

Implementing Active Offer of Services in Both Official Languages in a Hospital Setting in Ontario

Mise en œuvre de l'offre active de services dans les deux langues officielles dans un milieu hospitalier en Ontario



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Abstract

Providing services in a patient's preferred language is linked to safe and quality care. This paper presents the process and outcomes of implementing practices of active offer (AO) of French-language services in a hospital setting in a region of Ontario with a low density of francophones. Participating unit managers and site coordinators selected AO practices and carried out an implementation plan. The implementation's success was linked to the support

received from higher management and site coordinators. Challenges included the managers' rival priorities and perceived language priorities. This process could be applied to meet the needs of other language communities.

Résumé

La prestation de services dans la langue préférée du patient est liée à des soins sécuritaires et de qualité. Ce document présente le processus et les résultats de la mise en œuvre des pratiques d'offre active de services en français dans un milieu hospitalier situé dans une région ontarienne à faible densité de francophones. Les gestionnaires d'unité et les coordonnateurs locaux participants ont choisi les pratiques d'offre active et ont déployé un plan de mise en œuvre. Le succès de la mise en œuvre était lié au soutien reçu de la part des cadres supérieurs et des coordonnateurs locaux. Les défis rencontrés comprenaient les priorités concurrentes des gestionnaires et les priorités linguistiques perçues. Ce processus pourrait être appliqué pour répondre aux besoins d'autres communautés linguistiques.

Introduction

Language discordance, which occurs when healthcare professionals and patients are not proficient in the same language, is linked to decreased quality of care and patient safety (Bowen 2015; Reaume et al. 2024). Canada has two official languages, and the impact of language discordance has been observed for people whose main language is neither of the official languages and for members of the official language minority communities (OLMCs). OLMCs are groups of people whose preferred language is French but live in English majority-language regions outside the province of Quebec or whose preferred language is English but live in the French-majority province of Quebec (de Moissac and Bowen 2018; Seale et al. 2022).

Many francophones, defined as individuals who have French as their mother tongue or first official language, especially those living in OLMCs, have indicated that they would prefer receiving their health services in French; however, only a smaller percentage will ask for French-language services (FLS) and an even smaller percentage will receive them (Léger 2020). There are several reasons for the low number of FLS requests, including a concern that waitlists are longer (de Moissac and Bowen 2017; Savard et al. 2020) or that services will be of lower quality (Léger 2020). Some francophones may not request FLS as they consider themselves capable in both official languages or more proficient in English. Thus, bilingual francophones may often accept health services in English. Importantly, second-language proficiency at home or at work does not mean that patients are equally proficient in a healthcare context (Itzhak et al. 2017). The resulting language discordance can create challenges. For example, patients may ask healthcare providers fewer questions, have difficulties understanding medical details (Sauvé-Schenk et al. 2024) or experience issues with consent

(Peled 2018). There are many reported situations of francophones being unable to effectively use English in a highly emotional or stressful health situation, for example, when presenting to the emergency room for mental health assistance (Vandyk et al. 2022).

Studies have shown that actively offering services in both official languages can increase the request and use of FLS (Bélanger et al. 2018). Increasing active offer (AO) shows the potential to reduce events of language discordance in a healthcare encounter and increase quality and safety of care. AO is defined as “an invitation, verbal or written, to speak in the official language of one’s choice. The offer to speak in the official language of choice must precede the request for services” (translated from Bouchard et al. 2012: 46).

Canadian provinces have different laws and policies mandating the provision of services in French and English. For example, bilingual services are provided in all publicly funded healthcare organizations in New Brunswick and only in some organizations that are identified or designated by the provincial government in Ontario and Manitoba (Foucher 2017). In Ontario, fully or partially publicly funded health organizations are not automatically designated to offer services in French; rather, an organization can self-identify or be identified by the Local Health Integration Network (LHIN) to receive a designation. Having a designation means that the organization must provide services in both official languages, and being identified implies that the organization is working toward an official designation (Government of Ontario 2023).

Over the past 20 years, there have been governmental efforts to increase access to health services in the official languages, both from the provincial government (e.g., the introduction of prescribed principles of AO under the *French Language Services Act*, 1990 [O. Reg. 544/22]) and from the federal government (e.g., Health Canada’s financial support resulting from the action plans and roadmaps for the official languages [Bouchard et al. 2024]). Société Santé en français (SSF) is one such funded national organization with a mandate to improve access to French-language health services for OLMCs (SSF 2021). Importantly, the SSF was instrumental in collaborating with the national health services accreditation organization to set a new voluntary norm that recognizes access to services in both official languages (Accreditation Canada n.d.).

Several factors can influence the implementation of an innovation, such as the implementation of AO practices in a healthcare site. The Consolidated Framework for Implementation Research (CFIR) presents five domains with constructs that can be used to guide the implementation process as well as understand implementation outcomes (Damschroder et al. 2022a). According to the CFIR, the implementation process can be affected by the innovation itself as well as the determinants, including those related to the inner setting domain where implementation is taking place (e.g., workplace culture); the individuals working in this setting (e.g., motivation); and the outer domain in which the implementation setting exists (e.g., provincial laws) (Damschroder et al. 2022a). This framework also clarifies anticipated versus actual implementation outcomes. Actual implementation outcomes are the adoption of the

innovation, the success or failure of the implementation of the innovation and the sustainment of the innovation over the longer term (Damschroder et al. 2022b).

In English majority-speaking settings, the implementation of FLS is subject to a particular set of contextual factors or determinants (Forgues et al. 2017). For example, determinants from the inner setting include administrative will, human resource availability and organizational policies on language of services, as well as individual factors such as employee perceptions about the importance of providing FLS in their communities. Outer setting determinants include the provincial language policies and the local language needs (Forgues et al. 2017).

Our understanding of how to successfully implement AO practices in healthcare settings continues to be limited, especially in OLMCs where there is a low density of FLS users and low number of French-speaking staff. The objectives of the study were to understand how an organization, via unit managers, can initiate and conduct the implementation of AO practices and to identify the factors that influenced the implementation outcomes.

This paper reports on the implementation process and outcomes of introducing AO of FLS practices in one acute healthcare setting with a low density of FLS users and low number of French-speaking staff.

Methods

Site selection and participant recruitment

To participate in the study, a healthcare site needed to express an interest in improving health services for their francophone patients. Potential hospital sites were approached by the SSF via a general e-mail invitation. Five sites, from communities with a variety of densities of French-language speakers, responded. Three sites initially accepted to participate in the project. Of these, two sites later declined. Reasons were a lack of human resources and a major provincial healthcare restructuring. Hence, this project was carried out in only one hospital located in Ontario.

From this participating site, the research team sought the assistance of local hospital members to act as site coordinators by liaising with the higher administration, unit managers and the researchers. Study participants were the site coordinators and unit managers who were recruited from the units where AO practices could be introduced.

Innovation and implementation process

The first phase of the study served to set up implementation. The managers and site coordinators attended a three-hour workshop, led by the researchers, that focused on language discordance in healthcare, national and provincial language laws and principles of AO of services in both official languages.

The researchers guided the unit managers and the site coordinators to work together to enumerate current AO practices in their hospital and to identify potential additional practices that could be implemented (innovation). They used a list of research-based practices,

derived by the researchers from a literature review, to help conceptualize AO using small manageable practices to choose from. They chose four practices and then created an implementation process plan.

In the second phase, the site coordinators and unit managers began introducing these AO practices in the selected units. A research assistant was available to them at each step to support implementation.

Ethical consideration

Participating hospital's research ethics board approval was obtained (certificate #2017101). Approval was also obtained from the researchers' institutions (certificates # FC-30-11-16 and A04-17-05). All study participants provided written consent.

Data collection

The managers and site coordinators were invited to participate in two semi-structured interviews. The first focused on the workshop's effectiveness, the process for choosing the innovation and the implementation process plan, with a focus on anticipated implementation outcomes (e.g., "What do you foresee will be the challenges or difficulties in implementing your action plan?"). The second interview took place approximately eight months later following implementation of the actions and focused on the perceived outcomes (e.g., "What do you see as the main results of the implementation of this action plan on your unit [impact on the organization, the unit, the personnel, the patients]?").

Data analysis

The data stemming from the recorded semi-structured interviews were transcribed and the verbatims were analyzed using a general inductive approach (Thomas 2006). With this approach, meaning was found both inductively and deductively using the project objective and the main domains and constructs of the CFIR (Damschroder et al. 2022a, 2022b). This framework guided the analysis of the implementation process and implementation outcomes. Data were managed using NVivo 12 software (2018) (QSR International, Doncaster, Australia).

Results

Site and participants

The project was carried out in a regional hospital where AO of FLS practices were not common, located in a region of Ontario with a low density of French-speaking individuals. The regional hospital provides services within a large health district, of which approximately 2% identify as francophone (Ontario Health 2025). The LHIN had recently identified this hospital as an organization that should be offering FLS (NWLHIN 2013).

Three site coordinators supported this study: two upper-level managers and one administrative assistant who was the new FLS officer. These leaders assisted with tasks

such as research ethics board applications, site/researcher communication and participant recruitment.

Managers from the four following units participated in the study: in-patient unit, out-patient clinic, admitting service and staff management office. One manager left their unit (interview UM002) and the incoming unit manager agreed to participate in the study (interview UM006); they reviewed the workshop content with the research assistant. As this is a small hospital and there is a risk of reidentification of the participants, units are not linked to the interviews (Table 1).

TABLE 1. Participants and interview identifiers

Participants	Participant identifier		Participant preferred language of communication
	Participants Interview 1	Interview 2	
Unit managers	UM001 UM002 UM003 UM004	UM005 UM006 UM007 UM008	English unilingual English unilingual/English unilingual English unilingual English preference, also speaks French
Site coordinator	-	SCO09	English preference, also speaks French

The process and outcomes of implementation are described in the following section, guided by the CFIR and focusing on the innovation domain, setting domains (outer, inner and individual), implementation process constructs and indicators of implementation outcomes (Damschroder et al. 2022a, 2022b).

Innovation domain

In collaboration with the participants, the scope of AO was defined. Using the evidence-based list of possible AO practices provided by the research team during the workshop, the managers, with the support of the site coordinators, followed a process to choose practices for implementation. They considered innovation constructs, including adaptability of the practices to their context, complexity and cost.

Are we doing this? Can we do this? Is this doable for us? And we kind of went through [the practices on the list] and then decided which ones we thought we could get done quickly, some things would take a little more time to get implemented, and then [there were] other things that may never, might not be possible. (UM004)

The site coordinator reported that this list of research-based practices prepared by the researchers helped to better understand the concept of AO.

I think that the most valuable piece was the list of suggestions [on] how to make an active offer of French language services and how very easy most of them would be

for managers to implement. [...] Things like identify the people in your unit who speak French, and here's a pin for them. Think about your signage. Very simple and effective. (SC009)

The managers chose to introduce four practices that could be adapted to their individual units and that they thought were relatively low cost and low complexity. These practices were to (1) add French/English bilingual telephone messages; (2) add bilingual signage on the units (large hospital directional signs were already in both official languages); (3) add bilingual educational/informational resources on the units; and (4) have French-speaking unit staff wear lapel pins indicating that they can provide their services in both languages.

Implementation process

The unit managers were initially responsible for leading the implementation of the AO practices; however, the site coordinators took a larger responsibility in guiding implementation because of the managers' pressing administrative challenges and competing priorities from the acute care hospital setting. For example, the timing of the flu season bed-capacity crisis coincided with the implementation. The unit managers stated that this assistance from the site coordinators was an important facilitator for the success of the implementation. "[It was helpful getting reminders from [site coordinators] because sometimes we get overwhelmed with other tasks ...]" (UM008).

The signs [were] easy [...] what I ended up doing was taking pictures of all the signs I had on my unit and sending them to [the site coordinator]. And then she just made arrangements to get them all done bilingual[ly] ... (UM007)

The site coordinators recognized their role in supporting managers with implementation, especially in the context of rival priorities.

[The managers] also knew that, you know, some of those decisions [related to the choice of active offer practices] were made because those were the things that we could provide them the most support in implementing ... I think they just looked at us and said, "Okay, you're going to get our signs translated? Great. Tell me when they're done." (SC009)

A manager recognized additional determinants from the inner, outer and individual domains (CFIR) that facilitated implementation. They stated that higher hospital management supported implementation of AO practices because their organization was identified for designation by the provincial government. This facilitated access to external support services, such as translators, information technology technicians and facility management,

to carry out implementation. Additional costs were also incurred, and delays occurred in the implementation calendar because of these external services.

Implementation outcomes

The unit managers and site coordinators identified that their implementation was successful and that there was concrete evidence from the implementation of the four practices, for example, translated education materials on their units.

While the unit managers adopted the innovation and played a key role in the successful implementation of outcomes, several of them reported having doubts about the importance of the implemented practices for OLMCs in relation to other hospital priorities and questioning their impact.

To be 100 per cent honest, here at the [hospital], in my nineteen years of working for this organization, I have never really come across a French-speaking patient [who] was unable to communicate in English. So, it hasn't been, like, I haven't really necessarily seen a benefit. (UM002)

You know, we've made those changes, but did it have any effect on anybody [who] is a French-speaking person? I don't know. Because ... did we ask any of our patients when they were discharged, "Did you notice our signage is now in English and French? [D]id it enhance your experience? [W]as it something that you found helpful?" (UM007)

Nevertheless, the site coordinators championed the project and reported feeling motivated to implement additional AO practices. "... we've [site coordinators] gone beyond the parameters of the research project to actively offer French. And we're motivated. I think [...] the primary piece for me is [that] I want to keep going". (SC009)

The site coordinators self-initiated the implementation of two additional AO practices. The first was "Welcome/Bienvenue" signs at all patient contact points with instructions guiding clerks on how to obtain French-interpretation services for the patients. The second was the addition of, in English-language pre-operative letters sent to patients, a French sentence informing patients that they can contact the FLS officer for clarifications or a French version of the letter. The site coordinator explained the positive impact of the addition of this sentence in the letters for a particular patient for whom they were able to organize interpretation services.

So, had we not included that information [to call the FLS officer] and had [the patient] not called, he would have shown up for his appointment. [...] He would have not been prepared for the procedure. He would have been on the medications [he was instructed to cease one week prior to the appointment]. He would have been

sent home. He would have been extremely frustrated. The hospital resources would have been wasted. (SC009)

The coordinators also began transferring lessons learned to other minority-language groups. For example, they set up a centralized list of francophone staff who could provide services in French and added workers who could provide services in other languages spoken in that region.

So, in addition to a list of staff who speak French and English, we have a list of staff who speak Finn[ish] and Italian and Ukrainian, etc. So, that information is housed in the same place, on the Intranet, as the list of francophones or French-speaking staff. So, if you know the process to have somebody attend and provide service to a patient in French, you know the process for Italian or whatever [language]. (SC009)

Managers reported being concerned about the sustainment of AO practices that were linked to their limited number of French-speaking staff in the organization. "... We don't have any French-speaking staff in this department" (UM008). Even with established language priorities, they were unable to fill their French-language positions. "[French speaking] Clerical [staff]? I have none. And that's not for lack of, you know, I know every posting that we put up, you know, French language is one of the criteria" (UM004).

Sustainment was also at risk because of the managers' general lack of conviction that the francophone population had priority needs to be addressed compared with the region's other language groups.

We have a large Indigenous population in [this region]. There's a lot of Indigenous people [who] do not speak any English. We have a large Italian population, a large Finnish population ... But I haven't come across a French family or a French patient [who] doesn't speak English. (UM008)

The site coordinator reported that three of the practices would be sustainable: the bilingual signs, educational materials as well as the telephone messaging system, because these practices were now integrated into formal hospital processes and did not rely on French-speaking staff. "Every single new and newly revised patient education material [now] goes through the translation process, and it's not approved until it is bilingual" (SC009).

Discussion

Respecting language of preference is a key tenet of providing health services in an officially bilingual country such as Canada, a central concept of patient-centred care (Picker Institute 2024) and a recognized element of quality of care (Accreditation Canada n.d.). Actively

offering services in both official languages is therefore an important step toward meeting the needs of the OLMCs.

This project served to improve our understanding of the key factors that influenced the implementation of AO of FLS practices in an Anglo-dominant regional hospital in a low-density francophone region of Canada. The main factor influencing the successful implementation process and its outcomes, specifically the sustainment of the AO practices, was support from higher administration and site coordinators.

We originally planned to have the acute care unit managers lead the implementation process. Since they were closest to those patients who would benefit from AO, we believed that they would be best to spearhead the process. The managers were fully engaged in identifying needs and priorities and determining the chosen practices for implementation, which likely increased the acceptability and adoption of the practices in their units (Damschroder et al. 2022a, 2022b). However, as the process of implementation progressed, roles needed to be redefined to adapt to the setting's rival priorities and limited resources, and the site coordinators took charge of concrete tasks and directed the implementation process to completion.

The project seemed to have minimal influence on the managers' beliefs about the importance of AO of services in both official languages. Vézina (2017) suggests that the best way to encourage such a change in attitudes toward FLS is to link the importance of the change to quality and safety, which are values of patient-centred care common in most healthcare organizations. This minimal conviction on the part of the managers was offset by the support of higher hospital administration (Forgues et al. 2017; Sawang and Unsworth 2011), who, during the study, created an FLS officer position and met with the research team to discuss implementation and offer additional resources. The site coordinators also acted as internal champions of AO and FLS and had a positive influence on effectiveness of the implementation (Greenhalgh et al. 2004; Miech et al. 2018). While healthcare professionals need to be aware of the importance of the principles of AO of services in both official languages and be willing to adopt such behaviours, this type of high-level managerial support has been shown to be critical in inciting employees to enact AO (Savard et al. 2017).

Sustainment of FLS innovations can be influenced by factors such as lack of staff buy-in and resource challenges, specifically limited bilingual staff (Drolet et al. 2014). Sustainment, which is an implementation outcome that refers to the innovation being delivered over the long term (Damschroder et al. 2022b), was also supported by higher administration as they allowed the official integration of several of the AO practices into the hospital processes.

While this project reinforced the participants' understanding of official language laws and policies and understanding of the role of language in patient-centred care, it also encouraged them to recognize that similar practices and strategies could be applied to support the language needs of other minority-language groups receiving services in their hospital (e.g., asking language of preference at the admission, suggesting translation/interpretation services).

This project's approach to implementation of AO practices was used in a region with low density of francophones, but could be applied in other OLMCs, with possible increased success in areas with higher density of francophones. More specifically, in such high-density areas, units would be more likely to admit French-speaking patients and have less difficulty hiring a minimal number of bilingual staff, which in turn may increase unit managers' ownership of practices needed to meet the needs of this population. This should be confirmed in future studies.

While the CFIR highlights the importance of gathering outcome data from innovation deliverers and key decision makers, as they have the most influence on success of the implementation, the voices of innovation receivers should be collected when possible (Damschroder et al. 2022b). An important limitation of this study was this lack of data from francophone patients. A future study could focus on their experience of AO practices and on their perception of the benefit and importance of AO practices.

Based on our experiences, the following are the recommendations to facilitate implementation processes and outcomes:

1. At project onset, secure buy-in from higher administration and site coordinators.
2. Support innovation deliverers, such as the unit managers, to have a good understanding of local language laws and policies and of the link between language and patient-centred care. Adding examples taken from their own setting of local francophone patients' communication barriers in the initial workshop may be helpful to positively change their beliefs about the importance of the implementation in their region.
3. Encourage the transfer of AO practices designed for OLMCs to help meet the needs of other language minority groups.
4. Support the organization to define their needs: Where will actions have the most impact? Which actions are more feasible to implement (e.g., choosing practices at the level of the healthcare professionals or more centralized actions such as signage)? Provide a list of tangible research-based AO practices that can be adapted to the local context. Considering current limitations in the healthcare setting, ensure that suggested actions have varying resource requirements.

Conclusion

Ensuring that healthcare services are actively offered in the patient's preferred language is a basic tenet of patient-centred care. Anglo-dominant health organizations in low-density francophone regions who are mandated to provide FLS may benefit from support to implement practices of AO of services in both official languages. This project outlined a process for implementation and served to improve our understanding of the key determinants that influence the success of this type of implementation, particularly the significance of support from higher administration and site coordinators.

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