"I am glad that I am alive to tell my story."

Read story inside.

Nanehkatehnimohiiwehwin:
Medical Transportation, Final Report 2019

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I am glad that I am alive to tell my story.

When I was a child, I was shipped out with a yellow envelope pinned to my blouse. It was summer time. I was being sent out by medical services. I remember that I had a long Norseman plane come to pick me up. Back then there were bush planes. They landed at all the bush camps. There were these two men that got on the plane when I boarded. One of them was my first cousin. I felt at least comfortable that I knew a person in the plane while traveling out.

We had to land in the middle of nowhere. I had to get out too. My mother had bought me a pair of new runners. Nowadays they look like converse, high top runners. But back then they were called 'ajiitahmoo wahkeesinnun'-squirrel runners. So I was wearing those brand new shoes. There was no dock where we had to get off that plane and I was told to get out. They were unloading supplies for that camp site. I had to go into the water and it was up to my knees. I had to go into the water with my brand new runners and I didn't like it. We had to wait there for awhile and then I continued my journey.

We took off again to Pickle Lake. I had to overnight there. I didn't understand one word of English. This man put me in this place. I was so scared. I don't know if I slept that night. I couldn't eat too, when he gave me food to eat. It didn't taste like the food I ate at home. The next day I continued my journey to Sioux Lookout to the hospital. When I got to Sioux Lookout, I got picked up by a driver that I didn't even know who it was. He took me to the Indian Hospital –the Zone Hospital. I stayed there for the summer.

I am glad that I am alive to tell my story. This happened in 1964. I was five years old.

~ Kathleen Beardy, Muskrat Dam

"When we signed with the Crown, healthcare was, and still is, part of our Treaty rights. Each First Nation individual has the right to access all medical services and specialists. When we signed Treaties with the Crown, we were supposed to be equal with Canadians.

Somewhere along the way we started getting capped and limited. I think today, First Nations get less than one-third of the basic services every Canadian enjoys. We are the People that are overlooked. The only way First Nations are going to have better healthcare is to have a regionally First Nation run health system."

~ Chief Matthew Keewaykapow,
Cat Lake First Nation

Nanehkatehnimohiiwehwin Medical Transportation

The introduction of basic health services for the people eventually aligned with Treaty #5 signed in 1875, Treaty #9 signed in July 1905, and the Adhesion of Treaty #9 in 1929. When the treaties were signed, there was no reference to a "medicine chest" for the people of Treaty #5 and Treaty #9. Accordingly, the government's position continues to be, "...health is not a treaty right.".

The first form of health service was a private nurse hired, usually by a religious denomination. Eventually, the government took an active role and began building nursing stations to serve a cluster of aligned villages. During Treaty Days the people gathered at hubs and camped for the summer months. There would be a health blitz while treaty money was given out. Essentially, the people received their basic annual medical checkup. In today's standard of offering a service, in this case health, it is considered precedent setting. Health service has since evolved. It has become a part of the government service, taking care of the people.

Clustering of villages or creating an aggregation of communities continues to be a government trend to provide services today. This is the government's way of maintaining its Parliamentary division of responsibility for "*Indians and lands reserved for the Indians.*" Even today, the government continues to cluster communities for political expediency and services through numbered treaties, to provincial treaty organizations and tribal councils.

The federal government, through policy initiatives, continues to express recognition of its special relationship with the First Nations people. In 1979, it implemented the Indian Health Policy, as a basis of upholding and maintaining its legal responsibility. The policy states, "*... the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.*"

As part of the relationship, the Non-Insured Health Benefits (NIHB) came into being. The NIHB program can be characterized for the First Nations people as, **Nanehkatehnimohiiwehwin**. The NIHB program is very intrusive, pierces personal medical privacy boundaries, worrisome, stressful and it takes a toll on vulnerable First Nations people. It takes a toll on patients that do not understand the English language or how the system works. First Nations people have no choice but to leave the comforts of their

home to receive unavailable health services which normally exist everywhere else in non-native communities.

Nanehkatehnimohiiwehwin, brings patients out to unfamiliar urban centres for health services. Often times, it is the first time for most patients, especially seniors and Elders. Travelling out for health treatment is traumatic for patients unfamiliar with outside health services. Often times, patients do not fully comprehend their health conditions, language is a barrier, communication of appointments usually rushed, health service destination a mystery. All this adds more stress to an already ill patient. These were the common elements heard throughout the five Tribal Council and Independent Bands community engagements held this summer.

Going forward, the vision of health service must be to eliminate the stress of the patients and for patients to have more understanding of their health. To achieve that outcome, professionals that understand First Nations people must be at the forefront. To develop a cadre of trained professionals, culturally sensitive and most importantly, empathetic to patient's medical situation is a prerequisite.

Nanehkatehnimohiiwehwin, the NIHB program, can lessen the stress of all patients where the NIHB program is First Nations controlled.

~ James Cutfeet, K.I. Consulting

Nanehkatehnimohiiwehwin:

An authority that is beyond ones control and causes hardship and distress; an external authority negatively impacting one's well-being.


CHIEFS IN ASSEMBLY
Resolution #15-27
ENHANCEMENT OF MEDICAL ESCORT SERVICES
CHIEFS IN ASSEMBLY
Resolution #16-08
GUIDELINES FOR ESCORT SERVICES

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Executive Summary

One of the greatest challenges when striving to make change is recognizing that we must first make change within ourselves.

Over the summer of 2019, sixty-seven people, residing in or serving one of the thirty-three communities composing the Sioux Lookout First Nation Health Authority (SLFNHA) catchment area, gathered to examine areas of concern regarding the Non-Insured Health Benefits (NIHB) medical transportation policy framework. Presently, SLFNHA provides limited services within the medical transportation policy framework which includes ground transportation, accommodations and meals. The financial arrangement flows through a per diem basis, with all hostel operations covered through that per diem.

Many of these delegates were invited to the sessions because they were employed in a role that had a direct connection to medical transportation services, whether clerk, health director or leadership, but these delegates were also community members.

The gatherings were compelled by three resolutions passed by SLFNHA Chiefs which sought to improve medical transportation services, and especially non-medical escort services (Appendices 1, 2 and 3).

Before developing a list of recommendations to transform medical transportation services, participants were asked to examine their own community's weaknesses. In doing so, recommendations were developed in parallel to mitigation of infrastructure and capacity needs. By developing strategies to eliminate and avoid internal areas of concern, a strong foundation is laid to ensure the best opportunity for the successful implementation of recommendations.

By drawing the courage to be truthful about their own capacity needs, including education, these First Nation community members have raised a bar that must be met by Tribal Councils, leadership, First Nation organizations and government bodies. All entities must conduct themselves with transparency which also requires ownership of their deficiencies, in order to advance a medical transportation service transformation that is urgently needed.

Participants also identified historical issues of division created by the artificial constructs imposed by government boundaries like Treaties, Provincial Territorial Organizations and Tribal Councils. Focusing on the commonalities shared among Tribal Councils and Independent Bands, such as NIHB's failure to deliver adequate medical transportation services which contributes to poor health outcomes for the First Nations; and the desire of All Treaty People, regardless of government constructs, to improve health outcomes for the First Nations. The work outlined in the following pages must be carried forward by All Treaty People. The support of the leadership in this regard, is fundamental.

In addition to five gatherings for each Tribal Council area, with Independent Bands choosing what community engagement session they wanted to join, a sixth gathering took place on August 13th and 14th, 2019. This returning delegation of thirteen people, the Recommendation Table, were invited back to examine preliminary findings and create final recommendations.

The preliminary findings were informed by qualitative data and narratives -personal and professional, compiled from community engagement sessions. Conversations and exercises focused on medical transportation areas for improvement; role accountability; solutions; and potential recommendations.

Recommendations are centred around the recurring themes, and the ones most relevant to the three resolutions at hand. In summary, these themes include:

- Notification and Communication Inefficiencies: Not enough notice is provided to patients regarding medical appointments and travel; privacy concerns; Travel cannot be booked 24 hours a day and 7 days a week
- Travel- Ground, Air and Airport: Inflexible NIHB policies; shortage of medical vehicles; small charter flights that make multiple stops before delivering patients to destination; delays on medevacs
- Accommodations: Unsafe and undesirable locations and lodgings; Patients required to check out and back in to room between medical appointments; Patients and non-medical escorts must share private quarters with strangers
- Inter-provincial travel: There is no Ontario presence when First Nations living in Ontario travel for service to other provinces; NIHB inconsistently interprets policy province to province
- Non-medical escort Services: Patients have been frequently abandoned by non-medical escorts; Non-medical escorts are voluntary and untrained roles; Language barriers between patients and non-medical escorts
- Discriminatory and Non-Equitable Services: NIHB rates vs. Treasury Board rates, Service delivery and personnel interactions

The Recommendation Table developed four recommendations based on the above findings, also anticipating for infrastructure and capacity needs.

Recommendation #1

Calls for establishing a Chief's Negotiation Table to strategize the procurement of Medical Transportation as a First Nation run health system providing a medical transportation model that is responsive and equitable.

Recommendation #2

Calls for supporting the development of professionally trained and educated First Nation members, fluent in an Ancestral language and English, to serve in paid positions as Medical Escort Workers.

Recommendation #3

Calls for the Chiefs to direct Sioux Lookout First Nation Health Authority to form a committee to explore a presence in Manitoba.

Recommendation #4

Calls for the Chiefs of the Sioux Lookout First Nation Health Authority to bring an end to discriminatory and non-equitable services.

These recommendations are responsive to the personal and professional stories shared by the community engagement session participants. The issues brought forward by the People are not just nuanced details of inconveniences to be endured by patients, and their non-medical escorts. These inequities affect not just daily health outcomes, but also life and death conclusions for the First Nations.

Nanehkatehnimohiiwehwin Non-Insured Health Benefits: Medical Transportation

1.0 Introduction

In 1995, the Sioux Lookout First Nations Health Authority (SLFNHA) took on the client services program through a Health Canada contribution agreement. SLFNHA administers the medical transportation policy framework according to the contribution agreement on behalf of the Non-Insured Health Benefit program (NIHB). The NIHB medical transportation program operated a thirty-nine-bed facility for which it paid all costs. The facility provided accommodation for medical patients traveling from the north as well as their non-medical escorts.

In February 2011, SLFNHA entered into a memorandum of understanding (MOU) with the First Nation Inuit Health Branch (FNIHB). The MOU was established to transition from a contribution agreement to a fee for service model. This coincided with the opening of the new Jeremiah McKay Kabayshewekamik hostel (JMK) which opened its doors in February 2011. Since that time, the one-hundred-bed facility has maxed out its occupancy and beyond. In the summer of 2019, JMK II opened with an additional one hundred and twenty beds.

NIHB has the sole decision-making power under the medical transportation policy framework. SLFNHA has no decision-making power.

Since 2015, SLFNHA has been given directions with three resolutions to advocate for improved non-medical escort services, to work with partners and hold community sessions towards developing guidelines and enhancing the non-medical escort program. In March 2019, SLFNHA retained K.I. Consulting to conduct community sessions with respect to the three resolutions, and to explore how non-medical escort services can be improved within the Non-Insured Health Benefit (NIHB) policy framework.

2.0 Methodology

Between May 14th, 2019 and August 7th, 2019 a total of sixty-seven participants representing five Tribal Councils, two Independent Bands, and twenty communities gathered in Thunder Bay to address three resolutions, passed by Chiefs of the Sioux Lookout First Nation Health Authority, that seek to improve medical transportation services for their combined thirty-three communities.

The three resolutions of focus include:

- **Resolution #15-27 Enhancement of Non-medical Escort Services** (Appendix 1) that advocates for clients to receive escort services when needed; and to increase communication between Tribal Council/Community Health Director and Health Clinics
- **Resolution #16-08 Guidelines for Escort Selection** (Appendix 2) that calls for a community engagement process that involves communities, Tribal Councils and partners to develop regional guidelines for non-medical escort selection; draft guidelines for ratification and the process for implementation; and political leadership will engage with Health Canada
- **Resolution #18-17 Non-medical Escort Service Program** (Appendix 3) that calls for the establishment of a Working Group with representation from Tribal Councils, communities, and partners to explore a non-medical escort service program; incorporate best practices, First Nation values; and a component to recruit community members that are designated and trained; advocate for funding and implement the non-medical escort services program; and report to the Chiefs in Assembly on their progress at the 2019 SLFNHA Annual General Meeting

Five Tribal Council engagement sessions were facilitated over a three-month period. With the exception of Matawa Tribal Council, whose leadership requested a one-day session to accommodate extenuating circumstance, four two day long community engagement sessions were held for each Tribal Council. Independent Bands were invited to choose which Tribal Council session was suitable to attend.

Tribal Councils and Independent Bands included:

- **Mishkeegogamang Independent Band**
- **Sandy Lake Independent Band**
- **Independent First Nation Alliance:** Muskrat Dam, Lac Seul
- **Matawa First Nations:** Marten Falls; Neskantaga; Nibinamik; Webequie

- **Shibogama First Nations Council:** Wawakapewin; Wunnumin Lake; Kingfisher Lake
- **Windigo First Nations Council:** Sachigo; Cat Lake; Slate Falls; North Caribou; Bearskin
- **Keewaytinook Okimakanak Tribal Council:** Keewaywin; Fort Severn; McDowell Lake; Poplar Hill

The delegation was represented by health directors; clerks; band administrators; program coordinators; patient advocates; Board members; Elders; and Chief and Council. With emphasis upon the three Resolutions, and the long identified need to improve the medical transportation system for the First Nations in northwestern Ontario, the engagement sessions focused activities and discussions to highlight the deficiencies of the system; accountabilities and roles; solutions; and potential recommendations.

Over a collective period of nine days, people shared stories, knowledge and expertise originating from their professional, as well as personal experiences, with medical transportation as offered through NIHB. Stories shared were often of frustration, indignity, and needless suffering sometimes resulting in death which otherwise could have been preventable -all of this, as expressed by many participants, rooted in a colonial service delivery model, and in a spirit of paternalism towards the First Nations.

On August 13th and 14th, 2019 a delegation of thirteen individuals who had previously participated in a Community Engagement Session returned to form a Recommendation Table to take part in a two-day session to review the preliminary findings generated from the five Community Engagement Sessions. The Recommendation Table also examined the internal strengths and internal weaknesses of their communities, organizations, and Tribal Councils; and external threats, such as changing governments or airline services, to develop strategies to overcome infrastructure and capacity needs. Utilizing all of this information, the Recommendation Table developed strong and achievable recommendations, with the added benefit of strategizing for infrastructure and capacity requirements, and creating a work plan for implementation of recommendations.

3.0 Key Findings

The most pressing areas of concern identified by Community Engagement participants include:

- **Notification/Communication:** Appointments, Travel Information
- **Travel:** Ground, Air, Airport services
- **Accommodation:** Safety, Privacy, Availability
- **Non-medical escorts:** Reliability, Professionalism, Training
- **Interprovincial Services:** Accommodation, Transportation and Reliable point of contact
- **Discriminatory and Non-Equitable Services:** NIHB rates vs. Treasury Board rates, Service Delivery-personnel interactions

Underpinning all of the above concerns were language barriers, and especially in regard to the suitability of Non-medical escorts

Sixty percent of communities composing the SLFNHA catchment area were represented over the course of five community engagement sessions. Though the combined delegation totaled sixty-seven, the recurring themes were highly consistent among all participants. Often the only variations in these themes were differentiated by personal details numerous storytellers associated with the six areas of concern noted above. For this reason, a high degree of confidence is assigned to the findings.

3.1 Medical Transportation

Concerns with medical transportation services encompassed notification and communication deficiencies; deficiencies with ground travel and air travel including airports; accommodation deficiencies; and inflexible NIHB policies.

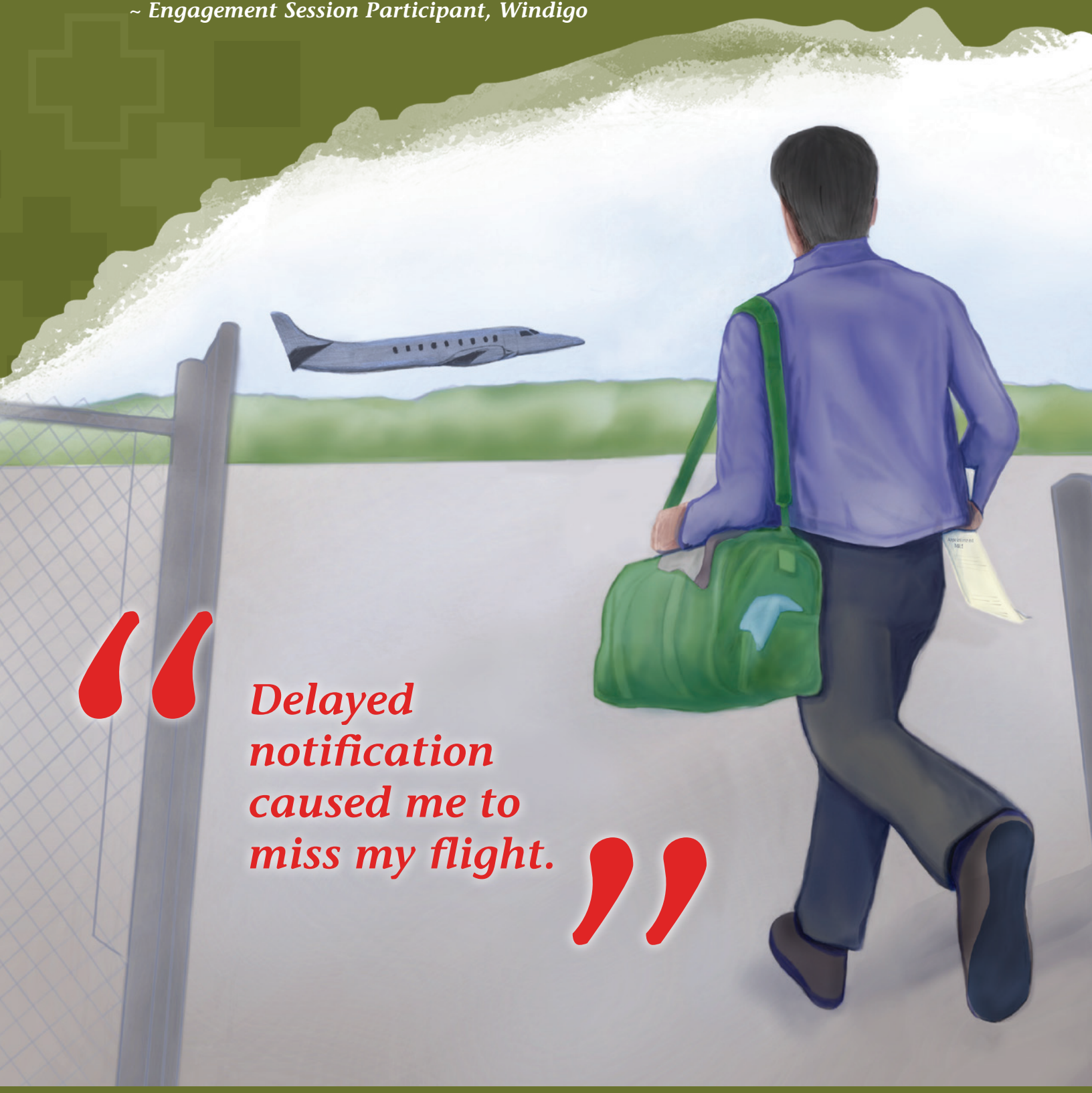
3.1.1 Notification and Communication

Participants presented varied narratives regarding the process and timeliness of medical appointment notification. Expressed more often than not by participants, follow-up medical appointments are funneled through the NIHB clerks who then inform the patient of their scheduled appointment. Especially troublesome is that this line of communication provides clerks with arbitrary decision-making powers over whose travel is approved and who should be eligible for non-medical escort services. More so, clerks are permitted to ask intrusive questions about a person's reason for travel, all at the expense of the patient's right to privacy.

Participants shared that it is not uncommon that notice for medical travel often comes on the day of travel or the day before. This has resulted in patients missing appointments owing to

At the very last minute NIHB sends the information in - the morning you are supposed to travel. You might have to fill out forms for your employer to get a leave for work, run home, pack your stuff and by the time you get to the airport you may have missed your flight. And the person misses their appointment. And they could have waited months for that appointment. And now they have to wait months more.

~ Engagement Session Participant, Windigo



"Delayed notification caused me to miss my flight."

an inability to find babysitters, take time off work or any other prior commitment on such short notice.

Challenges traveling for medical appointments, and returning from medical appointments, are made more difficult by a travel booking service that only operates during the weekdays. Participants shared that travel cannot be made in the evenings, on the weekends or on the holidays, resulting in the patient having to wait hours or days to return home. Sometimes this means finding and covering accommodation/meal costs while waiting to arrange for return medical travel back to community.

Participants shared that they have observed, or experienced, travel for urgent medical situations delayed because of inflexible medical travel booking hours.

In summary, the impact of poor notification and communication processes upon the patient and medical transportation services include:

- **Appointments missed owing to NIHB notification delays**
- **'Black-listing' of patients who miss flights owing to NIHB notification delays. NIHB requires patient to pay for their next flight to get back into 'the good books' –some can never afford to do this**
- **Missed appointments owing to NIHB notification delays, burden patients with missed appointment charges and rescheduling medical appointments may take months**
- **Patients stuck or stranded trying to get home when released from medical care outside of NIHB's office hours (evenings/weekends/holidays)**
- **Loss of privacy when having to disclose private medical details to clerks in order to advocate for their right to access NIHB**

3.1.2 Travel

Over and over again, participants shared that the turn of phrase, "Take an Advil or a Tylenol and go home and get some rest," was too frequent at the nursing stations.

Many participants expressed that it is not uncommon that patients experiencing a medical crisis are booked for medical travel on a commercial flight rather than being medevaced to hospital. Noted was that often there are not doctors present during these situations and the nurse in charge must await direction from a physician before ordering a medevac for the patient. Several participants shared stories about the medevac being requested too late.

Participants indicated after surgeries, patients are not provided enough recovery time in hospital and NIHB does not extend stays in hostels or hotels to ensure that patients have adequate opportunity to heal before travel. Patients are sent back via commercial travel too early after surgery. Forcing patients to travel before they are well enough to do so, have resulted in further injury to surgical sites. This inconsideration also impacts patients who are undergoing medical treatments such as chemotherapy.

"I was travelling on the plane. It was so cold. I didn't even have any extra stuff, a blanket, or anything like that. There was a pile of newspapers in front of me, so I stacked them up against my body. And then my incisions hurt so much from the shivering."

~ Engagement Session Participant, Independent First Nation Alliance

The Elder's funeral is today.

"We recently had an Elder pass away. He was taken to the health clinic three times during the week. The last time the workers took him to the clinic the nurse said give him more Tylenol. So, the Chief had to intervene to send him out. The receiving doctor was here in Thunder Bay. The doctor said, 'maybe if you brought him out sooner things would have been different.' The Elder's funeral is today."

~Engagement Session Participant, Mishkeegogamang

'No, you can't do that.

I was looking after my mom. I became her primary caregiver. So, my mom was in the Sioux Lookout hospital and she was being discharged. I happened to be in Thunder Bay. So, I called up NIHB and I said, 'how about you pay one way of my fare from Thunder Bay and I'll pick up my Mom and bring her home to Big Trout'. Do you know what their response was? 'No, you can't do that. You have to go all the way back to Big Trout first, come back out to Sioux Lookout, pick up your Mom, and then go back to Big Trout.' That is how ludicrous are the decisions being made by NIHB.

~Community Member, Kitchenuhmaykoosib Inninuwuug

Further to travel concerns are shortage of properly equipped vehicles designated for medical travel. One participant shared that other than a stretcher and a First Aid kit in the back of the van, no other medical equipment or supplies were available. Communities receive inadequate funding to purchase and maintain vehicles. Road conditions on reserves take an exceptional toll on vehicles.

Participants noted that there are not enough drivers, as well as drivers with medical training. Training also extends to courtesy. Participants shared numerous times that shuttle drivers between the airport and destination have been discourteous with patients, and inconsiderate of the health of the person. As well, the shortage of vehicles and drivers has left patients stranded at airports, hotel lobbies, and hospitals lobbies for hours waiting for pick-up.

Problematic to air travel is the practice of NIHB scheduling the first available flight which often consists of patients spending much time on a plane that is making multiple community stops. There are no direct flights that will bring patients out of community and into larger locations like Sioux Lookout, Thunder Bay or Winnipeg, where their medical appointments are scheduled.

It was presented through the engagement sessions that there are growing problems with the limited airline services offered to First Nation communities in northwestern Ontario. Patients have reported missing medical appointments for chemotherapy treatments or consultations with specialists because airlines are cancelling flights or overbooking which results in denying patients to board the plane. Patients may wait months to reschedule missed appointments and,

as shared by some participants, some patients die before ever making it to their rescheduled appointments.

Overall, inflexible NIHB 'rules' are creating unnecessary stress and prolonged suffering for patients and also for non-medical escorts. Participants provided examples of how these inflexible rules affected their medical travel:

- People who get sick while out, perhaps on business or personal travel, and who require hospitalization, will not be covered by NIHB for return travel home, ground transportation, accommodations, meals and non-medical escorts
- When a person who is medevaced from a northern community that is not their own home community, upon their discharge NIHB sends the person back to their original point of departure- not back to their home community
- Non-medical escorts, in a neighbouring community, who must travel to northern communities to assist a patient, a parent perhaps, to travel out for medical will not have their flight to the patient's community covered by NIHB. The non-medical escort must cover their flight to the community where the patient is located at their own expense
- Discharge time and departure time can be very compressed which resulted in one participant missing her flight home while quite ill and struggling to find an alternate way home

The NIHB 'rulebook', which participants expressed often negates the application of common sense, was a great source of frustration. During the engagement session, one person provided an account of their encounter with NIHB while attempting to escort his mother back to community after her medical visit.

In summary, the impact of NIHB travel policy upon the patient and medical transportation services include:

- **Patients miss appointments or flights owing to late ground transportation**
- **Patients may wait hours for pick-ups to and from hospital, accommodations, or airport**
- **Patients have been treated discourteously by drivers**
- **Patients spend hours taking off and landing in multiple communities instead of flying directly to their destination**
- **Patients experience pain and discomfort while flying owing to smaller aircraft, multiple take-offs and landings, and to early discharges from hospital and no accommodation provisions by NIHB**
- **Inflexible NIHB travel rules for patients and non-medical escorts that, as an example, only accommodate travel to and from community of origin are unfair, inconvenient and may delay medical care**
- **Delays in medical care owing to inflexible travel rules; and misdiagnosis or non-urgent care at nursing station, including delays or non-approvals for medevacs, further perpetuate and deteriorate poor health, and in some cases, lead to death that otherwise could have been prevented**

3.1.3 Accommodation

Accommodations are provided at hospital facilities, hostels and hotels. Each accommodation has their own set of policies regarding how to discharge or accommodate patients.

SLFNHA, as required by FNIHB policy, has patients checking out of their accommodation arrangement too early following surgeries or necessary recovery time after medical treatments like chemotherapy. This policy is detrimental to the patient's health and well-being. Patients and non-medical escorts are expected to check out of and in to their hotel or hostel accommodation in between medical appointments. A Windigo Tribal Council participant provided a story about his experience accompanying his wife who had three medical appointments over a six-day period. The participant and his wife were required to check in and out of the same accommodation three times.

"Patients are asked to check out every morning and then they have to wait until after their appointments, and they have to wait all day, before they can be accommodated again. I've seen that many times where Elders are asked to check out- they go to their appointments, and they get back to the accommodations

and they are told to just wait. Just wait. And meanwhile the Elder is put in a position where their health becomes more critical instead of getting better."

~ Engagement Session Participant, Windigo

Safety and accommodation were expressed by participants as a significant concern. SLFNHA will accommodate patients and escorts in hotel and hostel rooms with complete strangers. A second Windigo Tribal Council participant shared an experience of being accommodated in a hostel. At some point in the night another man entered the room to occupy the bed next to the participant. The man was a stranger to the participant and appeared to be heavily under the influences of alcohol or drugs. The participant was scared and unable to sleep.

Many participants expressed feeling unsafe in the Sioux Lookout JMK hostels. Some of the concerns originate with security staff that, some participants shared, will enter rooms without knocking. More so, concerns about safety at the hostels are related to some of the guests at the hostels.

You don't feel safe.

All of a sudden, the cops are rushing around there, yelling and screaming and you don't know what is going on. You don't feel safe. I think the situation is escalating there.

~ Engagement Session Participant, Keewaytinook Okimakanak,

Participants elaborated that NIHB chosen vendor accommodation rates imposed medical travellers to take up shelter in undesirable lodgings and locations where they did not feel safe.

I personally went to the hostel in Osborne Village a few years ago and I felt scared walking to it because of where it's located. I can go out in the bush at the dead of night and feel no fear, but walking to that hostel, I felt scared. It happens everywhere – London, Thunder Bay…

~ Engagement Session Participant, Shibogama

Important to note is the significant disparity between NIHB rates and the governments Treasury Board rates for accommodation which is discussed further in the report.

In summary, the impact of NIHB accommodation policy upon the patient and medical transportation services include:

- **Patients and non-medical escorts safety is risked when accommodated in unsafe locations, and forced to share sleeping and private quarters with strangers**
- **Patients and non-medical escorts dignity and privacy is impacted when forced to share sleeping and private quarters with strangers**
- **Patient health situations are aggravated, and patients needlessly experience extra discomfort and suffering while waiting to be rebooked into accommodations**

3.2 Non-Medical Escort Services

Noted by participants, the non-medical escort role is a voluntary, unpaid and unscreened role which contributes to the concerns listed below.

Many participants were enthusiastic about omitting the word 'escort' from the 'non-medical escort' terminology. It was expressed that a more professional term be adopted. Further, by assigning a new title to this role, it was hoped among participants that this would support the development of criteria for selecting suitable and reliable supports to accompany patients during medical travel.

"I want to give them a new professional title. Escorts are just chosen on who is available to go. They come with the person they are used to hanging around with. And they end up getting separated in the medical situation."

~ Engagement Session Participant, Independent First Nation Alliance

Participants indicated they are knowledgeable about situations where non-medical escorts have travelled with patients to urban centres and then have left the patient to pursue recreational interests. Participants shared that when this happens, it is not uncommon that the non-medical escort engages in the use/misuse of alcohol and other substances. This underpins safety concerns for both the patient and the non-medical escort.

Participants expressed concern that non-medical escorts are selected based on familiarity to the patient, often a family member, or selected owing simply to availability to travel. It was shared by participants that often non-medical escorts are unfamiliar with the medical needs of the patient, and do not have any medical background even as measured by the most basic First Aid/CPR training.

It was identified that sometimes non-medical escorts do not understand the cultural responses from patients, particularly Elders, and that language fluency was often unmet by escorts. Participants shared their concern that these two issues would impede communication between the patient and medical practitioners, thereby compromising quality of care.

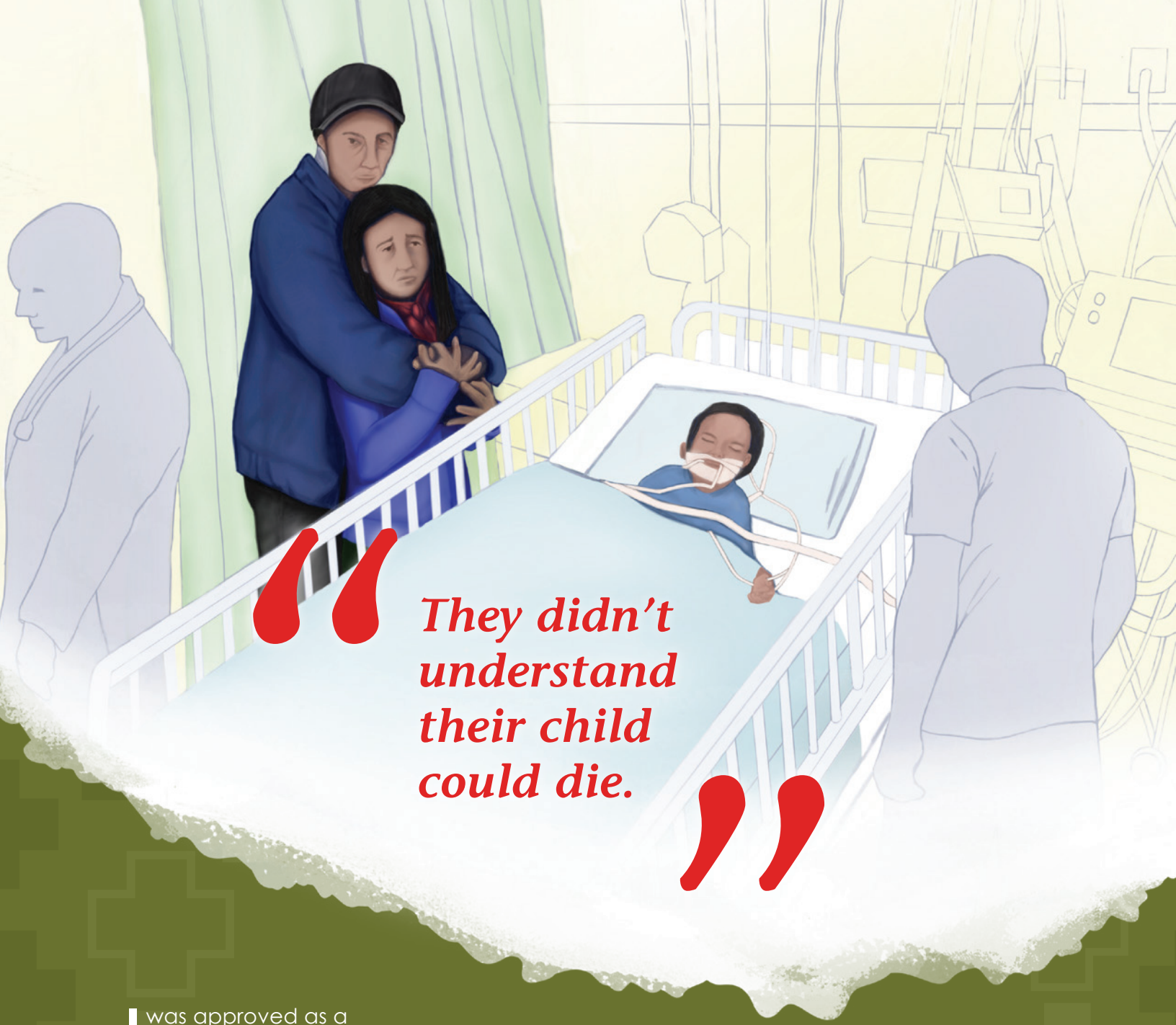
When NIHB denies coverage for a non-medical escort, patients travel on their own when family members or friends are unavailable or not able to afford to travel as a support. Participants also shared that some patients with greater needs require two non-medical escorts. This is especially a concern when one parent is travelling with a child as the child's non-medical escort. NIHB does not always provide funding for a second non-medical escort.

Two non-medical escorts are often required when supporting patients with extensive physical needs, such as requiring two-person lifts, or mental health needs, such as support during periods of suicidal ideation. Sometimes a second non-medical escort is required when the patient has a tendency to wander. These are instances where non-medical escorts could support the patient in shifts.

Tendency to wander.

I woke up. My patient was gone. I finally found him on a bridge with a girl. I dragged him back to the hotel and I couldn't go back to sleep because I didn't want him to take off again. And then the next night he disappeared on me again. I couldn't find him the whole evening. He ended up in someone's hotel room- drinking. Then he told his mom that I wasn't a good escort.

~ Engagement Session Participant, Windigo



"They didn't understand their child could die."

I was approved as a second escort. There was a language barrier with the first escort. It was the first time the family ever left their home community. The family told me what they wanted to do. I explained to the family what was being suggested by the doctor. They didn't understand what would happen. They thought their child was going to be fine, but I explained to them that if they unplugged their child from the ventilator, which they did agree to, he may live or die. They didn't understand that their child could die. They thought their child would be ok. That's why they agreed to it. So, I explained it to them that if they unplugged their child, their child could die. And they said, 'No!'. The doctor said their child was going to die anyways. That kid is 5 years old now.

~ Participant, Windigo Tribal Council

Language barriers also jeopardize the well-being of patient, and their loved ones.

In summary, the impact of non-medical escort approvals for travel coverage by NIHB, as well as non-medical escort selection, upon the patient and medical transportation services include:

- **Patients fending for themselves when traveling without a non-medical escort**
- **Patients fending for themselves when a non-medical escort abandons their responsibility**
- **Language barriers challenge patients/escorts ability to communicate with medical professionals; understand diagnosis, prescription instruction and doctor's orders; follow-up for appointments are miscommunicated**
- **Unpaid, untrained non-medical escorts do not have the skills or knowledge required to provide adequate health support**

3.3 Interprovincial Services

Patients travelling to Manitoba for medical services experience similar challenges patients face in Ontario. These difficulties begin when arriving at the Winnipeg airport where the patient must contact Manitoba Referrals to arrange pick-up. Participants reported that patients wait for "hours and hours".

Once collected by a taxi service or medical transportation, the challenges continue owing to language barriers. Participants expressed that navigating around the city, accessing accommodations, and engaging with medical professionals are difficult due to the unavailability of translation services.

Furthermore, filling prescriptions in Manitoba becomes a hassle once back in Ontario. NIHB, even though a national policy, often inconsistently interprets its own policy province to province.

> ***When patients are sent to Winnipeg, there are a lot of challenges. Using cabs, hotels without translation services is difficult. And even with the prescriptions - it's hard to transfer province to province.***
>
> ***~ Engagement Session Participant, Matawa***

Accommodation issues are a matter of concern where, as expressed above, locations and lodgings may be experienced by patients and medical escorts as unsafe and undesirable. Participants disclosed that patients in Manitoba are expedited out of their accommodation arrangement before it may be advisable to travel after surgeries or medical treatments.

We had to check out.

I was escorting a young guy. He just finished having surgery in Winnipeg. Medical services in Manitoba told us we had to check out of the hotel. We didn't have any information on our travel. The boy just finished having knee surgery. The hotel called us and said Manitoba medical services said we had to check out. He just had the surgery that morning.

~Engagement Session Participant, Windigo

In summary, the impact of inter-provincial travel inefficiencies upon the patient and medical transportation services include:

- **Pick-ups are not prescheduled upon arrival in Winnipeg. Participants reported that patients have spent up to three hours waiting for transportation to accommodation or medical appointment**
- **Medical appointments are missed owing to ground pick-up delays. Patients are left footing the bill associated with missed appointment charges**
- **Difficulty filling Ontario prescriptions written in Manitoba results in delays in treatment or pain management**

3.4 Discrimination and Non-Equitable Services

It was noted of participants that the quality and access to care, as well as engagement with NIHB and medical providers, were discriminatory and non-equitable. Participants expressed they have experienced colonial mentality and paternalistic attitudes as prevalent within the government sector. Participants shared that enduring stereotypes becomes a routine part of the medical process.

I remember going to emergency one time. The first question they asked me – 'have you been drinking?'"

~ Engagement Session Participant, Independent First Nation Alliance

Participants have observed communities that are not First Nations, are able to access medical professionals, such as nurses, to travel with patients during emergency situations but First Nations communities cannot.

Would that happen on a reserve?

My daughter checked into the hospital in a non-Indigenous community. They thought she had bacterial meningitis. They medevaced her out right away with her own nurse who never left her side. Would that happen on a reserve? I don't think so.

~ Engagement Session Participant, Independent First Nation Alliance

Even life-threatening medical situations occurring in First Nations communities seem not to be appointed urgency in some situations.

For medical situations which are non-life threatening -like a broken arm, or chronic conditions-like kidney disease, services such as X-ray or dialysis are not available in First Nations communities, and therefore travel to non-Indigenous communities is required for medical service. Only one community of thirty-three communities has a local pharmacy. This means many community members can be without appropriate medication until their pharmaceutical delivery is received by the nursing station –sometimes weeks after prescribing.

When medical arrangements are required outside of the Sioux Lookout First Nation Health Authority, individuals are forced to engage an NIHB clerical staff, and left with no option but to disclose personal medical information in order to justify their medical travel. Privacy is not an option provided to people living in First Nation communities in these situations.

Advice from the medical community regarding issues like diabetes or obesity, are presented as lifestyle changes and are unrealistic for First Nations living in remote communities. Dietary medical advice to increase consumption of fresh produce, as an example, is difficult to attain in communities where, when produce is available, the expense is great.

One participant emphasized their communities struggle with managing addiction and preventing the loss of life. Police services, as well as health services, are underfunded, under-trained and under-resourced in coping with the rapidly evolving landscape of the drug crisis.

Underpinning all of this is the discrepancy between NIHB travel rates and the government's Treasury Board travel rates. Participants shared that NIHB daily meal

“I witnessed a situation with a young child. He had a ruptured appendix. He was in pain. They didn’t medevac him out. They put him on a regular flight –and the pressure of the flight on his body hurt him so much. The next day he was in so much pain when he got to Sioux Lookout. When they got to the hospital he didn’t even get admitted right away. He had to wait his turn”

~ Participant, Independent First Nation Alliance

Very sick & in pain, but he still had to wait his turn.

allowance was grossly insignificant to Treasury Board Rates. Participants offered that they were allotted $13 dollars per day for meals, "barely enough for coffee", in comparison to the Treasury Board's daily meal allotment with incidentals that at the time of this report, totaled $107.60 –per day.

The disparity between NIHB mileage rates and Treasury Board mileage rates was just as extreme.

It's a double standard.

I question the mileage rate. It's a double standard. If I travel as a patient, I get 21 cents a kilometer. If I'm travelling for a meeting with the government, I get 58 cents. Why? I'm still the same person.

~ Engagement Session Participant, Shibogama

Over the course of community engagement sessions participants frequently expressed that patients and non-medical escorts experience unsafe lodgings in unsafe locations. This is also a direct influence of the significantly lower accommodation rates provided to First Nations People in comparison to the Treasury Board accommodation rates.

In summary, the impact of discriminatory and non-equitable services upon the patient and medical transportation services include:

- **Perpetuation of generations of colonial mentality and paternalistic attitudes towards First Nations People**
- **Inadequate, undignified health care that jeopardizes the health and life of First Nations People**
- **Patients grossly undercompensated for mileage, meal and accommodation rates**

4.0 Additional Findings

Participants generated robust conversations often spilling beyond the area of focus- the 3 SLFNHA Chiefs Resolutions at hand. These overflows of information, though not directly related to the resolutions, are the collateral issues owing to a paternalistic healthcare service model. It is hoped by addressing the key findings through a set of recommendations developed by participants, that opportunities to influence broad sweeping improvements to First Nation healthcare will be inevitable. (Appendix 4)

5.0 Non-Medical Escort Recommendation Table

On August 13th and 14th, 2019, thirteen delegates that participated in the combined community engagement sessions, returned to examine the preliminary findings and elaborate upon the most critical recommendations evolved from the summer discussions. The recommendations were chosen based on their relevancy to the three SLFNHA Chief's resolutions, and upon the measure of the most effective means of influencing medical transportation and service transformation for the First Nations.

The Recommendation Table also identified infrastructure and capacity needs in their communities, organizations and Tribal Councils to ensure that actions were identified to eliminate and avoid such areas of concern.

I think we need to takeover medical transportation because it is our people that are accessing the health care. We know what people need and want. That's where we get the complaints from, from our People. The system is failing them. We are scared to takeover and move forward; it is a big responsibility. We are afraid of failing.

~Community Engagement Session Participant, Sandy Lake

The sentiments of the above participant were shared among the Recommendation Table members who identified that communities lack human resources, and that there is a shortage of educated, knowledgeable and trained staff serving in entry level positions and high-level positions. Though it may be uncomfortable exposing areas in need of improvement, it is an important planning practice that contributes to eliminating internal weaknesses and creating strong recommendations that are possible. In this spirit, the Recommendation Table formulated responsive and achievable recommendations, augmented with clear direction to mitigate infrastructure and capacity needs.

SIOUX LOOKOUT FIRST NATION HEALTH AUTHORITY RECOMMENDATIONS

We never had input in the development of the policies that non-insured follow. And we are going to continue to have these recycling of events and mistakes happening to our patients and how they are treated in the healthcare system. As Chief Keewaykapow said, we need to take control of our OWN Health System. We need to take control and develop our own policies and procedures that can reflect our community situation and conditions. That's what has to happen.

~ CEO, Tribal Council Engagement Session Participant

Community Engagement Session Recommendations

Recommendation #1: FIRST NATION RUN MEDICAL TRANSPORTATION SYSTEM

Resolution(s):

Resolution #15-27 Enhancement of Non-Medical Escort Services
Resolution #18-17 Non-Medical Escort Service Program

Action: This recommendation calls for establishing a Chief's Negotiation Table to strategize the procurement of Medical Transportation as a First Nation run health system providing a medical transportation model that is responsive and equitable.

Description of Activity	Target Group	Responsible Entity(s)	Required Infrastructure/ Capacity	Timeline	Measurable Outcome
That the Chiefs of the SLFNHA First Nation Health Authority establish a Chief's Negotiation Table, composed of leadership and administration, to strategize and negotiate the take-over of the Medical Transportation for the SLFNHA catchment area.	All Treaty People who live or, regardless of Ontario residency, are present within the SLFNHA catchment area and require medical transportation services.	Chief's Negotiation Table (Tribal Council/ Independent Bands, Elder) Indigenous Services Canada MP or Lobbyist SLFNHA (Admin, Board, Chief's Committee on Health) Tribal Council	Resolution to take over Medical Transportation. SLFNHA researches necessary information so that the Chief Negotiation Table is effective. Assess readiness of Tribal Councils to support communities to undertake medical transportation.	September 2019 -September 30, 2019 October 1, 2019-March 31, 2020 April 1, 2020-March 31, 2021	Work to procure Medical Transportation begins. Development of research tools to acquire relevant community information re: medical health issues, medical travel. Provision of preliminary data and necessary information to the Chief Negotiation Table to strategize and negotiate medical transportation takeover. Training developed and mobilized as required.

			Assess readiness of community to undertake medical transportation (skills, expertise and training requirements).	Ongoing	Other relevant entities are informed.
			Tribal Council monitors SLFNHA's medical transportation transfer activities.	October 1, 2019-October 31, 2019	Treaty People accessing medical travel receive equal accommodation, mileage/travel and meal rates as the Treasury Board rates, so that the safety and security of medical travellers is assured whether in the community or out of the community.
			Review of medical transportation as a guideline to provide policy and procedures developed by the Chief's Negotiation Table.	October 1, 2019 – December 31, 2019	Negotiations team forms.
				January 2020-March 31, 2021	Negotiation begin and conclude.
				April 1, 2021	The Chief's Negotiation Table will utilize NIHB Medical Transportation Policy Framework as a guide to provide medical transportation benefits and will amend to meet First Nation patient needs.
			Development of Medical Transportation Design Team.		A plan to implement the takeover of Medical Transportation is developed.
			Development of a Service Delivery Team.		Community needs are validated.

			Development of a Human Resource strategy to ensure the successful takeover of the medical services program, and to build community capacity (education and training).		Educated and trained staff to implement and administer a Community Based Medical Transportation Framework. First Nation Inuit Health Branch medical transportation service in the SLFNHA region is dismantled.

Recommendation #2: MEDICAL ESCORT PROGRAM

Resolution(s):

Resolution #15-27 Enhancement of Non-Medical Escort Services
Resolution #16-08 Guidelines for Escort Selection
Resolution #18-17 Non-Medical Escort Service Program

Action: This recommendation calls for supporting the development of professionally trained and educated First Nations members, fluent in an Ancestral language and English, to serve in paid positions as Medical Escorts.

Description of Activity	Target Group	Responsible Entity(s)	Required Infrastructure/ Capacity	Timeline	Measurable Outcome
Medical escorts will be professionally trained in areas of medical terminology, interventions (naloxone, CPR etc.) and how to properly support individual health needs of patients.	First Nation members seeking employment in healthcare.	1. Tribal Councils, Community Health Directors, Oshki-Wenjack, Area Management Boards, Post-secondary institutions, SLFNHA and Working Group.	1. Development of a certified 6-month Medical Escort Worker program that includes, but not limited to: curriculum modules with focus on mental health; assistive devices; medication administration; lift techniques; safety interventions; non-violent crisis intervention; and	March 31, 2020-ongoing June 30, 2020-ongoing	Negotiate funding with NIHB to fund program to end of the fiscal year. Development of a certified program to professionally employ Medical Escort Workers.

Medical escorts will be fluent in patient language and English language. Medical escorts will be designated as paid professionally trained medical personnel and required to undergo criminal records check and vulnerable persons check. Furthermore, a suitable and professional term to replace the title of 'Medical Escort' be adopted .			trauma informed approaches.	August 2020-ongoing January 2021-ongoing August 2020-ongoing	Enrollment of students in Medical Escort Worker program. Patients are supported by Medical escort Workers who are trained in healthcare and fluent with language. Patients will be able to access Medical Escorts 24-hours when required. Professional and culturally appropriate support network for First Nation patients is increased. Medical Care Worker students have a designated classroom for program lessons. Medical Care Worker students access hands on training opportunities in a professional healthcare setting. Accreditation of Medical Escort Program. Name change from 'Escort' to 'Patient Support Worker' or 'Omaajii-kanawenjike', which means 'the one who travels with clients'. To be determined by responsible entities.

Recommendation #3: ONTARIO PRESENCE IN MANITOBA

Resolution(s):

Resolution #15-27 Enhancement of Non-Medical Escort Services

Action: This recommendation calls for the Chiefs to direct Sioux Lookout First Nation Health Authority to form a committee to explore a presence in Manitoba.

Description of Activity	Target Group	Responsible Entity(s)	Required Infrastructure/ Capacity	Timeline	Measurable Outcome
That the Chiefs of the Sioux Lookout First Nation Health Authority direct SLFNHA to establish in Winnipeg; adequate and dignified hostels; a culturally knowledgeable liaison; and adequate answering service including translation and support team. The Chiefs will authorize the SLFNHA Board regarding the procurement of a Hub in Manitoba.	Treaty People of the SLFNHA catchment area attending Manitoba for health services.	SLFNHA Working Group (Tribal Council, CAO, Director, Member of Chief's Negotiation Table) ISC (Ontario and Manitoba) Manitoba Referral	1. Research potential opportunities for a SLFNHA Hub in Manitoba. 2. Data from Referral Clerks (how many patients referred to Manitoba).	February 28, 2020 March 31, 2020	Option analysis developed for possible Hub in Manitoba. Infrastructure and capacity needs are identified. SLFNHA develops a Hub Implementation Strategy.

Recommendation #4: HUMAN RIGHTS COMPLAINT CONTINGENCY

Action: This recommendation calls for the Chiefs of the Sioux Lookout First Nation Health Authority to bring an end to discriminatory and non-equitable services.

That the Chiefs of Sioux Lookout First Nation Health Authority in the event of the Government of Canada's refusal to accept the Chief's Negotiation Table's mandate, that the Sioux Lookout First Nation Health Authority Chiefs file a Human Rights Complaint against the Government of Canada.

6.0 Conclusion

During this summer of 2019, sixty-seven people comprised of five Tribal Councils and two Independent Bands gathered to address the most pressing areas of concern as related to NIHB medical transportation services provided to thirty-three First Nation communities in the Sioux Lookout First Nation Health Authority catchment.

The information brought forward over a collective nine-day time period, and two additional days for recommendations, was abundant. Though five separate sessions were held for each distinct Tribal Council, it was discovered that Tribal Councils shared many more commonalities than differences when addressing deficits and solutions with existing medical transportation services. This is perhaps the finding that will be most critical in advancing a First Nation run medical transportation service. First Nations must work together as one People.

Conversations unveiled that the First Nations expect:

- An improved medical transportation system, including inter-provincial medical travel, which is fair and equitable. This includes medical travel rates that are in line with Treasury Board rates or greater when geographical considerations are exceptional; safe and dignified accommodations; improved reliable ground and air travel; improved notification and communication processes; and reliable access to language translation services

- Professional Medical escort services where Medical escorts are trained, screened, paid and fluent in required languages

- A determined leadership that will support and champion the negotiation of the medical transportation take over, and if unsuccessful, will strike a Human Rights Complaint against the Government of Canada for the sake of the health and dignity of their First Nations

Advancing the recommendations set forth by the Recommendation Table requires a hard look at community capacity –or the skills and expertise within a community, which is necessary to advance medical transportation services for the First Nations. Simply put, it is critical that education and professional training in the areas of medical services – as basic as First Aid or CPR; oversight and management of staff; trauma informed practice; self-advocacy -Treaty rights and the Indian Act; policy interpretation; and interpersonal skills are offered to people employed in entry level and high level positions that influence medical/ health outcomes for the First Nations.

Often times when transfer or program devolution happens to First Nations, the government provides the money for the program, limited training and no money for ongoing development. Furthermore, the transferred program does not contain equivalent salary levels as would be found in a government administered operation. This means that communities are unable to provide competitive salaries to attract and hire qualified professionals to administer programs. This places the transferred program at risk and sets First Nations up for failure.

There are many entry-level to high-level health related positions, clerks to Health Directors, and including leadership, filled by people who do not have a proper educated background or experience in their field of employment. This not only diminishes the quality of medical services provided to the First Nations, but also prevents productive and informed conversations when people gather for the purposes of improving health and medical service outcomes for First Nations. This became an apparent concern over the course of this information gathering process between May and August 2019.

Over a span of just three months, sixty-seven people travelled from twenty of the thirty-three SLFNHA communities. Other communities had hoped to send representatives, but fires, suicides and deaths kept people home to care for their loved ones and neighbours. One woman travelled despite the death of an Elder in her small community. She came with a message- the Elder's death could have been preventable if the First Nations had a better medical transportation and service in order.

The same woman told the Recommendation Table about the efforts her community was making to take charge of the ground medical transportation system. It was working. And after hearing of the challenges nearby communities are experiencing, she said, "We can help. We can help our neighbours with the ground transportation. We want to be good neighbours."

Artificial boundaries imposed by government constructs, such as Treaties, Provincial Territorial Organizations and

Tribal Councils, have nurtured division among the First Nations.

An unintentional finding of the summer gatherings illuminated that community members of different Tribal Councils and Independent Bands have more in common with one another than not.

All People, regardless of government constructs, expressed that NIHB medical transportation services are failing their People; and that the existing NIHB services are contributing to poor health outcomes for the First Nations.

All People, regardless of government constructs, want to improve health outcomes for the First Nations.

When the Recommendation Group gathered in August 2019, it was spoken by one participant that the willingness, or unwillingness, of Tribal Councils and Independent Bands to set aside differences, and to join strengths and determination together would be the defining factor in achieving the recommendations outlined in this report.

That it would be possible to dissolve invisible boundaries, acknowledge one another's suffering, and recover cultural guidance, and expert oversight, to ensure the physical and mental well-being of *All Treaty People* is the transformation. This is the capacity that already exists within the First Nations. Perhaps the greatest strength identified of the First Nations by the Recommendation Table was – "we take care of one another".

Mothers should no longer have to spend days cradling their agonized children to travel for medical interventions. Parents should no longer make uninformed decisions about the life of their child. First Nations people fighting for their life should no longer be forced to travel unwell or recently cut and stitched from surgery. Elders should no longer have to check out and in to accommodations between appointments because of an NIHB policy requirement. There should never be indignity, needless suffering, and preventable death among our First Nations.

The next step is courage. Courage to lay aside superficial lines of division; courage to honestly acknowledge what can be done better; and the courage to conquer an inadequate and oppressive health care system that jeopardizes the health and life of All Treaty People.

All of it has been written here.

Appendices

Sioux Lookout
First Nations
Health Authority

SIOUX LOOKOUT FIRST NATIONS HEALTH AUTHORITY

Resolution #15-27

ENHANCEMENT OF MEDICAL ESCORT SERVICES

WHEREAS, the Chiefs in Assembly are concerned about Elders and other vulnerable community members being denied a medical escort and/or not receiving the quality of escort services they require; and

WHEREAS, Sioux Lookout First Nations Health Authority (SLFNHA) has reported incidents at the Jeremiah McKay Kabayshewekamik (hostel) involving escorts and clients who have caused disturbances at the facility such as violent behaviour or drug & alcohol abuse; and

WHEREAS, incidences involving escorts often impact the care that clients receive and can also delay travel back to the community for both client and escort; and

WHEREAS, SLFNHA has presented data from these incident reports to the Chiefs in Assembly and have asked for guidance on how to reduce incidents and improve client care for patients coming to the hostel;

THEREFORE BE IT RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to explore options to enhance escort services by advocating for clients to receive escorts when needed and to facilitate the process of increasing communication between Tribal Council Health Directors, Community Health Directors, and Community Health Clinics for the purpose of improving the quality of escort services.

BE IT FURTHER RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to establish a working group to explore options and solutions for improving the availability and the quality of escort services and to work with the Tribal Councils Health Directors and to design an improved escort system.

BE IT FINALLY RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to report to the Chiefs on the information and feedback received from the working group and Health Directors regarding the proposed escort system.

Dated this 17th day of September 2015 in Lac Seul First Nation, Ontario.

Moved by: _____
Chief Connie Gray-Mckay, Mishkeegogamang First Nation

Seconded by: _____
Kelvin Moonias, proxy, Neskantaga First Nation

Decision: **CARRIED**

Signature of Meeting Chair: _____
Wally McKay, Meeting Chair

Sioux Lookout
First Nations
Health Authority

SIOUX LOOKOUT FIRST NATIONS HEALTH AUTHORITY

Resolution #16-08

GUIDELINES FOR ESCORT SELECTION

WHEREAS, incidents at the Jeremiah McKay Kabayshewekamik Hostel occur which must be managed by staff and, at times, police services; and

WHEREAS, in 2015-2016 approximately 32% of incidents involved escorts that had been selected to accompany patients to Sioux Lookout for medical services; and

WHEREAS, Health Canada's Medical Transportation Policy Framework outlines criteria that should be considered when selecting an escort; and

WHEREAS, community members may not be fully aware of these criteria and they may not meet the needs of communities, or address concerns that occur at the Jeremiah McKay Kabayshewekamik Hostel; and

WHEREAS, Resolution #15-27 Enhancement of Medical Escort Services directed Sioux Lookout First Nations Health Authority (SLFNHA) to establish a working group to explore options and solutions for improving the availability and quality of escort services, but it did not clearly identify the need for regionally established escort guidelines; and

WHEREAS, Health Canada is currently working on improving escort criteria, but the Chiefs in Assembly recognize the importance of selection guidelines that are specific to our region and developed in a collaborative way;

THEREFORE BE IT RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to develop and conduct a community engagement process involving communities, Tribal Councils and other partners to develop regional guidelines for escort selection for wherever patients are travelling.

BE IT FURTHER RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to report these draft guidelines for ratification, and the process for implementation, back to the Chiefs Committee on Health and at the next SLFNHA Chiefs meeting.

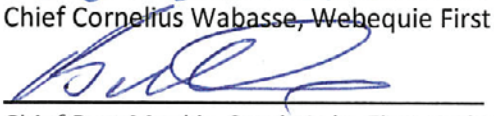
BE IT FURTHER RESOLVED THAT, once the criteria have been established and ratified by the Chiefs, that the political leadership will engage with Health Canada to respect the establishment of these criteria.

BE IT FINALLY RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to, once established, promote these Escort Guidelines within communities to help ensure a safe environment at the Jeremiah McKay Kabayshewekamik Hostel.

Dated this 15th day in September 2016 in Lac Seul First Nation, Ontario.

Moved by: 

Chief Cornelius Wabasse, Webequie First Nation

Seconded by: 

Chief Bart Meekis, Sandy Lake First Nation

Decision: **CARRIED**

Signature of Meeting Chair: 

Wally McKay, Meeting Chair

Sioux Lookout
First Nations
Health Authority

SIOUX LOOKOUT FIRST NATIONS HEALTH AUTHORITY

Resolution #18-17

MEDICAL ESCORT SERVICE PROGRAM

WHEREAS, the Chiefs in Assembly are concerned about Elders and other community members not having adequate and immediate medical escort services when needed; and

WHEREAS, Resolution #16-08 Guideline for Escort Selection directed SLFNHA to develop and conduct a community engagement process involving Tribal Councils, communities and other partners to develop regional guidelines for medical escort services programs for our Elders/patients who are travelling. This will reduce the stress of navigating services as a result of not having medical escorts; and

WHEREAS, Resolution #15-27 Enhancement of Medical Escort Services directed the Sioux Lookout First Nations Health Authority (SLFNHA) to establish a working group to explore options and solutions to design an improved medical escort services system.

THEREFORE BE IT RESOLVED THAT, the Chiefs in Assembly direct the Sioux Lookout First Nations Health Authority (SLFNHA) to establish a Working Group with representation from Tribal Councils, communities, and partners to explore options for a medical escort service program.

BE IT FURTHER RESOLVED THAT, the medical escort service program should incorporate best practices, First Nations values, and a component to recruit community members that are designated and trained as medical escorts.

BE IT FURTHER RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to advocate for funding and implement the medical escort services program in partnership with Tribal Councils and communities.

BE IT FINALLY RESOLVED THAT, the Chiefs in Assembly direct SLFNHA to report to the Chiefs in Assembly on their progress at the 2019 SLFNHA Annual General Meeting.

Dated this 13th day of September 2018 in Lac Seul First Nation, Ontario.

Moved by: _____
Ernest Quequish, proxy, North Caribou Lake First Nation

Seconded by: _____
Abigail Wesley, proxy, Cat Lake First Nation

Decision: **CARRIED**

Signature of Meeting Chair: _____
Wally McKay, Meeting Chair

Medical Facilities

Participants expressed that many concerns regarding non-medical escort services, travel services, counselling services and quality of care could be addressed through the development of medical infrastructure and capacity in First Nation communities. Further noted, was that years of boil water advisories have prevented the opportunity to receive kidney dialysis treatments in First Nation communities. The average cycle of treatment is four sessions, three times a week. This means many people must move away from their communities to receive kidney dialysis.

Counselling and Mental Health

Where opportunities for people struggling to overcome addiction often require an immediate response, for those living in First Nation communities their access to responsive treatment services is challenged: by the nature of not enough insured services for treatment; exacerbated by a requirement to travel; and have travel approved by an NIHB clerical staff (CR level). Further, owing to limited counselling services; services offered in community; and a varied list of mental health professionals approved for service, accessing appropriate support to serve the needs of Indian Residential School Survivors is woefully lacking.

Access to Traditional Food

When travelling outside of community for medical appointments, patients and escorts have experienced challenges in accessing enough food during meals. Participants expressed that often times, people are hungry over the duration of their medical travel and this is especially problematic when medical stays in urban centres are extended visits or longer-term stays. Participants also expressed that when accessing food, that they may have the option to choose traditional foods over westernized options.

SLFNHA has requested of Meno Ya Win that one traditional meal be served each week but a challenge exists in acquiring donations in the form of traditional foods. Participants stated that donation forms are too long and require specific information from individuals wanting to donate traditional foods, and from hunters who may desire to donate moose meat, partridge or rabbits as examples. These barriers are enforced by regulatory bodies, not SLFNHA.

Preventative Healthcare

Participant conversations sometimes diverted towards a focus on preventative healthcare. Early screenings for communicable or chronic conditions were pointed out as areas of deficit in First Nation communities. As well, providing educational interventions regarding healthy diets to negate obesity and diabetes rates was raised by a participant. On the matter of healthy diets, and as noted under 'Discriminatory and Non-Equitable Services', several participants expressed frustration towards health professionals who advised more fruits and vegetables on the plate. A suggestion, that in theory, sounded great to many participants but for the lack of access to fresh produce, and to available fresh produce that is affordable.

Unregistered Children

The issue of unregistered births was brought forward during the community engagement sessions. The number of unregistered births within the SLFNHA area is unknown. Unregistered births become a challenge when a child reaches 12 months and older. The issue manifests itself when the child requires medical services under NIHB. Unregistered children are normally denied NIHB financial support.

In researching unregistered births, the **Ontario Long Form Birth Certificate** is required by Ontario to register a birth as a two-step process:

1) Statement of Live Birth Form completed by parents and;
2) A Notice of Live Birth Form completed by qualified medical staff.

This two-step process is **free** when it's done online within 30 days after a child is born and as an exception, up to 12 months of age.

When the Long Form is sent through the mail, a copy of the birth certificate is **$35.00**. After 12 months, the cost to register is **$50.00.**

To register a child under the Indigenous Services Canada (ISC) process, the registration is also **free**. If registering at an Indigenous Affairs Regional Office, both parents can do so. The **Ontario Long Form Birth Certificate** is required with one piece of identification. In First Nations communities, where membership registration is administered locally, the application forms can be submitted to ISC for formal registration.

It is possible for the local health authorities and the First Nations membership clerks to collaborate in assisting parents to register children. This notion would require further exploration.

Looking ahead to an improved healthcare system.

Acknowledgments

To Marie Lands, Naomi Hoppe-Mackechnie and Darryl Quedent, your ongoing guidance, sharing of knowledge and fine eye for detail has been a great benefit to the community engagement sessions and the completion of this final report. Thank you.

And to the Community Engagement Session Participants, who came with passion and a willingness to bear down on the hard issues to inspire health transformation for the First Nations represented in this report, we are very grateful. Your stories and expertise are the strength of this report!

Megwetch to all!

Go Forward With Courage

"When you are in doubt, be still, and wait; when doubt no longer exists for you, then go forward with courage. So long as mists envelope you, be still; be still until the sunlight pours through and dispels the mists — as it surely will. Then act with courage".

~Ponca Chief White Eagle, 1800's -1914

Sioux Lookout First Nations Health Authority

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