Santé en français ÊTRE BIEN DANS SA LANGUE

Linguistic Competence and Quality of Services

Business Case for Quality French-Language Health Care Services

Prepared for Santé en français
By Hubert Gauthier in collaboration with Marc-André Reid Triantafyllos

Santé en français

As official representative of Manitoba's Francophone community in the areas of health and social services, Santé en français (formely known as Conseil communauté en santé du Manitoba) plays a leadership role in facilitating and promoting access to high quality French-language health and social services. Santé en français is part of the national French-language health services movement across the country.

Santé en français works as a catalyst with partners in finding innovative solutions towards access to high quality French-language care and services.

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Purpose of the report

The purpose of the report is to provide those interested or involved in developing French-language health care services in minority communities, with the tools and rationale needed to demonstrate the importance of these services and their impact on the health of Francophone minority communities, particularly in Manitoba.

Approach

Writing this report involved a process consisting of a literature review and community consultations.

Background and components of an effective system

Background information on access to French-language health care services

- Several studies show that language barriers have a direct impact on the health of Francophones in minority communities in Canada.
- This issue is one of the leading concerns of Francophone minority communities,[1] which represent nearly one million people in Canada (outside Quebec).
- Since 2000, the matter has received more and more attention from researchers and organizations across Canada.
- According to the Fortier and Gauthier report (2001) "between 50% and 55% of Francophones in minority communities often have little or no access to health services in their mother tongue." [2]

In this context, it seems appropriate to gather all the arguments and strategies from the studies, research and projects published to date, and the field experience of many who have worked and continue to work on implementing quality French-language health care through Francophone minority communities across Canada.

Components of an effective system

Research shows that the development of an efficient system for accessing French-language health services involves four components:

1. *Clinical* component;
2. *Organizational* component;
3. *System* component;
4. *Community* component.

It is important to emphasize that action should be taken on all four components at once rather than one at a time, because each component has its own responsibilities, as illustrated in the summary table on the next page.

Impacts and implications of French-language health care services

Linguistic competence comes down to providing quality services to the population. This issue must not be considered separately and seen as a privilege claimed by minorities, *"but as a fundamental issue, identified by the recognition of a right to equitable, accessible and quality health care."* [3]

Direct impact on health care

- Reduced recourse to preventive services;
- Increased consultation time, number of diagnostic tests and likelihood of diagnostic and treatment errors;
- Reduced probability of treatment compliance;
- Reduced satisfaction with the care and services received;
- Reduced quality of care and outcomes.

[1] *FORTIER, Marie E. and GAUTHIER, Hubert (2001). Report submitted to the Federal Minister of Health, Consultative Committee for French-Speaking Minority Communities.*

[2] *Idem, p. 3.*

[3] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, *Critical analysis of the literature] Submitted to Société Santé en français.*

Component	Description	Characteristics	Responsibilities
Clinical	• Patient – health care professional relationship • Interpersonal communication • Clinical decision-making process • Patient – provider trust	• Self-awareness and awareness of one's personal value system • Understanding the concept of culture • Sensitivity to cultural issues • Comprehension and ability in using specific methods to deal with cultural issues • Excellent understanding of one's own culture	• Develop attitudes, behaviours and knowledge that create a quality therapy relationship
Organization	• Health care organization management • Board leadership • Strategic priorities • Service planning • HR allocation and finance	• Active community representation and participation at all levels • Integration of linguistic competence within the organization's systems • Adopting a gradual approach to change • Leaders' commitment • Continuing education	• Establish an environment, policies, resources and training to provide appropriate services • Implement policies and a learning environment that recognize the role of linguistic competence
System	• Health system and social system • Government bodies (departments and agencies) • Health policies • Social policies	• Valuing diversity • Ability to assess oneself • Aware of the specific intercultural dynamics • Institutionalizing the knowledge of cultures • Adapting to the cultural needs of clients	• Introduce expertise, resources, policies and reporting methods for the organizations within the system
Community	• Level of community organization • Defending one's rights • Involvement of its members	• Bridge between the system, the organizations and the community • Proactive representatives • Involvement in committees • Knowing and asserting their rights	• Manage one's own development • Contribute to the development of linguistic competence • Participate in the system

Indirect impact on health care

- Under-representation of linguistic minorities in clinical research and research on health services;
- Reduced health care provider satisfaction;
- Increased health system costs.

Implementation of French-language health care services

Legal context

The legal context, which includes collective agreements, and provincial and national laws and policies, is regularly cited as an obstacle to developing the offer of French-language care services in facilities.

However, a recent study of the case law on the subject[4] made the following key findings:

- Collective agreements do not generally impede the designation and staffing of bilingual positions;
- Case law shows that it is possible and within health facilities' power to designate bilingual positions, if it is shown that the skill at issue is reasonably related to the needs of the population and that management is acting in good faith when imposing this type of designation;
- The number of positions that may be designated by a bilingual facility is at its discretion and no collective agreement can prevent these types of designations, if the terms and conditions stated in the initial finding above are met;
- In the vast majority of documented cases on the issue of designating or staffing a bilingual position, case law shows that linguistic competence is more important than seniority when the terms and conditions of the initial finding above are met.

Potential solutions and best practices

- Introduction of guidelines in collective agreements;
- Managers exercise their management rights regarding the designation and staffing of bilingual positions;
- Introduction of Canadian national standards similar to those in the U.S. (see Appendix B for the complete list of U.S. standards).

Legitimation measures

In a context where institutions must manage multiple health system priorities, it is sometimes difficult to make people understand why offering quality French-language services is so important. As such, it is always necessary to introduce legitimation measures.

Potential solutions and best practices

- Conduct awareness activities on a regular basis;
- Include linguistic and cultural competence as variables in studies and research;
- Gain recognition and support from all levels of government.

[4] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

Recruitment strategies

Recruiting competent staff is probably the biggest obstacle to developing a range of quality French-language services. A Hubert Gauthier Conseil Gestion[5] study produced the following findings:

- New graduates are more interested in working in urban acute care facilities and significantly less interested in rural and long-term care facilities.
- The shortage of bilingual staff mainly affects rural areas and long-term care facilities.
- Although there are staffing policies, there is no real recruitment strategy tailored to the needs of the community.

Potential solutions and best practices

- The following strategies were proposed in the Armand Boudreau report: [6]
    1. Early and sustained intervention with students;
    2. Promotion of innovative use of Francophone human resources;
    3. Synergy with the programs and guidelines for the entire system;
    4. Support for human resources research and planning in Francophone minority communities;
    5. Programs that provide adequate multiyear financial support.
- The Aucoin report[7] proposes the following strategies for facilitating recruitment:
    1. Facilitate the admission of candidates from linguistic and cultural minority communities in health science faculties;
    2. Facilitate recognition of diplomas of health professionals who have studied abroad.
- In the context of the Manitoba Nursing Strategy, Santé en français has, for its part, created a financial incentive project to help recruit and support bilingual nurses in Manitoba Regional Health Authorities (RHAs).
- The Hubert Gauthier report commissioned by Santé en français[8] proposed that a round table be established with the key players involved and more importantly those who are interested, as a forum for discussing strategy and adjustments to ongoing recruitment activities.

[5] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

[6] *BOUDREAU, Armand (2007).* A Master Plan for the Deployment of Francophone Health Human Resources in Minority Francophone Communities, *report commissioned by Health Canada.*

[7] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français, p. 18.*

[8] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

Community involvement

Developing quality French-language service delivery is impossible without the active participation of the communities for which these services are intended. Lack of community involvement helps strengthen the perception of some workers in the health care field that it is not necessary to provide these people with French-language service since they already speak English. The community has an important leadership role to play as a representative of the needs of the population in the area of health services.

Potential solutions and best practices

- "Inform these populations that they have the right to be served in their language and that it is a fundamental part of service quality;
- Build coalitions and create bridges between community groups, health professionals and health organizations;
- Identify the type and level of services, as well as the access procedures, which should be provided to the community in its own language, locally or elsewhere;
- Seek the support and participation of community residents, the media and local, regional, provincial and national politicians;
- Introduce cultural brokers, i.e. 'community representatives or facilitators who can act as liaison officers, cultural guides, mediators and catalysts for change.'" [9]
- Santé en français has, for its part, decided to involve communities by creating regional round tables on various topics concerning them.

Concerns in the field

This section of the report answers 20 of the specific questions most commonly asked in the field. A Question & Answer tool based on this section of the business case report has been developed and made available to interested parties on the Santé en français website. Here are some of the main questions answered in this report:

- *Francophones in a minority community are often bilingual, why would they need French-language services?*
- *When hiring, does bilingualism have to take precedence over other factors such as seniority, clinical skills, etc.?*
- *Do the rules of collective agreements and laws impede the designation and staffing of bilingual positions?*
- *Why not just use interpreters instead of requiring a bilingual employee?*
- *Bilingual people fear that if they identify themselves as bilingual, they will have to work harder. What should we tell them?*
- *What course of action should be taken when nobody can be found to fill a designated bilingual position?*
- *Isn't it more important to meet a patient's health needs before trying to meet a language requirement?*

[9] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français. p. 20-21.*

Conclusion

This business case report has attempted to demonstrate the relationship between linguistic competence and the quality of health care services. Once this relationship has been established and accepted, it becomes clear that pitting "linguistic competence" against "clinical priority" is equivalent to agreeing to provide lower quality services for the sake of clinical priority. Here are the key findings of the report:

- Developing an efficient health care system requires action at all levels of the system: at the individual, organizational, systemic and community levels, each of which has specific responsibilities to fulfil.
- Linguistic competence comes down to providing quality services to the population. This issue must not be considered separately and seen as a privilege claimed by minorities, "but as a fundamental issue, identified by the recognition of a right to equitable, accessible and quality health care." [10]
- It is clear that failure to provide services to clients in their mother tongue runs counter to the public good.
- Language barriers reduce health care provider satisfaction and increase health care system costs.
- Language barriers have more impact on the quality of care than do cultural barriers.
- Contrary to popular belief, legal considerations do not significantly impede the designation and staffing of bilingual positions. Managers must fully exercise their management rights and governments must support them in concrete terms, through reporting policies and procedures.
- A number of best practices should be introduced at all levels to increase the legitimacy of French-language health care services.
- Recruiting minority staff requires specific strategies involving all partners.
- The community has an important leadership role to play as a representative of the population in the area of health services.

[10] *AUCOIN, Léonard (2008)*. Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français. p. 20-21.*

Introduction

Purpose of the report

The purpose of the report is to provide those interested or involved in developing French-language health care services in minority communities, with the tools and rationale needed to demonstrate the importance of these services and their impact on the health of Francophone minority communities, particularly in Manitoba.

In addition to this general objective, this report seeks to achieve the following sub-objectives:

- *Propose a common language, discourse and approach to discussions that will help create a shared vision and a common approach to issues relating to French-language health care services;*
- *Demonstrate the relationship between linguistic competence and the quality of French-language care and services;*
- *Identify the main obstacles to implementing a range of French-language health care services that meets the needs of Francophone communities in Manitoba;*
- *Conduct an inventory of best practices and propose concrete solutions to overcome these barriers.*

By setting the above objectives, this report sets itself apart from other studies and research through its comprehensive approach to issues relating to the offer of French-language care services. In addition, this report reflects as closely as possible the daily situation of the players affected by and involved in French-language health care services and seeks to address practical issues faced by these people in the performance of their duties – for health care managers, public servants and workers alike.

It should be noted that the purpose of this report is not to make recommendations, but to propose the best practices identified for each obstacle listed and provide potential practical solutions.

We also wish to clarify that this report is the first phase of a broader strategy to develop a range of tools and resources for providers wishing to develop access to French-language care services. This report will provide a baseline for these tools and resources.

Approach

Writing this report required a process consisting of two major steps, a literature review and community consultations.

First, a literature review was conducted to gather key documentation on the issues surrounding access to French-language health services. The documents used are listed in the bibliography of the report and cited in the appropriate places throughout the text.

Group interviews were conducted to complement the literature review and provide a "field" perspective on issues regarding access to French-language care services. The interviews also identified the issues and barriers faced by providers in their respective communities.

Following completion of this report, it will be possible to develop various tools and make them available to those involved in developing access to quality French-language health care services.

Report structure

This report is divided into five main sections:

1. Background and components of an effective system: The first section provides a brief overview of the context of French-language health care services and presents the main components of an effective system in terms of access to French-language health care services.

2. Impacts and implications of French-language health care services: The second section describes the important relationship between linguistic competence and the quality of French-language care services, and the direct and indirect impacts on patients and the health system, demonstrating the importance of providing quality French-language health care services.

3. Implementation of French-language health care services: The third section deals with the major barriers identified in the literature and in the field, i.e. the legal context, recruitment strategies and legitimation associated with the development of health care services for each of these issues and suggests possible solutions and the best practices identified.

4. Concerns in the field: The fourth section provides some answers to the main questions asked in the field, as raised in the group interviews.

5. Conclusion: Finally, the fifth section concludes the report by reviewing the key findings and providing food for thought for future development of access to quality French-language health care services.

1. Background and components of an effective system

1.1 Background information on French-language health care services

Since the early 2000s, researchers and organizations across Canada have been focusing more closely on access to and the quality of French-language health care services. Every year, many reports, studies and research projects are published on the subject and provide insight into the challenges and issues surrounding this topic, which is one of the leading concerns of Francophone minority communities.[11]

These communities now represent nearly one million people across Canada – about 4% of Canadians outside Quebec.[12] These statistics do not include immigrant populations, increasingly present in these communities and whose second language is often French rather than English. These people also have access to French-language health care services. Although the *Canada Health Act* of 1984 stipulated that all Canadians were entitled to the health care services they needed, studies show that inequalities exist in terms of the quality of care received by majority Anglophone communities on the one hand and minority communities on the other. In the 1970s, professionals and analysts agreed that *"linguistic and cultural barriers impede effective delivery of services."* [13] This had direct repercussions on the health of these populations. In 2001, a report to the federal Minister of Health stated that "studies on a number of determinants have shown that the health status of minority Francophones is generally poorer than that of their fellow citizens in any given province." [14]

To combat these inequities and improve the quality of care provided to minority Francophone populations, increasing numbers of initiatives and organizations are emerging across Canada. Organizations like Société Santé en français, which has 17 community networks across the country, and initiatives such as Health Canada's *Language training and cultural adaptation program* (LTCA) are two concrete examples of initiatives that contribute to the development of access to French-language health services in Canada.

Despite the efforts and actions undertaken, the Fortier and Gauthier report (2001) stated "that between 50% and 55% of Francophones in minority communities often have little or no access to health services in their mother tongue." [15]

As well, there are still no laws or national standards governing access to French-language care services. This is partly due to the fact that the provinces are responsible for health care. Since each province is free to establish its own code of ethics to which health professionals must comply, the extent to which the requirement for access to French-language health services is binding depends on the legal and political context of the province.[16] The quality of these services therefore varies significantly from one region to the next.

Provincial boundaries make it difficult to coordinate a national effort and blunt the impact of initiatives. This situation also makes it difficult to create a common vision around the issue of access to quality French-language health care, which is crucial to developing this access. In this context, organizations and national initiatives such as the Société Santé en français network are essential for greater consistency between these jurisdictions in terms of existing services, policies and systems for developing access to French-language care services.

In the United States, the issue of linguistic and cultural competence has grown significantly, particularly since the early 1990s. Long before then, the government had found significant disparities between minority populations and the white English-speaking majority. Thus, for more than 20 years, the government has been implementing

[11] *FORTIER, Marie E. and GAUTHIER, Hubert (2001). Report submitted to the Federal Minister of Health, Consultative Committee for French-Speaking Minority Communities.*

[12] *2006 Census, Statistics Canada, www.statcan.gc.ca/start-debut-eng.html*

[13] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français, p. 4.*

[14] *FORTIER, Marie E. and GAUTHIER, Hubert (2001). Report submitted to the Federal Minister of Health, Consultative Committee for French-Speaking Minority Communities*

[15] *Idem, p. 3*

[16] *FORGUES et al. (2011). The Offer of Health Services in French in Minority Context, Canadian Institute for Research on Linguistic Minorities (CIRLM).*

many programs and requiring that the health community develop these competencies and continuously improve the quality of the care services provided to these populations. Federal organizations such as the *Office of Minority Health, The Center for Linguistic and Cultural Competence in Health Care* and the *National Center on Minority Health and Health Disparities* are responsible for monitoring changes in disparities and developing solutions to improve the situation. National standards have also been introduced and government funding is conditional on meeting them. Thus, as mentioned in the Aucoin report, "In the United States, the concept of cultural competence has grown from an interpersonal dimension to an organizational and systemic dimension." [17]

Given the context described above, it seems appropriate at this stage, to gather all the arguments and strategies from the studies, research and projects published to date. The field experience of many who have worked and continue to work on implementing quality French-language health care through Francophone minority communities across Canada will complement the information gathered. We believe that this rationale will help establish this common vision.

1.2 Components of an effective system

The four components of an effective system

Research shows that developing an efficient system for accessing French-language health services involves four components:

1. Clinical component: refers to the relationship between the patient and health care professional, interpersonal communication, the clinical decision-making process, both the patient's and the provider's beliefs and behaviours, and the trust between patient and intervener, etc.

2. Organizational component: refers to the variables relating to health care organization management, including leadership of the board and management team, strategic priorities, service planning, allocation of human and financial resources and the implementation of care procedures. The organization's role is to facilitate the implementation of an approach to linguistic competence among its members.

3. System component: i.e. (1) the health care system, and more generally (2) the social system. In terms of the health system, this component refers not only to governing bodies such as departments and agencies, but to all players in the system, including health professional training programs. In terms of the social system, several determinants of health lie outside health organizations, such as socioeconomic status, education and employment. It is therefore necessary to examine health (promotion, prevention, care and rehabilitation) and social policies based on the linguistic and cultural characteristics of the affected communities.

4. Community component: This final component refers to the community's organization, its general level of organization, protection of its rights, and its members' involvement and willingness to participate.

[17] *AUCOIN, Léonard (2008)*. Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français, p. 5.*

The characteristics of each component

For each of these components, characteristics are used to describe what it means to be linguistically competent, and therefore provide access to quality health services.

1. Clinical component

Sarah Bowen (2000) proposed the main essential elements for becoming a linguistically and culturally competent health care professional.

- *Self-awareness and awareness of one's personal value system;*
- *Understanding of the term culture and its place in a health care setting;*
- *Sensitivity to the cultural issues of each individual client;*
- *Comprehension and ability in using specific methods to deal with cultural issues;*
- *Excellent understanding of one's own culture.*[18]

2. Organizational component

Some guiding principles, set out by Wu and Martinez in their study for the Commonwealth Fund[19] can provide a framework for implementing these competencies in a service delivery organization or health professional school, including:

- *Community representation and active participation at all levels of the organization to provide a better understanding of patient needs, help allocate resources effectively and establish the necessary systems to hold the organization accountable for providing quality services;*
- *Linguistic and cultural competence must be integrated into all systems of a health care organization, particularly quality improvement efforts, so that they are not treated as a separate issue, but are viewed as integral and incorporated into all aspects of the organization;*
- *Adoption of an approach of gradual change where changes must be manageable, measurable and sustainable relative to the organization's capacity for change;*
- *Demonstrating the cost effectiveness of the benefits is a critical element for change, using accessibility, quality and patient satisfaction data as well as the benefits for the community;*
- *The commitment from leadership is a key factor in an organization's ability to integrate cultural competency among its members;*
- *Ongoing staff training is crucial to successful cultural competency efforts.*

3. System component

According to the Cross et al. study,[20] a care system that values linguistic and cultural competence has the following characteristics:

- *It values diversity;*
- *It has the capacity for cultural self-assessment;*
- *It is conscious of the dynamics inherent when different cultures interact;*
- *It has institutionalized cultural knowledge;*
- *It has developed adaptations to diversity.*

4. Community component

In terms of the community component, an engaged community has the following characteristics:

- *Its members are the bridge between the system, organizations and their community;*
- *Its members are proactive representatives of French-language care services;*
- *Its members are involved in care organization committees to ensure that their needs are clearly understood;*
- *Its members know their rights and claim them in health institutions.*

[18] *BOWEN, Sarah (2000).* Introduction to Cultural Competence in Pediatric Health Care, *Prepared for Health Canada, Government Services Canada.*

[19] *WU, E. and MARTINEZ, M. (2006).* Taking Cultural Competency from Theory to Action, *The Commonwealth Fund.*

[20] *Cross, T.L., Bazron, B.J., Dennis, K.W., Isaacs, M.R.* Toward a Culturally Competent System of Care. Volume 1. *National Institute of Mental Health, Child and Adolescent Service Program (CASSP) Technical Assistance Center, Georgetown University Child Development Center, 1989*

Each level's responsibilities

In terms of the components and characteristics mentioned above, the complexity of the problem involves many levels of responsibility that extend far beyond the individual responsibility of health and social services providers.

1. Individual responsibility: Develop attitudes, behaviours and knowledge that enable individuals to create a quality care relationship with patients and their families who speak a different language and come from a different cultural background. At this level, training and outreach activities play a major role.

2. Organizations' responsibility: Provide an environment, policies, resources and training to deliver services in their patients' language. Every organization that contributes to and influences the delivery of health care and services to diverse communities must have policies and a learning environment that recognize the role of linguistic competence in the delivery of quality health care. Continuous staff training is an essential component of successful linguistic and cultural competence programs.

3. System's responsibility: Introduce expertise, resources, policies and reporting methods for the organizations within the system, which value diversity and adapt to the needs and preferences of clients of various cultures.

4. Community's responsibility: Must manage its own development and help develop linguistic and cultural competence through its participation in the system, whether it relates to governance, management or the delivery of care and services. Ties with the various communities are therefore important in continually meeting their specific needs and developing relationships based on mutual trust. [21]

Highlights

Developing an efficient health care system requires action **at all levels of the system**: at the individual, organizational, systemic and community levels, each of which has specific responsibilities to fulfill.

[21] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

Component	Description	Characteristics	Responsibilities
Clinical	• Patient – health care professional relationship • Interpersonal communication • Clinical decision-making process • Patient – provider trust	• Self-awareness and awareness of one's personal value system • Understanding the concept of culture • Sensitivity to cultural issues • Comprehension and ability in using specific methods to deal with cultural issues • Excellent understanding of one's own culture	• Develop attitudes, behaviours and knowledge that create a quality therapy relationship
Organization	• Health care organization management • Board leadership • Strategic priorities • Service planning • HR allocation and finance	• Active community representation and participation at all levels • Integration of linguistic competence within the organization's systems • Adopting a gradual approach to change • Leaders' commitment • Continuing education	• Establish an environment, policies, resources and training to provide appropriate services • Implement policies and a learning environment that recognize the role of linguistic competence
System	• Health system and social system • Government bodies (departments and agencies) • Health policies • Social policies	• Valuing diversity • Ability to assess oneself • Aware of the specific intercultural dynamics • Institutionalizing the knowledge of cultures • Adapting to the cultural needs of clients	• Introduce expertise, resources, policies and reporting methods for the organizations within the system
Community	• Level of community organization • Defending one's rights • Involvement of its members	• Bridge between the system, the organizations and the community • Proactive representatives • Involvement in committees • Knowing and asserting their rights	• Manage one's own development • Contribute to the development of linguistic competence • Participate in the system

2. Impacts and implications of French-language health care services

This section seeks to show the relationship between linguistic competence and the overall quality of health care and services, and describe the main principles for developing access to French-language health care for Francophone minority communities.

2.1 Relationship between linguistic competence and the quality of health care and services

Studies conducted by renowned Canadian researcher Sarah Bowen have shown that "language and cultural barriers 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.*" [22]

As mentioned in the Aucoin report (2008),[23] a Commonwealth Fund report[24] uses the six principles of quality health care recognized by the Institute of Medicine (IOM) to illustrate how linguistic competence is related to quality of care:

- Safety: "Patient safety is not solely about not making errors in care delivery (such as administering the wrong medication or dosage). It also entails avoiding misdiagnosis, protecting patients from exposure to unnecessary risks and ensuring that the patient can provide informed consent. Hence the importance of clear communication between health professionals and patients, taking into account their language and culture. The professional–patient relationship must ensure that the words are clearly understood, as well as the context and impact of diagnosis and treatment decisions. Developing linguistic and cultural competence, both in terms of health professionals and health organizations, is essential to allowing patients to participate in safe clinical decision-making.
- Effectiveness: Two aspects of cultural competence can play a role in improving the effectiveness of care, according to Betancourt. First, care systems need access to information systems to enable them to detect care and health disparities based on the linguistic and cultural characteristics of populations. Second, effective care requires that health care providers be able to ascertain patient preferences and values.
- Patient-centeredness: According to the IOM, compassion, empathy, responsiveness to the needs, values and preferences of the individual patient are the hallmarks of patient-centeredness. Betancourt emphasized that these attitudes and skills are also central to linguistic and cultural competence.
- Equity: The IOM states that an equitable health system must provide care that does not vary because of personal characteristics such as gender, language, ethnicity, culture, geographic location or socioeconomic status.
- Timeliness and Efficiency: Betancourt acknowledges that linguistic and cultural barriers may contribute to increased length of stay in the hospital or longer wait times for scheduling a doctor's appointment or for accessing services in a hospital emergency department." [25]

[22] *BOWEN, Sarah (2000).* Introduction to Cultural Competence in Pediatric Health Care, *Prepared for Health Canada, Government Services Canada.*

[23] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français.*

[24] *BETANCOURT, J.R. (2006).* Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care, *The Commonwealth Fund.*

[25] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français.*

Thus, the issue of linguistic competence is *"a fundamental issue of accessibility, safety, quality and equity of services."* [26] This means that to provide quality service to minority populations, it is essential that linguistic competence be integrated at all levels of the system, including policies, programs and resource allocation.

Highlights

Linguistic competence comes down to providing quality services to the population. This issue must not be considered separately and seen as a privilege claimed by minorities, "but as a fundamental issue, identified by the recognition of a right to equitable, accessible and quality health care." [27]

2.2 Direct impact on health care

Sarah Bowen's studies have also shown the direct impact of the lack of health care services in the patient's mother tongue can have. This includes:

1. Reduced recourse to preventive services

"There is compelling evidence that language barriers have an adverse effect on initial access to health services. These barriers are not limited to encounters with physician and hospital care. Patients face significant barriers to health promotion/prevention programs: there is also evidence that they face significant barriers to first contact with a variety of providers." [27]

2. Increased consultation time, number of diagnostic tests and likelihood of diagnostic and treatment errors

"The literature review suggests that there are many intermediate effects (such as delays in seeking care, and reduced comprehension and compliance). Language barriers have been associated with increased risk of hospital admission, increased risk of intubation for asthmatics, differences in prescribed medication, greater number of reported adverse drug reactions, and lower rates of optimal pain medication." [28]

3. Reduced probability of treatment compliance

"A review of the literature reveals consistent and significant differences in patients' understanding of their conditions and compliance with treatment when a language barrier is present. Findings from these studies are consistent with general research on provider-patient communication, which finds that communication is a key factor in patient adherence to the treatment plan." [29]

[26] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français.*

[27] *BOWEN, Sarah (2001).* Language Barriers in Access to Health Care, *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf, Prepared for Health Canada, Government Services Canada, p. VI.*

[28] *Idem.* [29] *Idem.*

4. Reduced satisfaction with the care and services received

"A number of studies have examined different aspects of patient satisfaction with care. Patients who do not speak the same language as their health care providers consistently report lower satisfaction than those who share the same language as their providers." [30]

5. Reduced quality of care and outcomes

"The research suggests that there are several "pathways" by which language barriers have the potential to affect quality of care and outcomes. Analysis of narrative text of the communication process, when interpreters are used, demonstrates the prevalence of errors and the potential for such errors to affect diagnosis and treatment. Research related to provider-patient communication, health literacy, time spent in the consultation, and the relationship of language barriers to a regular source of care, provide insights as to how language barriers affect satisfaction, utilization and health outcomes." [31]

Highlights

It is clear that failure to provide services to clients in their mother tongue runs counter to the public good.

2.3 Indirect impact

In addition to the direct effects mentioned above, Sarah Bowen identified a number of indirect effects that language barriers can cause.

1. Under-representation of linguistic minorities

"Both clinical and health services research tend to under-represent ethnic minorities, especially those who are not proficient in an official language. Exclusion of certain ethnic groups from biomedical research may mean that study results cannot be generalized to the entire population, and that less is known about risk factors, disease prevalence, and response to treatment of specific ethnocultural groups." [32]

2. Reduced health care provider satisfaction

"Language barriers have a negative effect on provider effectiveness and satisfaction, make it difficult for providers to meet professional standards of care, and increase their exposure to the risk of liability." [33]

3. Increased health system costs

"There is some evidence that language barriers may have important effects on health care costs, through their impact on service utilization and health outcomes." [34]

Highlights

Language barriers reduce health care provider satisfaction and increase health care system costs.

[30] *BOWEN, Sarah (2001).* Language Barriers in Access to Health Care, *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf, Prepared for Health Canada, Government Services Canada, p. VI.*

[31] *Idem.* [32] *Idem.* [33] *Idem.* [34] *Idem*

2.4 Culture versus language

It is important to distinguish clearly between "culture" and "language." Two people speaking the same language do not necessarily have the same culture. Sarah Bowen defines culture as all aspects of an individual's or a group's identity: language, religion, gender, migration experience, social class, political affiliation, sexual orientation, geographic origins and other experiences.

The important thing is not to dwell on these differences, but to be sensitive to differences that may affect the efficiency and quality of the services to be provided. We must, for example, be aware that the prior experiences of some immigrants may affect how they view the services offered to them and how they are delivered. Sarah Bowen provides an example of a Winnipeg family services organization that had made great efforts to recruit and train home care providers who spoke the language of some groups of refugees. They were surprised that most people declined the service until they realized that the people recruited came from a different region, which was in conflict with the group in need of services. The people were declining the service because they did not feel safe with these workers.

We must be sensitive to these aspects, but the literature has shown that language barriers have more impact on the services than cultural barriers. These studies conducted in the United States dealt with health service utilization and the health of certain communities. They found, for example, that Hispanics who spoke English had a similar health status to that of whites, while Hispanics who spoke primarily Spanish had much less positive health outcomes.[35]

Highlights

Language barriers have more impact on the quality of care than do cultural barriers.

[35] *BOWEN, Sarah (2004).* Language Barriers Within The Winnipeg Regional Health Authority, Evidence and Implications, Winnipeg Regional Health Authority.

3. Implementation of French-language health care services

Once the need to provide quality French-language health care services is recognized, several obstacles impede their efficient and consistent implementation both provincially and nationally. This report provides a description of the main obstacles raised in the literature and by interviewees, and then describes the best practices identified and additional possible solutions to deal with these issues.

3.1 Legal context

Description

The legal context, which includes collective agreements, and provincial and national laws and policies, is regularly identified as an obstacle to developing the offer of French-language care services in facilities. Indeed, these collective agreements and laws appear to specifically impede the designation and staffing of bilingual positions.

A recent study of the case law on the subject,[36] commissioned by Santé en français, sought to clarify certain beliefs surrounding the issue of staffing of bilingual positions. The study established the following key findings:

1. Collective agreements do not generally impede the designation and staffing of bilingual positions;
2. Case law shows that it is possible and within health facilities' power to designate bilingual positions, if it is shown that the skill at issue is reasonably related to the needs of the population and that management is acting in good faith when imposing this type of designation;
3. The number of positions that may be designated by a bilingual facility is at its discretion and no collective agreement can prevent these designations, when the terms and conditions stated in the initial finding above are met;
4. In the vast majority of documented cases on the issue of designating or staffing a bilingual position, case law shows that linguistic competence trumps seniority when the terms and conditions of the initial finding above are met.

Thus, when certain conditions are met, it has been demonstrated that the legal context, including collective agreements, is not an insurmountable obstacle to providing a range of quality French-language services.

However, although the legislation ultimately supports administrators when bilingual positions are disputed, the fact remains that in some quarters, there is still ongoing resistance and opposition. This resistance is partly due to certain principles, such as seniority, which are part of the union culture. Managers have to deal with these challenges on a regular basis and increase their efforts to meet their objectives.

Interviews conducted as part of the case law study showed that it was sometimes simply "*a lack of resolve to make difficult decisions regarding minority situations and/or service delivery requirements.*"[37] This situation means that managers do not always fully exercise their management rights regarding the designation and staffing of bilingual positions.

The limited support provided by some governments in terms of existing policy and reporting requirements on the designation and staffing of bilingual positions partly explains the administrators' lack of resolve.

[36] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

[37] *Idem.*

Finally, an additional challenge for managers is the difficulty in finding qualified people to fill designated bilingual positions. During group interviews conducted as part of this report, many respondents reported having had difficulty recruiting staff and that adding a bilingual competence requirement significantly compounds the problem. As well, whenever a designated bilingual position ends up being filled by a non-bilingual person, it reinforces the perception that it was therefore not critical that this position be designated bilingual.

Thus, it appears that this is not simply a legal issue, but a legitimation and recruitment issue. We will take a closer look at the issues surrounding legitimacy and recruitment in subsequent sections of this report. Below, we recommend potential solutions to address the legal issue.

Potential solutions and best practices

1. Introduction of guidelines in collective agreements

Firstly, since the necessary laws already appear to be in place for designating and staffing bilingual positions, some decision-makers are focusing more on actions to be taken in terms of collective agreements, which must be clear on the issue of designated bilingual positions.

Introducing guidelines in health care workers' collective agreements facilitates and legitimizes the designation and staffing of bilingual positions for managers responsible for assigning these positions, since they can now make their decisions based on clear, easy to use designation and staffing principles. This measure also significantly reduces the resistance sometimes expressed by some unions. A concrete example of this type of guideline is found in the recent agreement between the St. Boniface General Hospital and the nurses' union.

2. Manager's role

It is also important for managers to understand their management rights and exercise them when it comes to defending the designation and staffing of bilingual positions. Case law shows that if there is a real need and the procedure is carried out in good faith, the number of designated bilingual positions is at the manager's discretion. Collective agreements must not impede this fundamental management right to develop access to quality French-language health care services.

3. Implementation of Canadian national standards

The American model of national standards has enabled the U.S. to make significant advances in the quality of care provided to minority populations in the United States. By implementing these standards and the related reporting requirements, the U.S. recognizes the important relationship between linguistic and cultural competence and quality of care.

A study by Spiegel and Cobb (2007) also noted that compliance with standards represented a significant benefit for health facilities that had implemented them, since they produced the following outcomes:

- *Increased market share of patients with limited English skills;*
- *Substantial reductions in language interpretation costs;*
- *Increased patient and health care provider satisfaction;*
- *More efficient use of staff and reduction of communication delays between patients and health care providers;*
- *Cost savings from shorter hospital stays.*[38]

[38] *SPIEGEL, J, COBB, A. (2007)* Developing the Business Case for culturally and linguistically appropriate services in health care, *American Public Health Association*

Another significant advantage of these standards is that they are an extremely useful measurement tool for efficiently and accurately assessing and comparing the quality of health care services in connection with linguistic and cultural competence.

Ultimately, it would be necessary and beneficial for Canada, like its southern neighbour, to adopt these types of linguistic and cultural competence standards. To be effective, however, these standards should also be subject to stringent reporting requirements. To achieve this objective, the support and collaboration of every province would be indispensable. Given the complexity of this type of project and the level of coordination required, it must be seen as a longer term solution, and other measures need to be taken to improve access to bilingual health care services. The full list of U.S. standards is presented in Appendix B.

Highlights

Contrary to popular belief, legal considerations do not significantly impede the designation and staffing of bilingual positions. Managers must fully exercise their management rights and governments must support them in concrete terms, through reporting policies and procedures.

3.2 Legitimation measures

Description

In a context where institutions must manage multiple health system priorities, it is sometimes difficult to make people understand why offering quality French-language services is so important. Many people believe that, in general, the issue of bilingualism in health has difficulty competing with other health priorities or crises. As well, although more and more people are aware of the issues surrounding linguistic competence, many myths and beliefs persist and impede the development of this offer of services.

As such, it is always necessary to introduce legitimation measures. This makes providers and managers feel supported in their daily work, in addition to bolstering the general recognition of the work performed by bilingual employees.

Potential solutions and best practices

1. Conduct outreach activities on a regular basis

It appears that outreach activities such as workshops, conferences, etc., at several levels and with several client groups are good ways to continually stress the importance of French-language health care because of their major impact on the level of legitimacy given to linguistic competence issues. Facilities where all employees are made aware of these issues are better able to implement these services and face less resistance.

Following recent workshops for staff and teachers at the Northern Ontario School of Medicine (NOSM), participants reported that they had a better understanding of the issues relating to linguistic competence. After having thought about these issues at the workshops, they decided to take meaningful action in their communities.

For its part, Santé en français developed a workshop on actively offering French-language health and social services. The workshop was given to managers, supervisors and employees who found the content very compelling. They said that it provided them with a better understanding of their clients and their respective needs, and how active offer addressed these needs.

The Aucoin report[39] provided the following outreach strategies:

- *Provide continuing education to physicians and their staff on knowledge, attitudes and skills to be developed in conjunction with linguistic and cultural competence;*
- *Make information on care and services, patients' rights, health education, etc. available in the language of the minority and adapt it to its culture.*

There are countless numbers of potential initiatives for educating and informing people at all levels.

2. Include linguistic and cultural competence as variables in studies and research

In the U.S., the turning point that led to the development of linguistic and cultural competence came from compelling statistics showing that the health of minority populations was significantly poorer according to many health indicators. Furthermore, linguistic and cultural competencies were included as study variables to measure the real impact and benefits of the measures undertaken.

In her studies, Sarah Bowen (2001) proposed "including wherever possible, proficiency in an official language as a variable for analysis in health services research. *This should always occur when ethnicity is one of the factors to be considered.*"[40]

A study conducted jointly by Société Santé en français (SSF) and the Consortium national de formation en santé (CNFS) (2010),[41] also deplored the lack of data describing the situation in Francophone minority communities. In general, the study showed that this lack of evidence was an obstacle to effective development of French-language health care.

For example, in terms of human resource planning to meet requirements, Santé en français stated in a proposal to the Nurses Recruitment and Retention Fund committee, "*that it is virtually impossible to determine the number of French-speaking nurses in Manitoba. We therefore have no reliable data on the number of French-speaking nurses in Manitoba who are able to offer French-language nursing services.*" [42] It is therefore essential that all levels of government start to include questions regarding this issue in its studies and other data identification methods that it has at its disposal.

The SSF and CNFS study[43] proposed courses of action to identify and monitor the three following aspects of the changing needs of Francophone communities:

1. Health and well-being of minority Francophone populations;
2. Care services offered to these populations;
3. Francophone human resources that can provide these services.

[39] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français, p. 18.*

[40] *BOWEN, Sarah (2001).* Language Barriers in Access to Health Care, *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf, Prepared for Health Canada, Government Services Canada, p. IX.*

[41] *Société Santé en français (SSF) and Consortium national de formation en santé (CNFS) (April 2010).* La santé des francophones en situation minoritaire : un urgent besoin de plus d'informations pour offrir de meilleurs services [The health of Francophones in minority communities: an urgent need for more information to provide better services] (summary). *Ottawa, Ontario.*

[42] *Santé en français (formely known as Conseil communauté en santé du Manitoba) (2011).* Initiative de recrutement et de maintien en poste du personnel infirmier bilingue au Manitoba [Initiative to recruit and retain bilingual nurses in Manitoba], *Proposal to the Nurses Recruitment and Retention Fund committee, p. 7.*

[43] *Société Santé en français and Consortium national de formation en santé (April 2010).* La santé des francophones en situation minoritaire : un urgent besoin de plus d'informations pour offrir de meilleurs services [The health of Francophones in minority communities: an urgent need for more information to provide better services] (summary). *Ottawa, Ontario.*

The Aucoin report[44] proposed the following measures:

- *Collect and analyze demographic, social, health and socioeconomic data as well as data on health status and consumption of health services for minority language and/or minority culture populations. Identify and describe the disparities in access / quality / continuity of services as well as the impact on health status;*
- *Initiate and fund research on best practices in the field of linguistic and cultural competence. Encourage the sharing of experiences and expertise, and networking between partners.*

3. Gain recognition and support from all levels of government

Countries, provinces or regions that receive concrete support from the various levels of government through the adoption of laws, standards or departmental policies, find it easier to legitimize and defend decisions and actions relating to the enhancement of the quality of care for minority populations.

As suggested in a recent Hubert Gauthier report,[45] a government policy on French-language health services that includes labour issues and all issues related to the designation and staffing of bilingual positions makes it easier for managers to designate and staff bilingual positions. Since it is recognized by various government agencies as an important factor in the quality of care, linguistic competence is becoming significantly more legitimate.

The Aucoin report proposes the following strategies, which involve the various levels of government:

- *Develop and implement policies requiring that health organizations include linguistic and cultural competencies as core values in their mission statement and their service quality process;*
- *Recognize the official bilingual status of certain health care organizations;*
- *Develop national linguistic and cultural competence standards through national accreditation bodies.*

Highlights

A number of best practices should be introduced at all levels to increase the legitimacy of French-language health care services.

[44] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français, p. 18.*

[45] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

3.3 Recruitment strategies

Description

Recruiting competent staff is probably the biggest challenge to developing a range of quality French-language services. Many believe that if designated bilingual positions were easier to fill, progress on issues, including union relations, would be greatly facilitated.

A Hubert Gauthier Conseil Gestion study[46] produced the following findings:

- New graduates are more interested in acute care and urban settings and far less keen on working in rural facilities or long-term care. As a result, these graduates are often not in designated bilingual positions;
- The lack of bilingual staff mainly affects rural communities and long-term care facilities. In fact, young people are reluctant to work in rural areas where they are often alone and have less experience than veteran workers; also, long-term care facilities appear to have difficulty attracting staff;
- Although there are staffing policies, there is no real recruitment strategy tailored to the needs of the community.

In addition to these findings, a survey by the Canadian Nurses Association (CNA)[47] of 300 nurses working in minority communities as part of an initiative called *Projet soins infirmiers en français [French-language nursing care project]*, produced the following supplementary findings:

- "By identifying themselves as French-speaking, nurses often take on additional duties and their responsibilities become disproportionate compared to those of unilingual English-speaking nurses;
- French-speaking nurses often feel more comfortable working in English because most of them had to study in English. Linguistic competence and maintaining this knowledge in a workplace that is often English are significant challenges.
- Fatigue and stress increase for nurses providing services in French. Besides sometimes having to play the role of "translator," nursing staff must prepare reports in English, deal with computer systems in English, take on additional work to treat Francophone clients that English-speaking nurses cannot understand and serve.
- Patient / client safety also adds to the stress experienced by the nursing staff. Providing clients with the correct information in French is always a concern.
- Bilingual nurses can sometimes find it more difficult to take their holidays because they must be replaced by bilingual nurses;
- We should also keep in mind that unless they work in an environment that encourages the systematic use of French, bilingual nurses often suffer from a sense of professional isolation. This has an impact on the morale of professionals and they often give up and only speak English." [48]

For all these reasons, several respondents said they preferred not to identify themselves as bilingual, which compounds the recruitment problem and makes it more difficult to develop the provision of French-language care services.

[46] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

[47] *Canadian Nurses Association (August 2007).* Projet soins infirmiers en français [French-language nursing care project].

[48] *Santé en français (formely known as Conseil communauté en santé du Manitoba) (2011).* Initiative de recrutement et de maintien en poste du personnel infirmier bilingue au Manitoba [Initiative to recruit and retain bilingual nurses in Manitoba], *Proposal to the Nurses Recruitment and Retention Fund committee, p. 7.*

Potential solutions and best practices

Several key recruitment factors identified in the literature should be explored. Here are some examples taken from key studies on the subject.

1. The Boudreau report on the deployment of health human resources

Armand Boudreau's report entitled "*A Master Plan for the Deployment of Francophone Health Human Resources in Minority Francophone Communities*" [49] presented several avenues for promoting, attracting, retaining and mobilizing health human resources in Francophone and Acadian minority communities.

The following five strategies were proposed in the Armand Boudreau report:

1. "An early and sustained intervention with primary and secondary school students, followed by support measures during professional studies and throughout the career of Francophone human resources. This involves visualizing the trajectory of Francophone human resources and developing innovative ways to attract them to the field, encouraging them to study and work in Francophone minority communities and valuing them in these environments.

2. Promote innovation in the use of Francophone human resources by reviewing the deployment of Francophone human resources in health care facilities, rethinking the way work is organized, mobilizing these human resources and offering different services.

3. Synergy with the programs and guidelines for the entire system. This involves guidelines and programs at all levels of government (federal, provincial / territorial and regional). The idea is to not act alone, but to try to influence ongoing activities to promote the recruitment and development of linguistically competent human resources.

4. Support for human resources research and planning in Francophone minority communities. The lack of data on human resources is a complex problem that requires sustained and concerted efforts at all levels (federal, provincial / territorial and regional).

5. Programs that provide adequate multiyear financial support. The objectives of the Consultative Committee for French-Speaking Minority Communities (CCFSMC) with respect to Francophone human resources in minority communities cannot be achieved without special funding." [50]

Mr. Boudreau's report acknowledged "*the great diversity in Francophone communities*" and emphasized that each region must determine its own approach, which does not mean that they cannot all "*benefit from one another's progress and innovations.*" [51] The author therefore recommended the implementation of advisory committees at the provincial / territorial and regional levels.

[49] *BOUDREAU, Armand (2007).* A Master Plan for the Deployment of Francophone Health Human Resources in Minority Francophone Communities, *report commissioned by Health Canada.*

[50] *Idem.* [51] *Idem.*

2 . The Aucoin report on linguistic and cultural competence in health care organizations

The Aucoin report,[52] proposed the following strategies to facilitate recruitment:

- Facilitate the admission of candidates from linguistic and cultural minority communities in health science faculties;
- Facilitate recognition of diplomas of health professionals who have studied abroad.[53]

3. The French-language nursing care project report

In the context of the Manitoba Nursing Strategy, Santé en français has proposed a financial incentive through the Nurses Recruitment and Retention Fund in order to help recruit and support bilingual nurses in Manitoba Regional Health Authorities (RHAs).

In terms of the support to be provided, the report stressed the importance of having access to French-language tools and information on health topics. This prevents nurses from having to perform translation work for which they are not necessarily qualified, and which increases their workload. It seems that since the report was published in 2007, significant progress has been made with respect to the support provided to bilingual nurses, particularly in terms of translation and the availability of French-language tools and publications. To encourage and support bilingual nurses, Santé en français also proposes the offer of a signing bonus.

4. The Gauthier report on linguistic competence as a hiring criterion

The Hubert Gauthier report commissioned by Santé en français[54] proposed that a round table be established with the key players involved and more importantly those who are interested, as a forum for discussing strategy and adjustments to ongoing recruitment activities.

In general, it is important to strengthen medical schools' ties with the community and engage the community with respect to linguistic competence. This would involve establishing partnerships and creating stronger relationships with key representatives and players in minority communities in need of quality French-language services.

The schools could also involve their own Francophone students. These schools could be involved at several levels, such as building relationships with the community and making all students more aware of these issues.

Highlights

Recruiting minority staff requires specific strategies involving all partners.

[52] *AUCOIN, Léonard (2008). Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] Submitted to Société Santé en français. p. 18.*

[53] *Idem.*

[54] *GAUTHIER, Hubert (2011).* Étude exploratoire sur les compétences linguistiques à l'embauche [Exploratory study on linguistic competence as a hiring criterion], *Report submitted to Santé en français (formely known as Conseil communauté en santé du Manitoba), Prepared by Hubert Gauthier Conseil Gestion.*

3.4 Community involvement

Description

Developing quality French-language service delivery is impossible without the active participation of the communities for which these services are intended. Many people from these communities are not aware of their rights to health care in their own language and therefore do not ask for French-language care when they receive treatment. Lack of community involvement helps strengthen the perception of some workers in the health care field that it is not necessary to provide these people with French-language service since they already speak English.

Potential solutions and best practices

There are several ways that communities can help develop access to French-language services. Here are a few of them taken from the Aucoin report:

- "Inform these populations that they have the right to be served in their language and that it is a fundamental part of service quality;
- Publish a directory of linguistically proficient resources;
- Promote the services in the media of the minority communities where the services are delivered;
- Build coalitions and create bridges between community groups (civic leaders, socioeconomic, community and religious organizations, etc.), health professionals and health care organizations to implement linguistic and cultural competence;
- Identify the type and level of services (for example: primary, secondary and tertiary) to which the community should have access in its own language, locally or elsewhere, as well as how to access them (for example: an organization of French-language services, the presence of French-speaking professionals, access to interpreters, etc.).
- Seek the support and participation of community residents regarding this matter;
- Get the support of leaders in the majority community;
- Obtain the support of local, regional, provincial and national politicians;
- Obtain media support;
- Introduce cultural brokers, i.e. "community representatives or facilitators who can act as liaison officers, cultural guides, mediators and catalysts for change." [55] These representatives are not caregivers; they are champions and advocates, representatives of the community's needs.

Santé en français has, for its part, decided to involve communities by creating regional round tables on various topics concerning them. This approach builds ties with the community and provides it with an opportunity to express its needs.

Highlights

The community has an important leadership role to play as a representative of the population in the area of health services.

[55] *AUCOIN, Léonard (2008).* Compétences linguistiques et culturelles des organisations de santé, Analyse critique de la littérature, [Linguistic and cultural competence in health care organizations, Critical analysis of the literature] *Submitted to Société Santé en français. p. 20–21.*

4. Concerns in the field

This section of the report provides answers to the main questions asked in the field, as raised in the group interviews. The providers who were interviewed reported repeatedly having to deal with the same questions / objections, when defending measures for developing access to French-language care services. Based on the preceding sections of this report, we are proposing some answers to each of these questions.

Why French and not other languages?

As Sarah Bowen stated in her 2001 study, [56] the impact of language and cultural barriers on access to health care and its quality affects several groups – not only the Francophone population. The author identified four main constituencies that may face language and cultural barriers in Canada:

1. First Nations and Inuit communities;
2. Newcomers to Canada;
3. Deaf persons, and
4. Depending on location of residence, speakers of one of Canada's official languages.

Francophones living outside Quebec are part of this fourth constituency. It is important to understand that the defence and development of French-language care services do not run counter to the development of these skills for other minority populations. On the contrary, by developing the rationale and other tools for French-language health care services, these initiatives provide indirect support to all constituencies that have to deal with more limited access to health care services in their language.

Francophones in a minority community are often bilingual, why would they need French-language services?

It is simply wrong to assert or believe that all Francophones in minority communities are bilingual. It is important to keep in mind that nobody is born bilingual. Furthermore, when people are in a vulnerable situation, they often find it difficult to express their needs, fears, pain, etc. It is even more difficult to express them in a language other than one's own.

French-language services are an expensive, unnecessary luxury.

As mentioned earlier in the report, studies show the opposite. By increasing recourse to preventive services, decreasing consultation time, the number of diagnostic tests and the likelihood of diagnostic and treatment errors, quality French-language services reduce health care costs.[57]

How can we measure an employee's linguistic competence?

In Manitoba and the rest of Canada, there are many effective tools for reliably and effectively measuring an individual's linguistic competence.

When hiring, does bilingualism have to take precedence over other factors such as seniority, clinical skills, etc.?

Managers regularly find themselves in difficult situations where an employee with less seniority and work experience is given a position at the expense of an employee with more seniority and sometimes more clinical experience. These situations regularly lead to confrontations with employees and their union and complicate matters for managers. However, if one considers that linguistic competence and clinical skills are both quality factors, as we have argued in this report, the question that needs to be asked is whether we are

[56] *BOWEN, Sarah (2001).* Language Barriers in Access to Health Care, *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf, Prepared for Health Canada, Government Services Canada, p. VI.*

[57] Consultative Committee for French-Speaking Minority Communities (2007). *Towards a New Leadership For The Improvement of Health Services in French,* Report to the Federal Minister of Health, Ottawa.

prepared to compromise a quality factor when selecting a candidate. If we cast aside linguistic competence, we are neglecting an important quality factor.

Some would argue that in a crisis, clinical skills prevail over linguistic competence. However, the vast majority of regular care in Canada is not provided in crisis situations. In this context, linguistic competence must be on an equal footing with clinical skills.

The rules of collective agreements and laws impede the designation and staffing of bilingual positions.

As mentioned in the report's section on legal considerations, case law shows that employers are fully entitled to designate and staff bilingual positions, if it is shown that the skill at issue is reasonably related to the needs of the population and that management is acting in good faith when imposing this type of designation.

Thus, when certain conditions are met, it has been demonstrated that the legal context, including collective agreements, is not an insurmountable obstacle to providing a range of quality French-language services.

If I post a bilingual position, unilingual English-speaking candidates will not apply.

The purpose of posting a bilingual position is not to attract candidates who speak English only. This issue appears to be more related to the shortage of bilingual resources, in which case employers usually decide to turn to unilingual candidates, as a practical expedient.

However, we believe it is important to keep in mind that by making this type of decision, managers are compromising an important quality factor in services to Francophones, when there are alternatives. As mentioned in this report, managers must develop different recruitment strategies tailored to bilingual clients. These strategies must involve all players at all levels.

Some people lack confidence in their language skills and will therefore not apply for these positions.

To encourage as many qualified candidates as possible to apply for bilingual positions, we must reassure them that they will be offered tools and training to support them in developing their linguistic competence, including language upgrading, a bilingual terminology bank, etc. This matter also involves various issues surrounding the legitimation and valuation of bilingual employees, their role and the support offered to them.

In addition, distributing and demystifying the assessment tools can sometimes make some candidates feel more secure about their linguistic competence.

Why not just use interpreters instead of requiring a bilingual employee?

In a study conducted by Sarah Bowen for the Winnipeg Regional Health Authority,[58] the author warned health authorities in Winnipeg about the risks of using informal interpreters such as family or community members or health care providers with no training in interpretation. Various studies have shown that these informal interpreters make the following standard errors:

- *Omitting information provided by the client or provider;*
- *Adding information to what the provider or the client said;*
- *Substituting words, concepts or ideas;*
- *Using inappropriate terminology to describe the anatomy, symptoms and treatments;*
- *Refusing to convey a message;*
- *Inappropriate editorial comments;*
- *Inadequate linguistic competence;*
- *Role substitution (e.g.: assuming the provider's role).*

[58] *BOWEN, Sarah (2004).* Language Barriers Within The Winnipeg Regional Health Authority, Evidence and Implications, Office régional de la santé de Winnipeg.

There would also be many warnings regarding the assessment of providers' actual linguistic competence and the impact on service quality. Finally, many studies show that direct service is far preferable to the services of an interpreter.

As Sarah Bowen stated[59]:

"As important as professional interpretation services are to equitable access to health care for those who do not speak an official language, provision of such services is not a sufficient response. Without addressing the larger issues of equity within health institutions, and continuing efforts to promote socially responsive and culturally competent care, provision of language services will not have the desired effect."

Thus, the use of interpreters should not be seen as the solution to all problems. However, given certain constraints, the use of interpreters is a strategy to be considered given the availability of resources.

Why do all employees have to be bilingual?

In some designated bilingual facilities, all positions must be filled by bilingual staff. In this context, some employees question the legitimacy of this requirement, particularly for some janitorial positions, etc. However, it is important to remember that these employees need to be bilingual because they are in direct contact with clients.

Often, janitors and other employees come into contact with clients as frequently as caregivers do.

How can we determine the number of bilingual positions needed?

It is understood that in designated "Francophone" facilities, all positions are designated bilingual. Services are therefore available in both languages but the working language is French.

However, there are relatively few of these facilities in Canada, and therefore in other facilities, every manager needs to determine the number of bilingual positions required.

To answer this question, we have to go back to the rationale for bilingual positions: having the bilingual human resources needed to provide quality French-language services to Francophone clients in minority communities. The number of positions to be designated bilingual is therefore directly related to this client base and the question to be asked is: *how many bilingual people do I need in my facility to serve the Francophone population in my area effectively?*

Why is it necessary to designate bilingual positions in specific services instead of using a bilingual person elsewhere in the facility?

The answer to this question is essentially the same as the one about using interpreters instead of bilingual people. Basically, this is a question of the competence of the person being called upon to act as a translator. This person does not necessarily have the knowledge to accurately translate the requests of each care speciality, which leads to the same problems as those encountered when using an interpreter.

Moreover, this practice makes resource allocation less efficient and reinforces bilingual people's feeling that they will be called every time someone needs translation services and that their workload will increase. It is therefore an inappropriate, harmful and inefficient use of bilingual resources.

[59] *BOWEN, Sarah (2001).* Language Barriers in Access to Health Care, *www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-lang-acces/2001-lang-acces-eng.pdf, Prepared for Health Canada, Government Services Canada.*

English-speaking staff does not understand the need to offer services in both languages and believe that they are providing a quality service. How should we respond to this view?

This view arises from the English-speaking staff's lack of awareness of linguistic competence issues. To counter this situation, regular, ongoing outreach activities are essential for achieving a long-term shift in attitude and culture. All providers need to understand that it is a question of service equality and safety.

This argument and all the tools that we have proposed should help equip those who want to provide a defence and arguments to counter this attitude and lack of understanding of the importance of French-language health care.

Bilingual people fear that if they identify themselves as bilingual, they will have to work harder. What should we tell them?

As mentioned previously, several providers are worried about identifying themselves as bilingual for fear of being assigned more work. It is true that if a facility does not ensure that bilingual staff receive all the necessary support to do their job and does not understand the role of bilingual staff, bilingual employees could be adversely affected as a result of their status.

However, in an environment where these employees have clear job descriptions and the tools and support they need, bilingual employees' workload should be the same as that of all other employees.

For example, if they are constantly called upon to act as translators between clients and members of the English-speaking staff, it reflects an inadequate number of bilingual positions to provide quality service to Francophone minorities. We must therefore ensure that the number of designated bilingual positions is proportional to the needs of the population and that there are therefore sufficient numbers of Francophone staff to respond efficiently to the demand for services.

In terms of tools, management must ensure that bilingual staff has all the tools in both languages, so that they do not waste valuable time translating these tools for patients and are able to work as efficiently as English-speaking employees.

Finally, the French-speaking staff must be valued for the work they perform and all staff must understand their role in the organization of work and respect that role.

Why do bilingual people (particularly Francophones) have to pass language proficiency tests?

Several factors are taken into account when assessing people's linguistic proficiency, even when their mother tongue is French. For example, the language in which people were educated may have an impact on fluency when communicating with a patient in French. Each individual's experience comes into play as well. Therefore, two people whose mother tongue is French may not have the same level of proficiency. An Anglophone may also have developed better French-language skills than those of a Francophone. For this reason it is important that linguistic proficiency be assessed, even that of Francophones.

Proficiency tests are one of the methods used in some regions. In others, individual interviews are conducted to assess proficiency.

What course of action should be taken when nobody can be found to fill a designated bilingual position?

Recruitment staff finds recruiting bilingual employees particularly difficult. If we take a close look at the situation, it is easy to see why it is so difficult to recruit bilingual staff.

- There are not enough bilingual individuals to meet demand;
- People who are actually bilingual are worried about ending up with an increased workload or do not have enough confidence in their abilities to apply for these positions;
- There are already shortages in some workplaces, particularly in outlying areas or long-term care centres.

For these and many other reasons, standard recruitment methods cannot be used to recruit bilingual staff. Health facilities must develop specific strategies to attract, recruit and retain bilingual staff. This involves the full range of good practices set out earlier in this report, including:

- Valuing bilingual employees in the facility;
- Clear job descriptions and clear policies that demonstrate that there is no additional workload for these individuals, particularly in terms of translation and interpretation in the workplace;
- Support and tools to facilitate the work of bilingual staff;
- Recruitment activities at source (in universities, Francophone communities, etc.);
- Innovative, proactive recruitment strategies rather than passive initiatives. We need to do more than place advertisements. For example, we should use our professional networks and contact networks.

How can we make bilingual positions attractive?

Several factors can help make a bilingual position attractive. Firstly, it is important to demonstrate to those interested in this position that they will receive all the support required and that this position will not put them at a disadvantage. A clear job description and policy are therefore essential.

Secondly, it is important to demonstrate that these positions bring additional linguistic competence to the workplace, especially by recognizing and emphasizing the fact that the bilingual person (tested and meets the selection criteria) adds value with that proficiency. The job description must emphasize this important specification.

Isn't it more important to meet a patient's health needs before trying to meet a language requirement?

This question, asked many times in hospital settings, makes the fundamental mistake of pitting *"health requirements"* against *"language requirements"* whereas our rationale demonstrates that they are one and the same: **responding to health needs requires linguistic competence.** Suggesting that linguistic competence is an unnecessary luxury is to misunderstand the health issues related to it. Again, employee outreach and education are essential to combat such erroneous thinking.

How can we address the "culture of seniority" in the workplace, which sometimes discourages younger candidates from applying for bilingual positions for fear of reprisal?

It can take several years to implement effective, sustainable culture change. However, simple actions can help mitigate the potential impact of this "culture of seniority" in the shorter term.

Firstly, it is important that in a work environment in which some positions are designated bilingual, all employees have a basic understanding of the issues and the rationale for these positions. Basically, if linguistic competence is seen as a Francophone whim and a luxury that involves costs and staffing inequities, it will be difficult to implement this type of culture change. It is therefore important to continually make employees aware of these issues and educate them about linguistic competence.

Secondly, it is essential to establish clear rules with respect to the designation and staffing of bilingual positions and apply them with the greatest possible consistency and transparency. When a position is designated bilingual, care must be taken to clearly demonstrate the rationale for the designation. With respect to selecting the successful candidate, it is important to specify the method for selecting the candidate before beginning the recruitment process.

Finally, the best way to secure the support of union members is still reaching an agreement with the unions on guidelines for the designation and staffing of bilingual positions.

How should we show that we value bilingual employees?

There are several measures and strategies that can be used to show that we value bilingual employees and every manager can find creative ways to achieve this objective. Here are a few suggestions:

- Openly and actively position the facility as one that offers services in both languages (outreach posters, buttons for bilingual employees, information pamphlets at reception desks and in offices, etc.);
- Organize training and other activities specifically for bilingual staff (training dinners, conferences, etc.);
- Keep the issue of the organization of French-language services on the agenda (put it on meeting agendas, include it in the strategic plan, etc.);
- Create a system for recognizing bilingual employees;
- Ensure that tools, promotional materials and documentation are available in both languages;
- Place advertisements in local Francophone newspapers when new employees are hired or when bilingual employees make significant achievements;
- Ongoing professional development in linguistic and cultural competence;
- Legitimation strategy to provide everyone with a clear understanding of all the issues and the importance of bilingual employees in the organization and their role;
- Organize activities with neighbouring Francophone communities (in schools, workplaces, etc.);
- Get clear support from senior management. This also involves actions demonstrating this support (Director taking French courses, personalized messages to bilingual employees, etc.).

5. Conclusion

This business case report has attempted to demonstrate the direct relationship between linguistic competence and the quality of health care services. Once this relationship has been established and accepted, it becomes clear that pitting "linguistic competence" against "clinical priority" is equivalent to agreeing to provide lower quality services for the sake of clinical priority.

In order to increase access to French-language health care services, it is essential that all providers understand and fulfil their respective responsibilities. Whether at the individual, organization, system or community level, everyone has an important role in implementing an efficient system that meets the needs of Francophone minority populations.

As we have seen, many obstacles remain, and it will take many years of concerted and sustained effort to implement this type of system. However, it is important to keep in mind that organizations and programs have already begun to lay the groundwork for establishing this type of system, and several solutions are available to continue to work in this direction. This report has sought to highlight best practices for overcoming some of the obstacles most commonly encountered in the field. In particular, these best practices demonstrate the need to work proactively rather than reactively, since this quickly leads to no-win situations.

From the legal standpoint, case law has shown that the legal framework supports managers when there are challenges to decisions relating to the designation and staffing of bilingual positions. Fear of this type of retaliation should not deter managers from making the necessary decisions with respect to developing quality French-language health care delivery by designating and staffing bilingual positions.

Obviously, a high level of legitimacy is needed to support these managers. This support, again, must come from all levels of the system: at the government level, through the adoption of laws, policies or standards; at the organizational level, by introducing an environment and resources conducive to the recognition of these issues, at the individual level, by supporting the cause and pursuing their personal development, and finally at the community level, by active community involvement in all aspects of developing access to French-language care services.

Finally, in terms of the availability of bilingual resources, it is clear that further efforts must be made. This involves several partners working together to ensure that bilingual human resources are developed, trained and then directed to where they are needed. To achieve this objective, the community, training institutions, health facilities and governments must develop a sound common strategy that will ensure the long-term sustainability of an efficient health system that provides quality French-language health care services.

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Appendix A – Glossary*

Linguistic competence: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate.[60]

Cultural competence: A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. [61]

Provision of health care that responds effectively to the needs of patients and their families, recognizing the racial, cultural, linguistic, educational and socioeconomic backgrounds within the community. [62]

Active offer: An offer of services in French which reflects measures taken to ensure that services in French are evident, readily available, easily accessible (whether provided by oral, written or electronic methods) and of comparable quality to those offered in English. [63]

Francophone vitality: Refers to a set of characteristics or resources that facilitate the linguistic promotion of the community or contribute to it, and that can be interpreted as a state or process of development.

Bilingualism: Refers to the ability to communicate competently in both official languages (English and French).

Required bilingualism: Refers to the requirement to communicate in both official languages, which is a bona fide occupational requirement for a designated bilingual position.

Designated bilingual facilities, programs, services and agencies: Facilities, programs, services and agencies that are required to actively offer services in both French and English.[64]

Designated bilingual position: A position that is to be filled by an individual who speaks both official languages and is able to adequately deliver comparable service in both official languages, in accordance with the principle of active offer.[65]

Designated Francophone facilities, programs, services and agencies: Facilities, programs, services and agencies where the working language is French and that are required to actively offer services in French.[66]

Designated bilingual health service centres: Refers to service centres located in a designated area where the Francophone population is concentrated and whose staff has a set number of bilingual employees to provide and promote services in both official languages. Designated bilingual health service centres will clearly indicate the availability of French-language services with appropriate signage and reception messages. Greetings to the public and clients are in both official languages. Posters, public notices and display materials are to be bilingual, as are documents, forms and other materials for the general public offered by the Centres.

Linguistic profile: Description of linguistic skills required in each official language. This includes a proficiency level for speaking (oral expression), comprehension (listening skills), reading and writing, as applicable for a designated bilingual position.[67]

[60] National Center for Cultural Competence (2011). Georgetown University, *www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html*

[61] *CROSS, T.L., BAZRON, B.J., DENNIS, K.W., ISAACS, M.R. (1989). Toward a Culturally Competent System of Care, Vol. 1, National Institute of Mental Health, Child and Adolescent Service Program (CASSP), Technical Assistance Center, Georgetown University Child Development Center*

[62] *BOWEN, Sarah (2000).* Introduction to Cultural Competence in Pediatric Health Care, *Prepared for Health Canada, Government Services Canada.*

[63] *French-language Services Policy – Designation of Bilingual Positions, Winnipeg Regional Health Authority, Policy no. 10.40.240, June 2008*

[64] *Idem.* [65] *Idem.* [66] *Idem.* [67] *Idem.*

Bilingual format: For forms, English and French are printed side by side or one after the other. Bilingual format includes the following options: side by side in two columns, two-sided (English on one side of the page, French on the other), top down (each version is in an inverse position compared to another). Due to the fact that English is the working language of the provincial governement and of the regional health authorities, the English usually appears before the French text or above it.

Separate language format: English and French texts are printed on separate sheets of paper. This technique is generally used when the English text is more than 10 pages long and cost and distribution are factors. In such cases, the French version must be of the same quality and both versions must be published simultaneously. Both documents must clearly indicate that the document is available in the other official language.

Designation of bilingualism: A designated bilingual position is to be filled by a person who can communicate in both official languages (English and French) and adequately deliver comparable service in both official languages, in accordance with the requirements of the Government of Manitoba's French-language Services Policy, from concept AD-124 French-language Services – General Policy.doc

* *N.B.: It should be noted that the definitions above may not reflect those used in all organizations throughout the province and may vary from one organization to another.*

Appendix B – United States CLAS Standards [68]

Culturally Competent Care (Standards 1 – 3)

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Language Access Services (Standards 4 – 7)

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

[68] *United States Culturally & Linguistically Appropriate Services (CLAS). Office of Minority Health, U.S. Department of Health and Human Services, www.hhs.gov*

Organizational Supports for Cultural Competence (Standards 8 – 14)

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.