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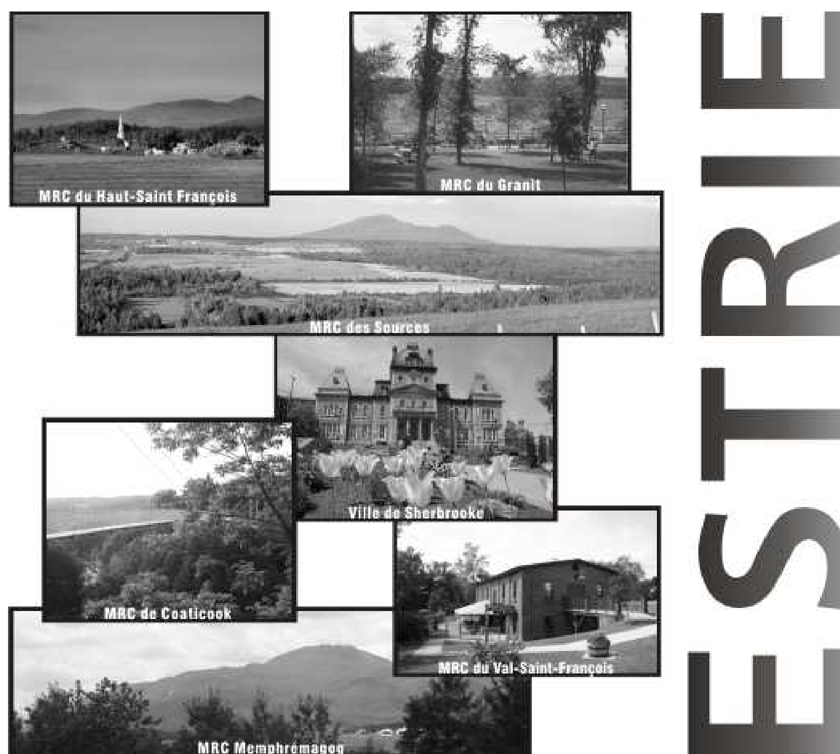
REGIONAL PROGRAM FOR ACCESS TO SERVICES IN ENGLISH ESTRIE

2007-2010



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ACRONYMS AND ABBREVIATIONS USED IN THIS DOCUMENT

ADS :	Sex-differentiated analysis
Agency :	Agence de la santé et des services sociaux
CH :	Hospital (Centre hospitalier)
CHSSN :	Community Health and Social Network
CLSC :	Local community health centre (Centre local de services communautaires)
CSSS :	Health and social services centre (Centre de santé et de services sociaux)
CSSS-IUGS :	Geriatrics institutute (Centre de santé et de services sociaux – Institut universitaire de gériatrie de Sherbrooke)
LPJ :	Youth Protection Act (YPA)
LSJPA:	Youth Criminal Justice Act (YCJA)
LSSSS :	Health and social Services Act
MRC :	Regional county municipality (Municipalité régionale de comté)
MSSS :	Quebec Health and social services ministry (Ministère de la Santé et des Services sociaux)
PI :	Treatment plan
PSI :	Personalized service plan
RI :	Intermediate resources
RTF :	Family-type resources
RUIS :	Integrated university services network
TRP :	Physical rehabilitation technician
TS :	Social worker

INTRODUCTION

The right of English-speaking persons to health and social services in English was expressly affirmed by the Act amending the Health and Social Services Act assented to on December 19, 1986.

In 1991, the new Health and Social Services Act (R.S.Q., C S-4.2) reaffirmed article 15, covering the right of all English-speaking persons to receive health and social services in English, insofar as is provided for in the access program under article 348 of the Act. This right and the obligations stemming from it have been maintained through various changes and amendments to the Act since then, the most recent of which came about through the adoption of Bills 25 and 83.

Following the recent overhaul of the health and social services network, the Ministry undertook to update of the *Cadre de reference*, or "framework", the document that guides the development of the programs outlining access to health and social services in English, produced in 1994. The 2006 version of the framework presents the legal and organizational basis for the access programs and the orientations to be favoured in providing services for English-speaking persons living in Quebec. According to the process that has been proposed, the *agencies*, or health agencies, were to present their access programs to the MSSS by January 31, 2007 at the latest.

Three major principles buttress the framework to revise the revision process presented to the health boards:

- To allow the harmonious integration of the access program into the health care system based on local networks and new responsibilities towards the population;
- To translate a level of flexibility allowing existing programs to be reviewed and new models developed, to improve the response to the needs of the English-speaking population and create linkages with clinical projects;
- To ensure that the right to services in English and the right of workers to work and carry out their activities in French co-exist.

The objective of the access program remains much the same, that is, to ensure that *English-speaking persons have access to a range of health and social services dispensed in English by institutions, whether in their own area, in their region or, if necessary, in another region.*

The revision of the Program for access to services in English in the Estrie region was carried out within these parameters and requirements. The results of this process are presented here.

CHAPTER I

THE LEGAL AND ORGANIZATIONAL CONTEXT

Other than articles 1 to 14 in the Health and Social Services Act (R.S.Q., C-S-4.2) that deal with the rights of all beneficiaries of health and social services, a number of articles deal with the particular rights of English-speaking services users.

Article 15 states that English-speaking persons "*are entitled to receive health services and social services in the English language, in keeping with the organizational structure and human, material and financial resources of the institutions providing such services and to the extent provided by an access program referred to in section 348*".

Article 348 requires the health and social services agency to develop *"a program of access to health services and social services in the English language for the English-speaking population of its area in the centres operated by the institutions of its region that it indicates or, as the case may be, develop jointly, with other agencies, such a program in centres operated by the institutions of another region. Such an access program must take into account the human, financial and material resources of institutions and include any institution in the region designated under section 508*."

Article 508 states that, "*The Government shall designate from among the institutions recognized under of section 29.1 of the Charter of the French language (chapter C-11) those which are required to make health services and social services accessible in the English language to English-speaking persons.*" Following the most recent updating of the list of recognized institutions, the following may be designated: the CSSS-IUGS, the Wales Home, the Dixville Centre of the Regroupement CNDE-Dixville. This means that other institutions must fill the gap by offering services in English in the Estrie region.

To ensure that English-speakers participate in drawing up the access program, the Act provides for, among other things, the formation of regional committees (article 510) charged with giving their opinion to the Agency about the access program that has been drawn up *"in accordance with 'article 348, to evaluate this access program and, if appropriate, to suggest modifications"*.

Besides these assurances, the government formed a provincial committee, by regulation (article 509) which is charged with advising the government on *the approval, evaluation and modification by the Government of each access program developed by an agency in accordance with section 348 for* the dispensing of health and social services in the English language.

In the Estrie region, an "access committee", made up of representatives of the English-speaking community and the institutions, has been in place since 1987.

When the draft version of Law 83 was adopted in 2005, the objective of which was to bring services closer to the population and to facilitate the interactions of citizens with the health care system, it specified the roles and responsibilities of the Agencies and also those of the local and regional authorities in relation to the populations on their territories. As a consequence, the Agencies must facilitate the development and management of the local services networks and ensure the coordination of services with other regions, support the institutions in organizing services and intervene to assist in reaching agreements to meet the needs for services. For their part, local authorities (health and social services centres) must define clinical projects and, at the same time, respect the new responsibilities that have been given to them.

The responsibility for revising the access program has been passed down to the Agencies. This revision must be carried out while respecting the two fundamental principles of the reform: shared responsibility for the population by all partners in the local network and creation of a hierarchy of services.

As part of the implementation of the measures stemming from bills 25 and 83, seven local authorities were created in the Estrie region. These authorities must develop service networks on their territory which will make it possible to reach the objectives related to access, quality and continuity of health and social services. Developing the draft clinical and organizational projects which will be done in the coming years is at the heart of responsibility for the population. It should be remembered that clinical projects must take into account the specific needs of the English-speaking community.

CHAPTER II

THE TARGET POPULATION AND ITS NEEDS

The Target Population

English-speaking persons are those who, in their dealings with an institution that offers health and social services, indicate their wish to receive services in English or who feel more at ease in explaining their needs in this language.[1]

The health and social services ministry has chosen the variable *"first official language spoken"* (with the acronym, PLOP, in French) as the one that presents the most faithful portrait of the clientele targeted by this program. It takes into account the knowledge of the official language, mother tongue, and language spoken at home. Data used for this program come from the 2001 census by Statistics Canada. In line with ministerial guidelines with regard to sex-differentiated analysis (ADS), the data are sorted by sex when available.

According to the 2001 census, the Estrie region has 279,700 inhabitants. Of this number, 22,730 (8.1%) are English-speaking (PLOP). Since the 1991 census, the number of English-speaking persons in the region has declined by around 1,400 persons (1%). The largest group, 8,415 persons, is found in the MRC de Memphrémagog while Sherbrooke has 6,735. Next is Val-Saint-François with 2,340, the Haut-Saint-François with 2,590; and Coaticook, with 1,890, while the MRC du Granit has 265 Anglophones and Asbestos has 480.

During the decade from 1991-2001, the number of English-speaking people increased in the MRC de Mémphrémagog (+ 542), Haut-Saint-François (+ 127) and Coaticook (+ 495). These increases were in part a result of a re-drawing of the MRC territories. In the same period, we note the decline in the English-speaking population in four other parts of the Estrie region: Sherbrooke lost 1774 English-speaking residents, Val-Saint-François, 210, Asbestos, 153 and Le Granit lost 40 English-speaking residents.

We note that because of tourism and the geographic situation of the region as well as the significant student population at the CEGEP and university levels, these statistics represent a minimum in terms of critical mass of the English-speaking clientele that might request services in English.

Table 1 presents the data used to draw up the access program in 1999. This data came from the 1991 census.

[1] See: National Assembly. *Hansard*, Thursday, December 8, 1986, pages 4930-4943 and Wednesday, December 10, 1986, page 5129.

TABLE 1 **PROFILE OF THE ANGLOPHONE CLIENTELE BY MRC - 1999** (according to the first official language spoken - StatsCan 1991)								
MRC	***Anglophone population***	***0-14 yrs. of age***		***15-65 yrs of age.***		***65 yrs. of age +***		
Granit	**(225)**	**55**	**(24 %)**	**150**	**(67 %)**	**20**	**(9 %)**	
Asbestos	**(500)**	**50**	**(10 %)**	**280**	**(55 %)**	**170**	**(35 %)**	
Haut-Saint-François	**(2,915)**	**555**	**(19 %)**	**1,830**	**(63 %)**	**530**	**(18 %)**	
Val-Saint-François	**(2,650)**	**485**	**(18 %)**	**1,645**	**(62 %)**	**520**	**(20 %)**	
Sherbrooke	**(7,935)**	**1,220**	**(12 %)**	**5,030**	**(66 %)**	**1,690**	**(22 %)**	
Coaticook	**(1,535)**	**380**	**(25 %)**	**995**	**(63 %)**	**160**	**(12 %)**	
Memphrémagog	**(8,130)**	**1,435**	**(18 %)**	**4,980**	**(61 %)**	**1,715**	**(21 %)**	
Estrie : total	**23,895**	**4,180**		**14,910**		**4,805**		

1999-05-31

Table 2 presents the share of the English-speaking population of the region, according to StatsCan 2001. For a more precise portrait, data on first official language spoken is given in the Appendices, for Quebec, the Estrie region and the seven territories of the CSSS, by age group and by sex.

		Total - Sex				
		Total - First official	English	French	English and French	Neither English nor
05 - RSS de l'Estrie	**Total - Age group**	279700	22730	255075	1325	570
	0 - 4 yrs. of age	14820	1045	13450	95	225
	5 - 17 yrs. of age	48085	3680	44080	245	85
	18 - 29 yrs. of age	43780	2835	40570	315	60
	30 - 64 yrs. of age	137165	10780	125635	575	175
	65 - 74 yrs. of age	21380	2285	19015	55	25
	75 yrs. and over	14470	2105	12330	40	0

Needs

Existing information systems in the health and social services network are limited in their usefulness for teasing out information related to language by limitations in the data structures. As a result, and as provided for in the *Aide Mémoire pour l'élaboration des projets cliniques* produced by the MSSS, the portrait of the English-speaking population and its needs presented here is based on:

- documentation about the English-speaking clientele;
- consultation about these studies with representatives of the English-speaking community;
- consultation with partners;
- consultation with certain professionals in the network regarding their perception of the needs of this community;
- qualitative treatment of the socio-economic and demographic data available.

The principal sources of information used to develop a picture of the needs and expectations of the English-speaking population are:

- *A Time for Change* (March 2004) produced for Townshippers Association;
- *The Evolving demographic context of the Anglophone Communities in the Eastern Townships* (March 2004), William Floch and Jan Warnke;
- The *Baseline data report 2005-2006, English-language health and social services access in Québec* (February 2006) by the Community Health and Social Services Network (CHSSN). [2]

Meetings and discussions with various stakeholders, notably the regional access committee for English services, the Health and Social Services Committee of the Townshippers Association, and the persons responsible for revising the access program in the institutions of the health care system enriched this information.

The CHSSN *Baseline data report 2005-2006* is based on telephone interviews carried out between May 16 and July 5, 2005 with 3,129 Quebec English-speaking and 1,002 francophone residents. The report provides the following portrait of the English-speaking population in the Estrie region and access to health and social services:

- The *Anglophone* population *65+ years old* is proportionately larger in the Estrie region than elsewhere in Quebec;
- the ratio of *close family or friends or natural caregivers* (35 to 64 years of age) versus the *elderly population* is very low (1.5 relative/Anglophone elderly person). In the francophone population, this ratio is 3 caregivers /elderly person. It can therefore be deduced that there is a greater burden on the English-speaking caregiver-relatives and a greater need among the elderly English-speakers;
- the proportion of Anglophones aged *15+ and over who did not graduate from high school* is larger than is the case for Francophones, and so is the school dropout rate;
- the English-speaking population cohort *25-65 years of age below the low-income line* is 20% higher than it is on the Francophone side;
- Anglophones living in the Estrie region are twice as likely as those in other regions to call upon a community resource in the case of illness. They are less likely than Francophones to use public social services;
- The phenomenon of the exodus of English-speaking youth is a significant issue.

With regard to health and social services in English in Estrie, the CHSSN report makes the following points:

- 87.2% of English-speaking persons in the Estrie region feel that it is very important to receive services (long-term care, home support, nursing care) in English;
- 82% of respondents say they have been served in English by a physician in private practice or a private clinic;
- 67.8% of Estrie region respondents say they have been served spontaneously in English in a CLSC; the service in question (other than the Info-santé help line) was offered in English in three-quarters of the cases, while the other one quarter of respondents had to ask to be served in English;

[2] Community Health and Social Services Network : a network of groups and community resources and public institutions that work to ensure access to health and social services to all Anglophones living in Quebec.

- 59% of respondents say they have been served in English by Info-Santé; which is slightly lower than the Quebec average (63%);
- In emergency rooms and in outpatient clinics in the Estrie region, 51.4% of respondents say they were served in English; among those who were served in French, 2 respondents out of 5 had asked to be served in English;
- During a hospital stay of more than 24 hours, 52.5 % of respondents were served in English; of this number, 7 persons out of 10 were offered care in English, while 3 out of 10 had to ask;
- Questioned about their reluctance to ask for services in English, respondents identified their main reasons as follows: they were embarrassed to ask (19.6%); they were afraid to ask (11%); they were afraid of receiving a negative response (12.6%); they did not want to place an additional burden on the staff (27.9%); they were afraid of delays in obtaining the service (20.9%);
- With regard to the information about services in English, 30% of respondents said they had received such services in the past two years. They obtained this information from leaflets (64%), newspapers (32%), and community groups (34%). With regard to information about prevention and promotion programs, the information comes from the schools (35%), from community groups (31%) and the health care system itself (21%);
- While the Quebec average is about 45.9%, the rate of satisfaction with regard to the access to services in English is 36.8% in Estrie.

Among the various sectors studied, the situation of Info-Santé, emergency rooms and stays in hospital lasting more than 24 hours should be reviewed.

A Time for Change, a qualitative evaluation, is based on information gathered during 12 focus groups and interviews with six key figures in the English-speaking community. With regard to health and social services, the document considered the following needs:

- More responsive and centralized information about services, an information campaign;
- A single gateway or access point to a range of services and easy referral;
- Better harmonization between the CLSC (CSSS) based on the needs of the local population;
- Access to an Anglophone family physician;
- Access to home care services;
- A transportation system.

The priorities identified by respondents in *A Time for Change* were:

- Social problems (abuse of youth and the elderly, addictions, poverty and unemployment, stress, suicide);
- Access to services (knowledge of the offer of service by the CSSS and how the institutions function);
- Language;
- Chronic diseases;
- Lifestyles (diet and obesity, consumption of medications and over-medication);
- Mental health;
- The environment (environmental problems that cause disease).

A Time for Change proposes that:

- the links between CLSCs (now CSSSs) and English-speaking people on their territory be consolidated and strengthened (through the greater availability of documents, translation of documents, training in English as a second language (ESL) for staff, periodic meetings with the Anglophone population, the Canadian Networking and Partnerships Initiative, etc.);
- a single gateway or access point be set up in the region for the Anglophone population;
- a strategy to remedy the lack of a relationship/communication between institutions, the English-speaking leaders of the community and English-speaking users of services be developed;
- the basket of basic services available in all CLSCs (CSSSs) be identified;
- a committee representing the entire population be set up;
- implementation of the Quebec *Holland Centre* model (a centralized service model) be examined;
- federal funding to support networking efforts continue to benefit the region;
- a recruiting strategy for bilingual doctors be developed;
- partnerships with the Francophone milieu be established to ensure that there is training in English as a second language for the staff;
- ways of ensuring that the Anglophone population is adequately represented on boards of institutions be found;
- the possibility of setting up services for young adults around the campus of Bishop's University be considered.

Specific findings

A Time for Change also identifies certain strengths and weaknesses in the Anglophone community. Among the positive aspects: the Estrie Anglophone milieu recognizes and appreciates the quality of services offered in the institutions in the Estrie region and the efforts by the network to work with the Anglophone population. Constructive forces are found in the community. There is a strong sense of solidarity and a feeling of belonging on the part of members. There is a feeling of confidence and the assurance of the survival of the community. This rests in part on its strengths and in part on its relationship with French-speaking neighbours by whom they feel "accepted and appreciated".

The report identifies the following weaknesses in the community:

- The Anglophone population is dispersed across the Estrie region;
- The population is aging;
- The population is getting poorer.

Floch and Warnke note in their report, *The Evolving demographic context of the Anglophone Communities in the Eastern Townships*:

- The ongoing demographic decline;
- The aging of the population;
- The socio-economic weakness (in jobs and education) faced by youth in the 15-24 and those in the 25-44 age cohorts, compared to that of older members of their community and their Francophone neighbours;

- The challenges women must deal with related to access to jobs and responsibilities for dependent children and their own parents and older relatives.

Perception of the health care system

Meetings with the main stakeholders and actors as part of the revision process for the access program (the regional committee which is responsible for the file in the institutions) added the following elements to the portrait of access to services in English:

NEEDS

- Translation of documents and greater coordination /complementarity between the CSSSs;
- Ongoing training in English as a second-language for the personnel.

PROBLEMS

- Little or no formal linkage or coordination between the health and social services network and the Anglophone educational milieu;
- Serious problems in recruiting and retaining workers; increased when knowledge of English must be part of the requirements for a job posting;
- Shortage of resources; difficulty brought about by the absence of a critical mass on the territory, or in a particular program or service;
- Respect for the wishes of English-speaking residents living in long-term care facilities (CHSLDs) not to be put together at one site or in a wing of a facility when it would be more logical to group English-speaking residents to create a more compatible environment;
- Questions with regard to there being nursing care on duty 24/7.

CHALLENGE

To work with the cultural differences of the English population.

PATHS TO SOLUTIONS

- Gather documents which have been translated in a regional translation bank;
- Systematically evaluate the English language skills of the staff, especially during the hiring process;
- Include the concept of quality of language skills in which the service is provided as part of the accreditation process for the institutions.

CHAPTER III

REGIONAL PROCESS TO REVISE THE ACCESS PROGRAM

The regional program for access to services in English in the Estrie region, adopted in 1999, provides for the evaluation of measures put in place to ensure access to services in English. Because the information systems used throughout the network are limited in the fields that could serve as language indicators, it has not been possible to track the changes in services at this level. On the other hand, a work plan for the revision of the Access program in Estrie was adopted by the Agency, in May, 2006.

To meet the requirements of the MSSS, the following components of the work plan were identified:

- dissemination of the work plan in the institutions and to the regional access committee;
- identification of a person in charge of the access file in each institution;
- presentation of the work plan to the regional access committee and to the Townshippers' health and social services committee;
- a meeting with each person responsible for the access file in each institution;
- preparation of a preliminary document;
- validation of the document by the persons responsible for the access file;
- additions and changes to the preliminary document;
- validation of the preliminary document by the regional access committee;
- public consultation;
- compilation of briefs and comments received;
- preparation of a final document submitted to the boards of the institutions;
- adoption of resolutions by the boards of the institutions concerned, leading to the presentation of the file to the board of the Agency for adoption.

Because of the fragility of the access program, it was agreed with those responsible for drawing up the version for 2007-2010 that it would contain an action plan to support the offer of services that would be covered by the government decree.

Each of the principal participants associated with the revision of the file (those responsible for it in the institutions, the committees, etc.) were therefore invited to:

- read the frame of reference from the MSSS and the data on the Anglophone population;
- look at the existing offer of services in English and the methods of access and the available resources in relation to the list of services identified in the 1999 decree;
- give an opinion about the degree of accessibility to the entire range of services named in the program for 1999-2002;
- give an opinion on the needs and special characteristics of the target population;
- become familiar with the expectations of the MSSS and the Agency.

Because the list of services in new programs/services was not available when the revision process began, it was agreed to use the new names when they became available and to leave each institution to use its own list of services while waiting for the appearance of a basket of services in every program. There was also a question about services provided out-of-region and services offered by the integrated university services network (RUIS or réseaux universitaires intégrés de services) with regard to specialized services and ultra-specialized services.

We note that it has been established with the partners that *linguistic access is based on the concept that the person who asks for the service in English can obtain the response to this request in English, either directly or through an intermediate person*. This has been the practice in the Estrie region since 1995.

CHAPTER IV

THE SITUATION IN THE ESTRIE REGION IN 2006

The following findings come out of the above documents, discussions with people involved in the milieu, and, as well, the complaints files, documented cases and discussions in the regional committee for access to services in English.

Findings

The general percentage indicates that since the adoption of the first decrees on access to services in English in 1989, the implementation of the program has been a success in both the 1989 and 1999 versions, and progress has been made with regard to the number of institutions involved in making services accessible, the variety of such services and their reach, and the measures put in place to ensure accessibility.

The program allowed the network to take into account the needs and particular circumstances of the English-speaking population of the Estrie region while major changes in health and social services were taking place between 1989 and 2006. This operation also made it possible for institutions, with representatives of the population, to make the necessary adaptations to ensure that the English-speaking community had access to the same possibilities of services as Francophones.

The action plan in 1999 allowed progress to be made on a certain number of aspects that had been found to be problems during the evaluation of 1995. The definition of an "English-speaking person" no longer appears to be a source of confusion. The responsibilities of the system regarding the availability and dissemination of information about services to the Anglophone population, and the mechanics of the offer of and request for service in English are better understood and are better handled by those providing services.

Even though progress has been made, the fact remains that the access program is a work in progress that requires ongoing support, as shown by the research cited in Chapter 2. Without this support, the rights of English-speaking consumers of services could be drowned in the multitude of legal requirements and expectations of every kind that are exercised in the network. The adoption of Act 83 and the *measures intended to meet objectives in terms of accessibility to, quality and continuity of services* in this law should permit, as a complement to the access program, other gains to be made with respect to the rights of English-speaking persons.

Understanding of the concept of means and resources

The translation into English of documents in response to the development of services in the milieu has been a welcome contribution to improving access. In each institution and for various programs, translations have been made to allow English-speaking consumers of health

care services in the area to have information and instruction related to health and social services and a better understanding of the network. These translations were done in large part from the budgets of the institutions. Financial support for these initiatives was provided from a special budget set aside by the Agency.

Information visits were made twice to all the MRCs thanks to collaboration between the Townshippers Association, the CLSCs and the regional institutions. These meetings, which dealt with the offer of service in English, allowed English-speaking people to meet and talk with representatives of the institutions named in the access program.

In certain institutions, it has become the practice to evaluate the level of understanding of English of new staff members during the hiring process. This allows managers to have a certain latitude to take into account and respect both the right to work in French and the right to services in English. As a complement to this measure and with funds from their own budgets, institutions have organized and offered language practice and improvement sessions in English as a second language to employees called upon to deal with Anglophone services users.

Measure 1 of the McGill Project 2005-2008 (staff training in English as a second language) will enable hundreds of workers targeted to improve their English language skills. This has been made possible thanks to a grant from the Contribution program to improve access to health and social services for official language minority communities, by Health Canada, administered by McGill University.

Measure 2 of the McGill Project for the same period is intended to allow institutions in the region to recruit and retain staff members who are able to provide care in English.

Health Canada's Primary Health Care Transition Fund made it possible to carry out four projects in two institutions in the Estrie region:

- the CSSS-IUGS : Info-Santé project; the psychological and social services project; and the project dealing with the adapted living environment.
- Regroupement CNDE-Dixville : Family-type resources project.

Aside from the measures noted above, the Access program does not benefit from any special human, material or financial resources. The institutions identified by the Agency must, therefore, ensure that English-speaking services users on their territory receive the services they need, whether in their facilities or in partnership with another institution or group, or through an agreement with an institution in another region, in a new context of responsibility towards the population.

Among the individual initiatives by institutions in the Estrie region that have been mentioned by Anglophone users of services in recent years, we note the setting up of an access committee by the CHUS, a liaison position with the Anglophone community, training in English as a second language, information about services in the media and the partnership agreement with Hôpital Saint-Boniface in Manitoba. Their comments are further examples of the appreciation expressed by respondents in the various surveys noted in Chapter 2.

Appreciation of services

Since 1999, the English-speaking population of the Estrie region has benefited from a virtually complete offer of services in English. On the other hand, examination of the documentation and information gathered as part of the revision process gives a different picture. The efforts of some actors identified in the regional access plan have not always been productive.

Feedback from English-speaking services users:

- There is a missing link in the communications plan between the Anglophone milieu and the institutions of the network;
- Measures are needed to bring together English-speaking persons and their service providers, especially by the leaders of the English-speaking community;
- Measures are needed to forge a greater sense of belonging on the part of the population towards the institutions.

Such linkages would facilitate, on the one hand, the identification of special needs in this group and, on the other, the emergence of a response crafted to meet these needs.

Differences between the CSSSs in terms of the basket of services are also noted. The identification of such a "basket of services" accessible throughout the Estrie region would be helpful. Implementing clinical projects under the two program services (Public Health and General Services) which are for the entire population, is one possible way of addressing this lack. The action plan for the access program should, of necessity, contain answers to these expectations. The results of the survey by the CHSSN point in the same direction: accessibility of services in the CLSC (CSSS) should be reviewed; emergency room services and outpatient clinics, and hospital stays longer than 24 hours should also be improved.

Aside from the programs-services that address the needs of all ages (Public Health and General Services), Mental Health, Youth in difficulty and their families; Addiction, and Loss of independence related to aging are areas which the English-speaking population identifies as priorities.

The study dealing with the satisfaction of Anglophone services consumers, the problems and the expectations of Anglophones and the problems and challenges named by the main service providers are unquestionably major themes for the access program 2007-2010. Progress over the last 16 years, particularly with regard to the form and content of the program, should serve as a springboard to launch measures to improve the offer of services in English on an on-going basis.

Other measures that could promote accessibility

The implementation of Act 83, specifically with regard to the new responsibilities related to the development of clinical projects for both clienteles at risk and the entire population, will make it possible to advance in providing accessible services for the English-speaking population.

The new responsibility shouldered by health and social services centres for the population will enable the commitments, made by the institutions in the Estrie region when the access program decree was adopted in 1999, to be consolidated. In this context, adopting the new decree will allow each CSSS to identify even more clearly the offer of services to the English-speaking consumers of services on its territory and the complementarity / continuity of services agreed to by other institutions and partners. The action plan for the access program will itself identify more specific measures to be put in place so that the issues of accessibility, quality and continuity raised in the clinical projects will also be carried out in terms of language. These measures will also be shaped to meet the expectations expressed by the Anglophone milieu with regard to communications with the institutions in the Estrie network.

Other measures could contribute to improving services in English. The articles in the Health and Social Services Act dealing with the respect for and promotion of the rights of users (users' committees, the code of ethics, handling of complaints, etc.) are also ways for users of services to receive services in their own language. Other examples include the right of those served to be informed, to participate in their treatment (I.P., I.S.P.), to receive personalized, appropriate and adequate services in scientific, human and social terms, and to receive continuity of care, and have access to their files.

The participation of the population in managing health care services (elections to boards of direction of institutions and the Agencies, the provincial committee for English language services, the regional access committee for English language services, users' committees) offer other ways of ensuring that the needs of English-speaking persons are taken into account. The presence of representatives of the English community within these structures has certainly proved very helpful over the years.

The service planning and coordination process (the development of clinical projects) presents another opportunity to ensure that the rights to services in the English language are respected.

Sectors to be prioritized

In light of information available on the level of satisfaction and the expectations of English-speaking users of services, information gathered from the principal actors in the file dealing with access to services in English and in the context of implementation of clinical projects, there is reason to focus the access program, and the action plan which must support it, on the major guidelines or objectives of Act 83:

- accessibility,
- quality,
- continuity.

Clinical projects being developed in the CSSS will have part of the response to the needs expressed by the Anglophone clientele of the region by taking into account the special aspects of this target clientele in each program/service. The access program will also provide another part of the response by attempting to answer the following questions:

- What services are required, or should be put in place, to meet the special needs of English speaking people in the region?
- How should the level of satisfaction of English-speaking consumers of services be measured?
- What measures are needed to ensure that the English-speaking services are accessible, that there is continuity of services and that the services are of high quality, within the clinical projects?

CHAPTER V

ACTION PLAN

Action Plan: The connecting link for the access program

The access program, as drawn up, proposes a list of institutions and services that are responsible for making services accessible in English to users on their territory (see Chapter VIII on the services required) in response to the needs and expectations identified by English-speaking consumers of services in the Estrie region. This offer of service in English will be found in the government decree and in the clinical projects of various program-services as they are drawn up by the institutions in the network. The action plan that follows identifies specific measures to be implemented with regard to the legal obligation set out in article 348 of the law and as a function of the orientations of Act 83, in such a way that the objectives of this law can also be achieved for English-speaking users of services in the Estrie region. These measures will serve as guidelines for the institutions in the application of their responsibilities for the territory and the people who live there.

Accessibility

The frame of reference from the MSSS (March 2006) proposes the following definition of accessibility: "*a service is accessible in the English language when the user expresses himself or herself in English and can receive an adequate response in English*". For this definition to be applicable to the access program and in the clinical projects, the action plan must include the list of targeted services; and identify a certain number of measures where linguistic access will be available, and the links between the clinical projects and the access program.

For this purpose, the following regional objective is proposed with regard to accessibility:

> *"Fifteen months at the latest after the adoption of the program, every English-speaking person will have access to the services mentioned in the decree in English."*

Quality

As part of their responsibilities stemming from Act 83, health and social services centres must draw up clinical projects that take into account the special social, cultural and linguistic features of the population on their territory.

The "checklist" produced by the MSSS to support the development of clinical projects testifies to the complementarity between the access program and the clinical project. According to this document, the clinical project *will serve as a lever for the access program*

and this will complete the elements that will make it possible to meet the obligations to English-speaking persons.

In the debate about quality, the appropriate strategies and measures to ensure ongoing improvement in the quality of services offered in the living environment and in care must be identified.

To this end, the proposed regional objective with regard to quality is:

> *"In the plan for ongoing improvement of quality, each institution will put in place measures to identify the level of satisfaction of English-speaking users."*

Continuity of care

Act 83 is intended to facilitate the user's travel through the heath and social services system. In the literature review mentioned in Chapter 2, the Anglophone population names the same issues: integrated networks, clear description of the responsibilities of the institutions, home support, family physicians, a single gateway, etc. Whether within an institution, during a referral to services provided by a community group, a social economy business or a specialized institution in or outside of the region, the risk of a break in the continuum of services applies to the population in general. The reticence of English-speaking users to ask for service in their language, a point made in the CHSSN survey, increases the risk of such a break. There is, therefore, reason to put in place measures in each program-service so that the follow-up and referral mechanisms already established or to be established are clearly defined and take into account Anglophone consumers of services.

For this reason, the following is the regional objective for continuity of care:

> *"Within fifteen (15) months following the adoption of the program, any English-speaking person whose needs must be met by a group or an institution other than his own health and social services centre will be able to take advantage of support and accompaniment measures."*

The operational objectives are proposed in light of these three regional objectives. They deal with:

- the services themselves;
- information about these services;
- the human, material and financial resources that must be made available;
- management of these resources.

In order to facilitate the follow-up of these actions and estimate the operational costs of reaching these operational objectives, one or several players have been identified, along with a deadline.

Operational Objectives

A) THE FOLLOWING OPERATIONAL OBJECTIVESARE PROPOSED FOR THE SECTION DEALING WITH **"SERVICES REQUIRED IN ENGLISH LANGUAGE":**

- The list of services that will be in the decree will be known. (Chapter VIII: Service required in English).
- Services identified in the decree concerning the major activity sectors in the programs-services (prevention /promotion, evaluation and diagnosis, treatment, monitoring, adaptation/social rehabilitation, and integration/social reintegration) will be subject to measures to improve the language aspect of the service.

ACTIONS PROPOSED	ACTORS CONCERNED	DEADLINE
1. The list of services accessible in English in each institution will be set by a resolution of its board of directors.	Designated and indicated institutions[3]	January 2007
2. Ten months after the program is adopted, the list of services will be adapted according to the major activities sectors of the programs-services (prevention/ promotion, evaluation and diagnosis, treatment, follow-up, adaptation / rehabilitation, social integration / reintegration).	Agency	December 2007
3. The living and care environments will be adapted to accommodate English-speaking benficiaries of services.	CSSS CHUS	December 2007

B) THE FOLLOWING OPERATIONAL OBJECTIVES ARE PROPOSED FOR THE SECTION DEALING WITH "INFORMATION ABOUT SERVICES":

- Caseworkers in the network and the English-speaking population will be informed about the access program. (It is understood that caseworkers means anyone who works with the patients).
- Written information for users will be available in English.
- Message and voice mail systems will be adapted in the "indicated" institutions.
- The needs of the English-speaking population and the level of satisfaction will be made known.

[3] Indicated institution: an institution that has agreed to be named in the program.

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
4. The regional program will be disseminated in all the institutions and community groups.	Agency	October 2007
5. Each institution will make its staff aware of the definition of an “English-speaking person” and the rights, obligations and conditions governing access to services in English.	CSSS and regional institutions	October 2007
6. The program will be disseminated to the English-speaking population in the form of a folder. Information meetings will be organized as needed.	Agency CSSS	October 2007
7. The list of services named in the decree will be disseminated to the staff of the institutions.	Agency All institutions	October 2007
8. The list of indicated services in the Access program will be integrated into the directory of resources for Info-Santé.	CSSS-IUGS	October 2007
9. The Agency and the health and social services centres will ensure that information continues to be provided to English-speaking persons on their territory. This information will relate to the access program, the obligations of the network and the rights and responsibilities of Anglophones with regard to communication in English.	Agency CSSS	Annually
10. Starting with an inventory of documents required in French in each program, a list of documents available and/or to be made available in English will be established. Written information includes “menus, folders on services and care, notices in the newspaper, etc.”	Agency	December 2007
11. The documents available in English will be shared among the institutions concerned. The list of these documents will be gathered by program/services and register.	Agency, CSSS, regional institutions	March 2008
12. The list of documents that are needed in English will	Agency, CSSS, regional	April 2008

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
be established and prioritized for translation.	institutions	
13. Translation of documents will be supported financially by the Agency as a function of available budgets, by the program-services involved or the regional program support budget.	Agency All institutions	Ongoing
14. The central telephone answering system used in the institutions will be accessible in English. The voice messages for the services identified in the Access program will be adapted for English users.	CSSS, regional institutions	September 2007
15. Information campaigns for prevention and promotion, special measures will be set up to reach English-speaking persons.	Agency, CSSS, regional institutions	Ongoing
16. In each CSSS, mechanisms for discussion with the English community on the territory (periodic meetings) will be put in place to ensure that the services offered, the special needs of users and the level of satisfaction are known.	CSSS	Annually

C) The following operational objectives are proposed for the section dealing with "Human, financial and material resources":

- Within 15 months of the adoption of the regional access program, the staff required to meet the requests for service in English will be available in all the services listed in the program.

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
17. For each service named in the decree, the institution concerned will identify the target posts and the level of language fluency required to respond to requests in English. When the service is made accessible by an intermediary person, the institution will maintain a list of names of these bilingual persons.	CSSS, regional institutions	March 2008
18. The institution will take the necessary	CSSS, regional institutions	Ongoing

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
measures to ensure the presence of staff with competence in English (bilingual position or intermediary person) in the services named in the decree.		

D) The following operational objectives are proposed for the section dealing with "Management of resources":

- Staff targeted for services named in the decree who do not meet the requirement for knowledge of English will receive the training needed to ensure an adequate response to requests in English.
- Protocols of agreement to ensure continuity of services at the local, regional and supra-regional levels will deal with the methods of orientation and referral for English-speaking persons.
- The notion of quality of services in the English language will be included in the ongoing process to improve the quality of services in the institutions named in the decree.
- In each institution, one person will be mandated to ensure the coordination of measures provided for in this plan.

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
19. Each institution indicated in the access program will ensure that the protocols of agreement among local, regional and supra-regional partners with which it is associated, identify clearly the particular measures for English-speaking patients.	CSSS, regional institutions	June 2008
20. Institutions that refer an English-speaking person to another resource will make sure that the services required are accessible in English.	CSSS, regional institutions	Ongoing
21. The list of community groups that offer services in English will be disseminated to the institutions named in the access program. They will be integrated into the directory of resources of Info-Santé.	Agency	December 2007
22. Each institution will identify the means that	CSSS, regional institutions	December 2007

ACTIONS PROPOSED	STAKEHOLDERS CONCERNED	DEADLINE
will be put in place to find out the level of satisfaction of English-speaking consumers of services with regard to the services named in the decree. A basic model will be proposed for this evaluation by the Agency.		
23. The institution named in the access program will handle complaints in English.	CSSS, regional institutions	September 2007
24. Information about the accessibility of service in English will be found in the annual report of each institution named in the access program.	CSSS, regional institutions	Ongoing
25. When deemed necessary, training sessions in English as a second language will be offered to staff members who deal with Anglophone consumers of services. The staff in community groups and working at the switchboard (Centrale de communication-Santé) will also be able to take advantage of such training.	CSSS, regional institutions	Annually, starting in 2007-2008
26. Each institution will identify the person responsible for the implementation of the action plan (file manager).	CSSS, regional institutions	June 2007

CHAPTER VI

IMPLEMENTATION OF THE PROGRAM

Among the major concerns identified by Anglophone respondents in *A Time for Change* were the language of and accessibility to services. The reluctance of Anglophones to ask for a service in English language for fear of putting an additional burden on the service provider or for fear of being refused or facing additional delays were also factors that indicate the importance of the guarantee of accessibility that the decree carries, and, as well, the burden that must be assumed by the institutions that have indicated their willingness to be included in the access program.

Guarantees of accessibility sought by English-speaking consumers of services must find a response in the measures the partners assume under the action plan of the program. Transparency and dialogue between the Anglophone community and the health and social services network are two crucial elements in reaching the objectives set by the Agency for the Estrie region.

For this reason, the adherence of each institution to the regional objectives in the action plan, to the implementation of the means proposed and their collaboration in the mechanism for monitoring the action plan is the cornerstone on which the access program rests.

CHAPTER VII

MONITORING AND EVALUATION OF THE ACCESS PROGRAM

Evaluation of the program

As part of the *Cadre de Référence* for revising access programs, the MSSS announced that it would develop, in collaboration with the Provincial committee and the Agencies, a framework for monitoring and evaluation that would lay out the desired monitoring and evaluation, the priorities and the methods. Indicators would then be proposed based on available measurement tools.

Monitoring of the regional action plan

While waiting for the evaluation framework, there is reason to ensure that there is a first level of follow-up of the implementation of the program and its operations, to ensure that they correspond to what was planned. This means monitoring and appraising the setting up of the methods and the various actions proposed in terms of services offered, information provided, human resources available and management of them, and tracking the evolution of the situation over a period of three years. This allows the various bodies responsible (from the regional coordination to the

partner institutions) to monitor the differences between what has been accomplished and what was planned, and to take the necessary measures to correct the situation. The information needed to monitor the program is recurrent and comes from the annual reports or matrices for gathering specific information. As an example, questions that could be asked include the following:

With regard to the implementation of activities:

Was the regional program published within the deadlines established for all institutions and groups and for the English-speaking population?

Did the institutions concerned provide training for staff in the targeted services?

Was the list of indicated English language services in the regional access program integrated into the directory of Info-Santé resources?

With regard to changes in the ways and means put in place:

Has there been a change in the numbers of staff who have received language training in these services?

What changes have taken place in the level of language competence of the staff?

How many documents have been translated into English?

Evaluation of the results of the regional access program

A second level evaluation is to check the results in terms of whether accessibility targets have been reached and to explain the results. This means making a structured judgement on real accessibility to English language services and making these findings known to the regional population and the MSSS. Information about the clientele is gathered from information systems and from surveys of the English-speaking population, depending on the availability of financing. As an example, questions that could be asked might include:

What proportion of English-speaking persons is aware of the regional access program?

What proportion of the English-speaking community has asked for services in English in the institutions concerned at least once?

How many English-speaking consumers of services received a response in English?

What is the average waiting time?

How many English-speaking users are referred by indicated institutions listed in the regional access program?

What is the level of satisfaction about linguistic accessibility of services among the population?

We have seen that the existing information systems in the health and social services network allow little if any of this type of information to be collected. The CHSSN survey is the source of much of this information. There is, therefore, reason to look at and identify measures to be put in place to obtain a portrait of the results of various regional access programs, with the Ministry and the provincial committee.

Mandates and responsibilities

The person in charge of regional coordination of the access program has the responsibility of carrying out the first level of evaluation; that is, an estimate of the implementation and evolution of the program. Evaluating results is the responsibility of the evaluation team at the Agency, which also provides support to the person responsible for coordinating the tracking of the program.

The institutions involved in carrying out various measures must, for their part, send the regional coordinator information about the management aspects. They are asked, when the evaluation framework becomes available, to participate in the assessment of results. In order to track the overall general evaluation process, a monitoring committee is also proposed. Under the direction of the regional coordinator, this committee is made up of one person from the evaluation team at the Agency and representatives of those responsible for the access file in the institutions and representatives from the English-speaking community.

CHAPTER VIII

ENGLISH LANGUAGE SERVICES REQUIRED

REGIONAL PROGRAM OF ACCESS TO SERVICES IN ENGLISH
"LIST OF SERVICES REQUIRED THAT WILL BE INCLUDED IN THE DECREE"

INSTITUTIONS	GUARANTEED SERVICES
SHERBROOKE	
CSSS-IUGS (designated institution)	**Programs specifically for Early Childhood-Youth-Family** Mental health services for youth; School health services (elementary and secondary); Dental services; Psychological and social services; Community action services; Integrated program for 0-5 yrs. of age; Services for the intellectually impaired and for autism spectrum disorders; Postnatal liaison; Auxiliary family and social services; Addiction program; Maternity centre (midwifery service); **Programs specifically for adults and general services** Intake; Regional Info-Santé (regional service); Urgence –Détresse (regional emergency hotline service under Info-Santé); Mental health services; Psychological and social services; Walk-in nursing services; Clinic for international travellers; HIV detection centre (regional service). **Program for the elderly and those losing their independence** ***<u>Home care support</u>*** Specialized program (severe respiratory difficulties); Intake; Intake for psychological and social services; Home care services for the elderly; Home support services for persons with a physical impairment; Walk-in nursing services; Day centre; Intermediary housing resources. ***<u>Accommodation / Housing</u>*** Long-term care and emergency-respite social housing; Intake and chaplain; Alternating accommodation; Specialized program for persons with behavioural problems (regional service);

INSTITUTIONS	GUARANTEED SERVICES
CSSS-IUGS (designated institution) (cont'd.)	Professional, volunteer services; Other services (cafeteria and Accounts Receivable). ***Hospital*** Day surgery; Short-term geriatric services (regional service); Intensive, functional rehabilitation (regional service); Specialized outpatient geriatric clinics (regional service); Gerontolgical-psychiatric services for seniors (regional service).
Centre hospitalier universitaire de Sherbrooke *Regional mission* *Mission and services RUIS …*	**Services guaranteed by the decree** Interdisciplinary team; Admission; Surgery and recovery room; Day centres; Nursing units; Chemotherapy centre; Haemodialysis –ambulatory peritoneal dialysis; Emergency; Intensive care; Day surgery and surgery prep. clinic; Maternity, neonatalogy, paediatrics; Laboratory for pulmonary function testing; Test centre; Inhalation therapy, electrophysiology, radiobiology; Medical imaging; Mental health; Social services; Breast cancer screening program; Archives; Pharmacy; Appointment centre; Outpatient clinics; Telecommunications; Complaints service; Accounts and administration; Cafeteria and parking.
Estrie Centre jeunesse *Regional mission*	Intake service; Reception and report handling service (YPA); Evaluation and orientation services; Emergency social services; Outpatient psycho-social and rehabilitation services (LSSS); Outpatient psycho-social and rehabilitation services (YPA); Pyscho-social services (YCJA: Youth Criminal Justice Act); Pre-sentencing services (YCJA); Expert services, Superior Court, related to custody of children and visiting rights and outings; Adoption services; Research for and meeting with biological parents; Family- and intermediate-type resources.

INSTITUTIONS	GUARANTEED SERVICES
These service will be available in the institutions targeted	
Regroupement CNDE - Dixville *Regional mission* - Centre Notre-Dame de l'Enfant and Centre d'accueil Dixville (designated institution)	**Services to individuals:** Access to evaluation and orientation services; Adaptation and rehabilitation services; - In the residential integration context (residential service in a substitute home setting; specialized residential service in a substitute home setting; intensive adaptation/rehabilitation service in a specialized residential setting; - In the context of integration in the workplace (specialized service for access to employment (support for trial periods); intensive adaptation/rehabilitation service (workshops and workplaces); - Support services for integration into the community, skills and knowledge maintenance and quality of services (day centre activities). **Services to families and their loved ones:** Special education assistance services. **Services to partners** Specialized support services.
Centre de réadaptation Estrie inc. *Regional mission*	**PROGRAM FOR ADULTS** (adults with one or more motor impairments). General reception - intake; Orientation; Specialized education; Occupational therapy; Medicine; Neuropsychology; Speech therapy; Physiotherapy; Psychology; Techniques of physical rehabilitation; Social services. **INTENSIVE FUNCTIONAL REHABILITATION** (for adults who are unable to return to their homes right after their hospital stay). Assistance to those receiving services; Specialized education; Occupational therapy; Intermediate resources; General medicine; Neuropsychology; Speech therapy Physiotherapy; Psychology; Social services; Nursing care; Techniques of physical rehabilitation.

INSTITUTIONS	GUARANTEED SERVICES
Centre de réadaptation Estrie inc. *Regional mission* (cont'd.)	**TRAUMATOLOGY PROGRAM** (Outpatient rehabilitation and social integration services for children, adolescents and adults). Specialized education; Occupational therapy; Intermediate resources; General medicine; Neuropsychology; Speech therapy; Physiotherapy; Psychology; Social services; Nursing care; Techniques for physical rehabilitation. **PROGRAM FOR CHILDREN AND ADOLESCENTS** Eight sub-programs (Adolescents; Dyspraxia; Encephalopathies; Language/speech; Musculoskeletal lesions; Neuromuscular diseases; Myelopathies; Developmental delays) for persons aged 0 to17 years. Specialized education; Occupational therapy; Medicine; Neuropaediatrics (consultation); Neuropsychology; Speech therapy; Paediatrics; Paedopsychiatry (consultation); Physiotherapy; Psychology; Social services. **RESDIENTIAL AND HOUSING RESOURCES** (For children, adolescents and adults who present significant and persistent impairment and who therefore need temporary or permanent housing or specialized services to allow them to remain in their natural living environment). Family-type resources (RTF); Intermediate resources (RI); Respite care and "trouble-shooting" back-up; Specific resources; Placements in private resources; Specialized education; Occupational therapy; Instructors; Physiotherapy; Social services; Nursing care; Leisure techniques.

INSTITUTIONS	GUARANTEED SERVICES
Centre de réadaptation Estrie inc. *Regional mission* (cont'd.)	**Sensory impairment** (auditory, visual, motor) and compensatory aides. (Adaptation, rehabilitation and social re-integration services for children, adolescents, adults and the elderly). (Orthotics, prostheses, wheel chairs, special shoes …). Repair of wheel chairs; Trouble-shooting back-up service; Audiologogy; Specialized education; Speech pathology; Social services; Optometry; Mobility orientation; Visual impairment specialization; Occupational therapy; Physiotherapy; Techniques – orthotics and prostheses; Mechanics - orthotics,-prostheses; Mechanics wheel chairs.
Villa Marie-Claire inc. *Regional mission*	Intake, evaluation, orientation; Follow-up in the home.
Le Centre Jean-Patrice-Chiasson / Maison Saint-Georges *Regional mission*	
- Maison St-Georges **(Mental health)**	Intake, evaluation and orientation:services; Mental health rehabilitation services; In-house and outpatient services.
- Centre Jean-Patrice-Chiasson **(addictions)**	Intake, evaluation and orientation services; Addiction rehabilitation services; Outpatient and in-house services.
MRC Les Sources	
CSSS des Sources	**PALV Program: Aging-related loss of independence** Home support services; Home care services; Psychological and social services; Housing and long-term care; Temporary housing. **Physical Health and General Health Program** Emergency department; Short-term unit; Intake and admission services; Medical services;

INSTITUTIONS	GUARANTEED SERVICES
CSSS des Sources **(cont'd.)**	Specialized medical services; Walk-in nursing services; One-stop reception gateway and walk-in psychological and social services; Inhalation therapy services; Occupational therapy services; Physiotherapy services. **Specific programs** Mental health services; Services for youth in difficulty.
MRC de Coaticook	
CSSS de la MRC de Coaticook *CLSC Mission*	**Program for persons losing their independence** Home support services; Home care services; Professional health services (social workers, physiotherapists); Community organization services; Day centre. **Childhood-Youth-Family and Adult Program** One-stop gateway - intake for social services; Nursing services; Psychological and social services; Services for children and adults presenting mental health problems. **Physical health program** Admission; Diagnostic support services; Diagnostic support services (electrophysiology); Walk-in nursing services; Emergency; Health prevention and promotion services; Inhalation therapy; Cardiac health. **Housing-living environment program** Intake, information, accompaniment and referral; Nursing services; Support and assistance services; Activities and leisure services; Psychological and social services; Clinical services; Chaplain.
MRC du Granit	
CSSS du Granit *CLSC Mission*	**CLSC Childhood, youth, family, adult program** Intake, information, accompaniment and referral; Single gateway to health services intake;

INSTITUTIONS	GUARANTEED SERVICES
CSSS du Granit *CLSC Mission* (cont'd.)	Single gateway to social services intake ; Urgence-Détresse (regional emergency hotline under Info-Santé); Social services childhood, family; Health services childhood, family; Maternal, child health services; Dental health services; Psychological and social services; Youth clinic; Prevention, promotion and health protection services; Services for children and adults with mental health problems; Services related to community organization. **CLSC Persons losing their independence** Intake, information, accompaniment and referral; Assistance services in the home; Intensive care services and support to remain at home (SIMAD); Medical services; Home support services; Professional and support health services (physiotherapy, occupational therapy and nutrition); Palliative care at home for patient and loved ones; Community organization services; Mental health services. **Housing for persons losing their independence** Day centre; Alternative living environment (RI and RTF); Temporary accommodation (respite care, "trouble-shooting" and back-up and convalescence); Compensatory measures. **Hospital: Physical health** Outpatient clinic and physiotherapy; Day hospital; Geriatric short-term unit; Medical services; Intake, information, accompaniment and referral; Medical services (points of services); Admission; Outpatient clinics; Medical services in outpatient clinics; Diagnostic support services (radiology); Diagnostic support services (laboratory and test centre); Diagnostic support services (electrophysiology); Walk-in nursing services; Switchboard and reception; Emergency; Health promotion and prevention services (nutrition and nursing services); Surgery department; Day surgery.

INSTITUTIONS	GUARANTEED SERVICES
CSSS du Granit *CLSC Mission* ((cont'd.).)	Medical services; Endoscopy; Inhalation therapy; Nutrition; Cardiac health; Acute care. **Housing, Living environment** Intake, information, accompaniment and referral; Dentistry; Occupational therapy; Physical rehabilitation (TRP and physiotherapy); Nutrition services; Nursing services; Support and assistance services; Activities and leisure service; Medical services; Psychological and social services.
MRC du Haut-Saint-François	
CSSS du Haut-Saint-François *- CLSC Mission*	Intake-evaluation-orientation and referral; Nursing care at home; Assistance services in the home; Rehabilitation services at home; Medical services; Walk-in nursing services; General psychological and social services; School psychological and social services; Integrated services for 0-5 years of age; Mental health; Workplace safety; Dental health (hygiene); Day centre.
- *Housing Mission* Centre d'hébergement d'Est Angus	Housing and long-term care (PALV).
MRC du Val-Saint-François	
CSSS du Val Saint-François *CLSC Mission*	**CLSC Childhood Family Adult** Reception/Intake, information, accompaniment and referral; Single gateway for health services intake; Single gateway for social services intake; Urgence détresse (Emergency regional hotline service through Info-Santé) Medical services; School health services (elementary); School social services (elementary); Social services childhood-family; Health services childhood-family;

INSTITUTIONS	GUARANTEED SERVICES
CSSS du Val Saint-François *CLSC Mission*	Maternal and infant health services; Dental health services (elementary); Psychological and social services; Health promotion, prevention, and protection services; Services for children and adults with mental health problems; Services in community organization. **CLSC Persons losing their independence** Reception-intake, information, accompaniment and referral; Assistance services in the home; Intensive care services to allow the person to remain at home (SIMAD); Evaluation and medical monitoring at home; Medical services; Support services in the home; Health professional and support services (physio- and occupational therapy, nutrition); Palliative care at home for the patient and loved ones; Services in community organization; Mental health services. **Housing for persons losing their independence** Day centre; Alternative living environment (RI and RTF); Temporary accommodation (respite care, trouble-shooting and back-up and convalescence).
Foyer Wales	All services.
MRC de Memphrémagog	
CSSS de Memphrémagog *CLSC Mission*	**Childhood, youth, family, adult program** Unified reception and intakes services; Medical services; Nursing services; Psycho-social services; Dental health services (elementary); Youth clinic; Psychological services; Health promotion, prevention, and protection services; Services for children and adults presenting mental health problems; Services in community organization; Social and child-family health services; Home support services; Health and social services in the school (elementary); Maternal and child health services.
CSSS de Memphrémagog	**Program: For those losing their independence**

INSTITUTIONS	GUARANTEED SERVICES
CLSC Mission (cont'd.)	Home support services; Medical services; Home care services; Professional services in health (physio-; occupational therapy; nutrition); Palliative care at home for patients and loved ones; Services in community organization; Day centre; Alternative living environment (RI and RTF); Temporary accommodation (respite care, trouble-shooting and back-up and convalescence); Geriatric short-term care unit. **Physical health program (outpatient services and diagnostics)** Telephone and reception; Medical services; Admission; Outpatient clinics; Diagnostic support services (radiology, laboratory and test centre, electrophysiology); Walk-in nursing services; Emergency department. **Physical health program (hospital services and day surgery)** Surgery department; Day surgery; Medical services; Dialysis unit; Endoscopy; Cardiac and respiratory health; Acute care - 31 beds (nursing care, assistance and support). **Housing, living environment program** Reception; Dentistry; Physical rehabilitation; Nutrition service; Nursing services; Support and assistance services; Activities and leisure service; Medical services; Psycho-social services; Chaplain.
La Maison Blanche de North Hatley inc.	Reception/intake, referral; Housing and long-term care services; Physiotherapy; Diet; Leisure/activities; Social services.

APPENDICE

Total population distribution according to first official language

Québec, Estrie and RSS, 2001

		Total - Sex				
		Total - First official language spoken	English	French	English and French	Neither English nor French
Province of Quebec	Total - Age group	7125575	828730	6059115	180450	57285
	0 - 4 yrs.	376655	43635	312325	6370	14325
	5 - 17 yrs.	1190335	131470	1023655	31185	4025
	18 - 29 yrs.	1110725	130120	937215	41170	2215
	30 - 64 yrs.	3569800	409845	3056705	85665	17590
	65 - 74 yrs.	534155	62740	450850	10965	9600
	75 yrs. and over	343905	50915	278370	5100	9525
05 - RSS de l'Estrie	Total - Age group	279700	22730	255075	1325	570
	0 - 4 yrs.	14820	1045	13450	95	225
	5 - 17 yrs.	48085	3680	44080	245	85
	18 - 29 yrs.	43780	2835	40570	315	60
	30 - 64 yrs.	137165	10780	125635	575	175
	65 - 74 yrs.	21380	2285	19015	55	25
	75 yrs. and over	14470	2105	12330	40	0
0501 - RLS du Granit	Total - Age group	21400	265	21110	20	0
	0 - 4 yrs.	1105	10	1095	10	0
	5 - 17 yrs.	3850	60	3785	10	0
	18 - 29 yrs.	3155	30	3130	0	0
	30 - 64 yrs.	10425	125	10295	10	0
	65 - 74 yrs.	1780	35	1745	0	0
	75 yrs. and over	1075	15	1060	0	0
0502 - RLS d'Asbestos	Total - Age group	14230	480	13685	55	0
	0 - 4 yrs.	595	10	570	15	0
	5 - 17 yrs.	2345	40	2305	10	0
	18 - 29 yrs.	1890	55	1830	10	0
	30 - 64 yrs.	6985	230	6725	30	0
	65 - 74 yrs.	1460	75	1385	0	0
	75 yrs. and over	950	70	880	0	0
0503 - RLS du Haut-Saint-François	Total - Age group	21020	2590	18400	25	0
	0 - 4 yrs.	1155	125	1030	0	0
	5 - 17 yrs.	4075	405	3665	10	0
	18 - 29 yrs.	2630	320	2310	0	0
	30 - 64 yrs.	10450	1285	9160	10	0
	65 - 74 yrs.	1635	190	1445	0	0
	75 yrs. and over	1065	275	790	0	0
0504 - RLS de Val Saint-François	Total - Age group	27890	2340	25485	60	0
	0 - 4 yrs.	1525	105	1420	0	0
	5 - 17 yrs.	5170	420	4735	15	0
	18 - 29 yrs.	3895	295	3595	0	0
	30 - 64 yrs.	14090	1070	12995	25	0
	65 - 74 yrs.	2060	250	1800	15	0
	75 yrs. and over	1150	210	940	0	0
0505 - RLS de Coaticook	Total - Age group	18030	1890	16085	50	0
	0 - 4 yrs.	1030	80	950	0	0
	5 - 17 yrs.	3725	365	3355	10	0
	18 - 29 yrs.	2485	225	2255	0	0
	30 - 64 yrs.	8505	865	7610	30	0
	65 - 74 yrs.	1385	230	1160	0	0
	75 yrs. and over	900	130	760	10	0
0506 - RLS de Memphrémagog	Total - Age group	41715	8415	33125	165	10
	0 - 4 yrs.	1995	495	1470	20	0
	5 - 17 yrs.	6870	1430	5395	45	0
	18 - 29 yrs.	5100	800	4275	20	0
	30 - 64 yrs.	21700	4090	17545	70	0
	65 - 74 yrs.	3825	935	2875	10	0
	75 yrs. and over	2225	660	1570	0	0
0507 - RLS de Sherbrooke	Total - Age group	135415	6735	127180	945	560
	0 - 4 yrs.	7410	225	6920	45	225
	5 - 17 yrs.	22045	965	20840	160	85
	18 - 29 yrs.	24630	1120	23175	275	60
	30 - 64 yrs.	65000	3110	61310	405	170
	65 - 74 ans	9225	570	8605	30	15
		7110	750	6330	25	0

Source: Statistics Canada, 2001. Census.

NB: Persons living in an institutional-type group household are exckuded.

Répartition de la population (masculine) selon la première langue officielle

Québec, Estrie et RSS, 2001

		Masculin				
		Total - Première langue officielle parlée	Anglais	Français	Anglais et français	Ni l'anglais ni le français
Province de Québec	Total - Groupe d'âge	3491685	409495	2962770	96790	22630
	0 - 4 ans	194295	22770	160615	3415	7495
	5 - 17 ans	606940	67780	521120	15660	2375
	18 - 29 ans	559475	65630	471395	21645	805
	30 - 64 ans	1758385	203645	1502160	46610	5960
	65 - 74 ans	243170	29530	203965	6560	3115
	75 ans et plus	129420	20135	103510	2900	2875
05 - RSS de l'Estrie	Total - Groupe d'âge	138080	10960	126045	780	295
	0 - 4 ans	7840	555	7075	65	150
	5 - 17 ans	24420	1815	22390	170	50
	18 - 29 ans	22160	1380	20610	165	10
	30 - 64 ans	68460	5385	62670	315	90
	65 - 74 ans	9655	1030	8585	40	0
	75 ans et plus	5550	800	4720	30	0
0501 - RLS du Granit	Total - Groupe d'âge	10940	120	10810	10	0
	0 - 4 ans	590	0	590	0	0
	5 - 17 ans	1930	35	1890	0	0
	18 - 29 ans	1665	15	1650	0	0
	30 - 64 ans	5455	60	5390	0	0
	65 - 74 ans	815	10	815	0	0
	75 ans et plus	480	10	465	0	0
0502 - RLS d'Asbestos	Total - Groupe d'âge	7085	245	6810	30	0
	0 - 4 ans	345	10	330	0	0
	5 - 17 ans	1155	15	1135	0	0
	18 - 29 ans	960	30	925	0	0
	30 - 64 ans	3515	145	3355	10	0
	65 - 74 ans	660	20	640	0	0
	75 ans et plus	450	25	420	0	0
0503 - RLS du Haut-Saint-François	Total - Groupe d'âge	10715	1235	9465	15	0
	0 - 4 ans	700	85	610	0	0
	5 - 17 ans	2015	195	1820	10	0
	18 - 29 ans	1340	165	1170	0	0
	30 - 64 ans	5360	610	4745	0	0
	65 - 74 ans	795	60	735	0	0
	75 ans et plus	510	120	385	0	0
0504 - RLS de Val Saint-François	Total - Groupe d'âge	14180	1115	13035	35	0
	0 - 4 ans	745	30	710	0	0
	5 - 17 ans	2745	205	2530	10	0
	18 - 29 ans	2090	170	1920	0	0
	30 - 64 ans	7125	520	6595	20	0
	65 - 74 ans	975	105	865	0	0
	75 ans et plus	500	80	415	0	0
0505 - RLS de Coaticook	Total - Groupe d'âge	9100	975	8095	30	0
	0 - 4 ans	505	50	460	0	0
	5 - 17 ans	1885	185	1695	0	0
	18 - 29 ans	1265	90	1165	0	0
	30 - 64 ans	4445	480	3945	15	0
	65 - 74 ans	650	105	545	0	0
	75 ans et plus	350	60	280	10	0
0506 - RLS de Memphrémagog	Total - Groupe d'âge	20695	4135	16440	120	0
	0 - 4 ans	1060	260	785	15	0
	5 - 17 ans	3365	710	2620	35	0
	18 - 29 ans	2540	375	2150	15	0
	30 - 64 ans	11000	2040	8915	45	0
	65 - 74 ans	1865	515	1335	10	0
	75 ans et plus	865	235	635	0	0
0507 - RLS de Sherbrooke	Total - Groupe d'âge	65365	3140	61390	545	290
	0 - 4 ans	3895	120	3590	40	150
	5 - 17 ans	11315	470	10695	105	45
	18 - 29 ans	12305	540	11620	140	10
	30 - 64 ans	31550	1530	29725	220	85
	65 - 74 ans	3895	220	3650	25	0
	75 ans et plus	2400	265	2115	20	0

Source: Statistique Canada, Recensement de 2001.
NB: Les personnes résidant en ménage collectif de type institutionel sont exclues.