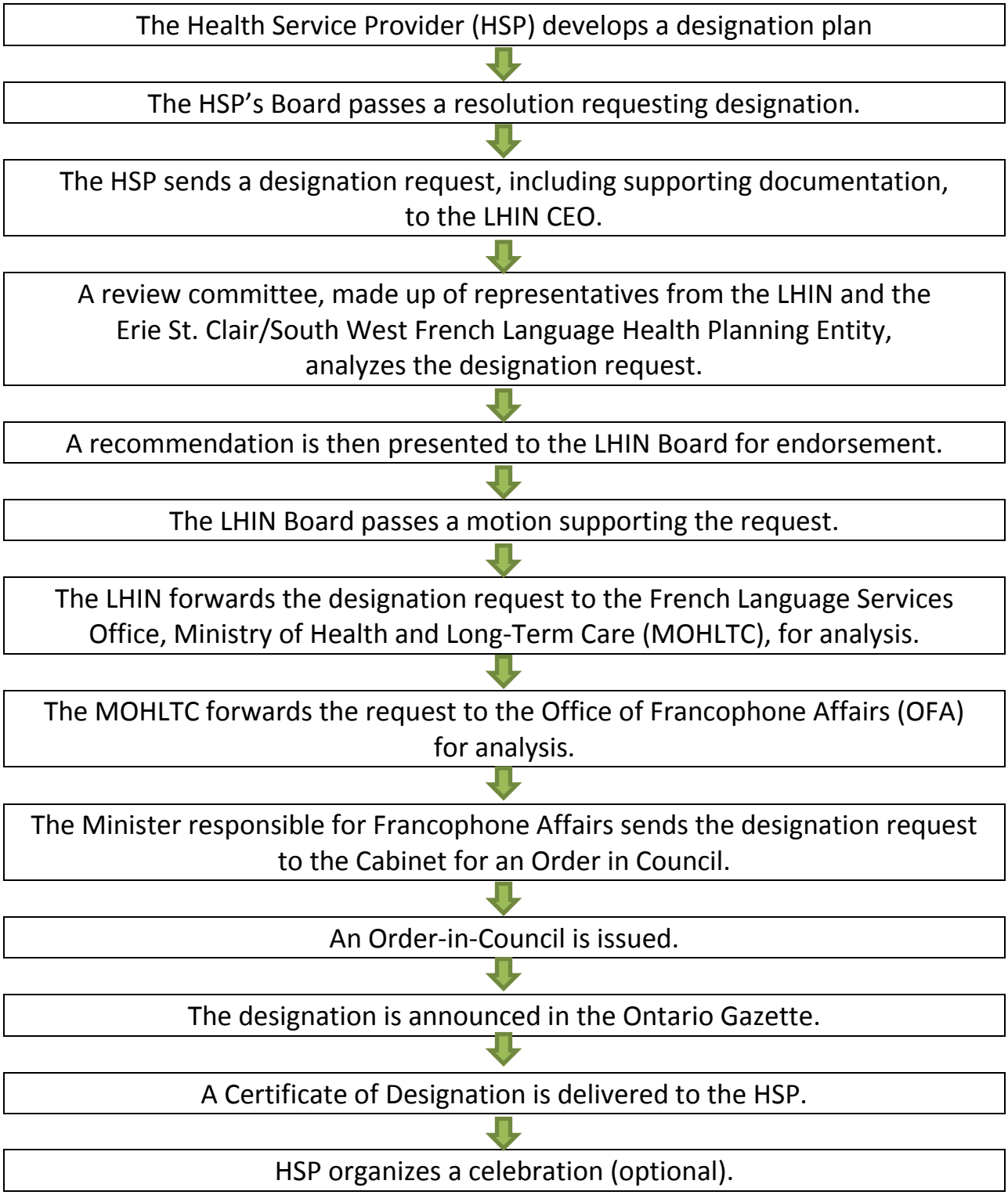
Advanced level:

At this level one is able to use a variety of sentence types to express general ideas and opinions on non-specialized topics. One can write simple letters and reports required of the position. Although still hesitant, one experiences few problems with either grammar or spelling. However, the writing may resemble literal translations. Nevertheless, a sense of organization is emerging and one is beginning to sense what is stylistically and grammatically correct in French.

Superior level:

At this level one is able to express oneself effectively in most formal and informal writing on practical, social and professional topics. One is able to recognize awkwardness in sentence structure and paragraphs. Errors in grammar and spelling are minor and infrequent.

Designation Process
Requesting designation under the French Language Services Act



A SELF-ASSESSMENT TOOL – IMPLEMENTATION OF FRENCH LANGUAGE SERVICES

The self-assessment tool

The self-assessment tool covers common aspects of service delivery in French, from direct service delivery like counter and telephone services to less tangible but equally important aspects like business and operational planning and program and policy development. The service delivery standards used are set out in general government policies like the *Practical Guide to French Language Services* developed by the FLS Office of the MOHLTC. These standards reflect the underlying principle of FLS: service in French must be equivalent in quality and availability to service in English.

Instructions for completing the self-assessment tool

The self-assessment tool has two parts. First, it asks you to assess how well you meet expectations and includes space for your comments in the right column. And second, on the last page, it asks you to create an action plan to remedy the three most important gaps or challenges your assessment reveals.

The tool can be used to survey the capacity to provide services in your various departments and programs over the year. Depending on the size of your organization, you can use one self-assessment for the entire organization or one per department.

Please assess your FLS performance on the following scale*:

Not sure	Never	Rarely	Usually	Most of the time	Always	Not applicable
N/S	1	2	3	4	5	N/A

*Note: For certain standards, a different scale is used.

Circle (or "x") the appropriate rating in the second column and insert your comments, as appropriate, in column 3. If you are completing the report electronically, the space will expand to fit your comments.

Adapted from *French Language Services at the Ministry of Health and Long-Term Care: Service Quality Self-Assessment*, January 2001

SELF-ASSESSMENT TOOL

Division/Branch/Unit: _____

Standard	Rating							Comments	
Frontline Services	N/S = Not sure 1 = Never		2 = Rarely 3 = Usually					4 = Most times 5 = Always	N/A = Not applicable
(reception, telephone, counter)									
1. All frontline staff invite clients to use their preferred language of service by using a bilingual greeting:									
On the telephone	N/S	1	2	3	4	5	N/A		
In person/at the counter	N/S	1	2	3	4	5	N/A		
In recorded messages (IVR/voice mail)	N/S	1	2	3	4	5	N/A		
2. A sign is prominently posted to let clients know service is available in both English and French	N/S	1	2	3	4	5	N/A		
3. Signage intended for the public is posted in bilingual format and is correct in both languages	N/S	1	2	3	4	5	N/A		
4. Displays of posters and brochures are in both English and French	N/S	1	2	3	4	5	N/A		
5. French or bilingual versions of all public forms are available at the front counter	N/S	1	2	3	4	5	N/A		
6. Services delivered to the public are available in English and French during all business hours and are of equal quality:									
On the telephone	N/S	1	2	3	4	5	N/A		
In person/at the counter	N/S	1	2	3	4	5	N/A		
In writing	N/S	1	2	3	4	5	N/A		
Electronically (including on the Internet)	N/S	1	2	3	4	5	N/A		
Correspondence									
7. My office answers all French correspondence in French in 15 working days	N/S	1	2	3	4	5	N/A		

Adapted from *French Language Services at the Ministry of Health and Long-Term Care: Service Quality Self-Assessment*, January 2001

Customer Feedback/Complaint Resolution	N/S = Not sure 1 = Never	2 = Rarely 3 = Usually	4 = Most times 5 = Always	N/A = Not applicable
8. My customer feedback tools (e.g. comment cards) are in English and French, in bilingual format	N/S 1 2 3 4 5 N/A			
9. I have a complaints process in place to investigate and resolve complaints about the quality of service in French	N/S 1 2 3 4 5 N/A			
10. I resolve FLS problems identified in complaints and consult FLHS	N/S 1 2 3 4 5 N/A			
Publications/Forms/Ads/Notices				
11. I release all publications simultaneously in English and French in bilingual format (unless exempted).	N/S 1 2 3 4 5 N/A			
12. In publications produced in separate versions, I include a statement on how to obtain the other language version.	N/S 1 2 3 4 5 N/A			
13. I get FLHS's permission before releasing technical/reference documents in English only (OReg 411/97)	N/S 1 2 3 4 5 N/A			

Standard	Rating	Comments
14. The forms and documents my office uses with the public (like certificates, applications, registrations) are printed in bilingual format	N/S 1 2 3 4 5 N/A	
15. I issue all advertising (like tender notices, program ads, PSAs) simultaneously in English and French.	N/S 1 2 3 4 5 N/A	
16. English ads appear in the English media and French ads in the French media (or both in English media where there are no French).	N/S 1 2 3 4 5 N/A	
17. Staff in designated positions have bilingual business cards with English on one side and French on the other	N/S 1 2 3 4 5 N/A	
18. Service in French is available at the numbers listed in the French blue pages for my program/office.	N/S 1 2 3 4 5 N/A	
Consultations/Community Relations/Public Events		
19. I include francophone stakeholders, providers and clients in consultation processes and public information sessions	N/S 1 2 3 4 5 N/A	
20. I assign knowledgeable French-speaking staff to make presentations, facilitate sessions and answer questions in French	N/S 1 2 3 4 5 N/A	
21. Session materials (handouts, presentations, report summaries) are available and distributed simultaneously in English and French	N/S 1 2 3 4 5 N/A	
22. I make sure FLS are provided at public info sessions, focus groups and stakeholder/public consultations in a way that suits community.	N/S 1 2 3 4 5 N/A	

Adapted from *French Language Services at the Ministry of Health and Long-Term Care: Service Quality Self-Assessment*, January 2001

Planning and Accountability for FLS

N/S = Not sure
1 = Never
2 = Rarely
3 = Usually

23. I include FLS considerations in annual and project/program planning and budget processes.	N/S	1	2	3	4	5	N/A		
24. I hold my staff and myself accountable for the quality of FLS in our performance contracts and evaluations.	N/S	1	2	3	4	5	N/A		
25. I include FLS in my office's customer service plans and reporting.	N/S	1	2	3	4	5	N/A		
26. I consult FLHS on FLS issues affecting business, program and policy development and implementation.	N/S	1	2	3	4	5	N/A		
27. I make sure third parties delivering service to the public on behalf of MOHLTC provide service in English and French.	N/S	1	2	3	4	5	N/A		
28. I include FLS requirements in RFPs, agreements and evaluations for all services delivered on our behalf by another party.	N/S	1	2	3	4	5	N/A		
29. I include FLS requirements in RFPs, agreements and evaluations for all services delivered on our behalf by another party.	N/S	1	2	3	4	5	N/A		

Human Resources/Staffing

30. My office has an FLS HR plan with an appropriate level/number of designated positions to ensure all services to the public are available in English and French at all times (including backups).	Y		N		N/A				
31. I establish targets (%, timelines) for implementing the FLS HR plan for my office.	N/S	1	2	3	4	5	N/A		
32. My office follows staffing policies/procedures for designated positions.	N/S	1	2	3	4	5	N/A		
33. Of the designated positions in my office, the incumbents of __% meet the language requirements for their position.				%					
34. My office funds French language training where the request is consistent with branch needs/learning plans and staff career plans.	N/S	1	2	3	4	5	N/A		

Resources

35. My office has established FLS procedures and all staff know them.	N/S	1	2	3	4	5	N/A		
36. I include translation costs in project budgets and allow enough time for translation	N/S	1	2	3	4	5	N/A		
37. Our software packages, keyboards, printers produce French diacritics on both lower and upper case letters and accommodate French grammatical usage and conventions.	N/S	1	2	3	4	5	N/A		

Adapted from *French Language Services at the Ministry of Health and Long-Term Care: Service Quality Self-Assessment*, January 2001

ACTION PLAN

To identify priorities for actions in your action plan, you could focus on the standards to which you have assigned a rating of 1, 2, or 3. These are probably fairly indicative of the areas where you have the greatest gaps or face the biggest challenges.

1. **My agency's most important gap or challenge for delivering service in French is:**

   To remedy this gap or challenge, I plan to:

   My timeline is:

2. **My agency's second most important gap or challenge for delivering service in French is:**

   To remedy this gap or challenge, I plan to:

   My timeline is:

3. **My office's next most important gap or challenge for delivering service in French is:**

   To remedy this gap or challenge, I plan to:

   My timeline is:

Adapted from *French Language Services at the Ministry of Health and Long-Term Care: Service Quality Self-Assessment*, January 2001

Section 4

Human Resources

Section 4
Human Resources

Bilingual human resources are essential to successful delivery of quality services in French.

Steps in Building a Bilingual Staff Complement

- Identifying existing capacity.
- Defining needs.
- Hiring for designated and non-designated positions.
- Retaining bilingual staff.

Identifying Existing Capacity

Most HSPs have French-speaking staff in their organization, but they are not aware of it. Start by developing the linguistic profile of existing staff, and then do the same with all new employees.

Methods of Evaluating Language Skills

Self-Assessment

Employees are asked to indicate their level of proficiency based on definitions of the different levels of competence as established by the Government of Ontario. A sample self-assessment tool and definitions of proficiency levels are provided on pages 143–144.

Informal Evaluation

This method involves one staff member with superior French-language skills asking questions in French to another staff member. Using definitions of levels of competence on pages 143–144, the first staff member assesses language skills of the second employee. This method is usually used during the interview process, but it could also be used to establish the linguistic profile of all staff members. The Erie St. Clair or South West LHINs' French Language Services Coordinator can also support HSPs with an informal evaluation of language skills.

Formal Evaluation

This method involves hiring a professional evaluator to conduct a formal linguistic evaluation based on strict criteria and is usually used as part of the hiring process for designated positions. In a unionized workplace, this method should be privileged to avoid potential grievances. The Erie St. Clair or South West LHINs' French Language Services Coordinators can provide some assistance to HSPs in finding professional evaluators.

> ***1. Bona fide occupational requirement***
>
> *The Ontario Human Rights Commission recognizes that proficiency in a certain language may be a reasonable and legitimate requirement for employment… Fluency in a particular language could be a bona fide requirement in some employment or service situations."*

Ontario Human Rights Commission, www.ohrc.on.ca/en/policy-discrimination-and-language/language-related-grounds-discrimination-ancestry-ethnic-origin-place-origin-race.

Defining Needs

Using a template such as the one provided on pages 145–146, develop a human resource plan for each department.

Looking at the staff complement, determine the number of French-speaking staff members needed to provide services in French. Consider all the different job categories as well as coverage during vacation or illness. Francophone clients/patients should have access to comprehensive services in French during all hours of operations.

Designate these positions for the delivery of services in French and make proficiency in French a job requirement. The next time these positions become vacant, look for bilingual candidates. In the meantime, encourage employees holding these positions to learn French, if they are not bilingual. Please refer to Section 5 for more information on French language training.

Once positions have been designated, establish the linguistic profile, oral and written, for each position. Consider the role and nature of contact with patients/clients and the public. As an illustration, for a communication officer in charge of preparing press releases and communicating with the media, superior oral and written skills are a must and for a triage nurse at the emergency department, superior oral skills are required. A minimum of an advanced level is required to communicate with ease.

For more information, please refer to *Staffing and Managing Designated Positions, A Practical Guide for Managers* produced by the Office of Francophone Affairs on pages 147–167.

Hiring for Designated and Non-Designated Positions

When a position becomes vacant, if it is a designated position, ensure that proficiency in French is a requirement and include in the job description and posting a statement such as "This is a designated position. Proficiency in Canada's two official languages is required." The job posting should be available in both English and French. If the position is not designated, a statement like "Priority consideration will be given to candidates who are proficient in Canada's two official languages" or "Proficiency in French is an asset" could be added.

When advertising, consider placing the posting in English and French newspapers. There are French community newspapers in a number of communities across Ontario and Canada (see list on pages 357–359). Locally, *Le Rempart* with a circulation of 7,500 serves the Windsor-

Essex-Chatham-Kent area and *L'Action* with a circulation of 4,000 serves the London-Sarnia area (marketing@altomedia.ca).

Other options to advertise:[10]

- *Employment Options Emploi*, bilingual employment services offered through Collège Boréal in Windsor (519 988-1766 or 519 252-1308) and London (519 672-1562).
- *CliquezSanté*, www.cliquezsante.ca/en.
- *Le bloc-notes*, leblocnotes@nexussante.ca.
- *TFO*, Ontario French public television, www.tfo.org (requires a facebook account).
- *Thehealthline.ca*, www.southwesthealthline.ca, in the South West LHIN area – in the Health Careers section.
- *Thehealthline.ca*, www.eriestclairhealtline.ca, in the Erie St. Clair LHIN – job posting option to be available soon.
- *HealthForceOntario*, www.hfojobs.ca/default.aspx.
- Colleges and universities offering specific programs are an excellent way of reaching out to new or recent graduates and alumni. There are several colleges and universities offering French post-secondary education programs (see list on page 355).
- Secrétariat international des infirmières et infirmiers de l'espace francophone (SIDIIEF), info@sidiief.org.
- Email distribution.
- *LinkedIn*.
- *Charity Village* and other similar websites.
- Erie St. Clair LHIN website, 519 351-5677.

Retaining Bilingual Staff

Increased job satisfaction will help with the retention of bilingual staff. They are more likely to remain in the organization's employ when:

- Delivery of services in French is part of their normal duties and French-speaking patients/clients are assigned to them.
- Delivery of services in French is not an additional workload.
- French-language training opportunities are offered.
- Professional development opportunities in French are available.
- Etc.

The *Regroupement des intervenantes et intervenants francophones en santé et en services sociaux de l'Ontario* (RIFSSSO) has developed a useful HR Support Kit, available online at www.rifssso.ca/ressources/publications/ressources-docs/trousse-d%E2%80%99appui-rh-vers-un-service-bilingue/.

10 The list is not comprehensive.

Section 4

List of Appendixes

Staff Survey – French-language skills

French Language Oral and Written Capability Levels

Human Resources Plan

Staffing and Managing Designated Positions, A Practical Guide for Managers

Staff Survey – French Language Skills

To be completed by all employees.

(Name of agency) is required by the *French Language Services Act* to provide services in French to the Francophone population.

Please help us assess our current capacity by completing the survey below and returning to your Departmental Manager by (date).

The information will be used to plan the delivery of services in French. It will remain confidential. We also ask that you keep the HR Department informed of any training that you might take in the future to upgrade your skills.

Based on the definitions provided, please indicate your linguistic abilities. Check one box under "Oral Skills" and one box under "Written Skills".

Thank you.

Name:	Enter name	**Date:**	Enter date of completion
Position:	Enter title of position	**Status:**	Choose F/T or P/T
Department:	Enter name of department		
Profession:	Enter professional title, if different than above		

Answer	Level	Description
ORAL SKILLS		
●	**No proficiency**	▪ No ability to communicate in French.
●	**Elementary**	▪ Has limited ability to speak - some memorized material on familiar topics related to work. ▪ Able to verbalize isolated words and two or three word expressions (e.g. greetings, expressions of courtesy). ▪ Can express simple, unconnected sentences. ▪ Limited vocabulary, frequent errors and slow delivery inhibit communication.
●	**Intermediate**	▪ Has some ability to work in French. ▪ Shows some spontaneity in language production, but fluency is uneven and speech is halting. ▪ Able to participate in simple conversations on one-to-one basis. ▪ Limited vocabulary – simple, non-technical daily conversational usage. ▪ Able to make/answer requests for information or directions and to give simples instructions.
●	**Advanced**	▪ Able to participate with some ease in conversations on work-related matters and to express opinions. ▪ Can participate in meetings and discussion groups. ▪ May still need some assistance with complicated or difficult conversations.
●	**Superior**	▪ Can speak with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations on all topics. ▪ Able to give verbal presentations in both formal and informal settings.
WRITTEN SKILLS		
●	**No proficiency**	▪ No ability to write in French.
●	**Elementary**	▪ Able to write a few words, perhaps sentences on work-related topics, maybe with the help of a dictionary. ▪ Can complete forms, giving general information (e.g. time and location of meetings) using a standard format. ▪ Vocabulary is limited to daily use. ▪ Has no practical communicative writing skills.
●	**Intermediate**	▪ Able to write words and simple sentences. ▪ Can make/answer simple requests for information. ▪ Vocabulary is limited to daily use. ▪ Often experiences problems with grammar and spelling. ▪ Able to meet some practical elementary writing needs.
●	**Advanced**	▪ Able to use a variety of sentence types to express general ideas and opinions on non-specialized topics. ▪ Can write simple letters and reports, with little grammar and spelling errors. ▪ Able to write with some sense of organization and stylistics.
●	**Superior**	▪ Able to express oneself effectively in most formal and informal writing on all topics. ▪ Errors in grammar and spelling are minor and infrequent.

FRENCH LANGUAGE ORAL CAPABILITY LEVELS

No proficiency: At this level, one possesses no ability to work or communicate in French.

Elementary level: At this level one has no real autonomy of expression. The ability to speak is limited to some memorized material on familiar topics related to work. One is able to verbalize isolated words, expressions of two or three words, and express simple, unconnected sentences. The range of vocabulary is limited and the delivery is slow and awkward. One can handle greetings, leave taking, and other expressions of courtesy. The limited vocabulary, the frequent errors, and slow delivery severely inhibit communication.

Intermediate level: At this level one possesses some ability to work in French. One shows some spontaneity in language production but the fluency is very uneven resulting in halting speech. One is able to participate in simple conversations on a one-to-one basis. The vocabulary is limited to that used in simple, non-technical, daily conversational usage. One can make and answer requests for information or directions, give simple instructions and discuss simple needs. When addressing this person the speaker may have to slow down and repeat if he/she wishes to be understood.

Advanced level: At this level one has the ability to participate in conversations and satisfy many work requirements. One can discuss work related matters with some ease and facility, expressing opinions and offering views. One is able to take part in a variety of verbal exchanges and to participate in meetings and discussion groups. However, one still needs help with handling complications and difficulties. One is generally good in either grammar or vocabulary but not in both.

Superior level: At this level one has the ability to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations on practical, social and professional topics. One is able to give verbal presentations in both formal and informal settings. One masters some idioms and specific vocabulary relevant to a variety of contexts.

FRENCH LANGUAGE WRITTEN CAPABILITY LEVELS

No proficiency: At this level one possesses no ability to write in French.

Elementary level: At this level one is able to write a few words, maybe sentences on topics related to work, maybe with the help of a dictionary. One can fill in forms, give general information such as time and location of meetings and notices of cancellation using a standard format. Vocabulary is limited to daily use with no mastery of idiomatic expressions. One has no practical communicative writing skills. One cannot produce French text.

Intermediate level: At this level one is able to write words and simple sentences. One can make and answer simple requests for information. The vocabulary is limited to that of daily general use. One often experiences problems with grammar and spelling. One is able to meet some practical elementary writing needs but cannot produce acceptable French text.

Advanced level: At this level one is able to use a variety of sentence types to express general ideas and opinions on non-specialized topics. One can write simple letters and reports required of the position. Although still hesitant, one experiences few problems with either grammar or spelling. However, the writing may resemble literal translations. Nevertheless, a sense of organization is emerging and one is beginning to sense what is stylistically and grammatically correct in French.

Superior level: At this level one is able to express oneself effectively in most formal and informal writing on practical, social and professional topics. One is able to recognize awkwardness in sentence structure and paragraphs. Errors in grammar and spelling are minor and infrequent.

Human Resource Plan – Part I

Name of Service: _____

Specify category of staff, total number of each and work schedule (full time = FT, part time = PT)

	FT	PT		FT	PT		FT	PT		FT	PT

Human Resource Plan – Part II

Name of Service: _____

Positions for which French language proficiency is REQUIRED. (Refer to competency levels.)

Position	Work Schedule (FT, PT, Other)	Present French Language Capacity Level		French Language Capacity Level Required	
		Oral	Written (if required)	Oral	Written (if required)

Staffing and Managing Designated Positions

A Practical Guide for Managers

Office of Francophone Affairs

October, 2002

TABLE OF CONTENTS

1. INTRODUCTION

Under the *French Language Services Act (FLSA)*, French-speaking Ontarians have the right to receive provincial government services in French from central and head offices as well as offices located in or serving designated areas.

The Minister Responsible for Francophone Affairs is responsible for the administration of the *FLSA*, while deputy ministers are accountable for its implementation and the quality of French-language services in their respective ministries.

Managers of program areas with obligations under the *FLSA* must ensure that their program areas have a sufficient number of designated positions filled with bilingual staff to ensure that French-speaking Ontarians have access to services of equal quality to those offered in English.

Staffing and Managing Designated Positions, A Practical Guide for Managers was developed by the Office of Francophone Affairs (OFA). It is the central agency responsible for the development of French-language services guidelines and policies. The *Practical Guide* sets out the steps to manage the main aspects of staffing designated positions effectively. It also includes useful tips, links to key web sites, references to other relevant resources as well as Qs and As. **Please note that where there are variations between this guide and the collective agreement, the relevant collective agreement provisions prevail.**

The *Practical Guide* complements:

- the OFA's *French-language Services Guideline # 4* entitled *Managing Positions Designated to Provide Services in French;*
- the *Staffing Operating Policy,* Management Board Secretariat (MBS); (*)
- *A Manager's Guide to Staffing in the OPS* (MBS),
- *French Language Training and Evaluation Guideline*, (MBS).

For more information on French-language services, contact your ministry's French-language-services Coordinator or visit the OFA's Intranet and Internet sites (*) The OFA would like to thank all those who offered their knowledge, skills, experience and time to the development of this *Practical Guide*.

2. HOW TO DECIDE WHICH POSITIONS SHOULD BE DESIGNATED

In consultation with the ministry's French-language services coordinator and the local human resources consultant, managers should ensure that positions are designated to cover all tasks related to the planning and delivery of public services in French at central offices and offices located in or serving designated areas. For instance,

- administrative (e.g., receptionists, administrative assistants);
- communications (e.g., communications advisers, media relations officers);
- human resources (e.g., human resources consultants);
- inspection, investigation and enforcement (e.g., police officers, conservation officers);
- operational (e.g., radio dispatchers);
- policy and program development, stakeholder relations and public consultations (e.g., policy analysts, program consultants);
- technical (e.g., technicians with contacts with the public);
- specialized (e.g. engineers, biologists with contacts with the public).

In addition, ministries should consider designating management and senior management positions as well as positions for which incumbents are responsible for proof-reading French-language publications, forms and documents aimed at the general public (after translation and before printing), revising correspondence written by staff in French and assisting the Webmaster with the development and updating of the government's French-language web sites.

Note: both classified and unclassified positions can be designated.

Other factors to consider when determining how many designated positions are needed include the potential volume of contact with French-speaking clients and Francophone groups, the number of hours the office is open and shift work.

New and expanded programs

When a ministry introduces a new program or expands an existing program in a central office or office located in or serving a designated area, the program area manager should consult the ministry's French-language services coordinator to determine the best way to ensure that this service is available in French.

Language of administration

English is the language of administration in the Government of Ontario – unlike the federal government where both English and French are languages of administration in some areas.

3. HOW TO FILL A DESIGNATED POSITION

When filling a vacant designated position, your goal should be to hire a candidate who is proficient in both English and French and has the other qualifications for the job. The following are seven key steps related to staffing designated positions. **Please note that these steps highlight those particular aspects of the staffing process where specific things need to be considered or attended to when staffing and filling a designated position. It does not include all necessary steps to be followed when staffing a designated position. The *Staffing Operating Policy* and the *Managers Guide to Staffing* , as well as your human resources consultant should be consulted.**

Step 1 – Determine the French-language proficiency requirements of the position

Employees in designated positions are required to be proficient in English and French at the advanced or superior levels. As explained in **A Manager's guide to Staffing in the Ontario Public Service** (Section 1.7: *Staffing Positions Requiring Proficiency in French*), "*Only individuals who possess the required language skills can be appointed to positions that require proficiency in French"*.

Consequently, when French-language proficiency is a requirement of the position, it can be used as a criterion to screen out candidates who are not at the requisite levels. It is the responsibility of managers to determine the specific French-language proficiency level that is required for the position (advanced or superior) and to determine if written French-language skills are also required. This must be done in consultation with the ministry's French-language services coordinator and local Human Resources consultant, and the information should be recorded in the WIN system.

Description of French-language proficiency levels

Verbal Proficiency

Advanced level: At this level, one has the ability to participate in conversations and satisfy many work requirements. One can discuss work-related matters with some ease and facility, expressing opinions and offering views. One is able to take part in a variety of verbal exchanges and to participate in meetings and discussion groups. However, one still needs help with handling complicated issues or situations. One is generally good in either grammar or vocabulary but not in both.

Superior level: At this level, one has the ability to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations on practical, social and professional topics. One is able to use idioms and specific vocabulary relevant to a variety of contexts and to give verbal presentations in both formal and informal settings.

Written Proficiency

Advanced level: At this level, one is able to use a variety of sentence types to express general ideas and opinions on non-specialized topics. One can write simple letters and reports required of the position. One experiences few problems with either grammar or spelling. However, the writing style may represent literal translations. Nevertheless, a sense of organization is emerging and one is beginning to sense what is stylistically and grammatically correct in French.

Superior level: At this level, one is able to express oneself effectively in most formal and informal writing tasks/assignments on practical, social and professional topics. One is able to recognize awkwardness in sentence structure and paragraphs. Errors in grammar and spelling are minor and infrequent.

Useful tips

- If the incumbent in a designated position has to make presentations to Francophone groups in French, participate in consultations with Francophone groups on proposed or new legislation or programs, or review proposals submitted by Francophone organizations, *superior verbal* French-language proficiency is generally required.
- If the incumbent has to write correspondence and other documents in French on a regular basis (e.g., comments on proposals submitted in French by Francophone organizations, presentation material) *advanced written* French-language proficiency is generally required. However, documents written in French by advanced-level staff should be reviewed by someone who possesses the *superior written* French-language proficiency level.
- For translator and bilingual communications adviser positions as well as for positions in which the incumbents are responsible for reviewing the quality of French-language publications and web sites, the *superior written* French-language proficiency level is generally required.
- If it is anticipated that the incumbent will rarely have to prepare written documents in French, the manager may, in consultation with the ministry's French-language services coordinator, decide to use translation services rather than require the *written* French-language proficiency for the position. However, the manager must ensure that the OPS standards for responding to correspondence (15 working days) are met. ***Note:*** this may not be an option for certain positions that require that incumbents produce reports or documents in French "on the spot".

Step 2 – Prepare/review job ad and job description

When preparing or reviewing the job ad for a designated position, make sure it includes the phrase "proficiency in English and French". The ad must not specify the French-language proficiency level required (advanced or superior). If the ad is to be posted in *Job Mart* or external media, the English version of the ad should be sent for translation into French to an MBS-approved translation services supplier, if a French version of the ad does not already exist.

When preparing or reviewing the job description for a designated position, make sure it specifies the French-language proficiency level required (advanced or superior) and that it indicates which responsibilities the incumbent may be called upon to carry out in French (e.g., respond to inquiries in English and French).

Note: the job description is an internal document, and therefore does not need to be translated into French, even if it is given to candidates before an interview.

Step 3 - Post the job ad

The OPS is committed to broad access to employment. Ministries are encouraged to widen the area-of-search in employment advertising for designated positions. As a result, competitions for designated positions are generally *open* rather than OPS-wide *restricted.* **Please note that specific exceptions to the requirement to post are included in collective agreements, the Staffing Operating Policy, the Managers Guide to Staffing, etc.**

Job ads must be sent to the Communications Services Branch of Management Board Secretariat for review and posting. The **Staffing Operating Policy** stipulates that: *"All external paid employment advertisements must be sent for processing to Management Board Secretariat."*

Competitions for designated positions generally appear in:

- *Jobmart* (in English and French);
- *GoJobs* (in English and French);
- English-language newspapers (in English);
- French-language newspapers (in French).

Note: job ads for non-designated positions do not have to be advertised in French-language newspapers.

LeDroit is the only daily French-language newspaper in Ontario; most French-language newspapers are weekly or bi-weekly papers. When there are no French-language newspapers in the area of search, the ad for a designated position that runs in the English-language newspapers must include a phrase in French giving candidates the name and telephone number of the person to call to get information in French about the position. For example, you can use the following: "Pour renseignements, veuillez communiquer avec…".

Useful tips

- Consult your ministry's French-language services coordinator or your local human resources consultant about effective ways to reach potential candidates for designated positions, or about developing coordinated ministry-wide initiatives to attract qualified bilingual candidates.
- Consider placing both the English and French ads on external job boards, such as Workopolis.
- Consider adding the phrase in French ("Pour renseignements, veuillez communiquer avec…") in the English ad even if the French ad appears in a local French-language newspaper, again to attract the attention of French-speaking readers.
- Consider placing ads in French-language newspapers outside the province, especially for professional or specialized positions.

Outreach strategies

- Since ads in *Jobmart* and newspapers are not always sufficient to reach qualified bilingual candidates, consider using outreach strategies to increase the pool of potential candidates. Ministries have often been successful in recruiting bilingual candidates by:
  - Placing ads in the newsletters or on the bulletin/job boards of Francophone agencies and organizations;
  - Using the services of search firms/head hunters that specialize in bilingual positions;
  - Placing ads in professional French-language journals;
  - Developing links with Francophone colleges, and with bilingual universities that may be able to identify candidates and advertise the position on their bulletin boards;
  - Participating in job fairs at Francophone colleges, and bilingual universities.

Links

- *Renewing and Revitalizing the Workforce: Actions for Managers* (MBS) (http://intra.hropenweb.gov.on.ca/hrstrategy/rr_catalogue/manager/entry.htm)

Step 4 - Review applications

As outlined in the **Staffing Operating Policy** (Corporate Management Directives, 2000) there are mandatory requirements in the process of recruitment and selection. They are:

- *Recruitment activities must be based on a documented description of the duties, responsibilities and qualifications required of the work to be performed.*
- *Employee selection must be based on a thorough assessment of a candidate's ability to demonstrate the qualifications required for effective performance. For permanent work, candidates must be assessed using at least one screening method(e.g. review of resumes) and* ***at least three rating methods*** *(e.g., work samples, interviews, work-related tests, written or oral presentations, behavioral competency assessments, personnel file reviews, reference checks, etc.)*

The **Staffing Operating Policy** also points out that:

- Selection criteria form the basis on which all candidates are screened and rated and must :
  - Be developed from, and weighted in accordance with, the relative importance of the duties of the work to be performed,
  - Reflect the required qualifications for each vacancy to be staffed,
  - Be established at the outset and not changed during the selection process,
  - Reflect legal and mandatory requirements for credentials, where required.

- Selection criteria for positions requiring proficiency in French must include French-language proficiency at either the advanced or superior level and proficiency in English. It is also important to remember that French-language skills and levels must be identified as mandatory selection criteria and that the ministry French-language Services (FLS) Coordinator must be consulted before any staffing action takes place.
- Candidates applying for a designated position may choose to send their application in French. This correspondence should be treated as any other external correspondence in French. As a result, applications received in French must be responded to in French.

Useful tips

- If possible, use a standard acknowledgment response that has already been translated into French. The Human Resources Branch may have some samples.
- To ensure that applications received in English and French are given equal consideration, have résumés in French reviewed in confidence by a manager or member of the selection panel who is proficient in French and who understands the duties, responsibilities and requirements of the position being filled.
- Do <u>not</u> ask an applicant who has provided a résumé in French for a résumé in English; if the applicant does not have a résumé in English, the applicant may feel that his/her application in French will not be given equal consideration. In some cases, the manager may wish to have the résumé translated into English.

Step 5 – Conduct preliminary screening for French-language proficiency

When screening candidates applying for a designated position to determine who to interview, managers should first verify whether the candidate states in his/her letter of application or résumé that he/she is proficient in French or that he/she has provided French-language services in the past. If this information is not available, arrange for a bilingual employee to call the candidates and have an informal chat with them to determine if they can speak French.

Step 6 – Interview candidates (if interviews used)

If no preliminary screening for French-language proficiency has been conducted, at least one member of the selection panel, if used, should be present to ask one or two questions in French. If following the interview, candidates are given written tests in English and French, the test in French should complement – not replace – a French-language written proficiency evaluation.

Step 7 – Arrange for French-language proficiency evaluations

The selected candidate should undergo a French-language evaluation for verbal proficiency, and written proficiency if required, before being offered the job to make sure he/she is at the required level.

The OFA strongly encourages all managers to arrange for **formal evaluations** conducted by MBS-approved suppliers for the following reasons:

- suppliers are professionally trained to assess French-language skills;

- suppliers provide evaluation reports or certificates that identify the candidates' specific proficiency level (e.g., intermediate-plus, advanced, superior);
- the results of the evaluation are transferable to other OPS designated positions requiring the same French-language proficiency level.

The costs associated with the formal evaluations (approximately $60 per evaluation) are the responsibility of the program area involved in the recruitment.

Informal evaluations of verbal and written French-language proficiency are evaluations conducted by a bilingual employee who informally talks to candidates to determine if they can perform certain tasks in French in a particular work context. These evaluations do not specify the exact level of proficiency (e.g., intermediate plus) and whether the candidates' ability in French is transferable to another work context.

Useful tips

- Consult the ministry's French-language services coordinator to find out what measures are in place to evaluate the French-language proficiency level of candidates.
- Ask candidates if they have a certificate from an MBS-approved evaluation services supplier showing that they have the required proficiency. Those who have been previously formally evaluated by an MBS-approved vendor at the required proficiency level do not need to be evaluated again.
- Ask a French-speaking employee to contact candidates by phone and discuss in French the French-language proficiency evaluations being arranged. Candidates who are not in fact bilingual and who did not know that they would be evaluated for their French-language skills may withdraw from the competition at this stage.

Links

- *French-language Training & Evaluation Guideline* (MBS), (http://intra.cpb.gov.on.ca/pdf/Frtraing.pdf)
- *List of French-language proficiency evaluators approved by MBS,* SSB intranet site. ()

Step 8 – Record the French-language proficiency level of candidates

When the position is filled, the manager is responsible for recording the French-language proficiency level of the selected candidate. It is expected that WIN will be able to record this information at a future date.

Useful tips

- The language proficiency results of external candidates whose French-language skills were formally evaluated but who were not hired should be kept on file for 6 months with the candidates' consent. This information can be used to identify potential candidates for other designated positions.
- All candidates who were formally evaluated for their French-language proficiency should be given copies of their evaluation report or certificate for their personal files. If

they apply again for a designated position and this information is no longer kept on file, they can provide proof that they have already been evaluated.

4. HOW TO BACK-FILL A DESIGNATED POSITION

When an employee in a designated position takes a temporary assignment or leave of absence from work, the best way to maintain the program area's level of French-language services is to back-fill the position with a person who has the French-language proficiency level and all other skills required for the job.

Consult your ministry's French-language services coordinator if you need advice and assistance to back-fill a designated position.

5. WHAT TO DO WHEN THE INITIAL SEARCH IS UNSUCCESSFUL

If after having followed all the recruitment procedures to fill a designated position, you are unable to find a qualified bilingual candidate, consider outreach strategies (see *3. Post job ad, Useful tips, outreach strategies*).

If the outreach strategies utilized do not lead to the hiring of a qualified bilingual candidate, consult your ministry's French-language services coordinator. Together, you can explore whether alternative measures are possible, such as transferring the designation within your program area to another equivalent vacant position (e.g. administrative, technical, policy-related). These options must be weighed carefully as to not adversely affect an area's overall capacity to provide service of equal quality and accessibility in English and French.

In any situation where your best efforts are not yielding the required results, continue consulting your ministry's FLS coordinator for information and advice.

Useful tips

- Document all your efforts to fill the position (e.g., open competition, outreach efforts, formal evaluation results).

6. HOW TO ABOLISH A DESIGNATED POSITION

Restructuring exercises, program reviews and other organizational changes may lead to the abolition of designated positions. However, when such a situation occurs, it is most important to ensure that designated positions remain in sufficient numbers to ensure that any service that continues to be offered also continues to be offered in French.

Please note that relevant collective agreements, the Public Service Act, Regulation 977, the Operating Procedure for the Workforce Adjustment of Employees in the Management Compensation Plan and Excluded Category, and all other relevant legislation, policies, guidelines and procedures must be followed.

The following describes the steps to abolish a designated position:

Step 1 - Inform your ministry's French-language services coordinator of your intention to abolish a designated position as a result of restructuring. Explain rationale for the decision.

Step 2 - The coordinator will seek authorization from the deputy minister to proceed with the abolition of the designated position and the deputy minister will in turn inform the OFA.

7. STRATEGIES TO RECRUIT BILINGUAL CANDIDATES

Program areas that continue to have difficulty recruiting bilingual employees for certain designated positions may need to work in close collaboration with their ministry's French-language services coordinator to develop some medium and long-term strategies that will eventually produce the bilingual workforce that is needed.

Useful tips

- Contact Francophone colleges and work with them to develop training programs that will produce graduates who will have the technical skills that are needed for certain positions and who may be fluent in English and French.
- Work with other ministries to promote career opportunities for bilingual people within the Ontario government.
- Consider having a ministry booth at job fairs held in areas designated under the *FLSA*.
- Signal your interest to MBS in having French-speaking interns assigned to your area.
- Encourage French-speaking staff to participate in mentoring or career development programs in order to eventually access bilingual positions with a higher classification level.

8. BUMPING RIGHTS AND DESIGNATED POSITIONS

Please see applicable collective agreement provisions regarding bumping, and contact your Human Resources Branch if you have any questions.

9. REPORTS ON DESIGNATED POSITIONS

Deputy ministers are required to submit an annual report to the OFA on the status of designated positions within their ministry. This report is prepared by the ministry's French-Language services coordinator. The information pertaining to each ministry is incorporated in a report prepared by the OFA for the Minister Responsible for Francophone Affairs.

10. STRATEGIES TO RETAIN STAFF IN DESIGNATED POSITIONS

Bilingual employees are in demand. When you have staff in designated positions, do what you can to support them in offering high quality French-language services and encourage them to stay. Here are seven retention strategies:

Provide appropriate equipment and supplies

Staff in designated positions may need equipment that will help them perform their French-language services duties, such as:

- A keyboard programmed to produce French-language diacritics, such as accents;
- A French spell-check program;

- French dictionaries (e.g., *Le Robert*) and English-French and French-English dictionaries (e.g., *Robert & Collins*).

They should also know how to conduct an online terminology search using the ONTERM database, which gives the official Government of Ontario English and French terminology. If staff members in designated positions have business cards, the cards should be in a bilingual format.

Link

- *How Do I Make Accents?*, OFA's Intranet site, Communications http://intra.ofa.gov.on.ca/Communications/communications.html
- ONTERM, (http://www.onterm.gov.on.ca/)
- DICO, on-line French-English-French Dictionary (http://www.net-dico.com/)

Do not require staff in designated positions to perform tasks that are not part of their job descriptions

Bilingual candidates may be reluctant to apply for designated positions because they fear managers will ask them to perform tasks for which they lack the training and experience. They may also fear that their workload will be much heavier than the workload of their unilingual colleagues.

It should be noted that most people in designated positions are not hired as translators and are not trained to provide translation services. Although they may be able to prepare letters in French and review materials received in French (e.g., proposals from Francophone organizations), they should not be asked to translate documents or publications aimed at the general public (e.g., brochures, ads, forms). Managers must ensure that all publications for general distribution to the public in designated areas are translated (from English to French) by an MBS-approved translation services supplier.

Employees in designated positions should also not be asked to provide simultaneous translation services for conferences or in complex situations such as those related to legal procedures. This should be done by professional interpreters.

Useful tips

- Most ministries have an employee who is responsible for coordinating translation requests. If you do not know who this employee is, contact your ministry's French-language Services Coordinator.
- If you require the services of an interpreter, contact the Association of Translators and Interpreters of Ontario at 1-800-234-5030.

Links

- *English and French-English Translation and Proofreading Services Operating Policy*, (http://intra.cpb.gov.on.ca/pdf/Transrvd.pdf)

Encourage partnerships with other bilingual colleagues

An employee in a designated position may be the only employee in the program area who speaks and/or writes French, and may have few opportunities to discuss issues related to French-language services with peers. This can be a serious problem for employees who are expected to answer inquiries or write letters in French, or review materials received in French. While a letter written in English will be proof-read and checked by many employees throughout the approval process, there may be no other bilingual employee within a program area to proof-read a letter in French. Only a few ministries have bilingual staff (e.g., translators) who are responsible for proof-reading documents written in French by staff, such as correspondence and presentation material.

Useful tips

- If there is no employee responsible for proof-reading documents written in French, encourage staff in designated positions to develop partnerships with colleagues in designated positions to check each other's documents in French.
- Provide opportunities for staff in designated positions to meet (face-to-face or by teleconference) with other ministry staff in designated positions to discuss common issues and concerns about French-language services.
- Encourage <u>all</u> staff to contact the ministry's French-language services coordinator for information on French-language services requirements.

Provide opportunities to maintain French-language skills

Some employees in designated positions may receive very few calls or requests in French, and have few opportunities to speak or write in French. Staff in professional level positions may have few opportunities to make presentations to French-language groups or to participate in consultations involving the Francophone community.

This can make it difficult for staff in designated positions to maintain or upgrade their verbal or written French-language skills and to offer quality French-language services to the public.

Useful tips

- Offer training in French to staff in designated positions to maintain or upgrade their French-language skills (e.g., grammar refresher, business writing, presentation skills, group facilitation). *Note:* Ministry program areas generally fund French-language training out of their general budget for training.
- Offer French-language training to employees who are at least at the intermediate French-language proficiency level to allow them to reach the advanced level and be considered for some bilingual positions and broaden the pool of potential candidates for designated positions.
- Encourage staff in designated positions to attend conferences and seminars that are available in French.

- Work with other program areas to organize meetings for bilingual staff and arrange for presentations to be given in French by bilingual OPS staff on issues related to French-language services or other issues or subjects of interest.
- Consult your ministry's French-language services coordinator to obtain information on French-language training suppliers and for advice or assistance on organizing other training or events in French for bilingual staff.

Provide career development opportunities

Bilingual candidates, internal or external to the OPS, will be more willing to apply for designated positions if they feel that they will have the same career development and learning opportunities as employees in non-designated positions (e.g., acting assignments, secondments). Managers should ensure that employees in designated positions have the same career development and learning opportunities as staff in non-designated positions.

Reference: *4. How to back-fill a Designated Position*

Useful tip

- When an employee in a designated position changes positions within a unit or branch, whether temporarily or permanently, it may be possible to temporarily transfer the designation to that position. In this way, the employee has the career development opportunity and the program still meets its French-language requirements. Consult your ministry's French-language services coordinator if you wish to make such a change.

Educate all staff about French-language services procedures

Managers need to ensure that all employees know who is responsible for providing services in French within the program area. This will allow for calls from French-speaking members of the public to be transferred promptly to an employee who speaks French. All staff should also be familiar with French-language services requirements. For instance, staff answering main phone lines should answer with a bilingual greeting, such as "Ministry of Environment, Bonjour", to indicate that services are available in French.

Useful tips

- Make sure that employees answering general inquiry phone lines have a list of names and phone numbers of employees in designated positions. They should also know when these employees are away and who provides back-up French-language services. If you have bilingual employees in non-designated positions who are willing to occasionally provide services in French, include them in the list.
- Staff answering general inquiry phone lines should be encouraged to use the phrase "Un instant, s'il vous plaît" (meaning "One moment please") before promptly transferring a French-language call.

Links

- http://intra.ofa.gov.on.ca/ and http://www.ofa.gov.on.ca/english/indexeng.htm

Provide formal recognition by including French-language services in job performance reviews

All staff members, from front-line to senior management staff, in central offices or offices located in or serving designated areas, are accountable for the effective planning and delivery of French-language services. Whether or not their positions are designated, all employees must follow OPS directives and guidelines related to services in French. This aspect of their work should be reflected in their performance agreement and discussed during their performance review.

Useful tips

- In the context of your own performance review, discuss your responsibilities related to French-language services with your supervisor.
- When reviewing the performance of staff, discuss responsibilities related to French-language services with each employee, as well as the resources and French-language training needed to provide high quality French-language services.

Link

- *Performance Management Operating Policy,* HR OpenWeb intranet site (http://intra.cpb.gov.on.ca/pdf/Perfmgmtop.pdf)

11. ROLES AND RESPONSIBILITIES OF KEY PLAYERS

Minister Responsible for Francophone Affairs

The Minister Responsible for Francophone Affairs is responsible for the administration of the *FLSA*.

Secretary of Cabinet

As the most senior public servant in the Ontario government, the Secretary of Cabinet assesses the performance of deputy ministers. Customer services, including French-language services, are an important component of the performance contract of deputy ministers.

Management Board Secretariat (MBS)

MBS sets the corporate requirements for human, financial and physical resources and the service delivery standards for ministries and agencies. Its policies, directives and guidelines must take into account legislated French-language requirements. MBS also manages the WIN system, which can produce required reports on designated positions.

Office of Francophone Affairs (OFA)

The OFA is a central agency that assists the Minister Responsible for Francophone Affairs with the administration of the *FLSA*. It sets OPS policies, procedures and guidelines with respect to the planning and delivery of provincial government services in French. It works

closely with ministry French-language Services Coordinators to monitor compliance with the *FLSA*. It reviews requests to abolish designated positions as well as ministry annual reports on designated positions. It reports to the Minister Responsible for Francophone Affairs on the status of French-language services in the Ontario public service.

Deputy ministers

Each deputy minister is accountable to the Executive Council for the implementation of the *FLSA* and the quality of French-language services in his or her ministry. Deputy ministers are required to put in place adequate resources and mechanisms to meet the needs of Ontario's Francophone community. They are also responsible for submitting to the OFA an annual report on the status of French-language services in their ministry including information on designated positions.

French-language Services Coordinators

The duties of French-language Services Coordinators consist mainly of management functions for the integration of French-language services into ministry activities and into service delivery processes. They include short-term and long-term strategy and action planning, policy development, consultation, enforcement and monitoring, facilitation, problem solving, liaison and communication, outreach and community relations. French-language Services Coordinators also provide advice regarding the management and staffing of designated positions; may assist with recruitment, interviewing and coordination of French-language proficiency evaluation. They review proposed changes to the status of designated positions and seek authorization from the Deputy Minister to abolish designated positions. They also prepare an annual report on designated positions to submit to the OFA.

Program area managers

Managers of program areas that plan and/or deliver services to the public in designated areas are responsible for ensuring that all of their staff members comply with French-language services government directives and guidelines. They must ensure that their program areas have sufficient bilingual staff in designated positions to provide high quality French-language services. They are responsible for staffing and managing designated positions.

Employees

All employees in central offices or offices located in or serving designated areas who are involved in the planning and/or delivery of services to the public are responsible for ensuring that French-speaking Ontarians have access to services in French that are equivalent in quality and accessibility to those offered in English. Employees in designated positions are responsible for the delivery of high quality French-language services.

Human resources consultants

Human resources consultants are responsible for providing advice and assistance to managers with respect to the application of legislation, policies, guidelines, and collective agreement provisions related to the staffing and management of designated positions.

Government Translation Service Unit (Management Board of Cabinet)

The Government Translation Service Unit selects suppliers of translation. It also manages large or complex translation projects. It provides standardization of French terminology specific to the Ontario government.

Shared Services Bureau (SSB) (Management Board of Cabinet)

SSB is responsible for maintaining vendors of record for both French-language training and French-language competency evaluation. SSB is also responsible for providing corporate clearance (or assigning surplus employees) prior to a manager proceeding to posting.

12. CONCLUSION

As the Ontario Public Service strives to renew and revitalize its workforce, it faces stiff competition from other employers bidding for the same human resources. Recruiting people for designated positions who have the required French-language proficiency level and the other qualifications for the job can be a challenge, especially for specialized or professional level positions.

Managers should work closely with their ministries' French-language services coordinators to make sure that all reasonable efforts are made to recruit qualified staff for designated positions and ensure that their program areas have the capacity to provide high quality French-language services to French-speaking clients.

13. Qs & As

1) How does a manager determine which position(s) to designate when his/her program area is going to be responsible for the delivery of new and expanded programs?

In consultation with the ministry's French-language services coordinator and the local human resources consultant, managers should ensure that positions are designated to cover all tasks related to the planning and delivery of services for the public in French at central offices and offices located in or serving designated areas. For instance,

- Administrative (e.g., receptionists, administrative assistants);
- Communications (e.g., communications advisers, media relations officers);
- Human resources (e.g., human resources consultants);
- Inspection, investigation and enforcement (e.g., police officers, conservation officers);

- Operational (e.g., radio dispatchers);
- Policy and program development, stakeholder relations and public consultations (e.g., policy analysts, program consultants);
- Technical (e.g., technicians with contacts with the public);
- Specialized (e.g. engineers, biologists with contacts with the public).

In addition, ministries should consider designating management and senior management positions as well as positions of individuals responsible for proof-reading French-language publications, forms and documents aimed at the general public (after translation and before printing), correspondence written by staff in French and assisting the Webmaster with the development and updating of the government's French-language web sites.

It should be noted that both classified and unclassified positions can be designated.

Other factors to consider when determining how many designated positions are needed include the potential volume of contact with French-speaking clients and Francophone groups, the number of hours the office is open and the number of shifts scheduled.

Reference: *2. How to decide which positions should be designated.*

2) Who determines the required French-language proficiency levels?

The manager, in consultation with the ministry's French-language services coordinator and the local Human Resources consultant, reviews the job description and determines if the position requires both verbal and written French-language skills at the advanced or superior levels as specified by the guidelines. Once the French-language requirements and skills levels have been established for the position, the information should be recorded in the WIN system.

Reference: *3. How to fill a designated position, Step 1*

3) What can be done to attract a good selection of qualified bilingual candidates?

Since ads in *Jobmart* and newspapers are not always sufficient to reach qualified bilingual candidates, managers should consider using outreach strategies to increase the pool of potential candidates. Ministries have often been successful at recruiting bilingual candidates by:

- Placing ads in the newsletters or on the bulletin boards of Francophone agencies and organizations;
- Developing links with Francophone colleges, and with bilingual universities that may be able to identify candidates and advertise the position on their bulletin boards;
- Participating in job fairs at Francophone colleges.

Reference: *3. How to fill a designated position, Step 3*

4) Should formal or informal French-language services evaluations be conducted?

The OFA strongly encourages all managers to arrange for **formal evaluations** conducted by MBS-approved suppliers for the following reasons:

- Suppliers are professionally trained to assess French-language skills;
- Suppliers provide evaluation reports or certificates that identify the candidates' specific proficiency level (e.g., intermediate-plus, advanced, superior);
- The results of the evaluation are transferable to other OPS designated positions requiring the same French-language proficiency level;

The costs associated with the formal evaluations (approximately $60 per evaluation) are the responsibility of the program area involved in the recruitment.

Informal evaluations of verbal and written French-language proficiency are evaluations conducted by a bilingual employee who informally talks to candidates to determine if they can perform certain tasks in French in a particular work context. These evaluations do not specify the exact level of proficiency (e.g., intermediate plus) and whether the candidates' ability in French is transferable to another work context.

Reference: *3. How to fill a designated position, Step 5*

5) Can a manager back-fill a designated position with a unilingual incumbent?

When an employee in a designated position takes a temporary assignment or leave of absence from work, the best way to maintain the program area's level of French-language services is to back-fill the position with a person who has the French-language proficiency level and all other skills required for the job.

Managers should consult their ministry' French-language services coordinator if they need advice and assistance to back-fill a designated position.

Reference: *4. How to back-fill a designated position*

6) What if all the recruitment procedures to fill a designated position have been followed and there is no candidate with the French-language proficiency level and the other skills required for the job?

If after having followed all the recruitment procedures to fill a designated position, you are unable to find a qualified bilingual candidate, consider outreach strategies (see *3. Post job ad, Useful tips, outreach strategies*).

If the outreach strategies utilized do not lead to the hiring of a qualified bilingual candidate, consult your ministry's French-language services coordinator. Together, you can explore whether alternative measures are possible, such as transferring the designation within your program area to another equivalent vacant position (e.g. administrative, technical, policy-related). These options must be weighed carefully as to not adversely affect an area's overall capacity to provide service of equal quality and accessibility in English and French.

In any situation where your best efforts are not yielding the required results, continue consulting your ministry's FLS coordinator for information and advice.

Reference: *5. What to do when the initial search is unsuccessful*

7) Can a designated position be abolished?

Restructuring exercises, program reviews and other organizational changes may lead to the abolition of designated positions. However, when such a situation occurs, it is particularly important to ensure that a sufficient number of designated positions remain to ensure that any service that continues to be offered to the public is available in French.

Please note that relevant collective agreements, the Public Service Act, Regulation 977, the Operating Procedure for the Workforce Adjustment of Employees in the Management Compensation Plan and Excluded Category, and all other relevant legislation, policies, guidelines and procedures must be followed.

Reference: *6. How to abolish a designated position.*

8) How can managers retain staff in designated positions?

Employees in designated positions will be motivated to stay in designated positions and within the OPS if managers:

- Provide them with appropriate equipment and supplies to deliver services in French;
- Do not require them to perform tasks that are not part of their job descriptions, such as translation services;
- Encourage them to establish partnerships with other bilingual colleagues;
- Provide them with opportunities to maintain or upgrade their French-language skills;
- Provide them with the same career development opportunities as other staff.

Reference: *10.* Strategies *to retain staff in designated positions*

Section 5

Training

Section 5
Training

French Language Training

French language training is one way for health service providers to increase their capacity to deliver services in French and provide better quality care. Training could help build and/or reinforce language skills of staff so they can provide direct services in French.

There are different ways health service providers can support their staff in learning French or upgrading their skills.

- Pay for all or part of their tuition fees.
- Compensate staff for their learning time. Even a partial compensation would be appreciated by staff who are upgrading their French skills.
- Offer courses onsite.

These measures could be good incentives for staff to learn French.

It is also important to recognize and value the staff for their added skills, by giving them, for example, the opportunity to practice their skills by assigning French-speaking patients/clients to them. Research has shown staff members will often not identify as French-speaking because of fear of having an increased workload (no double-duty). Therefore, this should be considered when scheduling staff.

French-Language Training Options

The training options presented below are available to all health service providers, designated, identified or non-identified. Cost varies from one program to the other and from one institution to the other.

Regular French Program

French as second language certificate program allows participants to acquire the necessary knowledge and skills to communicate effectively in French in a work or a social environment.

Windsor area: *Collège Boréal*, 519 948-6019
www.collegeboreal.ca

St. Clair College, 519 972-2711
www.stclaircollege.ca

Chatham area: *St. Clair College*, 519 354-9100
www.stclaircollege.ca (intro 1 only)

Sarnia area: *Lambton College*, 519 542-7751, ext. 2400
www.lambton.on.ca

London area: *Collège Boréal*, 519 451-5194
www.collegeboreal.ca

E-learning: *Collège Boréal*
www.collegeboreal.ca
(courses are offered live through the Web)

Please note that the *University of Windsor* offers a bachelor's degree in French studies and *Western University* offers French studies at the bachelor, master and doctorate levels.

French Program for Healthcare Staff

Collège Boréal also offers a French program designed for individuals working in a healthcare setting. Consisting of a series of ten thirty-hour courses at the intermediate and advanced levels, participants will progressively become fluent in French and ultimately be able to carry a conversation with their patients/clients as part of their usual duties as health care professionals.

- Minimum of eight participants.
- Can be offered at the organization's location or in a college's classroom. Contact *Collège Boréal* in Windsor (519 948-6019) or London (519 451-5194).
- Also offered through distance education. Contact *Collège Boréal* in Toronto at 416 289-5130 or 1 800 361-6673, ext. 5120.

My Language, My Culture, My Health

Collège Boréal is also offering *My Language, My Culture, My Health*, a French-language training program adapted to culture. This program consists of three series of ten one-hour modules (intermediate, advanced and skills maintenance), plus a few additional modules, where participants will not only learn French, but will also gain cultural competence.

- Minimum of eight participants at the organization's location. Contact *Collège Boréal* in Windsor (519 949-6019) or London (519 451-5194).

French Immersion Program

Participating in a French immersion program allows individuals to live the language and culture in a complete French environment. There are several immersion programs, mostly in Quebec that range from one week individual learning to six weeks in a group environment and there are several formats to meet the needs of working adults. Look for a program that includes accommodation in a local French-speaking family to take advantage of all the benefits immersion has to offer. Cost varies widely from one institution to the other.

Some Options:[11]

- *Centre de formation linguistique de Jonquière*, three-week immersion for adults or intensive individual training, www.langues-jonquiere.ca/page_jonquiere.php?rubrique=servicesjonquiere
- *Western University Trois-Pistoles French Immersion School*, one-week immersion for adults, www.uwo.ca/cstudies/tp/english/adults.html
- Université du Québec à Trois-Rivières, École internationale de français, one to six-week immersion, oraprdnt.uqtr.uquebec.ca/pls/public/gscw030?owa_no_site=1973
- Université du Québec à Montréal, three-week and six-week immersion, www.langues.immersion.uqam.ca/en.html
- Université du Québec à Chicoutimi, École de langue française et de culture québécoise, three-week and five-week immersion, elf.uqac.ca/ecole-de-langue
- Écoles de langues de l'Université Laval,five-week immersion, www.elul.ulaval.ca/en/our-courses/french-as-a-foreign-language
- Université Sainte-Anne, Nova Scotia, one-week and five-week immersion, www.usainteanne.ca/5-week
- Immersion in France through Alliance française, www.alliance-francaise.ca/en/adult-courses/french-immersion-in-france

MOHLTC-Sponsored French-Language Training

At present, the MOHLTC French Language Services Office is sponsoring French-language training by providing reimbursement of tuition fees (to a maximum of $300 per course) to eligible participants.

- **Only offered to staff members of identified or designated health service providers.**
- Priority given to professionals who provide direct patient care.
- Applies to courses at the intermediate level or higher.
- Successful completion of the course and minimum attendance of 70% of classes are required.

11 The list is not extensive. For more options, please search the Internet.

The program is managed by *Accueil francophone de Thunder Bay*, with the administrative support of Jean Carrière. Ms. Carrière can be reached at 1 877 907-4040 or at jdcarriere@sensenbrennerhospital.on.ca.

Please refer to the program guidelines, including eligibility criteria and reimbursement rules and the *Conditional Eligibility Form* on pages 177–183.

Professional Development in French

There are several options for staff to maintain and/or upgrade their professional skills in French. It could be a general education program, such as courses that are part of a nursing degree or a program specially targeting the Francophone population, such as the *TEACH* training on tobacco cessation (www.nicotinedependenceclinic.com/Francais/teach/Pages/home.aspx), that includes a component for professionals working with Francophone individuals and is offered in French.

The *Consortium national de formation en santé* (CNFS) is a Canada-wide umbrella organization bringing together 11 university and college educational institutions which deliver training programs in various health disciplines in French, as well as regional partners who facilitate access to these training programs. Several courses are offered through distance education. For more information, please visit www.cnfs.net.

The *Programme d'excellence professionnelle* of the University of Ottawa offers monthly conferences over lunch on a variety of health care topics and some online training. All conferences and training are offered in French by videoconference or via web streaming. A new schedule is posted twice per year, in August and December. For more information, please visit www.cnfs.ca/formation/programme-dexcellence-professionnelle or call 613 746-4621, ext. 6020.

Health Nexus (www.healthnexus.ca), *RIFSSSO* (www.rifssso.ca), *e-santé-ontario* (www.esante-ontario.ca) and other organizations offer many training opportunities in French, often in webinar formats. Please visit the applicable website.

French-language conferences are also excellent opportunities to upgrade professional and language skills.

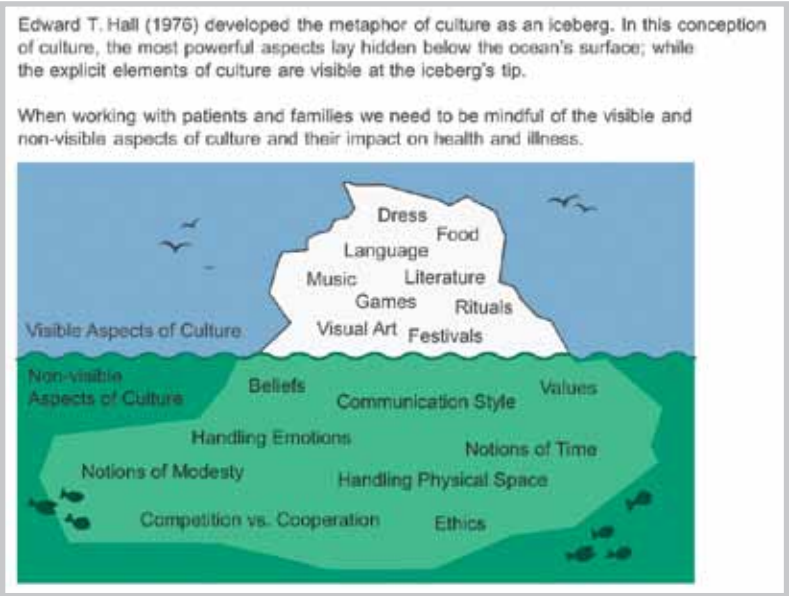
Cultural and Linguistic Competence[12]

Cultural competence is integral to providing quality, equitable and safe healthcare to all patients/clients.

Culturally competent care is a process occurring on many levels but can be summarized as caring for families and patients in a respectful manner that takes into consideration:

- The diversity of their social, cultural and linguistic backgrounds and beliefs;
- How these affect health beliefs, behaviours and outcomes.

The following picture, taken from the Sick Kids website, illustrates the complex concept of culture.



SickKids is a leader in Canada in cultural competence. They have developed excellent resources on cultural competence, including train-the-trainer workshops and a series of e-learning modules. These are accessible online at www.sickkids.ca/culturalcompetence/index.html.

> *"Quality of care and patient safety can be compromised when health-care providers do not respond to language and cultural preferences and differences."* [12]
>
> SickKids website

12 SickKids, www.sickkids.ca/culturalcompetence/index.html, March 30, 2013.

Staff Orientation regarding French Language Services

It is important to train staff, either through an annual in-service and/or orientation, about the need to serve the Francophone population.

Topics to be covered could include:

- Characteristics of the local Francophone population.
- *French Language Services Act*.
- Cultural and Linguistic Competence and Equity.
- Obligations as an identified or designated health service providers.
- Action plan for the next three to five years.

Section 5
List of Appendixes

Letter re: Reimbursement Program for French Language Courses

French Language Training Program Information – South Region

French Language Training Program – Fact Sheet

French Language Training Program, Conditional Eligibility Form

Collège Boréal

My Language, My Culture, My Health

L'Accueil francophone de Thunder Bay

292, rue Court Sud, Thunder Bay, ON P7B 6C6
Tél. : 807 684-1940 / Téléc. : 807 343-5790
info@accueilfrancophone.com / **www.accueilfrancophone.com**

August 14, 2013

Dear Sir/Madam:

RE: REIMBURSEMENT PROGRAM FOR FRENCH LANGUAGE COURSES

This letter is to confirm that l'Accueil francophone de Thunder Bay is coordinating the French Language Training Program funded by the Ontario Ministry of Health and Long-Term Care, French Language Services Office. The program offers reimbursement of tuition fees for French language courses to eligible employees of designated organizations, organizations in the process of being designated, or institutions that have been identified to provide French language services under the *French Language Services Act*.

For your information, we have attached the following documents:

- French Language Training Program Information – provides basic information about the program and the approved providers;
- Fact Sheet – provides information about eligibility and requirements for reimbursement;
- Conditional Eligibility Form – must be completed and submitted by interested employees prior to registering for classes;
- Evaluation Questionnaire – must be completed by participants at the end of the session.

We are seeking your assistance in distributing the above information to employees who:

- Work with patients, clients, families and the public; and
- Have attained at least the Intermediate level of proficiency in the French language.

We may, from time to time, request feedback from the participants' immediate supervisors regarding their progress.

Any questions concerning the above can be addressed to Ms. Jean Carrière, Resource Person for the French Language Training Program. You can reach her by telephone at (877) 907-4040 or (705) 337-4040 or by e-mail at jdcarriere@sensenbrennerhospital.on.ca.

Sincerely,

Angèle Brunelle

Angèle Brunelle
Executive Director

Encl. (4)

French Language Training Program Information – South Region

- Do you want to improve your French language communication skills?
- Have you already reached the intermediate level?
- Do you work in direct contact with patients, clients, families or the public in a health care environment?

If you answered YES to all of the above, this opportunity is for you!

The French Language Training Program is offering to reimburse tuition fees only of eligible participants who take French language courses.

Note: Funding is limited! Please see Fact Sheet for eligibility criteria and requirements for reimbursement.

For information about approved French Language course offerings in your area, please contact Collège Boréal.

Collège Boréal	Barrie	(705) 737-9088
	Chatham/Windsor	(519) 948-6019
	Hamilton/Niagara	(905) 544-9824
	London	(519) 451-5194
	Toronto	(416) 289-5130

Interested employees may also contact the English-language community college or university in their area.

After reviewing the French Language Training Program Fact Sheet, if you require further information, please contact Jean Carrière at by telephone at (877) 907-4040 or (705) 337-4040 or by email at: jdcarriere@sensenbrennnerhospital.on.ca.

The French Language Training Program is funded by the French Language Services Office of the Ministry of Health and Long-Term Care and coordinated by L'Accueil francophone de Thunder Bay.

292, rue Court Sud, Thunder Bay, ON P7B 6C6
Tél.: 807 684-1940 / Téléc. : 807 343-5790
info@accueilfrancophone.com / **www.accueilfrancophone.com**

French Language Training Program – Fact Sheet

ELIGIBILITY CRITERIA

Employees are eligible to participate in the French Language Training Program provided they meet the following Ministry of Health and Long-Term Care criteria:

1. Be a permanent employee of a health service provider that has been identified or designated for the provision of French Language Health Services.
2. Provide direct services to clients, families or the public at large.
3. As funding is limited, priority will be given to employees providing direct health care professional services, then to employees providing administrative support services that improve the agency's capacity to deliver services in French to the public.
4. Have reached at least an Intermediate Level of proficiency. Testing may be arranged with the training facilities, however the cost of placement tests is not reimbursable.
5. Complete all sections of the Conditional Eligibility Form and submit for approval prior to registering for the course.
6. Once approval is granted, register for an approved French Language Training Course at the appropriate level.

REQUIREMENTS FOR REIMBURSEMENT

Employees are eligible for reimbursement of their tuition fees only, up to a maximum of $300.00. Employees must:

1. Submit the original receipt for the paid tuition after attending the second class.
2. Attend a minimum of 70% of classes.
3. Successfully complete the course.
4. Complete and submit an Evaluation Questionnaire immediately upon completion of the course.
5. Employees who drop out of the French Language Training Program will be solely responsible for all costs and cancellation fees.

The Ministry of Health and Long-Term Care guarantees reimbursement , through L'Accueil francophone de Thunder Bay, to approved participants who have met the above criteria. Due to changes in the program administration, reimbursements may be delayed up to three months after submission of final report to the Ministry.

FOR MORE INFORMATION, PLEASE CONTACT:

Jean Carrière
Telephone: (705) 337-4040 or (877) 907-4040
Email: jdcarriere@sensenbrennerhospital.on.ca

This French Language training opportunity is offered by the French Language Services Office of the Ministry of Health and Long-Term Care.

French Language Training Program

CONDITIONAL ELIGIBILITY FORM

Name:				
Agency Name:				
Position:				
Department/Program Area:				
Immediate Supervisor:				
Contact Information:	Work tel:		Work fax:	
E-mail:				
Work Address:				
City & Postal Code				
Home Address:				
City & Postal Code				
Home Telephone:				
Home E-mail:				

Please check all that apply:

I am a first time participant in the French Language Training Program				☐
I have previously participated in the FLTP; specify course/level:				☐
I have direct contact with patients, clients, families and the public	Yes	☐	No	☐
I wish to register for a French as a Second Language course				☐
I wish to register for a French as a First Language course				☐

COURSE INFORMATION

Training/Educational Institution:			
Course Name/Code/Level:			
Course Start Date:		Completion Date:	
Tuition Cost:		Paid by:participant ☐	employer ☐

PARTICIPANT DECLARATION

- I understand that completion of this form does not guarantee my participation in the French Language Training Program.
- I am a permanent employee (full-time or part-time).
- I am proficient at the Intermediate Level or above.
- I must successfully complete the course, attend 70% of the classes, complete an Evaluation Questionnaire and provide the original receipt of my paid tuition in order to be reimbursed for the tuition fees.
- If I drop the French Language Training Course, I will be solely responsible for paying any cancellation fees charged by the supplier or the educational institution.
- I consent to allow the educational institution to release academic information to L'Accueil francophone de Thunder Bay for the purpose of preparing a request for reimbursement.

Signature: _ _____Date: ____ _____

Please return to Jean Carrière, no later than , by fax at (705) 337-4024 or by email at jdcarriere@sensenbrennerhospital.on.ca.

Section 6

Translation and Interpretation

Section 6
Translation and Interpretation

> *It is a serious misconception to assume that a person who has fair fluency in two languages will, by virtue of that fact alone, be consistently competent to translate between them."*
>
> en.wikipedia.org/wiki/Translation

Translation Services

Written material is a good way to communicate with patients/clients, often supporting the information provided orally. This is of particular importance when direct services are not available in French where written documents often become the only information understood by patients/clients. Consent and intake forms, facts sheets, discharge instructions, pamphlets, signage and websites are a few examples of documents that should be made available in French. The chart on pages 191–194, produced by the Government of Ontario as part of its *Communications in French Guidelines, 2009* highlights requirements for each type of communication. Use it as a guide.

Translation is a fine art of balancing the character of the original language and giving it new life in a fresh language. Translators are language professionals who have receive extensive training. Written documents should also be adapted to the target audience to take into consideration their literacy level, their regional characteristics, their culture, etc.

Costs of translation services should be included into the organization's operational budget and/or project budget.

To Find Qualified Translators

The *Association of Translators and Interpreters of Ontario* (ATIO) maintains a directory of certified translators and other language professionals. The directory is accessible online and is searchable by language combinations, by region, by specialization, etc. Please visit www.atio.on.ca.

The Erie St. Clair or South West LHINs' French Language Services Coordinators can also provide some assistance to HSPs in finding qualified translators.

MOHLTC-Sponsored Translation Services

At present, the MOHLTC French Language Services Office funds a provincial network of translators. The translation network:

- **Is available only to identified and designated health service providers**.
- Offers free translation services from English to French of admissible documents.
- See translation guidelines and request form on pages 195–211.
- For more information, contact Louise Baillargeon, Translation Service Administrator/Translator, at lbaillargeon@niagarahealth.on.ca or 905 732-6111, ext. 32313.

The translation network maintains a master list of translated documents that are of a general nature on a variety of health subjects and therefore, can be useful to many organizations. Contact the original authoring organization to get permission to use or adapt any document on the list. To receive a copy of the master list, please contact Louise Baillargeon at lbaillargeon@niagarahealth.on.ca or (Ms.) Jean Carrière at jdcarriere@sensenbrennerhospital.on.ca.

Interpretation Services

Sometimes the only way to communicate with patients/clients is through the words of an interpreter. Although it will never replace direct health services, interpretation is a good way to ensure more effective communication between professionals and their patients/clients. Many organizations already use interpretation to overcome language barriers.

Use of staff members as interpreters is discouraged as it may require them to act outside of their scope of practice. For example, a radiation technologist asked to help out at the triage assessment in the emergency department. Bilingual staff members should be called upon to provide direct services in French as part as their normal duties. Similarly, use of family members is also discouraged as it places the patient/client in an uncomfortable position, having to share private and personal medical information. Use of professional interpreters is highly recommended as it ensures quality, safety and privacy of care. Interpreters are professionally trained and certified. Some interpreters have taken additional training in medical or legal interpretation.

For Francophone patients/clients, interpretation is seen as an interim solution, to be used only until services can be delivered in French by a French-speaking professional.

To Find Qualified Interpreters

- In the Windsor-Essex area: *Multicultural Council of Windsor and Essex County*, 519 255-1127, www.themcc.com (over 50 languages).
- In the London area: *Across Languages*, 519 642-7247, www.acrosslanguages.org (over 74 languages).
- **Language Services Toronto**
  More than 30 health care organizations, from hospitals to primary care providers and community support service providers, in the Toronto Central, Central, Central East, Central West and Waterloo Wellington LHIN areas, have recently partnered to buy telephone interpretation services. The program is called *Language Services Toronto* and is managed by the *University Health Network*. *Language Services Toronto* is being supported by the RIO Network, which is a Toronto-based not-for-profit social enterprise, who has partnered with a larger provider, *Language Line*, to provide immediate access to 175 languages 24 hours a day, 7 days a week. All interpreters are qualified medical interpreters. For more information, please see *Language Services Toronto: Information for Interested Participants* on pages 213–215. The Erie St. Clair or South West LHINs' French Language Services Coordinators can assist interested HSPs in joining the partnership.

Section 6

List of Appendixes

Chart taken from the *Communication in French Guidelines*

Revised Translation Service Guidelines

Request for Service

Fact Sheet, Language Services Toronto

Interpretation Guide for Health Care Professionals

The following chart summarizes, for each type of communication, the requirements related to FLS.
The chart is organized by format, not content of communication.
The same document can exist in different formats (e.g. news release in printed and electronic form).

Format	Type	Principle	Strategy	Details
PRINTED MATERIALS	News release	Government responsibility	Both languages	For electronic news releases, post English and French versions simultaneously.
	Backgrounder	Government responsibility	Both languages	
	Speech transcript	Active offer	Important speeches: in both languages	Speeches should contain sections in French. Refer to p. 7 for more details.
			Other: Translation available upon request	
	Correspondence	Government responsibility	Language of request	Within the same turnaround time as the English.
	Form letters and surveys	Government responsibility	Bilingual format or in both languages	
	Stationery	Government responsibility	Bilingual format	
	Business cards/badges	Government responsibility	Bilingual for staff in designated positions	
	Display stands	Government responsibility	Bilingual format or in both languages	
	Signage	Government responsibility	Bilingual format	
	Forms & official documents	Government responsibility	Bilingual format or in both languages	
	Publications	Government responsibility	Bilingual format or in both languages, with exemptions for technical and scholarly documents; however, provision must be made to assist French-speaking citizens who wish to review exempted documents.	For online publications that are exempt from translation: If the English version is posted, post a fairly detailed précis in French so that the reader can grasp the content and some of the terminology.
	Householders	Government responsibility	Bilingual format	

Legend « In both languages » means two separate documents—one in French and one in English. « Bilingual » means both French and English in the same document (on the same page, on either side of the page or head-to-foot).

	Ad/Marketing campaign	Government responsibility	Both languages	Distribution / media placement in the Francophone media. The particularities and deadlines of French publications must be taken into account (generally not published daily).
	Promotional material	Government responsibility	Bilingual format or in both languages	French version may need to be adapted to be effective in reaching Francophone target audience.

ELECTRONIC FORMAT	Intranet	Government responsibility	English Documents in French if available	FLSA does not apply; however, documents in French can be very useful for bilingual employees (e.g., for vocabulary) and should be posted in French whenever possible.
	Internet sites (info)	Government responsibility	Both languages	English and French posted simultaneously.
	Newsroom	Government responsibility	Both languages	The option of subscribing to the news service in English or in French.
	News release/ backgrounder	Government responsibility	Both languages	English and French posted simultaneously. See External Links below.
	External links	Best reference	Links to French version of sites NEVER post a link to an English site or document without a notice such as *Site/document en anglais seulement*	Whenever possible, if a reference site only exists in English: - Refer to a similar site in French - Add the link to both English and French versions (indicating in the English that the site only exists in French, if that is the case). Ensure external links open in another window, making it clear that the visitor is leaving a government site.
	E-mail from public	Government responsibility	Language of request	Within the same turnaround time as the English.
	Speech transcript	Active offer	Important speeches: in both languages	Speeches should always contain sections in French. Key elements need to be considered. For more details, refer to p. 7.
			Other: Translation available upon request	
	Publications	Government responsibility	Bilingual format or in both languages, with exemptions for technical and scholarly documents with very limited target audiences.	For publications that are exempt: If the English version is posted, post a fairly detailed précis in French so that the reader can grasp the content and some of the terminology.

Legend « In both languages » means two separate documents—one in French and one in English. « Bilingual » means both French and English in the same document (on the same page, on either side of the page or head-to-foot).

	Blogs, journals	Active offer	Both languages Responses of the public in either English or French with a notice to that effect.	
	External sites (social networking, etc)	Active offer		
	Discussion forums	Active offer	Subject, context and introduction in both languages, as well as interventions from government spokesperson/minister if applicable. Contributions of the public in either English or French with a notice to that effect.	Compile and analyze contributions in both languages. When relevant, include subjects of particular interest to the Francophone community.

ORAL	In person	Government responsibility	Service in both languages	
	Telephone call	Government responsibility	Service in both languages	
	Conference/media scrum	Government responsibility	Depending on the minister's language skills For major announcements, ensure presence of bilingual staff	List of ministers who have French skills to be provided by Cabinet Office and updated after every Cabinet appointment.
	Speech	Active offer	Language of the speaker with passages in the other language	Key elements need to be considered. For more details, refer to p. 7.
	Public event	Government responsibility	Service in both languages	Key elements need to be considered. For more details, refer to p. 7.
	Statement in the Legislature	MPP discretion	Video simultaneous translation	
	Hearings	Government responsibility	Video simultaneous translation	
	Consultations	Government responsibility	Documents in both languages Bilingual staff or interpretation services	Organize separate discussion groups or consultations for subjects of particular interest to the Francophone community. When relevant, compile and analyze the views of Francophones separately, because they may have different concerns.

Legend « In both languages » means two separate documents—one in French and one in English. « Bilingual » means both French and English in the same document (on the same page, on either side of the page or head-to-foot).

AUDIO/VIDEO	Videos	Active offer	Video recordings of events: in the language of the event. Audio/Video productions: see p. 8.	In the website menus, identify videos that are only available in English.
	Pictures, maps & graphs	Government responsibility	Depending on the medium in which they appear (websites, videos, publications)	
	Podcasts, audio recordings	Active offer	As for videos	

Legend « In both languages » means two separate documents—one in French and one in English. « Bilingual » means both French and English in the same document (on the same page, on either side of the page or head-to-foot).

French Language Health Services (FLHS)

Revised Translation Service Guidelines

October 2011

TABLE OF CONTENTS

BACKGROUND

The Office of French Language Health Services funds a Translation Network[1], comprised of translation offices staffed by professional translators, to assist identified and designated transfer payment agencies (TPAs), in the provision of quality written material in French to the general public.[2]

ELIGIBILITY

Designated agencies and those identified to offer French Language Services can request the Translation Network's FREE services, FROM ENGLISH TO FRENCH (except where otherwise indicated), for the following types of documents intended for the general public.

The Translation Network reserves the right to decline a request for translation based on timeframes, budget allocations or other factors. In all cases, the Administrator Translator (AT), in collaboration with the Senior Administrator, makes the final decision regarding the admissibility of a request.

Admissible Translation Requests

AFF Signage (including temporary signs) in areas accessible to clients and the general public, except for signage intended for staff only.

ANN Job postings and interview questions (to be asked in French only) for positions where French language skills are a requirement or an asset.

APP Documents published by a third party, which support programs and services offered by an agency and which are essential or useful to a client recovering from a disease, surgery or medical treatment. Before sending documents for translation, the agency must receive written permission from the third party to use its documents and have them translated. This type of translation request is subject to the approval of the Senior Administrator of the Translation Network.

BUL Newsletters or sections of newsletters intended solely for the general public.

CAF Business cards for employees able to offer services in French.

COM Press releases, media notices.

[1] Affiliated to the French Language Health Services Program of the Ontario Ministry of Health and Long-Term Care.

[2] The term "general public" includes, but is not limited to the following groups: clients/patients/residents of an agency; volunteers; members of the community who receive general health information from an agency; school boards, schools, teachers and students; members of a resident council or patient alumni association; daycares and day care workers; members of the community who sit on a working group. Health care professionals are generally not included in these groups.

CON Consent forms, including consents to research projects and clinical trials involving patients or members of the general public.

COPT Correspondence from an agency to a client or members of the general public who speak French (letters, acknowledgement of receipt, notices of annual general meetings, etc.)

CPU Correspondence from a French-speaking client or member of the general public to an agency (translation from French to English), when the translation of this material is essential to the delivery of quality care to this individual.

DIR Client instructions (e.g. fire and safety rules).

DIS Speeches.

DOC Public consultation documents.

DOS Therapy reports or summaries of patient files to be given to the client.

EXP Display material, banners and posters intended for the general public.

FON Fundraising material (correspondence, forms, flyers, etc.) for distribution to the general public.

FOR Forms, surveys or questionnaires to be filled out or signed by clients or members of the general public.

INF Information provided or published by an agency (e.g. educational material, brochures, flyers, guides) for use by clients or the general public, if equivalent material does not already exist in French, including mission and vision statements and terms of reference for committees with public representation.

INS Name tags.

JOU Newspaper notices, advertisements and articles for publication in French.
N.B.: Notices, advertisements and articles to be published in English newspapers must contain a statement in French indicating where readers can obtain information in French. Notices, advertisements and articles to be published in French newspapers must contain a statement in English indicating where readers can obtain information in English.

MAJ Updates of existing documents previously translated by the FLHS Translation Network. **Please note that agencies are responsible for indicating where changes have been made.**

MEN Menus for clients and residents of an agency.

MES Messages recorded on a voice mail system.

PLA French language service regional plans and any supporting documents, including designation plans.

PRO Motions at meetings of boards, councils or subcommittees (English to French) and, exceptionally, motions at meetings of French language service committees (French to English).

RAN Annual reports of agencies which will use this information to communicate with the public, through newspapers or distribution in the community.

RAP Reports, executive summaries, studies and recommendations issued by an agency and intended for the general public.

REC Promotional material to recruit health care professionals who can offer quality services in French.

REU Meeting notices, agendas and material distributed at a public meeting or at a working group meeting with participants from the community.

VID Scripts for videos intended for clients and the general public. If the video has been produced by a third party, the agency must receive permission from the third party to have the script translated. This type of translation request is subject to the approval of the Senior Administrator of the Translation Network.

VOL Information, procedures, guidelines or newsletters for volunteers of an agency.

WEB All information intended for the general public that is admissible according to the descriptions above, for inclusion on a website. This includes navigation buttons, menus and side bars.

The following types of documents do not qualify for free translation services. This does not mean, however, that they would not be beneficial to the intended audience if an agency chose to have them translated at its expense.

Inadmissible Translation Requests

ACA Administrative correspondence between agencies.

AFI Signs (permanent or temporary) in areas not accessible to clients or the general public.

ANA Job postings for positions where French language skills are **NOT** a requirement or an asset.

AUT Copyrighted documents for which permission to translate was not granted.

BUI Material intended for staff, professionals or other agencies.

COR Revision of French material written by French-speaking staff.

COS Consent forms for research projects and clinical trials, not intended for patients and the general public, but for health care professionals and/or other academics OR sponsored by a private company.

DEJ Documents for which there is an existing translation or a relatively similar French equivalent that can be adapted to meet the needs of an agency, at the discretion of the Translation Network Senior Administrator.

DIV Documents for which the MOHLTC or other ministry/agency/corporation has granted funding for translations or advised the agency to foresee translation costs.

FIN Grant proposals and requests for funding.

FTA Documents to be translated from French to English (except where otherwise indicated).

INT Internal documents and forms (for staff only), i.e. bylaws, policies, strategic plans.

JOB Job descriptions.

LON Very lengthy documents for which translation costs would be excessive.

MEM Memorandums of understanding between agencies and others (e.g. school boards).

MOH Documents for programs not funded by the MOHLTC.

OND Documents produced by an agency excluded from the regional or provincial list of designated or identified agencies.

PAT Requests that do not allow sufficient lead time.

PRV Complete minutes of board, subcommittee or French Language Services Committee meetings.

RFP Documents that an agency should provide in French in accordance with a contract obtained through a request for proposals.

SCI Academic papers, commissioned reports on technical questions, technological development updates and literature reviews in specialized areas of research.

VEN Material for which the translation will subsequently be sold for profit by the agency or a third party.

WID Information not widely distributed to the general public or target audience (with the exception of personal correspondence).

There may be documents and circumstances other than those listed above. In these cases, the translation offices will consult the Senior Administrator of the Translation Network.

TRANSMITTAL

Texts to be translated should be sent by e-mail. Agencies are to send only final approved versions of documents to be translated, allowing for timely and efficient delivery of translation services. Agencies should inform the AT of incoming e-mails with large files attached, as space limitations on some servers may prevent a message from being delivered. The electronic size of a file increases with elaborate layouts containing graphics, pictures, etc.

REQUEST FOR SERVICE FORM

A ***STANDARDIZED*** Request for Service form (attached) must be completed for each request. Agencies must send the completed request form to the translation office.

WORD COUNT

Agencies must always indicate a word count on the request form. Most software programs have a function that counts the number of words typed in the document. Please note that text boxes are not included in the word count and therefore these words must be counted separately and added to the total count. If the word count function is not available, the agency is still required to provide the exact number of words in the document.

EQUIVALENT FRENCH MATERIAL

Upon receipt of a request for service, the translation office will check if the document is already translated or if an equivalent (i.e. covering the same subject) is available in French. If so, the translation office may inform the agency of the existing equivalent. If the agency is interested in using an equivalent document already available in French, they may take steps to obtain appropriate permission to use the document.

LAYOUT

Translation offices can perform simple layout tasks, but they are not responsible for complex layouts (e.g. charts, graphics).

TIME FRAMES

Since the translation offices serve over 400 agencies, we ask that agencies consider the translation process early in the planning stage of developing a document, especially lengthy or time-sensitive ones . In cases of lengthy documents, agencies should estimate the number of pages or words that will need to be translated and contact the translation office in advance to discuss feasibility and timelines. We ask that only FINAL versions be sent to the translation offices in order to increase efficiency of service.

The response time to a translation request varies according to the nature of the document. Documents to be published or distributed within a very short time frame, such as press releases, postings, letters, etc., may be dealt with before less urgent requests. Material needed for a public health emergency will be translated promptly upon receipt. The urgency of a request will be determined by the AT. In the event of an urgent request, clients are asked to confirm by telephone and not rely solely on e-mail.

There may be instances when the lead time is insufficient, in which case the translation request may be considered ”inadmissible” and the agency will be encouraged to obtain translation services by contacting freelance translators directly.

DISTRIBUTION OF TRANSLATED MATERIAL

In keeping with the *French Language Services Guidelines* of the Office of Francophone Affairs, information material, such as publications, forms, news releases, speeches, fact sheets, promotional packages, advertisements, signs and notices, etc., intended for public display and/or distribution should be available simultaneously in English and French and of equal quality.

The English version of a document should bear the wording *“Document disponible en français”*. Similarly, the French translation should bear the wording *“This document is available in English”*.

REQUESTS FOR MATERIAL WHICH WILL BE SOLD

Translation offices will not translate material if the French version is intended to be sold for profit.

TRANSLATION FROM FRENCH TO ENGLISH

Translation offices will not translate documents from French to English, except for motions at meetings of FLS committees and correspondence from French-speaking members of the public (see list of admissible and inadmissible documents).

Agencies that are implementing FLS should have French-speaking staff to assist with the interpretation of documents written in French (e.g. patient files written in French). However, French-speaking staff should not be expected to produce accurate written translated versions of these documents. If the documents are complex and the agencies want to obtain translated versions, the documents should be sent to freelance translators specialized in translation from French to English and the agencies will assume responsibility for the translation costs. A list of certified English translators is available from any translation office.

DOCUMENTS WRITTEN IN FRENCH BY AGENCY STAFF

Translation offices will not revise texts written in French by agency staff. Agencies are responsible for obtaining the required materials and equipment to use when French-speaking staff wish to compose documents in French. This includes purchasing French language resources such as dictionaries and software. Costs related to purchasing such materials are the responsibility of the agency.

AGENCIES WHO SUPPLY SERVICES TO CCACs

Agencies that provide health care services on behalf of a CCAC through a contractual agreement CANNOT obtain free translation for documents linked to these particular services, or for documents describing their general services (ex. brochures, flyers, etc.). [Since CCACs purchase services through a competitive process, respondents to a request for proposal must calculate and include the additional costs of providing services in French in their quoted price. The Ministry cannot give an unfair advantage to some providers for future competitions.]

However, if those providers are mandated by the MOHLTC to provide a program of the Ministry, they can access our translation services for documents relating to such programs only.

CONFIDENTIALITY

Translation offices will ensure the confidentiality and security of the content of documents while in their possession for the purpose of translation and proofreading services. We ask that all identifying information (names, addresses, etc.) be removed from texts sent to our service.

PROOFREADING

If a translation is retyped or reformatted (in-house or by an outside firm), the agency should have the formatted version of the document proofread by the translation office prior to printing and distribution.

PROJECTS RECEIVING FUNDING FROM A THIRD PARTY

Projects receiving funding from a third party will not be entitled to FLHS Translation Services as we reserve our resources for project funded by agencies entitled to our services. In such cases where several partners are involved in a project, FLHS will only provide translation services if the lead-agency in the project is an FLHS Translation Network client.

COPYRIGHTED MATERIAL

With regards to texts protected by copyright, please note that it is the responsibility of the client requesting the translation to obtain written permission from the copyright holder to have the document translated. A copy of this authorization must accompany the translation request.

INTERNET TRANSLATION TOOLS

Please note that FLHS strongly advises against the use of instant translation tools commonly found on the Internet (i.e. Google Translate). Although these appear at first glance to be a quick and cost-free solution to your translation needs, they are extremely unreliable, can cause your agency additional costs and much embarrassment, as well as tarnish the positive relationship that you have worked so diligently to build with your Francophone clients. Please refer to Appendix A, Instant Translation Tools, for actual examples.

DISCLAIMER

Should an agency modify, retype or reformat a translated document without having it proofread by their FLHS translation office, the FLHS Translation Network will not be held responsible for errors.**CONTACT PERSON**

Your contact person for translation services is:

Louise Baillargeon, Translation Services Administrator/Translator
French Language Health Services
Welland Hospital Site
Niagara Health System
Third Street, Welland ON L3B 4W6
Telephone: 905 732-6111, ext. 32313 Fax: 905 732-2080
E-mail: lbaillargeon@niagarahealth.on.ca

Appendix

INSTANT TRANSLATION TOOLS

This appendix aims at demonstrating the possible hazards of using instant translation software for your translation needs. All examples below were taken from actual cases where agencies resorted to these means for their translation needs.

Original Text refers to English text for which a French translation was needed.

Automated Translation refers to the translation provided by the translation software or Internet site offering instant translation services.

Back Translation refers to the automated translation translated back into English, in order to demonstrate the obvious flaws in automated translation software.

Original Text	If you require medical advice – consult your family doctor or call Telehealth Ontario at 1-866-797-0000; For emergencies call 911 or go to the nearest emergency department.
Automated translation	Si vous avez besoin du conseil médical - consultez votre médecin de famille ou appel Telehealth Ontario à 1-866-797-0000; Pour l'appel d'urgence 911 ou allez au département le plus proche de secours.
Back Translation	If you need the medical council – call your family doctor or call Telehealth Ontario at 1-866-797-0000; For the urgent 911 call or go to the nearest department of help.

You will undoubted agree that the final product fails to convey the messages intended in the original text. In addition, it failed to translate 'Telehealth Ontario', it failed to conjugate the verb 'appel' and failed to use correct terminology.

Original Text	OVERNIGHT HOSPITAL STAYS As of Thursday, October 6, 2005, all in-patient services at the Ontario Street Site at 155 Ontario Street (formerly known as the Hotel Dieu Hospital) will be relocated to the St. Catharines General site at 142 Queenston Street, St. Catharines and to other sites across the Niagara Health Systems. Patients requiring overnight acute care hospital stays in the city of St. Catharines will be cared for at the St. Catharines General Site of the Niagara Health System.
Automated translation	SÉJOURS DURANT LA NUIT D'HÔPITAL En date de jeudi, octobre 6, 2005, tous les services d'hospitalisé à l'emplacement de rue d'Ontario à la rue de 155 Ontario (autrefois connue sous le nom d'hôpital de Dieu d'hôtel) seront replacés à l'emplacement général de rue Catharines à la rue de 142 Queenston, rue Catharines et à d'autres emplacements à travers les systèmes de santé de Niagara. Des patients ayant besoin des séjours aigus durant la nuit d'hôpital de soin dans la ville de la rue Catharines seront entretenus à l'emplacement général de rue Catharines du système de santé de Niagara.
Back Translation	HOSPITAL STAYS DURING THE HOSPITAL NIGHT Dated Thursday, October 6, 2005, all hospitalized services at the site of Ontario's street at the street of 155 ontario (in the past known as hôpital de Dieu d'hotel) will be placed once again at the general site of St, Catharines street and at other sites through the Niagara Health System. Patients needing acute hospital stays during the hospital night of care will be maintained at the general site of St. Catharines street of the Niagara Health System.

Where does one begin to describe this atrocity? It even attempted (unsuccessfully) to translate Hotel Dieu Hospital. The date format is incorrect. What is a 'hospitalized service'? Again, we can easily detect terminology errors, conjugation errors, etc. Note: it 'thinks' that St. Catharines is Catharines Street.

Original Text	When you need hospital care in St. Catharines, Thorold and surrounding area, you need to know that your health care team will be there for you. A number of important changes are taking place across in-patient and emergency care services at Niagara Health System Hospital sites located in the city of St. Catharines. To help serve you better, please take a moment to familiarize yourself with the changes.
Automated translation	Quand vous avez besoin du soin d'hospitalier dans la rue Catharines, Thorold et abords, vous devez savoir que votre équipe de santé sera là pour vous. Un certain nombre de changements importants interviennent à travers l'hospitalisé et les services de soin de secours aux emplacements d'hôpital de système de santé de Niagara situés dans la ville de la rue Catharines. Pour aider à vous servir mieux, prenez svp un moment pour se familiariser avec les changements.
Back Translation	When you need the *(has no meaning)* on St. Catherine street, Thorold and the area around it, you need to know that your health team will be there for you. A certain number of important changes intervene through the hospitalized and emergency help services at the Niagara Health System hospital sites in the city of Catharines Street. To help serve you better, please take a moment to get familiarized with the changes.

Again we see many problems with this example. 'Soin d'hospitalier' does not mean anything; Also note that it translated word per word the last sentence, which gave it as very poor style in French. Again, it 'thinks' that St. Catharines is Catharines Street.

Original Text	Free Parking Lot A
Automated translation	Libérer garant le Lot A
Back Translation	To Free warrantor the Lot A

Was warrantor sequestered?

Original Text	Staff Parking No parking Tuesdays between 8:00 am and 1:30 pm.
Automated translation	Équiper le parking Aucun parking le Mardi De 8 :00 am à 1 :30 pm
Back Translation	Equip the parking

I suppose the natural response would be: Equip it with what? Failed to translate the second word (parking = stationnement). French has its own way of rendering time (8 h à 13 h 30). Days of the week are not capitalized in French.

As you can probably conclude, these translations had to be redone and reposted, causing losses of time and resources. In some cases, enire signs had to be removed, reordered and reinstalled.

Because it has no idea of the context, translation software simply offers one of thousands of possibilities when translating, and more often than not, it will produce the wrong translation. Translating requires that you slip into a person's mind and convey his or her message. No software can accomplish this successfully.

Your Administrator/Translator is a trained professional with many years of experience. She can be trusted to do the job right the first time.

REQUEST FOR SERVICE

(Electronic format)

So that we may process your translation request promptly, please provide ALL requested information.

Title of document: Number of words:	☐ Translation from English to French ☐ Proofreading ☐ Update

Date translation required: ***(A specific date must be given. Please allow as much time as possible)***

Agency:	Department / Branch / Program:	
Contact person *(for general/administrative questions)*:	Tel.:	Ext.:
E-mail address:		
Resource person *(for content questions):*	Tel.:	Ext.:
E-mail address:		

Who is the intended audience for this document? **What is the source of the text** (Drop down menu below)**?**	How will the translated document be made available (Drop down menu below)?

Translation Instructions:

- Provide equivalents for titles specific to your agency (or indicate if they have never been translated before).
- Explain any abbreviations and acronyms.
- Ensure that only the final version of the document is submitted for translation.
- If retyping or reformatting translations, please send proof for final approval (see *Translation Services Guidelines*).

Translation Services Terms

- Documents translated through our services cannot be sold for profit.
- Only MOHLTC-funded programs designated or identified to offer French Language Services are eligible for translation services.
- Agencies that provide health care services on behalf of a CCAC through a contractual agreement cannot obtain free translation for documents linked to these particular services (for details, see *Translation Service Guidelines*).
- Translated documents should be equal in quality and availability to the English version.
- Texts protected by copyright cannot be translated without written permission from copyright holder.

I have read and I accept the above terms. Name: Date:

***PLEASE SEND YOUR REQUEST AND THE DOCUMENT VIA E-MAIL*:**

Louise Baillargeon, Translation Services Administrator/Translator
French Language Health Services
Welland Hospital Site
Niagara Health System
Third Street, Welland ON L3B 4W6
Telephone: 905 732-6111, ext. 32313 Fax: 905 732-2080

E-mail: lbaillargeon@niagarahealth.on.ca

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Toronto Central LHIN

425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4
Tel: 416 921-7453 • Fax: 416 921-0117
Toll Free: 1 866 383-5446
www.torontocentrallhin.on.ca

Fact Sheet

Language Services Toronto

- A key program for the Toronto Central LHIN that will significantly increase access to health care services for immigrants, seniors and other limited-English speakers;
- Addresses the need for accessible, high quality medical interpretation services, a top health equity issue identified by the TC LHIN.
- 19 hospitals, 14 community agencies, including a family health team and the CCAC in Toronto Central, Central, Central East, Central West and Waterloo-Wellington LHINs will offer the service.
- The TC LHIN saw that hospitals were purchasing their own telephone interpretation services and paying vastly different rates, ranging from $1.70/minute to $8/minute.
    - The LHIN saw an ideal opportunity for hospitals and other agencies to bulk purchase phone interpretation services as a way to cut costs while offering language support to more patients.
    - The LHIN also saw the need to offer support to non-English patients receiving home care and community health services. With these low rates, TC LHIN is funding community agencies and health centres in Toronto to offer this service.

Significance of Language Services Toronto

For the Patient

- Approximately 400,000 to 500,000 people in the GTA have limited English ability and require interpretation support in a medical setting.
- Language Services Toronto will provide increased and expanded access to high-quality phone interpretation services in many more hospitals and community agencies throughout the GTA.
- Immigrants and others facing language barriers experience better health outcomes and have fewer health problems when they receive care in their own language.
- Evidence shows that seniors need interpretation services more than others.
    - Particularly, those with dementia often see a diminished ability to speak a second language as they age.

Ontario Local Health Integration Network

For Health System

- When non-English speaking patients are unable to understand treatment instructions, or when miscommunication leads to errors, there is not only harm to patients, but also an unnecessary cost to the health care system.
- Through bulk-purchasing the service, hospitals and community health agencies will see a lower rate, with some hospitals seeing their rates drop by as much as 80 per cent - savings that can be reinvested back into the health care system.

Where to Access Language Services Toronto

(List hospitals and agencies)

Hospitals

- Baycrest
- Bridgepoint Health
- Centre for Mental Health and Addictions
- Holland Bloorview Kids Rehabilitation Hospital
- Hospital for Sick Children
- Humber River Regional Hospital
- Lakeridge Health Care
- Mount Sinai Hospital
- North York General Hospital
- Providence Healthcare
- Rouge Valley Health System
- St. Joseph's Health Centre
- Sunnybrook Health Sciences Centre
- Toronto East General Hospital
- University Health Network
- West Park Healthcare Centre
- William Osler Health System
- Women's College Hospital
- Guelph General Hospital

Community

- Alzheimer Society of Toronto
- Access Alliance Multicultural Health and Community Services
- Canadian Mental Health Association - Toronto Branch
- Four Villages Community Health Centre

- Humber Community Seniors Services Inc.
- Jean Tweed Centre
- Parkdale Community Health Centre
- St. Stephen's Community House
- Stonegate Community Health Centre
- Storefront Humber Inc.
- Toronto Central Community Care Access Centre
- Taddle Creek Family Health Team
- Unison Health and Community Services
- WoodGreen Community Services
- Women's Health in Women's Hands

Top 10 Languages Spoken in Toronto after the Official Languages*

More than 170 different languages and dialects spoken in TC LHIN that will be supported through Language Services Toronto:

1. Italian
2. Chinese languages
3. Cantonese
4. Punjabi
5. Portuguese
6. Spanish
7. Tagalog
8. Urdu
9. Tamil
10. Polish

*According to Statistics Canada, 2006 Population Census.

Section 7

Legislation regarding French Language Services

Section 7
Legislation regarding French Language Services

Our two official languages, English and French, are fundamental characteristics of our Canadian identity. This is why throughout its history, our country has passed laws and adopted policies to better protect and promote its official languages. In Ontario, the *French Language Services Act* (FLSA) guarantees the rights of the Franco-Ontarian population.

French Language Services Act

The *French Language Services Act, R.S.O. 1990* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 25 designated areas (see pages 249–250).

The preamble of the FLSA *recognizes the contribution of the cultural heritage of the French-speaking population and wishes to preserve it for future generations*.[13]

"In the Lalonde case (also known as the Montfort case), the Ontario Court of Appeal established that... the FLSA must be interpreted in light of the fundamental constitutional principle of respect for and protection of minorities. Consequently, it must be interpreted broadly and liberally, in accordance with its objectives of promoting and protecting Ontario's Francophone community. The Ontario Court of Appeal also recognized the quasi constitutional nature of the FLSA."[14]

Under the FLSA, all services that are provided to the public by a ministry or agency of the Government of Ontario should be made available in French in the government offices located in or serving a designated area. In the Erie St. Clair LHIN, designated areas include the City of Windsor, the towns of Belle River and Tecumseh, the townships of Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West and Rochester as well as the town of Tilbury and the townships of Dover and Tilbury East. In the South West LHIN, designated areas include the City of London. As crown corporations of the Government of Ontario, Local Health Integration Networks (LHINs) are subject to the FLSA. They must ensure that their services and the services they fund are available in French to the Francophone population.

13 *French Language Services Act*, R.S.O. 1990.

14 *Special Report on French Language Health Services Planning in Ontario*, p. 13.

Agencies that are partially funded by the province (hospitals, daycare centers, group homes, etc.) are not automatically subject to the FLSA. These agencies may ask to be officially designated, in which case Cabinet will pass a regulation to designate them as official providers of services in French.[15]

As just noted, health service providers are not automatically subject to the FLSA. The LHIN has the authority to identify any or all of its providers, as recipients of public funding, to plan and deliver their services in French and to report on their progress to the LHIN. The long-term goal is to bring these "identified" providers to ask for designation under the FLSA.

Please refer to the FLSA and its regulations on pages 225–247.

Local Health System Integration Act, 2006

In its preamble, the *Local Health System Integration Act* (LHSIA) declares that: "The people of Ontario and their government believe that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the *French Language Services Act* in serving Ontario's French-speaking community." The Erie St. Clair and South West LHINs, as all LHINs in Ontario, work to support both the LHSIA and the FLSA.

Please refer to the LHSIA and regulation 284/11 on pages 251–276.

French Language Health Planning Entities

Under LHSIA, LHINs have an obligation to engage the French Language Health Planning Entity (FLHPE) in their geographic area. Six entities have been created across the province. Locally, one entity covers both Erie St. Clair and South West LHIN areas.

The mandate of FLHPEs is to advise the LHINS on:

- *methods of engaging the Francophone community in the area;*
- *the health needs and priorities of the Francophone community in the area, including the needs and priorities of diverse groups within that community;*
- *the health services available to the Francophone community in the area.*
- *the identification and designation of health service providers for the provision of French language health services in the area;*
- *strategies to improve access to, accessibility of and integration of French language health services in the local health system; and*
- *the planning for and integration of health services in the area.*[16]

15 Office of Francophone Affairs, www.ofa.gov.on.ca/en/flsa.html

16 O. Reg. 515/09, s.3 (1).

For more information on the Erie St. Clair/South West French Language Health Planning Entity, please see pages 277–278 or visit their website at www.entite1.ca.

Office of Francophone Affairs

The Office of Francophone Affairs (OFA) works with the ministries to ensure that the FLSA is applied. It ensures that the public has access to services in French in the 25 designated areas and provides information on the province's Francophone population to other levels of government and the public.

Specifically, the OFA:

- *Supports the Minister Responsible for Francophone Affairs in the development of French-language services, policies and programs that meet the needs of Ontario's Francophones;*
- *Provides expert advice on matters relating to Francophones and the delivery of French-language services;*
- *Gathers and provides information on Ontario's Francophone community;*
- *Acts as a link between the Francophone community and government ministries and their agencies.*[17]

To read more on the OFA, visit www.ofa.gov.on.ca/en/ofa.html.

French Language Services Commissioner

The Office of the French Language Services Commissioner is an agency of the Government of Ontario. Its primary mandate is to ensure compliance with the FLSA in the delivery of government services. As such, the French Language Services Commissioner conducts independent investigations under the FLSA, either in response to complaints or on his own initiative, prepares reports on his investigations and monitors the progress made by government agencies in the delivery of French-language services in Ontario.

The French Language Services Commissioner reports directly to the Minister Responsible for Francophone Affairs. He advises the Minister and makes recommendations to the Minister with respect to the application of the Act. Working independently of the Office of Francophone Affairs, the Office of the French Language Services Commissioner's primary roles are:

- *To listen to the Francophone population;*
- *To receive and handle complaints and to follow up on them;*

17 Office of Francophone Affairs, www.ofa.gov.on.ca/en/ofa.html.

- *To increase the public service's awareness of the public's expectations;*
- *To exercise its powers of investigation and to make recommendations with respect to the delivery of French-language services;*
- *To advise the Minister and make recommendations to her.*[18]

To learn more about the French Language Services Commissioner and to read his annual and special reports, please visit www.flsc.gov.on.ca/en.

Health Equity Impact Assessment (HEIA)

The Ministry of Health and Long-Term Care has identified equity as a key component of quality care. The Ministry has developed HEIA to support improved health equity, including the reduction of avoidable health disparities between population groups. HEIA also supports improved targeting of health care investments—the right care, at the right place, at the right time.

HEIA is a decision support tool which walks users through the steps of identifying how a program, policy or similar initiative will impact population groups in different ways. HEIA surfaces unintended potential impacts. The end goal is to maximize positive impacts and reduce negative impacts that could potentially widen health disparities between population groups—in short, more equitable delivery of the program, service, policy etc. Effective use of HEIA is dependent on good evidence.

The HEIA tool that has been developed by MOHLTC has four key objectives:

1. *Help identify unintended potential health equity impacts of decision-making (positive and negative) on specific population groups;*
2. *Support equity-based improvements in policy, planning, program or service design;*
3. *Embed equity in an organization's decision-making processes;*
4. *Build capacity and raise awareness about health equity throughout the organization.*[19]

For more information, please see the HEIA Tool on pages 279–332 or visit www.health.gov.on.ca/en/pro/programs/heia/tool.aspx.

Impact of Language Barriers

Language barriers put not only the patient at risk, but also the health service provider, and they jeopardize the safety of the patient. Communication problems may lead to:

- *reduced patient compliance;*

18 French Language Services Commissioner, www.csf.gouv.on.ca/en/mandat/.

19 MOHLTC, www.health.gov.on.ca/en/pro/programs/heia/.

- *reduced access to preventative care/services;*
- *mistaken diagnosis/medical errors;*
- *increased numbers of tests/medical consultations;*
- *negative health repercussions;*
- *critical incidents;*
- *lower patient and provider satisfaction; and*
- *higher healthcare costs.*[20]

By removing language barriers, health service providers will not only improve health outcomes of the Francophone population but also contribute to the betterment of the health status of the whole community.

> *"Language barriers have been demonstrated to have adverse effects on access to health care, quality of care, rights of patients, patient and provider satisfaction, and most importantly, on patient health outcomes. ((…)) There is also evidence that language barriers contribute to inefficiencies within the health system."*
>
> Sarah Bowen, *Language Barriers in Access to Health Care*, Health Canada, 2001.

20 Bowen, S. and J. Roy. *Intégration des services d'interprétation dans la gestion des risques*, p. 6.

Section 7

List of Appendixes

French Language Services Act

Ontario Regulation 407/94

Ontario Regulation 398/93

Ontario Regulation 671/92

Ontario Regulation 284/11

Map of Designated Areas

Local Health System Integration Act

Ontario Regulation 515/09

Erie St. Clair/South West French Language Health Planning Entity

Health Equity Impact Assessment (HEIA) Workbook

French Language Services Supplement

HEIA Template

French Language Services Act

R.S.O. 1990, CHAPTER F.32

Consolidation Period: From June 1, 2011 to the e-Laws currency date.

Last amendment: 2009, c. 33, Sched. 6, s. 60.

Preamble

Whereas the French language is an historic and honoured language in Ontario and recognized by the Constitution as an official language in Canada; and whereas in Ontario the French language is recognized as an official language in the courts and in education; and whereas the Legislative Assembly recognizes the contribution of the cultural heritage of the French speaking population and wishes to preserve it for future generations; and whereas it is desirable to guarantee the use of the French language in institutions of the Legislature and the Government of Ontario, as provided in this Act;

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Definitions

1. In this Act,

"Commissioner" means the French Language Services Commissioner appointed under section 12.1; ("commissaire")

"government agency" means,

(a) a ministry of the Government of Ontario, except that a psychiatric facility, residential facility or college of applied arts and technology that is administered by a ministry is not included unless it is designated as a public service agency by the regulations,

(b) a board, commission or corporation the majority of whose members or directors are appointed by the Lieutenant Governor in Council,

(c) a non-profit corporation or similar entity that provides a service to the public, is subsidized in whole or in part by public money and is designated as a public service agency by the regulations,

(d) a long-term care home as defined in the *Long-Term Care Homes Act, 2007* that is designated as a public service agency by the regulations, other than a municipal home or joint home established under Part VIII of the *Long-Term Care Homes Act, 2007*, or a home for special care as defined in the *Homes for Special Care Act* that is designated as a public service agency by the regulations,

(e) a service provider as defined in the *Child and Family Services Act* or a board as defined in the *District Social Services Administration Boards Act* that is designated as a public service agency by the regulations,

and does not include a municipality, or a local board as defined in the *Municipal Affairs Act*, other than a local board that is designated under clause (e); ("organisme gouvernemental")

"service" means any service or procedure that is provided to the public by a government agency or institution of the Legislature and includes all communications for the purpose. ("service") R.S.O. 1990, c. F.32, s. 1; 1997, c. 25, Sched. E, s. 3; 2007, c. 7, Sched. 16, s. 1; 2007, c. 8, s. 204.

Provision of services in French

2. The Government of Ontario shall ensure that services are provided in French in accordance with this Act. R.S.O. 1990, c. F.32, s. 2.

Use of English or French in Legislative Assembly

3. (1) Everyone has the right to use English or French in the debates and other proceedings of the Legislative Assembly. R.S.O. 1990, c. F.32, s. 3 (1).

Bills and Acts of the Assembly

(2) The public Bills of the Legislative Assembly introduced after the 1st day of January, 1991 shall be introduced and enacted in both English and French. R.S.O. 1990, c. F.32, s. 3 (2).

Translation of Statutes

4. (1) Before the 31st day of December, 1991, the Attorney General shall cause to be translated into French a consolidation of the public general statutes of Ontario that were re-enacted in the Revised Statutes of Ontario, 1980, or

enacted in English only after the coming into force of the Revised Statutes of Ontario, 1980, and that are in force on the 31st day of December, 1990. R.S.O. 1990, c. F.32, s. 4 (1).

Enactment

(2) The Attorney General shall present the translations referred to in subsection (1) to the Legislative Assembly for enactment. R.S.O. 1990, c. F.32, s. 4 (2).

Translation of regulations

(3) The Attorney General shall cause to be translated into French such regulations as the Attorney General considers appropriate and shall recommend the translations to the Executive Council or other regulation-making authority for adoption. R.S.O. 1990, c. F.32, s. 4 (3).

Right to services in French

5. (1) A person has the right in accordance with this Act to communicate in French with, and to receive available services in French from, any head or central office of a government agency or institution of the Legislature, and has the same right in respect of any other office of such agency or institution that is located in or serves an area designated in the Schedule. R.S.O. 1990, c. F.32, s. 5 (1).

Duplication of services

(2) When the same service is provided by more than one office in a designated area, the Lieutenant Governor in Council may designate one or more of those offices to provide the service in French if the Lieutenant Governor in Council is of the opinion that the public in the designated area will thereby have reasonable access to the service in French. R.S.O. 1990, c. F.32, s. 5 (2).

Idem

(3) If one or more offices are designated under subsection (2), subsection (1) does not apply in respect of the service provided by the other offices in the designated area. R.S.O. 1990, c. F.32, s. 5 (3).

Existing practice protected

6. This Act shall not be construed to limit the use of the English or French language outside of the application of this Act. R.S.O. 1990, c. F.32, s. 6.

Limitation of obligations of government agencies, etc.

7. The obligations of government agencies and institutions of the Legislature under this Act are subject to such limits as circumstances make reasonable and necessary, if all reasonable measures and plans for compliance with this Act have been taken or made. R.S.O. 1990, c. F.32, s. 7.

Regulations

8. The Lieutenant Governor in Council may make regulations,

(a) designating public service agencies for the purpose of the definition of "government agency";

(b) amending the Schedule by adding areas to it;

(c) exempting services from the application of sections 2 and 5 where, in the opinion of the Lieutenant Governor in Council, it is reasonable and necessary to do so and where the exemption does not derogate from the general purpose and intent of this Act. R.S.O. 1990, c. F.32, s. 8.

Public service agencies; limited designation

9. (1) A regulation designating a public service agency may limit the designation to apply only in respect of specified services provided by the agency, or may specify services that are excluded from the designation. R.S.O. 1990, c. F.32, s. 9 (1).

Consent of university

(2) A regulation made under this Act that applies to a university is not effective without the university's consent. R.S.O. 1990, c. F.32, s. 9 (2).

Notice and comment re exempting regulation, etc.

10. (1) This section applies to a regulation,

(a) exempting a service under clause 8 (c);

(b) revoking the designation of a public service agency;

(c) amending a regulation designating a public service agency so as to exclude or remove a service from the designation. R.S.O. 1990, c. F.32, s. 10 (1).

Idem

(2) A regulation to which this section applies shall not be made until at least forty-five days after a notice has been published in *The Ontario Gazette* and a newspaper of general circulation in Ontario setting forth the substance of the proposed regulation and inviting comments to be submitted to the Minister responsible for Francophone Affairs. R.S.O. 1990, c. F.32, s. 10 (2).

Idem

(3) After the expiration of the forty-five day period, the regulation with such changes as are considered advisable may be made without further notice. R.S.O. 1990, c. F.32, s. 10 (3).

Responsible Minister

11. (1) The Minister responsible for Francophone Affairs is responsible for the administration of this Act. R.S.O. 1990, c. F.32, s. 11 (1).

Functions

(2) The functions of the Minister are to develop and co-ordinate the policies and programs of the government relating to Francophone Affairs and the provision of French language services and for the purpose, the Minister may,

(a) prepare and recommend government plans, policies and priorities for the provision of French language services;

(b) co-ordinate, monitor and oversee the implementation of programs of the government for the provision of French language services by government agencies and of programs relating to the use of the French language;

(c) make recommendations in connection with the financing of government programs for the provision of French language services;

(d) REPEALED: 2007, c. 7, Sched. 16, s. 2 (1).

(e) require the formulation and submission of government plans for the implementation of this Act and fix time limits for their formulation and submission,

and shall perform such duties as are assigned to the Minister by order in council or by any other Act. R.S.O. 1990, c. F.32, s. 11 (2); 1993, c. 27, Sched.; 2007, c. 7, Sched. 16, s. 2 (1).

Annual report

(3) The Minister, after the close of each fiscal year, shall submit to the Lieutenant Governor in Council an annual report upon the affairs of the Office of Francophone Affairs and shall then lay the report before the Assembly if it is in session or, if not, at the next session. R.S.O. 1990, c. F.32, s. 11 (3).

Regulations

(4) Subject to the approval of the Lieutenant Governor in Council, the Minister responsible for Francophone Affairs may make regulations generally for the better administration of this Act and, without limiting the generality of the foregoing,

(a) governing the publication of government documents in French;

(b) governing the provision of services in French under a contract with a person who has agreed to provide services on behalf of a government agency, including the circumstances in which the agency may enter into such a contract. 2007, c. 7, Sched. 16, s. 2 (2).

Office for Francophone Affairs

12. (1) Such employees as are considered necessary shall be appointed under Part III of the *Public Service of Ontario Act, 2006* for the administration of the functions of the Minister responsible for Francophone Affairs, and shall be known as the Office of Francophone Affairs. R.S.O. 1990, c. F.32, s. 12 (1); 2006, c. 35, Sched. C, s. 48.

Function of Office of Francophone Affairs

(2) The Office of Francophone Affairs may,

(a) review the availability and quality of French language services and make recommendations for their improvement;

(b) recommend the designation of public service agencies and the addition of designated areas to the Schedule;

(c) require non-profit corporations and similar entities, facilities, homes and colleges referred to in the definition of "government agency" to furnish to the Office information that may be relevant in the formulation of recommendations respecting their designation as public service agencies;

(d) recommend changes in the plans of government agencies for the provision of French language services;

(e) make recommendations in respect of an exemption or proposed exemption of services under clause 8 (c),

and shall perform any other function assigned to it by the Minister responsible for Francophone Affairs, the Executive Council or the Legislative Assembly. R.S.O. 1990, c. F.32, s. 12 (2); 1993, c. 27, Sched.

French Language Services Commissioner

12.1 (1) The Lieutenant Governor in Council shall appoint an individual to act as French Language Services Commissioner. 2007, c. 7, Sched. 16, s. 3.

Official name

(2) The person appointed shall be known in English as the French Language Services Commissioner and in French as commissaire aux services en français. 2007, c. 7, Sched. 16, s. 3.

Office established

(3) There is hereby established an office to be known in English as the Office of the French Language Services Commissioner and in French as Commissariat aux services en français. 2007, c. 7, Sched. 16, s. 3.

Employees

(4) Such employees as are considered necessary shall be appointed under the *Public Service of Ontario Act, 2006* for the administration of the functions of the Office of the French Language Services Commissioner. 2007, c. 7, Sched. 16, s. 3, 4.

Temporary replacement

(5) The Commissioner may designate in writing an employee in his or her office to act on a temporary basis in his or her place when the Commissioner is for any reason unable to carry out his or her functions and, when acting in that capacity, the designate has all the powers of the Commissioner, subject to any conditions, limitations or restrictions set out in the designation. 2007, c. 7, Sched. 16, s. 3.

Immunity

(6) No proceeding shall be commenced against the Commissioner or any employee in the Commissioner's office for any act done or omitted in good faith in the execution or intended execution of his or her duties under this Act. 2007, c. 7, Sched. 16, s. 3.

Crown liability

(7) Despite subsections 5 (2) and (4) of the *Proceedings Against the Crown Act*, subsection (6) does not relieve the Crown of any liability to which the Crown would otherwise be subject. 2007, c. 7, Sched. 16, s. 3.

Functions of Commissioner

12.2 It is the function of the Commissioner to encourage compliance with this Act by,

(a) conducting investigations into the extent and quality of compliance with this Act, pursuant to complaints relating to French language services made by any person or on the Commissioner's own initiative;

(b) preparing reports on investigations, including recommendations for improving the provision of French language services;

(c) monitoring the progress made by government agencies in providing French language services;

(d) advising the Minister on matters related to the administration of this Act; and

(e) performing such other functions as may be assigned to the Commissioner by the Lieutenant Governor in Council. 2007, c. 7, Sched. 16, s. 3.

Commissioner's discretion to investigate complaints

12.3 (1) The Commissioner may, in his or her discretion, decide not to take any action based on a complaint relating to French language services, including refusing to investigate or ceasing to investigate any complaint, if, in his or her opinion,

(a) the subject-matter of the complaint is trivial;

(b) the complaint is frivolous or vexatious or is not made in good faith;

(c) the subject-matter of the complaint has already been investigated and dealt with;

(d) the subject-matter of the complaint does not involve a contravention of or failure to comply with this Act or, for any other reason, does not come within the authority of the Commissioner under this Act. 2007, c. 7, Sched. 16, s. 3.

Notice to complainant

(2) If the Commissioner decides not to act on a complaint, or to take no further actions with regard to a complaint, he or she shall give the complainant notice in writing of the decision, and of the reasons for it. 2007, c. 7, Sched. 16, s. 3.

Investigations

12.4 (1) Subject to this Act, the Commissioner may determine the procedure to be followed in conducting an investigation. 2007, c. 7, Sched. 16, s. 3.

Notice to be given to deputy head

(2) Before beginning an investigation, the Commissioner shall inform the deputy head or other administrative head of the government agency concerned of his or her intention to conduct an investigation. 2007, c. 7, Sched. 16, s. 3.

Application of *Public Inquiries Act, 2009*

(3) Section 33 of the *Public Inquiries Act, 2009* applies to an investigation by the Commissioner. 2009, c. 33, Sched. 6, s. 60.

Report on results of investigation

(4) The Commissioner shall report the results of an investigation,

(a) where the investigation arises from a complaint, to the complainant, the deputy head or other administrative head of the government agency concerned and the Minister;

(b) where the investigation is at the Commissioner's own initiative, to the deputy head or other administrative head of the government agency concerned and the Minister. 2007, c. 7, Sched. 16, s. 3.

Annual and special reports

12.5 (1) The Commissioner shall prepare and submit to the Minister responsible for Francophone Affairs an annual report on his or her activities, which may include recommendations for improving the provision of French language services. 2007, c. 7, Sched. 16, s. 3.

Special report

(2) The Commissioner may at any time make a special report to the Minister on any matter related to this Act that, in the opinion of the Commissioner, should not be deferred until the annual report and may request the Minister to submit it to the Speaker of the Assembly to be laid before the Assembly. 2007, c. 7, Sched. 16, s. 3.

Tabling of report

(3) The Minister shall, without delay, submit to the Speaker the annual report and any special report that the Commissioner requests the Minister to submit under subsection (2), and the Speaker shall lay it before the Assembly forthwith if it is in session or, if not, at the next session. 2007, c. 7, Sched. 16, s. 3.

Publication of report

12.6 The Commissioner may publish, in any manner he or she considers appropriate, a report mentioned in this Act 30 days after it has been given to the Minister, unless the Minister consents to the report's earlier publication. 2007, c. 7, Sched. 16, s. 3.

French language services co-ordinators

13. (1) A French language services co-ordinator shall be appointed for each ministry of the government. R.S.O. 1990, c. F.32, s. 13 (1).

Committee

(2) There shall be a committee consisting of the French language services co-ordinators, presided over by the senior official of the Office of Francophone Affairs. R.S.O. 1990, c. F.32, s. 13 (2).

Communication

(3) Each French language services co-ordinator may communicate directly with his or her deputy minister. R.S.O. 1990, c. F.32, s. 13 (3).

Deputy minister

(4) Each deputy minister is accountable to the Executive Council for the implementation of this Act and the quality of the French language services in the ministry. R.S.O. 1990, c. F.32, s. 13 (4).

Municipal by-laws re official languages

14. (1) The council of a municipality that is in an area designated in the Schedule may pass a by-law providing that the administration of the municipality shall be conducted in both English and French and that all or specified municipal services to the public shall be made available in both languages. R.S.O. 1990, c. F.32, s. 14 (1).

Right to services in English and French

(2) When a by-law referred to in subsection (1) is in effect, a person has the right to communicate in English or French with any office of the municipality, and to receive available services to which the by-law applies, in either language. R.S.O. 1990, c. F.32, s. 14 (2).

Regional councils

(3) Where an area designated in the Schedule is in a regional municipality and the council of a municipality in the area passes a by-law under subsection (1), the council of the regional municipality may also pass a by-law under subsection (1) in respect of its administration and services. 2002, c. 17, Sched. F, Table.

SCHEDULE

MUNICIPALITY OR DISTRICT	AREA
City of Greater Sudbury	All
City of Hamilton	All of the City of Hamilton as it exists on December 31, 2000
City of Ottawa	All
City of Toronto	All
Regional Municipality of Niagara	Cities of: Port Colborne and Welland
Regional Municipality of Peel	City of Brampton
Regional Municipality of Peel	City of Mississauga
County of Dundas	Township of Winchester
County of Essex	City of Windsor
	Towns of: Belle River and Tecumseh
	Townships of: Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West and Rochester
County of Frontenac	City of Kingston
County of Glengarry	All
County of Kent	Town of Tilbury
	Townships of: Dover and Tilbury East
County of Middlesex	City of London
County of Prescott	All
County of Renfrew	City of Pembroke
	Townships of: Stafford and Westmeath
County of Russell	All
County of Simcoe	Town of Penetanguishene
	Townships of: Tiny and Essa
County of Stormont	All
District of Algoma	All
District of Cochrane	All
District of Kenora	Township of Ignace
District of Nippissing	All
District of Parry Sound	Municipality of Callander
District of Sudbury	All
District of Thunder Bay	Towns of: Geraldton, Longlac and Marathon
	Townships of: Manitouwadge, Beardmore, Nakina and Terrace Bay
District of Timiskaming	All

R.S.O. 1990, c. F.32, Sched.; O. Reg. 407/94, s. 1; 1997, c. 26, Sched.; 1999, c. 14, Sched. F, s. 4; 2000, c. 5, s. 12; O. Reg. 407/94, s. 2 (as remade by O. Reg. 405/04, s. 1); O. Reg. 407/94, s. 3 (as made by O. Reg. 184/06, s. 1).

French Language Services Act

ONTARIO REGULATION 407/94
DESIGNATION OF ADDITIONAL AREAS

Consolidation Period: From May 1, 2009 to the e-Laws currency date.

Last amendment: O. Reg. 184/06.

This is the English version of a bilingual regulation.

1. The following area is added to the Schedule to the Act:

County of Middlesex	City of London

O. Reg. 407/94, s. 1.

2. The following areas are added to the Schedule to the Act:

Regional Municipality of Peel	City of Brampton
District of Parry Sound	Municipality of Callander

O. Reg. 405/04, s. 1.

3. The following area is added to the Schedule to the Act:

County of Frontenac	City of Kingston

O. Reg. 184/06, s. 1.

French Language Services Act

ONTARIO REGULATION 398/93
DESIGNATION OF PUBLIC SERVICE AGENCIES

Consolidation Period: From January 1, 2013 to the e-Laws currency date.

Last amendment: O. Reg. 402/12.

This is the English version of a bilingual regulation.

1. The following are designated as public service agencies for the purpose of the definition of "government agency" in section 1 of the Act:

1. Access (Aids Committee of Sudbury) in respect of the programs carried out on behalf of the Ministry of Health.
2. L'Accueil Francophone de Thunder Bay in respect of the programs carried out on behalf of the Ministry of Health.
3. ACFO Rive-Nord Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services by Garderie Petit Trésor in Elliot Lake.

3.1 Addiction Services of Eastern Ontario/Services de toxicomanie de l'Est de l'Ontario in respect of the following programs carried out on behalf of the Ministry of Health and Long-Term Care, namely, Administration Services and Community Treatment Program.

4. Algoma District Social Services in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
5. Algonquin Nursing Home Limited in Mattawa in respect of the programs carried out on behalf of the Ministry of Health.
6. Alzheimer Society of Cornwall and District/Société Alzheimer de Cornwall et Région but only in respect of community information sessions, self-help groups, individual support services and family support groups programs carried out on behalf of the Ministry of Health.
7. Andrew Fleck Child Care Services in respect of the programs carried out on behalf of the Ministry of Children and Youth Services.
8. L'Arche-Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
9. Association canadienne-française de l'Ontario — Conseil régional des Mille-Îles (ACFO — Mille-Îles) but only in respect of the employment programs carried out by Services d'employabilité ACFOMI Employment Services on behalf of the Ministry of Training, Colleges and Universities.
10. Association for Persons with Physical Disabilities of Windsor and Essex County but only in respect of the Central Y Supportive Housing program carried out on behalf of the Ministry of Health.
11. REVOKED: O. Reg. 402/12, s. 1 (1).
12. Association pour l'intégration communautaire de Nipissing Ouest/West Nipissing Association for Community Living in Sturgeon Falls in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
13. Association pour l'intégration communautaire d'Iroquois Falls/Iroquois Falls Association for Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
14. L'Association pour l'intégration sociale d'Ottawa-Carleton in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
15. "Au Ballon Rouge" (Garderie des Petits) in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
16. REVOKED: O. Reg. 285/11, s. 1 (2).
17. La Boîte à soleil co-opérative Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.
18. Les Bouts d'Choux in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

19. Cambrian College in Sudbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services by l'Arc-en-ciel and le Carrousel.

20. Canadian Mental Health Association/L'Association canadienne pour la santé mentale - Champlain East/Champlain Est in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

21. Canadian Mental Health Association, Sudbury Branch in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

22. Canadian Mental Health Association Timmins Branch in respect of the Family Resource Centre and the Community Outreach Program carried out on behalf of the Ministry of Community and Social Services and in respect of the programs carried out on behalf of the Ministry of Health.

23. Canadian Mothercraft of Ottawa-Carleton but only in respect of the programs carried out by the Ontario Early Years Centre/Centre de la petite enfance de l'Ontario on behalf of the Ministry of Children and Youth Services.

23.1 Carlington Community Health Centre/Centre de santé communautaire Carlington in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

24. Carrefour des Femmes du Sud-Ouest de l'Ontario in respect of the programs carried out on behalf of the Ministry of the Attorney General.

25. The Catholic Family Service of Ottawa-Carleton/Service familial catholique d'Ottawa-Carleton in respect of the Community Integration Program and the Family Violence Program, excluding New Directions, carried out on behalf of the Ministry of Community and Social Services.

26. Central Care Corporation: Centre de soins de longue durée Montfort/Montfort Long-Term Care Centre but only in respect of programs at the Centre carried out on behalf of the Ministry of Health and Long-Term Care.

27. REVOKED: O. Reg. 285/11, s. 1 (4).

28. Centre d'accueil Roger-Séguin in Clarence Creek in respect of the programs carried out on behalf of the Ministry of Health.

29. Centre d'activités françaises de Penetanguishene in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

29.1 Centre de counselling de Sudbury/Sudbury Counselling Centre in respect of the programs carried out on behalf of the Ministry of the Attorney General and the Ministry of Community and Social Services.

30. Centre de counselling familial de Timmins/Timmins Family Counselling Centre Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services and the Ministry of the Solicitor General and Correctional Services.

31. Centre de jour des Petits Poucets in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

32. Le Centre de jour polyvalent des aînés francophones d'Ottawa-Carleton in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

33. Centre de jour Séraphin-Marion d'Orléans in respect of the programs carried out on behalf of the Ministry of Health.

34. Centre de la Jeunesse de Toronto/La maison Montessori in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

35. The corporation named in its letters patent as the "Centre de reeducation Cor Jesu de Timmins Incorporee", operating under the name Centre Jubilee Centre, but only in respect of initial assessment and treatment planning services, case management services, entry services and individual services of the Residential Treatment Program, carried out on behalf of the Ministry of Health and Long-Term Care.

35.1 Centre de santé communautaire de Kapuskasing et région in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

36. Centre de santé communautaire de l'Estrie Ontario in respect of the programs carried out on behalf of the Ministry of Health.

36.1 Centre de santé communautaire de Nipissing Ouest/West Nipissing Community Health Centre in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

36.2 Centre de santé communautaire du Grand Sudbury in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

37. Centre de santé communautaire du Niagara in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

37.1 Le centre de santé communautaire du Témiskaming in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

38. Centre de santé communautaire Hamilton-Wentworth-Niagara Inc. in Welland and Hamilton in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

39. Centre de santé et services communautaires, Hamilton Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

40. Centre de services à l'emploi de Prescott-Russell Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

41. Centre de services familiaux de Prescott-Russell in Hawkesbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

42. Centre des Femmes Francophones du Nord-Ouest de l'Ontario in respect of the programs carried out on behalf of the Ministry of the Attorney General.

43. Centre des petits d'Ottawa Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

44. Centre des services communautaires de Vanier — Vanier Community Service Centre in respect of the programs carried out on behalf of the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

45. Centre des services de développement pour Stormont, Dundas et Glengarry in Cornwall in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

46. Centre Éducatif Soleil des Petits in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

47. Centre francophone d'aide et de lutte contre les agressions à caractère sexuel d'Ottawa in respect of the programs carried out on behalf of the Ministry of the Attorney General.

48. Centre francophone de Sault-Ste-Marie in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

49. Centre francophone de Toronto in respect of the programs carried out on behalf of the Ministry of the Attorney General, the Ministry of Community and Social Services, the Ministry of Children and Youth Services, the Ministry of Health and Long-Term Care, the Ministry of Training, Colleges and Universities and the Ministry of Citizenship and Immigration.

50. Centre Lajoie des Aînés(es) francophones de Pembroke in respect of the programs carried out on behalf of the Ministry of Health.

51. Centre médical Ste-Anne Inc. in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

52. Centre Novas - CALACS francophone de Prescott-Russell in respect of the programs carried out on behalf of the Ministry of the Attorney General.

53. Centre parascolaire des Pionniers in Orléans in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

54. Centre parascolaire "La Clémentine" d'Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

55. Le Centre parascolaire l'Hirondelle d'Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

56. Centre Passage Parallèle des ressources familiales du Nipissing Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

57. Centre Passerelle pour femmes du Nord de l'Ontario in respect of the programs carried out on behalf of the Ministry of the Attorney General and the Ministry of Community and Social Services.

58. Centre Pivot du Triangle magique de Rayside-Balfour in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

59. Centre pour enfants Timiskaming Child Care in respect of the Private Home Day Care Program carried out on behalf of the Ministry of Community and Social Services.

60. Centre préscolaire Coccinelle d'Orléans in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

61. Centre psychosocial pour enfants et familles Ottawa-Carleton in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

62. Le Centre Victoria pour femmes (Sudbury) in respect of the programs carried out on behalf of the Ministry of the Attorney General and the Ministry of Community and Social Services.

63. Les Centres d'Accueil Héritage in Toronto but only in respect of Centre des Pionniers and the Supportive Housing Programs for the elderly and for AIDS patients of Place Saint-Laurent carried out on behalf of the Ministry of Health.

64. Château Gardens (Lancaster) Inc. in respect of the programs carried out on behalf of the Ministry of Health by Château Gardens Lancaster Nursing Home.

65. REVOKED: O. Reg. 402/12, s. 1 (3).

66. Child Care Resources/Ressources sur la garde d'enfants in respect of the programs carried out on behalf of the Ministry of Community and Social Services and in respect of the following programs carried out on behalf of the Ministry of Children and Youth Services:

    i. Autism Clinical Services.

    ii. Best Start Hubs.

    iii. Integrated Services for Northern Children.

    iv. Out-of-Home-Respite program.

    v. Regional Autism Intervention Program.

    vi. Residential Programs.

    vii. School Support Program - Autism Spectrum Disorder.

67. REVOKED: O. Reg. 285/11, s. 1 (6).

68. The Children's Aid Society of Ottawa-Carleton/La société de l'aide à l'enfance d'Ottawa-Carleton in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

69. The Children's Aid Society of the District of Sudbury and Manitoulin in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

70. The Children's Aid Society of the United Counties of Stormont, Dundas and Glengarry/La société de l'aide à l'enfance des comtés unis de Stormont, Dundas et Glengarry in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

71. Children's Hospital of Eastern Ontario/L'Hôpital pour enfants de l'Est de l'Ontario but only in respect of the Audiology, Occupational Therapy, Child Life, Speech Therapy, Clinical Pharmacy, Psychology, Clinical Nutrition, Social Work and Planning of Discharges programs carried out on behalf of the Ministry of Health.

72. Children's Mental Health Services (Sudbury)/Services en santé mentale à l'enfance (Sudbury) but only in respect of the residential placement advisory committee, counseling services and the day treatment program carried out on behalf of the Ministry of Community, Family and Children's Services.

73. City View Centre for Child & Family Services but only in respect of the programs carried out by the Early Years Centre Nepean-Carleton/Centre de la petite enfance Nepean-Carleton on behalf of the Ministry of Children and Youth Services.

74. La Clef du Bonheur de Verner in respect of the programs carried out on behalf of the Ministry of Health.

75. Clinique juridique bilingue Windsor-Essex/Windsor-Essex Bilingual Legal Clinic in respect of the programs carried out on behalf of the Ministry of the Attorney General.

76. Clinique juridique communautaire Grand-Nord Community Legal Clinic in respect of the programs carried out on behalf of the Ministry of the Attorney General.

77. Clinique juridique populaire de Prescott et Russell Inc. in respect of the programs carried out on behalf of the Ministry of the Attorney General.

78. Clinique juridique Stormont, Dundas and Glengarry Legal Clinic in respect of the programs carried out on behalf of the Ministry of the Attorney General.

79. Club Accueil/âge d'or d'Azilda in respect of the programs carried out on behalf of the Ministry of Health.

80. Club d'âge d'or de la Vallée Inc./Golden Age Club of the Valley in Hanmer in respect of the programs carried out on behalf of the Ministry of Health.

81. Club d'âge d'or River Valley/Golden Age Club in River Valley in respect of the programs carried out on behalf of the Ministry of Health.

82. Colibri - Centre des femmes francophones du comté de Simcoe in respect of the programs carried out on behalf of the Ministry of the Attorney General and the Ministry of Community and Social Services.

83. Collège Boréal d'arts appliqués et de technologie (Collège Boréal) in respect of the programs carried out on behalf of the Ministry of Training, Colleges and Universities.

84. Community Counselling Centre of Nipissing in respect of the programs carried out on behalf of the Ministry of Community and Social Services and in respect of the Addiction Services of Nipissing carried out on behalf of the Ministry of Health.

85. Community Lifecare Inc. in respect of the programs carried out on behalf of the Ministry of Health by Community Nursing Home in Alexandria.

85.1 Community Living Kirkland Lake in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

86. Community Living-Stormont County but only in respect of the Adolphus Street Residence, the Community Contact and the Resource Teacher programs carried out on behalf of the Ministry of Community and Social Services.

87. Community Living Timmins Intégration Communautaire in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

88. Community Service Order Program of Ottawa-Carleton/Programme d'ordonnance de service communautaire d'Ottawa-Carleton in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

89. Les Compagnons des Francs-Loisirs in respect of the programs carried out on behalf of the Ministry of Community and Social Services by Garderie Soleil in North Bay.

90. Conseil de planification des services communautaires de Prescott-Russell Inc. in respect of the programs carried out on behalf of the Community and Social Services.

91. Coopérative Brin d'herbe Inc. in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

92. Coopérative Carrousel pour parents et enfants francophones Inc. in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

92.1 Cornwall Community Hospital - Hôpital Communautaire de Cornwall in respect of the following programs carried out by the Hospital on behalf of the Ministry of Health and Long-Term Care:

i. Administration/Corporate Services.

ii. Admission Prevention Services.

iii. Adult Counselling and Treatment.

iv. Ambulatory Care Clinics.

v. Assertive Community Treatment Team (ACT Team).

vi. Business Office.

vii. Computer Assisted Tomography.

viii. Critical Care Unit.

ix. Diabetic Clinic.

x. Diagnostic Services Administrative Support.

xi. Dietary.

xii. Discharge Planning.

xiii. Emergency.

xiv. Health Information Services.

xv. Human Resources.

xvi. Inpatient Mental Health Unit.

xvii. Inpatient Social Work.

xviii. Inpatient Surgery.

xix. Mammography.

xx. Mental Health Crisis Team.

xxi. Nuclear Medicine.

xxii. Obstetrics.

xxiii. Occupational Therapy.

xxiv. Operating Room.

xxv. Outpatient Mental Health.

xxvi. Paediatrics.

xxvii. Patient Registration.

xxviii. Pharmacy.

xxix. Physiotherapy.

xxx. Pre-admission.

xxxi. Speech Language Pathology.

xxxii. Spiritual Care.

xxxiii. Switchboard.

xxxiv. Ultrasound.

xxxv. X-Ray.

93. Cornwall Home Assistance Services to Seniors Inc. in respect of the programs carried out on behalf of the Ministry of Health.

94. Corporation de garde d'enfants du Nipissing Ouest/West Nipissing Child Care Corporation in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

95. The Council on Aging/Le Conseil sur le vieillissement — Ottawa-Carleton in respect of the programs carried out on behalf of the Ministry of Health.

96. District of Cochrane Social Services Administration Board in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

97. Early Years Centre North Inc. in respect of the programs carried out on behalf of the Ministry of Children and Youth Services.

98. East Ferris Golden Age Club in Corbeil in respect of the programs carried out on behalf of the Ministry of Health.

99. Elliot Lake and North Shore Community Legal Clinic in respect of the programs carried out on behalf of the Ministry of the Attorney General.

100. Employment and Education Resource Centre of Cornwall and District Inc. in respect of the programs carried out on behalf of the Ministry of Training, Colleges and Universities and the Ministry of Community and Social Services.

101. L'Équipe d'hygiène mentale pour francophones de Stormont, Dundas et Glengarry Inc. in Cornwall in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

102. Extendicare Northeastern Ontario Inc. in respect of the programs carried out on behalf of the Ministry of Health by Extendicare/Tri-Town Nursing Home in Haileybury, Extendicare/Cochrane and Extendicare/Kapuskasing.

103. Extendicare Northwestern Ontario Inc. in respect of the programs carried out on behalf of the Ministry of Health by Extendicare/Hearst and Extendicare/Timmins.

104. Family Services Centre of Sault Ste. Marie and District in respect of the Adult Protective Services program and the Community Counselling program carried out on behalf of the Ministry of Community and Social Services.

105. Foyer Richelieu Welland in respect of the programs carried out on behalf of the Ministry of Health.

106. La Fraternité — The Fraternity in Sudbury in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

107. Garderie Arc-en-ciel des Mousses Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

108. Garderie Brin de Soleil d'Ottawa Est Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

109. La Garderie des Petits Poussins de Port Colborne Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

110. La Garderie Française de Hamilton Co-opérative Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

111. Garderie Francophone de St-Catharines Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

112. Garderie La Farandole de Toronto in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

113. Garderie La Joie de North York Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

114. Garderie Le Cerf-volant de Gaston Vincent in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

115. La Garderie Le Petit Navire de Hamilton Co-opérative Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

116. Garderie Rayon de Soleil de North York Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

117. Garderie "Sur un nuage" d'Ottawa-Carleton in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

118. La Garderie Touche-à-tout de Sudbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

118.1 Geriatric Psychiatry Community Services of Ottawa/Services communautaires de géronto-psychiatrie d'Ottawa in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

119. Glengarry Association for Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

120. The Glengarry Inter-Agency Group Inc. in Alexandria in respect of the following programs:

   i. Adult Protective Services Program carried out on behalf of the Ministry of Community and Social Services.

   ii. Adult Day Service carried out on behalf of the Ministry of Health and Long-Term Care.

   iii. Ontario Early Years Centre carried out on behalf of the Ministry of Children and Youth Services.

121. Glengarry Memorial Hospital in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

122. Gloucester Centre for Community Resources/Centre des ressources communautaires de Gloucester in respect of the Family Violence Program and the Home Support Program carried out on behalf of the Ministry of Community and Social Services.

123. Golden Age "Club" d'âge d'or de Field in respect of the programs carried out on behalf of the Ministry of Health.

124. Golden Age "Club" d'âge d'or de Sturgeon Falls in respect of the programs carried out on behalf of the Ministry of Health.

125. Groupe Action pour l'Enfant, la Famille et la Communauté de Prescott-Russell in Hawkesbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

126. Habitat Interlude in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

126.0.1 Hamilton Community Legal Clinic/Clinique juridique communautaire de Hamilton in respect of the programs carried out on behalf of the Ministry of the Attorney General.

126.1 Health Nexus, also known as Nexus Santé, in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

127. Hearst, Kapuskasing, Smooth Rock Falls Counselling Services/Services de counselling de Hearst, Kapuskasing, Smooth Rock Falls in respect of the programs carried out on behalf of the Ministry of Health.

128. REVOKED: O. Reg. 285/11, s. 1 (11).

129. Hôpital général de Hawkesbury and District General Hospital Inc. in respect of the programs carried out on behalf of the Ministry of Health.

130. Hôpital général d'Ottawa/Ottawa General Hospital in respect of the programs carried out on behalf of the Ministry of Health.

131. Hôpital Montfort in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

132. Hôpital Notre-Dame Hospital in Hearst in respect of the programs carried out on behalf of the Ministry of Health.

133. Hôpital privé Beechwood Private Hospital in respect of the programs carried out on behalf of the Ministry of Health.

134. Hôpital régional de Sudbury Regional Hospital, operating under the name Health Sciences North/Horizon Santé-Nord, in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care, the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

134.1 Horizons Renaissance Inc. in Ottawa in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

135. ICAN Independence Centre and Network in Sudbury in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

136. Intégration Communautaire Cochrane Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

136.0.1 Intégration communautaire Hearst Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

136.1 Iris Addiction Recovery for Women in Sudbury in respect of the individual counseling in the treatment and aftercare programs and the intake services carried out on behalf of the Ministry of Health and Long-Term Care.

137. Kapuskasing & District Association for Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

138. The King's Daughters Dinner Wagon in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

139. REVOKED: O. Reg. 402/12, s. 1 (5).

140. The Lady Minto Hospital at Cochrane in respect of ambulance services carried out on behalf of the Ministry of Health.

140.1 Lakeshore Community Services in respect of the North Shore meals on wheels and North Shore friendly visiting programs, switchboard, reception and administration carried out on behalf of the Ministry of Health and Long-Term Care.

141. Laurentian Hospital in Sudbury in respect of the programs carried out on behalf of the Ministry of Health.

142. Maison Arc-en-ciel Centre de réhabilitation du nord de l'Ontario Inc. in Opasatika in respect of the programs carried out on behalf of the Ministry of Health.

143. Maison d'amitié in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

144. Maison Décision House in Ottawa in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

145. Maison Fraternité — Fraternity House in Vanier in respect of the programs carried out on behalf of the Ministry of Health and the Ministry of Community and Social Services.

146. Maison Interlude House Inc. in Hawkesbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

147. Maison Renaissance de la Réhabilitation in Hearst in respect of the programs carried out on behalf of the Ministry of Health.

148. Maryfarm Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

149. Minto Counselling Centre in Cochrane in respect of the programs carried out on behalf of the Ministry of Health.

150. La Montée d'Elle Centre de ressource pour violence familiale S.D. et G. Inc. in Alexandria in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

151. Nipissing Children's Mental Health Services in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

152. Nipissing District Social Services Board in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

153. Nipissing District Youth Employment Service Inc. in respect of the community service order program carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

153.1 Nipissing Mental Health Housing and Support Services in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

154. North Algoma Health Organization in respect of the programs carried out on behalf of the Ministry of Health by Medical Centre in Dubreuilville.

155. North Bay and District Association for Community Living in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

156. North Eastern Ontario Family and Children's Services/Services à la famille et à l'enfance du Nord-Est de l'Ontario in respect of the programs carried out on behalf of the Ministry of Children and Youth Services.

157. Oasis Centre des femmes Inc. in respect of the programs carried out on behalf of the Ministry of the Attorney General and the Ministry of Community and Social Services.

158. REVOKED: O. Reg. 285/11, s. 1 (14).

159. Options Bytown Non-Profit Housing Corporation of Ottawa-Carleton but only in respect of the Supportive Housing Program carried out on behalf of the Ministry of Community and Social Services.

159.1 Orléans-Cumberland Community Resource Centre/Centre de ressources communautaires Orléans-Cumberland in respect of the programs carried out on behalf of the Ministry of Children and Youth Services.

160. Ottawa-Carleton Association for Persons with Developmental Disabilities but only in respect of the Centre de transition communautaire and the supported employment, supported independent living and Maryland programs carried out on behalf of the Ministry of Community, Family and Children's Services.

161. Ottawa-Carleton Regional Residential Treatment Centre in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

162. Ottawa Children's Treatment Centre in respect of the programs carried out on behalf of the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

163. Ottawa Civic Hospital Corporation in respect of the in-vitro fertilization and dentistry clinics carried out on behalf of the Ministry of Health.

164. The Ottawa Hospital/L'Hôpital d'Ottawa but only in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care at the General Campus.

165. Ottawa Salus Corporation but only in respect of community support, residential rehabilitation (Fisher and Crichton sites), community development (Athlone, Gladstone and MacLaren sites) and administrative services programs carried out on behalf of the Ministry of Health and Long-Term Care.

166. Pavilion Family Resource Centre in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

167. Penetanguishene General Hospital Inc. but only in respect of admitting, discharge, switchboard, reception, ambulatory care programs, people systems and business office services carried out on behalf of the Ministry of Health and Long-Term Care.

168. Personal Choice Independent Living/Choix personnel Vie autonome in Ottawa, but only in respect of supportive housing services, attendant care services and case co-ordination programs at the Bronson Avenue site, carried out on behalf of the Ministry of Health and Long-Term Care.

169. Le Petit Chaperon Rouge: Garderie Francophone in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

170. La Petite Étoile de Niagara Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

171. Physically Handicapped Adults' Rehabilitation Association-Nipissing-Parry Sound in respect of the programs carried out on behalf of the Ministry of Health.

172. Pinecrest-Queensway Health and Community Services/Services de santé et services communautaires Pinecrest-Queensway but only in respect of the programs carried out by the Ontario Early Years Centre Ottawa West-Nepean/Centre de la petite enfance d'Ottawa-Ouest-Nepean on behalf of the Ministry of Children and Youth Services.

173. Pleasant Rest Nursing Home Limited in L'Orignal in respect of the programs carried out on behalf of the Ministry of Health.

174. The Prescott-Russell Association for the Mentally Retarded/L'Association pour les déficients mentaux de Prescott-Russell in Hawkesbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

175. La Présence, Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

176. Programme parascolaire La Vérendrye in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

177. Recon Association in Timmins in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

178. The Religious Hospitalers of St. Joseph of Cornwall, Ontario at Kingston but only in respect of the business office, administration, cardio-respiratory, chronic care, critical care unit, diabetic, dietary, human resources, lifeline, medical, operating room, physical therapy, surgical, social work, switchboard and volunteer programs carried out by Hotel Dieu Hospital at Cornwall on behalf of the Ministry of Health and only in respect of the administration, switchboard, dietary and social work programs carried out by St. Joseph Villa at Cornwall on behalf of the Ministry of Health.

178.1 Réseau des femmes du Sud de l'Ontario - Sarnia/Lambton in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

178.2 Réseau des services de santé en français de l'Est de l'Ontario in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

179. La ribambelle, centre préscolaire francophone de London in respect of the programs carried out on behalf of the Ministry of Children and Youth Services.

180. Royal Ottawa Health Care Group/Services de Santé Royal Ottawa but only in respect of the rehabilitation Centre, geriatric psychiatric services and psychiatric rehabilitation program carried out on behalf of the Ministry of Health and the St-Bonaventure Day Treatment Program for Youth carried out on behalf of the Ministry of Community and Social Services.

181. Sandy Hill Community Health Centre, Inc./Centre de santé communautaire Côte-de-Sable, Inc. in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services.

182. Sensenbrenner Hospital in Kapuskasing in respect of the programs carried out on behalf of the Ministry of Health.

183. Service Coordination for Persons with Special Needs/Coordination des services pour personnes ayant des besoins spéciaux in Ottawa in respect of the programs carried out on behalf of the Ministry of Community, Family and Children's Services.

184. Service d'entraide communautaire in Ottawa in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

185. REVOKED: O. Reg. 139/12, s. 1 (7).

186. Services à la Jeunesse de Hearst Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

186.1 REVOKED: O. Reg. 402/12, s. 1 (7).

187. Les Services à l'enfance Grandir ensemble in respect of the programs carried out on behalf of the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

187.1 Services aux victimes Prescott Russell Victim Services in respect of the programs carried out on behalf of the Ministry of the Attorney General.

188. Services communautaires de Prescott-Russell in Hawkesbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

189. Services communautaires et de santé Carlington Community and Health Services Corporation but only in respect of the Family Violence Program carried out on behalf of the Ministry of Community and Social Services.

190. Les Services correctionnels communautaires de Prescott-Russell et Glengarry in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

191. Services de garde de Rayside-Balfour in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

192. Services de santé de Chapleau Health Services in respect of the programs carried out on behalf of the Ministry of Health.

193. Services de toxicomanie Cochrane Nord Inc. — North Cochrane Addiction Services Inc. in Kapuskasing, Cochrane, Hearst and Smooth Rock Falls in respect of the programs carried out on behalf of the Ministry of Health.

194. REVOKED: O. Reg. 402/12, s. 1 (9).

195. Services psychiatriques francophones de l'est de l'Ontario in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

196. The Sisters of St. Joseph of Sault Ste. Marie but only in respect of accounting, administration, day surgery, diabetic clinic, food services, housekeeping, human resources, maintenance, pastoral, patient information, radiology, social services and seniors home support programs carried out on behalf of the Ministry of Health by St. Joseph's Health Centre in Blind River.

197. Smooth Rock Falls Hospital Corporation in respect of the programs carried out on behalf of the Ministry of Health.

198. La Société de l'aide à l'enfance de Prescott-Russell/The Children's Aid Society of Prescott-Russell in Plantagenet in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

199. Société Alzheimer Society Sudbury-Manitoulin in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

200. Les Soeurs de la charité d'Ottawa/Sisters of Charity at Ottawa in respect of the following businesses:

    i. Centre de santé Élisabeth-Bruyère/Elisabeth-Bruyère Health Centre in Ottawa in respect of the programs carried out on behalf of the Ministry of Health and the Lifeline Program carried out on behalf of the Ministry of Health.

    ii. Hôpital général de Mattawa/Mattawa General Hospital in respect of the programs carried out on behalf of the Ministry of Health.

    iii. La Résidence Saint-Louis in Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

    iv. Saint-Vincent Hospital/Hôpital Saint-Vincent at Ottawa in respect of the programs carried out on behalf of the Ministry of Health.

201. Soins palliatifs Horizon-Timmins Inc./Horizon-Timmins Palliative Care Inc. in respect of the programs carried out on behalf of the Ministry of Health and Long-Term Care.

202. South Cochrane Addictions Services Inc. in respect of the programs carried out on behalf of the Ministry of Health.

203. The Sudbury and District Association for Community Living/Association pour l'intégration communautaire de Sudbury et district in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

204. Sudbury Community Service Centre in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

205. Sudbury Young Women's Christian Association in respect of the Service Co-ordination and administration programs carried out on behalf of the Ministry of Community and Social Services.

206. Sudbury Youth Services Inc., Services à la Jeunesse de Sudbury Inc. in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

207. Sudbury Y.W.C.A. Brookwood Apartments in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

208. Sudbury Y.W.C.A. Genevra House in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

209. Timmins and District Hospital/L'Hôpital de Timmins et du district in respect of administrative services at the Timmins and District Hospital Corporation, primary, secondary and acute care at the St. Mary's General Hospital, and chronic care at the Porcupine General Hospital carried out on behalf of the Ministry of Health.

210. Union Culturelle des Franco-Ontariennes in Sudbury in respect of the programs carried out on behalf of the Ministry of Community and Social Services.

210.1 University of Ottawa Heart Institute - Institut de cardiologie de l'Université d'Ottawa in respect of the following programs carried out by the Institute on behalf of the Ministry of Health and Long-Term Care:

    i. Admitting.

    ii. Ambulatory Care.

    iii. Arrhythmia Monitoring Centre.

    iv. Auxiliary Services.

    v. Cardiac Anaesthesia.

    vi. Cardiac Associates/Surgery.

    vii. Cardiac Cath Lab.

    viii. Cardiac Imaging.

    ix. Cardiac Operating Room.

    x. Cardiac Surgery & Cardiac Valve Surgery Clinic.

    xi. Cardiac Surgical Unit & Recovery Room.

    xii. Communication Centre.

    xiii. Coronary Care Unit.

    xiv. French Language Services.

xv. Heart Failure Clinic.

xvi. HI Telehealth APN.

xvii. Human Resources Services.

xviii. Library.

xix. Nursing Unit H3.

xx. Nursing Unit H4.

xxi. Nutrition.

xxii. Pacemaker & Defibrillator Clinic.

xxiii. Pastoral Services.

xxiv. Pharmacy Outpatient.

xxv. Pre-Admission Unit.

xxvi. Prevention and Rehab Centre.

xxvii. Telehealth APN.

xxviii. Wait List Management Office (Triage).

211. Victorian Order of Nurses, Sudbury Branch but only in respect of the Home Support, Foot Care, Supportive Housing, Placement Coordination Service and Nursing Programs carried out on behalf of the Ministry of Health.

212. Volunteer Organization in Community Correctional Services (V.O.I.C.S.S.) in Sudbury in respect of the programs carried out on behalf of the Ministry of the Solicitor General and Correctional Services.

213. Western Ottawa Community Resource Centre but only in respect of the Program Against Woman Abuse/Programme contre la violence faite aux femmes, excluding the shelter services provided by Chrysalis House, and in respect of the programs carried out by the Carleton-Ontario Early Years Centre/Centre de la petite enfance de l'Ontario-Carleton on behalf of the Ministry of Children and Youth Services and the Ministry of Community and Social Services.

214. The West Nipissing General Hospital/Hôpital général de l'ouest Nipissing in respect of the programs carried out on behalf of the Ministry of Health.

215. Youth Services Bureau of Ottawa, Bureau des Services de la Jeunesse d'Ottawa in respect of the Community Services Program located in the East, Centre Town and Ottawa units and the Sherwood Observation and Detention Home Program carried out on behalf of the Ministry of Community and Social Services.

216. 519179 Ontario Inc. in respect of the programs carried out on behalf of the Ministry of Health by St. Joseph Nursing Home in Rockland.

217. 656955 Ontario Limited in respect of the programs carried out on behalf of the Ministry of Health by Pinecrest Nursing Home in Plantagenet.

O. Reg. 398/93, s. 1; O. Reg. 406/94, s. 1; O. Reg. 62/96, s. 1; O. Reg. 486/96, s. 1; O. Reg. 100/98, s. 1; O. Reg. 109/99, s. 1; O. Reg. 166/02, s. 1; O. Reg. 77/04, s. 1; O. Reg. 299/07, s. 1; O. Reg. 148/08, s. 1; O. Reg. 211/09, s. 1; O. Reg. 144/10, s. 1; O. Reg. 1/11, s. 1; O. Reg. 285/11, s. 1; O. Reg. 139/12, s. 1; O. Reg. 402/12, s. 1.

2. OMITTED (REVOKES OTHER REGULATIONS). O. Reg. 398/93, s. 2.

French Language Services Act

ONTARIO REGULATION 671/92
EXEMPTIONS

Consolidation Period: From November 19, 1997 to the e-Laws currency date.

Last amendment: O.Reg. 411/97.

This is the English version of a bilingual regulation.

1. The following are exempt from the application of sections 2 and 5 of the Act:

1. Publications prepared by or for government agencies or institutions of the Legislature, or appendices to those publications, that are of a scientific, technical, reference, research or scholarly nature and that,

   i. although not restricted in circulation to the confines of the Government of Ontario, are not normally available for general circulation to members of the public, or

   ii. are normally consulted by members of the public with the assistance of public servants. O. Reg. 671/92, s. 1.

2. REVOKED: O. Reg. 411/97, s. 1.

French Language Services Act

ONTARIO REGULATION 284/11

PROVISION OF FRENCH LANGUAGE SERVICES ON BEHALF OF GOVERNMENT AGENCIES

Consolidation Period: From July 1, 2011 to the e-Laws currency date.

No amendments.

This is the English version of a bilingual regulation.

Definition

1. In this Regulation,

"third party" means a person or entity that has agreed with a government agency to provide a service on behalf of the agency. O. Reg. 284/11, s. 1.

Provision of services in French

2. (1) By the day specified in subsection (3), every government agency shall ensure that all services that a third party provides to the public on its behalf under an agreement between the agency and the third party are provided in accordance with the Act. O. Reg. 284/11, s. 2 (1).

(2) By the day specified in subsection (3), every government agency shall ensure that a third party providing a service in French to the public on its behalf shall take appropriate measures, including providing signs, notices and other information on services and initiating communication with the public, to make it known to members of the public that the service is available in French at the choice of any member of the public. O. Reg. 284/11, s. 2 (2).

(3) Subject to section 7 of the Act, the day mentioned in subsection (1) or (2) is,

(a) the three-year anniversary of the day this Regulation comes into force, if the agreement that the government agency has entered into with the third party comes into force before the day this Regulation comes into force; or

(b) the day the agreement that the government agency has entered into with the third party comes into force, if it comes into force on or after the day this Regulation comes into force. O. Reg. 284/11, s. 2 (3).

Report

3. (1) By 30 days after the day specified in subsection 2 (3), every government agency that retains a third party to provide a service to the public on behalf of the agency shall file a report in accordance with subsection (2) setting out,

(a) the name of the agency and the name and contact information of a contact person in the agency for the purposes of the report;

(b) a statement whether the Act requires the agency to provide the service to the public in French;

(c) if the Act requires the agency to provide the service to the public in French, a description of the service provided and a statement whether the agency has complied with section 2. O. Reg. 284/11, s. 3 (1).

(2) A government agency shall file the report with,

(a) the Minister responsible for Francophone Affairs, if the agency is a ministry or if the agency is not a ministry and does not have a minister responsible for it; or

(b) the minister responsible for the agency, if the agency is not a ministry and has a minister responsible for it. O. Reg. 284/11, s. 3 (2).

(3) A minister who receives a report of a government agency for which the minister is responsible shall promptly forward the report to the Minister responsible for Francophone Affairs. O. Reg. 284/11, s. 3 (3).

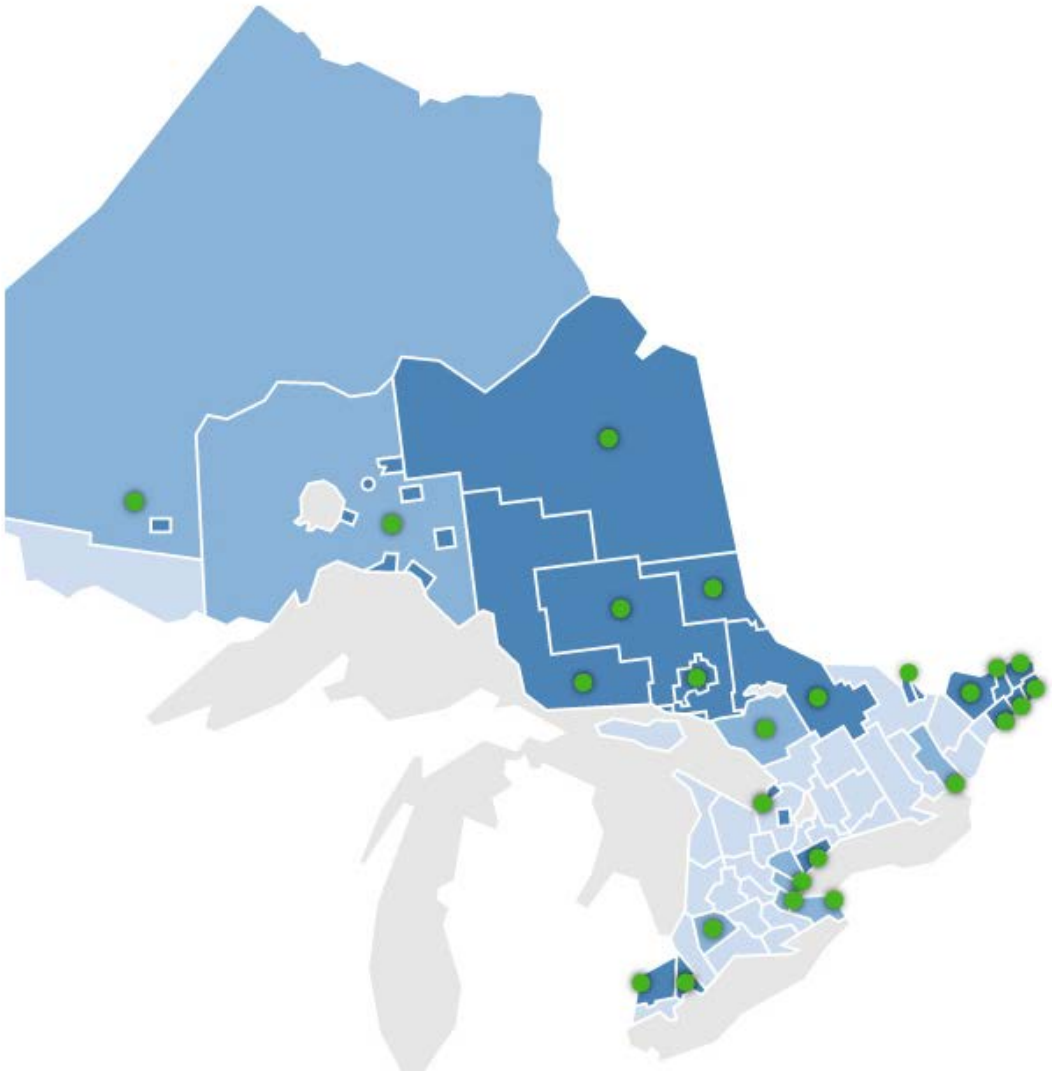
4. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). O. Reg. 284/11, s. 4.

Map of Designated Areas

The *French Language Services Act* guarantees the right to services in French from the provincial government in government offices in designated areas of the province.

There are currently 25 designated areas under the FLSA. For an area to obtain designation, technically, Francophones must make up at least 10% of its population; urban centres must have at least 5000 Francophones.

- The whole area is designated under the FLSA.
- Only a portion of the area is designated.
- Non-designated areas.



1. **City of Toronto** (All)
2. **City of Hamilton** (All of the City of Hamilton as it exists on Dec. 31, 2000)
3. **Regional Municipality of Niagara:** Cities of: Port Colborne and Welland
4. **City of Ottawa** (All)
5. **Regional Municipality of Peel:** City of Mississauga, City of Brampton
6. **City of Greater Sudbury** (All)
7. **County of Dundas:** Township of Winchester
8. **County of Essex:** City of Windsor, Towns of Belle River and Tecumseh; Townships of: Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West and Rochester
9. **County of Glengarry** (All)
10. **County of Kent:** Town of Tilbury, Townships of Dover and Tilbury East
11. **County of Prescott** (All)
12. **County of Renfrew:** City of Pembroke, Townships of:Stafford and Westmeath
13. **County of Russell** (All)
14. **County of Simcoe:** Town of Penetanguishene, Townships of: Tiny and Essa
15. **County of Stormont** (All)
16. **District of Algoma** (All)
17. **District of Cochrane** (All)
18. **District of Kenora:** Township of Ignace
19. **District of Nipissing** (All)
20. **District of Sudbury** (All)
21. **District of Thunder Bay:** Towns of Geraldton, Longlac and Marathon, Townships of Manitouwadge, Beardmore, Nakina & Terrace Bay
22. **District of Timiskaming** (All)
23. **County of Middlesex:** City of London
24. **District of Parry Sound:** Municipality of Callander
25. **County of Frontenac:** City of Kingston

Local Health System Integration Act, 2006

S.O. 2006, CHAPTER 4

Consolidation Period: From January 1, 2011 to the e-Laws currency date.

Last amendment: 2010, c. 25, s. 26.

CONTENTS

Preamble

The people of Ontario and their government,

(a) confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability, accessibility and accountability as provided in the *Canada Health Act* (Canada) and the *Commitment to the Future of Medicare Act, 2004*;

(b) are committed to the promotion of the delivery of public health services by not-for-profit organizations;

(c) acknowledge that a community's health needs and priorities are best developed by the community, health care providers and the people they serve;

(d) are establishing local health integration networks to achieve an integrated health system and enable local communities to make decisions about their local health systems;

(e) recognize the need for communities, health service providers, local health integration networks and the government to work together to reduce duplication and better co-ordinate health service delivery to make it easier for people to access health care;

(f) believe that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the *French Language Services Act* in serving Ontario's French-speaking community;

(g) recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities;

(h) believe in public accountability and transparency to demonstrate that the health system is governed and managed in a way that reflects the public interest and that promotes continuous quality improvement and efficient delivery of high quality health services to all Ontarians;

(i) confirm that access to health services will not be limited to the geographic area of the local health integration network in which an Ontarian lives; and

(j) envision an integrated health system that delivers the health services that people need, now and in the future.

Therefore Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

PART I
INTERPRETATION

Purpose of the Act

1. The purpose of this Act is to provide for an integrated health system to improve the health of Ontarians through better access to high quality health services, co-ordinated health care in local health systems and across the province and effective and efficient management of the health system at the local level by local health integration networks. 2006, c. 4, s. 1.

Definitions

2. (1) In this Act,

"accountability agreement" means the accountability agreement in respect of the local health system that the Minister and a local health integration network are required to enter into under subsection 18 (1); ("entente de responsabilisation")

"geographic area", in relation to a local health integration network, means,

(a) if the network is continued under subsection 3 (1) and no geographic area is prescribed for the network, the geographic area for the network that is set out on the local health integration network maps numbers 1 to 14 dated August 2005 that are available for inspection by the public at the offices of the Ministry and published on the Ministry's website on the Internet, and

(b) if clause (a) does not apply to the network, the geographic area that is prescribed for the network; ("zone géographique")

"health service provider" has the meaning set out in subsection (2); ("fournisseur de services de santé")

"integrate" includes,

(a) to co-ordinate services and interactions between different persons and entities,

(b) to partner with another person or entity in providing services or in operating,

(c) to transfer, merge or amalgamate services, operations, persons or entities,

(d) to start or cease providing services,

(e) to cease to operate or to dissolve or wind up the operations of a person or entity,

and "integration" has a similar meaning; ("intégrer", "intégration")

"integrated health service plan" means the plan that a local health integration network develops under section 15 for the local health system; ("plan de services de santé intégrés")

"integration decision" means a decision issued under subsection 25 (2); ("décision d'intégration")

"local health integration network" means a corporation that is continued under subsection 3 (1) or incorporated by regulation under subsection 3 (3); ("réseau local d'intégration des services de santé")

"local health system" means the part of the health system that provides services in the geographic area of a local health integration network, whether or not the services are provided to people who reside in the geographic area; ("système de santé local")

"Minister" means the Minister of Health and Long-Term Care or such other member of the Executive Council to whom the administration of this Act is assigned under the *Executive Council Act*; ("ministre")

"Ministry" means the Ministry of the Minister; ("ministère")

"prescribed" means prescribed by the regulations made under this Act; ("prescrit")

"provincial strategic plan" means the plan that the Minister develops under section 14 for the health system; ("plan stratégique provincial")

"service accountability agreement" means the service accountability agreement that a local health integration network and a health service provider are required to enter into under subsection 20 (1). ("entente de responsabilisation en matière de services") 2006, c. 4, s. 2 (1).

Health service provider

(2) In this Act,

"health service provider", subject to subsection (3), means the following persons and entities:

1. A person or entity that operates a hospital within the meaning of the *Public Hospitals Act* or a private hospital within the meaning of the *Private Hospitals Act*.
2. A person or entity that operates a psychiatric facility within the meaning of the *Mental Health Act* except if the facility is,
   i. REPEALED: 2009, c. 33, Sched. 18, s. 14.
   ii. a correctional institution operated or maintained by a member of the Executive Council, other than the Minister, or
   iii. a prison or penitentiary operated or maintained by the Government of Canada.
3. The University of Ottawa Heart Institute/Institut de cardiologie de l'Université d'Ottawa.
4. A licensee within the meaning of the *Long-Term Care Homes Act, 2007*, other than a municipality or board of management described in paragraph 5.
5. A municipality or board of management that maintains a long-term care home under Part VIII of the *Long-Term Care Homes Act, 2007*.
6. REPEALED: 2007, c. 8, s. 214 (1).
7. A community care access corporation within the meaning of the *Community Care Access Corporations Act, 2001*.
8. A person or entity approved under the *Home Care and Community Services Act, 1994* to provide services.
9. A not for profit corporation without share capital incorporated under Part III of the *Corporations Act* that operates a community health centre.

Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 9 is amended by striking out "Part III of the *Corporations Act*" and substituting "the *Not-for-Profit Corporations Act, 2010* or a predecessor of that Act". See: 2010, c. 15, ss. 231 (1), 249.

10. A not for profit entity that provides community mental health and addiction services.
11. Any other person or entity or class of persons or entities that is prescribed. 2006, c. 4, s. 2 (2); 2007, c. 8, s. 214 (1, 2); 2009, c. 33, Sched. 18, s. 14.

Same, exclusions

(3) The following are not health service providers:

1. Any of the following individuals when they provide, or offer to provide, health services to individuals within the scope of practice of their profession:
   i. A member of the College of Chiropodists of Ontario in the podiatrist class under the *Chiropody Act, 1991*.

ii. A member of the Royal College of Dental Surgeons of Ontario under the *Dentistry Act, 1991*.

iii. A member of the College of Physicians and Surgeons of Ontario under the *Medicine Act, 1991*.

iv. A member of the College of Optometrists of Ontario under the *Optometry Act, 1991*.

2. A health profession corporation that holds a certificate of authorization issued by the College of Chiropodists of Ontario, the Royal College of Dental Surgeons of Ontario, the College of Physicians and Surgeons of Ontario or the College of Optometrists of Ontario under the *Regulated Health Professions Act, 1991* or under Schedule 2 to that Act. 2006, c. 4, s. 2 (3).

PART II
LOCAL HEALTH INTEGRATION NETWORKS

Continuation and establishment

3. (1) Each corporation that was incorporated under the *Corporations Act* under the name in English set out in Column 1 of the following Table and the name in French set out opposite in Column 2 on the date set out opposite in Column 3 is continued as a corporation without share capital under the name in English set out opposite in Column 4 and the name in French set out opposite in Column 5 and is a local health integration network.

TABLE/TABLEAU
CORPORATIONS CONTINUED AS LOCAL HEALTH INTEGRATION NETWORKS/PERSONNES MORALES PROROGÉES EN TANT QUE RÉSEAUX LOCAUX D'INTÉGRATION DES SERVICES DE SANTÉ

	Column/Colonne 1	Column/Colonne 2	Column/Colonne 3	Column/Colonne 4	Column/Colonne 5
Item Point	Name of corporation in English Dénomination sociale anglaise de la personne morale	Name of corporation in French Dénomination sociale française de la personne morale	Date of incorporation Date de constitution	Name of continued corporation in English Dénomination sociale anglaise de la personne morale prorogée	Name of continued corporation in French Dénomination sociale française de la personne morale prorogée
1.	Central Health Integration Network	Réseau d'intégration des services de santé du Centre	June 2, 2005 2 juin 2005	Central Local Health Integration Network	Réseau local d'intégration des services de santé du Centre
2.	Central East Health Integration Network	Réseau d'intégration des services de santé du Centre-Est	June 2, 2005 2 juin 2005	Central East Local Health Integration Network	Réseau local d'intégration des services de santé du Centre-Est
3.	Central West Health Integration Network	Réseau d'intégration des services de santé du Centre-Ouest	June 9, 2005 9 juin 2005	Central West Local Health Integration Network	Réseau local d'intégration des services de santé du Centre-Ouest
4.	Health Integration Network of Champlain	Réseau d'intégration des services de santé de Champlain	June 2, 2005 2 juin 2005	Champlain Local Health Integration Network	Réseau local d'intégration des services de santé de Champlain
5.	Health Integration Network of Erie St. Clair	Réseau d'intégration des services de santé d'Érié St-Clair	June 2, 2005 2 juin 2005	Erie St. Clair Local Health Integration Network	Réseau local d'intégration des services de santé d'Érié St-Clair
6.	Health Integration Network of Hamilton Niagara Haldimand Brant	Réseau d'intégration des services de santé de Hamilton Niagara Haldimand Brant	June 2, 2005 2 juin 2005	Hamilton Niagara Haldimand Brant Local Health Integration Network	Réseau local d'intégration des services de santé de Hamilton Niagara Haldimand Brant
7.	Health Integration Network of Mississauga Halton	Réseau d'intégration des services de santé de Mississauga Halton	June 9, 2005 9 juin 2005	Mississauga Halton Local Health Integration Network	Réseau local d'intégration des services de santé de Mississauga Halton
8.	North East Health Integration Network	Réseau d'intégration des services de santé du Nord-Est	June 9, 2005 9 juin 2005	North East Local Health Integration Network	Réseau local d'intégration des services de santé du Nord-Est
9.	Health Integration Network of North Simcoe Muskoka	Réseau d'intégration des services de santé de Simcoe Nord Muskoka	June 9, 2005 9 juin 2005	North Simcoe Muskoka Local Health Integration Network	Réseau local d'intégration des services de santé de Simcoe Nord Muskoka
10.	Local Health Integration Network (North West Ontario)	Réseau d'intégration des services de santé (Nord-Ouest de	June 16, 2005 16 juin 2005	North West Local Health Integration Network	Réseau local d'intégration des services de santé du

	Column/Colonne 1	Column/Colonne 2	Column/Colonne 3	Column/Colonne 4	Column/Colonne 5
Item Point	Name of corporation in English Dénomination sociale anglaise de la personne morale	Name of corporation in French Dénomination sociale française de la personne morale	Date of incorporation Date de constitution	Name of continued corporation in English Dénomination sociale anglaise de la personne morale prorogée	Name of continued corporation in French Dénomination sociale française de la personne morale prorogée
		l'Ontario)			Nord-Ouest
11.	South East Health Integration Network	Réseau d'intégration des services de santé du Sud-Est	June 9, 2005 9 juin 2005	South East Local Health Integration Network	Réseau local d'intégration des services de santé du Sud-Est
12.	South West Health Integration Network	Réseau d'intégration des services de santé du Sud-Ouest	June 2, 2005 2 juin 2005	South West Local Health Integration Network	Réseau local d'intégration des services de santé du Sud-Ouest
13.	Health Integration Network of Toronto Central	Réseau d'intégration des services de santé du Centre-Toronto	June 2, 2005 2 juin 2005	Toronto Central Local Health Integration Network	Réseau local d'intégration des services de santé du Centre-Toronto
14.	Health Integration Network of Waterloo Wellington	Réseau d'intégration des services de santé de Waterloo Wellington	June 2, 2005 2 juin 2005	Waterloo Wellington Local Health Integration Network	Réseau local d'intégration des services de santé de Waterloo Wellington

2006, c. 4, s. 3 (1).

Extinguishment of letters patent

(2) The letters patent issued to constitute a corporation continued under subsection (1) are extinguished. 2006, c. 4, s. 3 (2).

Establishment

(3) The Lieutenant Governor in Council may by regulation incorporate one or more corporations as corporations without share capital and a corporation incorporated under this subsection is a local health integration network. 2006, c. 4, s. 3 (3).

Regulations

(4) The Lieutenant Governor in Council may, by regulation,

(a) amalgamate or dissolve one or more local health integration networks;

(b) divide a local health integration network into two or more local health integration networks;

(c) change the name of a local health integration network;

(d) do all things necessary to accomplish the amalgamation, dissolution or division of one or more local health integration networks made by a regulation under clause (a) or (b), including,

(i) dealing with the assets and the liabilities of any of the networks in the manner specified in the regulation, including by,

(A) liquidating or selling the assets and paying the proceeds into the Consolidated Revenue Fund, or

(B) transferring the assets or liabilities to the Crown, an agency of the Crown or to another network, or

(ii) transferring employees to the Crown, an agency of the Crown or to another network. 2006, c. 4, s. 3 (4).

Crown agency and status

4. (1) A local health integration network is an agent of the Crown and may exercise its powers only as an agent of the Crown. 2006, c. 4, s. 4 (1).

Other Acts

(2) The *Corporations Act* and the *Corporations Information Act* do not apply to a local health integration network, except as prescribed. 2006, c. 4, s. 4 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is repealed and the following substituted:

Non-application of *Corporations Information Act*

(2) The *Corporations Information Act* does not apply to a local health integration network, except as prescribed. 2010, c. 15, s. 231 (2).

See: 2010, c. 15, ss. 231 (2), 249.

Same

(3) The following Acts do not apply to a local health integration network, the members of its board of directors or to its officers, employees or agents:

1. REPEALED: 2009, c. 33, Sched. 2, s. 45.
2. *Charities Accounting Act*. 2006, c. 4, s. 4 (3); 2009, c. 33, Sched. 2, s. 45.

No charitable property

(4) The property of a local health integration network is not charitable property. 2006, c. 4, s. 4 (4).

Objects

5. The objects of a local health integration network are to plan, fund and integrate the local health system to achieve the purpose of this Act, including,

(a) to promote the integration of the local health system to provide appropriate, co-ordinated, effective and efficient health services;

(b) to identify and plan for the health service needs of the local health system in accordance with provincial plans and priorities and to make recommendations to the Minister about that system, including capital funding needs for it;

(c) to engage the community of persons and entities involved with the local health system in planning and setting priorities for that system, including establishing formal channels for community input and consultation;

(d) to ensure that there are appropriate processes within the local health system to respond to concerns that people raise about the services that they receive;

(e) to evaluate, monitor and report on and be accountable to the Minister for the performance of the local health system and its health services, including access to services and the utilization, co-ordination, integration and cost-effectiveness of services;

(f) to participate and co-operate in the development by the Minister of the provincial strategic plan and in the development and implementation of provincial planning, system management and provincial health care priorities, programs and services;

(g) to develop strategies and to co-operate with health service providers, including academic health science centres, other local health integration networks, providers of provincial services and others to improve the integration of the provincial and local health systems and the co-ordination of health services;

(h) to undertake and participate in joint strategies with other local health integration networks to improve patient care and access to high quality health services and to enhance continuity of health care across local health systems and across the province;

(i) to disseminate information on best practices and to promote knowledge transfer among local health integration networks and health service providers;

(j) to bring economic efficiencies to the delivery of health services and to make the health system more sustainable;

(k) to allocate and provide funding to health service providers, in accordance with provincial priorities, so that they can provide health services and equipment;

(l) to enter into agreements to establish performance standards and to ensure the achievement of performance standards by health service providers that receive funding from the network;

(m) to ensure the effective and efficient management of the human, material and financial resources of the network and to account to the Minister for the use of the resources; and

(n) to carry out the other objects that the Minister specifies by regulation made under this Act. 2006, c. 4, s. 5.

Powers

6. (1) Except as limited by this Act, a local health integration network has the capacity, rights and powers of a natural person for carrying out its objects. 2006, c. 4, s. 6 (1).

Use of revenue

(2) A local health integration network shall carry out its operations without the purpose of gain and shall not use its revenue, including all money or assets that it receives by grant, contribution or otherwise, for any purpose other than to further its objects. 2006, c. 4, s. 6 (2).

Cabinet approval

(3) A local health integration network shall not exercise the following powers without the approval of the Lieutenant Governor in Council:

1. Acquiring, disposing, leasing, mortgaging, charging, hypothecating or otherwise transferring or encumbering any interest in real property, except for leasing office space that is reasonably necessary for the purposes of the network.
2. Borrowing or lending money.
3. Investing its money.
4. Pledging, charging or encumbering any of its personal property.
5. Creating a subsidiary.
6. Indemnifying any person from liability or guaranteeing the payment of money or the performance of services by another person, except if the indemnification is given under subsection 8 (6).
7. Providing, directly through its directors, officers, employees or agents, any health services to people. 2006, c. 4, s. 6 (3).

Approval of two Ministers

(4) A local health integration network shall not exercise the following powers without the approval of both the Minister and the Minister of Finance:

1. Receiving money or assets from any person or entity except the Crown in right of Ontario.
2. Acting in association with a person or entity that conducts any fundraising activities or programs, directly or indirectly, for the network. 2006, c. 4, s. 6 (4).

Approval of Minister

(5) A local health integration network shall not exercise the following powers without the approval of the Minister:

1. Making charitable donations except as authorized by this Act.
2. Applying for or obtaining registration as a registered charity under the *Income Tax Act* (Canada).
3. Entering into an agreement with any person, entity or government for the provision of services outside Ontario.
4. Entering into an agreement with any government or government agency outside Ontario, including the Government of Canada or the government of a province or territory of Canada. 2006, c. 4, s. 6 (5).

No political donations

(6) A local health integration network shall not make any political donations. 2006, c. 4, s. 6 (6).

Board of directors

7. (1) Subject to subsection (10), each local health integration network shall consist of no more than nine members appointed by the Lieutenant Governor in Council who shall form the board of directors of the network. 2006, c. 4, s. 7 (1).

Term

(2) Subject to subsections (3) and (4), the members of the board of directors of a local health integration network shall hold office for a term of up to three years at the pleasure of the Lieutenant Governor in Council and may be reappointed for one further term. 2006, c. 4, s. 7 (2).

Termination

(3) A member ceases to be a member of the board of directors of a local health integration network if, before the term of the member expires,

(a) the Lieutenant Governor in Council revokes the member's appointment as a member of the network; or

(b) the member dies, resigns as a member of the board of directors or becomes a bankrupt. 2006, c. 4, s. 7 (3).

Successor's term

(4) If a person ceases to be a member of the board of directors before the term of the member expires, the first term of the person's successor shall be for the remainder of the first person's term or 13 months, whichever is the longer. 2006, c. 4, s. 7 (4).

Remuneration

(5) The members of the board of directors shall receive the remuneration and reimbursement for reasonable expenses that the Lieutenant Governor in Council determines. 2006, c. 4, s. 7 (5).

Chair and vice-chair

(6) Subject to subsection (10), the Lieutenant Governor in Council shall designate a chair and at least one vice-chair from among the members of the board of directors. 2006, c. 4, s. 7 (6).

Chair's role

(7) The chair shall preside over the meetings of the board of directors. 2006, c. 4, s. 7 (7).

Vice-chair

(8) If the chair is absent or otherwise unable to act or if the office is vacant, a vice-chair has all the powers and shall perform the duties of the chair. 2006, c. 4, s. 7 (8).

Absence of chair and vice-chairs

(9) In the absence of the chair and the vice-chairs, a director that the board of directors designates shall act as the chair. 2006, c. 4, s. 7 (9).

Transition

(10) A director, chair or vice-chair of a corporation continued under subsection 3 (1) as a local health integration network who holds office on the day that this section comes into force shall be deemed to be a first director, chair or vice-chair of the network appointed under this section and shall hold office until the Lieutenant Governor in Council appoints or designates a successor in accordance with this section. 2006, c. 4, s. 7 (10).

Powers and duties of board

8. (1) The affairs of each local health integration network are under the management and control of its board of directors. 2006, c. 4, s. 8 (1).

By-laws

(2) Subject to subsections (3) and (4), a board of directors may pass by-laws and resolutions for conducting and managing the affairs of the local health integration network, including establishing committees. 2006, c. 4, s. 8 (2).

Minister's approval

(3) The Minister may require the board of directors to submit a proposed by-law to the Minister for approval before making the by-law concerned and if so, the board shall not make the by-law concerned until the Minister approves it. 2006, c. 4, s. 8 (3).

Same, after making

(4) The Minister may require the board of directors to submit a by-law to the Minister for approval and if so,

(a) the by-law concerned ceases to be effective from the time that the Minister imposes the requirement until the Minister approves the by-law;

(b) anything that the board has done in compliance with the by-law concerned before the Minister imposes the requirement is valid; and

(c) the board may do anything that, before the Minister imposes the requirement, it has agreed to do. 2006, c. 4, s. 8 (4).

Committees

(5) The board of directors of a local health integration network shall,

(a) establish, by by-law, the committees of the board that the Minister, by regulation made under this Act, specifies;

(b) appoint as members of the committees the persons who meet the qualifications, if any, that the Minister specifies in the regulation; and

(c) ensure that the committees operate in accordance with the other requirements, if any, that the Minister specifies in the regulation. 2006, c. 4, s. 8 (5).

Duty of care and indemnification

(6) Subject to subsection (7), subsection 134 (1) and section 136 of the *Business Corporations Act* apply with necessary modifications to each local health integration network, its board of directors and its officers. 2006, c. 4, s. 8 (6).

Approval of indemnity

(7) A local health integration network shall not give an indemnity under section 136 of the *Business Corporations Act* to any person unless the indemnity has been approved in accordance with section 28 of the *Financial Administration Act*. 2006, c. 4, s. 8 (7).

Conflict of interest

(8) The board of directors of a local health integration network shall develop, in consultation with the Minister, conflict of interest policies for the members and employees of the network. 2006, c. 4, s. 8 (8).

Meetings

9. (1) The board of directors of a local health integration network shall meet regularly throughout the year and in any event shall hold at least four meetings in each calendar year. 2006, c. 4, s. 9 (1).

Quorum

(2) A majority of the directors constitutes a quorum for the conduct of business of the board. 2006, c. 4, s. 9 (2).

Notice

(3) A local health integration network shall give reasonable notice to the public of the meetings of its board of directors and its committees. 2006, c. 4, s. 9 (3).

Public meetings

(4) All meetings of the board of directors of a local health integration network and its committees shall be open to the public. 2006, c. 4, s. 9 (4).

Exceptions

(5) Despite subsection (4), a local health integration network may exclude the public from any part of a meeting if,

(a) financial, personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;

(b) matters of public security will be discussed;

(c) the security of the members or property of the network will be discussed;

(d) personal health information, as defined in section 4 of the *Personal Health Information Protection Act, 2004*, will be discussed;

(e) a person involved in a civil or criminal proceeding may be prejudiced;

(f) the safety of a person may be jeopardized;

(g) personnel matters involving an identifiable individual, including an employee of the network, will be discussed;

(h) negotiations or anticipated negotiations between the network and a person, bargaining agent or party to a proceeding or an anticipated proceeding relating to labour relations or a person's employment by the network will be discussed;

(i) litigation or contemplated litigation affecting the network will be discussed, or any legal advice provided to the network will be discussed, or any other matter subject to solicitor-client privilege will be discussed;

(j) matters prescribed for the purposes of this clause will be discussed; or

(k) the network will deliberate whether to exclude the public from a meeting, and the deliberation will consider whether one or more of clauses (a) through (j) are applicable to the meeting or part of the meeting. 2006, c. 4, s. 9 (5).

Motion stating reasons

(6) A local health integration network shall not exclude the public from a meeting before a vote is held on a motion to exclude the public, which motion must clearly state the nature of the matter to be considered at the closed meeting and the general reasons why the public is being excluded. 2006, c. 4, s. 9 (6).

Taking of vote

(7) The meeting shall not be closed to the public during the taking of the vote on the motion under subsection (6). 2006, c. 4, s. 9 (7).

Chief executive officer

10. (1) Each local health integration network shall appoint and employ a chief executive officer. 2006, c. 4, s. 10 (1).

Restriction

(2) The chief executive officer of a local health integration network shall not be a member of the board of directors of any local health integration network. 2006, c. 35, Sched. C, s. 63 (1).

Role

(3) The chief executive officer of a local health integration network is responsible for the management and administration of the affairs of the network, subject to the supervision and direction of its board of directors. 2006, c. 4, s. 10 (3).

Remuneration

(4) The Minister may fix ranges for the salary or other remuneration and benefits of a chief executive officer and each local health integration network shall provide a salary or other remuneration and benefits to its chief executive officer within the ranges, if any, that the Minister fixes. 2006, c. 4, s. 10 (4).

Other employees

11. (1) A local health integration network may employ the employees, other than a chief executive officer, that the network considers necessary for the proper conduct of the business of the network. 2006, c. 4, s. 11 (1).

(2) REPEALED: 2006, c. 35, Sched. C, s. 63 (2).

Audit

12. (1) The board of directors of a local health integration network shall appoint an auditor licensed under the *Public Accounting Act, 2004* to audit the accounts and financial transactions of the network annually. 2006, c. 4, s. 12 (1).

Other audits

(2) In addition to the requirement for an annual audit,

(a) the Minister may, at any time, review or audit any aspect of the operations of a local health integration network; and

(b) the Auditor General may, at any time, audit any aspect of the operations of a local health integration network. 2006, c. 4, s. 12 (2); 2010, c. 25, s. 26.

Reports

13. (1) Each local health integration network shall submit to the Minister an annual report, within the time period that the Minister specifies, on its affairs and operations during its immediately preceding fiscal year. 2006, c. 4, s. 13 (1).

Fiscal year

(2) The fiscal year of a local health integration network commences on April 1 in each year and ends on March 31 of the following year. 2006, c. 4, s. 13 (2).

Contents

(3) The annual report shall include,

(a) audited financial statements for the fiscal year of the local health integration network to which the report relates; and

(b) data relating specifically to Aboriginal health issues addressed by the local health integration network. 2006, c. 4, s. 13 (3).

Form

(4) The annual report shall be signed by the chair and one other member of the board of directors of the local health integration network and shall be in the form that the Minister specifies. 2006, c. 4, s. 13 (4).

Tabling

(5) The Minister shall,

(a) submit the annual report to the Lieutenant Governor in Council;

(b) lay the report before the Assembly if it is in session; and

(c) deposit the report with the Clerk of the Assembly if the Assembly is not in session. 2006, c. 4, s. 13 (5).

Reports to Ontario Health Quality Council

(6) Each local health integration network shall provide the Ontario Health Quality Council with the information about the local health system that the Council requests. 2006, c. 4, s. 13 (6).

PART III
PLANNING AND COMMUNITY ENGAGEMENT

Provincial strategic plan

14. (1) The Minister shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system and make copies of it available to the public at the offices of the Ministry. 2006, c. 4, s. 14 (1).

Councils

(2) The Minister shall establish the following councils:

1. An Aboriginal and First Nations health council to advise the Minister about health and service delivery issues related to Aboriginal and First Nations peoples and priorities and strategies for the provincial strategic plan related to those peoples.
2. A French language health services advisory council to advise the Minister about health and service delivery issues related to francophone communities and priorities and strategies for the provincial strategic plan related to those communities. 2006, c. 4, s. 14 (2).

Members

(3) The Minister shall appoint the members of each of the councils established under subsection (2) who shall be representatives of the organizations that are prescribed. 2006, c. 4, s. 14 (3).

Consultation

(4) In developing priorities and strategic directions for the health system and the local health systems in the provincial strategic plan, the Minister shall seek the advice of province-wide health planning organizations that are mandated by the Government of Ontario. 2006, c. 4, s. 14 (4).

Integrated health service plan

15. (1) Subject to subsection 16 (1), each local health integration network shall, within the time and in the form specified by the Minister, develop an integrated health service plan for the local health system and make copies of it available to the public at the network's offices. 2006, c. 4, s. 15 (1).

Contents

(2) The integrated health service plan shall include a vision, priorities and strategic directions for the local health system and shall set out strategies to integrate the local health system in order to achieve the purpose of this Act. 2006, c. 4, s. 15 (2).

Restrictions

(3) The integrated health service plan shall be consistent with a provincial strategic plan, the funding that the network receives under section 17 and the requirements, if any, that the regulations made under this Act prescribe. 2006, c. 4, s. 15 (3).

Community engagement

16. (1) A local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities. 2006, c. 4, s. 16 (1).

Definition

(2) In this section,

"community" includes, in respect of a local health integration network that engages the community,

(a) patients and other individuals in the geographic area of the network,

(b) health service providers and any other person or entity that provides services in or for the local health system, and

(c) employees involved in the local health system. 2006, c. 4, s. 16 (2).

Methods of engagement

(3) The methods for carrying out community engagement under subsection (1) may include holding community meetings or focus group meetings or establishing advisory committees. 2006, c. 4, s. 16 (3).

Duties

(4) In carrying out community engagement under subsection (1), the local health integration network shall engage,

(a) the Aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed; and

(b) the French language health planning entity for the geographic area of the network that is prescribed. 2006, c. 4, s. 16 (4).

Health professionals advisory committee

(5) Each local health integration network shall establish a health professionals advisory committee consisting of the persons that the network appoints from among members of those regulated health professions that the network determines or that are prescribed. 2006, c. 4, s. 16 (5).

Engagement by health service providers

(6) Each health service provider shall engage the community of diverse persons and entities in the area where it provides health services when developing plans and setting priorities for the delivery of health services. 2006, c. 4, s. 16 (6).

PART IV
FUNDING AND ACCOUNTABILITY

Funding of networks

17. (1) The Minister may provide funding to a local health integration network on the terms and conditions that the Minister considers appropriate. 2006, c. 4, s. 17 (1).

Savings by a network

(2) When determining the funding to be provided to a local health integration network under subsection (1) for a fiscal year, the Minister shall consider whether to adjust the funding to take into account a portion of any savings from efficiencies

that the local health system generated in the previous fiscal year and that the network proposes to spend on patient care in subsequent fiscal years in accordance with the accountability agreement. 2006, c. 4, s. 17 (2).

Accountability of networks

18. (1) The Minister and each local health integration network shall enter into an accountability agreement in respect of the local health system. 2006, c. 4, s. 18 (1).

Accountability agreement

(2) An accountability agreement shall be for more than one fiscal year and shall include,

(a) performance goals and objectives for the network and the local health system;

(b) performance standards, targets and measures for the network and the local health system;

(c) requirements for the network to report on the performance of the network and the local health system;

(d) a plan for spending the funding that the network receives under section 17, which spending shall be in accordance with the appropriation from which the Minister has provided the funding to the network;

(e) a progressive performance management process for the network; and

(f) all other prescribed matters, if any. 2006, c. 4, s. 18 (2).

If no agreement

(3) If the Minister and a local health integration network are unable to conclude an accountability agreement through negotiations, the Minister may set the terms of the agreement which shall include the matters set out in clauses (2) (a) to (f). 2006, c. 4, s. 18 (3).

Reports to Minister

(4) A local health integration network shall provide to the Minister, within the time and in the form that the Minister specifies, the plans, reports, financial statements, including audited financial statements, and information, other than personal health information as defined in subsection 31 (5) of the *Commitment to the Future of Medicare Act, 2004*, that the Minister requires for the purposes of administering this Act. 2006, c. 4, s. 18 (4).

Availability to the public

(5) The Minister and each local health integration network shall make copies of the accountability agreement of the network available to the public at the offices of the Ministry and the network, respectively. 2006, c. 4, s. 18 (5).

Funding of health service providers

19. (1) A local health integration network may provide funding to a health service provider in respect of services that the service provider provides in or for the geographic area of the network. 2006, c. 4, s. 19 (1).

Terms and conditions

(2) The funding that a local health integration network provides under subsection (1) shall be on the terms and conditions that the network considers appropriate and in accordance with the funding that the network receives under section 17, the network's accountability agreement and the prescribed requirements, if any. 2006, c. 4, s. 19 (2).

Assignment of agreements

(3) The Minister may assign to a local health integration network the Minister's rights and obligations under all or part of an agreement between the Minister and a health service provider, including an agreement to which a person or entity that is not a health service provider is also a party. 2006, c. 4, s. 19 (3).

Exception

(4) Despite subsection (3), the Minister shall not assign to a local health integration network an agreement for the provision of funding for services by a person described in subsection 2 (3) that the Minister has entered into under the authority of paragraph 4 of subsection 6 (1) of the *Ministry of Health and Long-Term Care Act* or subsection 2 (2) of the *Health Insurance Act*. 2006, c. 4, s. 19 (4).

Termination date

(5) In an assignment under subsection (3), the Minister may provide that the agreement, or the part of it assigned, terminates on the earliest of,

(a) the date set out in the agreement;

(b) the date that the network and the health service provider enter into a service accountability agreement; and

(c) the date, as the Minister specifies, that the network and the health service provider have to enter into a service accountability agreement. 2006, c. 4, s. 19 (5).

Accountability of health service providers

20. (1) A local health integration network and a health service provider that receives funding from the network under subsection 19 (1) shall enter into a service accountability agreement, as defined in Part III of the *Commitment to the Future of Medicare Act, 2004*. 2006, c. 4, s. 20 (1).

No restriction on patient mobility

(2) A local health integration network shall not enter into any agreement or other arrangement that restricts or prevents an individual from receiving services based on the geographic area in which the individual resides. 2006, c. 4, s. 20 (2).

Community care access corporations

(3) Subsection (2) does not apply to any agreement between a local health integration network and a community care access corporation that requires the latter corporation to deliver services in the area in which it is approved to provide services. 2006, c. 4, s. 20 (3).

Audit

21. A local health integration network may, at any time, direct that a health service provider that receives funding from the network under subsection 19 (1) engage or permit one or more auditors licensed under the *Public Accounting Act, 2004* to audit the accounts and financial transactions of the service provider. 2006, c. 4, s. 21.

Information and reports

22. (1) A local health integration network may require that any health service provider to which the network provides funding or proposes to provide funding under subsection 19 (1) provide to the network the plans, reports, financial statements and other information, other than personal health information as defined in subsection 31 (5) of the *Commitment to the Future of Medicare Act, 2004*, that the network requires for the purposes of exercising its powers and duties under this Act or for the purposes that are prescribed. 2006, c. 4, s. 22 (1).

Same, other persons

(2) A local health integration network may require that a prescribed person or entity provide to the network the prescribed plans, reports and other information, other than personal health information as defined in subsection 31 (5) of the *Commitment to the Future of Medicare Act, 2004*, that the network requires for the purposes of exercising its powers and duties under this Act or Part III of the latter Act or for the purposes that are prescribed. 2006, c. 4, s. 22 (2).

Form of reports

(3) A person or entity that is required to provide plans, reports, financial statements or information under subsection (1) or (2) shall provide them within the time and in the form that the local health integration network specifies. 2006, c. 4, s. 22 (3).

Disclosure of information

(4) A local health integration network may disclose information that it collects under this section,

(a) to the Minister or another local health integration network if the Minister or that network, as the case may be, requires the information for the purposes of exercising powers and duties under this Act or Part III of the *Commitment to the Future of Medicare Act, 2004*; or

(b) to the Ontario Health Quality Council if the Council requests the information for the purposes of exercising its powers and duties under the *Excellent Care for All Act, 2010*. 2006, c. 4, s. 22 (4); 2010, c. 14, s. 19.

PART V
INTEGRATION AND DEVOLUTION

Definition

23. In this Part,

"service" includes,

(a) a service or program that is provided directly to people,

(b) a service or program, other than a service or program described in clause (a), that supports a service or program described in that clause, or

(c) a function that supports the operations of a person or entity that provides a service or program described in clause (a) or (b). 2006, c. 4, s. 23.

Identifying integration opportunities

24. Each local health integration network and each health service provider shall separately and in conjunction with each other identify opportunities to integrate the services of the local health system to provide appropriate, co-ordinated, effective and efficient services. 2006, c. 4, s. 24.

Integration by networks

25. (1) A local health integration network may integrate the local health system by,

(a) providing or changing funding to a health service provider under subsection 19 (1);

(b) facilitating and negotiating the integration of persons or entities where at least one of the persons or entities is a health service provider or the integration of services between health service providers or between a health service provider and a person or entity that is not a health service provider;

(c) issuing a decision under section 26 that requires a health service provider to proceed with the integration described in the decision; or

(d) issuing a decision under section 27 that orders a health service provider not to proceed with the integration described in the decision. 2006, c. 4, s. 25 (1).

Integration decision

(2) A local health integration network shall issue an integration decision when the network,

(a) facilitates or negotiates the integration of persons or entities where at least one of the persons or entities is a health service provider or the integration of services between health service providers or between a health service provider and a person or entity that is not a health service provider and the parties reach an agreement with respect to that integration;

(b) requires a health service provider to proceed with an integration under section 26; or

(c) orders a health service provider not to proceed with an integration under section 27. 2006, c. 4, s. 25 (2).

Prohibition

(3) No integration decision shall permit a transfer of services that results in a requirement for an individual to pay for those services, except as otherwise permitted by law. 2006, c. 4, s. 25 (3).

Parties to decision

(4) The following persons and entities are parties to an integration decision issued by a local health integration network:

1. If the decision is issued under clause (2) (a), the parties to the agreement that the network facilitates or negotiates under that clause.
2. If the decision is issued under clause (2) (b) or (c), the health service provider to which the decision is issued. 2006, c. 4, s. 25 (4).

Form of decision

(5) An integration decision issued by a local health integration network shall set out,

(a) the purpose and nature of the integration, except in the case of a decision issued under section 27;

(b) the parties to the decision;

(c) the actions that the parties to the decision are required to take or not to take, including any time period for doing so;

(d) a requirement that the parties to the decision develop a human resources adjustment plan in respect of the integration;

(e) the effective date of all transfers of services involved in the integration, if any; and

(f) any other matter that the network considers relevant. 2006, c. 4, s. 25 (5).

Notice of decision

(6) On issuing an integration decision, a local health integration network shall give the decision to the parties to the decision and make copies of it available to the public at its offices. 2006, c. 4, s. 25 (6).

Non-application of other Act

(7) The *Statutory Powers Procedure Act* does not apply to an integration decision. 2006, c. 4, s. 25 (7).

Not a regulation

(8) An integration decision is not a regulation as defined in Part III (Regulations) of the *Legislation Act, 2006*. 2006, c. 4, ss. 25 (8), 40 (3).

Amendment

(9) A local health integration network that issues an integration decision under clause (2) (a) or (b) may amend the decision; subsections (3) to (8) apply to the amendment with necessary modifications and, in the case of an integration decision under clause (2) (b), section 26 also applies to the amendment. 2006, c. 4, s. 25 (9).

Revocation

(10) A local health integration network that makes an integration decision may revoke the decision and subsections (4), (6), (7) and (8) apply to the decision that does the revocation. 2006, c. 4, s. 25 (10).

Required integration

26. (1) Subject to subsections (2) to (6), a local health integration network that has made copies of an integrated health service plan available to the public may, if it considers it in the public interest to do so, make a decision that requires one or more health service providers to which it provides funding under subsection 19 (1) to do any one or more of the following on or after a date set out in the decision:

1. To provide all or part of a service or to cease to provide all or part of a service.
2. To provide a service to a certain level, quantity or extent.
3. To transfer all or part of a service from one location to another.
4. To transfer all or part of a service to or to receive all or part of a service from another person or entity.
5. To carry out another type of integration of services that is prescribed.
6. To do anything or refrain from doing anything necessary for the health service providers to achieve anything under any of paragraphs 1 to 5, including to transfer property to or to receive property from another person or entity in respect of the services affected by the decision. 2006, c. 4, s. 26 (1).

Restrictions

(2) A decision made by a local health integration network under this section,

(a) shall not be contrary to the network's integrated health service plan or accountability agreement;

(b) shall not relate to services for which a local health integration network does not provide or propose to provide funding, in whole or in part, to the health service provider;

(c) shall not require a health service provider to cease operating or carrying on business or to dissolve or wind up its operations or business;

(d) shall not require a health service provider to change the composition or structure of its membership or board of directors;

(e) shall not require two or more health service providers to amalgamate;

(f) shall not unjustifiably as determined under section 1 of the *Canadian Charter of Rights and Freedoms* require a health service provider that is a religious organization to provide a service that is contrary to the religion related to the organization;

(g) shall not require a health service provider to transfer property that it holds for a charitable purpose to a person or entity that is not a charity;

(h) shall not require a health service provider that is not a charity to receive property from a person or entity that is a charity and to hold the property for a charitable purpose; and

(i) shall not require a health service provider to do anything that is prescribed in addition to the restrictions set out in clauses (a) to (h). 2006, c. 4, s. 26 (2).

Notice of proposed decision

(3) At least 30 days before issuing a decision under subsection (1), a local health integration network shall,

(a) notify a health service provider that the network proposes to issue a decision under that subsection;

(b) provide a copy of the proposed decision to the service provider; and

(c) make copies of the proposed decision available to the public. 2006, c. 4, s. 26 (3).

Submissions

(4) Any person may make written submissions about the proposed decision to the local health integration network no later than 30 days after the network makes copies of the proposed decision available to the public. 2006, c. 4, s. 26 (4).

Issuing a decision

(5) If at least 30 days have passed since the local health integration network gave the notice mentioned in subsection (3) and after the network has considered any written submissions made under subsection (4), the network may issue an integration decision under subsection (1), and subsections (3) and (4) do not apply to the issuance of the decision. 2006, c. 4, s. 26 (5).

Variance

(6) An integration decision mentioned in subsection (5) may be different from the proposed decision that was the subject of the notice mentioned in subsection (3). 2006, c. 4, s. 26 (6).

Integration by health service providers

27. (1) A health service provider may integrate its services with those of another person or entity. 2006, c. 4, s. 27 (1).

Application of other Act

(2) Nothing in this Act shall be interpreted as preventing the application of the *Public Sector Labour Relations Transition Act, 1997*, in accordance with the terms of that Act, to an integration mentioned in subsection (1). 2006, c. 4, s. 27 (2).

Notice to network

(3) If the integration mentioned in subsection (1) relates to services that are funded, in whole or in part, by a local health integration network, the health service provider,

(a) shall give notice of the integration to the network, unless the regulations made under this Act prescribe otherwise;

(b) may proceed with the integration if the service provider is not required to give the notice mentioned in clause (a);

(c) shall not proceed with the integration until 60 days have passed since giving the notice mentioned in clause (a), if the service provider is required to give the notice and the network does not give notice under subsection (4);

(d) shall not proceed with the integration until 60 days have passed since the network gives notice under subsection (4), if,

(i) the service provider is required to give notice under clause (a),

(ii) the network gives notice under that subsection, and

(iii) the network does not issue a decision under subsection (6); and

(e) shall not proceed with the integration that is the subject of a decision under subsection (6), if the network issues such a decision. 2006, c. 4, s. 27 (3).

Notice of proposed decision

(4) No later than 60 days after the health service provider gives the notice required under subsection (3), the local health integration network may,

(a) notify a health service provider that the network proposes to issue a decision under subsection (6);

(b) provide a copy of the proposed decision to the service provider; and

(c) make copies of the proposed decision available to the public. 2006, c. 4, s. 27 (4).

Submissions

(5) Any person may make written submissions about the proposed decision to the local health integration network no later than 30 days after the network makes copies of the proposed decision available to the public. 2006, c. 4, s. 27 (5).

Issuing a decision

(6) If more than 30 days, but no more than 60 days, have passed after the local health integration network gives notice under subsection (4) and after the network has considered any written submissions made under subsection (5), the network may, if it considers it in the public interest to do so, issue a decision ordering the health service provider not to proceed with the integration mentioned in the notice under clause (3) (a) or a part of the integration. 2006, c. 4, s. 27 (6).

Matters to consider

(7) In issuing a decision under subsection (6), a local health integration network shall consider the extent to which the integration is not consistent with the network's integrated health service plan and any other matter that the network considers relevant. 2006, c. 4, s. 27 (7).

Variance

(8) An integration decision mentioned in subsection (6) may be different from the proposed decision that was the subject of the notice given under subsection (4). 2006, c. 4, s. 27 (8).

Integration by the Minister

28. (1) After receiving advice from the local health integration networks involved, the Minister may, if the Minister considers it in the public interest to do so and subject to subsection (2), order a health service provider that receives funding from a local health integration network under subsection 19 (1) and that carries on its operations on a for profit or not for profit basis to do any of the following on or after the date set out in the order:

1. To cease operating, to dissolve or to wind up its operations.
2. To amalgamate with one or more health service providers that receive funding from a local health integration network under subsection 19 (1).
3. To transfer all or substantially all of its operations to one or more persons or entities.

4. To do anything or refrain from doing anything necessary for the health service provider to achieve anything under any of paragraphs 1 to 3, including to transfer property to or to receive property from another person or entity in respect of the operations affected by the order. 2006, c. 4, s. 28 (1).

Religious denomination

(2) An order made by the Minister under subsection (1) shall not unjustifiably as determined under section 1 of the *Canadian Charter of Rights and Freedoms* require a health service provider that is a religious organization to provide a service that is contrary to the religion related to the organization. 2006, c. 4, s. 28 (2).

Restrictions

(3) Despite subsection (1), the Minister shall not,

(a) issue an order under that subsection to a board of management described in paragraph 5 of the definition of "health service provider" in subsection 2 (2) or a municipality;

(b) issue an order under that subsection to a health service provider described in paragraph 4 of the definition of "health service provider" in subsection 2 (2), if the service provider is not also described in another paragraph of that definition;

(c) issue an order under paragraph 1 of that subsection, in respect of the operation of a long-term care home, to a health service provider described in paragraph 4 of the definition of "health service provider" in subsection 2 (2), if the service provider is also described in another paragraph of that definition;

(d) issue an order under paragraph 2 of that subsection to a health service provider that carries on operations on a not for profit basis to amalgamate with one or more health service providers that carries on operations on a for profit basis; or

(e) issue an order under paragraph 3 of that subsection to a health service provider that carries on operations on a not for profit basis to transfer all or substantially all of its operations to one or more persons or entities that carries on operations on a for profit basis. 2006, c. 4, s. 28 (3); 2007, c. 8, s. 214 (3, 4).

Application of other subsections

(4) Subsections 25 (3) to (10), clauses 26 (2) (g) and (h) and subsections 26 (3) to (6) apply to an order made by the Minister under subsection (1) as if it were an integration decision and all references to a local health integration network in those subsections shall be read as references to the Minister. 2006, c. 4, s. 28 (4).

Compliance

29. (1) A person or entity that is a party to an integration decision or a Minister's order made under section 28 shall comply with it. 2006, c. 4, s. 29 (1).

Corporate powers

(2) Despite any Act, regulation or other instrument related to the corporate governance of a health service provider that is a corporation and that is a party to an integration decision or a Minister's order made under section 28, including the *Business Corporations Act*, the *Corporations Act*, any articles of incorporation, any letters patent, any supplementary letters patent or any by-laws, the service provider shall be deemed to have the necessary powers to comply with the decision or the order, as the case may be. 2006, c. 4, s. 29 (2).

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection (2) is amended by striking out "the *Corporations Act*" and substituting "the *Not-for-Profit Corporations Act, 2010* or a predecessor of that Act". See: 2010, c. 15, ss. 231 (3), 249.

Court order

(3) A local health integration network that has issued an integration decision or the Minister after making an order under section 28 may apply to the Superior Court of Justice for an order directing a person or entity that is a party to the decision or the Minister's order, as the case may be, to comply with it. 2006, c. 4, s. 29 (3).

Transfer of property held for charitable purpose

30. (1) If an integration decision or a Minister's order made under section 28 directs a health service provider to transfer to a transferee property that it holds for a charitable purpose, all gifts, trusts, bequests, devises and grants of property that form part of the property being transferred shall be deemed to be gifts, trusts, bequests, devises and grants of property to the transferee. 2006, c. 4, s. 30 (1).

Specified purpose

(2) If a will, deed or other document by which a gift, trust, bequest, devise or grant mentioned in subsection (1) is made indicates that the property being transferred is to be used for a specified purpose, the transferee shall use it for the specified purpose. 2006, c. 4, s. 30 (2).

Application

(3) Subsections (1) and (2) apply whether the will, deed or document by which the gift, trust, bequest, devise or grant is made, is made before or after this section comes into force. 2006, c. 4, s. 30 (3).

No compensation

31. (1) Despite any other Act and subject to subsection (3), a health service provider is not entitled to any compensation for any loss or damages, including loss of revenue or loss of profit, arising from any direct or indirect action that the Minister or a local health integration network takes under this Act, including an integration decision or a Minister's order made under section 28. 2006, c. 4, s. 31 (1).

Same, transfer of property

(2) Despite any other Act and subject to subsection (3), no person or entity, including a health service provider, is entitled to compensation for any loss or damages, including loss of use, loss of revenue and loss of profit, arising from the transfer of property under an integration decision or a Minister's order made under section 28. 2006, c. 4, s. 31 (2).

Exception

(3) If an integration decision or a Minister's order made under section 28 directs a health service provider to transfer property to or to receive property from a person or entity, a person who suffers a loss resulting from the transfer is entitled to compensation as prescribed in respect of the portion of the loss that relates to the portion of the value of the property that was not acquired with money received from the Government of Ontario or an agency of the Government, whether or not it is a Crown agent. 2006, c. 4, s. 31 (3).

No expropriation

(4) Nothing in this Act and nothing done or not done in accordance with this Act constitutes an expropriation or injurious affection for the purposes of the *Expropriations Act* or otherwise at law. 2006, c. 4, s. 31 (4).

Transfers, application of other Act

32. (1) The *Public Sector Labour Relations Transition Act, 1997* applies when an integration occurs that is,

(a) the transfer of all or part of a service of a person or entity under an integration decision;

(b) the transfer of all or substantially all of the operations of a health service provider under a Minister's order made under section 28; or

(c) the amalgamation of two or more persons or entities under an integration decision issued with respect to an integration described in clause 25 (2) (a) or under a Minister's order made under section 28. 2006, c. 4, s. 32 (1).

Same

(2) For the purposes of the application of the *Public Sector Labour Relations Transition Act, 1997*,

(a) the changeover date is the effective date of the integration described in subsection (1) as set out in the integration decision or the Minister's order, as the case may be;

(b) the predecessor employer or employers are,

(i) each person or entity from which the service or operations is or are transferred, in the case of an integration described in clause (1) (a) or (b), or

(ii) each of the persons or entities that is amalgamated, in the case of an integration described in clause (1) (c); and

(c) the successor employer or employers are,

(i) each person or entity to which the service or operations is or are transferred, in the case of an integration described in clause (1) (a) or (b), or

(ii) the person or entity that exists when the amalgamation takes effect, in the case of an integration described in clause (1) (c). 2006, c. 4, s. 32 (2).

Exception

(3) Despite subsection (1) but subject to subsection (5), the *Public Sector Labour Relations Transition Act, 1997* does not apply when an integration described in subsection (1) occurs if the following describes the person or entity who would be the successor employer if that Act applied:

1. That person or entity is not a health service provider.
2. The primary function of that person or entity is not the provision of services within or to the health services sector. 2006, c. 4, s. 32 (3).

Same, consent of all parties

(4) Despite subsection (1) but subject to subsection (5), the *Public Sector Labour Relations Transition Act, 1997* does not apply when an integration described in subsection (1) occurs if all of the following agree in writing that that Act does not apply to the integration:

1. The person or entity who would be the successor employer if that Act applied.

2. Every bargaining agent that has bargaining rights in respect of a bargaining unit at the person or entity who would be the successor employer if that Act applied.

3. Every bargaining agent that would have bargaining rights in respect of a bargaining unit at the person or entity who would be the successor employer if that Act applied. 2006, c. 4, s. 32 (4).

Certain provisions still apply

(5) Where the *Public Sector Labour Relations Transition Act, 1997* does not apply to an integration described in subsection (1) by virtue of subsection (3) or an agreement entered into under subsection (4), sections 12 and 36 of that Act are not affected and, if applicable, apply to the integration in question. 2006, c. 4, s. 32 (5).

Definition

(6) In subsections (7) to (21),

"Board" means the Ontario Labour Relations Board. 2006, c. 4, s. 32 (6).

Application

(7) Any person, entity or bargaining agent described in paragraph 1, 2 or 3 of subsection (4) may request the Board to make an order declaring that the *Public Sector Labour Relations Transition Act, 1997* does not apply to an integration described in subsection (1). 2006, c. 4, s. 32 (7).

Board order

(8) If requested to do so under subsection (7), the Board may by order declare that the *Public Sector Labour Relations Transition Act, 1997*, other than sections 12 and 36 of that Act, does not, despite subsection (1), apply to the integration in question. 2006, c. 4, s. 32 (8).

Factors to consider

(9) When deciding whether to make an order under subsection (8), the Board shall consider the factors set out in subsection 9 (3) of the *Public Sector Labour Relations Transition Act, 1997* and the other matters that it considers relevant. 2006, c. 4, s. 32 (9).

Certain provisions still apply

(10) If the Board makes an order under subsection (8), the order shall specify that it does not affect sections 12 and 36 of the *Public Sector Labour Relations Transition Act, 1997* and that, if applicable, those provisions apply to the integration. 2006, c. 4, s. 32 (10).

Proceedings before the Board

(11) Subject to subsections (12) to (19), sections 110 to 118 of the *Labour Relations Act, 1995* apply, with necessary modifications, with respect to anything the Board does under this section. 2006, c. 4, s. 32 (11).

No panels

(12) If the Board is given authority to make a decision, determination or order under this section, it shall be made,

(a) by the chair or, if the chair is absent or unable to act, by the alternate chair; or

(b) by a vice-chair selected by the chair in his or her sole discretion or, if the chair is absent or unable to act, selected by the alternate chair in his or her sole discretion. 2006, c. 4, s. 32 (12).

Labour relations officers

(13) The Board may authorize a labour relations officer to inquire into any matter that comes before it under this section and to endeavour to settle the matter. 2006, c. 4, s. 32 (13).

Rules to expedite proceedings

(14) The Board has, in relation to any proceedings under this section, the same powers to make rules to expedite proceedings as the Board has under subsection 110 (18) of the *Labour Relations Act, 1995*. 2006, c. 4, s. 32 (14).

Non-application of other Act

(15) Rules made under subsection (14) apply despite anything in the *Statutory Powers Procedure Act*. 2006, c. 4, s. 32 (15).

Not regulations

(16) Rules made under subsection (14) are not regulations within the meaning of Part III (Regulations) of the *Legislation Act, 2006*. 2006, c. 4, ss. 32 (16), 40 (3).

Interim orders

(17) The Board may make interim orders with respect to a matter that is or will be the subject of a pending or intended proceeding. 2006, c. 4, s. 32 (17).

Timing

(18) The Board shall make decisions, determinations and orders under this Act in an expeditious fashion. 2006, c. 4, s. 32 (18).

No appeal

(19) A decision, determination or order made by the Board is final and binding for all purposes. 2006, c. 4, s. 32 (19).

Application of other provisions

(20) Subsections 96 (6) and (7) and sections 122 and 123 of the *Labour Relations Act, 1995* apply, with necessary modifications, with respect to proceedings before the Board and its decisions, determinations and orders under this section. 2006, c. 4, s. 32 (20).

Non-application of *Arbitration Act, 1991*

(21) The *Arbitration Act, 1991* does not apply with respect to a proceeding before the Board under this section. 2006, c. 4, s. 32 (1).

Integration by regulation

33. (1) The Lieutenant Governor in Council may, by regulation, order one or more persons or entities that operate a public hospital within the meaning of the *Public Hospitals Act* and the University of Ottawa Heart Institute/Institut de cardiologie de l'Université d'Ottawa to cease performing any prescribed non-clinical service and to integrate the service by transferring it to the prescribed person or entity on the prescribed date. 2006, c. 4, s. 33 (1).

Compliance

(2) The persons and entities mentioned in a regulation made under subsection (1) shall comply with the regulation and subsections 29 (2), (3) and (4) and sections 30 and 31 apply with respect to the persons and entities, except that references in those subsections to an integration decision or a Minister's order shall be read as references to the regulation. 2006, c. 4, s. 33 (2).

Human resources adjustment plan

(3) A person or entity that is required to cease performing a service described in a regulation made under subsection (1) shall develop a human resources adjustment plan in respect of the integration of the service. 2006, c. 4, s. 33 (3).

Application of other Act

(4) Unless otherwise prescribed, the *Public Sector Labour Relations Transition Act, 1997* applies when the integration of services ordered by a regulation made under subsection (1) occurs and for the purposes of that Act,

(a) the changeover date is the effective date of the integration or whatever other date the regulation prescribes;

(b) the predecessor employer or employers are each person or entity prescribed in the regulation from which the services are transferred; and

(c) the successor employer or employers are each person or entity prescribed in the regulation to which the services are transferred. 2006, c. 4, s. 33 (4).

Same

(5) Even if a regulation made under this Act prescribes that the *Public Sector Labour Relations Transition Act, 1997* does not apply to the integration, sections 12 and 36 of that Act apply to the integration, if applicable. 2006, c. 4, s. 33 (5).

Restriction

(6) The Lieutenant Governor in Council shall not make a regulation under subsection (1) on or after April 1, 2007. 2006, c. 4, s. 33 (6).

Revocation of regulations

(7) The Lieutenant Governor in Council may, by regulation, revoke a regulation made under subsection (1) and section 38 does not apply to a regulation made under this subsection. 2006, c. 4, s. 33 (7).

Repeal

(8) This section is repealed on a day to be named by proclamation of the Lieutenant Governor. 2006, c. 4, s. 33 (8).

Devolution

34. (1) Despite any other Act, and except as provided in subsection (2), the Lieutenant Governor in Council may, by regulation, devolve to a local health integration network any of the powers, duties or functions, under any other Act for whose administration the Minister is responsible at the time of making the regulation, of the Minister or a person appointed by the Minister or the Lieutenant Governor in Council. 2006, c. 4, s. 34 (1).

Exceptions

(2) A regulation made under subsection (1) shall not devolve to a local health integration network,

(a) a power to make regulations under any other Act for whose administration the Minister is responsible; or

(b) a power, duty or function that applies to a person described in subsection 2 (3) and that exists under the *Health Insurance Act*, Part II of the *Commitment to the Future of Medicare Act, 2004* or paragraph 4 of subsection 6 (1) of the *Ministry of Health and Long-Term Care Act*. 2006, c. 4, s. 34 (2).

List of Acts

(3) The Minister shall publish on the Ministry's website on the Internet a list of the Acts for whose administration the Minister is responsible and shall maintain the list current. 2006, c. 4, s. 34 (3).

Conditions on devolution

(4) A regulation under subsection (1) may devolve all or part of a power, duty or function to a local health integration network and may set out conditions on the exercise by a local health integration network of the power, duty or function and the modifications with which the power, duty or function is to apply. 2006, c. 4, s. 34 (4).

Effect of devolution

(5) If a regulation under subsection (1) devolves a power, duty or function under an Act to a local health integration network,

(a) the person or entity on which the Act confers the power, duty or function,

(i) shall no longer perform the power, duty or function to the extent that the regulation devolves it to the network, and

(ii) is released from any liability with respect to the power, duty or function to the extent that the regulation devolves it to the network if the liability arises on or after the day on which the regulation comes into force;

(b) the network,

(i) has the authority to exercise the power, duty or function to the extent that the regulation devolves it if it does so in accordance with the Act, and

(ii) has the rights and immunities of the person or entity on which the Act confers the power, duty or function to the extent that the regulation devolves it to the network, as if the network were that person or entity under that Act; and

(c) the powers, duties or functions of any other person in respect of the devolved power, duty or function shall be read as if the Act provided that the network had the power, duty or function. 2006, c. 4, s. 34 (5).

PART VI
GENERAL

No liability

35. No proceeding for damages or otherwise, other than an application for judicial review under the *Judicial Review Procedure Act* or a claim for compensation that is permitted under subsection 31 (3), shall be commenced against the Crown, the Minister, a local health integration network, any member, director or officer of a local health integration network or any person employed by the Crown, the Minister or a local health integration network with respect to any act done or omitted to be done or any decision or order under this Act that is done in good faith in the execution or intended execution of a power or duty under this Act. 2006, c. 4, s. 35.

Information for public

36. The Minister and each local health integration network shall establish and maintain websites on the Internet and shall publish on their respective websites the documents that the Minister or the network, as the case may be, is required to make available to the public under this Act. 2006, c. 4, s. 36.

Regulations

37. (1) The Lieutenant Governor in Council may make regulations,

(a) governing anything described in this Act as being prescribed;

(b) specifying persons, entities or classes of persons or entities that are excluded from the definition of "health service provider" in section 2;

(c) exempting a health service provider, a local health integration network or a class of health service providers or local health integration networks from any provision of this Act or the regulations made under it and specifying circumstances in which the exemption applies;

(d) prescribing provisions of the *Corporations Act* that apply to a local health integration network and the modifications with which those provisions are to so apply;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause (d) is amended by striking out "the *Corporations Act*" and substituting "the *Not-for-Profit Corporations Act, 2010*". See: 2010, c. 15, ss. 231 (4), 249.

(e) specifying a person or any class of persons who may not be appointed as members of a local health integration network;

(f) respecting community engagement under section 16, including how and with whom a local health integration network or a health service provider shall engage the community, the matters about which a local health integration network or a health service provider shall engage the community and the frequency of the engagement;

(g) respecting the health professionals advisory committee established under subsection 16 (5), including requirements for the membership on the committee and its functions;

(h) governing funding that a local health integration network provides to health service providers under subsection 19 (1);

(i) requiring a health service provider to institute a system for reconciling the funding that it receives from a local health integration network on the basis set out in the regulation, including,

(i) requiring the service provider to pay the network for any excess payment of funding, and

(ii) allowing the network to recover any excess payment of funding by deducting the excess from subsequent payments to the service provider;

(j) respecting matters that relate to or arise as a result of a transfer of property under an integration decision or a Minister's order made under section 28, including matters related to present and future rights, privileges and liabilities;

(k) governing compensation payable under subsection 31 (3), including who pays the compensation, the amount payable, how the loss for which compensation is payable is to be determined and how the portion of the value of the property that was not acquired with money from the Government of Ontario or an agency of the Government is to be determined;

(l) defining, for the purposes of this Act, any word or expression used in this Act that has not already been expressly defined in this Act. 2006, c. 4, s. 37 (1).

Same, Minister

(2) The Minister may make regulations,

(a) specifying additional objects of a local health integration network;

(b) respecting any matter that can be dealt with by a regulation mentioned in subsection 8 (5). 2006, c. 4, s. 37 (2).

Scope

(3) A regulation made under this Act may be general or specific in its application, may create different classes and may make different provisions for different classes or circumstances. 2006, c. 4, s. 37 (3).

Classes

(4) A class described in the regulations made under this Act may be described according to any characteristic or combination of characteristics and may be described to include or exclude any specified member, whether or not with the same characteristics. 2006, c. 4, s. 37 (4).

Public consultation before making regulations

38. (1) Subject to subsection (8), the Lieutenant Governor in Council or the Minister shall not make any regulation under this Act unless,

(a) the Minister has published a notice of the proposed regulation in *The Ontario Gazette* and given notice of the proposed regulation by all other means that the Minister considers appropriate for the purpose of providing notice to the persons and entities who may be affected by the proposed regulation;

(b) the notice complies with the requirements of this section;

(c) the time periods specified in the notice, during which persons may make comments under subsection (2) have expired;

(d) the Minister has considered whatever comments that persons have made on the proposed regulation in accordance with subsection (2) or an accurate synopsis of the comments; and

(e) if the Lieutenant Governor in Council may make the regulation, the Minister has reported to the Lieutenant Governor in Council on what, if any, changes to the proposed regulation the Minister considers appropriate. 2006, c. 4, s. 38 (1); 2007, c. 10, Sched. J, s. 3.

Contents of notice

(2) The notice mentioned in clause (1) (a) shall contain,

(a) a description of the proposed regulation and the text of it;

(b) a statement of the time period during which any person may submit written comments on the proposed regulation to the Minister and the manner in which and the address to which the comments must be submitted;

(c) a statement of where and when any person may review written information, if any, about the proposed regulation; and

(d) all other information that the Minister considers appropriate. 2006, c. 4, s. 38 (2).

Time period for comments

(3) The time period mentioned in clause (2) (b) shall be at least 60 days after the Minister gives the notice mentioned in clause (1) (a) unless the Minister shortens the time period in accordance with subsection (4). 2006, c. 4, s. 38 (3).

Shorter time period for comments

(4) The Minister may shorten the time period if, in the Minister's opinion,

(a) the urgency of the situation requires it;

(b) the proposed regulation clarifies the intent or operation of this Act or the regulations made under it; or

(c) the proposed regulation is of a minor or technical nature. 2006, c. 4, s. 38 (4).

Discretion to make regulations

(5) Upon receiving the Minister's report mentioned in clause (1) (e), the Lieutenant Governor in Council, without further notice under subsection (1), may make the proposed regulation with the changes that the Lieutenant Governor in Council considers appropriate, whether or not those changes are mentioned in the Minister's report. 2006, c. 4, s. 38 (5).

Same, Minister's regulations

(6) If the Minister may make the proposed regulation and the conditions set out in subsection (1) have been met, the Minister, without further notice under that subsection, may make the proposed regulation with the changes that the Minister considers appropriate. 2006, c. 4, s. 38 (6).

No public consultation

(7) The Minister may decide that subsections (1), (2), (3), (4), (5) and (6) should not apply to the power to make a regulation under this Act if, in the Minister's opinion,

(a) the urgency of the situation requires it;

(b) the proposed regulation clarifies the intent or operation of this Act or the regulations made under it; or

(c) the proposed regulation is of a minor or technical nature. 2006, c. 4, s. 38 (7).

Notice

(8) If the Minister decides that subsections (1), (2), (3), (4), (5) and (6) should not apply to the power to make a regulation under this Act,

(a) those subsections do not apply to the power to make the regulation; and

(b) the Minister shall give notice of the decision to the public as soon as is reasonably possible after making the decision. 2006, c. 4, s. 38 (8).

Contents of notice

(9) The notice mentioned in clause (8) (b) shall include a statement of the Minister's reasons for making the decision and all other information that the Minister considers appropriate. 2006, c. 4, s. 38 (9).

Publication of notice

(10) The Minister shall publish the notice mentioned in clause (8) (b) in *The Ontario Gazette* and give the notice by all other means that the Minister considers appropriate. 2006, c. 4, s. 38 (10).

No review

(11) Subject to subsection (12), no court shall review any action, decision, failure to take action or failure to make a decision by the Lieutenant Governor in Council or the Minister under this section. 2006, c. 4, s. 38 (11).

Exception

(12) Any person resident in Ontario may make an application for judicial review under the *Judicial Review Procedure Act* on the grounds that the Minister has not taken a step required by this section. 2006, c. 4, s. 38 (12).

Time for application

(13) No person shall make an application under subsection (12) with respect to a regulation later than 21 days after the day on which the Minister publishes a notice with respect to the regulation under clause (1) (a) or subsection (10), if applicable. 2006, c. 4, s. 38 (13).

Review of Act and regulations

39. (1) A committee of the Legislative Assembly shall,

(a) begin a comprehensive review of this Act and the regulations made under it no later than two years from the date when no exemption under the regulations applies to the requirement under subsection 20 (1) for local health integration networks to enter into service accountability agreements with health service providers that are approved corporations within the meaning of the *Charitable Institutions Act*, municipalities or boards of management maintaining homes for the aged or joint homes for the aged under the *Homes for the Aged and Rest Homes Act* or licensees within the meaning of the *Nursing Homes Act*; and

(b) within one year after beginning that review, make recommendations to the Assembly concerning amendments to this Act and the regulations made under it. 2006, c. 4, s. 39 (1); 2010, c. 1, Sched. 15, s. 1.

Definition

(2) In this section,

"year" means a period of 365 consecutive days or, if the period includes February 29, 366 consecutive days. 2006, c. 4, s. 39 (2).

40. OMITTED (PROVIDES FOR AMENDMENTS TO THIS ACT). 2006, c. 4, s. 40.

41.-54. OMITTED (AMENDS OR REPEALS OTHER ACTS). 2006, c. 4, ss. 41-54.

55. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS ACT). 2006, c. 4, s. 55.

56. OMITTED (ENACTS SHORT TITLE OF THIS ACT). 2006, c. 4, s. 56.

Local Health System Integration Act, 2006

ONTARIO REGULATION 515/09

ENGAGEMENT WITH THE FRANCOPHONE COMMUNITY UNDER SECTION 16 OF THE ACT

Consolidation Period: From January 1, 2010 to the e-Laws currency date.

No amendments.

This is the English version of a bilingual regulation.

Purposes

1. The purposes of this Regulation are,

(a) to prescribe a French language health planning entity for the geographic area of each local health integration network for the purposes of clause 16 (4) (b) of the Act; and

(b) to set out the duties of each local health integration network for engaging the French language health planning entity for the geographic area of the network for the purposes of section 16 of the Act. O. Reg. 515/09, s. 1.

French language health planning entity

2. (1) For the purposes of clause 16 (4) (b) of the Act and for each local health integration network, the Minister shall select an entity as the French language health planning entity for the geographic area of the network in accordance with this section,

(a) no later than six months after this Regulation comes into force for the first entity selected for the area; and

(b) upon the cancellation or the expiry of the selection of an entity for the area under this section. O. Reg. 515/09, s. 2 (1).

(2) The Minister shall not select an entity as the French language health planning entity for the geographic area of a local health integration network unless the entity meets the following criteria:

1. It is incorporated under the laws of Ontario and is a going concern.
2. It has a demonstrated relationship with the Francophone community in the area.
3. It has experience with or knowledge of the local health system and the health needs of the Francophone community in the area, including the needs of diverse groups within the Francophone community.
4. It has demonstrated an awareness of or involvement in the planning or delivery of health services.
5. It has demonstrated the capacity and skills to engage the network about the local health system under subsection 16 (1) of the Act to further the purpose of the Act, including the ability to provide timely advice consistent with the planning cycles of the network.
6. It agrees to engage the network on the matters listed in clauses 3 (1) (a) to (f) of this Regulation in accordance with section 16 of the Act.
7. It agrees to engage the network on the matters listed in clauses 3 (1) (a) to (f) of this Regulation in the best interests of the Francophone community in the area and not seek to obtain any benefit for itself.
8. It agrees to enter into an agreement with the network about roles and responsibilities relating to the matters listed in clauses 3 (1) (a) to (f) of this Regulation. O. Reg. 515/09, s. 2 (2).

(3) The Minister may select an entity to act as the French language health planning entity for the geographic area of more than one local health integration network but shall ensure that there are at least five French language health planning entities selected in Ontario. O. Reg. 515/09, s. 2 (3).

(4) The Minister shall consult with a local health integration network before selecting the French language health planning entity for the geographic area of the network. O. Reg. 515/09, s. 2 (4).

(5) If an entity selected as a French language health planning entity ceases to meet the criteria set out in subsection (2) after having been selected, the Minister may cancel the selection and, in that case, shall select another entity to act as the French language health planning entity. O. Reg. 515/09, s. 2 (5).

(6) Subject to subsection (5), the selection of an entity as a French language health planning entity expires five years after it was made, at which time that Minister shall make a selection as required under subsection (1), either reselecting the same entity or selecting another entity. O. Reg. 515/09, s. 2 (6).

Community engagement

3. (1) For the purposes of section 16 of the Act and subject to subsection (2), each local health integration network shall engage the French language health planning entity selected under section 2 of this Regulation for the geographic area of the network to advise the network on,

(a) methods of engaging the Francophone community in the area;

(b) the health needs and priorities of the Francophone community in the area, including the needs and priorities of diverse groups within that community;

(c) the health services available to the Francophone community in the area;

(d) the identification and designation of health service providers for the provision of French language health services in the area;

(e) strategies to improve access to, accessibility of and integration of French language health services in the local health system; and

(f) the planning for and integration of health services in the area. O. Reg. 515/09, s. 3 (1).

(2) Before carrying out the engagement mentioned in subsection (1), a local health integration network shall enter into an agreement with the French language health planning entity selected under section 2 for the geographic area of the network about roles and responsibilities relating to the matters listed in clauses (1) (a) to (f). O. Reg. 515/09, s. 3 (2).

Reporting

4. Each local health integration network shall report, in its annual report, on its engagement activities described in section 3, including the content, frequency and format of the activities. O. Reg. 515/09, s. 4.

5. OMITTED (PROVIDES FOR COMING INTO FORCE OF PROVISIONS OF THIS REGULATION). O. Reg. 515/09, s. 5.

ABOUT THE ERIE ST. CLAIR/SOUTH WEST FRENCH LANGUAGE PLANNING ENTITY

- One of 6 French Language Health Planning Entities in Ontario
- Mandated by the Ministry Health and Long-Term Care (MOHLTC) under Ontario Regulation 515/09
- Funded by the Erie St. Clair and South West LHINs
- Governed by a volunteer Board of Directors representing the communities of Windsor, Sarnia, Chatham-Kent, London and surrounding areas
- Offices in Windsor and London

OUR MANDATE

Provide advice to the LHINs relative to the following matters:

- methods of engaging the Francophone community in the area;
- the health needs and priorities of the Francophone community in the area, including the needs and priorities of diverse groups within that community;
- the health services available to the Francophone community in the area;
- the identification and designation of health service providers for the provision of French language health services in the area;
- strategies to improve access to, accessibility of and integration of French language health services in the local health system;
- the planning for and integration of health services in the area.

OUR VISION

Better access to quality French-language health services.

OUR MISSION

Through its knowledge of health services and the needs of the francophone community, the ESC/SW FLHPE makes recommendations to and supports the LHINs with regards to the provision of quality French health services.

OUR VALUES

- Excellence
- Transparency
- Accountability
- Collaboration

OUR STRENGHTS

- Relationship with the LHINs
- Knowledge of the community
- Networking

OUR MEMBER ORGANIZATIONS

- Centre communautaire régional de London
- Collège Boréal
- Centre culturel francophone Jolliet, Sarnia
- Centre communautaire de Chatham-Kent La Girouette
- Centre communautaire francophone Windsor-Essex-Kent
- Conseil scolaire de district des écoles catholiques du Sud-Ouest
- Conseil scolaire Viamonde
- Place du Partage, Windsor
- Regroupement multiculturel francophone de London

TO REACH US

Windsor Office
7515 Forest Glade Drive
Windsor, ON
N8T 3P5
519 948-1515

London Office
920 Huron Street, Suite 175b
London, ON
N5Y 4K4
519 850-4309

www.entite1.ca

TEAM

Jacques Kenny
Executive Director
jkenny@entite1.ca

Yvan Poulin
Planning Officer
ypoulin@entite1.ca

Jean-Marc Boisvenue
Planning Officer
jmboisvenue@entite1.ca

Supported by:
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Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

Ontario
South West Local Health Integration Network
Réseau local d'intégration des services de santé du Sud-Ouest

HEIA

Health Equity Impact Assessment

Health Equity Impact Assessment (HEIA) Workbook

Ontario

Table of Contents

Acknowledgements

HEIA Version 2.0 (Spring 2012)

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Core Equity Assessment Framework/HEIA Working Group
Public Health Ontario
Brian Hyndman, Senior Planner, Health Promotion, Chronic Disease and Injury Prevention **Christiane Mitchell,** Research Assistant, Health Promotion, Chronic Disease and Injury Prevention
Ontario Ministry of Health and Long-Term Care
Wendy Katherine, Manager, Women's & Family Health Unit, Health System Strategy & Policy Division **April MacInnes,** Senior Policy Advisor, HEIA Project Lead, Community & Population Health Branch, Health System Strategy & Policy Division **Janice Tepper,** Manager, Strategic Policy & Planning Branch, Planning & Liaison Branch, Public Health Division **Lindsay Boychuk,** Planning & Liaison Advisor, Strategic Policy & Planning Branch, Planning & Liaison Branch, Public Health Division **Vanessa Perry,** Public Health Practice Advisor, Public Health Standards, Practice and Accountability Branch, Public Health Division **Ian Chan,** Public Health Practice Analyst (A), Public Health Standards, Practice and Accountability Branch, Public Health Division
Other Significant Contributors/Advisors
Public Health Ontario (Developed the Equity Assessment Framework that is the basis of the HEIA PHU Supplement)
Dr. Heather Manson, Chief, Health Promotion, Chronic Disease and Injury Prevention **Dr. Ingrid Tyler,** Public Health Physician **Brian Hyndman,** Senior Planner, Health Promotion, Chronic Disease and Injury Prevention
Ontario Ministry of Health and Long-Term Care
Dr. Arlene King, Ontario Chief Medical Officer of Health **Vasanthi Srinivasan,** Assistant Deputy Minister, Health System Strategy & Policy Division **Sheree Davis,** Director, Community & Population Health Branch, Health System Strategy & Policy Division **Elizabeth Walker,** Director, Public Health Planning & Liaison Branch, Public Health Division **Paulina Salamo,** Manager, Standards and Performance, Public Health Standards, Practice & Accountability Branch **Gerrilynne Carroll,** Director, Emergency Management Branch, Public Health Division **Sylvia Shedden,** Director, Public Health Standards, Practice & Accountability Branch, Public Health Division **Chloe Macrae,** Policy Analyst, Community & Population Health Branch, Health System Strategy & Policy Division **Mark Schroter,** Policy Analyst, Community & Population Health Branch, Health System Strategy & Policy Division **Véronique Dault,** Program/Policy Officer, French Language Services Office

Consultations – March 5, 2012 Focus Group Participants
Public Health Units
Jo Ann Salci, Public Health Nurse, Social Determinants of Health, Public Health Services, City of Hamilton **Marcia Nauta,** Public Health Nurse, Social Determinants of Health, Public Health Services, City of Hamilton **Rebecca Dupuis,** Public Health Nurse, Social Determinants of Health, Simcoe Muskoka Public Health Unit **Erika Haney,** Public Health Nurse, Social Determinants of Health, Simcoe Muskoka Public Health Unit **Caroline Wai,** Public Health Nurse, City of Toronto (also acting as representative from the OPHA-aLPHa Health Equity Working Group) **Siu Mee Cheng,** Executive Director, Ontario Public Health Association
Ontario Ministry of Health and Long-Term Care
Ayasha Mayr Handel, Team Lead, Assistant Deputy Minister's Office, Health System Accountability & Performance Division **Thomas Appleyard,** Senior Consultant, Emergency Management Branch, Public Health Division **Sheela Subramanian,** Planning and Policy Analyst, Canadian Mental Health Association
Consultations – March 22, 2012 Webinar Participants
Too numerous to mention individually, but invitees included: **Public Health Unit Social Determinant of Health nurses** from across Ontario **Medical Officers of Health** from across Ontario **Council of Medical Officers of Health** members
HEIA Champions
Ontario Ministry of Health and Long-Term Care
Dr. Arlene King, Ontario Chief Medical Officer of Health **Vasanthi Srinivasan,** Assistant Deputy Minister, Health System Strategy and Policy Division
Community Champions
Dr. Kwame McKenzie, Centre for Addictions & Mental Health **Branka Agic,** Manager Equity, Centre for Addictions & Mental Health
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The HEIA Team
Ontario Ministry of Health and Long-Term Care
Scott Andison, Director, Health System Policy and Relations Branch **Elliot Cappell,** Policy Analyst, Equity Unit **Sheree Davis,** Director, Health System Strategy Branch **Marc Despatie,** Manager, French Language Services Office **Ben Elling,** Policy Analyst, Equity Unit **Lauren Ettin,** Manager, Equity Unit **Judy Fiddes,** Senior Policy Adviser, Equity Unit **Julia Gallo,** Manager (A), Equity Unit **Lorraine Greaves,** Executive Director, Health System Strategy Division **Wendy Katherine,** Manager, Population Health Strategy and Integration Unit **Ayasha Mayr Handel**, Senior Policy Advisor, Population Health Strategy and Integration Unit **Anthony Mohammed,** Manager (A), Equity Unit **Hélène Moncion,** Senior Policy/Program Officer, French Language Services Office **Véronique Dault,** Program/Policy Officer, French Language Services Office **Michèle Sanborn,** Director, Corporate Management Branch **Vasanthi Srinivasan,** Assistant Deputy Minister, Health System Strategy Division
North East LHIN
Erika Espinoza, Consultant, Planning, Integration and Community Engagement **Phil Kilbertus,** Senior Consultant, Planning, Integration and Community Engagement **Marc Lefebvre,** Planning and Decision Support Consultant **Mike O'Shea,** Senior Consultant, Planning, Integration and Community Engagement **Dave Pearson,** Consultant, Planning, Integration and Community Engagement
Toronto Central LHIN
Vanessa Ambtman, Community Engagement Consultant **Krissa Faye,** Senior Community Engagement Consultant **Janine Hopkins,** Director Planning, Integration and Community Engagement
Waterloo Wellington LHIN
Thomas Custers, Senior Manager, Health System Design **Mike Dwyer,** Senior Analyst, Health System Transformation **Linda Lopinski,** Program Lead, Community Engagement **Kate Reid,** Program Assistant **Patricia Syms Sutherland**, Manager, Health System Transformation
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Bob Gardner, Consultant, The Wellesley Institute **Margot Lerner,** Consultant, Wasabi Consulting **Consultation and pilot participants**

HEIA Workbook: How to Conduct an HEIA

For the latest resources, please visit: www.ontario.ca/healthequity
For further information, please contact: HEIA@ontario.ca

Introduction

Health Equity Impact Assessment (HEIA) has broad application and is intended for use by organizations and health service providers who have an impact on the health of Ontarians. Thus, HEIA is not only intended for use by organizations across the Ontario health care system, such as the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs), Public Health Units (PHUs), and health service providers; but also by organizations outside the health care system whose work can have an impact on health outcomes. Examples include other Ontario social policy ministries such as the Ministry of Education, Ministry of Transportation, and Ministry of Children and Youth Services, and various non-profit organizations and community service providers. The HEIA tool also has the intention of being a bridging tool across relevant sectors to encourage creative thinking, collaboration, and practical, actionable solutions on current policies, programs, or initiatives impacting health outcomes.

Getting Started

The HEIA Workbook provides general information on how to conduct a health equity impact assessment, and how to use the HEIA Template in your everyday practice. The workbook:

- Explains what HEIA is, when to use it, and who should use it;
- Leads users through the 5 steps of conducting an HEIA;
- Provides examples and prompts users to illustrate how each section of the HEIA Template is designed to be completed;
- Provides information you should have available while completing an HEIA (Appendix C); and
- Refers users to additional complementary resources to access when conducting an HEIA. These will be noted throughout the workbook as **Supplementary Resources.**

Supplementary Resources

In addition to the HEIA Template and HEIA Workbook, users may access various complementary resources to assist completing the tool. These resources are available on the MOHLTC's HEIA website at www.ontario.ca/healthequity. Visit this webpage for the most up-to-date information.

Currently Available Resources

- **French Language Services (FLS) Supplement** – outlining specific legislation and requirements regarding the *French Language Services Act.*
- **Public Health Unit (PHU) Supplement** – outlining special considerations for the public health sector in applying HEIA, including how the HEIA tool can assist local PHUs with meeting Ontario Public Health Standards (OPHS) requirements.
- Various **web links** to external resources and data sources to inform the user when using the tool.

Resources Under Development

- **Evidence summaries** of useful data and information on vulnerable population groups;
- **Case studies** illustrating the application of HEIA; and
- **Web links** to external resources and data sources.

What is the HEIA tool?

HEIA[1] is a flexible and practical assessment tool that can be used to identify *unintended* potential health impacts (positive or negative) of a policy, program, or initiative on vulnerable or marginalized groups within the general population. In identifying those impacts, the user can then make recommendations to decision-makers as to what adjustments might mitigate negative impacts and maximize positive impacts on the population groups identified.

It is important to emphasize that HEIA is focused on the identification of **unintended** positive and negative impacts – not the **intended** benefits of the planned policy, program, or initiative.

What do we mean by *unintended* impacts versus *intended* impacts?

Consider, for example, the *intended* goal of a province-wide diabetes prevention and management program. Imagine the intended goal of the program is to reduce the incidence rate of diabetes and improve care and health management for those with diabetes. The *unintended* consequence of an operational decision to only provide this program online may be that it excludes those who have no Internet access, having a potential inequitable impact on the health of those groups. A further impact is that those who may already be vulnerable and at risk of poorer health will be disproportionately affected and thus further marginalized – an unintended consequence contravening the intended goals of the program, which is province-wide improvements in diabetes incidence rates and care. Mitigation strategies to improve access should then be considered to avoid increased marginalization of those identified vulnerable groups.

The primary focus of this tool is to reduce inequities that result from barriers in access to quality health services and programming and to increase positive health outcomes by identifying and mitigating *unintended* impacts of an initiative prior to implementation.

Broader corporate initiatives such as strategic and business planning, budget or resource allocation, accreditation, governance, accountability, legislative and regulatory, and community engagement processes can also benefit from HEIA, as it supports integration of health equity across an organization.

Although intended primarily for application during the design phase of an initiative (pre-implementation), the tool can also be applied retrospectively to reviews, evaluations, or decisions related to expansion, realignment, or closure of existing programs or services.

At a macro level, the tool can be used on broad strategies or to assess the "mix" of programs or services to determine whether that mix will result in equal benefit across the population or whether it will exacerbate existing health inequities. HEIA may also be useful in identifying equity-based indicators of success.

[1] Health Equity Impact Assessment (HEIA) arose out of Health Impact Assessment (HIA) methodology which has gathered considerable momentum internationally over the past decade as a decision support tool to enable "healthy public policy." While HIA often addresses health inequities, its structure did not lend itself to a more targeted and systematic focus on health inequities. As a result, a model of equity-focused Health Impact Assessment evolved and is currently in use in the U.K. (Wales), New Zealand, Australia and other jurisdictions.

Why use the HEIA tool?

Addressing health equity can make a critical contribution to health system sustainability by reducing the incidence of costly and preventable illnesses and related treatments. Addressing disparities in health program and service delivery and planning requires a solid understanding of key barriers that inhibit equitable access to high quality care, and an understanding of the specific needs of health-disadvantaged populations. This requires an array of effective and practical planning tools.

HEIA is often seen as a "first-pass" screening tool that can assist decision-makers in integrating equity considerations into new initiatives and more detailed planning. In this way, HEIA supports the achievement of the long term strategic priority of improved access and responding to the needs of diverse communities identified as an important priority by the Ontario Ministry of Health and Long-Term Care and the health sector.

HEIA has five primary purposes for users:

1. Help identify potential unintended health impacts (positive or negative) of a planned policy, program, or initiative on vulnerable or marginalized groups within the general population;
2. Help develop recommendations as to what adjustments to the plan may mitigate negative impacts as well as maximize positive impacts on the health of vulnerable and marginalized groups;
3. Embed equity across an organization's existing and prospective decision-making models, so that it becomes a core value and one criterion to be weighed in all decisions;
4. Support equity-based improvements in program or service design, i.e., through considerations such as "How must this program be adjusted to meet the needs of specific populations?";
5. Raise awareness about health equity as a catalyst for change throughout the organization, so decision-makers develop 'stretch goals' through considerations, such as "How can we include more people in this program, especially those often missed?" or "What barriers should we look for?" and "Are we as effective as we could be, especially those with the greatest health needs?"

HEIA provides a strong framework for examining whether an organization's policies, programs, and initiatives are on the whole taking advantage of available opportunities to improve equity, or whether they may potentially result in widening the health disparities between vulnerable and marginalized populations and the general population.

While users may apply HEIA at the **micro level** to assess individual policies, programs, or initiatives, they may also apply HEIA at a **macro level** to assess their mix of current or planned offerings, to determine whether they potentially widen health disparities or improve health equity.

Finally, the aim is that after an HEIA is conducted and the chosen mitigations are implemented, there should be an assessment of whether the anticipated positive impacts on health and equity were maximized, and the negative impacts minimized. If not, then why not, and how can future plans be further adapted to promote health equity?[2]

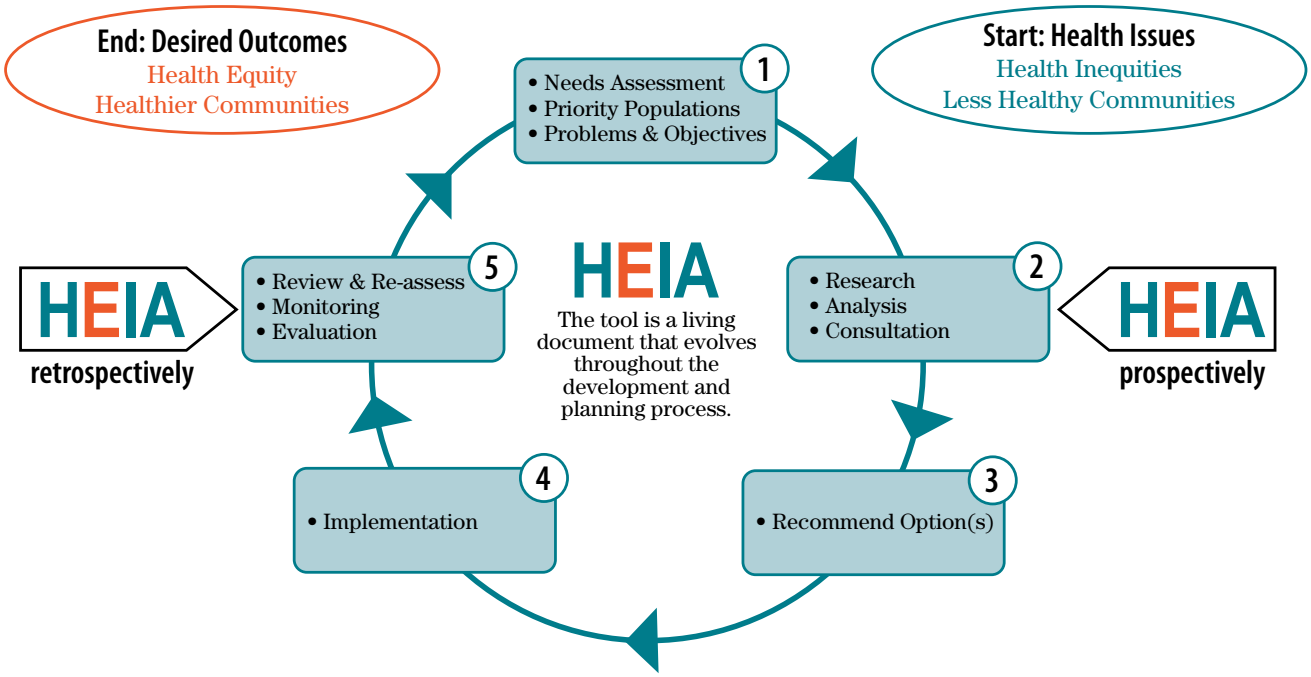
[2] UCLA Health Impact Assessment Clearinghouse. "Phases of HIA." Available at http://www.hiaguide.org/methods-resources/methods/phases-hia-4-reportingevaluation

When should the HEIA tool be used?

HEIA should be conducted **as early as possible** in the development and planning stages in order to enable adjustments to the policy, program, or initiative before opportunities for change become more limited (e.g., such as during implementation).

Figure 1 depicts a simplified development and planning process, indicating the stages at which the HEIA tool can be applied, as part of either a prospective or retrospective analysis.

Figure 1 – When to use HEIA



While early assessment is ideal, HEIA can be introduced at later points in the development and planning process, such as during post-implementation reviews or evaluations. For example, HEIA could be used to assess program or service expansion, re-alignment, or discontinuation. However, recommendations resulting from a late-stage HEIA may be constrained by factors such as prior decisions, previous investments, available resources, and time commitments. Nonetheless, these considerations should not limit or preclude HEIA analysis.

HEIA is only one part of a collection of equity-driven planning tools, and may not be appropriate for all purposes. For example, HEIA is not as well suited as other equity tools for needs assessment, measuring and tracking action on equity, program and service evaluation, or strategic planning.

Who should use the HEIA tool?

HEIA is typically conducted by the development and planning staff working on the policy, program, or initiative. The results of HEIA should then be considered by decision-makers in the organization. HEIA is not intended to be conducted by third parties to policy-making (e.g., consultants), as they are further removed from the process and the cost can be prohibitive.

What is the scope of the HEIA tool?

Among impact assessment methodologies there are usually three broad categories of assessment:[3,4]

- **Desktop Assessment**
  - Information is gathered by the user from existing data and resources.
  - Generally completed within a few days.
- **Rapid Assessment**
  - More detailed and involves more outreach and sourcing of information.
  - Generally completed in a few weeks.
- **Comprehensive Assessment**
  - Involves more extensive research such as community and sector consultation.
  - Complete assessment can take months.
  - Typically used for large scale, very complex projects.

Generally, HEIA falls between the desktop and rapid assessment categories. These types of assessments can be completed in a shorter timeframe, and generally use existing information, data, and resources. The level and intensity of the HEIA application is decided by the user, often determined by the available time and resources.

HEIA Definitions and Concepts

Supplementary Resources: For an extended glossary of terminology and the different meanings throughout different sectors, please see the HEIA website for an up-to-date list, available at: www.ontario.ca/healthequity/

For simplicity, we have chosen the most commonly accepted terms and used them throughout the HEIA Workbook and Template.

Health Equity

Within the health system, equity means reducing systemic barriers in access to high quality health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations. Equity planning acknowledges that health services must be provided and organized in ways that contribute to reducing overall health disparities.

Health inequities or disparities are differences in health outcomes that are avoidable, unfair and systemically related to social inequality and marginalization. Research shows that the roots of health disparities lie in broader social and economic inequality and exclusion, and that there are clear social gradients in which people's health tends to be worse the lower they are on the scales of income, education and overall privilege.

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[3] Centers for Disease Control and Prevention. "Health Impact Assessment." Available at http://www.cdc.gov/healthyplaces/hia.htm

[4] Centers for Disease Control and Prevention. "Health Impact Assessment Fact Sheet." Available at http://www.cdc.gov/healthyplaces/factsheets/Health_Impact_Assessment_factsheet_Final.pdf

Health equity, then, works to reduce or eliminate socially structured differentials in health outcomes. Health equity builds on broader ideas about fairness, social justice, and civil society.

Determinants of Health

The Public Health Agency of Canada defines the determinants of health (DOH) as:

> *"...the range of personal, social, economic and environmental factors that determine the health status of individuals or populations.*[5] *The determinants of health can be grouped into seven broad categories:*[6] *socio-economic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services."*

While the list continues to evolve, the Public Health Agency of Canada currently identifies the following determinants of health,[7] which is the list referred to throughout the HEIA Workbook and Template:

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

For a definition of each determinant of health see Appendix A.

Why focus on the Determinants of Health?

The most effective way to address health disparities is grounded in a framework that includes consideration of the determinants of health – the factors impacting health beyond the traditional confines of the health care system. It is important to focus "upstream" of the health sector, on a broad range of socio-economic influences and outcomes that affect individual, community, and population health.

The *Commission on Social Determinants of Health* established by the World Health Organization (WHO) states that "health care is an important determinant of health (and) lifestyles are important determinants of health, but it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."[8]

Although many of the determinants that produce health disparities lie beyond the health care system itself, analysis of the broader determinants of health has the potential to clarify important pathways to health outcomes and may suggest powerful approaches to address identified health inequities.

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[5] World Health Organization (WHO), Health Promotion Glossary, 1998. Available at http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

[6] Source: Public Health Agency of Canada. "Canada's Response to WHO Commission on Social Determinants of Health." Available at http://www.phac-aspc.gc.ca/sdh-dss/glos-eng.php

[7] Public Health Agency of Canada (PHAC), "What Determines Health?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#key_determinants

[8] Work Health Organization (WHO), "*Closing the gap in a generation: Health equity through action on the social determinants of health.*" Available at http://ww.who.int/social_determinants. The Commission identifies 9 key themes: early child development, employment conditions, globalization, social exclusion, health systems, priority health conditions, women and equity, urbanization, measurement and evidence.

Determinants of Health or Social Determinants of Health?

Terminologies to describe the factors impacting on health include the 'determinants of health' (DOH) and the 'social determinants of health' (SDoH). The terms have slightly different meanings, although many of the same concepts are encompassed within both terms.

SDoH can be understood as the social conditions in which people live and work.[9] They are "the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. These resources include but are not limited to: conditions for early childhood development; education, employment, and work; food security, health services, housing, income, and income distribution; social exclusion; the social safety net; and unemployment and job security."[10]

In the HEIA Workbook and Template, the broader umbrella term DOH will be used to refer to the concept of determinants of an individual or group's health that looks beyond the traditional medical concept of health. DOH is a broader term that encompasses the spectrum of influences on health, and it has been designated by Ontario's Chief Medical Officer of Health as the preferred terminology.

As the importance of the social environment in determining health outcomes becomes clearer, research into the particular social factors that are most critical is intensifying. Other lists of these social factors impacting health can be referenced as needed when applying the HEIA.

For example, researchers at York University[11] have recently defined fourteen key social factors impacting health, including: income and income distribution; education; unemployment and job security; employment and working conditions; early childhood development; food insecurity; housing; social exclusion; social safety networks; health services; Aboriginal status; gender; race; and disability. Other determinants of health identified by various individuals and organizations include wealth distribution and poverty, gender, race and ethnicity, citizenship and immigration status, language, ability, sexual orientation, age, racism and discrimination, social exclusion, and natural and built environments. These lists vary depending on the focus or emphasis of the work of that individual or organization.

When completing the HEIA tool, users are welcome to use any list of SDoH or DOH most relevant to their organization or project, and that they are most comfortable or familiar with. In the HEIA Workbook and Template, the Public Health Agency of Canada's DOH list is used.

[9] World Health Organization (WHO) Commission on SDH discussion paper, "Towards a Conceptual Framework for Analysis and Action on SDH." Available at http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

[10] Raphael, Dennis (Ed) 2004. Social Determinants of Health: Canadian Perspective.

[11] Mikkonen, J. and Raphael, D. *Social Determinants of Health: The Canadian Facts.* Toronto: York University School of Health Policy and Management, 2010.

Gathering the Evidence

HEIA provides a framework of analysis, while the user inputs evidence that is appropriate for the effective consideration of potential equity impacts. The HEIA analysis is as robust as the quality of evidence fed into the tool.

However, mainstream research (i.e., quantitative and qualitative research studies) has tended to not equally reflect the realities and issues faced by marginalized or vulnerable population groups. As a result, users can sometimes experience difficulties in accessing mainstream evidence that relates specifically to the populations under consideration.

For best results, when undertaking an HEIA analysis, consider using a 'realist' approach – integrating mainstream research evidence with broader streams of evidence, including:

- Grey literature (e.g., policy, program, or project reports, informal practice guidelines, recommended or promising practices, etc.);
- Inter-jurisdictional evidence;
- Online resources;
- Consultation and community engagement findings;
- Key informant interviews (e.g., with local experts or staff from relevant organizations);
- Program evaluation results;
- Client surveys; and
- Field evidence, staff evidence, organizational data, tacit evidence, etc.

A broad consideration of evidence will facilitate a robust analysis and will ensure that the needs of populations that may experience exclusion from mainstream research are adequately considered in completing the HEIA. All evidence sources should be weighed based on their strength and quality.

Supplementary Resources: Appendix B and C of this HEIA Workbook has a comprehensive list of resources to assist you in gathering the relevant information for conducting a HEIA. Please refer to this before completing the HEIA Template.

HEIA in Five Steps

If the policy, program, or initiative has the potential to impact the health of vulnerable or marginalized groups, HEIA is applicable. It is desirable that **all potential decisions or plans** be considered, and a recommendation made whether to proceed further to complete an HEIA, and with what scope of analysis.

1. Scoping

Identify affected populations or groups and potential unintended health impacts (positive or negative) on those groups of the planned policy, program, or initiative. Consider a wide range of vulnerable or marginalized groups to avoid overlooking unintended consequences of an initiative.

2. Potential Impacts

Use available data or evidence to prospectively assess the *unintended* impacts of the planned policy, program, or initiative on vulnerable or marginalized groups in relation to the broader population. It is both useful and important to consider a broader range of evidence, including consultation findings, grey literature, or field evidence. These sources of evidence should be weighed based on their strength and quality. Where there is very limited data or no evidence available, note this in the HEIA tool or, where possible, implement

strategies to gather required evidence. Strategies could include conducting surveys, focus groups, or consultation with experts or members of the affected groups where time permits.

3. Mitigation

Develop evidence-based recommendations to minimize or eliminate negative impacts and maximize positive impacts on vulnerable or marginalized groups. These recommendations comprise your mitigation strategy. Uptake of these recommendations in the rollout of the initiative will help to ensure that the initiative contributes to equity and does not perpetuate or widen existing health disparities. Where possible, recommendations should be informed by a diversity of members of the affected communities.

4. Monitoring

Determine how the rollout of the initiative will be monitored to determine its impacts on vulnerable or marginalized groups in comparison to other subpopulations or the broader target population. The resulting data will enhance the overall evidence base for equity-based interventions and can be fed back into the development and planning process. After the HEIA is completed, conduct a short process and impact evaluation to determine whether the tool was practical and appropriate (process), and whether there was uptake of the recommendations for adjustments made as part of the mitigation strategy (impact).

5. Dissemination

This step involves sharing results and recommendations for addressing equity. Dissemination is a cyclical process, interacting with step four (monitoring). By sharing the results of your HEIA, you are raising awareness of the gaps in equity and service provision that need to be filled, and sharing lessons learned which are important to reduce inequities in the long run.

It is important to document and share the results of the HEIA with relevant groups and stakeholders who would be interested in learning from the information you have collected. By sharing the results of your application of the HEIA, you are contributing to the growing body of knowledge on the reduction of health inequities. By sharing results of new indicators and evaluation you are also increasing access to evidence and evaluation data for the future. It is especially important to share your results and recommendations with stakeholders from non-health sectors, such as housing, transportation and childcare, as their initiatives and policies can have a substantive impact on health inequities.

After the HEIA process has been completed, it is useful to consider your results, particularly those from the monitoring strategy and how these can be incorporated into broader planning instruments such as corporate and regional strategies, annual planning and reports and other similar documents.

Supplementary Resources: For all steps of the HEIA, access the following complementary resources for assistance in completing the HEIA Template:

- If your work is in the public health sector or falls under the Ontario Public Health Standards (OPHS), please refer to the **Public Health Unit (PHU) Supplement** for additional information.
- Please refer to the **French Language Services (FLS) Supplement** to confirm whether your organization or project falls under the parameters of the *French Language Services* Act. This legislation defines where individuals are guaranteed to receive services in French. Crown agencies, Government of Ontario ministries (including all Local Health Integration Networks) as well as third-party designated agencies are covered by this legislation.

Completing the HEIA Template

This section of the HEIA Workbook guides users through each part of the HEIA Template, with prompts and examples. The examples are not meant to be comprehensive, but are for illustrative purposes only.

Please Note: Each numbered step in the Workbook corresponds to the appropriate step in the HEIA Template. A graphic at the beginning of each section highlights where in the template you are located.

Step 1: Scoping

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

While it is difficult to identify all groups that are vulnerable or marginalized with respect to a specific health policy, program, or initiative, disparities in access and quality of care have been repeatedly associated with particular populations and sub-populations. Marginalized groups, however, may vary from one project to another. In completing the HEIA tool, the populations of concern will be identified by the user based on knowledge of the project to anticipate groups that would likely be impacted.

Supplementary Resources: Although not directly applicable to all organizations, such as the PHUs, the "Key FLS Considerations for both MOHLTC and LHIN Staff" section of the **French Language Services (FLS) Supplement** provides key questions for consideration in the incorporation of French Language at the beginning of a project. Please refer to this supplement at the beginning of the development and planning process to support meaningful FLS integration.

Questions

Determine if your initiative could have a positive or negative impact on the health of vulnerable or marginalized communities by asking questions such as:

- How does your policy, program, or initiative affect health equity for identified vulnerable or marginalized populations in your area?
- Will it have a differential impact on people or communities that you serve? Will some clients have different access to care, or overall health outcomes, than others?
- Are there other vulnerable or marginalized communities which may experience unintended results of this program?

Potential Vulnerable or Marginalized Populations (Step 1a)

The following list of populations is not exhaustive, and the terminology used may or may not be preferred by members of the communities in question, as preferences vary both within and across communities. If preferences are not known, it is helpful to seek guidance with respect to preferred terminology from local experts and representatives of the communities themselves. Examples are provided under each population outlined below, in an effort to clarify populations listed.

When completing Step 1a of the HEIA, vulnerable and marginalized subpopulations may include, but are not limited to, the following:

- **Aboriginal peoples:** The Aboriginal peoples of Canada comprise the First Nations, Inuit and Métis (FNIM) peoples. These distinct groups have unique heritages, languages and cultures.[12]
- **Age-related groups:** Refers to populations whose health or equity could be specifically impacted by factors related to their age (such as the ability to vote) or developmental factors (early childhood) or physical changes (such as frail elderly). Potential groups within this category include infants, children, youth, seniors, the elderly, etc.
- **Disability:** Refers to people with physical or mental disability, infirmity, malformation or disfigurement such as blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, mental impairment (developmental or learning disability), a mental disorder, or a workplace injury or disability.[13] This could also refer to people with a mental illness, addiction, or substance use problem.
- **Ethno-racial Communities:** An ethnic group (or ethnicity)[14] is a group of people whose members identify with each other, through a common heritage, often consisting of a common language, a common culture (often including a shared religion) and/or an ideology that stresses common ancestry or endogamy. Potential communities include racial or racialized groups, cultural minorities, immigrants, refugees, etc.
- **Francophone:** People who communicate in French as their primary official or preferred language, including new immigrant francophones, deaf communities using French or Quebec sign language (la langue des signes québécoise) (LSQ)/la langue des signes francaise (LSF), etc.
- **Homeless:** Includes marginally or under-housed people, those without a permanent address, and those without stable housing or high-quality housing, including transient people.
- **Linguistic Communities:** People uncomfortable receiving care in either English or French or who prefer a first language other than English or French, or those whose literacy level affects communication in any language.

[12] Statistics Canada. "Aboriginal peoples." Available at http://www5.statcan.gc.ca/subject-sujet/theme-theme.action?pid=10000&lang=eng
[13] Ontario Human Rights Code, R.S.O. 1990, Available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h19_e.htm
[14] Ornstein, M. "Ethno-Racial Groups in Toronto, 1971-2001," Institute for Social Research. Available at http://www.isr.yorku.ca/download/Ornstein--Ethno-Racial_Groups_in_Toronto_1971-2001.pdf

- **Low income:** includes economically vulnerable people who are underemployed, unemployed, living on a fixed income, receiving social assistance, etc.
- **Religious/Faith Communities:** Refers to systems of religious beliefs or faith that may also include specific dietary or cultural practices.
- **Rural/remote or inner-urban populations:** Includes people facing geographic or social isolation, or living in under-serviced areas, or living in densely populated areas.
- **Sex/gender:** Sex refers to the biological and physiological characteristics that define male and female, while gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.[15] Potential groups include female, male, women, men, transsexual, transgendered, two-spirited, etc.
- **Sexual orientation:** Sexual orientation is a personal characteristic that covers the range of human sexuality from lesbian and gay, to bisexual and heterosexual.[16]
- **Other:** Includes any other relevant population group not captured in the HEIA Template. For example, uninsured people (people without legal status in Canada and no government health insurance), people without a family doctor, etc.

Intersecting Populations (Step 1a)

One of the most important considerations in assessing health disparities is that these various lines of inequality and identity can **intersect and often reinforce** each other in individuals and communities.

For example, health disadvantages faced by homeless people with disabilities and limited literacy or English fluency will be even worse, and low-income older immigrant women may face specific multiple barriers. Disadvantage is almost always multi-dimensional. Similarly, research on the DOH indicates these different lines of inequality can themselves contribute to poorer prospects and positions within the labour market, which contributes to higher levels of poverty, poorer housing, and other DOH.

Supplementary Resources: For more in-depth explanations and descriptions of the DOH, refer to Appendix A of this Workbook. In addition, refer to the HEIA website for more information and evidence on selected population groups. The website is available at: www.ontario.ca/healthequity/

Examples

When identifying vulnerable or marginalized populations, look for these kinds of health disparities as they relate to your project:

- For a project designed to address a chronic condition such as arthritis, diabetes or depression, it is important to consider how it will impact on women. While Ontario women live longer than men, a majority are more likely to suffer from disability and chronic conditions. It is also important to consider low-income women as a vulnerable and marginalized population as they have more chronic conditions, greater disability, and a shorter life expectancy than high-income women.[17]
- For a project designed to improve early years' health it would be important to take into account the often poorer infant and child health of certain populations. For example, the death rate from injury for Aboriginal infants is four times the rate of that for infants in the broader Canadian population, while Aboriginal preschoolers experience five times the rate, and teenagers experience three times the rate of death from injury versus the broader Canadian population.[18]

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[15] World Health Organization. "What do we mean by 'sex' and 'gender'?" Available at http://www.who.int/gender/whatisgender/en/
[16] Ontario Human Rights Commission. "Sexual orientation and human rights." Available at http://www.ohrc.on.ca/en/issues/sexual_orientation
[17] Bierman, A. et al. POWER Study, 2009.
[18] Bierman, A. et al. POWER Study, 2009.

- For a project designed to assist under-housed individuals obtain stable housing it would be important to keep in mind that homeless people often suffer from poorer health. In 2006, homeless people in Toronto were 20 times as likely to have epilepsy, five times as likely to have heart disease, four times as likely to have cancer, three times as likely to have arthritis or rheumatism, and twice as likely to have diabetes.[19] Acknowledging and developing methods to address these disparities could help make your program or initiative more effective.
- For a project developing a service that requires people to come into a hospital or clinic it will be important to identify populations that experience transportation barriers, such as persons with physical disabilities, those with low incomes, or those who are more geographically isolated. Additionally, if your initiative requires that individuals have access to a primary care physician or specialist, those who reside in rural areas may experience barriers. In 2004, 21.4 per cent of the Canadian population lived in rural areas, where only 9.4 per cent of physicians (15.7 per cent of family physicians and 2.4 per cent of specialists) practised.[20]

- For a project developing a service that suggests people purchase items, such as mosquito repellent and/or sun block for a public health initiative, it is important to consider those who may not be able to follow the recommendations due to barriers such as low income, or the item not being readily available in their geographic area. Acknowledging these barriers and being able to suggest mitigations, such as staying in the shade or remaining indoors when mosquitoes are most active will assist in making your program or initiative more effective, inclusive and practical.

Identified Vulnerable Populations

Based on your research and analysis, have you identified vulnerable or marginalized groups who may be affected by your planned policy, program, or initiative? If so, highlight them in the HEIA Template, or add them to the "Other" section as needed.

Determinants of Health (Step 1b)

In this step, identify the relevant DOH and health inequities facing the vulnerable or marginalized population group identified in Step 1a.

A project could have an effect beyond its formal objectives and targets on client social connectedness, skills building and labour market opportunities, or individual or family living conditions; all of which can have a major impact on health. It could unintentionally also broaden the inequities commonly faced by a certain vulnerable population. Therefore, examining the project through a DOH 'lens' may help identify additional potential adjustments that will reduce the disparate impact on these groups.

Applicable determinants of health can be noted in column 1b adjacent to the corresponding population groups. Once recorded, impacts related to these determinants of health will be examined in Step 2.

Examples

- A health service for seniors was delivered in a community health setting, but is now redesigned to provide in-home service. This could result in a negative impact on social supports and connectedness by removing an opportunity for social interaction for isolated elderly individuals.
  - **Population:** seniors
  - **DOH:** Social Support Networks/Social Environments

[19] Khandor E & Mason K. *The Street Health Report 2007*. www.streethealth.ca
[20] Pong RW, Pitblado JR. *Geographic Distribution of Physicians in Canada: Beyond How Many and Where*. Ottawa: Canadian Institute for Health Information, 2006.

- A community kitchen program is designed to strengthen healthy eating behaviours for members of a specific ethno-cultural community at high risk for diabetes. The program has additional positive impacts relating to social connectedness for members of this community by bringing together members who might otherwise be isolated by both cultural and linguistic barriers. The positive impacts on social connectedness might be further enhanced in the program design by providing participants with additional social supports such as child care.
  - **Population:** specific ethno-cultural communities
  - **DOH:** Social Support Networks/Social Environments/Healthy Child Development
- A network of health system navigators or "health ambassadors" is created to assist members of a community of recent immigrants who require assistance to overcome cultural and linguistic barriers to their health care. Navigators with medical or health system skills or expertise from their country of origin are hired from within the community to fill this role. Experience on this project is leveraged to overcome barriers to employment experienced by the health ambassadors themselves and to assist them to advance their careers in the health system in Ontario.
  - **Population:** recent immigrants/communities experiencing linguistic barriers
  - **DOH:** Social Support Networks/Employment and Literacy/Income and Social Status

Step 2: Potential Impacts

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Once you have identified populations that could be affected by the initiative, the next step is to analyze the potential *unintended* impact (both positive and negative) on the health of these populations.

Assessment of Potential *Unintended* Impacts on Identified Populations

Thinking back to the vulnerable or marginalized groups and relevant determinants of health that you identified in Step 1a and Step 1b, what are the positive and negative impacts you have identified for each of the groups? It may be necessary to rely on research and analysis to determine these impacts.

Questions

Determine whether your initiative will have a positive or negative impact on vulnerable or marginalized communities by asking questions such as:

- How will the policy, program, or initiative affect access to care for this population?
- Is it likely to have positive impacts or effects that enhance health equity?
- Is it likely to have negative effects that contribute to, maintain or strengthen health disparities?
- How will it affect the quality and responsiveness of care for this community?
- Will providing this program, or improving access to it, help to narrow the gap between the best and worst off in terms of health outcomes?
- If you don't know, what more do you need to know and how will you find out?
- Will some people or communities benefit more from the program than others, and why?

Your appraisal should also consider:

- The nature and quality of the evidence you are using to assess impact;
- The probability of the predicted impact(s);
- The severity and scale of the impact(s); and
- Whether the impact(s) will be immediate or latent.

Examples

- Imagine that a program is designed to increase access to pre-natal care for lower income women and is being rolled out in designated neighbourhoods, with a facility that will be open from 10:00 a.m. to 6:00 p.m. Many people with a low income work more than one job, or have a job that falls outside of traditional 9 to 5 hours. Taking this into consideration might mean that the hours of service for this facility would have to be altered to ensure access.
- You are planning to roll out a heart health awareness campaign. People with higher education and income levels typically use health promotion programs more, with the unintended consequence that these programs can serve to increase health disparities. Could this be the case here? Will the program be understandable and relevant for people from diverse cultural backgrounds? Not all groups communicate and access information in the same manner, and understanding how to best access your intended audience can contribute to your program's success.

More Information Needed

In some instances, you will identify the fact that you require further data or evidence in order to more accurately identify the impacts of your initiative on a specific population. In this instance, you may identify this information in the "More Information Needed" column of the HEIA Template. If information cannot be located within the necessary timelines, the missing information should be noted in the template as a possible missing component of the analysis.

Step 3: Mitigation

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Once you have identified the impacts of your project, the next step is to plan how to minimize the negative impacts that create or contribute to existing health disparities, and to maximize positive impacts that create or contribute to health equity. Although you can be creative, the point is to be feasible and practical – consider what can be mitigated now, and what can perhaps be mitigated later.

Questions

Analyze how the impact of your initiative will be mitigated by asking questions such as:

- How can you reduce or remove barriers and other inequitable effects?
- How you can you maximize the positive effects or benefits that enhance health equity?
- What specific changes do you need to make to the initiative so it meets the needs of each vulnerable or marginalized community you have identified? How does it need to be customized or targeted?
- Could you engage the population in designing and planning these changes or consult with key stakeholders?
- How will the program address systemic barriers to equitable access to care created by the health care and other systems?
- Will you be making recommendations to decision-makers?

Examples

- If a cancer screening program is being designed to reach women in low-income neighbourhoods, its strategies might include extending opening hours to accommodate a range of work schedules, ensuring it is located in a building easily accessible by public transit, and providing free child care services for those women who require it. If a particular low-income neighbourhood has one or more significant ethno-racial populations, strategies should also address potential barriers to these groups, such as linguistic accessibility, cultural competence, or system navigation.

- Community Health Centres and others have employed strategies that include training and supporting community-based peer workers in outreach and system navigation services to overcome language and cultural barriers. For example, volunteers from particular ethno-cultural communities provide health promotion to particular communities, in a language and culture they understand.
- Language can be a significant barrier to accessing care and can affect care quality as it may lead to poor communication between patients and providers (i.e., possible misdiagnoses or inappropriate prescriptions or treatment). Common directions have included enhanced interpretation services, engaging directly with affected language and other communities, and training in culturally competent care.
- Some populations have complex needs and can be particularly difficult to reach. Psychiatric services have been delivered to homeless people in shelters and other non-medical sites, rather than assuming homeless people will come into hospitals or clinics to receive psychiatric care. These services can be combined with multi-disciplinary care and support to address the underlying reasons individuals are homeless (i.e., the "upstream" social factors).
- Some Community Health Centres directly provide or partner with other agencies to offer employment, literacy and other social services that help to address the underlying causes of ill health such as poverty and broader determinants of health to support their clients.

Mitigation Strategies

For each of the *unintended* negative and positive impacts identified in Step 2, outline the recommended adjustments to the initiative you will make in order to:

- Minimize unintended negative impacts on the populations identified, in Step 1; and
- Maximize unintended positive impacts on the populations identified in Step 1.

Please use these additional prompt questions to help identify mitigation strategies to either minimize negative impacts or maximize positive impacts:

Additional Questions

Consider how your policy, program, or initiative can be changed to bring about a reduction in health inequities. Here are some prompt questions:

- Reducing or eliminating barriers to access (e.g., translation, transportation, childcare, etc.);
- Ensuring appropriate reading or comprehension level for communications materials;
- Ensuring cultural appropriateness of communications and service delivery;
- Increasing priority group participation in the development and planning process;
- Changing the way in which a program, policy, or initiative is implemented;
- Changing the way in which a program, policy, or initiative is promoted;
- Changing internal policies and procedures;
- Ensuring greater alignment and collaboration with complementary projects or partners (i.e., local, regional, provincial, or federal organizations) both inside and outside of the health sector; and
- Offering staff education, training, or professional development opportunities.

Supplementary Resources: If your work is in the public health sector or falls under the Ontario Public Health Standards (OPHS), please refer to the **Public Health Unit (PHU) Supplement** for additional mitigation strategy considerations.

Step 4: Monitoring

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

The next step of the HEIA is to determine, if possible, if your planned mitigation strategy has been effective. You will want to monitor:

- Whether or not your mitigation strategy was implemented;
- Whether or not your mitigation strategy was effective;
- Since the HEIA is a living document, go back to determine and record your results, comparing them back to your original HEIA objectives; and
- How roll-out of the initiative will be monitored to determine its impacts on vulnerable or marginalized populations identified in Step 1 of the analysis.

Once finalized, the monitoring strategy should be integrated within the overall evaluation or performance measurement plan for the project. The resulting data will enhance the evidence base and feed back into the planning and development process.

Questions

Analyze how the impact of your initiative will be monitored by asking questions such as:

- How will you know if your program has enhanced equity?
- How will you know when the program is successful?
- What equity indicators and objectives will you measure, and how?

Monitoring Impact of Mitigation Strategies

Additional Questions (same as Step 3)

Consider whether your mitigation strategy addressed the following issues, and will be measured effectively by your monitoring strategy:

- Reducing or eliminating barriers to access (e.g., translation, transportation, childcare, etc.);
- Ensuring appropriate reading or comprehension level for communications materials;
- Ensuring cultural appropriateness of communications and service delivery;
- Increasing priority group participation in the development and planning process;
- Changing the way in which a program, policy, or initiative is implemented;
- Changing the way in which a program, policy, or initiative is promoted;
- Changing internal policies and procedures;
- Ensuring greater alignment and collaboration with complementary projects or partners (i.e., local, regional, provincial, or federal organizations) both inside and outside of the health sector; and
- Offering staff education, training, or professional development opportunities.

Examples

There are many ways you can monitor the impacts on equity as your initiative is implemented, including:

- Client satisfaction surveys – questionnaires could be provided to members of identified vulnerable or marginalized populations to monitor quality of care issues; or the broader population could be surveyed with results stratified by gender, ethno-cultural background or socio-economic status.
- Monitoring the organization's broader community engagement activities for information and feedback from particular marginalized populations.
- Program evaluation that disaggregates and tracks measures of program success by vulnerable or marginalized groups (e.g., tracking hospital re-admission or cancer screening rates).
- Process evaluation to ensure that developers, planners, and decision-makers are integrating equity considerations into their processes.
- Consultation with key providers and other stakeholders on how they are seeing the equity impact of the initiative. For example, run focus groups with affected populations.

Step 5: Dissemination

You Are Here

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts**	**Unintended Negative Impacts**	**More Information Needed**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.)							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic/social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

Step 5 involves sharing results and recommendations for addressing equity, a process which is closely linked to the monitoring strategy you put in place in Step 4. Now that you have a process for collecting data and evaluating the effectiveness of your mitigations, it is only logical to:

- Embed this information into your organization's planning and operational structures (such as corporate and regional strategies, annual/operational planning and reports, etc.); and
- Share the results of your evaluation with relevant groups and stakeholders who may be interested in learning from the information you have collected. By sharing the results of your application of the HEIA, you are contributing to the growing body of knowledge and information on marginalized and vulnerable groups. It is particularly important to share your results and recommendations with stakeholders from non-health sectors, such as housing, transportation and childcare, as their initiatives and policies can have a substantive impact on health inequities.

Sharing the results of your HEIA through knowledge exchange activities helps to ensure that other health planners benefit from your experience. Here are some suggested knowledge exchange activities:

- Sharing the assessment as a case study through a conference presentation, webinar or other vehicle for knowledge exchange;
- Publication of literature review or evidence summary;
- Submission of an abstract at a scientific meeting;
- Development of a workshop or professional development activity based on your experience; and
- Formation of a community of practice focused on the reduction of health inequities.

Also:

- Document your changed policies and revised decision-making (including relevant corporate documents such as briefing notes, decision papers, etc.);
- This is useful for corporate memory, and to reflect on when reviewing a program and its impact on populations; and
- Document your suggested frequency of future follow-up or assessments (i.e., program re-design at a later date), and if there are any statutory requirements for program review.

Questions

- Where would be a logical place in your organization to document the results of your HEIA?
- What would be a good forum and/or strategy to disseminate the results of your HEIA?

Sharing your evaluation results is an important contribution to the growing body of knowledge on the reduction of health inequities. This step helps you to link impacts to mitigation strategies your organization may have implemented to reduce health inequities among vulnerable or marginalized groups. These results should be reviewed to identify any additional modifications to your project.

Appendix A: Determinants of Health

You are welcome to use any determinants of health or social determinants of health list – this list is provided here for your reference.

Source: The Public Health Agency of Canada website:
www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php

What Makes Canadians Healthy or Unhealthy?

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian:

> "Why is Jason in the hospital?
> Because he has a bad infection in his leg.
>
> But why does he have an infection?
> Because he has a cut on his leg and it got infected.
>
> But why does he have a cut on his leg?
> Because he was playing in the junkyard next to his apartment building and there was some sharp, jagged steel there that he fell on.
>
> But why was he playing in a junkyard?
> Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.
>
> But why does he live in that neighborhood?
> Because his parents can't afford a nicer place to live.
>
> But why can't his parents afford a nicer place to live?
> Because his dad is unemployed and his mom is sick.
>
> But why is his dad unemployed?
> Because he doesn't have much education and he can't find a job.
>
> But why ...?"
>
> *– from Toward a Healthy Future: Second Report on the Health of Canadians*[21]

There is a growing body of evidence about what makes people healthy. The Lalonde Report[22] set the stage in 1974, by establishing a framework for the key factors that seemed to determine health status: lifestyle, environment, human biology and health services. Since then, much has been learned that supports, and at the same time, refines and expands this basic framework. In particular, there is mounting evidence that the contribution of medicine and health care is quite limited, and that spending more on health care will not result in significant further improvements in population health. On the other hand, there are strong and

[21] Public Health Agency of Canada. "Toward a Healthy Future: Second Report on the Health of Canadians." Available at http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/pdf/toward_a_healthy_english.PDF

[22] Lalonde, M. "A new perspective on the health of Canadians. A working document." Ottawa: Government of Canada, 1974. Available at http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/1974-lalonde/lalonde-eng.pdf

growing indications that other factors such as living and working conditions are crucially important for a healthy population.

The evidence indicates that the key factors which influence population health are:[23]

- Income and social status;
- Social support networks;
- Education;
- Employment and working conditions;
- Social environments;
- Physical environments;
- Personal health practices and coping skills;
- Healthy child development;
- Biology and genetic endowment;
- Health services;
- Gender; and
- Culture.

Each of these factors is important in its own right. At the same time, the factors are **interrelated**.

> *For example: a low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and a sense of control and mastery over life circumstances also come into play.*

The following Underlying Premises and Evidence Table provides an overview of what we know about the ways the determinants influence health. The source documents are:

- *Toward a Healthy Future: Second Report on the Health of Canadians*[24]
- *Strategies for Population Health: Investing in the Health of Canadians*[25]

[23] Public Health Agency of Canada. "What Determines Health."
Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants
[24] Public Health Agency of Canada. "Toward a Healthy Future: Second Report on the Health of Canadians."
Available at http://www.phac-aspc.gc.ca/ph-sp/report-rapport/toward/pdf/toward_a_healthy_english.PDF
[25] Public Health Agency of Canada. "Strategies for Population Health: Investing in the Health of Canadians."
Available at http://www.phac-aspc.gc.ca/ph-sp/pdf/strateg-eng.pdf

Key Determinant 1 – Income and Social Status	
Underlying Premises	**Evidence**
Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Why are higher income and social status associated with better health? If it were just a matter of the poorest and lowest status groups having poor health, the explanation could be things like poor living conditions. But the effect occurs all across the socio-economic spectrum. Considerable research indicates that the degree of control people have over life circumstances, especially stressful situations, and their discretion to act are the key influences. Higher income and status generally results in more control and discretion. And the biological pathways for how this could happen are becoming better understood. A number of recent studies show that limited options and poor coping skills for dealing with stress increase vulnerability to a range of diseases through pathways that involve the immune and hormonal systems	There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health. **Evidence from the Second Report on the Health of Canadians** • Only 47 per cent of Canadians in the lowest income bracket rate their health as very good or excellent, compared with 73 per cent of Canadians in the highest income group. • Low-income Canadians are more likely to die earlier and to suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race and place of residence. • At each rung up the income ladder, Canadians have less sickness, longer life expectancies and improved health. • Studies suggest that the distribution of income in a given society may be a more important determinant of health than the total amount of income earned by society members. Large gaps in income distribution lead to increases in social problems and poorer health among the population as a whole. **Evidence from Investing in the Health of Canadians:** • Social status is also linked to health. A major British study of civil service employees found that, for most major categories of disease (cancer, coronary heart disease, stroke, etc.), health increased with job rank. This was true even when risk factors such as smoking, which are known to vary with social class, were taken into account. All the people in the study worked in desk jobs, and all had a good standard of living and job security, so this was not an effect that could be explained by physical risk, poverty or material deprivation. Health increased at each step up the job hierarchy. For example, those one step down from the top (doctors, lawyers, etc.) had heart disease rates four times higher than those at the top (those at levels comparable to deputy ministers). So we must conclude that something related to higher income, social position and hierarchy provides a buffer or defence against disease, or that something about lower income and status undermines defences. • See also evidence from the report Social Disparities and Involvement in Physical Activity.[26] • See also evidence from the report Improving the Health of Canadians.[27] • See also **The Social Determinants of Health**: income inequality[28] and food security:[29] • Are poor people less likely to be healthy than rich people?[30] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[26] Gauvin, L and the Interdisciplinary Research Group on Health. Social Disparities and Involvement in Physical Activities, Montreal (2003). http://www.gris.umontreal.ca/rapportpdf/R03-02.pdf

[27] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367

[28] Scott, K and Lessard, R. Income Inequality as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/02_income_e.pdf

[29] McIntyre, L and Tarasuk, V. Food Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/08_food-eng.php

[30] http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr1-eng.php

Key Determinant 2 – Social Support Networks	
Underlying Premises	**Evidence**
Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems. In the 1996-97 National Population Health Survey (NPHS), more than four out of five Canadians reported that they had someone to confide in, someone they could count on in a crisis, someone they could count on for advice and someone who makes them feel loved and cared for. Similarly, in the 1994-95 National Longitudinal Survey of Children and Youth, children aged 10 and 11 reported a strong tendency toward positive social behaviour and caring for others.	**Evidence from Investing in the Health of Canadians:** Some experts in the field have concluded that the health effect of social relationships may be as important as established risk factors such as smoking, physical activity, obesity and high blood pressure. • An extensive study in California found that, for men and women, the more social contacts people have, the lower their premature death rates. • Another U.S. study found that low availability of emotional support and low social participation were associated with all-cause mortality. • The risk of angina pectoris decreased with increasing levels of emotional support in a study of male Israeli civil servants. • See also **The Social Determinants of Health**: social inclusion and exclusion[31] and social economy.[32] • How do relationships with others affect people's health?[33] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[31] Galabuzi, G-E and Labonte, R. Social Inclusion as a Determinant of Health. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php

[32] Vaillancourt, Y and Armstrong, P. Social Policy as a Determinant of Health: The Contribution of the Social Economy. Summary of paper and presentations prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/03_inclusion-eng.php

[33] Public Health Agency of Canada. "How do relationships with others affect people's health?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr2-eng.php

Key Determinant 3 – Education and Literacy	
Underlying Premises	**Evidence**
Health status improves with level of education. Education is closely tied to socio-economic status, and effective education for children and lifelong learning for adults are key contributors to health and prosperity for individuals, and for the country. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people's ability to access and understand information to help keep them healthy.	**Evidence from the Second Report on the Health of Canadians:** • Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy. • People with higher levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier foods. • In the 1996-97 National Population Health Survey (NPHS), only 19 per cent of respondents with less than a high school education rated their health as "excellent" compared with 30 per cent of university graduates. **Evidence from Investing in the Health of Canadians:** • The 1990 Canada Health Promotion Survey found the number of lost workdays decreases with increasing education. People with elementary schooling lose seven workdays per year due to illness, injury or disability, while those with university education lose fewer than four days per year. • See also evidence from the report: How Does Literacy Affect the Health of Canadians?[34] • See also **The Social Determinants of Health**: education.[35] • How does education affect health?[36] This question was prepared by the Canadian Council on Social Development.

[34] Public Health Agency of Canada. "How Literacy Affects the Health of Canadians." Available at http://www.phac-aspc.gc.ca/ph-sp/literacy-alphabetisme/index-eng.php
[35] Public Health Agency of Canada. "The Social Determinants of Health: Education as a Determinant of Health." Available at http://www.phac-aspc.gc.ca/ph-sp/oi-ar/10_education-eng.php
[36] Public Health Agency of Canada. "How does education affect health?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr3-eng.php

Key Determinant 4 – Employment and Working Conditions	
Underlying Premises	**Evidence**
Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.	**Evidence from the Second Report on the Health of Canadians:** • Employment has a significant effect on a person's physical, mental and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth. When a person loses these benefits, the results can be devastating to both the health of the individual and his or her family. Unemployed people have a reduced life expectancy and suffer significantly more health problems than people who have a job. • Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being. • Participation in the wage economy, however, is only part of the picture. Many Canadians (especially women) spend almost as many hours engaged in unpaid work, such as doing housework and caring for children or older relatives. When these two workloads are combined on an ongoing basis and little or no support is offered, an individual's level of stress and job satisfaction is bound to suffer. Between 1991 and 1995, the proportion of Canadian workers who were "very satisfied" with their work declined, and was more pronounced among female workers, dropping from 58 to 49 per cent. Reported levels of work stress followed the same pattern. In the 1996-97 NPHS, more women reported high work stress levels than men in every age category. Women aged 20 to 24 were almost three times as likely to report high work stress than the average Canadian worker. **Evidence from Investing in the Health of Canadians:** • A major review done for the World Health Organization found that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families and their communities. • See also **The Social Determinants of Health**: employment and job security[37] and working conditions.[38]

[37] Tremblay, D-G. Employment Security as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/04_employment_e.pdf

[38] Andrew Jackson, A. and Polanyi, M. Working Conditions as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/05_working_e.pdf

Key Determinant 5 – Social Environments	
Underlying Premises	**Evidence**
The importance of social support also extends to the broader community. Civic vitality refers to the strength of social networks within a community, region, province or country. It is reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others. The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. A healthy lifestyle[39] can be thought of as a broad description of people's behaviour in three inter-related dimensions: individuals; individuals within their social environments (e.g., family, peers, community, workplace); the relation between individuals and their social environment. Interventions to improve health through lifestyle choices can use comprehensive approaches that address health as a social or community (i.e., shared) issue. Social or community responses can add resources to an individual's repertoire of strategies to cope with changes and foster health. In 1996-97: • Thirty-one per cent of adult Canadians reported volunteering with not-for-profit organizations in 1996-97, a 40 per cent increase in the number of volunteers since 1987. • One in two Canadians reported being involved in a community organization. • Eighty-eight per cent of Canadians made donations, either financial or in-kind, to charitable and not-for-profit organizations.	**Evidence from the Second Report on the Health of Canadians** • In the U.S., high levels of trust and group membership were found to be associated with reduced mortality rates. • Family violence has a devastating effect on the health of women and children in both the short and long term. In 1996, family members were accused in 24 per cent of all assaults against children; among very young children, the proportion was much higher. • Women who are assaulted often suffer severe physical and psychological health problems; some are even killed. In 1997, 80 per cent of victims of spousal homicide were women, and another 19 women were killed by a boyfriend or ex-boyfriend. • Since peaking in 1991, the national crime rate declined 19 per cent by 1997. However, this national rate is still more than double what it was three decades ago.

[39] Lyons, R. and Langille L. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Prepared for Health Canada (2002). http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf

Key Determinant 6 – Physical Environments	
Underlying Premises	**Evidence**
The physical environment is an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being	**Evidence from the Second Report on the Health of Canadians** • The prevalence of childhood asthma, a respiratory disease that is highly sensitive to airborne contaminants, has increased sharply over the last two decades, especially among the age group 0 to 5. It was estimated that some 13 per cent of boys and 11 per cent of girls aged 0 to 19 (more than 890,000 children and young people) suffered from asthma in 1996-97. • Children and outdoor workers may be especially vulnerable to the health effects of a reduced ozone layer. Excessive exposure to UV-B radiation can cause sunburn, skin cancer, depression of the immune system and an increased risk of developing cataracts. **Evidence from Investing in the Health of Canadians:** • Air pollution, including exposure to second-hand tobacco smoke, has a significant association with health. A study in southern Ontario found a consistent link between hospital admissions for respiratory illness in the summer months and levels of sulphates and ozone in the air. However, it now seems that the risk from small particles such as dust and carbon particles that are by-products of burning fuel may be even greater than the risks from pollutants such as ozone. As well, research indicates that lung cancer risks from second-hand tobacco smoke are greater than the risks from the hazardous air pollutants from all regulated industrial emissions combined. • See also **The Social Determinants of Health**: housing.[40] • What affects health more: germs and viruses, or the environment?[41] This question was prepared for the Canadian Health Network by the Canadian Council on Social Development.

[40] Bryant, T., Chisholm, S. and Crowe, C. Housing as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/09_housing_e.pdf

[41] Public Health Agency of Canada. "What affects health more: germs and viruses, or the environment?" Available at http://www.phac-aspc.gc.ca/ph-sp/determinants/qa-qr4-eng.php.

Key Determinant 7 – Personal Health Practices and Coping Skills	
Underlying Premises	**Evidence**
Personal Health Practices and Coping Skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health. Definitions of lifestyle[42] include not only individual choices, but also the influence of social, economic, and environmental factors on the decisions people make about their health. There is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. These influences impact lifestyle choice through at least five areas: personal life skills, stress, culture, social relationships and belonging, and a sense of control. Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events. However, there is a growing recognition that personal life "choices" are greatly influenced by the socio-economic environments in which people live, learn, work and play. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.	**Evidence from the Second Report on the Health of Canadians** • In Canada, smoking is estimated to be responsible for at least ¼ of all deaths for adults between the ages of 35 and 84. Rates of smoking have increased substantially among adolescents and youth, particularly among young women, over the past five years and smoking rates among Aboriginal people are double the overall rate for Canada as a whole. • Multiple risk-taking behaviours, including such hazardous combinations as alcohol, drug use and driving, and alcohol, drug use and unsafe sex, remain particularly high among young people, especially young men. • Diet in general and the consumption of fat in particular are linked to some of the major causes of death, including cancer and coronary heart disease. The proportion of overweight men and women in Canada increased steadily between 1985 and 1996-97, from 22 to 34 per cent among men and from 14 to 23 per cent among women. **Evidence from Investing in the Health of Canadians:** • Coping skills, which seem to be acquired primarily in the first few years of life, are also important in supporting healthy lifestyles. These are the skills people use to interact effectively with the world around them, to deal with the events, challenges and stress they encounter in their day-to-day lives. Effective coping skills enable people to be self-reliant, solve problems and make informed choices that enhance health. These skills help people face life's challenges in positive ways, without recourse to risky behaviours such as alcohol or drug abuse. Research tells us that people with a strong sense of their own effectiveness and ability to cope with circumstances in their lives are likely to be most successful in adopting and sustaining healthy behaviours and lifestyles. • See also evidence from the report Social Disparities and Involvement in Physical Activity.[43] • See also evidence from the report Improving the Health of Canadians.[44]

[42] Lyons, R. and Langille L. Health Lifestyle: Strengthening the Effectiveness of Lifestyle Approaches to Improve Health. Prepared for Health Canada (2002). Available at http://www.phac-aspc.gc.ca/ph-sp/docs/healthy-sain/pdf/lifestyle.pdf

[43] Gauvin, L and the Interdisciplinary Research Group on Health. Social Disparities and Involvement in Physical Activities, Montreal (2003). http://www.gris.umontreal.ca/rapportpdf/R03-02.pdf

[44] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367

Key Determinant 8 – Healthy Child Development	
Underlying Premises	**Evidence**
New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right. At the same time, we have been learning more about how all of the other determinants of health affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care.	**Evidence from the Second Report on the Health of Canadians** • Experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain's neurons. Positive stimulation early in life improves learning, behaviour and health into adulthood. • Tobacco and alcohol use during pregnancy can lead to poor birth outcomes. In the 1996-97 National Population Health Survey, about 36 per cent of new mothers who were former or current smokers smoked during their last pregnancy (about 146,000 women). The vast majority of women reported that they did not drink alcohol during their pregnancy. • A loving, secure attachment between parents/ caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others in later life. • Infants and children who are neglected or abused are at higher risk for injuries, a number of behavioural, social and cognitive problems later in life, and death. **Evidence from Investing in the Health of Canadians:** • A low weight at birth links with problems not just during childhood, but also in adulthood. Research shows a strong relationship between income level of the mother and the baby's birth weight. The effect occurs not just for the most economically disadvantaged group. Mothers at each step up the income scale have babies with higher birth weights, on average, than those on the step below. This tells us the problems are not just a result of poor maternal nutrition and poor health practices associated with poverty, although the most serious problems occur in the lowest income group. It seems that factors such as coping skills and sense of control and mastery over life circumstances also come into play. • See also evidence from the report Improving the Health of Canadians.[45] • See also **The Social Determinants of Health**: early childhood education and care.[46]

[45] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367.

[46] Friendly, M. and Browne, G. Early Childhood Education and Care as a Determinant of Health. Summary of paper and presentation prepared for The Social Determinants of Health Across the Life-Span Conference, Toronto (2002). http://www.phac-aspc.gc.ca/ph-sp/oi-ar/pdf/07_ecec_e.pdf

Key Determinant 9 – Biology and Genetic Endowment	
Underlying Premises	**Evidence**
The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic endowment appears to predispose certain individuals to particular diseases or health problems.	**Evidence from the Second Report on the Health of Canadians** • Studies in neurobiology have confirmed that when optimal conditions for a child's development are provided in the investment phase (between conception and age 5), the brain develops in a way that has positive outcomes for a lifetime. • Aging is not synonymous with poor health. Active living and the provision of opportunities for lifelong learning may be particularly important for maintaining health and cognitive capacity in old age. And studies on education level and dementia suggest that exposure to education and lifelong learning may create reserve capacity in the brain that compensates for cognitive losses that occur with biological aging.

Key Determinant 10 – Health Services	
Underlying Premises	**Evidence**
Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health. The health services continuum of care includes treatment and secondary prevention	**Evidence from the Second Report on the Health of Canadians** • Disease and injury prevention activities in areas such as immunization and the use of mammography are showing positive results. These activities must continue if progress is to be maintained. • There has been a substantial decline in the average length of stay in hospital. Shifting care into the community and the home raises concerns about the increased financial, physical and emotional burdens placed on families, especially women. The demand for home care has increased in several jurisdictions, and there is a concern about equitable access to these services. • Access to universally insured care remains largely unrelated to income; however, many low- and moderate-income Canadians have limited or no access to health services such as eye care, dentistry, mental health counselling and prescription drugs.

Key Determinant 11 – Gender	
Underlying Premises	**Evidence**
Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. "Gendered" norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles.	**Evidence from the Second Report on the Health of Canadians** • Men are more likely to die prematurely than women, largely as a result of heart disease, fatal unintentional injuries, cancer and suicide. Rates of potential years of life lost before age 70 are almost twice as high for men than women and approximately three times as high among men aged 20 to 34. • While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence. • While overall cancer death rates for men have declined, they have remained persistently stubborn among women, mainly due to increases in lung cancer mortality. Teenage girls are now more likely than adolescent boys to smoke. If increased rates of smoking among young women are not reversed, lung cancer rates among women will continue to climb. See also articles: *Rural, remote and northern women – where you live matters to your health* and *How being Black and female affects your health.*

Key Determinant 12 – Culture	
Underlying Premises	**Evidence**
Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.	**Evidence from the Second Report on the Health of Canadians** • Despite major improvements since 1979, infant mortality rates among First Nations people in 1994 were still twice as high as among the Canadian population as a whole and the prevalence of major chronic diseases, including diabetes, heart problems, cancer hypertension and arthritis/rheumatism, is significantly higher in Aboriginal communities and appears to be increasing. • In a comparison of ethnic groups, the highest rate of suicide occurred among the Inuit, at 70 per 100,000, compared with 29 per 100,000 for the Dene and 15 per 100,000 for all other ethnic groups, comprised primarily of non-Aboriginal persons. • The 1996-97 National Longitudinal Survey of Children and Youth found that many immigrant and refugee children were doing better emotionally and academically than their Canadian born peers, even though far more of the former lived in low-income households. The study suggests that "poverty among the Canadian-born population may have a different meaning than it has for newly arrived immigrants. The immigrant context of hope for a brighter future lessens poverty's blows; the hopelessness of majority-culture poverty accentuates its potency." See also evidence from the report Improving the Health of Canadians.[47]

[47] Canadian Institute for Health Information, "Improving the Health of Canadians 2007-2009." Available at https://secure.cihi.ca/estore/productSeries.htm?pc=PCC367.

Appendix B: Supplementary Resources

In addition to the HEIA Template and HEIA Workbook, users may access various complementary resources to assist completing the tool. These resources are available on the MOHLTC's HEIA website at www.ontario.ca/healthequity. Visit this webpage for the most up-to-date information.

Other General Health Equity Resources

- Project for an Ontario Women's Health Evidence-Based Report, *the POWER Study*: www.powerstudy.ca/
- Echo: Improving Women's Health in Ontario: www.echo-ontario.ca./echo/en.html
- Public Health Agency of Canada: www.phac-aspc.gc.ca
- Ontario Health Quality Council: www.ohqc.ca
- Toronto-based Health Equity Council: www.healthequitycouncil.ca
- National Institute of Public Health in Quebec: www.ncchpp.ca/en/
- World Health Organization: www.who.int/social_determinants
- HIA gateway (UK): www.apho.org.uk/default.aspx?QN=P_HEIA
- HIA connect (NSW Australia): www.HEIAconnect.edu.au/
- World Health Organization HIA: www.who.int/hia/en/
- Health Quality Ontario: www.hqontario.ca
- Better Outcomes Registry Network (BORN): www.bornontario.ca
- Wellesley Institute: www.wellesleyinstitute.com

Health Equity Terminology

- Public Health Agency of Canada Glossary: www.phac-aspc.gc.ca/sdh-dss/glos-eng.php
- World Health Organization Glossary: www.who.int/hia/about/glos/en/index.html

Appendix C: Methodology

Useful resources and methods for gathering information and evidence for the HEIA

The following sources of data are listed according to the degree of time and effort that need to be expended in obtaining this information:

Your common knowledge and working experiences related to the project:

Your planning to date may already have involved some background research or needs assessment that enabled you to easily identify potentially vulnerable groups. You may be able to go through the "populations" column of the HEIA Template and highlight or eliminate some groups simply based on your current understanding of the issue at hand. Similarly, you may already be aware of some interventions that are used in this area, or of significant data, research or other knowledge gaps that may need to be filled in order to effectively reduce related inequities. Furthermore, your team or manager may be able to share important observations, such as attendance levels in certain programs, the effectiveness of certain outreach methods and perceived barriers to participation among certain priority populations.

Literature review

A literature review will naturally be informed by the above information. It is important to consider a literature review for any areas of uncertainty regarding populations affected or interventions that may be effective. A rapid review focused on synthesized evidence sources will be appropriate in most cases. If your area is particularly new or the profile of your program/policy is very high, then a primary literature search may be appropriate. Some key documents addressing the link between health inequities and the determinants of health are listed below.

Environmental scan

An environmental scan can help to raise your awareness of the policy landscape surrounding an issue, identifying community groups and government organizations already working on this issue. An environmental scan can also increase your knowledge of priority groups affected by your program or equity issues that you may not have perceived in your original conceptualization of the project.

Analysis of existing data

- Lack of existing or sufficient data related to the determinants of health and other drivers of inequalities is a key challenge in Ontario and other jurisdictions. However, available data should be disaggregated in order to highlight inequities that may be related to the issue under consideration. Examples of data sources are listed below.
- If data are unavailable, and you believe such an analysis is of significant importance to your work, this should be noted in Step 2 of the HEIA Template under "More Information Needed." This assists you in recording the gaps in the information from your analysis, and gives you a platform from where to start looking (i.e., expert consultation, grey literature, etc.).

Stakeholder/Expert consultation

If the preceding steps do not provide adequate information regarding health inequities related to your program or policy, formal or informal stakeholder or expert consultation may be considered.

Community consultation

Community consultation is unlikely to be an early step in an HEIA of your project. However, as you progress you may find that it becomes increasingly important to consult with priority group members in order to better understand the impact of your work on their perceived health status, quality of life, access to programs/services, etc.

Collection of new data

For some questions, particularly those related to evaluation, developing a protocol for the collection, analysis and dissemination of new data may be necessary. This may also go under the "More Information Needed" section of the HEIA Template, to ensure that the need for new data is recorded.

Data Sources Containing Socio-demographic and Economic Variables for Scoping Analysis

- The Rapid Risk Factor Surveillance System (RRFSS)
- Integrated Public Health Information System (iPHIS)
- Canadian Community Health Survey (CCHS)
- Census data (typically obtained via data requests)
- Administrative databases
- Data and reports from other local, regional, provincial and national sources

Useful Resources on Health Inequities and the Determinants of Health

Ontario

Gardner, B. (2008). *Health Equity Discussion Paper*. Toronto Central Health Integration Network. Retrieved May 25, 2010, from http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/Report_and_Publications/Health%20Equity%20Discussion%20Paper%20v1.0.pdf

Region of Waterloo Public Health. (2009). Evidence and Practice-based Planning Framework with a focus on health inequities. Retrieved May 28, 2010, from http://chd.region.waterloo.on.ca/web/health.nsf/DocID/FD80C0D143A204F78525761D0061829A/$file/EPPF_maindoc.pdf?open

Sudbury and District Health Unit. (2010). Implementing Local Public Health Practices to Reduce Social Inequities in Health. Retrieved June 1, 2010, from http://www.sdhu.com/uploads/content/listings/EXTRAInterventionProjectDraftFinalReportSDHUJanuary2010_External.pdf

Toronto Public Health. (2008). *The Unequal City: Income and Health Inequalities in Toronto.* Retrieved May 25, 2010, from: www.toronto.ca/health/map/pdf/unequalcity_20081016.pdf.

Canada

Bell, B. (2009). *Actions to Reduce Health Inequalities in Canada: A description of strategic efforts led or supported by public health organizations.* Working Document prepared for the Public Health Agency of Canada Strategic Initiatives and Innovations Directorate. Retrieved May 21, 2010, from http://www.opha.on.ca/resources/docs/StrategicInitiatives-PHAC-6Mar09.pdf

Canadian Institute for Health Information. (2008). *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada*, Ottawa, ON. Retrieved May 25, 2010, from: http://secure.cihi.ca/cihiweb/products/Reducing_Gaps_in_Health_Report_EN_081009.pdf.

Keon, W.J., and Pepin, L. (2009). *A Healthy, Productive Canada: A Determinant of Health Approach. Final Report of the Senate Subcommittee on Population Health.* Retrieved May 21, 2010, from: www.parl.gc.ca/40/2/parlbus/commbus/senate/Com-e/popu-e/rep-e/rephealthjun09-e.pdf

Public Health Agency of Canada. (2008). *The Chief Public Health Officer's Report on the State of Public Health in Canada.* Retrieved May 21, 2010, from http://www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/index-eng.php.

International

Commission on Social Determinants. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization. Retrieved, May 20, 2010, from: www.who.int/social_determinants/thecommission/finalreport/en/index.html.

HEIA

Health Equity Impact Assessment

French Language Services Supplement

Ontario

Table of Contents

Integration of French Language Considerations: Guide for the Ministry of Health and Long-Term Care and the Local Health Integration Networks

Introduction

Health Equity Impact Assessment (HEIA) is a flexible and practical tool used to identify and respond to *unintended* potential health impacts (positive or negative) of a policy, program, or initiative on a broad range of vulnerable or marginalized groups within the general population. This includes assessing potential impacts of decisions on francophone communities, including sub-populations of francophones. In addition, francophone populations are afforded specific constitutional and legal rights reflected in provincial legislation, including the *French Language Services Act, 1986* (FLSA).

This guide is a resource for staff at the Ministry of Health and Long-Term Care (MOHLTC) and the Local Health Integration Networks (LHINs) to support the effective integration of French language service (FLS) considerations in decision-making, policy, and program development – in particular when health equity issues are being addressed. FLS integration should be considered upfront and alongside other equity issues that may surface in a HEIA, including those impacting francophone populations.

French Language Services Act

The FLSA contains specific obligations for Ontario government ministries and Crown Agencies, which includes the LHINs. The FLSA also identifies designated areas, defined in the Schedule. About 85 per cent of Franco-Ontarians live in a designated area.

The FLSA can be accessed at:

- French: www.e-laws.gov.on.ca/html/statutes/french/elaws_statutes_90f32_f.htm
- English: www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm

The FLSA defines where individuals are guaranteed to receive services in French, stating that:

> *"A person has the right in accordance with this Act to communicate in French with, and receive available services in French from, any head or central office of a government agency or institution of the Legislature, and has the same right with respect of any other office of a government agency or institution that is located in or serves an area designated in the Schedule."* FLSA, s. 5(1)

Government of Ontario ministries and Crown agencies, including all LHINs and third-party designated agencies, that are located in and/or serve the 25 designated areas are covered by the FLSA.

It is important to note that third-party health service providers (HSPs) are not automatically subject to the FLSA. Many of the direct services provided by the MOHLTC to the public are provided through third-party HSPs such as hospitals, long-term care homes, and mental health programs. For further information on the scope of the legislation, refer to s. 1 of the FLSA which defines "government agency".

The FLSA also provides for the appointment of a French Language Services Commissioner, appointed by the Minister Responsible for Francophone Affairs, to encourage compliance with the legislation. The role of the Commissioner is defined in the FLSA, s. 12.1(1).

TIPS:

You may contact the MOHLTC French Language Health Services Office at (416) 327-8975 or the French Language Services Coordinator in your LHIN for further support.

The *OPS Framework for Action: A Modern Ontario Public Service (2006)* promotes an 'active offer' of services in French. An active offer is when French language services are offered proactively, as opposed to provided only upon request.

Ontario's Designated Areas defined in the FLSA Schedule (last updated January 7, 2011):

Toronto
Hamilton
Port Colborne
Welland
Ottawa
Mississauga
Brampton
Sudbury
Winchester
Windsor
Belle River
Tecumseh
Anderdon
Colchester North
Maidstone
Sandwich South
Sandwich West
Tilbury North
Tilbury West
Rochester
Glengarry
Tilbury
Dover
Tilbury East
Prescott County
Pembroke
Stafford
Westmeath
Russell County
Penetanguishene
Tiny
Essa
Stormont County
Algoma District
Cochrane District
Ignace
Nipissing District
Sudbury District
Geraldton
Longlac
Marathon
Manitouwadge
Beardmore
Nakina
Terrace Bay
Timiskaming District
London
Callander
Kingston

Local Health System Integration Act

The *Local Health System Integration Act, 2006* (LHSIA) contains specific provisions with respect to French language services. This includes the preamble which states that:

> *"The people of Ontario and their government…believe that the health system should be guided by a commitment to equity and respect for diversity in communities in serving the people of Ontario and respect the requirements of the French Language Services Act in serving Ontario's French-speaking community."* LHSIA, Preamble s(f)

In addition, specific provisions are identified relating to engagement of francophone communities at both the provincial and regional level:

- **The French Language Health Services Advisory Council (Provincial)**
  The establishment of a French Language Health Services Advisory Council (FLHSAC) to advise the minister of service delivery issues related to francophone communities and priorities and strategies for the provincial strategic plan related to those communities (LHSIA, s.14(2)).
- **French Language Health Planning Entities (Regional)**
  The establishment and engagement of French language health planning entities at the LHIN level (LHSIA, s.16(4)(b)).

The LHSIA can be accessed at:

- French: www.e-laws.gov.on.ca/html/statutes/french/elaws_statutes_06l04_f.htm
- English: www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

LHINs play a key role in delivering on legislated FLS commitments

To meet their commitment to equity and community diversity, and to respect the requirements of the FLSA in serving Ontario's French-speaking community, the MOHLTC and LHINs have worked together to establish mechanisms to ensure effective integration of FLS requirements. Here is a snapshot of some of the work underway:

- **LHINs now play a role in identifying HSPs for designation under the FLSA**
  Once an identified HSP can demonstrate that it can provide services in French on a permanent basis, it can apply for official designation under the FLSA. Designation guarantees that services will be available in French. Currently, there are 84 partially or fully designated HSPs across Ontario. The LHINs have taken on the responsibility for identifying HSPs, or specific health services within an HSP for potential designation under the FLSA. This is the first step toward a potential full or partial designation, which is ultimately granted through a designation by Cabinet.

- **LHINs ensure Service Accountability Agreements (SAAs) align with FLSA requirements**
  The LHINs have included specific FLS requirements within their Service Accountability Agreements (SAAs) with HSPs located or serving a designated area.

- **MOHLTC and LHINs are working together to implement the French Language Health Planning Entities**
  On January 1, 2010 the Francophone Community Engagement Regulation came into effect. The regulation elaborates on the roles and responsibilities of the French Language Health Planning Entities under LHSIA s.16(4)(b).

The regulation can be accessed at:

- French: www.e-laws.gov.on.ca/html/regs/french/elaws_regs_090515_f.htm
- English: www.e-laws.gov.on.ca/html/regs/english/elaws_regs_090515_e.htm

For further status updates on the French Language Health Planning Entities go to:

- French: www.health.gov.on.ca/french/publicf/programf/flhsf/health_planning_entitiesf.html
- English: www.health.gov.on.ca/english/public/program/flhs/health_planning_entities.html

Key FLS considerations for both MOHLTC and LHIN staff

French Language considerations should be incorporated upfront at the beginning of a policy or program development process in order for meaningful integration to occur. Listed below are a number of key questions designed to support ministry and LHIN staff in effective integration of FLS considerations at the onset of a policy or program development process.

1. Getting Started:

- Does the initiative fall within the parameters of the FLSA?
- What impact will the policy/program have on the delivery of health services and information to Ontario's French-speaking population?

2. Project Planning and Budget

- Have project timelines and budget incorporated specific activities and costs related to meeting FLS obligations (e.g., including time and adequate funding to support translation/adaptation)?

3. Consultation and Community Engagement

- Was appropriate consultation/collaboration undertaken regarding the policy/program's possible impact on francophone communities? For example with:
  - The French Language Services Office of MOHLTC
  - The appropriate LHIN FLS Coordinator(s)
  - The French Language Health Planning Entities
  - Key stakeholders and/or the broader francophone community

TIP:

The French Language Health Services Office, MOHLTC, and the LHIN FLS Coordinators can support you in identifying key francophone stakeholders when designing your community engagement or consultation strategy.

4. Communications

- When a MOHLTC or LHIN policy or program is directed to the public, it is a requirement that news releases, announcements and information materials must be available to the media and general public in both English and French. Here are some key questions to assist with incorporating these requirements in your project planning:
  - How will the policy or program be communicated to the French-speaking population?
  - Have you fully incorporated the Communications in French Guidelines (i.e., news releases, public announcements and posts on MOHLTC or LHIN websites etc.)?

The *Communications in French Guidelines* can be accessed at:

- French: http://www.agnes.gov.on.ca/directives%20and%20Policies/PDF/GuidelinesCommunicationsinFrench20110511_FR.pdf
- English: http://www.agnes.gov.on.ca/directives%20and%20Policies/PDF/Guidelines_Communications_in_%20French_%20FINAL_12-5-2011_EN.pdf

TIP:

For support using these guidelines you can contact: the MOHLTC French Language Health Services Office at (416) 327-8975.

5. Human Resources

- If the policy or program being developed will require offering services or information directly to the public, have the FLS requirements been considered in terms of ensuring a) appropriate staffing resources (i.e., designated staff), and b) training on FLS obligations for existing staff?
- Are there additional expenses that should be factored in during bilingual recruitment?

6. Contracts

- Some services may be provided by outside organizations, such as transfer payment agencies. Contracts must include agreements to provide the services in French if relevant, and should define the service levels.

TIP:

Contracting a service out to a third party does not negate the government's (or its agencies', including LHINs') obligation to provide services in French per the FLSA.

HEIA Health Equity Impact Assessment

HEIA is a flexible and practical assessment tool that can be used to identify and address **potential unintended health impacts** (positive or negative) of a policy, program, or initiative on specific population groups.

NOTE: The *HEIA Template* is designed to be used alongside the accompanying *HEIA Workbook*, which provides definitions, examples, and more detailed instructions to help you complete this template.

Date:

Organization:

Name and contact information for the individual or team that completed the HEIA:

Project Name:

Project Summary:

Objective for Completing the HEIA:
(e.g. to determine where to best invest resources in a new policy, program, or initiative?)

NOTE: This section to be filled in after completing the following HEIA template.

Conclusions:
(e.g. what decisions were made following completion of the HEIA tool?)

The numbered steps in this template correspond with sections in the HEIA Workbook. The workbook with step-by-step instructions is available at www.ontario.ca/healthequity.

Step 1. SCOPING		Step 2. POTENTIAL IMPACTS			Step 3. MITIGATION	Step 4. MONITORING	Step 5. DISSEMINATION
a) Populations* Using evidence, identify which populations may experience significant unintended health impacts (positive or negative) as a result of the planned policy, program or initiative.	**b) Determinants of Health** Identify determinants and health inequities to be considered alongside the populations you identify.	**Unintended Positive Impacts.**	**Unintended Negative Impacts.**	**More Information Needed.**	**Identify ways to reduce potential negative impacts and amplify the positive impacts.**	**Identify ways to measure success for each mitigation strategy identified.**	**Identify ways to share results and recommendations to address equity.**
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)							
Age-related groups (e.g., children, youth, seniors, etc.)							
Disability (e.g., physical, D/deaf, deafened or hard of hearing, visual, intellectual/developmental, learning, mental illness, addictions/substance use, etc.)							
Ethno-racial communities (e.g., racial/racialized or cultural minorities, immigrants and refugees, etc.)							
Francophone (including new immigrant francophones, deaf communities using LSQ/LSF, etc.)							
Homeless (including marginally or under-housed, etc.)							
Linguistic communities (e.g., uncomfortable using English or French, literacy affects communication, etc.).							
Low income (e.g., unemployed, underemployed, etc.)							
Religious/faith communities							
Rural/remote or inner-urban populations (e.g., geographic or social isolation, under-serviced areas, etc.)							
Sex/gender (e.g., male, female, women, men, trans, transsexual, transgendered, two-spirited, etc.)							
Sexual orientation, (e.g., lesbian, gay, bisexual, etc.)							
Other: please describe the population here.							

* NOTE: *The terminology listed here may or may not be preferred by members of the communities in question and there may be other populations you wish to add. Also consider intersecting populations (i.e. Aboriginal women).*

Section 8

thehealthline.ca

Section 8
thehealthline.ca

Thehealthline.ca is an information database on health services and health resources managed by Community Care Access Centres (CCACs). Available in English and in French, it is a valuable tool, for consumers, CCAC staff members, other health professionals, the LHINs and the system as a whole.

Thehealthline.ca was developed in 1992 as an innovative partnership between hospitals, the health unit and the CCAC in London, Ontario. The tool was adopted by CCACs across the province, and deployment should be completed in the summer of 2013.

In the South West LHIN area, recent additions and enhancements to the SouthWesthealthline.ca have increased the capacity to search and access French language services information and resources. In the Erie St. Clair LHIN area, enhancements to the French section of the ErieStClairhealthline.ca are expected in the coming year.

Please refer to the attached fact sheets for more information on thehealthline.ca in Ontario and specifically in the South West LHIN area.

Section 8

List of Appendixes

Introducing thehealthline.ca to Ontario

French Language features on SouthWesthealthline.ca

February 2012

Introducing thehealthline.ca to Ontario

Ontario's CCACs have an important and growing role as health system navigators and care connectors. One of the key enablers is the CCAC's Information and Referral (I&R) function. CCAC staff members provide information to clients, family members, the public, and other health system partners about health services, electronically, by telephone, and in person. They also make referrals to a variety of community supports, health care and other services. As the role of CCACs continues to expand, the I&R function also grows.

A provincial CCAC Work Group was formed in 2011 to enhance this critical function. One of the Group's first major initiatives is the deployment of thehealthline.ca.

thehealthline.ca, a proven resource

To navigate a complex and multi-faceted health system, most CCACs have developed electronic tools and databases. After some study, the leaders of Ontario's CCACs have decided to consolidate current information tools and databases into a single solution. They have selected thehealthline.ca, currently in use in the South West and Champlain, as the provincial model.

Developed in 1992 as an innovative partnership between hospitals, the health unit and the CCAC in London, Ontario, thehealthline.ca has proven to be popular, flexible, easy to use, reliable, robust, and cost-effective. It is the resource of choice for consumers, health providers, CCAC Information & Referral staffers, and a key source for planning information by the South West LHIN, an important partner and funder. Each year, the site receives more than 1.5 million visitors. thehealthline.ca spread first to Champlain and now will go province wide.

Visit http://informationnetwork.thehealthline.ca to learn more about thehealthline.ca.

Going Ontario-wide

Over the next 18 months, thehealthline.ca will be implemented across Ontario. This project will create:

- A single provincial database of more than 50,000 health service profiles
- A common provincial portal designed to guide users to regional CCAC sites
- 14 regional sites

It is expected that one regional site will be deployed each month, beginning in March 2012.

The province-wide access phone numbers:

- 310-CCAC (310-2222)
- 310-CASC (310-2272), French

will continue to operate as they currently do.

The Benefits

Ontario's thehealthline.ca will be a valuable tool for consumers, CCAC staff members, other health

professionals, the LHINs and the system as a whole. Information supports the delivery of outstanding care, client self-management and wellness, and system efficiency and effectiveness. It's good news for all of us.

Benefits for consumers

- thehealthline.ca makes it easy and quick to find health information, using geography, topics, or Google searches.
- Regular updating ensures the information is accurate and up-to-date.
- Service profiles provide a wealth of information including special features such as video links and mapping.

Benefits for CCACs

- A centralized provincial database makes it easier to share, import and export data across the province.
- Special features make it easy for health organizations to update profile information regularly, ensuring greater accuracy and reliability.
- Good searchability makes providing information and referral more efficient and effective.
- A robust and consistent system will provide a foundation for other enhancements, such as e-referral tools.

Benefits for health providers and the system

- Consumers can find the information they need easily, reducing demand on other system resources.
- Better informed consumers are empowered and more likely to practice self-management.
- Family physicians and other health professionals have a reliable source of information about health resources in their communities at their fingertips.
- Health providers can profile their services for free within a centralized provincial web site that attracts many more visitors than a stand-alone site.
- thehealthline.ca serves as an integrator, bringing together information from public, non-profit and for-profit health organizations and supporting partnership and collaboration.

Other enhancements to I&R

The I&R Work Group will also be looking at other aspects of the I&R function, including standards of care, e-referral systems, data collection and maintenance, and training and organizational development.

Give us a test drive!

Visit thehealthline.ca to explore its many features. Stay tuned for updates on when thehealthline.ca is coming to your community.

For more information contact Sandra Coleman, CEO, South West CCAC (519 641-5496) or contact the CEO of your local CCAC.

CCAC Community Care Access Centre
CASC Centre d'accès aux soins communautaires
thehealthline.ca
OACCAC Ontario Association of Community Care Access Centres
ACASCO Association des Centres d'accès aux soins communautaires de l'Ontario

February 2012

French Language features on SouthWesthealthline.ca

SouthWesthealthline.ca has introduced new features that make it easy to find French Language services information and other resources. A number of data and site navigation enhancements were launched in spring 2013 through a LHIN-funded initiative that brings together:

- Health and social services provided in French
- Detailed listings of what they offer and how to access
- Resource library
- Career opportunities seeking candidates with French Language skills
- Tips on accessing services and a video on how to navigate the site
- Searching in French by visiting **www.lignesantesud-ouest.ca**, and
- A French Language Services toolkit produced by the South West and Erie-St. Clair LHINs.

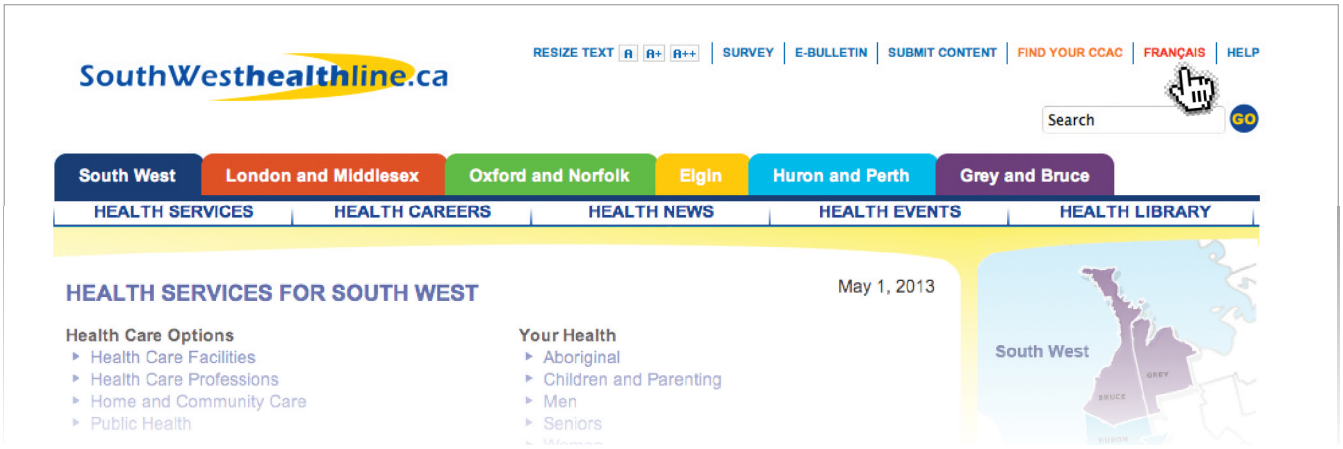
Getting Started

A bilingual welcome page provides a menu of all the French Language features as well as instructions for navigating the site.

Expanded Service Information

Details about French Language service offerings are provided within service profiles. Organizations are asked to provide information on the level and type of French Language services they offer, such as:

- Reception including referral to other services and resources
- Programs delivered in French
- Interpretation
- Websites and publications
- Further details under Language Notes



Finding French Services

Users of SouthWesthealthline.ca can find and identify French services at a glance via the following features:

A **special icon** Fr indicates the programs that are offered in the French Language, providing a simple visual cue when browsing or searching the site for services.

The **site free-text search** is fully bilingual and offers suggested key matches based on the search query entered.

A live **service directory** of organizations and programs that offer service in French is available at the push of a button. The directory is grouped topically by categories such as Francophone community, settlement, translation and interpretation, information services, etc.

A **Service by Language View** presents a list of services that offer French with the language details displayed. This feature is accessible from any category service listing page and helpful when looking for language information in addition to French.

French Language Resources is a library of resources with links to Francophone service directories and health, seniors, settlement, education and employment websites.

How to Update your Service Listing or Suggest Resources

Ensuring that accurate information about your services is available to the public and other service providers is important. It's easy for service providers to update or add a new listing through our online submission process. Click the 'Submit Content' link in the upper right hand corner of the site or use the 'Update Your Profile' link on your service profile page. Tips for completing the language information are provided.

If you have a suggestion about a French Language resource or service you'd like to see included on the site, please email us at **editor@thehealthline.ca**.

About SouthWesthealthline.ca

SouthWesthealthline.ca is an innovative website that puts accurate and up-to-date information about health and social services at the fingertips of consumers, health care professionals and service providers across the South West region of Ontario (LHIN 2).

With over 1.5 million visits every year, SouthWesthealthline.ca is a very popular resource. 5,000 service listings describe organizations and programs serving people who live in London and Middlesex, Oxford, Elgin, Huron, Perth, Norfolk, Grey and Bruce Counties.

thehealthline.ca was launched in 2002 by four founding partner organizations in London, Ontario: the Community Care Access Centre, the London hospitals and the Health Unit. With the launch of 14 regional sites across the province in early 2013, one for every LHIN,

Caractéristiques de lignesantéSud-Ouest.ca en matière de services offerts en français

Lignesantesud-ouest.ca a introduit de nouvelles caractéristiques qui facilitent la recherche de renseignements sur les services et autres ressources en français. De nombreuses améliorations en matière de données et de navigation sur le site ont été lancées au printemps 2013 dans le cadre d'une initiative financée par le réseau local d'intégration des services de santé (RLISS) qui réunit ce qui suit :

- Services de santé et services sociaux fournis en français;
- Listes détaillées de ce qu'offrent les services et façon d'y accéder;
- Bibliothèque de ressources;
- Possibilités de carrière pour des candidats ayant des compétences linguistiques en français;
- Conseils sur la façon d'accéder aux services et une vidéo au sujet de la navigation sur le site;
- Recherche en français en visitant le **www.lignesantesud-ouest.ca**;
- Trousse de services en français produite par le RLISS de la région du sud-ouest et d'Érié St. Clair.

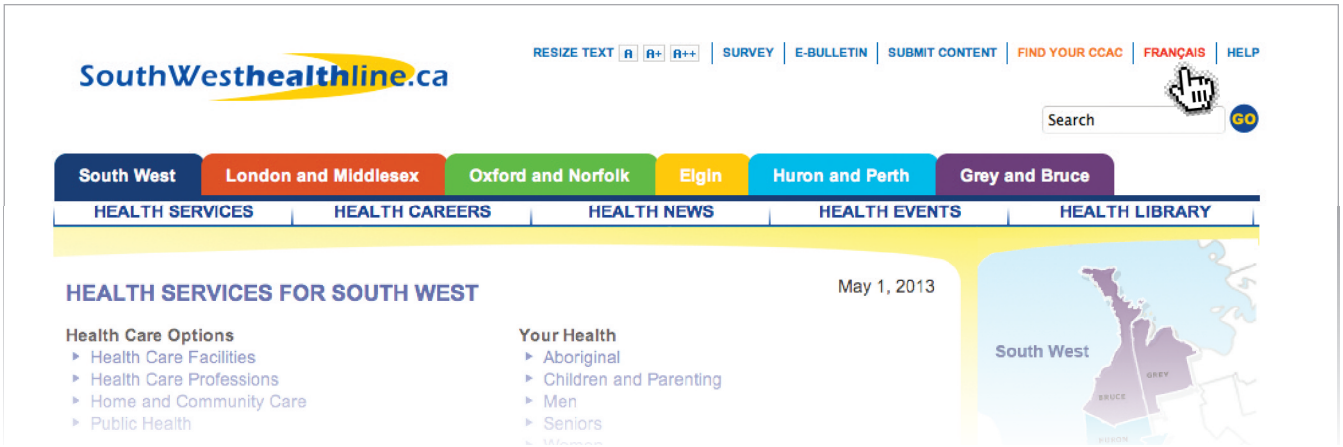
Comment démarrer

Une page d'accueil bilingue présente un menu de toutes les caractéristiques en français et des instructions sur la façon de naviguer sur le site.

Information sur les services accrus

Des renseignements détaillés sur les services en français offerts sont fournis dans les profils des services. On demande aux organisations de fournir des renseignements sur le niveau et le type de services en français qu'elles offrent, comme les suivants :

- Réception y compris recommandation à d'autres services et ressources;
- Programmes exécutés en français;
- Interprétation;
- Sites Web et publications;
- Autres détails fournis à la rubrique Langues - Notes.



Trouver des services en français

Les utilisateurs de lignesantesud-ouest.ca peuvent trouver des services en français en un seul coup d'œil au moyen des caractéristiques suivantes :

Une **icône spéciale** Fr indique les programmes qui sont offerts en français, fournissant un simple repère visuel durant la navigation ou la recherche de services sur le site;

La **recherche en forme libre du site** est entièrement bilingue et suggère des concordances par clé fondées sur la demande de recherche entrée.

Un **répertoire de services** en direct d'organisations et de programmes qui offrent des services en français s'affiche en ne touchant qu'un seul bouton. Le répertoire est divisé en groupes thématiques par catégorie comme : communauté francophone, établissement, traduction et interprétation, services d'information, etc.

Une **vue des services en fonction de la langue dans laquelle ils sont offerts** présente une liste des services notamment en français y compris les détails linguistiques. Cette caractéristique est accessible à partir de toute page de services par catégorie et est utile pour trouver des renseignements linguistiques autres que sur le français.

Ressources en français est une bibliothèque de ressources contenant des liens aux répertoires de services francophones et aux sites Web sur la santé, les aînés, l'établissement, l'éducation et l'emploi.

Comment mettre à jour votre liste de services ou suggérer des ressources

Il est important de s'assurer que des renseignements exacts sur vos services sont accessibles au public et aux autres fournisseurs de services. Les fournisseurs de services peuvent facilement mettre à jour leur information ou y ajouter des éléments au moyen de notre processus de soumission en ligne. Cliquez sur le lien 'Soumettez votre contenu' dans le coin supérieur droit du site ou utilisez le lien 'Mettez votre profil à jour' à la page de votre profil. Des conseils sur la façon d'entrer vos renseignements linguistiques sont fournis.

Si vous souhaitez suggérer l'ajout au site d'une ressource ou d'un service en français, veuillez nous envoyer un courriel à **editor@thehealthline.ca**.

À propos de lignesantéSud-Ouest.ca

LignesantéSud-Ouest.ca est un site Web novateur qui met des renseignements précis et à jour sur les services de santé et les services sociaux à la disposition des consommateurs, des professionnels de la santé et des fournisseurs de services partout dans la région du sud-ouest de l'Ontario (RLISS 2).

Comptant plus de 1,5 million de visites par année, lignesantéSud-Ouest.ca est une ressource très utilisée. Une liste de 5 000 services décrit des organisations et des programmes à l'intention des personnes qui vivent à London et dans les contés de Middlesex, Oxford, Elgin, Huron, Perth, Norfolk, Grey et Bruce.

Le site lignesantesud-ouest.ca a été lancé en 2002 par quatre organisations partenaires fondatrices à London, en Ontario : Community Care Access Centre, hôpitaux de London et l'unité de services de santé. Grâce au lancement de 14 sites régionaux partout dans la province au début de l'année 2013, un dans chaque RLISS, lignesantéSud-Ouest.ca est maintenant un service à l'échelle de toute la province.

Section 9

Resources

Section 9
Resources

Promotional Material

Francophone Resources in Erie St. Clair LHIN

Francophone Resources in South West LHIN

Support Networks and Organizations

Online Advertising

Bilingual or French-language universities and colleges in Ontario

French media per regions in Ontario

Rifssso

cliquezsante.ca

Répertoire des services en français du sud-ouest de l'Ontario

Promotional Material

This toolkit includes samples of items that were produced to support HSPs in the delivery of services in French. These are meant to be used to promote the availability of services in French. Buttons, lanyards and badge pulls are available for French-speaking staff. There are also desk/wall signs for entrance and reception areas.

Medical Badge Pull
available in 2 formats

Button
available with magnet or pin

Lanyard with breakaway closure at the back

Sign

Additional quantities of these promotional items are available by contacting the LHIN's French Language Services Coordinators.

Marthe Dumont
Erie St. Clair LHIN
1 866 231-5446 or 519 351-5677, ext. 3241
Marthe.Dumont@lhins.on.ca

Suzy Doucet-Simard
South West LHIN
1 866 294-5446 or 519 672-0445, ext. 2612
Suzy.Doucet-Simard@lhins.on.ca

Francophone Ressources in Erie St. Clair LHIN[1]

Community Cultural Centres

Centre communautaire francophone de Windsor Essex Kent "Place Concorde", Windsor, 519 948-5545, reception@placeconcorde.org, www.placeconcorde.org

Centre communautaire de Chatham-Kent La Girouette, Chatham, 519 436-1092, cclagirouette@gmail.com

Centre culturel francophone Jolliet, Sarnia, 519 337-3774, info@centreculturelljolliet.com, www.centreculturelljolliet.com

Daycare Centres

Franco-Sol, 11 daycare centres and resource centre, Windsor, 519 948-4339, francosol@bellnet.ca

Garderie « Les petites mains », Windsor, 519 971-6246, lespetitesmains@bellnet.ca

Garderie Petit Pas, Chatham, 519 354-5580 / Pain Court, 519 351-3111 / Stoney Point 519 360-2426 / Tilbury, 519 682-9127 / info@tilburytots.ca / http://tilburytots.ca/

La ribambelle – Saint-Thomas d'Aquin and Carrefour Les Rapides, Sarnia, 1 800 575-0674, info@laribambelle.ca / www.laribambelle.ca

Seniors Clubs *(for name and contact information of club presidents, contact the ESC LHIN French Language Services Coordinator)*

Club Jean-Paul II, Windsor

Club de l'âge d'or de la Résidence Richelieu, Windsor

Club de l'âge d'or Le Foyer, Stoney Point

Club de l'Amitié, Pain Court

Club des aînés la Gaieté, Sarnia

Other Organizations

ACFO de London-Sarnia, 519 332-2600, www.acfo-ls.org

ACFO de Windsor-Essex-Kent, 519 948-9322, www.acfowindsor.ca

AEFO Sud-Ouest catholique, 519 949-2365, www.aefo.on.ca

[1] For other resources, refer to the attached directory produced by *Le Rempart* and *L'Action*.

Carrefour des femmes du Sud-Ouest de l'Ontario, Windsor-Essex-Kent, 519 800-7358 / Sarnia-Lambton-Woodstock, 519 858-0954 / bienvenue@carrefourfemmes.on.ca / www.carrefourfemmes.on.ca

Centre francophone pour immigrants de Windsor-Essex, 519 256-0283

Clinique juridique bilingue Windsor/Essex, 519 253-3526, www.bilinguallegalclinic.com

Club Alouette, 519 945-1189, contact@clubalouette.ca, www.clubalouette.ca

Club Richelieu Windsor, 519 948-5545, trinshed@gmail.com, www.clubrichelieuwindsor.org

Collège Boréal, Windsor, 519 948-6019, www.collegeboreal.ca

Conseil scolaire de district des écoles catholiques du Sud-Ouest, 519 948-9227, www.csdecso.on.ca

Conseil scolaire Viamonde, 1 888 583-5383, www.csviamonde.ca

Employment Options Emploi, 519 988-1766, www.employmentoptionsemploi.ca

Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest, 519 948-1515, www.entite1.ca

Le Rempart, 519 948-4139, info@lerempart.ca or marketing@altomedia.ca, www.lerempart.ca

Place du partage, 519 988-0090, infoplacedupartage@bellnet.ca, www.placedupartage.ca

Réseau des femmes du Sud-Ouest de l'Ontario, Sarnia, 519 332-8897 / Windsor, 519 946-3029 / Essex and Kent, 1 888 946-3029 / rdfso@bellnet.ca

Résidence Richelieu, 519 974-6436, lrr@mnsi.net

Francophone Resources in South West LHIN[1]

Community Cultural Centres

Centre communautaire régional de London (CCRL), London, 519 673-1977, www.ccrlondon.on.ca

Daycare Centres

La ribambelle – La Tamise, Ridgewood, Saint-Jean-de-Brébeuf, Sainte-Jeanne-d'Arc, Marie-Curie and Frère-André – London, 519 472-2334 or 1 800 575 0674, www.laribambelle.ca

Centre francophone de la petite enfance, London www.laribambelle.ca

Seniors Clubs *(for name and contact information of club presidents, contact the South West LHIN French Language Services Coordinator)*

Cercle des copains, London, 519 472 8897, www.cercledescopains.ca

Other Organizations

ACFO de London-Sarnia, London, 519 850-2236, ext. 201, www.acfo-ls.org

AltoMédia (French newspapers in Central South West Ontario), Brampton, 905 790-3229, marketing@altomedia.ca

Carrefour des femmes du Sud-Ouest de l'Ontario, Windsor-Essex-Kent, 519 800-7358 / Sarnia-Lambton-London-Woodstock, 519 858-0954 / 1 888 858-0954 / bienvenue@carrefourfemmes.on.ca / www.carrefourfemmes.on.ca

Centre d'acquisition des compétences et de talents des immigrants francophones de l'Ontario (CACTIFO), London, 519 457-3551, Co.cactifo@gmail.com

Centre canadien de leadership en évaluation - Élargir l'espace francophone (CLÉ), Ottawa 613 747-7021 or 1 800 372-5508, www.lecle.com

Centre de santé intercommunautaire de London, London, 519 660-0874, www.lihc.on.ca

Collège Boréal, London, Citi Plaza, 519 451-5194, www.collegeboreal.ca

Conseil scolaire de district des écoles catholiques du Sud-Ouest, 519 948-9227, www.csdecso.on.ca

Conseil scolaire Viamonde, Toronto, 416 614 0844 or 1 888 583-5383, www.csviamonde.ca

Employment Options Emploi, 519 672-1562, www.employmentoptionsemploi.ca

[1] For other resources, refer to the attached directory produced by *Le Rempart* and *L'Action*.

Entité de planification des services de santé en français Érié St. Clair/Sud-Ouest, Windsor, 519 948-1515 / London, 519 850-4309, www.entite1.ca

Fédération africaine canadienne de London et de ses environs, London, www.acfola.ca

Regroupement multiculturel francophone de London (RMFL), London, rmflondon@rogers.com

Réseau des femmes du Sud-Ouest de l'Ontario, Sarnia 519 332-8897 / Windsor 519 946-3029 / Essex and Kent 1 888 946-3029 / rdfso@bellnet.ca

Vanier Children's Services/Centre d'enfance Vanier, London, 519 433-3101, ext. 228, www.vanier.com

RÉSEAUX ET ORGANISMES D'APPUI
SUPPORT NETWORKS AND ORGANIZATIONS

To help you with your recruiting

Regroupement des intervenantes et intervenants francophones en santé et en services sociaux de l'Ontario
www.rifssso.ca

Réseau franco-santé du Sud de l'Ontario
www.francosantesud.ca

Réseau du mieux-être francophone du Nord de l'Ontario
www.reseaudumieuxetre.ca

Réseau des services de santé en français de l'Est de l'Ontario
www.rssfe.on.ca

Local Health Integration Network (LHIN)
www.lhins.on.ca

Société Santé en français
www.santefrancais.ca

Health Nexus Santé
http://www.healthnexus.ca/index_eng.php

CNFS Consortium national de formation en santé
http://cnfs.net/fr/

Online Advertising

Organizations in Ontario offering online jobs postings.

Cliquez santé
www.cliquezsante.ca/offres
(click on Insérez un nouvel emploi)

Assemblée de la francophonie de l'Ontario
www.monassemblee.ca/fr/Offres_Demploi_Au_Sein_Du_Reseau_Francoontarien_34
(send email and job offers to comm1@monassemblee.ca)

Centre francophone de Toronto
www.centrefranco.org/jobs
(click on Ajouter une offre d'emploi)

FrancoService. Info
www.francoservice.info
(you must become a member to be able to post an ad)

French Language Health Services Network of Eastern Ontario
www.rssfe.on.ca/section.php?ID=8&Lang=En&Nav=Section
(click on clicking here)

Grand Toronto.ca
www.grandtoronto.ca/offresdemploi/?recherche=go
(you must become a member to be able to post an ad)

Health Nexus santé
www.leblocnotes.ca/taxonomy/term/85
(send email and job offers to info.nexussante.ca)

Le réseau du mieux- être francophone du nord de l'Ontario
www.reseaudumieuxetre.ca/index.cfm?Voir=menu&Repertoire_No=2137985358&M=3411
(send email and job offers to info@rmefno.ca)

Société Santé en français
http://santefrancais.ca/index.cfm?Repertoire_No=-661868150&Voir=menu&M=2774
(send email and job offers to a.desilets@santefrancais.ca)

TFO Télévision française de l'Ontario
www.facebook.com/TFOGroupeMedia?sk=app_202980683107053
(you must have a facebook login click on New topic)

Universités et collèges bilingues ou de langue française en Ontario
Bilingual or French-language universities and colleges in Ontario

To help you with your recruiting

La Cité collégiale
www.cnfs.lacite.on.ca

Collège Boréal
www.collegeboreal.ca/programmes-cours/cnfs/

Université Laurentienne
www.cfnslaurentienne.ca

Université d'Ottawa
www.cnfs.ca/uottawa

Collège Glendon de l'Université York
www.glendon.yorku.ca/francais/index.html

Université de Hearst
http://www.uhearst.ca/

Université St-Paul
www.ustpaul.ca/

Collège d'Alfred de l'Université de Guelph
www.alfredc.uoguelph.ca/

École de médecine du Nord de l'Ontario (Affaires francophones)
www.nosm.ca/communities/francophone_affairs/general.aspx?id=3844

Les médias francophones de l'Ontario par régions

French media per regions in Ontario

To help with your job posting

Journaux/ Newspapers

L'Association de la presse francophone (APF)
Network of Canadian French-Language Newspapers
apf@apf.ca
www.apf.ca

CENTRE SUD-OUEST DE L'ONTARIO/CENTER SOUTHWEST ONTARIO

Journaux/Newspapers

L'Action (London)
journaliste@laction.ca
www.laction.ca

Le Goût de vivre (Penetanguishne)
legoutdevivre@bellnet.ca
http://journaux.apf.ca/legoutdevivre

Journal Canora
canoraaa@on.aibn.com
www.canoraaa.com

Le Métropolitain (Durham, Halton and York, Brampton, Toronto, Markham, Mississauga, Newmarket, Oshawa, Pickering, Whitby)

info@lemetropolitain.com
www.lemetropolitain.com

Le Régional (Brantford, Burlington, Cambridge, Fort Erie, Guelph, Hamilton, Kitchener, London, Niagara Falls, Oakville, Port Colborne, Welland, St Catherines)

info@leregional.com
www.leregional.com

L'Express de Toronto
express@lexpress.to
www.lexpress.to

Le Rempart (Windsor)
info@lerempart.ca
www.lerempart.ca

La Tribune de Toronto
latribune@cedap.ca

NORD DE L'ONTARIO/ NORTHERN ONTARIO

Journaux/Newspapers

L'Ours Noir (Cochrane)
www.cochranetimespost.com

Le Nord (Hearst)
lenord@lenord.on.ca
www.lenord.on.ca

L'Horizon (Kapuskasing)
newseditor@kapuskasingtimes.com

Le/The Weekender (Kapuskasing)
newseditor@kapuskasingtimes.com

Tribune (Sturgeon Falls)
tribune@westnipissing.com

Le Voyageur (Sudbury)
levoyageur@levoyageur.ca
www.levoyageur.ca

Les Nouvelles (Timmins)

lesnouvelles@thedailypress.ca
www.lesnouvellestimmins.com

EST DE L'ONTARIO/ EASTERN ONTARIO

Journaux/Newspapers

Le Journal de Cornwall
www.lejournaldecornwall.ca

Agricom (Clarence Creek)

agricom@lavoieagricole.ca
www.lavoieagricole.ca

La Nouvelle (Embrun)
www.journallanouvelle.ca

Le Reflet de Prescott-Russell (Embrun)
info@lereflet.com
www.lereflet.com

La Tribune Express (Hawkesbury)
nouvelles@eap.on.ca
www.tribune-express.ca

Le Carillon (Hawkesbury)
nouvelles@eap.on.ca
www.lecarillon.ca

Le/The Regional (Hawkesbury)
regional@hawk.igs.net

Le Droit (Ottawa) – Daily
editorial@ledroit.com
nouvelles@ledroit.com

L'Express d'Orléans (Orléans, Gloucester)
www.expressottawa.ca

Vision Prescott-Russell (Rockland)
vision@eap.on.ca
www.visionrockland.ca

Voir Gatineau/Ottawa
info@gatineau.voir.ca
www.voir.ca

Rifssso

Regroupement des intervenantes
et intervenants francophones
en santé et en services sociaux de l'Ontario

www.rifssso.ca

Who we are

Le Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario (Rifssso) is a not-for-profit umbrella organization of French-speaking professionals working in the fields of health and social services. Its goal is to develop and support leadership among its members by offering them a variety of activities such as continuing professional development, networking, and so forth. In addition, Rifssso works to raise awareness within government of the challenges facing French-speaking professionals working in these fields.

Vision

To contribute at improving service access, quality, and delivery in the area of French-language health and social services in Ontario.

Mission

Rifssso is a growing network of stakeholders in health and social services that aims at developing and supporting professional leadership in its members.

Programs managed by the Rifssso

Carrières en santé et services sociaux. By its various activities the young Francophone's in Ontario are presented with career options in health and social services.

Cliquezsanté.ca Website where you could easily find a professional or a service in the field of health and social services in French in Ontario. Provides access to applications and job offers.

Esanté-Ontario. Providing quality continuing education by videoconferencing, teleconferencing or live conferences with leading experts. Allows the development of professional skills. The network facilitates the sharing of knowledge among stakeholders and experts.

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Qui sommes-nous

Le Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario est un organisme sans but lucratif qui regroupe les intervenants francophones qui œuvrent dans les domaines de la santé et des services sociaux. Il vise à développer et à soutenir le leadership professionnel de ses membres et ce, en leur offrant une variété d'activités telles que la formation continue, le réseautage et autres. De plus, par différentes démarches, le Rifssso à sensibilisé les instances gouvernementales aux divers enjeux que rencontrent les intervenants francophones dans ce domaine. Pour en savoir plus sur les activités du Rifssso, consultez notre site web à www.rifssso.ca.

Notre vision

Contribuer à améliorer l'accès, la qualité et la prestation des services dans les domaines de la santé et des services sociaux en français, en Ontario.

Notre mission

Le Rifssso est un réseau grandissant d'intervenantes et d'intervenants en santé et en services sociaux qui vise à développer et à soutenir le leadership professionnel de ses membres.

Projets pilotés par le Rifssso

Carrières en santé et en services sociaux. Ses différentes activités permettent de sensibiliser les jeunes Francophones de l'Ontario au sujet des carrières disponibles dans le domaine de la santé et des services sociaux.

Cliquezsanté. ca Site web permettant de trouver facilement un professionnel ou un service dans le domaine de la santé et des services sociaux en français en Ontario. Donne accès aux demandes et offres d'emplois disponibles.

Esanté-Ontario. Offre de la formation continue de qualité, par vidéoconférences, téléconférences ou en face à face, avec des experts de renom. Permet le développement des compétences professionnelles. Le réseau facilite le partage de connaissances des intervenants et des experts.

cliquezsante.ca

French-language Health and Social Services in Ontario At Your Fingertips!

Who uses it, why and how

Individuals

Need services?

- Find a professional in your area who provides French-language health and social services.
- Locate a health or social service program or organization in your area able to serve you in French.

Professionals

Need to network and to know?

- Join a network of French-speaking professionals.
- Read the latest news (e-newsletter).
- Discover new career opportunities.

Service Providers and Managers

Need to let people know?

- Promote the availability of French-language services.
- Refer a Francophone client to a colleague or an organization in your area offering French-language services.
- Advertize job postings free of charge.

Rifssso

CLIQUEZSANTÉ.CA
is an initiative of Rifssso, *Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario*, a provincial network of French-speaking stakeholders and professionals working in the health and social services fields.

Through this initiative, Rifssso helps to improve access to French-language health and social services across Ontario.

For information,
contact Rifssso at
416-968-6759 or
1-800-265-4399 toll free

or by email at
info@rifssso.ca

cliquezsante.ca

Pour trouver en français... en santé et services sociaux... en Ontario !

Qui s'en sert, pourquoi et comment

Individus

Besoin de soins ?

- Trouvez un professionnel qui offre des soins de santé ou services sociaux en français.
- Identifiez un programme ou un organisme de santé ou de services sociaux dans votre région apte à vous desservir en français.

Professionnels

Besoin d'échanger et de savoir ?

- Faites partie d'un réseau de professionnels francophones.
- Tenez-vous au courant des derniers développements (e-bulletin).
- Découvrez des possibilités en matière d'emplois.

Gestionnaires ou **fournisseurs** de services

Besoin de faire savoir ?

- Faites la promotion de vos services en français.
- Référez un client francophone à un collègue ou à un organisme offrant des services en français dans votre région.
- Annoncez gratuitement vos offres d'emploi.

Rifssso

CLIQUEZSANTÉ.CA
est un projet du *Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario* (Rifssso).

Par l'entremise de cette initiative, le Rifssso contribue à faciliter l'accès aux services de la santé et aux services sociaux disponibles en français partout en Ontario.

Pour information,
communiquez avec le Rifssso :
416-968-6759 ou
1-800-265-4399 sans frais.

Ou envoyez un courriel à
info@rifssso.ca

Evaluation of Toolkit and Comments

Name of organization: _____

Name of respondent: _____

Email: _____

For each of the 16 questions below, please put an **X** in the box under the heading that best matches your answer.

How would you rate	Poor	Fair	Very Good	Excellent
The usefulness of the toolkit				
The appearance of the toolkit				
The user-friendliness of the toolkit				
The quality of the toolkit				

How clear is the information in the FLS toolkit with respect to the following	Not at all clear	Somewhat unclear	Somewhat clear	Very clear
The Francophone community				
The active offer of French language services				
The four key result areas defined by the Ministry				
Your requirements as a health service provider				
thehealthline.ca				

See over ▶

How likely are you to use the following tools	Will not use	Might use	Will definitely use	Not Applicable
Promotional items for developing an active offer of French language services (badges, lanyards, signs)				
Fact Sheets on Active Offer				
A Self-Assessment Tool – Implementation of French Language Services				
Staff Survey – French Language Skills				
French language services implementation plan				
Human resources plan				
Health Equity Impact Assessment tools				

What would make the resources more useful?

Please provide any additional comments below:

Please forward to your French Language Services Coordinator.
For Erie St. Clair, Marthe Dumont,
180 Riverview Drive, Chatham, ON N7M 5Z8
Marthe.Dumont@lhins.on.ca.

For South West, Suzy Doucet-Simard,
201 Queens Avenue, Suite 700, London, ON N6A 1J1
Suzy.Doucet-Simard@lhins.on.ca.

Evaluation of Toolkit and Comments