QUEBEC FIRST NATIONS'
HEALTH AND SOCIAL SERVICES
GOVERNANCE PROCESS

FINAL REPORT

REGIONAL INVENTORY OF HEALTH AND SOCIAL SERVICES WORKFORCE OF THE FIRST NATIONS COMMUNITIES IN QUEBEC

JULY 20, 2020

REPORT PRODUCED BY

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

CSSSPNQL • FNQLHSSC

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NOTE TO THE READER

This document was originally written in French.

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1 INTRODUCTION

1.1 HEALTH AND SOCIAL SERVICES GOVERNANCE PROCESS

Since 2014, First Nations have been working on a process of self-determination for health and social services. Difficulty accessing resources and a lack of flexibility in health and social services programs and funding are contributing factors to their desire for a greater degree of self-determination. An overview of current needs and of the human resources working in health and social services in the community will, in the medium and long term, help to facilitate better planning and implementation of new governance structures that are adapted to the realities of First Nations in Quebec.*

Access to quality health care and services is a fundamental issue for First Nations communities, and varies considerably from one community to another. This has led to significant inequities, both between communities and by comparison to the rest of Quebec and Canada. According to the First Nations Regional Health Survey (RHS) published in 2008, approximately 40% of First Nations adults feel that health services are less accessible to them than to the rest of the Canadian population. The two main obstacles reported were excessively long waiting lists (27.9% of respondents) and no doctor or nurse in their region (15.7%).

The *Canada Health Act* guarantees universal and equitable access to health services for all residents. However, many communities and regional and national organizations have indicated that application of the law continues to fall short of that guarantee, and independent research has confirmed these shortcomings. Multiple Canadian Human Rights Tribunal reports have highlighted the urgent necessity for regional authorities to take more steps to ensure First Nations access to quality health care and social services. While some data are available, to the best of our knowledge no report currently exists on the human resources working in health and social services in First Nations communities.

The stability of the health care and social services available to a community, and the level of access to other nearby services, are deeply affected by challenges in recruiting and retaining medical personnel. These challenges are critical for First Nations communities, and influenced by many factors: the community's cultural aspects, language, geographical location, etc. This report will also address the impact of such factors on a community's service offer. This aspect, too, is largely absent from the current literature.

* The specific health and social services governance process referred to in this document as well as the inventory do not include the Crees, the Naskapis or the Inuit.

1.2 HEALTH STATUS OF QUEBEC FIRST NATIONS

Many efforts have been launched over the last several years in attempts to counteract the disparity in health status between Quebec First Nations and the rest of the Quebec and Canadian population. The results of the last First Nations Regional Health Survey (2015) highlighted health issues such as obesity (44% of adults and 46% of children ages 2 11) and diabetes (17% of adults), among others.[1] In some cases, there may be improvement on a particular problem, such as tobacco use, but more work remains to be done to monitor the issue (for example, more than a third of people over 12 years of age are smokers). Many other issues that affect First Nations people require equally careful attention: physical inactivity, addiction, mental health, etc.

Social determinants are outside the scope of this report, but the importance of such factors on health should be kept firmly in mind when interpreting this report's findings and when developing potential mitigation strategies. Our findings should be considered in the context of an analytical framework that includes issues like employment rate, education, housing, income, and so on. For example, the 2015 RHS found that First Nations people who had a low income and/or had not finished high school were less likely to consult a physician or nurse.

Because of their current health status, in addition to historical and political factors, First Nations population is currently labeled as vulnerable. Strategic planning is therefore essential to ensure that First Nations health continues to improve.

To that end, the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) has built a strategic plan[2] around the following priority focus areas:

- *Access to quality care and services*
- *Governance in the recognition of rights and interests of First Nations*
- *Capacity-building*
- *Healthy lifestyle habits*
- *Cultural sensitivity*

1. Quebec First Nations Regional Health Survey – RHS – 2015
2. Strategic plan 2017-2020 - On our path to equitable access to quality care and services

1.3 PROJECT OBJECTIVES AND MANDATE

A population's health status is affected by its level of access to quality health care and social services. Good management of health and social services, meanwhile, is based on a qualitative and quantitative understanding of a population's needs and available resources. Currently, there is a significant lack of data on the subject as regards First Nations. An assessment of the medical and professional services available in communities will help to inform efforts and priorities at the local and regional levels in order to better meet the needs of First Nations. This report is intended to provide such an assessment in support of the strategic priorities above.

The project's objective was to create a portrait of the labour force currently working in health and social services in First Nations communities in Quebec.[3] This report summarizes the findings of that work, and is intended to help improve the quality of and access to health and social services. It is also intended to facilitate an interim stage of the governance process between First Nations and regional and federal governmental bodies.

1.4 DESIRED OUTCOMES OF THE PROJECT

This project's results will be used, first and foremost, to inform the Quebec First Nations' health and social services governance process. In addition, they will help to improve the FNQLHSSC's service offer to First Nations. An improved picture of health and social services needs and resources will support decision makers and professionals on the regional and community levels.

More concretely:

- *Understanding the health and social services needs and resources of both communities and organizations will help the FNQLHSSC to provide support for establishing or renewing agreements with the provincial network.*
- *Understanding the issues affecting jobs, skills or specific needs will help with creating tools adapted to First Nations realities.*
- *A regional training offering could be developed based on existing needs, so that more interveners from different communities could simultaneously benefit from that training.*
- *Community info sheets containing the information reported, such as the number of human resources and the number of hours they work, will be sent to communities. The goal is to provide a longitudinal perspective by enabling communities to update these info sheets over time (annually, for example). This will have administrative benefits for the communities in terms of both information management (by and for First Nations) and facilitation of ongoing professional development (quality of services).*

3. With the exception of the Crees, the Naskapis or the Inuit.

2 METHODOLOGY

2.1 DATA COLLECTION AND ANALYSIS

Data was collected from April to October 2018, from observations made during visits to health and wellness institutions in the communities, including meetings with directors of health and social services and their support staff. Data collection meetings lasted approximately three hours and took the form of structured and semi-structured interviews. In total, 29 communities from eight different Nations, as well as one First Nations organization, participated in the project. The list of participating communities and organizations and the interview dates are given in Appendix 1.

Two types of data were collected, **qualitative** and **quantitative**.

Qualitative data were gathered from questions centred on the following issues:

- *Identified needs for training and professional development*
- *Specific obstacles to an ideal provision of services*
- *Successes or positive experiences in health and wellness*
- *Incentives for hiring and retaining staff*

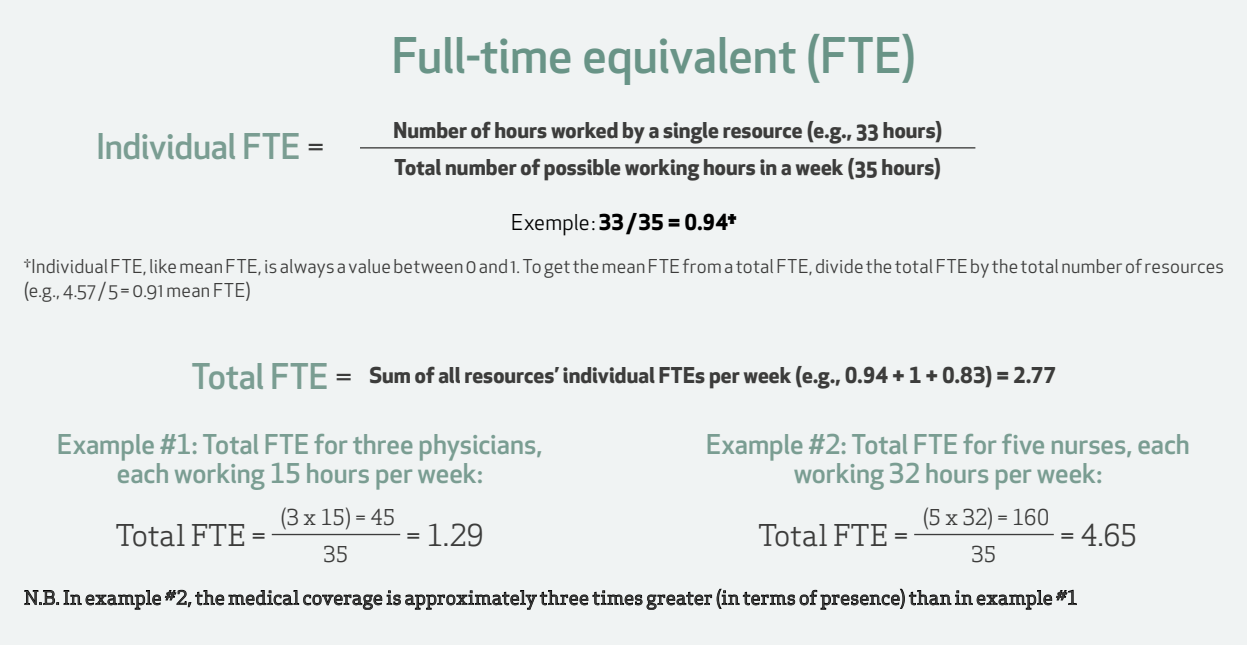
Quantitative data related to the human resources working in health and social services in the community:[4]

- *Number of professionals (e.g., 8 nurses)*
- *Number of hours worked per person per week (e.g., all full time—35 hours)*

Since some data were provided as hours per month or per year rather than per week, the number of hours worked was converted into full-time equivalent (FTE) form to facilitate comparisons. This is a measure of the labour capacity of a company or organization. An **individual or average** full-time equivalent (i.e., an average for one person or an overall average) is always a number between 0 and 1. The maximum possible number of hours worked per week (i.e., FTE = 1) was fixed at 35 hours per week per person. Accordingly, a person working full time for six months of the year would have an FTE of 0.5. Total full-time equivalents were calculated by adding the individual FTE values (full-time and part-time) for all employees. As an example of **total FTE**, three people working full time for the full year would represent a total FTE of 3 for their organization. See the figure on next page for a visual representation of FTE calculations.

4. Those working in private practice were not counted for the purposes of this inventory.

Figure 1. Calculation of full-time equivalence, with examples



Data analysis was carried out by members of the FNQLHSSC team. The median was preferentially used, rather than the mean, as it gives a more accurate picture of the real situation, since the mean is highly influenced by outlying data (for example, communities with a very large population). The median is a measure of central tendency that is less influenced by outlying data than the mean. In addition, FTE figures were reported in the form of FTE per 1,000 residents, in order to control for the factor of population size and allow for more reliable comparisons between communities.

Some communities had no members living on a reserve, and thus had to be excluded from the quantitative analysis. However, the qualitative data from these communities is an integral part of this report.

2.2 METHODOLOGICAL LIMITATIONS

One limitation, related to the high turnover of staff within communities (which will be discussed below), is that data collection took place over a six-month period. It is therefore reasonable to assume that staffing changes occurred in some communities between the start and end of data collection.

A second limitation is that no effort was made to verify that staff had the education, degrees or years of experience reported in this inventory. Such data were indirectly collected on the basis of interviews with representatives of health and social services institutions in First Nations communities and organizations. However, it is important to note that no component of this project entails any assessment related to these factors.

Also, due to significant variation in titles for equivalent jobs, we grouped the data by professional role (for example, using rehabilitation professionals for physiotherapists, occupational therapists, kinesiologists, etc.). This was done in the interest of comparability, and in order to provide a more complete picture of the on-the-ground reality.

This project focused on access to professionals working in health and social services in communities. It did not account for resources that residents might seek outside the community. Since interviews were conducted with health and wellness institutions (health centres, nursing stations, social services), it is possible that some professionals (for example, speech pathologists) hired by other sectors of the community, such as educational institutions, may not have been accounted for in the data our team collected.

2.3 ETHICAL CONSIDERATIONS

Written consent was obtained from each community before data collection (see Appendix 2). All respondents also received a letter (see Appendix 3) providing information about the project (objectives, implications, etc.).

To preserve confidentiality, all data have been presented as medians or ratios, and never as individual data (i.e., by community). Similar measures were used to safeguard respondent confidentiality with regard to all details reported in qualitative data. Throughout the project, all work complied with the First Nations principles of ownership, control, access and possession (OCAP).[5]

5. Applying these principles is used to protect the informational and knowledge heritage of First Nations. These principles are about collective ownership of information by a community, a nation or a group. They expand to research, population studies, documentary monitoring, information management systems and cultural knowledge. They target all aspects of information, including its creation and management. These principles apply to all kinds of research and all research fields which take place on First Nations territories or concern First Nations.
https://cssspnql.com/docs/default-source/centre-de-documentation/protocole_recherche_en_web.pdf?sfvrsn=2

3 QUANTITATIVE FINDINGS ON HUMAN RESOURCES

3.1 PHYSICIANS PRACTICING IN THE COMMUNITY

Some specific findings emerged regarding physicians (and nurses). Below is a table summarizing the amount of time that physicians are present in each community.

Figure 2. Overview† of the presence and number of physicians by community

Location		Number of physicians	Total coverage (total number of hours of physician presence, by week)	Population	Coverage per inhabitant (minutes per week)
Community		-	-	-	-
Zone 1	A	2	55	Small or medium	15 minutes††
	B	2	16	Small or medium	Between 1 and 2 minutes
	C (generalists)	12	N/A†††	Large or very large	N/A
	C (specialists)	6	46.8	Large or very large	Less than 1 minute
	D	4	24.6	Large or very large	Between 1 and 2 minutes
	E	2	16	Large or very large	Less than 1 minute
	F	2	15	Large or very large	Less than 1 minute
	G	0	-	Large or very large	0
	H	1	32	Large or very large	Less than 1 minute
	I	1	3.5	Small or medium	Less than 1 minute
	J	6	48	Large or very large	Between 1 and 2 minutes
	K	4	7	Small or medium	Less than 1 minute
	L	2	4.8	Small or medium	Less than 1 minute
	M	1	8	Large or very large	Less than 1 minute
	N	2	29	Large or very large	Between 1 and 2 minutes
	O	1	1.75	Small or medium	Between 1 and 2 minutes
Zone 2, 3 and 4	P	0	-	Small or medium	0
	Q	1	1	Small or medium	Less than 1 minute
	R	1	1	Small or medium	Less than 1 minute
	S	3	6	Small or medium	Less than 1 minute
	T	5	31.5	Large or very large	Less than 1 minute
	U	4	9.2	Large or very large	Less than 1 minute
	V	4	7	Small or medium	Less than 1 minute
	W	3	21	Large or very large	Between 1 and 2 minutes
	X	4	15	Small or medium	Between 1 and 2 minutes
	Y	1	3.5	Small or medium	Less than 1 minute
	Z	2	35	Large or very large	Between 1 and 2 minutes

Small and medium communities (N=13) = communities with fewer than 1,000 residents;
Large and very large communities (N=13) = communities with 1,000 or more residents.

Some communities deal with significant rotation of physicians (i.e., a large number of physicians for a low number of hours present). Those numbers were often reported by month (for example, one physician visit per month). In the interests of comparability, reports of monthly physician visits were converted into total hours of presence per week. That should not be interpreted as necessarily meaning that the same physicians are present week to week, in terms of a continuum of services.

*Communities without a land base and communities without a health centre or nursing station are not represented in this table.

**The agreement between this community and one physician stipulates that that physician may also see their non-Indigenous patients in the community. This agreement is intended to guarantee the physician's presence in the community without penalizing them in terms of the number of patients seen.

***Although the community provided us a figure (FTE = 5.6), this number could not be included for comparison purposes, since the quantification methodology was not the same. It is also relevant to note that this community has a hospital rather than a health centre or nursing station, which explains the disparity in the number of physicians there compared to other communities.

For the vast majority of participating communities (81.5%), there is no written contract between the community and the physician(s) providing services there. Accordingly, it is difficult if not impossible for these communities to guarantee a number of hours of service provided by a physician. The majority of communities (with or without a verbal agreement) report either that physicians are present in their community for an insufficient number of hours, or that physicians do not abide by their initially stated availability. In the latter case, they may only have a sporadic presence and/or may communicate their time slots to health institutions in the community on a tight schedule that leaves them little ability to plan.

The table below suggests that the number of physicians in communities with a written agreement is lower than in communities with a verbal agreement. However, communities with a written agreement nonetheless seem to have more complete coverage in terms of physician presence (i.e., in physician FTE per 1,000 residents), even with a smaller number of physicians (see the Methodology section on p. 8 for more details on calculating FTE). These results suggest that written agreements may be beneficial for First Nations communities.

Figure 3. Comparison between communities based on the type of agreement with physicians (number of physicians / 1,000 residents and full-time equivalence—total FTE)

	Number of physicians per 1,000 residents* (median)	**Total FTE per 1,000 community residents** (median)
No agreement and no MD (N=2)	0.00	0.00
Verbal agreement only (N=19)	2.87	0.33
Written agreement (N=5)	2.00	0.44
Total (N=26)	2.42	0.38

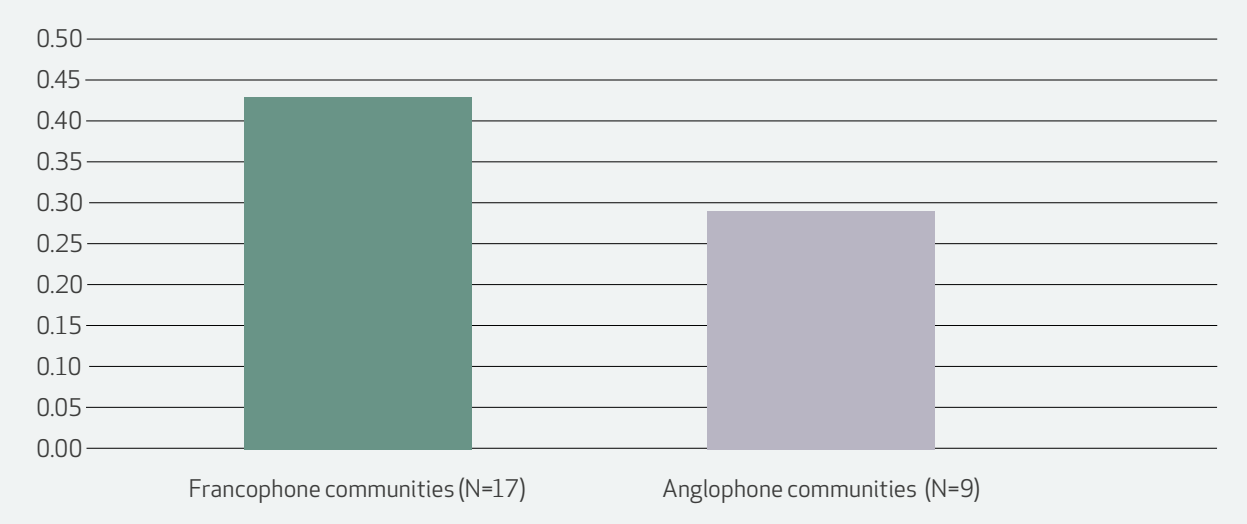
*Figure was calculated based on the number of community residents (data on number of community residents from Indigenous Services Canada, 2018).

N.B. In Quebec in 2017, the number of general practitioners per 1,000 residents was 1.11, and 1.24 for specialist physicians, for a total of 2.35 physicians (source: Institut de la statistique du Québec, 2019). For Canada in 2015, the mean was 2.54 physicians per 1,000 residents (source: Université de Sherbrooke, 2019). However, figures for the full-time equivalent for physicians in Quebec and in Canada have not been given here, because the methodological basis for those calculations differed (for example, based on salary).

Agreements with physicians may be highly complex. Some communities that make verbal agreements feel that they require less of a commitment from the physicians and that therefore the communities are more likely to be able to benefit from the physician's presence. Others categorically refuse to have a physician present in the community because of a fear that Indigenous Services Canada (ISC) will refuse to reimburse travel costs of community members who choose to consult a physician outside the community. For some communities, members' freedom to consult the physician of their choice is a priority.

Other communities lack a physician due to situational issues rather than choice. Language is one example. The table below illustrates the difference in terms of physician presence in the community (Anglophone versus Francophone). This difference may be explained in part by the fact that non-Francophone physicians are required to take a French proficiency test in order to be able to practice in Quebec.[6] This limits the pool of potential physician candidates for Anglophone communities, especially for Anglophone communities near borders.

Figure 4. Comparison between communities in terms of language spoken (full-time equivalent—total FTE for physician per 1,000 residents)



Obviously, a lack of any physician presence may impose limitations on a community, such as an inability to access collective prescriptions.[7] It also makes it more difficult to refer patients directly to a physician directly when needed. Health care staff must instead refer to another nearby institution's emergency department. Whatever the reason why a community has no physician, it is the community members who are affected first and foremost by this absence. RHS 2015 reported that around 9% of First Nations adult respondents and 20% of First Nations teenagers had never consulted a physician in their lives, although the lack of a physician is not the only relevant causal factor. This can lead to a generalized lack of screening and diagnosis within a population, as well as perpetuating disengagement since community members are not informed about their own health status.

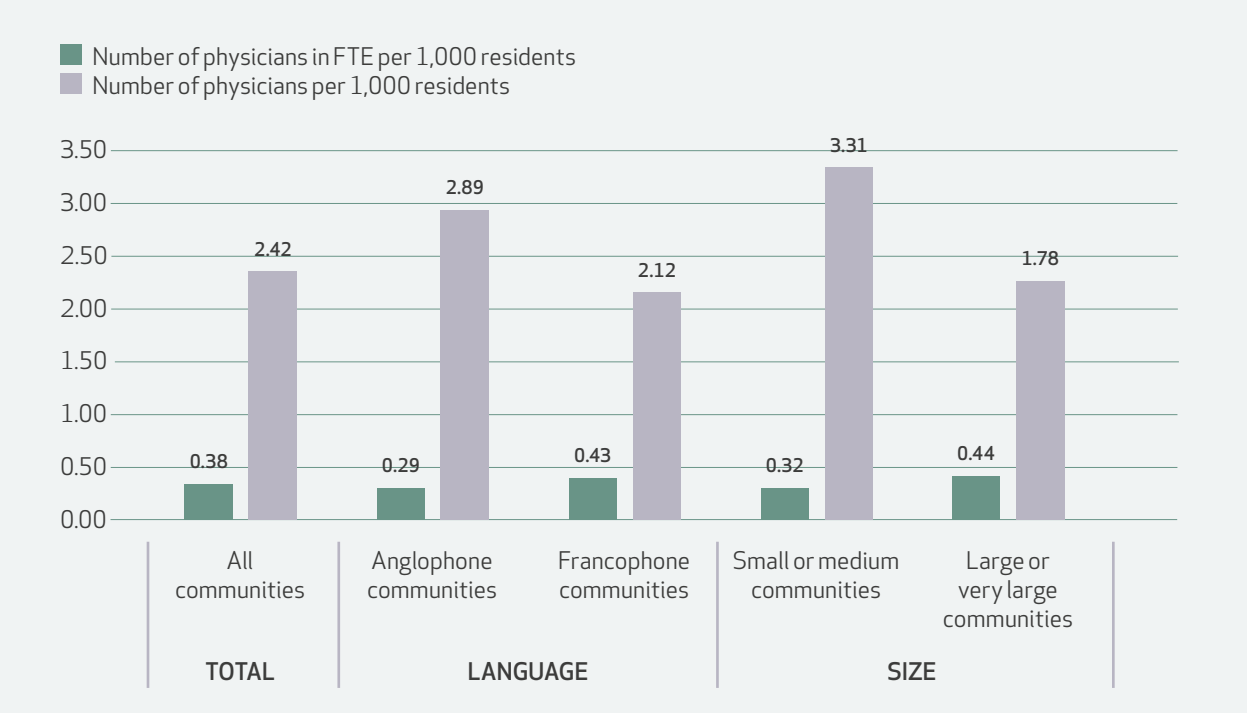
In order to improve the current situation, it may be beneficial to review some of the terms under which physicians practice in communities. Communities might revisit whether their agreements with physicians should be made in writing, or seek to clarify physician payment practices (fee-for-service models or per-day payments; contracts for shared services or private practice; whether or not physicians are affiliated with the RAMQ, etc.). Lack of clarity on such matters may be an obstacle to providing services. For example, if community members are not diligent about attending their medical appointments, the lack of an effective system for

6. http://www.cmq.org/page/en/les-examens-requis.aspx
7. [Translation] "...a prescription given by a physician or a group of physicians to a health professional or authorized person. It refers to medications, treatments, examinations or care to be given to group of people or in clinically determined situations. It specifies the circumstances under which they may be given, as well as contraindications." https://www.oiiq.org/

reminders may be irritating for a physician paid by the day, because they could have served more patients at another location. This irritation would be all the greater for a physician with a fee-for-service model, because their income would be affected as well. Also, according to some respondents, a lack of a clear written agreement with a physician or their affiliated institution may lead to billing for things that beneficiaries of the provincial network would not normally pay for (for example, medical certificates).

Respondents expressed hopes for improved physician practice in the community, including a desire for more hours of physician presence in the community and for physician schedules to be better planned and more reliable. For an illustration of the current shortcomings in medical coverage, see *Figure 2: Overview[*] of the presence and number of physicians by community*. Additionally, the large number of rotations (i.e., different physicians taking turns) was identified as an issue for physician schedules. Our inventory's findings suggest that this issue may be more pronounced in small or medium communities. This may be seen in the graph below, which illustrates differences between communities in the number and presence (full-time equivalent) of physicians, according to community size and language.

Figure 5. Number and presence (full-time equivalence—total FTE) of physicians (per 1,000 residents) according to community size and language spoken



Small and medium communities (N=13) = communities with less than 1,000 residents

Large and very large communities (N=13) = communities with 1,000 or more residents

*In interpreting this graph, it is important to note the undesirability of having a large number of physicians with a very low full-time equivalence (time present), since this is synonymous with a significant rotation of physicians, and thus a potential lack of stability and continuity in their service offer.

**It is important to remember that FTE values (dark blue) represent the total number of physicians in FTE, and thus could have had a value greater than 1. Also, although the difference between 0.29 and 0.43 seems small, it represents a difference of 5 hours per week (out of a maximum possible 35 hours). See the Methodology section on p. 10 for more details on FTE calculations.

***For a more detailed scatter plot of this graph, see Appendix 4.

Figure 5 also suggests that in order to have a comparable full-time equivalence, small and medium communities need twice as many physicians as large or very large communities do. This finding may explain the higher rate of turnover in small and medium communities (i.e., different physicians present for many short periods). From this, we can extrapolate that a larger number of sporadically present physicians may result in a sub-optimal continuity of services (pharmaceutical follow-up, methadone treatment, pregnancy monitoring, diagnostic changes, continuum of services, etc.). This also means that patients must continually re-explain their problems (which may be of a sensitive nature: STIs and blood-born infections, mental health problems, etc.) and rebuild trust relationships. It also introduces a risk of variability in medical treatment (for example, changes to medications or dosage).

Regarding follow-ups, First Nations expressed a desire for improved coordination between physicians (for example, when one physician is on vacation) and a desire to develop strategies to facilitate such coordination.

Some community representatives would also like for physicians to focus more on home visits for members of their communities. It goes without saying, as well, that some regions of Quebec have a serious lack of specialists. In Quebec, minimum physician quotas are set by provincial authorities. However, some of those minimum quotas have not been met for over five years, due to significant turnover combined with the confusion caused when the posted status of positions changes rapidly from filled to open. It remains essential to look for methods to improve First Nations access to health services.

One potential solution to address the issue of physician presence in communities that respondents suggested was the creation of a family medicine group (FMG). An FMG is a group of family physicians working in close collaboration with other health and social services professionals. This system facilitates access to health care and first-line care, and allows for better follow-up and a higher quality of service. Each physician cares for their own patients, but all physicians in the same FMG have access to all files of that FMG. A patient coming in for a consultation can be seen more quickly and easily by a physician who is already familiar with their medical file. The patient can also meet with a nurse, social worker or other health professional for other kinds of follow-up if needed.[8] Joining an FMG could stabilize and officially confirm the number of hours a physician is present in the community, in addition to facilitating patient file management and other benefits. Large-scale efforts (for example, by administrative region) could be undertaken jointly with the Ministère de la Santé in order to set such agreements in motion between communities and FMGs. There would also be an opportunity to implement additional initiatives for ongoing professional development between FMGs and First Nations.[9]

8. https://www.quebec.ca/en/health/health-system-and-services/service-organization/family-medicine-group-fmg-u-fmg-and-super-clinic/
9. http://www.royalcollege.ca/rcsite/health-policy/initiatives/indigenous-health/faq-royal-college-indigenous-health-initiative-e

3.2 NURSES PRACTICING IN THE COMMUNITY

Some conclusions can also be drawn regarding nurses practicing in the community. Underfunding was a major issue reported by project respondents. Funding is generally insufficient to pay nurses' salaries, which makes it hard for communities to compete on the provincial job market, let alone the federal one. However, it is often difficult to compare the salaries in communities with those offered provincially or federally, because the situations are generally different. For example, nurses in a community may need to fill a broader role, which may decrease the potential candidate pool. A nurse at a nursing station must have an extremely versatile skill set to respond to the wide variety of needs they encounter there, and to do so with the resources available in remote areas. The fact that a nurse must act in many roles simultaneously may also affect the time they can dedicate exclusively to patients. Respondents reported, however, that ISC funding does not increase based on the number of individuals in a community. Some communities currently receive funding for fewer than two nurses. It is difficult to imagine how a health centre could function at optimal levels with a single nursing staff member. It would be complicated, if not entirely impossible, for that staff member to be ill, take a vacation or get training outside the community. ISC funding for the number of nurses in a community is reportedly based on a population scale formula (such as 0-500, 500-2500, etc.) that dates from the 1990s, and is no longer representative of current reality nor a realistic reflection of real-life needs. This inventory's results accord with that conclusion, and suggest that 61.5% of communities (across all geographic regions) have a lower ratio of nurses per 1,000 residents than Quebec's provincial ratio.

Figure 6. Comparison between communities (Francophone and Anglophone) and the province (ratio of nurses / 1,000 residents)

	Francophone communities (N=17)	**Anglophone communities** (N=9)	**Total** (N=26)
Communities < Quebec[10]	47.1%	88.9%	61.5%
Communities > Quebec	52.9%	11.1%	38.5%
Total	100.0%	100.0%	100.0%

This low number of nurses per 1,000 residents across First Nations communities as compared to the province is even more marked for Anglophone communities. As the table above shows, 88.9% of Anglophone communities have a lower number of nurses per 1,000 residents than Quebec as a whole. This trend is also visible when we compare the FTE of nurses per 1,000 residents in Francophone versus Anglophone communities. The results of our data collection show a total FTE per 1,000 residents of 8.47 (or 8.82 nurses in terms of number of resources, with an average FTE of 0.96) for Francophone communities, compared to 6.28 (or 6.75 nurses in terms of number of resources, with an average FTE of 0.93) for Anglophone communities.

10. OIIQ. (2017). Rapport statistique sur l'effectif infirmier 2016-2017 [Statistical report on the nursing labour force, 2016–2017], https://www.oiiq.org/documents/20147/1456160/Rapport_statistique_2016-2017.pdf (in French only)

To put these results into perspective, imagine one nurse working in a population of 1,000. In a Francophone community, the nurse would have the equivalent of 35 hours for a patient load of 113 patients (or approximately 18.5 minutes per patient), while a nurse working in an Anglophone community would have a load of 148 patients (or approximately 14 minutes per patient). Whether at a nursing station or a health centre, we must assume that nurses with such a patient load per 35 hours are also carrying out a multitude of other tasks besides clinical encounters (for example, prevention, case notes and training), which would further decrease the time per patient from the estimates above. However, estimates of time per patient for one nurse are a useful illustration of one theoretical metric for nursing labour capacity.

Furthermore, communities that have difficulty competing with the surrounding job market to fill nursing positions must at times turn to agencies. It is important to note that a nurse recruited through an agency can cost as much as twice as much as a usual nurse's salary. In addition, such services are often temporary, and some communities are obliged to use six to eight different nurses in one year to cover the regular schedule of a single nursing position. In such a situation, a community must continually start from scratch to familiarize nurses with the position and build their knowledge and skills. Patient relationships, as well, are continually disrupted.

Nurse training is connected to another issue. It is true that the majority of training sessions for nurses are covered by the First Nations and Inuit Health Branch of Indigenous Services Canada (ISC-FNIHB). However, nurses frequently accept positions in the community, take several training sessions and then leave to work in the provincial network. Several communities have had to take creative measures in order to reduce the impact of this issue, such as limiting the amount of training a nurse may take during their first year in a position. Other communities have opted instead to add a clause to the hiring contract stipulating that the value of the training must be reimbursed in the event of early departure.

Respondents also listed other First Nations-specific issues that need to be addressed, such as earmarking funding for a nursing resource whose time will be entirely dedicated to diabetes prevention, screening and treatment. Some health centres may have as many as 200 beneficiaries with diabetes, which creates a significant workload in terms of insulin adjustments alone. Home care is another such issue. Some patients prefer to be cared for by a nurse who comes from the community, which can complicate the provision of such services.

3.3 OTHER SPECIALIST PROFESSIONALS PRACTICING IN HEALTH AND SOCIAL SERVICES

It is possible to develop a picture of the situation for certain specialist professionals based on three key situational factors for communities: geographical remoteness, community size and language spoken. Let us take nutritionists as an example. Figure 7 suggests that communities in Zone 1 (urban settings)[11] are more likely to have a greater number of nutritionists per 1,000 residents than the provincial rate. Conversely, the majority of communities in Zones 2,

11. Zone 1: Community located less than 50 km from a service centre with year-round road access.
Zone 2: Community located between 50 and 350 km from the nearest service centre to which it has year-round road access
Zone 3: Community located over 350 km from the nearest service centre to which it has year-round road access
Zone 4: Community which has no year-round road access to a service centre and, as a result, incurs higher transportation costs

3 and 4 (remote zones) are disadvantaged when it comes to access to nutritionists compared to the province as a whole. These results suggest that it is more difficult for residents of communities in the three remote zones to access nutrition specialists. Further supporting this is the fact that research indicates that approximately 1 in 10 First Nations adults have not been able to access care that they needed[12] within the past year (RHS 2015). That finding, too, was higher for residents of communities in the remote zones (2, 3 and 4).

Figure 7. Comparison between communities by geographical zone (number of nutritionists / 100,000 residents and full-time equivalence) as compared to Quebec provincial rates

	Zone 1 (N=15)	**Zones 2, 3 & 4** (N=11)	**Total** (N=26)
Community < Quebec	20.0%	**72.7%**	42.3%
Community > Quebec	**80.0%**	27.3%	57.7%
Total	100.0%	100.0%	100.0%

To continue with this example, the table below suggests that small and medium communities have a greater lack of access to nutrition specialists when compared to large and very large communities. It is important to note here that needs for specialist professionals may differ from one community to another. For example, a community of less than 300 people might not need a full-time nutrition specialist. Nevertheless, many communities lack any access to such professionals, and this data should be taken into consideration, all the more so given that obesity and diabetes are connected to diet and are of critical concern throughout First Nations communities.

Figure 8. Comparison between communities by size (nutritionist(s) present or absent in the community)

	Small and medium communities (N=13)	**Large and very large communities** (N=12)	**Total** (N=25)
Present	38.5%	**91.7%**	64.0%
Absent	**61.5%**	8.3%	36.0%
Total	100.0%	100.0%	100.0%

To complete our examination of community access to nutritionists, the table below shows the difference in the number and presence of specialists in terms of language spoken. The data suggest that, despite a comparable number of nutritionists per 1,000 residents, the FTE in Anglophone communities is approximately 10 times lower than in Francophone communities. These results point to a major accessibility problem in Anglophone communities for nutritional specialist resources.

12. Note that this RHS finding is based on questions asked of First Nations respondents regarding health needs as a whole, and does not relate solely to nutritionists.

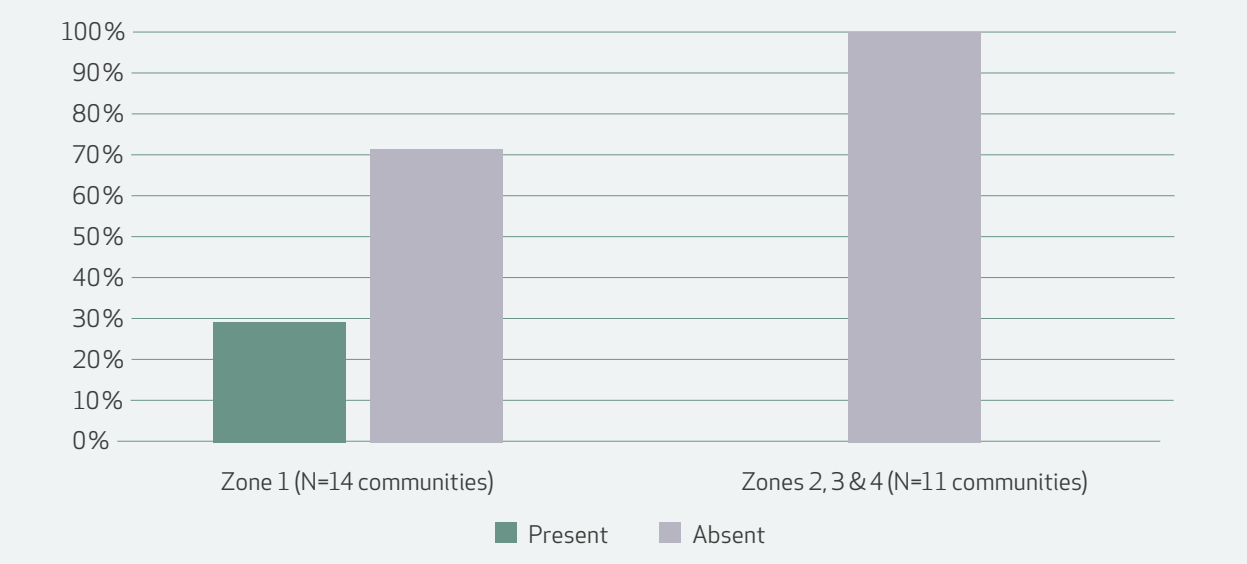
Figure 9. Comparison between communities by language spoken (number of nutritionists / 1,000 residents and full-time equivalent)

	Number of nutritionists per 1,000 residents (median)	**Full-time equivalent per 1,000 residents** (median)
Francophone communities (N=17)	0.48	**0.35**
Anglophone communities (N=9)	0.48	**0.03**
Total (N=26)	0.48	0.19

Taken as a whole, these data suggest that access to nutritional specialists is a major challenge, particularly for small Anglophone communities in remote zones. This could be explained by many factors, such as the degree of access to qualified professionals, recognition of training or need for part-time jobs.

The findings seem more generalized for other health and social services resources. For example, access to physical rehabilitation specialists (occupational therapists, physiotherapists, etc.) seems to be complicated for all communities. The table below indicates a marked lack of ad-hoc services from physical rehabilitation specialists in the community. These access challenges seem to be markedly worse for communities in the remote zones. The results also reflect the jurisdiction disputes that may arise when provincial services or laws are applied to federal land and legislation (Quebec First Nations communities). This issue will be discussed in greater detail in section 6.2.

Figure 10. Comparison between communities by geographical zone (ad-hoc physical rehabilitation services present or absent in the community)



The data we collected suggest that various other specialists seem to be nearly totally absent in communities. This is the case for many types of health professionals, such as audiologists and midwives. Traditional healers, as well, seem to be often absent from wellness institutions. However, in the great majority of cases, access to traditional healers was reported as accessible within the community (i.e., unaffiliated with health or wellness institutions).

4 OVERALL QUALITATIVE FINDINGS

In addition to the quantitative overview of human resources working in health and social services in communities, we obtained a great deal of important information from our meetings with contact people. The next sections will give our overall qualitative findings, as well as findings specific to subsets of the communities that were part of this project. Our objective in these sections is to give as complete and accurate a depiction as possible of the lived experience of the populations of First Nations communities in Quebec.

All of the communities had their own particular characteristics in terms of population and situation. For example, some communities have a health centre, others a nursing station (see table below). Some communities have integrated health services and social services at both the management and operational levels, while others administer the two as separate sectors. The same is true for other services—such as education, housing, sports and recreation that are potential complements to wellness. According to respondents, the work of different sectors is "siloed" as a result of this lack of integration and coordination between community service sectors. Greater cooperation between the staff of different sectors could result in more effective planning as well as better alignment between the services provided and the needs of the population, and thus an improved health status for the population.

Figure 11. Number of communities with a health centre, nursing station or hospital

Institution	Number of communities
Health centre	18
Nursing station	10
Hospital	1

Some findings were common to all the communities. For example, we observed that they all aspire to greater self-determination in terms of management and delivery of health and social services. The majority of communities are grappling with challenges in recruiting human resources, sometimes because of remoteness, sometimes because of competition from neighbouring areas. Additionally, the majority of communities reported underfunding for infrastructure, including both community capital properties (for example, housing) and health and social services infrastructure (for example, expansion of health centre). Such underfunding is a major roadblock to improved delivery of services, and thus to improved quality of life for a community. Insufficient housing funding can have many harmful effects on the health of a population (hygiene, safety, overcrowding, etc.), as well as limiting a community's ability to host health or social services professionals from outside the community.

The health issues that seemed to be of greatest concern for the participants interviewed included chronic illnesses (for example, diabetes), abuse of drugs and alcohol, issues of violence, and the quality and continuum of mental health services. All the communities, regardless of which issues they saw as the most pressing, wanted more freedom to determine their own wellness priorities, and wanted the federal government to respect those priorities.

In terms of social services, the majority of communities fully manage their own first-line services, and the others all had the goal of doing so. Many communities were in the process of taking over management of their own youth protection services, or were preparing to do so. Development of parental skills was also a priority for a large number of communities. In addition to funding for first-line services, communities that did not directly receive funding from the First Nations Child and Family Services program were potentially eligible for new dedicated funding for community projects (five-year grant, until fiscal year 2022-2023) to support preventive services for children and families. Some communities expressed interest in developing an action plan to submit to ISC. It is important to note that to repatriate these services, communities must meet certain requirements for capacity, planning, quality of services and collaboration with key partners. Each community can undertake this process at its own pace and in accordance with its own capacities.

Before we move on to more specific findings, here is an overview of the inventory of human resources working in health and social services in First Nations communities in Quebec.

Figure 12. Global overview of the presence of various health and social services resources by community and geographic zone[13]

Community		Type of health professional									
		Physician	Nurse	Dentist	Speech pathologist	Midwife*	Nutritionist	Psychologist	Rehabilitation professional	NNADAP agent	First-line services provider
Zone 1	A	X	X				X			X	X
	B	X	X				X	X	X	X	X
	C	X	X	X			X	X	X	X	X
	D	X	X				X	X		X	X
	E	X	X				X	X		X	X
	F	X	X		X		X	X	X	X	X
	G		X		X		X	X	X	X	X
	H	X	X		X		X			X	X
	I	X	X				X	X	X	X	X
	J	X	X				X	X		X	X
	K	X	X				X	X		X	X
	L	X	X					X		X	X
	M	X	X				X	X		X	X
	N	X	X				X	X		X	X
	O	X	X				X				X
Zone 2, 3 and 4	P		X							X	X
	Q	X	X					X		X	X
	R	X	X		X			X		X	X
	S	X	X					X		X	X
	T	X	X	X			X	X		X	X
	U	X	X	X			X	X		X	X
	V	X	X					X		X	X
	W	X	X	X	X			X		X	X
	X	X	X	X				X		X	X
	Y	X	X	X				X		X	X
	Z	X	X	X				X		X	X

* Many efforts are underway to increase access to midwives in the community: reserved space for First Nations in the UQTR training program, agreements with CISSS/CIUSSSs regarding issues such as liability insurance and exception clauses, etc. Access to midwives continues to be a need raised by communities.

13. Indigenous and Northern Affairs Canada (formerly Indian and Northern Affairs Canada) Band Classification Manual. URL: http://publications.gc.ca/collections/Collection/R22-1-2000E.pdf. French version consulted online June 8, 2018.

5 SITUATIONAL QUALITATIVE FINDINGS

In addition to the overall considerations for communities, there were also some considerations specific to certain communities in similar situations. This section details our situational findings on the experiences of three such situations:

1. **Communities in remote zones**
2. **Communities with small populations**
3. **Communities that are majority or entirely Anglophone**

Geographical remoteness is a significant factor influencing the delivery of health and social services. For communities far from urban centres, access to specialist resources is generally difficult. They also often find long-term retention of professionals extremely challenging when the professionals do not come from the community, as they are far from family. According to respondents, marriage with a member of the community is a factor that increases the duration of retention. To attract and retain personnel, then, communities must offer various measures of compensation including financial incentives, transportation, housing and more.

Some concrete examples of issues faced by communities in remote areas

The issue of funding is directly connected to geographical remoteness. Not only are financial incentives necessary to attract professionals, but employee travel costs can represent a very high percentage of total annual expenses. A one-way flight from a remote community to an urban centre can cost as much as $1,600. The cost of living in remote communities is also generally higher than elsewhere, as are equipment delivery costs. Research conducted from 2013 to 2016 found that in some communities, food prices were as much as 15–30% higher than in reference grocery stores. For remote regions, finance is a factor of paramount importance, since providing the same population wellness services as elsewhere is in reality far more costly for those regions.*

*http://www.chaireconditionautochtone.fss.ulaval.ca/documents/pdf/PRAP-RAPPORT-D-ACTIVITE-2012-2017.pdf (French only)

A second factor common among many communities is a small population base. This sometimes coincides with geographical remoteness, further complicating the administration of optimal health and social services. **Less populous communities** (under 500 residents) face significant human resources challenges. The small size of the population shrinks their pool of potential candidates to replace current personnel, as does the lower graduation rate among First Nations.[14] This issue must be addressed more broadly rather than in the health and wellness sectors alone (for example, by promoting opportunities for First Nations youth to succeed academically).

14. https://journalhosting.ucalgary.ca/index.php/cjeap/article/view/42767

Due to the lack of candidates for open positions, many staff members must fill multiple positions at once. Such a multiplicity of professional roles can impede the person's ability to carry out the tasks of each role. This problem is exacerbated for those who hold management positions, but at the same time must fill clinical roles as well. This decreases the quality of internal coordination of services and hinders staff from applying for funding or implementing innovative projects. It can also lead to greater risks of burnout for the professionals forced to juggle more and more roles.

A community with a small number of residents may have fewer needs, but fulfilling those needs via part-time positions comes with its own challenges. Some respondents reported that in general, fewer candidates seem to be interested in applying for part-time positions, which often come without benefits. There is also a greater possibility that candidates will take part-time positions as a transitional job while they await an offer of full-time work. Furthermore, given their close-knit nature, communities with small populations are more susceptible to problems with confidentiality and political interference.[15] These issues may potentially affect perceptions of quality of life at work for employees in the community.

A third factor common to many communities is being a **majority or entirely Anglophone community** in a majority-Francophone province. This can result in access to wellness services offered nearly exclusively in French.

Some concrete examples of issues faced by communities that are majority or entirely Anglophone (in Quebec)

To access specialists (for example, speech pathologists), some communities must approach ISC multiple times—sometimes without success—in order to justify hourly rates that may be higher than what it would cost to access the same specialist outside Quebec (for example, in Ontario). This already deplorable situation is made worse by the fact that for some Anglophone communities, it would be quicker (in terms of both distance and wait times) and sometimes less costly to authorize a referral to professionals in Ontario or New Brunswick rather than directing patients to Quebec centres such as Montréal. Follow-ups and emergency referrals also need to be improved in terms of hospital choice and specialist choice. Various examples of problematic situations were reported, such as an Anglophone individual with dementia who was transferred to a Francophone institution. The individual was unable to make themselves adequately understood, which complicated their admission and caused them greater confusion.

Training offered primarily in French poses a similar problem. This issue may play out in discipline-specific ways. Training for nurses, for instance, is conducted mainly in French in Quebec, and this also affects professional development such as refresher courses and the acquisition of new skills. There are also broader consequences, such as for recruiting Anglophone personnel. Some candidates were educated and trained in an Anglophone province. Some or all of that training, however, may not be recognized by Quebec. If it is complicated or impossible for professionals to get their training recognized in Quebec, that makes it all the more difficult for communities to entice those professionals to fill positions there.

15. https://geiselmed.dartmouth.edu/cfm/resources/ethics/chapter-07.pdf

In sum, significant coordination work is needed to mitigate the challenges of geographical remoteness and linguistic variation among First Nations communities in Quebec in order to provide quality care in terms of access to specialists.

The next section discusses issues identified by respondents, including where they currently stand and points for consideration on issues faced by many communities in terms of access to health and social services professionals.

6 OBSTACLES TO SERVICE DELIVERY IN THE COMMUNITIES

Many of the issues that affect or hinder the delivery of health and social services are specific to First Nations experiences and current situations. Below are some examples.

6.1 FINANCIAL OBSTACLES

The majority of communities reported overall dissatisfaction with current funding formulas for health and social services. Infrastructure was one of the primary complaints from respondents. Communities want to be able to provide holistic health and social services. However, funding is often granted by program, with very little flexibility for community decision makers. For example, it is difficult and sometimes impossible for communities to access funding for renovating or enlarging infrastructure. This makes it complicated to integrate quality services into a family centre, an elder residential care or activity centre, a youth centre, etc. This can pose significant challenges to a continuum of quality services in communities. For example, without infrastructure, a woman who has been the victim of domestic violence may have to be cared for family members on a temporary basis, without adequate support. Similarly, a community without a residential care centre may be forced to send its elders in need several hours away so that they can receive the care they require, thereby isolating them from their families and community. The availability and quality of housing in a community also has a significant influence on recruitment of personnel. A lack of community infrastructure often forces personnel to cohabitate or can make hiring outright impossible if there is no housing available.

Another complaint was that ISC funding has not been adjusted in proportion to legislation[16] that has increased the number of new members belonging to a given community. These new members are eligible to receive health and social services from the community, but the communities are unable to receive increased funding to match their increased need.

16. https://bdp.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/LegislativeSummaries/PDF/42-1/s3-e.pdf

Moreover, specific funding criteria do not always align with a community's needs. For example, it is often difficult to get an escort for medical transportation. Some respondents stated that elders do not receive all the support they need during meetings with specialists in urban centres (for example, someone to assist an individual with limited mobility or an interpreter). Expectant fathers may not be allowed to accompany their partners to prenatal appointments. Furthermore, communities must pay directly for certain essential medical equipment, such as electric beds for home care.

One strategy, other than renegotiating agreements, is for communities to turn toward alternative sources of funding or make creative use of current funding, in order to create some budgetary flexibility in line with their priorities. Other strategies that participants mentioned include creating agreements and service corridors with the provincial network, including regular meetings with representatives of nearby CISSS/CIUSSSs, in order to ensure smooth delivery of services.

6.2 LEGAL AND POLITICAL OBSTACLES

One of the primary legal obstacles is conflicts of jurisdiction between the province and the reserves (federal territory), making it difficult to access some resources. According to our project data, just over 50% of communities reported having difficulties accessing occupational therapy in the community or even a total inability to do so. In the majority of cases, they reported that some professionals refuse to travel to the community to provide services, and that this has been an ongoing issue for years. This particularly hampers at-home assessments for individuals with reduced mobility living in the community, since such assessments must be conducted by an occupational therapist. The same issue was also reported for other health professionals such as respiratory therapists, psychologists, physiotherapists, special educators, etc. It may seem paradoxical that communities offer health and social services (including home care) to all their residents, regardless of status, while an occupational therapist will travel to the community only to provide services to non-Indigenous residents. This situation causes inequities between individuals living in the same neighbourhood.

Another major issue is communities without recognized land. Access to funding for human resources is very difficult and limited for such communities, despite the presence of First Nations members who would benefit from wellness services (for example, prevention) that are adapted to First Nations (for example, connected to traditional activities).

Lastly, some respondents mentioned issues of internal politics, both within communities and with regional actors. Band Councils have the power to influence certain decisions about health and social services, such as budget administration. For example, there have been cases where a Band Council was in deficit overall but had a surplus in health services. What mechanisms should be set up in order to ensure that the funding necessary for health and social services remains dedicated to those programs and efforts? Communities could develop mechanisms and strategies for striking a balance between political concerns and community health and wellness services.

6.3 OBSTACLES TO DATA COLLECTION AND MANAGEMENT

Important areas for improvement include raising awareness of social determinants of health and incorporating data into health and social services planning. Among the obstacles is the fact that some communities may have difficulty accessing data management systems on the network due to geographical remoteness or insufficient bandwidth, among other factors. In some communities, health and social services information is always archived in physical files. This type of system makes it more difficult to generate pictures of a community's overall health to support planning and prioritization. Some respondents emphasized that a lack of data for a community can result in certain funders turning down plans for training or restructuring. Another area for improvement relates to First Nations members seeking consultations outside their community. These situations generally involve a loss of information in terms of follow-up in the community, and thus a loss of information for the community health overview and community planning. Once again, collaboration agreements with institutions in the provincial network (for example, in mental health) could be set up so that information is always sent back to health and social services institutions in the community.

Communities reported a disconnect between community objectives and ISC requirements for health plans, which creates a disincentive to health plan updates and observation. They also reported that ISC-FNIHB requirements vary from one community to another, even for the same program funding, as well as a lack of consistency in the information given to different professionals within the ISC-FNIHB. For all these reasons, as well as because of the administrative burden, many communities have hired consultants to draft their health plans. Hiring external consultants, however, interferes with internal skills development, and creates a gap between the drafting of the plan and the real needs of the community.

Regarding access to new technologies, the communities use very little telehealth or telemedecine, aside from annual screening for diabetic retinopathy. These technologies would allow data that would potentially get lost in the provincial network to be hosted directly within the communities. Similarly, respondents reported having observed a reluctance to use medical data collection tools (for example, iCLSC), specifically among support staff in health and wellness institutions. Common reasons cited for this included forgetting procedures and the complexity of the tools. It is important to provide support for communities to adopt electronic medical records (EMRs). Adopting EMRs can help a community improve its administrative planning and determine wellness priorities. EMRs can also facilitate billing and physician reimbursements through Quebec's electronic medical record adoption program (for example, equipment purchases, training costs or incidental costs connected to EMRs).[17]

17. http://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/infolettres/2012/info201-2.pdf (in French only)

6.4 OBSTACLES TO CANDIDATES' EDUCATION AND TRAINING

The pool of potential candidates for recruitment and hiring is limited by the fact that approximately half the adults in communities have a high school diploma. Because the qualified labour force from within communities is so small, positions are sometimes filled by individuals without all the necessary qualifications. This can result in the employee feeling ineffective, and in beneficiaries lacking confidence in service providers.

Recruiting from outside the community can also pose multiple challenges. For example, candidates are often inexperienced, which can interfere with their ability to carry out aspects of the position such as expanded responsibilities or being on call 24 hours a day at nursing stations. Potential candidates also may not have experience working in the communities (cultural competence) or simply not want to work in the communities.

6.5 OBSTACLES TO ORGANIZATIONAL STABILITY

Many factors may influence a candidate's decision about working in a community: geographical remoteness, a different culture and language, a different population's health status, different working conditions, etc. Because of the need to adapt to so many aspects of the job, communities see significant turnover of personnel at both clinical and administrative levels. This turnover has a negative impact on the stability and effectiveness of an organization and, ultimately, the delivery of services. According to the Canadian Institute for Health Information (2015), the stability of a health or social services institution is directly linked to the quality of the services it provides, and to its number of visitors[18].

Stability, then, is another important factor for improving populations' health status. One potential approach could be to re-evaluate the minimum length of contracts for work in communities. Respondents also raised the issue of turnover among ISC liaison agents, which forces communities to start over with the same consolidation processes with every new agent. Sometimes, for example, communities must repeatedly explain their expectations for support or their values, principles and guiding vision.

18. Continuity of Care With Family Medicine Physicians: Why It Matters. Ottawa: CIHI. https://secure.cihi.ca/free_products/UPC_ReportFINAL_EN.pdf

7 INCENTIVES FOR HIRING AND RETAINING PERSONNEL IN THE COMMUNITY

To address challenges and obstacles, including those detailed in the previous section, community decision-makers have proposed various strategies for hiring and retaining professionals in the community. Below are some examples.

The majority of communities whose budgets allow them to offer hiring and retention bonuses do so. Such bonuses take various forms depending on the community's situation, but are offered over and above standard working conditions (such as benefits and vacations). For example, remote communities generally offer bonuses for remoteness and cost of living.[19] Communities that are only accessible by air may also defray leaving expenses (for example, the employer might pay travel fees for six trips out of the community per year). In communities with nursing stations, where staff have broader responsibilities, an employer might offer an expanded scope bonus. As an incentive for professionals to continue working in the community in the longer term, some respondents mentioned offering bonuses for staying in a position or for renewing a contract.

Some hiring and retention incentive strategies are targeted to the specific professional role the community is seeking. For example, a physician might be offered a fully equipped office in a health centre or nursing station, and institutions generally also try to offer clinical and administrative support to facilitate a physician's work. That might include requests for reimbursement from the Régie de l'assurance maladie du Québec (RAMQ), appointment scheduling, nursing support, technical support and IT, etc.

Some community health institutions have made themselves available as internship locations for physicians in training. This helps them attract and keep practicing physicians, and helps the community to make connections with the next generation of physicians while raising their awareness of First Nations realities.

A brief overview of strategies proposed by some communities to encourage hiring or retention of personnel:

- *Bonuses*
- *Training*
- *Clinical and administrative support*
- *Assistance with amenities (housing, for example)*
- *Partial or full payment of dues for professional orders*
- *Spotlighting community strengths and accomplishments*

19. http://www23.statcan.gc.ca/imdb-bmdi/pub/document/2321_D2_T9_V1-eng.pdf

This could be carried further, for example by paying for a physician to attend one conference a year to develop and update their professional skills. Some respondents also spoke of the benefits of physician "seduction campaigns," with tactics such as giving guided tours of the community, arranging meetings with children or highlighting local opportunities for fishing and hunting. Such strategies can help to promote the community and encourage a physician to come there to practice.

Similarly, community employers often offer to pay part or all of the dues to professional orders (for example, for nurses or dental hygienists). Some communities offer financial compensation to employees who decide to go back to school. Employers also pay for mandatory training and the employee's choice of optional training, which can be a significant incentive.

Clearly, a community's financial situation affects the incentives it is able to offer. Although hiring and retention incentives may be an onerous financial burden, it is important for communities to be able to develop such strategies, insofar as they are able. Many have had to use creativity in doing so. For example, Band Councils and First Nations organizations may offer incentives based on services already available in their communities, such as free access to a fitness room or gym. Some professionals are offered low-cost housing and/or housing that includes additional incentives (for example, internet or satellite television). Communities must also be persuasive, and must highlight incentives that have no directly associated costs, for example by emphasizing the level of teamwork and coordination between professionals and between sectors.

Some respondents also mentioned policies of preferential hiring for resources from within the community as potential strategic solutions to fill positions while lowering community unemployment rates. In order to avoid creating barriers to filling positions or retaining personnel, however, it is important to set up clear communication strategies to manage the insecurity such policies may create in some employees or potential candidates.

8 FINDINGS ON TRAINING AND SUPPORT NEEDS

8.1 PROFESSIONAL CLINICAL SUPPORT

The communities spoke of certain sectors as higher priorities for support. These included general and specific knowledge on diabetes, mental health, new drugs (including opioids and the legal aspects of cannabis legalization), community health, palliative care, parental responsibilization and suicide prevention. For mental health training, communities also wanted to learn more about harm reduction strategies (for example, adopting a prevention and relapse management strategy for substance abuse rather than directing addicted individuals to quit cold turkey). They also seemed to want more access to training on data entry and database management in general and on iCLSC specifically. Personalized support could be provided on topics such as data collection, analysis and interpretation; setting priorities; and planning efforts that have quantifiable effects on health and social services.

In addition, communities would like access to training from roaming teams. This would facilitate community access, avoid service interruptions and allow professionals to apply the training directly in their workplaces. Objectives might also include lower travel costs for costly or long training sessions (for example, training in foot care for nursing staff). Many respondents also expressed a desire for more information on how ISC-FNIHB covers training (for example, how many resources training is covered for annually).

8.2 ADMINISTRATIVE AND MANAGEMENT SUPPORT

The communities expressed a desire for access to training in financial management. They also spoke of dissatisfaction with the available options for skill development for communities dealing with post-default interventions[20] (for example, a management action plan, joint management or receivership). Communities also wanted training in the roles and responsibilities of Band Council members (sector directors, advisors, etc.) in order to facilitate cross-disciplinary collaboration and the development of common objectives and strategies.

8.3 COMMUNICATION SUPPORT

Communication support would be beneficial as well. Communities want to raise awareness (currently often lacking) among their populations about their health status (for example, by using health promotion strategies). Training on developing communication and engagement strategies would therefore be helpful. Communities also stated a desire for training on writing documents such as annual reports, medical follow-ups, protocols, etc.

9 FINDINGS ON CULTURAL INTEGRATION

Certain cultural considerations emerged as recurring themes in the interviews we conducted with managers in communities. The first is that the vast majority of communities want more freedom to promote their identity and cultural heritage as part of health and social services efforts.

A second consideration relates to First Nations languages, which remain the primary language of communication for some individuals. Some beneficiaries have limited proficiency in English and/or French, which means that their communities require additional support and funding to meet their needs (for example, hospital interpreters).

20. https://www.aadnc-aandc.gc.ca/eng/1386790074541/1386790301856

As for integration of traditional healers into health and wellness institutions, access to such healers seems to take place primarily outside of those institutions. Similarly, some communities expressed an interest in midwifery, but did not report any such resources as part of their wellness labour force.

Some examples of cultural integration that were mentioned:

- *Offering a space for traditional healers within health or social services institutions in the community, and incorporating traditional healers into interventions (for example, spiritual guidance or working in concert with mental health professionals for therapy in natural environments)*
- *Hiring employees with knowledge of traditional medicine (for example, medicinal plants)*
- *Encouraging professionals to make house calls for community members*
- *Creating a traditional medicine centre that works in harmony with modern medicine*

Whatever the method of incorporating living culture into wellness activities, the important thing is to ensure that First Nations members are provided culturally safe care.

10 BEST PRACTICES IN HEALTH AND WELLNESS IN COMMUNITIES

Over the course of this project, a significant number of best practices in health and social services were suggested. Below are some examples.

10.1 REINFORCING LOCAL CAPACITY AND MULTI-SECTORAL COLLABORATION

On a community health level, aligning the sectors of health care, social services and recreation seems to yield positive results for employees as well as beneficiaries of the services. For example, care coordination strategies can allow various health and social services professionals to develop unified and personalized intervention plans. There are many examples of beneficial inter-community collaboration in mental health, telemedicine, wellness and more. As for external partnerships, the majority of communities have good relationships with the provincial network (nearby CISSSs and CIUSSSs). Agreements to facilitate the continuum of wellness could be made (for example, with mental health institutions, for medication prescriptions with a responsible physician, for training or to facilitate vaccinations). Partnerships with universities could also be used to support communities, for example with advice on medical best practices, continuing education or assistance with readings from medical devices.

10.2 IMPROVING THE POPULATION'S ACCESS TO SERVICES

Full use of Jordan's Principle is probably one of the best examples of how a community can enable its under-18 members to access quality health services.

Some communities were able to create as much as $4,000,000 in annual full-time salaries thanks to Jordan's Principle.† At the regional level, over 8,000 direct professional services have been provided to children (more than 14,000) and families from Quebec First Nations as of the date of this report, totalling approximately $15,000,000 since October 2018. Medical follow-up can also be done within the community.

†It is important to mention that a significant portion of this funding has been invested in the private sector rather than in developing sustainable partnerships or building capacity with the provincial network. Also, the federal government has yet to fully confirm that Jordan's Principle will be continued in the long term.

To ensure access to certain rare or essential professional roles, communities plan for a certain degree of budgetary flexibility (for example, 5%) in order to be able to successfully negotiate the hiring of the desired professionals in accordance with community priorities.

Access can also be improved by community health institutions using wait list and cancellation management strategies to provide services to as many people as possible. First Nations communities identified overlong wait lists as a potential contributing factor for difficulties in accessing health and wellness care (RHS, 2015).

Some communities also facilitate access to services through methods such as paying a portion of housing costs for beneficiaries when they travel to a treatment centre. To ensure an effective continuum of services, some have opted to hire a post-therapy agent who provides support and relapse prevention, as well as an NNADAP[21] agent responsible for intervention and prevention. Other initiatives such as building women's centres or respite houses help to ensure the long-term continuity of wellness services in the community.

10.3 INTERNAL ORGANIZATION

A third category of best practices in the community is internal organizational practices. Respondents reported that a global organizational restructuring, from a top-down model of hierarchical relationships to a circular model, can have positive effects on the working environment. Another example is reorganizing schedules to better fit a health centre's needs and encourage employees' work-family balance.

In order to better address the needs of their population, some communities have reached out to their beneficiaries to confirm what they need in terms of health and social services, and also in terms of jobs in those sectors. This is a strategic step in setting priorities within a community health plan. Developing their own community health plan, rather than hiring an external consultant, is also an important practice for communities to consider, especially within a holistic and multi-sectoral approach.

21. National Native Alcohol and Drug Abuse Program https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/funding/national-native-alcohol-drug-abuse-program.html

In terms of optimizing the effectiveness of health and wellness institutions, many respondents reported that having sector leaders present (for example, a head nurse) is extremely beneficial for both delivery of services and the organizational climate. Similarly, a full-time employee dedicated to certification, accreditation and developing guides and procedures is a factor that encourages regulatory compliance, responsibility and best practices in health and wellness. For some communities, it has been extremely fruitful to adopt administrative governing principles such as salary scales. A bookkeeper can also expedite requests and facilitate access (for example, for training, medical transport or financial statements).

11 CONCLUSION

The objective of this project was to take an overall inventory of the human resources working in health and social services in First Nations communities in Quebec. This report gives a broad overview of that labour force, as well as an overview of various issues that First Nations communities have encountered with regard to health and social services. Each community is unique, and so are its situational factors (geography, language, population, etc.) and its needs in health and social services. Nonetheless, based on the data in this report, we have been able to come to some conclusions on overall findings that apply to the majority of communities. These include a need for a stronger training foundation for physicians practicing in the community, underfunding of particular health and wellness sectors, conflicts of jurisdictions, and the need to develop strategies for hiring and retaining qualified personnel.

We were informed of many measures that some communities have already successfully used to facilitate access to professionals working in health and social services and to improve the delivery of quality services to community members.

This report's findings will help to provide a basis for further analysis and planning toward developing service agreements that meet community needs. Ultimately, our hope is that the data presented here will contribute to a collective effort by First Nations, regional organizations and governmental bodies to reflect and take action to improve the quality of and access to health and social services, as part of an interim process on the way to achieving governance by and for First Nations.

Such a collective effort is even more critical when viewed in the light of the current context, in which a great many changes have affected First Nations planning and delivery of health services and social services (reforms, new financial relationships, ministry unification of ISC, etc.). Communities must consider whether collective efforts are likely to be more effective in overcoming the current obstacles to optimal access to quality care (for example, jurisdictional disputes) than each community's individual efforts have been.

12 PERSPECTIVES

One of the key elements for effective intervention is the importance of educating First Nations community members about their own health status. This element was frequently mentioned in connection with absenteeism from medical appointments. We were told that in some communities, funding is adequate and personnel are in place to carry out prevention efforts and other activities, but there remains a persistent problem of non-participation from the population. People do not seem to be sufficiently motivated to act regarding their own health and their family's health.

There are many possible approaches, some of which are already underway in several communities, to the problem of educating people on their health status before they develop severe symptoms and pathological conditions. For example, a community might take steps to increase the visibility of and communications from its health institutions. A community-wide meeting can be organized to survey community members about their wants and needs in terms of health and social services information and communication. It may be beneficial to have a full-time employee such as a communications technician, whose role would include promoting the health centre and its services. Some communities use large electronic signs to spread the word about health and wellness activities (for example, a vaccination campaign). Another approach some respondents mentioned is using incentives, such as a drawing for a gift certificate, to attract the population to participate in wellness activities. It is also important to attempt to include all sectors of the community in health mobilization efforts (for example, police services, nurses, social workers, elders and youth).

In considering a similar future project or a second phase of this project, many elements must be taken into account. It would be interesting to expand upon our findings by identifying correlations between various quantitative variables that can affect a population's health status, such as life expectancy or a quality of life index (for example, wellness indexes or psychometric surveys). It could also be useful to assess beneficiary perceptions of quality and access to services (for example, comparisons with the provincial network, or whether services were provided by a First Nations professional).

Similarly, in order to get a clearer picture of time health and social services professionals spend present in communities, it could be useful to do an analytical breakdown of their activities in practice (time spent in clinical consultation, number of patients seen per week, number of prevention and promotion activities, clerical tasks, etc.) This analysis could be complimented by a more detailed analysis of the professional status of personnel. For example, in the case of nurses, it would be interesting to be able to break down the picture by type of nurse (nursing assistant, clinical nurse, etc.) and medical tasks they carry out (diagnosis, prescriptions, etc.). Individuals from the community could also be asked about their hopes and expectations for different types of professionals. More broadly, it could be beneficial to survey communities about their hopes for developing regional agreements with the province.

13 APPENDICES

Appendix 1. First Nations communities (N=29) and organization (N=1) that participated in the project, and the dates on which researchers met with them.

Nation	Community	Collection date
Abenaki	Odanak	April 19, 2018
	Wôlinak	June 14, 2018
Algonquin	Barriere Lake	August 14, 2018
	Kebaowek	June 7, 2018
	Kitcisakik	August 15, 2018
	Kitigan Zibi	May 25, 2018
	Lac-Simon	August 29, 2018
	Winneway	May 25, 2018
	Pikogan	August 28, 2018
	Timiskaming	June 6, 2018
	Wolf Lake	June 6, 2018
Atikamekw	Manawan	August 1, 2018
	Wemotaci	October 3, 2018
Innu	Ekuanitshit	May 30, 2018
	Essipit	May 3, 2018
	Mashteuiatsh	May 15, 2018
	Matimekush-Lac John	May 31, 2018
	Nutashkuan	August 9, 2018
	Pakua Shipu	April 25, 2018
	Pessamit	June 18, 2018
	Uashat mak Mani-Utenam	July 23, 2018
	Unamen Shipu	July 24, 2018
Malecite	Viger	July 30, 2018
Mi'kmaw	Gesgapegiag	May 16, 2018
	Gespeg	July 27, 2018
	Listuguj	July 17, 2018
Huron-Wendat	Wendake	May 2, 2018
Mohawk	Kahnawake	September 5, 2018
	Kanesatake	August 21, 2018
First Nations organization	Mamit Innuat tribal council	May 29, 2018

Appendix 2. Consent form for project participation

COMMISSION DE LA SANTÉ
ET DES SERVICES SOCIAUX
DES PREMIÈRES NATIONS
DU QUÉBEC ET DU LABRADOR

250, place Chef-Michel-Laveau, bureau 102
Wendake (Québec) G0A 4V0
418-842-1540 418-842-7045 cssspnql.com

Consent form

INVITATION TO PARTICIPATE IN THE SURVEY OF THE HUMAN RESOURCES WORKING IN HEALTH AND SOCIAL SERVICES ACCESSIBLE TO FIRST NATIONS IN QUEBEC

Please complete this section:.

☐ **I hereby give my consent** to the participation of my community, _____, in the survey of human resources in health and social services accessible to First Nations in Quebec.
(name of your community)

or

☐ **I hereby DO NOT consent** to the participation of my community, _____, in the survey of human resources in health and social services accessible to First Nations in Quebec.
(name of your community)

Signature

_____ _____
Executive Director Date

Please return a signed copy of this form by fax to 418-842-7045 or by email (in PDF format) to the following email address:

Jean.Levasseur-Moreau@cssspnql.com

ATTENTION: Jean Levasseur-Moreau
Special Project Manager – Governance, FNQLHSSC

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Appendix 3. Letter of information about the project

COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX
DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR
FIRST NATIONS OF QUEBEC AND LABRADOR
HEALTH AND SOCIAL SERVICES COMMISSION

250, place Chef-Michel-Laveau, bureau 102
Wendake (Québec) G0A 4V0
418-842-1540 418-842-7045 cssspnql.com

MEMO

Description of the Proposed Survey

Survey of human resources working in health and social services accessible to First Nations communities in Quebec

Dear Sir or Madam:

We would like to inform you that, with your collaboration, the FNQLHSSC will conduct a survey of the human resources working in health and social services in First Nations communities and organizations in Quebec.

Objective: As part of the health and social services governance process undertaken in 2012 by First Nations in Quebec, the FNQLHSSC will be surveying human resources working in health and social services accessible to First Nations communities and organizations. This step is crucial to the adoption of an effective strategic planning aimed at repatriating health and social services-related functions and responsibilities currently handled by the federal government.

Background: On many occasions, First Nations communities' political representatives have voiced discontent about the current situation of health and social services in Quebec (e.g. access, fairness, funding, program development, service continuity, etc.) and have pledged to serve as agents of change in this regard. It is a question of capitalizing on the current political initiative (ministerial changes, recommendations of the Truth and Reconciliation Commission of Canada, etc.) and acting upstream. One crucial aspect of self-determination concerns choosing which functions and responsibilities currently handled by the federal government should be repatriated. This aspect also depends on human resources working in health and social services who are already accessible to First Nations communities. Recognizing and supporting First Nations governance efforts are a priority focus area of the FNQLHSSC's 2017–2020 Strategic Plan.

Data collection and ethical considerations: The information will be collected throughout 2018 on a one-time basis via in-person or telephone interviews with the person in charge of health and/or social services. The survey will be conducted in accordance with the First Nations in Quebec and Labrador's Research Protocol (AFNQL, 2014) and the principles of data ownership, control, access and possession (OCAP®) by the First Nations. The data collected will be kept confidential. In the event that a report derived from the data

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collection is made public, the data will be presented in such a way that they cannot be directly linked to the community from which they were collected.

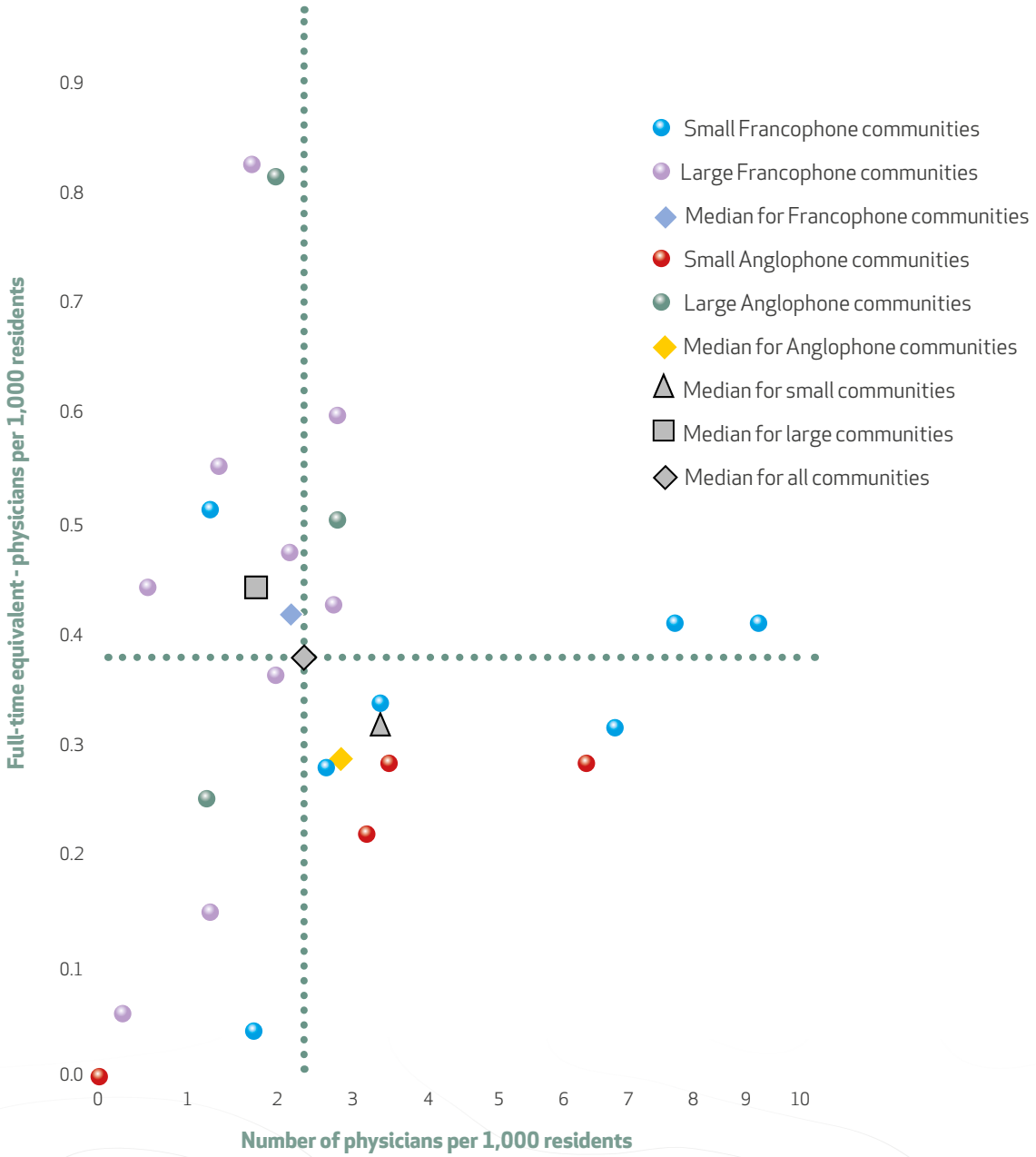
Impact: Health and social services resources accessible to First Nations have never been surveyed in this way. The survey results may be helpful to communities and organizations in connection with their future development and planning efforts. In addition, guidance may be provided to the FNQLHSSC concerning First Nations health and social services governance. The results will also provide a clearer picture of First Nations health resources and needs in Quebec, in addition to identifying future needs in terms of recruiting, vocational training, professional development and improvements to the service offer for communities and organizations. In addition to supporting First Nations governance initiatives, two other priority focus areas in our strategic plan are involved: access to quality care and services, and capacity building in terms of accompaniment for the FNQLHSSC. This will be with a view to benefiting the communities and organizations.

The consent form provided below authorizes the FNQLHSSC to contact the main actor(s) involved in health and social services in your community or organization.

For further information, please contact Jean Levasseur-Moreau at 418-842-1540, ext. 2106, or Jean.Levasseur-Moreau@cssspnql.com.

Thank you in advance for your participation!

Appendix 4. Distribution of the number of physicians and their full-time equivalence by community size and language spoken



Small communities = communities with fewer than 1,000 residents
Large communities = communities with 1,000 or more residents
Note: Some communities with outlying values are not shown on this graph. However, all values were included when calculating medians.

*In interpreting this graph, it is important to note the undesirability of having a large number of physicians with a very low full-time equivalence (time present), since this is synonymous with a significant rotation of physicians, and thus a potential lack of stability in the continuum of services (lower right quadrant). Conversely, the upper left quadrant can be interpreted as representing a more desirable situation in which, given the equivalence of time present (with the upper right quadrant), a smaller number of physicians is required, implying improved stability and continuity of care.

Quebec First Nations are faced with major health human resources issues. However, to date, no exhaustive report has been available to allow for an analysis of the situation. The report provides a portrait of health and social services human resources in First Nations communities in Quebec. In all, 29 communities and one First Nations organization participated in the project.

The report illustrates the major issues facing First Nations communities, particularly regarding the sustainability of the continuum of services, and the hiring and retention of staff. The report provides comparisons with the province, possible avenues for actions to improve the accessibility and quality of human resources as well as best practices identified throughout data collection

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION