Prepared for the MOH and the MOLTC

PROVINCIAL FLHS REPORT

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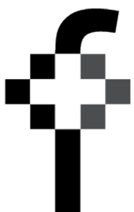
POWERED BY

OZI



French Language
Health Services Network
of Eastern Ontario

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Executive Summary

The Ontario health care system relies on evidence-based data to make informed decisions on issues that affect the health of the population. However, prior to OZi, limited standardized information on the services offered in French was available.

Offering French language health services (FLHS) derives from an obligation under the French Language Services Act (FLSA). According to MOHLTC guidelines, all health system stakeholders have specific roles to uphold in order to provide reasonable access to local FLHS across the entire continuum of care.

The OZi project aims to collect and analyze data in order to provide a portrait of FLHS capacity across the province. This initiative seeks to address the lack of standardized data in order to enable effective planning and informed decision-making.

Through the use of the OZi portal, data was collected from LHIN-funded health service providers (HSPs) on their capacity to provide FLHS. This report covers the second year of data collection (2018-2019).

The analysis focuses on four perspectives: distribution of HSPs, continuum of services, compliance to designation, and human resources. The highlights of the analysis are as follows:

- There has been a notable increase in the compliance rate of designation requirements, indicating some advancement in the provision of FLHS among the HSPs with such responsibility.
- In this second year, there appears to be a general improvement in the quality of the data collected through the OZi portal, especially with HR and with the categorization data by sector.
- In terms of responsibility for providing FLHS, the LTC sector remains the least well represented, both in number and in the breadth of the continuum of service. When considering the high number of HR with French language proficiency in this sector, the latter also has the greatest potential for improvement of FLHS.
- Almost two thirds of the designated local areas have no HPSs with the responsibility to provide FLHS in at least one sector of care. More than a third of the designated local areas have no designated or identified HSPs in 3 or more sectors.

With the introduction of performance indicators, we are able for the first time to demonstrate measurable progress in organizational behaviour with respect to designation requirements. It will be interesting to see if this leads to a measurable impact on the offer of FLHS in the future.

We also observed an increase in the uptake of OZi by various health care stakeholders, as it becomes a mainstay of FLHS accountability. The quality of the data improved as a byproduct of this uptake, and we expect this trend to continue. This will allow us to further develop the analysis perspectives and provide more in depth findings.

Recently, the MOHLTC was split into two separate ministries: the Ministry of Health (MOH) and the Ministry of Long-Term Care (MOLTC). With this change, there is recognition that the LTC sector needs a particular focus in order to address the challenges unique to that sector. When we consider FLHS, the LTC sector is the one that has the most potential to gain, and OZi could measure the impact of that reorganization.

The initial trends demonstrate that there is value in investing in the designation process. Identifying HSPs for future designation is the first step in this process, and the designated local areas with fewer FLHS could benefit from this. Furthermore, the data collected through OZi could also be used to identify the HSPs that would most improve the offer of FLHS, should they become designated.

Over the course of two years, the OZi project was able to provide baseline data on the status of FLHS at different levels, as well as some preliminary trends. In the long run, OZi has the potential to measure the impact of policy changes on FLHS.

Introduction

The Ontario health care system relies on evidence-based data to make informed decisions on issues that affect the health of the population. As such, health service planning takes into account the state of health of Ontarians as well as their use of health care services.

At present, however, the Ministry of Health and Long-Term Care (MOHLTC), Local Health Integration Networks (LHINs) and French Language Health Planning Entities (Entities) possess limited standardized information on the services offered in French. This lack of consistent data hampers efficient planning of French language health services (FLHS) across the continuum of care, and impedes the development and measurement of robust accountability related to the provision of FLHS.

Offering FLHS derives from an obligation under the French Language Services Act (FLSA), whereby all Ontario government services must be provided in French. In the health care system, this responsibility was reaffirmed in the MOHLTC's Guide to Requirements and Obligations Relating to French Language Health Services (Guide to FLHS) (2017); all system stakeholders (MOHLTC, LHINs, Entities, and Health Services Providers (HSPs)) have specific roles to uphold in order to provide reasonable access to local FLHS across the entire continuum of care.

The OZi project was a comprehensive data collection, analysis and reporting exercise aimed at providing a capacity analysis framework to support the system stakeholders. Through the use of the OZi portal, baseline data was collected from LHIN-funded HSPs. The OZi data, along with other data sources, was then analyzed using a set of 15 indicators grouped into three themes: FLHS responsibility; organizational practices conducive to FLHS; and FLHS opportunities. To further understand the current state of regional FLHS capacity, data was compiled by the LHINs and further broken down by health sector and local area. For a detailed view of each individual LHIN's FLHS capacity, with analyses by local areas and sectors of care, please reference the RSSFE's 14 LHIN capacity report.

For the purposes of this report, two dimensions were added to the analysis framework. These dimensions are the Francophone Population density regions and the designated local areas. The themes were also remodelled into four capacity analysis perspectives: the HSP distribution; the FLHS continuum of care; the compliance to designation; and human resources. This framework provides a high-level view of the current state of Ontario's FLHS capacity across the continuum of care and how it is more suited to support the roles and responsibilities of the Ministry.

Analytical Framework

The data has been analyzed using various distributions and concepts that are defined in this section. A glossary of terms is available in Appendix 1.

Responsibility for the Provision of FLHS

Responsibility for French-language services (FLS) is exercised through designation, which is a legal and administrative procedure that follows the rules and procedures prescribed by the FLSA, Ontario Regulation 398/93 and MFA directives. This legislative and regulatory framework enables HSPs to demonstrate that they have the capacity to provide French-language services on a permanent basis while meeting the specific needs of the Francophone population they serve. (This applies only to the services included in their designation.)

The Guide to FLHS indicates that all providers within a given region may contribute to providing FLHS. All HSPs should, therefore, be included when determining the FLHS capacity of a region. It is not necessary for all HSPs to be able to offer FLHS with the same degree of coverage in the continuum of care, but their efforts must be combined to arrive at an efficient provision of FLHS all along the continuum of services and care. To achieve this, the Guide to FLHS assigns different levels of responsibility to HSPs: Designated, Identified, and Non-Identified.

All HSPs within a given region must contribute to the provision of FLHS, in accordance with their level of responsibility. This obligation gives rise to the concept of FLHS capacity. "Capacity" refers to the ability to provide FLHS and may be examined at different levels: in an HSP; in a local area; by sectors of care; or across a LHIN.

At the LHIN level, capacity is ensured through the distribution of responsibility for FLHS. At the HSP level, capacity is ensured through sufficient human resources (HR) with an adequate level of French language proficiency. For the purpose of this report, designated HSPs are considered to have full FLHS capacity, while identified HSPs are considered to have a certain capacity that is being developed through designation. Non-identified HSPs are not considered to have the capacity to offer FLHS, though they may have some HR with varying levels of French language proficiency.

It is worth recalling the different levels of responsibility that HSPs may have – according to their designation status – related to the provision of FLHS.

Designated HSPs have an obligation to provide all their services in French on a guaranteed and permanent basis, in compliance with the 34 designation requirements. They must also submit a statement of compliance to the MFA on a three-year basis to demonstrate that they are still compliant with the designation requirements. It is worth noting that a designated HSP is considered to have full capacity to provide services in French and its presence is analogous to the existence of effective FLHS delivery.

Identified HSPs have been selected to work toward designation under the FLSA. These HSPs have a responsibility to develop a French Language Services Plan and to provide services in French in accordance with existing FLHS capacity. The progress these HSPs make toward designation tells us about the development of FLHS in the region.

Non-identified HSPs are neither identified for designation nor designated under the FLSA. Although there is no expectation for these HSPs to have FLHS capacity, they still have a responsibility to develop and implement a plan to address the needs of their local Francophone community. This includes providing information on health services available in French in their region. To this end, they should adopt certain organizational practices conducive to the provision of French language services. These practices will be further explored in section 2 ("Analytical Framework for Assessing Capacity").

Provincial, LHIN and Local Area Distribution

The provincial level represents Ontario as one large all-encompassing geographical region/territory. It includes by default the sum of any other geographic distribution.

The LHIN level outlines the 14 geographical regions/territories under each LHIN's jurisdiction.

The local area level represents the 76 local areas found in Ontario. This level can also be represented by LHIN. In this case, it represents the local areas found specifically within a given LHIN's geography.

Sectoral Distribution

The distribution by sectors of care provides a high-level overview of FLHS capacity across the continuum of care. The five sectors of care considered are:

- hospitals
- mental health and addiction services (MHA)
- long-term care (LTC)
- community support services (CSS), and
- community health centres (CHC).

Each HSP was attributed to one or more sector(s) of care by their LHIN, and this attribution serves as the basis of the sectoral distribution.

Francophone Population Density Region Distribution

Francophone population density varies significantly in certain regions. To better represent capacity, two Francophone population density region distributions were created for this report: the high Francophone population density region and the low Francophone population density region. The high Francophone population density region is composed of the Champlain and North East LHINs. The Low Francophone Population density region encompasses the 12 remaining LHINs. A detailed rationale of distribution can be found in the Francophone population overview section.

Designated Local Areas

A designated local area is a local area that shares its geography, whether entirely or partially, with a designated area. These were defined by cross-referencing all 26 designated areas according to the FLSA with the 76 local areas according to the MOHLTC and LHINs. This distribution provides insight into the application of the FLSA in the health care planning framework. Further information is provided in the overview of the designated local area section below.

Note that it is possible for an HSP to be designated or identified in a non-designated local area when such HSP provides services to the population of a designated area. This minimizes the need for a facility to be present in the designated local area. In health care, this allows planning access to FLHS, while recognizing that various types of services are planned using a per capita ratio and cannot be expected to be provided physically in every designated local area.

Caveats/Limitations

This report is based on data collected for administrative purposes as part of each HSP's obligation to provide a yearly French Language Services report. This is the first year of data collection of this nature using a web-based reporting software new to all stakeholders (LHINs, Entities and HSPs).

As a result, there may be limits related to:

- differences in the definitions of the concepts
- a level of data quality control
- a lack of complete data.

To reduce the anticipated effects of these limits, training and support were provided to staff responsible for collecting the data. In addition, a report validation review was done locally by LHINs and Entities to ensure the highest degree of FLS report completion and submission by the HSPs.

- The data collected provides a portrait of FLHS capacity in accordance with the parameters set by the analytical framework and set indicators. The data will also serve as a baseline for evaluation of FLHS provision.
- Furthermore, as some indicators are based on percentages, the sample size must be taken into consideration.

Finally, the following caveats should be noted:

- Some LHINs chose not to extend the OZi data collection project to their Indigenous HSPs, while other LHINs invited their Indigenous HSPs to take part in the data collection project on a voluntary basis. For the purpose of this report, Indigenous HSPs who submitted an FLS Report were included in the figures and analyses, while Indigenous HSPs who did not submit an FLS Report were excluded.
- The distribution of HSPs by local areas and sectors of care means that a single HSP may be counted a number of times if it operates in several local areas or sectors. The number of HSPs counted by local areas or sectors may thus be greater than the total number of HSPs actually present in the geographic distribution.

Evolution of Results

In order to properly compare the results between the 2017-2018 period and the 2018-2019 period, it

is necessary to highlight some factors that may have an impact on the results. Note that in order to ensure temporal consistency, the data collection and processing methods remains unmodified for this reporting period.

However, as highlighted in the previous section on Data Limitations, the availability and the quality of the data along with the interpretation of the definitions naturally evolve. As HSPs and LHINs gain a more thorough understanding of the measurements, and as practices become more standardized, it is normal to expect that the measurement methods used within the organizations improved. Thus, the accuracy of the reported data is expected to improve over time.

Also, in an effort to integrate user feedback and improve user satisfaction and the quality of the data collected, some adjustments were made to the OZi Portal. The more notable changes were:

- An online tool that allows the LHINs to validate the allocation of care sectors and local areas for each HSP. Previously, this was only done via email.
- The data entry method for human resources in non-identified HSPs was modified to allow a count for job positions filled with HR with French language proficiency. Previously, a unique entry was required for each position filled. This method was already in place for identified and designated HSPs.

The area in which we observe the greatest evolution is in the assignment of care sectors and local areas for each HSP. For the current period, some of these assignments were changed to be more reflective of the reality. As a result, some of the year-over-year changes are not caused by a trend in FLHS, but rather due to the changes in number and categorization of HSPs. The effect on the results is more noticeable when the sampling size is smaller, such as at the local area level, and less so at the provincial level.

Overview of Designated Local Areas

In health care, the geographic catchment areas are distributed in accordance with the health system boundaries created by the LHINs and the local areas. From a provincial perspective, the geography can be viewed as one single province, 14 LHIN catchment areas and 76 local areas.

From the FLSA perspective, a geographic region in Ontario can become a designated area if, according to the Ministry of Francophone Affairs (MFA), Francophones make up at least 10% of the population in a given area. Also, in urban centres, there must be at least 5,000 Francophones. In designated areas, a Francophone has the right to receive services in French from government services and programs. In Ontario, there are 26 designated areas under the FLSA (see Appendix 2 for a complete list), and these geographic catchment areas serve as the basis to French-language service planning and delivery.

To understand the correlation between the geographic boundaries in the health care system - regions where Francophones have a right to receive health care services in French - we superimpose designated areas and local areas to identify where they coincide.

We use the term designated local areas to define a local area that shares its geography, partially or completely, with a designated area.

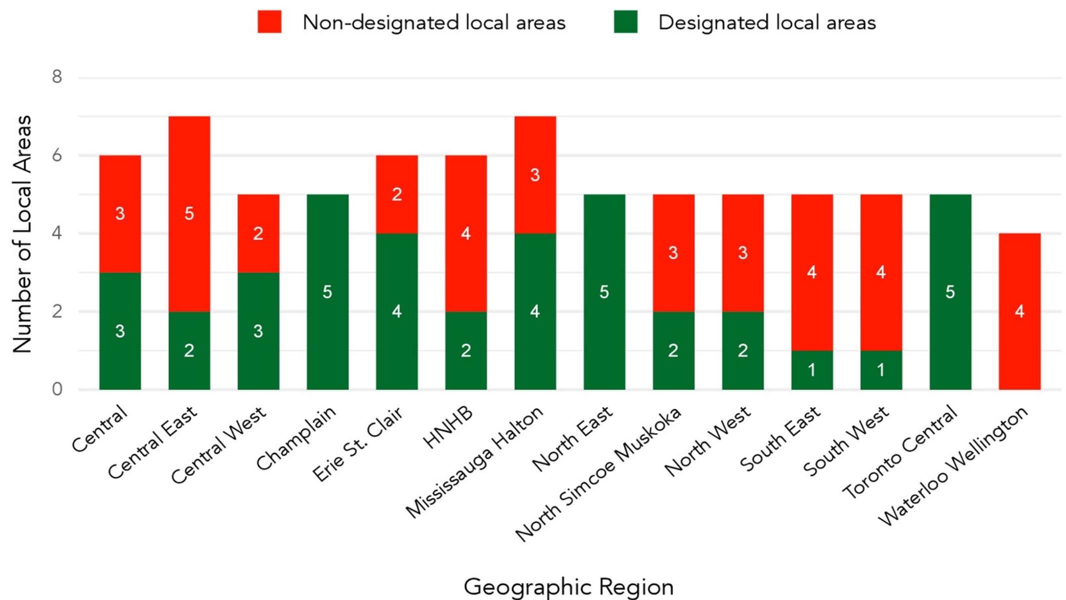
In total, there are 37 local areas in Ontario that coincide with the 26 designated areas and therefore, 37 designated local areas. A complete list of designated local areas per LHIN can be found in Appendix 3.

Figure 1 demonstrates that all the local areas found in the Champlain, North East and Toronto Central LHINs are designated local areas. The Waterloo Wellington LHIN, on the other hand, is the only LHIN without designated local areas. For the remaining 10 LHINs, the portion of the designated local area ranges between 1 and 4. In essence, 13 of 14 LHINs have designated local areas in which they need to plan FLHS.

An in-depth analysis was conducted of the designated and non-designated local areas in order to understand how they were distributed across Ontario. The goal of this analysis was to discover the distance between the designated local areas, and to see if there were any obvious FLHS obligations - or, to borrow a term from telecommunications - dead zones in Ontario. The greater the breadth of these dead zones, the more difficult it would be for a Francophone living in such region to access services in French.

This analysis highlighted that only seven non-designated local areas were not directly adjacent to a designated local area. Seven out of 76 is a relatively small proportion, but based on how they are positioned, they create two significant geographic dead zones where there are no obligations to provide French Language Services under the FLSA to Francophones living in those regions. These dead zones are found between Scarborough and Kingston, as well as in and around the Waterloo Wellington LHIN region.

Figure 1. Distribution of Designated and Non-Designated Local Areas



Overview of the Francophone Population

The distribution of the Francophone population drives the need for FLHS and therefore leads to the FLHS capacity. Figure 2 represents the proportion of Francophone population found in each LHINs. Table 1 provides the distribution by at the provincial and regional level, and also within the designated local areas.

Most LHINs have a Francophone population ranging between 1.4% to 3.3%, with two notable exceptions: the Champlain LHIN and the North East LHIN. The Champlain and the North East LHINs have significantly higher Francophone population density, ranging from 19.8% and 22.5% Francophone population respectively.

Figure 2: Distribution of the Francophone Population

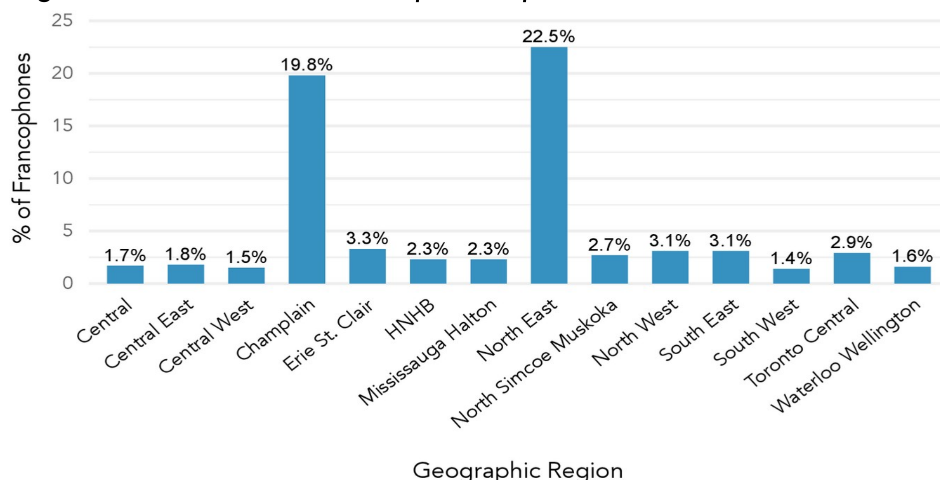


Table 1. Distribution of the Francophone Population at a Provincial, Regional and Designated Local Area Level

Geographic region	Total Population	# of Francophones	% Francophones	# of Francophones living in a designated local area	% of Francophones living in a designated local area
Ontario	13,242,160	616 ,805	4.7 %	531,240	86.13 %
Central	1,796,585	30,810	1.7 %	17,935	58.21 %
Central East	1,528,935	27,425	1.8 %	10,055	36.66 %
Central Weat	916, 755	13,625	1.5 %	12,095	88.77 %
Champlain	1, 266,560	251,205	19.8 %	251,205	100 %
Erie St. Clair	615,375	20,230	3.3 %	16,260	80.37 %
Hamilton Niagara Haldimand Brant	1,372,640	31,260	2.3 %	23,695	75.79 %
Mississauga Halton	1,153,200	26,445	2.3 %	17,185	64.98 %
North-East	541,705	121,740	22.5 %	121,740	100 %
North Simcoe Muskoka	455,660	12,250	2.7 %	9,145	74.65 %
North West	224,105	6,970	3.1 %	3,270	46.92 %
South East	470, 510	14,570	3.1 %	5,765	39.57 %
South West	935, 410	12,960	1.4 %	7,990	61.65 %
Toronto Central	1,209,845	34,905	2.9 %	34,905	100 %
Waterloo Wellington	754, 875	12,410	1.6 %	0	0 %

Table 2: Distribution of the Francophone Population Between Low and High Francophone Density Regions

Geographic region	Number of Francophones	% of Francophones
Low Francophone Population Density Region	243,860	39.53%
High Francophone Population Density Region	372,945	60.46%
Total	616,805	100%

In fact, Table 2 demonstrates that 60.46% of the Francophone population of Ontario is located in the Champlain and North East LHINs, with the remaining 39.5% distributed amongst the remaining 12 LHINs. This variance in population density gives rise to the high and low Francophone population density regions described in the analytic framework.

Viewed from the distribution of designated local areas, it can be observed that 86% of the Francophone population resides in such catchment areas (see Table 1). By cross-referencing local areas with the Francophone population data, five non-designated local areas are highlighted as having more than 5,000 Francophones. These local areas are located in:

- Kitchener-Waterloo-Wellesley-Wilmot-Woolwich (Waterloo Wellington LHIN)
- Oakville (Mississauga Halton LHIN)
- Western York Region (Central LHIN)
- Durham North East (Central East LHIN), and
- Durham West (Central East LHIN).

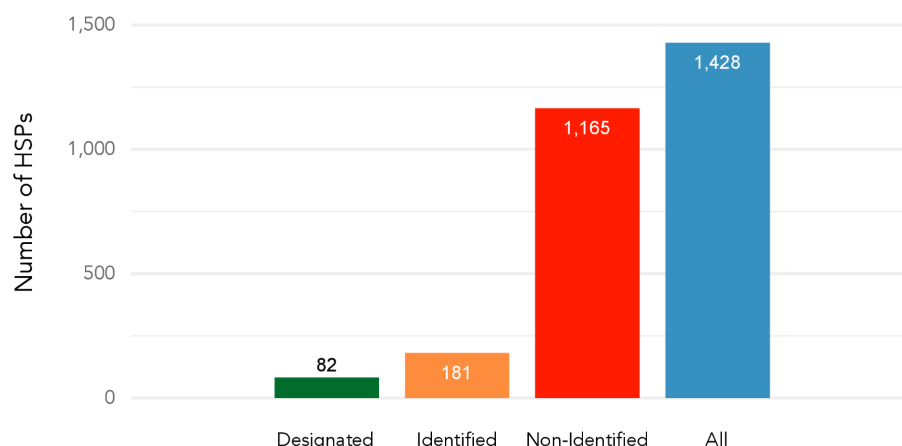
In many cases, local areas are no bigger than some designated urban areas under FLHS. In addition, the aforementioned local areas are mostly found in the FLSA dead zones.

Capacity Analysis Perspective 1: Distribution of HSPs

HSPs are responsible for providing health services to the population. Understanding their level of responsibility, the health sector they belong to and where each HSP is located, is the basis of the FLHS capacity analysis. This defines where there currently is capacity, where it is being developed, where there is room for improvement and, ultimately, if the current capacity is sufficient to ensure a reasonable provision of FLHS.

The provincial distribution presented in Figure 3 demonstrates that, out of the 1,428 LHIN-funded HSPs, 82 or 6 % of HSPs are designated and 181 or 13% of HSPs are identified. This means that a combined percentage of 18% of HSPs have, by definition, a responsibility to provide or develop their services in French. The remaining 1,165, which represents 82% of all LHIN-funded HSPs, are non-identified.

Figure 3: Provincial Distribution of HSPs by Responsibility Level



There is a slight difference in the total number of HSPs when compared to the previous year. This can be explained in part by the HSP mergers that were reported during the reporting period. In addition, some HPSs with a mixture of identified and non-identified services reported as multiple HSPs in the previous year, whereas their reports were consolidated for this reporting period. This is particularly noticeable among the HSPs that provide services in more than one sector of care, or for which only a part of the programs are identified or designated. However, the proportions have remained more or less the same.

Table 3: Provincial Distribution of HSPs by Responsibility Level

	Designated		Identified		Designated & Identified		Non-Identified		All
	# of HSP	%	# of HSP	%	# of HSP	%	# of HSP	%	# of HSP
Ontario	82	6%	181	13%	263	18%	1165	82%	1428

When the data is distributed by sector, it is evident that the distribution of designated and identified HSPs is uneven. For instance, the percentage of designated and identified long-term care homes is significantly lower than other sectors, with a combined percentage of 8%. On the other hand, the hospital sector has a fair proportion of HSPs either designated or identified, at 46%. At a provincial level, it is hard to determine if this translates into reasonable capacity. A LHIN-level distribution will provide a more appropriate view.

Figure 4: Distribution of HSPs by Responsibility Level and Sector

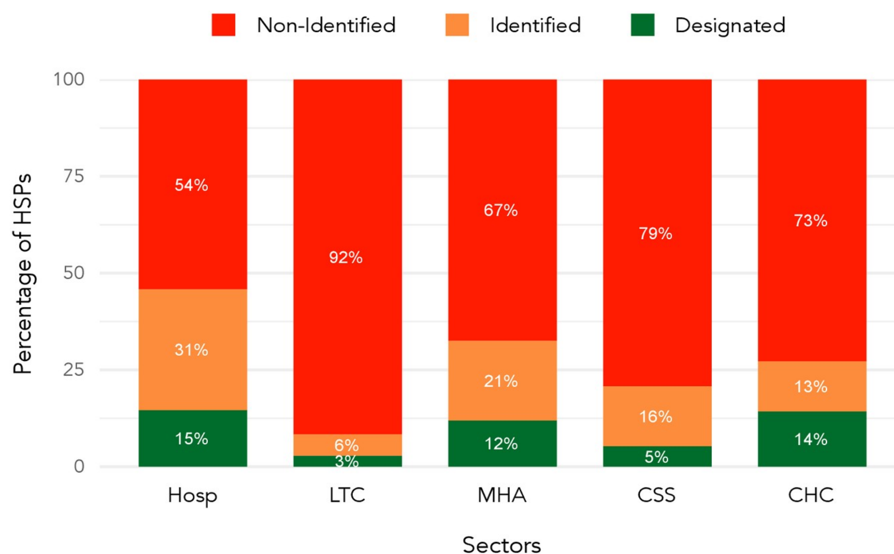


Table 4: Provincial Distribution of HSPs by Responsibility Level and Sector

Sector	Designated		Identified		Designated & Identified		Non-Identified		All
	#	%	#	%	#	%	#	%	#
Hosp	21	15%	45	31%	66	46%	78	54%	144
LTC	17	3%	33	6%	50	8%	547	92%	597
MHA	36	12%	62	21%	98	33%	203	67%	301
CSS	26	5%	76	16%	102	21%	388	79%	490
CHC	11	16%	10	13%	21	27%	56	73%	77

At the LHIN level, the distribution of HSPs per sector helps to identify high-level gaps more clearly. For instance, the absence of designated HSPs in one or more sectors demonstrates that an entire sector lacks capacity. No identified HSPs in one or more sector means that no capacity is being developed in a given sector. There might be some cases where it is not necessary to develop capacity in a sector if designated HSP assumes the responsibility, but this is seldom the case.

Figure 5 represents the number of sectors with at least one identified or designated HSP and demonstrates some clear gaps in capacity. As a matter of fact, only the Champlain and North East LHINs have at least one designated HSP in each sector. All sectors in North Simcoe Muskoka, Érié St-Clair, Hamilton Niagara Haldimand Brant, North West, as well as the South West LHINs, have at least one HSP responsible - or a combination of identified HSPs - for providing or developing capacity through identified HSPs.

In contrast, in four LHINs, at least three sectors of care have no designated or identified HSP. Finally, of the 14 LHINs with designated locations, only two have at least one designated HSP per area of care. Again, this is the Champlain and North East LHINs. A detailed table can be found in Appendix 4.

Figure 5: Sector(s) with at Least One Designated and/or Identified HSP

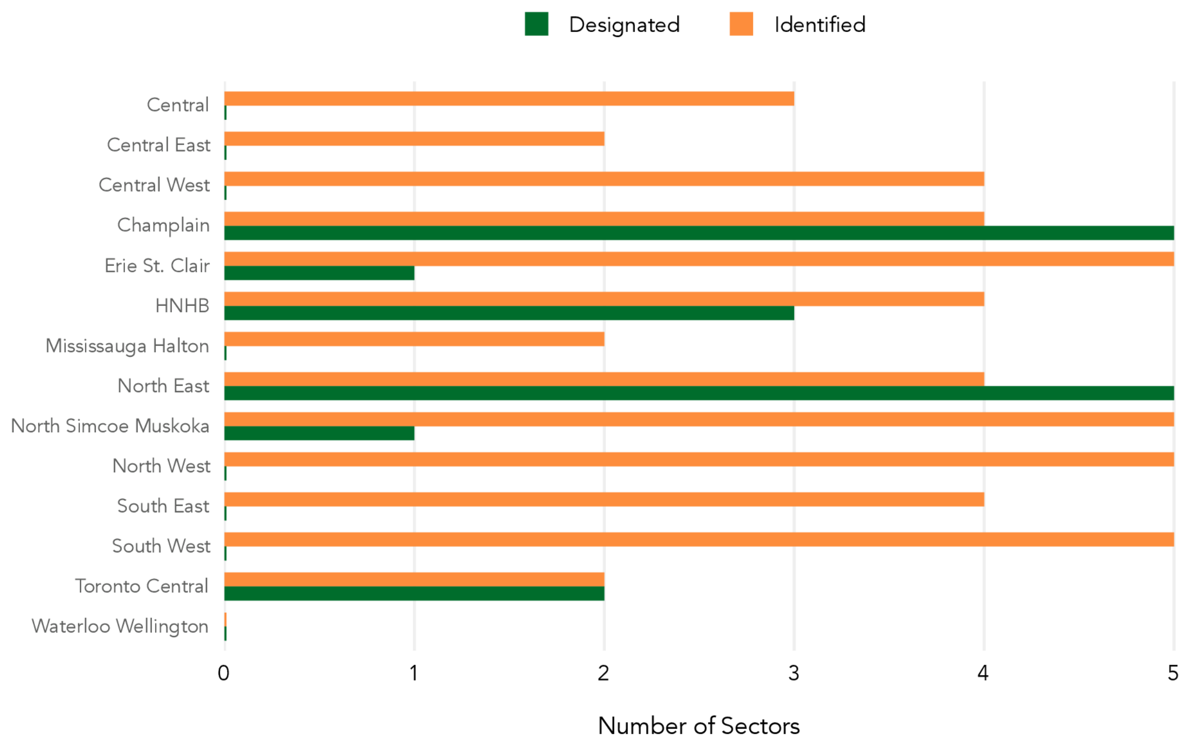


Table 5: Provincial Distribution of HSPs by Level of Responsibility and Francophone Population Density Regions

Francophone Population Density Region	Designated		Identified		Designated & Identified		Non-Identified		All
	#	%	#	%	#	%	#	%	#
Low	7	1%	117	10%	124	11%	1043	89%	1067
High	75	29%	64	25%	139	53%	122	47%	261
Total	82	6%	181	13%	263	18%	1165	82%	1428

When HSPs are distributed between low and high Francophone population density regions, the number and percentage of designated HSPs is small in low Francophone population density region. In fact, there are seven designated HSPs in a geographic area that equates to 12 LHINs. It is hard to imagine that seven designated HSPs would suffice to provide FLHS in such vast geography.

In contrast, the high Francophone density region has 75 designated HSPs distributed over two LHINs. This number represents 91% of all designated HSPs across the province, and 29% of all HSPs in the high Francophone density region.

In terms of identified HSPs, the low Francophone density region have almost double the number of identified HSPs found in the high density region, with 117 (65% of all identified HSPs) compared to 65 in the high Francophone density region.

A distribution of HSPs by sector, both in high and low Francophone population density regions, quickly brings to light the scarcity of designated HSPs in the low Francophone population density region. For example, only one hospital, one HSP in the mental health and addictions sector, and one long-term care home have the obligation to offer a certain level of FLHS capacity.

In both low and high density regions, the LTC sector is the one where the proportion of identified and designated FSS is the lowest. This is especially acute in the low Francophone density region.

Figure 6: Distribution of HSPs in High Francophone Population Density Region

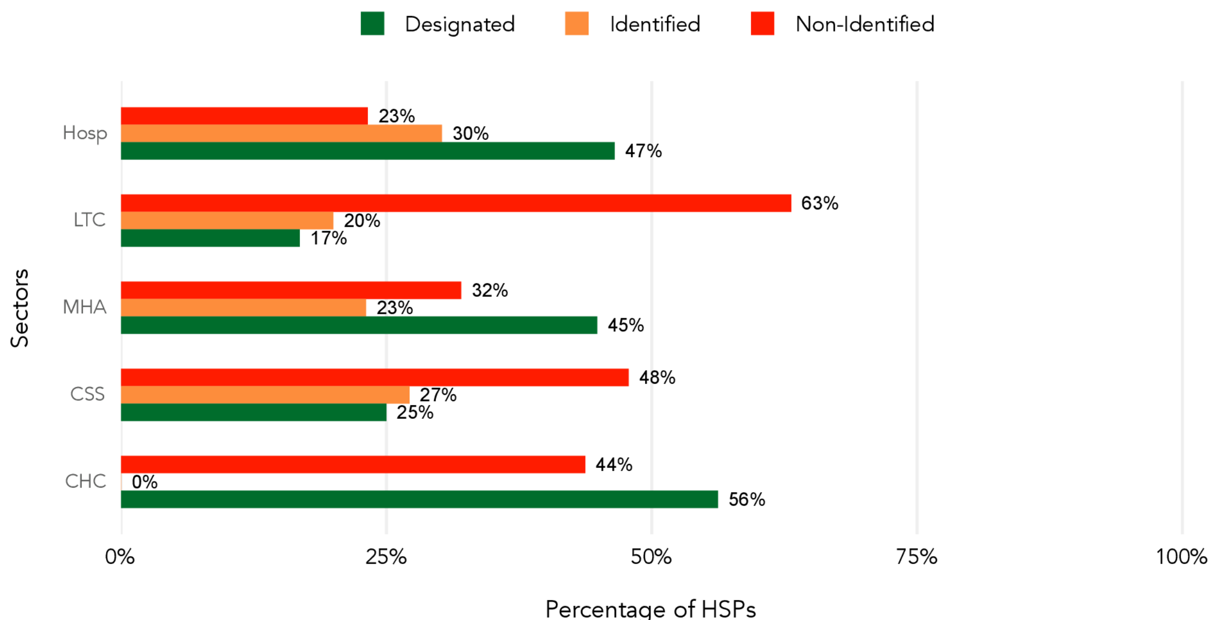


Figure 7: Distribution of HSPs in Low Francophone Population Density Region

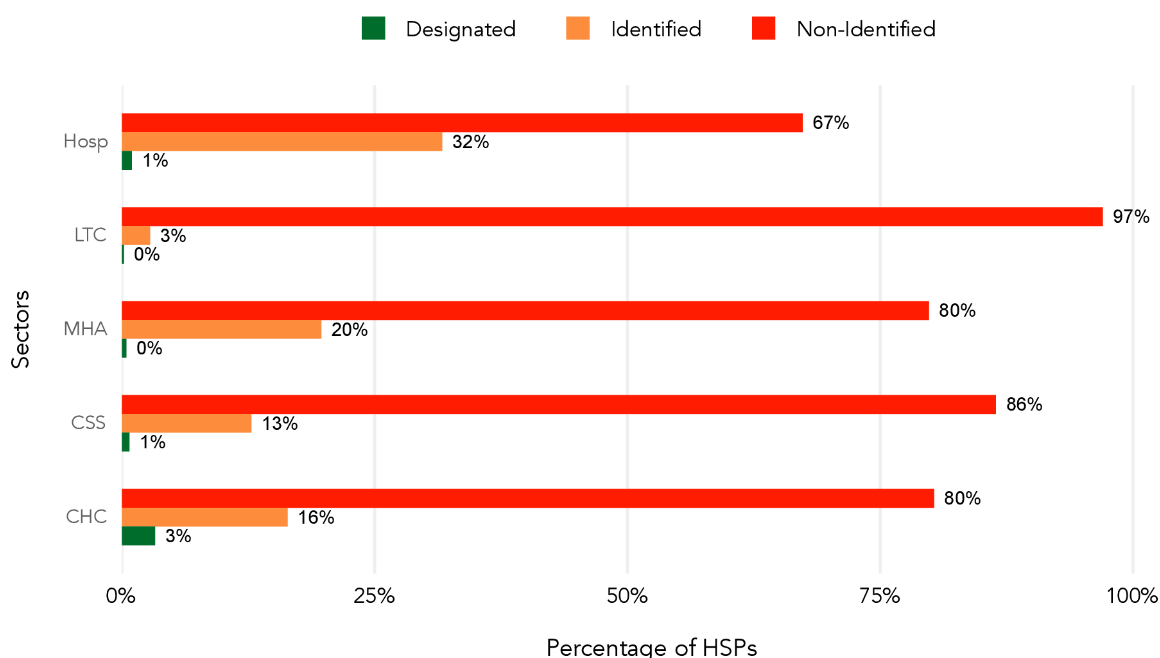


Table 6: Provincial Distribution of HSPs by Francophone Density Regions and Sectors

Sector	Designated				Identified				Non-Identified				All	
	Low Density		High Density		Low Density		High Density		Low Density		High Density		Low	High
	#	%	#	%	#	%	#	%	#	%	#	%	#	#
Hosp	1	1%	20	47%	31	32%	13	30%	65	67%	10	23%	97	43
LTC	1	0%	16	16%	10	2%	20	20%	488	98%	62	63%	499	98
MHA	1	0%	35	44%	36	16%	17	22%	182	83%	27	34%	219	79
CSS	3	1%	23	26%	49	12%	26	29%	344	87%	41	46%	396	90
CHC	2	4%	9	53%	7	13%	0	0%	44	83%	8	47%	53	17

A sectoral distribution, at the local area level, can also help understand capacity and gaps. In fact, since local areas are smaller geographic catchment areas, capacity can translate, to some degree, the level of accessibility of FLHS. In addition, by differentiating between HSPs providing services to a designated local area vs a non-designated local area, gaps in FLHS provision also become gaps in access to services in French in a designated area under the FLSA. Please note that in this distribution, an HSP is providing serving in a local area as opposed to only being physically found in a local area. As a result, one HSP can provide services to more than one local area, whether it is a designated or non designated local area.

Figure 8 and Table 7 demonstrate that almost all designated HSPs provide services exclusively to designated local areas, with a small exception of three HSPs in the CSS sector. As for identified HSPs, there is a higher proportion in designated local areas in every sector. When designated and identified HSPs are combined in designated local areas, their proportion becomes significant, ranging between 12% (LTC) and 69% (hospitals). When the designated and identified HSPs are combined in non designated localities, their proportion is lower, ranging between 3% (LTC) and 23% (hospitals).

Figure 8: Distribution of HSPs in Designated Local Areas

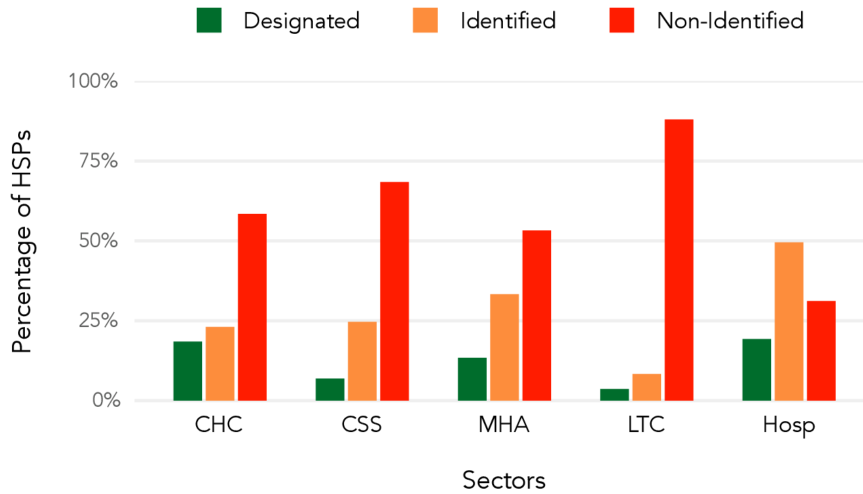


Figure 9: Distribution of HSPs in Non-Designated Local Areas

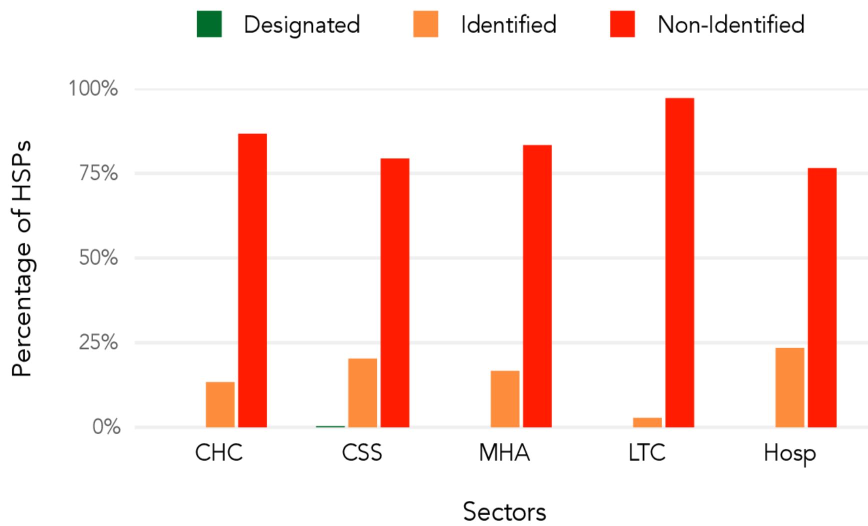
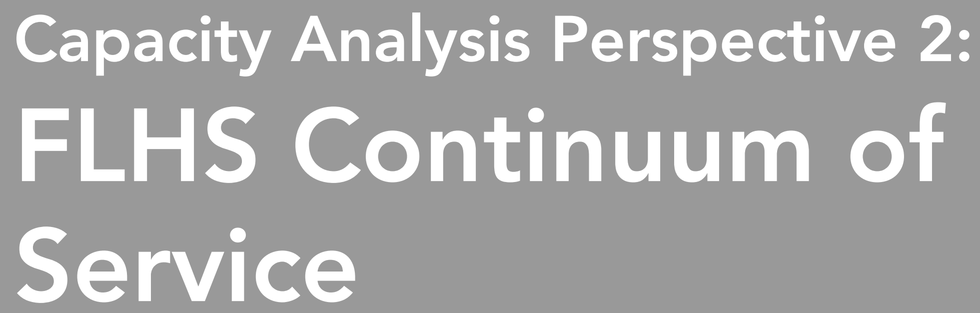


Table 7: Provincial Distribution of HSPs Providing Services in Designated vs Non-Designated Local Areas and Sectors

Sector	Designated				Identified				Non-Identified			
	Designated Local Area		Non-designated		Designated Local Area		Non-designated		Designated Local Area		Non-designated	
	#	%	#	%	#	%	#	%	#	%	#	%
Hosp	21	19%	0	0%	54	50%	15	23%	34	31%	49	77%
LTC	17	4%	0	0%	39	8%	9	3%	412	88%	312	97%
MHA	37	13%	0	0%	92	33%	24	17%	147	53%	120	83%
CSS	30	7%	1	0%	107	25%	64	20%	297	68%	250	79%
CHC	12	18%	0	0%	15	23%	4	13%	38	58%	24	87%



Capacity Analysis Perspective 2:

FLHS Continuum of Service

The service perspective defines to what extent each HSP is contributing to the breadth of service continuum accessible in French. This is done by identifying the percentage of LHIN-funded direct services of each HSP using functional centres subject to designation or identification.

In The Guidelines for Management Information Systems in Canadian Health Service Organizations, financial and statistical data is recorded by functional centre, type of expense, and revenue source. The functional centres correspond to the core activities carried out by the HSPs and enable organizations to have comparable financial information and related statistics (such as workload and patient activity) for the many clinical services they provide. This data can then be used to calculate key indicators, providing a useful tool to measure and monitor performance.

By listing all funded functional centres from each HSP, removing redundancies to capture unique functional centres, and extracting those that represent direct services to the population (thus removing administrative functional centres), we are left with a representation of the continuum of direct services provided in a given geographic region. From a provincial level, all LHIN-funded HSPs were taken into account. At a LHIN level, only the HSPs funded by its respective LHIN were taken into account. The same method applies to the sectoral distribution, where only the functional centres funded in a given sector are taken into account.

Two methods were used to represent the direct service continuum per responsibility level. The first method is to distribute all unique functional centres per responsibility as presented in Figure 10 and Table 8. In this representation, the same unique functional centres can be attributed to more than one responsibility level. This is possible when a designated, an identified HSP, and even a non-identified HSP are funded for the same functional centre. This allows us to understand the continuum of direct services for each responsibility level independently. This representation is useful for the planning and development of capacity at a local level, as accessibility to various local areas may require more than one HSP per functional centre.

For the second method, each unique functional centre can be categorized at only one responsibility level, as presented in Figure 11 and Table 9. To do so, priority was given to designated services, then identified service and lastly, non-identified services. As a result, the sum of all services adds up to 100%. This representation of the continuum of service provides a clearer sense of the proportion of accessible services, those that are developing capacity, and those that are considered to have no capacity (or where capacity is left to chance). This provides a more adequate representation to understand gaps in the continuum of direct services.

Figure 10: Provincial Distribution of LHIN-Funded Direct Service by Sector

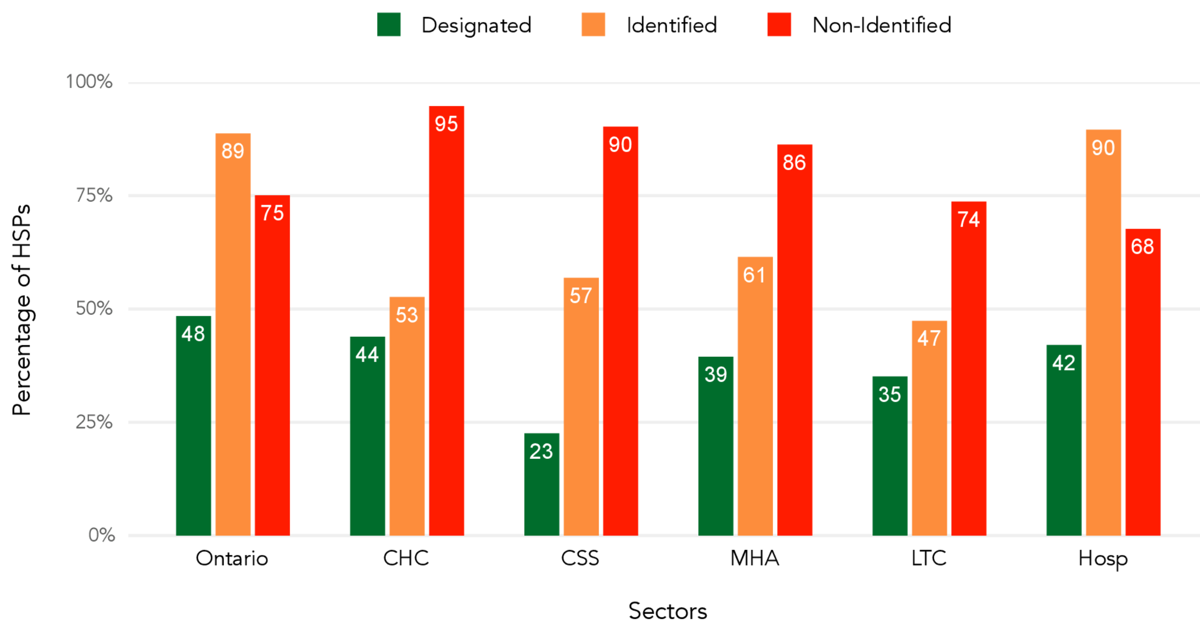


Table 8 informs us that 48% of all LHIN-funded direct services have at least one designated HSP in Ontario. As a result, 52% of LHIN-funded direct services are not guaranteed to be accessible in French in Ontario. Furthermore, the distribution by sector demonstrates that a sector such as CSS can guarantee only 23% of all CSS-funded services in French. Identified services, when combined with designated services, on the other hand, cover a significant proportion of the continuum of care, with 89%. Further information on this data is available in Appendix 5. This baseline data will help improve the capacity of FLHS, making it possible to measure and trend over time the progress of designated services.

The distribution of direct services prioritized by responsibility level highlights where there is a lack of service or with developing capacity. This lack is represented by the non-identified services portion of Figure 11 for each sector.

When comparing this data with that of the 2017-2018 period, we observe an increase in the proportion of designated services in the majority of sectors. This change is mainly due to the adjustment of the distribution of FSS among the care sectors for the period 2018-2019, and gives a more accurate picture.

Figure 11: Provincial Distribution of Prioritized LHIN-Funded Direct Services by Responsibility Level

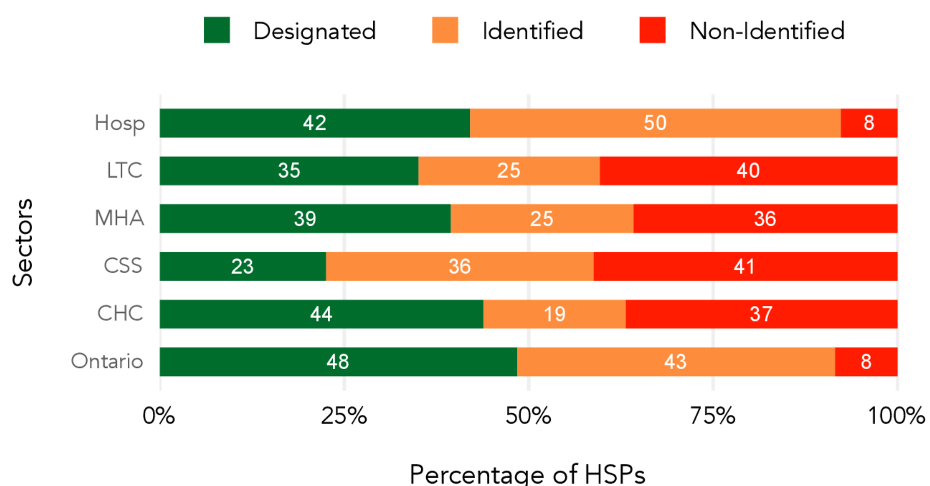


Table 8: Provincial Distribution of LHIN-Funded Direct Services per Sector

Responsibility Level	% of LHIN-Funded Unique Direct Services by priority of responsibility level					
	Hospitals	LTC	MHA	CSS	CHC	Ontario
Designated	42%	35%	39%	23%	44%	48%
Identified	90%	47%	61%	57%	54%	89%
Non-Identified	68%	74%	86%	90%	95%	75%

Table 9: Provincial Distribution of Prioritized LHIN-Funded Direct Services by Responsibility Level and Sector

Responsibility Level	% of LHIN Funded Direct Services					
	Hospitals	LTC	MHA	CSS	CHC	Ontario
Designated	42%	35%	39%	23%	44%	48%
Identified	50%	25%	25%	36%	19%	43%
Non-Identified	8%	40%	36%	41%	37%	8%

Table 10 provides a list of designated local areas where no service in at least one area of care is offered by a designated or identified HSP. A total of 23 out of the 37 designated local areas contain at least one care sector with no HSP with FLHS obligations. In addition, 14 local areas do not have services offered by identified or designated HSPs in at least three sectors of care.

Table 10: Designated Local Areas Where All LHIN-Funded Direct Services Are Only Offered by Non-Identified HSPs in at Least One Sector

LHIN	Designated Local Area	# of Francophones	Sector(s) with services only offered by non-identified HSPs
Central	Eastern York Region	5,270	CSS, Hosp, LTC, MHA
	North York Central	8,890	CHC, CSS, LTC
	North York West	3,775	CSS, Hosp, LTC
Central East	Scarborough North	2,345	CHC, CSS, LTC, MHA
	Scarborough South	7,710	CSS, Hosp
Central West	Bramalea and Area	3,550	CHC, LTC
	Brampton and Area	5,525	LTC
	North Etobicoke, Malton, West Woodbridge	3,020	LTC
Champlain	Western Champlain	8,405	CHC
	Western Ottawa	26,460	Hosp, LTC, MHA
Mississauga Halton	East Mississauga	5,765	CHC, LTC, MHA
	North West Mississauga	5,920	CSS, LTC, MHA
	South Etobicoke	2,550	CSS, LTC, MHA
	South West Mississauga	2,950	LTC, MHA
North Simcoe Muskoka	Barrie and Area	6,075	CHC, CSS, LTC
North West	District of Kenora	1,125	CSS, LTC, MHA
	District of Thunder Bay	2,145	CSS
South East	Kingston	5,765	CHC
Toronto Central	East Toronto	7,130	CHC, CSS, Hosp, LTC, MHA
	Mid-East Toronto	5,885	CHC, Hosp, LTC, MHA
	Mid-West Toronto	9,800	CSS, LTC
	North Toronto	5,450	CHC, CSS, LTC, MHA
	West Toronto	6,640	CHC, CSS, Hosp, LTC

Figures 12 to 16 represent the LHIN-level distribution of funded unique direct services prioritized by responsibility level. Each figure represents a sector. At a glance, these figures make the lack of FLHS service quite obvious in various sectors. In the hospital sector, most LHINs, except for the Central East LHIN, have capacity being developed through identified HSPs. As for the other sectors, the gaps are variable from one LHIN to the other.

As a reminder, only the Waterloo Wellington LHIN does not have any designated areas, designated or identified HSPs and therefore, 100% of its direct services are non-identified.

Figure 12: Provincial Distribution of Prioritized LHIN-Funded Direct Services in the Hospital Sector

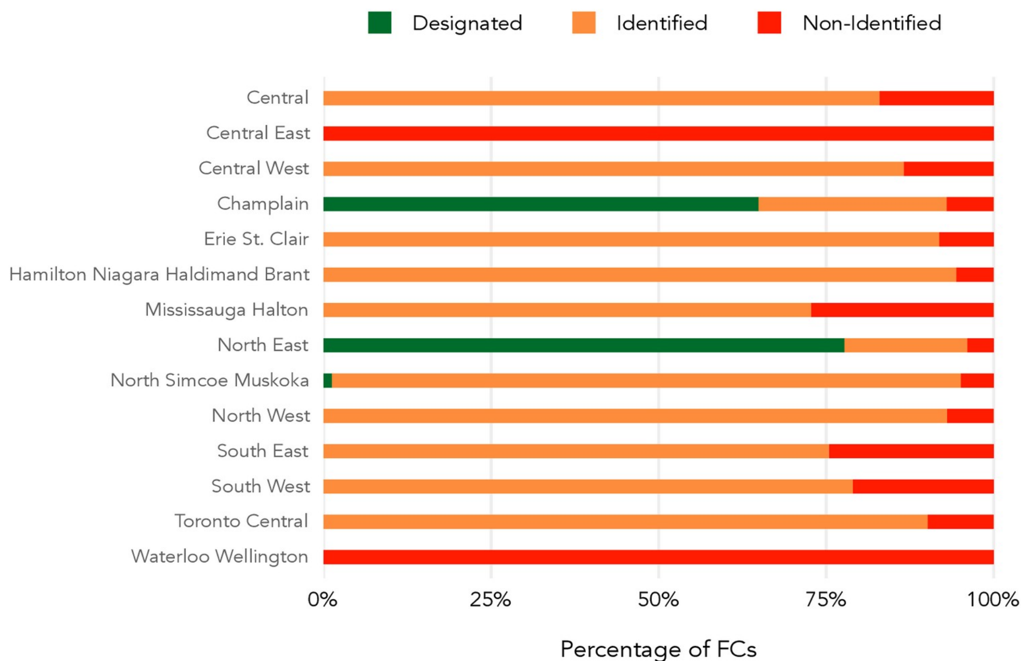


Figure 13: Provincial Distribution of Prioritized LHIN-Funded Direct Services in the Hospital LTC

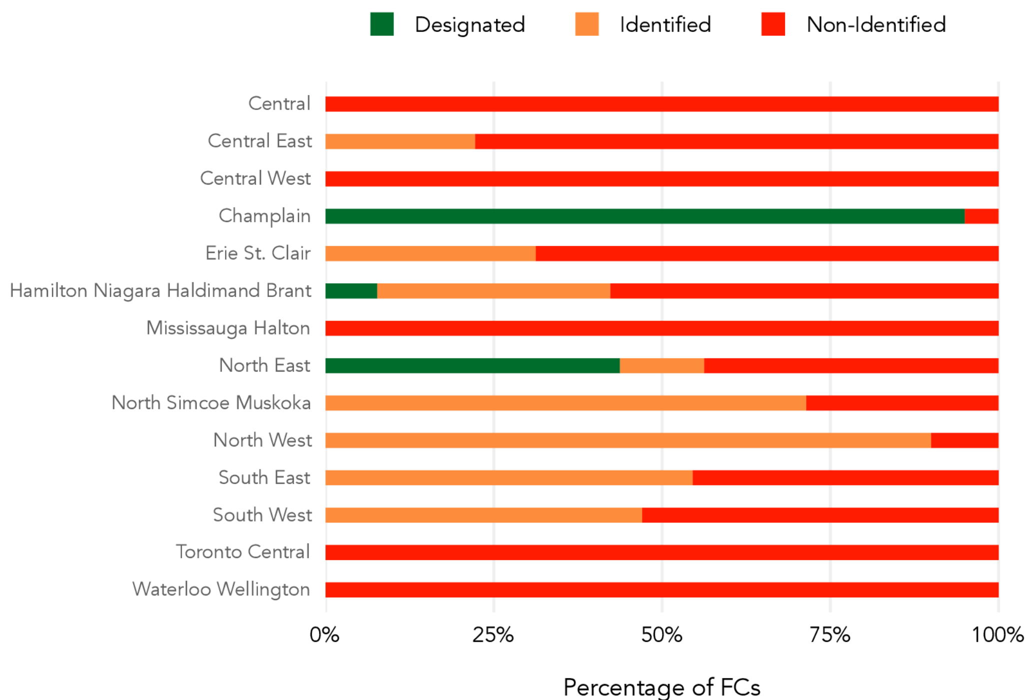


Figure 14: Provincial Distribution of Prioritized LHIN-Funded Direct Services in the MHA Sector

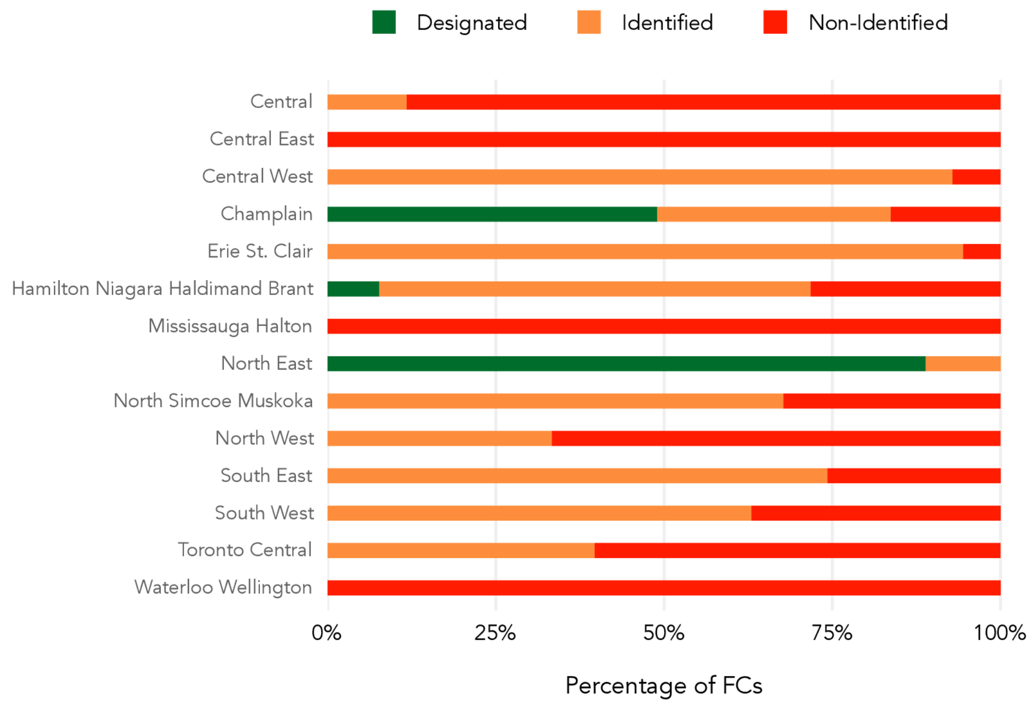


Figure 15: Provincial Distribution of Prioritized LHIN-Funded Direct Services in the CSS Sector

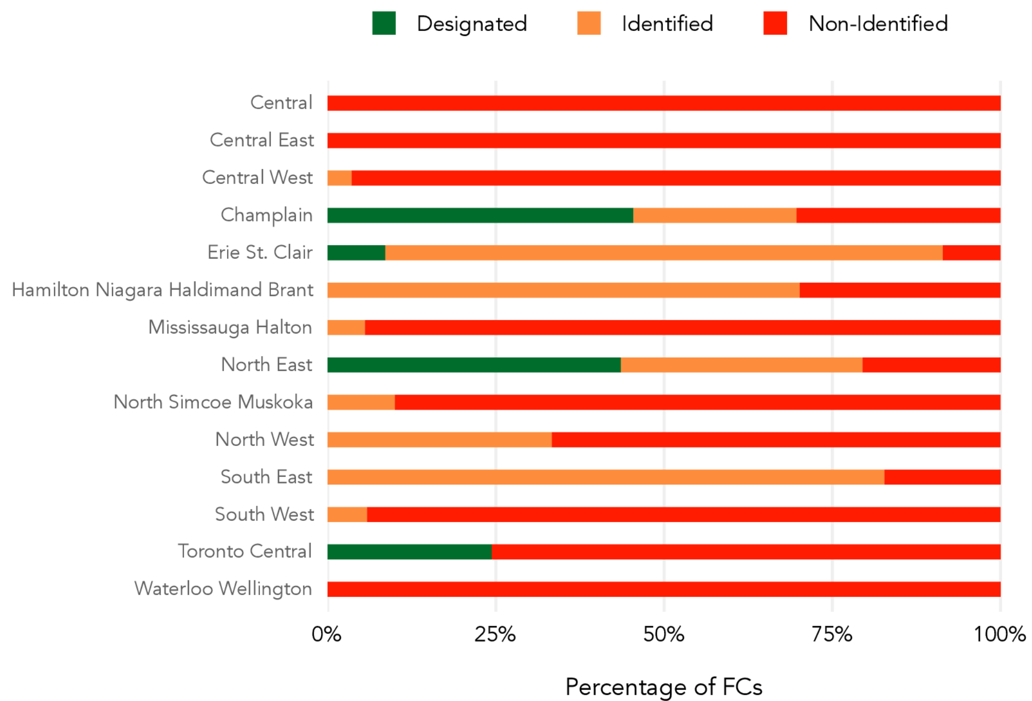
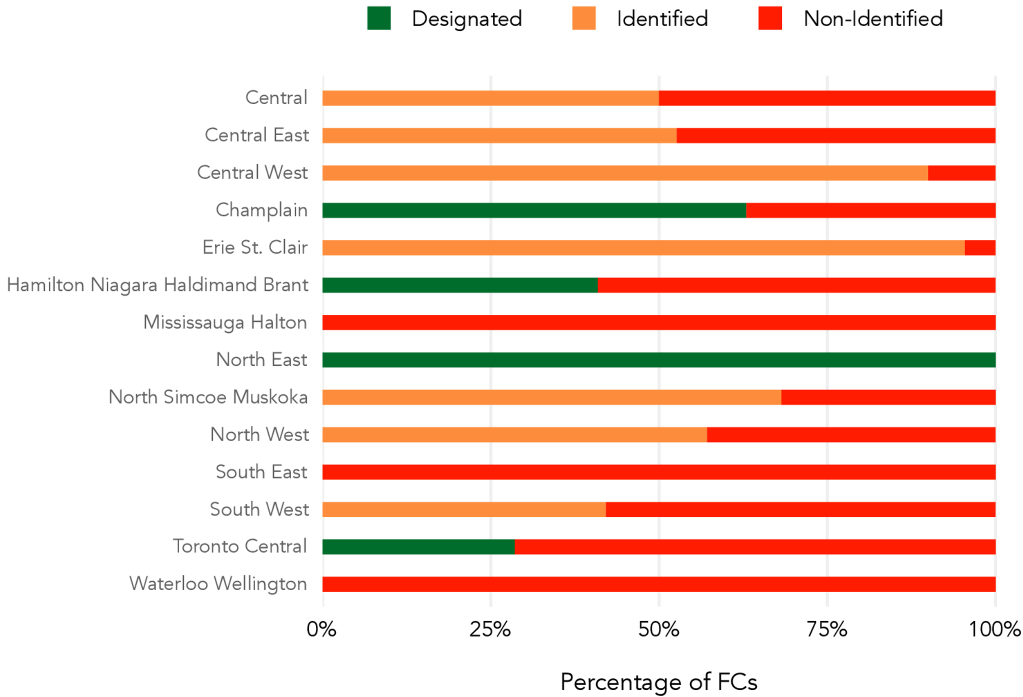
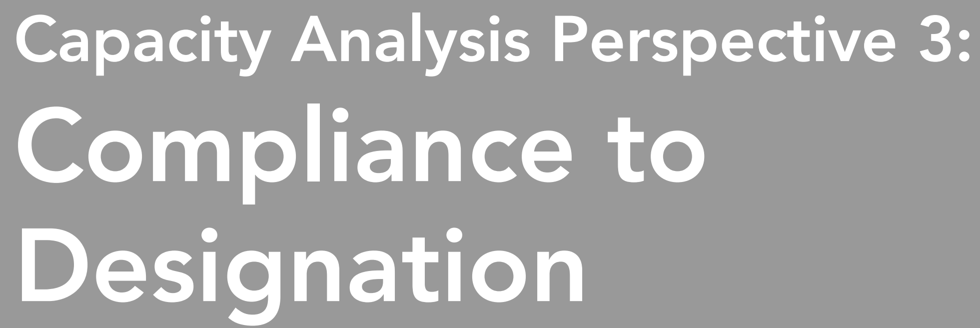


Figure 16: Provincial Distribution of Prioritized LHIN-Funded Direct Services in the CHC Sector





Capacity Analysis Perspective 3:

Compliance to Designation

The average percentage of compliance related to the 34 requirements for compliance of the designation provides insight both for designated and identified HSPs.

- For designated HSPs, the average percentage of compliance related to the designation requirements expresses how well designation has been implemented or maintained organizationally. A high level of compliance translates the likelihood of effective capacity.
- For identified HSPs, the average percentage of compliance related to the designation requirements provides a state of progress towards designation. The higher the compliance rate, the more eminent the designation request and, by extension, the addition of effective capacity of FLHS.

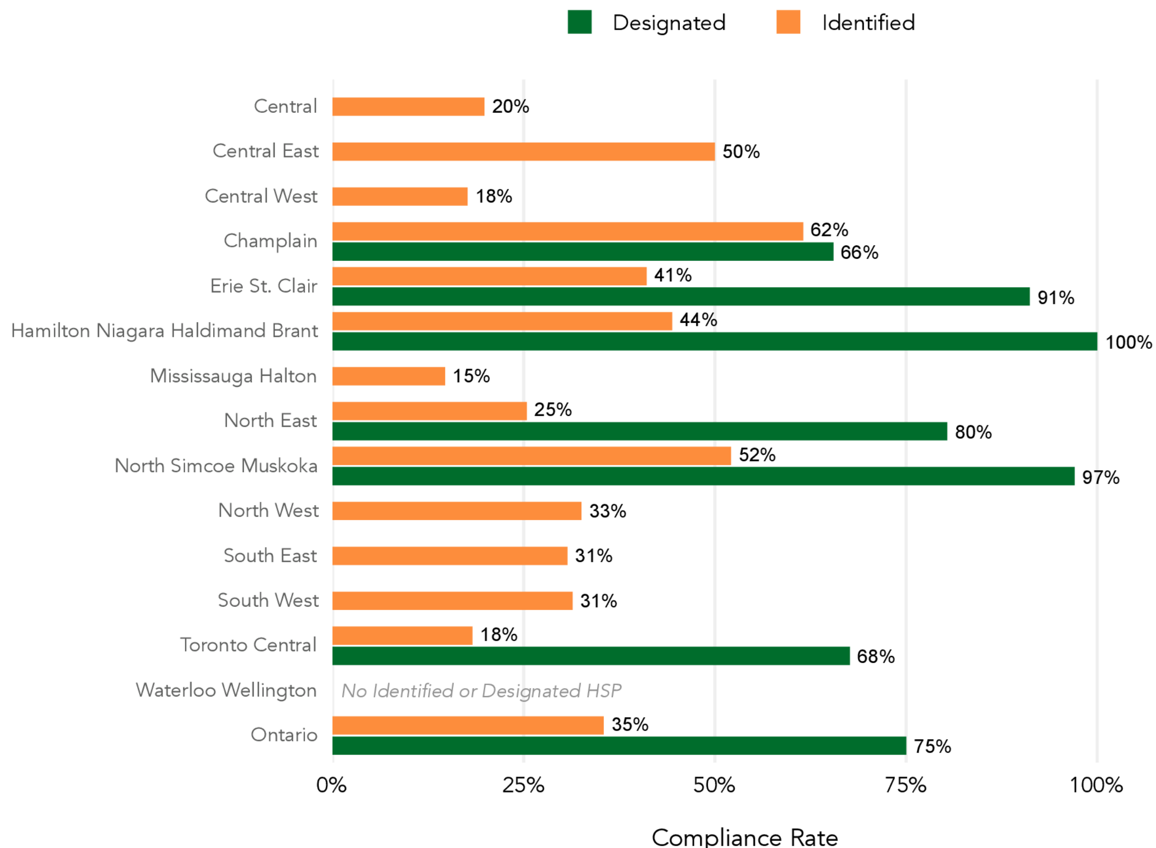
This is the second year of data collection. Thus, the collection of data over two years allows us to determine the level of completion of the designated HSPs and the rate of progress towards the designation of the identified HSPs. Below, we first present the current state of completion of the designation requirements followed by an observation of the evolution of the rate of completion between 2017-18 and 2018-19.

In addition, as it is a rate, it is worth noting that some HSPs are at a very high rate and others have a very low rate. The number of HPSs also plays a role. The smaller the number, the greater the impact of each requirement on the average.

As shown in Figure 17, identified HSPs are generally in the first tier of the designation process, with 35% of completion. This is an indication that they have a fair way to go (optimistically, should expect 2 to 5 years if no action or additional obligations are set) to reach 100% compliance. Compared to 2017-18, this is an increase of 6% (Figure 18). Designated HSPs have an average rate of 75%. Compared to 2017-18, this is an increase of 12%.

Among the identified HSPs, a progression in the rate of completion of the requirements was noticed in 9 LHINs, while a notable progression of more than 20% took place in 4 of them. This progression could reflect some advancement among HSPs towards designation.

Figure 17: Average Completion of the Designated Requirements by Responsibility Level

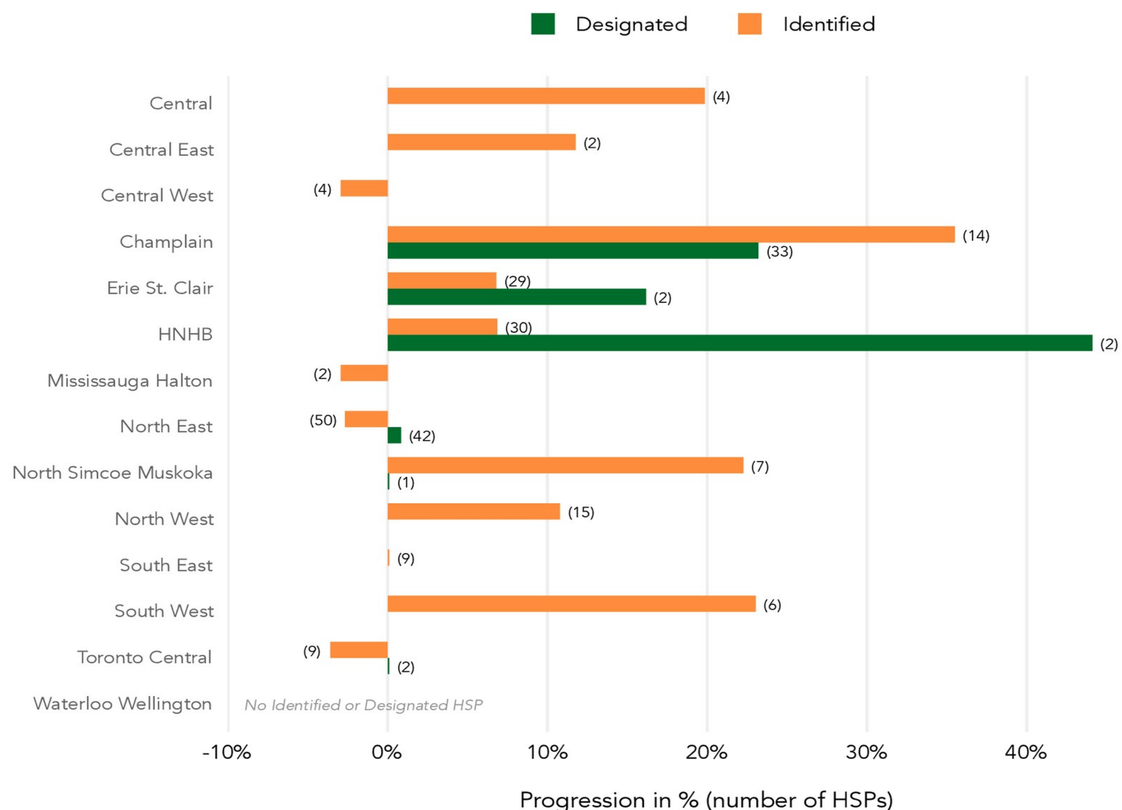


Among the designated HPSs, progression was observed in 4 LHINs. While this may indicate some progress, it should be noted that the designated HSPs should have met all of the requirements in order to obtain designation. This increase may therefore be partly attributed to a gradual improvement in data collection.

While the expectation is ideally 100%, some organizations may still be adapting to the revised requirements for compliance set out by the MFA in 2014-2015. It is also possible that some HSPs in some region may not have been advised that a statement of compliance process was in place.

A complete list of the average compliance rate by LHIN is available in Appendix 6.

Figure 18: Progression of the Designation Requirements Completion by Responsibility Level



When this data is distributed by designated and non-designated local areas, we notice that the average completion rate is higher in non-designated localities. Identified HSPs in non-designated local areas appear to be more advanced in the process of obtaining designation than those in designated local areas. This observation holds true in every sector.

As a reminder, it is possible for an HSP to be designated even if it is not located in a designated area, since it is providing services to a Francophone population residing in a designated area.

Compared to 2017-2018, there has been an increase in the completion rate in general, and in almost all sectors, whether in designated or non-designated locations.

Figure 19: Average Completion of the Designated Requirements by Responsibility Level in Designated Local Areas

Figure 20: Average Completion of the Designated Requirements by Responsibility Level in Non-Designated Local Areas

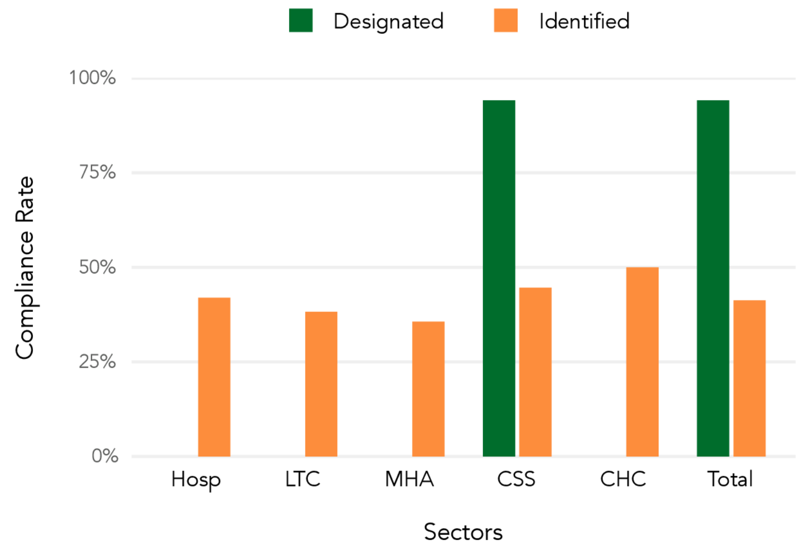


Table 11: Average Completion of the Designation Requirements by Sector and Local Areas

Local Area Status	Responsibility level	HOSP	LTC	MHA	CSS	CHC	Total
Designated	Designated	86%	78%	72%	81%	82%	75%
	Identified	32%	32%	36%	40%	46%	36%
Non-designated	Designated	0%	0%	0%	94%	0%	94%
	Identified	42%	38%	36%	45%	50%	41%

From a Francophone population density perspective, we notice that the compliance rate of designated HSPs is higher in high Francophone population density region in all sectors. Likewise, identified HSPs in high Francophone population density region have a better rate than their counterparts in general. There has been a noticeable increase in the average completion rate of the designation requirements in the low Francophone population density region between 2017-18 and 2018-19 for both designated and identified HSPs.

Figure 21: Average Completion of the Designation Requirements by Responsibility Level in Low Francophone Population Density Region

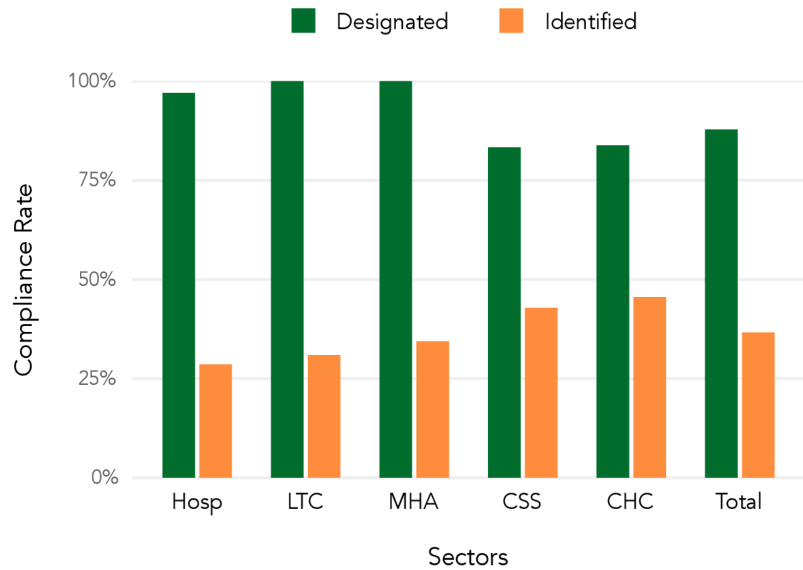


Figure 22: Average Completion of the Designation Requirements by Responsibility Level in High Francophone Population Density Region

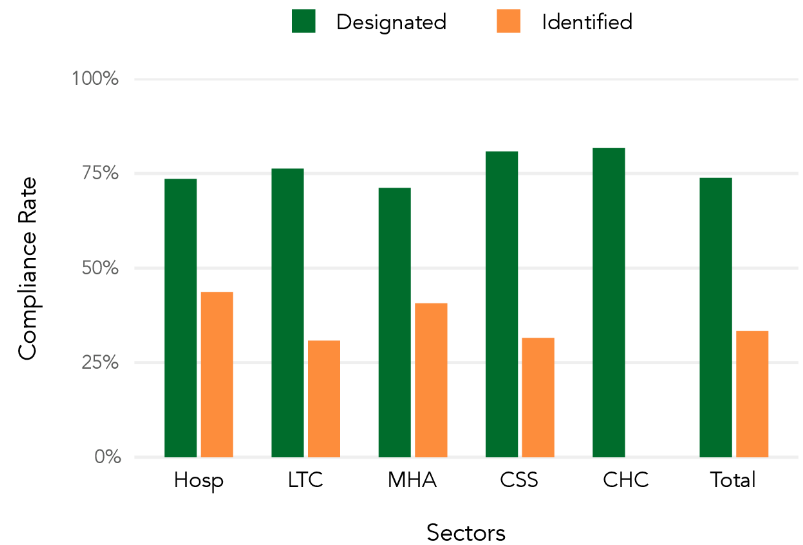


Table 12: Average Completion of Designation Requirements by Francophone Population Density Regions and Sectors

Geographic region		Hosp	LTC	MHA	CSS	CHC	Total
Low	Designated HSPs	97%	100%	100%	83%	84%	88%
	Identified HSPs	29%	31%	34%	43%	46%	37%
High	Designated HSPs	74%	76%	71%	81%	82%	74%
	Identified HSPs	44%	31%	41%	32%	0%	33%

Capacity Analysis Perspective 4:
Human Resources

Human resources with the proper French Language Proficiency level is the essence of FLHS. Human resources able to provide FLHS are those who have an advanced-minus to a superior level of proficiency (see Appendix 7 for the proficiency level definitions). For the purpose of this report, only human resources able to provide FLHS will be showcased. For a complete distribution of human resources with proficiency, including intermediary and elementary, see Appendix 8.

For this perspective, additional caveats should be considered. Some designated HSPs use formal linguistic assessments but, based on our understanding, they are a minority. In addition, HSPs reported all their all human resources with French language proficiency, not only those providing direct services. Further investigation/analysis is required to determine what portion of human resources is actually able to provide direct health services in French.

In Figure 23, the distribution of human resources by responsibility level demonstrates that the vast majority of HR able to provide FLHS are found in designated and identified HSPs. There is also a noticeable amount of HR in non-identified HSPs, which will provide opportunities to improve capacity.

Distributed by sector, this data illustrates that designated HSPs in the hospital sector host a significant portion, both in percentage (Figure 24) and number (Table 13), of HR able to provide FLHS. The long-term care sector provides the greater opportunity to improve capacity, as its non-identified HSPs host the highest percentage and number of HR able to provide FLHS.

Figure 23: Provincial Distribution of HR Able to Provide FLHS by Responsibility Level

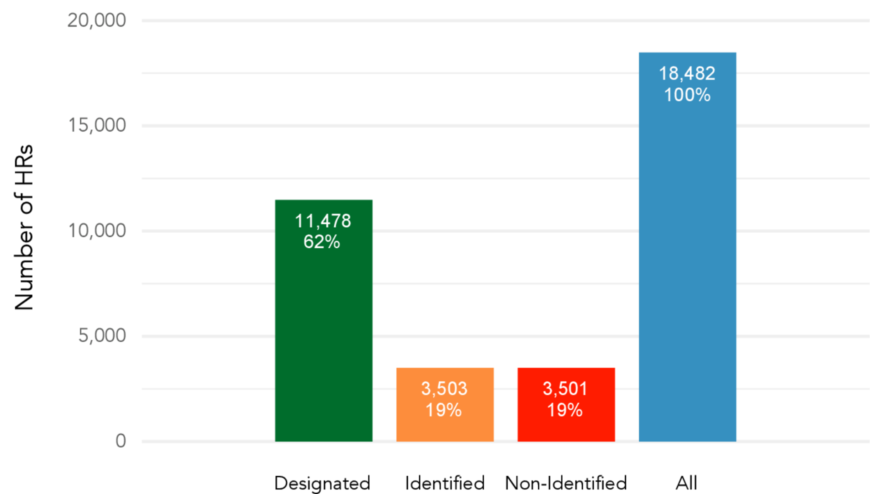


Figure 24: Provincial Distribution of HR Able to Provide FLHS by Responsibility Level and Sector

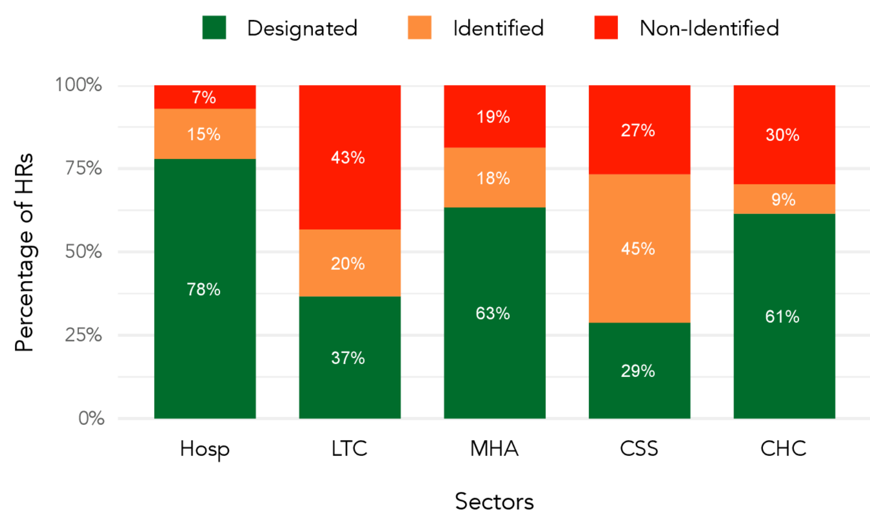


Table 13: Provincial Distribution of Human Resources Able to Provide FLHS by Sectors and Responsibility Level

Sectors	Number of HR Able to Provide FLHS		
	Designated	Identified	Non-Identified
Hosp	8064	1559	725
LTC	1536	841	1811
MHA	888	251	262
CSS	505	782	469
CHC	485	70	234

Figure 25 shows the proportion of HR able to provide FLHS by LHIN, whereas Table 14 provides the data in numbers. In half of the LHINs, the highest proportion of HR able to provide FLHS is found in non-identified HSPs. This points to opportunities to improve FLHS capacity in the future.

Figure 25: LHIN Distribution of HR Able to Provide FLHS by Responsibility Level

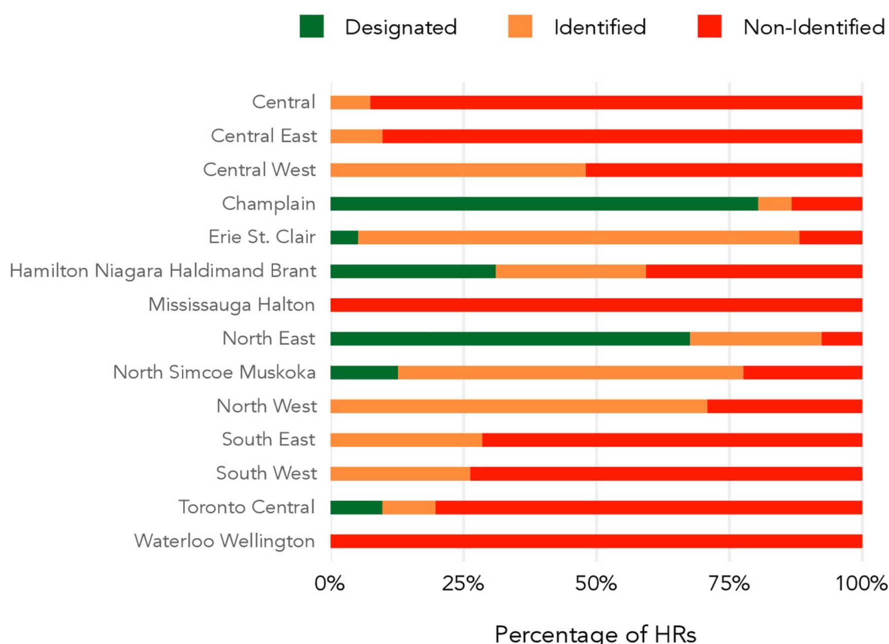


Table 14: LHIN Distribution of Human Resources able to Provide FLHS by Responsibility Level

Geographic Region	Number of HR Able to Provide FLHS		
	Designated	Identified	Non-Identified
Central	0	10	124
Central East	0	41	380
Central West	0	24	26
Champlain	7315	568	1211
Erie St. Clair	43	688	98
Hamilton Niagara Haldimand Brant	110	100	144
Mississauga Halton	0	0	67
North East	3914	1432	442
North Simcoe Muskoka	56	287	99
North West	0	168	69
South East	0	65	163
South West	0	79	222
Toronto Central	40	41	380
Waterloo Wellington	0	0	126

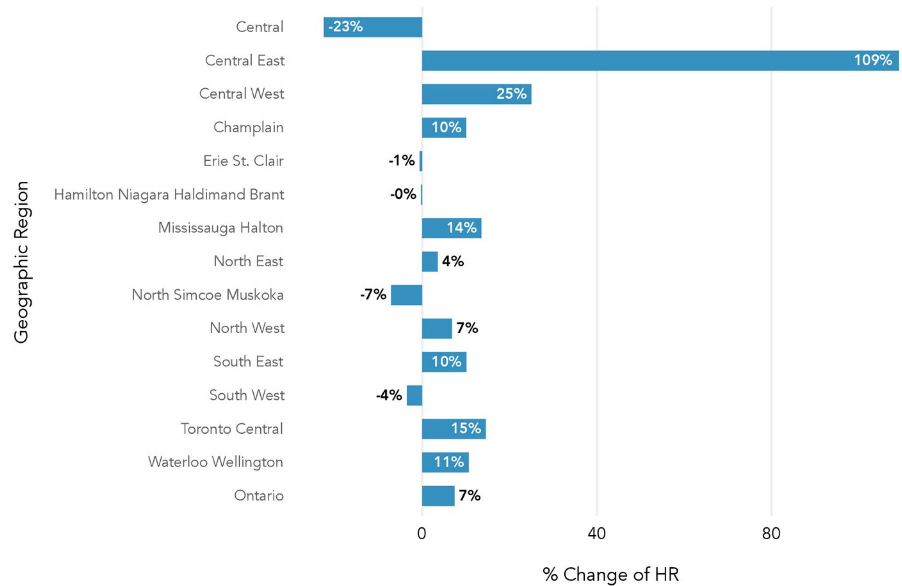
Compared to the previous year, when we look at the figures and tables in this section, we seem to note a general decrease in HR able to offer FLHS in general. This decrease is false; this is mainly due to the refinement of the distribution of FSS among the care sectors as submitted by the LHINs. It also affected the distribution of HR across sectors for HSPs present in more than one sector. That said, if the same technique had been used for the 2017-18 data, the result would be an increase in HR capable of providing FLHS overall, or 7% at the provincial level.

The generalized increase in HR capable of providing FLHS as shown in Figure 26 and could be explained by the following reasons:

- Improvements in the data entry method available in the OZi Portal may have made it easier for HSPs, so more HR would have been reported. Indeed, the data shows that more HPSs have either reported their HR when they had not done so during the last reporting cycle, or reported more HR than last year. For example, in the Central East LHIN, the increase of more than 100% is due to an HSP that reported a large number of HRs, whereas it did not report any HR in 2017-2018.
- Compared to 2017-18, the number of HR with an "undetermined" level of language proficiency has decreased significantly. It is possible that many HSPs were able to determine the skill level of some of their HR, and were therefore considered in the capacity analysis this year.

Thus, in Figure 26, we observe that there has been an increase in HR able to provide FLHS in most LHINs,

Figure 26: Change in Percentage of Human Resources able to Provide FLHS, Year-over-Year



and most notably in the Central East and Central West LHINs. However, the decrease in number in the Central LHIN is quite significant. This is largely due to a single identified HSP who reported a significant number of HR last year, and omitted to report HR this year.

Conclusion

Prior to OZi, limited standardized information regarding the offer of French language health services was available. For a second year, through the use of the OZi portal, data was collected from LHIN-funded health service providers (HSPs) on their capacity to provide FLHS; data which has fueled this report. Ontario's health care system can use this evidence-based data to guide its decision-making relating to issues that affect the health of the francophone population.

The 2018-2019 period was marked by the appropriation of measurement tools and the improvement of data collection methods, and this at all levels. This has contributed to a general improvement in the quality of the data collected, as well as in organizational practices conducive to the offer of FLHS. However, some important weaknesses remained.

The results were analyzed from four perspectives: the distribution of HSPs, the continuum of services, compliance with designation requirements and human resources.

Uneven distribution of designated HSPs

Analysis of the geographic distribution of designated HSPs revealed that access to FLHS can be challenging in many regions and local areas, despite the designation status of these areas.

- At the regional level, half of the LHINs have no designated HSPs. Only two LHINs have designated HSPs in each sector of care.
- At the local level, 23 of the 37 designated local areas have at least one sector of care that does not have any HSPs with an obligation towards FLHS. 14 of these local areas have this same challenge in at least 3 care sectors.
- There are dead zones across important geographic areas where no HSPs have an obligation towards FLHS. These dead zones lie between Scarborough and Kingston, as well as in and around the Waterloo Wellington LHIN region.

Disparities across the continuum of care

With respect to the obligation to offer FLHS, the LTC sector is the least well represented, both in number and in scope of the continuum of care. The LTC sector remains the sector with the lowest proportion of identified and designated HSPs when compared to other sectors. However, if we consider the high number of HR with adequate French language proficiency, the long-term care sector has the greatest potential for improvement with respect to FLHS.

At the regional level, HSPs from the LTC and CHC sectors are often the ones that have no obligation towards FLHS. Furthermore, where identified or designated HSPs did exist, they often covered a small proportion of the continuum of care within a given LHIN.

Improved compliance to designation requirements

Compared to 2017-2018, there has been a notable increase in the rate of compliance to designation requirements, indicating some advancement in the provision of FLHS among the HSPs with such responsibility, and this across most sectors. The average completion rate increased by 6% among the identified HSPs, and by 12% among the designated HSPs.

Furthermore, we also observed that identified HSPs in non-designated local areas seem to be more advanced in the designation process than those in the designated local areas.

More human resources (HR) capable of providing FLHS

Compared to the previous year, we are seeing an increase in HR capable of providing FLHS – across the province, as well as in most individual LHINs. Some hypotheses can explain this increase:

- the determination of the French language proficiency level among HR who previously had an undetermined level (the number of RH with an undetermined level has decreased)
- the increased reporting of HR capable of providing FLHS

When taking into account the aforementioned hypotheses, it

becomes difficult to assess the share of new HR acquired by the HSPs in their efforts to increase FLHS. We nonetheless observe a general improvement in the quality of the data collected through the OZi portal during this year of data acquisition. In the years to come, when the appropriation of tools will naturally stabilize, it will be possible to measure the impact of the acquisition of new HR in the quest for improved FLHS.

Future prospects

With the introduction of performance indicators, we are able - for the first time, in the health system across Onrario - to demonstrate measurable progress in organizational behaviour with respect to designation requirements. It will be interesting to see if this leads to a measurable impact on the offer of FLHS in the future.

We also observed an increase in the uptake of OZi by various health care stakeholders, as it becomes a mainstay of FLHS accountability. The quality of the data improved as a byproduct of this uptake, and we expect this trend to continue. This will allow us to further develop the analysis perspectives and provide more in depth findings.

Recently, the MOHLTC was split into two separate ministries: the Ministry of Health (MOH) and the Ministry of Long-Term Care (MOLTC). With this change, there is recognition that the LTC sector needs a particular focus in order to address the challenges unique to this sector. When we consider FLHS, the LTC sector is the one that has the most potential to gain, and OZi could measure the impact of that reorganization.

The initial trends demonstrate that there is value in investing in the designation process. Identifying HSPs for future designation is the first step in this process, and the designated local areas with fewer FLHS could benefit from this. Furthermore, some non-designated local areas qualify to become designated. Thus, the data collected through OZi could also be used to identify local areas and HSPs that would most improve the offer of FLHS, should they become designated.

Over the course of two years, the OZi project was able to provide baseline data on the status of FLHS at different levels, as well as some preliminary trends. In the long run, OZi has the potential to measure the impact of policy changes on FLHS.

Appendices

APPENDIX 1

ACRONYMS, ABBREVIATIONS AND GLOSSARY OF TERMS

ACRONYMS AND ABBREVIATIONS

CHC: Community health centre
CSS: Community support services
Entities: French Language Health Planning Entities
FLHS: French language health services
FLS: French language services
FLSA: French Language Services Act
HR: Human resources
HSP: Health service provider
LHIN: Local health integration network
LTC: Long-term care
MFA: Ministry of Francophone Affairs
MHA: Mental health and addiction services
MOHLTC: Ministry of Health and Long-Term Care

GLOSSARY OF TERMS

Active offer: Active offer can be defined as a regular and permanent provision of French language health services – delivered at a quality that is comparable to that of services provided in English – offered systematically and proactively to Francophone clients across the continuum of care. To ensure an active offer of French language health services, health service providers must implement a series of organizational practices. These practices are also designation requirements.

Actual capacity: According to designation requirements, staff members with one of the following French language proficiency levels are considered able to provide services in French and can hold designated bilingual positions: “Advanced Minus”, “Advanced”, “Advanced Plus” or “Superior.” The presence of human resources with these proficiency levels thus corresponds to a health service provider’s actual capacity to provide FLHS.

Continuum of care: The continuum of care is composed of different components of the health care system that are structured to ensure that a patient or client can be cared for without any interruption or rupture of services. In Ontario, the continuum of care is composed of the following sectors of care: hospitals; mental health and addiction services; long-term care; community health centres; and community support services.

Designated HSP: Designated health service providers have an obligation, under the French Language Services Act, to provide services in French on a guaranteed and permanent basis, in compliance with the 34 designation requirements. (This obligation applies only to the services for which the HSP is designated.) Designated HSPs must also submit a statement of compliance to the Ministry of Francophone Affairs on a three-year basis to demonstrate they are still compliant with the designation requirements. For the purpose of this report, designated HSPs are considered to have a full capacity to provide French language health services.

Designation: Designation is a legal and administrative procedure that follows the rules and procedures prescribed by the French Language Services Act, Ontario Regulation 398/93, and Ministry of Francophone Affairs directives. This legislative and regulatory framework enables health service providers to demonstrate that they have the capacity to provide French language services on a permanent basis while meeting the specific needs of the Francophone population they serve.

Designation plan: To become designated, health service providers must submit a designation plan that demonstrates how they comply with the 34 designation requirements. The designation plan contains the Human Resources Plan.

Designation requirements: To become designated, health service providers must comply with 34 requirements established by the Ministry of Francophone Affairs. These requirements are based on the following five criteria.

- The agency must offer quality services in French on a permanent basis, which is ensured by employees with the requisite French language skills.
- Access to services must be guaranteed and follow the principle of an active offer.
- Provisions for effective representation of Francophones on the board of directors and its committees are included in the administrative by-laws and must reflect the proportion of the

Francophone population within the community served.
- The senior management team must have an effective representation of Francophones.
- The board of directors and the senior management team must be accountable with respect to the quality of French language services.

FLHS capacity: Capacity can be defined as the ability to provide FLHS in order to ensure that LHIN-funded services meet the needs of the local Francophone population. At the LHIN level, capacity is ensured through the distribution of responsibility toward FLHS. At the HSP level, capacity is ensured through sufficient HR with an adequate level of French language proficiency ("Advanced Minus", "Advanced", "Advanced Plus" and "Superior"). For the purpose of this report, designated HSPs are considered to have full FLHS capacity, while identified HSPs are considered to have a certain capacity that could be developed through designation. Non-identified HSPs are not considered to have the capacity to offer FLHS, though they may have some HR with varying levels of proficiency. HR with the "Advanced Minus", "Advanced", "Advanced Plus" and "Superior" levels are considered to have effective capacity to provide FLHS, while HR with the "Intermediate" proficiency level are considered to have the potential capacity that could be developed through language training. HR with the "Elementary" proficiency level are considered to have a limited capacity to provide FLHS.

FLHS responsibility: In the current report, the concept of responsibility for FLHS corresponds to an HSP's designation status. Responsibility encompasses the FLHS obligations assigned to designated HSPs, identified HSPs and non-identified HSPs, as set out in the Guide to FLHS.

FLS Report: For the purpose of this report, LHIN-funded HSPs had to submit a French Language Services Report through the OZi Portal. Two different reporting templates were used: one for designated and identified HSPs, which was based on the 34 designation requirements (and included the HR Plan), and one for non-identified HSPs.

French language proficiency: An employee's French language proficiency is determined through linguistic evaluation by an accredited firm. According to the Government of Ontario, staff can be classified according to seven levels of oral and written proficiency (or linguistic profiles): "No Proficiency" (not collected in the present report); "Elementary"; "Intermediate"; "Advanced Minus"; "Advanced"; "Advanced Plus"; and, "Superior". Employees with the following proficiency levels are considered capable of providing FLHS: "Advanced Minus", "Advanced", "Advanced Plus" and "Superior." A detailed description of each linguistic profile is available in Appendix 2.

French Language Services Act: This is Ontario Regulation 398/93. The French Language Services Act was first passed by the Ontario Legislative Assembly in 1986 and came into effect in 1989. The legislative and regulatory framework for designation is comprised of the French Language Services Act.

Guide to FLHS: This document was published by the Ministry of Health and Long-Term Care and released in November 2017. The Guide to FLHS details the requirements and obligations of LHINs, health service providers and Planning Entities with regards to French language health services.

Human Resources Plan: The Human Resources Plan (HR Plan) is submitted as part of the designation plan. The purpose of this document is to demonstrate that designated positions are held by staff members who possess the necessary French language proficiency levels ("Advanced Minus", "Advanced", "Advanced Plus" or "Superior") to provide FLHS.

Identified HSP: Identified HSPs have been selected to work toward designation under the FLSA. Identified HSPs have a responsibility to develop a French Language Services Plan and to provide services in French in accordance with existing FLHS capacity. For the purpose of this report, identified HSPs are considered to have a certain capacity to provide FLHS; this capacity is to be enhanced through the designation process.

Inclusive Definition of Francophone (IDF): A definition used by the Government of Ontario to identify the Francophone population. According to this definition, Francophones are individuals whose mother tongue is French, plus those whose mother tongue is neither French nor English but who have a particular knowledge of French as an

Official Language and use French at home.

Limited capacity: For the purpose of this report, a staff member with an "Elementary" French language proficiency level is considered to have a limited capacity to provide FLHS. While this capacity could eventually be enhanced through French language training, these human resources do not, at the moment, contribute significantly to an HSP's FLHS capacity.

Non-identified HSP: Non-identified health service providers are neither identified for designation nor designated under the French Language Services Act. While they have no obligation to provide French language health services or to submit a designation plan, these HSPs still have a responsibility to develop and implement a plan to address the needs of their local Francophone community. This plan includes the provision of information on health services available in French in their region. For the purpose of this report, non-identified HSPs had to submit a French Language Services Report through the OZi Portal. In the current report, non-identified HSPs are not considered to have the capacity to offer FLHS.

OZi Portal: An online data management solution created by the Réseau to collect and analyze data on the provision of French language health services at the provincial, local, and sectoral levels. The OZi Portal was deployed to 1,464 LHIN-funded health service providers between February and June 2018 to collect data for the purpose of this report.

Planning Entity: French Language Health Planning Entities (sometimes referred to in this report as Entities or Planning Entities) were established by Ontario Regulation 515/09 Engagement with the Francophone Community. Entities have the responsibility to advise LHINs on FLHS, primarily by engaging with the local Francophone community. There are currently six Planning Entities in Ontario.

Potential capacity: For the purpose of this report, a staff member with an "Intermediate" French language proficiency level is considered to have a potential capacity to provide FLHS. This capacity could be developed through French language training.

Réseau: This is the French Language Health Services Network of Eastern Ontario, also known in French as Réseau des services de santé en français de l'Est de l'Ontario. The Réseau is the Planning Entity for the Champlain and South East regions. The Réseau created the OZi Portal and also managed the data collection and analysis project for the purpose of this report.

Statement of compliance: Designated health service providers must submit a statement of compliance to the Ministry of Francophone Affairs on a three-year basis to demonstrate they are still compliant with the 34 designation requirements.

APPENDIX 2

DESIGNATED AREAS

1. City of Toronto – all
2. City of Hamilton – as boundaries existed on Dec. 31, 2000
3. Cities of Port Colborne and Welland in Regional Municipality of Niagara
4. City of Ottawa – all
5. Cities of Mississauga and Brampton – Regional Municipality of Peel
6. Sudbury – city and greater Sudbury area
7. Township of Winchester – Dundas County
8. Essex County:
   - City of Windsor
   - Towns of Belle River and Tecumseh
   - Townships of Anderdon, Colchester North, Maidstone, Sandwich South, Sandwich West, Tilbury North, Tilbury West and Rochester
9. Glengarry County – all
10. Kent County:
    - Town of Tilbury
    - Townships of Dover and Tilbury East
11. Prescott County – all
12. Renfrew County:
    - City of Pembroke
    - Townships of Stafford and Westmeath
13. Russell County – all
14. Simcoe County
    - Town of Penetanguishene
    - Townships of Tiny and Essa
15. Stormont County – all
16. District of Algoma – all
17. District of Cochrane – all
18. Township of Ignace in District of Kenora
19. District of Nipissing – all
20. District of Sudbury – all
21. District of Thunder Bay
    - Towns of Geraldton, Longlac and Marathon
    - Townships of Manitouwadge, Beardmore, Nakina and Terrace Bay
22. District of Timiskaming – all
23. City of London
24. Municipality of Callander in District of Parry Sound
25. City of Kingston
26. City of Markham (starting July 1, 2018) in Regional Municipality of York

APPENDIX 3

DESIGNATED LOCAL AREAS PER LHIN

LHIN	Sub-region	Local area status
Erie St. Clair	Windsor	Designated local area
	Tecumseh Lakeshore Amherstburg LaSalle	Designated local area
	Essex South Shore	Designated local area
	Chatham City Centre	Non-designated local area
	Rural Kent	Designated local area
	Lambton	Non-designated local area
South West	Grey Bruce	Non designated local area
	Huron Perth	Non-designated local area
	London Middlesex	Designated local area
	Elgin	Non designated local area
	Oxford	Non-designated local area
Waterloo Wellington	Guelph-Puslinch	Non-designated local area
	Cambridge-North Dumfries	Non-designated local area
	Kitchener-Waterloo-Wellesley-Wilmot-Woolwich	Non-designated local area
	Wellington	Non-designated local area
Hamilton Niagara Haldimand Brant	Hamilton	Designated local area
	Burlington	Non-designated local area
	Niagara North West	Non-designated local area
	Niagara	Designated local area
	Brant	Non-designated local area
	Haldimand Norfolk	Non-designated local area
Central West	North Etobicoke Malton West Woodbridge	Designated local area
	Dufferin	Non-designated local area
	Bolton-Caledon	Non-designated local area
	Bramalea	Designated local area
	Brampton	Designated local area
Mississauga Halton	East Mississauga	Designated local area
	Halton Hills	Non-designated local area
	Milton	Non-designated local area
	Oakville	Non-designated local area
	North West Mississauga	Designated local area
	South West Mississauga	Designated local area
	South Etobicoke	Designated local area

LHIN	Sub-region	Local area status
Toronto Central	West Toronto	Designated local area
	Mid-West Toronto	Designated local area
	North Toronto	Designated local area
	Mid-East Toronto	Designated local area
	East Toronto	Designated local area
Central	North York West	Designated local area
	North York Central	Designated local area
	Western York Region	Non designated local area
	Eastern York Region	Designated local area
	South Simcoe	Non-designated local area
	Northern York Region	Non-designated local area
Central East	Peterborough City and County	Non-designated local area
	Haliburton County and City of Kawartha Lakes	Non-designated local area
	Northumberland County	Non-designated local area
	Durham North East	Non-designated local area
	Durham West	Non-designated local area
	Scarborough North	Designated local area
	Scarborough South	Designated local area
South East	Rural Hastings	Non-designated local area
	Quinte	Non-designated local area
	Rural Frontenac, Lennox & Addington	Non-designated local area
	Kingston	Designated local area
	Lanark, Leeds & Grenville	Non-designated local area
Champlain	Central Ottawa	Designated local area
	Western Ottawa	Designated local area
	Eastern Champlain	Designated local area
	Western Champlain	Designated local area
	Eastern Ottawa	Designated local area
North Simcoe Muskoka	Barrie and Area	Designated local area
	South Georgian Bay	Non-designated local area
	Couchiching	Non-designated local area
	Muskoka	Non-designated local area
	North Simcoe	Designated local area
North East	Nipissing-Temiskaming	Designated local area
	Sudbury-Manitoulin-Parry Sound	Designated local area
	Algoma	Designated local area
	Cochrane	Designated local area
	James and Hudson Bay Coasts	Designated local area

LHIN	Sub-region	Local area status
North West	District of Kenora	Designated local area
	District of Rainy River	Non-designated local area
	District of Thunder Bay	Designated local area
	City of Thunder Bay	Non-designated local area
	Northern	Non-designated local area

APPENDIX 4

DISTRIBUTION OF HSPS BY LHIN, SECTOR AND RESPONSIBILITY LEVEL

Geographic Region	Responsibility Level	Number of HSPs				
		Hosp	LTC	MHA	CSS	CHC
Central	Designated	0	0	0	0	0
	Identified	2	0	1	0	1
Central East	Designated	0	0	0	0	0
	Identified	0	1	0	0	1
Central West	Designated	0	0	0	0	0
	Identified	1	0	4	2	1
Champlain	Designated	9	9	15	11	4
	Identified	2	6	4	7	0
Erie St. Clair	Designated	0	0	0	2	0
	Identified	4	3	13	17	3
Hamilton Niagara Haldimand Brant	Designated	0	1	1	0	1
	Identified	4	2	9	19	0
Mississauga Halton	Designated	0	0	0	0	0
	Identified	1	0	0	1	0
North East	Designated	11	7	20	12	5
	Identified	11	13	14	18	0
North Simcoe Muskoka	Designated	1	0	0	0	0
	Identified	3	1	2	1	1
North West	Designated	0	0	0	0	0
	Identified	6	5	2	4	2
South East	Designated	0	0	0	0	0
	Identified	2	1	5	6	0
South West	Designated	0	0	0	0	0
	Identified	2	1	5	1	1
Toronto Central	Designated	0	0	0	1	1
	Identified	7	0	3	0	0
Waterloo Wellington	Designated	0	0	0	0	0
	Identified	0	0	0	0	0

APPENDIX 5

DISTRIBUTION OF PRIORITIZED LHIN-FUNDED DIRECT SERVICES BY SECTOR AND RESPONSIBILITY LEVEL, IN PERCENTAGE

Sector	LHIN	Designated	Identified	Designated & Identified	Non-Identified
Hospital	Central	0	83	83	17
	Central East	0	0	0	100
	Central West	0	87	87	13
	Champlain	65	28	93	7
	Erie St. Clair	0	92	92	8
	Hamilton Niagara Haldimand Brant	0	94	94	6
	Mississauga Halton	0	73	73	27
	North East	78	18	96	4
	North Simcoe Muskoka	1	94	95	5
	North West	0	93	93	7
	South East	0	75	75	25
	South West	0	79	79	21
	Toronto Central	0	90	90	10
	Waterloo Wellington	0	0	0	100
LTC	Central	0	0	0	100
	Central East	0	22	22	78
	Central West	0	0	0	100
	Champlain	95	0	95	5
	Erie St. Clair	0	31	31	69
	Hamilton Niagara Haldimand Brant	8	35	42	58
	Mississauga Halton	0	0	0	100
	North East	44	12	56	44
	North Simcoe Muskoka	0	71	71	29
	North West	0	90	90	10
	South East	0	55	55	45
	South West	0	47	47	53
	Toronto Central	0	0	0	100
	Waterloo Wellington	0	0	0	100

Sector	LHIN	Designated	Identified	Designated & Identified	Non-Identified
MHA	Central	0	12	12	88
	Central East	0	0	0	100
	Central West	0	93	93	7
	Champlain	49	35	84	16
	Erie St. Clair	0	94	94	6
	Hamilton Niagara Haldimand Brant	8	64	72	28
	Mississauga Halton	0	0	0	100
	North East	89	11	100	0
	North Simcoe Muskoka	0	68	68	32
	North West	0	33	33	67
	South East	0	74	74	26
	South West	0	63	63	37
	Toronto Central	0	40	40	60
	Waterloo Wellington	0	0	0	100
CSS	Central	0	0	0	100
	Central East	0	0	0	100
	Central West	0	4	4	96
	Champlain	45	24	70	30
	Erie St. Clair	9	83	91	9
	Hamilton Niagara Haldimand Brant	0	70	70	30
	Mississauga Halton	0	6	6	94
	North East	44	36	79	21
	North Simcoe Muskoka	0	10	10	90
	North West	0	33	33	67
	South East	0	83	83	17
	South West	0	6	6	94
	Toronto Central	24	0	24	76
	Waterloo Wellington	0	0	0	100
CHC	Central	0	50	50	50
	Central East	0	53	53	47
	Central West	0	90	90	10
	Champlain	63	0	63	37
	Erie St. Clair	0	95	95	5
	Hamilton Niagara Haldimand Brant	41	0	41	59
	Mississauga Halton	0	0	0	100
	North East	100	0	100	0
	North Simcoe Muskoka	0	68	68	32
	North West	0	57	57	43
	South East	0	0	0	100
	South West	0	42	42	58
	Toronto Central	29	0	29	71
	Waterloo Wellington	0	0	0	100

APPENDIX 6

AVERAGE COMPLETION OF THE DESIGNATED REQUIREMENTS

LHIN	Designated	Identified
Ontario	75%	35%
Central	n/a	20%
Central East	n/a	50%
Central West	n/a	18%
Champlain	66%	62%
Erie St. Clair	91%	41%
Hamilton Niagara Haldimand Brant	100%	44%
Mississauga Halton	n/a	15%
North East	80%	25%
North Simcoe Muskoka	97%	52%
North West	n/a	33%
South East	n/a	31%
South West	n/a	31%
Toronto Central	68%	18%
Waterloo Wellington	n/a	n/a

APPENDIX 7

FLS PROFICIENCY LEVELS

ORAL	WRITTEN
Elementary level	***Elementary level***
At this level one has no real autonomy of expression. The ability to speak is limited to some memorized material on familiar topics related to work. One is able to verbalize isolated words, expressions of two or three words, and express simple, unconnected sentences. The range of vocabulary is limited and the delivery is slow and awkward. One can handle greetings, leave taking, and other expressions of courtesy. The limited vocabulary, the frequent errors, and slow delivery severely inhibit communication.	At this level one is able to write a few words, maybe sentences on topics related to work, maybe with the help of a dictionary. One can fill in forms, give general information such as time and location of meetings and notices of cancellation using a standard format. Vocabulary is limited to daily use with no mastery of idiomatic expressions. One has no practical communicative writing skills. One cannot produce French text.
Intermediate level	***Intermediate level***
At this level one possesses some ability to work in French. One shows some spontaneity in language production but the fluency is very uneven resulting in halting speech. One is able to participate in simple conversations on a one-to-one basis. The vocabulary is limited to that used in simple, non-technical, daily conversational usage. One can make and answer requests for information or directions, give simple instructions and discuss simple needs. When addressing this person the speaker may have to slow down and repeat if he/she wishes to be understood.	At this level one is able to write words and simple sentences. One can make and answer simple requests for information. The vocabulary is limited to that of daily general use. One often experiences problems with grammar and spelling. One is able to meet some practical elementary writing needs but cannot produce acceptable French text.
Advanced Minus level	***Advanced Minus level***
At this level, the individual has the ability to handle a variety of communication tasks. The individual is able to describe and explain in all timeframes in most informal and some formal situations across a variety of familiar topics. The vocabulary often lacks specificity. Nevertheless, the individual is able to use rephrasing and paraphrasing. Although grammatical, lexical and pronunciation errors are evident, the individual can speak with enough accuracy to be understood.	At this level, the individual is able to meet basic workrelated writing needs. The individual is able to narrate and describe in major verb forms or tenses and is able to compose simple summaries on familiar topics. The individual is able to combine and link sentences into paragraphs to form full texts. Writing is understood although some additional effort may be required.
Advanced level	***Advanced level***
At this level, the individual has the ability to participate in conversations and satisfy many work requirements. The individual can discuss work-related matters with some ease and facility, expressing opinions and offering views. The individual is able to take part in a variety of verbal exchanges and to participate in meetings and discussion groups. However, the individual still needs help with handling complicated issues or situations. The individual is generally good in either grammar or vocabulary but not in both.	At this level, the individual is able to use a variety of sentence types to express general ideas and opinions on non-specialized topics. The individual can write simple letters and reports required by the position. The individual experiences few problems with either grammar or spelling. However, the writing style may represent literal translations. Nevertheless, a sense of organization is emerging and the individual is beginning to sense what is stylistically and grammatically correct in French.

Advanced Plus level	*Advanced Plus level*
At this level, the individual is able to give oral presentations in both formal and informal settings. The individual is able to present a fairly detailed outline of his/ her line of reasoning on general or work-related topics in formal and informal settings, in meetings and in discussion groups. Some mastery of idioms and of specific vocabulary appropriate to a variety of contexts is evident. Grammar is generally appropriate. Deficiencies in vocabulary are compensated for by synonyms and paraphrases. Problems may be encountered when discussing more specialized topics, but the individual at this level has very little difficulty in making himself / herself understood.	At this level, the individual is able to write about a variety of topics with significant precision and detail. The individual can handle informal and formal correspondence according to appropriate conventions, and write summaries and reports of a factual nature. The individual can also write extensively about topics relating to particular interests and specialized areas of competence, although their writing tends to emphasize the concrete aspects of such topics.

Superior level	*Superior level*
At this level, the individual has the ability to speak the language with sufficient structural accuracy, fluency and vocabulary to participate effectively in most formal and informal conversations on practical, social and professional topics. The individual is able to use idioms and specific vocabulary relevant to a variety of contexts and to give verbal presentations in both formal and informal settings.	At this level, the individual is able to express him/herself effectively and accurately in most formal and informal writing tasks/assignments on practical, social and professional topics. The individual is able to recognize awkwardness in sentence structure and paragraphs. Errors in grammar and spelling are minor and infrequent.

APPENDIX 8

DISTRIBUTION OF HR WITH FRENCH LANGUAGE PROFICIENCY BY LHINS AND RESPONSIBILITY LEVEL AND PROFICIENCY LEVEL

LHIN	Responsibility Level	Sector	Superior	Advanced-Plus	Advanced	Advanced-Minus	Intermediate	Elementary
Central	Identified	MHA	1	1	5	0	0	0
		CHC	0	0	0	3	0	0
	Non-Identified	Hosp	0	0	13	4	8	12
		LTC	8	5	13	4	27	63
		MHA	8	3	7	1	18	25
		CSS	9	8	25	14	74	101
		CHC	0	0	0	2	0	5
Central East	Identified	LTC	5	0	14	16	0	0
		CHC	4	2	0	0	0	0
	Non-Identified	Hosp	23	28	42	159	520	2037
		LTC	20	7	32	10	64	64
		MHA	5	2	4	12	39	243
		CSS	6	4	8	11	49	175
		CHC	1	1	2	3	4	15
Central West	Identified	MHA	1	0	5	18	0	0
	Non-Identified	Hosp	1	0	0	0	0	1
		LTC	7	2	1	7	15	99
		CSS	1	2	3	1	11	41
		CHC	1	0	0	0	0	0
Champlain	Designated	Hosp	26	69	3851	1387	0	0
		LTC	192	128	355	373	0	0
		MHA	219	42	125	106	0	0
		CSS	42	50	57	33	0	0
		CHC	104	68	88	0	0	0
	Identified	Hosp	0	0	5	3	0	0
		LTC	9	168	52	26	0	0
		MHA	4	45	6	10	0	0
		CSS	0	5	55	180	0	0
	Non-Identified	Hosp	20	14	27	5	33	54
		LTC	205	330	216	94	351	576
		MHA	29	13	31	8	32	33
		CSS	35	22	24	27	53	79
		CHC	54	17	38	2	30	30

LHIN	Responsibility Level	Sector	Superior	Advanced-Plus	Advanced	Advanced-Minus	Intermediate	Elementary
Erie St. Clair	Designated	CSS	12	30	0	1	0	0
	Identified	Hosp	5	1	72	449	0	0
		LTC	0	1	29	16	0	0
		MHA	7	9	19	14	0	0
		CSS	7	10	22	13	0	0
		CHC	3	2	7	2	0	0
	Non-Identified	Hosp	3	5	5	4	20	146
		LTC	21	16	22	11	45	123
		MHA	3	0	0	0	2	29
		CSS	4	0	2	0	7	27
		CHC	0	0	1	1	2	29
Hamilton Niagara Haldimand Brant	Designated	LTC	0	0	68	0	0	0
		CHC	42	0	0	0	0	0
	Identified	Hosp	3	0	6	2	0	0
		LTC	1	9	0	0	0	0
		MHA	1	1	0	1	0	0
		CSS	4	8	9	55	0	0
	Non-Identified	Hosp	1	3	0	6	18	54
		LTC	13	14	56	11	64	129
		MHA	6	0	1	3	10	75
		CSS	3	2	4	11	18	62
		CHC	2	2	3	3	11	50
Mississauga Halton	Non-Identified	Hosp	0	0	1	0	0	0
		LTC	6	0	9	7	14	66
		MHA	3	0	5	2	7	16
		CSS	10	6	12	4	24	32
		CHC	1	0	1	0	3	11
North East	Designated	Hosp	61	5	2287	322	0	0
		LTC	7	17	267	129	0	0
		MHA	48	31	253	64	0	0
		CSS	27	41	114	64	0	0
		CHC	29	77	71	0	0	0
	Identified	Hosp	84	15	93	383	0	0
		LTC	9	17	38	380	0	0
		MHA	1	1	19	14	0	0
		CSS	8	6	76	288	0	0
	Non-Identified	Hosp	6	0	2	0	3	5
		LTC	189	84	90	56	119	111
		CSS	7	1	7	0	9	17

LHIN	Responsibility Level	Sector	Superior	Advanced-Plus	Advanced	Advanced-Minus	Intermediate	Elementary
North Simcoe Muskoka	Designated	Hosp	0	0	56	0	0	0
	Identified	Hosp	15	12	136	48	0	0
		LTC	3	8	1	22	0	0
		MHA	0	1	4	19	0	0
		CSS	0	0	0	2	0	0
		CHC	6	1	5	4	0	0
	Non-Identified	Hosp	7	3	8	0	60	189
		LTC	12	5	23	4	17	56
		MHA	3	2	4	1	2	4
		CSS	13	2	6	0	10	44
		CHC	1	4	0	1	3	4
North West	Identified	Hosp	40	2	32	50	0	0
		LTC	1	0	6	10	0	0
		MHA	0	0	2	2	0	0
		CSS	0	0	1	8	0	0
		CHC	0	9	2	3	0	0
	Non-Identified	Hosp	3	2	2	1	16	12
		LTC	5	1	4	2	3	0
		MHA	3	4	3	5	16	40
		CSS	7	15	10	0	11	84
		CHC	1	1	0	0	0	0
South East	Identified	Hosp	5	15	8	9	0	0
		MHA	0	1	3	1	0	0
		CSS	2	14	4	3	0	0
	Non-Identified	Hosp	12	9	6	10	23	99
		LTC	14	10	16	7	33	77
		MHA	1	1	4	4	29	103
		CSS	10	2	7	10	24	141
		CHC	17	1	16	6	32	46
South West	Identified	Hosp	11	0	6	11	0	0
		MHA	2	1	3	26	0	0
		CSS	2	0	0	0	0	0
		CHC	1	2	4	10	0	0
	Non-Identified	Hosp	15	9	33	24	142	881
		LTC	26	12	20	20	121	773
		MHA	3	1	8	0	11	19
		CSS	17	6	12	15	52	211
		CHC	0	0	0	1	7	28

LHIN	Responsibility Level	Sector	Superior	Advanced-Plus	Advanced	Advanced-Minus	Intermediate	Elementary
Toronto Central	Designated	CSS	0	34	0	0	0	0
		CHC	6	0	0	0	0	0
	Identified	Hosp	10	7	21	0	0	0
		MHA	0	0	3	0	0	0
	Non-Identified	Hosp	3	2	122	37	13	0
		LTC	11	6	7	5	16	26
		MHA	7	8	29	10	33	51
		CSS	6	2	16	11	37	54
		CHC	12	3	23	10	36	85
Waterloo Wellington	Non-Identified	Hosp	10	7	11	17	53	115
		LTC	9	6	11	9	34	78
		MHA	6	2	1	6	14	53
		CSS	8	5	12	4	13	14
		CHC	0	0	1	1	4	26